Policy Recommendations for Modernizing the Stark Law

FACT SHEET | MARCH 2016

Overview

The physician self-referral law, known as the "Stark Law," was passed by Congress in 1989 and substantially amended in 1993. Health care delivery has changed dramatically since then, but this antiquated statute has not kept pace with new and innovative delivery models.

The Stark law and its complex and voluminous regulations were designed to prevent inappropriate financial relationships that incentivize physicians to increase overall utilization (volume), use more expensive services (value), or direct a referral stream to a given provider.

Congress enacted the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA) to repeal the Sustainable Growth Rate (SGR) and enable Medicare beneficiaries to benefit from more coordinated care that physicians were often providing in the private sector. Starting in 2019, physicians will operate under one of the following:

- The Merit-Based Incentive Payment System (MIPS), a modified fee-for-service system in which a portion of physician payments will be based on quality, resource use across the entire Medicare program, meaningful use of electronic health records, and clinical practice improvements;
- Alternative Payment Models (APMs), an arrangement like an Accountable Care Organization or bundled payment model that requires physicians to take on risk and bases compensation on quality. As such, physicians will need to coordinate care, control volume and work as teams.

Policy Recommendations

DHPA applauds the U.S. Senate Finance and U.S. House Ways and Means Committees for recognizing that the Stark law was not designed for this post-MACRA payment system, and for soliciting comments on how it can be modernized. DHPA has the following requests to update this antiquated law, which are supported by 21 other leading physician groups as outlined ina joint letter to both committees:

- In 2011, CMS created a set of waivers for ACOs in the Medicare Shared Savings Program. **DHPA asks Congress to create a new Stark exception extending the terms of these waivers to all physicians in an APM so that physicians can coordinate care and work as teams across specialties.**
- Many Stark exceptions require an entity to be a "group practice," but the rules around this term are very complex. A "group practice" may not compensate its members on the basis of the "volume or value" of referrals, unless a narrow exception applies. **DHPA asks Congress to remove "volume or value" from the group practice definition to ensure that a physician practice can properly compensate its members on the basis of quality and cost savings.**
- CMS also added the phrase "volume or value" to the definition of "fair market value." **DHPA asks Congress to clarify that incentives for improved quality or reduced costs are indeed "fair market value."**
- Just as Congress in 1993 could not divine how health care would be delivered two decades hence, this Congress is not in a position to identify how health care will change and what modifications to the Stark law may be necessary in the future. **DHPA asks Congress to give CMS significantly more flexibility to create new Stark exceptions in the future.**

The Digestive Health Physicians Association (DHPA) is a trade association currently comprised of 60 independent gastroenterology (GI) physician practices across the country with the aim of promoting and preserving accessible, high quality and cost-efficient care in the independent GI medical practice setting.

DHPA's member practices include more than 1,300 gastroenterologists and other physician specialists who provide care for more than 2 million people in over 4 million distinct patient encounters annually. DHPA member practices employ more than 8,000 employees in their medical groups.

DIGESTIVE HEALTH PHYSICIANS ASSOCIATION