[We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requestor.]

[name and address redacted]

RE: Advisory Opinion No. CMS-AO-2007-01

Dear [name redacted]:

We are writing in response to your request for an advisory opinion on behalf of [name redacted] (the "Hospital" or the "Requestor"). Your request pertains to a physician recruitment arrangement (the "Arrangement") that was originally made between the Hospital and [name redacted] (the "Physician") and which was later amended to include [name redacted] (the "Medical Group"), the physician-owned medical group practice into which the Physician was recruited. Specifically, you seek a determination regarding whether the Hospital was required under the physician self-referral statute, section 1877 of the Social Security Act (the "Act"), to include an excess receipts provision in the Arrangement and, if not, whether the Hospital may now amend the income guarantee loan agreement portion of the Arrangement to delete the excess receipts provision.

You have certified that all of the information provided in your request, including all supplementary materials and documentation, is true and correct and constitutes a complete description of the relevant facts and agreements among the parties. In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of this information. This opinion is limited to the facts presented. If material facts have not been disclosed or have been misrepresented, this advisory opinion is without force and effect.

Based on the facts certified in your request for an advisory opinion and supplemental submissions, and for the reasons set forth below, we conclude that the Arrangement, if amended to delete the excess receipts provision, would not satisfy the requirements of the recruitment exception to the physician self-referral prohibition in section 1877 of the Act. We express no opinion regarding whether the Arrangement otherwise complies with section 1877 of the Act and the physician self-referral regulations as they apply to the Hospital, the Physician, or the Medical Group. This advisory opinion is further qualified as set forth in section IV below and in 42 C.F.R. §§ 411.370 through 411.389.

This opinion may not be relied on by any persons other than the requestor of this opinion, [name redacted].

I. FACTUAL BACKGROUND

The Hospital is a small, acute care facility in [State redacted]. The Physician is a general surgeon who relocated to [State redacted] in April 2004 from [location redacted] to practice medicine in the geographic area served by the Hospital, as defined at 42 C.F.R. § 411.357(e)(2). The Medical Group specializes in general surgery and employed the Physician as of April 2004.

In April 2004, the Hospital and the Physician executed an agreement (the "Original Agreement"), whereby the Hospital agreed to provide financial assistance to the Physician in return for the Physician's agreement to relocate to the geographic area served by the Hospital in order to provide medical services. (The Medical Group was not a party to the Original Agreement.) The financial assistance provided by the Hospital under the Original Agreement was in the form of three loans: (1) a moving expense loan; (2) a $25,000 loan if the Physician furnished professional services in the Hospital's service area during April and part of May 2004; and (3) an income guarantee loan. Under the terms of the secured promissory note provisions attached to the Original Agreement, the Hospital would forgive all three loans if the Physician complied with the terms of the Original Agreement, including remaining in the Hospital's service area for a period after the term of the income guarantee loan.

At issue are the provisions of the Arrangement concerning the income guarantee loan under the Original Agreement. Under the terms of that loan, the parties agreed that, for 12 consecutive months beginning in September 2004, the Hospital would guarantee the Physician monthly revenue of $14,585, plus up to $19,296 per month for actual start-up and operating expenses directly attributable to the Physician's medical practice ("Physician Expenses"), less the monthly amount collected by the Physician attributable to his performance of services for the Medical Group ("Physician Receipts"). The Hospital informed the Medical Group that the income guarantee being paid to the Physician by the Hospital included amounts for all of the practice expenses attributable to the Physician's practice. Although the Medical Group was not a party to the Original Agreement, the Medical Group and the Physician arranged for the Physician to reimburse the Medical Group for such expenses.

The income guarantee loan agreement portion of the Original Agreement also included an excess receipts provision, which specified that, if the Physician Receipts exceeded the sum of the guaranteed revenue and Physician Expenses in any monthly period, the Physician would be obligated to remit such excess to the Hospital, up to the amount of the then-outstanding principal and accrued interest under the income guarantee loan.

On July 26, 2004, the "Phase II" regulations under the physician self-referral (or "Stark") law became effective. 69 Fed. Reg. 16054. Significantly, the new regulations in 42 C.F.R. § 411.357(e)(4)(iii) contained a requirement that an income guarantee offered by a

hospital to a physician joining a physician practice could only include amounts for practice expenses that are the "actual additional incremental costs attributable to the recruited physician." Four days earlier, on July 22, 2004, the Hospital, the Physician, and the Medical Group modified the Original Agreement by executing an amended agreement (the "Amended Agreement").

The Requestor certified that the Amended Agreement limited the monthly Physician Expenses to the actual additional incremental costs that the Physician or the Medical Group incurred and that were directly attributable to the Physician. As a result, the Amended Agreement reduced the maximum allowable monthly Physician Expenses from $19,296 to $15,120. Thus, the maximum monthly allowable payment the Medical Group was entitled to receive under the Amended Agreement for reimbursement of the Physician Expenses was considerably less than what the Hospital was liable to pay the Physician for expenses under the Original Agreement. In addition, this change in the Amended Agreement potentially increased the amount that the Physician would be obliged to repay the Hospital. For example, under the Original Agreement, if the Physician had Physician Expenses of $19,296 in a given month, and had practice revenues of $40,000 for that month, the Hospital would have been entitled to receive $6,119 under the excess receipts provision to apply towards any outstanding principal and accrued interest under the income guarantee loan, because the Physician Receipts of $40,000 would have exceeded the Hospital's payment obligations ($14,585 as guaranteed income and $19,296 in expenses, or $33,881) by $6,119. However, if the same monthly expenses and receipts were to occur under the Amended Agreement, the Hospital would be entitled to receive $10,295 under the excess receipts provision to apply to any outstanding principal and accrued interest. In other words, the amount of the Physician's receipts of $40,000 would have exceeded the amount of the Hospital's liability ($14,585 in guaranteed income and $15,120 in expenses, or $29,705) by $10,295.

II. LEGAL ANALYSIS

A. Law and Regulations

Under the physician self-referral statute, section 1877 of the Act (42 U.S.C. § 1395nn), a physician may not refer a Medicare patient for certain, designated health services ("DHS") to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies.[1] Section 1877 also prohibits the entity furnishing the DHS from submitting claims to Medicare, the beneficiary, or any other entity for Medicare DHS that are furnished as a result of a prohibited referral.

Section 1877 of the Act sets forth an exception for certain remuneration paid by a hospital to induce a physician to relocate his or her medical practice to the geographic

[1] In 1993, the physician self-referral prohibition was made applicable to the Medicaid program. 42 U.S.C. § 1396b(s).

area served by the hospital in order to become a member of the hospital's medical staff. The statutory exception for recruitment payments provides that: (i) the physician must not be required to refer patients to the hospital; (ii) the amount of the remuneration under the arrangement must not be determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician; and (iii) the arrangement must meet such other requirements as may be imposed by regulation. At the time the Original Agreement was executed in April 2004, the only additional requirements imposed by regulation and in effect were that: (1) the arrangement must be set out in writing and signed by both parties; and (2) the physician must not be precluded from establishing staff privileges at another hospital or referring business to another entity.[2] 42 C.F.R. §§ 411.357(e) (2003). Certain additional requirements relative to the physician recruitment exception were promulgated in the Phase II regulations, effective July 26, 2004. Phase II set forth criteria for remuneration provided by a hospital to a physician either indirectly through payments made to another physician or physician practice or directly to a physician who joins an existing physician practice. For example, 42 C.F.R. § 411.357 (e)(4)(iii) provides that, in the case of an income guarantee made by a hospital to a recruited physician who joins a physician practice, the costs allocated by the physician practice to the recruited physician cannot exceed the actual additional incremental costs attributable to the recruited physician. Also, paragraph (e)(4)(i) provides that, if the payments from the hospital are made directly to the physician practice, the physician practice must be a signatory to the written agreement.

Regulations on issuing advisory opinions appear in 42 C.F.R. § 411.370 et seq. Section 411.370(b)(1) states that CMS does not consider, for purposes of an advisory opinion, requests that present a general question of interpretation, pose a hypothetical situation, or involve the activities of third parties.

B. Analysis

We decline to opine on the Requestor's inquiry regarding whether the Original Agreement would have complied with the law if it did not contain an excess receipts provision. Because the Original Agreement contained an excess receipts provision, the question of whether the arrangement would have complied with the law if it did not contain the provision is hypothetical. As noted in our advisory opinion regulations, we do not answer advisory opinion requests that present general questions of interpretation or pose hypothetical situations.

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[2] These additional regulatory requirements were imposed in a 1995 final rule and applied with respect to the recruited physician's referrals to the Hospital for clinical laboratory services. However, as we explained in the preamble to the 1995 final rule, a majority of the interpretations in the 1995 rule would apply to referrals for other designated health services, and we would rely on those regulations when reviewing referrals for other designated health services in appropriate cases. 60 Fed. Reg. 41914, 41916 (Aug. 14, 1995).

With respect to the question of whether the parties may delete the excess receipts provision in the Amended Agreement, although the recruitment exception in 42 C.F.R. § 411.357(e) does not require the use of an excess receipts provision such as the one contained in the Arrangement, we conclude that the parties cannot now delete it from the Arrangement. The purpose of the physician recruitment exception is to permit certain compensation arrangements to induce a physician to relocate his or her medical practice to the geographic area served by a hospital in order to become a member of the hospital's medical staff. We do not believe that the parties should now be able to amend the Arrangement to provide for additional (or potentially additional) compensation to the Physician. Because the Physician has already relocated his medical practice, the additional compensation is not for the purpose of inducing relocation and may directly or indirectly reflect the volume or value of the recruited physician's actual or potential referrals.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the recruitment arrangement, if amended to delete the excess receipts provision, would not meet the criteria set forth in the physician recruitment exception in section 1877(e)(5) of the Act and 42 C.F.R. § 411.357(e). We express no opinion regarding whether the existing recruitment arrangement complies with section 1877 of the Act and the regulations as they apply to the Hospital, the Physician, or the Medical Group. We have not considered, nor do we express an opinion about, any other relationship or arrangement between the Hospital and the Physician, between the Hospital and the Medical Group, between the Physician and the Medical Group, or between the Hospital and any other entity.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to the Requestor of this opinion. This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity.

- This advisory opinion may not be introduced into evidence in any matter involving an entity or individual that is not a Requestor of this opinion.

- This advisory opinion is applicable only to the statutory and regulatory provisions specifically noted above. No opinion is expressed or implied herein with respect to the application of any other Federal, state or local statute, rule, regulation, ordinance or other law that may be applicable to the Medical Group or the Requestor, including, without limitation, the Federal anti-kickback statute, section 1128B(b) of the Act (42 U.S.C. § 1320a-7b(b)).

- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services. CMS reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, rescind, modify or terminate this opinion.

- This advisory opinion is limited in scope to the specific arrangement described in this letter and has no applicability to other arrangements, even those which appear similar in nature or scope.

- No opinion is expressed herein regarding the liability of any party under the False Claims Act or other legal authorities for any improper billing, claims submission, cost reporting, or related conduct.

This opinion is also subject to any additional limitations set forth in 42 C.F.R. §§ 411.370 through 411.389.

Sincerely,

Elizabeth A. Richter
Acting Director
Center for Medicare Management