



Value-Based Care Models: Deep Dive FAQs for Hospital-Affiliated Physicians

This document provides information for physicians who are affiliated with a hospital and are considering participation in a value-based care arrangement. Such arrangements may include Alternative Payment Models (“APMs”) operated by the Centers for Medicare and Medicaid Services (“CMS”), private payor models, and other opportunities to work with hospitals in arrangements other than fee-for-service. For more AMA Medicare payment resources, see ama-assn.org/medicare-payment.

General Questions:

Q. What is a hospital affiliation model and how is it different from hospital employment?

A. The phrase “hospital affiliation” covers a wide variety of relationships between physicians, their practices, and hospitals. These affiliations can range from highly integrated models to contractual arrangements that allow the physician(s) to maintain more independence. Hospital affiliation arrangements are often created to support participation in formal or informal value-based payment relationships that involve payment based on factors other than volume (such as quality or reduced costs).

The AMA has a number of resources for hospital-employed physicians, including a [Deep Dive FAQ for Hospital-Employed Physicians participating in the Quality Payment Program \(“QPP”\) in 2018](#).

Q. What are common legal structures for hospital affiliation arrangements?

A. Hospital affiliations can be structured in a variety of legal forms, depending on the nature of the parties and the goals of the arrangement. In most cases,

affiliations involve contracts (including employment contracts and independent contractor arrangements) between individual physicians, physician practices, and hospitals. In some cases, physician practices and hospitals may jointly invest in a new legal entity (or “joint venture”) to perform various functions within the affiliation. Different organizational structures may be more or less desirable, depending on the parties’ goals, applicable legal rules, and the parties’ abilities to invest time or money into the joint venture. We discuss a number of common legal structures used in affiliation agreements below.

Q. Does my practice have to participate in a formal government program in order to affiliate with a hospital to provide value-based care?

A. No. The federal government and certain states have established official models involving value-based care. Models include Accountable Care Organizations (“ACOs”), bundled payment programs, and specialty APMs such as the Oncology Care Model. However, hospitals and physician practices frequently enter into affiliations outside of these formal governmental models. Affiliations may be created to achieve certain strategic goals independent of governmental models (such as achieving more efficient care for a patient population, or securing expert management for a hospital service line). Participants in governmental models may also receive certain incentives for entering into affiliations, including Medicare payment bonuses and waivers that exempt some arrangements under fraud and abuse laws.

Q. If there are no governmental programs involved, what kinds of legal and business issues do I need to consider while entering into these arrangements?

- A. The healthcare industry is highly regulated and there are a variety of federal and state laws that govern any legal arrangements between physicians and hospitals. If you bill the Medicare or Medicaid programs, federal fraud and abuse laws such as the Stark Law and Anti-Kickback Statute will place certain limits on the kinds of financial relationships available to you. Even if you do not bill these governmental programs, state fraud and abuse laws (such as fee-splitting laws and “Baby Stark” laws) may apply to your activities on an “all-payer” basis.

Many hospitals are tax exempt organizations; Internal Revenue Service (“IRS”) regulations and state laws often require all funds spent by such entities to fulfill a public, charitable purpose and avoid unreasonably benefiting any private individuals. Anti-trust law may also impact hospital-physician affiliations as well, particularly if they involve shared negotiation or pricing data.

Independent of regulatory requirements, the actual financial and contractual structure of these arrangements is a major focus of negotiation. Because practices have latitude to establish different kinds of affiliations, physicians and practices must pay close attention to the specific terms of each contract to ensure the affiliation meets their needs.

Management and Service Agreements with Hospitals:

Hospital affiliation strategies typically involve contractual agreements between physicians, practices, and other entities to work together for specific purposes.

Q. What is the general structure of a management or service agreement between parties participating in a value-based care arrangement?

- A. While these arrangements can vary, generally, physicians and hospitals jointly agree to perform services on one another’s behalf, collect and achieve certain quality and cost metrics, and share savings or other revenue among the parties. Frequently, the physicians provide professional medical and administrative services, and the hospital provides certain administrative functions, data analytics, and care coordination personnel and services. In some cases, the hospital and physician practice will be operating under a formal arrangement with a third party payer, under which each bills separately. In other cases, the hospital will pay a fee to the practice. This

fee may be explicitly tied to performance, such as a payment based on quality, or a share of the savings generated through the physicians’ services.

Q. What are some examples of services that my practice could provide through a contractual arrangement?

- A. Physician practices can contribute different kinds of services for patients under value-based models, depending on their goals and the degree of independence they would like to maintain. For example, practices can provide specialty or sub-specialty care, as well as on-call care coverage. Similarly, practices can enter into transfer agreements or co-management agreements in which they commit to accepting patients discharged from the hospital who need certain kinds of care. The affiliation can be made closer by providing additional services.

Alternatively, the practice could enter a full-time professional services agreement in which it is the exclusive provider of services to certain hospital patients. Under that approach, the practice frequently reassigns its right to bill for all professional services to the hospital and the hospital is responsible for billing for all of the physicians’ professional services. Physicians can also provide (or arrange for) services other than professional medical services to patients, e.g. administrative or management services.

Q. What are the most important legal rules that apply to compensation under management or service arrangements?

- A. Federal fraud and abuse laws including the Stark Law and Anti-Kickback Statute apply to these arrangements if the physicians refer patients covered by Medicare or Medicaid to the hospital. The arrangements must meet certain standards to remain compliant under these laws. For example, in most cases the relevant contracts must be in writing, and include compensation that is set in advance, fair market value for services provided, and do not vary with the volume or value of the physician’s referrals to the hospital.

Q. Are there options to manage a larger portion of the hospital’s services?

- A. Practices can go beyond agreements to provide clinical services and provide administrative or management services for a larger hospital service line. For example, an orthopedic practice may contract with a hospital to manage the hospital’s orthopedic

service line (which may include medical director services, management of surgical services, and management of associated physical therapy and other ancillary services). In this case, the practice may enter into a co-management agreement under which the specialists work with the hospital to ensure coordinated care is available for both pre and post-hospitalization.

Q. Are there ways to incentivize the hospital and an independent physician practice to work together to achieve certain quality-based goals?

- A. The management services described in this section could also be provided through sophisticated joint venture arrangements between the hospital and physician practice, in which the entities jointly invest in a separate management services organization (or “MSO”) to manage clinical aspects of care. The MSO is paid a management fee, and the hospital and physician practice both receive profit distributions from the MSO based on the overall performance of the service line. In most cases, the management contract between the MSO and hospital will include detailed standards requiring high quality performance and/or cost savings.

Q. What other contractual elements can physicians include in their agreements with hospitals to be consistent with value-based payment principles?

- A. The parties can include a wide variety of tools to align the interests of hospitals and physicians to achieve higher quality and/or decreased healthcare costs. For example, an increasing number of physician agreements provide for bonuses to be paid based on achieving objective quality metrics or cost savings. Parties can be even more aggressive by agreeing to a “withhold,” under which the hospital retains a portion of the money it would otherwise pay to the physicians. Withheld funds would only be released if the physicians achieve the quality and savings standards. Finally, agreements may include “gainsharing” or “shared savings” arrangements, in which the parties analyze the cost of providing care in multiple different settings; if they generate savings, a portion of these savings may be paid to the physicians.

ACOs and Clinically Integrated Networks:

Physician practices and hospitals may choose to go beyond contractual and employment arrangements and participate in formal APMs. APMs, including ACOs and Clinically Integrated Networks (“CINs”), are formal arrangements under which the physician practice and

hospital (and possibly other entities) work together to achieve certain programmatic goals.

Q. What’s the difference between an ACO and a CIN?

- A. ACOs generally operate under formal Medicare program rules, under which one or more health-care entities come together to manage the cost and quality of care of a defined set of Medicare beneficiaries. The healthcare providers in an ACO are paid on a fee-for-service basis, but at the end of each participation period CMS compares the total spending by Medicare on this population to an expected “benchmark” amount. If the ACO generates sufficient savings compared to this benchmark, the providers can receive a portion of these “shared savings.” While ACOs are generally grounded in the Medicare payment rules, there are an increasing number of commercial and Medicaid ACOs that are modeled on these Medicare rules.

CINs operate similarly to ACOs but are designed for the narrower purpose of facilitating clinical integration between various entities (including hospitals and physician practices). CINs are often used to allow hospitals and physicians with a high degree of clinical integration to jointly negotiate with commercial payers. However, because they do not necessarily involve participation in a formal governmental program, they may not enjoy the same kinds of legal protection and/or flexibility as ACOs.

Q. Are there any advantages to physicians and/or practices in structuring a hospital affiliation to participate in a value-based arrangement through an ACO or CIN?

- A. The advantage to physicians in operating in an ACO is that they are formal programs with a widely-understood set of rules. As a result, hospitals, payers, and others tend to have more experience administering these programs, which may make it easier to understand opportunities, incentives, and potential problems. Government ACOs also enjoy greater legal flexibilities under fraud and abuse laws, waivers of certain payment rules (including reimbursement for skilled nursing facility care and telehealth), and advantageous treatment under the QPP. Finally, hospitals may be able to be more flexible in paying physicians under a CIN than they are under other, non-integrated models.

Q. Because I’m a primary care physician, the ACO in which I participate has encouraged me to limit my new Medicare patients while ensuring that

my established Medicare patients are seen on a regular basis. Why is that?

- A. Under the QPP's applicable rules governing APMs, Advanced APM ACOs (e.g., Medicare Shared Savings Program (MSSP) ACOs in Tracks 1+, 2, and 3) must meet certain statutorily defined patient or payment thresholds. The QPP uses specific patient "attribution" rules which attribute or link patients who receive primary care services to the ACO. The QPP's thresholds basically consider what portion of the ACO's patients or payments receive their care from physicians and other providers who participate in the ACO, as compared to those practitioners who do not. The combination of the MSSP and the QPP's APM requirements are designed to encourage the ACO and its participating providers to assume responsibility for providing the care to the ACO's affiliated population of patients. As a result, your ACO may encourage you to ensure that all of your established Medicare patients have access to you and your practice to get the care that they need, and the ACO may seek to help you manage that access by limiting the number of new Medicare patients to whom you provide care.

Q. Is there a barrier to hospital-affiliated physicians taking on a leadership role in an ACO?

- A. No. ACOs (and most other APMs) are designed to be physician led, given the critical leadership role of physicians in the delivery system. Although participation in an APM is likely to have its own challenges, physicians who engage in and assume a leadership role in the APM will be in a better position to drive change in a way that aligns with appropriate approaches to practice and patient care.

Q. Is the composition of participating providers in my APM entity (i.e., ACO or otherwise) likely to change over time?

- A. Yes. Some APMs already limit the types of physicians who can participate in the APM such as episode based models that focus on cardiac or orthopedic conditions, or models that are restricted to primary care practices such as the CPC+ model. MSSP ACOs are allowed to be multispecialty models under their arrangements with CMS, but it's likely that these models will become more primary care driven over time as organizations move to APMs due to the fact that the applicable patient count or payment thresholds applicable to the APM increase over time. These statutorily imposed thresholds will require ACOs and other APMs to become more selective in choosing their participating physicians and other practitioners in coming years.

Physician Compensation:

Q. How do all of these hospital affiliation models impact my physician compensation?

- A. No matter which form of hospital affiliation model is used, it will usually result in some degree of compensation being paid to physicians or their practices. The nature of the compensation being paid to each individual physician will depend on the kind of affiliation. In many cases, the hospital will pay the practice a certain contractual fee (such as a management fee or professional service fee) – this fee will usually include a pre-set component as well as bonuses based on quality performance, productivity, or efficiency (including cost savings). Alternatively, in joint ventures or affiliations involving physician-owned entities, the physicians will realize a profit when they achieve the goals of the affiliation.

Q. Is my practice required to divide funds to the physicians in my practice in any particular way?

- A. In general, practices have a great deal of latitude around dividing funds received from hospital affiliations to their physicians. However, the federal fraud and abuse laws may still apply to regulate these models. Most importantly, physicians should be careful about any models that involve payments that vary with the volume or value of a physician's referrals to the hospital entity. Payments based on achieving cost/efficiency goals may be lower risk.

Q. Are there compensation models that are particularly common in value-based care?

- A. Many value-based care models employ tools that explicitly tie physician compensation to achieving value-based targets. These may include explicitly defined bonuses based on hitting quality goals. Alternatively, many practices withhold a portion of physicians' salaries on the condition that they meet quality and cost targets – this withheld amount is either paid upon meeting the targets, or used for further investment in the practice's value-based methodology. In some cases, the withhold is defined in the practice's agreement with the hospital (as part of the larger affiliation), while in others it is only defined in the practice's employment arrangements.

Q. Is my practice required to hold me accountable for shared losses or other negative impacts of a value-based affiliation?

- A. In general, no. Affiliations are typically negotiated between the physician practice entity and the hos-

pital. As a result, there is usually no formal requirement to reduce the compensation of individual physicians if the affiliation fails to achieve its goals. At the same time, practices may choose to accept and/or implement such payment reductions under certain affiliation structures. As a result, physicians should be careful to understand the terms of any contractual arrangements governing their practice's affiliation models.

Q. Will I be automatically entitled to a share of any bonus my practice receives through a hospital affiliation?

- A. Because these models are generally based on contracts between the practice and hospital, your compensation will be primarily determined through your employment agreement (or other contract with your practice). These contracts should describe your entitlement to any bonus compensation, including bonuses received by the practice as a result of any affiliation. Practices generally have a great deal of freedom to decide how bonuses will be divided, but any methodology used should ideally be set in advance in contracts with physicians.

Q. What information should I obtain to understand whether a hospital's proposed change to my or my practice's compensation is fair?

- A. At a minimum, you should understand how your compensation is determined under the relevant affiliation agreement(s), and you should have confidence that the methodology is accurate and uses accurate data that can be validated. This means, for example, that any adjustments to your compensation linked to the Merit-Based Incentive Payment System (MIPS) or other programs should be able to be tracked and understood by you. You should also receive meaningful reports and feedback that help you understand your current performance on important variables, and how that performance may impact your future compensation. It's in your own best interest (and the best interest of the hospital as your employer) to ensure that you optimize your performance under MIPS and any APM in which you participate.

Q. I am concerned about adjustments to my compensation based on the performance of other clinicians who are part of my hospital affiliation. How can I protect myself from their poor performance?

- A. To start, you can advocate for individual reporting under MIPS as that will permit your performance to

be separated from the performance of your colleagues. Depending on your specialty and practice, you might also want to encourage the use of APM models that focus on episodes that allow you to participate as an affiliated practitioner, rather than be subject to the aggregate performance of all of the providers in the Tax Identification Number (TIN) of your employer practice entity. Depending on the legal structure of your employment relationship, you might want to seek a new legal structure (meaning you will bill through a TIN that is separate from the TIN used by your lower performing colleagues) as a means to ensure you have maximum autonomy and control over your performance and compensation.

Q. Is there a way to avoid limiting my compensation for professional services to an amount that's fair market value?

- A. Most hospital-physician employment relationships are subject to fair market value limitations due to legal and compliance requirements. What level of compensation is (or is not) fair market value for your services is likely to evolve over time as value-based reimbursement becomes more common in Medicare and commercial payor arrangements. The QPP encourages the migration to APMs that involve at-risk arrangements, and certain "at-risk" payment arrangements (such as ACOs) can be structured to avoid the application of fair market value limitations in some circumstances if a waiver applies.

Q. My compensation includes a productivity element defined by the number work RVUs I produce. How does this affect my performance under value-based affiliation models?

- A. Work RVUs (wRVUs) are a common measure of productivity in a fee-for-service system, since they reflect both the number of services you provide and the relative complexity of these services. These are common throughout the industry, and they are frequently used to set the terms of compensation within physician practices. However, wRVUs are less ideal for measuring the overall performance of a physician practice under a hospital affiliation, where considerations like overall outcomes, performance on quality measures, and cost savings may be more important. In practice, while wRVUs are likely to become less common in measuring overall practice performance in an affiliation, they will likely continue to be a significant share of each individual physician's compensation from his or her practice.

Q. Does the QPP require hospitals and other organizations to change the compensation methodology or the amount of compensation I receive as a matter of law?

- A. No. Changes are not required under the QPP, although it's likely that hospitals and other employers will change compensation methodologies over time as payment models become increasingly "value-based" (i.e., focused on quality and cost), including in connection with the on-going roll-out of the QPP's MIPS and Advanced APM tracks.

Unwinding and Independence Considerations

Q. Is it important that I preserve my ability to back out of an affiliation and/or renegotiate the deal?

- A. Ideally, the affiliated physician practice and hospital will achieve their shared goals and be satisfied with the outcome. However, particularly in novel models of affiliation, physicians may fear becoming too entangled with the hospital, such that it is difficult or impossible to regain independence. As a result, at the very beginning of any affiliation, it is important to consider strategies for potentially unwinding the arrangement or otherwise re-establishing an independent practice.

Q. How can I build in the ability to back out of a hospital affiliation?

- A. Physicians may negotiate certain initial contractual terms in their affiliation agreements (e.g., the professional service or independent contractor agreement, on-call agreement, employment agreement) and terms of sale that may make it easier to unwind an unsatisfactory arrangement. "Backing out" of such an arrangement may mean simply terminating your current affiliation with the hospital, affiliating with a hospital competitor, or returning to private practice. Regardless of the scenario, consider negotiating contract termination rights that allow you to more easily terminate the agreement (i.e. without-cause termination rights with a shorter notice period, such as 90 days). You should also pay attention to any non-competes (i.e. agreeing not to practice within a certain geographic area for a specified time frame), which may restrict your ability to return to private practice, or work for a competitor, after terminating the affiliation.

Q. What are examples of contractual provisions I may want to include in an affiliation agreement to allow me to re-establish independent practice if it does not work out?

- A. Provisions may include negotiating rights to repurchase or sublease equipment or space at a specified price (e.g., book value; purchase price minus applicable depreciation), rehire other clinical or administrative personnel, or transfer electronic health records. Most importantly, physicians should not overlook the administrative difficulties in unwinding such arrangements or returning to private practice. For example, providers may need significant financial liquidity to restart a practice given lag time between claims submission and reimbursement. You may consider keeping accounts receivable (billed, but not yet collected) received post-closing in a separate bank account to provide cash flow for any potential return to practice.

Q. How should I approach access to the hospital's information technology (IT) infrastructure to preserve my independence?

- A. Affiliated physicians often convert to the hospital's IT infrastructure (potentially including its electronic health record software and billing & coding system) as part of their affiliation. Practices may consider negotiating for upgrades/access to current (and future upgrades of) hospital IT infrastructure as part of any affiliation. However, transitioning to the hospital's IT infrastructure can be difficult if it is different than yours. Differences in electronic billing software, even different versions of the same software, can affect billing and reimbursement efficiency for administrative/billing personnel who continue with you through the affiliation. You may experience a disruption in documented productivity (and associated billing) if such personnel are unfamiliar with the hospital's IT infrastructure.

Q. Are there specific IT risks I should consider if the hospital will be billing and coding on behalf of my practice?

- A. If hospital administrative/billing personnel will replace practice administrative/billing personnel, you may experience a disruption in productivity and billing as hospital personnel may be unfamiliar in billing for your practice's types of procedures or services. Such a transition particularly may affect affiliation arrangements involving productivity-based compensation, as these physicians may not receive credit for claims not properly submitted by the hospital. Physicians may consider negotiating a transition period (e.g., 3 months) during which productivity compensation is based on historical performance (e.g., wRVUS from the 3 months prior

to affiliation), rather than actual wRVUs, to allow for a transition without a loss of productivity compensation. You may also consider negotiating for the right to continued access to then-current hospital IT infrastructure upon termination or unwinding of any affiliation.

Q. Are there any considerations for my non-clinical staff?

A. If you affiliate with the hospital via employment or as an independent contractor, do not assume that the hospital will retain any non-clinical staff, unless specifically included within the terms of the affiliation. This is particularly true when a practice is sold, or cases in which the hospital manages all practice operations. You may want to consider negotiating for retention of certain key administrative and billing personnel (e.g., practice administrator) to ease your transition into the affiliation as they may allow you to maintain stable billing and productivity. If these members of your staff become hospital employees, many contracts prohibit solicitation of such employees if the affiliation contract terminates. As part of your initial agreement, consider negotiating specific rights to re-hire these administrative employees in the event that you unwind your hospital affiliation under certain circumstances.

Q. What kinds of informational rights should I seek?

A. As part of your initial affiliation agreement, you should negotiate information rights from the hospital sufficient to understand your performance, and any potential effects on your compensation, under any value-based models and generally based on your affiliation with the hospital. This may include negotiating access rights to:

- The methodology applied in determining your performance under any productivity-based compensation arrangement (i.e. billing and collections information) to assess and validate for accuracy calculations used in the methodology;
- Performance metrics and associated results for quality-based compensation to understand how the hospital evaluates performance and to foresee performance issues (e.g., metrics that may negatively affect your compensation) and identify areas for improvement; and
- Meaningful reports and feedback regarding the above throughout the year.

Q. What might I request if the hospital wants me to learn how to use an electronic health record (EHR) other than the one I am used to using?

A. Interoperability of EHR systems is often a key part of value-based affiliations. This kind of integration is vital to improving transitions of care, and coordination between different settings of care. However, migration from one EHR system to another can be disruptive to a physician practice, impacting personal production, compensation and satisfaction with the practice of medicine. Hospitals and health systems commonly provide support in the form of additional personnel, additional compensation or other types of transitional assistance to support physicians as they transition from one EHR system to another. However, all of these support services and personnel should be described in detail in the initial affiliation agreement. Practices and/or physicians on a production-based compensation plan (i.e., dollars per RVU), the practice/physicians may seek to be held harmless from decreases in production (often for a defined period of time) to reflect the disruption caused by a change to the EHR system as part of the compensation plan. Likewise, for physicians on a base salary compensation model, the inevitable dip in production due to EHR transition can be addressed (and excluded) from any evaluation of productivity in setting and/or adjusting the base salary.