July 23, 2013

Mr. Daniel Werfel
Principal Deputy Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20024

Re: Comments Concerning Accountable Care Organizations

Dear Principal Deputy Commissioner Werfel:

Enclosed are comments concerning Accountable Care Organizations. These comments represent the view of the American Bar Association Section of Taxation and Health Law Section. They have not been approved by the Board of Governors or the House of Delegates of the American Bar Association, and should not be construed as representing the policy of the American Bar Association.

Sincerely,

Rudolph R. Ramelli
Chair, ABA Section of Taxation

David L. Douglass
Chair, Health Law Section

Enclosure

cc: Mark J. Mazur, Assistant Secretary (Tax Policy), Department of the Treasury
William J. Wilkins, Chief Counsel, Internal Revenue Service
Emily S. McMahon, Deputy Assistant Secretary (Tax Policy), Department of Treasury
These comments (“Comments”) are submitted on behalf of the American Bar Association Section of Taxation and Health Law Section and have not been approved by the House of Delegates or Board of Governors of the American Bar Association. Accordingly, they should not be construed as representing the position of the American Bar Association.

Principal responsibility for preparing these Comments was exercised by Frederick J. Gerhart, Robert W. Friz and Bernadette Broccolo of the Exempt Organizations Committee of the Section of Taxation and the Tax and Accounting Interest Group of the Health Law Section. Substantive contributions were made by Ralph DeJong, Michael Fine, Richard Frazier, Elizabeth Mills, Richard Sevcik, Gwen Spencer, and Karen Hayes. The Comments were reviewed by Suzanne Ross McDowell, Chair of the Exempt Organizations Committee of the Section of Taxation, LaVerne Woods of the Committee on Government Submissions of the Section of Taxation, Michael A. Clark, Council Director for the Exempt Organizations Committee, and William W. Horton of the Health Law Section, in his role as Secretary of the Section and Co-Chair of the Section’s Health Law and Policy Coordination Committee.

Although the members of the Section of Taxation and Health Law Section who participated in preparing these Comments have clients who might be affected by the federal tax principles addressed by these Comments, no such member or the firm or organization to which such member belongs has been engaged by a client to make a government submission with respect to, or otherwise to influence the development or outcome of, the specific subject matter of these Comments.

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Date: July 23, 2013
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>1</td>
</tr>
<tr>
<td>COMMENTS ON ACCOUNTABLE CARE ORGANIZATIONS</td>
<td>3</td>
</tr>
<tr>
<td>I. THE AFFORDABLE CARE ACT</td>
<td>3</td>
</tr>
<tr>
<td>II. NOTICE 2011-20</td>
<td>3</td>
</tr>
<tr>
<td>III. MSSP ACOs</td>
<td>3</td>
</tr>
<tr>
<td>A. GOALS OF MSSP ACOs</td>
<td>3</td>
</tr>
<tr>
<td>B. STRUCTURE AND OPERATIONS OF MSSP ACOs</td>
<td>4</td>
</tr>
<tr>
<td>C. TAX-EXEMPT PURPOSES</td>
<td>6</td>
</tr>
<tr>
<td>D. PRIVATE INUREMENT AND PRIVATE BENEFIT</td>
<td>7</td>
</tr>
<tr>
<td>1. GENERAL PRINCIPLES</td>
<td>7</td>
</tr>
<tr>
<td>2. FIVE-FACTOR TEST FOR MSSP ACOs</td>
<td>9</td>
</tr>
<tr>
<td>E. UBIT AND JOINT VENTURES</td>
<td>10</td>
</tr>
<tr>
<td>1. BACKGROUND ON UBIT AND JOINT VENTURES</td>
<td>10</td>
</tr>
<tr>
<td>a. General Principles</td>
<td>10</td>
</tr>
<tr>
<td>b. <em>Plumstead</em> and Before</td>
<td>11</td>
</tr>
<tr>
<td>c. Whole-Hospital Joint Ventures</td>
<td>12</td>
</tr>
<tr>
<td>d. Ancillary Joint Ventures</td>
<td>13</td>
</tr>
<tr>
<td>2. APPLICATION TO JOINT VENTURE MSSP ACOs</td>
<td>14</td>
</tr>
<tr>
<td>F. UBIT TREATMENT OF SERVICES PROVIDED TO ACO</td>
<td>15</td>
</tr>
<tr>
<td>G. MSSP ACO AS TAX-EXEMPT ORGANIZATION</td>
<td>16</td>
</tr>
<tr>
<td>IV. NON-MSSP ACOs</td>
<td>16</td>
</tr>
<tr>
<td>A. GOALS OF NON-MSSP ACOs</td>
<td>16</td>
</tr>
<tr>
<td>B. STRUCTURE AND OPERATIONS OF NON-MSSP ACOs</td>
<td>17</td>
</tr>
<tr>
<td>C. TAX-EXEMPT PURPOSES OF NON-MSSP ACOs</td>
<td>18</td>
</tr>
<tr>
<td>1. LESSENING THE BURDENS OF GOVERNMENT</td>
<td>19</td>
</tr>
<tr>
<td>2. PROMOTION OF HEALTH</td>
<td>21</td>
</tr>
<tr>
<td>a. PSROs</td>
<td>22</td>
</tr>
<tr>
<td>b. Health Planning Agencies</td>
<td>23</td>
</tr>
<tr>
<td>c. Computerized Organ Donor Retrieval Systems</td>
<td>23</td>
</tr>
<tr>
<td>d. Regional Health Data System</td>
<td>23</td>
</tr>
<tr>
<td>e. Electronic Health Records (&quot;EHR&quot;)</td>
<td>24</td>
</tr>
</tbody>
</table>
f. Regional Health Information Organizations ...................................... 26

g. Conclusion .................................................................................. 27

D. PRIVATE INUREMENT AND PRIVATE BENEFIT .................................. 27

1. PRIVATE INUREMENT AND PRIVATE BENEFIT IN HEALTH CARE CONTEXT .............................................. 27

a. PSROs. ..................................................................................... 28

b. Gainsharing. ............................................................................. 28

c. Electronic Health Records. .......................................................... 29

d. Professional Corporations. ........................................................... 30

e. Integrated Delivery Systems. .......................................................... 31

f. Physician Incentive Compensation. .................................................. 31

g. The Notice’s Five-Factor Test. ......................................................... 32

h. RHIOs and PLR 201250025. .......................................................... 32

2. ADDRESSING THE SERVICE’S QUESTIONS .................................... 33

a. IHC Health Plans. ......................................................................... 34

b. Federation Pharmacy Services. ..................................................... 35


d. Negotiating with Payers. ................................................................. 35

e. Safeguards in lieu of CMS Oversight .............................................. 37

3. CONCLUSION REGARDING SERVICE’S PRIVATE INUREMENT AND PRIVATE BENEFIT QUESTIONS .......... 38

E. UBIT AND JOINT VENTURES.............................................................. 39

F. UBIT TREATMENT OF SERVICES PROVIDED TO ACO .................. 39

G. NON-MSSP ACO AS EXEMPT ORGANIZATION ............................. 39

V. EXAMPLES AND SPECIFIC RECOMMENDATIONS ..................................... 39

A. EXAMPLE 1: MSSP JOINT VENTURE................................................. 39

1. Statement of Facts .......................................................................... 39

2. Recommendations .......................................................................... 40

3. Analysis of Exempt Purpose and UBIT ........................................... 41

4. Analysis of Private Inurement and Private Benefit .......................... 41

B. EXAMPLE 2: NON-MSSP JOINT VENTURE ....................................... 42

1. Statement of Facts .......................................................................... 42

2. Recommendations .......................................................................... 42

3. Analysis of Exempt Purpose and UBIT ........................................... 42

4. Private Inurement and Private Benefit ............................................ 43
C. EXAMPLE 3: TAX-EXEMPT ACO

1. Statement of Facts
2. Recommendations
3. Exempt Purpose and UBIT
4. Private Inurement and Private Benefit
EXECUTIVE SUMMARY

In Notice 2011-20\(^1\) the Service stated that it was considering the tax treatment of hospitals and other health care organizations described in section 501(c)(3)\(^2\) (“tax-exempt organizations”) that participate in the Medicare Shared Savings Program (“MSSP”) through an accountable care organization (“ACO”) as defined in the Patient Protection and Affordable Care Act (the “Affordable Care Act”).\(^3\) The Service later issued a fact sheet (“Fact Sheet”) in Q&A format that confirmed and supplemented Notice 2011-20.\(^4\)

Notice 2011-20 reviewed existing guidance relevant to the participation of tax-exempt organizations in MSSP ACOs and solicited comments on whether existing guidance is sufficient and, if not, what additional guidance is needed. Notice 2011-20 also solicited comments on what guidance is needed for tax-exempt organizations that participate in shared savings arrangements with payers other than Medicare, such as commercial health insurers, managed care plans and self-insured programs (“non-MSSP ACOs” or “non-MSSP activities”).

These Comments analyze the authorities cited in Notice 2011-20 and other authorities not cited in Notice 2011-20 that are important in considering the issues presented by ACOs. We also respond specifically to questions the Service raised in Notice 2011-20 about whether non-MSSP activities (i) further the exempt purpose of the promotion of health and (ii) comply with the private inurement and private benefit doctrines. We make several recommendations and reflect them in three Examples set forth at the end of these comments. Six of our recommendations are summarized below.

First, we commend the Service for very helpful statements in Notice 2011-20 regarding its expectation that, as a general matter, a tax-exempt organization that participates in the MSSP through an ACO will not jeopardize its tax-exempt status, will not violate the private inurement or private benefit doctrines, and will not be subject to the unrelated business income tax (“UBIT”).\(^5\) We recommend that the guidance in Notice 2011-20 be formalized in a Revenue Ruling and our Example 1 provides a framework for such guidance.

Second, Notice 2011-20 focuses primarily on the exempt purpose of “lessening the burdens of government” and leaves open the question of whether the exempt purpose of “promotion of health” would support an ACO’s tax-exempt status. We review the applicable authorities and recommend that, in general, the promotion of health be recognized as an exempt purpose for MSSP ACOs as well as non-MSSP ACOs.

\(^1\) 2011-1 C.B. 652.
\(^2\) All references to a “section” are to a section of the Internal Revenue Code of 1986, as amended (the “Code”), unless otherwise indicated, and reference to “Regulations” are to the Treasury Regulations promulgated thereunder.
\(^5\) I.R.C. §§ 511-514.
Third, Notice 2011-20 requests comments on whether non-MSSP activities will result in private inurement or impermissible private benefit. Our analysis reviews several authorities in the health care area where the Service has addressed comparable situations and provided guidelines that overcame questions about private inurement and impermissible private benefit. Our Examples 2 and 3 recommend guidelines and safeguards that should allow the Service to provide similar precedential guidance for non-MSSP ACOs.

Fourth, we recommend through our Example 2 that, in general, a tax-exempt organization should not be subject to UBIT when it participates in non-MSSP activities through an ACO joint venture.

Fifth, we recommend in our Example 3 that the Service confirm in precedential guidance that an ACO would qualify for section 501(c)(3) status where it is organized as a nonprofit subsidiary of a tax-exempt organization and is subject to the same safeguards that the Service has approved for integrated health care systems and in other contexts where ultimate control of an entity resides in the parent’s community-controlled board of directors.

Sixth, we recommend in our Examples that a tax-exempt organization that provides services to an ACO in which it participates or which it controls, including project management, actuarial, population management, and clinical care design services, should not be subject to UBIT on payments it receives from the ACO for such services.
COMMENTS ON ACCOUNTABLE CARE ORGANIZATIONS

I. THE AFFORDABLE CARE ACT

Many challenges to the validity of the Affordable Care Act were brought after it was enacted in 2010. On June 28, 2012, the United States Supreme Court upheld the constitutionality of the Affordable Care Act’s individual mandate provision as a tax,\(^6\) which removed a cloud over the continuing implementation of the Affordable Care Act.

The broad goals of the Affordable Care Act include increasing the number of Americans covered by health insurance and reducing the cost and improving the quality of health care provided to all Americans. For example, Title I of the Affordable Care Act is entitled Quality, Affordable Health Care for All Americans; Title III is entitled Improving the Quality and Efficiency of Health Care. The Affordable Care Act’s provisions on Medicare, the MSSP and ACOs are only part of its extensive reach into all facets of health care in the United States.

II. NOTICE 2011-20

The Service announced in Notice 2011-20 that it was considering the tax treatment of tax-exempt organizations that participate in the MSSP through ACOs. Notice 2011-20 reviewed existing guidance and expressed an expectation that participation in MSSP ACOs would be consistent with a tax-exempt organization’s section 501(c)(3) status. Notice 2011-20 acknowledged that ACOs may conduct non-MSSP activities by engaging in shared savings arrangements with health insurance payers other than Medicare. Notice 2011-20 offers no guidance on non-MSSP activities and solicits comments on how tax-exempt organizations that participate in them should be treated.

These Comments first discuss the application of existing precedential guidance to MSSP ACOs, including the exempt purposes they serve, compliance with the private inurement and private benefit doctrines, and the application of UBIT and joint venture principles. We then review the application of existing guidance to non-MSSP ACOs on those very same issues. Finally, we offer three examples for the Service to consider as a framework for providing precedential guidance with respect to both MSSP ACOs and non-MSSP ACOs.

III. MSSP ACOs

A. GOALS OF MSSP ACOs

Notice 2011-20 describes the Affordable Care Act’s goals of reducing the cost and improving the quality of health care provided to Medicare beneficiaries as follows:

Section 3022 of the Affordable Care Act … directs the Secretary of the Department of Health and Human Services … to establish a Medicare shared savings program that promotes accountability for care of Medicare beneficiaries, improves the coordination of Medicare fee-for-service items and services, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. 7

Thus, accountability, coordination of care, investment in infrastructure, and redesigned health care processes are means under the Affordable Care Act to reduce the cost and improve the quality of health care for Medicare beneficiaries.

Notice 2011-20 acknowledges that ACOs are a key instrument in meeting these goals of greater accountability, improved coordination, more infrastructure investment, and redesigned processes, stating that “groups of health care providers and suppliers that have established a mechanism for shared governance and that meet criteria specified by HHS are eligible to participate as ACOs under the program.” 8 These criteria include being accountable for the quality and cost of its assigned Medicare beneficiaries; having processes to promote evidence-based medicine and coordinate care; and being patient-centered. 9 A principal goal of ACOs is to create and maintain a structure for defining common clinical standards, modifying practice patterns, creating a high degree of integration and cooperation among health care providers, and establishing accountability for quality and cost of health care.

B. STRUCTURE AND OPERATIONS OF MSSP ACOs

Notice 2011-20 describes the Affordable Care Act and guidance provided by the Secretary of the Department of Health and Human Services (“HHS”) and its Centers for Medicare and Medicaid Services (“CMS”) relating to the structure and operations of ACOs that participate in the MSSP. The Fact Sheet describes the effect of CMS’s final regulations. 10 We understand that the Service is working closely with HHS and CMS on the implementation of the Affordable Care Act.

HHS and CMS guidance described in Notice 2011-20 requires, among other things, that an ACO’s structure bring together groups of health care providers serving at least 5,000 Medicare beneficiaries, including primary care physicians, suppliers, and hospitals. The ACO must be a legal entity having a recognized form of organization under state law and having a governing body that includes representation of the participating health care providers and Medicare beneficiaries.

It is the authors’ experience that many ACOs are being formed as partnerships (or limited liability companies (“LLCs”)) treated as partnerships for federal income tax

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7 2011-1 C.B. at 652.
8 Id.
9 Section 3022 of the Affordable Care Act.
purposes) among private physicians, tax-exempt organizations and other providers. ACOs are also being formed as single-member LLCs owned by tax-exempt hospitals or as nonprofit corporations controlled by tax-exempt hospitals.

Notice 2011-20 describes how an ACO will operate as follows:

ACOs eligible to participate in the MSSP will manage and coordinate care for their assigned Medicare fee-for-service beneficiaries. Health care service providers and suppliers participating in an ACO will continue to receive Medicare fee-for-service payments in the same manner as such payments would otherwise be made. In addition, an ACO that meets quality performance standards established by HHS and demonstrates that it has achieved savings against an appropriate benchmark of expected average per capita Medicare fee-for-service expenditures will be eligible to receive payments for Medicare shared savings (MSSP payments)…. 12

Notice 2011-20 thus recognizes that participating in the MSSP through an ACO will not affect the normal revenue stream of the participating health care providers. The providers, both tax-exempt organizations and private physicians, will continue to receive payments directly from Medicare for providing health care to the ACO’s Medicare beneficiaries. The ACO’s role is to coordinate the activities of its participating providers and distribute among them any incentive payments the ACO may earn if its providers meet benchmarks for cost, quality of care and patient satisfaction. Any MSSP incentive payment is shared among the ACO’s participants based on criteria the ACO develops.

Notice 2011-20 also mentions the “two-sided model” under which an ACO could earn incentive payments if it meets applicable benchmarks, but would be required to repay losses to CMS if it fails to meet applicable benchmarks.13 After an initial phase-in period, all ACOs and their participants will be required to enter the two-sided model under which they have something to lose as well as something to gain from participating in an ACO.14

In addition to making no change in the providers’ normal revenue streams from Medicare, participation in an ACO does not change the nature and type of services that participating providers deliver to their patients. There is also no change in the providers’ relationship with their patients or their relationship with Medicare. What does change is how the providers must coordinate with each other through the ACO to reduce cost and improve quality and patient satisfaction.

An MSSP ACO has no direct role in the delivery of health care services. It has no patients or contracts with patients. It does not sell services or products to patients or other persons. An MSSP ACO also plays no role in the payment for, or financing of,
health care services that are delivered to patients, apart from allocating any MSSP incentive payments or losses among its providers. The ACO’s participating providers continue to deliver all health care services to patients and to receive payments for those services directly from Medicare as they did previously.

The ACO’s role in the delivery of health care in the MSSP context is to coordinate and monitor the activities of its participating providers and to promote accountability for the cost and quality of care by reporting the results to HHS. To be able to coordinate and monitor its participating providers, ACOs must develop and implement protocols, systems and infrastructure that its participating providers use. Only if the ACO’s participating providers meet cost, quality and patient satisfaction benchmarks will the ACO itself receive any MSSP revenue.¹⁵

An MSSP ACO’s governing board and its committees are likely to include a substantial number of physicians who provide health care services to patients served by the ACO. The physicians’ expertise and active engagement is essential in developing clinical care protocols, quality and performance standards and measures, and related performance payment methodologies. This physician involvement is consistent with Affordable Care Act and other federal health policies that require an ACO to provide physicians an integral role in its governance and operations.¹⁶

Notice 2011-20 reviews the extensive oversight that the federal government, through HHS and CMS, exercises over ACOs that participate in the MSSP. Notice 2011-20 includes a description of the eight requirements established in the Affordable Care Act for an ACO to participate in the MSSP as well as the quality measures, reporting requirements and monitoring of ACOs that CMS has adopted.

An ACO participating in the MSSP has two sources of revenue. First, it receives capital contributions to fund its formation and the implementation of its cost savings and quality improvement programs. Second, it may receive MSSP payments if the ACO is successful in meeting HHS benchmarks for reducing cost and improving quality and patient satisfaction. Although the bulk of an MSSP payment is likely to be allocated and distributed to the ACO’s members, some portion of it may be retained by the ACO to pay administrative expenses.

C. TAX-EXEMPT PURPOSES

Notice 2011-20 reviews three tax-exempt purposes that an MSSP ACO’s activities further. To the extent an ACO participates in the MSSP and meets the eligibility requirements established by CMS, Notice 2011-20 states that the ACO will generally be regarded as furthering the exempt purpose of lessening the burdens of government,¹⁷ and states its rationale as follows:

¹⁶ 42 U.S.C. § 1395jjj, added by section 3022 of the Affordable Care Act.
¹⁷ Reg. § 1.501(c)(3)-1(d)(2)
Congress established the MSSP to be conducted through ACOs in order to promote quality improvements and cost savings, thereby lessening the government’s burden associated with providing Medicare benefits.\(^\text{18}\)

In support of this conclusion, Notice 2011-20 cites Rev. Rul. 81-276,\(^\text{19}\) which dealt with a professional standards review organization (“PSRO”) established by federal statute to review whether the quality of health care services provided to the government’s Medicare and Medicaid programs satisfied professionally recognized standards of care. Rev. Rul. 81-276 concluded that PSROs further the tax-exempt purpose of lessening the burdens of government.

Rev. Rul. 81-276 involved a PSRO that was formed under the mandate of the Social Security Act Amendments of 1972. Congress created PSROs due to concerns over increasing costs in the Medicare and Medicaid programs. Congress attributed these increased costs, in part, to unnecessary use of medical services.\(^\text{20}\) To help slow cost increases, PSROs were established to review the appropriateness, medical necessity, and quality of health care services that were financed by Medicare and Medicaid reimbursement.\(^\text{21}\)

Although Notice 2011-20 relies on “lessening the burdens of government” as its basis for concluding that an MSSP ACO furthers an exempt purpose, it mentions two other exempt purposes that could apply to an ACO. To the extent an ACO participates in non-MSSP activities involving Medicaid patients, Notice 2011-20 suggests that it will further the exempt purpose of relieving the poor and distressed or the underprivileged.\(^\text{22}\) Notice 2011-20 does not mention lessening the burdens of government as an exempt purpose for Medicaid ACOs even though part of the rationale in Rev. Rul. 81-276 for concluding that PSROs lessen the burdens of government was that PSROs reviewed health care provided to Medicaid patients as well as Medicare patients.

Notice 2011-20 also raises the possibility that ACOs could further a third exempt purpose, the promotion of health, but it reaches no conclusion on that point and asks for comments. The promotion of health as an exempt purpose for ACOs is analyzed below in the discussion of non-MSSP ACOs.

D. PRIVATE INUREMENT AND PRIVATE BENEFIT

1. GENERAL PRINCIPLES

As often happens in health care, an ACO brings together tax-exempt organizations and private persons such as physicians in a common endeavor. Notice 2011-20

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\(^\text{18}\) 2011-1 C.B. at 655.

\(^\text{19}\) 1981-2 C.B. 128.


\(^\text{21}\) 42 U.S.C. § 1320c et seq.

\(^\text{22}\) 2011-1 C.B. at 655.
anticipates that a tax-exempt organization may participate in an ACO by (1) having an ownership interest in a corporation, partnership or LLC along with private persons, (2) having a membership interest in a nonprofit corporation along with private persons, or (3) entering into contractual arrangements with private persons. Regardless of the form the ACO takes, Notice 2011-20 cautions that, for a tax-exempt organization’s participation in an ACO to be consistent with its section 501(c)(3) status, its dealings with private persons who also participate in the ACO must not result in either private inurement or impermissible private benefit.

The private inurement doctrine provides that an organization does not operate exclusively for a section 501(c)(3) exempt purpose if its net earnings inure in whole or in part to the benefit of private shareholders or private individuals. Private shareholders or individuals include persons having a personal and private interest in the activities of the organization. The IRS has described “private shareholders or individuals” as “persons who, because of their particular relationship with an organization, have an opportunity to control or influence its activities.” Such persons are commonly referred to as insiders.

The private benefit doctrine provides that an organization does not operate exclusively for an exempt purpose unless it serves a public rather than a private interest. Unlike the prohibition against private inurement, which applies only with respect to insiders, the private benefit prohibition can apply to any person receiving a benefit without regard to whether the person is in a position to influence the organization. Also unlike the private inurement prohibition, the private benefit prohibition is not absolute. Rather, private benefit is impermissible only if it is substantial. The IRS has taken the position that private benefit is not substantial if it is “incidental” in amount, and that whether an activity is “incidental” is tested both qualitatively and quantitatively. A private benefit will satisfy the qualitative test as incidental only 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 benefitting certain private individuals.” A benefit will be quantitatively incidental only if it is insubstantial when compared with the public benefit conferred.

The Service struggled with the private benefit doctrine in considering the tax-exempt status of PSROs. Although it conceded that PSROs further an exempt purpose, the Service initially took the position that PSROs are not tax-exempt under section

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23 Reg. § 1.501(c)(3)-1(c)(2). The private inurement prohibition has been broadly interpreted to include any device to distribute any advantage, profit, fruit, privilege, gain or interest derived from the organization. See Announcement 95-25, 1995-14 I.R.B. 11, citing Harding Hosp. v. United States, 505 F.2d 1068, 1072 (6th Cir. 1964); Loraine Ave. Clinic v. Comm’r, 31 T.C. 141 (1958); Birmingham Bus. College v. Comm’r, 276 F.2d 476 (5th Cir. 1960); Am. Campaign Acad. v. Comm’r, 92 T.C. 1053 (1989).

24 Reg. § 1.501(c)(3)-1(c); see, e.g., United Cancer Council, Inc. v. Comm’r, 165 F.3d 1173 (7th Cir. 1999).


26 Reg. § 1.501(c)(3)-1(d)(1)(ii).

27 GCM 39862 (Nov. 22, 1991) (citing GCM 37789 (Dec. 18, 1978)).

28 Id.

29 Id.

30 For discussion of PSROs, see the discussion of Rev. Rul. 81-276 in Section III.C above.
501(c)(3) because they provide impermissible private benefit to private physicians. After litigating and losing two cases, the Service conceded in Rev. Rul. 81-276 that the private benefit to physicians from PSROs is incidental both qualitatively and quantitatively. The Service concluded in Rev. Rul. 81-276 that any “benefits to members of the medical profession are incidental to the benefits [the PSRO] provides in promoting health and lessening the burdens of government.”

2. **FIVE-FACTOR TEST FOR MSSP ACOs**

Notice 2011-20 makes the following statements about the application of the private inurement and private benefit doctrines to MSSP ACOs:

Because of CMS regulation and oversight of the MSSP, as a general matter, the IRS expects that it will not consider a tax-exempt organization’s participation in the MSSP through an ACO to result in private inurement or impermissible private benefit to the private party ACO participants where:

- The terms of the tax-exempt organization’s participation in the MSSP through the ACO (including its share of MSSP payments or losses and expenses) are set forth in advance in a written agreement negotiated at arm’s length.  
- CMS has accepted the ACO into, and has not terminated the ACO from, the MSSP.  
- The tax-exempt organization’s share of economic benefits derived from the ACO (including its share of MSSP payments) is proportional to the benefits or contributions the tax-exempt organization provides to the ACO. If the tax-exempt organization receives an ownership interest in the ACO, the ownership interest received is proportional and equal in value to its capital contributions to the ACO and all ACO returns of capital, allocations and distributions are made in proportion to ownership interests.  
- The tax-exempt organization’s share of the ACO’s losses (including its share of MSSP losses) does not exceed the share of ACO economic benefits to which the tax-exempt organization is entitled.  
- All contracts and transactions entered into by the tax-exempt organization with the ACO and the ACO’s participants, and by the ACO with the ACO’s participants and any other parties, are at fair market value.

Notice 2011-20 thus concludes that where these five factors are present, as a general matter a tax-exempt organization’s participation in an MSSP ACO will not result in

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33 This is similar to the arm’s length requirement provided in earlier Service guidance regarding physician incentive compensation payments. See, e.g., Rev. Rul. 69-383, 1969-2 C.B. 113; GCM 35638 (Jan. 28, 1974).
34 2011-1 C.B. at 655.
private inurement or impermissible private benefit. The Service’s reliance on CMS and HHS regulation and oversight is reflected in the second of the five factors, which specifies that the ACO participates in the MSSP. The Fact Sheet supplements Notice 2011-20 by stating that “no particular factor must be satisfied in all circumstances to prevent inurement or impermissible private benefit.”

This guidance provided by the Notice is helpful to tax-exempt organizations considering participation in MSSP ACOs. We recommend that the Service include this five-factor test for MSSP ACOs in a Revenue Ruling. Example 1 at the end of these Comments provides a factual framework that the Service could use as a vehicle for such a Revenue Ruling.

As to non-MSSP ACOs, Notice 2011-20 does not express a view on the application of the private inurement and private benefit doctrines to them. Those issues are analyzed below in the discussion of non-MSSP ACOs.

E. UBIT AND JOINT VENTURES

Notice 2011-20 specifically asks that comments address the following principle of existing law with respect to tax-exempt organizations that participate in ACO joint ventures:

[I]f a tax-exempt organization is a partner (or member, in the case of an LLC) of an ACO treated as partnership for federal tax purposes, the ACO’s activities will be attributed to the tax-exempt organization for purposes of determining both whether the organization operates exclusively for exempt purposes and whether it is engaged in an unrelated trade or business.

Notice 2011-20 thus contemplates that tax-exempt organizations will often participate in ACOs through joint ventures. We first review general UBIT principles and then specific authorities relating to joint ventures.

1. BACKGROUND ON UBIT AND JOINT VENTURES

a. General Principles.

Section 511 imposes UBIT on the unrelated business taxable income of tax-exempt organizations. Section 512(a)(1) defines the term “unrelated business taxable income” as the gross income from an unrelated trade or business less deductions and with modifications. Section 513(a) defines the term “unrelated trade or business” generally as a trade or business the conduct of which is not “substantially related” to an organization’s exempt function or purpose. To be “substantially related” to an exempt purpose, the

36 2011-1 C.B. at 656; I.R.C. § 512(c).
regulations provide that an activity must “contribute importantly” to the accomplishment of the exempt purpose.\textsuperscript{37}

When a tax-exempt organization is a partner in a partnership, the activities of the partnership are attributed to the tax-exempt partner and the character of the activities for UBIT purposes is determined as if the tax-exempt partner participated in them directly.\textsuperscript{38} This is true whether the tax-exempt partner is a general partner or a limited partner.\textsuperscript{39}

\textbf{b. \textit{Plumstead and Before.}}

Prior to 1979, the Service viewed a tax-exempt organization’s participation as a general partner in a partnership with private investors as incompatible with section 501(c)(3) status.\textsuperscript{40} In 1979 the Service indicated that it would approve such participation if the joint venture had strict limits on the return to the private investors, using a “careful scrutiny” standard.\textsuperscript{41}

The Service further modified its position in the wake of \textit{Plumstead Theatre Society, Inc. v. Commissioner}, a seminal case which established that a charitable organization could participate in a properly structured joint venture with for-profit partners and maintain its tax-exempt status. In \textit{Plumstead}, the Tax Court considered whether a tax-exempt theater organization’s participation as a general partner in a limited partnership with private investors caused the organization to be operated for private, rather than public, benefit.

The Tax Court found that the organization’s participation in a partnership that produced a play furthered the organization’s charitable and educational purposes of promoting and encouraging the arts. The Tax Court then considered whether the organization’s participation as the general partner in the limited partnership resulted in the activities being conducted for the benefit of private investors rather than for public interests. The Tax Court found that (i) the formation of the partnership was the result of arm’s length negotiations; (ii) the exempt organization was not obligated to return any capital contribution made by the limited partners from its own funds; (iii) the partnership had no interest in the exempt organization; (iv) the limited partners had no control over the way the exempt organization operated or managed its affairs; and (v) none of the limited partners was an officer or director of the exempt organization. Based on these facts, the Tax Court concluded that the partnership arrangement did not cause the exempt

\textsuperscript{37} Reg. § 1.513-1(d)(2);  
\textsuperscript{38} I.R.C § 512(c); Reg. § 1.512(c)-1.  
\textsuperscript{39} Rev. Rul. 79-222, 1979-2 C.B. 236.  
\textsuperscript{40} E.g., PLR 7820058 (Feb. 17, 1978); GCM 36293 (May 30, 1975); GCM 37259 (Sept. 19, 1977). In GCM 36293 the Service stated that the tax-exempt organization’s duty as general partner to promote the financial interests of private investors “would necessarily create a conflict of interest that is legally incompatible with its being operated exclusively for charitable purposes.”  
\textsuperscript{41} GCM 37852 (Feb. 15, 1979) (partnership operated on a “break-even basis”).  
\textsuperscript{42} 74 T.C. 1324 (1980), aff’d per curiam, 675 F.2d 244 (9th Cir. 1982).
organization to be operated for private, rather than public, benefit, and upheld its section 501(c)(3) status.\textsuperscript{43}

c. Whole-Hospital Joint Ventures.

In the 1990s the Service’s attention turned to so-called “whole-hospital” joint ventures and similar arrangements. In a whole-hospital joint venture, a tax-exempt hospital typically transfers all of its operating assets to a partnership with a for-profit business organization. Thereafter, the tax-exempt organization’s primary, if not exclusive, activity is to conduct, indirectly through the partnership as a general partner, the continuing activities of the hospital now owned by the partnership. Because participation in the joint venture represents a substantial part of the tax-exempt organization’s activities, that participation has a direct effect on the organization’s tax-exempt status because no more than an insubstantial part of a tax-exempt organization’s activities can be in furtherance of a non-exempt purpose.\textsuperscript{44}

The Service addressed the tax consequences of participating in a whole-hospital joint venture in Rev. Rul. 98-15,\textsuperscript{45} in which the Service contrasted a whole-hospital joint venture that it approved (Situation 1) with a whole-hospital joint venture that it found to be inconsistent with section 501(c)(3) status (Situation 2). The Service’s position met with only mixed success in the courts.\textsuperscript{46} Factors that the Service considered critical in Rev. Rul. 98-15 to determining whether a tax-exempt organization’s participation in such a joint venture is consistent with section 501(c)(3) status include the following:

\begin{itemize}
  \item[(1)] Whether the exempt organization has control of the joint venture’s governing board;
  \item[(2)] Whether the exempt organization has control of the amendment of the joint venture’s governing documents with respect to major decisions;
  \item[(3)] Whether governing documents of the joint venture require each hospital operated by the venture to be operated in a manner that furthers exempt purposes by promoting the health of a broad cross-section of the community served by the venture;
  \item[(4)] Whether governing documents expressly provide that the duty of the members of the governing board to operate the joint venture in a charitable manner overrides any duty they may have to operate the joint venture for the financial benefit of its owners; and
  \item[(5)] Whether any management agreement involving management of the joint venture was with a management company that was unrelated to the joint venture’s owners and was for a specified term that was terminable by the joint venture for cause.
\end{itemize}

\textsuperscript{43} The Tax Court did not address the prohibition against private inurement because the IRS had conceded this issue on brief, which is not surprising because the recited facts indicate that none of the investors had any relationship to the exempt organization.
\textsuperscript{44} Reg. § 1.501(c)(3)-1(c)(1).
\textsuperscript{45} 1998-1 C.B. 718.
\textsuperscript{46} St. David’s Health Care System, Inc. v. United States, 2002 U.S. Dist. LEXIS 10453 (W.D.Tex. 2002), rev’d and remanded, 349 F.3d 232 (5th Cir. 2003); Redlands Surgical Services, Inc. v. Comm’r, 113 T.C. 47 (1999), aff’d per curiam, 242 F.3d 904 (9th Cir. 2001).
d. Ancillary Joint Ventures.

After the issuance of Rev. Rul. 98-15, many commentators requested guidance from the Service to confirm that the control requirement in Rev. Rul. 98-15 does not apply to joint ventures that represent less than a substantial part of a tax-exempt partner’s activities (often called “ancillary joint ventures”). It was assumed that a tax-exempt organization’s section 501(c)(3) status would not be threatened by entering into an ancillary joint venture, but guidance confirming that point was sought by many, including the Section of Taxation and the Health Law Section of the ABA.

The Service issued the requested guidance on ancillary joint ventures in Rev. Rul. 2004-51, which involved a tax-exempt university’s proposal to expand its program of summer seminars for elementary and secondary school teachers by entering into a joint venture LLC with a for-profit business that specialized in conducting interactive video training programs. The sole purpose of the joint venture was to offer the University’s teacher training seminars at off-campus locations using interactive video technology.

A key fact in Rev. Rul. 2004-51 was that the university’s participation in the joint venture did not represent a substantial part of its activities. A second key fact related to control. Although the university did not control the joint venture, it did retain exclusive control over those aspects of the LLC’s activities that affected whether the joint venture’s activities were substantially related to the university’s exempt purposes. Specifically, the university retained the exclusive right to approve the curriculum, training materials and instructors for, and to determine the standards for the successful completion of, the seminars offered by the LLC. Other facts recited in the ruling include (1) the university and the for-profit business each owned a 50% interest in the LLC and controlled 50% of the LLC’s governing board; (2) the 50% interests were proportionate to the value of their respective capital contributions; (3) all returns of capital, allocations and distributions were in proportion to the members’ respective ownership interests; (4) the members had an equal voice in making non-curriculum or business decisions with respect to the LLC; (5) all contracts and transactions between and among the LLC and the members were required to be at arm’s length and fair market value; and (6) the LLC could not engage in any activity that would jeopardize the university’s section 501(c)(3) status.

The Service ruled in Rev. Rul. 2004-51 that the university’s participation in the joint venture would not affect its continued qualification under section 501(c)(3) even though the university did not control all aspects of the joint venture’s activities. This ruling was based in large part on the fact that the joint venture did not represent a substantial part of the university’s activities.

The Service also ruled in Rev. Rul. 2004-51 that the university would not be subject to UBIT on its distributive share of the partnership’s income. The Service concluded that the partnership’s activities were substantially related to the university’s educational purposes because the university controlled the joint venture’s curriculum.

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47 2004-1 C.B. 974.
training materials, instructors and standards and because all joint venture transactions were at arm’s length and for fair market value.

Rev. Rul. 2004-51 thus confirmed that the potential adverse consequences to a tax-exempt organization of participating in a properly structured ancillary joint venture are limited to possible application of UBIT to the participating tax-exempt organization’s share of the joint venture’s income.

2. APPLICATION TO JOINT VENTURE MSSP ACOs

Notice 2011-20 focuses on the UBIT consequences of a tax-exempt organization’s participation in an ACO. This focus on UBIT is appropriate because where a tax-exempt organization participates in an ACO through a partnership, the partnership will generally not represent a substantial part of the tax-exempt participant’s activities, and therefore the ACO will not affect its tax-exempt status. Thus, the UBIT treatment of the tax-exempt organization’s participation in the ACO is the primary issue to be resolved. This result flows directly from the Service’s guidance regarding ancillary joint ventures in Rev. Rul. 2004-51.

Although Medicare patients and the revenue they generate may well represent a substantial part of a tax-exempt organization’s activities and revenue, an MSSP ACO would represent a much smaller activity. The number of Medicare patients that a tax-exempt organization serves is unlikely to be affected by the organization’s participation in an ACO. In addition, the basic fee-for-service revenue that a tax-exempt organization’s Medicare patients generate is expected to continue without regard to the ACO. It seems very unlikely that any incentive payment that a tax-exempt participant might receive from an ACO would represent a substantial part of the tax-exempt participant’s total revenue, or that the tax-exempt organization’s participation in the ACO’s activities that generate the incentive payment would represent a substantial part of the tax-exempt participant’s total activities.

Consistent with Notice 2011-20’s conclusion that an MSSP ACO will further the exempt purpose of lessening the burdens of government, Notice 2011-20 concludes that an MSSP ACO will not result in UBIT for a participating tax-exempt organization, as follows:

The IRS expects that, absent inurement or impermissible private benefit, any MSSP payments received by a tax-exempt organization from an ACO would derive from activities that are substantially related to the performance of the charitable purpose of lessening the burdens of government within the meaning of Treas. Reg. § 1.501(c)(3)-1(d)(2), as long as the ACO meets all of the eligibility requirements established by CMS for participation in the MSSP.48

48 2011-1 C.B. at 655.
This conclusion leaves open the UBIT treatment of non-MSSP ACOs, and does not address the application of other exempt purposes such as the promotion of health. Notice 2011-20 invites comments on the UBIT treatment of non-MSSP ACOs, and our Comments on those issues are set out below under a separate heading.

Notice 2011-20’s conclusion that MSSP ACOs will not generally give rise to UBIT is helpful to tax-exempt organizations considering participation in MSSP ACOs. We recommend that this conclusion regarding the UBIT treatment of MSSP ACOs be included in a Revenue Ruling reflecting facts common in such situations. Example 1 at the end of these Comments provides a factual framework that the Service could use as a vehicle for such a Revenue Ruling.

F. UBIT TREATMENT OF SERVICES PROVIDED TO ACO

Notice 2011-20 does not address the likely possibility that a tax-exempt organization will provide services to an ACO in which it participates. Many of the services that an ACO will require to function are services that a tax-exempt hospital already provides for its own operations, such as project management, actuarial, population management, and clinical care design services. In most cases it will be more efficient and cost effective for the ACO to acquire those services from a hospital participating in the ACO rather than hire additional staff to provide those services. It is therefore likely that in many cases such services will be provided by a tax-exempt participant to the ACO.

Prior to and since the enactment of the Affordable Care Act, tax-exempt hospitals have made serious efforts to coordinate the delivery of health care with physicians on their staffs and other health care providers. Tax-exempt hospitals were serving and promoting many of the goals of the Affordable Care Act and ACOs before enactment. Accordingly, for many tax-exempt hospitals, participation in an ACO is an extension of activities in which they are already engaged.

If an ACO’s activities are related to a tax-exempt partner’s exempt purposes, then providing services in support of those activities and purposes should also be related to the tax-exempt partner’s exempt purposes. Pursuant to Rev. Ruls. 98-1549 and 2004-51,50 the activities of an LLC treated as a partnership for federal income tax purposes are attributed to a tax-exempt member for determining whether the tax-exempt member (1) continues to qualify for exemption and (2) has engaged in an unrelated trade or business. This is an aggregate approach, whereby the LLC’s activities are deemed to be the activities of the members, including for determining whether income from the partnership constitutes unrelated business taxable income ("UBTI") to the members.51

In a number of pronouncements the Service has ruled that management fees paid by a partnership to a tax-exempt organization partner did not result in UBTI to the

49 1998-1 C.B. 718.
50 2004-1 C.B. 974.
51 I.R.C. § 512(c).
exempt organization (including situations where other partners in the partnership consisted of individuals or for-profit organizations).\(^{52}\) In reaching these conclusions, the Service pointed to several factors, including that (i) the operation of the partnership furthered the charitable purpose of the exempt organization; (ii) the management services performed were consistent with the exempt organization's responsibilities as a partner in the partnership; (iii) the management services were essential to the exempt organization's ability to provide the charitable services conducted by the partnership; (iv) the partnership would not be able to provide charitable services without the provision of management services by the exempt organization; (v) the management activities were to be conducted in a manner to further the exempt organization's charitable status; and (vi) the provision of the management services assured the operation of the partnership to meet the exempt organization's charitable goals.\(^{53}\)

G. **MSSP ACO AS TAX-EXEMPT ORGANIZATION**

Notice 2011-20 focuses on ACOs as joint ventures between tax-exempt organizations and private health care providers. The Fact Sheet confirms that an ACO engaged exclusively in MSSP activities can qualify for tax-exempt status under section 501(c)(3) because it will further charitable purposes.\(^{54}\) Our Example 3 provides a fact pattern that the Service could use to provide further guidance on when a separately organized ACO will qualify as an organization described in section 501(c)(3).

IV. **NON-MSSP ACOs**

The Service stated in Notice 2011-20 that it did not have sufficient information to address the tax treatment of non-MSSP ACOs and requested comments on the subject. The principal questions the Service wants addressed regarding the qualification of non-MSSP ACOs under section 501(c)(3) appear to be whether they further exempt purposes and whether they comply with the private inurement and private benefit doctrines.

A. **GOALS OF NON-MSSP ACOs**

To provide a factual framework with which to judge non-MSSP ACOs, these Comments offer Examples 2 and 3 below. By addressing the fact patterns in Examples 2 and 3, the Service could provide valuable guidance to tax-exempt organizations participating in non-MSSP activities. The Service could approach other situations involving non-MSSP activities using a facts and circumstances approach.

In our Examples 2 and 3, the non-MSSP ACOs have the same goals as MSSP ACOs -- reducing the cost and improving the quality of health care and enhancing patient satisfaction. Non-MSSP ACOs pursue those goals by the same means as MSSP ACOs --

\(^{52}\) TAM 200151045 (Dec. 21, 2001); PLR 9736039 (Sept. 5, 1997); PLR 8939024 (Sept. 29, 1989); PLR 9438030 (Sept. 23, 1994); PLR 200211052 (Mar. 15, 2002).

\(^{53}\) Id.

promoting accountability for the care provided, improving the coordination of care, and encouraging investment in infrastructure and redesigned processes for delivery of care.

**B. STRUCTURE AND OPERATIONS OF NON-MSSP ACOs**

Although the term “ACO” is found in the MSSP provisions of the Affordable Care Act, we use it to encompass non-MSSP activities as well. The Affordable Care Act’s goals of reducing cost and improving quality and patient satisfaction are not new and are not limited to the MSSP. The MSSP builds on prior efforts to accomplish the same goals by tax-exempt organizations and other health care providers.\(^{55}\)

Notice 2011-20 recognizes that ACOs may enter into shared savings arrangements with non-Medicare health insurance payers, such as Medicaid, commercial health insurers, managed care plans, and self-insured programs. These non-MSSP activities of ACOs are not defined or addressed by the Affordable Care Act or CMS guidance. Notice 2011-20 offers no guidance for non-MSSP activities because the Service had insufficient information.

The defining feature of non-MSSP activities is that payers other than Medicare (e.g., Medicaid, commercial health insurers, managed care plans and self-insured programs) will be the source of incentive payments to reduce cost and improve quality and patient satisfaction. Experience to date and emerging patterns of practice indicate that many ACO policies and procedures developed and used in the MSSP context will be adopted and used in the non-MSSP context. Other payers will have the very same interests as the MSSP in (i) establishing cost and quality performance standards, (ii) assessing ACO performance against such standards, (iii) assigning beneficiaries to the ACO, and (iv) determining when an ACO is eligible for shared savings incentives and the amount of such incentives.

Non-MSSP ACOs are likely to use many of the same standards used by Medicare in the MSSP and other Medicare programs. For example, non-MSSP activities are likely to incorporate not only the MSSP’s measurement concepts, but also those used in the Medicare program’s Physician Quality Reporting System (“PQRS”),\(^{56}\) the Hospital


Inpatient Quality Reporting Program,\textsuperscript{57} and other public and private sector initiatives, including those of the Institute of Medicine\textsuperscript{58} and the National Quality Strategy.\textsuperscript{59} The MSSP establishes 33 measures for determining whether an ACO qualifies for shared savings, many of which were also included in the PQRS, including providing preventive services and screenings and providing early interventions to individuals with known risks for major diseases.\textsuperscript{60}

Once an ACO has put together the structure and resources to participate in the MSSP, it is well-positioned to participate in non-MSSP shared-savings arrangements with other payers. Thus, many ACOs may conduct both MSSP and non-MSSP activities in the same LLC. Or, in some cases, one LLC may be created to conduct the MSSP activities and a separate LLC may be created to conduct the non-MSSP activities. It is also possible that an ACO that is initially created to participate in the MSSP, but decides to forego MSSP participation, will still engage in non-MSSP activities if non-MSSP payers provide more attractive terms and conditions than the MSSP. For example, a non-MSSP ACO may be more attractive if it does not impose a two-sided model that requires ACO providers to risk losses if the ACO does not meet the applicable benchmarks for cost, quality and patient satisfaction. Thus, it is possible that an ACO will conduct only non-MSSP activities.

\section*{C. TAX-EXEMPT PURPOSES OF NON-MSSP ACOs}

There is strong support for concluding that non-MSSP ACOs like those in our Examples 2 and 3 further an exempt purpose. This includes support for treating non-


\textsuperscript{60} In the final ACO regulations, CMS removed “operationally complex,” “redundant,” and “burdensome” measures and explained that the current set of 33 measures, though not final, provides a “starting point.” CMS plans to modify the measures during future reporting cycles. See Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Final Rule, 76 Fed. Reg. 67,802, 67,801.
MSSP ACOs as lessening the burdens of government, but the strongest support is for treating non-MSSP ACOs as furthering the exempt purpose of promoting health.

1. LESSENING THE BURDENS OF GOVERNMENT

Notice 2011-20 states that a tax-exempt organization’s participation in an MSSP ACO furthers charitable purposes because it lessens the burdens of government. In contrast, Notice 2011-20 states that the Service anticipates that a tax-exempt organization’s participation in non-MSSP ACOs is unlikely to lessen the burdens of government.

As discussed above in Section III.C, the Service’s conclusion in Notice 2011-20 that MSSP ACOs lessen the burdens of government is based in part on Rev. Rul. 81-276,61 in which the Service determined that PSROs were established to improve the efficiency and lower the cost of Medicare and Medicaid and thereby lessened the burdens of government. In Rev. Rul. 81-276 the Service concluded that the legislation authorizing PSROs was directed only at Medicare and Medicaid, and that the government burden lessened by the legislation related only to Medicare and Medicaid.

An important parallel exists between PSROs and ACOs in that Congress mandated their creation to improve the Medicare program. In addition, however, Congress is further relying on ACOs to “spur changes in our health care delivery system to emphasize patient outcomes and value.”62 According to a letter authored by seven members of the Senate Finance Committee, including Dr. Tom Coburn (R-OK), “rewarding high quality, efficient providers based on positive patient outcomes in an ACO model is a concept that sustained bipartisan support throughout the contentious health care debate of the 111th Congress.”63 The Congressional Record also reflects that Congress believed ACOs are valuable not only for Medicare but also for “Medicaid, and private sector” payers to “help ensure all Americans receive high-quality care no matter how they are insured.”64

In addition, the Affordable Care Act differs from the legislation cited in Rev. Rul. 81-276 because the federal health policy articulated and recognized in the Affordable Care Act is not limited to Medicare and Medicaid. Rather, the Affordable Care Act undertakes to establish and enforce standards for health insurance coverage offered by all payers, including commercial insurance companies, and further provides incentives to assure that all individuals (not just those covered by governmental health programs) have health insurance coverage meeting these standards.65

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65 See, e.g., Affordable Care Act §§ 1301, 1302; Title XXVII of Public Health Service Act, 42 U.S.C. § 300gg et seq.
The Affordable Care Act does not mandate ACO-type arrangements for non-MSSP payers and does not provide specific rewards for successful shared savings programs other than the MSSP. Nonetheless, standards to be developed under the Affordable Care Act indicate that private health insurance payers either will be required to include elements that are also found in MSSP ACOs or will be measured and rated by whether they include such elements.

For example, central requirements under the Affordable Care Act for MSSP ACOs are that they:

- are patient-centered;
- have processes to promote evidence-based medicine and patient engagement;
- report on quality and cost measures and coordinate care; and
- do not avoid at-risk patients who may have high-cost needs.  

The same requirements are imposed by the Affordable Care Act on private health insurance through various other mechanisms. For example, within two years following the Affordable Care Act’s enactment, health plans must report on, and are encouraged to have, “health care provider reimbursement structures that improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives,” including medical homes. Further, they must “implement activities to prevent hospital readmissions; improve patient safety through use of best clinical practices, evidence based medicine, and health information technology; and wellness and health promotion activities,” and must report to HHS, state insurance commissioners, and the public whether the plan’s benefits satisfy these requirements. These requirements apply to all group health plans, self-insured plans, and health insurance issuers, including those participating in health insurance exchanges, and thus cover most or all recipients of non-governmental insurance.

These provisions of the Affordable Care Act strongly suggest that making high-quality and efficient health care available to all, regardless of the source of payment, is a burden of government. The requirements that the Affordable Care Act imposes on non-governmental payers are a way of enlisting non-governmental payers to achieve the goals of reducing the cost and increasing the quality of health care and thus lessening that burden. To meet those requirements, non-governmental payers are likely to implement non-MSSP ACOs that contain many, if not all, of the same features as MSSP ACOs. In that way, non-MSSP ACOs would also be lessening the burdens of government.

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66 42 U.S.C. § 1395jjj (section 3022 of the Affordable Care Act).
67 Affordable Care Act §1001, enacting § 2717(a) of the Public Health Service Act, 42 U.S.C. § 300gg-17(a).
68 Id.
After issuing Rev. Rul. 81-276 to deal with PSROs, the Service summarized its position on when an activity lessens the burdens of government within the meaning of section 501(c)(3) in Rev. Ruls. 85-1 and 85-2. The first requirement is that the government considers the activity to be its burden, as demonstrated by an objective manifestation. The second requirement is that the activity actually lessens the burdens of government, as determined by all the facts and circumstances. We recommend that the Service consider whether the broader provisions of the Affordable Care Act referenced above, including the requirements imposed on non-governmental payers, are sufficiently clear indications that the federal government considers the provision of reduced-cost, high-quality health care for all citizens to be a burden of government within the meaning of these authorities, so that non-MSSP ACOs would be furthering the exempt purpose of lessening the burdens of government.

It appears that the Service’s views may have evolved since it stated in Notice 2011-20 that non-MSSP ACOs are unlikely to lessen the burdens of government. In the recent PLR 201250025 the taxpayer was a regional health information exchange that worked with several major health plans and health care providers to evaluate provider performance and improve the quality and reduce the cost of health care. The taxpayer performed many of the same data-gathering and provider-evaluation functions that an ACO performs, and worked across “an entire patient population” rather than benefiting only Medicare or Medicaid beneficiaries. The Service ruled in PLR 201250025 that the taxpayer was described in section 501(c)(3) because it served the charitable purpose of lessening the burdens of government.

2. PROMOTION OF HEALTH

After discussing the tax-exempt purpose of “lessening the burdens of government,” Notice 2011-20 goes on to recognize that the “promotion of health” may be another tax-exempt purpose that applies to ACOs. Nonetheless, Notice 2011-20 leaves unanswered the question of whether an ACO could rely on the promotion of health as its exempt purpose. The Service’s uncertainty appears to be based on a lack of information on how non-MSSP ACOs will operate, coupled with a separate question (discussed in Section IV.D below) as to whether non-MSSP ACOs could have a substantial non-exempt purpose if they provide impermissible private benefit to non-exempt providers. Notice 2011-20 specifically invites comments on these issues.

The term “charitable” is used in section 501(c)(3) “in its generally accepted legal sense” and is not limited to the purposes specifically enumerated in section 501(c)(3).

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70 Rev. Rul. 81-276, 1981-2 C.B. 128, is discussed in Sections III.C, IV.C.2.a and IV.D.1.a of these Comments.
71 1985-1 C.B. 177.
72 1985-1 C.B. 178.
73 Sept. 21, 2012. For further discussion of PLR 201250025, see Sections IV.C.2.e, IV.C.2.f and IV.D.1.h below.
74 2011-1 C.B. at 655-656.
75 Reg. § 1.501(c)(3)-1(d)(2).
In Rev. Rul. 69-545,\textsuperscript{76} the Service recognized that the promotion of health is a charitable purpose within the meaning of section 501(c)(3) where “the class of beneficiaries eligible to receive a direct benefit from activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community.”\textsuperscript{77} Since 1969 the Service has issued guidance recognizing the section 501(c)(3) status of a number of different types of organizations based on their promotion of health. The Service’s guidance with respect to several of these types of organizations supports the conclusion that ACOs further the exempt purpose of the promotion of health within the meaning of section 501(c)(3).

a. PSROs.

As described above in Section III.C, MSSP ACOs and PSROs share similar objectives of reducing the cost and improving the quality of health care in the Medicare and (in the case of PSROs) Medicaid programs. As authority for concluding that MSSP ACOs lessen the burdens of government, Notice 2011-20 cites Rev. Rul. 81-276,\textsuperscript{78} which held that PSROs qualify under section 501(c)(3). Although not mentioned in Notice 2011-20, Rev. Rul. 81-276 placed as much, if not more, emphasis on PSROs’ role in the promotion of health in concluding that PSROs qualify under section 501(c)(3). Rev. Rul. 81-276 expressed its conclusion in part as follows:

> By operating as a designated PSRO and restricting federal health care payments to services that are medically necessary, M [the PSRO] 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.\textsuperscript{79}

Similar reasoning is found in two cases that were decided before the issuance of Rev. Rul. 81-276. The courts in \textit{Professional Standards Review Organization of Queens County, Inc. v. Commissioner,}\textsuperscript{80} and \textit{Virginia Professional Standards Review Foundation v. Blumenthal,}\textsuperscript{81} did not distinguish between the two tax-exempt purposes of lessening the burdens of government and the promotion of health in holding that the two PSROs qualified under section 501(c)(3).\textsuperscript{82}

Like PSROs, ACOs promote health at least as much as they lessen the burdens of government. This is certainly true of MSSP ACOs because they have much the same

\textsuperscript{77} Id.
\textsuperscript{78} 1981-2 C.B. 128.
\textsuperscript{79} 1981-2 C.B. at 129.
\textsuperscript{81} 466 F.Supp. 1164 (D.D.C. 1979).
\textsuperscript{82} The Service had rejected the applications of both PSROs for section 501(c)(3) status and litigated the issue. After losing both cases, the Service reversed its position, as reflected in Rev. Rul. 81-276, and stated that it would follow those cases in like situations.
legislative purpose as PSROs. So long as non-MSSP ACOs have the same goals and are organized and operated in a manner similar to MSSP ACOs, as is the case with the non-MSSP ACOs described in our Examples 2 and 3, then the promotion of health purpose should extend to them as well.

b. Health Planning Agencies.

In Rev. Rul. 77-69, the Service recognized the section 501(c)(3) status of a health systems agency created pursuant to federal statute for the purpose of “improving the general health of residents in the health area, increasing the accessibility, acceptability, continuity, and quality of health services provided, restraining increases in the cost of providing health services, and prevention of unnecessary duplication of health services.”\footnote{Id.} To meet these responsibilities, the health planning agency gathered and utilized data, established health care goals, objectives and priorities, and coordinated activities within the area. The health planning agency did not provide health care services. The Service concluded that “[b]y establishing and maintaining a system of health planning and resources development aimed at providing adequate health care, the [organization] is promoting the health of the residents of the area in which it functions” and on that basis recognized its section 501(c)(3) status. ACOs share several of these same goals and purposes.

c. Computerized Organ Donor Retrieval Systems.

In Rev. Rul. 75-197, the Service concluded that “[b]y facilitating the donation of organs which will be used to save lives, the organization [that operated a free computerized donor-authorized retrieval system to facilitate the transplantation of body organs] is serving the health needs of the community and, therefore, is promoting health within the meaning of the general law of charity”. Although distinguishable from an ACO, one basis for the section 501(c)(3) status of the organ donor retrieval organization was its role in promoting the efficiency of health care delivery, which is also one purpose of an ACO.

d. Regional Health Data System.

In Rev. Rul. 76-455, the Service examined an organization that was formed to conduct studies and propose improvements regarding quality, utilization and effectiveness of health care and health care agencies and to educate those involved in furnishing, administering and financing health care. The Service concluded that a regional health data system advanced tax-exempt purposes by establishing uniform health data recordkeeping and reporting procedures and conducting scientific studies regarding quality, utilization, and effectiveness of health care agencies with an eye toward improving health care. The ruling focuses on the organization’s scientific and educational purposes, but the Service also notes the organization’s efforts to make “more efficient use

\footnote{1977-1 C.B. 143.}
\footnote{Id.}
\footnote{1975-1 C.B. 156.}
\footnote{1976-2 C.B. 150.}
of health facilities” and to “aid in the planning of better care for future health needs.”87 ACOs will undertake very similar efforts.

e. **Electronic Health Records (“EHR”).**

In a May 11, 2007 memorandum (the “EHR Directive”),88 the Service approved certain programs under which tax-exempt hospitals subsidized the acquisition of software and services by their medical staff physicians for use predominantly in processing EHR. The Fact Sheet specifically refers to the EHR Directive and confirms that the Service will continue to follow it and apply it to tax-exempt organizations participating in ACOs.89

The goal of the subsidized EHR described in the EHR Directive was to improve the effectiveness and efficiency of medical care and reduce medical errors. A premise of the EHR Directive was that promoting EHR furthered the tax-exempt purpose of promoting health. The EHR Directive focused most of its analysis on the question of whether providing subsidies to staff physicians might violate the private inurement and private benefit doctrines. The EHR Directive concluded that the Service would not treat EHR subsidies as private inurement or impermissible private benefit if the subsidies fell within the HHS’ guidelines that allowed such subsidies.90

The EHR Directive referred to the subsidized EHR software and services provided to staff physicians as “Health IT Items and Services,” which we will refer to as “HIT”. The EHR Directive’s recognition of HIT as important in promoting health is of particular relevance given the role that ACOs are expected to play in developing HIT and its application to EHR. An emphasis on HIT infrastructure pervades the provisions of the Affordable Care Act, which carries forward and builds on other recent federal legislative and programmatic initiatives, including the HITECH Act provisions of the American Recovery and Reinvestment Act of 2009 (“ARRA”)91 and the Patient Safety and Quality Improvement Act of 2005.92 ACOs will carry out the legislative purposes of the

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87 Id.
Affordable Care Act and the HITECH Act by developing and applying HIT infrastructure to extend and improve the use of EHR.

For example, the Affordable Care Act directs HHS to establish a national quality strategy (i) to improve the delivery of health care services, patient health outcomes, and population health through the use of data, (ii) to improve quality, efficiency, transparency and outcomes of health care services, and (iii) to disseminate best practices to improve patient safety and reduce medical errors, preventable readmissions and infections.\textsuperscript{93} In addition, the Affordable Care Act directs the new Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models with the goal of reducing expenditures while preserving or enhancing the quality of care furnished to Medicare and Medicaid beneficiaries. These models include the use of HIT in provider networks to support care coordination for chronically ill individuals at high risk of hospitalization and the use of technology such as EHR and patient-based remote monitoring systems to coordinate care over time and across settings.\textsuperscript{94} The Affordable Care Act also creates Community Health Teams and requires that they (1) collect and report information that permits the evaluation of the success of the collaborative effort on patient outcomes (including collection of data on patient experience and areas for improvement) and quality measures and (2) demonstrate the capacity to implement and maintain certified EHR technology to facilitate coordination among members of the care team and affiliated primary care practices.\textsuperscript{95}

To meet the Affordable Care Act’s goals of improving quality, reducing cost and providing patient-centered care, an ACO must have a clinical and administrative HIT infrastructure capable of promoting evidence-based medicine and patient engagement, reporting on quality and cost measures, and coordinating care, such as through the use of telehealth, remote patient monitoring and similar technologies. While HIT infrastructure requirements have been clearly established for MSSP ACOs, it will be critical for non-MSSP ACOs to have similar capabilities.\textsuperscript{96}

The HIT infrastructure must also allow ACOs to aggregate clinical care delivery components, provide infrastructure, and capture and report data on various performance metrics, including patient satisfaction, quality measurement and improvement, best practices, evidenced-based medicine protocols, and chronic disease management.\textsuperscript{97} The establishment and operation of this infrastructure by ACOs will carry out the Affordable Care Act’s goal of developing HIT and promoting EHR systems across the nation.


\textsuperscript{93} Affordable Care Act, §§ 3011-3012, amending 42 U.S.C. § 280j.

\textsuperscript{94} Id. at § 3021, 42 U.S.C. § 1315a.

\textsuperscript{95} Id. at § 3502, 42 U.S.C. § 256a-1.

\textsuperscript{96} See Amy S. Leopard, ACOs and Health Information and Technology, presented at the American Health Lawyers Association Annual Meeting (Jun. 2012), available at http://www.healthlawyers.org/Events/Programs/Materials/Documents/AM12/papers/EE_leopard.pdf (subscription required) (noting that “[t]he ACOs, whether through the MSSP, commercial or employer-based initiatives, are likely to find that HIT infrastructure is a critical element for success”).

\textsuperscript{97} Id.
The EHR Directive recognized the important, if not critical, role of EHR and HIT in the promotion of health. This view was reaffirmed in the recent PLR 201250025, where the Service stated that taken together the ARRA and the Conference Report to the ARRA98 “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.”99 Although PLR 201250025 did not discuss the promotion of health as a charitable purpose, it recognized the critical importance of EHR and HIT in reducing the cost and improving the quality of health care. By using EHR and HIT to reduce the cost and improve the quality of health care, ACOs also serve the exempt purpose of promoting health.

f. Regional Health Information Organizations.

Like the organization in Rev. Rul. 76-455, regional health information organizations (“RHIOs”) promote the development of HIT and EHR across a wide spectrum of providers and patients. The House Report with respect to ARRA expressly stated the expectation that RHIOs would be eligible for exemption under section 501(c)(3) on the basis that they lessen the burdens of government by furthering federal health policy goals, including the accelerated development of a federal electronic health records system and regional health information networks.100 The Service was uncertain whether RHIOs could qualify for section 501(c)(3) tax-exempt status when they were first introduced in connection with the federal government’s vision for the widespread electronic exchange of health information. Based on various public statements by its personnel since that time, the Service considered many bases for exemption including both the promotion of health and lessening the burdens of government.101 This uncertainty appears to have been resolved by the recent PLR 201250025,102 which ruled that a RHIO furthers the charitable purpose of lessening the burdens of government.

While the ARRA and PLR 201250025 chose to specify lessening the burdens of government as a tax-exemption rationale for RHIOs, the authorities cited above confirm that RHIOs promote health as well as lessen the burdens of government through their

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99 PLR 201250025 (Sept. 21, 2012).
100 The charitable nature of the primary activities of RHIOs was expressly recognized in the conference committee report accompanying the American Recovery and Reinvestment Act of 2009, which stated that a nonprofit organization that "engages in activities to facilitate the electronic use or exchange of health-related information to advance the purposes of [the Act], 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." H. R. Rep. No. 111-16 at 488 (2009), available at http://www.gpo.gov/fdsys/pkg/CRPT-111hrpt16/pdf/CRPT-111hrpt16.pdf.
102 Sept. 21, 2012.
efforts to foster and promote the use of HIT and EHR to make health care delivery more efficient. By encouraging the use of HIT and EHR, ACOs, too, are making health care more efficient and are furthering the tax-exempt purpose of promoting health as well as lessening the burdens of government.

g. Conclusion.

Much like PSROs, the regional health data system in Rev. Rul. 76-455, and the RHIO in PLR 201250025, ACOs will develop performance measurements, conduct analyses and develop reports focused on improving health care quality, efficiency, effectiveness and patient experience across a broad spectrum of health care providers and the communities they serve. For these reasons, we believe the promotion of health standard encompasses the kind of MSSP activities and non-MSSP activities described in our Examples 1, 2 and 3. In all three situations, the ACO is organized and operated to achieve the Affordable Care Act’s goals of improving patient care and health care quality, while reducing overall health care costs.

We believe that it is clear from the foregoing authorities that a non-MSSP ACO as described in our Examples 2 and 3 furthers the tax-exempt purpose of the promotion of health. There is ample authority in the Service’s own rulings that an organization that coordinates health care and strives to make it more efficient serves the tax-exempt purpose of promoting health.

D. PRIVATE INUREMENT AND PRIVATE BENEFIT

The general principles of the private inurement and private benefit doctrines discussed in Section III.D above apply equally to non-MSSP activities of ACOs. The reluctance of Notice 2011-20 to embrace the promotion of health as an exempt purpose for ACOs appears to be based on the Service’s unanswered questions about whether non-MSSP ACOs will comply with the private inurement and private benefit doctrines. The same questions exist whether an ACO’s tax-exempt purpose is the promotion of health or lessening the burdens of government.

The analysis below first reviews similar situations in the health care area where the Service has addressed the application of the private inurement and private benefit doctrines and has agreed that neither doctrine would be violated if guidelines were followed. We then address the statements in Notice 2011-20 that suggest the source of the Service’s questions on private inurement and private benefit.

1. PRIVATE INUREMENT AND PRIVATE BENEFIT IN HEALTH CARE CONTEXT

The private inurement and private benefit issues presented by non-MSSP ACOs are not unique, and are generally the same issues posed by MSSP ACOs. The types of financial dealings between tax-exempt organizations and private health care providers required by ACOs are commonplace and inevitable in the health care industry. Although CMS regulation of MSSP ACOs may provide some additional assurance of compliance
with the private inurement and private benefit doctrines, the Service has not found regulation and oversight of that sort to be essential in other contexts. Without such government regulation, the Service has developed guidelines in comparable situations that allow tax-exempt organizations to navigate interactions with private interests without violating the private inurement and private benefit prohibitions.

**a. PSROs.**

The similarities in the purposes of PSROs and ACOs are discussed in Sections III.C and IV.C.2 above. The Service’s initial refusal to recognize PSROs as tax-exempt organizations described in section 501(c)(3) was based on the private benefit doctrine. The Service was concerned that PSROs provided impermissible private benefit to physicians because PSROs promoted the reputation of physicians and protected them from outside regulation. In *Professional Standards Review Organization of Queens County, Inc. v. Commissioner,* the Tax Court rejected the Service’s position, stating that “respondent’s claim that petitioner and other PSROs were formed to promote the ‘interests’ of the medical profession is spurious and without foundation.” The Service acquiesced in the decision and accepted the Tax Court’s view in Rev. Rul. 81-276. To the extent the Service’s private benefit concerns about ACOs are similar to the private benefit concerns it had about PSROs, those concerns are answered by Rev. Rul. 81-276.

**b. Gainsharing.**

Gainsharing arrangements are incentive programs that allow hospitals to reward physicians who cooperate with the hospitals to lower medical costs. The Service issued an information letter in 2002 that provides a description of a typical gainsharing arrangement. ACOs have elements in common with gainsharing arrangements as both seek to improve patient care while reducing medical expenses. Gainsharing arrangements and ACOs both seek to align physician incentives with those of hospitals through a restructuring of incentives for providing care.

In January 1999, the Service issued an unpublished private letter ruling suggesting that gainsharing arrangements do not adversely affect tax-exempt status in certain circumstances. The unpublished private letter ruling concluded that the proposed gainsharing arrangement it described advanced charitable purposes and did not result in impermissible private benefit or private inurement because it was designed to enhance patient care while reducing expenses.

The 2002 information letter provides a useful analysis of gainsharing physician incentives from the perspective of the private inurement and private benefit doctrines. Specifically, the information letter set forth 12 factors as guidelines the Service would

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104 *Id.* at 249.
107 *See* note 105.
consider in determining whether gainsharing incentives violate the private inurement and private benefit doctrines, including whether the arrangement: (i) receives approval from an independent board (or committee) subject to a conflict of interest policy; (ii) results in total compensation that is reasonable; (iii) allows physicians to participate impermissibly in the organization’s management or to control their own compensation; (iv) includes a ceiling or reasonable maximum amount of physician compensation to protect against windfalls; (v) sustains charitable services or benefits otherwise provided; (vi) accounts for quality of care and patient satisfaction data; (vii) awards incentives based on net revenue rather than net income; (viii) transforms the organization’s principal activity into a joint venture between the hospital and physicians; (ix) distributes a portion of the hospital’s profits to persons who control the hospital; (x) serves a discernible business purpose (such as to achieve maximum efficiency and economy in operations) that is independent of any private benefit to physicians; (xi) includes effective controls, including those guarding against unnecessary utilization; and (xii) compensates only services actually performed by the physicians.

The 2002 information letter on gainsharing is a good example of a situation where the Service faced private inurement and private benefit issues very similar to those presented by non-MSSP ACOs. In the 2002 information letter the Service provided detailed guidelines with factors it would consider in applying the private inurement and private benefit concerns to gainsharing arrangements. We believe a similar approach is appropriate for non-MSSP ACOs, and our Examples 2 and 3 provide a framework for developing comparable guidelines for non-MSSP ACOs.

c. Electronic Health Records.

As noted above in Section IV.C.2.e, the Service’s EHR Directive approved EHR subsidies that tax-exempt hospitals provided to medical staff physicians because the subsidies furthered the exempt purpose of promoting health. In doing so, the EHR Directive focused primarily on the private inurement and private benefit issues raised by EHR subsidies. The EHR Directive expressly recognized that EHR has the potential to “improve the effectiveness and efficiency of … medical care and to reduce medical errors.” ACOs similarly seek to improve the efficiency of medical care, reduce medical errors and provide incentives tied to advancing patient care. The EHR Directive states that tax-exempt hospitals’ donations of EHR technology items and services to medical staff physicians will promote health and not result in private inurement or impermissible private benefit if the donations meet the following guidelines:108

- The benefits are provided in a manner and extent permitted under the applicable HHS regulations on self-referral and anti-kickback prohibitions109 for donations of EHR by hospitals to physicians;

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109 42 C.F.R. § 411.357(w); 42 C.F.R. § 1001.952(y).
The hospital enters into EHR donation agreements with the physicians before donating the EHR items and services and such agreements require the hospital and participating physicians at all times to comply with HHS regulations and permit the hospital to access the EHRs created by staff physicians using hospital-subsidized equipment to the extent permitted by applicable law; and

- The hospital makes the same donation arrangement available to all medical staff physicians or, if the arrangement varies, the variations are determined by applying criteria related to meeting the community’s healthcare needs.

In addition to providing guidelines to overcome private inurement and private benefit concerns similar to those presented by ACOs, the EHR Directive is important because it demonstrates the Service’s willingness to join other federal agencies in developing guidance to support federal health care policy initiatives such as the expansion of EHR. Non-MSSP ACOs present the Service with another opportunity to issue guidance that would support the federal government’s health care policies and health reform goals.

d. Professional Corporations.

The Service has recognized professional corporations affiliated with tax-exempt hospitals as tax-exempt organizations if certain guidelines are followed. Many of these guidelines address private inurement and private benefit concerns. With respect to board composition, the Service has stated that while the board of the professional corporation may consist of physicians (as often required by state laws on the corporate practice of medicine), the community board of the tax-exempt parent must retain and exercise reserved powers that are sufficient to ensure that the professional corporation’s activities accomplish charitable purposes and avoid private inurement and impermissible private benefit, including the right to (1) elect, appoint, remove, and change the number of directors; (2) amend, alter or repeal the articles of incorporation and bylaws; and (3) approve significant actions including (a) the annual operating and capital budgets and material deviations from such budgets, (b) the sale, lease, mortgage or other transfer or encumbrance of real or certain valuable personal property; (c) merger, acquisition, consolidation, liquidation, or dissolution; (d) settlements of material claims and litigation; and (e) selection of auditors.\(^\text{110}\)

The Service’s willingness to approve the section 501(c)(3) status of professional corporations is another example of the Service’s flexibility in structuring private inurement and private benefit guidelines to deal with the reality of health care delivery systems. The same flexibility should be extended to non-MSSP ACOs.

e. Integrated Delivery Systems.

In the 1980s and 1990s the Service reviewed numerous situations involving the acquisition by tax-exempt hospitals of physician practices and the creation or expansion of integrated delivery systems that involved physicians as both employees and independent contractors. Integrated delivery systems facilitated the kind of physician role in governance and operations in the delivery of health care that is required of ACOs by the Affordable Care Act. Such physician involvement is consistent with the Service’s prior acknowledgment that, while an independent community board must be responsible for “all decisions and charitable aspects” of a system’s health care delivery, it is appropriate to delegate responsibility for “clinical or professional aspects of the health care services” to committees that “may contain unlimited physician representation.”

The Service developed guidelines to deal with the private inurement and private benefit issues presented by integrated delivery systems and the involvement of physicians in their governance. These guidelines could be adapted for use with non-MSSP ACOs.

f. Physician Incentive Compensation.

The private inurement and private benefit issues that the Service faces with ACOs resemble issues that the Service has faced in establishing guidelines in the broader health care context to avoid private inurement and impermissible private benefit when designing physician incentive compensation arrangements. For example, the Service has approved incentive arrangements for physicians where the following five guidelines were included:

1. The arrangement was the result of arm’s length bargaining, with the physicians having no control over the tax-exempt organization paying the compensation;
2. The arrangement advanced a real and discernible business purpose of the tax-exempt organization that was independent of any benefit to the physicians;
3. The amount of compensation was not dependent principally on incoming revenues, but on accomplishing the objectives of the organization through the compensation arrangement;
4. The arrangement’s actual results did not reveal evidence of abuse or unwarranted benefits; and
5. The arrangement included a ceiling or reasonable maximum amount of compensation.

Similar guidelines could be used to ensure that ACOs and other shared savings arrangements do not violate the private inurement and private benefit doctrines. The nature of an ACO’s activities (receiving incentive payments from governmental and

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112 Id. at 13-14.
113 E.g., GCMs 38322 (Mar. 24, 1980) and 39674 (Oct. 23, 1987).
private payers for services rendered to enrollees) provides an inherent reasonableness test for compensation. MSSP payments will be set by the government. Payments from private payers will be negotiated at arm’s length with an unrelated party and would appear to satisfy the foregoing five guidelines.

The ACO’s only internal compensation decisions will relate to the allocation of the arm's length incentive payments among its member providers. These decisions will not be made in a vacuum. CMS issued final regulations on October 20, 2011, that require an ACO to describe in its CMS application the criteria it will use to distribute shared savings among its providers, as well as how the shared savings will be used in a manner consistent with the principal goals of the ACO program to achieve better care for individuals, better health for populations, and lower growth in expenditures. Private payers are likely to require similar information from ACOs because they will have the same interest in ensuring that incentive payments further the goals of better health and lower cost. This allocation process is susceptible to the same kind of guidelines that the Service developed for physician incentive compensation.

g. The Notice’s Five-Factor Test.

Section III.D.2 above discusses the five-factor test that Notice 2011-20 provides to assure that participation in an MSSP ACO does not result in private inurement or impermissible private benefit. The Fact Sheet specifically states that all five factors are not required to avoid private inurement and impermissible private benefit.114

Four of the five factors can be applied as readily to non-MSSP ACOs as they can to MSSP ACOs, and we would expect that non-MSSP ACOs would satisfy those four factors. The one factor that cannot be applied to non-MSSP activities is the one calling for participation in the MSSP.

Notice 2011-20 includes MSSP participation as one of the five factors because MSSP participation subjects the ACO to CMS regulation and oversight, which Notice 2011-20 regards as additional assurance that the ACO will comply with the private inurement and private benefit doctrines. Alternatives to CMS regulation and oversight can provide comparable assurance, however. For example, this Section IV.D.1 discusses several situations where the Service satisfied itself that a health care activity that was not subject to ACO-specific CMS regulation and oversight would not result in private inurement or impermissible private benefit. If a non-MSSP ACO satisfies the four factors that apply to it and provides additional assurances along the lines of the items reflected in this Section IV.D.1, there should be sufficient assurances that non-MSSP activities will not result in private inurement or impermissible private benefit.

h. RHIOs and PLR 201250025.

RHIOs and PLR 201250025 are discussed above in Sections IV.C.1, IV.C.2.e and IV.C.2.f. As explained in those Sections, RHIOs and ACOs both promote HIT and EHR

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and in doing so engage in many of the same data-gathering and provider-evaluation activities. The Service ruled in PLR 201250025 that a RHIO’s data-gathering and provider-evaluation activities did not lead to private inurement or impermissible private benefit. This suggests that the conduct of those same activities by an ACO will also not lead to private inurement or impermissible private benefit.

2. ADDRESSING THE SERVICE’S QUESTIONS

The Service’s questions about whether non-MSSP activities of ACOs will comply with the private inurement and private benefit doctrines are manifested in Notice 2011-20 in three principal ways. First, Notice 2011-20 asserts that “not every activity that promotes health supports tax exemption under section 501(c)(3),” citing IHC Health Plans, Federation Pharmacy Services and Rev. Rul. 98-15. Second, in referring to non-MSSP ACOs, Notice 2011-20 makes the following statement:

For example, negotiating with private health insurers on behalf of unrelated parties generally is not a charitable activity, regardless of whether the agreement negotiated involves a program aimed at achieving cost savings in health care delivery.

Third, the Service questions the effect of not having CMS regulation and oversight for non-MSSP activities. For example, in introducing the five-factor test (discussed above in Sections III.D.2 and IV.D.1.g), Notice 2011-20 explains that one reason the Service expects tax-exempt organizations’ participation in MSSP ACOs to comply with the private inurement and private benefit doctrines is “[b]ecause of CMS regulation and oversight of the MSSP…” Notice 2011-20 goes on to ask for comments on how to ensure that non-MSSP activities further exempt purposes in the absence of safeguards similar to those present in the MSSP, such as (1) any regulatory requirements imposing quality performance and other standards on the non-MSSP activities and (2) any oversight and monitoring of the non-MSSP activities by a government agency such as CMS.

The Service’s questions are understandable. It is certainly true that not every activity that promotes health is charitable within the meaning of section 501(c)(3). Nonetheless, the three authorities that the Notice 2011-20 cites for that proposition have no application to ACOs. The paragraphs below first address those three authorities and then analyze an ACO’s role in negotiating with payers and the effect of a lack of ACO-specific CMS regulation and oversight of non-MSSP activities.

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115 2011-1 C.B. at 655.
117 72 T.C. at 691-92.
118 1998-1 C.B. 718.
119 2011-1 C.B. at 655.
120 Id.
121 Id.
a. **IHC Health Plans.**

In *IHC Health Plans Inc. v. Commissioner*, the Tenth Circuit ruled that a health maintenance organization (“HMO”) that arranged to provide health care only to its member subscribers did not qualify under section 501(c)(3). ACOs are very different from HMOs and do not raise the same concerns.

One key difference between HMOs and ACOs is evident from the Tenth Circuit’s statement in *IHC Health Plans* that “petitioner’s sole activity is arranging for health-care services in exchange for a fee.” An ACO’s members are the health care providers, not the patients receiving health care services, and the ACO coordinates, measures and accounts for how its member-providers deliver health care services to their patients. An ACO has no patients or contracts with patients. It receives no fees or other payments from patients. Its participating providers continue to deliver health care services to patients and receive payments for those services directly from payers. An ACO does not arrange for the delivery of health care services in the same sense as an HMO because the delivery of health care would go on without the ACO’s involvement. Unlike an HMO, an ACO plays no direct role in the delivery of health care. Its participating hospitals and physicians continue to deliver their respective health care services, and are paid for those services by the same payers as before, whether or not there is an ACO. The ACO’s role is limited to coordinating and monitoring the delivery of health care services by its participating hospitals, physicians and other providers, and promoting accountability for the cost and quality of the care they deliver.

Another key difference is that an ACO plays no role in the financing of health care services beyond any incentive payments it may earn. In *IHC Health Plans* the Tenth Circuit made the following statement:

> In this case, we deal with organizations that do not provide health care services directly. Rather, petitioners furnish group insurance entitling enrollees to services of participating hospitals and physicians…. In other words, petitioners primarily perform a “riskbearing function.”

An ACO plays no such role in the financing of health care. It receives no premiums or fees from members, and it bears no insurance risk.

A third key difference relates to the Tenth Circuit’s reference to IHC’S “self-imposed requirement of membership” as a limitation on the community the HMO benefited. In *IHC Health Plans* the HMO sold products and services to its members and the Court viewed the membership requirement as a way to promote the HMO’s business. An ACO’s membership is not a market for the ACO’s products and services, and does not serve to limit the community the ACO benefits. Members of the public do not face a membership requirement and do not pay a fee or premium to benefit from the

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122 325 F.3d 1188, 1197 (10th Cir. 2003).
123 Id. at 1200.
124 Id. at 1199-1200.
125 Id. at 1201.
ACO. Members of the public are enrolled automatically and without charge by virtue of being covered by a payer, whether that payer is Medicare, Medicaid, a private health insurer, a managed care plan, a self-insured plan, or some other payer. An ACO may coordinate with several payers, and the community it benefits is open-ended. Thus, the membership factor in IHC Health Plans does not apply to an ACO.

Although the authorities involving HMOs serve as a useful reminder that not all activities that promote health qualify under section 501(c)(3), they have no bearing on the tax-exempt status of ACOs. HMOs and ACOs are entirely different types of organizations and serve entirely different purposes. The tax treatment of HMOs has no relevance to the tax treatment of ACOs.

b. **Federation Pharmacy Services.**

In *Federation Pharmacy Services, Inc. v. Commissioner*,\(^{126}\) the Eighth Circuit Court of Appeals and the Tax Court concluded that an organization that made pharmacy sales to elderly and handicapped persons at a discount was too commercial in nature to qualify as tax-exempt because it competed with commercial pharmacies.\(^{127}\) *Federation Pharmacy Services* is another useful reminder that not every activity that promotes health qualifies under section 501(c)(3). However, the case appears to have no relevance to ACOs because ACOs do not sell services or products to the public, have no direct relationship with the public, and do not provide services or products to its members’ patients. Nothing in *Federation Pharmacy Services* appears to undermine the status of ACOs as organizations that have a tax-exempt purpose.

c. **Rev. Rul. 98-15.**

As explained above in Section III.E.1.c, Rev. Rul. 98-15 dealt with whole-hospital joint ventures where the joint venture represented a tax-exempt organization’s sole activity. A joint venture operating a hospital differs substantially from a joint venture operating an ACO. More important, an ACO will typically not represent a substantial part of a tax-exempt organization’s activities and therefore is more appropriately treated as an ancillary joint venture subject to the guidelines in Rev. Rul. 2004-51. Although Rev. Rul. 98-15 serves as a useful reminder that not all activities that promote health qualify under section 501(c)(3), it, too, has no relevance to the tax treatment of ACOs.

d. **Negotiating with Payers.**

It is not clear whether the statement in Notice 2011-20 that “negotiating with private health insurers on behalf of unrelated parties is generally not a charitable activity” is based on a concern that the benefit to the unrelated parties is impermissible private benefit or that the activity is an unrelated business subject to UBIT. Neither should be a concern, however, because an ACO’s role in negotiating the cost, quality and patient-

\(^{126}\) 72 T.C. 687, 691-92 (1979), aff’d, 625 F.2d 804 (8th Cir.1980).

\(^{127}\) Tax-exempt hospitals are allowed to sell pharmaceuticals to patients as part of their tax-exempt activities, but sales to members of the public who are not patients are subject to the unrelated business income tax. *E.g.*, Rev. Rul. 68-376, 1968-2 C.B. 246; Rev. Rul. 68-375, 1968-2 C.B. 245.
satisfaction benchmarks that must be met to earn an incentive payment, the amount of the incentive payment, and related matters is an incidental and integral part of the ACO’s overall function and activities.

Preliminarily, this negotiation function is not a distinction between MSSP ACOs and non-MSSP ACOs. An MSSP ACO will be representing “unrelated third parties” in its dealings with Medicare in much the same manner that a non-MSSP ACO will be representing “unrelated third parties” in its dealings with non-MSSP payers. We see no basis for treating the two situations differently based on whether the ACO is negotiating with Medicare or with non-MSSP payers. If the negotiating function is permissible for MSSP ACOs, it should be permissible for non-MSSP ACOs.

The Service’s questions about an ACO’s negotiating function appear to be based on a lack of information about the type and extent of the negotiations that the ACO will be conducting. The ACO’s negotiations will focus on establishing the cost, quality and patient satisfaction benchmarks that it must meet to earn an incentive payment, the amount of the incentive payment, and related matters. The ACO will not be negotiating directly on behalf of its provider-members to increase their market share or to set the prices that non-MSSP payers pay them directly for their services. The Service may have been concerned that an ACO’s negotiations would be global in nature, determining all aspects of its provider-members’ financial relationship with payers, like an HMO. That is not the case. An ACO’s negotiations will be focused primarily, if not exclusively, on setting benchmarks and incentive payments.

An ACO’s negotiations with payers will be not just important, but essential, for the ACO to accomplish its exempt purposes. Establishing benchmarks for incentive payments and the amounts of those payments is a core part of an ACO’s activities. An ACO cannot function without negotiating incentive payments with its payers. If there is no incentive payment, there is no ACO. That is equally true of MSSP ACOs and non-MSSP ACOs. The negotiation function is not just related to, it is fundamental to the ACO’s exempt purpose.

To the extent an ACO’s negotiation with non-MSSP payers over incentive payments provides a private benefit to the ACO’s provider-members, that private benefit will be qualitatively and quantitatively incidental to the ACO’s exempt purpose of reducing cost and improving quality and patient satisfaction. The private benefit will be qualitatively incidental because it flows directly from establishing benchmarks and making incentive payments. The private benefit from negotiating the benchmarks for incentive payments is identical in principle to the private benefit from making incentive payments if the benchmarks are met. Awarding an incentive payment represents a sharing of cost savings and patient benefits, and directly carries out an ACO’s exempt purpose. An incentive payment cannot be awarded unless the ACO first negotiates the amounts and benchmarks for the payments, so negotiating those amounts and benchmarks directly carries out the ACO’s exempt purposes. The negotiation of the amounts and benchmarks for incentive payments is just as essential to fulfilling the ACO’s exempt purposes as the payment of the incentive payments. The ACO cannot carry out its exempt purposes without performing either of those core functions.
Any private benefit to the ACO’s members is also quantitatively incidental to the exempt purpose the ACO serves. The ACO’s provider-members will continue to receive their normal fees directly from payers, whether MSSP or non-MSSP. The providers will receive no benefit at all from the ACO unless cost, quality and patient satisfaction benchmarks are met. Accordingly, any benefit to members from an ACO’s negotiations with payers will be quantitatively incidental because it will be limited to establishing the ACO’s incentive payments and will not bear directly on the members’ direct financial relationship with those payers.

Any benefit to an ACO’s members from receiving an incentive payment is clearly anticipated as part of the ACO’s purpose. Any additional benefit that an ACO’s members may receive from the ACO’s negotiation of the incentive payments seems inconsequential, and is incidental both qualitatively and quantitatively to the ACO’s exempt purpose. Because negotiating the incentive payment is a core function and contributes importantly to the ACO’s exempt purpose, it is also related to the ACO’s exempt purpose. Accordingly, the ACO’s role in negotiating the incentive payment should not result in impermissible private benefit or be considered an unrelated activity.

e. Safeguards in lieu of CMS Oversight.

Although the Service relies in part on CMS regulation and oversight in concluding that MSSP participation will comply with the private inurement and private benefit doctrines, the lack of CMS regulation and oversight is no reason to conclude that non-MSSP activities will result in private inurement or impermissible private benefit. ACOs are not subject to ACO-specific CMS regulation and oversight of their non-MSSP activities, but they are subject to extensive general regulation and oversight by CMS. For example, non-MSSP activities are subject to CMS regulation and oversight under the Federal anti-kickback statute,128 the Physician Self-Referral Law,129 and the civil monetary penalties law.130 This more general CMS regulation and oversight is not as targeted as MSSP regulation and oversight,131 but it is nonetheless directed toward ensuring that transactions between providers are commercially reasonable and at fair market value, thus providing safeguards against private inurement and impermissible private benefit.

Non-MSSP activities will also be subject to the oversight of other federal agencies in carrying out their health care mission. For example, an ACO must comply with antitrust guidelines on clinical integration adopted by the Department of Justice ("DOJ") and Federal Trade Commission ("FTC").132 These guidelines establish standards for physician integration and demand significant efficiencies, active and ongoing program

130 42 U.S.C. § 1320a-7a.
131 For example, an ACO participating in the MSSP is subject to oversight of its governance and contracting activities. 42 C.F.R. § 425.210 (final ACO regulations).
evaluation, and mechanisms that assure cooperation and interdependence among the participating physicians. The requirements imposed by the DOJ and FTC guidelines help to assure that non-MSSP activities further the exempt purpose of promoting health and that there is no private inurement or impermissible private benefit.

The DOJ and FTC issued a joint policy statement describing how they would enforce U.S. antitrust laws with respect to ACOs. Recognizing that some ACOs will participate in commercial markets, the DOJ and FTC sought to “maximize and foster opportunities for ACO innovation and better health for [all] patients,” not just Medicare beneficiaries. In an effort to make it easier for ACOs to form, the DOJ and FTC abandoned their proposed mandatory antitrust review procedures to apply the more lenient “rule of reason” treatment to ACOs that meet CMS eligibility requirements, such as “the same governance and leadership structures and clinical and administrative processes” used in the MSSP “to serve patients in commercial markets.”

Another factor mitigating against the lack of ACO-specific CMS regulation and oversight is the common interest that non-MSSP payers will have in using and adopting many of the standards developed by HHS and CMS for the MSSP. Non-MSSP payers with shared savings programs will have the same interests in (i) establishing quality performance standards, (ii) assessing ACO performance against such standards, (iii) assigning subscriber patients to the ACO, and (iv) determining whether an ACO is eligible for shared savings incentives and the amount of such incentives. The non-MSSP payers will stand in the shoes of the HHS and CMS in imposing and enforcing the same or similar requirements that HHS and CMS impose.

Finally, as discussed above in Section III.D.1, there are many situations in the health care industry where the Service has found that private inurement and private benefit questions did not stand in the way of section 501(c)(3) status in the absence of the kind of CMS regulation and oversight that applies to the MSSP. In those situations the Service applied other safeguards to provide assurance that there would not be private inurement or impermissible private benefit. Similar safeguards could be applied to non-MSSP activities.

3. CONCLUSION REGARDING SERVICE’S PRIVATE INUREMENT AND PRIVATE BENEFIT QUESTIONS

There is nothing unique about ACOs from the standpoint of private inurement and private benefit in the health care context. The Service has dealt with those issues in many similar situations, including those involving PSROs, gainsharing, electronic health records, professional corporations, physician incentive compensation, integrated health systems, and regional health information organizations. In all of those situations the Service allowed the organizations in question to demonstrate that there was no private

134 Policy Statement at 2.
135 Policy Statement at 6.
inurement or impermissible private benefit, in some cases providing guidelines that could be adapted to ACOs.

Although the references in Notice 2011-20 to *IHC Health Plans, Federation Pharmacy Services* and Rev. Rul. 98-15 are helpful in illustrating situations where promoting health care was not sufficient to establish tax-exempt status, those authorities have no application to ACOs. With respect to an ACO’s negotiation with payers, those negotiations are limited to establishing the conditions for payment of incentive payments and are integral and incidental to the performance of an ACO’s exempt function.

Our Examples 2 and 3 provide fact patterns that provide sufficient safeguards against private inurement and impermissible private benefit that the Service should be able to rule that a non-MSSP ACO that meets those safeguards serves a tax-exempt purpose and does not provide private inurement or impermissible private benefit.

E. **UBIT AND JOINT VENTURES**

The principles relating to UBIT and joint ventures discussed above, especially in Section III.E, should apply to non-MSSP ACOs in the same manner that they apply to MSSP ACOs.

F. **UBIT TREATMENT OF SERVICES PROVIDED TO ACO**

The principles relating to the UBIT treatment of services that a tax-exempt partner in the ACO provides to the ACO discussed above in Section III.F should apply to non-MSSP ACOs in the same manner that they apply to MSSP ACOs.

G. **NON-MSSP ACO AS EXEMPT ORGANIZATION**

As noted in Section III.G above, although much of Notice 2011-20 and the Fact Sheet focus on joint venture ACOs, Q&A 16 in the Fact Sheet confirms that an ACO engaged exclusively in MSSP activities can qualify for tax-exempt status under section 501(c)(3). Q&A 17 of the Fact Sheet goes on to confirm that an ACO engaged in both MSSP and non-MSSP activities can qualify for tax-exempt status under section 501(c)(3). Our Example 3 provides a fact pattern that the Service could use to provide further guidance on when a separately organized ACO will qualify as an organization described in section 501(c)(3).

V. **EXAMPLES AND SPECIFIC RECOMMENDATIONS**

A. **EXAMPLE 1: MSSP JOINT VENTURE**

1. **Statement of Facts**

A is a hospital that the Service has recognized as a tax-exempt organization. B is a physician group practice that is owned by physicians and is treated as a C corporation.
for federal income tax purposes. A and B form L, a domestic LLC taxed as a partnership, to operate an ACO. A’s participation in L does not represent a substantial part of A’s activities.

L’s Articles of Organization and Operating Agreement (“governing documents”) provide that its purpose is to operate an ACO consistent with the requirements of the Affordable Care Act and to participate in the MSSP. CMS has accepted L into, and has not terminated L from, the MSSP. L will coordinate care for its assigned Medicare beneficiaries and L will be the recipient of any MSSP incentive payments. A and B will continue to receive their respective Medicare Part A and Part B payments directly for services provided by them to the Medicare beneficiaries assigned to the ACO.

A holds a 30 percent ownership interest in L and B holds a 70 percent ownership interest in L. These interests are proportionate to the value of their respective capital contributions to L. The governing documents provide that all returns of capital, allocations of income and losses, and distributions (except distributions of MSSP payments) shall be made in proportion to the members’ respective ownership interests. MSSP payments will be shared among the ACO participants according to criteria determined by the ACO consistent with the Affordable Care Act and CMS regulations. All other income, if any, will be distributed in proportion to the members’ ownership interests. A will provide certain services to L to facilitate the operation and management of the ACO, which may include project management, actuarial, population management, and clinical care design services. A will retain control over the services it provides to L.

L’s governing documents provide that it will be managed by a governing board consisting of ten directors, with three chosen by A and seven chosen by B. Under the governing documents, L will coordinate and manage all aspects of the ACO activities.

The governing documents require that the terms of all contracts and transactions entered into by L with A, B and any other parties be at arm’s length and that all contracts and transactions be at fair market value. The governing documents limit L’s activities to conducting an ACO and coordinating care for Medicare fee-for-service beneficiaries. The governing documents provide that if CMS terminates the ACO status of L, A may surrender its interest in L in consideration for the return of any capital account balance or if less, the fair market value of A’s interest. The governing documents further provide that L must not engage in any activity that would jeopardize A’s tax-exempt status. L does in fact operate in accordance with the governing documents in all respects.

2. Recommendations

Under the foregoing facts, we recommend that the Service issue precedential guidance confirming that:

a. A continues to qualify as a tax-exempt organization after it contributes assets to L and becomes a participant in the ACO.
b. A is not subject to UBIT on its distributive share of L’s income relating to the ACO.

c. A is not subject to UBIT on its share of any MSSP payments.

d. A is not subject to UBIT on any payments it receives from L for services A provides to L in connection with the operation and management of the ACO.

e. The terms of L’s governing documents and the physician group’s majority ownership and control of the governing body do not result in private inurement or impermissible private benefit.

3. Analysis of Exempt Purpose and UBIT

The facts of Example 1 are consistent with the Service’s treatment of MSSP ACOs in Notice 2011-20. Participation in L represents an insubstantial part of A’s activities within the meaning of Rev. Rul. 2004-51 and will not adversely affect A’s tax-exempt status. L is treated as a partnership for federal income tax purposes and A is treated as if it directly conducts L’s MSSP ACO activities in determining whether such activities are related to A’s exempt purposes. Consistent with Notice 2011-20, L’s MSSP ACO activities lessen the burdens of government, are not subject to UBIT, and do not result in private inurement or impermissible private benefit.

For the reasons set forth in Section IV.C.2 above, we believe that A’s MSSP ACO activities promote health as well as lessen the burdens of government. We encourage the Service to confirm that L’s operation of its MSSP ACO is related to A’s purpose of promoting health and is also not subject to UBIT on that basis.

4. Analysis of Private Inurement and Private Benefit

The arrangement in Example 1 satisfies each of the five factors set forth in Notice 2011-20 regarding inurement and private benefit. Specifically:

- The terms of A’s participation in the MSSP through L’s ACO (including its share of MSSP payments or losses and expenses) are set forth in advance in a written agreement negotiated at arm’s length.
- CMS has accepted L into, and has not terminated L from, the MSSP.
- A’s share of economic benefits derived from L’s ACO (including its share of MSSP payments) is proportional to the benefits or contributions A provides to the ACO. Further, A’s ownership interest in L is proportional and equal in value to its capital contributions to L, and all ACO returns of capital, allocations and distributions with respect to L other than the incentive payments are made in proportion to the ownership interests held by A and B.
• A’s share of the ACO’s losses (including its share of MSSP losses) does not exceed the share of the ACO’s economic benefits to which A is entitled.
• All contracts and transactions entered into by A with L and the ACO’s participants, and by L with the ACO’s participants and any other parties, are at fair market value.

Based on meeting this five-factor test, under Notice 2011-20, A’s participation in L should not result in private inurement or impermissible private benefit, whether or not A owns a majority interest in, or has majority control of, L’s governing body.

B. EXAMPLE 2: NON-MSSP JOINT VENTURE

1. Statement of Facts

Assume all the facts set forth in Example 1. In addition, L’s organizing documents specify that L can engage in ACO activities with third-party payers other than Medicare, including commercial health insurers, managed care plans and self-insured programs, to coordinate care for the patient populations covered by such payers in a manner similar to the way it coordinates care for Medicare beneficiaries. For each such non-MSSP payer, L brings together the tax-exempt and private health care providers delivering services to that payer’s subscribers and puts in place an ACO arrangement with those providers to coordinate the delivery of health care with the objective of reducing cost and improving quality and patient satisfaction. L negotiates the terms and conditions of the ACO, including benchmarks and amounts of incentive payments, with each private payer, based in part on L’s ACO arrangement with the MSSP. L does not negotiate the terms of the private payers’ direct relationship with L’s providers, and all of the private payers continue to pay L’s providers directly for the health care services they provide to subscribers in the same manner that Medicare continues to pay L’s ACO providers directly for their Medicare services. L's ACO will comply with the guidelines set forth in the Service's Electronic Health Records Directive.138 Approximately 60% of L’s activities relate to subscribers of one or more private payers.

2. Recommendations

We make the same five recommendations for L’s combined MSSP and non-MSSP ACO activities in Example 2 that we made for the MSSP activities in Example 1.

3. Analysis of Exempt Purpose and UBIT

Even though L conducts non-MSSP activities in addition to its MSSP activities, L still represents an insubstantial part of A’s activities. The joint venture is an ancillary

joint venture within the meaning of Rev. Rul. 2004-51, and A’s participation in L therefore does not adversely affect A’s tax-exempt status.

L’s non-MSSP activities and its MSSP activities both further the exempt purposes of lessening the burdens of government and promoting health, as discussed in Sections IV.C.1 and IV.C.2 above. Accordingly, L’s MSSP activities and non-MSSP activities are both substantially related to A’s exempt purposes and are not subject to UBIT.

A’s provision of project management, actuarial, population management, and clinical care design services to L is substantially related to A’s exempt purposes, and is not subject to UBIT. A will retain control over the services it provides to L, which will ensure that all of the services it provides under the ACO arrangement will further its exempt purposes. As discussed is Sections III.F and IV.F, A is not subject to UBIT with respect to the services it provides to L.

4. Private Inurement and Private Benefit

As in Example 1, for its MSSP activities L satisfies all of the five factors set forth in Notice 2011-20 regarding private inurement and private benefit. For L’s non-MSSP activities, L satisfies all five factors except the MSSP participation factor. Both the MSSP activities and the non-MSSP activities therefore include safeguards to assure the ownership interests and contractual arrangements among the participants will be arm’s length and at fair market value.

Notice 2011-20 includes the MSSP participation factor because CMS regulation and oversight provide additional assurance that L’s MSSP activities comply with the private inurement and private benefit doctrines. The Fact Sheet’s Q&A 18 specifically states, however, that a tax-exempt organization need not satisfy all five factors to avoid private inurement or impermissible private benefit.139 As discussed above in Section IV.D, although L’s non-MSSP activities are not subject to CMS regulation and oversight, other factors, including CMS’s general oversight and oversight by other government agencies, provide adequate safeguards that there will be no private inurement or impermissible private benefit in L’s non-MSSP activities.

C. EXAMPLE 3: TAX-EXEMPT ACO

Q&A 16 in the Fact Sheet states that an ACO engaged exclusively in MSSP activities could qualify for section 501(c)(3) status.140 Q&A 17 goes on to state that an ACO engaged in both MSSP and non-MSSP activities that accomplish charitable purposes may qualify for section 501(c)(3) status.141 The Fact Sheet thus anticipates that a separate nonprofit entity whose only activity is the operation of an ACO can qualify for tax exempt status under section 501(c)(3).142 This Example 3 presents an ACO that is

140 Id.
141 Id.
142 Id.
organized as a nonprofit entity, that is controlled by a parent tax-exempt organization with extensive health care operations, and that operates its ACO through contracts with both affiliated tax-exempt providers and unrelated providers. Because the ACO is a substantial activity, it affects both the entity’s tax-exempt status and UBIT. We believe that the analysis of exempt purposes, UBIT, private inurement and private benefit set forth in Notice 2011-20 and discussed above can be applied and extended to support the tax-exempt status of an organization like the one in this Example 3.

1. Statement of Facts

P is the parent entity that controls S, a hospital system. P is a tax-exempt organization and S consists of hospitals, clinics, ambulatory care centers and specialty care centers that are either operated by P or are separately organized as tax-exempt organizations controlled by P. A majority of the directors on P’s governing body are independent community members.

P forms A as a nonprofit corporation to support and carry out the tax-exempt purposes and health reform strategies of P and S. A’s sole activity will be to operate an ACO that participates in the MSSP and also conducts non-MSSP activities in the same manner as the ACO in Example 2. The ACO’s participating physicians include the entire network of primary care physicians, specialists, and acute and post-acute care physicians and other providers and suppliers that serve S’s patient population, some of whom are employed by S and others of whom are not employed by S but are members of one or more medical staffs in the S system. A will support the network of physicians with technology infrastructure that facilitates the sharing, use and analysis of clinical and claims data to assess outcomes and conduct other quality and performance analyses.

P is the sole member of A and as such has reserved powers that allow P’s community board to monitor and oversee A’s activities and to ensure that A conducts its activities in a manner consistent with section 501(c)(3). For example, P’s board of directors has the right to approve programs for providing, allocating and distributing shared-savings incentives; to approve parameters for participating in the MSSP and non-MSSP shared-savings arrangements, to approve a conflict of interest policy that A must adopt; to appoint the members of A’s Board of Directors from candidates nominated by A’s Board of Directors; to approve changes to A’s articles and bylaws or tax status; and to approve A’s strategic plan and capital and operating budgets. The final decisions concerning performance measurement, distributions and contracting parameters will be made by a committee of P’s Board which has board-delegated authority and will be comprised solely of disinterested members of the Board in a manner consistent with the criteria for rebuttable presumption of reasonableness under section 4958.

P and other entities in S will provide services to A, including project management, actuarial, population management, and clinical care design services, in much the same manner that the tax-exempt participants in Examples 1 and 2 provide services to the ACOs in those Examples.
2. **Recommendations**

We recommend that the Service issue precedential guidance confirming that on these facts:

a. A qualifies for exemption under section 501(c)(3).

b. A is not subject to UBIT on payments it derives from Medicare and non-Medicare payers with respect to its MSSP and non-MSSP activities.

c. A’s operation of the ACO will not result in private inurement or impermissible private benefit.

d. Any payments received by P and other S entities for providing services to A will not be subject to UBIT.

3. **Exempt Purpose and UBIT**

The Fact Sheet’s Q&A 16 and Q&A 17 state that an ACO engaged in MSSP and non-MSSP activities may qualify for section 501(c)(3) status. For this purpose, the authorities and analysis relating to exempt purposes in Section IV.C of these Comments apply directly in determining whether an ACO qualifies for section 501(c)(3) status.

In this Example 3, A operates its ACO in the same manner that A operates its ACO in Example 2. The same authorities discussed in Section IV.C that support treating the ACO in Example 2 as related to exempt purposes in applying UBIT principles also support treating the ACO in this Example 3 as furthering exempt purposes in establishing section 501(c)(3) status. Many of the authorities discussed in Section IV.C deal with health care organizations that were tax-exempt.

P’s reserved powers and ultimate control over A ensure that A will be operated for exempt purposes and support A’s section 501(c)(3) status. The Service established guidelines providing for similar reserved powers and ultimate control in recognizing the section 501(c)(3) status of professional corporations and integrated health care systems. A should be considered to have a community board within the meaning of the community benefit standard due to P’s ultimate control over A. The Service has acknowledged that, while an independent community board must be responsible for “all decisions and charitable aspects” of a system’s health care delivery, it is appropriate to delegate responsibility for “clinical or professional aspects of the health care services” to committees that “may contain unlimited physician representation.”

The Service also stated in a 1997 Continuing Professional Education article that “[i]n a multi-entity hospital system, the board of a subsidiary nonprofit health care organization is considered

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143 *Id.*

to be comprised of independent community members if it is controlled by an exempt organization whose board is comprised of a majority of voting members who are independent community members.\footnote{Chapter C, Tax-Exempt Healthcare Organizations Community Board and Conflicts of Interest Policy, 1997 Exempt Organizations Continuing Professional Education Technical Instruction Program Textbook (1996) at 21, available at http://www.irs.gov/pub/irs-tege/eotopicc97.pdf.}

Further support for A’s section 501(c)(3) status is provided by the integral part doctrine. A qualifies for section 501(c)(3) status under the integral part doctrine because (i) A is controlled by P and (ii) A’s ACO would not be an unrelated trade or business if it were carried on directly by P and S.\footnote{Reg. § 1.501-1(b); Rev. Rul. 78-41, 1978-1 C.B. 148. A’s ACO is related to the exempt purposes of P and S on the same basis as the ACO in Example 2.} A should qualify for integral part treatment even under the Service’s “essential services” view of the integral part doctrine\footnote{E.g., GCM 39830 (Aug. 24, 1990).} and the Third Circuit’s “boost” theory\footnote{Geisinger Health Plan v. Comm’r, 30 F.3d 494 (3d Cir. 1994).} because A is providing a service that is essential to P and S (carrying out their health reform strategies) and because A’s relationship with P and S provides a boost to A’s ability to achieve its exempt purposes.

4. **Private Inurement and Private Benefit**

Private inurement and private benefit issues should be of less concern in this Example 3 than they are in Examples 1 and 2. This is because P has reserved powers and ultimate control over A that the tax-exempt participants do not have over the joint venture ACOs in Examples 1 and 2.

In Examples 1 and 2 the tax-exempt organizations that participate in the ACO have only the authority and power provided to them under the LLC documents. In this Example 3, P’s reserved powers allow P’s community-controlled board to assure that A not only remains true to its section 501(c)(3) mission and purposes, but also complies with the private inurement and private benefit doctrines. P’s reserved powers thus provide assurances that A will comply with the private inurement and private benefit doctrines.