STROUDWATER

FMV UNDER THE MICROSCOPE:

PROTECTING YOUR HOSPITAL IN A $6.5B ENFORCEMENT ENVIRONMENT

June 18, 2026

INTRODUCTIONS

Speakers & Learning Objectives

MEET THE SPEAKERS

Shad Ritchie, MHA, FACMPE, CRCHP

Senior Consultant at Stroudwater Associates

Joe Theine, MHCDS, MBA

CEO at Southwest Health System

Megan Hazelton, MS-HCM

Consultant at Stroudwater Associates

KEY LEARNING OBJECTIVES

By the end of this session, participants will be able to:

- Explain the regulatory interplay between FMV, the Stark Law, and the Anti-Kickback Statute in a way that supports board-level oversight and governance.
- Identify compensation structures and documentation practices that reduce enforcement risk while maintaining market competitiveness.
- Implement practical guardrails and “safety valve” strategies to ensure compensation plans remain defensible in a heightened enforcement climate.

POLL QUESTION

In your opinion, how well does your organization understand the compliance and FMV considerations tied to provider compensation?

A. Extremely well
B. Moderately well
C. Slightly well
D. Not well at all

WHY IS THIS IMPORTANT?

The Current Regulatory State

PRIMARY LAWS AND STATUTES

Stark Law	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 (such as Fair Market Value) Strict liability statute – this is where technical violations happen!
Anti-Kickback Statute (“AKS”)	The AKS is a criminal law that prohibits the knowing and willful payment of “remuneration” to induce or reward patient referrals or the generation of business involving any item or service payable by the federal healthcare programs (e.g., drugs, supplies, or healthcare services for Medicare or Medicaid patients)
False Claims Act (“FCA”)	Triple the damage is caused for anyone who commits Medicare fraud Any violation of Stark or AKS is considered on its face false or fraudulent, and a violation of the FCA
Private Inurement	Applicable to not-for-profit organizations only Compensation that exceeds a typically fair salary for comparable positions Consequence is revocation of not-for-profit status

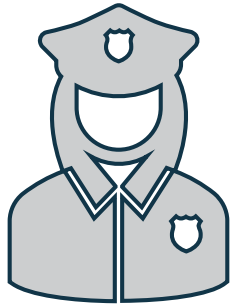
2025 RECORD-BREAKING $6.8B RECOVERY OF FEDERAL FUNDS BY OIG AND ITS AGENCIES

Of the $6.8B recovered, 83% or $5.7B was from the healthcare industry under the False Claims Act (FCA)

The primary focus of the total $6.8B in recoveries is on these sectors:

- Medicare Advantage: Risk adjustment practice and diagnostic code manipulation
- Pharmaceutical and Medical Devices
- DME
- Unnecessary Services and Substandard Care: Genetic tests and lab services
- Digital Health: Remote patient monitoring and AI-generated fake patient records

HOWEVER...



HHS, OIG, and DOJ have prioritized improper financial arrangements between hospitals and employed physicians as a core enforcement area

Specifically, those involving compensation above Fair Market Value (“FMV”)

Improper Medical Directorship Pay that violates the Anti-kickback Statute (“AKS”) and Stark Law

FALSE CLAIMS ACT RECOVERIES IN 2025

80% OF THE RECOVERIES FOR 2025 WERE OBTAINED THROUGH WHISTLE BLOWER ACTIONS – QUI TAM LAWSUITS

1,297 QUI TAM LAWSUITS WERE FILED IN 2025 (UP FROM 940 IN 2024)

APPROXIMATELY $5.3B IN RECOVERIES CAME FROM THIS TYPE OF LAWSUIT

CIVIL MONETARY PENALTIES LAW (CMPL)

The government is also seeing an increase in self-disclosure of alleged violations, resulting from incentives such as reduced penalties and damages to self-disclose

Many hospital-physician compensation violations are processed under the self-disclosure protocol to allow for reduced damages from 3.5 X to 1.5X

CMS Self Referral disclosures settlements related to physician compensation in 2025 were an aggregated $20M, a decrease from 2024 of $24.7M

OIG also processes self-disclosure cases and, in 2025, had a financial impact of $2.43B, not all from settlements related to hospital-physician compensation violations

THE RURAL IMPACT

Provider Compensation Strategy

KEY FINDINGS FROM THE 2025 STROUDWATER RURAL PROVIDER COMPENSATION REPORT (BASED ON 2024 DATA)

- There is significant variation in provider pay among rural organizations, and provider compensation continues to increase annually
- There is an urgent need for rural healthcare to align provider compensation with the organization's goals and ensure compliance with FMV
- Many rural healthcare organizations' current provider strategies are financially unsustainable, not consistent with best practices, and raise concerns about maintaining compliance
- It is imperative that rural healthcare leaders align provider pay with the changing market and their organization's goals to ensure financial and operational sustainability

POLL QUESTION

How would you describe your organization's provider compensation strategy across employed specialties?

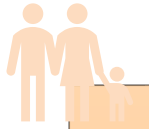
A. Clear and consistently applied
B. Somewhat defined but consistently applied
C. Not clearly defined
D. Not sure

KEY COMPENSATION BEST PRACTICES FOR CONSIDERATION

- Implement an organization-wide compensation strategy that aligns with industry best practices and FMV
- Compensation models may include the following components:

Annual Guarantee

- Starting base salary
- Base compensation – may or may not be readjusted annually based on prior year productivity



Productivity Incentive

- % of NPSR or Gross Charges mostly replaced by compensation per Work RVU (“wRVU”); compensation per visit; panel size compensation

Value-based Compensation

- Quality Incentives
- Value-based reimbursement (“VBR”) adjusted wRVU
- Distribution of ACO dollars

Administrative & Other Duties

- Medical Directorship
- APP Supervision
- Call Compensation

POLL QUESTION

How recently has your organization engaged a third-party to conduct an FMV review for provider compensation?

A. Within the last 2 years
B. 2-5 years ago
C. Not recently / not at all
D. Unsure

KEY COMPENSATION BEST PRACTICES FOR CONSIDERATION

Obtain FMV Opinions from a trusted, third-party resource that considers the following:

Specialty/subspecialty

Duties & responsibilities

Community need (e.g., deficits, wait times, closed specialties, high disease incidence, outmigration, seasonality)

Community benefit (e.g., new specialty or service)

The time it takes to recruit

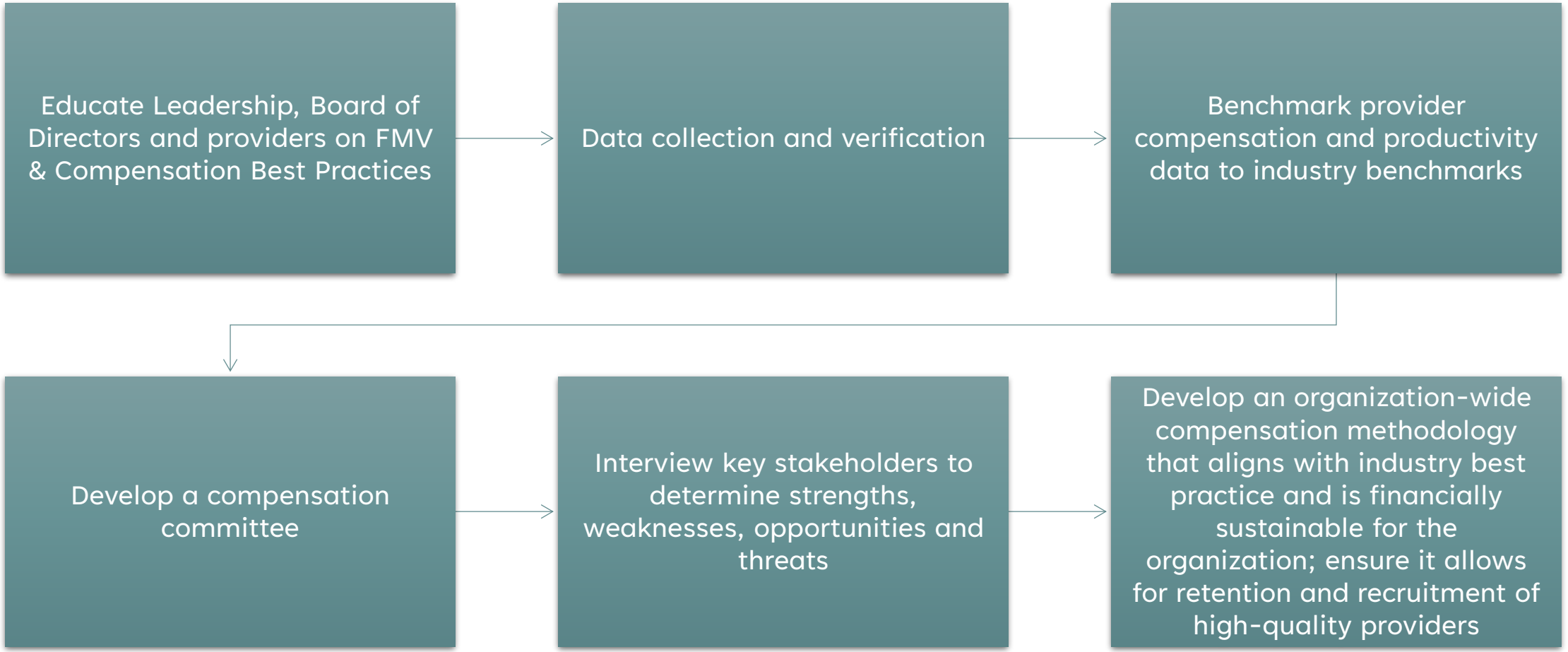
Training & experience

Compensation methodology & amount (including cash and in-kind compensation)

Benchmark comparison using a nationally recognized source

FMV opinions must be documented with the physician's contract, especially if compensation is greater than or equal to the 70th percentile of the benchmark and/or compensation-to-productivity is greater than 10%

COMPENSATION REDESIGN PROCESS



FIRESIDE CHAT

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

Shad Ritchie,
Senior Consultant
sritchie@stroudwater.com
(T) 704-305-0023

Let's Connect!

Megan Hazelton,
Consultant
mhazelton@stroudwater.com
(T) 207-221-8279

Let's Connect!

Joe Theine, CEO,
Southwest Health System
jtheine@swhealth.org

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