

NAVIGATING THE DOCUMENTATION OF COMMUNITY NEED

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Physician recruitment arrangements present risks to all hospitals engaged in physician recruiting and tax-exempt hospitals face additional risks. Laws and regulations in place weigh heavily on physician recruitment activities. Before a healthcare organization can recruit a physician that involves financial arrangements, it must demonstrate a need for that physician in the community. And the details required for verifying that need are rigorous.

Hospitals and health systems continue to recruit physicians and providers in their mission to provide the needed medical care for their communities. Hospitals are required to document the highest level of specificity to maximize documentation for the community need for recruited physicians. This documentation, which must be completed **prior to** allocating resources to recruit a physician, can increase or decrease the chances of adverse audit findings.

Laws affecting financial agreements between physicians and healthcare organizations include:

- Medicare and Medicaid Fraud and Abuse Laws/Safe Harbors
- The Stark Law
- Antitrust laws
- Tax-exempt status laws for non-profit health care providers

Penalties for violating these laws can include fines, incarceration, and exclusion from participating in the Medicare and Medicaid reimbursement programs, or loss of a non-profit status. The Internal Revenue Service (IRS),¹ the Office of the Inspector General (OIG),² and the Centers for Medicare & Medicaid Services (CMS)^{3,4} all provide guidance on physician recruitment arrangements. Because each agency is responsible for ensuring compliance with different regulations, the Certificate of Need (CON) requires a full examination of each agency's guidelines to determine where a hospital (tax-exempt or other) must demonstrate a community need for a physician--**prior to** entering into a recruitment arrangement. Therefore, to meet the CON requirements, it is important to document the data about access to care and forecasted statistical demand.

Though establishing community need can be burdensome in its level of detail, it has its benefits. Proper documentation of need helps set the expectations for the recruited physician's success in the new community.

Most hospitals have a recruitment program that sources, qualifies, and recruits new physicians each year. The hospital's ability to recruit relies heavily on a compliant process and a well-documented need for each recruit.

The following is a documentation checklist that can serve as a useful tool to ensure you are properly documenting community need.

EVIDENCE OF COMMUNITY NEED CHECKLIST: Date: _____	
Recruit Name:	Specialty:
QUANTITATIVE EVIDENCE:	
	There are not enough physicians in the community overall by population demand ratios of _____ (need) by _____ (year)
	The population-to-physician ratio in the zip code of the new practice location in the above specialty is below the ideal ratio in the GMENAC report or other accepted benchmark as shown by a report prepared by a qualified and experienced consultant or publicly available from other reputable sources, i.e., such report reflects a net need for services at the new practice location and specialty (attach Demand Tool Tab, report or relevant excerpts).
	Waiting periods or travel times for patients seeking the above specialty services in the hospital's service area exceed statewide or national averages (attach supporting survey Qualitative Tab Demand Tool).
	The practice location is in an area designated as a Health Professional Shortage Area ("HPSA") as defined in 42 C.F.R. §§ 5.1 – 5.4 (attach proof of designation).
	The practice location is in a Medically Underserved Area ("MUA"), designated by the Secretary of HHS pursuant to 42 U.S.C. § 254b(b)(3) (attach proof of designation).
	The population to be served is a Medically Underserved Population ("MUP"), designated by the Secretary of HHS pursuant to 42 U.S.C. 254b(b)(3) (attach proof of designation).
	The practice location has been designated a rural health clinic as defined in 42 U.S.C. § 1395x(aa)(2) or is an isolated rural area (attach copy of designation or other support).
	The practice location has been designated a federally qualified health center ("FQHC") as defined in 42 U.S.C. § 1395x(aa)(2) or is an economically depressed inner-city area with a median household income for a family of four of \$ _____ in the year _____ compared to statewide median of \$ _____ and a national median of \$ _____ (attach copy of designation and relevant census data or other proof of demographics).
	Recruit will agree to serve a substantial number of patients (i.e., ___%) who: reside in a zip code with a population-to-physician ratio below the ideal ratio; are part of an MUP; or reside in a HPSA, MUA, or isolated rural area (agreement must define commitment).
	There is a demonstrated reluctance of physicians to relocate to the hospital's service area (attach summary of unsuccessful recruitment efforts, including names of recruits, dates, specialties and current practice location based on AMA or equivalent databases).
	A reduction in the number of physicians in a specialty serving the community can be reasonably expected as a result of anticipated retirement within the next three years.
	There are an insufficient number of physicians in the above specialty willing to accept Medicare and/or Medicaid and indigent patients as determined by the hospital's community needs assessment and recruit will accept such patients on a nondiscriminatory basis (attach Demand Tool Qualitative Tab assessment).
	Recruit will staff a new facility or service in the community that has obtained a certificate of need pursuant to state law which process included an examination of the need for the service or facility in the community, i.e., a substantive or comparative review of need.
	Other factors related to cost, quality or access to care (e.g., disproportionately high number of residents in specialty leave the state, donate time at indigent clinic or FQHC, accept minimum level of charity care patients, essential to maintaining particular service at Hospital); requires approval of hospital legal counsel. Please explain here and attach supporting documentation:
	<u>Explain Need within range (High/Median/Low):</u>

QUALITATIVE EVIDENCE	
	Demonstrate inadequate access (specific payer access and appointment wait times) Explanation:
	Demonstrate loss of essential community program, not hospital-specific (i.e. Trauma). Explanation:
	Demonstrate risk of loss of physicians next several years due to departures, those at “risk of retirement,” or reducing hours of practice. D. Demonstrate succession need:
	Explanation:
	Completed by: Third-Party Assessment: _____ Date _____
	Completed by Hospital: _____ Date: _____
<i>This outline provides general information only and does not constitute legal or tax advice for any particular situation.</i>	

CONCLUSION

Physician recruitment arrangements present risks to all hospitals engaged in physician recruiting, and additional risk to tax-exempt hospitals.

Such financial arrangements potentially implicate violations of the organizational and operational tests required under § 501(c)(3), the Anti-kickback statute, and the Stark Law.

One factor that the agencies charged with enforcing these laws consider in scrutinizing physician recruitment arrangements is whether there is evidence of a demonstrated community need for the recruited physician. If such evidence exists, a hospital minimizes the risks posed by having physician recruitment arrangements. Therefore, (1) ensure that the recruitment decisions are made for legitimate patient care and community need reasons; (2) document all minutes, correspondence, and other memos to ensure compliance; and (3) be ready to demonstrate how your recruitment negotiations have been negotiated at arm’s length and how the community benefits.

To learn more about Documenting Community Need, please contact Sandy Champion at schampion@cokergroup.com by calling 678-832-2021.

This article is not a complete discourse on the law in this area and is not intended as legal advice. Specific situations require specific analysis and advice by a qualified attorney.

NOTES

¹ **Internal Revenue Service (IRS).** Revenue Ruling 97-21 (Rev. Rul. 97-21), issued in April 1997, was the first precedential guidance issued by the IRS specifically addressing the exemption implications of physician recruitment arrangements. Rev. Rul. 97-21, 1997-1 C.B. 121. The ruling was issued in the context of five factual situations, and reinforced the IRS's emphasis on documentation of a bona fide community benefit via a demonstrated community need for a particular physician or specialist. It is important to note that in all four situations, the IRS points out that the hospital provided objective evidence of a community need for a particular physician or specialist.

² **Office of the Inspector General (OIG).** The federal Medicare Anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by government health care programs, such as Medicare and Medicaid. The primary enforcement agency of the Anti-kickback statute is the OIG of the Department of Health and Human Services (HHS). In the context of physician recruitment incentive arrangements, the OIG is concerned that a hospital's intent behind offering incentives to physicians may not be to recruit physicians, but is instead intended as a kickback to obtain and increase patient referrals from the recruited physicians.

³ **Centers for Medicare & Medicaid Services (CMS).** The federal Ethics in Patient Referral Act, commonly known as the Stark Law, prohibits physicians from making referrals for "designated health services" which are payable by Medicare and Medicaid, to any entity with which the physicians have a financial relationship, unless a specific statutory or regulatory exception applies. 42 U.S.C. 1395nn. Under the Stark Law, which is interpreted by the CMS, physician recruitment arrangements are obviously part of the "financial relationship" that a physician has with a particular hospital entity. Although physician recruitment arrangements are implicated in the Stark Law, a demonstrable community need for a physician does not appear to be a factor in finding an exception to the prohibition against the physician referrals, even as the law has evolved over time.

⁴ The IRS and OIG have issued formal and informal guidelines requiring that hospitals demonstrate a community need for a particular physician prior to entering into a recruitment arrangement, while CMS has not yet incorporated similar requirements in the Stark Law. Because evidence of community need is required by at least two regulatory agencies, hospitals should look to establish objective evidence of a physician need in its community prior to entering into a physician recruitment arrangement.