Important Content Note:

This technical assistance resource was developed prior to the August 2017 release of the Health Center Compliance Manual by the Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care (BPHC). The BPHC Compliance Manual, issued August 2017, indicates where PINS, PALs and other program guidance are now superseded or subsumed by the BPHC Compliance Manual.

Developing Provider Incentive Programs that Pass Muster under IRS and Other Regulatory Standards

Health centers, like most other health care providers, face constant challenges from both the marketplace and regulators to improve their performance with respect to quality of care and patient satisfaction. At the same time, there are financial pressures to increase productivity and efficiency and to reduce costs. These pressures have led many health care providers, and, increasingly, health centers, to establish incentive compensation arrangements designed to encourage providers to work to achieve the organization’s goals.

This Information Bulletin discusses the key legal requirements for provider performance incentive arrangements and provider recruitment and retention. Specifically, the Bulletin:

- Describes rules under federal income tax exemption law for several common types of provider incentive arrangements
- Explains federal cost principles that must be observed when federal grant funds are used to pay for provider incentives
- Clarifies limitations on incentive compensation arrangements imposed by federal fraud and abuse statutes

1 Health centers also may provide incentive compensation to executives and key administrators.
PERFORMANCE INCENTIVES

Issues Related to Federal Income Tax Exemption

Providing Reasonable Compensation

All provider incentive compensation arrangements of organizations that are exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code ("IRC"), including most health centers, must take into account limitations on the organization's compensation practices contained in the IRC. It is, however, well established in Internal Revenue Service ("IRS") rulings and case law that a Section 501(c)(3) organization can pay "reasonable" compensation for services rendered to it.

No Private Inurement for Insiders – A Section 501(c)(3) organization must, as a condition of obtaining and maintaining tax exemption, ensure that its net earnings do not "inure" to the benefit of any private individual. The prohibition on private inurement essentially means that organizational "insiders," such as board members and key employees, may not take advantage of their position and use the organization's assets or income for their personal gain.

It is noteworthy that, at one time, the IRS took the position that all physicians were "insiders" subject to the prohibition on private inurement. However, the IRS now looks at all of the facts and circumstances of a particular situation, just as it does with other persons affiliated with the organization, to determine if a physician is an "insider." The test is a functional one that looks at the reality of a physician's ability to exercise control over the organization's key financial decisions as opposed to a job title or place on an organizational chart.

No Excess Benefits for Disqualified Persons – In addition, IRC Section 4958 imposes tax penalties on organizational insiders, referred to under that provision of the IRC as "disqualified persons," who derive an "excess benefit" from a Section 501(c)(3) organization, as well as tax penalties on organization managers, such as board members and key executives, who knowingly approve an excess benefit transaction. Under Section 4958, a disqualified person receives an "excess benefit" if he or she receives a benefit from the organization, such as compensation, that is worth more than the value of the services provided to the organization in return for the compensation.

Generally speaking, "disqualified persons" are the same insiders who are subject to the prohibition on private inurement. Certain persons such as the CEO, CFO, and board members are automatically considered to be disqualified persons. Additionally, any individual in a position to exercise substantial control over an organization is considered to be a disqualified person subject to potential tax penalties. As with the inurement rule, a functional "control" test is applied, taking into account all of the relevant facts and circumstances. Thus, a health center's Chief Medical Officer may well be a disqualified person.

In contrast, individual health center clinicians rarely (if ever) have the authority to use health center assets for personal gain or to make key financial decisions for the health center. Accordingly, most (if not all) of a health center's clinicians are neither insiders nor disqualified persons. There are, nevertheless, constraints on the compensation they can be paid. Section 501(c)(3) provides that an organization must operate exclusively for a tax-exempt purpose as opposed to conferring a private benefit on one or more persons.
The IRS regulations state that an organization will not be regarded as operating exclusively for exempt purposes if more than an insubstantial part of its activities is not in furtherance of exempt purposes, that is, unless any private benefit conferred is insubstantial. 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 (or if that person is a disqualified person, must not constitute an excess benefit transaction) and
- Must not confer an impermissible private benefit, whether or not that person is an insider or a disqualified person

Failure to prevent private inurement or an excessive private benefit is grounds for revocation of tax-exemption. At a minimum an insider/disqualified person will be subject to the Section 4958 tax penalties.² Reasonable compensation, however, will not be treated as an excessive private benefit or as an excess benefit transaction subject to Section 4958 penalties.³

**Determining Reasonable Compensation**

In determining the reasonableness of compensation, all compensation received must be taken into account including, for example:

- Base salary
- Incentive compensation and bonuses
- Fringe benefits
- Noncash benefits, such as personal use of a company car

In short, since incentive compensation is part of a provider’s total compensation package, any incentive compensation arrangement must operate in a manner that ensures that total compensation paid remains within the bounds of reasonable compensation.

Whether a particular compensation package is reasonable is a question of fact determined by the circumstances of each individual case. There are numerous factors that should be considered in determining the reasonableness of a particular compensation arrangement. These include:

- The amount of compensation that similar organizations in the community pay for similar services provided by comparably qualified and experienced providers
- Compensation surveys published by the health care trade industry and professional organizations as well as specially commissioned studies produced by independent compensation consultants
- Compensation of employed providers paid by for-profit organizations, such as a private medical group practice
- Individual’s background and experience, salary history, tenure with the organization, and knowledge of the organization and its operations
- Size and complexity of the organization
- Character and amount of responsibility undertaken
- Amount of time devoted to the job
- Individual’s overall value to the organization

² Note that IRS regulations set forth circumstances in which an excess benefit transaction subject to Section 4958 penalties will also be grounds for revocation of exemption. See 26 C.F.R. § 53.4958-8.
IRS rulings suggest two overarching principles:

1. First, compensation must be determined in an arm’s length transaction. In short, the person receiving the compensation cannot participate in the decision setting the amount of compensation.

2. Second, there should be a positive correlation between the amount of compensation that the organization pays for services rendered and the benefit that the organization derives in return. In other words, compensation should be tied to performance that advances the organization’s tax-exempt purposes.

There is no specific formula for determining the reasonableness of a compensation arrangement, and clearly some degree of judgment always will be involved. Therefore, it is extremely important to document the factors on which compensation decisions are made.

Types of Incentives

While all provider incentive arrangements must operate within the bounds of reasonable compensation, they can take many forms.

Typical approaches include:

- Paying an end of year “bonus” based on the provider’s performance and the financial performance of the organization
- Payments for exceeding a specified number of patient encounters
- Payments for generating more than a specified amount of patient billings
- Payments of a portion of patient revenue generated above a specified amount (also known as a revenue sharing transaction)

- Incentive arrangements with a combination of these features

As discussed below, revenue sharing transactions may well attract special IRS scrutiny. However, IRS rulings indicate that establishing a provider incentive compensation plan does not in and of itself result in private inurement (or a Section 4958 excess benefit transaction), or an excess private benefit, even where profits of the organization are considered in the formula for computing the incentive compensation.

It is extremely important that incentives promote the tax exempt purposes of the organization. For example, the IRS does not favor productivity bonuses that merely reward the generation of revenue for an organization. The incentives should promote charitable purposes, such as improving quality or expanding services. Similarly, the incentive compensation arrangement should not result in a reduction in charitable services or benefits on account of the financial burden of the incentives on the organization. Maintaining or improving quality of care and promoting patient satisfaction should be factors in an incentive program, particularly one that uses productivity incentives.

Revenue Sharing Transactions

As previously noted, paying providers incentive compensation based on a portion of the health center’s revenue is a “hot button” item with the IRS, in part because the statute specifically prohibits tax-exempt organizations from sharing net earnings with private persons and, in part, because there is significant potential that such an arrangement will provide a “windfall” to the recipient, with payments at levels unrelated to the provider’s actual contribution to the organization and exceeding reasonable comparables. In fact, the IRS’s Hospital Audit Guidelines specifically instruct IRS agents conducting an audit of a hospital to look for revenue sharing transactions. While an IRS agent auditing a health
center would not be required to follow the Hospital Audit Guidelines, it is virtually certain that the agent would be interested in whether revenue sharing is a feature of a health center’s incentive compensation program.

To reiterate, the most critical aspect of an incentive compensation arrangement that includes a revenue sharing feature is that the total compensation be “reasonable.” The best way to ensure that result, and the approach favored by the IRS, is to “cap” incentives so that the total compensation paid remains reasonable under the traditional reasonable compensation analysis. Indeed, it is advisable to include a “cap” on any otherwise open-ended incentive, such as encounter-based incentives. This could be done, for example, either by capping the total amount of compensation that can be earned or the number of encounters that generate incentive pay.

Notwithstanding the IRS’s wariness of revenue sharing transactions, IRS guidance suggests that an incentive compensation arrangement that includes revenue sharing is not per se improper. For example, in Revenue Ruling # 69-383, the IRS approved a tax-exempt hospital’s payment of a fixed percentage of the radiology department’s gross receipts to a radiologist for services rendered. In that case, the physician was a hospital employee (not an officer or other “insider”), the compensation arrangement was negotiated at arm’s length, and the amount paid was documented to be reasonable under the circumstances. This ruling should protect incentive compensation arrangements with providers who are not “insiders” or disqualified persons provided, of course, that the requirements in the ruling are met. However, since the IRS evaluates all compensation arrangements based on the facts and circumstances of the particular case, a health center would be well-advised to have knowledgeable legal or tax counsel review any incentive program that includes a revenue sharing feature.

**Issues Related to Federal Grant Cost Principles**

In addition to raising tax exemption issues, incentive approaches must be reasonable from a federal grant perspective for any health center that receives Section 330 or other federal grant awards.

**Using Federal Grant Funds**

Federal grant funds may be used to pay incentive compensation, provided that the incentive payments meet the conditions set forth in the Federal Cost Principles:

1. First, the incentive must be premised on cost reduction, improving performance or efficiency, or provide some other discernible benefit to the grant-funded program such as suggestion or safety awards.

2. Second, the overall compensation paid, including the incentive, must be “reasonable” under the circumstances. Reasonableness is determined essentially in the same manner as it is for purposes of federal income tax exemption, with salary comparability being very important to establishing reasonableness.

3. Finally, under the Federal Cost Principles, incentive compensation must be paid (or accrued):
   - Pursuant to an agreement entered into in good faith before the services generating the incentive were performed, or
   - Pursuant to an established plan followed by the organization so consistently as to imply, in effect, an agreement to make such payment.

---

4 See 45 CFR Part 75, Subpart E, Cost Principles.
Thus, the Federal Cost Principles require that an incentive compensation arrangement be in place, by contract or through well-established policies and procedures, before the services on which the incentive payment is based are performed.\(^5\)

**Using Non-Grant Revenues**

The Federal Cost Principles do not apply to a Section 330-supported health center’s non-grant revenue (“program income”), such as fee for service income and third party insurance payments. Therefore, one could argue that the requirement to have an explicit agreement or a well-established practice of paying incentive compensation in place does not apply to the expenditure of program income. However, Section 330 of the Public Health Service Act, which authorizes the award of funds to health centers, requires all program income be used to further the purposes of the grant-funded program.\(^6\) Accordingly, in order to document the nature of the incentive arrangement not only for federal grant purposes but also for federal tax purposes, it is advisable to have:

- The terms under which incentive payments will be made to providers established in writing in advance, reflecting criteria that furthers program objectives (productivity and quality); and
- Prospective incentive payments included in the compensation line item of the budget.

**Health centers also must attend to the requirements of the federal physician self-referral statute (the Stark Law) in implementing incentive compensation arrangements for physicians.**

**Issues Related to the Federal Stark Law**

Health centers also must attend to the requirements of the federal physician self-referral statute (the Stark Law) in implementing incentive compensation arrangements for physicians.\(^7\) The Stark Law is sweeping in scope and subject to numerous exceptions that must be precisely implemented to be effective. Accordingly, consultation with qualified legal counsel is advisable.

The Stark Law prohibits a physician from making a referral for certain health care services (referred to as “designated health services” or DHS in the statute) payable by Medicare or Medicaid to an entity with which he or she (or an immediate family member) has a direct or indirect financial relationship.\(^8\)

---

\(^5\) Note that Congress may impose restrictions on the use of appropriated funds in compensating employees. For example, for Fiscal Year 2014, the maximum allowable salary that could be charged to a health center grant award was $181,500.00


\(^7\) Physician is defined under the Stark Law as a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The Stark Law does not affect incentive compensation arrangements of other health care providers, such as nurses, nurse-practitioners, and physician assistants.

\(^8\) See 42 U.S.C. § 1395nn. Designated health services are defined to include:
- clinical laboratory services;
- physical, occupational, and speech therapy services;
- radiology and radiation therapy services;
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment and supplies;
- prosthetics, orthotics, and prosthetic devices;
- home health services and supplies;
- outpatient prescription drugs; or
- inpatient and outpatient hospital services.
The physician cannot refer a patient to an entity for a DHS, and, most importantly, the entity cannot bill for a DHS if the referral is prohibited by the Stark Law. Since a physician compensated by a health center obviously has a financial relationship with the center, the physician cannot send a patient to the health center’s laboratory, pharmacy, or radiology department (or refer a patient for any other DHS) unless one of the “exceptions” to the Stark Law applies.

**Exceptions to the Stark Law**

There are two exceptions to the Stark Law that permit physicians to receive compensation, including certain incentive compensation from an entity such as a health center, and to continue to refer patients to the entity for a designated health service (DHS).

1. The first covers a physician who is a *bona fide employee* of the entity.

2. The second covers a physician who is an *independent contractor* and who has a personal services contract with the entity.  

In order for either of these exceptions to apply:

- The services to be provided as an employee or as an independent contractor must be identified;
- The physician must be paid fair market value (including incentives) for the services provided; and
- The arrangement must be commercially reasonable even if the physician were not referring DHS to the entity.

Importantly:

- Incentive payments cannot be based on the volume or value of a physician’s referral of a patient for a DHS; but,
- The physician may receive incentive compensation for any services that the physician personally performs, even if the service is a DHS.

For example, an incentive compensation arrangement that rewards a physician employee or independent contractor under a personal services contract for every test that he or she orders from a health center’s laboratory would violate the Stark Law. Thus, the health center could not bill Medicare for those services.  

However, if the physician ordered a test and then personally performed the test, the physician could receive incentive compensation for the work that he or she personally performed and the health center could bill for the DHS.

---

9 Whether or not a provider is an employee or an independent contractor is determined by the so-called “right to control” test. That is, if a health center has the right to control not only what a provider does but how the provider carries out his or her duties, the provider will be treated as an employee. The mere existence of a written agreement does not control, although the terms of an agreement obviously would be an important consideration in determining a provider’s status as an employee or independent contractor.

10 Technically, the Stark Law does not directly prohibit billing Medicaid for a DHS provided pursuant to an illegal referral. It prohibits the state Medicaid agency from claiming the federal share of the cost of the prohibited referral. The Centers for Medicare and Medicaid Services has yet to issue regulations describing exactly how the Stark Law applies to Medicaid. However, many state Medicaid laws have restrictions on referrals similar to the Stark Law.
Independent Contract Physicians

There are four additional Stark Law requirements for an incentive compensation arrangement with an independent contractor physician working for a health center under a personal services agreement.

1. The agreement with the physician must be in writing, specify all of the services to be provided, and be signed by the parties. (As a practical matter, it is good practice to have a written agreement with both employed and contracted physicians).

2. The aggregate services contracted for must not exceed those that are necessary for the legitimate business purposes of the parties.

3. The term of the agreement must be for at least one year.

4. Most importantly, the compensation to be paid over the term of the agreement must be set in advance and may not be set in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

Note that for purpose of the Stark Law, the actual total amount of the incentive compensation to be paid a physician does not have to be determined in advance and in most cases, will not be able to be determined in advance. Rather, the “set in advance” requirement simply means that the methodology for determining incentive compensation, such as a fixed sum for every encounter over a stated amount or a fixed percentage of revenue, must be set in advance. Thus, so long as the methodology for computing incentive payments does not change during the term of the agreement, the arrangement will not violate the Stark Law even if the total amount of the incentive payments varies.

Issues Related to the Federal Anti-Kickback Statute

The federal anti-kickback statute prohibits any person or entity from knowingly or willfully soliciting or receiving (or offering and paying) remuneration directly or indirectly, in cash or in kind, to induce patient referrals or the purchase or lease of equipment, goods or services, payable in whole or in part by a federal health care program. Violation of the statute is a criminal offense, and violators may also be subject to civil penalties and exclusion from the Medicare and Medicaid programs. Unlike the Stark Law, the anti-kickback statute applies to all types of providers (and anyone else), not just to physicians. Because a provider incentive arrangement clearly involves the payment of remuneration, it could be construed as an inducement to the receiving provider to refer business or otherwise to do business with the paying entity.

Employed Providers

Nevertheless, the anti-kickback statute has no practical effect on incentive compensation arrangements with employed providers because the statute contains a very broad exception for payments made to bona fide employees.

Independent Contractor Providers

The situation is not so simple with respect to performance incentive payments made to independent contractor providers. The statute provides a “safe harbor,” i.e. protection from prosecution, for personal services contracts that are similar to the Stark Law exception for personal services contracts, including the requirement that the amount of total compensation to be paid be “set in advance.” However, unlike the Stark Law exception, the anti-kickback safe harbor requires that the total aggregate compensation, in fact, be established in advance. As
noted above, in most cases it will not be possible to determine the total amount of compensation to be paid if there is an encounter-based or percentage of revenue based incentive plan. In short, many incentive compensation arrangements with independent contractor providers will not be protected by an anti-kickback safe harbor even though they are acceptable under the Stark Law.\textsuperscript{11}

It is important to remember that the fact that a provider incentive compensation arrangement does not fit into an anti-kickback safe harbor does not mean that the arrangement is illegal. The arrangement is illegal only if the government can prove that the parties intended to induce referrals (or the doing of other health care business) by offering or paying remuneration. This underscores the importance of establishing, and documenting, that an incentive compensation arrangement is reasonable under the circumstances, that is, that the incentive was tied to the provider’s performance as opposed to being merely a reward for referring patients or business.

RECRUITMENT AND RETENTION INCENTIVES

In addition to performance incentives, health care organizations sometimes offer financial incentives in order to recruit or to retain providers. Recruitment and retention can be a particular problem for health centers which, by definition, serve medically underserved populations. As with performance incentives, health centers should pay attention to the federal tax exemption and fraud and abuse issues that these types of incentives may raise.\textsuperscript{12}

Issues Related to Federal Income Tax Exemption

The IRS has long recognized that a tax-exempt health care organization may have to offer inducements in order to attract qualified providers so that the organization can provide quality health care. However, recruitment incentives also entail a substantial private benefit to the recruited provider which, in the view of the IRS, may outweigh the benefit to the tax-exempt entity offering the incentive, creating a potential excess private benefit or, in the case of a physician who is an “insider,” a potential inurement or Section 4958 issue.

The IRS evaluates recruitment incentives paid to health care providers providing services (either as employees or as independent contractors) to a health care entity, such as a health center, using a traditional reasonable compensation analysis. In other words, there will be no excess private benefit – nor any private inurement – if the compensation provided to the physician, taking into account recruitment incentives and all other items of compensation, is reasonable.

\textsuperscript{11} Note that the anti-kickback safe harbor (enacted in 2003) that applies specifically to Federally Qualified Health Centers ("FQHCs") receiving Section 330 funds would not apply because the safe harbor protects payments made to covered health centers, not payments made by covered health centers to others.

\textsuperscript{12} Salary allowances and other fringe benefits incurred to attract professional personnel are allowable costs under the Federal Cost Principles, provided that they are reasonable and that they conform to the established practices of the organization. See 45 CFR Part 75.463(b).
The IRS addressed recruitment incentives provided by hospitals to non-employed physicians who will serve on the hospital’s medical staff and who will provide services in the community, but not necessarily for or on behalf of the hospital, in Revenue Ruling # 97-21. That ruling technically applies only to hospitals and does not deal with hospital-employed physicians. Thus, it does not directly apply to health centers that pay recruitment incentives to employed providers. However, in the ruling, the IRS outlined four threshold requirements for hospital recruitment incentives that health centers would be well advised to follow with respect to any recruitment incentive that they might provide.

- First, the recruitment incentive agreement with the provider must be in writing.
- Second, the agreement must be negotiated at arm’s length.
- Third, the agreement must be approved by the governing board or its designee, or be in accord with board-approved recruitment guidelines that the board reviews from time to time to ensure that they are consistent with the organization’s tax-exempt purposes.
- Fourth, the recruitment arrangement may not include any benefits that are not specifically addressed in the written agreement. While not specifically required by the revenue ruling, it is critical to maintain appropriate documentation of the nature, purpose, and amount of the incentives.

Revenue Ruling # 97-21 does not address incentives paid to retain a provider’s services. While there is no formal IRS guidance on retention incentives, it is likely that they will be evaluated using the customary “reasonable compensation” analysis. The analysis considers whether the total compensation paid to the provider, including any premium or noncash benefit paid to induce the provider to continue working for the health center, “reasonable” under the circumstances.

Issues Related to Federal Fraud and Abuse Statutes

Recruitment and retention payments made to a physician establish a financial relationship that may implicate the Stark Law. Further, recruitment payments made to any provider, and recruitment or retention payments made to an independent contractor provider, may implicate the federal anti-kickback statute if they are made to induce referrals or the doing of other business paid for by a federal health care program.

However, there are specific recruitment and retention exemptions available to FQHCs under the Stark Law. A practitioner recruitment safe harbor to the anti-kickback statute also may be available, although it is not directed specifically toward FQHCs. The requirements of the FQHC exceptions and the anti-kickback safe harbor are discussed in detail in Information Bulletin #5 in the Human Resources Series – Legal Developments in Joint Recruitment and Retention Efforts by Hospitals and Health Centers, April 2015. The Bulletin can be found at http://mylearning.nachc.com/

13 Revenue Ruling # 97-21 is discussed in more detail in Human Resources Series Information Bulletin #5, Legal Developments in Joint Recruitment and Retention Efforts by Hospitals and Health Centers, January 2016, at http://mylearning.nachc.com/.

14 Health centers and other health care entities sometimes establish deferred compensation plans to induce providers to continue employment with the entity. Under these plans, a provider is offered additional compensation on the condition that the provider continues his or her employment for a period specified in the plan, payment being made when the provider fulfills the condition. Deferred compensation also is subject to a reasonable compensation analysis. However, deferred compensation plans must be structured carefully to ensure that the income will be taxed to the provider when it is actually received as opposed to being imputed to the provider beforehand. Accordingly, health centers should implement deferred compensation arrangements only with the advice and assistance of knowledgeable tax counsel.

15 As previously noted, the federal anti-kickback statute exempts payments made to bona fide employees. Thus, retention payments made to an employed provider would not implicate the statute.
CONCLUSION

Incentive compensation can be an effective method to motivate providers to perform productively and in accordance with quality measures, and to begin or to continue a relationship with a health center. However, as significant bodies of federal law and regulation impact the operation of incentive plans, they should be implemented carefully, with attention to applicable law, and preferably with the advice and assistance of qualified counsel.

This Information Bulletin was written for NACHC by:

Michael B. Glomb, Esq.
Feldesman Tucker Leifer Fidell LLP
Washington, D.C.

For information about these bulletins, contact:
Betsy Vieth at NACHC at bvieth@nachc.com