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 The BPHC Compliance Manual, issued August 2017, indicates where PINS, PALs and other program guidance are now superseded or subsumed by the BPHC Compliance Manual.

Legal Developments in Joint Recruitment and Retention Efforts by Hospitals and Health Centers

A strategy used by some federally qualified health centers (“FQHCs”) to enhance physician recruitment and retention is to work with their area hospital(s) to combine resources for paying recruitment expenses and offering a strong compensation package. The purpose of this Information Bulletin is to:

♦ Present legal issues that arise in the context of hospital-funded recruitment and retention payment arrangements
♦ Suggest ways to appropriately address those issues

The bulletin examines:

1. **Stark Physician Self-Referral Law (“the Stark Law”) exceptions** for physician recruitment and retention payments;

2. **Federal Anti-Kickback safe harbor** for certain physician recruitment arrangements, as well as the recent safe harbor for health center grantees

3. **Internal Revenue Service (“IRS”) standards** for tax-exempt organizations to hospital-funded recruitment and retention payments.

Although physician compensation is but one factor of a multi-faceted approach, it is a factor with legal ramifications if not done in compliance with applicable federal law and regulations. For example, in some communities, local hospitals have contributed funds to allow a health center to make payments to a physician or to guarantee a certain
level of income for a physician in order to attract or retain a physician within a community. Unless carefully structured, however, these hospital-funded recruitment or retention payments may be viewed by government regulators as disguised kickbacks to the physicians for referring patients to the funding hospitals and may raise potential violations under the Stark Law, the Anti-Kickback Statute, or both.¹ Such violations could expose both the health center and health center physician to liability.

## FINDING THEM AND KEEPING THEM

FQHCs are all too familiar with the challenges of attracting and retaining physicians on their staff. For one thing, FQHCs are located in geographical areas of the country with documented physician shortages. Small, isolated, rural towns and crowded, poor, inner cities often face challenges in finding and keeping clinical providers. With about 66 million people living in areas of the country that have a shortage of primary care physicians, translating to one in five Americans who lack access to care,² those shortages have a dramatic impact on meeting the health care needs in many communities.

In recognition of the problem that physician shortages present for many health centers, the U.S. Department of Health and Human Services (“HHS”) Health Resources and Services Administration’s (“HRSA”) National Health Service Corps (“NHSC”) received a $283 million investment in fiscal year 2014 through the Affordable Care Act.³ The NHSC provides financial, professional, and educational resources (such as loan repayment and scholarship awards) to medical, dental, and mental and behavioral health care providers practicing in areas of the country with limited access to care. HHS notes that the number of primary care providers in the NHSC has more than doubled since 2008 as a result of the American Recovery and Reinvestment Act and Affordable Care Act funding.⁴

In addition, the NHSC State Loan Repayment Program has increased its grants to states by nearly 50 percent.⁵

Previously, FQHCs were subject to federal grant-related expectations for a multi-faceted approach to enhance recruitment and retention, including:

- Systems and policies that support clinicians
- Management-based collaboration
- Work that is structured to be meaningful and challenging
- Shared decision-making
- Fair compensation and benefit package
- Appropriate incentive and deferred compensation plans.

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² See the George Washington University School of Public Health, “New Study Finds Less Than 25 Percent of New Doctors Work in Primary Care,” (June 12, 2013) accessed Dec. 18, 2014 at [http://publichealth.gwu.edu/content/new-study-finds-less-25-percent-new-doctors-work-primary-care](http://publichealth.gwu.edu/content/new-study-finds-less-25-percent-new-doctors-work-primary-care). The article also notes that the shortfall of physicians is expected to increase as health reform leads to more people seeking care as a result of insurance coverage.


⁴ Id.

⁵ Id.
These expectations were described in the Bureau of Primary Health Care’s Policy Information Notice (“PIN”) number 98-23, “Health Center Program Expectations.” While this PIN has been retired, meaning its requirements are no longer binding on health centers, HRSA’s commitment to its recruitment and retention principles are demonstrated by the agency’s investment in NHSC’s mission to provide NHSC clinicians with financial, professional, and personal benefits.6 Health centers may wish to keep HRSA’s prior expectations in mind when crafting their recruitment and retention programs.

**The Stark Law**

The Stark Law prohibits a physician from making referrals for certain designated health services payable by Medicare or Medicaid to an entity with which the physician (or an immediate family member) has a direct or indirect financial relationship.7 Unless an exception applies, the physician cannot refer to the entity and the entity cannot bill for the referred services.

In other words, a financial relationship is established under the Stark Law when an entity, such as a hospital, pays recruitment or retention payments either directly to a physician, or indirectly to a health center that employs or contracts with a physician. If then, the physician makes a referral to the entity, such as the hospital, for services payable under Medicare or Medicaid, a violation occurs.

**The Physician Recruitment Exception of the Stark Law**

The Stark Law includes exceptions for employment relationships and personal services arrangements, thereby allowing hospitals to employ or contract with physicians.8 However, those exceptions do not cover payments made by a hospital to a physician who is, or will be, employed or contracted by another entity, such as a health center.

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7 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;
- outpatient prescription drugs; or
- inpatient and outpatient hospital services.

8 See 42 U.S.C. §1395nn(e)(2)-(3); 42 C.F.R. §411.357(c)(d).
The **Physician Recruitment Exception** applies to payments by a hospital to a physician for the purpose of inducing the physician to relocate to the hospital’s geographic area and become a member of the hospital’s medical staff, and also applies to payments by a hospital to a physician either indirectly through payments to a health center, or directly to a physician employed by or contracted with a health center.  

**REQUIRED CONDITIONS: Hospital Recruitment Payments to Health Center Physician**

In the context of health centers that employ or contract physicians, the **Physician Recruitment Exception** requires all nine of the following conditions to be met in order to allow hospital-funded recruitment payments to a health center’s employed or contracted physician:

1. The arrangement must be in writing, signed by all of the parties – the health center, the recruited physician, and the hospital; 
2. The arrangement may not be conditioned on the recruited physician referring to the hospital; 
3. The recruitment payment must not be based on the value or volume of referrals, or expected referrals, from the recruited physician or health center, or other business generated between the parties; 
4. The recruited physician must be allowed to establish privileges at other hospitals and refer to other facilities; 
5. All of the recruitment payment must remain with or pass through to the recruited physician except for the actual costs incurred by the health center in recruiting the new physician; 
6. In the case of income guarantees, only the actual incremental costs attributable to the recruited physician may be allocated by the health center to the new physician; 
7. Records of the costs, and passed through amounts, must be kept for five years, and made available to the HHS upon request; 

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9 See 42 U.S.C. § 1395nn(e)(5); 42 C.F.R. § 411.357(e). A hospital’s geographic area is defined as the lowest number of contiguous postal zip codes from which the hospital draws at least 75 percent of its inpatients. A physician will be deemed to have relocated to the hospital’s geographic area if:

   (i) the physician has relocated the site of his or her practice a minimum of 25 miles; or  
   (ii) at least 75 percent of the physician’s revenues from services provided by the physician to patients (including services to hospital inpatients) are derived from services provided to new patients.  

However, residents and physicians who have been in medical practice less than one year, as well as physicians employed on a full-time basis for at least two years immediately prior to the recruitment by (a) a Federal or State bureau of prisons (or similar entity operating at least one correctional facility) to serve a prison population, the Department of Defense or Department of Veterans Affairs to serve active or veteran military personnel and their families, or a facility of the Indian Health Service to serve patients receiving medical care exclusively through the Indian Health Service, and (b) did not maintain a private practice in addition to such full-time employment, will not be considered to have an established practice and will therefore be eligible under the physicians’ recruitment exception regardless of whether the physician actually moved his or her practice location. When determining the geographic service area of rural hospitals, (1) zip codes may in some cases be noncontiguous and (2) at least 90 percent of inpatients must be drawn from this area. The Secretary of the U.S. Department of Health and Human Services (HHS) may also issue an advisory opinion under 42 U.S.C. §1395nn(g)(6) deeming that the physician does not have an established medical practice that serves or could serve a significant number of patients who are or could become patients of the recruiting hospital, thereby exempting the recruited physician from the relocation requirement.  

10 See 42 C.F.R. § 411.357(e).
8. The health center may not impose any additional practice restrictions on the recruited physician, other than those relating to quality of care; and

9. The arrangement may not violate the Federal Anti-Kickback Statute, or any federal or state law or regulation governing billing or claims submission.

If all of the above conditions have been met, then a hospital may:

♦ Make an indirect payment to a physician, by way of the health center passing payment from the hospital to the recruited physician, or

♦ Make a direct payment to a recruited physician who contracts with, or is employed by, a health center.

REQUIRED CONDITIONS: FQHC Recruitment Payments to Physician

The Physician Recruitment Exception includes a special provision for FQHCs that make recruitment payments. Under this exception:

1. The Stark Law physician recruitment exception will apply to FQHCs on the same basis as it applies to hospitals for recruitment payments to physicians.

2. FQHCs can make a payment to a physician to induce him or her to relocate to the community served by the FQHC without contracting or employing the physician. For example, a health center located in an area with a high prevalence of pediatric asthma may wish to make a recruitment payment to a pediatric specialist in order to recruit the physician to establish an independent practice in the community. As a result of the FQHC recruitment exception, the specialist (who will not be employed by or contracted to the FQHC) may make referrals to the FQHC’s pharmacy for prescription drugs furnished to patients covered by Medicare or Medicaid, regardless of the recruitment payment from the health center to the physician.

The Physician Retention Exception of the Stark Law

To assist hospitals and other entities in certain rural and inner city areas in retaining sufficient numbers of qualified physicians in the community, the Stark Law regulations also include an exception for retention payments made by hospitals or FQHCs to physicians who practice in a rural area or Health Professional Shortage Area (“HPSA”) or where at least 75 percent of the physician’s patients reside in a medically underserved area or are members of a medically underserved population.

CONDITIONS: Hospital or FQHC Retention Payments to Physicians

To qualify for this exception, a physician must have a bona fide written recruitment or employment offer or must provide a written certification that he/she has received a bona fide opportunity for future employment, as explained below.

11 A non-compete agreement would constitute a practice restriction while personnel policies, clinical policies, and record-keeping requirements probably would not. See 69 Fed. Reg. 16096-97 (Mar. 26, 2004).

12 See 42 C.F.R. § 411.357(e)(6).

13 Pursuant to 42 U.S.C. § 254e(a)(1), all FQHCs are automatically designated as having the designation of a health professional shortage area.

14 See 42 C.F.R. § 411.357(t).
**Bona Fide Written Offer** – A physician must first have a bona fide firm written recruitment offer from another hospital, FQHC, rural health clinic, academic medical center, or physician organization. The offer must specify the amount of remuneration, and require the physician to relocate from a location that is at least 25 miles outside of the geographic location served by the hospital or FQHC making the retention payment and outside of the geographic area serviced by the hospital or FQHC making the retention payment.\(^\text{15}\) The retention payment is subject to the same obligations and restrictions on repayment or forgiveness as contained in the offer. Finally, the retention payment may not exceed the lower of (a) the amount obtained by subtracting the physician’s current income from the offer, or (b) the reasonable costs the hospital or FQHC would have to expend to recruit a new physician.

**Written Certification from Physician** – A physician must provide a written certification of bona fide employment from another hospital, FQHC, rural health clinic, academic medical center, or physician organization that would require the physician to move his or her practice at least 25 miles and outside of the geographic area served by the hospital or FQHC making the retention payment.\(^\text{16}\) The certification must contain the following information:

- Details regarding the steps taken by the physician to effectuate the opportunity
- Details of the physician’s employment opportunity, including the identity and location of the physician’s future employer or employment location or both, and the anticipated income and benefits (or a range thereof)
- A statement that the future employer is not related to the hospital making the payment
- The date on which the physician anticipates relocating his or her medical practice outside of the geographic area serviced by the hospital

Information sufficient for the hospital to verify the information included in the written certification

In addition, the hospital or FQHC must take reasonable steps to verify the physician’s opportunity. Finally, the retention payment made by the hospital or FQHC may not exceed the lower of (a) 25 percent of the physician’s current income,\(^\text{17}\) or (b) the reasonable costs the hospital or FQHC would have to expend to recruit a new physician.

If the physician qualifies for a retention payment under this exception, the retention payment must meet the same first four requirements of the **Physician Recruitment Exception**, namely:

1. The retention payment arrangement must be in writing and signed by the parties;
2. The payment may not be conditioned on the retained physician referring to the hospital;
3. The payment may not be based on the value or volume of referrals; and
4. The retained physician must be allowed to establish privileges and refer to other hospitals.

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15 The Secretary of HHS may waive the relocation requirement for payments made to physicians practicing in a HPSA or an area with demonstrated need for the physician through an advisory opinion issued in accordance with 42 U.S.C. §1395nn(g)(6), if the retention payment arrangement otherwise complies with all of the otherwise required conditions.

16 The Secretary of HHS may waive the relocation requirement for payments made to physicians practicing in a HPSA or an area with demonstrated need for the physician through an advisory opinion issued in accordance with 42 U.S.C. §1395nn(g)(6), if the retention payment arrangement otherwise complies with all of the otherwise required conditions.

17 The amount must be measured over no more than a 24-month period using a reasonable and consistent methodology that is calculated uniformly.
Further, a hospital or FQHC providing the remuneration may not enter into a retention arrangement with a physician any more frequently than once every five years and the terms of the retention payment may not be altered during the term of the arrangement in any manner that takes into account the volume or value of referrals or other business generated by the physician for the hospital or FQHC. In addition, the arrangement may not violate the Federal Anti-Kickback Statute or any federal or state law or regulation governing billing or claims submission.

**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.\(^\text{18}\)

A hospital’s offer to contribute to a recruitment or retention payment (i.e., remuneration) or a health center physician’s acceptance of the hospital payment (directly or through the health center) could be viewed as an inducement by a hospital for a physician to refer patients to the hospital for services payable by Medicare or Medicaid. Consequently, these arrangements implicate the Anti-Kickback statute.

Congress and the Office of the Inspector General (“OIG”) have created “safe harbors” to exempt certain business practices from constituting violations of the Anti-Kickback statute. Unlike the Stark Law which makes practices illegal if they do not fall with a specific exception, a practice that does not fall within a safe harbor of the Anti-Kickback statute is not necessarily illegal, but rather is subject to further legal analysis on the basis of the particular facts and circumstances, and on the parties’ intent in entering into the proposed transaction or arrangement.

**Practitioner Recruitment Safe Harbor**

The OIG has established a narrow safe harbor for any payments or exchange of anything of value by an entity (e.g., a hospital) to induce a primary care practitioner (e.g., a physician) who has been practicing within his or her specialty for less than one year to relocate, or to induce any other practitioner to relocate, his or her practice to a HPSA for his or her specialty area that is served by the entity.

**REQUIRED CONDITIONS: Payments to Induce a Practitioner to Relocate**

The Practitioner Recruitment Safe Harbor applies if all nine of the following conditions are met:

1. The arrangement is set forth in writing, specifying the benefits and obligations, and is signed by each of the parties;

2. If the recruited practitioner is leaving an existing practice, at least 75 percent of the revenues of the new practice (i.e., the health center) must be generated from new patients;

3. The period of agreement cannot exceed three years, and the terms of the agreement cannot be renegotiated during the three-year period;

4. The arrangement cannot require the recruited practitioner to make referrals to, or otherwise generate business for, the entity, although the entity may require the physician to maintain staff privileges;

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\(^{18}\) See 42 U.S.C. § 1320a-7b(b).
5. The practitioner may not be restricted from establishing staff privileges at, from referring any patient to, or otherwise generating any business for any other entity;

6. The amount of benefits provided to the physician may not vary in any manner based on the volume or volume of any expected referrals to or business generated for the entity;

7. The practitioner must agree to treat patients receiving Medicare benefits or assistance from another Federal healthcare program in a nondiscriminatory manner;

8. At least 75% of the revenue from the new practice must be generated from patients who reside in a HPSA or a Medically Underserved Area (“MUA”) or who are part of a Medicare Underserved Population (“MUP”); and

9. The payment or exchange of anything of value does not benefit, directly or indirectly any person (except for the practitioner who is being recruited) or entity in a position to make or influence referrals of items or services payable by a federal health care program to the entity providing the recruitment benefits.¹⁹

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**Differences Between Stark Law and Anti-Kickback Law**

Unlike the Stark recruitment exception (which applies solely to the recruitment of physicians), the Practitioner Recruitment Safe Harbor applies to health professionals beyond physicians. However, the safe harbor also is more restrictive than the Stark exception in that it applies only to practitioners who have been practicing for less than one year, who relocate to geographic areas designated as HPSAs, and for terms not greater than three years.

Health centers, in particular, may have difficulty in satisfying the following requirements:

1. The Practitioner Recruitment Safe Harbor requires at least 75 percent of the revenues of the new practice be generated from new patients. For two reasons, a practitioner recruited to work at an existing health center may not be able to satisfy this requirement:
   a. While moving to an existing health center may be viewed as a "new practice" from the perspective of the recruited practitioner, an existing health center may not be considered a "new practice" for purposes of satisfying the Stark requirement, and
   b. It is highly unlikely that 75% of the revenues generated by the recruited practitioner will be attributable to new patients of the health center.

2. The Practitioner Recruitment Safe Harbor prohibits the recruitment payment from benefiting, directly or indirectly, any person (except for the recruited practitioner) or entity in a position to make or influence referrals of items or services payable by a federal health care program to the entity.

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¹⁹ See 42 C.F.R. § 1001.952(n).
providing the recruitment benefits. However, health centers that employ or contract practitioners who have received recruitment benefits from the health center's community-based partner (i.e., the local hospital) may receive an indirect "intrinsic" benefit from the recruitment payment in the form of good staff morale (and, therefore, more productive practitioners).

3. Lastly, the Practitioner Recruitment Safe Harbor does not address either retention or joint recruitment by a hospital and a group practice (e.g., a health center), a common practice among many health centers.

Federally Qualified Health Center Safe Harbor

Given the potential issues faced by health centers in satisfying the requirements of the Practitioner Recruitment Safe Harbor, it may be advisable for health centers to look towards the Health Center Safe Harbor to protect their practitioner recruitment (and retention) arrangements from prosecution under the Federal Anti-Kickback statute. In December 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which, among other things, provides a safe harbor to health centers that receive grant funds under Section 330 of the Public Health Service Act ("health center grantee") for any remuneration offered and paid to health center grantees by any individual or entity so long as the arrangement contributes to the health center grantee's ability to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, and the health center documents the basis for the reasonable expectation prior to entering the arrangement;

1. The transfer is made pursuant to an agreement that (a) is set out in writing; (b) is signed by the parties; and (c) covers, and specifies the amount of, all goods, items, services, donations, or loans to be provided by the individual or entity to the health center;22

2. The goods, items, services, donations, or loans are medical or clinical in nature or relate directly to services provided by the health center as part of the scope of the health center's section 330 grant;

3. The health center reasonably expects the arrangement to contribute meaningfully to the health center's ability to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, and the health center documents the basis for the reasonable expectation prior to entering the arrangement;

4. At reasonable intervals, but at least annually, the health center must re-evaluate the arrangement to ensure that the arrangement is expected to continue to satisfy the standard set forth in standard #3, and must document the re-evaluation contemporaneously;

The Health Center Safe Harbor regulations consist of nine standards.21 As long as the following nine standards are met, remuneration does not include the transfer of goods, items, services, donations or loans (whether in cash or in-kind), or a combination thereof from an individual or entity to an FQHC:


21 42 C.F.R. §1001.952(n).

22 The amount of goods, items, services, donations, or loans specified in the agreement may be a fixed sum, fixed percentage, or set forth by a fixed methodology. The amount may not be conditioned on the volume or value of Federal health care program business generated between the parties.
5. The individual or entity does not require the health center (or its affiliated health care professionals) to (a) refer patients to a particular individual or entity, or (b) restrict the health center (or its affiliated health care professionals) from referring patients to any individual or entity;

6. Individuals and entities that offer to furnish goods, items, or services without charge or at a reduced charge to the health center must furnish such goods, items, or services to all patients from the health center who clinically qualify for the goods, items, or services, regardless of the patient’s payor status or ability to pay;

7. The agreement must not restrict the health center’s ability, if it chooses, to enter into agreements with other providers or suppliers of comparable goods, items, or services, or with other lenders or donors;

8. The health center must provide effective notification to patients of their freedom to choose any willing provider or supplier. In addition, the health center must disclose the existence and nature of an agreement (of the type described in standard #1) to any patient who inquires; and

9. The health center may, at its option, elect to require that an individual or entity charge a referred health center patient the same rate it charges other similarly situated patients not referred by the health center or that the individual or entity charge a referred health center patient a reduced rate (where the discount applies to the total charge and not just to the cost-sharing portion owed by an insured patient).

Traditionally, arrangements under which a hospital that receives referrals from a health center offers to assist a health center in recruiting practitioners to the health center’s area by providing assistance such as payments for travel and moving expenses and salary guarantees have been subject to scrutiny under the Anti-Kickback Statute. These forms of assistance may be protected under the Health Center Safe Harbor provided that the assistance is given to the health center and not the individual practitioner (and the other requirements of the Safe Harbor are satisfied).

**INTERNAL REVENUE CODE**

Physician recruitment and retention payments are also subject to scrutiny by the Internal Revenue Service (“IRS”). The Internal Revenue Code (“IRC”) prohibits tax-exempt organizations from establishing compensation arrangements that result in any part of the organization’s net earnings inuring, in whole or part, to the benefit of private individuals. A recruitment or retention payment is a type of compensation arrangement that has to be structured with this prohibition in mind.

**Revenue Ruling**

In 1997, the IRS issued Revenue Ruling 97-21 (“the Ruling”) that:

♦ Provides a framework for analyzing the legality of physician recruitment payments through five sample fact patterns;24

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23 Where a health center has multiple individuals or entities willing to offer comparable remuneration, the health center must employ a reasonable methodology to determine which individuals or entities to select and must document its determination. In making these determinations, health centers should look to the procurement standards for recipients of Federal grants.

Does not address whether a tax-exempt hospital could assist an existing medical practice, such as a health center, with the recruitment of a new physician to join the practice;

Describes four requirements for a tax-exempt hospital providing recruitment payments to physicians who will provide services to members of the hospital’s surrounding community, but not necessarily for or on behalf the hospital itself:

1. The hospital may not engage in substantial activities that do not further the entity’s exempt purposes or that do not bear a reasonable relationship to the accomplishment of those purposes.

2. The hospital must not engage in activities that result in inurement of the hospital’s net earnings to a private shareholder or individual.

3. The hospital may not engage in substantial activities that cause the hospital to be operated for the benefit of a private interest rather than public interest.

4. The hospital may not engage in substantial unlawful activities.

If a tax-exempt hospital indirectly makes a recruitment or retention payment to a physician through a direct payment to a health center, then the health center, also a tax-exempt entity, must ensure that its payment to the physician does not constitute private inurement or private benefit. In an Information Letter, the IRS set forth twelve factors to consider in regard to compensation arrangements:

- The involvement of an independent board of directors (i.e., the health center board) or compensation committee to establish the arrangement
- Whether the total compensation is reasonable
- Whether there is an arm’s length relationship between the organization and the physician
- Whether there is a ceiling or cap on compensation to protect against errors or windfalls
- The potential for the compensation arrangement to result in a reduction in charitable programs
- Whether the compensation arrangement takes into account data that measures quality of care and patient satisfaction
- If net revenue-based, whether the arrangement accomplishes the organization’s charitable purposes
- Whether the arrangement transforms the organization’s principal activity into a joint venture with the physician
- Whether the compensation arrangement is a device to distribute all or a portion of the health care organization’s profits to persons who are in control of the organization
- Whether the compensation arrangement serves a real and discernable business purpose of the organization (e.g., achieving maximum operational efficiency without resulting in direct or indirect benefit to the organization’s physicians)
- The presence of safeguards against abuse or unwarranted benefits, including unnecessary utilization
- Whether the compensation is based upon services which are personally performed by the physician

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25 See IRS Information Letter 2002-0021 (Jan. 9, 2002).
In determining whether any particular compensation arrangement is reasonable, health centers should ensure that any recruitment or retention payments are consistent with formal policies and procedures related to compensation, including standards of conduct and conflict of interest policies.

Health centers should also be aware of a recent court ruling on the tax implications of physician “loans”, a commonly used recruitment mechanism. These loans often require a physician to work at the organization for a certain period of time in exchange for an advancement of funds; if the physician does not remain with the organization during that period of time, the physician must repay the advanced funds, typically with interest. However, a 2013 court ruling held that such funds are considered part of physicians’ compensation packages, rather than loans. The case involved a clinic that advanced funds to physicians, but did not withhold income or payroll taxes and did not report the payments as compensation on a Form W-2, but instead issued a Form 1099 when the physicians’ “debts” were forgiven. The court cited a number of factors to consider when determining whether an advance should truly be considered a loan:

- Whether the promise to repay is evidenced by a note or other instrument
- Whether interest was charged
- Whether a fixed schedule for repayments was established
- Whether collateral was given to secure payment
- Whether repayments were made
- Whether the borrower had a reasonable prospect of repaying the loan and whether the lender had sufficient funds to advance the loan
- Whether the parties conducted themselves as if the transaction were a loan

In sum, a health center offering advance payments or loans to physicians for recruitment or retention purposes should carefully structure the arrangement to reflect whether the arrangement is a loan or compensation. If a health center seeks to provide a loan to a provider, it should ensure that the above factors are met; if a health center intends the funds as an advance, it should consult with tax professionals to understand the tax implications.

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27 See Vancouver Clinic, Inc. v. United States, No. 3:12-cv-05016-RBL (W.D. Wash. Apr. 8, 2013), 4 citing Welch v. Comm’r, 204 F.3d 1228, 1230 (9th Cir. 2000).
CONCLUSION

Recruitment and retention payments can be an effective tool to successfully recruit and retain physicians to practice within a geographic community served by a health center. However, when a hospital funds the recruitment or retention payment, it can raise legal issues under the Stark Law or Anti-Kickback statute. Moreover, when a hospital makes the recruitment or retention payment to a health center (which in turn makes a payment to a physician), it can raise legal issues under IRS standards for organizations that are tax-exempt.

As a guard against placing the hospital, health center, and/or physician in violation of applicable Federal laws and regulation, **health centers should:**

♦ Instruct legal counsel to review recruitment or retention payment arrangements for compliance with the Stark Law, Anti-Kickback statute, and IRS standards for tax-exempt organizations.

♦ Ensure that its recruitment and retention payments to physicians (in addition to other staff) are reasonable and comply with the health center’s own compensation policies and procedures.

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