D. UPDATE ON HEALTH CARE

by
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1. Introduction

This update discusses health maintenance organizations, joint ventures, health clubs, behavioral health care consortia, gainsharing, and the community benefit standard. The community benefit standard discussion reviews its application to hospitals and other health care providers, including the role of a charity care policy.

2. Health Maintenance Organizations (HMOs)

A. I.R.C. 501(m)(1)

In 1986, Congress added I.R.C. 501(m)(1) to provide that an organization described in I.R.C. 501(c)(3) or I.R.C. 501(c)(4) does not qualify for exemption if it provides "commercial-type insurance" as a substantial part of its activities. Unfortunately, the statute does not define "commercial-type insurance" in the HMO context, although I.R.C. 501(m)(3)(B) provides it is not "incidental health insurance provided by a health maintenance organization of a kind customarily provided by such organizations." We do not interpret this exception as evidence of congressional intent to generally except HMOs from the proscription of I.R.C. 501(m)(1).

As this article is written, three HMO-related cases are pending in the U.S. Tax Court: *IHC Group, Inc*. (Docket No. 14599-99X*), IHC Health Plans, Inc*. (Docket No. 14600-99X), and *IHC Care, Inc.* (Docket No. 14601-99X). These cases are the first HMO cases under I.R.C. 501(c)(3) since Geisinger Health Plan v. Commissioner, 30 F.3d 494 (3d Cir. 1994). They are also the first cases to interpret I.R.C. 501(m) in the HMO context. The principal issues in each case are whether the organization is described in I.R.C. 501(c)(3), either on its own or as an integral part of an I.R.C. 501(c)(3) organization, and, if so, whether I.R.C. 501(m)(1) precludes exemption.

IRM 7.8.1, Exempt Organizations Examinations Guidelines Handbook, Chapter 27, Health Maintenance Organizations, provides compensation guidelines to determine if an HMO provides "commercial - type insurance" as a substantial part of its activities. However, each case must be decided on all the facts and circumstances.

A major consideration under the compensation guidelines is how the HMO contracts with its primary care providers. IRM 7.8.1.27.10.1 states that one factor demonstrating an HMO is not providing commercial-type insurance is that the HMO has shifted a significant portion of its risk of loss to its primary care providers. *See* Rev. Rul. 68-27,

1968-1 C.B. 315. An example of risk shifting is an HMO that compensates contracting primary care providers using capitated fees, where the HMO pays the providers a predetermined fixed amount per patient regardless of the actual primary care costs incurred for each patient. Another example is an HMO that compensates contracting primary care providers using a fee-for-service method, based on a substantially discounted fee schedule, and withholding a substantial portion of the fees paid.

Examiners should apply the compensation guidelines to HMOs that use employed or contracted primary care providers as "gatekeepers." Under the gatekeeper concept, enrollees choose or are assigned a primary care provider and must obtain a referral from the primary care provider to use inpatient or outpatient hospital services, specialist physician services, or ancillary health care services. *See* IRM 7.8.1.27.3(1)c.

An HMO satisfies I.R.C. 501(m)(1) if substantially all the compensation it pays primary care gatekeepers meets these compensation guidelines, and the HMO also meets the other examination guidelines. A determination whether an HMO complies with the compensation guidelines need consider only the compensation the HMO pays to primary care providers. If more than a substantial part of the compensation the HMO pays primary care gatekeepers does not meet these compensation guidelines, further inquiry is needed. An HMO that does not meet the guidelines may still satisfy I.R.C. 501(m)(1) by establishing that no substantial part of its activities consists of providing commercial-type insurance. To determine risk shifting under Rev. Rul. 68-27, supra, outside the compensation guidelines, one must consider an HMO’s method for compensating all its health care providers, and not just its primary care providers.

HMOs applying for exemption that have not complied with the compensation guidelines in the past are urged to comply with these guidelines prospectively. For example, the Service would give favorable consideration under the guidelines if an HMO demonstrates that its projected operations will likely satisfy the guidelines, even if its current operations do not.

B. Deficit Sharing

IRM 7.8.1.27.10.2(2) states:

> An HMO that compensates providers using a fee-for-service arrangement may enter into an arrangement with the providers for the providers to share a portion of the HMO's operating losses. Whether a deficit sharing arrangement that an HMO has with its providers shifts a significant portion of the HMO's risk of loss depends on all the facts and circumstances.

a. An HMO that has a deficit sharing arrangement with a related organization does not shift a significant portion of its risk of loss because the related organization is part of the HMO's economic family. See Rev. Rul. 77-316, 1977-2 C.B. 53; Rev. Rul. 78-338, 1978-2 C.B. 107.

Rev. Rul. 2001-31, 2001-26 I.R.B. 1348 (June 4, 2001), obsoleted Rev. Rul. 77-316 and modified Rev. Rul. 78-338. Rev. Rul. 2001-31 stated that because no court has fully accepted the economic family theory in Rev. Rul. 77-316, 1977-2 C.B. 53, to address a captive insurance transaction, the Service would no longer invoke it in those cases. However, Rev. Rul. 2001-31 points out that the Service may continue to challenge certain captive insurance transactions on the facts and circumstances. *See*, *e.g.*, Malone & Hyde, 62 F.3d 835 (6th Cir. 1995), in which the court held that brother-sister transactions were not insurance because the taxpayer guaranteed the thinly-capitalized and loosely-regulated captive's performance, and Clougherty Packing Co. v. Commissioner, 811 F.2d 1297 (9th Cir. 1987), in which the court applied a balance sheet test, rather than the economic family theory, to find that a transaction between parent and subsidiary was not insurance.

In light of Rev. Rul. 2001-31, examiners should consult with EO Technical in determining if an HMO's deficit sharing arrangement shifts significant risk of loss to a related organization.

C. Revocation Issues

If an examiner determines that an HMO does not satisfy I.R.C. 501(c)(3) or I.R.C. 501(m)(1), and proposes to revoke exemption, the examiner should consider whether retroactive relief under I.R.C. 7805(b) might be appropriate to make revocation prospective from the date the Service proposes revocation, and whether to suggest that the organization request relief. Section 13.09 of Rev. Proc. 2001-4, 2001-1 I.R.B. 121, 153, (or the annual update) describes procedures for requesting I.R.C. 7805(b) relief. Under Delegation Order 96 (Rev. 13) (Effective 12/02/96, updated 10/02/00), IRM 1.2.2.46, the TE/GE Division Commissioner must approve all requests for retroactive relief under I.R.C. 7805(b).

If I.R.C. 7805(b) relief is not granted and the examiner determines that the organization was an insurance company during the revocation period, the organization is subject to tax under subchapter L of the Code. The organization should file Form 1120-PC for each open tax year and for future years.

Even if the TE/GE Division Commissioner approves I.R.C. 7805(b) relief limiting the retroactive effect of revocation, the organization is still subject to unrelated business income tax on any unrelated business income during the relief period unless the I.R.C.

7805(b) relief includes tax under I.R.C. 501(m)(2). *See* Rev. Rul. 78-289, 1978-2 C.B. 180, in which an organization whose I.R.C. 501(c)(3) exempt status was revoked prospectively under I.R.C. 7805(b), but which carried on an unrelated trade or business during the relief period, was subject to tax on the unrelated trade or business income earned during that period. Any unrelated business income the organization earned during the relief period from an activity that constituted insurance would be subject to tax under subchapter L, rather than I.R.C. 511. I.R.C. 501(m)(2). For each of the tax years during the relief period, the organization should report all its unrelated business income on Form 990-T, whether or not it has insurance income. If the organization has insurance income, it may use Form 1120-PC as a supporting worksheet, but should not separately file Form 1120-PC.

An HMO whose exemption under I.R.C. 501(c)(3) has been revoked either retroactively or prospectively may be able to satisfy I.R.C. 501(c)(4) and I.R.C. 501(m)(1) in the future. In that event, even if I.R.C. 7805(b) relief has been approved, an organization that wants the Service to recognize it as tax-exempt under I.R.C. 501(c)(4) prospectively should submit a completed Form 1024. Examiners should not use Form 6018 (Consent to Proposed Adverse Action) to change a revoked organization's status to I.R.C. 501(c)(4).

3. Joint Venture Arrangements

The 1999 CPE and 2000 CPE texts discussed joint ventures in the health care area. These two articles detailed the structures, issues, analysis, and guidance regarding these transactions.

Rev. Rul. 98-15, 1998-1 C.B. 718, provides examples illustrating whether nonprofit hospitals that participate in joint ventures with for-profit entities continue to qualify for exemption under I.R.C. 501(c)(3). Rev. Rul. 98-15 analyzes two fact patterns of whole hospital joint ventures between an exempt hospital and a for-profit entity. The joint venture discussed in *Situation 1* satisfies the requirements of I.R.C. 501 (c)(3) for the exempt partner. *Situation 2* describes a joint venture that causes the exempt participant to violate the requirements for continuing exemption.

The Service has conducted and participated in CEP exams involving whole hospital joint venture arrangements. It has continued to consider exemption applications from organizations involved in ancillary joint ventures.

A. Whole Hospital Joint Ventures

Several news reports in the past year have described whole hospital joint ventures that have unwound or are unwinding. In addition, one hospital, St. David's Health

System, Inc. ("St. David's"), that was revoked because of its participation in a whole hospital joint venture, has filed a refund suit in the Western District of Texas (W.D. Texas 01-CV-46), contesting revocation and the resulting tax assessment.

St. David's Health System, Inc. v. United States

St. David's formed a partnership with Round Rock Hospital, an affiliate of HCA, formerly known as Columbia/HCA, to operate the partners' hospitals and related health care properties. Another HCA affiliate managed the partnership. The Service examined St. David's for years 1996 to 1998, and concluded it no longer qualified for exemption under I.R.C. 501(c)(3).

After paying corporate tax income, plus interest and penalties, St. David's filed a claim for refund, which the Service disallowed. It then filed a refund suit in District Court, contending the Service erred in revoking its I.R.C. 501(c)(3) exemption. As of this time, the Government has not filed its brief.

B. Other Joint Ventures

(1) Redlands Surgical Services, Inc. v. Commissioner

Redlands Surgical Services, Inc. ("Redlands") is a nonprofit subsidiary of Redlands Health System, the I.R.C. 501(c)(3) parent of a tax-exempt hospital system. Redlands entered into a general partnership with Surgical Care Affiliates ("SCA"), a for-profit entity in the business of operating surgical centers. Each partner had an equal voice in the operation of the partnership. In turn, the general partnership held a 59 percent interest as the sole general partner in a limited partnership to operate an outpatient surgical facility. Physicians owned the limited partnership interests. SCA Management Company, a for-profit subsidiary of SCA, managed the surgery center. The management agreement was renewable at the sole option of SCA Management Company, which employed all non-physician personnel at the surgery center.

The Service denied Redlands' request for recognition of exemption. The Service concluded that the joint venture benefited the for-profit partners more than incidentally, causing Redlands to operate for a substantial nonexempt purpose. The Service also concluded that the joint venture did not operate to promote the health of the community as in Rev. Rul. 69-545, 1969-2 C.B. 117. The Service found that Redlands did not have effective control nor was there any other evidence that charitable purposes took precedence over profit motives. In addition, the Service determined that Redlands was not tax-exempt as an integral part of Redlands Community Hospital or their joint parent. Redlands filed for declaratory judgment under I.R.C. 7428.

In Redlands Surgical Services, Inc. v. Commissioner, 113 T.C. 47 (1999), the Tax Court upheld the Service's denial, concluding that the limited partnership's operation of the surgical center had a purpose to benefit the for-profit partners. The court found Redlands lacked formal control over the partnerships' decisions. Redlands was a mere co-general partner, which enabled it only to veto actions. It could not initiate action. Its control was further diluted in the limited partnership. Without clear control of the partnerships and the operation of the facility, Redlands could not show it operated exclusively for charitable purposes through the joint venture operations. In addition, the fact that an SCA affiliate managed the surgical facility under a long-term management contract yielded broad powers to the manager, giving the for-profit control over the day-to-day operations and an incentive to maximize profits. Finally, the court found Redlands had no informal influence, noting that it had no resources apart from its partnership assets to effectively enable it to monitor the surgery center's operations. Thus, Redlands could not insure that charitable purposes would take precedence over for-profit motives.

In a one paragraph *per curiam* opinion, the Ninth Circuit Court of Appeals affirmed the Tax Court's decision that Redlands does not qualify for tax-exempt status under I.R.C. 501(c)(3). 242 F.3d 904 (2001). In an unpublished order dated May 30, 2001, the Ninth Circuit denied Redlands' motion for a rehearing.

(2) Falling Short of *Situation I* - What If the For-Profit Partner Manages the Venture?

In *Situation 1* of Rev. Rul. 98-15, a third party was hired to manage the venture. Although a fact pattern where the for-profit partner manages the venture makes it harder to show that the joint venture will further the exempt participant's charitable purposes, management by the for-profit partner is not necessarily fatal.

EXAMPLE: A tax-exempt I.R.C. 501(c)(3) hospital ("Hospital") formed a subsidiary organization ("Applicant") to provide home care infusion services for patients discharged from Hospital and other local tax-exempt hospitals. Applicant's sole activity is participating in a general partnership ("Partnership") with a for-profit management company ("FP") to operate the home care infusion service. Partnership uses Hospital's home health, and labor and delivery nurses.

Applicant owns 65 percent of the Partnership and FP owns 35 percent. Profits and losses are allocated in the same ratio. FP, a regional leader in the management of home infusion programs, will manage the service. The Management Agreement, which was negotiated at arm's length, sets a fixed-fee payment for management services for a five-year term that can be renewed for subsequent two-year terms by the agreement of both partners. The fee is comparable to those paid for similar services. FP is responsible

for day-to-day operations, but its control is subject to the authority of Partnership's Management Committee.

Partnership's seven-member Management Committee governs major decisions, including all policy decisions. Applicant appoints five members and FP appoints two. A quorum requires three Applicant designees and one FP designee. Most decisions require a majority vote, though certain decisions need unanimous approval. Charity care or other community benefit issues are not actions that require unanimous approval.

The Partnership Agreement provides that it is formed for charitable purposes, which take precedence over profit maximization. This provision is binding and legally enforceable under state law.

A large percentage of Partnership's patients are indigent or are covered by Medicare or Medicaid. Partnership's fees are set on a sliding fee scale based on ability to pay. Partnership has a written charity care policy that it makes known to patients.

In this example, Applicant qualifies for exemption under I.R.C. 501(c)(3). Its participation in the Partnership furthers the charitable purposes of Hospital, and allows Applicant to be operated exclusively for charitable purposes with only incidental benefit to FP. Although FP manages the day-to-day operations, Applicant controls all charity-care policy decisions and can ensure that charitable purposes prevail over private interests.

(3) Falling Short of *Situation 1* of Rev. Rul. 98-15 - Is Control Necessary?

Rev. Rul. 98-15 does not say that the tax-exempt entity must own the majority interest and control the joint venture's governing board to remain exempt under I.R.C. 501(c)(3). However, majority control by the tax-exempt partner is one of the most important favorable factors in establishing that profit motives do not subvert the charitable mission. If the tax-exempt entity lacks majority representation or vote on the board to ensure it controls major decisions, it must have another mechanism to ensure the joint venture will operate to further the exempt organization's charitable purposes. To date, the Service has recognized exemption in very few cases where the tax-exempt entity's share of the control was as low as 50 percent, and none where control was lower.

(4) Valuation

In *Situation 1* of Rev. Rul. 98-15, the tax-exempt hospital's and the for-profit entity's ownership interests in the LLC were proportionate to and equal in value to their respective contributions. A proper valuation of interests is essential in determining that ownership interests of the tax-exempt organization in the joint venture are proportionate

to and equal in value to what it has contributed to the joint venture. Otherwise, the for-profit entity might receive undue private benefit from the transaction.

If the tax-exempt hospital or health care provider contributes assets other than cash to a joint venture, it should obtain a certified appraisal by an independent third-party appraiser to ensure its contributions are valued appropriately. The tax-exempt hospital or tax-exempt health care provider should be credited with the value of any existing business contributed, including the value of the income generated by the facility. Only then can the tax-exempt hospital or health care provider evaluate if the joint venture is an appropriate way to achieve its charitable purposes, or if the transaction will provide more-than-incidental private benefit to the for-profit partners.

C. Joint Venture Checklist

The following checklist can help determine if a joint venture between a tax-exempt organization and a for-profit entity satisfies the requirements of Rev. Rul. 98-15. It is not exhaustive, nor is it conclusive as to how an organization can achieve a favorable result in a joint venture arrangement. However, it is useful to ensure compliance with *Situation 1* of Rev. Rul. 98-15.

- Did the exempt organization receive an ownership interest in the joint venture proportionate to the value of the assets it contributed?

- Does the exempt organization have voting control over the joint venture board with respect to policies and actions that affect the exempt organization's tax-exempt purposes?

- Are the representatives of the exempt organization on the joint venture board representative of the community?

- Does the exempt organization have voting control on joint venture policies and actions that affect the exempt organization's tax-exempt purposes?

- Does the joint venture agreement require the joint venture to operate its hospitals or other health care operations for charitable purposes, by community benefit standards?

- Does the joint venture agreement explicitly state that the joint venture's duty to further charitable purposes overrides its duty to operate for the financial benefit of its partners or members?

- Does the joint venture agreement have a dispute resolution provision that would cause the joint venture to satisfy charitable purposes without regard to profitability when a disagreement arises between the board and the members over the joint venture's policies or actions?

- Are the provisions in the joint venture agreement with respect to charitable activities legal, binding and enforceable under the laws of the state where the joint venture was formed?

- Does the joint venture agreement contain a non-compete provision that causes the exempt organization to yield significant market advantages and competitive benefits to the for-profit partner or member?

- Does a company related to the for-profit partner or member manage the day-to-day operations of the joint venture?

- Are the terms and conditions of the management agreement reasonable and comparable to similar arrangements in the marketplace?

- Does the management company have a binding and enforceable obligation to further the charitable purposes of the exempt organization?

- Does the exempt organization have the unilateral right to terminate the management agreement if the management company is not acting to further (or is acting contrary to) the exempt organization's charitable purposes?

- If a CEO manages the day-to-day affairs of the joint venture, does the exempt organization have the unilateral right to remove the CEO if he or she is not acting to further (or is acting contrary to) the exempt organization's charitable purposes?

4. Health Clubs

Article A. in the FY 2000 CPE text extensively discussed various issues raised by health clubs, including whether separately-organized health clubs qualify under I.R.C. 501(c)(3), and if health clubs operated by larger I.R.C. 501(c)(3) organizations are unrelated trade or business. The Service has since considered more cases that illustrate how the principles discussed in the article apply.

In PLR 200051049 (9/26/00), an I.R.C. 501(c)(3) hospital purchased a sport and fitness center providing cardiac rehabilitation services, a fitness/wellness center, a roller skating rink, and tenant services. The hospital operates the sport and fitness center as one of its activities. As part of a plan to provide continuing care to its patients and increase

wellness awareness in the community, the hospital established a cardiac rehabilitation section in the fitness center for its heart patients. The cardiac rehabilitation program starts before the patient leaves the hospital. It continues after discharge, with the center helping outpatients reach optimal function while monitoring heart rates. The organization then focuses on risk reduction and maintenance and assists patients with suspected cardiovascular disease or other risk factors. The organization permits low-risk individuals to exercise independently with the active assistance of trained medical professionals.

The state-of-the-art fitness center occupies most of the physical facility. It has an open fitness room with cardiovascular and strength equipment, an indoor track, exercise rooms, racquetball and tennis courts, an aquatic area with two pools, a nutrition center/juice bar, tanning beds, and child care areas. These services and facilities are available to members only. The wellness programs include weight management, nutrition counseling, smoking cessation programs, arthritis therapy, personal training, prenatal and postnatal exercise programs, and stress management programs. The organization also offers educational programs on disease identification and prevention, health trends, and other medically newsworthy subjects. The overall goals of the fitness center are to enhance cardiovascular, physical and psychosocial function, reduce morbidity and mortality, improve quality of life, and promote a lifelong prevention program.

Each member is entitled to a fitness assessment of various health factors. The staff of exercise physiologists then designs an individual exercise program and provides instruction about the equipment.

Membership consists of three segments of the community: the public, the organization's employees, and former rehabilitation patients. General public members pay an initiation fee and a monthly fee. Employees pay reduced initiation fees and reduced monthly fees. Cardiac rehabilitation center patients referred by their physician pay no initiation fee. Further distinctions are based on age and restrictions on the availability of the facilities during specific hours.

The fitness center has many members. The organization hired a professional consulting firm to survey its members' needs. This survey showed that based on its current membership, its sports and fitness center facilities were available to an economic cross-section of the community it serves. In addition, the organization will monitor its membership in the future and offer scholarships as necessary to insure that low-income individuals have access to and participate in its programs.

The issue in this PLR was whether any of the health and fitness center's services were unrelated trade or business. A hospital can promote health under I.R.C. 501(c)(3)

by operating a fitness center in certain instances. This determination requires analyzing whether use by each membership class furthers the hospital's exempt purposes.

Rehabilitating hospital inpatients and outpatients by treatment plans prescribed by physicians or appropriate hospital personnel furthers the hospital's exempt purpose of serving the healthcare needs of the community. Therefore, the cardiac rehabilitation program is substantially related to the hospital's exempt purposes under I.R.C. 501(c)(3) because it promotes the health of the community within the meaning of Rev. Rul. 69-545, 1969-2 C.B. 117.

Use of the fitness center by the organization's employees is a convenience to them and thus excepted from unrelated trade or business by I.R.C. 513(a)(2).

Providing a fitness center for the general public can serve a charitable purpose by providing community recreational facilities if the center is available to a significant segment of the community. To be "available," the center's fees must be affordable to the community served. In PLR 200051049, the hospital, with a professional consultant, surveyed the fitness center's members to find out their income levels and compared the results to income data for the general community. The survey data showed that an economic cross-section of the community could afford the fitness center. In addition, the organization would continue to monitor its membership and offer scholarships to assure that its membership included low-income individuals. Therefore, the fitness center was related to the hospital's exempt purposes because it was available to a significant segment of the community, and income the fitness center received from the general public membership was related.

PLR 200101036 (10/12/00) is another illustration of how the unrelated business income tax provisions apply to a health club operated by an I.R.C. 501(c)(3) hospital. It describes a hospital that built a new rehabilitation health care facility including a health and fitness center (the "Center") to meet increasing patient demand. The Center has a gym, track, hydrotherapy pool, swimming pool, lap pool, racquetball and squash courts, health resources library, physical development equipment, aerobic studio rooms, exercise areas, massage therapy area, and several areas for education classes, including a demonstration kitchen and classrooms. The Center also has a pro shop, which carries various health and fitness items for members, and a café to serve employees and members.

The hospital stated that the primary purpose of the Center is to improve the health of the community by promoting healthy lifestyles as a way to prevent disease. It accomplished this purpose three ways: by providing various rehabilitation services to the hospital's patients, by offering medically and non-medically supervised comprehensive

exercise programs to members, and by administering prevention services and extensive, comprehensive educational programs to members and non-members in the community.

The Center requires members to complete a "Health Risk Appraisal" before using its facilities. The Center refers anyone whose appraisal shows a high risk of disease to a physician for approval to use the Center. The Center's staff also uses the appraisal to develop individual programs that may include referral to a physician, registered dietician, exercise physiologist, or registered nurse.

The Center used a feasibility and demographic survey and analysis performed by two consulting groups to measure demand and set fees. The Center, which is located in a low-to-moderate income area, stated that it set its fees to be affordable to the average household in the surrounding area, particularly those within a ten-mile radius. The Center offers a variety of discounted membership fees and more than half the members receive some form of discount. Individuals who cannot afford the discounted fees are eligible to apply for membership under the Center's charity care policy. The Center advertised its availability and charity care policy extensively in the area it serves, and expected up to 18 percent of its members to be funded by charity care scholarships. The Center submitted information showing that persons who benefit most from the discounts come from a wide variety of socio-economic levels.

The Center conducted another survey that showed its members come from three segments: the general community, the hospital's employees, and the hospital's patients. All economic segments of the community were significantly represented in the Center's survey of its members' annual income. The Center will periodically repeat this survey and use the results to adjust its fees to assure that individuals from all income levels can afford to use its facility.

An exempt organization operating a fitness center may be charitable because it promotes health under Rev. Rul. 69-545. Also, providing recreational facilities to the public can be a charitable purpose under I.R.C. 501(c)(3), as long as the facilities are available to a broad segment of the community. Thus, a fitness center conducted as an activity of an I.R.C. 501(c)(3) organization would not be unrelated trade or business if it benefits a significant segment of the population.

PLR 200101036 concluded that the Center's provision of rehabilitative services to the hospital's patients, by treatment plans prescribed by physicians and hospital personnel, serves the hospital's charitable purpose of providing for the health care needs of the community.

PLR 200101036 also concluded that the Center's provision of facilities for health improvement and recreation of its members is substantially related to the hospital’s

charitable purpose because the fees charged are affordable by the members of the community the Center serves. The Center used the survey data to establish that its membership fees would be affordable by a broad cross-section of the residents of the community it serves. In addition, the Center will update its survey data to adjust its fee schedule to assure that individuals from all income levels in the community actually use the facility. Further, the Center's charity care policy, which it advertised in local newspapers with wide circulation in the community, provided a significant number of memberships funded by scholarships. More than half of all members will benefit from some form of discount. These factors distinguish the Center from the organization described in Rev. Rul. 79-360, 1979-2 C.B. 237, in which an organization charged higher fees to some patrons in return for a fitness program with more luxurious facilities and services than those available to the general membership. The fees were comparable to those charged by commercial health clubs in the area, and sufficiently high to restrict participation to a limited number of the members of the community.

PLR 200101036 also considered the Center's extensive community education and prevention programs, including an array of free or reasonable cost programs available to community residents who are not members of the Center, in concluding that the Center's activities and programs further the hospital's tax-exempt purpose.

Services the Center provides for the hospital's employees fit within the employee convenience exception of I.R.C. 513(a)(2).

PLR 200101036 applied the rationale of Rev. Rul. 69-267 and Rev. Rul. 69-268, 1969-1 C.B. 160, in concluding that the Center's pro shop and cafe do not generally constitute unrelated trade or business. In Rev. Rul. 68-267, the Service held that a hospital gift shop patronized by patients, their visitors, and hospital employees contributed importantly to the hospital's tax-exempt purposes by contributing to the physical well being of its patients. Rev. Rul. 68-268 held that operating a cafeteria and coffee shop primarily for employees and medical staff increased the hospital's operating efficiency by keeping employees and medical staff on the premises throughout the workday. Similarly, the Center operates its pro shop and café primarily for the convenience of its members and employees. The pro shop contributes to the hospital's tax-exempt purpose by providing fitness-related items used at the Center by its members. The Center's members and employees use the café throughout the workday, thereby increasing the Center's operating efficiency. However, amounts attributable to sales of items by the pro shop that are not used at the Center, or amounts the café derives from the general public, would constitute unrelated trade or business.

5. Behavioral Health Care Consortia

A recent development is the emergence of behavioral health care consortia formed by groups of unrelated I.R.C. 501(c)(3) behavioral health care provider organizations to negotiate and administer managed care contracts on their behalf.

Behavioral health care providers frequently consist of large numbers of small provider organizations, such as local community health care clinics tax-exempt under I.R.C. 501(c)(3). Typically, these organizations employ or contract with only a few practitioners (such as psychologists, social workers, substance abuse counselors, etc.) who serve a relatively small number of patients. These organizations need to contract with third-party payers, such as large insurance companies or HMOs, to participate in a managed care arrangement. However, their small size makes it difficult to negotiate managed care arrangements with large third-party payers, who find it cumbersome and inefficient to negotiate separate contracts with a large number of small provider organizations. As a result, in many communities, groups of unrelated small behavioral health care provider organizations have formed a consortium to negotiate and administer managed care contracts with one or more large third party payers. By combining resources, these small provider organizations can offer enrollees access to a large number of practitioners, often at favorable rates.

In a typical application case, several unrelated behavioral health care provider organizations form a nonprofit membership corporation ("Consortium"). The provider organizations are the Consortium's only members. The Consortium will negotiate managed care contracts with one or more large insurance companies, HMOs, or state Medicaid agencies ("Payers"). The Consortium will also provide management and administrative services for these contracts on behalf of its member organizations. The managed care contracts give the Payers' enrollees access to all individual practitioners associated with the provider organizations. Thus, the Consortium's practitioners become part of each Payer's provider network. The Payers usually pay the Consortium capitated fees. The Consortium retains a small portion of these fees to cover its expenses and remits the balance its member organizations on a capitated basis.

The first step in determining if a Consortium qualifies for exemption under I.R.C. 501(c)(3) or I.R.C. 501(c)(4) is identifying its purpose. If a Consortium's purpose is, in return for a prepaid fee, either to directly provide behavioral health care services for its enrollees, or to contract with providers to perform behavioral health care services for its enrollees, the Consortium operates like an HMO. In that event, the criteria for HMO's, including those under I.R.C. 501(m)(1) relating to the provision of commercial-type insurance, apply in determining if the consortium qualifies for exemption under I.R.C. 501(c)(3) or I.R.C. 501(c)(4).

If a Consortium's purpose is to negotiate, manage, and administer managed care contracts on behalf of unrelated I.R.C. 501(c)(3) provider organizations, even if limited to its member organizations, it is performing commercial services for a group of unrelated tax-exempt organizations. In that event, the Consortium's activities are similar to those in the long line of authority holding that performing commercial services for unrelated tax-exempt organizations is not an inherently charitable activity.

Rev. Rul. 54-305, 1954-2 C.B. 127, held an organization whose primary purpose was to operate and maintain a purchasing agency for otherwise unrelated members exempt under the predecessor to I.R.C. 501(c)(3) does not qualify for exemption. Rev. Rul. 54-305 concluded that purchasing supplies and performing other services are ordinary business activities rather than charitable activities. The activities were not performed in a charitable manner merely because they were provided for charitable organizations. Similarly, Rev. Rul. 69-528, 1969-2 C.B. 127, held an organization providing investment services for fees only to organizations exempt under I.R.C. 501(c)(3) does not qualify for exemption under I.R.C. 501(c)(3). The organization invested funds received from participating organizations. The participating charities had no control of the organization, which had absolute and uncontrolled discretion over investment policies. Thus, the organization was engaged in a trade or business ordinarily carried on for profit.

Rev. Rul. 72-369, 1972-3 C.B. 245, considered an organization that provided management and consulting services at cost to unrelated tax-exempt organizations. It held that the organization did not qualify for exemption. The services were a trade or business ordinarily carried on for profit. Merely providing them "at cost" and solely for tax-exempt organizations was not sufficient to characterize the activity as charitable within the meaning of I.R.C. 501(c)(3).

A consortium controlled by I.R.C. 501(c)(3) organizations that are structurally related through a common exempt parent might qualify for exemption under the integral part doctrine in Regs. 1.502-1(b). For example, Rev. Rul. 78-41, 1978-1 C.B. 148, held a trust created by an I.R.C. 501(c)(3) hospital to accumulate and hold funds to pay malpractice claims against the hospital qualified for exemption as an integral part of the hospital because the hospital exercised significant financial control over the trust. The nature of consortia, however, suggests that member behavioral health care providers are not likely to be structurally related through a common exempt parent.

To illustrate the principles discussed above, assume that X, Y, and Z are unrelated nonprofit corporations that operate behavioral health care clinics in the same community. Each is recognized as tax-exempt under I.R.C. 501(c)(3). Each employs or contracts with licensed psychologists and social workers to provide therapy and counseling to individuals with mental health or substance abuse problems. X, Y, and Z form C, a

nonprofit corporation of which X, Y, and Z are the sole members, to negotiate managed care contracts with a large for-profit insurance company ("Insco") that operates an HMO. The contract gives Insco's HMO enrollees access to all X, Y, and Z practitioners for treatment of mental health and substance abuse problems. Insco pays C capitated fees based on the number of HMO enrollees. C keeps five percent of the fees to cover operating expenses and remits the balance to X, Y, and Z based on the number of HMO patients each serves. C also provides contract management and administrative services on behalf of X, Y, and Z required by the contract. On these facts, C does not qualify for exemption under I.R.C. 501(c)(3). The services C provides are not inherently charitable activities, but common commercial services of a kind ordinarily carried on for profit. C does not provide them in a charitable manner, since the contract provides for payment to cover its costs.

6. Gainsharing

"Gainsharing" is an incentive compensation arrangement that allows physicians to share in savings derived from reducing a hospital's patient care costs attributable in part to the physicians' efforts.

The Service initially took a ruling position that gainsharing between a hospital and physicians was consistent with the hospital's exemption under I.R.C. 501(c)(3). However, it reconsidered that position after the Office of the Inspector General of the Department of Health and Human Services ("OIG") issued a Special Advisory Bulletin on July 8, 1999, concluding that federal law prohibits hospital-physician gainsharing arrangements and subjects them to civil penalties because they induce physicians to reduce or limit clinical services to Medicare or Medicaid patients.

OIG soon clarified the July 8th Special Advisory Bulletin. In an August 24, 1999, letter, OIG specified that the gainsharing ban in Medicare and Medicaid programs applies only to fee-for-service operations. (*See* www.hhs.gov/progorg/oig/frdalrt/gsletter.htm.) The ban does not apply to hospital-physician incentive plans limited to Medicare or Medicaid beneficiaries in managed care programs. In addition, physician-incentive programs run by Medicare+Choice managed care plans likely are also legal under Health Care Financing Administration guidelines.

Gainsharing was addressed in the Preamble to the Temporary Regulations under I.R.C. 4958 (intermediate sanctions) (T.D. 8920, 2001-8 I.R.B. 654, 667). Citing the July 8, 1999 OIG Special Advisory Bulletin, the Preamble states that because the OIG believes the methodology for calculating payments under gainsharing arrangements may violate federal law if patient care may be affected by the cost saving, the Service will not issue private letter rulings under I.R.C. 4958 on these arrangements. The Preamble also notes that the question remains whether gainsharing arrangements, which involve payments

contingent on cost savings to the organization, should be treated in the same manner as "revenue-sharing" arrangements, which involve payments contingent on the revenues of the organization.

On January 11, 2001, the OIG concluded that a limited gainsharing arrangement between an I.R.C. 501(c)(3) hospital and a professional association of cardiac surgeons with medical staff privileges at the hospital was an improper payment to induce reduction or limitation of services under the Social Security Act, but that the OIG would not sanction the hospital. OIG Advisory Opinion No. 01-1 (1/18/01). (*See* www.hhs.gov/progorg/oig/advopn/2001/index.htm.) The gainsharing arrangement in this case was limited to medical supplies and certain drugs used in operating rooms.

In light of the question whether gainsharing arrangements should be treated as revenue-sharing arrangements, it is unlikely the Service would issue PLRs even on gainsharing arrangements the OIG considers legal until final regulations on revenue-sharing transactions under I.R.C. 4958 are published.

7. The Community Benefit Standard

A. Overview

An organization must be both organized and operated exclusively for charitable purposes to qualify for exemption under I.R.C. 501(c)(3). Regs. 1.501(c)(3)-1(a). I.R.C. 501(c)(3) uses the term "charitable" in its generally accepted legal sense. In the general law of charity, the promotion of health is considered as a charitable purpose. Restatement (Second), Trusts, §§ 368 and 372; 4A Scott & Fratcher, The Law of Trusts §§ 368, 372 (4th ed. 1989).

Rev. Rul. 56-185, 1956-1 C.B. 202, held that for a hospital to establish that it is exempt under I.R.C. 501(c)(3), it must demonstrate that it operates to the extent of its financial ability for those not able to pay for its services and not exclusively for those who are able and expected to pay. Rev. Rul. 56-185 stated that the hospital could provide charity by furnishing services to those unable to pay at no charge or at reduced rates below its cost.

Rev. Rul. 69-545, 1969-2 C.B. 117, modified Rev. Rul. 56-185 and established a community benefit standard a hospital must meet to qualify for exemption under I.R.C. 501(c)(3). The community benefit standard focuses on a number of factors to determine if a hospital operates to benefit the community as a whole.

The community benefit standard applies to other health care provider organizations under I.R.C. 501(c)(3), such as clinics or HMOs, as well as traditional hospitals. *See*

Eastern Kentucky Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), vacated on other grounds, 426 U.S. 26 (1975); and Sound Health Association, 71 T.C. 158 (1978), acq., 1981-2 C.B. 2.

In Rev. Rul. 69-545, the hospital that qualified for exemption had a board of trustees comprising prominent citizens in the community; medical staff privileges in the hospital were available to all qualified physicians in the area, consistent with the size and nature of its facilities; the hospital operated a full time emergency room where no one requiring emergency care was denied treatment; and the hospital used operating surpluses to expand and replace existing facilities and equipment, amortize indebtedness, improve patient care, medical training, education and research. Rev. Rul. 69-545 held that these significant factors established that the hospital qualified for exemption as a charitable organization under I.R.C. 501(c)(3).

Other than the emergency room, which was open to all regardless of ability to pay, the hospital in Rev. Rul. 69-545 ordinarily limited admissions to those who can pay the cost of their hospitalization, either themselves, or through private health insurance, or with the aid of public programs, such as Medicare. Patients who could not meet the financial requirements for admission were ordinarily referred to another hospital in the community that serves indigent patients. Rev. Rul. 69-545 expressly modified Rev. Rul. 56-185 to remove the requirements to care for indigent patients without charge or at rates below cost.

Rev. Rul. 83-157, 1983-2 C.B. 94, held that a nonprofit hospital identical to the hospital in Rev. Rul. 69-545, except it did not operate an emergency room, can still qualify under I.R.C. 501(c)(3) if other significant factors establish that it operates exclusively to benefit the community as a whole. In Rev. Rul. 83-157, the state health-planning agency had determined the hospital did not need an emergency room because it would duplicate emergency services and facilities adequately provided by another medical institution in the community. Rev. Rul. 83-157 also explained that certain specialized hospitals, for example, eye or cancer hospitals, that offer medical care limited to special conditions unlikely to require emergency care, do not, as a practical matter, maintain emergency rooms. But, as explained in Rev. Rul. 69-545, a hospital that does operate an emergency room must open it to all persons regardless of ability to pay.

Thus, a hospital or other health care provider must satisfy the community benefit standard to qualify for exemption under I.R.C. 501(c)(3). To do this, the organization must establish the presence of significant factors demonstrating that it promotes the health of a class of persons that is broad enough so that the community as a whole benefits. As long as a health care provider can establish the presence of these significant factors, it is not required that it establish the presence of all the factors in Rev. Rul. 69-545 for the organization to satisfy the community benefit standard.

For example, Rev. Rul. 83-157 points out that operating a full-time emergency room providing emergency medical services to all regardless of ability to pay is one significant piece of evidence that a hospital is operating for the benefit of the community as a whole. But if a hospital does not operate an emergency room, it must show other significant factors that establish it promotes the health of a sufficiently broad class of persons so that the community as a whole benefits. In Rev. Rul. 83-157, the state health-planning agency independently determined that an emergency room would be unnecessary and duplicative. The hospital in Rev. Rul. 83-157 was able to demonstrate other significant factors establishing that it benefited the community as a whole. These other significant factors included a board of directors drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs like Medicare and Medicaid, and the application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research.

For a hospital to satisfy the community benefit standard, Rev. Rul. 69-545 requires that the hospital establish the presence of significant factors demonstrating that the hospital promotes the health of a class of persons that is broad enough so that the community as a whole benefits. One highly significant factor is an emergency room that is open to all persons regardless of their ability to pay. However, if a hospital does not operate an emergency room, another highly significant factor is that the hospital has adopted and implemented a charity care policy.

B. Examples

An organization that operated a mobile medical unit with medical examining rooms applied for recognition of exemption under I.R.C. 501(c)(3). The organization was controlled by a community board of directors and had adopted a substantial conflicts of interest policy. For several hours once a week, the unit, which was staffed by volunteer physicians and nurses, provided free medical screening, checkups and healthcare education to inner city neighborhoods. The unit stayed in an area approximately four weeks. If a health care provider determined that an individual had a medical problem, the provider would either treat the individual at the unit or refer the individual for treatment elsewhere. The unit did not maintain an emergency room, but nearby hospitals operated emergency rooms 24 hours per day. The organization did not receive revenue from Medicare, Medicaid or health insurance, since 99 percent of its patients were uninsured. Instead, it received financial support from private grants, fund raising events, private funding and government grants.

The organization's mobile medical unit visited inner city neighborhoods to offer free medical checkups, medical screening, health care education, and medical treatment to uninsured individuals with medical problems. These health care activities demonstrated that the organization benefited a sufficiently broad class of persons so the community as

whole benefited from the organization's services. Thus, it satisfied the community benefit standard of Rev. Rul. 69-545, notwithstanding that it did not operate an emergency room. As in Rev. Rul. 83-157, the special health care services this organization provided made an emergency room impractical to have and unnecessary, especially since nearby hospitals operated with 24-hour per day emergency rooms.

Another organization provided free dental care to children from low-income families. The organization was controlled by a community board of directors and had adopted a substantial conflicts of interest policy. The organization operated two vans equipped to provide dental services such as dental screenings, examinations, cleaning, x-rays, filings, crowns, simple extractions and sealants. The vans visited schools within its service area and provided free dental services and dental health education to needy children. Based on these facts, the organization satisfied the community benefit standard of Rev. Rul. 69-545, notwithstanding the absence of an emergency room. Under Rev. Rul. 83-157, the special health care services the organization provided made operating an emergency room unnecessary. Instead, the organization's activities demonstrated that it benefited a sufficiently broad class of persons in the community so the community as a whole benefited from the organization's services.