TAX EXEMPT AND
GOVERNMENT ENTITIES
DIVISION

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

Number: **201250025**
Release Date: 12/14/2012

Contact Person:

Identification Number:

Date: September 21, 2012

UIL: 501.32-00; 501.33-00; 512.00-00; 513.00-00

Legend:

Taxpayer =
State =
Program =
$x =

Dear :

We have considered your ruling request dated February 12, 2009, regarding the federal income tax consequences associated with the operation of the Program as described below.

Facts

Taxpayer is an organization exempt from federal income tax under § 501(c)(3) of the Internal Revenue Code (the "Code") and is classified as a Type I supporting organization under § 509(a)(3). Taxpayer's Articles of Incorporation indicate that Taxpayer was formed to benefit, perform the functions of, and carry out the public purposes of twelve organizations (the "Supported Organizations"). All but three of the Supported Organizations are corporations or governmental units described in § 509(a)(1). The remaining three Supported Organizations are exempt under § 501(c)(6) and would qualify as public charities under § 509(a)(2) if they were described in § 501(c)(3).

Taxpayer was formed to operate a regional health information exchange. In collaboration with another exempt organization, Taxpayer has developed a clinical database (the "Database"), which includes electronic medical and drug claims data compiled by participating health plans, patient prescription medication data and laboratory and test results, and clinical messaging data. Providers use the information contained in the Database to provide relevant, patient-specific information for a set of diagnoses and preventive care procedures. In addition, the Database provides physicians with alerts and reminders regarding the posting of laboratory results and the need to schedule upcoming patient treatments.

The Program

Taxpayer and several participating major health plans and health care providers in State collaborated to create Program. The Program combines claims data from multiple health plans and electronically submitted clinical data from providers to assist and evaluate performance and practice across an entire patient population, not just among patients who are members of a particular health plan. Based upon the information collected in the Database, Taxpayer provides reports to health care providers documenting their performance in a number of clinical quality and efficiency measures ("Clinical Quality Reports"). Physicians are able to use these reports to determine which patients require an intervention or treatment. Similar reports are also sent to health insurers that participate in Program. These reports allow health plans to evaluate their insureds' providers against the quality and efficiency measures noted above and reward providers accordingly in order to encourage higher levels of quality and efficiency in clinical care. Program includes treatment information for a large number of patients per measure for each provider, resulting in statistically valid reports

Health-Plan Participation

Commercial and government health plans ("Participating Health Plans") pay a fee to Taxpayer to participate in Program (the "Service Fee"). An agreement between Taxpayer and Participating Health Plans (the "Participating Health Plan Agreement") sets forth the amount of the Service Fee and the responsibilities of both parties. The amount of the Service Fee is primarily based on the number of subscribers in the Participating Health Plan, and is approximately 50 percent lower for some government Participating Health Plans. In some instances, a Participating Health Plan may provide an initial payment to enroll in the program against which its monthly Service Fees will be applied. In addition, Taxpayer and Participating Health Plans may agree on alternate pricing for the development and creation of special or ad hoc reports.

Under the terms of the Participating Health Plan Agreement, Participating Health Plans are responsible for providing, installing and maintaining all equipment, software, facilities, and connections associated with their participation in Program at their own expense. Participating Health Plans deliver to Taxpayer their enrollment data, medical, laboratory and prescription claims data, provider data, and other relevant information for their enrollees to be stored in the Database.

Participating Health Plans are responsible for designing and implementing a plan for compensating physicians who choose to participate in Program ("Participating Physicians"). This "Physician Compensation Plan" must be based on the quality and efficiency of the Participating Physicians' work. Participating Health Plans are responsible for making these payments, which could amount to up to $x per physician per year, depending on the physician's performance on a number of quality measures. Taxpayer will not be involved in determining the compensation that a Participating Health Plan will make to a Participating Physician. The Participating Physician will receive compensation based solely on the criteria set forth by the Participating Health Plans in the Physician Compensation Plans. Participating Health Plans provide Taxpayer with a periodic report disclosing the amount of aggregate compensation

payments estimated to be made to each Participating Physician based upon clinical measures determined by the Measures Committee (described below) and quarterly reports that Taxpayer issues. Taxpayer requires that Participating Health Plans comply with the following minimum requirements when establishing their Physician Compensation Plans:

- The Physician Compensation Plan must provide that upon completion of the first year that a Participating Physician is enrolled in Program, the Participating Physician automatically will receive a minimum payment in exchange for their participation in Program.
- The Physician Compensation Plan maintained by each Participating Health Plan must provide a financial incentive to Participating Physicians.
- The financial incentive must be made available to Participating Physicians at least annually.
- At least 50% of the Program clinical measures (described below) that are approved to be used for incentive payments, by specialty, must be used to determine the quality portion of incentive payments under a Physician Compensation Plan.
- At least 50% of the quality related incentives available under a Physician Compensation Plan must be based upon approved Program clinical measures (described below).

Physician Participation

Upon choosing to participate in Program, Participating Physicians enter into an agreement with Taxpayer (the "Physician Agreement"). However, they are not required to pay Taxpayer an enrollment or participation fee. Under the terms of the Physician Agreement, the Participating Physicians are responsible for providing, installing, and maintaining, at their expense, all equipment, software, facilities and encryption devices necessary to provide Taxpayer with their clinical data for storage in the Database. On a periodic basis, Participating Physicians deliver to Taxpayer the data needed to support measurement reporting, including data related to lab services provided to and examinations of Covered Enrollees in the Participating Physician's office(s). Upon enrolling in Program, Participating Physicians receive regular reports from Taxpayer, as well as alerts notifying them of test results out of approved range, when patients are not in compliance with their treatment plan, and when patients are due for routine screenings or follow-ups.

Taxpayer's Responsibilities

Taxpayer provides the overall management and administrative services for Program to run effectively. Taxpayer inputs and manages the clinical data that it collects from Participating Physicians and Participating Health Plans in the Database. The Participating Health Plan Agreement and the Physician Agreement set forth Taxpayer's other responsibilities in connection with Program, among which Taxpayer converts and stores electronic data into a workable format, maintains appropriate security measures to protect the data stored on the Database, and prepares the following reports on at least a quarterly basis:

- Taxpayer provides to each Participating Physician a Clinical Quality Report showing

measurement results for each of the Participating Physician's patients that qualify for an approved Program measurement.

- Taxpayer provides to each Participating Physician a summary of incentive payments reported by Participating Health Plans as having been made to the Participating Physician by a Participating Health Plan during the report period (a "Summary Incentive Report").
- Taxpayer provides to each Participating Health Plan a summary of the aggregate incentive payments reported by all such plans as having been made to Participating Physicians through Participating Health Plans' Physician Compensation Plans (an "Aggregate Incentive Report").
- Taxpayer provides each Participating Health Plan Clinical Quality Reports for each Participating Health Plan Covered Enrollee that Taxpayer is able to determine is attributable to a Participating Physician that implicated an approved Program measurement.
- Taxpayer will, upon such terms and for additional compensation as may be mutually agreed upon between Participating Health Plans and Taxpayer, provide customized Participating Physician scorecards to Participating Health Plans. In addition to the information contained in the Database, Taxpayer shall accept, for the purpose of incorporating into such scorecards, additional non-clinical information.

Taxpayer also coordinates a "Data Reconciliation Process" to respond to Participating Health Plans and Participating Physicians who notify Taxpayer about a Clinical Quality Report, Summary Incentive Report or Aggregate Incentive Report discrepancy. Taxpayer's role in the Data Reconciliation Process is to facilitate the reconciliation of data provided by the affected Participating Health Plans and Participating Physicians. Taxpayer makes any necessary corrections to the reports, as determined by the Data Reconciliation Process.

The Measures Committee

Among other responsibilities, the Program Measures Committee: (i) selects nationally-recognized, evidence-based measures to evaluate the quality and efficiency of the health care provided by the Participating Physicians; (ii) develops processes designed to ensure fairness in reporting; (iii) determines when measures are appropriate for public reporting; and (iv) recommends to the Administrative Committee which measures should be used in Physician Compensation Plans and how they might effectively be used. Currently, the Measures Committee has identified 27 measures ("Clinical Quality Measures") to evaluate the care that primary care Participating Physicians provide their patients. Subcommittees of the Measures Committee have begun work in determining appropriate measures for cardiologists and orthopedic physicians. As the Program continues to expand to additional specialty areas, the Measures Committee will determine appropriate nationally-recognized measures for evaluating physician care within such specialties.

The Administrative Committee

The Program Administrative Committee is responsible for providing overall direction for Program

and for representing the interests of all Program participants. Among other duties, the Administrative Committee: (i) addresses and resolves concerns raised by Program participants; (ii) determines Program rules for Participating Health Plans and Participating Physicians; (iii) determines minimum requirements for Physician Compensation Plans; (iv) recommends to Participating Health Plans which Clinical Measures should be used in Physician Compensation Plans; (v) reviews and considers for approval recommendations from the Measures Committee; (vi) reviews and considers for approval Program budgets; and (vii) periodically reviews and evaluates Taxpayer's performance.

Rulings Requested

Taxpayer has requested the following rulings in connection with the circumstances described above:

1. Taxpayer's management and facilitation of Program furthers its charitable and educational purposes under § 501(c)(3) of the Code.

2. The merit-based compensation payments made by the Participating Health Plans to the Participating Physicians, the Clinical Quality Reports that Participating Physicians and Participating Health Plans receive in connection with the Program, Participating Physicians' access to the Database, and any benefit in reduced expenses enjoyed by the Participating Health Plans do not constitute prohibited private inurement or private benefit from Taxpayer under § 501(c)(3) of the Code.

3. Neither the Service Fees received by Taxpayer from Participating Health Plans in conjunction with Program, nor any other income received by Taxpayer in connection with Program, will constitute unrelated business taxable income to Taxpayer under § 512(a) of the Code.

Law

Section 1.501(a)-1(c) of the Treasury Regulations (the "regulations") provides that the words "private shareholder or individual" in § 501 refer to persons having a personal and private interest in the activities of the organization.

Section 501(c)(3) of the Code provides for the exemption from federal income tax of corporations organized and operated exclusively for charitable and other exempt purposes.

Section 1.501(c)(3)-1(c)(1) the regulations provides that an organization will be regarded as operated exclusively for one or more exempt purposes only if it engages primarily in activities which accomplish one or more of such exempt purposes specified in § 501(c)(3). An organization will not be so regarded if more than an insubstantial part of its activities is not in furtherance of an exempt purpose.

Section 1.501(c)(3)-1(c)(2) of the regulations provides that an organization is not operated exclusively for one or more exempt purposes if its net earnings inure in whole or in part to the

benefit of private shareholders or individuals. Section 1.501(a)-1(c) defines the words "private shareholder or individual" in § 501 to refer to persons having a personal and private interest in the activities of the organization.

Section 1.501(c)(3)-1(d)(1)(ii) of the regulations provides that to be organized and operated for one or more exempt purposes the organization must serve a public rather than a private interest.

Section 1.501(c)(3)-1(d)(2) of the regulations provides that the term "charitable" is used in § 501(c)(3) in its generally accepted legal sense and includes relief of the poor and distressed or of the underprivileged, lessening of the burdens of government and promotion of social welfare by organizations designed to accomplish any of the above purposes.

Rev. Rul. 70-186, 1970-1 C.B. 129, described a nonprofit organization formed and operated in preserving and improving a lake for public recreation. The organization was financed by contributions from lake front property owners, from members of the community adjacent to the lake, and from municipalities bordering the lake. The ruling held that because the organization insured the continued use of the lake for public recreational purposes, it was performing a charitable activity. The benefits derived from the organization's activities flowed principally to the general public through the maintenance and improvement of public recreational facilities, and that any private benefits derived by the lake front property owners did not lessen the public benefits flowing from the organization's operations. In fact, it would have been impossible for the organization to accomplish its purposes without providing benefits to the lake front owners. Thus, the Service ruled that the organization was exempt under § 501(c)(3).

Rev. Rul. 73-313, 1973-2 C.B. 174, holds that providing office facilities to attract a physician to a community that had no available medical services furthered the charitable purposes of promoting the health of the community. The ruling states that certain facts are particularly relevant: (1) the demonstrated need for a physician to avert a real and substantial threat to the community; (2) evidence that the lack of a suitable office had impeded efforts to attract a physician; (3) the arrangements were at completely arm's length; and (4) there was no relationship between any person connected with the organization and the recruited physician. The ruling states that, under all the circumstances, the arrangement used to induce the doctor to locate a practice in the area bears a reasonable relationship to promotion and protection of the health of the community and any private benefit to the physician is incidental to the public purpose achieved.

Section 512(a) of the Code defines "unrelated business taxable income" as the gross income derived by any organization from any unrelated trade or business (as defined in § 513 of the Code) regularly carried on by the organization, less certain deductions allowed which are directly connected with the carrying on of such trade or business, computed with the modifications provided in 512(b) of the Code.

Section 513(a) of the Code defines an "unrelated trade or business" as any trade or business the conduct of which is not substantially related (aside from the need of the organization for funds or the use it makes of the profits derived) to the exercise of the organization's exempt

purposes or functions.

Section 1.513-1(b) of the regulations provides that for purposes of § 513 of the Code the term "trade or business" has the same meaning it has in § 162, and generally includes any activity carried on for the production of income from the sale of goods or the performance of services.

Section 1.513-1(c)(1) of the regulations provides that in determining whether trade or business from which a particular amount of gross income derives is "regularly carried on," within the meaning of § 512 of the Code, regard must be had to the frequency and continuity with which the activities productive of the income are conducted and the manner in which they are pursued. For example, specific business activities of an exempt organization will ordinarily be deemed to be "regularly carried on" if they manifest a frequency and continuity, and are pursued in a manner, generally similar to comparable commercial activities of non-exempt organizations.

Section 1.513-1(d)(2) of the regulations provides that trade or business is related to exempt purposes, in the relevant sense, only where the conduct of the business activities has causal relationship to the achievement of exempt purposes (other than through the production of income), and it is "substantially related," for purposes of § 513, only if the causal relationship is a substantial one. Thus, for the conduct of trade or business from which a particular amount of gross income is derived to be substantially related to purposes for which exemption is granted, the production or distribution of the goods or the performance of the services from which the gross income is derived must contribute importantly to the accomplishment of those purposes. Where the production or distribution of the goods or the performance of the services does not contribute importantly to the accomplishment of the exempt purposes of an organization, the income from the sale of the goods or the performance of the services does not derive from the conduct of related trade or business. Whether activities productive of gross income contribute importantly to the accomplishment of any purpose for which an organization is granted exemption depends in each case upon the facts and circumstances involved.

The American Recovery and Reinvestment Act of 2009 ("ARRA"), P.L. 111-5, enacted February 17, 2009, includes the provision of various economic incentives to encourage the use of health information technology.

The Conference Report to ARRA (H.Rept. 111-16, 111th Cong. 1st Sess., 2/12/09) includes the following statement relating to these incentives, at 488-9:

> As a result of the incentives and appropriations for health information technology provided in this bill, it is expected that nonprofit organizations may be formed to facilitate the electronic use and exchange of health-related information consistent with standards adopted by HHS, and that such organizations may seek exemption from income tax as organizations described in IRC sec. 501(c)(3). Consequently, if a nonprofit organization otherwise organized and operated exclusively for exempt purposes described in IRC sec. 501(c)(3) engages in activities to facilitate the electronic use or exchange of health-related information to advance the purposes of the bill, consistent with standards adopted by HHS, such activities will be considered activities that substantially further an exempt

purpose under IRC sec. 501(c)(3), specifically the purpose of lessening the burdens of government. Private benefit attributable to cost savings realized from the conduct of such activities will be viewed as incidental to the accomplishment of the nonprofit organization's exempt purpose.

Analysis

Issue 1: Whether the management and facilitation of Program furthers Taxpayer's charitable and educational purposes under § 501(c)(3) of the Code.

Taxpayer is organized and operated for charitable purposes so as to benefit, perform the functions of, and carry out the public purposes of its supported organizations – numerous governmental and health-related entities in State – by operating a health information exchange. As a part of its operations, Taxpayer maintains a Database that includes electronic medical and drug claims data compiled by health plans and physicians. Program combines the claims data in the Database to create patient summaries as well as Clinical Quality Reports documenting the performance of Participating Physicians in a number of clinical quality and efficiency measures selected by Taxpayer. These reports are provided to Participating Health Plans to enable them to design and implement Physician Compensation Plans under which the Participating Health Plans make payments to Participating Physicians based on the physicians' performance as to each quality measure.

Section 1.501(c)(3)-1(d)(2) of the regulations provides that the term "charitable" is used in § 501(c)(3) in its generally accepted sense, and includes "lessening the burdens of government." The Congress has said that activities to facilitate the electronic use or exchange of health-related information to advance the purposes of the American Recovery and Reinvestment Act of 2009 ("ARRA"), consistent with standards adopted by HHS, are to be considered activities that substantially further an exempt purpose under § 501(c)(3) of the Code, specifically the purpose of lessening the burdens of government. *See* H.R. Rep. No 111-16, at 488-89 (2009) (Conf. Rep.). Title XIII of ARRA, the HITECH Act (Pub. L. 111-5, § 13001 et seq.), establishes an Office of the National Coordinator to develop a nationwide health information technology infrastructure that allows for the electronic use and exchange of information and that, among other things:

- Improves health care quality, reduces medical errors, reduces health disparities, and advances the delivery of patient-centered medical care;
- Reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information;
- Provides appropriate information to help guide medical decisions at the time and place of care;
- Promotes early detection, prevention, and management of chronic diseases;
- Promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services; and,
- Improves efforts to reduce health disparities.

Taken together, the Act and the Conference Report imply that activities that make use of health

information technology to improve health care quality and reduce health care costs promote the purposes of the Act and are, thus, to be considered activities that further the charitable purpose of lessening the burdens of government.

Program promotes the purposes of the Act by using health information technology to reduce healthcare costs, improve healthcare quality, and promote a more effective marketplace. Program uses health information technology to improve healthcare quality by providing information to health care providers that helps them better monitor patient health and wellness. Using information from the Database, Program assembles lab results, immunizations, diagnoses, cardiology and radiology reports, procedures and medication information in easy-to-read patient summaries that allow the physician to make best use of his or her time. These reports allow physicians to track those patients who are due for preventive screening, provide reminders for health screen interventions to make the best use of patient appointments, enable early interventions and constituent support to those patients with chronic diseases, provide physicians with comparisons of their care to the physician community as a whole as a way to identify best practices, and enable physician offices to update information regularly to ensure accuracy of program reporting.

Program uses health information technology to reduce healthcare costs and promote a more effective marketplace by combining a health information exchange with a multi-carrier pay-for-performance program. It encourages providers to attain evidence-based, clinical outcomes in order to improve the quality, safety, and efficiency of health care in State. Program's patient summaries provide physicians with comprehensive, up-to-date health data that promotes earlier interventions and more consistent follow-up care for patients with chronic diseases, a critical first step in capping healthcare costs. Program generates Clinical Quality Reports documenting the performance of health care providers against Clinical Quality Measures selected by Taxpayer's Measures Committee. These reports eliminate the complexity and ease the burden of physicians in complying with federal mandates for health information technology use and reporting. Further, Program provides a structure for Participating Health Plans to reimburse physicians based on improvements in patient outcomes. The evidence-based measures selected by the Measures Committee to be included in the Clinical Quality Reports allow Participating Health plans to evaluate their insureds' providers and, under a Physician Compensation Plan that each Participating Health Plan is required to adopt as part of the Program, reward those providers that qualify for an approved Program measurement.

By lessening the burdens of government through the use of health information technology to improve health care quality and reduce health care costs, Program serves charitable purposes within the meaning of § 1.501(c)(3)-1(d)(2). Consequently, the management and facilitation of the Program furthers Taxpayer's charitable purposes within the meaning of § 501(c)(3).

Issue 2: Whether the merit-based compensation payments made by the Participating Health Plans to the Participating Physicians, the Clinical Quality Reports that Participating Physicians and Participating Health Plans receive in connection with the Program, Participating Physicians' access to the Database, and any benefit in reduced expenses enjoyed by the Participating Health Plans do not constitute prohibited inurement or private benefit from Taxpayer under § 501(c)(3) of the Code.

Program provides services, but not payments, to Participating Physicians and Participating Health Plans, neither of which is a private shareholder or individual (as defined in § 1.501(a)-1(c)) with respect to Taxpayer. And the merit-based compensation payments made to Participating Physicians under Physician Compensation Plans are determined by, and are paid from the assets of, the Participating Health Plans, not from the assets of Taxpayer. Therefore, the management and facilitation of Program would not result in the inurement of Taxpayer's net earnings to the benefit of private shareholders or individuals within the meaning of § 1.501(c)(3)-1(c)(2).

However, in addition to the inurement prohibition, under § 1.501(c)(3)-1(d)(1)(ii), an organization is not considered to be operated exclusively for one or more charitable purposes, unless it serves a public, and not a private, interest. The ultimate members of a charitable class need not always be the direct and immediate beneficiaries of a charitable organization's programs in order for the organization to be operated exclusively for charitable purposes. Activities that do not directly serve charitable ends may nevertheless benefit the community if the ultimate result of those activities is the achievement of a charitable purpose. *See* Rev. Rul. 73-313. While the direct and immediate beneficiaries of Program are the Participating Physicians and Participating Health Plans, the ultimate beneficiaries of Program are the general public of State who will enjoy better health care at lower costs on account of Program.

Furthermore, the regulations permit an insubstantial amount of private benefit without jeopardizing an organization's exempt status. Private benefit is considered insubstantial if it is both qualitatively and quantitatively incidental. A private benefit is qualitatively incidental if it is indirect or unintentional, or if it is a necessary concomitant of the activity which benefits the public at large in the sense that the benefit to the public cannot be achieved without necessarily benefiting certain private individuals. A benefit is quantitatively incidental only if it is insubstantial when compared with the public benefit conferred. *See* Rev. Rul. 70-186. Participating Physicians' access to the Database and the Clinical Quality Reports that Participating Physicians and Health Plans receive in connection with the Program confer private benefits on those Physicians and Plans that are qualitatively incidental because those benefits are a necessary concomitant of the activities that benefit the general public. That is, patients will enjoy the benefits of improved health care quality and earlier detection, prevention, and management of chronic diseases only if their physicians and health plans receive the information contained in the reports produced by Program. Likewise, the benefits provided to the Participating Physicians and Health Plans in the form of reduced costs is insubstantial in comparison to the public benefits bestowed by Program. Indeed, the Congress, in its report on the HITECH Act, explicitly said that any cost saving realized from the conduct of activities to facilitate the electronic use or exchange of health-related information to advance the purposes of the Act should be viewed as incidental to the accomplishment of exempt purposes.

Consequently, the activities undertaken by Taxpayer in connection with its management and facilitation of Program will not result in, or constitute, inurement within the meaning of § 1.501(c)(3)-1(c)(2) or impermissible private benefit within the meaning of § 1.501(c)(3)-1(d)(1)(ii).

Issue 3: Whether the Service Fees Received by Taxpayer from Participating Health Plans in Connection with Program Constitute Unrelated Business Taxable Income to Taxpayer under § 512(a).

Taxpayer derives income from Program by imposing a Service Fee on Participating Health Plans. These fees are used to maintain the Program's Database and to provide management and consultation services with respect to the Program. Program is a trade or business within the meaning of §1.513-1(b) because it is an activity that produces income from the performance of services. Insofar as Program is conducted on a continuous basis, it is considered to be "regularly carried on" within the meaning of § 1.513-1(c)(1). Thus, unless the conduct of Program is substantially related to Taxpayer's exempt purposes or function within the meaning of §1.513-1(d)(2), the Service Fees would be considered unrelated business taxable income under § 1.512(a)-1(a).

Taxpayer's exempt purpose is to benefit, perform the functions of, and carry out the public purposes of its twelve supported organizations by operating a regional health information exchange. As described above, the conduct of the Program, in which all the supported organizations participate, substantially furthers Taxpayer's charitable purposes by adding value to the health information exchange in ways that improve the health care of the citizens of State and reduce the costs of Participating Health Plans, including governmental health plans, thereby lessening the burdens of government. Likewise, any special or ad hoc reports derived from information in the Database supplement the Clinical Quality Reports and Incentive Reports provided to the Participating Health Plans and serve to reduce health care costs and promote a more effective marketplace, greater competition, greater systems analysis, and increased consumer choice, thereby lessening the burdens of government and benefiting all of Taxpayer's supported organizations. Therefore, the Service Fees and any fees received for the development and generation of ad hoc or special reports for Participating Health Plans are income from a trade or business that is substantially related to Taxpayer's exempt purpose and should not be considered unrelated business taxable income within the meaning of § 512(a) of the Code. This is true whether the Service Fees are paid on a monthly basis or the Participating Health Plan makes an initial payment against which the monthly Service Fees are applied.

Conclusions

Based on the information provided, we rule as follows:

1. Taxpayer's management and facilitation of Program furthers its charitable and educational purposes under § 501(c)(3) of the Code.

2. The merit-based compensation payments made by the Participating Health Plans to the Participating Physicians, the Clinical Quality Reports that Participating Physicians and Participating Health Plans receive in connection with the Program, Participating Physicians' access to the Database, and any benefit in reduced expenses enjoyed by the Participating Health Plans do not constitute prohibited private inurement or private benefit from Taxpayer under § 501(c)(3) of the Code.

3. Neither the Service Fees received by Taxpayer from Participating Health Plans in conjunction with Program, nor any fees received by Taxpayer in connection with the development and creation of special or ad hoc reports for Participating Health Plans under Program, will constitute unrelated business taxable income to Taxpayer under § 512(a) of the Code.

This ruling will be made available for public inspection under § 6110 after certain deletions of identifying information are made. For details, see enclosed Notice 437, *Notice of Intention to Disclose.* A copy of this ruling with deletions that we intend to make available for public inspection is attached to Notice 437. If you disagree with our proposed deletions, you should follow the instructions in Notice 437.

This ruling is directed only to the organization that requested it. Section 6110(k)(3) provides that it may not be used or cited by others as precedent.

This ruling is based on the facts as they were presented and on the understanding that there will be no material changes in these facts. This ruling does not address the applicability of any section of the Code or regulations to the facts submitted other than with respect to the sections described. Because it could help resolve questions concerning your federal income tax status, this ruling should be kept in your permanent records.

If you have any questions about this ruling, please contact the person whose name and telephone number are shown in the heading of this letter.

In accordance with the Power of Attorney currently on file with the Internal Revenue Service, we are sending a copy of this letter to your authorized representative.

Sincerely,

Elizabeth C. Kastenberg
Acting Manager, Exempt Organizations
Technical Group 1

Enclosure
Notice 437