# Physician Compensation: Fair Market Value

Supporting Compliance Within Large and Complex Health Systems

Physician compensation is on the rise due to ongoing labor shortages, evolving workforce expectations, and increased competition for talent.

As this trend continues, maintaining regulatory compliance with fair market value (FMV) and commercial reasonableness standards is critical in a complex and active enforcement environment.

**As defined by Stark Law:**

**Fair market value is** *"the value in an arm's-length transaction, consistent with the general market value of the subject transaction."*

**General market value is** *"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."*

## How is FMV Enforced?

### Fraud and Abuse Laws

**Stark Law**
*Civil Statute*
*(No intent needed)*

**False Claims Act**
*Whistleblower provision*

**Anti-Kickback Statute**
*Criminal Statute*
*(Intent must be proven)*

**Intermediate Sanctions**

**Civil Monetary Penalties**

### Governing Bodies

- Office of the Inspector General (OIG)
- Department of Justice (DOJ)
- Internal Revenue Service (IRS)
- Centers for Medicare & Medicaid Services (CMS)

### Physician Compensation

- Must be at fair market value (**FMV**)
- **Cannot** take into consideration the **value or volume of Medicare referrals**
- Must be **commercially reasonable**

### Why is FMV compliance important?

- **High Settlements**
- **Burden on Resources**
- **Reputational Risk**

The DOJ calculates a **$4.00 return for every $1.00 invested** in the Health Care Fraud and Abuse Control Program.

| Fiscal Year | Health Care Recoveries |
|---|---|
| 2021 | $5.0B |
| 2022 | $1.7B |
| 2023 | $1.8B |

- Whistleblowers can receive up to 30% of the recovery; an average of more than **12 qui tam suits are filed each week.**
- **$345M:** Amount paid by Community Health Network (CHN) in December 2023 in the largest Stark Law settlement in history.

## How Do We Manage FMV as a Large and Complex Organization?

**Effective FMV governance starts at the top and cascades down the organization.**

**Board of Directors:** Provides oversight of compensation program, has ultimate decision authority, and owns transaction policy.

**System / Enterprise Leaders:** Oversee compliance with Physician Review Policy; review performance-related goals established by Regional Compensation Steering Committees and assess how system goals can be incorporated into performance-related physician compensation programs.

**Local Regions / Markets:** Develop and manage compensation plan to ensure compliance with internal policies (e.g., base rates, incentive opportunities, shift requirements, etc.); reconcile and report compensation and productivity.

## Key Considerations

The impact of **downstream referrals or provider-based billing reimbursement differentials** cannot be used to determine physician compensation.

**FMV 'opinion shopping'** can create a potentially problematic trail of documentation. Ensure your FMV assessments are conducted by a reliable and experienced third party.

Organizations must **continually monitor physician compensation arrangements** to ensure FMV compliance beyond the initial assessment.

**Compensation arrangement terms** that are out of step with common market practice may not be commercially reasonable.

When free or undervalued services (staffing, leased space, etc.) are provided to physicians, the **value of those services** must be included in determining FMV.


**Sources:** *Annual Report of the Departments of Health and Human Services and Justice, Health Care Fraud and Abuse Control Program FY 2021*. U.S. Department of Justice, Office of the Attorney General. (2022, July). https://oig.hhs.gov/publications/docs/hcfac/FY2021-hcfac.pdf

*Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations*. Federal Register. (2020, December 2). https://www.federalregister.gov/documents/2020/12/02/2020-26140/medicare-program-modernizing-and-clarifying-the-physician-self-referral-regulations

*Community Health Network Agrees to Pay $345 Million to Settle Alleged False Claims Act Violations*. Southern District of Indiana | United States Department of Justice. (2023, December 18). https://www.justice.gov/usao-sdin/pr/community-health-network-agrees-pay-345-million-settle-alleged-false-claims-act


**Need help assessing fair market value?**

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