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Complete Healthcare Compliance Manual 2024
Physician Compensation: Contracts and Compensation Models

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What Are Physician Contracts and Compensation Models?

Financial arrangements between physicians and hospitals come in a variety of types; however, the majority fall under three main categories: employment agreements, foundation model agreements, and professional services agreements. With a variety of agreement types, compliance exposure risks related to physician contracts and compensation models for health systems have increased as well.

Employment Agreements

Health systems employ physicians in an effort to increase physician-hospital alignment. Under employment agreements, physicians become employees of the health system and provide professional medical/surgical services for the system. Practice assets are owned by the health system, operating costs are managed and incurred by the health system, and management of the practice staff fall under the responsibility of the health system. Each physician's compensation is determined by the specific terms within the employment agreement.

Foundation Model Agreements

Foundation models primarily occur in states that prohibit the corporate practice of medicine. Under foundation model arrangements, the health system will form a nonprofit foundation that owns the assets of the practice and manages the operations and staff. Physicians under such an arrangement will form an entity that contracts directly with the foundation for the provision of professional medical services. The medical group's compensation is determined by the foundation model agreement, and each individual physician's compensation is determined by the medical group.

Professional Services Agreements

Health systems contract with physician practices for specific professional clinical services on an hourly basis, a set fee schedule arrangement, and/or another basis. Health systems will typically assume the billing and collecting for physician services and compensate the practice out of these funds. This structure allows health systems to obtain physician services while not employing them directly. This is typically suited for health systems taking the initial steps toward physician-hospital integration or wanting less than a physician full-time equivalent. Physicians under these arrangements continue to maintain their autonomy over work hours, while reducing their administrative burden associated with billing and collecting. For more information about this kind of agreement, read "Contracts with Referral Sources: Entering into a Proper Physician Arrangement" in this chapter.

Compensation models vary within each of these agreement types, and it is within these models where the compliance risks reside.

Risk Area Governance

Physician transactions are highly regulated by federal law, a variety of state-specific fraud and abuse statutes, and government agencies. The activities and transactions of most physicians in private practice and those employed by health systems are affected by these regulations. The primary federal laws governing physician compensation include:

- Stark Law
- Anti-Kickback Statute (AKS)
- False Claims Act (FCA)

Stark Law (Physician Self-Referral Law), 42 U.S.C. § 1395nn

The Stark Law has undergone several phases to its rules, regulations, and exceptions since its introduction; however, at its core, the law "prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship, unless an exception applies; and prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those referred services."[2]

The following are considered to be designated health services by the Centers for Medicare & Medicaid Services (CMS):

- Clinical laboratory services
- Physical therapy, occupational therapy, and outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services[3]

In limited circumstances, the Stark Law does allow for certain exceptions. All exceptions must still comply with CMS requirements, AKS, and any other applicable federal and state regulations. Exceptions are noted for specific healthcare services as well as specific healthcare entities, such as academic medical centers (AMCs), ambulatory surgery centers, (ASCs) and federally qualified health centers (FQHCs). The most notable exceptions to this law include the following:

- Employment relationships
- In-office ancillary services
- Group practice arrangements

- Fair market value exception
- Physician services
- Provider recruitment
- Risk-sharing agreements
- Equipment and space leases
- Indirect compensation arrangements
- Nonmonetary compensation
- Medical staff incidental benefits[4]

Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)

The AKS is a federal fraud and abuse law that prohibits knowingly and willfully offering, paying, soliciting, or receiving remuneration in order to induce business payable by Medicare and/or Medicaid unless certain conditions are satisfied.[5] The AKS applies to all persons in all healthcare services, not solely physicians or hospitals. The intent of the law is to prevent overutilization of items or services through prohibiting incentive compensation to induce referrals.

In limited circumstances, the AKS does allow for certain safe harbors. All safe harbors must still comply with CMS requirements, Stark Law, and any other applicable federal and state regulations. The most notable safe harbors to this law include the following:

- Bona fide employment relationships
- Personal services arrangements
- Group purchasing organizations
- Referral services
- Fair market value exception[6]

False Claims Act, 31 U.S.C. §§ 3729–3733

The FCA was enacted to prevent contractors and suppliers from defrauding the US government. [7][8] The FCA states that "any person who knowingly presents…a false or fraudulent claim for payment…or knowingly makes… a false record or statement material to a false or fraudulent claim…is liable to the United States government for a civil penalty."[9] Claims made against Medicare, Medicaid, and various other federal and state health insurance plans may potentially fall under the FCA.

Common fraud and abuse examples that fall under the FCA include, but are not limited to, the following:

- Kickbacks
- Services billed but not rendered

- Lack of medical necessity
- Coding irregularities (e.g., upcoding or unbundling)[10]

Antitrust Laws

From their inception with the Sherman Act in 1890, antitrust laws are aimed at preserving competition while governing the mergers and acquisitions (M&A) that occur within industry.[11] The Federal Trade Commission is tasked with overseeing the enforcement of these antitrust laws.[12] The trend has been toward increased M&A in healthcare with a focus on generating economies of scale and obtaining investment in technologies and ancillary services.[13] Even in the context of the coronavirus pandemic, healthcare transactions may have been delayed but are projected to continue and catch up to historical trends.[14]

Government Agencies

In addition to these federal laws, there are many federal and state governmental agencies that are responsible for regulatory oversight of physicians and health systems. These include CMS; accrediting agencies; Office for Civil Rights; Federal Trade Commission; Internal Revenue Service; and various state level agencies, medical boards, and courts.

2020 Final Regulations to the Stark Law and Anti-Kickback Statute

In an effort to reconcile the healthcare regulatory framework with the increasing need for coordinated care, the Department of Health & Human Services (HHS) launched an initiative in 2018, which they called a "regulatory sprint to coordinated care."[15] The primary goal was to evaluate the current regulatory framework and to remove barriers for health systems and physicians to share information—from financial arrangements to incentivize coordinated care. As a result, HHS announced on November 20, 2020, the final rule changes to the Stark Law and AKS to facilitate physicians and hospitals to coordinate care and encourage value-based arrangements. While there are regulatory differences between Stark and AKS, attempts were made to align definitions and other regulatory guidance. Specifically, definitions were consistent among the following terms that are used in value-based arrangements for the purpose of exceptions/safe harbors: value-based enterprise (VBE), VBE participant, value-based purpose, value-based activity, value-based arrangement, and target population.[16][17] Among the other changes, these new final rules attempt to clarify the definitions of FMV and commercial reasonableness. Note that other regulatory changes are included; however, given the scope and topic for this article, those changes were not highlighted herein.

AKS: November 20, 2020, Final Rule Changes

Compensation Exceptions Based on Value-Based Arrangements

Three new value-based arrangement exceptions are now finalized to include:

- Arrangements under full-risk (i.e., capitated payments)[18]
- Arrangements with substantial downside risk where financial risk is between 20%–30% of any loss subject to specific criteria[19]
- Care coordination arrangements (in-kind remuneration only)[20]

- Patient engagement and support[21]
    - Safe harbor for patient tools used to improve quality, health outcomes, and efficiency
    - In-kind items, goods, and services only
    - Direct connection to the coordination and management of care of the target patient population

The value-based arrangements must meet specific criteria as well as satisfy the regulatory definitions pertaining to the compensation arrangement. All arrangements must be commercially reasonable. Under the care coordination arrangement safe harbor, the recipient is required to pay at least 15% of the offeror's cost for the remuneration or the in-kind remuneration needs to be within fair market value.

In addition, the following current regulations were amended:

- Personal services and management contracts[22]
    - Adds flexibility with respect to part-time arrangements
- Outcomes-based payment arrangements[23]
- CMS-sponsored models safe harbor[24]
    - Reduces the need for separate and distinct fraud and abuse waivers for new CMS-sponsored models
    - Subject to specific conditions

Stark Law: November 20, 2020, Final Rule Changes

Compensation Exceptions Based on Value-Based Arrangements

Three new value-based arrangement exceptions are now finalized to include:

- Arrangements under full-risk (i.e., capitated or global budget payments),[25]
- Arrangements with meaningful downside risk where physicians are liable for no less than 10% of the physician compensation if specific benchmarks are not met, and
- Value-based arrangements (regardless of risk).[26][27]

The value-based arrangements must meet specific criteria as well as satisfy the regulatory definitions pertaining to the compensation arrangement. Criteria varies based on the level of risk. All arrangements must be commercially reasonable.

In addition, the following current regulations were amended:

- Indirect value-based arrangements:[28]
    - When an unbroken chain of financial relationships includes a value-based arrangement to which the physician (or the physician organization in whose shoes the physician stands) is a direct party, the new exceptions at 42 C.F.R. § 411.357(aa) are applicable.

- This is in addition to the exceptions at 42 C.F.R. §§ 411.355, 411.357(n), and 411.357(p).

- Group practice rules where distribution of profits is directly attributable to a physician's participation in a value-based enterprise, notwithstanding 42 C.F.R. § 411.352 (g).[29]

Redefining Fundamental Terminology: FMV, Commercial Reasonableness, and the Value or Volume Standard

The final rule changes address the three key concepts that affect most of the exceptions in an effort to increase clarity and reduce the regulatory burden of moving toward value-based arrangements.

- **Fair market value (FMV)**. The final rule clarifies the definition subject to the transaction (asset acquisition, compensation arrangements, and equipment/office space rental). With each transaction type, FMV is defined to be consistent with "general market value":[30]

  - With respect to the purchase of an asset, the price that an asset would bring on the date of acquisition of the asset as the result of bona fide bargaining between a well-informed buyer and seller that are not otherwise in a position to generate business for each other.

  - With respect to compensation for services, the compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well-informed parties that are not otherwise in a position to generate business for each other.

  - With respect to the rental of equipment or the rental of office space, the price that rental property would bring at the time the parties enter into the rental arrangement as the result of bona fide bargaining between a well-informed lessor and lessee that are not otherwise in a position to generate business for each other.

- **Commercial reasonableness**: This is defined as a "particular arrangement [that] furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty."[31] The new rule clarifies that commercial reasonableness is not synonymous with profitability, but it may be satisfied if the arrangement makes sense toward the accomplishment of the goals set by the parties.

- **Volume or value standard**. The definition has uncoupled fair market value with the volume or value standard and has set a mathematical equation for determining compensation meets the standard. To this end, two new rules have been created:

  - **One for compensation to a physician**. The formula used to calculate the physician's (or immediate family member's) compensation includes the physician's referrals to (or other business generated by the physician for) the entity as a variable, resulting in an increase or decrease in the physician's (or immediate family member's) compensation that positively correlates with the number or value of the physician's referrals to the entity.[32]

  - **One for compensation from a physician**. The formula used to calculate the entity's compensation includes the physician's referrals to (or other business generated by the physician for) the entity as a variable, resulting in an increase or decrease in the entity's compensation that negatively correlates with the number or value of the physician's referrals to the entity.[33]