

Beware of Stark Law ‘self-dealing’ Savvy nursing facility administrators should seek legal and valuation assistance to assure compliance

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Skilled nursing facilities that pay physicians for medical director services may be at risk for violating Section 1877 of the Social Security Act; generally referred to as the “Stark Law.” Hospitals and other healthcare entities, as well as physicians and other providers, have been concerned about all aspects of this law since it was first enacted, with limited scope, in 1989 and subsequently revised and expanded in Stark II and Stark III. The scope of the Stark Law is broad enough to govern many financial relationships between healthcare entities and physicians, but is especially applicable to skilled nursing facilities.

Simply put, the Stark Law prohibits Medicare patient referrals from physicians who have a financial relationship with a nursing home for “designated health services,” as defined in the law. In the same way that most federal regulations affecting skilled nursing facilities rely on detailed definitions, so does the interpretation of the Stark Law. The term “referrals” includes common skilled nursing home physician activities such as establishing or approving plans of care, certifying and recertifying care needs, and is further interpreted to mean any physician orders for services paid by Medicare Part B and medications under Medicare Part D. Designated health services found in skilled nursing facilities encompass: clinical laboratory, occupational therapy, physical therapy, speech therapy, radiology, medications, and parenteral/enteral nutrients, equipment, and supplies. “Financial relationships,” as defined in the law, are interpreted as either (1) ownership by physician and/or physician's family of the healthcare entity and/or the designated health service, or (2) an arrangement whereby the skilled nursing facility compensates a physician for services, unless that compensation meets specific criteria.

Financial relationship



Most skilled nursing facilities contract with and pay one or more physicians for medical directorship, administrative consulting duties, and/or direct medical services. As federal regulations and interpretive guidelines for skilled nursing facilities have become more specific and as managed care contractors more closely review utilization, some skilled nursing facilities have contracted with medical directors for assistance with specific product lines or service areas. Thus, a skilled nursing facility might be receiving administrative physician services for areas such as quality assurance, utilization review, physiatry, orthopedics, psychiatry, pulmonology, neurology, and cardiology, in addition to traditional skilled nursing facility medical directorships. Since most skilled nursing facilities serve Medicare Part B and D recipients, and because most physicians performing administrative/or directorship (paid) duties also order or certify designated

health services at the contracted skilled nursing facility, the only variable the skilled nursing facility can direct to assure compliance with the Stark Law is the financial relationship with that physician.

The Stark Law allows skilled nursing facilities to structure nonclinical arrangements with physicians in a way that provides exceptions, or “safe harbors,” which may provide protection to the nursing home and the physician for the financial relationship. While there are many exceptions available as described in the Stark Law, the exception that applies most commonly to skilled nursing facilities is the “personal services exemption.” To meet the requirements of the personal services exemption, and to qualify for protection under a safe harbor, the nursing home and the physician must satisfy several key conditions.

These include, at a minimum:

- the relationship between the skilled nursing facility and the physician must be covered by a written, signed agreement covering at least one year of service.
- the services provided by the physician must be specifically identified.
- the services must be reasonable and necessary for legitimate business purposes.
- the amount paid must be set in advance and have no direct or indirect relationship to volume or referrals by the physician.
- the agreement must be commercially reasonable.
- the agreement must not involve counseling or promotion of any business arrangement or other activity that violates any state or federal law; and
- the amount paid must be consistent with fair market value (FMV).

While it is common for skilled nursing facilities to use an experienced healthcare attorney to assist with drafting agreements to address most of these issues, it becomes challenging for a skilled nursing facility operator to determine FMV. FMV is innocuously defined in the regulations as “the value in arm’s length transactions, consistent with the general market value.” But reading through the regulations provides a more detailed definition for general market value as “the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the services agreement.” The definition continues for the interested reader, but the conclusion is that if the parties want to “fit” into a safe harbor, and have the presumption of compliance, the FMV may not be easily identifiable and most importantly, *cannot be arbitrarily decided by the parties involved*. There must be a reasonable basis for deciding the fair market value, and more weight will be given to the determination if the value is derived from established methodologies or practices.

Two methods

From 2004 until December 7, 2007, two methods for determining FMV, commonly called the “safe harbor rates,” were noted. Those safe harbor methods relied on either using averaged results from approved surveys or by averaging local emergency room physician hourly pay rates. Last year, the definition of fair market value was changed. Effective December 7, 2007, the definition no longer describes or refers to those safe harbor methods for determining fair market value. Without specific guidance from the Stark Law, the skilled nursing facility operator must now consider how best to determine FMV. Many skilled nursing facility operators, interested in fitting into a safe harbor, will conclude that determining the FMV of physician administrative services is best performed by an experienced, confidential, impartial party outside their organization.

An FMV assessment, to be compliant with Stark, must consider all of the factors required in the personal services exemption. Because the Stark Law definition for physicians includes podiatrists, dentists, optometrists and chiropractors, the skilled nursing facility operator should carefully review all arrangements between the facility and its physicians to determine whether the agreements are in compliance. Key questions to ask include:

- Is there a written agreement?
- Does the agreement specify the physician's duties in detail?
- How do the duties performed by one medical director or administrative provider enhance, overlap, or conflict with duties by another, at the same facility and are the duties necessary?
- Do the hours of service permitted under the agreement seem reasonable for the facility and its resident/patient load?
- How was the payment rate selected?
- How does the facility document the activities of the physician to determine payment under the agreement?
- What resources were used when determining the market rate?
- Does the documentation support how the fair market value was made?

Just as there are potential penalties from violating regulations which govern resident care and facility operations, there are also penalties for violating the Stark Law. Those penalties include civil fines and penalties of \$15,000 per improper referral plus three times the amount of the claim and up to \$100,000 for circumvention schemes and exclusion from Medicare, Medicaid, and other federal health care programs. Intentions don't affect the enforcement of the Stark Law, and in fact, raise the possibility of violations of other laws, including the False Claims Act and the Anti-Kickback Law.

The risks for noncompliance with Stark are clearly significant. The prudent skilled nursing facility operator should consider how the Stark Law affects his or her business and should seek appropriate professional legal and valuation assistance to (1) comply with the law, (2) take advantage of the protections available under the Stark safe-harbors and, (3) to have a fair and reasonable financial relationship with the physician.

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