

STARK AND KICKBACK COMPLIANCE QUESTIONNAIRE

Questions

Yes

No

I. Threshold Questions - Stark

- A. Is there a referral from a physician for a designated health service (DHS)? If not, then there is no Stark law issue (although the anti-kickback statute, may be implicated).
- B. Does the physician (or an immediate family member) have a financial relationship (ownership or compensation) with the entity furnishing the DHS (e.g., the hospital)? Again, if the answer is no, the Stark law is not implicated.
- C. Does the financial relationship fit in a Stark exception? If the answers to I.A. and I.B are yes, then the answer to I.C. should be yes. If not, the Stark statute has been violated.

II. Threshold Questions - Kickback

- A. Does the hospital offer or pay any remuneration, directly or indirectly, to persons or entities in a position to generate Federal health care program business for the hospital (or its affiliates), including physicians and other health care professionals, ambulance companies, clinics, hospices, home health agencies, nursing facilities, and other hospitals?
- B. Could one purpose of the remuneration be to induce or reward the referral or recommendation of business payable in whole or in part by a Federal health care program?
- C. Does the remunerative relationship fit in a kickback safe harbor exception? If the answers to II.A. and II.B are yes, then the answer to II.C. should be yes. Although liability under the anti-kickback statute ultimately turns on a party's intent, the risks are too great to proceed without protection of a safe harbor.

Note: Remunerative relationships include, without limitation, the following: (1) physician recruitment and relocation payments; (2) medical directorships; (3) office and equipment leases; (4) employment and other personal services agreements; (5) loans; (6) physician practice acquisitions; (7) hospital-physician joint ventures; (8) hospital-supplied goods and services; and (9) gifts, travel and entertainment.

III. Joint Ventures

Yes No

- A. Are a substantial number of participants in a position to make or influence referrals to the venture or other participants?
- B. Are participants that are expected to make a large number of referrals offered a greater or more favorable investment or business opportunity in the joint venture than those anticipated to make fewer referrals?
- C. Are participants actively encouraged or required to make referrals to the joint venture?
- D. Are participants encouraged or required to divest their ownership interest if they fail to sustain an “acceptable” level of referrals?
- E. Does the venture (or its participants) track its sources of referrals and distribute this information to the participants?
- F. Are the investment interests nontransferable or subject to transfer restrictions related to referrals?
- G. Is the physician’s primary contribution a captive referral base, relying on another participant already engaged in the line of business to be conducted by the joint venture to provide or perform all or most of the items or services, or take responsibility for all or most of the day-to-day operations?
- H. Are participants offered investment shares for a nominal or no capital contribution?
- I. Is the amount of capital that participants invest disproportionately small, and the returns on the investment disproportionately large, when compared to a typical investment in a new business enterprise?
- J. Are participants permitted to borrow their capital investments from another participant or from the joint venture, and to pay back the loan through deductions from profit distributions, thus eliminating the need to contribute cash?
- K. Are participants paid extraordinary returns on the investment in comparison with the risk involved?
- L. Is a substantial portion of the gross revenues of the venture derived from participant-driven referrals?

IV. Physician Compensation Arrangements

Yes No

- A. Are the items and services obtained from a physician legitimate, commercially reasonable, and necessary to achieve a legitimate business purpose of the hospital (apart from obtaining referrals)?
- B. Assuming that the hospital needs the items and services, does the hospital have multiple arrangements with different physicians, so that in the aggregate the items or services provided by all physicians exceed the hospital's actual needs (apart from generating business)?
- C. Does the compensation represent fair market value in an arm's-length transaction for the items and services?
- D. Could the hospital obtain the services from a non-referral source at a cheaper rate or under more favorable terms?
- E. Does the remuneration take into account, directly or indirectly, the value or volume of any past or future referrals or other business generated between the parties?
- F. Is the compensation tied, directly or indirectly, to Federal health care program reimbursement?
- G. Is the determination of fair market value based upon a reasonable methodology that is uniformly applied and properly documented?
- H. Is the compensation commensurate with the fair market value of a physician with the skill level and experience reasonably necessary to perform the contracted services?
- I. Were the physicians selected to participate in the arrangement in whole or in part because of their past or anticipated referrals?
- J. Is the arrangement properly and fully documented in writing?
 - 1. Are the physicians documenting the services they provide?
 - 2. Is the hospital monitoring the services?
- K. Are safeguards in place to ensure that the physicians do not use hospital outpatient space, equipment, or personnel to conduct their private practice and that they bill the appropriate site-of-service modifier?

V. Recruitment Arrangements

Yes No

- A. Does the benefit exceed what is reasonably necessary to attract a qualified physician to the particular community?
- B. Has the hospital previously tried and failed to recruit or retain physicians?
- C. Does the duration of payout of the recruitment benefit extend longer than three years from the initial recruitment agreement?
- D. Is the physician a new physician with few or no patients or an established practitioner without a ready stream of referrals?
- E. Is the physician relocating from a substantial distance so that referrals are unlikely to follow?
- F. Is the recruited physician's specialty necessary to provide adequate access to medically necessary care for patients in the community?
- G. Do patients already have reasonable access to comparable services from other providers or practitioners in or near the community?
- H. Is the hospital engaging in "joint recruitment" with other entities or individuals, such as solo practitioners, group practices, or managed care organizations, pursuant to which the hospital makes payments directly or indirectly to the other entity or individual? Suspect payments to existing referral sources may include, among other things, income guarantees that shift costs from the existing referral source to the recruited physician and overhead and build-out costs funded for the benefit of the existing referral source.

VI. Malpractice Insurance Subsidies

Yes **No**

- A. Is the subsidy being provided on an interim basis for a fixed period in a State experiencing severe access or affordability problems?
- B. Is the subsidy being offered only to physicians new to the locality or in practice less than a year, i.e., physicians with no or few established patients?
- C. Are the criteria for receiving a subsidy unrelated to the volume or value of referrals or other business generated by the subsidized physician or his practice?
- D. Are the physicians receiving subsidies paying at least as much as they have been paying for malpractice insurance?
- E. Is the insurance available regardless of the location at which the physician provides services, including, but not limited to, other hospitals?