D. EXEMPTION OF MEDICAID HMOs AND MEDICAID SERVICE ORGANIZATIONS UNDER IRC 501(c)(3)

by
Lawrence M. Brauer and Marvin Friedlander

"The future ain't what it used to be." -- Yogi Berra

1. Introduction

A. Background

This article describes the circumstances under which nonprofit health maintenance organizations (HMOs) and Medicaid service organizations that provide services exclusively to Medicaid recipients may qualify for exemption from federal income tax as organizations described in IRC 501(c)(3).

Medicaid is a joint federal-state program that pays for medical assistance to low income persons and persons in certain other categories, including the blind, disabled, and children in foster care. Title XIX, Soc. Sec. Act, 42 U.S.C. sections 1396 - 13965. The federal government provides funds to the states. The states commit additional funds and arrange for the actual delivery of medical care to the program's beneficiaries.

Until recently, state Medicaid programs paid providers of health care services directly under traditional fee-for-service reimbursement arrangements. Following trends in the private sector, many states are adopting managed care systems.

The term "managed care" describes various strategies for reducing health care costs while maintaining or improving quality. The operations of a typical health maintenance organization (HMO) illustrate how managed care strategies may be used to reduce health care costs.

The typical HMO provides its enrollees, or "members," with all needed health care services in exchange for a fixed monthly fee. The key to HMO operations is that each enrollee chooses, or is assigned, a primary care physician, usually an internist, family practitioner, or pediatrician, who serves as "gatekeeper." Generally, enrollees must obtain approval of their primary care physician before seeing specialists or entering a hospital. The primary care physician helps keep costs down by preventing overuse of expensive services and procedures.

The gatekeeper allows the HMO to improve the quality of health care provided to its enrollees by (1) providing ready access to a primary care physician, thus reducing the

likelihood of more serious complications resulting from delayed care; (2) offering preventive care and (3) ensuring that care will be delivered by a provider who is familiar with an enrollee's medical history and who can coordinate health services from other providers.

HMOs also use the bargaining power afforded by their large enrollee bases to negotiate discounts for the services provided to their enrollees by primary care physicians, hospitals, pharmacies, and specialist physicians with whom they contract for patient care services.

In the typical Medicaid HMO arrangement, the state or local agency responsible for administering the Medicaid program pays the Medicaid HMO a monthly fixed fee based on the number of Medicaid enrollees. In return, the Medicaid HMO arranges for the provision of various health care services to its Medicaid enrollees. These services may be limited to primary care services or may also include hospital services.

B. Exemption Standard

Whether an HMO qualifies for exemption under IRC 501(c)(3) has been a much debated issue because an HMO merges two functions: providing health care, a traditional charitable activity; and providing insurance, which has traditionally been considered a noncharitable function. Additionally, an HMO provides services to a restricted group. The Service initially considered all HMOs ineligible for exemption under IRC 501(c)(3) because the insurance element was a substantial nonexempt purpose, and the membership element resulted in excessive private benefit. The Tax Court rejected application of this reasoning to all HMOs in Sound Health Association v. Commissioner, 71 T.C. 158, acq. 1981-2 C.B. 2, in which it held that the staff model HMO in question qualified for exemption under IRC 501(c)(3) because it provided direct health care to its enrollees and to the community in a manner similar to a charitable hospital.

However, not all HMOs satisfy the standards in Sound Health, especially HMOs that primarily arrange for health care services to be provided by others rather than directly providing services itself.

Where an HMO that arranges for health care benefits seeks exemption under IRC 501(c)(3) on the theory that its activities promote the health of the community as a whole, the organization must satisfy a "flexible community benefit standard." See Geisinger Health Plan v. Commissioner, 985 F.2d 1210 (3rd Cir. 1993) ("Geisinger II"), rev'g 62 T.C.M. (CCH) 1656 (1991) ("Geisinger I"). Under this standard, the HMO's activities must not be directed solely to its enrollees; it must benefit the community as a whole in addition to its enrollees.

Moreover, where an HMO that arranges for health care benefits seeks exemption under IRC 501(c)(3) based on the "integral part doctrine," in other words, that its activities benefit one or more IRC 501(c)(3) hospitals in the health care system of which it is a part, the organization must serve only patients of the related exempt hospitals. See Geisinger Health

Plan v. Commissioner, 100 T.C. 394 (1993) ("Geisinger III"), aff'd, 30 F.3d 494 (3rd Cir. 1994) ("Geisinger IV"). Under this principle, the HMO's enrollees and the patients of the related exempt hospitals must be substantially identical.

When an HMO arranges for health care benefits for segments of the community who are generally under served, the HMO generally will be able to qualify for exemption under IRC 501(c)(4) as an organization whose activities promote the general welfare of the people of a community. See GCM 39829 (September 10, 1990).

This article discusses whether charitable purposes are accomplished where an HMO benefits its enrollees who, as Medicaid recipients, are part of a class of persons identified by the government as having special health care needs. It also discusses whether charitable purposes are accomplished by a service organization that operates to assist in the provision of health care benefits to Medicaid recipients.

The following hypothetical examples, involving Medicaid HMOs and a Medicaid service organization, provide a vehicle for discussing these issues.

C. Hypothetical Examples

Example 1

Alwaysopen Medical Clinic ("AMC") is a nonprofit corporation that is exempt under IRC 501(c)(3). AMC operates a medical clinic offering primary health care services. AMC has been providing primary health care services to Medicaid beneficiaries in the state on a fee-for-service basis. AMC now intends to provide health care services to Medicaid beneficiaries in the state on a managed care basis. To accomplish this, AMC forms Community Health Plan ("CHP"), a nonprofit corporation, to operate a prepaid Medicaid program as an HMO by enrolling exclusively Medicaid beneficiaries and their dependents. CHP arranges for the provision of health care services to its enrollees through its network of health care providers.

Under CHP's contract with the state Medicaid agency, CHP receives "capitated fees," a fixed monthly fee for each Medicaid beneficiary enrolled in its HMO. The state Medicaid agency establishes standards for Medicaid eligibility and certifies persons as eligible for Medicaid benefits.

CHP contracts with AMC for AMC to provide primary health care services to CHP's enrollees. AMC provides almost all of these services at its clinics through its employed health care providers. CHP also contracts with independent physicians engaged in the private practice of medicine to provide primary and specialty health care services to CHP's enrollees at the physicians' own facilities on a non-exclusive basis. In addition, CHP has negotiated with several unrelated hospitals to provide inpatient and outpatient hospital services to CHP's enrollees.

CHP ensures that enrolled Medicaid beneficiaries are adequately informed about their health care benefits, providing counseling and assistance in making the transition to managed care. CHP educates beneficiaries regarding access to health care, providing direction as to the appropriate utilization of health care facilities and encouraging the use of preventive health care measures. CHP also ensures that enrolled Medicaid beneficiaries obtain appropriate health care by ensuring that providers are available and that services will be provided in a coordinated manner.

AMC's board of directors is comprised of independent members of the community. In addition, AMC has adopted a substantial conflicts of interest policy that also applies to CHP.

Example 2

Diversified Medical Corporation ("DMC") was incorporated as a non-profit membership corporation under state law. DMC operates an HMO exclusively for Medicaid beneficiaries in certain medically under served areas in the state.

DMC's members consist of five hospitals, all of which are exempt under IRC 501(c)(3). Each member appoints one director to DMC's Board of Directors. DMC has adopted a substantial conflicts of interest policy.

DMC has entered into a contract with the state's Department of Community Health to operate as a Medicaid HMO. Any individual who qualifies for Medicaid assistance in the state automatically qualifies for enrollment in DMC. The state pays DMC a monthly capitated fee for each enrollee.

DMC contracts with its member hospitals, which employ salaried physicians, to provide primary health care services at the members' facilities. DMC also contracts with independent physicians in private practice to provide primary care and specialty services.

DMC ensures that enrolled Medicaid beneficiaries are adequately informed about their health care benefits, providing counseling and assistance in making the transition to managed care. DMC educates beneficiaries regarding access to health care, providing direction as to the appropriate utilization of health care facilities and encouraging the use of preventive health care measures. DMC also ensures that enrolled Medicaid beneficiaries obtain appropriate health care by ensuring that providers are available and that services will be provided in a coordinated manner.

Example 3

Network Health Services ("NHS") was incorporated under state law as a nonprofit corporation. Under state law, the Department of Social Services in each county is required to furnish Medicaid benefits to county residents who are eligible for such services. In

connection with a county's Medicaid program, state law provides that a county may contract only with organizations that are exempt under IRC 501(c)(3) to perform the following services:

- Establish a network of primary care physicians who will provide health care services to Medicaid beneficiaries;
- Coordinate reimbursement, monitor quality, perform fiscal management, program development, quality assurance and utilization regarding the physician network;
- Provide Medicaid beneficiaries with certain services, such as instructing them how to use primary care physicians for obtaining routine health care instead of going to hospital emergency rooms; and
- Train teaching teams to go into the community to enroll additional Medicaid-eligible persons as participants in the program.

The Department of Social Services of one county in the state contracted with NHS for NHS to perform the services described above in connection the county's Medicaid program. The county pays NHS capitated fees. NHS pays the primary care physicians in the network capitated fees less $2.50 per enrollee per month, which NHS retains as an administrative fee.

NHS is a non-membership corporation. NHS has adopted a substantial conflicts of interest policy and a majority of the members of its board of directors is required to be independent community members.

2. Bases for Exemption

The activities of CHP and DMC demonstrate that their charitable purposes are (1) to promote the health of the community by arranging for the provision of health care services to Medicaid beneficiaries and (2) to relieve the poor and distressed by meeting the special health care needs of Medicaid beneficiaries.

The activities of NHS are activities that the state expressly authorized that counties transfer to tax-exempt charitable organizations as part of each county's obligation to provide health care services to Medicaid beneficiaries. These activities demonstrate that NHS's charitable purpose is to lessen the burdens of government.

Each of these rationales and other considerations involving exemption are discussed below.

A. Promotion of Health

(1) Law

Reg. 1.501(c)(3)-1(d)(2) provides that the term "charitable" is used in IRC 501(c)(3) in its generally accepted legal sense. The promotion of health has long been recognized as a charitable purpose. See Restatement (Second) of Trusts, IRC 368, 372 (1959); 4A Scott and Fratcher, The Law of Trusts, IRC 368, 372 (4th ed. 1989); Rev. Rul. 69-545, 1969-2 C.B. 117. The Service and the courts have recognized that the promotion of health includes activities other than the direct provision of patient care.

For example, Rev. Rul. 75-197, 1975-1 C.B. 156, holds that a nonprofit organization that operates a free computerized donor authorization retrieval system to facilitate transplantation of body organs upon a donor's death qualifies for exemption under IRC 501(c)(3). By facilitating the donation of organs that will be used to save lives, it is serving the health needs of the community and therefore is promoting health within the meaning of the general law of charity.

Rev. Rul. 77-69, 1977-1 C.B. 143, describes an organization formed as a Health Systems Agency (HSA) under the National Health Planning and Resources Development Act of 1974. As an HSA, the organization's primary responsibility was the provision of effective health planning for a specified geographic area and the promotion of the development within that area of health services, staffing and facilities that met identified needs, reduced inefficiencies and implemented the HSA's health plan. The revenue ruling concludes that by establishing and maintaining a system of health planning and resources development aimed at providing adequate health care, the HSA is promoting the health of the residents of the area in which it functioned. Therefore, the HSA qualifies for exemption under IRC 501(c)(3) on the basis that it promoted health.

Rev. Rul. 81-28, 1981-1 C.B. 328, holds that a nonprofit organization that provides housing, transportation and counseling to hospital patients' relatives and friends who travel to the locality to assist and comfort the patients qualifies for exemption under IRC 501(c)(3) because it promotes health by helping to relieve the distress of hospital patients who benefit from the visitation and comfort provided by their relatives and friends.

In Professional Standards Review Organization of Queens County, Inc. v. Commissioner, 74 T.C. 240 (1980), acq. 1980-2 C.B. 2 ("Queens County PSRO"), the Tax Court held that an organization that reviewed the propriety of hospital treatment provided to Medicaid recipients is exempt under IRC 501(c)(3) because it lessened the burdens of government and promoted the health of persons eligible for Medicare and Medicaid.

Rev. Rul. 81-276, 1981-2 C.B. 128, holds that a PSRO qualifies for exemption under IRC 501(c)(3) because it lessens the burdens of government and promotes the health of the beneficiaries of the Medicare and Medicaid programs. Regarding the promotion of health, the Service states:

> PSROs were intended to reduce overutilization of the health services provided under [M]edicare and [M]edicaid (and the impact of such on overutilization on the health of the aged and poor) by assuring that payments for health care services under governmental health care programs would be made only when, and to the extent, medically necessary. . . .
>
> By operating as a designated PSRO and restricting federal health care payments to services that are medically necessary, [the organization] is promoting the health of the beneficiaries of governmental health care programs by preventing unnecessary hospitalization and surgery.

In Geisinger II, supra, an HMO was part of a large health care system. It arranged for the provision of health care services only for its enrollees. A subsidized dues program was planned for individuals who could not afford to pay the premiums. Physician services were provided by a clinic that was part of the system and hospital services were provided by hospitals both in the system and outside of the system. System hospitals provided 80 percent of the hospital services to the HMO's enrollees and non-system hospitals provided 20 percent. More than 84 percent of physician services were provided by physicians employed by the system clinic. The Third Circuit held that the HMO did not qualify for exemption under IRC 501(c)(3) because by merely arranging for health care services for its members, the HMO primarily benefited its members, not the community as a whole.

The Third Circuit stated that a nonprofit hospital, including an HMO, will qualify for tax-exempt status if it primarily benefits the community. One way for a hospital (or an HMO that provides direct care) to benefit the community is to serve those who pay their bills through public programs such as Medicaid or Medicare. Other ways to benefit the community are through maintaining an emergency room or providing free care for indigents. In any event, an organization must meet a "flexible community benefit test based on a variety of indicia." 985 F.2d at 1217. Thus, to qualify under IRC 501(c)(3), the HMO must benefit the community as a whole in addition to its members.

The Third Circuit concluded that the HMO benefited only its members and itself, not the community as a whole. The subsidized dues program was insufficient because this alone did not result in the HMO primarily benefiting the community rather than just its members. The court stated:

> The mere fact that a person need not pay to belong does not necessarily mean that GHP, which provides services only to those who do belong, serves a public purpose which primarily benefits the community. The community benefited, is, in fact, limited to those who belong to GHP since the requirement of subscribership remains a condition precedent to any service. Absent any additional indicia of a charitable purpose, this self-imposed precondition suggests that GHP is primarily benefiting itself (and perhaps, secondarily benefiting the community) by promoting subscribership throughout the areas it serves.

Geisinger II, at 1219.

In summary, the Third Circuit stated:

> An HMO must primarily benefit the community, not its subscribers plus a few people, in order to qualify for tax-exempt status under section 501(c)(3).

Id. at 1220.

An organization that merely promotes health in the broad sense of the term, without more, does not qualify for recognition of exemption under IRC 501(c)(3). For example, although selling prescription pharmaceuticals promotes health, pharmacies cannot qualify for recognition of exemption under IRC 501(c)(3) on that basis alone. In Federation Pharmacy Services, Inc. v. Commissioner, 72 T.C. 687, 692 (1979), aff'd, 625 F.2d 804 (8th Cir. 1980), the Tax Court stated:

> Virtually everything we buy has an effect, directly or indirectly, on our health. We do not believe that the law requires that any organization whose purpose is to benefit health, however, remotely, is automatically entitled, without more, to the desired exemption.

Further, based on long-standing authority that providing ordinary business services for charitable organizations is not, in itself charitable, an organization that provides ordinary business services for exempt health care organizations does not promote health in a charitable manner.

Living Faith, Inc. v. Commissioner, 950 F.2d 365 (7th Cir. 1991), involves an organization that operated restaurants and health food stores with the intention of furthering the religious work of the Seventh-Day Adventist Church as a health ministry. The Seventh

Circuit held that these activities were primarily carried on for the purpose of conducting a commercial business enterprise. Therefore, the organization did not qualify for recognition of exemption under IRC 501(c)(3).

Rev. Rul. 54-305, 1954-2 C.B. 127, describes an organization whose primary purpose is the operation and maintenance of a purchasing agency for the benefit of its otherwise unrelated members who are exempt as charitable organizations. The ruling holds that the organization did not qualify under IRC 101(6) (the predecessor to IRC 501(c)(3)) because its activities consisted primarily of the purchase of supplies and the performance of other related services. The revenue ruling states that such activities in themselves cannot be termed charitable, but are ordinary business activities.

Rev. Rul. 69-528, 1969-2 C.B. 127, deals with an organization formed to provide investment services on a fee basis only to organizations exempt under IRC 501(c)(3). The organization invests funds received from participating tax-exempt organizations. The service organization is free from the control of the participating organizations and has absolute and uncontrolled discretion over investment policies. The ruling holds that the service organization did not qualify under IRC 501(c)(3) and stated that providing investment services on a regular basis for a fee is a trade or business ordinarily carried on for profit.

Rev. Rul. 72-369, 1972-3 C.B. 245, involves an organization formed to provide management and consulting services at cost to unrelated exempt organizations. The revenue ruling states:

> Providing managerial and consulting services on a regular basis for a fee is a trade or business ordinarily carried on for profit. The fact that the services in this case are provided at cost and solely for exempt organizations is not sufficient to characterize this activity as charitable within the meaning of section 501(c)(3) of the Code.

In Rev. Rul. 77-3, 1977-1 C.B. 140, a nonprofit organization that provides rental housing and related services at cost to a city for its use as free temporary housing for families whose homes have been destroyed by fire is not a charitable organization exempt under IRC 501(c)(3). The revenue ruling states:

> [I]t is the city rather than the organization that is providing free temporary housing to the distressed families. The organization is merely leasing housing property and providing certain maintenance and other services in connection therewith to the city at cost in a manner similar to organizations operated for profit, and is not itself engaged in charitable activities.

In B.S.W. Group, Inc. v. Commissioner, 70 T.C. 352 (1978), an organization entered into consultant-retainer relationships with five or six limited resource groups involved in the fields of health, housing, vocational skills and cooperative management. The organization's financing did not resemble that of the typical IRC 501(c)(3) organization. It had neither solicited, nor received, any voluntary contributions from the public. The court concluded that because its sole activity consisted of offering consulting services for a fee, set at or close to cost, to nonprofit, limited resource organizations, it did not qualify for exemption under IRC 501(c)(3).

In Christian Stewardship Assistance, Inc. v. Commissioner, 70 T.C. 1037 (1978), a nonprofit corporation that assisted charitable organizations in their fund raising activities by providing financial planning advice on charitable giving and tax planning to wealthy individuals was held not to qualify under IRC 501(c)(3) because its tax planning services were a substantial nonexempt activity enabling the corporation to provide commercially available services to wealthy individuals free of charge.

Although Rev. Rul. 70-535, 1970-2 C.B. 117, involves IRC 501(c)(4), the analysis is similar to revenue rulings involving IRC 501(c)(3). The revenue ruling, describing an organization formed to provide management, development and consulting services for low and moderate income housing projects for a fee, holds that the organization did not qualify under IRC 501(c)(4). The revenue ruling states:

> Since the organization's primary activity is carrying on a business by managing low and moderate income housing projects in a manner similar to organizations operated for profit, the organization is not operated primarily for the promotion of social welfare. The fact that these services are being performed for tax exempt corporations does not change the business nature of the activity.

(2) Discussion

CHP and DMC enroll only Medicaid beneficiaries in their HMOs, arrange for the provision of health care services for these individuals by a group of health care providers, and ensure that these individuals obtain access to appropriate health care.

Medicaid beneficiaries consist of persons who the government considers "poor and distressed" due to their financial resources or disabilities. As such, these persons generally have difficulty in obtaining basic necessities, including adequate health care. By enabling Medicaid beneficiaries to make effective use of a managed care health system, CHP and DMC ensure that the beneficiaries' health care needs are met. Promoting the health of Medicaid beneficiaries, low-income individuals who have special health care needs, promotes

the health of the community under Rev. Rul. 69-545, supra; Rev Rul. 75-197, supra; Rev. Rul. 77-69, supra; and Rev. Rul 81-28, supra. CHP and DMC also satisfy the flexible community benefit standard in Geisinger II, 985 F.2d 1210 (3d Cir. 1993); in addition to benefiting their enrollees personally, CHP and DMC benefit the community as a whole by promoting the health of Medicaid beneficiaries.

CHP's and DMC's activities are also similar to the activities in Queens County PSRO. In that case, the Tax Court reasoned that a PSRO promotes the health of the community because its activities help ensure that Medicare and Medicaid beneficiaries will receive health care that is medically necessary, thus discouraging the performance of unnecessary medical treatment. Similarly, by CHP and DMC enrolling only Medicaid beneficiaries in their HMOs and arranging for the provision of health care services for these individuals by a group of health care providers, they enable the federal and state governments to operate the Medicaid program more effectively and more efficiently. This promotes the health of the Medicaid beneficiaries and therefore also promotes the health of the community.

NHS, on the other hand, does not enroll Medicaid beneficiaries in an HMO that arranges for the provision of health care services to these individuals. NHS aggregates the claims of smaller providers to obtain a single reimbursement from the state agency and distributes the appropriate payments to the individual providers. NHS provides services to the state, enabling the state to perform its governmental obligation to provide health care services to Medicaid beneficiaries. NHS itself does not promote the health of the community. NHS may enable the state Medicaid program to operate in an efficient and economical manner, but this purpose does not promote the health of the community in a charitable manner. Instead, it is more of a typical commercial activity that the state has decided can be performed more effectively by an organization like NHS rather than by government. See Rev. Rul. 54-305, supra; Rev. Rul. 69-528, supra; Rev. Rul. 72-369, supra; Rev. Rul. 77-3, supra; B.S.W. Group, Inc. v. Commissioner, 70 T.C. 532 (1978); and Christian Stewardship Assistance, Inc. v. Commissioner, 70 T.C. 1037 (1978) As a result, NHS does not directly promote the health of the community, and can qualify for exemption under IRC 501(c)(3) only if it furthers another recognized charitable purpose.

B. Relief of the Poor and Distressed

(1) Law

Reg. 1.501(c)(3)-1(d)(2) provides that the term "charitable" includes relief of the poor and distressed. The Service has long held that poor and distressed beneficiaries must be needy, in the sense that they cannot afford the necessities of life.

For example, shelter is considered to be one of the necessities of life. Rev. Rul. 67-138, 1967-1 C.B. 129; Rev. Rul. 70-585, 1970-2 C.B. 115; and Rev. Rul. 76-408, 1976-2 C.B.

145, hold that the provision of housing for low-income persons accomplishes charitable purposes by relieving the poor and distressed. These revenue rulings refer to the needs of housing recipients and their inability to secure adequate housing to determine whether they are poor and distressed. See also Rev. Proc. 96-32, 1996-1 C.B. 717.

The Service has also recognized that conditions other than poverty may deprive individuals of the ability to satisfy their basic needs. For example, relief of the distress of the elderly or physically handicapped is an exempt purpose. See Rev. Rul. 72-124, 1972-1 C.B. 145; Rev. Rul. 79-18, 1979-1 C.B. 194; and Rev. Rul. 79-19, 1979-1 C.B. 195.

In Rev. Rul. 72-124, an organization operated a home for the aged that provided housing, limited nursing care, and other services and facilities needed to enable its elderly residents to live safe, useful, and independent lives. The revenue ruling states:

> . . . [I]t is now generally recognized that the aged, apart from considerations of financial distress alone, are also, as a class, highly susceptible to other forms of distress in the sense that they have special needs because of their advanced years. For example, it is recognized in the Congressional declaration of objectives, Older Americans Act of 1965, Public Law 89-73, 89th Congress, 42, U.S.C. 3001, that such needs include suitable housing, physical and mental health care, civic, cultural and recreational activities, and an overall environment conducive to dignity and independence, all specially designed to meet the needs of the aged. Satisfaction of these special needs contributes to the prevention and elimination of the causes of the unique forms of "distress" to which the aged, as a class, are highly susceptible and may in the proper context constitute charitable purposes or functions even though direct financial assistance in the sense of relief of poverty may not be involved.

Thus, an organization may further a charitable purpose by meeting either the basic needs of persons who are part of a charitable class or the special needs of persons who have been recognized as requiring specific forms of assistance.

In Rev. Rul. 77-3, 1977-1 C.B. 140, the owner of housing property contracted with the city to lease temporary housing to persons whose residences were destroyed by fire. The Service acknowledged that the provision of free temporary housing to distressed persons in need of adequate housing is a charitable activity. Nevertheless, the lessor did not qualify for exemption under IRC 501(c)(3) because the city, not the lessor, was responsible for providing the free temporary housing to the distressed families. The lessor merely leases the housing property to the city in a commercial manner, similar to organizations operated for profit, and is not engaged in charitable activities.

On the other hand, if the lessor in this revenue ruling had also undertaken responsibility to provide affordable housing to the fire victims, it would have been comparable to the low-income housing organizations described in Rev. Rul. 67-138, supra; Rev. Rul. 70-585, supra; and Rev. Rul. 76-408, supra. Or, if the lessor had undertaken the responsibility to provide social services to the fire victims to meet their other critical needs, it would have been comparable to the elderly housing organization described in Rev. Rul. 72-124, supra.

(2) Discussion

It is generally acknowledged that many low-income individuals have greater health care needs than other members of the population, yet these individuals are often unable to obtain adequate medical care because it is unavailable or it is unavailable at an affordable level. Therefore, low-income individuals comprise a group of persons with special health care needs. The federal and state Medicaid statutes expressly recognize the special health care needs of these low-income individuals and their families. Like organizations that provide housing to low-income individuals or that address the special needs of the elderly, such as for housing or physical and mental health (see Rev. Rul. 67-138, Rev. Rul. 70-585, Rev. Rul. 76-408, Rev. Rul. 72-124; Rev. Rul. 79-18, and Rev. Rul. 79-19), an HMO that enrolls only Medicaid beneficiaries and arranges for the provision of health care services to these individuals by a group of health care providers facilitates the provision of health care services to low-income individuals, a group having special health care needs. Therefore, CHP and DMC qualify for exemption under IRC 501(c)(3) because each is organized and operated exclusively for the charitable purpose of providing relief to the poor and distressed.

NHS, on the other hand, is similar to the organization in Rev. Rul. 77-3, supra. NHS provides services to the state, enabling the state to perform its governmental obligation to provide health care services to Medicaid beneficiaries. Therefore, NHS cannot qualify for exemption under IRC 501(c)(3) on the basis that it is operated exclusively for the charitable purpose of providing relief to the poor and distressed.

C. Lessening the Burdens of Government

(1) Law

Reg. 1.501(c)(3)-1(d)(2) provides that the term "charitable" includes "lessening of the burdens of government." This phrase has been interpreted in several cases involving health care organizations that assist the government to achieve the purposes of the Medicare and Medicaid statutes.

Virginia Professional Standards Review Foundation v. Blumenthal, 466 F. Supp. 1164 (D.D.C. 1979) ("Virginia PSRO"), involved the federal income tax status of a professional standards review organization ("PSRO") set up under the Social Security Amendments of 1972. The legislative history of this statute indicates that Congress created the PSRO

program to perform a quasi-governmental function of overseeing the delivery of health care services to Medicare and Medicaid beneficiaries. The purpose of the oversight was to promote effective, efficient and economical delivery of health care services to Medicare and Medicaid beneficiaries.

The court found that Congress expressly intended that the PSRO program save the government the difficulties and expense related to government oversight. The PSRO served governmental rather than private interests, because it supplied the review and regulation that Congress viewed as necessary for the continued viability of the Medicare and Medicaid programs. Therefore, based on a lessening of governmental burdens rationale, the court held that the PSRO qualified for exemption under IRC 501(c)(3) because its primary purpose was charitable and it had no substantial non-exempt purpose.

A similar organization was involved in Professional Standards Review Organization of Queens County, Inc. v. Commissioner, 74 T.C. 240 (1980), acq., 1980-2 C.B. 2 ("Queens County PSRO"), also discussed at section 2.A(1) of this article. In that case, the Tax Court rejected the Service's argument that the PSRO was formed to promote the interests of the medical profession. The Tax Court emphasized that the PSRO was authorized by federal law to perform a "quasi-governmental function" because Congress had the responsibility to establish a system to assure effective utilization review of services paid for by Medicare and Medicaid funds. However, Congress had shifted its burden of overseeing the system to the medical profession based on its belief that the medical profession, rather than Congress, was better able to conduct this review. The court reasoned that any benefits accruing to the medical profession in the form of a decreased likelihood of federal oversight of the profession were merely incidental to the attainment of the congressional objective of requiring health care providers to perform quality assurance function that would otherwise have to be performed by the government itself. Therefore, the PSRO qualified for exemption under IRC 501(c)(3) because it lessened the burdens of government and promoted the public health.

After the Virginia PSRO and Queens County PSRO decisions, the Service issued Rev. Rul. 81-276, supra, concluding that PSROs are charitable organizations because they lessen the burdens of government and promote the health of the beneficiaries in the Medicare and Medicaid programs. Regarding lessening the burdens of government, the revenue ruling states:

> The legislative history of the Social Security Amendments of 1972 and the statute itself indicate that Congress' objective in establishing PSROs were twofold. First, PSROs were intended to reduce overutilization of the health services provided under medicare and medicaid (and the impact of such overutilization on the health of the aged and poor) by assuring that payments for health care services under governmental health care programs would be made only when, and to the extent, medically

> necessary. . . . Second, PSROs were intended to enable the medical profession to assume the government's responsibility for reviewing the appropriateness and quality of services provided under medicare and medicaid. . . .
> By operating as a designated PSRO and restricting federal health care payments to services that are medically necessary, [the organization] is promoting the health of the beneficiaries of governmental health care programs by preventing unnecessary hospitalization and surgery. In addition, by assuming the government's burden of reviewing the appropriateness and quality of services provided under medicare and medicaid, M is lessening the burdens of government within the meaning of section 1.501(c)(3)-1(d)(2) of the regulations. [Emphasis added.]

To provide guidance in the area of lessening the burdens of government, the Service published Rev. Rul. 85-1, 1985-1 C.B. 177 and Rev. Rul. 85-2, 1985-1 C.B. 178. These revenue rulings hold that an organization lessens the burdens of government if it can establish that (1) a governmental unit has, through objective manifestations, demonstrated that it considers the organization's activities to be its burden; and (2) the organization's activities actually relieve the government's burden. Under the first requirement, the organization must demonstrate that the governmental unit accepts the activities conducted by the organization as its responsibility and recognizes that the organization is acting on its behalf. See Columbia Park and Recreational Association, Inc., 88 T.C. 1, 43 (1987); aff'd, without published opinion, 838 F.2d 465 (4th Cir. 1988).

Because the legislative history of the PSRO statute expressly provided that one of its objectives was to have the medical profession assume the government's responsibility for reviewing the propriety and quality of services provided under Medicare and Medicaid, it could be argued that the PSRO would have satisfied the objective manifestation test of Rev. Ruls. 85-1 and 85-2. The argument that the government's burden was relieved could be based on the fact that PSROs do in fact perform an oversight function that Congress had concluded was necessary to the proper operation of the Medicare and Medicaid programs.

States participating in the federal Medicaid program undertake the obligation to provide for the health care needs of persons who qualify as beneficiaries under the program. Traditionally, states have fulfilled this obligation by reimbursing health care providers at specified rates for services provided to Medicaid beneficiaries. Many states have now begun to change to a managed care arrangement, contracting with HMOs to provide comprehensive and coordinated health care services to Medicaid beneficiaries in return for capitated fees. Thus, states have changed the method by which they purchase and deliver health care services to Medicaid beneficiaries. But states have not transferred their obligation to provide for the health care needs of persons who qualify as Medicaid beneficiaries.

The Medicaid organizations with which a state contracts are vendors providing health care services to the government for a fee. The government is not abdicating any portion of its responsibility to provide health care services to its Medicaid population, nor are these organizations usurping any of this responsibility. Rather, the government is merely changing the manner in which it procures health care services for its Medicaid beneficiaries. Instead of reimbursing providers on a predetermined fee-for-service basis, the government contracts with an organization to arrange for the provision of health care services and pays the organization a fixed monthly fee for each Medicaid enrollee. The fact that the government extensively regulates and monitors these activities and the operations of these vendors to ensure high quality and cost reduction is not an objective manifestation by the government that these Medicaid organizations are performing any of its responsibilities.

Where a state statute, read as a whole, indicates that the legislative body intended that activities be performed by the private sector, albeit with public support, such activities are not considered to lessen the burdens of government. See G.C.M. 38693 (April 15, 1981). The fact that a government satisfies its burden by contracting, on a commercial basis, for goods or services, by itself does not establish that the organization providing these goods and services lessens the government's burden. See Public Industries, Inc. v. Commissioner, 61 T.C.M. (CCH) 1626 (1991); G.C.M. 39685 (December 10, 1987). See, generally, 1993 CPE 17 and 1996 CPE 45 - 48.

(2) Discussion

In the case of CHP and DMC, there has been no objective manifestation by a state, either administratively or in applicable legislation, of an intention that HMOs should assume any portion of the state's burden of providing health care for residents who are Medicaid beneficiaries. See Rev. Ruls. 85-1 and 85-2, supra. Neither state requested that HMOs assume any portion of its responsibility to provide health care for its Medicaid beneficiaries. Unlike the PSRO's, neither state has expressly delegated to HMOs its responsibility to perform certain health care activities that it previously performed. See discussion of Virginia PSRO and Queens County PSRO, above. Further, there is no objective manifestation by either state that it has accepted the HMOs' activities as the state's responsibility. See Columbia Park and Recreational Association, Inc., 88 T.C. 1, 43 (1987); aff'd, without published opinion, 838 F.2d 465 (4th Cir. 1988). Instead, like the organization in Public Industries, Inc. v. Commissioner, 61 T.C.M. (CCH) 1626 (1991), the HMOs have contracted on a commercial basis with the states to arrange for the provision of health care to the states' Medicaid beneficiaries.

Thus, neither CHP nor DMC qualifies for exemption under IRC 501(c)(3) on the basis that it lessens the burdens of government.

In the case of NHS, however, state law requires each county in the state to furnish Medicaid benefits to county residents who are eligible for such services. State law empowers each county to contract only with organizations that are exempt under IRC 501(c)(3) to perform various services related to the Medicaid program which the state or county would otherwise have to perform itself. Pursuant to this authority, the county Medicaid agency contracted with NHS for NHS to perform these services. The state legislation is an objective manifestation of the state's intention that a charitable organization should be given the responsibility of performing a portion of the government's health care responsibilities toward Medicaid beneficiaries. See Rev. Rul. 85-1 and Rev. Rul. 85-2, supra. Similar to the PSROs, the state has expressly delegated authority to counties to contract with a charitable organization to perform certain health care activities which are necessary for the implementation of the Medicaid program and which the state or county would otherwise have to perform. See Virginia PSRO, 466 F. Supp. 1164 (D.D.C. 1979) and Queens County PSRO, 74 T.C. 240 (1980), acq., 1980-2 C.B. 2. Further, the county's contract with NHS, pursuant to statutory authority, to perform these activities is an objective manifestation by the state that it has accepted NHS's activities as the state's responsibility. See Columbia Park and Recreational Association, Inc., supra.

Therefore, NHS qualifies for exemption under IRC 501(c)(3) on the basis that it lessens the burdens of government.

3. Other Considerations

A. Direct Provider

(1) Law

The most common method of promoting health is by the direct provision of health care services to individuals by physicians, hospitals and clinics. Rev. Rul. 69-545, 1969-2 C.B. 117, established a community benefit standard as the basis for the federal income tax exemption of a hospital. A hospital satisfies the community benefit standard if it promotes the health of a class of persons broad enough to benefit the community as a whole and it does not unduly benefit private individuals in achieving that objective.

The application of the community benefit standard of Rev. Rul. 69-545, to exempt hospitals and other exempt health care organizations was sustained in 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 in Sound Health Association, supra. Sound Health Association acknowledged that an HMO providing direct health care services to its members is subject to the same community benefit standards under IRC 501(c)(3) as a hospital.

(2) Discussion

Neither CHP, DMC, nor NHS is a direct provider of health care services. Therefore, under the principles of Sound Health Association, supra, none can be recognized as exempt under IRC 501(c)(3) on the grounds that it is a direct provider of health care services.

B. Integral Part Doctrine

(1) Law

Reg. 1.502-1(b) establishes the "integral part" doctrine for exemption. Under this principle, an organization may derive exemption from a controlling exempt organization if the subordinate organization is not engaged in an activity that would be an unrelated trade or business if the activity were performed by the controlling organization.

Thus, for the integral part doctrine to apply, two conditions must be satisfied: (1) the two organizations must be "related" and (2) the subordinate organization must perform "essential" services for the exempt parent organization.

For purposes of Reg. 1.502-1(b), organizations are "related" if one organization exercises significant structural or financial control over another organization. For example, in Rev. Rul. 78-41, 1978-1 C.B. 148, a trust created by an exempt hospital for the sole purpose of accumulating and holding funds to be used to satisfy malpractice claims against the hospital, and from which the hospital directs the bank-trustee to make payments to claimants, qualifies for exemption under IRC 501(c)(3) as an integral part of the hospital because the hospital exercised significant financial control over the trust.

Usually, organizations are related because one organization has structural control over one or more other organizations. One exempt organization is not related to another merely because both engage in the same type of exempt activities. See Reg. 1.502-1(b).

Under these regulations, a subordinate organization provides "essential" services for its controlling organization if the subordinate's activities would not be an unrelated trade or business if they were performed by the controlling organization. Thus, a subsidiary organization that is operated for the sole purpose of furnishing electric power to its exempt parent would qualify for exemption as an integral part of its parent. However, if the subsidiary furnished electric power to consumers other than its exempt parent and the parent's exempt subsidiaries, it would not be exempt.

In Geisinger Health Plan v. Commissioner, 100 T.C. 394 (1993), ("Geisinger III"), the Tax Court applied the integral part doctrine to an HMO that was created by an exempt hospital system. The Tax Court reasoned that the HMO did not qualify for exemption under the integral part doctrine because a substantial portion of the HMO's enrollees, approximately

20%, were not patients of the Geisinger system hospitals. The Tax Court concluded that by providing services to such a significant number of non-system patients, the HMO's activities were not devoted to furthering the exempt purposes of the Geisinger system hospitals.

On appeal, the Third Circuit affirmed the Tax Court and in the process expressed its own views on the integral part exemption. Geisinger Health Plan v. Commissioner, 30 F.3d 494 (3rd Cir. 1994) ("Geisinger IV").

According to the Third Circuit, the integral part doctrine has two requirements: (1) the subordinate organization must not be engaged in activities that would be unrelated trade or business activities if the parent engaged in these activities directly, and (2) the subordinate organization's relationship to the parent must enhance (or "boost") the subordinate's ability to accomplish charitable purposes to such a degree that the subordinate could qualify for exemption on its own merits.

The Third Circuit concluded that the HMO did not receive any boost from its association with the exempt hospitals in the Geisinger system. The patients the HMO provided to the system, i.e., the HMO's enrollees, were the same patients that it served without its association with the Geisinger system. Thus, the court concluded that the HMO did not satisfy the integral part test because it was not rendered "more charitable" by virtue of its association with the Geisinger system hospitals.

Therefore, under the Third Circuit's application of the integral part doctrine, if the enrollees of an HMO that is a component of an exempt hospital system and the patients of the hospital are not essentially the same, i.e., if a substantial portion of the HMO's enrollees are not also patients of the hospital, the "boost" requirement would apply. Thus, if the exempt hospital enhances the HMO's exempt activities to such a degree that, considering the HMO's own activities together with the enhancement received from the hospital, the HMO could qualify for exemption on its own, the integral part doctrine would be satisfied.

On the other hand, if the enrollees of an HMO that is a component of an exempt hospital system and the patients of the hospital are essentially the same, i.e., where almost all of the HMO's enrollees are also patients of the hospital, the Third Circuit's "boost" requirement would not apply. Thus, the HMO may qualify for exemption if it satisfies the traditional interpretation of the integral part doctrine as described above.

(2) Discussion

AMC, which controls CHP, is an exempt medical clinic that has been providing primary health care services to Medicaid beneficiaries in the state on a fee-for-service basis. Now CHP will operate an HMO that will enroll these same persons. CHP will contract with AMC and with unrelated primary care providers to provide these individuals with primary health care services. Thus, since CHP's enrollees and AMC's patients are not substantially the same, the Third Circuit's "boost" requirement would apply.

According to the Third Circuit, CHP has to demonstrate that its association with AMC enhances the health of the community to such an extent that CHP would qualify for exemption on its own merits as an organization that promotes the health of the community. However, there are no facts establishing that CHP provides health care to a broader class of persons as a result of its association with AMC than it would absent such association. Since CHP is not rendered "more charitable" because of its association with AMC, CHP does not satisfy the Third Circuit's "boost" requirement. Therefore, under this application of the integral part doctrine, CHP would not qualify for exemption under IRC 501(c)(3).

Under the traditional interpretation of the integral part doctrine, CHP and AMC must be structurally related and CHP's activities must not be an unrelated trade or business if AMC rather than CHP performed these activities. AMC controls CHP and CHP arranges for the provision of health care services for its enrollees by various providers, including AMC, independent physicians and several unrelated hospitals. Since CHP's enrollees may become patients of unrelated hospitals, CHP's activities include arranging for the provision of health care by unrelated health care providers. Hypothetically, if AMC arranged for the provision of health care services for CHP's enrollees by unrelated health care providers, this activity would be an unrelated trade or business. As a result, CHP is considered as not performing an "essential" service for AMC. Therefore, based on the integral part doctrine, CHP would not qualify for exemption under IRC 501(c)(3).

DMC is controlled by five unrelated IRC 501(c)(3) community health centers. Thus, no one exempt organization controls DMC. Hypothetically, if any one of these organizations provided the same services for the other organizations that DMC provides for itself, that activity would constitute an unrelated trade or business. Therefore, because DMC does not satisfy either requirement of the integral part doctrine, DMC would not qualify for exemption under IRC 501(c)(3).

NHS is a separate organization that is not related to a provider of health care services. Therefore, because NHS does not satisfy the relatedness requirement of the integral part doctrine, NHS would not qualify for exemption under IRC 501(c)(3) based on the integral part doctrine.

C. Cooperative Hospital Service Organizations

(1) Law

An organization that meets the requirements of IRC 501(e) as a cooperative hospital service organization is treated as an organization described in IRC 501(c)(3). To meet the requirements of IRC 501(e), an organization must be organized and operated on a cooperative basis solely for two or more tax-exempt hospitals and it must conduct certain activities specifically enumerated in the statute which, if conducted by the member hospitals

themselves, would constitute an exempt activity. Reg. 1.501(e)-1(a) provides that IRC 501(e) is the exclusive and controlling section under which a cooperative hospital service organization can qualify as a charitable organization. Accord, HCSC-Laundry v. U.S., 450 U.S. 1 (1981).

(2) Discussion

Because the activities that CHP, DMC, and NHS perform are not included in the list of the specific statutory activities described in IRC 501(e), none of these organizations qualifies for exemption under IRC 501(c)(3) on the basis that it is a cooperative hospital service organization, even if the other requirements of IRC 501(e) were satisfied.

4. IRC 501(m)

In addition to satisfying the requirements of IRC 501(c)(3), in order for an organization to be recognized as exempt, the organization must also satisfy IRC 501(m) by establishing that no substantial part of its activities is comprised of providing commercial-type insurance. Since a discussion of IRC 501(m) is beyond the scope of this article, an analysis of this provision is not included.

5. Conclusion

The use of managed care arrangements by states to provide health care services to their Medicaid population is a relatively new concept and is continuing to evolve. As the state and federal governments experiment with different forms of managed care to benefit the public and control health care costs, we expect that new arrangements will develop. While we cannot anticipate all the various forms managed care arrangements will take, this analysis provides some direction as to how the Internal Revenue Service presently views arrangements currently being used.