

# **CLE Resources: Texas Health Law Conference 1997**

## **Physician Compensation, Incentive Plans, and Tax Issues**

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### **I. INTRODUCTION**

Texas hospitals have been faced with understanding the basic legal principles related to compensation paid to physicians for many years. Payment for medical directorship services and physician recruitment guarantees of compensation under physician recruitment agreements are two examples of hospital involvement in physician compensation. With the growth of certified nonprofit healthcare corporations in the past five years and growing federal regulation affecting physician compensation, hospital administrators and their legal counsel must have a more in depth understanding of the subject.

For the most part, for-profit and nonprofit tax-exempt hospitals operate under the same legal principles when dealing with physician compensation. The principal difference is in the penalties they face from a federal income tax standpoint. For-profit hospitals face loss of deduction, interest and penalties for the payment of excessive compensation, while nonprofit tax-exempt hospitals face intermediate sanctions excise tax penalties and possible loss of exemption for making payments in excess of reasonable compensation. Both face civil monetary penalties, possible exclusion from Medicare, Medicaid and other federal and state payment programs, and criminal prosecution if the excess is found to be an inducement for referrals of business.

This outline presents principal statutory and regulatory provisions applicable to physician compensation. It does not deal with other very important, but very expansive and technical, provisions of law affecting particular aspects of compensation of physicians, such as fringe benefits, deferred compensation and qualified retirement plans. For guidance on such issues, the reader is referred generally to the excellent Tax Management Portfolio Series published by Tax Management, Inc., a subsidiary of The Bureau of National Affairs, Inc.

For ease of reference in this outline, the employer or other party making payments to a physician will often be referred to as the "hospital," although in Texas, the party involved may be another form of organization.

### **II. CLASSIFICATION AS EMPLOYEE OR INDEPENDENT CONTRACTOR**

#### **A. Overview.**

1. The starting place for analyzing the issues of physician compensation is classification of a physician as an employee or independent contractor. If the physician is an employee, the employer is obligated to withhold income and FICA taxes, match the physician employee's share of FICA taxes and pay unemployment taxes on wages paid to the physician. Other employee costs, such as paid vacation, deferred compensation plans, health insurance, and other compensatory benefits may be provided by the employer. If the physician is an independent contractor, the hospital, not being the employer of the physician, avoids an employer's obligations (which would fall on another party who is determined to be the physician's employer or on the physician as a self-employed person). Therefore, a significant economic incentive may exist for misclassification of physicians as employees or independent contractors. The Internal Revenue Service ("IRS") believes that this misclassification is a major area of noncompliance for health care entities. As important as this classification is for federal income tax purposes, status as an employee or independent contractor will determine whether and what safe harbors or exceptions are available for federal Anti-Kickback Law, Texas Illegal Remuneration Law and Stark Law purposes.

2. The principal determining factor in the classification decision is the degree of control, or lack of control, the purported employer has over the physician.

Treasury Regulations Sections 31.3121(d)-1(c)(2) (FICA Taxes) and 31.3401(c)-1(b),(c) (Income Taxes) provide that an employer-employee relationship exists when the person for whom the services are performed has the right to control and direct the individual performing the services, not only as to the result to be accomplished by the work, but also as to the details and means by which the desired result is

accomplished. The right to exercise control or direction over what will be done and how it will be done is sufficient without the actual exercise of that right. Having the right to control or direct merely as to the result to be accomplished, and not the means and methods for accomplishing the work, is indicative of an independent contractor relationship. The regulations sections state that generally individuals, such as physicians, who are engaged in the pursuit of an independent trade, business or profession in which they offer their services to the public, are considered independent contractors and not employees.

## **B. Common Law Rules.**

The determination of employee status is generally determined by application of the so-called "common law" rules. These rules for making classification decisions are set forth as a 20-factors test in Rev. Rul. 87-41, 1987-1C.B.296. These factors are used as guides for employment status determinations. The degree of importance of each of the factors varies dependent upon the facts of the case, including the occupation of the person being classified. The 20 factors are:

1. Instructions. An employee is required to comply with instructions about when, where and how to work.
2. Training. An employee is trained to perform services in a particular manner, while independent contractors use their own methods and receive no training from the purchasers of their services.
3. Integration. An employee's services are integrated into the business of his employer and are important to the success or continuation of the business.
4. Services Rendered Personally. An employee performs the services, and is therefore subject to control over the methods and the result to be achieved.
5. Hiring Assistance. Employees do not ordinarily hire their own assistants, whereas an independent contractor hires, supervises and pays his or her own assistants.
6. Continuing Relationship. A continuing relationship is indicative of an employment relationship even if the relationship is performed at frequently recurring although irregular intervals.
7. Set Hours of Work. An employer normally sets a schedule for work of an employee, while an independent contractor is the master of his or her own time.
8. Full Time Work. An employee normally works full time for an employer, while the independent contractor determines when and for whom he or she will work.
9. Work Done on Premises. An employee normally works on the premises of the employer or on a route or other location fixed by the employer.
10. Order of Sequence Set. An employee performs services in an order or sequence set by the employer, while the independent contractor determines when, where and how a particular job will be accomplished.
11. Reports. Employers typically have the authority to require employees to submit reports in order to ensure accountability.
12. Payments. Regular recurring payments are indicative of an employment relationship, while an independent contractor is normally paid on a job rate or straight commission.
13. Expenses. Normally an employee's expenses are paid by his or her employer.
14. Tools and Materials. An employee is not usually required to furnish the tools, materials or other equipment necessary to perform the assigned task, while the independent contractor normally provides tools necessary to accomplish the job.
15. Investment. The independent contractor normally has the burden of investment in the necessary tools or other items required to perform a job.
16. Profit or Loss. Normally the risk of profit or loss rests with an independent contractor, but not with an employee.
17. Works for More Than One Person or Firm. An independent contractor is free to work for as many or few persons as he or she chooses, while an employee normally performs services on behalf of one firm.
18. Offers Services to the General Public. The independent contractor offers his or her services to the general public, often advertising for those services. An employer normally advertises and secures customers and instructs the employee to perform services for those customers.
19. Right to Fire. Most employers have the right to fire employees, while firing an independent contractor may result in a breach of the contractual relationship and possible damages for breach of contract.

20. Right to Quit. An employee normally would be able to quit his or her job at any time without liability, while an independent contractor has usually agreed to accomplish a specific job and is responsible for its satisfactory completion or would be legally obligated to make good for failure to complete the job.

### **C. Application to Physicians.**

The IRS recognizes that in situations involving professionals such as physicians, the degree of control by an employer over the activities of the professional is more tenuous than when dealing with non-professional employees. Therefore, the IRS finds the common law factors that focus on independence of judgment, or the physician's skill in providing patient care, are less important than factors that focus on the independence of the business operations of the physician's practice from the business operations of the party on whose behalf the physician is performing services (a professional association, for example) or in whose premises or facility the physician performs the services (a hospital, for example). In essence, the determining factor or factors will be who has the right to control various components of the physician's practice that are not implicit to the physician's exercise of independent judgment in the care and treatment of the patient. If the physician's business operations, costs of doing business and risks of doing business remain with the physician, the physician is most likely an independent contractor. In the typical employment situation for a physician group practice, the requisite control is accorded to the practice entity through an employment contract or other personal services arrangement with the practice organization. In addition to this employment relationship, a physician may also be considered an employee of a hospital when performing services for and in the hospital, such as acting as a medical director of a hospital department or service. When it is desired that the physician remain as an employee of the practice entity for all purposes, it will be important that the practice entity enters into the contract with the hospital to provide the services of a physician to act in the desired capacity and that sufficient controls remain with the practice entity so that the physician performing those duties remains subject to such controls and, therefore, employment status stays with the practice entity.

### **D. Penalties for Misclassification.**

The penalties for misclassification can be severe. The employer may be assessed delinquent taxes, interest on the unpaid taxes and penalties. Generally, the employer is liable for all the taxes the employer would have owed as well as the taxes the employer should have withheld from the employee. Relief for misclassification may be available to an employer under several avenues. The first is provided by Section 530 of the Revenue Act of 1978, extended by the Tax Equity and Fiscal Responsibility Act of 1982 for indefinite duration. This section provides protection when the employer was justified in making the misclassification. This relief does not convert the status of a person from employee to independent contractor, but it does permit the continued nonpayment of federal employment taxes for the employer, although the employee remains liable for the employee's share of FICA.

In order to qualify for relief under Section 530, the employer must have had a "reasonable basis" for treatment of the individual as an independent contractor, the individual must have been consistently treated as independent contractor and filed the appropriate information returns on that basis and the employer must not have treated any other person in a substantially similar position as an employee. One of the bases for establishing a "reasonable basis" for treatment of a physician as an independent contractor rather than an employee, is demonstrating that such treatment was consistent with a long-standing recognized practice of a "significant segment" of the industry in which the employee is engaged. The IRS has interpreted "significant segment" to be 80% or more of all employers in the industry. Other relief may be available under Sections 3509 or 6205(a)(1) of the Internal Revenue Code ("Code").

## **III. REASONABLE COMPENSATION**

### **A. Overview.**

Whether a hospital is a for-profit entity or a nonprofit tax exempt organization, compensation paid to a physician for services must be reasonable in amount and be for services actually rendered.

In the case of a tax-exempt hospital, Section 501(c)(3) of the Code requires that the hospital be both "organized and operated exclusively for . . . charitable . . . purposes, . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual." The hospital is regarded as being "operated exclusively" for one or more exempt purposes only if it engages primarily in activities which

accomplish those exempt purposes. If more than an insubstantial part of its activities are not in furtherance of its exempt purpose, it will lose its exemption. (Treas. Regs. § 1.501(c)(3)-1(a)(1); (c)(1))

In order to be seen as carrying out its exempt purposes, the hospital must serve public rather than private interests and its net earnings must not inure, in whole or in part, to the benefit of private shareholders or individuals. (See Treas. Regs. § 1.501(c)(3)-1(c)(2); (d)(1)(ii)). The IRS recognizes that some private benefit must be allowed in order for a hospital to carry out its exempt purposes. However, in order to be permissible, any private benefit must be incidental to the public benefit in both a qualitative and quantitative sense. A private benefit is "qualitatively incidental" if, in order to achieve the public benefit, some benefits to private individuals necessarily result. A private benefit is "quantitatively incidental" if it is insubstantial when measured against the overall public benefit to be achieved from the activity. (See e.g., GCM 39862 (Nov. 21, 1991)) The restriction on private inurement is read more strictly than the limitation on private benefit. Due to the language "no part" in the statute and "in whole or in part" in the Regulations, there is no de minimis exception for private inurement. However, an exempt organization is permitted to pay reasonable compensation for services and fair market value for goods supplies it needs in order to carry on its activities.

The IRS has taken the position that staff physicians of a hospital will fall within the meaning of private shareholders or individuals. (See Hospital Examination Guidelines at 333.2(2) Announcement 92-83). As discussed in outline Section IV below, Congress in the legislative history of the Intermediate Sanctions Legislation cast doubt on this traditional interpretation by the IRS, stating that physicians should be considered to be "disqualified persons" only when they are in a position to exercise substantial influence over the affairs of the organization. More recently, as a part of the provider-sponsored organization provisions forming a part of the Balanced Budget Act of 1997, Section 501(o) was added to the Code providing that persons with a material financial interest in a provider-sponsored organization will be treated as an insider of a hospital participating in that same provider-sponsored organization. (See § 4041(a) of Pub. Law 105-33 effective August 5, 1997).

The central issue in determining whether the requirements for deductibility are met in a for-profit hospital situation and that the quantitatively incidental test for private benefit is met and no-private inurement results from payment of compensation to a physician is that the amount of compensation is "reasonable" or a fair market value for the purposes being performed.

### **B. Determining Reasonableness - Generally.**

The IRS will scrutinize a physician compensation arrangement to ensure (1) the compensation plan is not merely a device to distribute profits to principals or transform the organization's principal activity into a joint venture (See e.g., GCM 38952 (Nov. 21, 1991)), (2) the compensation plan is the result of arm's-length bargaining and (3) the compensation plan results in "reasonable" compensation. Other federal and state regulators may examine the arrangement to ensure (1) the compensation plan does not include any impermissible inducements for referrals or self-referrals, (2) the compensation plan is the result of arm's length bargaining and (3) the compensation plan results in "reasonable" compensation. Whether compensation is reasonable is ultimately a question of fact, to be determined by looking at all relevant circumstances. Treas. Reg. § 162.7-(b)(3) says it is just to assume reasonable compensation is an amount that would ordinarily be paid for like services by like organizations in like circumstances. Thus, the concept has two prongs: an amount test, focusing on the reasonableness of the total amount paid; and a purpose or intent test, examining the services for which the compensation was paid. (See e.g., *Thomas A. Curtis, M.D., Inc. v. Comm'r*, 67 TCM 1958 (1994)). These two prongs are not separate issues, focusing on separate facts. Rather, the various factors in a particular situation are taken together to determine whether either or both of the tests is satisfied. Because reasonableness of compensation is a question of fact, the IRS will not give an advance ruling in this area. (See Rev. Proc. 96-3 1996 CB 456, 457 § 3.01(8))

When evaluating a physician employee's compensation, all forms of compensation paid must be included in the analysis. Thus, the term "compensation" must include (i) salary or wages, (ii) contributions to pension and profit sharing plans, (iii) unpaid deferred compensation, (iv) payment of personal expenses, (v) rents, royalties or fees, and (vi) personal use of the organization's property or facilities.

### **C. Factors in Judging Reasonableness.**

The IRS has stated that twelve factors should be considered in judging reasonable compensation. The twelve factors are: (1) the nature of the employee's duties; (2) the employee's background and

experience; (3) the employee's knowledge of the business; (4) the size of the business; (5) the employee's contribution to profit-making; (6) the time devoted by the employee to the business; (7) the economic conditions in general and locally; (8) the character and amount of responsibility given to the employee; (9) the time of year when compensation is determined (10) the relationship of shareholder-officer's compensation to stockholdings; (11) whether the compensation is in reality in whole or in part payment for a business or assets acquired, and (12) the amount paid by similar businesses in the same area for equally qualified employees for similar services. (See Internal Revenue Manual at 4233 § 232.2(3)).

Case law, which numbers in the thousands, on reasonable compensation, indicates that courts consider the following factors: the employee's qualifications; the nature, extent and scope of the employee's work; the size and complexities of the business; a comparison of salaries paid with the gross income and the net income of the corporation; the prevailing general economic conditions; whether the corporation has sufficient net income after the payment of salaries to pay a return to shareholders; and the prevailing rates of compensation for comparable positions in comparable concerns. (See e.g., Curtis, M.D., Inc. supra at 1962).

Within the context of a health care organization's "integrated delivery system," the IRS has identified the following factors to be particularly relevant:

1. Arm's-length relationship. One of the most important factors in evaluating the reasonableness of compensation is whether the employer and employee negotiated the compensation at arm's-length. The negotiations may be viewed either as an indication of reasonableness or as one part of a three prong inurement analysis. Most cases and rulings simply list arm's-length negotiations simply as one factor in judging reasonableness. An alternate view is that negotiations, reasonableness and whether an arrangement is simply a device to distribute profits are three equal parts of an inurement analysis. Under either approach, arm's-length negotiations are critical. Evidence of an arm's-length relationship include formal offers that passed between the parties, or contemporaneous memoranda that document face-to-face negotiations or (as reviewed below for Intermediate Sanctions) a truly independent body has responsibility for review and final approval. Proof of valid offers from third parties are also helpful in establishing that negotiations were arm's-length and that compensation is comparable to that paid by similar institutions. It is important to note, however, that while lack of arm's-length bargaining is an important factor, it does not always create inurement.

2. Nature of the Employee's Duties. The employee's duties are an important factor in reasonableness. If the employee performs highly specialized and skilled tasks, has responsibility for a large volume of work, or supervises other employees, he or she may command a higher salary.

3. Employee's Background and Experience. If an employee is particularly well qualified for a position because of relevant prior experience, education or proven expertise in the area, a higher salary might be warranted than would otherwise be the case.

4. Employee's Salary History. In one judicial decision, the court noted that the employee's salary increased substantially over salaries in his previous positions after he became the sole shareholder of the corporation indicating that his salary reflected his new influence rather than any new duties or capabilities. (See e.g. Lefkowitz v. Comm'r, 46 TCM 485, 490-491 (1983)).

5. Salary Scale of Others in the Same Line of Business. Treasury Regulations section 162-7(b)3 states that "it is in general just to assume that reasonable compensation is only such amount as would ordinarily be paid for like services by a like enterprise under like circumstances." Code section 162 cases often focus on the "like industries" aspect of the regulations because comparability of salaries in an industry is arguably a more objective factor in judging reasonableness than some others. In the physician group context, this determination is easier in urban areas, where there are many similarly situated physicians and where there are likely to be regional studies of physician compensation.

6. Independence of Board. Another major factor in determining the reasonableness of compensation includes the independence of the committee or other party that determines the compensation terms and levels. Generally, if a compensation committee contains no financially interested members, there is a greater presumption that compensation is reasonable. Consideration should be given to implementing the following elements in a hospital Board approval process: (1) salaries should be determined by an independent board or committee comprised of individuals without a financial interest in the physician's practice; (2) written minutes from the Board or committee responsible for approving compensation should be maintained and (3) to avoid potential application of the "intermediate sanctions" penalties, the Board or committee should secure a "reasonableness" opinion from an independent consultant before approving

such compensation. (See FY 1993 Exempt Organizations CPE Technical Instruction Program text at p. 201 et seq.).

#### **D. Burden of Proof.**

The hospital has the burden of proving that the compensation paid is reasonable. Typically, the hospital must meet its burden of proof by presenting external, reliable documentary evidence, or testimony from impartial, credible, well-qualified witnesses. Physician compensation surveys are available from consulting firms to assist in determining comparable levels of physician compensation. Care must be used in relying on those surveys to be sure the various factors used in compiling and presenting the survey are comparable to the situation at hand. The IRS has specifically endorsed using such surveys. See e.g., Rev. Rul. 97-21, 1997-18 I.R.B. 8. A list of useful surveys is attached to this Outline.

#### **E. Consequences of "Unreasonable" Compensation.**

In the event there is a determination that compensation to a physician employee of a tax-exempt organization (or a taxable organization relying on the financial support of a tax-exempt organization is "unreasonable," the IRS may (i) revoke the tax exemption of the organization or (ii) impose monetary penalties against the recipient and possibly the members of the compensation committee under the "intermediate sanctions" statute. In a for-profit hospital context, a loss of deduction, interest and penalties on unpaid taxes may be assessed. In addition, the hospital, recipient, and members of the compensation committee may be subject to penalties and prosecution under the federal Anti-Kickback Law, the Texas Illegal Remuneration Law, and the Stark Law.

#### **F. Specific Issues in Physician Compensation.**

##### **1. No Absolute Cap.**

The IRS takes the position that incentive compensation arrangements lacking some sort of "cap" or upside limitation could result in unreasonable total compensation. This is particularly the case in percentage bonus arrangements that are not tied directly to services or personal productivity of the physician.

The hospital may consider a number of alternatives to establish a cap, including: (1) state a specific dollar amount in each agreement; (2) provide a "cap" based on independent surveys; or (3) include in the contracts a statement that "total compensation may not exceed an amount which is reasonable for the physician's specialty and geographic locale," and provide for securing an opinion from a qualified consultant on this factor before making payments under the agreement. In one IRS private letter ruling the hospital's independent auditor would determine whether the compensation was reasonable (PLR 9112006 December 20, 1990).

##### **2. Overhead Calculation.**

A hospital should be concerned about any situation in which the employer is paying significant compensation bonuses to the physicians despite the fact that it is operating at a loss and being subsidized by the hospital. A hospital should consider including as an element in any overhead calculation a reasonable return to the organization on its investment in the enterprise over time. In an integrated hospital system, identifying overload allocations and what may be considered a "system" investment in infrastructure is relevant the calculation and allocation of overhead.

##### **3. Computation of Compensation Based on Gross Collections or Revenues and Ancillary Services Revenues.**

In many cases a physician's incentive compensation may include revenues generated by (i) nurse practitioners and physician's assistants and (ii) subordinate physicians.

The IRS permits incentive compensation provisions based on net or gross revenues, provided that the incentives are based on revenue generated by the physician and/or medical personnel working directly under the physician's supervision and the aggregate compensation is "reasonable." These strictures dovetail with the Stark Law provisions permitting incentive compensation based on services "personally performed by the physician." While current regulations do not further define this element of the Stark Law, informal discussions with HCFA personnel indicate that HCFA intends to interpret "personally performed by the physician" to include services incident to such personally performed services. For services to be incident to services performed by the physician, they must be furnished as an integral, although incidental, part of the physician's personal professional services, and must be furnished under the physician's direct supervision by employees of the physician (or employees of the same entity

that employs the physician). See 42 U.S.C. § 1395x(s)(2)(A), 42 C.F.R. § 410.26, and Medicare Carriers Manual § 2050.

Thus, for purposes of a physician compensation plan, a physician's production or revenues may be allowed to include the revenues of a nurse practitioner or physician's assistant, provided that the mid-level providers are under the physician's direct supervision. A measure of gross revenues should not include the revenues of another physician, even if "subordinate" to the physician at issue. This raises significant Stark Law, federal Anti-Kickback Law, and Texas fee-splitting issues.

The Stark Law likewise will not permit a physician's compensation to include revenues from laboratory and ancillary services, unless the allocation of those revenues is unrelated to whether the physician made, or the volume of, referrals. For example, a division of ancillary services revenues "per capita," based on personal production of physician services or quality and patient satisfaction measures should be found permissible.

#### 4. Net Profit Split.

Compensation programs are sometimes proposed that provide that the physicians will retain all collections after accounting for the employer's expenses (including overhead and debt service). This arrangement is problematic for the following reasons. First, it could be construed to violate the Texas Non-Profit Corporation Act, which forbids distribution of the income of a non-profit corporation to its members, directors or officers. Second, permitting the physicians to keep 100 percent of revenues after expenses would appear to constitute an impermissible "split" of net profits strongly disfavored by the IRS. Third, such an arrangement would appear to be structurally unreasonable because it would not reflect the attributes of an arms-length relationship and could be viewed as transforming the employer's principal activity into a joint venture.

#### 5. Other Incentive Formulas.

The IRS's biggest concern with incentive arrangements based solely on gross or net revenues is that such arrangements do not provide necessary incentives to the physician to provide care to non-revenue patients. Accordingly, to further protect a compensation plan from attack by the IRS or other regulators, a hospital may consider modifying its incentive compensation arrangement to encourage the physician to treat indigent patients, participate in community education or scientific program, or engage in other activities which do not generate net revenues but which nevertheless further the hospital's exempt purposes. This could be accomplished by giving the physician revenue "credits" for such services. The IRS has issued favorable letter rulings on arrangements in which the incentive compensation was keyed to cost savings or other efficiencies achieved by the hospital with the services of the physicians. See e.g. PLR 880708 (November 30, 1987); PLR 8610050 (December 10, 1985). However, if designing such an incentive plan, consider the Stark Law and hospital incentive payments implications of payments intended to reduce costs and resource consumption.

## **IV. INTERMEDIATE SANCTIONS STATUTE**

### **A. Background.**

The Taxpayer Bill of Rights 2 (the "Act") was signed into law on July 31, 1996. Formally known as H.R. 2337, the Act adopts section 4958 of the Code, which creates excise taxes on management and other insiders of tax-exempt organizations. The new excise taxes are commonly referred to as "intermediate sanctions" because they are intended to address an absence of intermediate measures, short of revocation of tax-exempt status to be used by the IRS. As revocation of tax-exempt status is a draconian measure that may actually be detrimental to the general public rather than the individuals responsible for an entity's noncompliance, Congress deemed it necessary to give the IRS intermediate sanctions as a statutory tool to prevent and address certain abusive transactions by insiders of tax-exempt organizations. The legislative history states that these intermediate sanctions are generally the "sole sanction imposed" in situations where a tax-exempt organization's charitable status is not called into question. There is, however, no legislative limitation on the ability of the IRS to impose a revocation of tax-exempt status.

### **B. The Act.**

Section 4958 imposes multi-tiered excise taxes on a "disqualified person" that receives benefits in connection with an "excess benefit transaction" or as to any manager of an organization that knowingly participates in an excess benefit transaction.

A "disqualified person" is defined as:

1. any person who at any time during the five year period ended on the date of the subject transaction was in a position to exercise substantial influence over the affairs of the tax-exempt organization;
2. a member of the family of an individual described in paragraph 1. or
3. an entity which constitutes a 35% controlled entity (after applying constructive ownership rules) with respect to an individual described in paragraph 1.

A "manager" of a tax-exempt organization includes any officer, director, trustee or individual having similar powers or responsibilities of a tax-exempt organization.

The Committee Report indicates that a physician on a medical staff of a tax-exempt hospital will not be a disqualified person solely based upon his status as a physician, unless such physician otherwise constitutes a disqualified person by exercising substantial influence over the tax-exempt hospital. This is a departure from the IRS's long-standing position that all medical staff physicians are insiders. Additionally, just as significant is the absence of a per se inclusion of officers, directors and other management employees in the definition of disqualified person. For officers, directors and other management employees to constitute disqualified persons, such persons must likewise exercise substantial influence over the tax-exempt organization.

### **C. Excess Benefit Transaction.**

An "excess benefit transaction" is a transaction in which a disqualified person receives a benefit in excess of the fair market value received by the tax-exempt organization or pays the tax-exempt organization less than fair market value for property or services provided by the tax-exempt organization. The definition of an excess benefit transaction includes an indirect transaction by an entity controlled by or which is a subsidiary of a tax-exempt organization, whether or not a for-profit entity. Additionally, the Treasury is granted authority to identify excess benefit transactions that provide impermissible economic benefit to a disqualified person based on the revenues of one or more activities of the tax-exempt organization. The legislative history indicates that existing tax law standards will apply in determining reasonableness of compensation and fair market value.

Amounts paid by a tax-exempt organization as consideration for the performance of services are not to be considered compensation unless the tax-exempt organization clearly indicates its intent to treat such payments as compensation. Thus, non-salary fringe benefits (e.g., payments of personal expenditures of an officer) paid to compensate an individual for services rendered can be improper excess benefits unless such benefits were intended as compensation at the time payment was made. The legislative history indicates that payments intended as compensation should be contemporaneously documented according to established procedures and reported on Form W-2 or Form 1099.

Significantly, in determining whether or not an excess benefit has been paid by a tax-exempt organization, the legislative history provides that comparative data from for-profit entities as well as tax-exempt organizations is relevant. The Conference Committee Report further states that it is not intended that an individual accept reduced compensation merely because he or she renders services to a tax-exempt, as opposed to a taxable organization. This may signal an end to the long time debate as to whether tax-exempt organizations should be required to compensate their top executives at compensation levels lower than those of taxable organizations.

Finally, legislative history outlines a trap with respect to indemnity payments or indemnity insurance premium payments. Any reimbursements by the organization of excise tax liability or any payment of premiums on an insurance policy providing liability insurance to a disqualified person can constitute an excess benefit unless such are treated as part of the compensation paid to such disqualified person. Therefore, hospitals will want to review the indemnity protection currently available to their officers, directors or trustees and other management employees. Such protection includes D & O insurance and straight indemnification obligations from the tax-exempt organization. A tax-exempt hospital that desires to ensure that current or proposed indemnity protections will protect directors, officers and other management employees needs to review its existing insurance policies, bylaws and articles. Further, the hospital must determine whether any indemnity or premium payment on behalf of an officer, director or management employee constitutes an "excess benefit transaction" in its own right. To the extent a director of a tax-exempt organization is treated as receiving compensation in connection with an indemnity protection (e.g., payment of liability insurance premiums), such compensation may affect a volunteer director's Texas statutory immunity for certain actions.

#### **D. Excise Taxes.**

Section 4958 provides a two-tiered excise tax with respect to covered transactions. A person's liability with respect to the excise taxes is joint and several with other persons of the same classification, whether a disqualified person or a manager as to a tax-exempt organization.

1. Initial Tax. The initial tax is imposed on a "disqualified person" in the amount of 25% of the excess benefit. The excess benefit, as noted above, is the excess of the economic benefit provided by the tax-exempt organization over the consideration, including property or services, received by the tax-exempt organization. Additionally, an excise tax equal to the lesser of \$10,000 or 10% of the excess benefit is imposed on a "manager" of a tax-exempt organization that participates in an excess benefit transaction, unless the participation is not willful and is due to reasonable cause.

2. Additional Tax. The additional tax is imposed on a disqualified person in an amount equal to 200% of the excess benefit involved if such excess benefit is not corrected (i.e., undoing the excess benefit to the extent possible and taking additional measures necessary to place the organization in no worse position than it would have been had the disqualified person acted under the highest fiduciary standards) within the period beginning on the date such transaction occurred and ending on the earlier of the date of mailing a notice of deficiency by the IRS or the date on which the IRS assesses the initial tax.

#### **E. Rebuttable Presumption.**

Legislative history provides for a rebuttable presumption to be established by the IRS in regulations as to the reasonableness of a compensation arrangement or as to the fair market of other property transfers pursuant to transactions in which a disqualified person is involved. The rebuttable presumption applies if such arrangement was approved by the board of directors or a committee thereof and all of the following conditions are satisfied:

1. The board or committee was composed entirely of individuals unrelated to and not subject to the control of the disqualified person involved in the subject transaction.

2. The board or committee considers relevant and appropriate data as to market comparability (e.g., compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions; the location of the organization, including the availability of similar specialties in the geographic area; independent compensation surveys by nationally recognized independent firms; or actual written offers from similar institutions competing for the services of the disqualified person).

3. The board or committee adequately documented its determination.

It should be noted that the presumption is rebuttable by the IRS upon a showing of probative evidence to the contrary, which is sufficient to rebut the presumption.

#### **F. Retroactive Effective Date.**

Except for certain transition rules the intermediate sanctions are retroactively effective as of September 14, 1995.

### **V. PHYSICIAN INCENTIVE PLAN REGULATIONS**

#### **A. Background.**

Implementing certain statutory requirements for managed care organizations enacted in 1990, the Health Care Financing Administration ("HCFA") issued rules, which became effective January 1, 1997, to regulate certain physician incentive plans. Generally, these rules apply to Medicare risk and cost based contracts and Medicaid HMOs.

##### **1. Definition.**

A physician incentive plan means any compensation arrangement between a managed care organization (e.g., an HMO) and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare or Medicaid enrollees in the managed care organization.

##### **2. Forms of Compensation Arrangements.**

These compensation arrangements may take three different forms:

(1) incentives to the physician or physician group in the form of bonuses from the managed care organization beyond the normal salary, or fee-for-service or capitation payments;

(2) withholds (percentage or set dollar amounts that the managed care organization deducts from the physician's or physician group's service fee, capitation or salary payment) that may or may not be returned to the physician or physician group, depending on specific predetermined factors; or

(3) capitation payments where the physician or physician group may be responsible for services provided by the physician, referral services or all medical services.

### 3. Purpose.

Congress, in directing that physician incentive plans be regulated, was "concerned with insuring that under-use of necessary services does not occur." Federal Register, March 27, 1996, at 13434. This purpose was again reiterated in HCFA's Operational Policy Letter no. 96.045 in which it was stated "the purpose of the statute and regulation is to protect patients against improper clinical decisions made under the influence of strong financial incentives."

### 4. Basic Requirements.

The regulations incorporate four basic requirements:

(a) that a managed care organization not operate a physician incentive plan that directly or indirectly makes specific payments to a physician or physician group as an inducement to limit or reduce medically necessary services to an individual enrollee.

(b) that it disclose to HCFA its physician incentive plan arrangements;

(c) that certain disclosures be made to beneficiaries; and

(d) that if a physician incentive plan places a physician or physician group at "substantial financial risk" for services not provided directly, the managed care organization: i) must ensure that the physician or physician group has adequate and appropriate stop-loss insurance protections and ii) conducts surveys of currently and previously enrolled members to assess the degree of access to services and the satisfaction with the quality of services.

## **B. Analysis of Physician Incentive Plan Requirements.**

### 1. No Inducements to Limit Services.

The first requirement comes in the form of a general prohibition applicable to all managed care organizations with which HCFA contracts for the arrangement and provision of health care services to Medicare and Medicaid beneficiaries. It forbids a managed care organization from paying physicians to limit or reduce medically necessary services to a particular enrollee. It does not prohibit a managed care organization from paying incentives to physicians or implementing other measures designed to limit or reduce the amount or type of services used by enrollees, so long as these incentives or measures are applied uniformly to all beneficiaries in a certain group.

### 2. Disclosure to HCFA.

The depth of disclosure that must be made to HCFA is on a graduated system depending on the type and degree of risk transferred to physicians through the physician incentive plan. For example, a managed care organization that does not transfer risk to its physicians or physician groups for referral services must provide only general information. A managed care organization that does transfer referral risk to its physicians or physician groups is required to provide more detailed information to HCFA.

Because a managed care organization may have multiple contracting levels, HCFA requires that all levels of contracting be reported to it. This means that a managed care organization must survey all its "downstream contractors" to the lowest tier of contracts in order to collect the necessary information for disclosure to HCFA. Each contracting level will have some degree of disclosure, depending on the type of compensation arrangement involved. Thus a managed care organization which contracts with an IPA must not only disclose the incentive arrangements with that IPA, but must also report to HCFA the payment arrangements with the IPA's subcontractors and any other downstream arrangements flowing from those contracts.

### 3. Disclosure to Beneficiaries.

Managed care organizations are required to publish in the evidence of coverage notices, or such other notice as approved by the applicable regional HCFA office, that beneficiaries can request summary information on the managed care organization's physician incentive plans. The nature of the disclosure to beneficiaries will be general, as opposed to providing physician-specific financial incentives information. Materials must convey information about the types of incentives used and contracts affecting physicians in the managed care organization's network. In addition, the managed care organization must disclose to the beneficiary whether stop-loss protection is provided and, if it was required to conduct a beneficiary survey, a summary of the survey results. Managed care organizations will not be required to disclose for

each beneficiary requesting it the details of the particular incentive arrangement under which that beneficiary's physician operates. Managed care organizations will be allowed some discretion in crafting language to convey the required information to beneficiaries, although the degree of flexibility permitted depends in large part on the particular HCFA Regional Office. See HCFA Q&A Disclosure Question 3. In drafting the rules and subsequent guidelines, HCFA attempted to adhere to Congressional intent.

#### 4. Concept of Substantial Financial Risk.

While HCFA realized that physician incentive plans were permissible devices to ensure the cost-effective delivery of health care services, it also realized that there may exist a level of risk placed upon a physician beyond which he or she might not make as many referrals as he or she should. This risk, called referral risk, occurs when the physician's or physician group's payment from the managed care organization is tied to health care services that the physician or physician group orders or arranges for, but does not directly provide. To further assure that enrollees were receiving the referral services that they needed, HCFA had to set a percentage as a risk threshold above which a physician incentive plan places a physician or physician group at substantial financial risk.

"Substantial Financial Risk" means an incentive arrangement that places the physician or physician group at risk for amounts beyond the risk threshold, if the risk is based on the use or costs of referral services. The risk threshold is 25 percent.

The amount at risk for referral services is the difference between the maximum potential referral payments and the minimum potential referral payments. Bonuses unrelated to referrals (e.g., quality or access bonuses such as those related to member satisfaction or physician open panels) should not be counted as referral payments. Potential payments is defined as the maximum anticipated total payments that the physician or physician group could receive if use or costs of referral services were low enough. Payments may be for either direct or referral services, or for administration, but do not include bonuses paid for reasons other than referrals.

Substantial Financial Risk exists if:

- A physician or physician group is paid straight capitation (i.e., uses no withholds or bonuses), and that capitation covers services that the physician does not provide;
- Withholds from physician's payment for services exceed 25 percent;
- Withholds from physician's payment for services do not exceed 25 percent, but physician is liable for referral costs that exceed the withhold;
- A physician's bonus (in situations where there are no withholds) exceeds the limit of 33 percent of potential payment, not counting the bonus itself;
- Withholds plus bonuses equal more than 25 percent of potential payments;
- In a capitation arrangement, the difference between the maximum and minimum possible payments is more than 25 percent of the maximum possible payments, or if such an arrangement is not clearly explained in the physician's or physician group's contract; or
- Any other arrangement exists that could hold a physician or physician group liable for more than 25 percent of potential payments.

Once a physician incentive plan has been determined to place a physician or physician group at substantial financial risk, additional duties are placed on the managed care organizations and its physicians to ensure that physicians do not deny an enrollee necessary referral services. Specifically, the managed care organization must ensure that the physician or physician group has adequate and appropriate stop-loss insurance protections and must conduct surveys of currently and previously enrolled members to assess the degree of access to services and the satisfaction with the quality of services.

## **VI. HOSPITAL INCENTIVE PAYMENTS**

### **A. Statutory Provisions.**

A provision was included in the Omnibus Budget Reconciliation Act (OBRA) of 1986, later codified at 42 U.S.C. § 1320a-7a(b), which prohibits hospitals or rural primary care hospitals from knowingly making payments, directly or indirectly, to a physician as an inducement to reduce or limit services provided to Medicare beneficiaries or Medicaid recipients who are under the direct care of the physician. A hospital or rural primary care hospital which violates this section is subject to a civil money penalty (CMP) of not more than \$ 2000 for each such individual with respect to whom the payment is made, in addition to any other penalties prescribed by law.

## **B. Proposed Regulations.**

Proposed rules were issued to implement this section of OBRA on December 1, 1994. 59 F.R. 61,571. However, these rules were never adopted. Although these rules are not in effect, they do provide some insight as to what situations and what types of incentive arrangements will trigger the assessment of a CMP. Specifically, it was acknowledged that these rules would only apply to those physicians having direct care responsibilities, and not those functioning in a management or supervisory capacity.

The proposed regulations essentially mirror the statute itself, except that the regulations provide a list of factors which will be used in determining the amount of any penalty to be assessed. These include:

1. The nature of the payment designed to reduce or limit services and the circumstances under which it was made;
2. The extent to which the payment encouraged the limiting of medical care or the premature discharge of the patient;
3. The extent to which the prohibited arrangement caused actual or potential harm to program beneficiaries;
4. The number of program beneficiaries affected by such incentive plan;
5. The extent and prior history of offenses by the hospital and physician(s) making or accepting such payment;
6. The financial condition of the hospital involved in the offering of such prohibited incentive plan; and
7. Such other matters as justice may require.

## **C. GAO Report.**

The Supplementary Information to the regulations relied heavily on a General Accounting Office (GAO) report entitled "Physician Incentive Payments by Hospitals Could Lead to Abuse." HRD-86-103, July 1986.

"The GAO report highlighted several general characteristics or aspects of physician incentive plans that, individually or collectively, have tended to give physicians an incentive to reduce quality of care to program beneficiaries. Among those characteristics cited by GAO as significantly affecting physicians' financial incentives to undertreat or provide substandard care were: (1) The length of the period over which the physician's cost performance is assessed to determine the level of incentive payment, (2) the number of physicians over which cost performance is calculated to determine if an incentive plan is paid, and (3) the use of arrangements under which the physician is paid a percentage of savings or profits." 59 F.R. at 61,572.

The preamble to the regulations also enumerated a number of specific recommendations from the GAO's physician incentive plan report, including:

- Such plan payments should be based on the cost performance of a group of physicians rather than by individual physicians.
- Payments should be based on performance over a relatively long period of time, e.g., over a one year period, as opposed to a single month or quarter.
- Incentive payments should not be based on the hospital's profits resulting from treating any individual patient.
- Any physician payment system of this type by a hospital should include a strong program of utilization and quality of care review.

## **VII. STARK LAW**

### **A. Background.**

The federal Stark Law (42 U.S.C. §§ 1395nn, 1396b(s)) prohibits physicians (or their immediate family members) who have a financial relationship with an entity from referring Medicare or Medicaid patients to the entity for the furnishing of certain "designated health services" that are covered by either the Medicare or Medicaid programs, absent an applicable exception.

1. A "financial relationship" includes any compensation arrangement between a physician and an entity for payment of any remuneration, and any ownership or investment interest by a physician in an entity. Additionally, the entity may not present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a prohibited referral.

2. The term "referral" generally is defined as a request by a physician for an item or service for a patient, including the request by a physician for a consultation with another physician and any test or procedure ordered by, or to be performed by that other physician (or someone under his/her supervision).

3. "Designated health services" include inpatient and outpatient hospital services and ten other categories.

Physicians may have a financial relationship with a hospital through any number of compensation arrangements. An obvious one is a medical directorship agreement. Further, the services for which the physicians will refer patients to the hospital, on both an inpatient and outpatient basis, fall under the purview of designated health services. Therefore, one of the exceptions to the Stark Law must apply if a "financial relationship" exists with the hospital.

## **B. Applicable Exceptions.**

### **1. Bona Fide Employment Relationships.**

Any amount paid by an employer to a physician (or an immediate family member of such physician) who has a bona fide employment relationship with the employer for the provision of services does not trigger the prohibition on referrals if:

- a. the employment is for identifiable services,
- b. the amount of the remuneration under the employment --
  - (1) is consistent with the fair market value of the services, and
  - (2) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician,
- c. the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referral were made to the employer; and
- d. the employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

The requirement that the amount of remuneration not take into account the volume or value of any referrals does not prohibit the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or an immediate family member of such physician).

### **2. Personal Service Arrangements.**

a. In General. Remuneration from an entity under an arrangement (including remuneration for specific physicians' services furnished to a nonprofit blood center) does not constitute compensation that would trigger Stark's prohibition on referrals if:

- (1) the arrangement is set out in writing, signed by the parties, and specifies the services covered by the arrangement;
- (2) the arrangement covers all of the services to be provided by the physician (or an immediate family member of such physician) to the entity;
- (3) the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement;
- (4) the term of the arrangement is for at least 1 year;
- (5) the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value and, except in the case of a physician incentive plan described below, is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.
- (6) the services to be performed under the arrangement do not involve the counseling or promotion or a business arrangement or other activity that violates any State or Federal law, and
- (7) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

### **b. Physician Incentive Plan Exception.**

(1) Physician Incentive Plan Defined. - For purposes of this subparagraph, the term "physician incentive plan" means any compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the entity.

(2) In General. - In the case of a physician incentive plan between a physician and an entity, the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

(a) No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the entity.

(b) In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary pursuant to section 1876(i)(8)(A)(ii), the plan complies with any requirements the Secretary may impose pursuant to such section.

(c) Upon request by the Secretary, the entity provides the Secretary with access to descriptive information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance with the requirements of this clause.

### 3. Group Practice Bonus.

a. Physicians who practice in a group practice may be paid a share of the overall profits of the group as a productivity bonus when based on services performed personally by the physician or services incident to those services, so long as the share of the bonus is not determined in any manner directly related to the volume or value of referrals by the physicians. The term "group practice" is defined in subsection (h)(4)(A) of the Stark Law as "a group of 2 or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan or similar association"

- in which each physician member of the group provides substantially the full range of the services routinely provided by the physician through the joint use of shared office space, facilities, equipment and personnel
- substantially all of the services of the physician group members are billed under the group's provider number and amounts received are treated as receipts of the group
- overhead expenses of and the income from the practice are distributed in a manner previously agreed upon
- except for the profits and productivity bonus mentioned above, no physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals made by that physician.

## **VIII. FEDERAL ANTI-KICKBACK LAW; TEXAS ILLEGAL REMUNERATION LAW.**

### **A. Overview.**

1. Federal Anti-Kickback Law. The federal Anti-Kickback Law (See 42 U.S.C. Section 1320 a-7b(b)) prevents individuals and entities from knowingly and willfully soliciting, receiving, offering or paying any remuneration to other individuals and entities (directly or indirectly, overtly or covertly, in cash or in kind):

- a. in return for referring an individual to a person or the furnishing or arranging for the furnishing of any item or service for which payment may be made under a federal or state healthcare program; or
- b. in return for purchasing, leasing, ordering or arranging for, or recommending purchasing, leasing, or ordering any good, facility, service or item for which payment may be made under a federal or state healthcare program.

Federal and state healthcare programs for purposes of this law include medicare, CHAMPUS and Medicaid. Civil and criminal penalties are provided for violation of the Anti-Kickback Law. The few court cases interpreting the Anti-Kickback statute have broadly construed it to include virtually anything of value given to an individual or entity if one purpose of the remuneration is to influence the recipients' reason or judgment related to referrals. See e.g., *United States v. Greber*, 760 F.2d 68 (3rd Cir. 1985); *United States v. Baystate Ambulance and Hospital Rental Service, Inc., et al*, 874 Fed.2d 20 (1st Cir. 1989); *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995); *United States v. Jain*, 93 F.3d 436 (8th Cir. 1996, cert. den. 117 S.Ct. 2452 (1997)).

2. Texas Illegal Remuneration Law. The Texas Illegal Remuneration Law (Texas Health and Safety Code Section 161.091) makes it a criminal offense for any person, licensed, certified or registered by a Texas healthcare regulatory agency, to intentionally or knowingly offer to pay or agree to accept any remuneration (directly or indirectly, overtly or covertly, in cash or in kind) to or from any party for securing or soliciting patients or other business. While this statute parallels in many respects the Anti-Kickback Law, it applies more broadly because it is not limited to items or services reimbursable under a federal or Texas healthcare program.

## **B. Safe Harbors.**

Because of the breadth of application and significant penalties provided for in the Anti-Kickback Law and the Texas Illegal Remuneration Law, certain types of activities or relationships have been granted statutory or regulatory protection as "safe harbors" from being considered violations of law. (See 42 U.S.C. § 1320a-7b(b)(3) and Texas Health and Safety Code § 161.091(f)).

1. Employee Safe Harbor. A statutory safe harbor, amplified by federal regulations, exists for amounts paid by an employer to a bona fide employee for employment in the provision of covered items or services (42 U.S.C. § 1320a-7b(b)(3)(b); 42 CFR § 1001.952(i)). Employment status for purposes of the safe harbor is to be determined under the same criteria as applied under Code Section 3121, discussed in Section I of this Outline. Therefore, classifying a physician as an employee is of significant advantage for purposes of qualifying for the broad statutory safe harbor under the Anti-Kickback Law and the Texas Illegal Remuneration Law. Despite the breadth of the safe harbor, however, the Office of Inspector General of the Department of Health and Human Services has stated that payments to an employee for referrals may not qualify as a payment for the "provision of covered items or services" eligible for protection (See The Exempt Organization Tax Review, 705 (April 1993)).

2. Personal Services and Management Agreement Safe Harbor. The safe harbor for personal services and management contracts applies if 6 criteria are met. These criteria are:

- a. The agreement for services is written and signed by the parties;
- b. The agreement specifies the services to be provided by the agent;
- c. If the agreement provides for periodic, sporadic or part time services, rather than full time services during the term of the agreement, it specifies exactly the schedule of such intervals, their precise length and the exact charge for those intervals;
- d. The term of the agreement is for at least one year;
- e. The aggregate compensation to be paid over the term of the agreement is set in advance, is consistent with fair market value and arms-length transactions are not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties which may be paid in whole or in part under Medicare or Medicaid; and
- f. The services performed under the agreement do not involved the counseling or promotion of a business arrangement or other activity that violates any state or federal law.