REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
Determining Fair Market Value when Contracting with Physician Practices
(Reference Committee J)

EXECUTIVE SUMMARY

This report was self-initiated by the Council on Medical Service to address the need for further policy guidelines for physicians, especially independent physicians, in determining fair market value (FMV) under the Physician Self-Referral law, otherwise known as the Stark law, when contracting with a hospital or health system. The report examines the Stark law and its exceptions, various data sources for determining FMV, and the impact the law has on physician practices.

The Stark law was originally enacted in 1989 and applied only to physician referrals for clinical laboratory services. It has since undergone several revisions and expansions. As currently written, the law prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.

Designated health services include: 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; and inpatient and outpatient hospital services.

Some of the most common Stark law exceptions include In-office Ancillary Services, Personal Service Arrangements, Fair Market Value Compensation, Group Practice Compensation Methods, and the Professional Courtesy Exception.

Burdensome regulatory and administrative requirements, including those associated with the Stark law, are some of the drivers that are leading independent physician practices to being sold to hospitals, health systems, and private equity companies which increases consolidation in already consolidated markets. Employment preferences vary across the profession, and while employment by a hospital system or a hospital-owned practice are attractive options to some, it is also important to maintain the sustainability of independent practice. In order to reduce administrative burden related to Stark law compliance, this report highlights several ways physician practices can mitigate risk and ensure compliance.

The Council offers a series of recommendations to empower physicians during contract negotiations and encourage transparency in FMV compensation calculations.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-26

Subject: Determining Fair Market Value when Contracting with Physician Practices

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

The Physician Self-Referral law, otherwise known as the Stark law (42 U.S.C. §1395nn), prohibits physicians from referring patients to receive "designated health services" (DHS) payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships must align with fair market value (FMV) definitions and can include both ownership/investment interests and compensation arrangements. Ownership or investment interests can include equity (stock or partnership shares) or debt interests (loans tied to an entity's revenue). The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required.

This report was self-initiated by the Council on Medical Service to address the need for further policy guidelines for physicians, especially independent physicians, in determining FMV under the Stark law when contracting with a hospital or health system. The American Medical Association's (AMA) position on the Stark law and physician compensation is clear. However, the Council sees a policy gap regarding the definition of FMV, guidelines for independent physicians when negotiating contracts with hospitals, and best practices to avoid a Stark law violation. As such, this report examines the Stark law and its exceptions, various data sources for determining FMV, the impact the Stark law has on physician practices, and makes policy recommendations.

BACKGROUND

The Stark Law, Anti-Kickback Statute, and False Claims Act

The Stark law was originally enacted in 1989 and applied only to physician referrals for clinical laboratory services. In 1993-94, Congress expanded the law to include additional DHS and applied certain aspects of physician self-referral laws to Medicaid. In 1997, Congress added a provision to permit the Secretary of Health and Human Services (HHS) to issue written advisory opinions concerning whether a referral relating to DHS (other than clinical laboratory services) is prohibited under Section 1877.

Designated health services include: 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; and inpatient and outpatient hospital services.

Related statutes include the False Claims Act (FCA) and Anti-Kickback Statute (AKS). The FCA makes it illegal to submit claims for payment to Medicare or Medicaid that a physician knows to be

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false or fraudulent. "Knowing" is defined to include not only actual knowledge but also encompasses cases when an individual acts in deliberate ignorance or reckless disregard of the truth or falsity of the information. AKS is a criminal law that prohibits the knowing and willful payment or remuneration (which includes anything of value, in any form) to induce or reward patient referrals or the generation of business involving any item or service payable by federal healthcare programs. AKS has broader coverage than the Stark law, requires intent, and is not limited to certain services. While there is often overlap between these three laws, this report will focus specifically on the impact of the Stark law, the definition of FMV, and the impacts on independent physicians.[1]

Exceptions to the Stark Law

Most physician practices rely on one or more of the exceptions to the Stark law to maintain clinical operations. Many of the exceptions are complicated and can impose significant administrative burdens on physicians and their practices.[2] Common exceptions include:

1. In-office Ancillary Services Exception. This exception is widely used in group medical practices and allows physicians to refer Medicare patients for DHS within their own practice, if certain conditions are met. For example, the referring physician must be part of a qualifying group practice, the DHS must be provided either in the same building where the group provides non-DHS services or in a centralized building used by the group for diagnostic or clinical services, and the physician or the practice of the physician performing the service must submit the bill.[3]
2. Personal Service Arrangement Exceptions. This exception allows physicians to be paid FMV for services when there is a written, signed agreement in place that does not tie compensation to referral volume or value.
3. Fair Market Value Compensation Exception. This exception protects arrangements where compensation reflects market rates and does not depend on referrals.
4. Group Practice Compensation Methods Exception. This exception allows group practices to compensate physician employees using productivity and profit-sharing methods as long as the formulas used to calculate salary do not tie compensation to the volume or value of that physician's own DHS referrals.
5. Professional Courtesy Exception. This exception allows practices to extend courtesy discounts or free services as long as these benefits are available to all staff or community members and are not tied to referrals. The benefits must be in writing and approved in advance by the practice's governing body. They cannot be extended to federal program beneficiaries unless based on demonstrated financial need and they cannot violate AKS.

Impact of Regulatory Changes

Following the original enactment, the Stark law has undergone several additional expansions and changes. In 2003, Congress authorized the Secretary of HHS to promulgate an exception to the physician self-referral prohibition for certain arrangements in which the physician receives non-monetary remuneration that is necessary and used solely to receive and transmit electronic prescription information and established a moratorium on physician referrals to certain specialty hospitals in which the referring physician has an ownership or investment interest. In 2010, the Centers for Medicare & Medicaid Services (CMS) published the Voluntary Self-Referral Disclosure Protocol pursuant to Section 6409(a) of the Affordable Care Act, which sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of the physician self-referral law.[4]

More recently, in 2020, CMS issued "Modernizing and Clarifying the Physician Self-Referral Regulations." Established here were three new exceptions to the physician self-referral law applicable to compensation arrangements that qualify as "value-based arrangements." Notably, CMS defined "commercial reasonableness" in the regulation, which established an objective test for evaluating whether compensation takes into account the volume or value of referrals or other business generated between the parties. The definitions of "fair market value" and "indirect compensation agreement" were also revised.[5]

Also in 2020, HHS Office of the Inspector General (OIG) published the final rule "Revisions to the Safe Harbors under Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding Beneficiary Inducements." The two rules create a dual regulatory environment where a value-based arrangement could meet the requirement for protection under one law but not the other. This could hinder transitions to value-based healthcare delivery and payment systems. The AMA submitted a letter in response the proposed rules.[6] Finally, CMS finalized clarifications to the regulations defining a "group practice" for the purposes of the Stark law.[7]

The Stark Law, Independent Physicians, and Increasing Market Consolidation

Burdensome regulatory and administrative requirements, including the Stark law requirements, may be some of the drivers that are leading independent physician practices to be sold to hospitals, health systems, and private equity companies. This in turn increases consolidation in already consolidated markets. According to AMA analysis, a substantial majority of hospital markets are highly concentrated, and concentration continues to increase over time. Between 2012 and 2024, the share of physicians who work in private practice dropped 18 percentage points from 60.1 percent to 42.2 percent.[8] Research has found that mergers in concentrated markets can lead to price increases and concerns about physician autonomy and leadership. The AMA is an advocate for competitive healthcare markets and antitrust relief for physicians and maintains that healthcare markets should be sufficiently competitive to allow physicians to have adequate choices and practice options.[9]

Employment preferences vary among physicians and employment by large hospital systems or hospital-owned practices remains an attractive practice option for some physicians. It is also important to maintain the sustainability of independent practice for physicians who wish to pursue this career path. An alternative to direct employment by a hospital or health system would be for independent physicians to contract with hospitals or other groups to provide certain services (either clinical, administrative, or quality-based). However, many facilities and physicians are concerned about inadvertent violations of the Stark Law and thus utilize FMV to set proposed payments lower than the value of services or assume that an employment relationship is required to provide more coordinated or integrated care. While some of these relationships may fit under exceptions to the Stark law, the fear of prosecution can lead to a failure of these relationships to be developed in a way that would support both patient care and the success of an independent physician practice.

The Stark law has the potential to negatively impact private practice by imposing strict liability for often unintentional financial relationship violations, leading to large financial penalties, forced repayment of all Medicare revenue for the impacted service, and high compliance costs. The law also requires rigorous, signed documentation for all financial relationships. Failure to maintain, sign, or update these arrangements can invalidate them and the cost of hiring legal counsel to ensure compliance with FMV and commercial reasonableness can be high.

Calculating Fair Market Value and Sources of Physician Compensation Data

CMS provides a broad definition of FMV in Section 1877 of the Social Security Act, describing it as "the value in arm's length transactions, consistent with general market value, and, with respect to rentals or leases, the value of a rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee."[10] FMV protections are not solely a regulatory burden on physicians. Properly applied, they can protect patients and the healthcare system from fraud and abuse when compensation arrangements are being used to influence referrals.

CMS has acknowledged that there is a desire for a "clear bright line" for how FMV should be defined but argues that the definition is intentionally kept broad to account for nuances of different specialties, geographic locations, and practice types across the country. Because there is no specific definition, physicians, practices, and hospitals must rely on outside data sources, namely physician salary surveys and databases, to calculate FMV for individual employment scenarios. Some examples of arrangements that may warrant FMV negotiations include a radiologist contracting to provide medical director services, an independent physician group contracting for hospital coverage, including call and weekend hours, a specialist with clinical work and administrative obligations, or a physician practicing in a geographically underserved area where average salary may exceed the national survey average.

There are several prominent data sources for this information, each with benefits and limitations. It is best practice to consult several of these resources to determine FMV. Many of the most utilized sources are accompanied by high price tags (often annual subscriptions) that may be costly for independent physicians to access. The following are a list of some of the most utilized:

- Medical Group Management Association (MGMA) has been the default source for salary data for decades, providing national provider compensation and production data, often broken down by specialty, geographic region, and practice setting. Data are collected from healthcare organizations (employers) and not directly from physicians, meaning the compensation figures reflect what organizations report paying, which can differ from the payment actually received by physicians. The cost of accessing the dataset is also a limitation, as access starts at $3,000/year, requiring annual renewals. Premium access costs are even higher.
- Sullivan Cotter provides comprehensive datasets tailored for hospitals, health systems, and larger clinical networks. These data focus on executive, physician, and non-physician provider compensation. Sullivan Cotter provides 30 years of survey history, but access can also be cost prohibitive and is reported from the employer perspective, which could report data that is different than physician take-home pay.
- American Medical Group Association publishes robust medical group compensation and financial survey metrics, reflecting data from over 200 specialties, with a particular strength in reporting multi-specialty group practice data. This dataset includes region breakdowns and organizational size segmentation. Membership to the Association and data access could be cost prohibitive for smaller organizations.
- The Association of American Medical Colleges (AAMC) provides a Faculty Salary Report that displays total compensation statistics for full-time medical school faculty broken out by degree, rank, department/specialty, medical school type, region, gender, and race/ethnicity. The reported total compensation is the sum of fixed/contractual salary,

medical practice supplement, and bonus or incentive pay. The survey is fielded annually and can be purchased for $75 or $1,500, depending on AAMC membership status.[11]

- Bureau of Labor Statistics Occupational and Wage Statistics offers free physician compensation data organized by Standard Occupational Classification codes. While costs are friendly, the data provides only very broad specialty groupings (i.e., Physicians & Surgeons, All Others), limited percentile granularity, and a publication lag of 12-18 months. As such, these data are best used as a cross-validation source rather than a primary benchmark measure.
- Other sources that can be used include SalaryDr (provides physician-reported on-demand reports for a fraction of the costs), Doximity (provides self-reported physician data from its physician social network), and proprietary datasets from independent, third-party valuation firms which can vary in cost, access, and reliability.[12]

When utilizing these resources to calculate FMV, there are a few best practices to keep in mind. First, the data should be used as a guide, and multiple sources should be referenced. Second, both median and percentile data should be used as reference points as this is more accurate than using the mean in these circumstances. This allows for the consideration of various aspects of compensation, such as a shortage of services, the qualifications of the physician, and the non-clinical work being requested in determining an appropriate percentile. For example, only looking at the median as a ceiling for FMV could be inaccurate, as those earning at the 90th percentile can also be receiving a FMV salary based on their individual circumstances and qualifications. Third, current practice realities should be examined and leveled with physician salary expectations before applying necessary filters to specific scenarios.[13]

Recent Legal Activity

The following are a few examples of recent cases that focus on hospital compensation practices and that highlight either an alleged lack of sufficient safeguards to ensure that physicians are paid within the range of FMV or a calculated plan to capture and retain referrals through excessive compensation. Each of these entities have been defendants in Stark law-based FCA lawsuits, whose allegations focus on above FMV compensation to referring physicians:[14]

- Community Health Network (Indiana) allegedly engaged in a scheme to recruit a variety of specialists by offering them significantly higher salaries than they received in private practice, in order to capture these specialists' lucrative downstream referrals.
- The University of Pittsburgh Medical Center (UPMC) settled a lawsuit after a neurosurgeon and two other UPMC clinicians filed suit, alleging that UPMC incentivized its neurosurgeons to perform unnecessary and overly complex procedures at UPMC facilities by providing base pay and productivity bonuses that far exceeded FMV.
- The Department of Justice (DOJ) intervened in a case against Steward Health Network (Massachusetts) that alleged that the hospital paid a $5 million incentive compensation to the Chief of Cardiac Surgery for increasing the number of surgical cardiovascular cases performed at the hospital and that resulted in the hospital's submission of more than 1,000 claims to Medicare in violation of the Stark law, equaling tens of millions of dollars in improper Medicare payments. Steward has since filed for Chapter 11 bankruptcy.
- There is an ongoing case against Erlanger Health System (Tennessee) that alleges that Erlanger violated both the Stark law and AKS by paying physicians above FMV for referrals. The DOJ has partially intervened and the settlement is expected to exceed $60 million.[15,16]

These examples highlight real and alleged abuses that need to be prevented and show the importance of the Stark law in protecting patients, physicians, and the healthcare system as a whole from fraud and abuse. As a goal, the Stark law should be modernized to ensure fair payment for physicians in a variety of contractual relationships without increasing administrative or regulatory burdens rather than weakening meaningful protections.

Compliance Concerns and Risk Management

The above cases highlight the importance of proper risk management. There are several ways that physician practices can mitigate risk of violating the Stark law and related statutes, although it is important to note that the administrative costs of keeping up with these requirements can be expensive for independent physicians:

- Make sure all compensation agreements are in writing and signed by all relevant parties. Revisit the agreements on a regular basis to ensure continued compliance.
- Document all financial relationships and referral patterns clearly.
- Verify compliance with Stark law exceptions and AKS safe harbors.
- Have a consistent valuation process in place and ensure that physician compensation is consistently evaluated and documented as falling within the range of FMV and does not rely on the volume or value of referrals.
- Make compliance programs a priority and integrate them into operations through measures such as compensation policies, training, audits, and evaluations.
- Conduct regular internal audits and monitor regulatory arrangements for changes.
- Take whistleblower complaints seriously.
- Seek legal guidance when necessary, including for complex or novel arrangements.
- Monitor regulatory updates and OIG advisory opinions.[17,18,19]

AMA POLICY

Policy D-385.940 states that the AMA recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs, supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral," and supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care.

Policy H-385.914 states that the AMA opposes and continues to advocate against the misuse of the Stark law and regulations to cap or control physician compensation.

Policy H-225.973(3) states that the AMA opposes financial arrangements between hospitals and physicians that: a) either require physicians to compensate hospitals in excess of the fair market value of the services or resources that hospitals provide to physicians; b) require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request; and c) require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals.

Policy D-405.988 states that the AMA supports preserving the value of the private practice of medicine and its benefit to patients.

Policy E-9.6.9 addresses ethical challenges for self-referral in which patients' medical interests can be in tension with physicians' financial interests.

DISCUSSION

The Stark law prohibits physicians from referring patients to receive DHS payable to Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Most physician practices rely on complicated exceptions to the Stark law to maintain clinical operations. The Stark law is not meant to solely be an administrative burden on physicians, but when applied properly, these guidelines can protect the healthcare system from fraud and abuse.

In recent years, CMS has attempted to more clearly define FMV with regulatory updates; however, it has not gone far enough, and the definitions continue to be vague. In its recommendations, the Council encourages further specificity in the definition of FMV and offers suggestions for factors that should be included in the calculation.

Transparency in how FMV is calculated, including specific factors and data sources used, can empower physicians entering into contracts with hospitals or health systems to best advocate for themselves and their practices. To this end, the Council recommends supporting transparency in the disclosure of financial relationships, compensation models, and ownership structures between physicians, hospitals, and other healthcare entities, as well as encouraging physicians to ask for transparency when negotiating an employment contract and ask for employers to disclose and provide methodology, data sources, and calculations used in determining FMV.

Burdensome regulatory and administrative requirements, including those associated with the Stark law, are some of the drivers that are leading independent physician practices to being sold to hospitals, health systems, and private equity companies which increases consolidation in already consolidated markets. Employment preferences vary across the profession, and while employment by a hospital system or a hospital-owned practice are attractive options to some, it is also important to maintain the sustainability of independent practice. In order to reduce administrative burden related to Stark law compliance, there are several ways physician practices can mitigate risk and ensure compliance. The Council recommends encouraging physicians to seek independent valuation or legal counsel when negotiating compensation and contractual agreements where FMV is an issue as well as recommends supporting policies that ensure contractual integrity in physician-health system relationships.

Finally, the Council recommends reaffirmation of Policies D-405.988, D-385.940 and H-385.914, which support preserving the value of the private practice of medicine, recognize the substantial impact of the Stark law's unequal restrictions on independent physicians, and oppose and continue to advocate against the misuse of the Stark law and regulations to cap or control physician compensation.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support modernization of federal regulatory frameworks, including the Stark law and Anti-Kickback Statute, to reduce unnecessary administrative burden, mitigate penalties for technical or non-substantive violations, and better

enable value-based, patient-centered care while maintaining appropriate safeguards against fraud and abuse and protecting patients from conflicts of interest and inappropriate utilization. (New HOD Policy)

2. That our AMA support the Centers for Medicare & Medicaid Services (CMS) explicitly defining factors that can be utilized to calculate "fair market value" (FMV) as it relates to physician compensation including, but not limited to, the following factors:
   - Physician specialty, subspecialty, or physician services to be provided;
   - Geographic location;
   - Supervision of non-physician providers or trainees;
   - Whether a restrictive covenant is in place and its level of restrictiveness;
   - Additional roles and responsibilities (e.g., education, quality improvement duties, alternative payment model or value-based care participation, serving as licensed directors of hospital departments or laboratories);
   - Restrictions on outside activities or income opportunities (e.g. work at a Veterans Affairs facility, work at an academic institution, moonlighting, consulting, development of intellectual property owned by the physician, or other outside professional activities);
   - Specialty or subspecialty shortages, either locally or nationally; and/or
   - Other factors that impact value to the health system. (New HOD Policy)

3. That our AMA support CMS providing additional guidance on exceptions and/or safe harbors that physicians and employers can rely upon to adjust physician compensation, either through direct compensation, or through value-sharing of other payments that are based on the physician's contribution to the institution. (New HOD Policy)

4. That our AMA encourage physicians to ask for transparency when negotiating an employment contract and ask for employers to disclose and provide the methodology, data sources, and calculations used in determining FMV as it relates to the compensation of independent physicians contracting with the hospital whenever FMV is cited as a reason for the selected compensation level. (New HOD Policy)

5. That our AMA support transparency of ongoing and future proposed physician financial relationships, compensation models, and ownership structures between physicians, hospitals, and other healthcare entities during any negotiation to provide healthcare or administrative services between all parties. (New HOD Policy)

6. That our AMA encourage physicians, particularly those in independent practice that are entering contracting arrangements, to seek independent valuation, legal counsel, and third-party review when negotiating compensation and contractual agreements where FMV is an issue. (New HOD Policy)

7. That our AMA support policies that ensure fair and transparent integrity in physician-health system contractual relationships, including written, transparent, and time-limited agreements, appropriate limitations on restrictive covenants to protect patient access and continuity of care, and preservation of physician advocacy on behalf of patients. (New HOD Policy)

8. That our AMA reaffirm Policy D-405.988, which states that the AMA supports preserving the value of the private practice of medicine and its benefit to patients. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy D-385.940, which states that the AMA recognizes the substantial impact of Stark law's unequal restrictions on independent physicians, contributing

to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs, supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral," and supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-385.914, which states that the AMA opposes and continues to advocate against the misuse of the Stark law and regulations to cap or control physician compensation. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Policy Appendix

Stark Law Self-Referral Ban, D-385.940

1. Our American Medical Association recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs.
2. Our AMA supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral."
3. Our AMA supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care.

(BOT Rep. 03, I-25)

Stark Law and Physician Compensation, H-385.914

Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.
(BOT Rep. 6, I-15; Reaffirmed: BOT Rep. 09, A-25)

Financial Arrangements Between Hospitals and Physicians, H-225.973

1. Our American Medical Association opposes financial arrangements between hospitals and physicians that are unrelated to professional services, or to the time, skill, education and professional expertise of the physician.
2. Our AMA opposes any requirement which states that fee-for-services payments to physicians must be shared with the hospital in exchange for clinical privileges.
3. Our AMA opposes financial arrangements between hospitals and physicians that
    a. either require physicians to compensate hospitals in excess of the fair market value of the services and resources that hospitals provide to physicians.
    b. require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request.
    c. require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals.
4. Our AMA opposes financial arrangements between hospitals and pathologists that force pathologists to accept no or token payment for the medical direction and supervision of hospital-based clinical laboratories.
5. Our AMA urges state medical associations, HHS, the AHA and other hospital organizations to take actions to eliminate financial arrangements between hospitals and physicians that are in conflict with the anti-kickback statute of the Social Security Act, as well as with AMA policy.

(CMS Rep. C, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed and Appended: CMS Rep. 2, I-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22)

The Preservation of the Private Practice of Medicine, D-405.988

1. Our American Medical Association supports preserving the value of the private practice of medicine and its benefit to patients.
2. Our AMA will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care.

3. Our AMA will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians.
4. Our AMA will work through the appropriate channels to preserve choice and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt.
5. Our AMA will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine.
6. Our AMA will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice.
7. Our AMA will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.
8. Our AMA will issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices.

(Res. 224, I-10; Appended: Res. 604, A-12; Reaffirmation: I-13; Appended: Res. 735, A-14; Reaffirmed in lieu of Res. 223, I-14; Modified: Speakers Rep. 01, A-17; Reaffirmed: Res. 724, A-22; Reaffirmation: A-22; Appended: Res. 602, A-22; Reaffirmed: BOT Rep. 14, A-23; Reaffirmed: CMS Rep. 08, A-24; Reaffirmed: BOT Rep. 19, A-26)

Vertical Consolidation in Healthcare – Markets or Monopolies, D-160.908

1. Our American Medical Association advocates against anticompetitive business practices that have the potential to adversely affect the physician patient relationship, to result in higher costs or decreased quality of care, or are not in the best interest of patients, the public and/or physicians.
2. Our AMA supports efforts to increase transparency, review, and enforcement of laws with respect to vertical mergers that have the potential to negatively impact the healthcare industry.
3. Our AMA will work with all appropriate stakeholders to create model legislation to prohibit anticompetitive business practices within the healthcare sector.

(Res. 723, A-23; Reaffirmed: Res. 813, I-25)

AMA Principles for Physician Employment, H-225.950

1. Addressing Conflicts of Interest
    a. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
    b. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
    c. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, healthcare in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

d. A physician's paramount responsibility is to their patients. Additionally, given that an employed physician occupies a position of significant trust, they owe a duty of loyalty to their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
    a. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to their religious beliefs or moral convictions.
    b. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates their religious beliefs or moral convictions.
e. Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession
    a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the healthcare system or setting in which physicians practice, or the methods by which they are compensated.
    b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting
    a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, healthcare systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
    b. Physicians should never be coerced into employment with hospitals, healthcare systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
    c. When a physician's compensation is related to the revenue they generate, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
    d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under their care. When a physician's employment status is unilaterally terminated by an employer, the physician and their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by

the physician in their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of their patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations
   a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
   b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
   c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations
    a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
    b. Peer review should follow established procedures that are identical for all physicians practicing within a given healthcare organization, regardless of their employment status.
    c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
    d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
    e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
    f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign their hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
        a. The agreement is for the provision of services on an exclusive basis.
        b. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
        c. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Healthcare Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements
    a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
    b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
    c. The AMA will petition the appropriate legislative and/or regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, and/or employers will directly provide each physician it bills or collects for with a detailed, itemized statement of billing and remittances for medical services they provide biannually and at any time upon request. Upon review of billing and remittance statements, physicians should reserve the right to override the initial decisions by revenue cycle management entities and submit billing that they believe to be best aligned and most reflective of the medical services that they have provided. Additionally, the physician shall not be asked to waive access to this information. Our AMA will seek federal legislation requiring this, if necessary.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

(BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19; Reaffirmation: A-22; Reaffirmed: BOT Rep. 29, A-24; Modified: Speakers Rep. 02, I-24; Appended: Res. 712, A-25)

E-9.6.9 Physician Self-Referral

Business arrangements among physicians in the healthcare marketplace have the potential to benefit patients by enhancing quality of care and access to healthcare services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a healthcare facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first.

When physicians enter into arrangements that provide opportunities for self-referral they must:

(a) Ensure that referrals are based on objective, medically relevant criteria.
(b) Ensure that the arrangement:
(i) is structured to enhance access to appropriate, high quality healthcare services or products; and
(ii) within the constraints of applicable law:
a. does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
b. does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
c. adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
(c) Take steps to mitigate conflicts of interest, including:
(i) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
(ii) establishing mechanisms for utilization review to monitor referral practices; and
(iii) identifying or if possible, making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
(d) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

AMA Principles of Medical Ethics: II, III, VIII

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E-11.2.3 Contracts to Deliver Healthcare Services
Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the healthcare system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires that before entering into contracts to deliver healthcare services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Those physicians who enter into contracts with corporate entities, such as private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession.

Ongoing evolution in the healthcare system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for healthcare delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in healthcare, they can also put at risk physicians' ability to uphold professional ethical standards and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians seek capital to support their practices or enter into various differently structured contracts to deliver healthcare services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while some arrangements have the potential to promote desired improvements in care, other arrangements have the potential to put patients' interests at risk and to interfere with physician autonomy.

When contracting with entities, or having a representative do so on their behalf, to provide healthcare services, physicians should:
(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel to assure themselves that the arrangement:
(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;
(iii) ensures the physician can appropriately exercise professional judgment;
(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
(v) is transparent and permits disclosure to patients;
(vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;
(vii) prohibits the corporate practice of medicine.
(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.
When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:
(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.
(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.
(e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.
(f) Not enter into any contract that would require the physician to violate their professional ethical obligations.
When contracted by a corporate entity involved in the delivery of healthcare services, physicians should:
(g) Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms.

AMA Principles of Medical Ethics: I, II, III, V, VI, VIII, IX

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