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Comparing risks: Physician employment and clinical integration

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Most healthcare administrators and compliance managers are well versed in the risks related to hospital-physician employment models, for example, employed physician networks (EPNs). The Stark Law and the Anti-Kickback Statute (AKS) are also well understood by providers who must abide by these statutes once they go to work for hospitals and healthcare systems. What is not well known, however, are the compliance risks associated with participation in a clinically integrated network (CIN) and that these organizations may, in fact, be more perilous to traverse from a risk perspective than more traditional alignment models.

This article will explore the critical rules and regulations related to EPNs and CINS and compare and contrast these two organizational structures. The intent is to provide valuable information for those healthcare organizations (hospitals, healthcare systems, and physician practices) that are considering entering into one of these two models.

Employed provider networks (EPNs)

Hospitals or health systems now employ nearly one-half of US physicians.[1] In some specialties (e.g., cardiology), the percentage of employed physicians is much higher. In others (e.g., ophthalmology, plastic surgery), the numbers are much lower. Regardless of the specialties involved, specific stringent rules govern these relationships and must be followed to avoid serious legal or regulatory consequences.

The Stark Law is a set of statutes that address the fact that physicians and other providers, particularly those who participate with federal or state payer plans (e.g., Medicare, Medicaid), cannot self-refer to hospitals or other organizations with whom they have a vested interest (e.g., a hospital that employs providers and pays them significant compensation).[2] Although this does not mean that physicians do not or cannot refer patients to their employer organizations, it does mean that providers in such employment relationships may not receive direct compensation in return for these referrals. The practical result of this restriction is that hospitals and systems that employ providers must be very careful to:

- Limit their up-front payments to providers and pay only for hard assets (e.g., facilities, fixtures, furniture, and equipment) and avoid paying for things like goodwill or ancillary service operations;
- Pay only what is considered to be a commercially reasonable, fair-market value for the practice as determined by a non-biased third-party valuation; and
- Separate the revenues received for ancillary services ordered by the employed providers from those of direct patient care services (e.g., evaluation and management (E&M) or other current procedural terminology (CPT) services) used to capture provider work relative value units (wRVUs) that are then used to determine a provider's compensation.

The AKS is a criminal statute that prohibits organizations (e.g., hospitals) from offering payments or other rewards to providers in exchange for referrals within federal healthcare programs such as Medicare. Similar to the Stark Laws, the AKS must be considered when employing providers, and care should be taken to ensure that nothing is in the up-front payment for practice acquisition or the ongoing compensation models.[3]

The Health Insurance Portability and Accountability Act (HIPAA)* also comes into play with EPNs, because many of these networks are sharing IT systems, especially electronic medical records (EMRs).[4] Although it is, of course, entirely appropriate for providers who are actively involved in the care of a particular patient to access that patient's record on an EMR, it is not suitable for them to access the records of patients with whom they are not actively involved as a caregiver. Therefore, hospitals and other employers of large provider networks must be especially vigilant in maintaining the privacy of protected patient information.

Finally, medico-legal risk remains a primary concern for all healthcare providers, including EPNs. Medical malpractice insurance coverage must be in place, and quality and patient safety efforts should be enacted to reduce both clinical and financial risk.