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CHSOs: A Viable Opportunity to Centralize Services?

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Cooperative hospital service organizations (CHSOs) offer nonaffiliated tax-exempt hospitals the opportunity to join together to obtain and manage shared services (and potentially use their combined purchasing power to decrease costs). Internal Revenue Code Section 501(e) allows for the formation of a separate, tax-exempt corporation to provide certain services to its patron hospitals on a cooperative basis. In addition, CHSOs enjoy a valuable safe harbor under the federal anti-kickback statute.[1] As the federal government and commercial payers focus on accountable care organizations (ACOs) and payments for value and outcomes, hospitals can benefit from CHSOs as a cost-saving option to obtain shared services.

In 1968, Congress established CHSOs to encourage health care cost containment by allowing for hospitals to purchase services cooperatively.[2] CHSOs are a specific exception from the general rule in Section 502 prohibiting tax-exempt status for ''feeder organizations'' that are operated for the primary purpose of carrying on a trade or business for profit.[3]

CHSOs were initially popular in the years after enactment. However, the creation of larger hospital systems reduced the need for nonaffiliated hospitals to enter into joint purchasing agreements. The current focus by hospitals on population health, ACOs, cost reductions, and affiliations to recognize efficiencies, suggest hospitals may want to focus again on CHSOs.

I. Requirements for CHSOs

Unfortunately, the IRS and the courts have narrowly construed Section 501(e) as an exception to what is otherwise taxable activity. Accordingly, CHSOs must strictly meet the statutory requirements or they will lose their tax-exempt status and the safe harbor protection of the anti-kickback statute.

A. Patron Hospital Requirement

CHSOs must be owned solely by ''patron'' hospitals, who must be Section 501(c)(3) hospitals or hospitals owned or operated by the government or a division of the government (specifically, a ''government instrumentality''). Patron hospitals must be the only owners of the CHSO. Not all patron hospitals must have voting rights, but the CHSO must provide at least 50 percent of its services for patron hospitals with voting rights.

B. Allocation-Payover Requirement

Under Section 501(e), a CHSO must ''allocate or pay all of its net earnings within 8½ months after the close of the taxable year to its patron hospitals on the basis of the percentage of its services performed for each patron.''[4] CHSOs must make appropriate bookkeeping entries and ''provide timely written notice to each patron hospital disclosing the amount allocated to the hospital on the CHSO's books.''[5]

A CHSO may retain net earnings to pay its debt, expand its services or another necessary purpose, but such amounts must be allocated to the patron hospitals. Any accumulation of net earnings may not exceed reasonably anticipated needs of the CHSO.

C. Capital Stock-Limitations Requirement

If a CHSO is organized as a stock corporation, all of its stock must be owned by its patron hospitals (though

[1] 42 C.F.R. § 1001.952(q).
[2] *See* S. Rep. No. 744, 90th Cong., 1st Sess. 200 (1967).
[3] Rev. Rul. 54-305, 1945-2 C.B. 127. *See also* Douglas M. Mancino, Taxation of Hospitals and Health Care Organizations, Lexis Nexis, *Introduction to the Healthcare Industry* Coursebook; Internal Revenue Service, at 379.
[4] I.R.C. § 501(e)(2).
[5] *Id.*

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a CHSO need not be organized as a stock corporation). No dividends may be paid to patron hospitals based on the investment owned; the CHSO may only pay distributions based on the percentage of service performed as described above.

D. Enumerated Service Requirement

CHSOs may only provide one or more of the following enumerated services to its patron hospitals:

- data processing
- purchasing (including the purchasing of insurance on a group basis)
- warehousing
- billing and collection (including the purchase of patron accounts receivable on a recourse basis)
- food
- clinical
- industrial engineering
- laboratory
- printing
- communications
- record center
- personnel (including selection testing, training, and education of personnel) services

Hospitals sought to qualify for the exemption by sharing laundry services through a CHSO. The U.S. Supreme Court in *HCSC Laundry v. United States*,[6] concluded that the services enumerated in Section 501(e) were exclusive, and no tax exemption was available for any laundry services provided on a cooperative basis, because laundry services were not specifically listed. The court in a summary, *per curiam* decision, concluded that the listing was intended to be exclusive and noted that in the legislative history an attempt to add laundry to the list of services had been rejected.

So, if the CHSO provides services not enumerated, even if such services are provided in addition to the enumerated services, the CHSO will not be eligible for a tax exemption. This limitation does not preclude a CHSO from receiving membership dues, gifts, grants, rents from real property, or income from passive investments. But the CHSO may not engage in any other business and may not have an unrelated trade or business (there are certain exceptions for some passive income-generating activities).

A couple of the enumerated services are worth comment. The inclusion of ''laboratory'' in the list of enumerated services presumably reflects an intent to allow qualifying hospitals to centralize clinical reference laboratories. The term ''laboratory'' is broader, however, and could include cardiac catheterization laboratories and other services which may properly be included in the definition of ''laboratory.''

A CHSO can provide ''clinical services.'' The term is not further defined in the statute or Treasury regulations. The IRS has suggested that Section 501(e) contemplates that the services be performed for the patron hospitals and thus CHSOs cannot provide services directly to the general public.[7] However, the IRS, in its training materials, has suggested that ''clinical services'' includes those services provided to ''patients'' of the patron hospitals if the care is rendered by, and under the supervision of, the professional staff of a patron hospital as an extension of its inpatient and outpatient care.[8] A footnote in the IRS training manual states ''Consequently, 'clinical,' for IRC 501(e) purposes encompasses services provided in patients' homes after their discharge from inpatient status.''[9]

E. Prohibition on Services to Other Organizations

A CHSO may not perform any service for organizations other than its patron hospitals (other than a de minimis amount and as mandated by a governmental unit). This general prohibition includes services provided to both taxable or tax-exempt hospitals and other organizations, but does not include other CHSOs.[10]

II. Anti-Kickback Safe Harbor for CHSOs

CHSOs qualify for safe harbor protection for certain payments under the federal anti-kickback statute. The anti-kickback statute generally prohibits ''remuneration'' of any type in exchange for referrals for the use of hospital services. The safe harbor regulations applicable to CHSOs provide that ''remuneration'' does not include any payment made between a CHSO and its patron hospitals, as long as either:

- a payment by a patron hospital to the CHSO is made for the purpose of paying the bona fide operating expenses of the CHSO; or
- a payment by a CHSO to a patron hospital is for the purpose of paying a distribution of net earnings as required by Section 501(e), where the payment reflects the percentage of services performed by the CHSO.[11]

The safe harbor requires that CHSOs be exempt and comply with the provisions of Section 501(e).

The CHSO safe harbor allows for protection for payments made based on the volume and value of services consumed. Generally, the anti-kickback statute does not protect payments based on the volume or value of services. Often relationships that do not meet all the criteria for a safe harbor are structured to get as close as they can to the requirements and proceed on the basis that no improper intent is present. Patrons may take some risk and consider this approach in centralizing services that do not meet all of the requirements of Section 501(e) and thus the safe harbor.

Summary

While CHSOs have particular requirements that must be satisfied, if the circumstances fit, CHSOs present opportunities for qualifying hospitals to share certain services on a centralized basis as they try to look for syn-

[6] 450 U.S. 1 (1981).

[7] *See* P.L.R. 200218037 (March 27, 2002) (MRI imaging services); P.L.R. 200151045 (July 26, 2001) (lithotripsy services).

[8] *Introduction to the Health Care Industry*, Internal Revenue Service, Training 3302-102 (1-95), at 382 n.36. *See also* Rev. Rul. 68-376, 1968-2 C.B. 246.

[9] *Id.*

[10] Reg. § 1.501(e)-1(d)(1).

[11] 42 C.F.R. § 1001.952(q).

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ergies for more efficient operations. With the safe harbor protection under the anti-kickback statute, hospitals with referral relationships will also find certain payments protected under CHSOs that would otherwise not be.