

Internal Revenue Service  
**memorandum**

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TR-45-01178-95  
Br.6: RWDenick

date:

JUL 6 1995

to:

Director, Exempt Organizations Division E:EO  
Attn: Marvin Friedlander

from:

Assistant Chief Counsel  
(Employee Benefits and Exempt Organizations) CC:EBEO

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subject:

[REDACTED]

As you requested, we are returning the administrative files in the above referenced cases. Although we have not yet completed our review of the cases, we offer the following preliminary suggestions for your consideration:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

We believe that these representations are necessary to inform this Hospital and the exempt organization community that physician ownership of exempt health care organizations is permitted only in very restricted circumstances.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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1 [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] will not be involved in medical training or research. It was formed principally as a recruiting device of the Hospital. Presumably, the formation of [REDACTED] will allow the Hospital to compete more effectively in the managed care marketplace. We doubt that the administrative file currently contains sufficient information on whether [REDACTED] meets the community benefit standard of Rev. Rul. 69-545, 1969-2 C.B. 117. Other than the contractual obligation set forth in the employment agreement between [REDACTED] and its physician-employees (which requires the physician to render services to all patients without discrimination as to . . . ability to pay), there is no specific information on the level of charity care that [REDACTED] will provide or its obligation to provide charity care. The proposed budgets in the Form 1023 do not explicitly refer to allowances for charity care. (However, counsel for [REDACTED] stated in his letter dated March 11, 1994, that [REDACTED] will adhere to a policy separating bad debt from charity care).

Second, [REDACTED] makes sweeping statements that because it is an integral part of the Hospital it will be subject to the Hospital's charity care policy. However, it did not attach the Hospital's charity care policy. [REDACTED] also states that it "will be subject to Medicare and Medicaid requirements on serving patients since the Hospital participates in both the Medicare and Medicaid programs. Thus, [REDACTED] will render emergency services upon request to all persons irrespective of ability to pay."

[REDACTED]

[REDACTED]

In your transmittal memorandum of March 2, 1995, you requested advice on whether the physician "net income" incentive compensation arrangement set forth in [REDACTED] employment agreements causes [REDACTED] net earnings to inure to the benefit of the physician-employees. Although we have not reviewed this compensation arrangement in detail, we nevertheless have several concerns. The compensation arrangement is as follows:

An annual productivity bonus equal to 50% of the total revenue received by the Corporation from patient billings for the professional services provided to inpatients and outpatients by Physician or under Physician's



Net arrangements are permitted in certain narrowly-drawn circumstances.<sup>2</sup> In [REDACTED] G.C.M. 39674, EE-44-85 (June 17, 1987), stated that the mere establishment of profit-sharing incentive compensation plans for hospital employees does not result in inurement or undue private benefit, if three requirements are met:

- (1) the plans are the result of arms-length bargaining;
- (2) the amount of compensation is reasonable;
- (3) the plan is not a device to distribute the profits to principals or transform the organization's principal activity into a joint venture.

The GCM concluded that two plans were permissible under section 501(c)(3), but declined to determine in advance whether the amount of compensation was reasonable. Hospital A's plan was available to all management and nonmanagement employees (physicians were not employees), but any employee on the board of directors was precluded from voting on any matters affecting Plan A, including any decisions regarding the amount to be set aside to pay bonuses under Plan A. Plan A limited the contingent compensation available to a percentage of the actual margin of revenues from operations (less expenses) over the budgeted margin. The amount depended on results achieved under a quality assurance plan, patient guarantee expenses and capital expenditure needs and was 50 percent for the years at issue. The maximum bonus allocated to any employee could not exceed 10 percent of the employee's regular compensation. Hospital A's stated purposes in adopting Plan A were to recognize and reward employee performance, encourage cost containment and motivate and reinforce efficiency and quality of service and provide compensation competitive with that offered by other employers. Hospital A's charges for patient care were subject to review by a state agency. Hospital A represented that this review process effectively prevented management from artificially raising Hospital charges in order to directly benefit from such increases through Plan A.

Hospital B's plan involved only nurse employees, none of which was an officer, director, or member of the committee administering the plan. The total amount payable to employees .

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<sup>2</sup>But see, Rev. Proc. 93-19, 1993-1 C.B. 526, a revenue procedure defining private business use of bond proceeds under section 141(c), which prohibits any compensation based in whole or in part on a share of net profits

under Plan B was slightly less than one-third of Hospital B's net income from operations. Payments under Plan B were related to each employee's allocable share of the total amount payable and the performance of the employee's department with respect to standards designed to measure quality of patient care and patient satisfaction. Quality of patient care was measured by detailed objective standards reviewed and approved by Hospital B's chief executive officer and board of directors. Patient satisfaction was measured by a short questionnaire that asked patients to evaluate the timeliness, efficiency, accuracy and courtesy of service; the quality of room and dietary service; and the education and information provided with respect to diagnostic and treatment procedures and results. An employee could not receive incentive compensation under Plan B greater than 50 percent gross salary (excluding contingent compensation). Hospital B expected that Plan B would improve the quality of patient care and productivity, thereby reducing (or limiting increases in) patient costs.

Earlier, [REDACTED] G.C.M. 32423, I-17 (November 30, 1962), considered whether adopting a contingent compensation plan paying participants a percentage of revenues was inconsistent with exempt status as a section 501(c)(3) organization. The exempt organization (HP) had contracted with subscribers to establish and operate prepaid medical service and hospitalization plans. HP paid private physicians who actually performed the services a flat fee per member-month plus 50 percent of the "Net Health Plan Revenue" (which was specifically defined in the contracts). The other 50 percent of the Net Health Plan Revenue was payable to hospitals that also provided services to HP's subscribers. The purpose of the percentage fee was to maximize the efficiency of service and shift most of the risk under the plan to the physician groups and hospitals. Through this arrangement, HP could operate without large, insurance-type reserves. In practice, the per capita fees constituted 92-97 percent of the total amount paid under the contract and the incentive compensation could not exceed 10 percent of the total compensation payable. We concluded that the arrangement was not inconsistent with exempt status because it served a valid business purpose of providing compensatory incentives to contain costs and prevent unnecessary utilization of hospital services in prepaid medical care programs.

Here, we recognize that the physician-employees do not control [REDACTED] and that essentially the Hospital, through board control, sets the compensation for the physician-employees.<sup>3</sup>

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<sup>3</sup>Your memoranda on net revenue incentive compensation suggest that in order to insure that compensation arrangements will be consistent with exempt status, applicants should be required to submit information setting forth (1) a realistic

These physicians cannot be considered management. Thus, even if physician-employees are insiders, the requirement that an incentive compensation arrangement be at arms' length should be satisfied in this case.

While the two conditions in [redacted] employment contracts with its physician-employees supposedly are designed to provide safeguards against inurement,<sup>4</sup> [redacted] has supplied no information or criteria as to how these conditions will be measured or analyzed. Other than encouraging physician-employees to work hard and hold down expenses, there appears to be no business purpose served by the arrangement. This case does not involve a typical integrated delivery system fact pattern where the IDS purchases the existing practices of several physicians and the organization is concerned that it must offer incentives to induce the physicians to continue to achieve previous revenue levels. Rather, the physicians, who have no prior relationship with [redacted] have been recruited to join a newly formed organization and, in one instance, have received relocation assistance packages. Without more information, the manner of payment suggests the possibility of a joint venture or profit share arrangement.

Compensation plans which focus on productivity, as long as charitable services or benefits are not reduced or eliminated in

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estimate of total projected physician's compensation (base, bonus and benefits) for a three year period, (2) a realistic estimate of projected gross receipts on which compensation will be based and (3) information establishing that the physician's total compensation is reasonable for the geographic locale and specialty. With respect to the latter, the employment agreement conceivably could contain language that in determining reasonableness, [redacted] shall consider the amounts paid to other similarly-situated physicians in the same geographic local and specialty.

<sup>4</sup>There remains the question whether the incentive compensation arrangements result in more than incidental private benefit to the physicians. The private benefit derives from the operational test: to be exempt, an organization must be operated for one or more charitable purposes. If more than an insubstantial part of an organization's operations is for noncharitable (i.e., private) purposes, organization fails the operational test. See, American Campaign Academy v. Commissioner, 92 T.C. 1053 (1989). Thus, the issue here is whether the benefits to the physicians are insubstantial when viewed in relation to the public benefit conferred by the arrangement (not the overall good accomplished by [redacted] or Hospital). In their present form, the compensation arrangements appear to confer more than incidental benefit upon the physicians in relation to the public benefit conferred.

order to provide physicians with additional compensation, may be a form of permissible compensation. See, [REDACTED] G.C.M. 35638, I-269-73 (January 28, 1974). In this vein, the net revenue technique as set forth above does not provide any incentive or recognition of non-paying aspects of the exempt function (such as serving Medicaid or charity care patients, providing educational programs or the like) or other community benefit criteria, nor does it take into account a physician's nonmonetary contributions, including such elements as patient satisfaction or community service.<sup>5</sup> And, unlike the situations where we have approved incentive compensation arrangements, there is no "cap" on the amount that a physician-employee can earn which, in our view, is extremely troublesome.<sup>6</sup>

[REDACTED]

This organization, an integrated delivery system, has been formed as a non-stock professional corporation under [REDACTED] law. Its charter contains proper section 501(c)(3) purposes, limitations and a proper dissolution clause. Unlike [REDACTED] above, the Institute will pay its physicians a fixed salary with no provisions for compensation based on net income. It has apparently agreed to comply with the Service's request to amend its organizational documents so that no more than 20 percent of the voting directors of the Institute will be

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<sup>5</sup>Eligibility to receive incentive compensation could be based on the following community benefit criteria which could be stated in an employment contract: number of Medicare and Medicaid patients treated, number of charity care patients treated, participation in community education and scientific programs, plus traditional factors such as efficiency, quality of care, intensity of services required, patient satisfaction, hours worked and level of experience and expertise required.

<sup>6</sup>See also, University of Mass. Medical Group Practice v. Commissioner, 74 T.C. 1299 (1980), acq., 1980-2 C.B. 2 (compensation subject to a ceiling of 250 percent to maximum base salary established for the appropriate faculty rank and compensation paid bore no relation to the amount of fees generated by any specific clinical department or individual faculty member), B.H.W. Anesthesia Found., Inc. v. Commissioner, 72 T.C. 681 (1979), nonacq., 1980-2 C.B. 2 (doctors' salaries were capped at double the maximum academic salary for the university and productivity bore no direct relationship to compensation); University of Md. Physicians v. Commissioner, T.C. Memo. 1981-23 (salaries were subject to review by Dean of Medical School and the priority of application of patient fee revenue strongly suggests that faculty member compensation was not a function of productivity).

physicians providing services to the Institute or other persons who may be financially related, directly or indirectly, to any member or employee of the Institute.

Our primary concern in this case is the apparent lack of consensus between various state tribunals in [REDACTED] whether a nonprofit corporation may employ physicians. Applicant has not submitted any conclusive opinions from the Attorney General of [REDACTED] on this matter. In the interests of ruling uniformly on cases involving the "corporate practice of medicine" statutes, we believe that it would be appropriate to obtain a definitive opinion on this matter so that a representation (similar to the one we are advising that [REDACTED] make) can be made by [REDACTED] that a professional corporation is the structure that must be used.

Based on our limited review, this case appears to presents no other issues on which we have comments or suggestions.

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By:

  
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(Employee Benefits and  
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Attachments:

Adm. files