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Uncharitable and Out of Control? An Analysis of the Issues Governing Relationships Between Tax-Exempt Healthcare Organizations and Private Healthcare Providers

Stephen E. Weyl

It is axiomatic that very few things about the Internal Revenue Code (Code) are straightforward. However, one fundamental and seemingly clear rule is that charitable organizations cannot conduct their activities in a manner which results in private inurement. In the healthcare arena, perhaps no area receives greater scrutiny from the Internal Revenue Service (IRS) than relationships between tax-exempt healthcare providers and for-profit medical practitioners.

Until passage of the Intermediate Sanctions provisions of the Code in 1996, the IRS' only tool to deal with private inurement was the draconian remedy of loss of tax-exempt status. Given the severe consequences which accompany revocation of tax-exempt status, the IRS rarely sought that remedy. Accordingly, cases which uphold denial or loss of such status appear limited to three areas: use of the organization as a vehicle for partisan political advocacy;[1] failure of the organization to operate as a true public charity;[2] and ceding control of the organization to private interests. This last issue is at the heart of current controversies relating to tax-exempt status in the healthcare field.

Although adoption of Intermediate Sanctions has helped clarify certain principles governing not-for-profit provider-private practitioner relationships, the law in this area continues to evolve. There are some clear guidelines, most notably the safe harbors provided by the IRS in its regulations, revenue rulings. revenue procedures and information letters. However, charitable healthcare providers and private physicians often need to find a level of comfort when entering into arrangements that fall between these safe harbors and the proscription on private inurement. This article will explore the current state of the law governing such arrangements[3] and outline the critical issues that must be considered in attempting to structure relationships that can withstand scrutiny while still providing necessary flexibility.[4]

Private Inurement — Basic Principles

Section 501(c)(3) of the Code requires that an entity must be "organized and operated exclusively for charitable purposes"[5] to qualify for tax-exempt status. As its name suggests, the "organized exclusively" test focuses on organizational documents and structure. The entity's governing documents and its plan of operation must demonstrate that it has been formed and is intended to operate for charitable purposes and provide that, upon dissolution, its assets will be distributed exclusively for such purposes.

The "operated exclusively" test is both more complex and forgiving than its words suggest. Treasury Regulation 1.501(c)(3)-1(c) provides:

> [A]n organization will be regarded as "operated exclusively" for one or more exempt purposes only if it engages primarily in activities which accomplish one or more of such exempt purposes specified in section 501(c)(3). An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose.

The key phrases are "engages primarily" and "if more than an insubstantial part of its activities is not in furtherance of an exempt purpose."[6] Rather than connoting exclusivity, they make it clear that a tax-exempt entity must have its operational focus and the substance of its activities devoted to its exempt purpose. Put another way, an entity with tax-exempt status under Section 501(c)(3) may engage in non-exempt activities to a limited extent. Although this approach is realistic, it has resulted in the promulgation of numerous regulations, revenue rulings, revenue procedures, information letters and private letter rulings, as well as occasional litigation.

It is unlikely that there will ever be a set of bright line rules clearly defining the extent to which an exempt organization may pursue activities with non-exempt parties.[7] Because relationships between exempt healthcare institutions and private practitioners are in a constant state of flux, there is an ongoing need to return to, and understand, the fundamental principles of tax exemption and private inurement in order to keep pace with, and adapt to, the present healthcare environment.

Exempt Organization-Taxable Provider Relationships: The Legal Context

The Broad Outline: Revenue Ruling 98-15

The primary guidance from the IRS on joint ventures, partnerships or other collaborations[8] between exempt and taxable entities is Revenue Ruling 98-15, which contains two examples illustrating the types of factors the IRS considers in determining exempt status. Simply stated, the two critical factors are control and adherence to charitable purposes.

The first example involves a joint venture between an exempt hospital and a taxable provider in which the resulting entity seeks exempt status. In that example, the vesting of control in the hospital — by authorizing it to appoint three of the new entity's five directors — was coupled with the requirement that any exempt entity owned by the joint venture be operated in a manner consistent with its charitable purposes. This arrangement results in exempt status as any private benefits to the taxable provider would be incidental.

The second example's critical facts are: (1) the exempt and taxable entities each appointed one half of the new entity's directors; (2) major operational decisions for the new entity could only be approved by a majority vote of the directors; and (3) the organizational documents for the new entity, while requiring that any healthcare facilities owned by the entity be operated for healthcare purposes, did not obligate the entity to provide community services and operate for charitable purposes. On these facts, the exempt partner in the joint venture failed to demonstrate that the new entity would not be operated for the benefit of private interests.

The IRS relies heavily on Revenue Ruling 98-15 in sorting through applications for exempt status for joint ventures, partnerships and similar collaborations as well as in litigation. Two recent cases, discussed below, demonstrate that reliance and provide insight into how courts are receiving the IRS' view.

Recent Cases: Redlands and St. David's

Two recent cases involving collaborations between exempt healthcare providers and for-profit entities — Redlands Surgical Services v. Commissioner[9] (***Redlands***) and St. David's Health Care Sys., Inc. v. United States[10] (***St. David's***) — help define the current boundaries in these types of relationships.

In ***Redlands***, the IRS refused to grant tax-exempt status to Redlands Surgical Services (Surgical Services), an entity which was wholly-owned by Redlands Health Systems, Inc. (Health Systems). Surgical Services also was an affiliate of Redlands Community Hospital (Hospital), a tax-exempt hospital wholly-owned by Health Systems. Surgical Services was created to acquire Health Systems' interest in a general partnership with Redlands-SCA Surgery Centers, Inc. (SCA), a for-profit subsidiary of a publicly-held corporation. The agreement between Surgical Services and SCA split voting powers equally but gave SCA a majority interest in the partnership's profits. The Surgical Services-SCA partnership served as the general partner and majority owner of the operating entity, an ambulatory surgery center (ASC) located next to the Hospital. The limited partners were the private physicians who performed services at the ASC.

The Surgical Services-SCA partnership entered into a 15 year management agreement with SCA Management (Management), a for-profit subsidiary of SCA's parent. As part of the transaction the Hospital agreed not to expand or promote its own outpatient surgical services. Under the terms of the agreement, Management was paid a management fee equal to six percent of the revenues from the partnership. The IRS denied Surgical Service's application for exempt status. Surgical Services brought suit in the Tax Court seeking to overturn the IRS' decision.

The Tax Court agreed with the IRS that Surgical Services had not met its burden, finding it "patently clear"[11] that the Surgical Services-SCA partnership was not operated exclusively for exempt purposes. The Tax Court concluded that the transaction did not place Surgical Services' charitable mission ahead of the private interests held by SCA and Management. Although Surgical Services emphasized its equal voting rights, which gave it the power to veto any actions proposed by the SCA entities, the Tax Court found that unpersuasive when analyzed in the context of the length and revenue structure of the Management agreement and the Hospital non-competition agreement. Surgical Services appealed the decision to the Ninth Circuit Court of Appeals, which affirmed the Tax Court's decision in a brief opinion, stating:

> [W]e adopt the tax court's holding that the [non-profit organization] ***has ceded effective control*** over the operations of the partnerships and the surgery center to private parties, conferring impermissible private benefit.[12]

In ***St. David's***, St. David's Health Care System (System) entered into a limited partnership with HCA, Inc. (HCA)[13], a publicly-held corporation operating 180 hospitals in the United States. The assets of the limited partnership were comprised of the System's single hospital and its medical assets and HCA's hospitals and their medical assets in the Austin, Texas area. The System and an HCA for-profit subsidiary, Round Rock Hospital (Round Rock) were designated as the general partners of the limited partnership; the System and another for-profit HCA subsidiary were the limited partners; and Round Rock served as the managing partner. The System's interest in the limited partnership amounted to 45.9%, with the HCA-controlled entities holding the balance.

After reviewing the transaction, the IRS revoked the System's tax-exempt status retroactively to the partnership's formation on the basis that the System's participation in the partnership did not allow the System to operate exclusively for charitable purposes.[14] The System paid taxes under protest and brought suit in the United States District Court seeking a refund. The Magistrate Judge who heard the case in the first instance found in favor of the System, and the IRS sought review by the District Court judge. The System filed a Motion for Summary Judgment.[15] The IRS opposed the System's Motion and filed a Cross Motion for Summary Judgment.

The parties agreed that the System had been organized for charitable purposes. Thus, the only issue before the District Court was whether the System met the operational requirements for exempt status by ensuring that its primary activities were in furtherance of its charitable mission.

Judge Nowlin found in favor of the System, affirming the Judge Magistrate's conclusions. In his opinion Judge Nowlin chastised the IRS for its reliance on Revenue Ruling 56-185, which he felt was at best outdated authority, stating that the IRS "chooses to avert its eyes when Revenue Ruling 69-545 is raised."[16] Finding the later Revenue Ruling germane, Judge Nowlin analyzed its critical components and focused on whether: (1) the System had a community board which ran its operations and provided a community benefit; and (2) any private benefits to the HCA entities were more than incidental.

In addition to Revenue Ruling 56-185, the IRS relied on ***Redlands***, which Judge Nowlin found inapposite on its facts. He distinguished the case before him from ***Redlands*** because the System maintained an open emergency department:

> The facts of [***Redlands***] are only vaguely similar to this case. In ***Redlands***, the surgery center deemed non-exempt operated no emergency room and provided no free care to indigents.[17]

Although the System's board held equal voting power with the HCA interests, Judge Nowlin believed there were "exceptional protections against running this hospital in pursuit of private interests."[18] He focused on the provisions of the partnership agreement requiring that all hospitals be operated in a manner which met the community benefit standard and granting the System the ability to terminate the partnership agreement unilaterally if that standard was not met. Other provisions of the partnership agreement — providing that the board chair be appointed by the System and reserving to the System the power to remove the chief executive officer unilaterally — buttressed his conclusion that the System had not ceded its charitable purpose in the partnership. On the critical issue of control, he concluded:

> Voting strength is more than just a numbers game, and these provisions clearly protect the non-profit, charitable pursuits as well as any community board could. ***The government seems focused on majority control, but the law is more concerned with control, regardless of whether its control springs from a majority or from a corporate structure.***[19]

With respect to the private benefits conferred on the HCA entities, Judge Nowlin cited ***Redlands*** as support for his decision:

> To the extent that [an entity claiming tax-exempt status] cedes control over its sole activity to for-profit parties having an independent economic interest in the same activity and ***having no obligation to put charitable purposes ahead of profit-making objectives***, [the entity seeking tax-exempt status] cannot be assured that the partnership will in fact be operated in furtherance of charitable purposes.[20]

The IRS appealed Judge Nowlin's decision. On November 7, 2003, the Fifth Circuit Court of Appeals vacated the District Court's ruling. The Circuit Court concluded that the IRS had presented "genuine issues of material fact"[21] and remanded the case to the District Court for further fact finding.

In its decision, the Circuit Court relied primarily on Revenue Ruling 98-15 and ***Redlands***, rather than the authority deemed critical by the District Court. The Circuit Court accepted the concept that an exempt organization need not engage "exclusively" in charitable purposes in order to retain its tax-exempt status. But it took a somewhat more conservative view than the District Court, stating: "an organization cannot be deemed to operate exclusively or ***primarily*** for charitable purposes when a substantial portion of the organization's activities further non-charitable purposes."[22] The Circuit Court focused on the issue of control, and created a series of presumptions and assumptions:

> If private individuals or for-profit entities have either formal or effective control, we ***presume*** that the organization furthers the profit-seeking motives of those private individuals or entities.
>
> . . .
>
> When the non-profit organization cedes control over the partnership to the for-profit entity, we ***assume*** that the partnership's activities substantially further the for-profit's interests.
>
> . . .
>
> Conversely, if the non-profit organization enters into a partnership agreement with a for-profit entity, and retains control, we ***presume*** that the non-profit's activities via the partnership primarily further exempt purposes.[23]

In providing guidance to the District Court in its further proceedings, the Circuit Court reviewed what it considered to be critical facts requiring exploration. These included: (1) the contrast between the System's economic stress and HCA's economic health when the parties entered into the partnership agreement, which the Circuit Court concluded gave HCA superior bargaining power;[24] (2) the partnership documents, while allowing the System to "manage to secure some protections for its charitable mission,"[25] did not give the System majority control[26] and required the System to litigate to enforce the provision of the management agreement requiring that charitable interests be given priority; (3) the management company was a wholly-owned subsidiary of HCA, had a long-term contract and was paid a percentage of the partnership's ***net*** revenues;[27] (4) despite provisions of the partnership agreement allowing the System to terminate the CEO for failing to follow the charitable purposes of the partnership, the System had not taken steps to enforce the CEO's failure to do so;[28] and (5) despite a provision in the partnership agreement allowing the System to force dissolution of the partnership under certain circumstances, dissolution would result in neither the System nor HCA competing in the Austin area for two years after dissolution.[29]

It is important to note that the Circuit Court did not rule that the System had given up control to HCA or abandoned its charitable purpose. Rather, the Circuit Court focused on those factual matters requiring further exploration at the District Court level. The Circuit Court did make clear, however, that it viewed Revenue Ruling 98-15 and ***Redlands*** as the controlling authority and it confirmed that the burden of proving tax-exempt status falls on the entity seeking to obtain or maintain such status.

Simply stated, the fundamental and critical lesson from ***Redlands*** and ***St. David's*** is that tax-exempt status in a partnership or other relationship between a charitable entity and for-profit interests depends on the existence of a charitable purpose and the control requisite to ensure that it is maintained.

Intermediate Sanctions

In 1996 the IRS obtained authority to impose a remedy far drastic than loss of tax-exempt status in certain transactions resulting in a private benefit, known as "excess benefit transactions".[30] While the Intermediate Sanctions legislation and the related regulations provide a roadmap for compliance and remedial action in certain situations, they are not a panacea for the thorny issues of what constitutes maintenance of a charitable purpose and maintaining 'control. Intermediate Sanctions define certain critical relationships and actions, and must be taken into account in crafting collaborations between exempt entities and taxable providers.

Under the regulations, the persons or entities subject to imposition of these sanctions include officers, directors, and trustees of the exempt entity, their family members and entities controlled by them. In certain circumstances, for-profit management companies, physicians and other persons may be subject to Intermediate Sanctions. Under the law, these persons and entities are "disqualified persons" subject to scrutiny in their relationships with the exempt entity.[31] Penalties for "disqualified persons" who profit from an "excess benefit transaction" are threefold. There is an initial tax on the disqualified person equal to 25% of the excess benefit.[32] Failure to "correct" the transaction by repayment of the excess benefit to the exempt organization in a timely manner is subject to an additional 200% tax. Finally, to the extent a disqualified person with management powers ***knowingly*** approves or otherwise participates in an excess benefit transaction, that person can be liable for a further tax equal to the lesser of 10% of the value of the excess benefit transaction or $10,000.

The Intermediate Sanctions regulations provide a mechanism for creating a rebuttable presumption that a proposed transaction with a disqualified person is reasonable. This process requires: (1) approval by an independent[33] board (or a committee appointed by the board);[34] (2) use of, and reliance on, "appropriate comparability data"[35] which supports the transaction and demonstrates that it does not result in an excess benefit; and (3) written evidence of the board or committee action.

It is possible that a person may become disqualified during the course of a transaction. As an example, an exempt provider may conduct negotiations with someone who later becomes a member of senior management. The regulations provide guidance on what happens when the person becomes disqualified. Essentially, assuming the transaction otherwise complies with the applicable regulatory framework, any part of the transaction that occurs prior to disqualification may be exempt from Intermediate Sanctions. However, this exemption applies only when the compensation to be paid is reasonable and is fixed, rather than discretionary, in nature.

Physicians are potentially subject to Intermediate Sanctions.[36] Any person, including a physician, who has "substantial influence" over the exempt organization is considered a disqualified person.[37] Under the regulations, whether a physician is disqualified is a facts and circumstances test which must take into account such factors as: (1) being the founder of the organization; (2) being a substantial contributor to the organization; (3) receiving compensation tied to the organization's revenues (including revenues from a department controlled by the physician); (4) being a critical component of the decision-making process on budgetary or employee compensation matters; and (5) managing a part of the organization which "represents a substantial portion of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole."[38]

These considerations are important not only in reviewing direct physician employment arrangements, but also in collaborations with physicians in a venture such as an ASC or an agreement to manage a hospital department such as radiology. When physician owners of an ASC or a management

group enter into an agreement with an exempt entity, as was the case in ***Redlands***, Intermediate Sanctions likely will be implicated. This is another instance in which structuring the venture — and the actions of the parties in the related transaction — will require careful planning, review and implementation.

Compensation Issues

Incentive Compensation Arrangements

Incentive compensation arrangements between private practitioners and exempt entities provide their own set of issues. However, there is relatively recent guidance in this area. In an Information Letter (Letter) released on March 29, 2002,[39] the IRS discussed an incentive compensation arrangement between an exempt hospital and certain physicians. Under the arrangement, the hospital received a global payment for all Part A (hospital) and Part B (physician) services for inpatient care to certain Medicare beneficiaries. The hospital then divided the global payments between itself and the physicians based on an incentive system. Two key components of the incentive system were the requirements that the physicians "assist the hospital in improving the efficiency of inpatient care for Medicare beneficiaries" and that the physicians "meet strictly monitored standards for quality of care."[40]

The arrangement also included the following terms: (1) payments to physicians were within a 25% range of what they would have received under traditional Part B payments; (2) the payments were based on groupings of similarly situated Medicare beneficiaries; (3) the payments were not based solely on lowering the volumes and cost of the services being provided, but rather were keyed to meeting specific quality standards; (4) the beneficiaries were advised of the arrangement; and (5) the arrangement was limited to fully credentialed physicians and other providers at the hospital.

In determining that the arrangement was not proscribed, the IRS reviewed the types of factors that must be considered by exempt healthcare providers entering into similar incentive compensation arrangements.[41] These factors also apply to a determination of whether a tax-exempt provider will jeopardize its exempt status or be subject to Intermediate Sanctions by engaging in a transaction resulting in private inurement.

In the Letter the IRS set forth a list of arrangements which would not qualify, including: (1) a tax-exempt clinic which, through a "points" system, attempts to distribute substantially all of its net receipts to the physicians, with the largest amount going to those physicians who actually controlled the clinic; (2) a tax-exempt provider which compensates its shareholder employees in proportion to their stock ownership interests; and (3) an arrangement between physicians who previously owned a hospital and continue to share in the fees from the privately operated laboratory and x-ray facilities despite providing no services.

In determining whether a tax-exempt healthcare provider may enter into a qualifying, fixed percentage compensation plan, the IRS historically has taken the position that the plan: (1) cannot be either "a device to distribute profits to persons in control or to transform the organization's principal activity into a joint venture"; (2) must be the result of arm's-length bargaining; and (3) must result in "reasonable compensation."[42] In addition to these factors, the IRS also will consider factors that are relevant to exempt status generally, including: (1) the independence of the board of directors or trustees for the entity, which includes having an appropriate conflict of interest policy to assure that those who may be benefited by the arrangement will not participate in any decisions on it; (2) whether there is a reasonable ceiling on the compensation; (3) whether the arrangement might result in a reduction of the charitable services or benefits which the entity otherwise would provide; (4) whether the arrangement

takes quality of care and patient satisfaction into account; (5) whether the arrangement serves "a real and discernible business purpose"; and (6) whether the physicians actually provide the services underlying the arrangement.[43]

In passing on an incentive compensation arrangement, the applicable facts and circumstances will be the critical factor on which acceptance or rejection will turn. While it is not required that an entity receive a favorable prior ruling from the IRS, it is clear that such arrangements must be thought through and planned carefully before they are implemented.

Exempt Entities Financed With Tax-Exempt Bonds

One of the many advantages which comes with 501(c)(3) status is the ability to issue tax-exempt bonds at rates below commercial loans or taxable debt placements. Even if an entity has taken all steps necessary to ensure it does not jeopardize its exempt status or expose itself to Intermediate Sanctions, tax-exempt financing comes with a series of further requirements. In exempt entity-taxable provider collaborations where the facilities used by the taxable provider are financed with the proceeds of tax-exempt debt, the most significant compensation issues involve management contracts.

Management contracts are defined generally as any contract between an exempt organization and a taxable entity or other private party, such as a physician.[44] The regulatory framework, primarily embodied in Revenue Procedure 97-13[45], has broad application and applies when a non-profit healthcare provider enters into an agreement with a physician or a physician group which provides services provided in bond financed facilities.[46]

The Revenue Procedure states that management contracts "must provide for reasonable compensation for services rendered with no compensation based, in whole or in part, on a share of net profits from the operation of the facility." Although "net profits" cannot be used as a measure of compensation, there are circumstances in which variable, or incentive, compensation is permissible. Under the Revenue Procedure, there is a direct nexus between the length of the agreement and the extent to which compensation can have a variable component, with longer term agreements being more restrictive.

Arrangements which do not constitute "net profits" arrangements include: (a) arrangements involving a percentage of gross (or adjusted gross) revenues of a facility or a percentage of expenses from a facility, ***but not both***; (b) a capitation fee; or (c) a per-unit fee. In addition, there are circumstances in which a "productivity reward", defined as "a stated dollar amount based on increases or decreases in gross revenues (or adjusted gross revenues), or reductions in total expenses [but not both]", may be permitted[47]. Thus, there can be significant flexibility within the general parameters of the length of agreement/variable compensation rules contained in the Revenue Procedure. But this flexibility is available only if the terms of the agreement are properly structured.

The length of permitted compensation arrangements under the Revenue Procedure range from agreements with a 15 year term if the compensation is at least 95% fixed to agreements based solely on a percentage of gross or adjusted gross revenues or expenses which cannot exceed two years in length. Finally, the compensation agreement must be terminable by the exempt entity without penalty in certain circumstances.

State Law Issues

In addition to the federal regulatory issues which confront exempt providers and physicians in crafting collaborations, most states have laws which apply to these types of transactions. As an example, New Hampshire has what is known as a "pecuniary benefits" law.[48] That law requires that certain procedural and substantive steps be taken to make the transaction presumptively legal. Briefly stated, the New Hampshire law requires that any party who may benefit from the transaction not be part of the approval process, that the governing body of the exempt entity approve the transaction by a supermajority vote of those not affected by the transaction, and, in cases where the value of the transaction exceeds a relatively low threshold amount, prior written notice identifying the terms of the transaction and the parties involved be given to the Director of Charitable Trusts and published in an appropriate newspaper.

Conclusion

In attempting to navigate through the regulatory maze, exempt entities and taxable providers must consider the federal tax aspects of the transaction and any applicable state law provisions. Although the Code allows a certain amount of leeway in structuring collaborations, the exempt entity has the burden of demonstrating that the collaboration does not significantly affect its charitable purpose, cede control to the private party or result in conferring a significant private benefit on the private party.

Based on the recent case law, the most critical structural elements are provision of effective control of the collaboration to the exempt entity and maintenance of its charitable purpose . The governing law, regulations, revenue procedures, revenue rulings and case law make it clear that retention of control at the governing board level, whether by majority voting strength or agreement, is a fundamental prerequisite to obtaining and maintaining exempt status. Beyond that, the structure and operations of the collaboration must demonstrate a public purpose and a community benefit. Red flags include turning management over to a taxable affiliate of the private party, entering into a long term agreement with a taxable manager, providing compensation to a private party which either is unreasonable or keyed to the net revenues of the enterprise, and entering into a transaction with a party who holds significant power with respect to the exempt entity or control a substantial amount of the exempt entity's revenues.

The safest approach, of course, is to mirror the safe harbors contained in the existing regulatory framework. Nevertheless, and because prevailing economic and other business conditions may require creation of a structure not envisioned by the existing guidance, there is room for innovation and movement beyond the safe harbors so long as the fundamental principles requisite to obtaining and maintaining tax-exempt status are incorporated into the collaboration.

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The section of this article on Compensation Issues is derived from two articles published by the author in the Northern New England edition of The Healthcare Review in 2001 and 2002.

Figure 1

Issues in Collaborations Between Exempt Healthcare Organizations and Private Providers

Private Inurement — Basic Principles

- Tax-exempt entities must be organized and operated "exclusively" for charitable purposes
- Healthcare entities must provide a community benefit
- The "organized exclusively" test requires that the entity's organizational documents demonstrate it was formed and is intended to operate for charitable purposes
- The "operated exclusively" test requires that the entity engage "primarily" in exempt activities and that any activities not in furtherance of its exempt purpose are insubstantial
- Historically, the IRS' only remedy for private inurement was denial or revocation of tax-exempt status
- Since 1996 the IRS has had the power under the Intermediate Sanctions provisions of the Code to impose monetary penalties on a private party who participates in an "excess benefit transaction" with an exempt entity
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Governing Law

Basic Principles

- The exempt entity must retain control over its operations
- Control may be achieved by majority vote or reserved powers which permit the exempt entity to take those actions necessary to ensure that the collaboration adheres to the exempt entity's charitable purpose
- Adherence to the exempt entity's charitable purpose requires that charitable functions prevail and any private benefits to the taxable party are incidental
- Healthcare providers must have an open medical staff and either offer care generally or maintain an emergency department open to the public at reduced charges or without charge to those unable to pay

Revenue Ruling 98-15

- Majority voting control coupled with agreement provisions requiring adherence to charitable purposes and prohibiting more than incidental private benefit will result in recognition of exempt status
- Equal or minority voting rights where a majority vote is required for action by the entity coupled with agreement provisions that do not require adherence to charitable purposes and the provision of a community benefit will result in denial or revocation of exempt status

Recent Cases

Redlands Surgical Services v. Commissioner

- In a partnership between an entity seeking exempt status and a taxable entity to own and operate an ambulatory surgical center, exempt status was denied based on:
    - Majority control in the partnership not being retained by the exempt entity

  - The physicians who performed services at the ASC held limited partnership interests in the partnership
  - Management of the ASC was provided by a taxable subsidiary of a public corporation under a long term agreement with compensation based on the partnership's revenues
  - The not-for-profit hospital affiliate of the entity seeking exempt status agreed not to promote or expand its competing outpatient surgical services
- The Tax Court and Circuit Court of Appeals upheld denial of exempt status on the basis that control of the partnership and the surgery center had been ceded to the taxable entities, resulting in an "impermissible private benefit"

St. David's Health Care Sys., Inc. v. United States

- In a partnership between an exempt healthcare system and a taxable healthcare system to operate hospitals owned by both entities, the IRS revoked the exempt healthcare system's tax-exempt status
- The IRS' decision was overturned by the federal District Court
- The Circuit Court of Appeals vacated and remanded the District Court's decision, ordering the District Court to further examine the following factual issues:
  - The disparity in economic strength between the exempt system and the private party
  - The absence of majority voting control by the exempt system
  - The agreement, although stating that the charitable purposes were to be given priority, required the exempt system to litigate to enforce the agreement's provisions
  - The subsidiary relationship between the private management company and the taxable healthcare system
  - The length and terms of the management agreement between the partnership and the management company
  - The exempt system's failure to terminate the partnership's CEO for failure to enforce the partnership agreement's requirement that charitable purposes be given priority
  - The agreement provision prohibiting competition between the exempt and taxable hospitals upon dissolution of the partnership
- The Circuit Court focused on Rev. Rul. 98-15 and ***Redlands*** as controlling authority in determining tax-exempt status

Intermediate Sanctions

- Under the Intermediate Sanctions provisions of the Code and the related regulations, the IRS may impose monetary penalties on a private party who participates in an "excess benefit transaction" with an exempt entity if the private party is a "disqualified person"
- Private parties qualify as "disqualified persons" ***per*** se and are subject to Intermediate Sanctions if they are board members or senior management of the exempt entity, their family members or entities controlled by them
- "Disqualified persons" also include any private party (individual or corporate) who has "substantial influence" over the exempt entity based on the particular facts and circumstances
- In order to make a transaction between an exempt entity and a disqualified person presumptively legal, the following actions must be taken:
  - The disqualified person must not participate in any proceedings with respect to the transaction

    - Compensation to the private party must be based on review of, and reliance on "appropriate comparability data" by the exempt entity's board, one of its committees or a member of senior management with delegated review authority
    - Action by the board, its committee or senior management must be reflected in an appropriate writing
- Penalties for engaging in an "excess benefit transaction" include:
    - an initial 25% excise tax (based on the value of the excess benefit) imposed on the private party involved in the transaction
    - a 200% tax if the excess benefit transaction is not cured in a timely manner
    - an additional tax equal to the lesser of 10% or $10,000 if the private party "knowingly" participates in or approves the excess benefit transaction
- The availability of Intermediate Sanctions as a remedy does not preclude the IRS from revoking an entity's tax-exempt status

Compensation Issues

Incentive Compensation Arrangements

- Incentive compensation arrangements between physicians and exempt healthcare providers are permissible under limited circumstances
- Such arrangements must:
    - Not constitute a mechanism to distribute profits
    - Be the result of arms-length bargaining
    - Result in "reasonable" compensation
    - Not result in a reduction of charitable services provided by the exempt entity

Compensation Relating to Use of Bond Financed Facilities

- Revenue Procedure 97-13 sets out certain additional requirements for compensation arrangements between exempt entities and private parties where services will be performed using facilities or equipment financed with the proceeds of tax-exempt bonds
- Compensation may not be based on a share of net profits from operation of the bond-financed facility and must in all circumstances be "reasonable"
- Variable compensation tied to the facility's gross revenues, adjusted gross revenues or expenses is permitted under certain circumstances
- Compensation agreements vary in permitted length depending on the extent to which compensation is fixed or variable
- The exempt entity must have the ability to terminate the agreement without penalty in certain circumstances

State Law Issues

- Many states impose additional requirements on transactions between exempt entities and private parties who constitute "insiders"
- State law requirements may include:
    - Non-participation by the private party in the proceedings to authorize the transaction
    - A supermajority vote by the disinterested members of the governing body of the exempt entity
    - Prior publication and written notification to state officials of the proposed terms of the transaction, including the identities of the parties involved in the transaction

REFERENCES AND ENDNOTES

[1] Section 501(c)(3) explicitly provides that exemption is available to an organization "no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation. . . ."

[2] *See*, *e.g.*, IHC Health Plans, Inc. v. Commissioner, 325 F.3rd 1188 (10th Cir. 2003) in which the Tenth Circuit Court of Appeals held that an HMO did not qualify for tax-exempt status because it was not a true public charity.

[3] Attached to this article is a chart (see Figure 1) which sets forth certain critical considerations under governing statutes, regulations and case law that must be taken into account when structuring a transaction between an exempt healthcare provider and a private party. The chart is a guide, rather than an exhaustive treatment of all issues which may arise in these types of collaborations.

[4] The relationships between healthcare providers – whether for-profit or not-for-profit – and physicians are governed by a wide range of federal and state laws. Notably absent from this article are such regulatory schemes as the Stark and fraud and abuse laws and regulations, whose requirements also must be taken into account in crafting provider-practitioner agreements.

[5] A healthcare provider seeking tax-exempt status also must comply with the community benefit standard set forth in Rev. Rul. 69-545. It must have an open medical staff and either offer care generally or maintain an emergency department open to the public at reduced charges or without charge to those unable to pay.

[6] Leaving aside the obvious gap between the concepts of "exclusively" and "primarily", the "if more than an insubstantial part of its activities is not in furtherance of an exempt purpose" language has been the source of considerable comment and interpretation, not all of it flattering. In St. David's Health Care System, Inc. v. United States of America, 2002-1 U.S.T.C. ¶ 50,452 (W.D. Tex .) 2002, discussed at length later in this article, Judge Nowlin could not resist taking the drafters to task: "Sadly, the last sentence of that section is a horrible amalgamation of negatives arranged like an inside joke prompting laughter only from seasoned and sadistic bureaucrats. In plain English, it means that an organization cannot be exempt while devoting a substantial portion of its activities to non-exempt purposes." *Id*.

[7] There are, of course, a number of safe harbors which have been created by the IRS and are well-suited to certain relationships. Since not all collaborations between exempt entities and for-profit parties will fit easily within the safe harbors, the difficult but critical question is the extent to which the safe harbor can be regarded as the starting, rather than end, point.

[8] There are a number of ways in which an exempt entity and a private party may enter into a collaboration. This article will use the terms "arrangement", "collaboration", "partnership" and "venture" and the terms "taxable", "private" and "for-profit" interchangeably except where a particular term is appropriate because it refers to an actual factual situation.

[9] 113 T.C. 47 (1999), *aff'd* 242 F.3rd 904 (9th Cir. 2001).

[10] 2002-1 U.S.T.C. ¶ 50,452 (W.D. Tex. 2002) *vacated and remanded*, 2003 U.S. App. LEXIS 22851 (5th Cir. 2003).

[11] Redlands Surgical Services v. Commissioner, 113 T.C. at 77.

[12] Redlands Surgical Services v. Commissioner, 242 F.3rd 904 (emphasis added).

[13] HCA was previously known as Columbia/HCA Healthcare Corp.

[14] In its denial, the IRS concluded: "[The System's] participation in the [limited partnership] does not permit [the System] to act exclusively in the furtherance of its charitable purposes and allows for greater than incidental benefits to HCA and its for-profit subsidiaries." St. David's, *supra*, 2002-1 U.S.T.C. ¶ 50,452.

[15] A Motion for Summary Judgment is based on a party's contention that there are no genuine issues of material fact in dispute, making a trial unnecessary.

[16] St. David's, *supra* 2002-1 U.S.T.C. ¶ 50,452. Without getting into all of the details of the relationship between the two Revenue Rulings, the IRS attempted to argue that the System was not operating exclusively for charitable purposes because it did not provide care to patients without charge or at diminished rates, a specific requirement of Rev. Rul. 56-185. As Judge Nowlin pointed out, after Rev. Rul. 69-545 was promulgated that requirement was no longer a prerequisite to exempt status if the hospital had an emergency department open to the general public.

[17] St. David's, *supra*, 2002-1 U.S.T.C. ¶ 50,452.

[18] *Id*.

[19] *Id*. (emphasis added).

[20] *Id*., quoting Redlands, 113 T.C. at 78 (1999) (emphasis added by Judge Nowlin).

[21] St. David's, *supra*, 2003 U.S. App. LEXIS 22851 at 1-2.
[22] *Id*. at 13 n. 6 (emphasis original). The Circuit Court made it clear that there is a critical difference between providing charitable services and *primarily* providing such services: "We have no doubt that [the System] via the partnership provides important medical services to the Austin community. . . .[I]f the issue in this case were whether the partnership performed *any* charitable functions, we would be inclined to affirm the district court's grant of summary judgment in favor of [the System]." *Id*. (emphasis added).
[23] *Id*. at 15-17 (emphasis added).
[24] "[The System], by its own account, entered the partnership with HCA out of financial *necessity* (to obtain the revenues needed for it to stay afloat). HCA, by contrast, entered the partnership for reasons of financial *convenience* (to enter a new market)." *Id*. at 18 (emphasis original).
[25] *Id*. at 21.
[26] "[A]t best, [the System] can prevent the partnership from taking action that might undermine its charitable goals; [the System] cannot necessarily ensure that the partnership will take new action that furthers its charitable purpose." *Id*. at 27.
[27] As a general matter, management contracts or other compensation agreements between an exempt entity and a taxable provider based on net revenues will result in serious exemption issues for the exempt entity. As an example, Rev. Proc. 97-13, discussed below, prohibits all such agreements when the exempt entity has bond-financed facilities. While the partnership in St. David's itself was not an exempt entity, the System's participation in the partnership nevertheless made compensation based on net revenues an issue.
[28] Although this may seem like 20-20 hindsight, in St. David's the IRS revoked an existing grant of tax-exempt status. In that type of proceeding, review of the actual history of the partnership is entirely appropriate.
[29] "That result might be slightly unpleasant for HCA, but would not destroy the entity; HCA would still have its nationwide health care business. For [the System], by contrast, dissolution would be disastrous. [The System] serves only the Austin community. If it were forbidden from competing in that area, [the System] would (in effect) cease to exist. In light of the realities of the situation, it seems unlikely that [the System] would exercise its option to dissolve the partnership even if the partnership strayed from [the System's] charitable mission." St. David's, *supra* , 2003 U.S. App. LEXIS 22851 at 32-33.
[30] Generally stated, the fundamental point of Intermediate Sanctions is recapturing the "excess benefit". Certain persons deemed "disqualified" may face personal liability if they engage in such transactions in the first instance and further liability if they do not cure them in a timely manner.
[31] Under the final regulations, certain persons are *per se* considered "disqualified": board members who have voting powers, senior management (President, Treasurer, Chief Executive Officer, Chief Financial Officer and Chief Operating Officer), members of the families of board members and senior management, and entities in which any of the foregoing hold control equal or greater to 35%. Whether a physician or any other person or entity, including a for-profit management company is a "disqualified person" depends on the particular facts and circumstances.
[32] The "excess benefit" is the difference between the compensation actually paid and fair market value.
[33] Independence requires that the disqualified person not participate in discussion or approval of the transaction.
[34] In certain circumstances, if state law permits, the approval power may be delegated to an appropriate senior management officer such as the CEO. A board resolution granting such authority needs to set out in detail the steps which the authorized officer must take in reviewing the proposed transaction prior to granting approval.
[35] Many healthcare providers rely on national databases, such as those produced by the Medical Group Management Association (MGMA). While such databases provide a certain level of comfort, the ultimate inquiry will be into the particular facts and circumstances which govern the transaction. Thus, blind adherence to such statistical sources may not result in a determination that the data relied on meets the "appropriate comparability" standard as the particular facts and circumstances may require, or permit, a lower or higher level of compensation. As an example, a rural hospital without a specialist available to it such as a surgeon or radiologist may find that it needs to exceed the indicated level in order to attract and hire the specialist. Conversely, there may be circumstances in which the particular market has an abundance of practitioners in the specialty in question, and adherence to national and regional norms may not be appropriate. The critical requirement for any compensation arrangement is that it be "reasonable", which necessarily suggests an inquiry that takes into account the specific facts and circumstances. In instances where the exempt provider's circumstances are likely to vary from the norm, the best approach is using a general database as a starting point and supplementing it with an expert report that

takes into account the particular facts and circumstances. While it may seem that using a combined approach makes sense only when the database information is lower than the proposed compensation, it also should be used where the database information may result in higher than appropriate compensation.
[36] It is not only physicians who may be disqualified persons. The "substantial influence" principles apply to any person who can exercise such influence over the exempt entity.
[37] This applies where the physician or other party is not a member of the board or a designated member of senior management and thus not considered "disqualified" *per se*.
[38] 26 CFR § 53.4958-3(e).
[39] Information Letter 2002-0021.
[40] *Id*.
[41] It should be noted that the compensation arrangements approved by the IRS in the Letter may not meet the stricter standards applicable to exempt healthcare providers that have issued tax-exempt debt. That issue is discussed in the next section of this article.
[42] See Revenue Ruling 69-383.
[43] *Id*.
[44] Although not germane to this article, contracts for such services as management of a hospital cafeteria by a third party also are subject to Rev. Proc. 97-13.
[45] Rev. Proc. 2001-39 modifies the definitions of "capitation fee" and "per-unit" fee contained in Rev. Proc. 97-13 by permitting automatic fee increases based on "a specified, objective, external standard that is not linked to the output or efficiency of a facility" such as the Consumer Price Index.
[46] It is important to note that the limitations imposed by Rev. Proc. 97-13 relate *only* to facilities (including equipment) purchased, constructed, renovated or otherwise financed (or refinanced) with bond proceeds. There are, however, certain methods which can be used to allocate bond proceeds to parts of the facility that are not subject to the bond financing. As an example, if a hospital constructs a $20 million expansion, including a new radiology department and related equipment, and finances only $15 million of the expansion with bonds, careful and proper allocation of the proceeds may allow the radiology department to be exempt from Rev. Proc. 97-13. In effect, the hospital would designate $5 million of equity or fundraising proceeds for this purpose. Such allocation would not, of course, relieve the hospital's management agreement with its radiologists from compliance with the other issues discussed in this article.
[47] Revenue Procedure 97-13 § 5.02(1)
[48] New Hampshire Revised Statutes Annotated 7:19-a.