Bringing Hospital Tax Exemption into the Modern Era: Why ACO Activities Should Be Tax-Exempt

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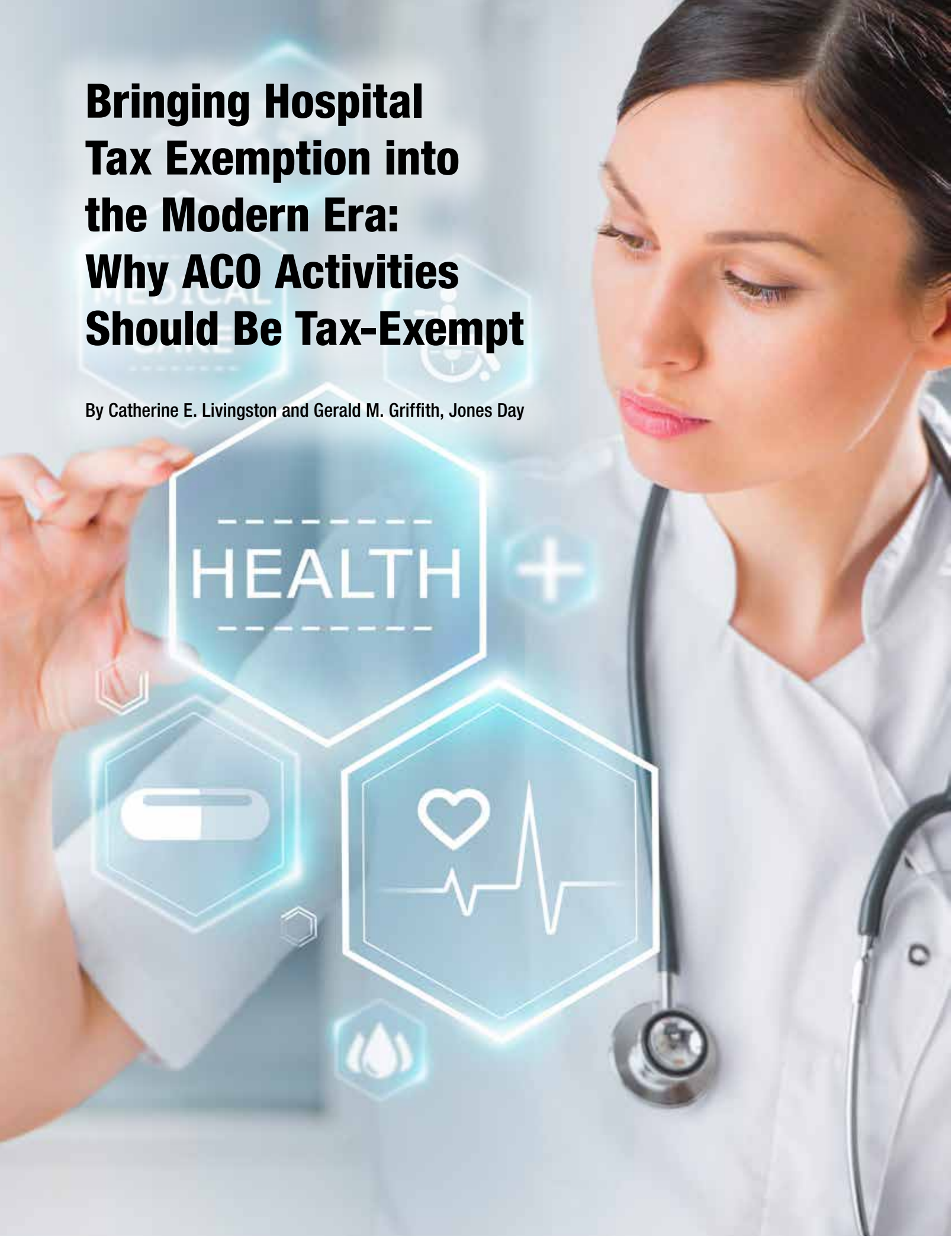

Accountable care organizations and clinically integrated networks (ACOs) are a key health care innovation designed to produce better care at lower cost for the community. Whether formed to participate in the Medicare Shared Savings Program (MSSP) or to coordinate clinical activities involving other payers, ACOs seek to align financial incentives so that they reward hospitals, physicians, and other providers for working together to serve a defined population. Participation in ACOs has grown substantially over the past five years.[1] The ability of tax-exempt hospitals and health systems to participate in ACOs depends on whether participation allows the hospital or health system to further charitable purposes within the meaning of Section 501(c)(3),[2] without generating more than incidental private benefit. Failure to meet that standard can have severe consequences, including unrelated business income tax (UBIT), loss of exemption for interest on bonds that finance hospital facilities, and loss of tax-exempt status.

To date, the Internal Revenue Service (IRS) has confirmed only that participation in a ACO that is limited to MSSP is consistent with the requirements for exemption as a Section 501(c)(3) organization.[3] The IRS has held open the possibility that non-MSSP ACO activities also can further charitable purposes and avoid producing impermissible private benefit,[4] but it has not described the criteria applicable to participation in non-MSSP ACOs. This leaves tax-exempt hospitals in a difficult position. They appreciate the importance of joining with other providers to address the fundamental problems of health care economics that jeopardize access to quality, affordable health care, but the current state of IRS guidance raises questions about the consequences of participation in non-MSSP ACO activities.

Requirements for Hospital Tax Exemption

To qualify as a Section 501(c)(3) organization, a nonprofit hospital must be organized and operated exclusively for charitable, scientific, educational, or other exempt purposes. Since 1969, the IRS has taken the position that a nonprofit hospital is furthering a charitable purpose if it engages in promotion of health for the benefit of the community as a whole.[5] Section 501(c)(3) hospitals are required to have a written financial assistance policy, but neither the statute nor the regulations specify criteria for whom, if anyone, must be offered financial assistance under the policy.[6] IRS guidance has long considered the provision of health care services to patients as a trade or business that furthers charitable purposes, but the provision of services to members of the public who are not otherwise receiving clinical care at the hospital (e.g., laboratory, pharmacy, or imaging services) is generally considered to be an unrelated trade or business unless the services are otherwise scarce or unavailable in the community.[7] Under this guidance, lowering cost and improving quality of care is irrelevant in determining 501(c)(3) eligibility and the focus instead is on whether the hospital provides hands-on care.

Activities that regulate or coordinate the delivery of health care, such as operating a professional standards review organization,[8] a health planning agency,[9] or a regional health data system,[10] but do not involve direct patient care also are considered as furthering charitable or educational purposes. However, providing ancillary services that support direct patient care, like management, fiscal, and administrative services, to other health care entities for a fee is generally considered to further an exempt purpose only if the other entities are related to the service provider or structurally and financially integrated with the service provider.[11] There is a very limited exception for providing certain services specifically identified in Section 501(e) (e.g., billing and collection, laboratory services, data processing) to hospital facilities with 100 or fewer beds at or below cost.[12] The provision of "commercial-type insurance" also is treated as an unrelated trade or business unless an exception applies.[13]

The IRS takes the position that a health care activity, whether or not it involves services to patients, fails to further a charitable purpose if it is conducted in a commercial fashion.[14] The parameters of what causes an activity to be too commercial are unclear and have never been captured in published guidance.

A nonprofit hospital will not qualify as a Section 501(c)(3) organization if a substantial portion of its activities benefit private parties, like physicians, unless the private benefit conferred is both qualitatively and quantitatively incidental to accomplishment of the hospital's charitable purpose. A private benefit is quantitatively incidental if it is reasonably necessary to achieve the broader public benefit,[15] and it is qualitatively incidental if it is insubstantial in amount compared to the public benefit.[16] Paying reasonable compensation for services generally results in only on incidental private benefit.[17]

Activities that a tax-exempt hospital conducts through its participation in a partnership or LLC that is treated like a partnership for tax purposes (i.e., a joint venture) must meet the same standards for tax exemption as activities a hospital conducts directly.[18] If the joint venture's activities do not further exempt purposes, or if the tax-exempt participant lacks sufficient controls to ensure that the joint venture furthers charitable purposes and provides no more than incidental private benefit, then participation in the joint venture may generate unrelated business income. If the joint venture constitutes a substantial portion of the participant's activities, those activities could jeopardize its tax exemption. The IRS has not issued any published guidance on what constitutes substantial activities for this purpose, though existing guidance in other areas focuses on the percentage of the organization's revenues and expenses associated with the activity.[19]

Many tax-exempt hospitals also are financed in part with the proceeds of tax-exempt bonds. To preserve the exemption for the interest on their bonds, hospitals must not allow more than *de minimis* levels of private use, which includes use in the trade or business of a private party (such as a for-profit physician group) or use in an unrelated trade or business of the hospital.[20] Arrangements that otherwise may result in private use can be protected by structuring them to fit within established safe harbors based primarily on the term, termination rights, and compensation methodology.[21] Although the latest safe harbor guidance from the IRS includes specific provisions tailored to MSSP ACOs, it does not address the threshold

question of when the operations of a typical ACO will result in private use. The answer should depend on a facts and circumstances analysis, and there may be no private use if the ACO itself is a Section 501(c)(3) organization, the ACO's offices are not located in bond-financed space, the ACO does not manage a hospital department or service line, and participants in the ACO have no special preference for use of any areas in the bond-financed hospital distinguishable from other members of the medical staff.[22]

IRS Position to Date on ACOs and Their Core Functions

MSSP ACO Guidance

IRS guidance concludes that participation by a tax-exempt hospital in an MSSP ACO furthers exempt purposes because the ACO lessens the burdens of government by helping to promote quality improvements and contain costs for the Medicare program but does not address whether it promotes the health of the community (the rationale that a non-MSSP ACO would advocate).[23] Notice 2011-20 relies heavily on Centers for Medicare & Medicaid Services' oversight of MSSP ACOs. It provides a five-factor test for determining whether a tax-exempt entity's participation in an MSSP ACO will result in private inurement, more than incidental private benefit, or UBIT: (1) terms of participation set in advance, written agreement negotiated at arm's length; (2) the ACO has been accepted into the MSSP and its activities are limited to participation in the MSSP; (3) the economic benefits, ownership interest, return of capital, distributions, and allocations are proportional in value to its capital contributions; (4) the exempt organization's share of losses does not exceed its share of economic benefits; and (5) all contracts and transactions among the parties are consistent with fair market value. Notably, those five factors do not include control of the MSSP ACO.

Subsequently, the IRS clarified this guidance, indicating that it will not be necessary for an exempt organization to meet all five factors and no one factor is determinative. This statement implies that a tax-exempt hospital may be able to participate in an ACO in which ownership is not directly proportional to capital contributions, or shared savings are not distributed in proportion to ownership interests, but no specific examples are offered to show what combination of factors is acceptable.[24]

The IRS has held open the possibility that non-MSSP ACO activities also can further charitable purposes and avoid producing impermissible private benefit, but it has not described the criteria applicable to participation in non-MSSP ACOs.

At least eight MSSP ACOs have received IRS determinations recognizing them as Section 501(c)(3) organizations.[25] The IRS, however, has not issued guidance on exemption or UBIT related to non-MSSP ACOs. Accordingly, tax-exempt hospitals cannot be certain when the IRS would agree that participation in a non-MSSP ACO is consistent with their tax-exempt status and will not result in UBIT. The IRS fact sheet notes that the IRS would apply a facts and circumstances test to non-MSSP ACOs to answer the UBIT and exemption questions, but it lists only generic factors that apply to any exempt organization activity and none that are specific to the activities ACOs undertake,[26] such as population health services, coordinated payer contracting designed to create interdependent incentives for providers, and other activities intended to improve or maintain quality while controlling the cost of health care. This leaves tax-exempt hospitals to wonder whether the activities of an ACO can further charitable purposes and avoid impermissible private benefit when they are improving quality and lowering cost outside of a governmental program like Medicare or Medicaid. We suggest that the answer should be yes. The new private use safe harbor supports that answer in that it recognizes that a productivity award based on meeting quality performance standards would not be treated as sharing net profits of the tax-exempt hospital.[27] The patchwork of older published guidance that bears on certain aspects of ACO structures and activities, however, results in a mixed picture.

Other IRS Guidance Applicable to ACOs

Population health services are designed to track data for an assigned set of beneficiaries in a geographic area who may receive services from hospitals, physicians, or other providers participating in the ACO. The participating providers join together to sponsor population health services and then use the data to identify opportunities to be proactive with individuals so that they can maintain or improve their health while containing costs. For hospitals, the population will necessarily include individuals who are not patients of the hospital under the traditional IRS definition—and if the services are especially effective in maintaining and improving health, may never be patients of the hospital.

Population health services also involve data analytics performed in offices with computers. The IRS has ruled that activities involving the review of data rather than direct patient care can further charitable purposes. For example, using data to plan for efficient deployment of health resources by a planning agency promotes the health of the community by "increasing the accessibility, acceptability, continuity, and quality of health services provided."[28] Similarly, the IRS ruled that a professional standards review organization (PSRO) promoted health because it prevented unnecessary hospitalization and surgery while lessening the burdens of government by

assuming the government's burden for reviewing the appropriateness and quality of Medicare-covered services.[29] Although the health planning agency and the PSRO, like MSSP ACOs, were established under the auspices of a government program, the reasons articulated for why they are furthering charitable purposes do not depend on participation in those programs. Therefore, this analysis would apply equally to non-MSSP activities.

The IRS also has ruled that operating a computer network that links Section 501(c)(3) libraries, governmental libraries, and private business libraries furthers an exempt purpose.[30] However, the IRS has been reluctant to say that performing data analytics in support of providing more efficient and effective health care for a set of patients linked by one or more private payers is an activity that furthers exempt purposes.[31] The IRS approved exemption for a regional health information organization (RHIO) that gathers electronic medical and drug claims data from commercial and government health plans, providers, pharmacies, and laboratories and uses it to provide clinical quality reports that allow providers and health plans to take steps to improve quality and efficiency in patient care.[32] That ruling, however, is based on the conclusion that the activities lessened the burdens of government because they promoted the purposes of the Health Information Technology for Economic and Clinical Health Act. Legislative history accompanying the Act said that activities to facilitate use of health IT under standards adopted by the Department of Health and Human Services were to be considered as substantially furthering an exempt purpose. It is unclear whether the IRS will agree that performing population health services to improve quality and reduce costs furthers charitable purposes if the use of technology is not under the auspices of a government program. The IRS also appears to remain concerned about the benefits to private payers from cost savings and unsure whether those benefits should be viewed as incidental to the benefits to the community as a whole.[33]

As for payer contracting, the IRS has long taken the position 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."[34] It expressed this view decades ago in concluding that independent practice associations that negotiate contracts with health maintenance organizations are akin to a billing and collection service and primarily benefit their member physicians,[35] in concluding that physician hospital organizations generally did not qualify for exemption,[36] and in denying exemption for a nonprofit organization engaged in payer contracting for physicians on the medical staff of the tax-exempt hospital that was its sole member.[37]

Finally, if a tax-exempt hospital participates in an ACO structured as an LLC or a partnership, even if the population health services and coordinated payer contracting of the ACO are viewed as furthering exempt purposes, the IRS may object that the activities do not exclusively further exempt purposes and could result in impermissible private benefit or inurement if the tax-exempt hospital does not control the ACO. The IRS objected to an equal division of control between a hospital and private partners in operating an ambulatory surgical center in *Redlands Surgical Services* and a whole hospital joint venture in *St. David's*. The IRS prevailed in the first case in a bench trial and lost in the second in a jury trial. The only published IRS position on joint ventures since *St. David's* ruled favorably on an ancillary joint venture between a university and a for-profit company to provide teacher training courses.[38] The university and the for-profit company each controlled an equal number of seats on the board; however, the university controlled the purely educational aspects by retaining sole and exclusive authority to select the curriculum, training materials and instructors, and standards for successful completion of the program.

Why ACO Activities Should Be Tax-Exempt

Promoting quality while reducing cost is vital not only to government-financed programs like Medicare, it is vital

to ensuring that the entire country can continue to have affordable access to quality care. The most significant factor currently affecting community health in the United States is the threat to access and quality from the unsustainable growth in our health care spending.[39] That threat affects health care funded by all payers. The Affordable Care Act responds to the concern about the profound effects on community health and on the broader economy, including through establishment of the MSSP. There is a sound basis for the IRS to recognize that participation in all ACOs promotes health for the benefit of the community as a whole by addressing the economic vulnerabilities that threaten affordable access and quality care.

The IRS has long taken the position that hospitals do not further a charitable purpose when they contract with payers on behalf of private physicians. The change from the fee-for-service payment model to a value-based payment model, however, means that the assumptions underlying this old position are no longer applicable. Contracting between an ACO and payers is not just about securing payment for services. Putting all ACO participants into a coordinated value-based payment arrangement is a specific strategic response to the fundamental economic problems that threaten health care quality and access. The contracts are what align the incentives of the private doctors with those of the tax-exempt hospital and what require all providers to take into account data and apply care protocols that keep patients healthier at a lower cost. Moreover, this approach to contracting forces a link between compensation and quality and shrinks the opportunity for windfalls or other substantial private benefits that were present when fees grew with the volume of services, regardless of the quality of the services provided. The published IRS guidance that is available was developed in the old fee-for-service world before there was access to the kind of data analytics that allow for robust monitoring of quality metrics and compliance with evidence-based care protocols.

It should also be possible to share control over an ACO structured as a joint venture with private physicians while still furthering charitable purposes and generating no more than incidental private benefit. The natural tensions between the providers and the payers with whom they are contracting through the ACO, and the need for cooperation and coordination of care that is fundamental to an ACO should ensure that the ACO furthers exclusively charitable purposes and does not provide more than incidental benefits to private parties. Although economic contributions and distributions need to be proportionate, and payments for services from the ACO to participants need to be at fair market value, that analysis should take into account the value to the community from anticipated improvements to population health.[40] Further protection can be achieved through charitable override provisions in the governing documents that require charitable purposes to trump maximization of profit, initiation rights for the tax-exempt participant tied to furthering charitable purposes, and a reasonable exit provision tied to exemption and UBIT risks.

There is a sound basis for the IRS to recognize that participation in all ACOs promotes health for the benefit of the community as a whole by addressing the economic vulnerabilities that threaten affordable access and quality care.

The essence of an ACO is serving a population of thousands of individuals in a given geographic area, in other words, a community. The distinction the IRS has historically made between services for hospital patients and services for individuals who are not otherwise the hospital's patients was based on the idea that a hospital promotes health by delivering clinical services. This distinction no longer makes sense once it is recognized that coordination among providers does a better job in maintaining and improving community health thereby reducing the need for health care services. The Affordable Care Act confirms that the basis for tax emption goes beyond delivery of clinical care when it requires tax-exempt hospitals to perform a community health needs assessment every three years that takes account of the significant health needs of the community, not just the hospital's patients, and identifies ways to address them.[41] Data analytics technology has made it possible to identify ways in which providers can intervene proactively to keep members of the community who do not yet have a patient relationship with a hospital from becoming hospital patients. That population health services and development of payer contracts are services performed in offices with computers rather than in clinical settings with health care professionals does not change the direct connection they have to health outcomes. They are distinguishable from the management and administrative services that the IRS has long held to be unrelated to furthering exempt purposes when performed for unrelated physicians and hospitals in that population health management has a direct impact on the health of the community. The IRS acknowledged the connection to quality and cost when it ruled that a RHIO's information technology based activity lessens the burdens of government because it promotes quality and lowers costs for the Medicare program.

The state of our country's health care system means that promoting health for the community as a whole depends on ensuring quality and access to care while lowering cost, regardless of whether a government or private payer is involved. ACOs allow providers to deploy resources efficiently and to monitor and promote quality of physician and hospital performance to protect the well-being of the patients and

avoid unnecessary costs and services. This is why participation by tax-exempt hospitals in an ACO, whether MSSP or non-MSSP, should be recognized as furthering exempt purposes by promoting the health of the community and resulting in no more than incidental private benefit to the private physicians and payers who participate in, or contract with, the ACO.

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Endnotes

1 In 2010, there were 41 ACOs in place. By the end of 2014, that number increased to over 700, including 405 MSSP ACOs, 19 Pioneer ACOs and over 300 commercial ACOs in place. ACOs Moving Ahead, The CMS Blog (Dec. 22, 2014), *available at* http://blog.cms.gov/2014/12/22/acos-moving-ahead/; D. Muhlestein, *Overview of the ACO Landscape*, Examining Health Care Competition Workshop, p. 2 (Feb. 24-25, 2015), *available at* www.justice.gov/atr/public/workshops/healthcare/2015/02/presentations/muhlestein.pdf.
2 All section references are references to the Internal Revenue Code of 1986, as amended (Code).
3 *See* Notice 2011-20, 2011-16 I.R.B. 652; IRS Fact Sheet 2011-11.
4 *See* Fact Sheet 2011-11, Q. 12.
5 Rev. Rul. 69-545, *modifying* Rev. Rul. 58-185, 1956-1 C.B. 202; Rev. Rul. 83-157, 1983-1 C.B. 94.
6 *See* Code § 501(r)(4); Treas. Reg. 1.501(r)-4(b)(2).
7 Rev. Rul. 85-109, 1985-2 CB. 165; Rev. Rul. 85-110 1985-2 C.B. 166; Rev. Rul. 68-376, 1968-2 C.B. 246.
8 Rev. Rul. 81-276, 1981-2 C.B. 128.
9 Rev. Rul. 77-69, 1977-1 C.B. 143.
10 Rev. Rul. 76-455; PLR 201250025 (Dec. 14, 2012).
11 *See, e.g., B.S.W. Group, Inc. v. Commissioner*, 70 T.C. 352 (1978); *Christian Stewardship Assistance, Inc. v. Commissioner*, 70 T.C. 1037 (1978) Rev. Rul. 78-41, 1978-1 C.B. 148; PLR 9844032 (Oct. 10, 1998); PLR 200215058 (Apr. 12, 2002); Darling and Friedlander, IRS Continuing Professional Education Text for FY1997, Ch. J, Virtual Mergers.
12 Code §§ 513(e), 501(e)(1)(A).
13 Code § 501(m).
14 *Federation Pharmacy Servs. v. Commissioner*, 625 F.2d 804 (8th Cir. 1980).
15 *See GCM 37789 (Dec. 18, 1978); GCM 39762 (Feb. 23, 1988); GCM 39862* (Nov. 21, 1991)
16 *See GCM 37789*; GCM 39762; GCM 39862.
17 *See, e.g., Lorain Ave. Clinic v. Commissioner*, 31 T.C. 141 (1958); *University of Mass. Med. Sch. Grp. Practice v. Commissioner*, 74 T.C. 1299 (1980); *acq.*, AOD 1980-176, 1980-2 C.B. 2.
18 Rev. Rul. 98-15, 1998-1 C.B. 718; Rev. Rul. 2004-51, 2004-22 I.R.B. 974; *St. David's Health Care Sys. v. United States*, 349 F.3d 232, 236-37 (5th Cir. 2003); *Redlands Surgical Servs.*, 113 T.C. 47, 92-93 (1999), *aff'd per curiam* 242 F.3d 904 (9th Cir. 2001).
19 *See Haswell v. United States*, 500 F.2d 1133 (Ct. Cl. 1974), *cert. den.*, 419 U.S. 1107 (1975) (16.6% to 20.5% was substantial); *Seasongood v. Commissioner*, 227 F.2d 907 (6th Cir. 1955) (5% was not substantial); HMO audit guidelines, Internal Revenue Manual Ch. 27, [7.8.1] 27.10.1 (05-25-1999) (less than 15% not substantial), withdrawn in Notice 2003-31, 2003-21 I.R.B. 948.
20 Code §§ 103, 141 & 145.
21 Rev. Proc. 97-13, 1997-1 C.B. 632, *amended by*, Rev. Proc. 2001-39, 2001-2 C.B. 38 and Notice 2014-67, 2014-46 I.R.B. 822.
22 *See* Treas. Reg. § 1.141-3(b)(2)-(4); Rev. Proc. 97-13, § 2.01 (examples of private use).
23 Notice 2011-20.
24 Fact Sheet 2011-11, Q. 9, 18, 19 & 21.
25 Those eight ACOs and the year of their exemption determination are: Methodist Patient Centered ACO (2014); North Country ACO (2013); Texoma ACO, LLC (2014); Morehouse Choice Accountable Care Organization and Education System (2014); UW Health ACO, Inc. (2014); HHC ACO Inc., an Accountable Care Organization (2014); St. Luke's Clinic Coordinated Care, Ltd. (2014); and Mercy ACO Clinical Services, Inc. (2015).
26 *Id.* at Q. 11-15.
27 Notice 2014-67, *supra*.
28 Rev. Rul. 77-69, 1977-1 C.B. 143.
29 Rev. Rul. 81-276, 1981-2 C.B. 128.
30 Rev. Rul. 81-29, 1981-1 C.B. 329.
31 *Compare* PLR 201436050 (Apr. 30, 2014) (denial of exemption to community health improvement organization formed by an insurer, an association and a medical research organization), *with* PLR 201424025 (Mar. 18, 2014) (favorable ruling on exemption and UBI issues related to a funding agreement between a health system parent and an unrelated nonprofit commercial health plan which was the system's largest non-governmental payer).
32 PLR 201250025.
33 See PLR 201436050, *supra*.
34 Notice 2011-20.
35 Rev. Rul. 86-98, 1986-2 C.B. 74.
36 Kaiser and Sullivan, IRS Continuing Professional Education Text, FY1996, Ch. P, Integrated Delivery Systems and Health Care Update; GCM 39732.
37 PLR 201145025 (Aug. 18, 2011).
38 Rev. Rul. 2004-51, *supra*.
39 *See, e.g.,* L. Bernstein, *Once Again, U.S. Has Most Expensive, Least Effective Health Care System in Survey,* The Wash. Post (June 16, 2014), *available at* www.washingtonpost.com/news/to-your-health/wp/2014/06/16/once-again-u-s-has-most-expensive-least-effective-health-care-system-in-survey/.
40 We posit that avoided costs, e.g., reduced need for hospitalization and declining work/school days lost to illness, have value that goes beyond the distribution of any shared savings from third-party payment programs.
41 *See* Code § 501(r)(3).