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Physician Recruitment After *Hermann Hospital*

*Robert C. Louthian III**
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INTRODUCTION

Tax-exempt hospitals that offer recruitment or retention incentives to physicians have new standards with which to evaluate their existing or planned arrangements. On October 17, 1994, the Internal Revenue Service (IRS) released the long-awaited "Hospital Physician Recruitment Guidelines" to the public (the "Guidelines").[1] Several years in the making, the Guidelines drifted about in recent times while the IRS was looking for an available vehicle for their release. Such a vehicle was discovered in *Hermann Hospital.* This article will discuss the significance of the vehicle—a closing agreement—used to release the Guidelines, summarize the evils the Guidelines are designed to prevent, summarize previous guidance on this issue, and address certain specific provisions of the Guidelines.

Hermann Hospital is a 560-bed tertiary-care hospital located in Houston, Texas. As best as can be gleaned from various press clippings and other public sources, Hermann Hospital was planning to issue tax-exempt bonds when concerns arose internally with respect to certain physician recruitment and other prac-

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1. *IRS Closing Agreement with Hermann Hospital with IRS' Physician Recruitment Guidelines*, 3 Health L. Rep. (BNA) No. 41, at 1522 (Oct. 20, 1994) [hereinafter *Guidelines*].

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tices.[2] Presumably in order to receive an opinion of bond counsel, Hermann voluntarily approached the IRS to clear any possible blight on its tax-exempt status.[3]

The Guidelines are symbolic both of the IRS' accomplishments and short comings in the past ten years. For a variety of reasons, the IRS has been unable to publish precedential guidance, such as revenue rulings, with respect to exempt organization issues for roughly the past fifteen years, despite the fact that the exempt organization community has long since outgrown the available guidance. In an effort to keep taxpayers informed and in compliance with the tax laws, the IRS has released several nonprecedential documents to the public, such as the Hospital Audit Guidelines,[4] the Examination Guidelines of Colleges and Universities,[5] and, most recently, the Guidelines. Although these guidelines may not be relied upon by the IRS or taxpayers, they serve to inform the public of current IRS thinking on a variety of issues. As such, the IRS deserves credit for keeping the public informed despite its inability to publish precedential guidance.

On the other hand, nonprecedential guidance can harm the exempt community where the IRS takes positions that are contrary to the law, regulations, and earlier IRS positions, and enforces such positions without affording the public the protections contained in the Administrative Procedure Act[6] or the internal procedures associated with the release of revenue rulings and procedures. The tax-exempt health care community has been particularly vulnerable to recent, questionable IRS positions. Of particular note is the 20% "safe harbor" provision, which provides that integrated health care delivery system enti-

2. *See* Joan Pryde, *IRS Pact Lets Houston Hospital Keep Tax Exemption, Issue Bonds*, BOND BUYER, Oct. 19, 1994, at 1; Dan Monk, *Family Docs Grapple with Buyout Offers*, CINCINNATI BUS. COURIER, Nov. 7, 1994, at 1; Annemarie Franczyk, *IRS Clamps Down on Incentives Hospitals Offer in Recruiting Doctors*, BUFFALO FIRST-BUFFALO, Jan. 16, 1995, at 5.

3. The IRS took this opportunity to release the Guidelines. In order to place the Guidelines in their proper perspective, it is important to understand the strong incentive that Hermann Hospital had in entering into the closing agreement and agreeing to its publication. Without the closing agreement, it is possible that Hermann Hospital would not have been able to enter into the bond deal. Because Hermann Hospital was in immediate need of a closing agreement, the IRS had significant leverage in structuring the closing agreement. As will be discussed later, this becomes important in determining the precedential value of the Guidelines.

4. I.R.S. Ann. 92-83; 1992-22 I.R.B. 59.

5. I.R.S. Ann. 94-112, 1994-37 I.R.B. 36.

6. 5 U.S.C. §§ 551-596 (1988 & Supp. 1993).

ties seeking exemption under section 501(c)(3) of the Internal Revenue Code (Code) should have no more than 20% physician representation on their boards of directors.[7] Although referred to as a "safe harbor," it is currently being applied as a virtual requirement for exemption under section 501(c)(3) for health care organizations within an integrated delivery system.

The release of the Guidelines represents the latest good news/ bad news story from the IRS. The Guidelines are fairly comprehensive and demonstrate a commendable understanding of current physician recruitment and retention practices, as well as other regulatory constraints faced by health care organizations. Specifically, the Guidelines eliminate the need under prior guidance to quantify benefit from recruitment activities while not running afoul of the Medicare and Medicaid anti-kickback provisions,[8] a virtually impossible exercise. However, the conclusions made in the Guidelines are often overbroad and, more importantly, subject to significant abuse by IRS agents in the course of an audit. They also illustrate the problems inherent in

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7. INTERNAL REVENUE SERV., 1994 EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM, at 228 (1994).

8. The anti-kickback laws, contained at 42 U.S.C. § 1320a-7b(b) (1988 & Supp. 1993), provide in part that:

> (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—
>
> (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part [by the Medicare or Medicaid program], or
>
> (B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part [by the Medicare or Medicaid program],
>
> shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
>
> (2) whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—
>
> (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part [by the Medicare or Medicaid program], or
>
> (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part [by the Medicare or Medicaid program],
>
> shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

Pursuant to 18 U.S.C. § 3571 (1988), the criminal fines that may be assessed have been raised to $250,000 for an individual and $500,000 for a corporation.

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a "safe harbor" type of guideline.[9] Where little precedent is available, safe harbors often do not serve as a haven for the risk averse, but instead tend to create an IRS-imposed industry norm. This is especially true where the potential sanction for any deviation from the safe harbor is revocation of tax-exempt status—the exempt organization's death penalty.

Before discussing the Guidelines in detail, this article will address closing agreements in general and inurement and private benefit issues as they relate to the Guidelines, for in order to understand how to interpret the Guidelines, a thorough knowledge of the concepts of inurement and private benefit is crucial.

I. Closing Agreements

Currently, revocation of tax-exempt status is the sole sanction the IRS can impose to enforce the federal tax laws involving charitable organizations. While the Department of the Treasury has heavily lobbied Congress for the enactment of some type of "intermediate sanctions" short of revocation of an organization's tax-exempt status,[10] to date, the Treasury's efforts have proved unsuccessful.[11] Revocation of exempt status, though often proposed, is seldom recommended by the IRS as it represents a penalty that is often disproportionate to the alleged violation. In addition, it usually penalizes the community in which the charitable organization sits rather than the alleged wrongdoer. Because the IRS lacks an intermediate sanction for orga-

9. While the Guidelines were not issued as a "safe harbor," it is likely that an organization that follows the Guidelines will not have its recruitment practices challenged by the IRS.

10. *See* Statement of Leslie B. Samuels, Assistant Secretary to the Treasurer, Tax Policy, *reprinted in* 9 Exempt Org. Tax Rev. 772 (1994).

11. Last year, both the House Ways and Means Committee and the Senate Finance Committee approved health reform packages that included "intermediate sanctions" for tax-exempt health care organizations. While the House Ways and Means and Senate Finance versions differed in several important respects, they both would have imposed an excise tax on "insiders" who engage in "excess benefit transactions" with affected exempt organizations. "Insiders" to whom the excise tax would apply included the organization's directors, officers, and other persons in a position to exercise substantial influence over the organization, as well as the families of and entities owned by such persons. In addition, during the debate on the General Agreement on Tariffs and Trade, the House included intermediate sanctions for all section 501(c)(3) organizations in their initial offer of compromise to the Senate. *See* H.R. Rep. No. 601(I), 103rd Cong., 2d Sess., pt. III, tit. XI, subtit. D, § 11402 (1994); *Title VII of Draft Senate Finance Committee Health Care Reform "Chairman's Mark"—Revenue Provisions*, 94 Tax Notes Today 126-9 (June 29, 1994). The Senate failed to include the intermediate sanctions provision in its response to the House offer, thereby preventing its enactment.

nizations exempt under section 501(c)(3) of the Code, the IRS has begun to enter into closing agreements with tax-exempt organizations on an increasingly frequent basis. Closing agreements vary widely, but their basic elements are often the same: a tax-exempt organization agrees to pay a "penalty" in return for the IRS not revoking the organization's tax-exempt status.

The authority granted to the IRS to enter into closing agreements is extremely broad. The Commissioner of the IRS, or her delegate, has the authority to enter into closing agreements with taxpayers for the purpose of settling *any* tax matter with a taxpayer for any tax period.[12] Although closing agreements may only resolve tax liabilities for closed taxable periods, they may also be used to cover future years, although only with respect to how a particular item will be treated, not the actual amount of tax owed. Finally, there is no requirement that a tax liability actually exist for a prior period as a precondition for entering into a closing agreement. The discretion to enter into closing agreements lies solely with the Commissioner, but taxpayers who voluntarily approach the IRS to settle a tax matter are seldom refused a request for an agreement.

Closing agreements between taxpayers and the IRS generally are not made available to the public. However, there is no statutory or regulatory prohibition against either party requesting that such document be made publicly available as a condition to entering into the arrangement. Thus, the IRS was within its authority to require Hermann Hospital to agree to make its agreement publicly available. Nonetheless, if the IRS adopts such a disclosure requirement as a matter of course with respect to closing agreements or other settlements, it will constitute a troubling erosion of the confidentiality provided by section 6103 of the Code.[13]

A closing agreement between a taxpayer and the IRS has absolutely no binding effect on any party other than the taxpayer entering into the closing agreement and the IRS. Therefore, the Guidelines attached to the closing agreement may not be used by the IRS against any other hospital. In fact, closing agreements have the same precedential value on organizations not parties to the agreement as do private letter rulings—none. The reason closing agreements are not precedential is obvious. Clos-

12. 26 U.S.C. § 7121 (1988). This is a generic provision used to settle tax matters with taxable as well as tax-exempt organizations.

13. 26 U.S.C. § 6103 (1988).

ing agreements do not follow the applicable administrative procedures necessary to publish precedential guidance. In addition, whatever facts motivated a taxpayer to enter into a closing agreement are uniquely suited to that taxpayer and should not be used as a basis for settling any tax matters of a different taxpayer. In Hermann Hospital's case, the closing agreement is devoid of any factual statement that would allow a basis for meaningful comparison by a similar taxpayer.

Although the Guidelines have no binding effect on any parties other than Hermann Hospital and the IRS, they will likely play a significant role in physician recruitment practices. First, the Guidelines will provide an in terrorem effect on certain physician recruitment practices. Because the Guidelines indicate that any deviation from the Guidelines may be considered inurement of net earnings or excessive private benefit, both of which are grounds for revocation of exempt status, many organizations will hesitate to stray from their strict confines.

Second, although the Guidelines do not represent precedent, IRS agents in the conduct of examinations will inevitably use the Guidelines as a checklist for "appropriate" physician recruitment practices. Any recruitment or retention practice that differs from the Guidelines will likely be written up as a potential revocation issue by the agent. Technically, this is not using the Guidelines as precedent because the agent will only be raising issues that could have been raised anyway. Thus, while the Guidelines do not give the agent actual precedent, they do give the agent significant leverage in pursuing a recruitment or retention issue. For example, the agent could use a particular recruitment incentive to propose revocation of exempt status and use such proposed revocation to secure an agreement from the taxpayer that results in a greater amount of employment taxes being owed over the same period. While highly questionable, it is not uncommon for an agent to threaten revocation, even when based on positions of questionable merit, to extract higher settlement payments. Thus, it becomes imperative to have a firm understanding of the precedential documents with respect to inurement and private benefit issues.

II. Inurement and Private Benefit

In order to understand the position of the IRS with respect to physician recruitment practices, it is important to understand two concepts unique to the charitable sector: inurement of net

earnings and excessive private benefit. The presence of either one of these elements is grounds for revocation of tax-exempt status. The Guidelines emphasize this point in Paragraph Z, wherein the closing agreement states that failure to comply with any provision of the Guidelines may be found to constitute prohibited inurement and excessive private benefit that is inconsistent with tax exemption under section 501(c)(3) of the Code.[14]

A. *Inurement*

In order to be recognized as exempt under section 501(c)(3) of the Code, an organization must demonstrate that it is organized and operated exclusively for charitable (or other exempt) purposes and that no part of its net earnings inures to the benefit of any "private shareholder or individual."[15] The words "private shareholder or individual" refer to persons having a personal and private interest in the activities of the organization.[16] Individuals who possess the attributes of a "private shareholder or individual" are commonly referred to as "insiders." The inurement proscription contained in section 501(c)(3) is absolute.[17] Therefore, any finding of inurement is a complete bar to exemption under section 501(c)(3).

Courts have long held that the payment of reasonable compensation to insiders does not constitute proscribed inurement of net earnings.[18] While taxable corporations have a specific statutory provision limiting ordinary and necessary business deductions for compensation to reasonable amounts,[19] the exempt organizations sector lacks a similar provision. Nonetheless, in

14. While Paragraph Z indicates that *any* deviation from the Guidelines may constitute inurement or substantial private benefit that is inconsistent with tax-exempt status, the text of the closing agreement itself, in Paragraph 14, indicates that isolated or inadvertent failures to comply with the Guidelines will not constitute noncompliance with the closing agreement; rather, the standard is a good faith effort to comply. This illustrates the "safe harbor" nature of the Guidelines; deviation is not necessarily inconsistent with exemption, but Hermann Hospital agreed not to deviate intentionally for the term of the closing agreement.

15. 26 U.S.C. § 501(c)(3) (1988); Treas. Reg. §§ 1.501(c)(3)-1(a)(1), 1.501(c)(3)-(1)(c)(2) (1990).

16. Treas. Reg. § 1.501(a)-1(c) (1990).

17. *See, e.g.*, Spokane Motorcycle Club v. United States, 222 F. Supp. 151 (E.D. Wash. 1963).

18. *See, e.g.*, Mabee Petroleum Corp. v. United States, 203 F.2d 872 (5th Cir. 1953).

19. 26 U.S.C. § 162 (Supp. 1993).

Enterprise Railway Equipment Co. v. United States,[20] the court applied the reasoning of section 162 to exempt organizations.[21]

General Counsel Memorandum (GCM) 38,322[22] has been interpreted as greatly expanding the definition of "insider" for purposes of the inurement proscription. In this memorandum, the IRS Chief Counsel stated that Congress intended that the inurement proscription apply to any individual who personally profits from the organization. Using this definition, the IRS concluded that a person serving in the role of administrator and general counsel of a voluntary employee benefits association exempt under section 501(c)(9) of the Code clearly comes within the inurement proscription. However, the GCM should not be interpreted as creating a "per se" rule with respect to the inclusion of administrators and general counsel as insiders for purposes of the inurement proscription. The facts contained in the memorandum laid a strong foundation for a finding of inurement. The particular individual involved received unreasonable compensation both for himself and for his law firm, which administered the trust. Because the individual had a sufficient degree of control over the assets of the organization so as to cause himself and his law firm to be unreasonably compensated, there were sufficient facts to show that he had a "personal and private interest" in the activities of the organization and, therefore, could be considered an insider.

In GCM 39,498[23] the Chief Counsel stated that, in the IRS' opinion, recruited physicians as *employees or as individuals with a close professional working relationship* with a hospital are persons who have a personal and private interest in the activities of the hospital. Thus, such physicians are subject to the inurement proscription. Stated otherwise, a physician staff member is considered to be an individual with significant influence over the operation of a hospital and, therefore, an insider. In GCM

20. 161 F. Supp. 590 (Ct. Cl. 1958).

21. There is substantial case law in the taxable sector regarding the reasonableness of compensation, which should be perused in the event an inurement charge is made. *See, e.g.*, Elliotts, Inc. v. Commissioner, 716 F.2d 1241 (9th Cir. 1983); Pacific Grains, Inc. v. Commissioner, 399 F.2d 603 (9th Cir. 1968); Mayson Mfg. Co. v. Commissioner, 178 F.2d 115 (6th Cir. 1949).

22. Gen. Couns. Mem. 38,322 (Mar. 24, 1980). A GCM is a legal opinion of the IRS Office of Chief Counsel. While instructive as to IRS policy, it has neither precedential value nor binding effect.

23. Gen. Couns. Mem. 39,498 (Jan. 28, 1986).

39,670,[24] the IRS again made the argument that an employee was an insider for purposes of the inurement proscription.

In *Senior Citizens of Missouri, Inc. v. Commissioner*,[25] the IRS denied the organization's application for exemption on the basis that the compensation paid to its employees constituted inurement of net earnings. The court, while upholding the denial of the applicant's exempt status, based its opinion not on inurement grounds, but on the grounds that the compensation arrangement furthered to a substantial extent the private interests of the employees. The issue of inurement was not even addressed by the court.

In GCM 39,862,[26] the Chief Counsel elaborated on the rationale for considering physicians on the medical staff insiders with respect to a hospital.

> While most physicians on the medical staffs of the subject hospitals presumably are not employees and do not provide any compensable services directly to the hospitals, they do have a close professional working relationship with the hospitals. The physicians have applied for and been granted privileges to admit and treat their private patients at the hospital. They are bound by the medical staff bylaws, which may be viewed as a constructive contract between them and the hospital. Individually, and as a group, they largely control the flow of patients to and from the hospital and patients' utilization of hospital services while there. Some may serve other roles at the hospital, such as that of part-time employee, department head, Board member, etc.[27]

The position taken in GCM 39,862, that physicians are to be treated as insiders of an exempt hospital, seems to be counter to the position taken in Rev. Rul. 69-383,[28] which states in relevant part that a hospital-based radiologist is not an insider for purposes of the inurement proscription. In this ruling, the hospital entered into an agreement with the radiologist to compensate him on the basis of a fixed percentage of the departmental income. Under the contract, the hospital agreed to provide space, equipment, and supplies, and to make nonmedical personnel available to the department of radiology. The hospital also billed and collected the charges. In return, the radiologist

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24. Gen. Couns. Mem. 39,670 (June 17, 1987).
25. 56 T.C.M. (CCH) 480 (1988).
26. Gen. Couns. Mem. 39,862 (Dec. 2, 1991).
27. *Id.* at 9-10 (footnote omitted).
28. Rev. Rul. 69-383, 1969-2 C.B. 113.

agreed to manage the department, participate in the hospital's educational program, and perform all radiological services required by hospital patients, employees, and students. The amounts charged to patients for services rendered were established by the hospital with the approval of the radiologist. The hospital paid the radiologist a fixed percentage of the department's gross billings, adjusted by an allowance for bad debts, which amount was not excessive when compared with the amounts received by radiologists having similar responsibilities and handling a comparable patient volume at other similar hospitals.

Despite all of these factors, the ruling concluded that under the circumstances described above, the radiologist did not control the organization and the agreement was at arm's length. For those reasons, it held that the arrangement entered into between the hospital and the radiologist did not constitute inurement of net earnings to a private individual within the meaning of Treasury Regulation sections 1.501(c)(3)-1(c)(2).[29]

Clearly, the IRS was in a bind in attempting to reconcile the position taken in Rev. Rul. 69-383 with its position in GCM 39,862. It resolved the dilemma in a masterly fashion; GCM 39,862 avoids the inconsistency by a de facto revocation of Rev. Rul. 69-383. The GCM states that "[d]ue to Medicare changes, the typical arrangement today provides for even hospital-based physicians to bill separately for their professional services, while the hospital bills separately for the technical component. Thus, while never revoked, Rev. Rul. 69-383 has little relevance to most hospital-physician relationships today . . . ."[30]

The first sentence is clearly true.[31] The second sentence does not necessarily follow. It does not represent the law as the courts have ruled[32] or as the IRS has interpreted the inurement proscription over the past 25 years.[33] Irrespective of whether a

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29. *Id.* at 114.

30. Gen. Couns. Mem. 39,862, at 11 (footnote omitted).

31. *See* Douglas M. Mancino, *Nonexempt Uses of Tax-Exempt Hospital Bonds*, 24 J. HEALTH & HOSP. LAW 73, 79-80 (1991).

32. *See, e.g.*, Goldsboro Art League, Inc. v. Commissioner, 75 T.C. 337, 345-46 (1980).

33. *See, e.g.*, INTERNAL REVENUE MANUAL pt. 7, ch. 770, subsec. 7751, ch. 300, subsec. 382.41(6) (Mar. 12, 1982) ("the presence of a percentage compensation agreement will destroy an organization's exemption under IRC 501(c)(3) where such arrangement transforms the principal activity of the organization into a joint venture between it and a group of physicians, or is merely a device for distributing profits *to persons in control*") (emphasis added); Birmingham Business College, Inc. v. Com-

GCM may be used to revoke a revenue ruling,[34] the level of influence an employee or doctor has over the hospital has not changed so significantly to warrant a virtual per se rule that medical staff doctors are insiders. What makes individuals insiders is their ability to divert assets to their private interests. The IRS may be able to sustain a conclusion that the leading thoracic surgeon in the country is an insider at that physician's hospital, but a physician who merely has staff privileges has not done enough to be considered an insider. To the extent Rev. Rul. 69-383 implies that a staff physician is not an insider with respect to a hospital, absent other facts that demonstrate control, the conclusion in the revenue ruling should remain in full force.

In support of its per se approach with respect to physicians as insiders, the IRS often cites certain court cases to support its position. However, these cases are factually distinguishable from most situations encountered today in the health care area. For example, in *Lowry Hospital Association v. Commissioner*,[35] the IRS successfully argued that the hospital in question was not entitled to exemption because of the inurement of its net earnings to insiders. The hospital in *Lowry* was created by Dr. Lowry, who also owned the building, either directly or as trustee for his children, in which the hospital leased space. Dr. Lowry was a principal in the Lowry-Henshaw Clinic, which also leased space in Dr. Lowry's building. The clinic and the hospital shared numerous services and facilities. In fact, if Dr. Lowry referred a patient to the hospital, the patient received a single bill that included not only Dr. Lowry's fees, but the hospital's fees as well. Although the hospital had an "open" medical staff policy, 92% of patients during the five years in question were treated by Dr. Lowry or his clinical partner. From these facts, among others, the court concluded that actual inurement existed and, therefore, the hospital was not entitled to exemption under section 501(c)(3) of the Code. In dicta, the court added the following note:

> [O]ur concern extends beyond these specifically identifiable instances of private inurement. Where a doctor or group of doctors dominate the affairs of a corporate hospital otherwise exempt from tax, the courts have closely scrutinized the underlying relationship to insure that the arrangements permit a

missioner, 276 F.2d 476 (5th Cir. 1960); Lorain Ave. Clinic v. Commissioner, 31 T.C. 141 (1958).

34. In these authors' views, a GCM cannot be used to revoke a revenue ruling.

35. 66 T.C. 850 (1976).

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> conclusion that the corporate hospital is organized and operated *exclusively* for charitable purposes without any private inurement.[36]

There have been other cases involving hospitals controlled by doctors in which the IRS' revocation of exempt status was upheld by the courts. But, like *Lowry*, the facts in those cases showed actual control by the physician(s) over the affairs of the hospital.[37]

It appears that the IRS is attempting to impose a self-dealing type of prohibition against transactions between a hospital and a physician similar to the prohibition contained in section 4941 of the Code.[38] In 1969, Congress imposed a series of excise taxes to curtail perceived abuses in the private foundation area. One provision prohibits virtually all dealings between a private foundation and a "foundation manager." A foundation manager, a statutorily defined term, includes an officer, director, or trustee of a foundation or an individual with similar powers.[39] It is interesting to note that even under the more restrictive provisions regulating private foundations, a physician would not be considered a foundation manager unless he or she had the powers of a director, officer, or trustee. Thus, without a legislative mandate, the IRS appears to be advancing a more restrictive policy in the hospital-physician area than in the private foundation area.

Absent facts that demonstrate a hospital has entered into a sharing of net earnings with physicians, or that physicians exercise actual control over the operations of a hospital, a physician should not be considered an insider for purposes of the inurement proscription. The per se argument is even more tenuous in the context of a newly recruited physician who has no control over the affairs of the hospital.[40]

B. *Private Benefit*

An entity is not organized or operated exclusively for exempt purposes unless it serves a public rather than a private interest.[41]

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36. *Id.* at 859 (emphasis added).

37. *See, e.g.*, Maynard Hosp., Inc. v. Commissioner, 52 T.C. 1006 (1969); Sonora Community Hosp. v. Commissioner, 46 T.C. 519 (1966), *aff'd*, 397 F.2d 814 (9th Cir. 1968); Lorain Ave. Clinic v. Commissioner, 31 T.C. 141 (1958).

38. 26 U.S.C. § 4941 (1988).

39. 26 U.S.C. § 4946(b) (1988).

40. We note that it is not clear why the IRS singles out physicians for its per se analysis as opposed to ministers, collegiate athletic coaches, or others who exhibit similar "controls" over certain activities of exempt organizations.

41. Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii) (1990).

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Thus, in order to be exempt, it must establish that it is not 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.[42] All activities of a charitable organization result in some type of private benefit to individuals. In order to comply with section 501(c)(3) of the Code, the organization must demonstrate that the private interests served by its activities are "incidental" to the exempt, public purposes of the organization.

The IRS employs a qualitative/quantitative analysis to determine whether an activity is incidental to public purposes. Although seldom challenged by practitioners, the qualitative/quantitative analysis is not a construct of the statute, the regulations, or the courts, but a creation of the Office of Chief Counsel of the Internal Revenue Service. In GCM 37,789, the IRS stated that the term "incidental," as used in the regulations, has both qualitative and quantitative connotations. To be qualitatively incidental, a 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 benefiting private individuals. To be quantitatively incidental, a benefit must be insubstantial when viewed in relation to the public benefit conferred by the organization's activities.[43]

The courts have not adopted the qualitative/quantitative test employed by the IRS. Instead, cases involving questions of private benefit examine the activities of the organization as a whole in determining whether an organization serves a public rather than a private interest. For example, in *American Campaign Academy v. Commissioner*,[44] the Tax Court stated that to demonstrate that an organization operates primarily for exempt purposes, the organization must establish that no more than an insubstantial part of its activities furthers a nonexempt purpose. Likewise, in *Aid to Artisans, Inc. v. Commissioner*,[45] the Tax Court examined the overall purpose served by the activities of the organization rather than the individual sales activities for particular artists who made up the organization.

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42. *Id.*
43. *See generally* Gen. Couns. Mem. 37,789 (Dec. 18, 1978).
44. 92 T.C. 1053 (1989).
45. 71 T.C. 202 (1978).

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Some private benefit is present in all typical hospital-physician relationships, such as physicians' use of hospital facilities at no cost to provide services to private patients for which they earn a fee. The IRS recognized that this type of private benefit is incidental to the overwhelming public benefit that results from having the combined resources of the hospital and its professional staff available to serve the public.[46] Given this recognition by the IRS, it is difficult to conceive how the IRS now proposes in the Guidelines that the payment of a single retention incentive to a physician outweighs the overwhelming public benefit served by the physician-hospital relationship. IRS officials recently made public statements to the effect that new physicians may not be treated as insiders until after they have been granted staff privileges. However, the payment of retention incentives, as contrasted with the payment of recruiting incentives, will still be subject to the more restrictive, and potentially more dangerous, inurement analysis if the IRS' view of physicians as "insiders" is sustained.

III. Previous Guidance on Physician Recruitment

Prior to the Guidelines, the primary guidance for tax-exempt hospitals in physician recruitment was GCM 39,498.[47] While GCM 39,498 did not announce a definite conclusion, it was read by most practitioners and hospitals by negative inference to define permissible practices. In GCM 39,498, the IRS described a tax-exempt hospital's physician recruitment program, which included guaranteed minimum annual income for two years with no obligation by the physician to repay subsidies out of income earned after the contract's two-year period, and concluded that the program could adversely affect exemption.[48]

One year later, the IRS, in response to a wave of criticism, released GCM 39,674,[49] which clarified the position taken in GCM 39,498. In GCM 39,674, the IRS stated:

> [W]hether a particular compensation plan adversely affects an organization's exempt status is an inherently factual question. So long as the compensation plan is not inconsistent with ex-

46. Gen. Couns. Mem. 39,862 (Dec. 2, 1991).
47. Gen. Couns. Mem. 39,498 (Jan. 28, 1986).
48. The subsidies could result in the physician's private interests being served other than incidentally and in inurement of the hospital's net earnings because it had not been demonstrated that all possible subsidies paid under the recruitment program would constitute reasonable compensation.
49. Gen. Couns. Mem. 39,674 (June 17, 1987).

> empt status as discussed above, is the result of arms length bargaining and the compensation under the plan, as well as all other compensation provided, is reasonable, the plan should not jeopardize the exempt status of the organization. . . . GCM 39498 . . . was not intended to create a *negative* presumption with respect to whether the compensation provided under any particular Plan of compensation is reasonable, nor did it intend to suggest that the Service will not issue advance rulings on issues other than the reasonableness of the compensation. On this issue, GCM 39498 simply stated that the Service cannot determine, in advance, whether compensation is reasonable.[50]

GCM 39,674 clarified that the negative implications of GCM 39,498 were based on the IRS' ruling procedures rather than disapproval of physician recruitment in general.

GCM 39,498 expressed general approval of physician recruitment activities and outlined the analysis to be used in their evaluation.

> [T]he Hospital's proposed revised guaranteed minimum annual income contract must be examined to determine the effect, if any, on the Hospital's exclusive pursuit of its charitable purpose. We view the question of subsidies under the Hospital's physician recruitment program to be essentially a question of whether a given compensation arrangement comports with the requirements of exemption.
>
> * * *
>
> In principle we agree that the Hospital must offer incentives or inducements to attract qualified physicians needed in a particular area of specialization to enable the Hospital to provide quality health care.[51]

The IRS in its analysis pointed out that there was no ceiling on amounts of subsidies to be paid, other than the total annual income guaranteed, and that there was no requirement that the physician provide further services or continue to benefit the hospital after the expiration of the two-year guarantee period. Finally,

> [T]he method of determining the amount of subsidies to be paid here bears no discernible direct relation to the value of a particular physician to the Hospital. Such subsidies may vary in amount based not on factors directly related to benefits to the Hospital, e.g., increased efficiency or enhanced productiv-

50. *Id.* at 17-18.
51. Gen. Couns. Mem. 39,498, at 6, 7.

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> ity for the Hospital because of his presence in the hospital's medical service area, but rather on factors that relate principally to the physician's performance in his or her "private" medical practice. Thus, it seems likely that amounts to be paid (and possibly not repaid) as subsidies may fall outside the range of reasonable compensation for the benefit to the Hospital of the doctor's relocation . . . .[52]

This analysis required tax-exempt hospitals to attempt to quantify and rank the benefits of various physicians' presence in the community and on the medical staff. This approach is in most cases impossible to reconcile with the prohibitions of the Medicare and Medicaid anti-kickback laws, because no anti-kickback "safe harbors" addressing physician recruitment exist.[53] A physician recruitment safe harbor was included in draft safe harbors informally circulated by the Office of Inspector General of the Department of Health and Human Services in August 1988. If promulgated, this safe harbor would have permitted benefits to physicians newly in practice in the area. However, it was not in the published proposed[54] or final[55] safe harbor regulations. Among additional safe harbors issued in proposed form on September 21, 1993[56] was one protecting physician recruitment arrangements that provide benefits for no more than three years to recruit new physicians to rural areas, provided certain other safeguards are satisfied. This regulation has not yet been adopted in final form.

GCM 39,862 intimated but did not explicitly state that the IRS recognized the inconsistency between the analysis in GCM 39,498 and the Medicare and Medicaid anti-kickback provisions and planned to resolve this conflict by eliminating institutional benefit to the hospital as an acceptable benefit in the weighing process. GCM 39,862 did not, however, indicate that the strained and illogical compensation and quantification of benefit analysis set forth in GCM 39,498 could be abandoned altogether. This nonetheless is the approach of the Guidelines. So long as the physician is new in practice and needed in the community, incentives are permissible.

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52. *Id.* at 9.

53. No remuneration may be offered, solicited, paid, or received in exchange for a patient referral for a service for which Medicare or Medicaid may pay. 42 U.S.C. § 1320a-7b(b) (1988 & Supp. 1993).

54. 54 Fed. Reg. 8,033 (Jan. 23, 1989).

55. 56 Fed. Reg. 35,952 (July 29, 1991).

56. 58 Fed. Reg. 49,008, 49,010 (Sept. 21, 1993).

IV. THE GUIDELINES

The Guidelines define both the physicians to whom retention and recruitment incentives may be provided and the types of permissible incentives. Significantly, the Guidelines apply only to incentives provided to nonemployee physicians.[57] In addition, while not specifically stated, the Guidelines do not apply to a state or county-owned hospital provided such hospital operates as an instrumentality of the state government, since the sole sanction the IRS has in its arsenal is revocation of exempt status. Unless the state or county hospital has applied for and received recognition of tax exemption under section 501(c)(3) of the Code, the IRS has no sanction against "impermissible" incentives offered by such hospitals.

A. Retention Incentives

The Guidelines do not permit *any* retention incentives of any kind to be provided to existing physicians. An "existing physician" is defined as a nonemployee physician having medical staff privileges at a hospital.[58]

Prior to the Guidelines, the IRS issued rulings where, at least implicitly, it recognized that retention of existing physicians would not result in inurement or substantial private benefit.[59] The absolute nature of the Guideline's prohibition on retention incentives reflects the IRS' belief that significant abuses exist in this type of incentive arrangement. Unfortunately, the absolute prohibition on retention incentives may lead to certain anomalous results. For example, if an existing nonemployee physician is planning to leave a particular hospital community, the hospital is prohibited by the Guidelines from paying a retention incentive to the physician. After the physician's departure, the same hospital may pay the equivalent amount, if not more, to recruit a new physician to the area to replace the lost specialist.

The likelihood of the IRS being able to sustain the revocation of a hospital's tax-exempt status in the courts on the sole basis of the payment of a retention incentive approaches that of a lottery contestant's chance of winning. Nonetheless, because retention incentives to existing physicians are strictly prohibited by the Guidelines, the presence of such arrangements is guaran-

57. *Guidelines*, *supra* note 1, at 1522.

58. *Id.*

59. *See, e.g.*, Priv. Ltr. Rul. 90-23-091 (Mar. 15, 1990); Priv. Ltr. Rul. 88-08-070 (Dec. 2, 1987).

teed to result in intense IRS scrutiny in the event of an audit. If a hospital is considering the payment of a retention incentive to an existing physician, it must be able to document the community's continuing need for the particular specialty or services of the physician.

B. Recruitment Incentives

Recruitment incentives are permissible only if provided to a "permissible recruit," defined as a physician who either (1) is a recent graduate of a residency or fellowship program, whether or not in the hospital's community, or (2) has not previously practiced in the hospital's community or been affiliated with another hospital serving all or part of the hospital's community (defined as the hospital's primary and secondary service area).[60]

Even if a new recruit is a "permissible recruit," recruitment incentives will not be considered permissible unless there is a demonstrable community need for the physician, as evidenced by one or more of the following:

> a. a population to physician ratio in the community that is deficient in the particular specialty (with reference to the ideal ratio set forth in [Graduate Medical Education National Advisory Council] reports) of the physician being recruited;
>
> b. demand for a particular medical service in the community coupled with a documented lack of availability of the service or long waiting periods for the service, if the physician is being recruited to increase availability of that service;
>
> c. [federal] designation of the community (or that portion of the community that the physician is serving) at the time the recruitment agreement is executed as a Health Professional Shortage Area . . . ;
>
> d. a demonstrated reluctance of physicians to relocate at the Hospital due to the Hospital's physical location (this criterion is intended to refer to a hospital located in a rural or economically-disadvantaged inner-city area);
>
> e. a reasonably expected reduction in the number of physicians of that specialty serving in the Hospital's service area due to the anticipated retirement within the next three year period of physicians presently in the community; or
>
> f. a documented lack of physicians serving indigent or Medicaid patients within [the] Hospital's service area, provided that

60. *Guidelines*, *supra* note 1, at 1522.

newly-recruited physicians commit to serving a substantial number of Medicaid and charity care patients.[61]

The Guidelines do recognize that courting a "permissible recruit" to join an existing physician's established medical practice is permissible.[62] However, in this instance, the hospital may pay no more than fifty percent of the recruiting costs incurred for that physician. The Guidelines further specify that recruiting fees or costs may not be paid to existing physicians under any circumstances, although such fees may be paid to outside search consultants.[63] If this provision is intended to mean something other than prohibiting payments of fees to existing physicians specifically for their efforts in recruiting, it is unclear how this is to be applied to existing recruitment practices.

There does not appear to be any legal basis for the fifty-percent limit on payment of recruiting cost expenditures. In addition, with respect to the payment of recruiting fees to outside search consultants, if the expenditure itself furthers a charitable purpose, it is difficult to imagine how the identity of the recipient somehow changes the nature of the payment. Stated otherwise, if an exempt organization is allowed to expend the funds to attract a physician to the area, why should the IRS care who receives the funds as long as these amounts further exempt purposes? These decisions are better left to the board of directors of the hospital rather than to IRS agents. Again, it appears as if the IRS is attempting to impose an absolute "self-dealing type" prohibition on transactions between exempt hospitals and physicians similar to the prohibitions contained in the various legislative proposals discussed earlier.

C. *Permissible Incentives*

1. Income Guarantees

Permissible incentives include reasonable income guarantees, offered to "permissible recruits," provided:

(a) such income guarantee is for a period of two years or less;

(b) no off-agreement benefits are offered or provided;

(c) all terms are agreed to in advance in writing and are not modified over the life of the agreement;

61. *Id.*
62. *Id.* at 1523.
63. *Id.* at 1524.

> (d) in the event periodic income guarantee advances are made to the physician, they will be structured as a loan or loans bearing a reasonable rate of interest with any loan terms or loan forgiveness complying with [particular provisions];
> (e) where the income guarantee is for a net income amount, a reasonable fixed ceiling amount must be placed on allowable expenses and amounts for which advances may be made; [and]
> (f) the guarantee represents all or part of a compensation package that is reasonable in its entirety.[64]

Even after the Guidelines, it appears that forgivable guarantees remain somewhat risky income vehicles for recruitment plans. However, if structured as fully repayable loans, such arrangements could continue to be a popular recruitment incentive and avoid intense IRS scrutiny.[65] In light of the Guidelines, and the above-discussed GCMs, the use of subsidy caps is highly recommended. In the absence of subsidy caps, additional services should be required of the physician in return for a clause that does not oblige repayment. Ideally, such additional services could be targeted to alleviate a demonstrable community need.

2. Loans

Loans, lines of credit, and loan guarantees offered to physicians are among the list of "permissible incentives," but only if such loans, lines of credit, or loan guarantees, are (a) documented and evidenced by an executed promissory note; (b) adequately secured; and (c) bear interest at a reasonable rate reflecting market conditions (for example, prime plus one or two percent, or the applicable federal rate).[66]

Further,

> [a]ny loan forgiveness component [must] be conditioned upon the continued presence of the physician in practice in the community and [must] be rateable for a period of not less than four years, with the time period specified by contract *at the time* the loan or loan guarantee is made. A *demonstrable* need for the particular physician and the amount of the particular incentive [must] be evidenced *when provision is made* for forgiveness of a loan.[67]

64. *Id.* at 1523.
65. When income guarantees are fully repayable, they are in essence a line of credit with draw-down amounts measured by practice income deficits, and to call them income guarantees is really a misnomer.
66. *Guidelines*, *supra* note 1, at 1523.
67. *Id.* at 1522-23 (emphasis added).

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Because the Guidelines list loans as incentives that can be provided to permissible recruits, they can be interpreted to suggest that loans, even interest-bearing, fully repayable loans, may not be provided to existing physicians. However, this conclusion is contrary to logic and precedent. If a loan is provided on an arm's length basis, no nonmarket compensation or benefit is being provided. Loans by a hospital to a physician are always suspect in the eyes of the IRS, but are grudgingly accepted when they meet the above conditions. For example, in the Hospital Audit Guidelines, the IRS permitted loans to existing physicians provided that such loans met the above conditions, with the exception of the four-year requirement for any loan forgiveness.[68] The Hospital Audit Guidelines warn examiners to be alert only for below-market loans. Cases citing loans as evidence of inurement or private benefit involved low-interest loans or loans on other favorable terms.[69]

As with income guarantees, the IRS would be hard pressed to sustain a proposed revocation of a hospital's tax-exempt status on the basis that it provided a loan to an existing physician that was documented, was secured, and bore a reasonable rate of interest. If, however, the tax-exempt organization makes repeated loans to the same physician, even if under the above conditions, the IRS may have a stronger argument that (1) the physician is an "insider" and (2) the insider is using the assets of the tax-exempt organization for personal gain. In this situation, inurement may be found.[70]

3. Signing Bonuses or Other Bonus Payments

The Guidelines provide that signing bonuses or other bonus payments are not permissible incentives under any circumstance.[71] This prohibition is another significant departure from earlier IRS positions. In GCM 39,498, the IRS stated that a hospital may pay a one-time recruitment bonus or incentive provided the amount is determined not by reference to services to be rendered, but by reference to the value assigned to recruiting a particular physician to the medical service area.[72] In fact, bo-

68. I.R.S. Ann. 92-83, 1992-22 I.R.B. 59.

69. *See* Orange County Agric. Soc'y, Inc. v. Commissioner, 55 T.C.M. (CCH) 1602 (1988), *aff'd*, 893 F.2d 529 (2d Cir. 1990); Lowry Hosp. Ass'n v. Commissioner, 66 T.C. 850 (1976).

70. *See generally*, Lowry Hosp., 66 T.C. 850.

71. *Guidelines, supra* note 1, at 1523.

72. Gen. Couns. Mem. 39,498, at 9 (Jan. 28, 1986).

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nuses are merely another form of compensation. Because the Guidelines permit the guarantee of reasonable market compensation for a permissible recruit, payment of a part of that reasonable compensation in the form of a signing bonus should not lead to a finding of inurement.

4. Other Types of Incentives

Permissible incentives to a permissible recruit include the payment of reasonable, actual moving expenses and relocation costs, and reimbursement of interview travel expenses.[73]

The following incentives are permissible *only if no comparable and related value is otherwise provided* to the permissible recruit through an alternative incentive mechanism, such as an income guarantee or a forgiven loan:

> a. Reasonable subsidies paid or provided, or other similar financing arrangement, for medical office space rent, overhead expenses (such as utilities), or rental of equipment for a permissible recruit; but no such subsidy may be provided unless the rental amount is (but for the subsidy) at fair rental value, and in no event may such subsidy be provided for more than two years.
>
> b. Reasonable subsidized equipment purchases or other assistance in acquiring equipment on behalf of a permissible recruit, but only if free or reduced cost use by the physician does not exceed two years. If title is transferred to the physician at the end of the period of free or reduced cost use, [the] Hospital will receive payment for such equipment's then fair market value from the physician.
>
> c. No assistance in acquiring equipment or space may be provided if it entails a conveyance or lease of such equipment or office space with a leaseback to [the] Hospital.[74]

The "payment or subsidized provision of private practice start-up or maintenance assistance, such as consulting services to assist in practice management, or other practice management design plans," is also not permissible "if an income guarantee has been or will be provided to the same physician."[75] By negative inference, such benefits should be permissible if no income guarantee has been provided.

73. *Guidelines*, *supra* note 1, at 1523.
74. *Id.*
75. *Id.*

5. Permissible Obligations of Physicians

Even though an incentive may be permissible, the incentive arrangement may only obligate the physician for certain specified duties. These allowable obligations include:

a. relocation to service area of Hospital;
b. establishment of a full-time private practice;
c. continued presence in the community for a specified period;
d. maintenance of license to practice;
e. acceptance of Medicaid and charity patients;
f. emergency room duty or other rotations;
g. performance of community or medical teaching;
h. performance of necessary administrative duties;
i. maintenance of staff privileges; and
j. maintenance of a practice in the specialty for which recruited.[76]

However, the hospital may not condition incentives on "a requirement or understanding that the physician admit or refer patients" to it, nor may it prohibit or restrict the physician's ability "to obtain or maintain staff privileges at other hospitals or to treat patients at or admit patients to other hospitals."[77]

6. Impermissible Incentives

The Guidelines also detail certain incentives that are not permissible under any circumstances. Permissible incentives do *not* include: (a) "travel and continuing education expenses for any non-employee physician where such expenses are primarily related to the physician's private practice of medicine"; (b) "Hospital subsidization of salary and benefit costs for the support personnel of a non-employee physician in his or her private practice"; and (c) "the payment or provision, directly or indirectly, of malpractice insurance for the current private practice of a non-employee physician." However, "[c]overage with respect to a physician's bona fide duties as Medical Director for [the] Hospital, or any other activity undertaken for or on behalf of the Hospital that is distinct from his or her private practice, is permissible."[78]

76. *Id.* at 1522.
77. *Id.*
78. *Id.* at 1523.

Further, permissible incentives do not include parking, telephone or car allowances, health insurance expenses, medical society dues, subsidies, or licensing fees.[79]

7. Procedural Requirements

The Guidelines also impose several procedural requirements on hospitals with respect to the payment of recruitment incentives. First, a physician who receives incentives other than a loan (or other type of line of credit), actual moving expenses, or interview travel expenses must agree to allow the exempt hospital to conduct a periodic accounting and inspect the physician's financial records and books.[80] If the hospital pays for actual moving expenses, travel costs, and/or interview expenses, the hospital must obtain documentation of expenses from the physician prior to providing the allowed reimbursements.

Second, while a hospital's management may negotiate recruitment agreements, the Guidelines require approval by the hospital board and review by the hospital's legal counsel or tax advisor before it executes the recruitment incentive for each individually recruited physician.[81] This requirement appears to be overly burdensome given the number of physicians that are recruited by larger hospitals. Nonetheless, board approval of a recruitment program and periodic review of certain incentive agreements would be prudent.

In addition, the Guidelines require that each recruitment arrangement contain a provision that the hospital may "terminate the agreement and recover from the physician any payment that is determined by a court or governmental agency to be illegal or inconsistent with [the hospital's] tax-exempt status."[82] Including such a provision is prudent.

Finally, the Guidelines require hospitals to report all incentives provided to physicians on a Form W-2 or Form 1099, as appropriate. IRS officials have indicated that there may be widespread failure to comply with reporting requirements.[83]

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79. The exception is if these expenses are related to a physician's bona fide duties as the hospital's Medical Director or other duties the physician undertakes on behalf of the hospital that are distinct from the physician's private practice. *Id.*

80. *Id.* at 1522.

81. *Id.* at 1524.

82. *Id.*

83. *See, e.g.*, Report on Remarks of Philip M. Corn, Special Assistant, Office of the Associate Chief Counsel, Internal Revenue Service, *in* 9 EXEMPT ORG. TAX REV. 37 (1994).

V. Physician Recruitment After *Hermann Hospital*

Health care organizations face two difficult questions with respect to physician recruitment after *Hermann Hospital.* First, what should a section 501(c)(3) health care organization do with respect to its existing recruitment or retention incentives that may deviate from the parameters of the Guidelines? Second, how should future recruitment and retention incentives for physicians be structured?

The best advice for section 501(c)(3) health care organizations is to reexamine their current recruitment and retention policies in light of the Guidelines. For those practices that deviate from the Guidelines, an organization has three principal choices: (1) continue the current practice; (2) restructure the practice to conform to the Guidelines and tell no one; or (3) contact the IRS to alert them that concerns exist with respect to a particular recruitment or retention practice and that the hospital would like to resolve any potential issues, possibly through a closing agreement. If an organization is contemplating the issuance of tax-exempt bonds in the near future and physician relationships deviate substantially from the Guidelines, the third alternative should be given serious consideration. If bonds are not contemplated, the best alternative depends on a variety of factors including an organization's risk tolerance and the existence of any facts that would support the legitimacy of recruitment or retention practice.

If the Guidelines are as their name suggests, "guidelines," recruitment and retention practices that are not specifically excluded may be permissible. For example, in discussing permissible incentives, the Guidelines state that even if a physician is a permissible recruit, an incentive will not be considered "permissible" unless there is a demonstrable community need for the physician, as evidenced by one or more of six factors.[84] It is doubtful that the six factors listed cover all potential situations where significant demonstrable need for such a physician exists.

In any tax challenge to a recruitment or an incentive practice, a hospital should focus its defense on the *law* as it relates to private inurement. A strong legal argument can be made that a physician with medical staff privileges may not be considered an "insider" for purposes of the inurement proscription solely on

84. *See generally* section IV(B) above.

the basis of such privileges. The IRS faces an even tougher battle trying to label a newly recruited physician as an "insider."

Once inurement is no longer a potential issue, the analysis shifts to whether the recruitment or retention incentive confers a substantial private benefit on the physician. There is no direct case law on this issue. There is also little IRS precedent in the area, although what is there favors the hospital more than the IRS. If the Guidelines are to be applied broadly, their conclusion that a single recruitment incentive could constitute a substantial private benefit justifying revocation is overbroad. To the extent that "impermissible" recruitment incentives are a frequent practice of a hospital, the IRS would have a stronger case.

In structuring recruitment and retention packages, a hospital should not let the Guidelines dictate programs that the hospital believes to be in its best interests. To the extent a hospital deviates from the Guidelines, it must be able to *demonstrate* why the incentive was paid, the relationship between the incentive and the needs of the community, and the terms or conditions of the incentive, if any. Hospital board involvement, either on a policy basis or on a case-by-case basis (particularly for those incentives that fall outside of the confines of the Guidelines) is essential, as is legal or tax advisor consultation. Given recent IRS pronouncements, hospitals with community-based boards may have an easier time justifying recruitment and retention incentives than those with less community involvement in governance.

CONCLUSIONS

The Guidelines represent the latest assault by the IRS in the recent war it has waged against the not-for-profit hospital community. From a business standpoint, the Guidelines could not have arrived at a worse time. Not-for-profit hospitals are finding it harder than ever to compete for physicians with for-profit hospital chains that may offer more exciting and potentially more lucrative equity incentive packages, among other arrangements. In fact, as not-for-profit hospitals continue to be unable to attract or retain physicians, the Guidelines may serve ultimately to create the very medical services shortages required in order to justify the recruitment and retention practices they seek to curtail.

Recently, James McGovern, Assistant Commissioner, Employee Plans and Exempt Organizations, stated that the IRS does not intend to apply the Guidelines across the board to all

hospitals.[85] While this provides some level of comfort, the statement appears fundamentally inconsistent with the IRS-mandated public disclosure of the Guidelines in the first place. In essence, it sounds like the proverbial physician holding a three-inch hypodermic needle, stating: "This won't hurt a bit."

Epilogue

As this article was going to publication, the IRS released to the tax media a proposed revenue ruling regarding physician recruitment.[86] Because the proposed revenue ruling deals with only five highly specific examples, an understanding of the *Hermann Hospital* Guidelines remains crucial to tax-exempt hospitals.

Like a phoenix from the ashes, the proposed revenue ruling represents a bold move from the IRS for not only reviving (hopefully) its revenue rulings program, but for issuing a proposed revenue ruling in an area as controversial as physician recruitment and, in addition, requesting public comments on the proposed ruling. While some tax practitioners have already questioned the value of the proposed revenue ruling by arguing that its examples are too limiting, such arguments miss the point. To the extent this proposed revenue ruling reactivates the long-dormant exempt organizations revenue rulings program, the fact that it may be considered too narrow is a small price to pay. Further, criticisms that its examples are too narrow misunderstand the nature, purpose, and use of revenue rulings.

I. Background

As with the Guidelines, the proposed revenue ruling has no precedential value and technically may not be used by the IRS to attack, or by exempt organizations to defend, a particular physician recruitment program or incentive. Nonetheless, a recruitment program or incentive that falls within its ambit should not invoke IRS scrutiny. Once the proposed revenue ruling is issued in final form, however, the revenue ruling will be binding on the IRS.[87] Therefore, recruitment practices that fall squarely within the examples provided in the revenue ruling will be

85. *See IRS's McGovern Downplays Hermann Hospital Closing Agreement*, 10 Exempt Org. Tax Rev. 1289 (1994).

86. I.R.S. Ann. 95-25, 1995-14 I.R.B. 11 (Mar. 15, 1995).

87. Although revenue rulings are not binding on the courts, they are given significant deference in court opinions.

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treated by the IRS in accordance with the rationale and conclusions found in the revenue ruling.

The reason the Guidelines remain relevant even after the revenue ruling is finalized lies in the nature of a revenue ruling. A revenue ruling does not preclude organizations from engaging in activities that do not fall squarely within the ruling's ambit. Specifically, merely because a particular recruitment practice includes facts not included in the revenue ruling does not mean that it is an improper activity. The revenue ruling serves as an indication of the particular facts the IRS views as important and a precedential safe harbor for those practices that fall squarely within its terms. In the real world, few practices, whether it be recruitment activities or unrelated business activities, ever fall squarely within the provisions of revenue rulings.

II. The Proposed Revenue Ruling

The proposed revenue ruling sets forth five situations involving a tax-exempt hospital and a particular physician recruitment incentive. In the first four situations, the recruitment incentive is determined not to jeopardize the hospital's exempt status. In the fifth situation, a court has determined that the recruitment program violates the anti-kickback statute and the resultant conviction leads to revocation of the hospital's tax-exempt status.

Situation One

Hospital A is located in a rural county. The United States Public Health Service designated the rural area as a Health Professional Shortage Area for primary medical care professionals. The hospital recruited a physician, Physician M, who had recently completed a residency in obstetrics/gynecology; the physician was not on the medical staff of Hospital A. Hospital A recruited this physician to maintain a full-time practice in obstetrics/gynecology and to become a nonemployee member of the hospital's medical staff. Pursuant to a written agreement that was negotiated at arm's length, Hospital A provided this new physician with a recruitment incentive package. The agreement was approved by the board of directors of the hospital (or its designees); no off-agreement incentives were provided.

Pursuant to this agreement, the hospital paid the recruited physician a one-time $5,000 bonus to the physician, paid one year of the physician's malpractice insurance premiums, pro-

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vided the physician office space for three years in a hospital-owned building at a rental rate below market value, and guaranteed the physician's residential mortgage. Pursuant to a documented agreement, the hospital provided unspecified start-up financial assistance at terms that were commercially reasonable.

Situation Two

Hospital B, located in an economically depressed inner-city area, performed a community needs assessment. The assessment concluded that (1) there was a shortage of pediatricians in its service area, and (2) Medicaid patients found it particularly difficult to obtain pediatric services. Physician N, a pediatrician, practiced outside of the service area for Hospital B and was not on its medical staff. Hospital B recruited the pediatrician to relocate to the city for the purpose of maintaining a full-time pediatric practice in its service area, becoming a nonemployee member of its medical staff, and treating a reasonable number of patients on Medicaid. Pursuant to a written agreement that was negotiated at arm's length, Hospital B provided this pediatrician with a recruitment package; the agreement was approved by the board of directors of the hospital (or its designees). No off-agreement incentives were provided.

Pursuant to the agreement, the hospital reimbursed the physician for moving expenses (as defined in section 217(b) of the Code[88]) as well as the expenses of the professional liability "tail" coverage from the pediatrician's former practice, and guaranteed the first three years of the physician's private practice income. Under a properly documented private practice income guarantee that bore commercially reasonable terms, the hospital guaranteed that during these first three years of the pediatrician's full-time practice in the service area, a certain level of net income, after reasonable practice expenses, would be generated. To the extent that the income level would not be generated, the hospital would make up the difference. The amount of net income that the hospital guaranteed fell within the average income range of physicians in the same specialty as identified in regional or national income surveys.

88. 26 U.S.C. § 217(b) (Supp. 1993).

Situation Three

Like Hospital B, Hospital C, located in an economically depressed inner-city area, performed a community needs assessment. Its assessment indicated that indigent patients found it difficult to access obstetrical care because of a shortage of obstetricians in the hospital's service area who were willing to treat Medicaid and/or charity care patients. The hospital recruited an obstetrician currently on Hospital C's medical staff, Physician O, for the purpose of providing these services. Hospital C and Physician O entered into a written agreement that was approved by the hospital's board of directors (or its designees); no off-agreement incentives were provided.

Under the recruitment agreement, the hospital promised to reimburse the obstetrician for one year of malpractice insurance in exchange for Physician O treating a reasonable number of Medicaid and charity care patients in that same year.

Situation Four .

Hospital D, in a medium- to large-sized metropolitan area, operated a neonatal intensive care unit. A minimum of four perinatologists was required in the unit to ensure proper coverage and high quality of care. Of the four perinatologists who provided coverage for this neonatal intensive care unit, two planned to relocate. Therefore, the hospital initiated a search for perinatologists.

Physician P, one of the two top candidates for the position, practiced in the same city, was a member of the medical staff of a hospital located in that city, and provided coverage for that hospital's neonatal intensive care unit. Physician P was not on the medical staff of Hospital D. Hospital D recruited this physician to cover its neonatal intensive care unit and become a nonemployee member of its medical staff. Pursuant to a written agreement that was negotiated at arm's length, Hospital D provided this perinatologist with a recruitment package; the agreement was approved by the board of directors of the hospital (or its designees). No off-agreement incentives were provided.

The hospital guaranteed the level of the physician's private practice income for a set period of time during which the physician was a member of the medical staff and provided neonatal intensive care unit coverage. Specifically, under a properly documented private practice income guarantee that bore commercially reasonable terms, the hospital guaranteed that during the

first three years of the perinatologist's practice, a certain level of net income from his private practice, after reasonable expenses of the practice, would be generated. To the extent that the income level would not be generated, the hospital would make up the difference. The amount of net income that the hospital guaranteed fell within the income range of physicians in the same specialty as identified in regional or national income surveys.

Situation Five

Hospital F, located in a medium- to large-sized metropolitan area, was found guilty of knowingly and willfully violating the Medicare and Medicaid Anti-kickback statute.[89] The hospital's violation was based upon its substantial practice of providing physician recruitment incentives that constituted referral payments.

III. Discussion

As noted earlier, the proposed revenue ruling states that the hospitals in Situations One, Two, Three, and Four did not violate the requirements for exemption as an organization described in section 501(c)(3) of the Code. All four of these situations involved the following common factors: (1) there was objective evidence demonstrating a need for the particular physician's specialty; (2) the recruitment incentive was evidenced by a written agreement with no off-agreement incentives provided; (3) the agreement was negotiated at arm's length; (4) the agreement was approved by the hospital's board of directors *or its designees*; and (5) the total compensation paid to each physician was within a range of reasonableness for the particular physician's specialty.

Income guarantees were permitted in Situations Two and Four for the first three years covered under the agreement, as opposed to the two-year limit imposed by the Guidelines. In addition, it is significant that the income guarantees were allowed despite the fact that other incentives were provided to the physician recruit. Unfortunately, the proposed revenue ruling does not discuss the appropriate structure of the income guarantee agreement and does not specifically provide that repayment is not required. Therefore, in the event periodic subsidies are to

89. 42 U.S.C. § 1320a-7b(b) (1988 & Supp. 1993).

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be provided, the article's earlier discussion of periodic advances under an income guarantee remains particularly relevant.

Situation Four is notable in that a recruitment incentive was allowed by the IRS even though the physician was not a "permissible recruit" under the definition contained in the Guidelines. (Physician P already practiced in City Y where Hospital D was located).[90] This is a significant concession on the part of the IRS, which addressed "cross-town recruiting" negatively in GCM 39,862 and the Guidelines.

Situation One is also interesting in that it allows the hospital to guarantee the physician's mortgage on a personal residence with no apparent limit on the amount and length of the guarantee, an incentive not addressed in the Guidelines.

By far the most intriguing of the five examples in the ruling is Situation Five. The IRS has long struggled with charitable organizations that engage in activities that are "illegal." IRS agents may enjoy using the potential illegality of an activity as a basis for proposing revocation of tax-exempt status. While the fifth example does recommend revocation of tax-exempt status based on illegal activities, such recommendation was based on two preconditions: (1) there must be an actual conviction under the statute; and (2) the illegal activities must be substantial.[91] This is consistent with section 501(c)(3) of the Code, which requires charitable organizations to be organized and operated exclusively for exempt *purposes*. Because the statute is a "purposes" test, the fact that a small number of activities may be illegal should not result in revocation of exempt status unless the acts are substantial in nature or so pervasive that the organization serves an illegal purpose.

The consequences associated with illegal activities were discussed in GCM 34,631.[92] In the memorandum, Chief Counsel states:

> If an organization carries on substantial illegal activities, it cannot qualify for exemption under section 501(c)(3) of the Code.
>
> To determine when disqualifying activities are present to a "significant extent" (that is, when they become "substantial"),

90. *See* section IV(B) above.

91. Of interest, Situation Five of the proposed revenue ruling should be contrasted with the discussion of illegality contained in GCM 39,862, the "net revenue stream." The discussion contained in Situation Five represents a more accurate statement of the law and answers questions posed by GCM 39,862.

92. Gen. Couns. Mem. 34,631 (Oct. 4, 1971).

> more must be considered than the ratio they bear to activities in furtherance of exempt purposes. The quality of such acts are as important as their quantity. A great many violations of local pollution regulations relating to a sizable percentage of an organization's operations would be required to disqualify it from 501(c)(3) exemption. Yet, if only .01% of its activities were directed to robbing banks, it would not be exempt. This is an example of an act having a substantial non-exempt quality, while lacking substantiality of amount.[93]

This position is also consistent with Rev. Rul. 75-384,[94] where the IRS holds that a nonprofit organization formed

> to promote world peace and disarmament by nonviolent direct action and whose *primary activity* is the sponsoring of antiwar protest demonstrations in which demonstrators are urged to commit violations of local ordinances and breaches of public order does not qualify for exemption under section 501(c)(3) or (4) of the Code.[95]

CONCLUSION

The issuance of the proposed revenue ruling should be viewed as good news by the affected community. When used in conjunction with the *Hermann Hospital* Guidelines, the Hospital Audit Guidelines, and the various GCMs and revenue rulings discussed in this article, an exempt hospital should be able to structure a recruitment program that is both effective and relatively safe from attack by the IRS. Two major principles to be drawn from the various IRS pronouncements are that (1) the overall compensation paid to a physician must be reasonable and (2) recruitment packages should not be executed in a vacuum without the approval of the hospital's board or its designees.

It is important that those who have comments respond to the general request in the proposed revenue ruling. It is not often the affected community is afforded the opportunity to provide input into IRS positions. If significant comments are received in a particular area, the IRS will likely pay heed to such comments. Silence will be interpreted by the IRS as acceptance.

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93. *Id.* at 12.
94. 1975-2 C.B. 204.
95. *Id.* at 204. (emphasis added).