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On-Call and Coverage Arrangements: A Formula for Hospital-Physician Tension

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The growing tendency among facilities to pay physicians for on-call services is in part a function of market forces driving supply and demand, as well as the degree to which physicians are willing to provide the service without separate compensation. Such market forces relating to physicians include physician shortages, reimbursement changes, quality-of-life issues, and professional liability exposure, while health systems and other medical facilities are impacted by increasing regulation and related enforcement activity, along with community need for physician availability in the emergency department.

The Regulatory Environment

Enforcement of federal and state statutes and regulations and litigation risks frequently is cited as a reason for physicians' increasing unavailability to provide emergency room coverage. Those laws include the Emergency Medical Treatment and Labor Act (EMTALA),[1] federal and state Anti-Kickback statutes and regulations, federal and state Stark laws, Medicare and Medicaid payment issues, state corporate practice of medicine issues, federal tax statutes and regulations, and Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirements.

EMTALA On-Call Requirements

EMTALA's interpretive guidelines and regulations require hospitals to comply with a series of provisions related to physician on-call obligations, including maintaining a list of physicians on call to provide stabilizing treatment.[2] The EMTALA Interpretive Guidelines in State Operations Manual, Appendix V, clarify that physicians' names must be identified on the on-call list.[3]

42 C.F.R. § 489.24(j) explains that a hospital may permit on-call physicians to schedule elective surgery during on-call time frames; have simultaneous on call duties; and to participate in a formal community call plan.[4] Failure of an on-call physician to respond to call or to appear within a reasonable time

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—from a declaration of the American Bar Association

subjects both the physician and the hospital to liability for an EMTALA violation under 42 U.S.C. § 1395dd(d)(1)(C).

Federal and State Anti-Kickback Statutes and Regulations

Physicians' contracting to provide on-call services and coverage of hospital departments may order items and services paid for by governmental healthcare programs, implicating federal and state Anti-Kickback statutes.[5]

Although on-call and coverage payments to physicians constitute remuneration, federal statutory and regulatory safe harbors limit the statute's reach by permitting certain non-abusive arrangements. Compliance with applicable Anti-Kickback safe harbors, including the employment and personal services and management contracts safe harbors,[6] assures that legitimate business practices are immune from prosecution. Practices outside the ambit of a safe harbor do not necessarily violate the Anti-Kickback statute but are subject to a case-by-case evaluation.[7]

On-call arrangements that potentially fail the personal service and management contracts safe harbor elements include part-time arrangements, as the safe harbor requires that services be predictable and pre-scheduled,[8] and must state at the agreement's onset the total amount of compensation to be paid as a liquidated sum.[9] Depending upon the payment arrangement, aggregate compensation may not be "set in advance," as the frequency of the on-call physicians' services likely would not be known in advance. On-call and coverage payments must also be consistent with fair market value and not exceed those reasonably necessary to accomplish the services' commercially reasonable business purpose. Commercial reasonableness depends upon whether the purchased services have intrinsic commercial value to the purchaser, are reasonably calculated to further the business of the purchaser, and are services that the purchaser needs, intends to utilize, and does utilize in furtherance of its commercially reasonable business objectives.[10]

In addition to Anti-Kickback statute safe harbors, the U.S. Department of Health and Human Services Office of Inspector General (OIG) issues advisory opinions regarding the Anti-Kickback statute's and other statutes' enforcement.[11] The arrangement addressed in Advisory Opinion No. 07-10 offers a unique insight into risks, problematic on-call compensation structures, and factors the OIG perceives should be avoided.[12] The OIG's key inquiries included whether the per diem compensation was: (1) fair market value in an arm's length transaction for actual and necessary items or services; and (2) not determined in any manner that takes into account the volume or value of referrals or other business generated between the parties.[13]

Problematic compensation structures included: "lost opportunity" or similarly designed payments that do not reflect bona fide lost income; payment structures that compensate physicians where no identifiable services are provided; aggregate on-call payments that are disproportionately high compared with the physician's regular medical practice income; and payment structures that compensate the on-call physician twice for the same service.[14]

Multiple states have enacted Anti-Kickback provisions relating specifically to illegal remuneration gained through soliciting, receiving, offering, or paying for referrals in connection with services paid for by state Medicaid agencies.[15] Violations of state Anti-Kickback statutes frequently result in the imposition of criminal and civil penalties[16] and may include no safe harbor protection.[17] Other states' statutes include protection for some types of referrals by certain healthcare practitioners and institutions,[18] and include safe harbors to state Anti-Kickback provisions,[19] limit violations to kickbacks or bribes as opposed to the broad term of "remuneration,"[20] or include a duty to report cases of suspected fraud and abuse involving the state healthcare program.[21]

Federal and State Stark Laws

On-call and coverage arrangements additionally implicate the physician self-referral statute or Stark law that prohibits a physician from referring Medicare patients for designated health services (DHS) to an entity with which the physician or the physician's immediate family member has a financial relationship, unless the relationship meets the specific requirements of a Stark exception.[22] Importantly, Stark includes statutory and regulatory exceptions that may protect on-call and coverage arrangements, including physician services and in-office ancillary services exemptions,[23] and compensation arrangement exceptions for personal service arrangements,[24] bona fide employment relationships,[25] fair market value compensation arrangements,[26] and indirect compensation arrangements.[27]

Many states' statutes prohibit physician self-referrals similar in varying degrees to the Stark law. State Stark statutes may apply generally to physician self-referrals, unlimited by payor type; to practitioners or immediate family members; only to referrals for certain services such as clinical laboratory, pharmacy, radiation therapy, physical therapy, x-ray and imaging services; or more broadly to nurses, midwives, physician assistants, and optometrists.[28] Or, a state's Stark statute may require disclosure of financial interests to referred patients.[29]

OB Malpractice Insurance Subsidy—Anti-Kickback Safe Harbor and Stark Exception

An Anti-Kickback safe harbor[30] and Stark exception[31] may protect hospital subsidy payments to reduce physicians' malpractice insurance costs in order to encourage physician call participation. As currently drafted, the safe harbor and exception protect only insurance subsidies provided to obstetricians.

Medicare Payment Issues

Allowability of Payments for "Physician Availability" on Hospital Cost Reports

Medicare reimbursement rules allow hospitals contracting for emergency department on-call services to include as allowable costs on cost reports the "reasonable costs" incurred in furnishing healthcare services.[32] Compliance requires hospitals to submit a written allocation agreement between the hospital and physician listing the physician's time commitment to hospital services, patient services, and services not payable by either Parts A or B.[33] The Provider

Reimbursement Manual justifies "physician availability services" payments on the basis of hospitals' difficulty securing emergency departments staffing and physicians' inadequate revenue receipts during times when physicians await patient arrival. Compensation to emergency department physicians on an hourly or salary basis or under a minimum guarantee arrangement is allowable for Medicare cost reporting purposes subject to limitation through the application of reasonable compensation equivalents.[34]

Anti-Markup Rule

Social Security Act § 1842(n)(1) imposes an "anti-markup" restriction on the technical component (TC) of diagnostic tests (described in Social Security Act § 1861(s)(3)) billed to the Medicare program if the test is not personally performed by the billing physician or another physician who "shares a practice" with the billing physician.[35] While historically the anti-markup rule applied to physicians' "purchase" of a TC from an "outside supplier,"[36] the Medicare CY 2009 Physician Fee Schedule final rule amended the regulatory "anti-markup" regulation to include restrictions on both the professional component and the TC of diagnostic tests.[37] If a coverage arrangement involves radiologists or other "performing physicians" assigning their rights to payment to the entity billing Medicare Part B, the entity should perform an anti-markup rule analysis identifying whether the structure meets an anti-markup rule exception or whether the billing entity would be better served to adopt a different arrangement.

Reassignment Rules

On-call and support arrangements may involve a physician being required to assign his right to Medicare payment to the entity making the on-call or support payments. As a general rule, Medicare pays amounts due to a supplier under an assignment from a Medicare beneficiary to the performing supplier. Exceptions to this rule at 42 U.S.C. § 1395u(b)(6) and 42 C.F.R. § 424.80 include an exception for payment to an entity under a contractual arrangement. Suppliers must also follow carrier jurisdictional rules specifying the carrier to which the supplier must submit claims based upon where the services are provided.[38]

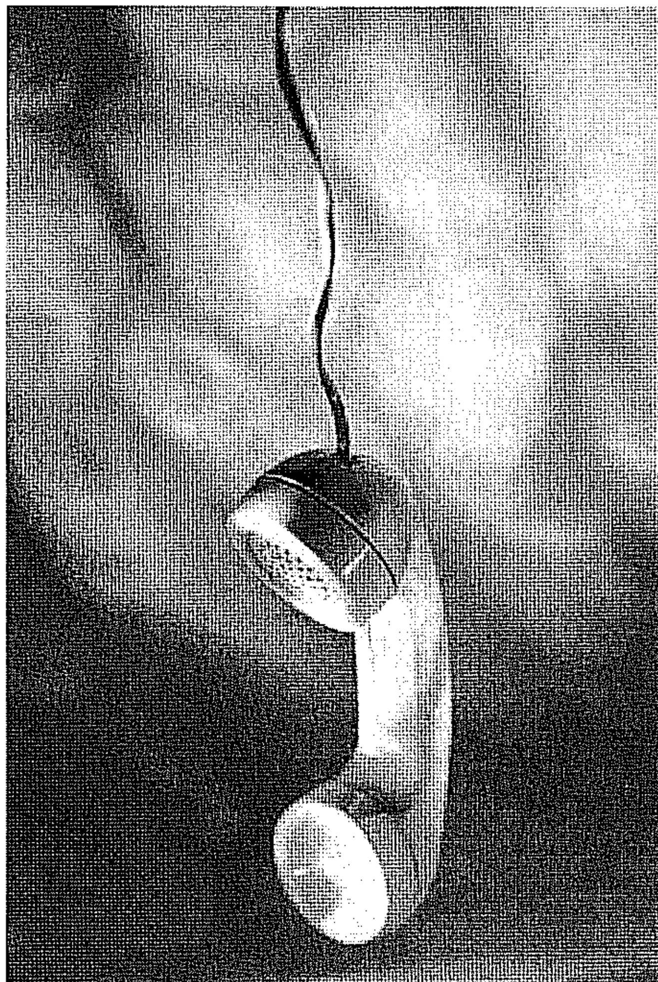
Tax Issues

Issues for Federally Tax-Exempt Entities

Federally tax-exempt entities contracting with physicians for on-call and coverage services must assure that those arrangements do not result in private inurement or convey "more than an insubstantial private benefit" to avoid jeopardizing the entities' tax-exempt status[39] or risking an excise tax because of an excess benefit transaction.[40] Further, exempt entities must protect the tax-exempt nature of their bonds to avoid the bonds being characterized as "private activity bonds."[41]

Tax Issues for Both For-Profit and Tax-Exempt Entities

Entities contracting with physicians for on-call and/or coverage services must determine whether the physician is a bona fide employee or an independent contractor—an important issue with tax consequences for the contracting entity. Internal Revenue Service (IRS) statutes, regulations, revenue rulings, private letter

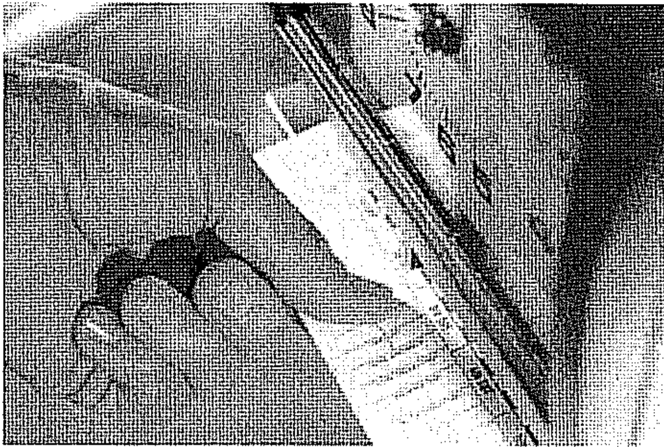


rulings, announcements, and other IRS publications identify factors critical in determining whether an employment relationship exists between an individual and an entity.[42]

Two private letter rulings issued six months apart (PLR 9335055 and PLR 9410041) considered the employment tax status of a group of physicians providing services in an emergency room—finding employment status in the first issued ruling and independent contractor status in the second—based on the same set of facts. Factors critical to the IRS' determination of independent contractor status included that a hospital did not set physicians' hours or pay malpractice insurance or license fees for the physicians; that physicians could hire additional assistants compensated by the physicians; that the physicians were not required to comply with particular rules and regulations (even hospital rules and regulations); that compensation was other than a fixed per diem or guaranteed minimum salary; and that physicians were able to provide services to other facilities.

Corporate Practice of Medicine Issues

An entity contracting with physicians to provide medical services should consider whether its state has adopted the corporate practice of medicine doctrine that prohibits certain corporate entities



from practicing medicine and whether exemptions exist.[43] The majority of states exempt certain corporations from the corporate practice of medicine doctrine's application, including nonprofit corporations, professional medical corporations, hospital corporations, and entities that employ physicians to provide employees with reduced-cost healthcare services.[44]

HIPAA Business Associate Agreement Requirements

When a facility's circumstances require that blended arrangements be provided, including on-call and administrative or medical director services, such arrangements may inevitably require the physician providing administrative or medical director services to access patients' protected health information to provide billing, risk management, and quality management services. In such an event, the privacy and security regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA)[45] require the parties to enter into a business associate agreement[46] memorializing the business associate's obligation and responsibility to protect patients' protected health information from inappropriate uses or disclosures, and to implement administrative, physical, and technical safeguards protecting electronic health information confidentiality, integrity, and availability.[47]

Structuring Coverage and Related Compensation Arrangements

As is the case in most physician contractual arrangements, on-call and physician coverage arrangements often vary dramatically. Variation can be driven by market conditions, the physician specialty, and the needs of the hospital or other facility for physician availability. In an unrestricted "beeper" call arrangement, the physician, while not restricted to physical presence in the facility, is obligated to respond within a specified time frame set forth in the on-call agreement and/or medical staff bylaws. Physicians in a restricted coverage arrangement must physically remain in the facility during the restricted coverage shift. Under certain circumstances, facilities may have need for more than one type of on-call coverage or service. These needs may take the form of blended arrangements, such as combined unrestricted and restricted coverage, blended on-call and patient care services, or blended on-call and administrative services.

Common Payment Arrangements

There are several common payment arrangements for physician on-call services. Payments often take the form of unrestricted or restricted rates, clinical services rates, administrative rates, or a blending of one or more of the above. Payment rates are often affected by the professional fee billing arrangements and can include hourly, shift, daily, monthly, or annual rates. Some facilities pay only under specific circumstances, such as paying only for shortage specialty emergency department coverage. Another payment option includes the activation fee (sometimes known as an activity-based payment), usually a flat fee payable when the physician is actually called in to the facility while furnishing unrestricted on-call availability. Other alternatives include subsidized or guaranteed amounts at levels appropriate to bring physician or group compensation to the market value for services furnished, especially with respect to uncompensated care and deferred on-call compensation until a specified milestone is reached, such as a specified period of time or tenure in the medical staff call rotation.

Valuation of Payment Arrangements

Valuation of physician compensation arrangements in the healthcare industry suffer from the absence of a body of knowledge related to the valuation of physician availability. A lack of standards on valuation of physician compensation has contributed in part to inconsistencies in the ways in which consultants and appraisers approach the valuation of physician compensation arrangements. In fact, valuation methods for physician availability range from simple reliance on historical compensation or survey data to complex analyses using algorithms and detailed market research. Typically, methods that follow fundamental appraisal principles are the most appropriate and yield the most defensible conclusions. The theoretical basis for the use of a particular method or set of methods will often be driven by the facts and circumstances of the specific contractual arrangement, and can be generally categorized into one of three broad approaches found in valuation theory: the Cost-Based, Income-Based, and Market-Based approaches. Within each broad approach, one or more methods can exist for determining value with the applicability and reliability of each being dependent on the circumstances and the valuation analyst's professional judgment.

Using the cost-based approach, the analyst seeking to reach a conclusion of value for compensation related to physician availability, such as an on-call or coverage arrangement, generally considers the cost of a substitute arrangement, such as the avoided cost to replace or recreate the subject service.

In valuing most unrestricted on-call and restricted coverage arrangements, the income-based approach is of little use in the valuation of physician availability. This is primarily attributable to the fact that physician availability generates no income for the purchaser of the service. However, when considering the value of

subsidized arrangements, such as in the case of outsourced emergency department coverage, the income approach is often one of the most significant methods available to the valuation analyst. The valuation analyst may give consideration to methods quantifying the shortfall experienced by the physician group, such as a measurement of the value of unpaid patient visits, as a proxy for the value of the service provided by the group.

Methods under the market-based approach are the most often applied—yet also often misapplied—methods for determining value. Methodology under the market-based approach seeks to assess fair market value by considering that the buyer of a service will not pay more than and the seller will not accept less than the value of a comparable service. Thus, the central focus of the market-based approach and its related valuation methods is to identify truly comparable services and to do so within the context of healthcare regulatory definitions of fair market value.

The valuation of physician compensation for on-call and coverage services is impacted in large measure by specific contractual requirements, market conditions, physician specialties, and other considerations such as the following: whether the physician will be providing unrestricted or restricted services; length of the shift; rotation; time of day or week; facility trauma level; payer mix; physician supply and demand; coverage; intensity and frequency; and whether the physician is providing concurrent coverage. In the valuation of on-call or coverage arrangements, one must understand in detail the makeup of the arrangements because, for example, material differences can be found in whether the conclusion of value relates to physician availability, the value of uncompensated care furnished by the physician, or both. The burden of physician availability (i.e., the time a physician spends apart from family, without sleep, or away from personal or other professional activities) is valuable to the physician as the "seller" of his or her availability. The physician may also suffer from lost earnings while providing uncompensated care—not only in the facility—but also when furnishing follow-up care. Understanding and appropriately accounting for these differences and factors are essential to an accurate analysis and proper value conclusion.

Conclusion

Hospitals and physicians must carefully balance their respective interests, reconciling their tensions by carefully considering the structure for on-call and coverage services arrangements. Although the different arrangement types may implicate a variety of state and federal laws, legal impediments may be resolved resulting in improved patient care and mutually beneficial relationships between hospitals and physicians.

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1 42 U.S.C. § 1395cc(a)(1)(I)(iii) (2008).

2 42 C.F.R. § 489.20(r)(2) (2008).

3 State Operations Manual (CMS-Pub. 100-07), Appendix V, Interpretive Guidelines, Responsibilities of Medicare Participating Hospitals in Emergency Cases, § 489.20(r)(2).

4 42 C.F.R. § 489.24(j); *see also* 2009 IPPS Final Rule, 73 Fed. Reg. 48434, 48663-65 (August 19, 2008) (to be codified at 42 C.F.R. § 489.24(j)(2)(iii)). The provisions related to community call plans in 42 C.F.R. § 489.24(j)(2)(iii), effective on October 1, 2008, permit hospitals to enter into arrangements coordinating on-call obligations for a particular geographic area, giving "additional flexibility to hospitals providing on-call services and improv[ing] access to specialty physician services for individuals in an emergency department." *Id.* at 48,663. Community call plans are intended to permit "a specific hospital in a region to be designated as the on-call facility for a specific time period, or for a specific service, or both." *Id.*

PRACTICE GROUPS

Chair's Column

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The Medical Staff, Credentialing, and Peer Review Practice Group (MSCPR PG) is excited to present this year's third newsletter—another edition containing timely and informative content. Our thanks to Publications Vice Chair Steve Kleinman and the authors for their efforts.

MSCPR PG has been active since we issued our last newsletter. Vice Chair for Membership Pat Hofstra reports that the MD/JD Affinity Group is gaining momentum, planning several projects, and working on developing their own Listserve. We hope to have a report of detailed progress before the Annual Meeting.

Vice Chair for Educational Programs Mike Callahan is assembling a team for a teleconference on the *Baptist Health* decision. MSCPR PG is also co-sponsoring a two-part teleconference on Exclusionary Conduct. The first presentation on April 2 discussed the current landscape of provider versus payor litigation; the second on May 5 will cover provider versus hospital litigation.

Vice Chair for Research Tim Adelman reports that work on the Peer Review Toolkit and the Fifty State Survey for Peer Review and Confidentiality Laws is progressing well. When the materials are available, Vice Chair for Website Development Keith Shiner will assist in making that information available.

5 Medicare and Medicaid Patients and Program Protection Act of 1987, Pub. L. No. 100-93, § 14 (July 30, 1987) (codified at 42 U.S.C. § 1320a-7b(b)) (federal Anti-Kickback statute); *see infra* notes 15-21 (state Anti-Kickback laws).

6 42 U.S.C. § 1320a-7b(b)(3)(B) (2008) (statutory employment); 42 C.F.R. §§ 1001.952(d), (i) (2008) (regulatory). The OIG has interpreted broadly the requirement that employment be purposed for program-covered services. *See* U.S. Dep't of Health & Human Servs. Office of Inspector General, Adv. Op. No. 07-03 (March 27, 2007).

7 U.S. Dep't of Health & Human Servs., Office of Inspector General., Adv. Op. No. 01-01 at 12 (Jan. 11, 2001).

8 42 C.F.R. at § 1001.952(d); *see generally* W. Bradley Tully, *Federal Anti-Kickback Law* (BNA Health L. & Bus. Series No. 1500) [hereinafter BNA – Anti-Kickback] 1500:0522 (2000).

9 42 C.F.R. § 1001.952(d).

10 Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule, 64 Fed. Reg. 63518, 63525 (Nov. 19, 1999).

11 42 U.S.C. § 1320a-7d(b) (2008); 42 C.F.R. § 1008.47 (2008).

12 U.S. Dep't of Health & Human Servs., Office of Inspector General, Adv. Op. No. 07-10 at 6 (Sept. 20, 2007).

13 The OIG cited to its Supplemental Compliance Program Guidance for Hospitals, reflective of these key inquiries. Medicare: OIG Supplemental Compliance Guidance for Hospitals, 70 Fed. Reg. 4858, 4866 (January 31, 2005).

14 U.S. Dep't of Health & Human Servs., Office of Inspector General, Adv. Op. No. 07-10 at 7 (Sept. 20, 2007).

15 *See, e.g.*, Miss. Code Ann. § 43-13-207 (2008). *See also* American Health Lawyers Association, Fraud and Abuse Practice Group, Summary of Fraud and Abuse Statues and Regulations, www.healthlawyers.org/Members/Practice20%Groups/FA/Surveys/Pages/FiftyStateSurvey.aspx (complete and updated listing of state Anti-Kickback, Stark, false claims act, fee splitting, unfair business practices, and whistleblower statutes from fifty states).

16 *See, e.g.*, Miss. Code Ann. § 43-13-215 (2008). Persons found violating the Mississippi statute are guilty of a felony, punishable by five years imprisonment, a fine of not more than $50,000, or both. Civil penalties may be imposed regardless of criminal liability.

17 *See* Miss. Code Ann. §§ 43-13-201 to 233 (2008) (no safe harbors created); Ala. Code § 22-1-11 (2008); Ala. Admin. Code r.560-x-4-.04 (2008).

18 *See* Ariz. Rev. Stat. § 13-3713 (2008) (Arizona statute excepting certain payments in connection by FDA-regulated clinical trials from state kickback statute violations); and N.Y. Soc. Servs. Law §§ 366-d, § 366-f (2008) (New York statutes incorporating federal Anti-Kickback safe harbors).

19 *See* N.Y. Soc. Servs. Law § 366-F (2008) (exempting activity from state's Anti-Kickback provisions regarding Medicaid providers if activity is exempt by federal statute or regulation—http://public.leginfo.state.ny.us/menugetf.cgi?COMMONQUERY=laws).

20 *See* Miss. Code Ann. § 43-13-207 (2008) (applies apparently only to kickbacks and bribes rather than to the broader "remuneration").

21 *See* Ariz. Rev. Stat. § 36-2918.01 (2008) (duty to report fraud and abuse with limited immunity if information or records are furnished in good faith).

22 42 U.S.C. § 1395nn (2008) (statute); 42 C.F.R. §§ 411.351 *et seq.* (2008) (regulations that include exceptions).

23 42 U.S.C. § 1395nn(b)(2) (2008); 42 C.F.R. §§ 411.355(a) and (b) (2008). The definition of "member of the group" or "member of a group practice" includes on-call physicians during the physicians' provision of on-call services for the group physicians. *Id.* § 411.351.

24 42 U.S.C. § 1395nn(e)(3) (2008); 42 C.F.R. § 411.357(d) (2008).

25 42 U.S.C. § 1395nn(e)(2) (2008); 42 C.F.R. § 411.357(c) (2008).

26 42 C.F.R. § 411.357(l) (2008).

27 *Id.* § 411.357(p).

28 *See* N.Y. Pub. Health L. § 238a (2008) (New York statute prohibiting "practitioner" self-referral and making statute violators jointly and severally liable to the payor).

29 Ariz. Admin. Code § R4-7-902 (2008) (chiropractors); Ariz. Rev. Stat. § 32-1401 (2008) (physicians); Ariz. Rev. Stat. Ann. § 32-1501 (2008) (naturopathic medicine practitioners); Ariz. Admin. Code § R4-21-303 (2008) (optometrists); Ariz. Rev. Stat. Ann. § 32-1854 (2008) (osteopathic physicians and surgeons); Ariz. Rev. Stat. Ann. § 32-2501 (2008) (physician assistants).

30 42 C.F.R. § 1001.952(o) (2008).

31 *Id.* § 411.357(r).

32 42 U.S.C. § 1395x(v)(1)(A) (2008); 42 C.F.R. §§ 415.50-415.70 (2008).

33 42 C.F.R. § 415.60(f) (2008) (compensation must be reasonable; intermediary assumes 100% of costs are for patients if documentation requirement not met).

34 Prov. Reimb. Man., Part 1, Chap. 21, § 2109 – 2109.4. Prov. Reimb. Man., Part 1, § 2109.3 allows emergency department physician availability services costs only when the provider demonstrates that no feasible alternative methods for obtaining physician coverage exist, the physicians agree to provide immediate response to life-threatening emergencies by being on the hospital premises in reasonable proximity to the emergency department, the physicians are not "on-call" and the hospital appropriately documents such payments. "Physician availability services" mean "the physical presence of a physician in a hospital under a formal arrangement with the hospital to render emergency treatment to individual patients as and when needed." *See Bournwood Hospital v. Blue Cross Blue Shield Assoc./Assoc. Hosp. Serv.*, PRRB Hearing Dec. No. 2004-02, Case Nos. 99-3609, 00-3050 and 01-2972 (Sept. 11, 2003) (psychiatrists' standby service costs allowed); *but see St. Benedicts Family Med. Ctr. v. Blue Cross/Blue Shield Assoc.*, CMS Administrator Decision (Feb. 16, 2007) (costs for physician assistant availability not allowed).

35 42 U.S.C. § 1395u(n)(1) (2008).

36 42 C.F.R. § 414.50 (2008) (regulation in effect prior to January 1, 2009, restricted marking up payment only on TC and required reporting of supplier and the supplier's net charge on claim form).

37 Medicare Physician Fee Schedule and Other Revisions to Part B for CY 2009; Final Rule, 73 Fed. Reg. 69726, 69935-36 (Nov. 19, 2008) (to be codified at 42 C.F.R. § 414.50(a)) [hereinafter CY 2009 PFS Rule].

38 42 U.S.C. § 1395u(b)(6); 42 C.F.R. § 424.80; Medicare Claims Processing Manual (CMS-Pub. No. 100-04), Chap. 1, § 10.1.1.3, § 30.2.7.

39 I.R.C. § 501(c)(3) (2008); Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (2008).

40 I.R.C. § 4958(c)(1)(A) (2008); Treas. Reg. § 53.4958-3(e)(2)(iii) (2002). Section 4958 imposes excise taxes on "disqualified persons" and "organization managers" in connection with "excess benefit transactions" between organizations exempt under § 501(c)(3) and disqualified persons when the value of the economic benefit provided exceeds the consideration (including the performance of services) provided by the disqualified person(s). A "disqualified" person includes persons with substantial influence over an organization.

41 I.R.C. § 103(a); Treas. Reg. § 1.141-3(b)(4)(ii). Private business use of tax-exempt bond financed property can occur under a management contract between a tax-exempt organization and private individuals. A management contract includes a service or incentive payment contract when the service provider provides services that involve all or a portion of a bond-financed facility." Treas. Reg. § 1.141-3(b)(4)(ii). Revenue Procedure 97-13 (Jan. 10, 1997) sets forth certain requirements that if met will result in a management contract not creating private business use.

42 *See* I.R.C. §§ 3101(a), 3102, 3111, 3121(b) and (d), 3301, 3402(a)(1) (statutes); Treas. Reg. §§ 31.3121(d)-1(c)(2) (1980); Treas. Reg. § 31.3306(i)-1(a) (1960); Treas. Reg. 31.3401(c)-1(b) (1970) (regulations); Rev. Rul. 87-41, 1987-1 C.B. 296 (revenue ruling); I.R.S. Priv. Ltr. Rul. 93-35-055 (Sept. 3, 1993); I.R.S. Priv. Ltr. Rul. 94-10-041 (Mar. 11, 1994); Priv. Ltr. Rul. 87-15-002 (Sept. 18, 1986) (private letter rulings); IRS Announcement 92-83, 1992-22 I.R.B. 59; and IRS Corporate Education Coursebook: Introduction to the Healthcare Industry (1995).

43 *See* www.aaem.org/corporatepractice/states.php (state by state listing of corporate practice of medicine statutes, cases and opinions).

44 *See, e.g.*, Tex. Rev. Civ. Stat. Ann. art. 1528F, §§ 2(B), 6 (2008) (exception for professional medical corporations); Ind. Code Ann. § 25-22.5-1-1.2(a)(22)(C) (2008) and Tenn. Code Ann. § 68-11-205 (2008) (exception for hospital corporations); and 65 Op. Cal. Atty's Gen. 223, 224 (1982) (exception for corporations offering employees reduced cost healthcare services).

45 Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (Aug. 21, 1996); 45 C.F.R. Parts 160, 162 and 164 (2008).

46 45 C.F.R. § 160.103 (2008).

47 *Id.* Part 164.