

It's Time to Dive in and Structure Your Compensation Pools: Stark Law Final Rule's Impact on Physician Compensation Plans



What Group Practices Need to Know About the Stark Law Final Rule's Impact on Physician Compensation Plans, Effective Jan. 1, 2022

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In the Stark Law Final Rule (Final Rule) issued in November 2020, the Centers for Medicare & Medicaid Services (CMS) made several “clarifications” to the definition of “group practice.”

These clarifications will impact how group practices must structure their compensation methodologies for distributing profits from Designated Health Services (DHS) in order to comply with the in-office ancillary services exception to the federal Physician Self-Referral Statute (the Stark Law). Recognizing that group practices need time to modify their physician compensation methodologies for compliance, CMS delayed the changes’ effective date until Jan. 1, 2022.

So, now is the time to evaluate your practice’s physician compensation structure to ensure compliance.

Meet a Stark Exception or Swim at Your Own Risk

Physician practices primarily rely on the Stark Law’s in-office ancillary services exception to exempt their physicians’ referrals of DHS to their own practice from violating the Stark Law. Among other things, the in-office ancillary services exception requires that the physician practice qualify as a “group practice.” When the requirements of the exception are met, the group practice can take advantage of special rules that allow the group to pay its physicians a share of its “overall profits” from DHS in a way not directly related to the volume or value of referrals by the physician.

All Physicians in the Pool or At Least Five Physicians in the Pool

Prior to the Final Rule, the Stark Law defined “overall profits” to mean:

(1) the group practice’s entire profits derived from DHS or

(2) the group practice's profits derived from DHS of any component of the group practice that consists of at least five physicians.

Under the Final Rule, a group practice can still set up one compensation pool for distributing its entire profits from DHS or multiple compensation pools consisting of five or more physicians for distributing profits from DHS referred by those physicians. If a group practice has fewer than five physicians, the group can share the profits derived from the entire group's DHS (i.e., one big pool).

No Split-Pooling

However, under the provisions of the Final Rule effective Jan. 1, 2022, group practices may *not* establish different compensation pools for distributing profits from different categories of services considered DHS. This is sometimes referred to as split-pooling. For instance, practices can't have different pools for imaging, physical therapy, laboratory tests, or durable medical equipment. That means –

- **For a Small Group** – A group practice of fewer than five physicians – or a larger group practice that elects not to establish pods of five physicians for distributing profits from DHS – must aggregate the profits from *all* DHS of the entire group and then distribute those profits using a single methodology that doesn't take into account who referred the DHS. Stark compliant distribution methods include sharing the profits equally, based on shareholder percentage or some other objective approach. Effective Jan. 1, 2022, the same distribution method must be used for *all* the profit from DHS.
- **For a Large Group** – A large group practice can elect to either aggregate its profits from *all* DHS of the entire group practice as described above *or* allocate the profits from DHS among one or more components of the group consisting of at least five physicians. For example, a multispecialty group of 15 physicians composed of three divisions organized by specialty and consisting of five internal medicine physicians, five orthopedic physicians and five cardiologists could elect to aggregate the profit from all DHS referred by physicians in the division and then distribute those profits to the physicians in that division using a single Stark-compliant methodology selected by that division.

The Final Rule clarifies that within each division, the same methodology must be used for all division profits from DHS – the division can't apply different allocation methodologies based on different types of DHS. However, divisions don't all need to use the same distribution method. That means the internal medicine division can use a distribution method different from the orthopedic physicians and the cardiologists.

Not in the Pool

The Final Rule clarifies that profits from DHS that are directly attributable to a physician's participation in a value-based enterprise are not subject to these rules on distributing profit from DHS. Instead, they can be distributed directly to the physician participating in the value-based arrangement. They don't have to be included in the overall profits of the group or of any pod of five or more physicians within the group practice.

The Final Rule also recognizes that the Stark Law applies only to specific types of services included in the definition of DHS that are payable in part or whole by Medicare. So, while many group practices find it simpler to treat all profits from ancillary services in the same manner, groups are free to allocate profits from ancillary services in any manner they wish if they are not covered by Medicare or are not of a type included in the definition of DHS. They are still subject to other laws that might apply.

No Time for a Pool Party

To avoid any period of noncompliance, group practices should use this time to review how they are currently handling profit from DHS and then come up with a fully compliant approach. This may require modification of physician contracts, compensation policies, and other documentation.

For More Alerts

As mentioned in our Health Law Group's prior client alerts, CMS adopted the Final Rule and the Office of Inspector General (OIG) for the Department of Health and Human Services adopted companion regulations as part of their *Health and Human Services' Regulatory Sprint to Coordinated Care* initiative to remove regulatory barriers that inhibit innovative arrangements for coordinating care.

Since their adoption on Nov. 20, 2020, we have been breaking down the more than 1,600 pages of regulatory changes relating to the Stark Law and Anti-Kickback Statute through a series of alerts. To see those alerts and check for new alerts, [click here](#).

This article is general in nature and does not constitute legal advice.

Readers with legal questions should consult the author, Lori Beam (lbeam@sb-kc.com) or any other shareholders in Seigfreid Bingham's Health Law Group, including Mark Thompson, Joseph Hiersteiner, Mark Gilgus, John Neyens, Heath Hoobing and John Fuchs, or your regular contact at Seigfreid Bingham at 816-421-4460.