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Do Proposed MPFS Changes Portend the Demise of Block Leases?

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Although block-leasing arrangements have become increasingly marginalized given recent Board of Medical Examiner decisions and a spate of high profile whistleblower cases, such arrangements clearly remain a target for the Centers for Medicare and Medicaid Services (CMS). The latest volley in this war of attrition came in the guise of CMS' proposed changes to the Medicare Physician Fee Schedule for Fiscal Year 2008. If the proposed changes are enacted as part of the final 2008 Payment Update, which will be released later this fall, the changes may very well mark the beginning of the end of the block leasing arrangements.

Specifically, CMS proposes making two (2) changes (among many) that could potentially impact the continued viability of block leasing arrangements both from an economic and legal perspective:

(i) expanding the purchased diagnostics rule (PDR) to cover both the professional and technical components of diagnostic test; and

(ii) adopting a new enrollment standard for Independent Diagnostic Testing Facilities (IDTFs) that would prohibit IDTFs from sharing space, equipment and personnel or leasing its operations to another.

Further, CMS indicated that if these changes are insufficient to stop the proliferation of "revenue driven arrangements that may be facilitating over utilization of diagnostic services," it would propose revisions to the in-office ancillary services exception to the Stark law, which is the exception by which a physician block leases imaging equipment and/or services and bills such services through his or her practice. Specifically, CMS sought comments as to whether an appropriate nexus should be established between the ancillary services being billed by the practice and the diagnosis and treatment that brought the patient to the physician's office.

With respect to the purchased diagnostics rule, CMS proposes expanding the scope of the rule so that the anti-mark up provision covers both the professional and technical components of diagnostic tests billed by a physician or medical group. CMS would also apply the purchased diagnostics rule in both purchased service and reassignment situations. Essentially, this change would prohibit physicians and medical groups from realizing a profit when they purchase or takes assignment of either the technical or professional component of a diagnostic test.

Under the expanded purchased diagnostics rule, CMS would limit payment to physicians and medical groups subject to the purchased diagnostics rule to the lower of: (i) the "supplier's net charge" to the physician; (ii) the physician's actual charge; or (iii) the fee schedule amount that would be allowed had the supplier billed the service directly. However, in seeking to prevent gaming of the anti-mark-up provision (ie, the billing physician or group charging the outside supplier for space or equipment to manufacture a margin of the component), CMS has proposed defining the "supplier's net charge" as excluding any payment made by the supplier to the billing physician or group for equipment or space rental.

CMS further proposes that for purposes of the purchased diagnostic rule, a diagnostic test is performed by an outside supplier whenever it is performed by someone other than a full-time employee of the billing physician or entity. Taken literally, this definition of an "outside supplier" would mean whenever the technical and/or professional component of a diagnostic test is furnished by either an independent contractor (regardless of whether part-time or full-time) or a part-time employee, the arrangement would be subject to the purchased diagnostics rule's mark-up prohibition.

Although the definition of "outside supplier" seems designed to address block lease arrangements, it is not clear that participants in such arrangements could not simply continue to rely on the argument that since they are bearing the risk for the furnishing the service (and/or furnishing supervision), the purchased diagnostics rule does not apply to such arrangements. In other words, one could argue that in the standard block-lease arrangement, the technical component of the test is neither purchased nor reassigned but instead furnished by the billing physician and therefore, beyond the scope of the purchased diagnostics rule. Hopefully, CMS will clear up its position on this issue with publication of the final changes.

However, such uncertainty does not exist with respect to IDTFs participating in such block-lease arrangements, since in the revised IDTF enrollment standards, CMS clearly takes the position that, regardless of the purchased diagnostics rule, IDTFs may not share personnel, equipment or space with another or otherwise lease its operations to another. The uncertainty here is whether an IDTF can enter into part-time arrangements with another and still meet the standard. For instance, under the revised enrollment standards for IDTFs, could an IDTF lease equipment, space and possibly, personnel from a third party on a part-time basis and qualify as an IDTF. That is, is the prohibition only on the IDTF being the lessor or is the prohibition intended to cover situations where the IDTF is also leasing such personnel, equipment and space.

CMS has also proposed a number of additional changes that may also impact the block-leasing arrangements, as well as other equipment leasing arrangements. For instance, CMS has proposed a number of changes to the Stark law that may require imaging centers (as well as others) to reevaluate their lease arrangements. Specifically, CMS has proposed: (i) expanding the definition of "entity" for Stark law purposes to include any individual or entity that performs the designated health service as well as those individuals and entities that Medicare pays for the designated health service; (ii) prohibiting per click leasing arrangements under the Stark law in situations where the equipment is being leased from a physician who also makes referrals for services furnished on the equipment; and (iii) limiting the use of percentage compensation arrangements under the Stark law to the payment of a percentage of revenue to a physician for those physician services personally performed by the physician.

Although all the proposed changes discussed herein will likely impact the operation of IDTFs, it remains to be seen whether these changes, in their present form, will be implemented in the final 2008 Payment Update. Given the number of outstanding questions, the fact that Phase III of the Stark law is expected in the near term, and that the proposed changes would require restructuring a number of arrangements, it seems unlikely that we have heard the last from CMS on these issues.