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FMV for Provider Contracts: Regulatory Standards

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As a general rule, healthcare employers are required to pay employed physicians and other contracted providers fair market value (FMV) for their services, but many employers do not understand relevant regulatory standards. In this health law update, we summarize Stark and Anti-Kickback Statute considerations.

I. STARK (PHYSICIANS AND PHYSICIAN FAMILY MEMBERS).

The federal Ethics in Patient Referrals Act (aka Stark) prohibits physicians[1] from referring certain designated health services (DHS)[2] payable by Medicare or Medicaid to entities with which the physician or a family member of the physician has a financial relationship unless the arrangement is structured to fit within a statutory exception or regulatory safe harbor.[3] Violations may result in significant penalties.[4]

Stark's safe harbor for employment contracts requires, among other things, that

> (2) The amount of the remuneration under the employment is—
> **(i) Consistent with fair market value of the services**; and
> (ii) … [I]s not determined in any manner that takes into account the volume or value of referrals by the referring physician.
> (3) The remuneration is provided under an **arrangement that would be commercially reasonable even if no referrals were made to the employer**.[5]

Similarly, the Stark safe harbors applicable to independent contractors require that

> (3) The compensation must be set in advance, **consistent with fair market value**, and not determined in any manner that takes into account the volume or value of referrals or other business generated by the referring physician….
> (4) **The arrangement would be**

> **commercially reasonable even if no referrals were made between the parties.**[6]

Although separate, the FMV and commercial reasonableness standards are often conflated under Stark; I will address both.

Fair Market Value. As amended in 2021, Stark defines "fair market value" as "[t]he value in an arm's-length transaction, consistent with the general market value of the subject transaction."[7] With respect to compensation for services, "general market value" means

> 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.[8]

As explained by the Centers for Medicare & Medicaid Services (CMS), "compensation arrangements should be at fair market value for the work or service performed … --not inflated to compensate for the physician's ability to generate other revenues."[9] More specifically,

> the general market value of a transaction is based solely on consideration of the economics of the subject transaction and should not include any consideration of other business the parties may have with one another. Thus, for example, when parties to a potential medical director arrangement determine the value of the physician's administrative services, they must not consider that the physician could also refer patients to the entity when not acting as its medical director…. [10]

Thus,

> a hospital may not value a physician's services at a higher rate than a private equity investor or another physician practice simply because the hospital could bill for designated health services referred by the physician under the OPPS [Outpatient Prospective Payment System], whereas a physician practice owned by the private equity

> investor or other physicians would have to bill under the PFS [Physician Fee Schedule], which may have lower payment rates. Put another way, the value of a physician's services should be the same regardless of the identity of the purchaser of those services.[11]

FMV is not a specific number; instead, as explained by CMS, FMV is a range dependent on the circumstances:

> [I]n most instances, what constitutes fair market value for an item or service will be expressed as a range and, accordingly, claimants should not face significant difficulty in establishing fair market value, provided that they use a methodology that is reasonable under the facts and circumstances, determine a payment amount that is within the range that the methodology yields, and maintain documentation regarding the determination of fair market value that was created at the time of the financial relationship.[12]

CMS has repeatedly stated that employers and physicians may use any commercially reasonable method to establish FMV so long as it does not take into account the volume or value of referrals or other business generated between the parties:

> As we have stated consistently in prior rulemakings, to establish the fair market value (and general market value) of a transaction that involves compensation paid for … services, we intend to accept any method that is commercially reasonable and provides us with evidence that the compensation is comparable to what is ordinarily paid for [a] service in the location at issue, by parties in arm's-length transactions that are not in a position to refer to one another (66 FR 944). We emphasize that our use of the language "commercially reasonable" in Phase I (and again in Phase II (72 FR 51015 through

> 51016)) was also not intended to limit the valuation of … compensation … to a specific valuation approach or prescribe any other particular method for determining the fair market value and general market value of compensation. Rather, … we will consider a range of methods of determining fair market value and that the appropriate method will depend on the nature of the transaction, its location, and other factors (69 FR 16107 and 72 FR 51015 through 51016). [T]he amount or type of documentation that will be sufficient to confirm fair market value (and general market value) will vary depending on the circumstances in any given case (66 FR 944)….[13]

While not required, common methods for determining physician compensation may include internal analyses, compensation paid for comparable arrangements in the relevant market,[14] external independent FMV opinions from qualified consultants,[15] or, perhaps most commonly, published physician salary surveys.[16] In prior versions of Stark regulations, CMS created a safe harbor for determining FMV so long as the compensation fit within the parameters of certain published salary surveys, including:

- Sullivan, Cotter & Associates, Inc.— Physician Compensation and Productivity Survey
- Hay Group—Physicians Compensation Survey
- Hospital and Healthcare Compensation Services—Physician Salary Survey Report
- Medical Group Management Association—Physician Compensation and Productivity Survey
- ECS Watson Wyatt—Hospital and Health Care Management Compensation Report
- William M. Mercer—

Integrated Health Networks
Compensation Survey[17]

CMS subsequently withdrew the safe harbor status for these surveys,[18] but such surveys (especially the MGMA survey) continue to be a common starting point if not the most prevalent standard for evaluating physician compensation. CMS has cautioned against relying too much on such surveys, however:

> stakeholders may have been under the impression that it is CMS policy that reliance on salary surveys will result, in all cases, in a determination of fair market value for a physician's professional services. It is not CMS policy that salary surveys necessarily provide an accurate determination of fair market value in all cases.[19]

Significantly, in its 2020 commentary, CMS expressly rejected commenters' request for a rebuttable presumption or safe harbor for physician compensation that is set at or below the 75th percentile in a salary survey:

> For the reasons explained in Phase I (66 FR 944 through 945), Phase II (69 FR 16092), and Phase III (72 FR 51015), we decline to establish the rebuttable presumptions and "safe harbors" requested by the commenters. We are uncertain why the commenters believe that it is CMS policy that compensation set at or below the 75th percentile in a salary schedule is always appropriate, and that compensation set above the 75th percentile is suspect, if not presumed inappropriate. The commenters are incorrect that this is CMS policy.[20]

Instead, CMS explained that "[c]onsulting salary schedules or other hypothetical data is an appropriate **starting point** in the determination of fair market value," but it is not conclusive.[21]

> Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value. Ultimately, the appropriate method for determining fair market value for purposes of the physician self-

> referral law will depend on the nature of the transaction, its location, and other factors. [A]lthough a good faith reliance on an independent valuation (such as an appraisal) may be relevant to a party's intent, it does not establish the ultimate issue of the accuracy of the valuation figure itself.[22]

Accordingly, healthcare employers and physicians must not assume that payment within a specific survey range (*e.g.*, up to the 75th percentile of MGMA) will necessarily reflect FMV or protect the parties; instead, the specific circumstances of the transaction should always be considered and documented, including, *e.g.*, compensation paid within the specific market for physicians practicing in the relevant specialty; the qualifications of the physician; the time and demands of the position; the physician's productivity; *etc.*

In its most recent commentary, CMS confirmed that some circumstances may warrant paying a physician outside rates specified in salary surveys, although the parties will have the burden of justifying the valuation:

> we continue to believe that the fair market value of a transaction and particularly, compensation for physician services, may not always align with published valuation data compilations, such as salary surveys. In other words, the rate of compensation set forth in a salary survey may not always be identical to the worth of a particular physician's services…. [E]xtenuating circumstances may dictate that parties to an arm's length transaction veer from values identified in salary surveys and other valuation data compilations that are not specific to the actual parties to the subject transaction (84 FR 55799). By way of example, assume a hospital is engaged in negotiations to employ an orthopedic surgeon. Independent salary surveys indicate that compensation of $450,000 per year would be appropriate for an orthopedic surgeon in the geographic location of the hospital. However, the orthopedic surgeon with whom the hospital is

> negotiating is one of the top orthopedic surgeons in the entire country and is highly sought after by professional athletes with knee injuries due to his specialized techniques and success rate. Thus, although the employee compensation of a hypothetical orthopedic surgeon may be $450,000 per year, this particular physician commands a significantly higher salary. In this example, compensation substantially above $450,000 per year may be fair market value. On the other hand, hypothetical data may result in hospitals and other entities paying more than they believe appropriate for physician services. Assume a hospital is engaged in negotiations to employ a family physician. Independent salary surveys indicate that compensation of $250,000 per year would be appropriate for a family physician nationally; no local salary surveys are available. However, the cost of living in the geographic location of the hospital is very low despite its proximity to good schools and desirable recreation opportunities, and, due to declining reimbursement rates and a somewhat poor payor mix, the hospital's economic position is tenuous. Although the physician may request the $250,000 that the salary survey indicates would be appropriate for a hypothetical (unidentified) physician to earn, and the hospital may believe that it is compelled to pay the physician this amount, the fair market value of the physician's compensation may be less than $250,000 per year.[23]

Furthermore:

> Consulting salary schedules or other hypothetical data is an appropriate starting point in the determination of fair market value, and in many cases, it may be all

> that is required. However, we agree … that a hospital may find it necessary to pay a physician above what is in the salary schedule, especially where there is a compelling need for the physician's services. For example, in an area that has two interventional cardiologists but no cardiothoracic surgeon who could perform surgery in the event of an emergency during a catheterization, a hospital may need to pay above the amount indicated at a particular percentile in a salary schedule to attract and employ a cardiothoracic surgeon. We also [emphasize] the need for an analysis of the actual terms of a transaction and the actual facts and circumstances of the parties. In our view, each compensation arrangement is different and must be evaluated based on its unique factors. That is not to say that common arrangements, where the services required are identical regardless of the identity of the physician providing them, do not lend themselves well to the use of salary surveys for determining compensation that is fair market value.[24]

According to CMS, these and other examples cited by CMS:

> were intended to show that a variety of factors could affect whether the amount shown in a salary schedule is too high or too low to be fair market value for the services of the subject transaction. In some instances, it is exactly right. Parties do not necessarily fail to satisfy the fair market value requirement simply because the compensation exceeds a particular percentile in a salary schedule; nor are parties required to pay a physician what is shown in a salary schedule if the specific circumstances do not warrant that level of compensation…. [W]e

> believe that salary schedules should not be used by a physician to demand compensation that is above what well informed parties that are not in a position to generate business for each other would agree is the fair market value of the physician's services. [25]

In sum, when it comes to determining FMV for services contracts for physicians or their family members under Stark: (i) CMS does not require a specific methodology for determining FMV although use of published salary surveys is common; (ii) the methodology used must be commercially reasonable and the overall compensation must not take into account, directly or indirectly, the volume or value of referrals; (iii) the FMV evaluation should take into account the specific circumstances relating to the subject agreement, including the nature of services provided, location, productivity, etc.; (iv) FMV is a range, not a specific number; and (v) the parties will have the burden of proving FMV if challenged.

Commercially Reasonable. In addition to FMV, the proposed contract must generally be commercially reasonable. For purposes of Stark,

> *Commercially reasonable* means that the particular arrangement 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. An arrangement may be commercially reasonable even if it does not result in profit for one or more of the parties.[26]

In commentary supporting the 2021 Stark amendments, CMS cited some reasons why providers might engage in certain arrangements even if they are not profitable, including:

> addressing community need, timely access to health care services, fulfillment of licensure or regulatory obligations (including those under the Emergency Medical Treatment and Labor Act (EMTALA)), the provision of charity care, and the improvement of quality and health outcomes. We believe that all of these purposes could qualify as ''legitimate business purposes'' of the parties to an arrangement, depending on the facts and

> circumstances of the parties.[27]

According to CMS:

> One commenter suggested that entire hospital service lines, with their needed management and other physician-provided services, are illustrative for operating at a loss and identified psychiatric and burn units as examples of such service lines. According to this commenter, with changes in reimbursement, more service lines will operate at a loss in the future. The commenter urged that these services are of vital need to communities and, unless CMS addresses the definition of "commercial reasonableness," health care providers may be prohibited from providing these services to their communities as a result of a fear of violating the commercial reasonableness standard. We find these comments and the concerns they highlight compelling.[28]

In contrast, "conduct that violates a criminal law, such as inducing or rewarding referrals in violation of the anti-kickback statute, would not be a legitimate business purpose for an arrangement," and, accordingly, would not be commercially reasonable.[29] Likewise, unnecessary services are not commercially reasonable. CMS has cautioned:

> arrangements that, on their face, appear to further a legitimate business purpose of the parties may not be commercially reasonable if they merely duplicate other facially legitimate arrangements (84 FR 55790). For example, a hospital may enter into an arrangement for the personal services of a physician to oversee its oncology department. If the hospital needs only one medical director for the oncology department, but later enters into a second arrangement with another physician for oversight of the department, the second arrangement merely duplicates the already-obtained medical directorship services and may not

> be commercially reasonable. Although the evaluation of compliance with the physician self-referral law always requires a review of the facts and circumstances of the financial relationship between the parties, the commercial reasonableness of multiple arrangements for the same services is questionable.[30]

Exceptions. There are some circumstances in which an employer may pay an employed or contracted physician above fair market value. For example, employers who otherwise satisfy the Stark recruitment or retention safe harbors are not limited by fair market value.[31] Also, physician group practices that qualify as a "group practice" under Stark are not limited to fair market value compensation so long as "[n]o physician who is a member of the group practice directly or indirectly receives compensation based on the volume or value of his or her referrals" and subject to special rules for sharing of profits, productivity bonuses, and value-based enterprise participation.[32]

II. ANTI-KICKBACK STATUTE (INDEPENDENT CONTRACTORS).

In addition to Stark, providers and employers must also consider the federal Anti-Kickback Statute (AKS), especially for independent contractors. The AKS generally prohibits offering remuneration in exchange for inducing or rewarding referrals for items or services payable by federal healthcare programs unless the arrangement is structured to fit within a statutory or regulatory safe harbor.[33] Violations may result in significant criminal, civil, and administrative penalties.[34]

Fortunately, the AKS generally does not apply to "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of … items or services" payable by federal programs.[35] Consequently, the AKS does not generally apply to employment contracts.

The AKS does, however, apply to independent contractor agreements with any providers (not just physicians) rendering, ordering, or referring items or services payable by federal health programs (not just DHS). The AKS safe harbor for independent contractors requires, among other things:

> (iv) The methodology for determining the compensation paid to the agent over the term of the agreement is set in advance, *is consistent with fair market value in arm's-length transactions*, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for

> which payment may be made in whole or in part under Medicare, Medicaid, or other Federal health care programs; [and]
>
> (vi) The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.[36]

Unlike Stark, the AKS does not define FMV in the context of services contracts; however, the Office of Inspector General (OIG) has stated that "'fair market value' must reflect an arm's length transaction which has not been adjusted to include the additional value which one or both of the parties has attributed to the referral of business between them."[37] The OIG's 2005 Supplemental Compliance Program Guidance for Hospitals contained directions to hospitals concerning physician agreements, which directions really apply to all providers:

> hospitals should review their physician compensation arrangements and carefully assess the risk of fraud and abuse using the following factors, among others:
>
> - 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)? 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)?
> - Does the compensation represent fair market value in an arm's-length transaction for the items and services? Could the hospital obtain the services from a

non-referral source at a cheaper rate or under more favorable terms? 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? Is the compensation tied, directly or indirectly, to Federal health care program reimbursement?

- Is the determination of fair market value based upon a reasonable methodology that is uniformly applied and properly documented? If fair market value is based on comparables, the hospital should ensure that the market rate for the comparable services is not distorted (e.g., the market for ancillary services may be distorted if all providers of the service are controlled by physicians).
- 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?[38]

The OIG reiterated essentially these same considerations relevant to the value of remuneration offered to providers in its 2023 General Compliance Program Guidance:

Value of the remuneration.

- Is the remuneration fair market value in an arm's-length transaction for legitimate, reasonable, and necessary services that are actually rendered?
- Is the entity paying an inflated rate to a potential referral source?
- Is the entity receiving free or

below-market-rate items or services from a provider, supplier, or other entity involved in health care business?

- Is compensation tied, either directly or indirectly, to Federal health care program reimbursement?
- Is the determination of fair market value based upon a reasonable methodology that is uniformly applied and properly documented?[39]

Exceptions. Like Stark, there are certain AKS safe harbors that would allow an employer to pay a contractor in excess of FMV, including the AKS practitioner recruitment safe harbor.[40] Unlike Stark, the AKS is an intent-based statute; accordingly, it is not essential to fit within a statutory or regulatory exception, in which case the test becomes, "is one purpose of the remuneration paid to the provider intended to induce or reward referrals."[41] That may be a difficult standard to defend against if the referring contractor is paid an excessive amount.

III. OTHER CONSIDERATIONS.

The foregoing only addresses the federal Stark and AKS. Employers and providers should also consider whether other potentially relevant laws apply. For example, states may have their own versions of Stark, AKS, or other relevant laws. If the employer is a non-profit entity, it may need to consider FMV in the context of any private benefit conferred upon the provider.[42] If the employer is or operates a laboratory, recovery home, or clinical treatment facility within the meaning of the Eliminating Kickbacks in Recovery Act (EKRA), the parties may need to ensure the compensation structure satisfies one of the statutory exceptions under EKRA.[43]

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[1] Under Stark, "physician" means a doctor of medicine or osteopathy (MD or DO), dentist (DDS or DMD), podiatrist (DPM), optometrist (OD), or chiropractor (DC). (42 CFR § 411.351, incorporating 42 USC § 1395x(r)).

[2] DHS generally include:

(i) Clinical laboratory services.

(ii) Physical therapy, occupational therapy, and outpatient speech-language pathology services.

(iii) Radiology and certain other imaging services.

(iv) Radiation therapy services and supplies.

(v) Durable medical equipment and supplies.

(vi) Parenteral and enteral nutrients, equipment, and supplies.

(vii) Prosthetics, orthotics, and prosthetic devices and supplies.

(viii) Home health services.

(ix) Outpatient prescription drugs.

(x) Inpatient and outpatient hospital services.

42 CFR § 411.351.

[3] 42 USC § 1395nn; 42 CFR § 411.353.

[4] Stark law violations may result in mandatory repayment of amounts paid by Medicare or Medicaid for the services that were provided per the improper referral and civil penalties of more than $27,000 per claim submitted. 42 CFR §§ 411.353 and 1003.310; 45 CFR § 102.3. In addition, Stark violations also violate the False Claims Act, which imposes an affirmative obligation on the parties to report and repay amounts paid by Medicare or Medicaid, civil monetary penalties of approximately $12,000 to $24,000 per improper claim submitted, an administrative penalty of approximately $23,000 per claim, treble damages, and potential exclusion from participating in Medicare and Medicaid. 42 USC § 1320a-7a(a); 42 CFR § 1003.210; 45 CFR § 102.3.

[5] 42 CFR § 411.357(c) (emphasis added).

[6] 42 CFR § 411.357(l)(3) (emphasis added); *see also id.* at §§ 411.357(d)(v) and 411.357(z)(1).

[7] 42 CFR § 411.351.

[8] 42 CFR § 411.351.

[9] 85 FR § 77552.

[10] 85 FR § 77552.

[11] 85 FR 77555.

[12] 73 FR 48739.

[13] 85 FR 77556.

[14] 85 FR 77552. When considering comparable arrangements, employers should beware situations in which compensation may be have been improperly inflated because of referral patterns as well as antitrust concerns. *See id.*

[15] *See* 66 FR 945 and 72 FR 51015. Although parties may obtain independent valuations, CMS emphasized, “We wish to be perfectly clear that nothing in our commentary was intended to imply that an independent

valuation is required for all compensation arrangements." 85 FR 77557.

[16] *See* 72 FR 51015 and 85 FR 77555.

[17] 69 FR 16092; *see also id.* at 16128.

[18] *See* 72 FR 51015.

[19] 85 FR 77557.

[20] 85 FR 77558.

[21] 85 FR 77557, emphasis added.

[22] 72 FR 51015, citing 69 FR 16107.

[23] 85 FR 77555, citing 84 FR 55799; *see also* 85 FR 77557.

[24] 85 FR 77557.

[25] 85 FR 77557.

[26] 42 CFR § 411.351. Although an arrangement may be commercially reasonable even if it is not profitable, profitability may still be relevant to the "commercially reasonable" test if, *e.g.*, there is no legitimate reason for the arrangement. 85 FR 7734.

[27] 85 FR 77533; *see also* 84 FR 55790.

[28] 84 FR 55790.

[29] 85 FR 77533, citing 84 FR 55791; *see also* 85 FR 77534.

[30] 85 FR 77533.

[31] 42 CFR § 411.357(e) and (t).

[32] 42 CFR § 411.352(g).

[33] 42 USC § 1320a-7b(b).

[34] An AKS violation is a felony punishable by up to 10 years in prison, a $100,000 criminal penalty, a $100,000+civil penalty, treble damages, and exclusion from participating in the Medicare or Medicaid programs. 42 U.S.C. §§ 1320a-7 and 1320a-7b(b)(2)(B); 42 C.F.R. §§ 1003.300 and 1003.310; 45 C.F.R. § 102.3. An AKS violation is likely also a violation of the federal False Claims Act (42 U.S.C. § 1320a-7b(g); 31 U.S.C. § 3729), which exposes defendants to mandatory self-reports and repayments, additional civil penalties of $11,000+ to $22,000+ per claim, treble damages, private qui tam lawsuits, and costs of suit. 31 U.S.C. §§ 3729 and 3730; 42 U.S.C. §§ 1320a-7a and 1320a-7k(d); 28 C.F.R. §§ 85.5 and 1003.200(a) and (b)(k).

[35] 42 USC 1320a-7b(b)(3)(B); *see also* 42 CFR 1001.952(i).

[36] 42 CFR § 1001.952(d).

[37] OIG Special Fraud Alerts (12/94), available at https://oig.hhs.gov/documents/physicians-resources/980/121994.pdf.

[38] OIG, *Supplemental Compliance Program for Hospitals* (1/31/2005), 70 FR 4866-67.

[39] OIG, *General Compliance Program Guidance* (11/23) at p.13, available at https://oig.hhs.gov/documents/compliance-guidance/1135/HHS-OIG-GCPG-2023.pdf#page=10.

[40] 42 CFR § 1001.952(n).

[41] *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *United States v. Greber*, 760 F.2d 68 (3d Cir. 1985).

[42] *See generally* https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3.

[43] 18 USC § 220.

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