

# ADHERING TO TAX-EXEMPT GUIDELINES FOR PHYSICIAN RECRUITMENT



By Brian Ackerman

Increased transparency and regulatory enforcement highlight the need for hospitals to re-evaluate physician recruitment practices to ensure compliance with Federal guidelines. Those not taking a pro-active stance in light of heightened scrutiny face the risk of having their tax-exempt status questioned by Federal regulators.

The Federal government continues to devote increased resources toward evaluating the appropriateness of a hospital's tax-exempt status. The IRS Form 990 redesign provides a clear indication of the government's desire to improve transparency and increase enforcement of tax exemption-related rules and regulations. Although such regulations for physician recruitment have been in place for over two decades, the government has yet to apply resources necessary for consistent enforcement.

In what can be seen as a warning sign of what is coming, the 2009 Inpatient Prospective Payment System Final Rule includes a "test run" for acquiring hospital information regarding financial relationships with physicians. The Disclosure of Financial Relationships Report will be sent to 500 hospitals and will serve as a preliminary audit of hospital/physician relationships. While this process relates most specifically to ensuring compliance with physician self-referral statutes, it certainly speaks to the government's intent to more closely monitor hospital/physician arrangements. This is likely just a first step, future auditing procedures are expected to probe more deeply into recruitment practices, specifically regarding whether a tax-exempt hospital is adhering to Federal recruitment guidelines.

## Demonstrating Community Benefit

As a tax-exempt entity, the IRS wants to ensure that a hospital's physician recruitment practices are not financially benefiting private individuals, and recruitment incentives are considered a benefit. If this illegal practice of "inurement" is taking place, a hospital could potentially lose its not-for-profit status.

Beginning in 1986, the IRS has provided guidance on how to appropriately structure permissible recruiting agreements. In summary, reasonable recruitment incentives can be provided to physicians if the benefit provided to that physician is incidental to the benefits that physician will provide to the hospital's community. The primary method of demonstrating community benefit is to provide an objective assessment of community need for the services the physician will provide.

Although the IRS evaluates physician recruiting on a case by case basis, it has provided guidance regarding the types of recruitment incentives that hospitals may offer. The table below includes recruitment incentives outlined by the IRS in Revenue Ruling 97-21:

Permissible Recruitment Incentives	
• Income guarantee	• Mortgage guarantee on physician's home
• Signing bonus	• Financial practice start-up assistance
• Malpractice insurance for a limited period	• Moving expense reimbursement
• Office space at below market rent	• Malpractice "tail" coverage

The IRS also provided guidance on ways to demonstrate community benefit in its 1994 closing agreement with Hermann Hospital in Texas. Although such agreements only apply to the subject party, it nonetheless provides guidance for demonstrating community need. According to the terms of this agreement, one or more of the following must apply for a hospital to pay recruiting incentives based on community benefit:

1. A calculated specialty deficiency based on supply and total market need, demonstrated through the application of industry benchmarks or ratios;
2. Demand for a medical service in the community coupled with a documented lack of availability or long waiting periods;
3. Federal designation as a Health Professional Shortage Area (HPSA);
4. A demonstrated reluctance of physicians to relocate to a hospital due to location (including rural or economically disadvantaged areas);
5. A reasonably expected reduction in number of physicians of a specialty serving the hospital's service area due to anticipated retirements within the next three years; or,
6. A documented lack of physicians serving indigent or Medicaid patients, provided the recruit commits to serve a "substantial number" of those patients.

Documentation of how community benefit was estimated must be a key component of any hospital's physician recruitment activities. In addition, recruitment incentives must be provided based on what is reasonable, and recruitment agreements must be in writing and approved by the hospital's Board.

## Defining a Hospital's Community

Although the IRS has provided guidance for demonstrating community benefit, it has remained silent on how to define a hospital's community for purposes of recruitment. Is a hospital's community its home county or primary service area? Can secondary and tertiary services assume a broader geography? To answer these questions hospitals should rely on the definition in the "Stark" legislation. Named for Congressman Pete Stark (D-CA), this legislation became effective in 1992 with the primary purpose of governing physician self-referral for Medicare and Medicaid patients. This legislation, which has been updated multiple times, explicitly defines the geographic area served by the hospital as the following:

Stark Defined Service Area - "Community"
Lowest number of contiguous zip codes from which the hospital draws at least <u>75 percent</u> of its inpatients

During its recent update, which became effective December 4, 2007, Stark provided an alternative test for determining the geographic service area of rural hospitals:

Alternative "Community" for Rural Providers
Lowest number of contiguous (or in some cases, noncontiguous) zip codes from which the hospital draws at least <u>90 percent</u> of its inpatients

Not only is it critical that an assessment of community need be based on this service area, but to comply with Stark regulations any physician that is recruited using financial recruitment assistance must relocate his or her practice to this service area and either move the practice a minimum of 25 miles or derive 75 percent of future practice revenues from new patients who live in that geography.

## Preparing a Compliant Community Physician Needs Assessment

While the recruiting priorities for most hospitals relate to clinical program growth, that driver must be balanced with a formal Community Physician Needs Assessment to protect against inurement. This document should incorporate an objective and systematic approach to identifying need and illustrate an effort to comply with recruiting regulations. At a minimum, such an assessment should incorporate the following steps:

- Determine the hospital's community (defined by Stark) by reviewing inpatient origin annually;
- Research total community provider supply, and account for specialty, office locations, and age (adjustments can be made for anticipated retirements based on age);
- Estimate the total physician demand of your community. Although physician-to-population ratios have historically been the standard, many of those benchmarks have become dated. Contemporary physician demand models more closely match the population's actual needs based on its demographic profile and expected utilization of health care services;
- Conduct surveys of area practices to determine time to first appointment and potential access issues related to insurance status;
- Determine where community shortages exist by specialty; and,
- Should a hospital offer recruitment incentives to a physician in a shortage specialty, two final steps should be taken:
  1. Per recent Stark updates, an attempt should be made to update the above analyses as close as possible to the signing of the recruiting agreement; and,
  2. Have final agreements reviewed by legal counsel and approved by the hospital Board.

Completing these steps will help to ensure compliance and should represent a critical piece of any hospital's medical staff plan. While a complete medical staff plan must also take into account a hospital's institutional needs, such as succession priorities, clinical growth objectives, and new market expansion opportunities, the community needs assessment will demonstrate the hospital's commitment to its community, while safeguarding against future regulatory scrutiny.

*Brian Ackerman is a managing consultant at Health Planning Source (HPS) located in the Research Triangle area of North Carolina. HPS and its consultants have decades of experience assisting provider organizations coast-to-coast with their strategic challenges and planning issues. Should you have any questions about this article, or any other medical staff planning topics, please contact Brian at [BrianAckerman@HealthPlanningSource.com](mailto:BrianAckerman@HealthPlanningSource.com).*