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# Recent Developments for Tax-Exempt Healthcare Organizations\*

*Thomas K. Hyatt\*\**

The 1990s have been a time of turbulence for tax-exempt healthcare organizations, which represent the vast majority of providers of healthcare services today. Much of this turbulence is due to the activism of the Internal Revenue Service (“IRS”), which heretofore had largely adhered to a policy of *laissez-faire* regulation of such organizations. The decisions of both federal and state courts have contributed to the turbulence as well; federal courts have grappled with the problem of applying decades-old law and policy to new breeds of healthcare providers, and state courts have taken the liberty of redefining the concept of the charitable hospital with little deference to either federal law or even the decisions of fellow state courts.

This article provides an overview of the most significant of these recent developments in tax law that affect tax-exempt healthcare organizations. It begins with an examination of noteworthy decisions issued by federal and state courts, and then reviews major policy changes and other actions undertaken by the IRS.

## I. JUDICIAL DEVELOPMENTS

### *Federal Courts*

At the federal level, one of the most watched developments has been the treatment accorded health maintenance organizations (“HMOs”) seeking recognition of tax-exempt status as charitable organizations described in section 501(c)(3) of the Internal Revenue Code (the “Code”).<sup>1</sup> Until recently, the 1978 decision of the Tax Court in *Sound Health Association v. Commissioner*<sup>2</sup> was the

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1. 26 U.S.C.A. § 501(c)(3) (West Supp. 1993).
2. 71 T.C. 158 (1978).

only case dealing with the status of HMOs as charitable organizations under section 501(c)(3). The Tax Court took the position in that case that a staff model HMO<sup>3</sup> that has features that benefit the community qualifies for 501(c)(3) status. In December of 1991, the Tax Court again examined the tax status of HMOs in *Geisinger Health Plan v. Commissioner*.<sup>4</sup>

In *Geisinger*, the Tax Court considered Geisinger Health Plan, an HMO that was not a staff model HMO; that is, the HMO did not directly employ providers of services under the HMO. The Tax Court, applying the "community benefit" analysis that it had adopted in its earlier decision in *Sound Health*, concluded that the facts established that the HMO's purpose was to promote health within its service area. It noted that the HMO's membership was virtually unlimited and the HMO provided a community benefit. Therefore, the court concluded, the HMO was a charitable organization described in section 501(c)(3).

Not surprisingly, the Service appealed the Tax Court's decision to the Third Circuit. On February 8, 1993, the Third Circuit reversed the Tax Court and ruled that Geisinger Health Plan, standing alone, was not entitled to tax-exempt status under section 501(c)(3).<sup>5</sup> The Third Circuit arrived at this conclusion by finding that the HMO "[did] no more than arrange for its subscribers, many of whom are medically under-served, to receive health care services from health care providers."<sup>6</sup> It further found that "[a]rranging for the provision of medical services only to those who 'belong' is not necessarily charitable, particularly where, as here, the HMO has arranged to subsidize only a small number of such persons."<sup>7</sup>

The Third Circuit decision in *Geisinger* appears to be a sizeable victory for the IRS, which desires to confine the Tax Court's decision in *Sound Health* to its unique facts. However, many will consider troubling the Third Circuit's conclusion that "arranging" for the provision of medical services carried out for the purpose of promoting health is insufficient to support recognition of exemption,

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3. A staff-model HMO is an HMO that directly employs physicians who provide services at facilities owned by the HMO. HMOs structured in this manner are clearly a minority of all HMOs. See generally NATIONAL HEALTH LAWYERS ASSOCIATION, *THE INSIDER'S GUIDE TO MANAGED CARE: A LEGAL AND OPERATIONAL ROADMAP* (1990).

4. 62 T.C.M. (CCH) 1656 (1991).

5. *Geisinger Health Plan v. Comm'r*, 985 F.2d 1210 (3d Cir. 1993).

6. *Id.* at 1220.

7. *Id.*

as they will the court's acceptance of the IRS' argument that more than the mere promotion of health is necessary in order for an organization to qualify for tax exemption. These positions do not square with the majority view of other courts, nor with a multitude of administrative decisions set forth in private letter rulings. Arguably, the Tax Court's analysis in *Geisinger* is more accurate; it concluded that "even if the activity of arranging for the delivery of health care services is not itself inherently charitable, it does further petitioner's exclusively exempt purpose of promoting health."<sup>8</sup>

It is important to note that the Third Circuit remanded the *Geisinger* case to the Tax Court for a determination of whether Geisinger Health Plan could qualify for exemption as a charitable organization described under section 501(c)(3) on the grounds that it is an integral part of the Geisinger System, a healthcare network comprised of nonprofit 501(c)(3) healthcare organizations. On May 3, 1993, the Tax Court concluded that Geisinger Health Plan also failed to qualify for exemption as a charitable organization under the "integral part" doctrine.<sup>9</sup> The court noted that the parties had agreed that if an organization's activities are carried on under an exempt organization's supervision or control and could be carried on by that exempt organization without constituting an unrelated trade or business, then the organization is entitled to exemption as an integral part of that exempt organization. The court concluded, however, that Geisinger Health Plan had not proven that its activities would not constitute an unrelated trade or business if carried on by its tax-exempt affiliates in the Geisinger System.

The result of the Third Circuit's decision, and the Tax Court's decision on remand, in the *Geisinger* case is clear: it will be extremely difficult for a non-staff model HMO to qualify for tax-exempt status as a 501(c)(3) charitable organization. Because most HMOs today are not organized as staff model HMOs, they will likely be forced to seek exemption under section 501(c)(4) of the Code<sup>10</sup> as social welfare organizations, or not at all.

Another federal court decision—one that has potentially dramatic implications for all tax-exempt organizations—is the Seventh

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8. 62 T.C.M. (CCH) at 1664.

9. *Geisinger Health Plan v. Comm'r*, 100 T.C. 26 (1993). Under the integral part doctrine, an organization can qualify for exemption through a related entity that is tax-exempt as long as the organization's activities would be exempt if they were carried on by the related entity and the activities further the related entity's exempt purposes.

10. 26 U.S.C.A. § 501(c)(4) (West Supp. 1993).

Circuit's decision in *Living Faith, Inc. v. Commissioner*.<sup>11</sup> The court explored and further developed a doctrine that has been labeled the "commerciality doctrine." The commerciality doctrine has become a major factor in determining unrelated business income taxation and is shaping the law governing qualification for tax-exempt status.<sup>12</sup> The doctrine has been described as follows: "A tax-exempt organization is engaged in a nonexempt activity when that activity is engaged in a manner that is considered 'commercial'. An act is a commercial one if it has a direct counterpart in the world of for-profit organizations."<sup>13</sup>

The *Living Faith* decision is the most expansive interpretation of the commerciality doctrine by an appellate court to date and one that portends significant obstacles to tax-free operation for today's nonprofit healthcare organizations. In *Living Faith*, the Seventh Circuit considered whether Living Faith operated its vegetarian restaurants and health food stores exclusively for exempt purposes within the meaning of section 501(c)(3) of the Code. The court affirmed the decision of the Tax Court that Living Faith was not operated for exempt purposes because it operated with a substantial commercial purpose. The court noted that when undertaking an inquiry of whether an organization operates for a substantial commercial purpose, "we look to various objective indicia. The particular manner in which an organization's activities are conducted, the commercial hue of those activities, competition with commercial firms, and the existence and amount of annual or accumulated profits, are all relevant evidence in determining whether an organization has a substantial nonexempt purpose."<sup>14</sup> The court found that the following ten factors demonstrated commerciality sufficient to deny exemption:

1. the sale of goods and services to the general public,
2. operation in direct competition with other for-profit enterprises,
3. setting prices competitively with area businesses and using pricing formulas common in commercial enterprises,
4. failure to use a below-cost pricing structure,
5. use of promotional materials and commercial catch-phrases to enhance sales,

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11. 950 F.2d 365 (7th Cir. 1991).

12. Bruce R. Hopkins, *The Most Important Concept in the Law of Tax-Exempt Organizations Today: The Commerciality Doctrine*, 5 EXEMPT ORGANIZATIONS TAX REV. 459 (1992).

13. *Id.*

14. 950 F.2d at 372.

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6. significant advertising expenditures,
7. lack of plans to solicit contributions,
8. commercially competitive hours of operation,
9. use of salaried workers rather than volunteers, and
10. a requirement that management have business ability and six-months training.

The court did not give substantial weight to the fact that Living Faith had no net profits, stating that a failure to show a profit is “only one factor among several, and does not per se entitle an organization to exempt status.”<sup>15</sup>

The *Geisinger* and *Living Faith* cases illustrate the difficulties faced by courts today in interpreting statutes and regulations that were drafted primarily in the 1950s and 1960s, and applying them to tax-exempt organizations that, of necessity, operate very differently than they did during those years. The decisions of the Tax Court and the Third and Seventh Circuits in these cases represent a conservative, even restrictive, approach to deciding the complex issues raised by the activities of tax-exempt healthcare organizations today. Whether other courts will follow this approach remains to be seen; however, given the dynamic nature of the healthcare field, and the activism of healthcare regulators, there will be ample opportunities for continued judicial review.

### *State Courts*

At the state level, the debate is more fundamentally focused on the extent to which hospitals, particularly those with far-flung commercial enterprises and those that provide limited amounts of free care, can qualify as charities for purposes of real property taxation. Because the taxing authorities range from the state itself down to counties and even local community school districts, the definitions of a “charity” adopted by the courts widely vary.

While the debate is always vigorous, many decisions made by state courts in recent years have upheld the tax treatment of hospitals as tax-exempt charities.<sup>16</sup> A recent example is the Texas District Court’s decision in *Texas v. Methodist Hospital*.<sup>17</sup>

In this high-profile case, the Attorney General of the State of Texas sued Methodist Hospital, which is located in Houston, alleging that the hospital did not provide sufficient charity care to jus-

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15. *Id.* at 374.

16. Many other actions brought (or threatened) against hospitals for state or local real property taxes have been settled, usually with the hospital retaining its status as a charity and making a “payment in lieu of taxes.”

17. No. 494,212 (Tex. D., 126th Jud. Dist., March 12, 1993).

tify its exemption from state tax. Methodist is the largest private, nonprofit hospital in the United States, with 1527 licensed beds, and the third most profitable nonprofit system in the country: in 1991 it reported \$76.6 million in profits on \$526 million in net revenues.<sup>18</sup> The State claimed that Methodist provided \$25.9 million in charity care between 1986 and 1990, while Methodist claimed that it provided \$191.9 million, using its own definition of "charity care."<sup>19</sup> The state district court, holding that the Attorney General did not have the power to determine how a nonprofit hospital must allocate its resources, ruled in favor of Methodist Hospital and threw out the Attorney General's law suit.<sup>20</sup>

The matter has now been concluded with the recent enactment by the Texas state legislature of a law that requires the state's tax-exempt hospitals to provide a certain amount of charity care starting in 1994.<sup>21</sup> On the heels of the law's passage, the state and Methodist agreed on a settlement that provides for the creation of an indigent care endowment fund by Methodist and for the application of the new law's highest standard of charity care—four percent of net revenues—to Methodist's operations.<sup>22</sup>

The state court decisions that have not upheld the charitable status of hospitals for property tax purposes have tended to adopt fairly critical views of hospital activities. A typical example is the decision by the Commonwealth Court of Pennsylvania in *School District of Erie v. Hamot Medical Center*.<sup>23</sup> The *Hamot* case involved an appeal by Hamot Medical Center from an order of the Court of Common Pleas of Erie County, which declared that Hamot was not entitled to retain its tax-exempt status for real property taxes because it was not a "purely public charity," as required in Pennsylvania.

In August of 1988, the City of Erie demanded that Hamot pay \$100,000 in lieu of taxes or the City would challenge the hospital's property tax exemption. Hamot refused to pay and the City appealed the Medical Center's tax-exempt status with the Erie County Board of Assessments and Appeals. The Board ruled that "Hamot was entitled to retain its tax-exempt status for the proper-

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18. Sandy Lutz, *Charity Care and the Law: Case is Far from Closed*, MODERN HEALTHCARE, Mar. 8, 1993, at 26.

19. *Id.* at 27.

20. *Id.* at 26.

21. Tex. S.B. 427, 73rd Leg., Reg. Sess. (signed May 31, 1993).

22. Sandy Lutz, *Methodist Makes Its Peace with the Tax Man in Texas*, MODERN HEALTHCARE, Jun. 7, 1993, at 3.

23. 602 A.2d 407 (Pa. Commw. Ct. 1992).

ties in question.”<sup>24</sup> On appeal from the Board, the Court of Common Pleas of Erie County held that Hamot had the burden of proving its eligibility for tax-exempt status, conducted a de novo hearing, and then reversed the Board’s ruling. Hamot appealed this decision.

The appellate court reviewed the trial court’s lengthy discussion of Hamot’s organizational structure and operations, noting its extensive corporate reorganization and its numerous subsidiaries involved in commercial enterprises. It also noted Hamot’s “copious” compensation of its executives, its investment of assets in commercial real estate ventures, and its aggressive pursuit of its patients for nonpayment of bills.

The court was faced with the issue of what standard to apply to Hamot Medical Center in determining whether Hamot was a “purely public charity.” One standard was developed by the Pennsylvania Supreme Court in *West Allegheny Hospital v. Board of Property Assessment*.<sup>25</sup> The court held that a hospital is a “purely public charity” (and therefore exempt from taxation) when the hospital maintains an open admissions policy and provides comprehensive health care without regard to a patient’s ability to pay. Thereafter, the Pennsylvania Supreme Court established a second standard in *Hospital Utilization Project v. Commonwealth*<sup>26</sup> when it developed a five-pronged test to determine whether an entity qualified as a “purely public charity.” The entity in this case was not a hospital, but rather prepared statistical abstracts of medical records distributed to area hospitals. The test established by the Supreme Court was whether an entity: “(1) [a]dvances a charitable purpose; (2) [d]onates or renders gratuitously a substantial portion of its services; (3) [b]enefits a substantial and indefinite class of persons who are legitimate subjects of charity; (4) [r]elieves the government of some of its burden; and (5) [o]perates entirely free from private profit motive.”<sup>27</sup> The Pennsylvania Supreme Court concluded that Hamot did not pass muster under either standard and consequently did not qualify as a purely public charity for property tax exemption purposes.<sup>28</sup>

This case, along with the five-pronged test of the *Hospital Utili-*

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24. *Id.* at 408.

25. 455 A.2d 1170 (Pa. 1982).

26. 487 A.2d 1306 (Pa. 1985).

27. *Id.* at 1317.

28. The *Hamot* decision was followed in a very similar case, *Allentown Hospital-Lehigh Valley Hospital Center v. Board of Assessment Appeals, Lehigh County*, 611 A.2d 793 (Pa. Commw. Ct. 1992).

zation Project case, reveals the type of hard-line analysis now being applied by some state courts across the country. Along with the development of the commerciality doctrine, discussed above, it may eventually force a substantial change in the way nonprofit hospitals operate if they wish to retain their tax exemption.

## II. ADMINISTRATIVE DEVELOPMENTS

### *GCM 39,862*

Certainly one of the most significant pronouncements by the IRS in several years, and a vanguard of IRS analysis of healthcare activities in the nineties, was the issuance in late November of 1991 of General Counsel Memorandum ("GCM") 39,862.<sup>29</sup> This lengthy GCM reversed an earlier IRS position by opining that certain types of hospital-physician joint ventures result in per se private inurement. In the process, the IRS displayed the breadth of its expanded expertise in the healthcare area, breathed new life into the twenty-four-year old community benefit standard, and for the first time discussed the link between tax policy and health policy by tying qualification for tax exemption to compliance with the Medicare and Medicaid fraud and abuse laws.<sup>30</sup>

The specific issue the IRS addressed in GCM 39,862 was "[w]hether a hospital, tax exempt because it is described in section 501(c)(3), jeopardizes its exempt status by forming a joint venture with members of its medical staff and selling to the joint venture the gross or net revenue stream derived from operation of an existing hospital department or service for a defined period of time."<sup>31</sup> The IRS concluded that a hospital that enters into such a transaction jeopardizes its tax-exempt status because (1) the hospital's net earnings inure to the benefit of private individuals; (2) private benefit stemming from such a transaction cannot be considered incidental to the public benefit achieved; and (3) such a venture may violate federal fraud and abuse law. The GCM stated that existing rulings conflicting with GCM 39,862 should be modified or revoked.

A significant part of the analysis in GCM 39,862 is the IRS's position that the fact that a joint venture furthers a hospital's com-

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29. Gen. Couns. Mem. 39,862 (Nov. 22, 1991). 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.

30. For a summary of GCM 39,862, see David Ball, *Tax Exemption for Charitable Hospitals*, 1 ANNALS HEALTH L. 71 (1992).

31. Gen. Couns. Mem. 39,862, at 1.

petitive position and may increase referrals and utilization of the facility is not sufficient to prevent a finding of private inurement or substantial private benefit. Rather, the IRS has taken the position that a transaction must provide benefit to the community rather than to the hospital itself and that those interests may not be the same.

The GCM raises three important points. First, the GCM confirms the IRS' previously stated position that any physician on the hospital's medical staff is an insider for purposes of applying the private inurement test. The IRS has frequently stated informally, however, that this is a rebuttable presumption and depending on the facts of the case, a physician may not be treated as an insider.<sup>32</sup> Formalization of this position may occur in an upcoming GCM on physician recruitment.

Second, there has long been a tension between the fraud and abuse requirements under the Medicare and Medicaid programs, under which hospitals and physicians must refrain from connecting remuneration and referrals, and the IRS' requirement that a benefit to the charitable hospital and the community be established in exchange for a benefit provided to physicians through a recruitment package or joint venture. In GCM 39,862, the IRS for the first time expressly discussed the interplay between tax law and healthcare fraud and abuse law and indicated that an act prohibited by the fraud and abuse law could be a sufficient basis for revoking a charitable hospital's tax-exempt status under the law of charitable trusts. The GCM walks a fine line between effectuating tax policy and health policy, and it is not yet clear whether, or how, the IRS will become involved in determinations of fraudulent activity under the Medicare and Medicaid programs by way of enforcing tax laws. Also troublesome is the effect of the recent Department of Health and Human Services Office of Inspector General Special Fraud Alert<sup>33</sup> on hospital incentives to physicians, which questions practices, several of which have been expressly approved by the IRS, on the grounds that they may violate fraud and abuse laws.

Third, GCM 39,862 reintroduces the doctrine of per se private inurement by finding that revenue stream transactions are per se

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32. See, e.g., *Remarks of T. J. Sullivan to NHLA Conference*, 6 EXEMPT ORGANIZATIONS TAX REV. 1073 (1992).

33. Office of Inspector General Special Fraud Alert-Hospital Incentives to Physicians (May, 1992), reprinted in [1992 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,200.

violations of the prohibition against inurement rather than by relying on a facts and circumstances analysis as has historically been the case. Thus, the IRS is apparently now identifying practices that, by their nature, cannot survive the private inurement test, notwithstanding an organization's attempt to justify those practices. The *per se* private inurement doctrine is likely to continue to evolve as the IRS addresses various healthcare delivery practices of tax-exempt providers.

Notwithstanding some of the initial overreaction to GCM 39,862, the IRS clearly left some activities unaffected. For example, GCM 39,862 does not outlaw all joint ventures between hospitals and physicians. The GCM expressly states that "nothing herein should be read to imply that a typical joint venture that involves true shared ownership, risks, responsibilities, and rewards and that demonstrably furthers a charitable purpose should be met automatically with suspicion or disapproved merely because physician-investors have an ownership interest."<sup>34</sup> Clearly, joint ventures that have demonstrable community benefit, particularly those involved in expanding services or creating a new provider, will continue to pass muster under the analysis of this GCM.

General Counsel Memorandum 39,862 also does not prohibit hospital employee incentive compensation plans that are based on the profits of the hospital. The IRS previously approved such plans in private letter rulings and explicitly stated in GCM 39,862 that "[w]e do not mean to suggest that a Section 501(c)(3) hospital cannot have an appropriately structured incentive compensation plan for employees in which profits are a factor in the compensation formula."<sup>35</sup>

There are clear and significant long-term implications of GCM 39,862. First, under the analysis of GCM 39,862, providers must go to greater lengths to demonstrate the community benefit derived from joint ventures and other transactions with physicians and other taxable entities. The IRS is now more interested in *how* the community will benefit from the transaction, and providers will likely no longer be able to rely on the justification that the transaction will improve the hospital's competitive position or increase the hospital's utilization.

Second, this GCM shows that the IRS is studying the ways in which federal health policy embodied in the fraud and abuse laws affects transactions undertaken by hospitals and physicians. There

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34. Gen. Couns. Mem. 39,862, at 35.

35. *Id.* at 14.

will no doubt continue to be a dialogue between the Office of the Inspector General, charged with enforcing the fraud and abuse laws, and the IRS, with the result being a clearer connection between a fraud and abuse violation and the loss of a hospital's tax exempt status.

Third, the IRS and the courts will likely use the *per se* private inurement doctrine again in the future. Although physician recruitment seems the most probable next target, other types of practices may also fall within the scope of this developing doctrine.

Fourth, the thorough analysis set forth in GCM 39,862, along with new hospital audit guidelines, discussed below, and the continuing education programs of the IRS all suggest more extensive and knowledgeable audits of healthcare organizations by the IRS' field staff. As a result, revocations of exemption can be expected in extreme cases and increased pressure brought to bear on Congress by the IRS and healthcare providers to permit the imposition of intermediate sanctions as an enforcement tool.

Finally, by no longer having the defense that a transaction improves its financial and competitive position, hospitals will be more conservative in their business ventures and will be under pressure to find other ways of staying in the black. As one commentator noted:

It is something of an anomaly that at the very time that Congress is clamoring for an increase in the charitable care provided by our tax-exempt hospitals, the IRS has moved toward a position which will place the financial structure and economic health of our hospitals on a less sound economic footing and possibly leave them with a diminished ability to afford any extension of charity care, despite arguments in the GCM to the contrary.<sup>36</sup>

General Counsel Memorandum 39,862 is a prime example of the type of regulation healthcare organizations can expect from the IRS in the nineties. Instead of issuing terse revenue rulings of binding effect, the IRS will issue lengthy policy statements through GCMs that are subject to broad interpretation. Moreover, healthcare organizations can expect knowledgeable and thorough discourse by the IRS on healthcare matters and gradually increasing enforcement as the IRS increases its activism in this area.

### *Hospital Audit Guidelines*

To implement the IRS' expressed desire to expand its role of

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36. Robert S. Bromberg, *IRS Announces New Position on Hospital-Physician Joint Ventures*, 5 EXEMPT ORGANIZATIONS TAX REV. 31 (1992).

auditing tax-exempt organizations, the IRS developed a new set of auditing guidelines that reflect the complexity and more business-like operation of healthcare organizations today. The guidelines were released to the public on April 1, 1992, but have been in use since October of 1991.<sup>37</sup> These guidelines are based upon industry information learned in congressional hearings and taxpayer compliance measurement program audits in the area of unrelated business income, congressional hearings on charity care, and the analysis in GCM 39,862. Although the guidelines do not have the force of law, they are likely to become the *de facto* standard for charitable hospital operation. Many hospitals are wisely using these guidelines to perform internal audits to verify their compliance with federal tax law.

The hospital audit guidelines provide an extensive list of situations that are to be reviewed by the field audit staff. The following is a summary of these situations:

- a. The Community Benefit Standard<sup>38</sup>
  - (1) governance and organizational issues
  - (2) open emergency room
  - (3) open medical staff
  - (4) patient dumping
  - (5) services available to all able to pay
  - (6) no Medicaid discrimination
- b. Private Inurement and Private Benefit
  - (1) different forms
  - (2) difference between inurement and benefit
  - (3) physicians as "insiders"
  - (4) transactions with directors and related parties
  - (5) conflict of interest policies
- c. Unreasonable Compensation
  - (1) compensation arrangements with physicians and senior executives
  - (2) recruitment/retention arrangements
    - (a) fixed compensation
    - (b) fee-for-service
    - (c) percentage of gross or adjusted gross
    - (d) income guarantees
    - (e) rent subsidies
    - (f) support staff

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37. INTERNAL REVENUE SERVICE, EXEMPT ORGANIZATIONS EXAMINATION GUIDELINES HANDBOOK, MANUAL TRANSMITTAL 7(10)69-38 (1991).

38. Rev. Rul. 69-545, 1969-2 C.B. 117.

- (g) unfunded deferred compensation arrangements
- (h) loans
- (i) use of hospital assets and services
- (j) conversion to nonprofit
- (3) disclosure of Form 990
- d. Joint Ventures
  - (1) connection with Medicare fraud and abuse
  - (2) fraud alert
  - (3) revenue stream ventures<sup>39</sup>
- e. Financial Analysis
- f. Balance Sheet Analysis
- g. Package Audit
- h. Unrelated Business Income Tax
  - (1) laboratory testing
  - (2) pharmacy sales
  - (3) cafeterias, coffee shops, and gift shops
  - (4) parking facility
  - (5) medical research
  - (6) laundry services
  - (7) leasing of medical buildings
  - (8) supply department
  - (9) Robinson-Patman Act "own use" rule
  - (10) 501(e) services
  - (11) Medicare income and expense allocations

The audit guidelines identify several situations that, because of their potential for abuse, will be subject to "close scrutiny," a higher standard of review than is usually applied by auditors. These include many types of physician recruitment techniques and joint ventures with taxable entities.

### III. INTEGRATED DELIVERY SYSTEMS

The continuing evolution of healthcare providers has produced numerous hybrid healthcare organizations. The latest of these to be analyzed for its ability to qualify as a tax-exempt organization is the integrated delivery system.<sup>40</sup> An integrated delivery system is generally defined as the integration of a physician group practice with a hospital or healthcare system, which system provides both

39. Gen. Couns. Mem. 39,862.

40. See generally GERALD R. PETERS, HEALTHCARE JOINT VENTURES: THE NEXT GENERATION 211-229 (1991); Gerald R. Peters et al., *A Practical Examination of the IRS and OIG Rules for Integrated Delivery Systems*, 7 EXEMPT ORGANIZATIONS TAX REV. 765 (1993).

hospital and physician services on a unified basis. While there are many possible variations of the structure of such systems, most involve the creation of a foundation that employs or contracts with a physician group.

The IRS has been actively considering the status of such systems for the last two years. It has now made its first moves in this area. On January 29, 1993, the IRS issued a determination letter to the Friendly Hills Health Care Foundation, an integrated delivery system, recognizing its exemption from federal income tax as an organization described in section 501(c)(3) of the Code.<sup>41</sup> Friendly Hills is a successful California foundation, comprised of a primary care hospital and a tertiary university medical center, that contracts with a large multi-specialty medical group for physician services.

On March 31, 1993, the IRS issued a second determination letter recognizing the tax-exempt status of an integrated delivery system, Facey Medical Foundation.<sup>42</sup> Unlike Friendly Hills, Facey evidently did not own or operate an acute care hospital. Instead, it facilitated the delivery of services to patients and enrollees of affiliated hospitals and managed care programs.

The structuring of both systems involved the acquisition of intangible assets from physicians by the exempt organization. While the IRS found that the acquisition of such assets at fair market value was consistent with exemption as a charitable organization, the HHS Office of the Inspector General took the position that payment to physicians by an integrated delivery system for the intangible assets of their practices could violate the Medicare anti-kickback statute.<sup>43</sup> Thus, as with hospital incentives to physicians, the IRS and the OIG are in conflict, leaving healthcare providers uncertain as to the lawfulness of their transactions.

The status of integrated delivery systems is of great import to healthcare providers as the healthcare industry is apparently moving in the direction of managed competition or some other form of managed care under the Clinton Administration's healthcare reform agenda. Given the role of physicians in these systems, as well

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41. 93 Tax Notes Today 40-113 (Feb. 19, 1993). See generally Michael W. Peregrine & Bernadette M. Broaccolo, *IRS Issues Guidance on Integrated Delivery Systems*, 7 EXEMPT ORGANIZATIONS TAX REV. 391 (1993).

42. 93 Tax Notes Today 83-116 (Apr. 15, 1993). See generally Michael W. Peregrine & Bernadette M. Broaccolo, *New "IDS" Determination Letter Offers Promise, Sparks Controversy*, 7 EXEMPT ORGANIZATIONS TAX REV. 757 (1993).

43. *HHS' Thornton Writes IRS' Sullivan*, 7 EXEMPT ORGANIZATIONS TAX REV. 705 (1993).

as issues such as asset valuation and physician compensation, there has been a great deal of uncertainty as to whether these systems would be recognized as tax-exempt by the IRS. While the IRS recognized Friendly Hills and Facey Medical Foundation as tax-exempt organizations, it is clear that the IRS' review of these systems is continuing. It is anticipated that in the near future it will issue a GCM and provide additional guidance on this matter.

#### IV. CONCLUSION

The developments described above are merely the first installment of what is expected to be continued activism by the Internal Revenue Service in the healthcare arena. General counsel memoranda are now the primary exempt organizations policy forum of the IRS, and additional GCMs are expected to be issued in 1993 in areas such as physician recruitment, health maintenance organizations, tax-exempt clinics, and integrated delivery systems. Further development of the Hospital Audit Guidelines, as well as the issuance of additional audit guidelines, are also anticipated.