NEW ARRANGEMENTS, NEW SCRUTINY

The IRS Reconsiders Hospital-Physician Relationships At Tax-exempt Facilities

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Summary The pressure to maintain adequate operating margins has forced many not-for-profit hospitals to adopt more overtly competitive behavior than they have in the past. However, in struggling to remain economically viable, these facilities should carefully avoid actions that would threaten their tax-exempt status. Not-for-profit facilities should be particularly careful that their arrangements with physicians, which often appear designed to increase referrals, do not violate the criteria according to which the Internal Revenue Code extends tax exemption to charitable organizations.

Section 501(c)(3) of the code exempts organizations "no part of the net earnings of which inures to the benefit of any private shareholder or individual." According to this provision, "insiders" (i.e., those with a personal interest in or opportunity to influence organization activities from the inside) are entitled to no more than reasonable payment for their goods or services. The Internal Revenue Service (IRS) takes the position that, as employees or individuals having a close professional working relationship with a hospital, physicians are insiders.

Thus a hospital that pays physicians what the IRS judges to be more than fair market value for services (or charges physicians less than fair market value for office rental) may find its exemption in jeopardy. If not-for-profit hospitals want to maintain their tax-exempt status, they must be certain the arrangements they enter into with physicians truly further their exempt purpose: to promote the health of the community.

As not-for-profit hospitals struggle, individually and collectively, to maintain their tax-exempt status, they must be aware of the characteristics and activities that most place their exemption in jeopardy. The trend toward more overtly competitive behavior, encouraged by third-party payers, professional managers, and outside advisers alike, provides the most visible contrast with the mission-oriented culture that prevailed in the past. In today's environment, with the healthcare needs of the uninsured and financial needs of local governments demanding attention, some economically adaptive strategies may place hospitals at odds with public or governmental expectations. Closing emergency rooms or limiting services to the poor in an attempt to reduce costs is only one facet of the problem. An equally palpable threat to exemption—and to charitability itself—lies in hospitals' recent propensity to meet nearly any demand by medical staff physicians to keep them loyal and happy.

Recent Scrutiny

Before considering specific arrangements between hospitals and physicians, it may be helpful to explore the Internal Revenue Service's (IRS's) recent scrutiny of hospitals and what is at stake.

Over the past year or two, the IRS has initiated coordinated examinations focusing on larger and

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more complex taxpayers, including large, multicorporate, tax-exempt organizations. Because hospitals and reorganized healthcare systems fall squarely within the latter group, they have drawn a fair amount of attention in the recently created Coordinated Examination Program (CEP). In fact, CEP examinations are, at least in part, a response to criticism the service received in the late 1980s that its examination activities had not kept up with the changes and growing sophistication in the not-for-profit hospital industry. Recognizing that voluntary compliance—the backbone of the American tax system—depends on having a meaningful enforcement program, the IRS is adjusting the way it uses its examination resources.

Coordinated examinations in the tax-exempt sector focus on organizations with substantial income and assets, as well as those made up of multiple entities. Like traditional hospital examinations, they typically include a review of compliance with employment tax and unrelated business income tax provisions. CEP examinations, however, are likely to delve in far greater detail into the characteristics and activities that qualify the hospital and its affiliates for exemption or may be inconsistent with exemption. This latter issue is most relevant to the present discussion. Certain financial arrangements between a hospital and physicians may so benefit the physicians as to violate the standards for exemption. Hospitals should expect CEP audits to include a careful look at all their relationships with physicians.

CEP examinations are conducted by teams of IRS experts, which may include exempt organization specialists, income tax agents, computer audit specialists, and attorneys from district counsel offices or the national office. To facilitate their efforts, the IRS has revised and expanded the examination guidelines used in hospital audits, adding significant guidance regarding arrangements with physicians.[1] In the pilot CEP hospital system examination, the audit team presented the hospitals a formal information document request for a copy of every written agreement with every physician on the medical staff of the hospitals involved. Additional information on CEP hospital examinations may be obtained by reviewing the IRS's internal training videotape, *Auditing Tax Exempt Hospital Systems.*[2]

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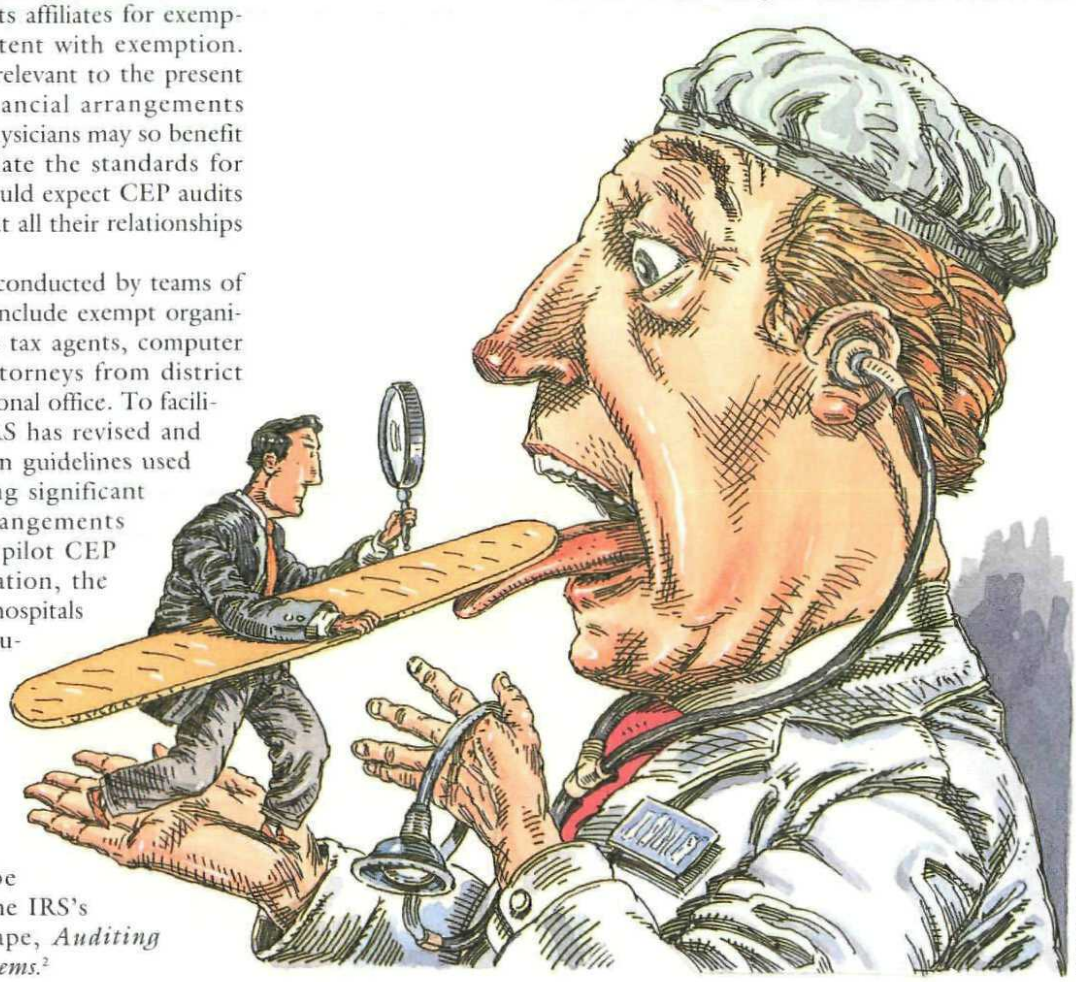
Charitable Trust Principle

The concerns underlying the IRS's scrutiny of hospitals' relationships with physicians—private inurement and private benefit—are not new. The part of the Internal Revenue Code (IRC) extending exemption to charitable organizations has always prohibited these organizations from using assets and earnings for private purposes. The service has always investigated whether private individuals benefit impermissibly from charitable organizations. Until recently, however, that chiefly meant monitoring the actions of hospital founders, trustees, and top administrators. The few troublesome situations involving physicians usually stemmed from previous ownership or control of the hospital by a small group of physicians or economically motivated limitations on availability of staff privileges. Today, newly forged financial ties with medical staff members are more likely to be at the heart of the issue.

Most not-for-profit hospitals are exempt from federal income tax under Section 501(c)(3) of the IRC based on the notion that they are organized and operated exclusively for charitable purposes within the meaning of the statute. Under the



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common law of charities, the IRC, and applicable regulations, these hospitals are viewed as charitable trusts for the benefit of the public. That explains why control by an independent board of trustees and a clause in the corporate charter forever dedicating assets to charitable purposes are among the essential factors entitling a hospital to tax exemption. In fact, the entire statutory and regulatory scheme under which hospitals enjoy exemption is designed to ensure the furtherance of public purposes and to prevent diversion of charitable assets into private hands.

Private Inurement Within this body of law are two key prohibitions. The first is private inurement. Section 501(c)(3) exempts organizations "no part of the net earnings of which inures to the benefit of any private shareholder or individual." This means an individual cannot pocket the organization's income or assets, except as reasonable payment for goods or services (e.g., reasonable salaries to employees). The inurement prohibition is absolute: No minimum amount threshold or de minimis exception exists.

The inurement proscription, however, applies only to "insiders," that is, those with a personal and private interest in the organization or an opportunity to influence its activities from the inside. Basically, the law is designed to prevent those in a position to do so from siphoning off charitable assets for personal use.

Private Benefit The second prohibition covers private benefit and is founded on the principle that a Section 501(c)(3) organization must be organized and operated to serve public, rather than private, interests. Unlike inurement, the private benefit prohibition is not restricted to insiders; benefits flowing to *anyone* outside the intended charitable class must be considered. However, it is not absolute. Instead, any private benefit must be incidental to (or a necessary concomitant of) the public benefits involved. This frequently requires balancing the private benefit resulting from an activity or transaction against the public benefit it achieves.

It could be said that some private benefit has always been present in the hospital-physician relationship. Physicians use hospital facilities to treat their private patients, for which they earn a fee. This private benefit generally may be viewed as incidental to the even greater public benefit resulting from having the hospital and physician work together to help the sick.

Physicians as Insiders An important issue in the hospital tax field is whether physicians on a hospital's medical staff are insiders for purposes of the inurement prohibition. The Office of Chief Counsel takes the position that, as employees or individuals having a close professional working relationship with the hospital, they are. Although this view has provoked controversy in the hospital community, it probably is the only position the IRS can reasonably take. The problem is that physicians' relationships with hospitals take a great many forms, ranging from employee to independent contractor, from nonadmitter to top admitter, and from new recruit to department head or board member. When reviewing transactions for rulings or during an audit, the IRS typically lacks information more specific than "so-and-so is a member of the medical staff." It may be best, then, to think of the service's position as a rebuttable presumption that medical staff physicians as a class are too likely to be in a position to exert inside influence not to be treated as insiders. However, even if the strict inurement analysis did not apply to a particular physician, the private benefit analysis would be applied as a fallback.

Truth and Consequences When the IRS's exempt organization specialists review the details of hospital financial arrangements, either in an advance ruling or on examination, inurement and private benefit concerns are likely to be reflected in the questions they pose. What is the hospital paying for? Does the expenditure further the hospital's exempt purposes, and, if so, how? Does the amount paid or received represent fair market value? Was the arrangement negotiated at arm's length?

Punishment for violating either prohibition is severe. Any private inurement, or too much (i.e., more than incidental) private benefit, could cause a hospital to lose its exemption.

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Types of Arrangements in Question

A few examples of transactions or arrangements that could raise inurement or private benefit concerns will help clarify what is at issue. Unlike in a for-profit corporation with stockholders, individuals typically do not take a share of profits in the form of a dividend or a share of assets on liquidation of a not-for-profit hospital. Such obvious wrongdoing is unusual. Nevertheless, the service uncovered one such case just last year. In a 1991 technical advice memorandum,[3] the IRS national office determined that a hospital's exemption should be revoked because its 12-member board of directors established a new for-profit corporation and sold the hospital to themselves at less than fair market value. When they subsequently resold the hospital, each director received more than $2.3 million as a share of the proceeds. Though rare, this was a classic case of insiders causing the accumulated earnings of a charitable organization to inure to their own individual benefit.

Compensation Most instances of potential inure-

ment are more subtle, such as paying salaries that exceed an amount considered reasonable. As noted earlier, paying reasonable compensation for any goods or services generally is permissible. Conversely, paying excessive (and therefore unreasonable) compensation may give rise to inurement. In the hospital context, this frequently comes up in the areas of incentive compensation and physician-recruiting incentives.

The flip side of paying unreasonably high salaries is receiving unreasonably low compensation for goods or services the hospital provides to private interests. An example would be where physicians pay less than fair market value for medical office building space or the hospital pays too much for something it purchases or rents from an insider. A related area of concern is below-market loans (i.e., those with no or low interest or inadequate security) to officers, employees, or physicians.

Rewarding Referrals Looking at hospital-physician economic relationships today, one cannot ignore the changes that have occurred since Medicare adopted its prospective payment system (PPS) and other payers started negotiating price concessions. Demand for inpatient care is down, and hospitals need more admissions to maintain efficiency and control costs. Of course, they need referrals for outpatient and other services as well. The truth is that physicians control most of these admission and referral decisions. Adding just one physician to the staff, or changing one physician's existing referral patterns, can mean several hundred thousand dollars in annual revenue to a hospital.

Thus it is no surprise that hospitals have entered into any number of complex financial arrangements with physicians on their staffs—and those they want on their staffs. These include, most notably, recruiting incentives, purchases of physician practices, partnerships, and joint ventures. Hospitals typically tell the IRS that the purpose of these arrangements is to attract and retain good physicians and, in some cases, to forestall competition from the physicians or other hospitals. Although they now rarely say so directly, what the hospital really wants in many cases is continued or additional patient referrals. With overcapacity and competition what they are today, referrals are deemed necessary for survival.

Some of the new financial arrangements between physicians and hospitals seem little more than thinly veiled ways to reward physicians for referrals without actually paying a set amount for each patient. Paying for referrals may make economic sense for an individual hospital. Doing so could help:

- Fill beds
- Avoid competition from physicians
- Achieve economies of scale
- Improve market share
- Justify modernization or expansion
- Attract referrals of less severely ill patients, allowing a greater return on PPS payments

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However, paying for referrals creates a serious problem. Actually offering or paying anything to induce referrals violates Medicare's antikickback statute, putting those involved at risk for severe criminal penalties and civil exclusion from the Medicare and Medicaid programs.[4] Post-PPS economic incentives are so strong, however, that aggressive hospitals and doctors, aided by imaginative lawyers and accountants, have devised arrangements intended to "cut the docs in" on the revenues generated by their referrals while avoiding prosecution. Only a few of these arrangements appear beyond question to violate the antikickback statute. A few others are protected by the Department of Health and Human Services' new "safe harbor" regulations,[5] which identify arrangements that will not be treated as civil or criminal violations (see Gregg J. Lepper and John Swoboda, "Narrow Harbors," *Health Progress*, December 1991, pp. 44-47). Most fall into a gray area of uncertain legal status where administrative enforcement and judicial interpretation have not yet caught up with creativity. To remain within this latter category, many arrangements are structured without any explicit requirement to refer or admit patients or as ownership interests with all payments determined solely by equity.

Joint Ventures As joint ventures and other hospital-physician economic arrangements have increased in popularity, hospitals have been forced to offer more and more generous terms to their physicians to keep up with the competition. Disappointed doctors might take their patients to another hospital or, worse, establish a competing outpatient facility. Except for sole community providers, most hospitals cannot afford to say no to some physician demands. Nevertheless, if hospitals want to maintain their tax-exempt status, they must be certain these arrangements truly further their exempt purpose: promoting the health of the community.

Hospitals have many reasons for entering into joint ventures with members of their medical staffs: to help in recruiting and retention, to raise capital, to head off competition from the physician-investors, to expand community health resources, and to lock up a stream of referrals from the physician-investors. Frequently, joint ventures are structured as limited partnerships, with the hospital or an affiliate serving as the general partner and the physicians holding limited

partner interests. Because of concern that fiduciary duties to partners may conflict with charitable purposes, the IRS was slow to approve hospital participation in partnerships. Currently, it closely scrutinizes such arrangements to ensure that participation furthers the hospital's exempt purposes and that the terms protect the hospital's assets and allow it to operate exclusively in furtherance of exempt purposes (see **Box**).

Physician Recruitment Some of the thorniest issues arise in physician recruiting. Under some circumstances, such as efforts to attract a new graduate as the first physician to establish a practice located in an underserved rural community, it may be easy to demonstrate substantial community benefit that justifies private practice income guarantees, loans, or other expenditures that confer a benefit on the recruited physician. In other circumstances, such as efforts to attract physicians already practicing at a competing hospital across town in order to lock up their referrals, little or no net benefit accrues to the community, but substantial private benefit accrues to the physicians. The highest-bidding hospital may benefit, but the other hospital sustains an equal loss, while the community as a whole has scarce healthcare dollars diverted into private hands without an offsetting gain. This type of activity places a hospital at risk of violating both the tax and antikickback laws.

A charitable hospital can do virtually anything that promotes the health of its community and does not violate applicable law.

Few precedents exist in this area. However, the Office of Chief Counsel published a general counsel memorandum in 1986 considering the use of private practice income guarantees.[6] Although it stated there is no per se rule against such payments where they are justified by the need for the recruited physician, the memorandum concluded that the IRS should not rule in advance on the arrangement in question because it was not possible to determine that all amounts to be paid would not exceed reasonable compensation.

The instant it becomes known that a hospital has offered recruiting incentives, existing medical staff members may pressure the facility to offer incentives for them to remain on staff. A 1990 *Modern Healthcare* cover story labeled this "the stick up."[7] This is dangerous territory for hospitals from both a tax- exemption and antikickback-law standpoint. Interestingly, however, although physicians may be well schooled in Medicare's antikickback law, they are likely to know or care little about the tax-exemption provisions because they affect only the hospital.

Again, little precedent exists here, but a few thoughts may be helpful. A hospital should resist the temptation to pay physicians big money for small responsibilities, especially where those responsibilities have traditionally been fulfilled as a condition of privileges. Some activities that help physicians' private practices but also benefit the community have received favorable rulings. The leading example is hospital proposals to establish medical office buildings near the facility so long as the hospital charges fair market–value rents. In retention efforts, too, hospitals would do well to evaluate how any expenditure will benefit the community, not just whether it might bring a short-term boost in market share.

NET REVENUE STREAM DEALS

In Private Letter Ruling 8820093, the Internal Revenue Service granted a favorable ruling to a hospital that wanted to set up a limited partnership with medical staff physicians. The hospital would be the general partner and the physicians limited partners, with the latter owning from 50 percent to 90 percent.

The partnership would purchase the net revenue stream of the hospital's outpatient surgery department for the next five years, with an additional five-year option. The purchase price was established by an independent appraiser at fair market value, discounted to present value, but did not reflect any changes in utilization or referral patterns that might occur as a result of the purchase.

After the purchase, the hospital would continue to own and operate the facilities under its license. The hospital received its anticipated revenues up front and expected that the deal would increase utilization of its other facilities. According to the hospital, the partnership bought only the *chance* that outpatient surgery net revenues would increase. However, since limited partnership interests were sold only to physicians in a position to refer patients, it appeared likely that utilization of the facility and revenue would increase.

Despite initially approving the arrangement, the service announced shortly thereafter that the Office of Chief Counsel was formally reexamining the ruling and had advised the service not to rule on similar transactions until the review was completed. In general counsel memorandum (GCM) 39862 (November 21, 1991), the Office of Chief Counsel analyzed this and two similar joint ventures. The GCM concludes that a hospital engaging in such a transaction jeopardizes its exemption for three reasons: (1) the arrangement causes the hospital's net earnings to inure to the benefit of private individuals, (2) the private benefit involved is not incidental to the public benefits achieved, and (3) the transaction may violate federal law (Medicare's antikickback statute). The GCM recommends that all three private letter rulings be revoked.

What Can a Hospital Do?

All this talk of prohibitions and restrictions is not meant to suggest that tax-exempt hospitals have little flexibility. Although they must comply with tax law, Medicare, and other legal standards, hospitals are otherwise free to fulfill their missions in any way they choose. A charitable hospital can do virtually anything that promotes the health of its community and does not violate applicable law.

One hospital attorney I know tells audiences they can "pay fair market value for *legal* goods and services." Assuming the expenditure either furthers exempt purposes or is insubstantial, he is right.

Nevertheless, this may, under some circumstances, add up to less than what a for-profit hospital can do. For-profit facilities ultimately must answer to their shareholders and are bound by Medicare's antikickback law in exactly the same manner as tax-exempt hospitals. Still, they are not constrained by the inurement and private benefit prohibitions. In ruling requests and examinations, the IRS is constantly confronted by the "survival" argument. To operate efficiently and, thus, to survive, hospitals argue, they must do whatever it takes to attract more admissions and forestall new competition. Since tax-exempt hospitals have to compete with for-profit facilities, any restriction imposed by the IRC or the IRS threatens their very survival.

This argument raises an important issue. Should the IRS accept strategies designed to enhance efficiency, competitiveness, and market share to justify acts that otherwise appear impermissible? For example, should the service ever view rewarding physicians for admissions or referrals as furthering a hospital's exempt purposes? These questions have not yet been answered. The survival argument also ignores the fact that tax-exempt hospitals receive significant tangible benefits through their exemption that for-profit hospitals do not enjoy.

Ultimately, the survival argument suggests that sharing the economic value of continued or additional referrals with physicians is necessary for the continued efficient operation, or even existence, of the hospital. An implicit part of this argument is that continued availability of the hospital benefits its community. Nevertheless, harm to the community can result from arrangements that involve payments for referrals. First, revenues that might otherwise have been available to fulfill public purposes, such as providing more charity care, are shifted to rewarding physicians, who are private interests. In addition to this "revenue shifting," the community may sustain other harm, including unnecessary utilization of services, inflated hospital costs without offsetting benefits, undermined competition, reduced patient freedom of choice, and care decisions based on pecuniary factors. Ironically, as more facilities accede to physician demands, the benefit to individual hospitals is weakened, so that, in the end, hospitals have a new cost of doing business and only the physicians benefit.

Economic issues aside, some of these arrangements may violate federal law. The principle is well established that a tax-exempt organization's purposes or activities cannot be illegal. Thus violating the antikickback statute could jeopardize a hospital's exemption as well.

A hospital, its trustees, and its managers would do well to evaluate every proposed course of action not by how it would help the hospital, but by how it would help the community.

If the IRS Calls

If the IRS calls on a hospital to defend a transaction or arrangement, being able to show actual, informed consideration and approval by the board may be crucial. A chief executive officer who is reluctant to share details of a proposed hospital-physician transaction with the board, or who fears board disapproval, ought to be on notice that the transaction may be questionable and may not meet the private benefit and inurement standards. One thing that could help demonstrate a public purpose or benefit to help balance an otherwise close arrangement is to include a clause obligating the other party to serve Medicaid patients and to treat charity care patients in accordance with the hospital's policy. Another strategy is to structure agreements with physicians as employment rather than contractor arrangements if a corporate-practice-of-medicine statute does not dictate otherwise.

More fundamentally, a hospital, its trustees, and its managers would do well to evaluate every proposed course of action not by how it would help the hospital, but by how it would help the community. Whenever the potential for inurement or private benefit arises, the careful hospital will seek a ruling from the service before entering into an arrangement. At least in the near term, hospitals should expect continued scrutiny of their relationships with physicians. With millions uninsured, and access to care once again a national issue, ensuring that not-for-profit hospitals' assets are used exclusively for charitable purposes has never been more important. □

NOTES

1. Current guidelines are published in the *Internal Revenue Manual* at part 7(10)(69).
2. Reprints of the tape, obtained under the Freedom of Information Act, are available for $10 from the Catholic Health Association, St. Louis. Contact Karen Kaltenbach at 314-427-2500, ext. 258.
3. LTR 9130002. A technical advice memorandum is sent from the IRS national office to a field office providing guidance in interpreting tax law or applying it to a specific set of facts. See Rev. Proc. 91-5, 1991-4 I.R.B. 44.
4. See 42 U.S.C. Sec. 1320a-7b(b).
5. See 56 Fed. Reg. 35952 (July 29, 1991), to be codified at 42 C.F.R. Secs. 1001.951-1001.953.
6. GCM 39498 (January 28, 1986).
7. "Healthcare's Hidden Costs," *Modern Healthcare*, January 15, 1990, p. 22.