



DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
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TAX EXEMPT AND
GOVERNMENT ENTITIES
DIVISION

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Dear _____ :

This letter is in response to your recent request for an information letter concerning the effect of participation by section 501(c)(3) hospitals in the L sponsored by the M.

The N of the M, formerly known as the O of the P, is adopting a demonstration program for cardiovascular services and certain orthopedic services, referred to as the L (the "Program"). The goal of the Program is to use bundled payments for certain high volume, high cost procedures to align the incentives of hospitals and nonemployee ("staff") physicians to work together to provide coordinated, cost effective care. By giving hospital and physicians the flexibility to allocate resources in a manner they determine most appropriate, services can be better coordinated to improve the quality of care provided to beneficiaries as well as achieve savings to the Medicare program.

Under the Program, a participating hospital receives a global payment for all Part A (hospital) and Part B (physician) services provided on an inpatient basis to certain fee-for-service Medicare beneficiaries. From this global payment, the hospital makes payments to the physicians involved in providing care to these patients. The hospital and the physicians

determine how the global payment will be distributed. The global rate includes all inpatient hospital and associated physician services for the Medicare beneficiaries. In addition to the range of specialty services routinely associated with the particular Diagnosis Related Groups (“DRGs”) covered, all other specialty physicians services that may be required are also included in the global rate.

Under the Program, the hospital is permitted to make incentive payments to physicians who assist the hospital in improving the efficiency of inpatient care for Medicare beneficiaries as long as the hospitals and the physicians meet strictly monitored standards for quality of care. Hospitals participating in the Program participate in a quality consortium that is supported by M financial resources.

Payment arrangements between a hospital and a staff physician providing services to Medicare beneficiaries under the Program meet the following criteria:

1. The incentive payments or financial risk to an individual physician or to a group of physicians may be neither 25 percent more than, nor 25 percent less than, the amount the physician or group of physicians would have been paid under the traditional Medicare program for the services provided to beneficiaries covered under the Program, as determined on an annual basis.
2. Incentive payments are based on aggregate costs of all similarly covered beneficiaries, such as Medicare patients discharged under a given DRG and/ or group of related DRGs, and do not reflect the experience of individual beneficiaries. For this purpose, a grouping includes not less than ten discharges.
3. Incentive payments are not focused solely on lowering the volume and cost of services provided to beneficiaries. Incentive plans require that the hospital and physician meet specific quality standards approved by M. Quality standards are monitored by M. In addition, an independent organization conducts an evaluation of the Program that includes a review of the quality of care provided under the Program.
4. The hospital informs eligible beneficiaries, upon admission to the hospital as patients, about the Program and, upon request, provides nonproprietary information regarding any nontraditional payment arrangements involving incentives. The hospital and the participating physicians provide M, upon request, information regarding physician incentive plans under the Program and the distribution of incentive payments in any Program period.
5. Only physicians and other licensed health care providers who are fully credentialed at the hospital to perform the services for which payment is sought are included under the incentive payment plan. This includes independent physicians as well as salaried hospital staff who care for Program patients and who are eligible for Medicare reimbursement, either directly or as a member of a group or other organization.

The Program is being conducted in a limited geographic area. M selects hospitals to participate in the Program based on their applications and recommendations from a panel of technical experts.

Hospitals participating in the Program meet minimum procedure volume requirements, provide evidence of high quality outcomes and have the infrastructure in place to support continuous quality improvement efforts. In addition, participating hospitals and their physicians are able to deliver high quality care in a cost-effective manner.

Participating hospitals provide all of the covered services in the relevant specialty, such as cardiovascular services or total joint replacement services, and do not elect to provide only selected DRGs. In addition, all eligible fee-for-service Medicare beneficiaries who receive services from the participating hospitals under the Program DRGs are included in the Program.

Participating hospitals and their physicians are required to maintain appropriate internal quality improvement programs as well as to participate in any external quality assurance mechanism and data collection effort established by M and/or the Program evaluator.

M will conduct a formal evaluation of the Program to assess the overall performance of the hospitals participating.

Hospitals and physicians not participating in the Program continue to provide services under the traditional Medicare program. Medicare beneficiaries continue to be free to choose the physicians and hospitals from which they wish to receive services.

Organizations that promote health in a charitable manner can be exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code if no portion of their net earnings inures to the benefit of any private shareholder or individual. See section 1.501(c)(3)-1(c)(2) of the Income Tax Regulations.

Section 1.501(a)-1(c) of the regulations states that the term "private shareholder or individual" refers to persons "having a personal and private interest in the activities of the organization." For convenience, persons meeting this definition are sometimes referred to as "insiders."

Physicians per se are not insiders. Whether a physician is an insider depends on an analysis of all the facts and circumstances concerning whether the physician's relationship with the organization offers the physician the opportunity to make use of the organization's income or assets for personal gain. As stated in an appellate court decision:

The test is functional. It looks to the reality of control rather than to the insider's place in a formal table of organization. The insider could be a "mere" employee -- or even a nominal outsider, such as a physician with hospital privileges in a charitable hospital, Harding Hospital, Inc. v. United States, 505 F.2d 1068, 1078 (6th Cir. 1974) .

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United Cancer Council, Inc. v. Commissioner, 165 F.3d 1173, 1176 (7th Cir. 1999).

Section 501(c)(3) of the Code requires that an organization be organized and operated exclusively for exempt purposes. Section 1.501(c)(3)-1(c)(1) of the regulations provides that an organization will be regarded as operated exclusively for exempt purposes only if it engages primarily in activities that accomplish one or more of the exempt purposes specified in section 501(c)(3) of the Code. But an organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose. Thus, an organization that operates primarily in a manner that results in conferring impermissible private benefit on one or more persons does not satisfy this requirement.

Thus, any compensation arrangement between a section 501(c)(3) organization and an employee or an independent contractor must not result in private inurement if that person is an insider, and must not confer impermissible private benefit whether or not that person is an insider. Implicit in these two proscriptions is the requirement that the compensation actually paid must be reasonable.

Lorain Avenue Clinic v. Commissioner, 31 T.C. 141 (1958), involved a tax-exempt clinic controlled by a small number of employed physicians. The clinic compensated its employed physicians using a "point system." Under this arrangement, a sum of money was set aside as total salary, which would be divided among the physicians in a ratio based on each physician's point score. Thus, a physician's compensation was based on the number of points assigned to the physician. Points were based on the amount of the physician's charges for professional services, the number of patient visits, the number of new patients seen, the length of time the physician was associated with the clinic during which the physician had total charges above a certain minimum, and other criteria. However, substantially all of the organization's net receipts, after all expenses other than salaries, were set aside and distributed to the physicians, including the small number of employed physicians who were in control. These controlling physicians received the bulk of the distributions. The Tax Court held that this arrangement violated the proscription against inurement of net earnings.

In Birmingham Business College v. Commissioner, 276 F.2d 476 (1960), a tax-exempt school that compensated its three employee shareholders in proportion to their stock ownership did not qualify for exemption.

In Sonora Community Hospital v. Commissioner, 46 T.C. 519 (1966), aff'd, 397 F.2d 814 (9th Cir. 1968), two doctors who previously owned the hospital facilities and founded the hospital shared in the fees from the privately operated laboratory and x-ray departments within the hospital although they performed no associated services. This showed that the hospital operated to a considerable extent for the private benefit of the two founding doctors, rather than exclusively as a charitable organization.

Rev. Rul. 69-383, 1969-2 C.B. 113, provides that a fixed percentage compensation plan of an exempt hospital does not result in prohibited private inurement if: (1) the compensation plan is not merely a device to distribute profits to persons in control or to transform the organization's principal activity into a joint venture; (2) the compensation plan is the result of arm's-length bargaining; and (3) the compensation plan results in reasonable compensation by

comparing the amounts paid to amounts received by physicians at similar hospitals having comparable responsibilities and patient volume. Whether these criteria are met depends upon the facts and circumstances of each case. In this revenue ruling, the Service approved a compensation arrangement where the hospital paid a radiologist a fixed percentage of the radiology department's gross billings, adjusted by an allowance for bad debts. However, as G.C.M. 39862 (November 22, 1991) explains, at page 11, the physician was not receiving a percentage of the revenues of the hospital's radiology department. The hospital was acting as the billing and collection component for the physician's services performed at the hospital and the physician was receiving a fixed percentage of only his/her billings. The G.C.M. states:

[T]he hospital in Rev. Rul. 69-383 was billing (presumably on a global charge basis) and collecting for the radiologist's professional services, as well as its own facility charge. Thus, the percentage compensation at issue represented an allocation of a portion of the global charge (referred to as the "professional component") to the physician to compensate him for his services. The hospital retained the remainder (the "technical" or "facility component") as compensation for use of its facilities and equipment.

Rev. Rul. 69-545, 1969-2 C.B. 117, established a community benefit standard a hospital must meet to qualify for exemption under section 501(c)(3) of the Code. The community benefit standard focuses on a number of factors to determine if a hospital operates to benefit the community. In Rev. Rul. 69-545, the hospital that qualified for exemption had a board of trustees comprising prominent citizens in the community; medical staff privileges in the hospital were available to all qualified physicians in the area, consistent with the size and nature of its facilities; the hospital operated a full time emergency room where no one requiring emergency care was denied treatment; and the hospital used operating surpluses to expand and replace existing facilities and equipment, amortize indebtedness, improve patient care, medical training, education and research. Rev. Rul. 69-545 held that these significant factors established that the hospital qualified for exemption as a charitable organization under section 501(c)(3).

Rev. Rul. 97-21, 1997-1 C.B. 121, provides that certain physician recruitment incentives provided to persons who do not have substantial influence over the affairs of the recruiting hospital can be consistent with section 501(c)(3) status. This revenue ruling includes four situations that do not affect exempt status because the recruiting incentives do not result in unreasonable compensation for services from the staff physicians.

In analyzing any physician incentive compensation arrangement, the Service has generally considered various factors to determine whether the arrangement violates the proscriptions against private inurement and impermissible private benefit.

A. Independent Board of Directors and Conflicts of Interest Policy

Was the compensation arrangement established by an independent board of directors or by an independent compensation committee?

In determining whether a health care organization complies with the community benefit standard established in Rev. Rul. 69-545, one significant fact the Service considers is whether the organization has a community board of directors. The Service considers a community board as one in which independent persons who are representative of the community comprise a majority. Another significant fact the Service considers is whether the board of directors has adopted a substantial conflicts of interest policy. This policy should include restrictions barring a physician who is a voting member of the board of directors and who receives compensation from the organization from discussing and voting on matters pertaining to that member's compensation. This policy should also restrict physicians from membership on the organization's compensation committee and should preclude a voting member of a compensation committee from voting on matters pertaining to that member's compensation. However, physicians are not prohibited from providing information to the board of directors or to any committee regarding physician compensation.

B. Reasonable Compensation

Does the compensation arrangement with the physician result in total compensation that is reasonable?

The Service will not rule on whether compensation to be paid to any particular employee is reasonable since this involves a factual matter that cannot be determined in advance. See section 8.01, Rev. Proc. 2001-4, 2001-1 I.R.B. 121, 134. However, in considering applications for recognition of exemption and requests for private letter rulings, the Service considers whether the compensation information indicates a potential problem with inurement or impermissible private benefit.

Therefore, the Service may request from health care organizations more information on compensation plans, such as representative physicians' employment contracts, especially those that apply different methods in determining incentive compensation. In addition, reliable physician compensation survey data for the physician specialty and geographic locale are helpful in establishing reasonableness.

C. Arm's-Length Relationship

Is there an arm's-length relationship between the health care organization and the physician, or does the physician participate impermissibly in the management or control of the organization in a manner that affects the compensation arrangement?

D. Ceiling

Does the compensation arrangement include a ceiling or reasonable maximum on the amount a physician may earn to protect against projection errors or substantial windfall benefits?

E. Reduction in Charitable Programs

Does the compensation arrangement have the potential for reducing the charitable services or benefits that the organization would otherwise provide?

F. Quality of Care and Patient Satisfaction

Does the compensation arrangement take into account data that measures quality of care and patient satisfaction?

G. Net Revenue Based

If the amount a physician earns under the compensation arrangement depends on net revenues, does the arrangement accomplish the organization's charitable purposes, such as keeping actual expenses within budgeted amounts, where expenses determine the amounts the organization charges for charitable services?

H. Joint Venture

Does the compensation arrangement transform the principal activity of the organization into a joint venture between it and a physician or a group of physicians?

I. Distribution of Profits

Is the compensation arrangement merely a device to distribute all or a portion of the health care organization's profits to persons who are in control of the organization?

J. Business Purpose

Does the compensation arrangement serve a real and discernible business purpose of the exempt organization, such as to achieve maximum efficiency and economy in operations that is independent of any purpose to operate the organization for the impermissible direct or indirect benefit of the physicians?

K. Abuse or Unwarranted Benefits

Does the compensation arrangement result in no abuse or unwarranted benefits because, for example, prices and operating costs compare favorably with those of other similar organizations?

This includes effective controls to avoid increases in compensation predicated on increases in fees charged to patients. Effective controls to guard against unnecessary utilization are also important.

L. Services Personally Performed

Does the compensation arrangement reward the physician based on services the physician actually performs, or is it based on performance in an area where the physician performs no significant functions?

In summary, there is no prohibition or per se rule that prevents health care organizations from making incentive payments to physicians. In determining whether a health care organization utilizing an incentive compensation program for physicians complies with the proscriptions against private inurement and impermissible private benefit, the Internal Revenue Service will examine all the relevant incentive compensation factors discussed above.

A section 501(c)(3) hospital participating in a Program that wishes to request a private letter ruling from the Internal Revenue Service regarding its participation may do so by following the procedures described in Section 9 of Rev. Proc. 2001-4, 2001-1 I.R.B. 121, 135.

In accordance with Section 3.06 of Rev. Proc. 2001-4, 2001-1 I.R.B. at 127, this information letter is advisory only and has no binding effect on the Internal Revenue Service.

Sincerely,

Marvin Friedlander
Manager, Exempt Organizations
Technical Group 1