

Checkpoint Contents
Federal Library
Federal Editorial Materials
WG&L Journals
Taxation of Exempts/Journal of Taxation of Exempt Organizations (WG&L)
Taxation of Exempts (WG&L)
2009
Volume 20, Number 06, May/June 2009
Columns
IRS Standards for Clinic/Group Practice Exempt Status, Taxation of
Exempts (WG&L), May/Jun 2009

HEALTH CARE ORGANIZATIONS

IRS Standards for Clinic/Group Practice Exempt Status

Author: CHRISTOPHER M. JEDREY and CHARLES R. BUCK

CHRISTOPHER M. JEDREY is the Partner-in-Charge of, and CHARLES R. BUCK is a partner in, the Health Law Department in the Boston Office of McDermott Will & Emery. They can be contacted at cjedrey@mwe.com and cbuck@mwe.com, respectively.

[pg 35]

The highly-regarded "Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations" (the "Guide")¹ includes as Principle 12 that: "A substantial majority of the board of a public charity, usually meaning at least two-thirds of the members, should be independent." Independence, for this purpose, is defined as not being an employee of the organization or otherwise receiving, directly or indirectly (e.g., through a family member), material financial benefits from the organization. The Guide acknowledges exceptions for private foundations and certain medical research organizations, supporting organizations, religious organizations, and charitable trusts.

The nonprofit world is moving toward the adoption of "best practice" governance standards. Congress, the IRS, and state regulators are also moving toward strongly recommending or even mandating such standards. The nonprofit world, however, is very large and very diverse in its structures and purposes, and the governance needs of its constituents are accordingly varied. For example, the Guide does not acknowledge an exception for tax-exempt physician organizations, which exist in large numbers in both academic and community settings, and which often have physician-controlled boards. The application of the "board independence" standard to tax-exempt physician organizations would upset a careful balance that the IRS has established between accepting physician control as the most effective way for these organizations to achieve their clinical and other charitable goals, and placing limitations on that control with respect to the determination of physician compensation.

While the IRS itself recommends majority independent boards in its recently issued and somewhat controversial guidance on governance,² the IRS has also long recognized that such physician organizations, with appropriate safeguards in place, can best achieve their tax-exempt purposes under the control of their physician employees. In particular, while the IRS prefers that boards of tax-exempt hospitals be comprised principally of independent members, it historically has not imposed such a requirement on clinics, faculty practice foundations, or other tax-exempt physician organizations.

The IRS position on physician presence on the boards of Section 501(c)(3) health care organizations has had a long evolution but has never clearly been stated in any precedential guidance. Furthermore, most of the guidance available, whether precedential or not, relates specifically to hospitals, not to clinics, faculty practice foundations, or other types of tax-exempt physician organizations.

The IRS released its first written position with respect to the requirements applicable to a hospital seeking tax-exempt status under Section 501(c)(3) in 1956. In Rev. Rul. 56-185, 1956-1 CB 202, exemption for hospitals was based solely on whether the hospital provided care to the poor to the extent of its financial ability to do so. There was no discussion concerning the composition of the board.

In 1969, the IRS issued Rev. Rul. 69-545, 1969-2 CB 117, which both modified Rev. Rul. 56-185 (by removing the requirement to care for poor patients at no charge or below cost) and provided other grounds for how hospitals could qualify for tax-exempt status under Section 501(c)(3). In Rev. Rul. 69-545, which is still in effect today, the IRS compared a hospital that qualified for tax-exempt status under Section 501(c)(3) with a hospital that did not qualify. The IRS listed five factors that it found relevant to its determination that the first hospital was tax exempt.³ Four of the five favorable factors related to the operations of the hospital. The other favorable factor, however, was that the hospital was governed by a board of "prominent citizens in the community." By contrast, the hospital that did not qualify for tax-exempt status was governed by "the five doctors [who were responsible for all admissions to the hospital], their accountant, and their lawyer." This distinction between the governance of the "good" hospital and the

[pg 36]

governance of the "bad" hospital is the basis of the IRS's current restrictive position on the presence of physicians on the boards of tax-exempt hospitals.⁴

For a time there was a question as to whether a hospital seeking tax-exempt status must have all five favorable factors (including the community board factor). In 1983, the IRS clarified Rev. Rul. 69-545 by releasing Rev. Rul. 83-157, 1983-2 CB 94. The new ruling stated explicitly that a hospital does not have to have all five favorable factors in order to qualify for tax-exempt status. Rather, the IRS said, its determination of tax-exempt status was based on the totality of the facts and circumstances. The IRS also stated that a significant factor in demonstrating that a hospital was operating for the benefit of the community—and, therefore, entitled to tax-exempt status—was a hospital with "a board of directors drawn from the community." There is no requirement,

however, that a tax-exempt hospital (or any other tax-exempt health care organization) have a majority of its board comprised of non-physicians.

Between 1979 and 1981, the IRS denied tax-exempt status to three faculty practice foundations—i.e., organizations that employ physicians with medical staff privileges at a teaching hospital and faculty appointments at a medical school affiliated with the hospital.⁵ In each case, the Tax Court reversed the Service's denial, and granted tax-exempt status to the organization based on its support of the teaching, research, and clinical care mission of the teaching hospital and medical school. In each case, the IRS noted that the organization was controlled by its employed physicians, but had made arrangements to ensure that the physicians did not finally determine their own compensation (e.g., through the use of an independent compensation committee or medical school compensation guidelines). Because the determinations of tax-exempt status for the so-called "great clinics" (e.g., Mayo, Lahey, Geisinger) were made so long ago, and through an administrative process that did not generate precedential or other guidance, these cases remain the best guidance for physician organizations seeking tax-exempt status. Moreover, since these decisions, the IRS has granted tax-exempt status to many community hospital-affiliated group practices. These organizations provide clinical care at convenient locations in the community but, in most cases, have little or no involvement in teaching and research. These organizations, many of which have physician or physician-majority boards, usually rely on independent compensation committees to approve physician compensation.

In private letter rulings issued the early 1990s, the IRS issued its most restrictive position with respect to the ability of physicians to serve on the boards of certain health care organizations—the "20% safe harbor." Under the 20% safe harbor, a health care organization seeking tax-exempt status was required to include a provision in its governing documents that limited physician membership on the board of directors to 20% or less of the total number of directors. In the 1994 IRS publication that set it out, the 20% safe harbor was to be limited to group practices that were part of integrated delivery systems.⁶ This safe harbor was subject to much criticism. In particular, the critics asserted that physician control was appropriate for some tax-exempt health care organizations, and noted that most tax-exempt faculty practice foundations and clinics did not comply with the safe harbor and could not do so without making fundamental, and unhelpful, changes to their governance. The IRS responded by stating that the 20% safe harbor was a standard for initial determinations of tax-exempt status, and was not intended to be applied to existing tax-exempt health care organizations.

[pg 37]

In 1997, the IRS supplemented the 20% safe harbor with a policy more consistent with its historical position on tax-exempt status requirements for physician organizations. It did so in an article on tax-exempt status requirements for certain health care organizations in its Continuing Professional Education (CPE) text in which board composition was again discussed.⁷ In this CPE article, the IRS set out its "Community Board and Conflicts of Interest Policy." According to the IRS, this policy is to be "generally applied" by IRS agents in reviewing exemption applications for health care organizations that are part of larger health care systems. Under this policy, to be recognized as tax exempt under Section 501(c)(3), the organization must demonstrate that it has a "community board" and a substantial conflict of interest policy, like the model

policy attached to the CPE article. "Community board" is defined as a board in which independent members comprise a majority. Practicing physicians associated with (e.g., employed by, on the medical staff of) the organization are not considered independent under this policy and so, while they may serve on the board, they must comprise less than 50% of its members. The policy also stated, however, that for existing health care organizations, the IRS will consider historic development and the record of charitable operations to determine whether a community board is necessary. Specifically, the IRS stated that "[w]here facts and circumstances, such as a long history of community service and the absence of inurement or private benefit, provide assurance that the community benefit standard is satisfied, the community board standard may not be required."⁸

As noted above, the Service's concerns regarding physicians serving on the boards of tax-exempt health care organizations stems from the important decisions that boards make that could directly affect the ability of physicians to earn income by providing medical services to patients. Accordingly, to the extent that a Section 501(c)(3) organization puts in place policies and procedures designed to protect against possible abuses—specifically activities that could result in improper private benefit to physicians—the Service's concern regarding physician control over governance can be addressed. In Rev. Rul. 83-157, the IRS stated explicitly that its determination of tax-exempt status is based on the totality of facts and circumstances, not just a single factor such as board composition. To that end, if a Section 501(c)(3) physician organization (1) adopts and adheres to a substantial conflict of interest policy similar to the Service's model policy;⁹ (2) has its physician compensation reviewed and approved by an independent compensation committee or other disinterested person (e.g., a medical school dean);¹⁰ and (3) carries on additional charitable activities such as teaching, research, and/or community outreach, physician control of the board should not raise significant tax-exempt status issues.

Conclusion

When it called for a two-thirds super-majority of independent directors in the "Principles for Good Governance and Ethical Practice," the Panel on the Nonprofit Sector was focused on the *ethical* operation of charities. "Ethical," in this context, means that charitable funds are devoted to charitable purposes and are not misapplied in a non-charitable manner. As stated in its Preamble, the Panel's report "[sets] forth a comprehensive set of principles to inform the field" of ethical practices. The purpose of the principles "is to reinforce a common understanding of transparency, accountability, and good governance for the sector as a whole—not only to ensure ethical and trustworthy

[pg 38]

behavior, but equally important, to spotlight strong practices that contribute to the effectiveness, durability, and broad popular support for charitable organizations of all kinds."¹¹

So while the Panel acknowledged the importance of the *effective* operation of charities, and the positive effect that ethical practices can have on efficiency, efficiency was not the focus of its principles. Ethical and effective operations are two very different matters. Indeed, the Panel questioned whether it is possible

and/or reasonable to measure the effectiveness of charitable organizations (i.e., whether the charities actually achieve their mission).¹² Health care organizations, however, already have their effectiveness actively measured and assessed. Indeed, such efforts, which are expanding rapidly, are seen by many as a key component of meaningful health care reform. While there are concerns about the fairness of these assessments, there is a broad consensus that American health care consumers are not getting their money's worth from either charitable or non-charitable providers. As the Institute of Medicine stated in the very first line of its seminal report: "Fundamental changes are needed in the organization and delivery of health care in the United States."¹³ The report takes its title from the conclusion that: "Between the health care we have and the health care we could have lies not just a gap, but a chasm."¹⁴

The problems do not, however, appear to be tied to physicians' control or lack of control over health care organizations. The changes needed in the health care system instead go to the core of how health care is delivered. To champion and drive such changes, charities that provide health care services will need leadership that understands the failings of the current system and how such failings can be remedied. That is, charities that provide health care services will need practicing clinicians in board leadership positions, because such clinicians are often the best source of such knowledge. The major challenges that nonprofit health care providers face with respect to their effectiveness, and the imperative that they serve as leaders of fundamental health care delivery reform, do not compel a conclusion that such organizations must be controlled by physicians (i.e., non-independent board members). But those challenges do compel a conclusion that physician control of charitable health care providers should not be prohibited unless it can be demonstrated that other, substantial harms will stem from such control. As the IRS has recognized, the existence of other procedures and controls can prevent such harms while still permitting charitable health care providers to take full advantage of the leadership physicians can provide.¹⁵ A diverse and robust non-profit sector that permits as broad a range of leadership models as possible will offer the best hope that the health system will be equal to the daunting challenges ahead.

¹

The Guide was released by the Panel on the Nonprofit Sector, which was convened by Independent Sector, in 2007. See also www.nonprofitpanel.org.

²

IRS, "Governance and Related Topics—501(c)(3) Organizations" (2/4/08), available at http://www.irs.gov/pub/irs-tege/governance_practices.pdf. See also the Advisory Committee on Tax-Exempt and Government Entities, "The Appropriate Role of the Internal Revenue Service With Respect to Tax-Exempt Organization Good Governance Issues" (6/11/08).

³

In GCM 32002, 5/31/61, as updated by GCM 34905, 6/9/72, the IRS indicated that the factors set out in Rev. Rul. 69-545 should be used as well in making exempt status determinations for clinics and other physician organizations.

⁴

See, for example, the IRS's Hospital Audit Guidelines, Exempt Organizations Examination Guidelines Handbook, pages 7(10), 69-27-7(10). 69-30.7, §333.1(1)(a).

⁵

B.H.W. Anesthesia Foundation, 72 TC 681 (1979); University of Mass. Med. School Group. Pract., 74 TC 1299 (1980); University of Md. Physicians, P.A., TC Memo 1981-23, PH TCM ¶81023, 41 CCH TCM 732 .

6
See, Kaiser and Reilly, "Integrated Delivery Systems," *Exempt Organizations Continuing Professional Educational Technical Instruction Program for FY 1994* (1993). While revenue rulings are binding precedent on the IRS (but not taxpayers), CPE articles are not precedential and may not be relied on by either the IRS or the taxpayer as official guidance. Nonetheless, these articles can provide insight into how the IRS views various fact patterns.

7
Brauer and Kaiser, "Tax-Exempt Health Care Organizations Community Board And Conflicts Of Interest Policy," *Exempt Organizations Continuing Professional Educational Technical Instruction Program for FY 1997* (1996). The IRS described its "Community Board and Conflicts of Interest Policy" as an alternative to the 20% safe harbor. According to the article, a physician organization with a physician or physician-majority board, but subject to the authority of a community board at the parent-company level, could still comply with community board standard.

8
See, for example, GCM 31688, 5/17/60; GCM 39763, 10/13/88 ("by the early 1960s, however, the [IRS and its Office of Chief Counsel] had decided that physician control, without a showing of actual operation, was not sufficient to deny exemption to a provider of medical prepayment plans.") Also, in Kaiser and Friedlander, "Corporate Practice of Medicine," *Exempt Organizations Continuing Professional Educational Technical Instruction Program for FY 2000* (1999), the IRS acknowledged that, in some states, physicians can only practice medicine through professional corporations, which by statute must have physician or physician-majority boards, and concluded that, with appropriate safeguards in place, such corporations could qualify for tax-exempt status. See also University of Md. Physicians, P.A., *supra* note 5.

9
See Brauer and Kaiser, *supra* note 7.

10
See, for example, Brauer and Kaiser, *supra* note 7, at 30-33, and B.H.W. Anesthesia Foundation, *supra* note 5.

11
Guide, *supra* note 1, at 3.

12
According to the Panel's report, "it will take further research" to determine whether effectiveness can be fairly assessed. Similarly, in its 2005 report to Congress, the Panel stated: "Because of the diversity of the sector and the subjective nature of performance measures, requiring more detailed statements of performance measures on the Forms would not provide meaningful information for the public or regulators." Panel on the Nonprofit Sector, "Strengthening Transparency, Governance, and Accountability of Charitable Organizations," a final report to Congress and the Nonprofit Sector, June 2005.

13
The Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (National Academy Press, 2001).

14
Id. at Executive Summary, page 1.

15
In this respect it is interesting to note that in its 2005 report, the Panel on the Nonprofit Sector recommended that "at least one-third of the members of a qualifying public charity's governing board be independent." The Guide, published two years later, does not explain why this recommendation was

changed.

© 2010 Thomson Reuters/RIA. All rights reserved.