



JULY 2016

IRS Denial of Accountable Care Organization Raises More Questions Than It Answers

In a recent ruling, PLR 201615022, the IRS denied tax exemption to an accountable care organization on the basis that it was conferring private benefit on its participating physicians by negotiating shared savings arrangements with private health insurers. The denial has some tax-exempt hospitals concerned about whether their participation in certain ACOs might jeopardize their tax exemption or result in unrelated business income tax. We do not believe such a pessimistic interpretation is warranted for at least three reasons. First, neither the facts of the case nor the analysis are presented in sufficient detail to discern exactly what position the IRS is taking in the denial ruling. Second, the governing law and prior IRS guidance support the argument that an ACO with substantial shared savings arrangements with private insurers may qualify for exempt status under the right circumstances. Third, even if an ACO does not qualify for exempt status because of substantial shared savings arrangements with private insurers, a tax-exempt hospital's participation in such an ACO will not necessarily jeopardize its exemption or result in UBIT.

This news alert will place the denial ruling in context and explain how, with careful tax planning, an ACO entering into and operating substantial shared savings

arrangements with private insurers should be able to qualify for tax-exempt status.

General Requirements for Exemption

In order to be tax-exempt under §501(c)(3), an organization must engage primarily in activities that accomplish one or more of the exempt purposes specified in that section. An organization will not be considered engaged primarily in exempt activities if more than an insubstantial part of its activities further purposes other than those described in §501(c)(3).

An activity that more than incidentally serves a private (as opposed to public) interest does not further an exempt purpose described in §501(c)(3). Consequently, an organization will not qualify for exemption under §501(c)(3) if more than an insubstantial part of its activities confers nonincidental private benefit.

Among the exempt purposes specified in §501(c)(3) are "charitable" purposes, which include lessening the burdens of government and the promotion of health. With respect to the purpose of promoting health, the IRS has repeatedly warned that "not every activity that promotes

This publication may constitute "Attorney Advertising" under the New York Rules of Professional Conduct and under the law of other jurisdictions.

health supports tax exemption under §501(c)(3).” (See, for example, Notice 2011-20, Rev. Rul. 98-15.)

While an entity generally must qualify for tax exemption based on its own characteristics, an exception to this general rule is the “integral part doctrine.” This doctrine allows an organization to be exempt from tax under §501(c)(3) if (1) it is related to a §501(c)(3) organization by reason of its being controlled by that organization, and (2) its activities are such that they are an integral part of the exempt activities of the related §501(c)(3) organization.

ACOs and Notice 2011-20

Under §3022 of the Patient Protection and Affordable Care Act, groups of doctors, hospitals and other health care providers and suppliers that meet certain criteria specified by the Department of Health and Human Services may come together to provide coordinated, high-quality care at lower costs to their Medicare patients through ACOs and participate in a program called the Medicare Shared Savings program (MSSP). Those participating ACOs that meet the quality performance standards established by HHS and demonstrate that they have achieved savings against a benchmark of expected average per-capita Medicare expenditures are eligible to receive payments for Medicare shared savings.

In Notice 2011-20 and a related FAQ (FS-2011-11), the IRS concluded that the participation of tax-exempt hospitals in MSSP activities through an ACO both further and are substantially related to the charitable purpose of lessening the burdens of government, provided that the ACO meets all of the eligibility requirements established by HHS for participation in the MSSP. The IRS reasoned that Congress established the MSSP to

be conducted through ACOs in order to promote quality improvements and cost savings, thereby lessening the federal government’s burden associated with providing Medicare benefits. Because MSSP activities were found to further the charitable purpose of lessening the burdens of government, the IRS concluded that an ACO engaged exclusively in MSSP activities could qualify for tax exemption under §501(c)(3) as long as it met all of the other requirements for tax exemption under that section.

The IRS recognized in Notice 2011-20 that some tax-exempt organizations might participate in ACOs conducting activities unrelated to the MSSP, including entering into and operating under shared savings arrangements with private insurers. In contrast to activities conducted as part of the MSSP, the IRS said it anticipated that these activities conducted by or through an ACO were unlikely to lessen the burdens of government. The notice also specified that “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.” In the end, however, the notice declined to address whether and under what circumstances an ACO’s entering into and operating under shared savings arrangements with private insurers would be inconsistent with tax-exemption or result in UBIT. Although the notice requested comments on this issue, the IRS has yet to issue any additional guidance on this topic.

PLR 201615022

In PLR 201615022, the IRS denied exemption under §501(c)(3) to an ACO entering into and operating under

shared savings arrangements with private insurers. The ACO applying for exemption was formed by a §501(c)(3) health care corporation (called “System” in the ruling) to achieve clinical care integration, coordination and accountability among both employed and independent physicians practicing throughout System’s affiliated facilities, as well as physicians practicing at other non-System affiliated hospitals and other health care systems. The ACO did not participate in the MSSP. The ACO represented that all of its time and resources would be dedicated to the furtherance of the “Triple Aim” health care reform goals established by the Patient Protection and Affordable Care Act: namely, reducing the cost of health care for individuals, improving patient access to and the quality of care, and improving population health and the patient experience. The ACO entered into participation agreements with physicians meeting its eligibility and performance standards and developed and implemented performance measures to assess the care delivery of participating providers. It also developed and implemented financial incentives to motivate the participating providers to achieve improvement, tying payments to their collective success at achieving the Triple Aim goals, as evaluated by the ACO’s performance measures.

According to the terms of its participation agreements with providers, the ACO acted as a representative for the participating providers in the negotiation and execution of certain agreements with third-party payers, which linked rewards and penalties for participants to their achievement of the ACO’s performance measures in order to incentivize change in participant behavior in furtherance of the Triple Aim goals.

In denying exemption, the IRS noted that the negotiation of payer agreements on behalf of the participating providers constituted a substantial activity of the ACO and that “negotiating with private health insurers on behalf of unrelated health care providers is not a charitable activity.” Because the IRS found that more than an insubstantial part of the ACO’s activities served private interests and did not further exempt purposes, the IRS concluded that the ACO did not qualify for tax exemption under §501(c)(3).

With respect to the ACO’s Triple Aim goals, the IRS noted that, while they generally promoted health, they were “not coextensive with exempt purposes under §501(c)(3), and not all activities advancing those goals are necessarily in furtherance of charitable purposes.”

The ACO had also established data infrastructure for collecting, aggregating and analyzing data, including an electronically integrated clinical information data warehouse and analyzer, a patient satisfaction survey tool, and clinical network infrastructure necessary for tracking provider performance and sharing survey data. The IRS acknowledged that these “electronic health records activities may further charitable purposes under §501(c)(3)” but concluded that this fact was immaterial because the presence of a substantial nonexempt purpose destroys exemption under §501(c)(3) regardless of the number or importance of exempt purposes.

Unanswered Questions

The summary of the facts and analysis in the denial omitted many details relevant to assessing the strength of the ACO’s case for §501(c)(3) status.

1. *Who controlled the ACO?*

Perhaps most importantly, the denial says nothing about who controlled the ACO. In the context of joint ventures between hospitals and physicians, the IRS has repeatedly held out control as a central consideration, reasoning that control by a §501(c)(3) hospital helps ensure that the activities of a joint venture (which would not uncommonly include negotiating with private insurers) will primarily further charitable purposes and only incidentally benefit the physician partners.

The denial does say that the System “formed” the ACO. It also repeatedly highlights the fact that the ACO’s negotiating activities were on behalf of providers that were not “related” or “affiliated” to the System, a fact that would seemingly be relevant only as a way of refuting any claim that the ACO might qualify for §501(c)(3) status as an “integral part” of System—a claim that could potentially apply only if the ACO were controlled by System.

Together, these aspects of the denial suggest that the ACO was, indeed, controlled by System, a §501(c)(3) health care corporation. This factor should weigh in favor of granting §501(c)(3) status to the ACO because control by a §501(c)(3) organization should help ensure that the ACO’s activities (including its negotiation of contracts with private insurers) further charitable purposes and only incidentally benefit the participating physicians.

2. *Why was the private benefit conferred by the negotiation activity not incidental?*

In support of its assertion in the denial that “negotiating with private health insurers on behalf of unrelated

healthcare providers is not a charitable activity,” the IRS cited Rev. Rul. 86-98, which denied exemption to an independent practice association that negotiated with health maintenance organizations. The independent practice association described in Rev. Rul. 86-98, however, was different from typical ACOs in at least three important respects. First, it was an association of physicians only and did not include a tax-exempt hospital as a member (much less a controlling member). Second, unlike an ACO, it was not developing and negotiating for patient-focused performance measures based on improving patient access to, and the quality of, care and on improving population health and the patient experience. Third, it was negotiating for access to the HMO’s subscribers and for the entire amount the participating physicians would receive from the HMOs for medical services provided to these subscribers. By contrast, most ACOs have (so far) been focusing their negotiations much more narrowly on performance measures and incentive payments based on those measures.

The IRS does not specify whether the ACO in the denial focused its negotiations with insurers narrowly on the Triple Aim benchmarks and incentive payments or instead negotiated more broadly for the entire reimbursement participating providers would receive from the insurers for their health care services. But if the negotiations were focused on performance measures and incentive payments (as would be more typical), the ACO would have a much stronger case that the private benefit conferred by its negotiation activities was incidental to the purpose of achieving the Triple Aim goals. Other factors that would tend to support the proposition that the community benefit of the Triple

Aim goals was primary and the private benefit was only incidental would be:

(1) If the ACO first developed the performance measures and financial incentives based on its own independent assessments of what would best achieve the Triple Aim goals and only subsequently attempted to negotiate agreements with private insurers that reflected those measures and incentives (as opposed to simply implementing measures and incentives that arose from the negotiation process itself).

(2) To the degree the measures and incentives reflected in the agreements negotiated with insurers did not converge with the ones the ACO had independently developed, the ACO based its payments to participants on its own measures and incentives rather than on those in its agreements with the insurers. (Such a divergence between the ACO's payments and the insurers payments would arguably suggest the ACO was negotiating the agreements with insurers on its own behalf rather than on behalf of the participating providers.)

Unfortunately, the denial does not contain any of the details necessary to determine whether or not any of these factors applied. In addition, the denial contains no analysis revealing why the IRS concluded that the private benefit conferred on participating providers was primary and the community benefit of the Triple Aim goals was incidental, rather than vice versa. Indeed, the only explanation the denial provides as to why the negotiation activity was "primarily beneficial" to the participating providers and "only indirectly benefi(cial) to the community as a whole" was that this activity provided the participants with "specific long and short term planning information that can be used in their

business activities." The ruling fails to elaborate as to why the provision of long- and short-term planning information should be considered so qualitatively and quantitatively beneficial to the participating providers as to render incidental the community benefit associated with the Triple Aim goals.

3. *Why was the ACO's promotion of health not in furtherance of charitable purposes?*

The IRS acknowledges in the denial that the ACO's Triple Aim goals "generally promot[e] health," but then adds that the Triple Aim goals "are not coextensive with exempt purposes under §501(c)(3), and not all activities advancing those goals are necessarily in furtherance of charitable [purposes]." As an example, the IRS notes that, while selling pharmaceuticals promotes health, pharmacies cannot qualify for §501(c)(3) status on that basis alone, and cites for support *Federation Pharmacy Services, Inc. v. Commissioner*, a case in which the Tax Court concluded that the pharmacy at issue did not qualify for §501(c)(3) status because it was operated for a substantial commercial purpose. The denial contains no indication that the ACO under consideration was operated for a substantial commercial purpose, however. And indeed, it does not appear that the ACO was selling any goods or services whatsoever. As a result, the one example provided in the denial to support the proposition that the ACO's promotion of health was not charitable appears to be inapposite.

Moreover, the fact that the ACO itself was not directly providing medical care or other health care services should not mean that its promotion of health does not further a charitable purpose. Over the years, the IRS has recognized §501(c)(3) status on the basis of the promotion of health for many organizations that do not

directly provide medical care, including professional standards review organizations (Rev. Rul. 81-276), health planning agencies (Rev. Rul. 77-69), and organizations operating computerized donor-authorized retrieval systems to facilitate the transplantation of body organs (Rev. Rul. 75-197).

It is possible that the IRS thought that the ACO's coordination of health care required some additional indicia of community benefit or charitable purpose for its promotion of health to be considered charitable. The IRS recognized in the denial that the ACO was engaged in other activities — specifically, those related to electronic health records — that further charitable purposes, however, and it is unclear why these additional charitable activities were not sufficient to render the ACO's overall operations charitable.

Another possible indicia of community benefit that the IRS and courts have recognized as supporting §501(c)(3) status is serving Medicare and Medicaid beneficiaries. (See Rev. Rul. 69-545.) Consequently, it is possible that the IRS would have granted §501(c)(3) status to the ACO if it had entered into and operated under shared savings arrangements not only with private insurers but also with Medicare and/or Medicaid, which would have ensured that the ACO was serving the health needs of a much broader segment of the community.

Unfortunately, the IRS did not discuss or analyze any of these issues in the denial, so we do not know why, precisely, the IRS found the ACO's promotion of health to be insufficiently charitable.

4. If an ACO does not qualify for exemption, what are the consequences for its tax-exempt participants.

If an ACO does not qualify for tax-exemption and is a corporation for federal tax purposes (which would include entities organized as nonprofit corporations under state law), its activities should not generally be attributed to its participants, meaning its non-exempt activities should generally not pose a risk to any participant's tax-exempt status. If an ACO is a partnership for federal tax purposes, its activities are attributed to each partner (or member in the case of an LLC) for purposes of determining the partner's tax-exempt status. However, a tax-exempt partner's proportionate share of an ACO's non-exempt activities would have to be substantial in proportion to the partner's overall operations to pose any risk to its tax-exempt status. If an ACO's non-exempt activities were limited to the activity of negotiating and executing agreements with private insurers (as appeared to be the case in the denial), it seems unlikely that a tax-exempt hospital's proportionate share of such activities would constitute a substantial portion of the hospital's overall activities, given the scope and scale of most hospitals' operations.

As for UBIT, the incentive payments received by a tax-exempt hospital from a non-exempt ACO engaged in shared savings arrangements with private insurers should not generally be subject to UBIT to the extent the payments can reasonably be attributed to the hospital's satisfaction of performance measures with respect to its own patients (that is improving its patients' quality of care, health outcomes and experience and reducing their costs).

Key Take-Aways

ACOs, or tax-exempt hospitals participating in them, should not interpret PLR 201615022 to suggest

that entering into and operating shared savings arrangements with private insurers may never further a charitable purpose and, if substantial, may never be consistent with tax exemption. The denial simply contains too many holes in the facts and analysis to draw any blanket conclusions. In particular, the denial does not rule out the possibility that such an ACO may still qualify for §501(c)(3) status if it:

- Is controlled by a §501(c)(3) organization.
- Focuses its negotiations with private insurers narrowly on performance measures and incentives that it itself has independently designed to improve patient outcomes and experience, and to the degree the measures and incentives it negotiates with insurers differ from those it has designed, uses its own measures and incentives to distribute payments (and penalties) to participating providers.

- Engages in other activities recognized as charitable or indicative of community benefit, such as maintaining electronic health records, participating in shared savings arrangements with respect to Medicare and/or Medicaid beneficiaries, and/or engaging in education or research activities.

If you have any questions about whether your ACO may qualify for tax-exempt status or whether your hospital's participation in an ACO might pose any risk to its tax-exemption or result in UBIT, please contact [Preston Quesenberry](mailto:pquesenberry@loeb.com) (202-524-8470, pquesenberry@loeb.com).

This alert is a publication of Loeb & Loeb and is intended to provide information on recent legal developments. This alert does not create or continue an attorney client relationship nor should it be construed as legal advice or an opinion on specific situations.

© 2016 Loeb & Loeb LLP. All rights reserved.

Nonprofit and Tax-Exempt Organizations Practice

LAURA B. BERGER	LBERGER@LOEB.COM	310.282.2274
LEAH M. BISHOP	LBISHOP@LOEB.COM	310.282.2353
DEBORAH J. BROSS	DBROSS@LOEB.COM	310.282.2245
REGINA I. COVITT	RCOVITT@LOEB.COM	310.282.2344
LINDA N. DEITCH	LDEITCH@LOEB.COM	310.282.2296
PAUL N. FRIMMER	PFRIMMER@LOEB.COM	310.282.2383
ELIOT P. GREEN	EGREENE@LOEB.COM	212.407.4908
RACHEL J. HARRIS	RHARRIS@LOEB.COM	310.282.2175
DIARA M. HOLMES	DHOLMES@LOEB.COM	202.618.5012
KAREN L. KUSHKIN	KKUSHKIN@LOEB.COM	212.407.4984
JASON R. LILIEN	JLILIEN@LOEB.COM	212.407.4911
TALIA G. METSON	TMETSON@LOEB.COM	212.407.4285

ANNETTE MEYERSON	AMEYERSON@LOEB.COM	310.282.2156
MARCUS S. OWENS	MOWENS@LOEB.COM	202.618.5014
PRESTON QUESENBERRY	PQUESENBERRY@LOEB.COM	202.524.8470
RONALD C. PEARSON	RPEARSON@LOEB.COM	310.282.2230
ALYSE N. PELAVIN	APELAVIN@LOEB.COM	310.282.2298
TZIPPORAH R. ROSENBLATT	TROSENBLATT@LOEB.COM	212.407.4096
BRANDON A.S. ROSS	BROSS@LOEB.COM	202.618.5026
CRISTINE M. SAPERS	CSAPERS@LOEB.COM	212.407.4262
JENNIFER TAM	JTAM@LOEB.COM	202.618.5023
STUART P. TOBISMAN	STOBISMAN@LOEB.COM	310.282.2323
JESSICA C. VAIL	JVAIL@LOEB.COM	310.282.2132
DANIEL M. YARMISH	DYARMISH@LOEB.COM	212.407.4116