Annals of Health Law

Volume 1
Issue 1 *1992*

Article 6

1992

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Recommended Citation
David W. Ball *Internal Revenue Service General Counsel's Memorandum Threatens Tax Exemption for Charitable Hospitals*, 1 Annals Health L. 71 (1992).
Available at: http://lawecommons.luc.edu/annals/vol1/iss1/6

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Internal Revenue Service General Counsel's Memorandum Threatens Tax Exemption for Charitable Hospitals

David W. Ball *

Internal Revenue Service ("IRS") General Counsel Memoranda ("GCM") usually deal with technical tax matters and are not reported in newspapers. However, in November, 1991, the IRS issued GCM 39,862, which was reported in the Wall Street Journal and USA Today, for good reason. GCM 39,862 reverses the IRS' longstanding favorable treatment of certain hospital-physician relationships and threatens the tax exempt status of many hospitals.

BACKGROUND

In 1983, the Medicare method of reimbursement for hospitals was changed. Under the old method, hospitals were reimbursed based on a retrospective cost-based reimbursement system. Under the new prospective payment system, hospitals are reimbursed based on payment categories called Diagnostic Related Groups. The payment is fixed prospectively. As a consequence of these categories, hospitals have strong financial incentives to admit certain types of patients, those who are profitable, and to release patients more quickly. Because hospitals receive most of their patients as referrals from private practice physicians, hospitals have sought to establish stronger relationships with their medical staffs to ensure a greater physician referral stream. Joint ventures and other arrangements are commonly used to "bond" physicians to a hospital. Until GCM 39,862, these arrangements were generally viewed as acceptable and in fact had been "blessed" by numerous favorable private letter rulings ("PLR") issued by the IRS. GCM 39,862 specifically reverses the IRS position set forth in three earlier PLRs and casts significant doubt on the continued tax exempt status of hospitals that engage in certain bonding arrangements.

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Published by LAW eCommons, 1992

TAX EXEMPT STATUS REQUIREMENTS

To qualify for tax exempt status under Internal Revenue Code section 501(c)(3), an organization must show, among other things, that no part of the net earnings of the organization inure to the benefit of a private shareholder or individual. To meet this requirement, two elements must be established: (1) there must be no private inurement, and (2) any private benefit must be incidental to the public benefit.

Private inurement occurs if the net earnings or other assets of an exempt organization improperly benefit insiders. "Insiders" are generally considered to be officers, directors, or persons who created the organization. The IRS, even before GCM 39,862, took the position that physicians with hospital staff privileges are insiders.[1] However, payment of reasonable compensation to physician employees and independent contractors does not constitute private inurement.[2]

The incidental private benefit requirement prohibits an organization from being "organized or operated for the benefit of private interests such as designated individuals, the creator or [creator's] family, shareholders of the organization, or persons controlled, directly or indirectly, by such private interests."[3] A private benefit that results from a charitable organization's activities will not threaten its tax exempt status if the private benefit is only incidental to the public benefit derived from the activity.[4]

THE OLD VIEW

As noted above, GCM 39,862 modifies or revokes three prior PLRs approving hospital-physician joint ventures. Each of the PLRs involved the sale of the revenue stream from a division of the hospital to the hospital-physician joint venture. In all three cases, the IRS ruled favorably.

In PLR 8820093, the net revenue streams of the outpatient surgical program and gastroenterology laboratory were sold. It was argued that this would offer a financial incentive to the physicians to increase usage of the facilities.

In PLR 8942099, the joint venture acquired the gross revenue stream of the outpatient surgery department, less certain debts and

1. Gen. Couns. Mem. 39,498 (Jan. 28, 1986).
2. *Id.* at 10.
3. Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (as amended in 1990).
4. Gen. Couns. Mem. 39,862, at 16 (Nov. 22, 1991).

expenses of the department. The hospital maintained that operating its outpatient surgery department was costly, and that it had recently been at increased financial risk due to changes in the healthcare marketplace, including increased competition. The hospital further claimed that, if it was unable to maintain physician support of its outpatient surgery department, it might have to raise patient charges to cover its costs, and its ability to provide a wide range of outpatient surgical services and timely access to its outpatient surgery facilities might be affected.

In the third PLR, which GCM 39,862 refers to as an unpublished PLR, a joint venture was formed to allow medical staff participation in the operation of four hospital outpatient departments, surgery, diagnostic, ophthalmology, and cardiac nuclear medicine. Here, the argument to support participation was to maintain or increase utilization of the hospital's various services, both inpatient and outpatient, so it could provide to the public the highest level of service at the lowest price. The hospital was located in an "overbedded" service area and faced competition from two nearby hospitals as well as potential competition from a private physician who was planning to develop an outpatient facility to be jointly owned with other doctors. The hospital argued to the IRS that the proposed transaction would maintain or increase facility utilization, which had been experiencing a decline.

THE NEW VIEW

GCM 39,862 begins with a discussion of the changing economics of health care. It notes that many medical and surgical procedures, once done on an inpatient basis, are now performed on an outpatient basis, with every private physician a potential competitor of the hospital. It also notes that hospitals must efficiently improve utilization and that the physician is the determinant to maintaining or improving utilization; therefore, hospitals must stimulate loyalty among these physicians. Notwithstanding this need of hospitals to protect their market shares, the IRS concluded that all three PLRs should be modified or revoked because the three transactions involved jeopardized the hospitals' tax exempt status by (1) allowing private inurement, (2) conferring more than incidental benefits on private interests, and (3) potentially violating the Medicare/Medicaid anti-kickback laws.[5]

5. *Id.* at 1.

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Private Inurement

With regard to the private inurement issue, the IRS determined that the sale of the revenue streams was indistinguishable from a for-profit corporation paying stock dividends. The IRS looked at what the hospital received in return for the benefit conferred on the physician-investors. "Here, there appears to be little accomplished that directly furthers the hospitals' charitable purposes of promoting health. No expansion of health care resources results; no new provider is created. No improvement in treatment modalities or reduction in cost is foreseeable."[6] The IRS concluded that a sale of a hospital's (or part of a hospital's) revenue stream to its medical staff physicians constitutes a private inurement.[7] Thus, any tax exempt hospital that carves out a portion of its services and sells or gives it to physicians will have placed its tax exempt status in jeopardy.

Incidental Private Benefit

As stated above, the tax exempt organization must serve a public interest, and any private benefit must be incidental. With regard to the three transactions at issue, the IRS concluded that the benefit to the physicians was more than incidental and that the hospitals' tax exemption was jeopardized.

GCM 39,862 first applied the traditional analysis in stating that the private benefit must be incidental in both a qualitative and quantitative sense if the organization is to remain exempt. To be qualitatively incidental, the private benefit must occur as a necessary concomitant of the activity that benefits the public at large. In other words, the benefit to the public cannot be achieved without necessarily benefitting private individuals. To be quantitatively incidental, a benefit must be insubstantial when viewed in relation to the public benefit conferred by the activity.

The IRS then applied two concepts in balancing the public and private benefits. First, they balanced the public good conferred only by that activity, not the overall good accomplished by the organization. Second, they viewed the public benefit on a community basis instead of the hospital basis.

> The public benefit expected to result from these transactions—enhanced hospital financial health or greater efficiency achieved through improved utilization of their facilities—bears only the

6. *Id.* at 12.
7. *Id.* at 14.

> most tenuous relationship to the hospitals' charitable purposes of promoting the health of their communities. Obtaining referrals or avoiding new competition may improve the competitive position of an individual hospital, but that is not necessarily the same as benefitting its community.
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> In our view, there are a fixed number of individuals in a community legitimately needing hospital services at any one time. Paying doctors to steer patients to one particular hospital merely to improve its efficiency seems distant from a mission of providing needed care. We question whether the [Internal Revenue] Service should ever recognize enhancing a hospital's market share vis-a-vis other providers, in and of itself, as furthering a charitable purpose. In many cases, doing so might hamper another charitable hospital's ability to promote the health of the same community.[8]

The IRS concluded that the private benefit in the three transactions at issue was not incidental when balanced against the public benefit.

The community basis standard is perhaps the most important element of the GCM. New hospital ventures, physician recruitment endeavors, and other activities raising private benefit issues must be supported by projections showing the benefit to the community, rather than the more easily met standard of increased efficiency and productivity of the hospital alone.

The IRS then incorporated the Medicare and Medicaid Fraud and Abuse Law[9] (commonly called the anti-kickback statute) into its analysis.

Anti-kickback Statute

After concluding that the three hospitals failed the exemption test, the IRS noted that their tax exempt status was also jeopardized by possible anti-kickback violations. The IRS explicitly concluded that anti-kickback violations are inconsistent with tax exemption. The merging of these considerations signals a far more ominous and broad reaching threat to both hospitals and physicians.

The federal anti-kickback statute prohibits the offer, solicitation, payment, or receipt of any remuneration, in cash or in kind, in return for or to induce the referral of a patient for any service that

8. *Id.* at 17, 21.
9. 42 U.S.C.A. § 1320a-7 (West 1991).

may be paid for by Medicare or Medicaid.[10] The IRS's analysis regarding the threat to tax exemption due to anti-kickback violations is quite simple: "We believe that engaging in conduct or arrangements that violate the anti-kickback statute is inconsistent with continued exemption as a charitable hospital. No matter how economically rewarding, such activities cannot be viewed as furthering exempt purposes."[11] The GCM does not conclude that all joint ventures violate the anti-kickback statute. In providing guidance as to which may, the GCM refers to the Special Fraud Alert—Joint Venture Arrangements issued by the Office of the Inspector General in April, 1989.[12]

While the IRS concluded that all of the criteria establishing anti-kickback violations were present in the three transactions, the facts of the financing arrangements were insufficient. The IRS further concluded that it had "good reasons for believing that net revenue stream joint ventures may violate the anti-kickback statute."[13]

IRS Enforcement Efforts

The IRS took two major steps to enforce the new rules. First, in Announcement 92-70,[14] it stated that hospitals intending to rescind net revenue stream joint ventures and wishing to enter into closing agreements or other arrangements with the IRS regarding the tax consequences, which include undoing the original transactions, could submit a request to the IRS by September 1, 1992. If a hospital did so, the IRS would consider resolution of the tax issue without loss of tax exemption if the hospital terminated the arrangement without further private benefit to the physician-investors. After September 1, 1992, the IRS would apply "the usual procedures governing tax consequences, including consideration of revocation of recognition of the tax exemption."[15]

10. *Id.* at § 1320a-7b(b).

11. Gen. Couns. Mem. 39,862, at 29 (citation omitted). The IRS virtually admitted that it failed to pay attention to the anti-kickback problems inherent in its prior rulings when it stated: "We also recognize that, in past instances, both the [Internal Revenue] Service and the Office of Chief Counsel may not have comprehended or devoted sufficient attention to this aspect of proposed transactions." *Id.* at 34. Clearly, the IRS is now educating itself about the anti-kickback issues and is in regular communication with the Office of Inspector General of HHS. At a recent conference, James J. McGovern, the IRS's Associate Chief Counsel for Employee Benefits and Exempt Organizations, stated that the IRS is doing so and is also stepping up current enforcement activities.

12. *Id.* at 27.

13. *Id.* at 37.

14. 1992-19 I.R.B. 89.

15. *Id.*

Second, on March 27, 1992, the IRS issued new audit guidelines for its own field audit staff that contain a new section on joint ventures.[16] Under the new guidelines, audit staff are instructed to examine joint ventures for inurement and incidental private benefit issues. Anti-kickback violations are included as evidence of inurement and private benefit. Other evidence of violations include contractual obligations of a hospital that conflict with its exempt purposes, commercially unreasonable loans to a joint venture by a hospital, disproportionate allocations of profits and losses to physicians from a hospital joint venture, and a hospital's provision of property or services to a joint venture at below fair market value rates.[17]

Conclusions to be Drawn From GCM 39,862

It is clear that the IRS has set a new direction in analyzing hospital-physician joint ventures. Hospitals will not be able to carve out an interest in existing revenue streams and transfer them to physicians without jeopardizing their tax exempt status and potentially incurring anti-kickback sanctions.

While the threat of loosing tax exempt status due to a revenue stream joint venture principally concerns the hospitals involved, the anti-kickback statute also threatens physicians. An anti-kickback investigation can result in stiff money penalties, exclusion from participation in the Medicare and Medicaid programs, loss of professional reputation, and other sanctions.

It is clear that the new IRS analysis will be extended into other areas. The IRS has indicated it is working on another GCM concerning hospitals' physician recruitment activities that will follow the guidelines set forth in GCM 39,862. Other new guidelines already added to the audit guidelines now provide for closer scrutiny of other business relationships between hospitals, executives, and physicians, including recruitment activities. Both hospitals and physicians should heed the warning shot fired in this landmark GCM.

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16. The new guidelines are contained in the Exempt Organizations Examinations Guidelines Handbook, manual transmittal 7(10)69-38. 4 Internal Revenue Manual (CCH) ¶ 22,453.

17. *Id.* at ¶ 22,457-3 to 22,457-8.