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An Overview of the “Community Benefit” Standard of Federal Tax Exempt Status

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Few issues are more critical to the financial stability and mission credibility of nonprofit hospitals than the “Community Benefit” standard of tax-exempt status. This is particularly the case given the ongoing public policy debate as to its continued viability. Fiduciary obligations mandate that governing boards take a leadership role on this key issue in order to provide strategic direction and advise executive leadership on operational responses.

Overview

The Community Benefit standard was adopted in 1969 by the Internal Revenue Service (IRS) as the basis for recognizing hospitals as income tax-exempt under Section 501(c)(3) of the Internal Revenue Code. Thus, it was a regulatory (as opposed to legislative) manner of addressing tax exemption standards. Now, almost 40 years later, questions about whether and how hospitals are meeting that standard have been raised in the Congress and the federal agencies that oversee it.

The Current Connection

This new focus on the Community Benefit standard is arising for three basic reasons. *First*, controversial class action and related litigation in recent years has targeted the charity care, billing and collection practices of nonprofit hospitals and health systems. While these cases have been defeated “across the board,” they have been successful to the extent that they have turned a spotlight on the arguably inconsistent manner with which nonprofit hospitals address these issues. *Second*, previous sessions of Congress (particularly the Senate Finance and House Ways and Means Committees) focused on the issue as part of its broader oversight of nonprofit, tax-exempt organizations, and their continuing claim to favorable tax exemptions. *Third*, various policy makers—including the head of the Government Accountability Office, the Commissioner of the Internal Revenue Service, and the then-Chair of the Senate Finance Committee—have adopted a similarly skeptical perspective of the larger question of whether federal tax exemption is justified. In various ways, each has indicated that it is becoming increasingly difficult to differentiate nonprofit healthcare providers from for-profit healthcare providers when it comes to recognition of tax-exempt status.

What is the Proper Board Focus?

Evolving concepts of fiduciary duty make it clear that governing board members of nonprofit hospitals must “tackle” this issue and bring it squarely into the board room. The director of a nonprofit corporation has a basic fiduciary duty to preserve the charitable mission of the organization as set forth in its articles of incorporation and/or bylaws. For most nonprofit hospitals, this purpose is likely to incorporate the charitable promotion of health of the communities served by the organization. For some nonprofits, this mission may be implemented through the “prism” of the tenets of a particular religious sponsorship. The director’s duty is to assure that the corporation by its actions furthers those charitable purposes.

The director’s obligation to monitor the financial solvency of the organization is subsumed within the fiduciary duty of care. This basic duty requires directors to act (1) in good faith,



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(2) with the care an ordinarily prudent person would exercise in like circumstances, and (3) in a manner that they reasonably believe to be in the best interests of the corporation. This duty of care extends both to the director's consideration of transactions and other major decisions as they come before the board, as well as to the general oversight of the day-to-day business operations of the corporation. Directors' obligations to monitor the financial solvency of the organization arise within the context of the latter "oversight" function. Assuring the availability and preservation of the federal income tax-exemption of the hospital (as well as related favorable tax benefits) must fairly be regarded as being subsumed within the director's oversight function under the duty of care.

Thus, the obligation of the governing board to be attentive to Community Benefit standard compliance is based on two fundamental concepts of fiduciary duty—the duty of obedience to charitable mission and the oversight function of the duty of care.

Evolving Controversy

Further evidence of the Community Benefit controversy can be found in recent levels of legislative and regulatory activity. Within the last two years, (a) the IRS has conducted its first comprehensive review of community benefit by sending a *Community Benefit Compliance Check Questionnaire* to some 550 nonprofit hospitals, inquiring about the ways in which hospitals provided benefits to their respective communities and related issues such as board composition and executive compensation; (b) both the Senate Finance and the House Ways and Means Committees have conducted several hearings on issues associated with the Community Benefit standard; (c) issuance of new Intermediate Sanctions regulations describing the related risk to tax-exempt status; (d) the IRS has conducted "soft contact" audits of nonprofit hospitals on the specific issue of executive compensation—a subject of interest to the entire tax-exempt community; and (e) the IRS has commenced an education and compliance initiative focused on corporate governance of tax-exempt hospitals and the relationship to tax exemption compliance.

Basic Exemption Concepts

In order for governing board members to properly respond and provide direction to executive leadership with respect to the Community Benefit standard controversy, they must have an understanding of the specific components of the standard as the IRS perceives it.

The Community Benefit standard is the most common test applied by the IRS to determine whether a hospital (as well as a clinic or other healthcare provider) is operated to promote health in a manner that serves a charitable purpose and, accordingly, merits tax-exempt status.

The Community Benefit standard has its origins in a Revenue Ruling (which does not involve Congressional approval or input) adopted in 1969. Prior to the 1969 Ruling, the sole basis under which hospitals could obtain charitable tax-exempt status was the "relief of the poor" standard for exemption. Under this earlier standard, sometimes referred to as the Financial Ability Test, tax-exempt status was conditioned on the extent to which a hospital provided uncompensated care to patients unable to pay (either without charge or at below-rates cost). In contrast to the Financial Ability Test, the Community Benefit standard (while recognizing the relevance of charity care) takes into account a series of additional factors that speak to the operation of the hospital for the benefit of the community as a whole.



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Form 990

The new Form 990, introduced by the IRS in December, 2007, has significant implications for the determination of community benefit as reported to the IRS. The majority of the community benefit-related questions are contained in “Schedule H—Hospitals,” which consists of six specific sections and related worksheets.

Part I of Schedule H requires reporting of the organization’s charity care policies, the availability of community benefit reports, and the cost of certain charity care and community benefit programs. “Charity care” is defined for purposes of Schedule H as “free or discounted health services provided to persons who meet the organization’s criteria for financial assistance and are thereby deemed unable to pay for all or a portion of the services.” This definition of charity care excludes bad debt or uncollectible charges, the difference between the cost of care provided under governmental care and the revenue derived therefrom, and third-party contractual adjustments.

Part II calls for the reporting of costs associated with the organization’s community building activities (*i.e.*, activities it engaged in to protect or improve the community’s health or safety). These activities include the provision or rehabilitation of housing for vulnerable populations; economic development; community support (*e.g.*, public health emergency activities); environmental improvements; leadership development and training for community members; coalition building (*e.g.*, collaborative efforts with the community to address health and safety issues); community health improvement advocacy (*e.g.*, efforts to support policies and programs to safeguard and improve public health and access to healthcare services); and workforce development (including recruitment of physicians and other healthcare professionals to medical shortage areas).

Part III requires reporting of bad debt expense information; Part IV inquires about the organization’s collection practices; Part V requires the name and address of each of the organization’s licensed healthcare facilities; and Part VI allows for the submission of supplemental information relating to community benefit. For example, information is requested concerning the manner in which the organization determines eligibility for free or discounted care under the charity care policy; how it evaluates community need; how it informs and educates patients and persons regarding their eligibility for financial assistance; the communities served by the organization; and how the organization’s community building activities (see Part II, above) promote community health. Part III also asks the organization to confirm compliance with core Rev. Rul. 69-545 criteria (*e.g.*, board control in a majority of independent community leaders; an “open” medical staff; and whether and how the organization applies surplus funds to improvements in patient care, medical education and research).

Thus, both the Schedule H and the specific instructions for its completion combine to provide useful guidance on how the IRS is likely to apply the community benefit standard of exemption.

GAO Report

Further contributing to the discussion is the October 14, 2008 release of the Government Accountability Office’s report, *Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements*. GAO found that among the standards and guidance used by nonprofit hospitals to determine community benefit, consensus exists on



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the following definitions: charity care, the unreimbursed cost of means-tested government healthcare programs (programs for which eligibility is based on financial need, such as Medicaid), and several other activities that serve as community benefit. The GAO also found that no consensus exists among hospitals to define bad debt and the unreimbursed cost of Medicare as community benefit. As a result, differences in the activities nonprofit hospitals define as community benefit create material variations in the amount of community benefit they report.¹

Specific Exemption Details

At its core, the Community Benefit standard is a facts and circumstances test that examines a variety of factors to determine whether a healthcare provider should be tax-exempt. As articulated in the 1969 Ruling, the following five specific criteria have great importance under the Community Benefit standard.

- **Community Board:** Whether the hospital maintains a governing board (e.g., board of directors, board of trustees) that is composed of prominent civic/community leaders rather than persons professionally connected to the hospital (e.g., hospital executives, physicians). Such independent “community leaders” must comprise a majority of the hospital’s board. Physicians on the hospital’s medical staff, corporate executives, department heads, and other hospital employees are not considered independent because they are deemed to have a “close and continuing connection” with the hospital. These non-independent persons are not prohibited from board service; rather, they are prohibited from constituting a majority of the board. Other directors who may have some business dealings with the hospital are generally to be included within the majority.

“Control” for purposes of the Community Board criterion references authority over structural (e.g., appoint or remove directors) and financial (e.g., approve budgets and strategic plans) aspects of hospital operations. The governing board should be subject to a conflict of interest policy to help avoid potential private inurement, private benefit and intermediate sanctions violations. Satisfaction of this Community Board criterion is considered by the IRS to be a significant factor in determining community benefit.

- **Open Staff:** Whether the hospital medical staff privileges allow all qualified physicians, including those who are not hospital employees, to practice at the hospital. The goal of this particular criterion is to assure that the hospital furthers the interests of the community rather than the interests of a select group of physicians. In this regard, “open staff privileges” is not intended to mean there can be no restrictions on staff membership. A hospital may, consistent with the terms of tax-exempt status, limit medical staff membership based on candidates satisfying professional, regulatory and board-based standards of care, medical education, licensure and accreditation, as well as the hospital’s practice and capacity limitations.

¹ www.gao.gov/cgi-bin/getrpt?GAO-08-880



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- **Emergency Room:** Whether the hospital operates a full-time emergency room open to all patients, regardless of their ability to pay. Key factors noted by the IRS in determining whether a hospital meets this criterion include: (a) no one is denied treatment in the emergency room for reasons related to their ability to pay for services and (b) the hospital's emergency room generally has patient transportation arrangements with local police, fire and ambulance services. In 1983, the IRS issued another Revenue Ruling indicating that the existence of an emergency room was not an absolute condition of exemption if the emergency needs of the hospital's community were already satisfied.
- **Non-Emergency Care:** Whether the hospital provides non-emergency care to all patients in the community able to pay for services rendered, either privately or through third parties such as Medicare or Medicaid. A hospital's participation in Medicare or Medicaid is regarded by the IRS to be a key factor that assists in establishing that a hospital satisfies the Community Benefit standard.
- **Use of Surplus Funds:** Whether the hospital uses its surplus funds to improve the quality of patient care, expand its facilities, and advance its medical training education and research programs.
- **Other Favorable Factors:** The failure to have any or all of the above five characteristics, however, is not determinative of whether an organization is entitled to recognition as an organization described in Section 501(c)(3). Hospitals may also demonstrate community benefit through the provision of other services that are designed to serve the healthcare needs of the community.
- **Charity Care:** Whether the hospital serves a broad cross-section of the community through research or charity care. The IRS has stated that the provision of charity care is an important factor in measuring compliance with the Community Benefit standard. Many hospitals seek to satisfy this criterion by the adoption of a charity care policy designed to assist the healthcare needs of the medically indigent members of their communities.

From the IRS' perspective, a charity care policy must be formally adopted by the hospital and must include objective standards to be applied in making delivery of care decisions. The IRS does not recognize "bad debt" as the provision of charity care. The IRS views a charity care policy as providing for certain classes of patients to receive free or reduced-cost care (often according to use of a sliding scale) in accordance with a patient's ability to pay. The IRS expects hospitals to be able to describe the amounts expended (or expected to be expended) on charity care.

Other favorable characteristics under the Community Benefit standard not expressly discussed in the 1969 Ruling include free medical education programs (e.g., cardiac information, pregnancy counseling), seminars (e.g., stop smoking seminars) or community health fairs (e.g., blood pressure or cholesterol testing). The provision of these types of services, when combined with the other factors set forth above, can help establish the requisite community benefit required for tax-exemption.

Helpful Resources

The governing board's role is principally to provide strategic leadership in support of the organization's compliance with the Community Benefit standard and other mission-related duties and obligations. An enhanced appreciation of the public policy and regulatory challenges



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associated with tax-exempt status will better position the board to provide advice and direction to the executive management team as they respond on a day-to-day basis to these challenges.

Several key resources exist from which the governing board may educate itself concerning Community Benefit issues and possible responses. The American Hospital Association (AHA), for example, has published a series of materials which provide related guidance to board and executive management. These include AHA's *Hospital Billing and Collection Practices Statement of Principles and Guidelines*, together with hospital assistance and tax-exemption policies and procedures that build on those guidelines. Also relevant is the Community Benefit Reporting document (containing specific Community Benefit guidelines) published by Catholic Health Association/Voluntary Hospitals of America.

Conclusion

Issues associated with the Community Benefit standard of federal tax exemption are of vital importance to nonprofit hospitals. The fiduciary duties owed by governing boards subsume the obligation to oversee preservation of tax-exempt status. Thus, board members should take a prominent leadership role in the manner in which their institution complies with the Community Benefit standard and corollary public policy issues.

Note: Mr. Peregrine's partner, Robert C. Louthian, made significant contributions to the preparation of this chapter. The text of this chapter originally appeared in relevant part in the June, 2007 edition of *Trustee* magazine and is re-styled above with specific permission.

Bibliography

1. Rev. Rul. 69.545, 1969-2 C.B. 117.
2. Janet E. Gitterman and Marvin Friedlander, "Health Care Provider Reference Guide," IRS Continuing Professional Education Technical Instruction Program for FY 2004.
3. Lawrence M. Brauer and Charles F. Kaiser, "Tax Exempt Health Care Organizations Community Board and Conflicts of Interest Policy", IRS Exempt Organizations Continuing Professional Education Technical Instruction Program for FY 1997.