ACOs AND OTHER MODELS OF CARE: FROM FORMATION TO OPERATION – TAX CONSIDERATIONS AND MORE

Donald B. Stuart, Esq.
Waller Lansden Dortch & Davis, LLP

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XV. FUTURE OF ACOs
I. ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

A. Background

1. Traditional fee-for-service model primarily rewards “volume.” ACO is the new healthcare model that is a shared savings model that rewards “value.” Goals of ACOs are improving quality of health care to patients and achieving cost savings (for example, to the Medicare program).

2. ACOs are basically groups of doctors, hospitals and other health care providers, who come together to give coordinated high quality care to their patients. ACOs have a collective responsibility for delivering and coordinating care for patients. Accountable care and reimbursement of shared savings is a major change for Medicare.

3. Basic ACO model - “a provider-led entity that contracts with payers, with financial incentives to encourage providers to deliver care in ways that reduce overall costs while meeting quality standards.”

   See “The Commonwealth Fund Report”

4. Money flowing into ACO from payers (fee for service payments and shared savings) and money flowing out of ACO to the providers such as hospitals and physicians).

   a. Contract arrangements with payers and health plans.

   b. Contract arrangements with hospital providers and physicians.

5. ACO can be defined narrowly or broadly:

   a. Narrow - provider led organization that is solely enrolled in MSSP.

   b. Broad - provider led organization participating in value based shared savings/risk arrangement that is population based with payers.

6. Costs to establish an ACO are significant.

   a. One estimate for a small single hospital with 80 physicians and 250 specialist would have ACO start-up costs of over $5 million and $6 million in annual costs.

   b. ACOs will typically require significant investment in information technology.
7. If there are more hurdles from the government (including IRS), it could stall further ACO formations.

B. Current State of ACOs

1. Estimates of around 428 different ACOs throughout the country. Nearly every state has some form of an ACO operating in it. According to estimates, between 25 to 31 million Americans are currently receiving health care services from an ACO. 40% of Americans live in areas with at least one ACO.

2. Sponsors of the ACOs include:
   a. Hospital Systems
   b. Physician Groups
   c. Insurers
   d. Community based organizations

Source: Continued Growth Of Public And Private Accountable Care Organizations, David Muhlestein Feb 19, 2013
C. Early ACO Reports

1. “Despite gaps in readiness and infrastructure, most of the ACOs are moving ahead with risk-based contracts, under which the ACO shares in savings achieved; a few are beginning to accept ‘downside risk’ as well.”

2. “The most advanced ACOs are seeing reductions or slower growth in health care costs and have anecdotal evidence of care improvements.”

3. “Some of the ACOs studied have begun or are planning to share savings with providers if quality benchmarks are met.”


II. AFFORDABLE CARE ACT AND ACOs

A. Formal establishment of ACO models

1. Created the Center for Medicare and Medicaid Innovations. Purpose is to test different innovative care and service delivery models.

   a. Pioneer ACO Model.
   b. Advance Payment ACO Model.

3. Authorized CMS to create the Medicare Shared Savings Program (MSSP).

B. Pioneer ACO Model

1. Pioneer Model tests a shared savings and shared losses payment arrangement. Higher levels of reward and risk than the MSSP. Designed for organizations with experience proven track record operating as ACO or in similar arrangements in providing more coordinated care to beneficiaries at a lower cost to Medicare. Pioneer Model will test the impact of different payment arrangements in helping organizations achieve the goals of providing better care to patients, and reducing Medicare costs.
2. Risk = ACO faces financial losses if patients' healthcare costs exceed the target.


4. First-year results:
   a. All of the participants improved patient care on quality measures and patient satisfaction.
   b. 13 of 32 were able to lower costs enough for their Medicare patients to qualify for shared savings bonus payments.
   c. Savings totaled $140 million, $76 million will be distributed to them as shared savings.
   d. Two had significant losses in the first year and will likely owe money back to the program - This is the “Risk”.
   e. Seven who didn’t produce any cost savings are leaving Pioneer and moving to the MSSP model.
   f. Two intend to leave the ACO Medicare program completely.
   g. Now down to 23 participants in Pioneer Program for the second year.
   h. Conclusion: Lowering health-care costs is tougher than improving the quality of care (i.e., blood pressure control, cholesterol control).
C. **Advance Payment ACO Model**

1. Designed for smaller physician-based groups and rural providers who have joined together. Will provide additional support to physician-owned and rural providers participating in the MSSP who would benefit from additional start-up resources to build the necessary infrastructure, such as new staff or information technology systems.

2. There was a concern about lack of access to the capital needed to invest in infrastructure and staff - there are start-up costs - participants serve rural populations and have large number of Medicaid beneficiaries. Participants in this model receive upfront and monthly payments (advance on future shared savings), which they can use to make investments in their care coordination infrastructure. Participants benefit from additional start-up resources to build the necessary infrastructure, such as hiring employees or upgrading IT systems. Tests whether this approach will increase participation in the MSSP and generate savings more quickly.

3. 35 ACOs participating in the Advance Payment ACO Model.
III. MEDICARE SHARED SAVINGS PROGRAM (MSSP) and ACOs

A. Background

1. Authorized by Affordable Care Act. Program started in 2012 and established by CMS to facilitate coordination and cooperation among providers with goal to (1) improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and (2) reduce unnecessary costs. CMS published final rules for the MSSP on November 2, 2011.

2. Provides incentives for ACOs that meet standards for quality performance and reduced costs while putting patients first. Think of the MSSP as creating a partnership between a designated group of providers operating as an ACO and CMS.

3. MSSP viewed as a shift in payment structure to shared savings - if ACO delivers high-quality care and spends health care dollars more wisely, ACO will share in the savings it achieves for the Medicare program.

4. A party participates in the MSSP by creating or participating in an ACO.

B. MSSP Design
1. To improve beneficiary outcomes and increase value of care by:
   a. Promoting accountability for the care of Medicare FFS beneficiaries.
   b. Requiring coordinated care for all services provided under Medicare FFS.
   c. Encouraging investment in infrastructure and redesigned care processes.

C. **Reward**

1. ACOs will be rewarded under the MSSP if they lower their growth in health care costs, while meeting performance standards on quality of care and putting patients first. Most ACOs will set up a pool of funds that it receives from MSSP payments and will then share that pool with the ACO participants based on their individual efforts to achieve the goals and objectives. A residual may also be left over to be shared.

2. With initial agreement with CMS, an ACO may elect to participate in (i) one-sided model where the ACO shares in savings but is not at risk for sharing in losses or (ii) two-sided model where the ACO agrees to take on the risk of sharing in losses in exchange for a greater share in savings. All ACOs will operate under a two-sided risk model during subsequent MSSP agreement periods.

D. **MSSP is really a pay-for-performance program**

1. Medicare is the payor - trying to align incentives between payor and provider - opportunity to earn additional reimbursement based on meeting objectives such as quality of care and cost efficiency. Instead of traditional reimbursement model, ACO payments are based on quality of care patient satisfaction, care coordination and outcomes.

2. Does this different fee structure change a tax-exempt hospital organization’s underlying charitable purposes and mission?

E. **Current State of MSSP ACOs**

1. Around 220 ACOs participating in the MSSP.
2. Represent about 3.2 million Medicare beneficiaries (only about 6.5% of the Medicare population).

3. Payment arrangement that does not include the risk of financial losses at early stages.

4. ACO is reimbursed on a fee-for-service basis and also eligible to receive shared savings if the ACO meets cost goals (total spending below target amount) and quality goals.

5. More flexible to initially allow a one-sided (bonus) financial arrangement.

6. Different from Pioneer program (in which they must assume “downside” risk for losses).

7. Once ACO achieves savings, it will need to find new savings to generate future bonus payments. As ACO matures, it can take on downside risk and face financial loss for failing to meet targets.

IV. OTHER TYPES OF ACOs

A. Medicaid ACO
1. ACO type of arrangements with state Medicaid programs.
2. States are exploring or now implementing ACO arrangements.
3. See Colorado and Minnesota for ACO models for Medicaid beneficiaries.

B. Private/Commercial ACOs

1. Commercial arrangement ACOs have been in existence for some time. These are arrangements involving providers and payers in various forms. The exact number of commercial ACOs is unclear, but likely between 150 and 200 commercial ACOs exist.
2. Variety of arrangements in the private sector. Advantage - Flexible arrangements with variety of incentives and agreements.
3. Can follow form of the MSSP model or other design.
4. Can also contract with Medicare and state Medicaid.
5. Not subject to a precise regulatory framework like MSSP ACOs.

C. Bundled Payments for Care Improvement Initiative

1. Organizations enter into payment arrangements that include financial and performance accountability for episodes of care.
2. Goal is higher quality, more coordinated care, and lower cost to Medicare.

V. FORMATION OF ACOS

A. Participants

1. An ACO may include both taxable and tax-exempt participants
2. Examples:
   a. Physicians and other health care professionals in a group practice.
   b. A network of individual practices.
   c. A hospital (for-profit or tax-exempt) that employs physicians.

B. A single, clinically-integrated organization may be an ACO (i.e., hospital employing physicians)

1. ACO does not need to be a separate entity.
2. ACO could be part of the 501(c)(3) hospital and treated as a division.

3. This arrangement, however, could present difficulties due to limitations on participants and governance.

C. ACO will generally be a separate legal entity from its participants

1. An ACO involving two or more otherwise independent participants must be a legal entity with a governing body that is distinct and separate from each participant (e.g., a partnership, a corporation or an LLC).

2. Most ACOs will be formed as separate legal entities to allow for participation of others such as physicians and groups.

3. Also allows the adoption of governance structure that meets requirements of MSSP.

D. Types of separate ACO entities

1. Nonprofit corporation

   a. Has member(s).

      (i) Hospital organization, any other members?

   b. Either taxable as a separate corporate subsidiary or would need to apply for Section 501(c)(3) tax-exempt status.

   c. How long to obtain Section 501(c)(3) status from IRS? - Needs to be considered.

2. For-profit corporation

   a. Income will be taxable.

   b. Common and preferred stock can be issued.

3. Limited Liability Company

   a. Single member LLC.

      (i) Either disregarded for tax purposes and treated as a division of the sole member or can elect to be treated as a corporation for tax purposes.

      (ii) Still a separate entity for state law purposes and for Medicare and other payers.
b. **Multi-member LLC.**

   (i) Treated as a partnership or elects to be a corporation for tax purposes.

   (ii) As a partnership, its activities will generally be attributed to its tax-exempt partners under Revenue Rulings 98-15 and 2004-51.

E. **ACO as joint ventures**

1. Hospital’s employed physicians and/or contracted physician group partner with hospital that has the resources (capital, IT, management). Physicians don’t seem to have capital obligation in these arrangements.

2. Shared savings are divided.

3. After formation, ACO will look to other parties to contract with to share savings.

4. In forming ACOs, physicians will likely need some form of incentive/subsidy from hospitals to participate in the ACO. Such incentives could be information technology, practice management services, clinical case management and support services, or other discounted services. If subsidies and discounts meet HHS regulations (no anti-kickback or referral issues due to waiver or other exception from HHS), there should not be a tax issue in the ACO context - similar to subsidies for EHRs.

F. **Hospital participation**

1. Hospitals should be able to participate in an ACO without jeopardizing their tax-exempt status.

   a. Aren’t tax-exempt hospitals already performing in some respects functions that ACOs will perform?

      (i) Providing high quality care delivery to patients.

      (ii) Partnering, contracting and entering into arrangements with other health care providers.

      (iii) Allocating revenue for meeting certain benchmarks like quality and cost.

2. Existing IRS guidance may be adequate to address new arrangements such as ACOs, but safe harbors are better.
VI. **TAX-EXEMPT ISSUES FOR HOSPITAL ORGANIZATION PARTICIPATING IN AN ACO**

A. **Tax-exempt status**

1. Exempt status is key to many nonprofit hospitals being able to fulfill their charitable missions and provide healthcare services. Hospitals want to be assured that their tax-exempt status is not jeopardized when participating in an ACO or other similar model.

B. **Concerns**

1. Continued qualification as a Section 501(c)(3) organization.
2. Private benefit - not result in exempt organization being operated for the benefit of private parties.
3. Private inurement - not result in exempt organization’s net earnings inuring to the benefit of private shareholders or individuals.

VII. **IRS GUIDANCE**

A. **Notice 2011-20 - March, 2011**

1. IRS’s view or “expectation” on exempt organizations participating in the MSSP through an ACO.
2. Notice released at the time CMS’s proposed regulations were issued.
3. Notice was a mixed message from the IRS.
4. IRS asked if additional guidance is needed - Yes!
5. “Expectations” are not a comfort level for the degree of certainty needed considering the negative consequences (loss of exempt status, UBTI, etc.).

B. **Fact Sheet 2011-11 - October, 2011**
1. After CMS released its final regulations, the IRS issued Fact Sheet 2011-11 to confirm that its earlier statements in its Notice continue to be the IRS’s position on ACOs and provided some additional information.

C. Observations

1. Guidance and requirements should not be any different than what is currently required for an exempt organization collaborating and joint venturing with other healthcare related parties - it should be a confirmation of existing guidance and not impose new requirements.

2. The IRS thinks the primary (only?) charitable purpose of participating in MSSP through ACO would be to lessen burdens of government. Government considers providing Medicare to be its burden and ACO will reduce government’s burden of providing Medicare benefits.

3. What about other charitable purposes?
   a. What about promotion of health charitable purpose, relieving the poor and distressed or underprivileged?
   b. ACO participants could also be fulfilling those purposes through participation in the MSSP.

4. The IRS’s inference of narrow charitable purpose may not be justified. ACO makes delivery of health care more efficient and quality oriented for all, why would the source of reimbursement impact analysis? Those purposes should not be excluded, whether for ACOs operating in the MSSP or outside the MSSP with Medicaid or private payors.

5. Definitive guidance from the IRS is recommended, such as a revenue ruling including a safe harbor to minimize uncertainty.

VIII. IRS POSITION ON ACO PARTICIPATION IN THE MSSP

A. Background

1. IRS has only “expectation.”

2. Participation in properly structured ACO that meets CMS criteria, should not jeopardize exempt status nor create UBTI.
   a. IRS will still review ACO on a case-by-case basis looking at all facts and circumstances.
b. Even if you comply with all of CMS requirements, still may be at risk? Why have this level of uncertainty?

c. IRS should provide a more blanket exception or waiver.

d. Need a clear statement from the IRS - No negative consequences as long as ACO complies with CMS regulations.

3. IRS “expects” that it will not consider a tax-exempt organization’s participation in the MSSP through an ACO to result in inurement or impermissible private benefit to the private party ACO participants if certain factors are present.

4. Facts and circumstances test - May not need to satisfy all factors.

B. IRS’s Factors

1. **The terms of the exempt organization’s participation in the MSSP through the ACO are set forth in advance in a written agreement negotiated at arm’s length.**

   a. It may be difficult to state in advance the exact percentages that each ACO participant will share in the MSSP payments received by the ACO. ACO will want ability to allocate funds in a manner that rewards those who helped achieve the savings and based on what benefit they provided.

   b. IRS has stated that it is sufficient if you only set forth the “methodology” for determining the allocation of shared savings payments to the exempt organization. The parties don’t necessarily have to specify the precise share or exact amount of any shared savings payments distributed by the ACO.

   c. Set in advance in writing should not be a significant issue as CMS regulations require the ACO to submit in writing the methodology for distributing shared savings among all the parties.

   d. If you set up exact percentages for sharing in advance, the ACO participants may not be incentivized to contribute since they are essentially guaranteed a percentage of bonus payments regardless of their efforts. Better to only show methodology in advance, not exact percentages.

2. **CMS has accepted the ACO into, and has not terminated the ACO from, the MSSP.**
a. Still a great deal of uncertainty in terms of whether ACOs will be able to achieve the measured goals of MSSP - termination should not be fatal.

b. If ACO tries in good faith to meet quality and cost efficiency objectives, but doesn’t, and ends up terminated from MSSP, should it be penalized (loss of exempt status or UBTI) for its failure?

c. Termination from MSSP doesn’t necessarily mean something “bad” happened (inurement, private benefit).

d. IRS has now stated that termination of an ACO from the MSSP does not automatically jeopardize the status of the exempt partner.

e. If terminated, ACO’s activities will be non-MSSP activities and you would default to IRS’s guidance for those types of entities.

f. Why is this factor necessary? Acceptance into the MSSP is one way to achieving the goals, but not the only way. Just doesn’t seem like a factor that should be automatic.

3. The 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 exempt organization provides to the ACO.

a. There is going to be significant investment in forming ACO by the participants, including the exempt hospital.

b. Hospital likely to contribute significant capital dollars for start-up costs.

c. The principle of proportionality on contributions and benefits may not work with ACO shared payments.

d. Could tie the hospital’s hands if they must recover investment first and physicians are limited.

4. If the 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.

a. Not all participating in ACO will contribute capital. Many providers may only be contributing services.
b. Physicians and physician group practices may not contribute capital but may instead contribute expertise to achieve goals, “sweat equity” should count as contribution for ownership interest.

c. What are the “economic benefits” to hospital? Portion of shared savings distributed by ACO should be proportional to quality performance and contribution to cost savings achieved. Limiting it to capital contribution may distort who is really responsible.

d. Allocations and distributions should not include distribution of MSSP payments from pool under contractual arrangements, only net income and losses in proportion after payment of such expenses.

e. Non-equity owners in the ACO may also want to participate in the pool of funds.

f. Distribution of net income and loss, however, should be in proportion to equity ownership percentages. Not an issue.

g. IRS traditionally looked at ownership interest which is determined by capital contributions of the owners to determine gains distributed being proportional.

h. CMS looks to distribution of shared savings based on participant’s contributions toward achieving the stated goals of quality and cost savings - not necessarily based on their ownership interest.

Example:

(i) New ACO LLC is formed. “Exempt Hospital” contributes $20M in capital for 55% ownership interest. “Other Participants” (physicians, etc.) contribute some form of value for 45% ownership interest. After first year, ACO LLC receives $10,000 in shared savings. It is determined that Other Participants are 70% responsible for ACO LLC meeting quality and cost goals. Should $10,000 shared savings be distributed 55/45 or 30/70? to Exempt Hospital and Other Participants?

i. IRS has now stated that you look to the totality of circumstances as to whether share of economic benefits is proportional to the benefits or contributions provided.

j. Should take into account all contributions made by the ACO participants, in whatever form (cash, property, services), and all economic benefits received by the ACO participants.
k. How difficult is it for the exempt organization to value non-monetary contributions of ACO participants?

l. How difficult is it to determine each individual transaction is at FMV - is there a market for such services at the time?

   (i) Is this saying that everything needs to be provided at FMV? Exempt organization may have information systems and technology it is willing to make available to ACO at less than FMV.

5. 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.

   a. ACO and participants should be able to allocate out the MSSP payments and/or losses in manner that matches up incentives to achieve MSSP objectives.

6. 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.

   a. What if ACO is tax-exempt itself, should transactions between the exempt ACO and the exempt hospital participant have to be at FMV. Could there be charitable contributions between each other?

   b. How do you determine FMV of participant’s efforts to achieve savings (i.e., physician’s efforts?).

   c. Some suggest an alternative commercial reasonable standard for such transactions.

C. IRS’ 2007 Electronic Health Records Directive

1. Issue involved benefits a hospital provides to its medical staff physicians.

2. Tax-exempt hospital that complies with CMS and OIG standards, and if subsidies do not favor any specific physicians, would not be at risk of private inurement or private benefit with respect to those subsidies paid to physicians to set up EHRs.

3. Benefit to physicians is incidental to goal of adoption of EHRs.

4. IRS has confirmed that its 2007 EHR Memorandum applies to an exempt organization participating in MSSP through an ACO.
IX. IRS POSITION ON ACO ACTIVITIES UNRELATED TO MSSP

A. General

1. Examples include Medicaid and commercial insurance shared savings activities.

2. IRS said it will analyze under general tax rules - 4 prong analysis. IRS will ask whether these types of activities:
   a. further a charitable purpose
   b. are attributed to the tax-exempt partner (via ACO partnership tax treatment or disregarded status)
   c. represent an insubstantial part of the exempt partner’s total activities
   d. result in private inurement or private benefit

3. IRS believes that not every activity that promotes health supports tax exemption under Section 501(c)(3).

4. Use of a corporate entity will eliminate attribution issues.
   a. Corporate ACO’s conduct of non-charitable activities will not jeopardize the tax-exempt status of exempt partner since not attributed.

5. If ACO is treated as partnership or disregarded for tax purposes (ex. LLC), activities are attributed to a tax-exempt member.
   a. If non-charitable activities are an insubstantial part of the tax-exempt member’s total activities, tax-exempt status not in jeopardy.

6. If IRS does not provide more definitive guidance, it may have a chilling effect on participating in other types of ACOs. How do you segregate investments between MSSP and other activities if one activity is tainted by the IRS? Participation by exempt organizations in these governmental accountable care programs should raise no issues different than MSSP and should have the same presumptions from the IRS.

B. Shared Savings Arrangements with Medicaid

1. ACO’s activities related to serving Medicaid or indigent populations.
a. IRS stated they “might” further the charitable purpose of relieving the poor and distressed or the underprivileged.

b. Why according to the IRS are these activities unlikely to lessen the burdens of government? It is a govt. program just like Medicare. The IRS should confirm that it also lessens the burden of govt. if organization’s participation is focused on improving quality of care and efficiencies to result in cost savings to Medicaid. Serving poor Medicaid patients is charitable. It furthers charitable purpose of relieving the poor and distressed or the underprivileged.

c. Notice 2011-20 relies on Revenue Ruling 81-276 which recognized both promotion of health and lessening burdens of government with respect to professional standards review organizations.

2. Contracting with state Medicaid should not jeopardize exemption, just as participating in MSSP should not jeopardize exemption.

C. Shared Savings Arrangements with Commercial Health Insurance Companies

1. ACOs that focus on privately insured individuals and revenue comes from private health plans. CMS seems to also be intending to extend the shared savings model to commercial payors - see for example the Pioneer ACO. CMS has preference for ACOs that are contracting with commercial payers.

2. IRS seems very hesitant on these ACO arrangements. Doesn’t think it lessens burden of government. What about promotion of health?

3. Step back and think about traditional tax-exempt hospital that provides healthcare to Medicare, Medicaid, private insurance individuals serving a charitable purpose of promotion of health.

4. ACO activities performed outside the Medicare environment should also qualify. Delivering healthcare to community serves charitable purposes regardless of how the patient is covered (Medicare, Medicaid, commercial insurance, self-insurance, etc. in their communities). This is a shift in payment methods to achieve quality thresholds to improve care and efficiency.

5. Still should be able to look to lessening the burden of government purpose. Private insurance individuals enrolled in ACOs should receive improved coordinated care from the participating hospital and others that are part of the ACO. Better care could result in fewer treatments and costly medical care. Medicare and Medicaid programs would benefit if reduced cost down the road for these programs if individuals eventually are enrolled in Medicare or Medicaid - a form of lower financial burden on the government - whether MSSP or non-MSSP programs.
6. If ACO has larger population of individuals enrolled from various payor sources, including private pay, economies of scale could be present that could contribute to greater success of MSSP goals of quality of care and cost savings. Stronger argument is made if the ACO and a non-MSSP program agree to similar quality of care and cost savings benchmarks as mandated under the MSSP program - benefit goes to nation’s comprehensive health care goals and priorities of the healthcare reform act.

7. An exempt organization participating in ACO sponsored by commercial payor - should not be an issue because furthering charitable purposes of promotion of health, etc. Exempt organization enters and negotiates with commercial insurance and HMO arrangements all the time and it doesn’t jeopardize exempt status. Aren’t the activities with non-governmental ACOs overall aiming to reduce health care costs and lower demand for government subsidy?

X. **UNRELATED BUSINESS INCOME TAX**

A. **Related Income**

1. Hospital revenues such as shared savings bonuses and other incentive payments received for meeting quality and cost thresholds should be related income. The IRS has stated that as long as ACO meets all eligibility requirements of CMS, any MSSP payments would be from activities substantially related to hospital’s charitable purpose of lessening burdens of government.

B. **Observations**

1. What about non-MSSP activities? IRS recognizes that certain non-MSSP activities may be substantially related to charitable purposes, so should not generate UBTI.

2. What about ACO’s activities not substantially related to a charitable purposes? Dividends and interest from ACO will be excluded from UBTI. Other income will require traditional UBTI analysis (trade or business, regularly carried on, etc.).

3. Hospital receiving funds from an ACO is not engaging in a separate business unrelated to its charitable purposes, it is just collecting revenue in a different manner.

   a. Payment for services is dependent on cost and quality and reaching the achievement levels agreed to by the ACO participants.

   b. Payments are still made solely on the healthcare services the hospital delivers to the patient.
c. By participating in an ACO, the hospital does not enter into a new line of business or different market separate from what it is serving its charitable purposes.

4. It does not make sense that revenue received from services provided to private insurance patients that is exempt would be transformed into UBTI if the revenue comes through an ACO. Hospitals more and more are being reimbursed based on quality and efficiency and the insertion of an ACO into the picture does not change that scenario. Why does it matter whether shared savings payments come from Medicare or Medicaid or private payors that they wouldn’t be substantially related to charitable purposes?

XI. ACO JOINT VENTURES

A. Joint Venture Structure

1. Many of the new ACOs are or will be joint ventures.

2. Issues if ACO is structured as a joint venture (partnership for tax purposes):
   b. Majority control or special reserved powers?
   c. Could be problematic.

3. Only requirement should be ACO structured to meet MSSP requirements.
   a. ACO with tax-exempt and for-profit partners should be deemed acceptable if it meets CMS requirements and rules.

B. Control

1. IRS in its Fact Statement said that the exempt organization doesn’t necessary need to have control over the ACO joint venture. Typically, control in joint ventures is relevant to determine whether participation by the exempt organization in the joint venture will further the exempt’s charitable purposes.
   a. Special circumstance - If ACO has been accepted into MSSP, CMS’s regulation and oversight of the ACO may be enough comfort for the IRS that charitable purpose of lessening the burdens of government is being met.
   b. Exception: If ACO engages in activities other than MSSP, normal IRS rules on joint ventures will apply.
XII. **SEPARATE TAX-EXEMPT STATUS FOR ACOs**

A. **501(c)(3)**

1. Can a stand-alone ACO be granted separate 501(c)(3) status?

2. IRS has stated that an ACO engaged exclusively in MSSP could qualify for separate 501(c)(3) status, as long as the ACO also meets all of the other requirements for tax-exemption.

B. **What about an ACO participating in MSSP and other non-MSSP activities?**

1. IRS has stated that if all of these activities accomplish charitable purposes, it may qualify for 501(c)(3) status, as long as the ACO also meets all of the other requirements for tax-exemption.

C. **Observations**

1. One could argue that ACOs “per se” promote health of the community, therefore, qualification should depend on meeting general requirements for exemption.

   a. RHIOs were granted tax-exempt status based on promotion of health basis.

2. Same rational should apply for ACO, regardless of whether solely MSSP or MSSP and other programs.

XIII. **ABA COMMENTS ON ACOs**

A. **ABA Comments**

1. On July 23, 2013, the ABA Section of Taxation and Health Law Section submitted ACO comments to the IRS.

2. [http://www.americanbar.org/content/dam/aba/administrative/taxation/072313comments.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/taxation/072313comments.authcheckdam.pdf)

B. **Issues Raised**

1. The Comments analyze the authorities cited in Notice 2011-20 and other authorities to consider in addressing issues with ACOs.

2. Also address questions raised by the IRS in Notice 2011-20 about whether non-MSSP activities of ACO further the exempt purpose of the promotion of health and comply with the private inurement and private benefit rules.
3. ABA provides examples for consideration.

C. **Specific recommendations**

1. The guidance in Notice 2011-20 should be formalized in a Revenue Ruling.

2. The promotion of health generally be recognized as an exempt purpose for MSSP ACOs as well as non-MSSP ACOs.

3. Guidelines and safeguards that should alleviate any concerns of private benefit or inurement with respect to non-MSSP ACOs.

4. A tax-exempt organization should not be subject to UBIT when it participates in non-MSSP activities through an ACO joint venture.

5. An ACO qualifies 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 IRS has previously approved and where ultimate control resides in the parent’s community-controlled board of directors.

6. 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.

**XIV. NATIONAL ASSOCIATION OF BOND LAWYERS (NABL) COMMENTS**

A. **NABL Comments**

1. On March 29, 2013, the NABL submitted comments to the IRS in the form of a “Request For Guidance Concerning Private Business Use When a Tax-Exempt Bond Borrower Participates in an Accountable Care Organization”.

2. Tax-exempt participants in ACO may include entities that are issuers or borrowers of tax-exempt bond financings.

B. **Concerns**

1. Private business use.

2. Certain specific arrangements (e.g., ownership, leases, management or service contracts) can result in private business use. Also any other arrangement that gives rise to a "special legal entitlement" or "special economic benefit" comparable to the specifically identified arrangements can result in private business use.
3. Unclear whether an ACO is a "comparable" arrangement because of its contractual arrangements. For example, an ACO may provide case management services to coordinate care among the participating providers in an ACO. If the ACO is a "comparable" arrangement, and results in private business use, the NABL believes it will be an impediment to the implementation of the Affordable Care Act’s health care reform goals.

4. Incentives will not transfer the benefit of tax-exempt financing to a private business and will not cause health care providers to be compensated based on a share of net profits.

C. **NABL Recommendations - Two safe harbors**

1. **Safe Harbor 1** - The creation of or participation in an ACO does not give rise to private business use if:
   a. The terms of the tax-exempt organization’s participation in the MSSP through the ACO are set forth in advance in a written agreement negotiated at arm’s length.
   b. CMS has accepted the ACO into, and has not terminated the ACO from, the MSSP; and
   c. Any incentives based on cost savings are based exclusively on savings in operational costs (as opposed to the cost of capital of the tax-exempt health care borrowers).

2. **Safe Harbor 2** - “Health Care Service Contract” exception.
   a. Defined generally as a management or service contract for health care services that is between an ACO and a medical provider.
   b. For a "Health Care Service Contract," incentive features based on quality measures, patient or provider satisfaction, and efficiency or expense control, but not increased revenue or volume, will not cause the contract to give rise to private business use if, but for these incentives, the contract would meet one of the Revenue Procedure 97-13 safe harbors.
   c. For purposes of the safe harbors of Revenue Procedure 97-13 regarding the maximum contract term and the ability to terminate a contract without penalty or cause, a Health Care Service Contract will be treated as satisfying such requirements as long as the term of the contract does not exceed the greater of either (a) the term of the agreement signed between the ACO and CMS, or (b) five years.
XV.  FUTURE OF ACOs

A.  Observations

1. Many are still sitting on the sidelines taking a wait and see approach. Large health systems may soon finally be jumping into the MSSP.

2. Some critics argue that it would be difficult for ACOs to achieve any significant savings or the critical mass needed.

3. Providers participating in MSSP likely will shift to such value based arrangements with all of its population base.

4. Many organizations are dipping their toes in the water. Providers and payers are testing models with select partners. Results will determine whether to shift into the MSSP.

5. Labels are not going to be enough as far as just branding the organization as an ACO and participating in the MSSP. Really going to be a significant transformation that will need to take place to improve quality and care and also lower costs.

6. Incentives for providers, particularly physicians for “buy in” can be an issue.
   a. Amounts too small to generate interest.
   b. Time delay in receiving payments.
   c. How to fairly divide savings and incentive payments among group.