

Stark III Changes to Recruitment Rules

BY GINA SHAW

You're a neurologist, or part of a group, considering hiring a new partner for your practice. You're probably thinking about issues like prior experience, patient base, specialty training, and rapport with partners. But you may not be thinking about two words that can have an important effect on physician recruitment: Stark III.

The Stark law — or physician self-referral law — prohibits physicians from referring Medicare patients for certain health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship — unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a DHS furnished as a result of a prohibited referral



Phased in incrementally, the latest updates to the law, in effect since December 2007, pertain to physician recruitment. The new regulations are extensive and complex, and can lead to major penalties if ignored.

Stark III makes some major modifications — mostly positive, from the re-

cruiting practice's point of view — to the rules regarding physician recruitment.

"When Stark first came out, there wasn't any ability for a hospital to work with a group to provide recruitment benefits that would entice a physician to relocate. That situation changed in later iterations. Now, the recruitment exception covers remuneration paid by a hospital to recruit a physician to the area," said Albert Shay, a partner in the firm of Sonnenschein, Nath and Rosenthal, which represents hospitals, single and multispecialty physician groups, and other health-care providers.

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ALBERT SHAY: "Income guarantees ... have been used for many years to compensate for the expectation that for several months after a move, a doctor's full-income potential won't be realized. Stark III clarifies how that income guarantee may be structured..."

The Drachmans

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the way of scientific understanding, and less in terms of treatment. What has changed dramatically for the better is the ability to relate science to the clinical features, and especially the ability to treat so many of the formerly intractable neurological diseases. On the other hand, it goes without saying that the business of the health care and medical insurance industry, and its implications for neurology, are the features that are least attractive.

David: The therapeutic and scientific changes are the ones I like. Imaging advances are remarkable; the genetic testing capabilities are extraordinary. On the other hand, the tedium of dealing with too many different insurance companies; wasting time getting "prior authorizations" for procedures or medications; the multiplication of self-perpetuating bureaucracies; the decline in opportunities for NIH funding; and the intrusiveness of regula-

tory agencies can't be fun for anyone.

WOULD YOU DO ANYTHING DIFFERENTLY IF YOU HAD THE CHANCE?

Daniel: In the broadest sense, I have been extremely lucky in my career in neurology. I had excellent mentors: Derek Denny-Brown, MD, from whom I learned clinical skills; Milton Shy, MD, who was one of the first to recognize and teach the importance of modern science to neurology; and Alfred J. Coulombre, PhD, who taught me scientific method and laboratory techniques. Although I discovered that botulinum toxin could be injected into a single muscle and paralyze it without being lethal in rats, in the early days, we didn't patent our discoveries. I didn't apply it to humans, but it eventually led to the use of Botox in humans. A patent could have been nice!

David: One unique "error" that I made was related to my seminal observation

that cholinergic blockade mimicked the changes of aging and dementia. My only goal then was to publish the data and advance knowledge. At the time (1974), the thought of getting a use patent on the therapeutic implications of cholinergic treatments that I considered was not even on the radar.

WHAT HAVE BEEN YOUR MOST VALUABLE LESSONS LEARNED?

Daniel: The most valuable lesson is to learn what is already "known," but not necessarily be limited by it. Virtually all the research advances I have been able to make resulted from questioning accepted dogma, and moving beyond it.

David: I now realize that if it had indeed been possible to know all of neurology and neuroscience, it would have become boring in short order. The limitless expansion of knowledge about the nervous system, its normal function and its disor-

ders, and the people affected, keep it fascinating.

WHAT ADVICE WOULD YOU GIVE YOUNG NEUROLOGISTS STARTING OUT TODAY?

Daniel: For a young academic neurologist, the goal is applied — not pure basic — science. So, my advice is to find a clinical problem that is both challenging and soluble, find a mentor who is willing to help work on it, and try to ask as many questions along the way that you can!

David: For most young neurologists, there is a desire to understand more about "how the brain works" and to comprehend how the neural machinery generates thought, motion, and art. Don't lose that important goal; and never forget your responsibility to serve those who seek your help with the highest level of excellence available in the field of neurology. As Rabbi Hillel famously said (about the Golden Rule), "All the rest is commentary!" •



DR. DAVID A. DRACHMAN has been practicing neurology and teaching at the University of Massachusetts Medical School (UMass) for almost 31 years.

Before that he was at Northwestern University (where three former presidents of the Academy were his students or residents: Roger N. Rosenberg, MD; Sandra F. Olsen, MD; and Kenneth M. Viste Jr., MD). He currently serves as professor of neurology and physiology, and Chairman Emeritus (after 25 years as Chair).

David's interests include dementia, Alzheimer disease, and the neurology of aging. He continues to do basic research, see outpatients, conduct weekly Distinguished Professor Rounds with residents and students, and teach in the "Brain and Behavior" basic neuroscience course.



DR. DANIEL B. DRACHMAN has been at Johns Hopkins University School of Medicine since 1969 when Hopkins recognized neurology as a specialty and created the department. He later founded the neuromuscular unit, now officially called "The Daniel B. Drachman Neuromuscular Service."

Among many other achievements, he discovered the pathogenesis of clubfoot and arthrogryposis multiplex congenita and the role of embryonic movement in the development of joints; was the first to publish the value of prednisone therapy for Duchenne muscular dystrophy; identified the defect in myasthenia gravis (MG) and showed the role of antibodies to the acetylcholine receptor in the pathogenesis of MG. He also introduced the use of steroids and of mycophenolate (CellCept) in treating myasthenia.

He attends on the general neurology service and has innumerable myasthenic patients who come from across the globe for diagnosis and treatment.

Legal Ease

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UPDATE TO RECRUITMENT REGULATIONS

For the most part, Stark III makes life a little easier when it comes to recruitment, relaxing previous regulations when it comes to issues such as geographic service area, income guarantee restrictions, and permitted practice restrictions.

For example, Stark III permits hospitals to offer financial remuneration to physicians in an effort to induce them to relocate their practice to the hospital's geographic service area in order to join the hospital's medical staff. But there are some conditions that must be met — for example, the remuneration offered cannot be based on the volume or value of anticipated referrals to the physician.

Stark III also makes clarifications and modifications to rules about how group practices can accept a hospital or health system's economic assistance for recruiting a new physician.

"Income guarantees from a hospital to a newly recruited physician serve as a safety net, and have been used for many years to compensate for the expectation that for several months after a move, a doctor's full-income potential won't be realized," explained Shay. "Stark III clarifies how that income guarantee may be struc-

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tured: it can only take into account *actual* incremental additional expenses incurred in recruiting and employing the doctor."

For example, if your group works with your local hospital to recruit and employ Dr. Smith, paying him \$200,000 as an employee and \$50,000 in malpractice insurance, those are *actual* additional costs that you will incur in employing this physician. Costs that are *not* actual additional costs include, for example, the costs of an unused exam room if Dr. Smith's practice is not up to full speed and she's not using it yet.

"The practice cannot say that the square footage allocation expense of this office is an additional incremental cost that I am going to incur to employ this physician," said Shay. "You already incur the cost."

PRACTICE RESTRICTIONS

Stark III also allows certain practice restrictions on newly recruited physicians that were barred under Stark II. "Stark II

contained a requirement that told group practices that they could not impose practice restrictions that 'unreasonably restricted' the doctor's ability to practice in the geographic service area if they leave the group," Shay said. "The point was that the overall intent of the recruiting provisions of Stark was to relocate physicians into the community to provide it with a needed specialty service. To allow a group to say, in essence, if things don't work out we can prevent you from practicing in this area — that was inconsistent."

But such a blanket prohibition on things such as non-compete agreements raised many concerns, concerns that have in many cases been addressed with this latest iteration of the regulations. With Stark III, the Centers for Medicare and Medicaid Services clarified that the only restrictions it intended to ban were those that "would have a substantial effect on the recruited physician's ability to remain and practice medicine in the hospital's geographic service area after leaving the physician practice or group practice."

For example, Stark III now allows:

- "Reasonable" non-compete provisions.
- Restrictions on moonlighting.
- Non-solicitation provisions directed at both patients and employees.
- Requirements that the physician treat Medicaid and indigent patients.
- Requirements that the physician not use confidential information about the practice he or she is leaving.
- Provisions requiring that the physician repay the practice's losses that are not made up for by hospital recruitment payments.
- "Reasonable" liquidated damages if the physician leaves the practice and remains in the community.

The final rule is published online in the Federal Register: www.cms.hhs.gov/PhysicianSelfReferral.

UPCOMING AAN ANNUAL MEETINGS

- SEATTLE, WA •
APRIL 25-MAY 2, 2009
- TORONTO, ON •
APRIL 10-APRIL 17, 2010