AMERICAN HEALTH LAWYERS ASSOCIATION
Tax Issues for Health Care Organizations

Washington, D.C.
(October 20, 2014)

Clinically Integrated Organizations

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I. Nonprofit/For-profit Joint Ventures

A. Two Prong Test – Purpose and Control Considerations

Participation by a tax-exempt hospital in a joint venture with physicians or other non-exempt parties (such as a for-profit hospital company or management firm) is subject to a two part test. Participation is not limited solely to equity investment. The tax exempt hospital's participation can take the form of provision of services, staff or delegation of contracting authority.

In that regard, participation in the joint venture must: (1) further a charitable purpose (the "purposes test"), and (2) not involve the exempt organization ceding control over a substantial portion of its activities to the non-exempt partner or failing to retain sufficient control to avoid an inappropriate benefit to the non-exempt partner (the "control test").[1] The consequences of failing either test depend on the size of the joint venture. If the joint venture involves all or substantially all of the activities of the exempt organization, then failure to satisfy both the purposes test and the control test may jeopardize exempt status.[2] If the joint venture activity is insubstantial, then a failure to satisfy those tests may result in any actual or deemed distributions from the joint venture being taxable as unrelated business income.[3] The terms of a joint venture arrangement also may raise traditional inurement or private benefit concerns affecting exemption if the physicians/for profit providers participate on terms that are not consistent with fair market

[1] *See, e.g.*, Plumstead Theatre Society, Inc. v. Commissioner, 74 T.C. 1324 (1980), *aff'd*, 675 F.2d 244 (9th Cir. 1982); Rev. Rul. 2004-51, 2004-22 I.R.B. 974; Rev. Rul. 98-15, 1998-1 C.B. 718; GCM 39005 (Dec. 17, 1982); GCM 39444 (July 18, 1985). Although General Counsel Memoranda ("GCM"), Private Letter Rulings ("PLR"), Technical Advice Memoranda ("TAM"), and other informal guidance are technically not binding precedent, they are generally reflective of current viewpoint and administrative practice at the Service when issued. See, e.g., Code § 6110(k)(3); Hanover Bank v. Commissioner, 369 U.S. 672, 686-87, 82 S. Ct. 1080 (1962) (private letter rulings are evidence of administrative practice); Penn v. Howe-Baker Engineers, Inc., 898 F.2d 1096, 1105 (5th Cir. 1990) (a GCM is a mere nonbinding legal opinion from one IRS division to another). Revenue rulings and revenue procedures; PLRs, TAMs and GCMs, however, can constitute substantial authority for tax positions. Treas. Reg. § 1.6662-4(d)(3)(ii) & (iii).

[2] Redlands Surgical Services v. Commissioner, 113 T.C. 47 (1999), *aff'd per curiam*, 242 F.3d 904 (9th Cir. 2001); St. David's Health Care System v. U.S., 89 AFTR 2d 2002-2998 (W.D. Tex. 2002), *vacated and remanded*, 349 F.3d 232 (5th Cir. 2003); Rev. Rul. 98-15, 1998-1 C.B. 718.

[3] Rev. Rul. 2004-51, 2004-22 I.R.B. 974.

value,[4] or as discussed below, excess benefit with associated excise tax liability for influential physicians and organization managers.

In reviewing the purpose test, it is important to document how the exempt organization reasonably expects the activities of the clinically integrated organization ("CIO") will further charitable purposes, such as by promoting the health of the community in a charitable manner. Qualifying activities in this regard may include participation in Medicare and/or Medicaid,[5] or improving the quality, cost of and access to health care items and services.[6]

The more difficult questions tend to revolve around control. The degree of control exerted by the tax exempt hospital on a joint venture is relevant for purposes of determining whether the exempt organization may engage in a joint venture with a for-profit entity and still operate exclusively in furtherance of its exempt purpose (i.e., the operational test). This is because the activity of the joint venture is attributable to the exempt participant.[7] If the joint venture's activities constitute a substantial part of the exempt participant's activities, the tax-exempt participant must control the activities of the joint venture or jeopardize its exempt status because control of the joint venture is tantamount to control of the exempt organization itself (i.e., it has no charitable activities or assets beyond those included in the joint venture).[8]

Control for this purpose may include majority voting control of the governing body of the joint venture; however, it also may be possible to show effective control through various other rights that allow the exempt organization to compel the joint venture to take action to further exempt purposes, such as by enforcing minimum, reasonable charity care standards or substantial participation in Medicaid, protections against conflict of interest transactions, the ability to override decisions that may jeopardize the nonprofit participant's tax-exempt status, result in excess benefit or unrelated business income, and an option for the nonprofit to unwind the joint venture on reasonable terms in the event of an adverse tax or regulatory event (e.g., change in law or threatened revocation of exempt status). Even without control, it also may be possible to show that the operations are substantially related to exempt purposes or another exclusion may

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[4] See, e.g., PLR 201350043 (Sept. 17, 2013) (more than incidental private benefit to the directors and affiliated physicians from the intended operations of a nonprofit management company formed to develop and operate a network of nonprofit critical access hospitals in rural areas; applicant was controlled by a physician providing medical services to the applicant and an attorney who was a family member of the physician and provided legal services to the organization); PLR 201350044 (Sept. 17, 2013) (related ruling involving organization purportedly intended to own the hospital, though there was no evidence of ownership or other current activities or that it had the funding to purchase a hospital).

[5] *See, e.g.*, Rev. Rul. 83-153, 1983-2 C.B. 48 (509(a)(2) support test); Rev. Rul. 69-545, 1969-2 C.B. 117; TAM 200151045 (July 26, 2001) (approved joint venture for operation of a lithotripsy facility as a substantially related activity – no impact on exemption and no UBI from distributions or management fees – with 19-22% Medicare, 1-2% Medicaid and 1-2% "indigent care").

[6] *See, e.g.*, Rev. Rul. 69-464, 1969-2 C.B. 132; GCM 39862 (Nov. 21, 1991).

[7] *See* Butler v. Commissioner, 36 T.C. 1097, (1961)

[8] *See* Redlands Surgical Services v. Commissioner of Internal Revenue, 113 T.C. 47 (1999); Rev. Rul. 98-15.

apply, such as the exclusion for items and services provided for the convenience of patients.[9] There is, however, a higher degree of uncertainty as to the tax treatment of joint ventures where governance control is lacking, and majority voting control of the governing body (with no or limited veto rights or quorum protections for the other party) is the clearest way to establish control.

Voting control also plays a role in determining whether income generated from joint ventures should be taxed as unrelated business taxable income. The IRS has recognized that there can be circumstances where it is appropriate for a tax-exempt hospital to continue its mission entirely through the activities of a partnership with a for-profit organization, so long as it has not ceded control to the for-profit.[10] This conclusion is supported by the plain language of Code Section 512(c) as long as the activities of the joint ventures are related to the exempt organization's tax-exempt purpose.

In two significant court cases and one Revenue Ruling on point, the IRS and the courts focused on control of the nonprofit entity.[11] Joint ventures in the health care context formed between a for-profit entity and a tax-exempt entity (e.g., a hospital) can basically be categorized as either a "whole-hospital" (or "whole entity" for non-hospital joint ventures) joint venture or an ancillary joint venture. The IRS has explained its position in the context of a whole-hospital joint venture and court cases have also issued decisions for these types of joint ventures.[12]

In *Redlands Surgical Services* v. *Commissioner,* the Tax Court, and later the Ninth Circuit, affirmed the revocation of the tax-exempt entity's tax-exempt status. In this case, the exempt organization invested in an outpatient surgery center, its sole activity, through a joint venture that it formed with a for-profit entity. The Tax Court supported its decision in favor of revoking the tax-exempt status since the tax-exempt organization did not control the joint venture and the activities of the joint venture were a substantial part of the tax-exempt entity's activities.[13] The Tax Court said that, irrespective of the purpose or activities of the joint venture, because the joint venture's activities were not controlled by the exempt organization, the organization could offer no assurance that the joint venture would be operated in furtherance of a charitable purpose.[14] Exemption for an entity is an all or nothing proposition – either the entity is exempt or it is not (except for certain hospitals under Section 501(r)). Without control, there was no assurance that the entity would be operated in furtherance of exempt purposes. That is a different question than whether actual operations are substantially related under the relatedness test – a test which does not include a control element. In the latter instance, the IRS looks to actual operations of the joint venture.

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[9] Code § 513(a)(2).

[10] *See* Rev. Rul. 98-15, 1998-1 C.B. 718, Situation 1.

[11] Rev. Rul. 98-15, 1998-1 C.B. 718; Redlands Surgical Services, Inc. v. Commissioner, 113 T.C. 47 (1999), aff'd 242 F.3d 904 (9th Cir. 2001); St. David's Health Care System, Inc. v. United States

[12] *Id.*

[13] *See* Redlands, 113 T.C. 47 (1999).

[14] Redlands, 113 T.C. at 65.

In Revenue Ruling 98-15, the IRS ruled that an exempt organization's participation in a joint venture with a for-profit entity will satisfy the operational test if (1) participation in the joint venture furthers a charitable purpose, and (2) the joint venture arrangement permits the exempt organization to act exclusively in furtherance of its exempt purpose and only incidentally for the benefit of the for-profit partners.[15] In applying the two-pronged test to a whole hospital joint venture, the IRS said control is paramount to ensure that the tax-exempt parent can continue to act exclusively in furtherance of its exempt purpose.

According to the holdings in *Redlands* and Revenue Ruling 98-15, when an exempt entity divests itself of its sole exempt activity (contributes/conducts the activity via the joint venture) as part of entering into a joint venture with a for-profit entity,[16] the tax-exempt entity cannot operate exclusively in furtherance of its charitable purpose unless it controls the activity now performed through the joint venture.[17] This needs to be distinguished from the situation where a tax-exempt organization enters into an ancillary joint venture with a for-profit entity when considering the impact that control has on whether the income generated by the ancillary joint venture is taxed as unrelated business income ("UBI"). For a more detailed overview of UBI issues, please refer to Section IV of this outline.

For individual activities such as the operation of a patient care department, the IRS considers the retention of control over the aspects of the activity that render it an exempt function (i.e., one that furthers exempt purposes) to be sufficient to avoid unrelated business income.[18] In the context of hospital-physician joint ventures, it is also clear that the IRS applies the aggregate theory of partnerships so that the actual activities of the joint venture determine whether it furthers exempt purposes (and whether it produces unrelated business income).[19] Accordingly, in addition to not being a *per se* case of inurement or more than incidental private benefit, a joint venture to operate a department of the hospital would not produce any UBI for the hospital with the possible limited exception of certain non-unique services for non-hospital patients that are readily available from other sources in the community.[20] All patients of the hospital outpatient department staffed by members of the hospital's medical staff would be patients of the hospital, regardless of whether the department itself is operated by a joint venture.[21] Obtaining ACO services to improve the hospital's operations may be analogous to co-management of the hospital's quality or managed care contracting department (discussed in Section VII.D). As ACOs and CIO s evolve their functions and roles will become clearer and their impact on their

[15] Rev. Rul. 2004-51 at 2.

[16] Treas. Reg. 1.501(c)(3)-1(c).

[17] Rev. Rul. 98-15; Rev. Rul. 2004-51.

[18] *See* Rev. Rul. 2004-51, 2004-2 I.R.B. 974.

[19] INFO 2005-0051 (Jan. 26, 2005) (relying on, inter alia, Code 512(c)).

[20] *See* Code 513(a)(2); Rev. Rul. 68-376, 1968-2 C.B. 246.

[21] *See* Rev. Rul. 68-376, *supra*; PLR 9750056 (Sept. 16, 1997).

tax exempt hospital participants also will evolve. Whether the analysis to be applied is at a department or whole hospital level is not yet clear.[22]

On audit, the IRS has attempted to apply the control test developed in the whole-hospital cases to ancillary services joint ventures, asserting that definitive control by the exempt organization is necessary to determine whether the tax-exempt entity has sufficient control to ensure that the joint venture will be operated in a manner such that the joint ventures activities will be substantially related to the tax-exempt entity's exempt purposes. In order to ensure this type of control, however, voting control of the joint venture is not essential. Rather, control can be shown by other facts and circumstances related to the particular joint venture activities that relate to the member's exempt purposes. Following that approach, for example, the IRS bifurcated the control analysis in a joint venture for educational services, focusing on control of the educational aspects of the joint venture's operations rather than the business aspects.[23] Such lines may seem more difficult to draw in practice for joint ventures of clinically integrated networks with participating charitable healthcare organizations. Whether the organization is educational or healthcare, however, the same UBI rules apply and thus the same analysis should apply to questions of control. It is unlikely that the IRS will issue further joint venture guidance in the foreseeable future given that previous ABA efforts to secure such guidance were unsuccessful, and the IRS has adopted a no-rule position for the exemption and UBI impact of nonprofit/for-profit joint ventures (except to the extent presented in an exemption application).[24]

Appointment by the exempt organization (including *ex officio*) of a voting majority of the governing board of the joint venture, with no supermajority or quorum protections for the for-profit partner(s), remains the clearest path to demonstrating effective control. Based on the guidance referenced above, facts and circumstances showing effective day-to-day control for the exempt organization include a combination of the following powers for the exempt organization:

- Approval and initiation/override rights,[25] regardless of board votes, over anything that makes the hospital charitable or could jeopardize exemption, e.g., charity care, Medicaid participation, configuration of services, affiliations, compensation, etc. (the shorter the list the higher the risk)

- Appointment/removal of CEO and management company

[22] Although the IRS has not yet addressed the full range of exemption related issues that may arise out of co-management arrangements, it has ruled favorably on private use questions for a management agreement bearing a factual resemblance to the basic structural elements of co-management arrangements, including basing compensation for the medical group on achieving predetermined performance metrics. See PLR 201338026 (May 13, 2013).

[23] *See* Rev. Rul. 2004-51.

[24] *See* Rev. Proc. 2013-4, 2013-1 I.R.B. 126, § 6.12.

[25] Initiation and override rights allow the exempt organization to act of its own volition without the need for board approval or to act contrary to the vote of the board. Accordingly, these rights are broader than a mere veto power and allow the exempt organization to cause actions to be taken by the joint venture rather than simply to prevent them.

- Charitable purpose trumps any fiduciary duty of members and governing board and controls any dispute resolution process; takes priority over duty to maximize profits (though the venture may earn a profit)

- Day-to-day management through employees or subsidiary of the exempt organization or an independent manager not controlled by the for-profit partner(s)[26]

- Objective community benefit standards (e.g., charity care %, Medicaid and Medicare participation)

- Prohibition on acts jeopardizing exemption (e.g., political contributions, excessive compensation)

- Tax dissolution clause (reasonable determination that exemption is at risk allows the exempt organization to trigger an unwind, without a post-termination noncompete or liquidated damages imposed on the exempt organization)

In order for these rights to be effective, the exempt organization should require regular reports of the joint venture's activities and engage in monitoring the activities of the joint venture—which implies that the exempt organization has staff available to monitor the operations of the joint venture. Regular reports should address topics such as financial assistance, other community benefits, and the items required to be reported on Form 990 Schedule H. The exempt organization also must have sufficient financial resources to take action (e.g., to exercise buy-out rights).

It is also important to note that for most federal tax purposes, under the aggregate theory of partnerships the IRS will treat a nonprofit as being engaged directly in the activities carried on by a joint venture that is structured as a partnership (including if it is a limited liability company treated as a partnership for federal tax purposes).[27] Accordingly, if the joint venture engages in activities which could disqualify a Section 501(c)(3) organization from exemption, such as prohibited political campaign activity or paying disqualified persons more than fair market value, those actions likely will be attributable to, and jeopardize the exemption of, the hospital or its parent or tax-exempt affiliate. The same standards and concerns would apply to HMOs and clinics that are exempt as organizations described in Section 501(c)(3) or (4).

B. Form 990 Reporting and Joint Venture Policies

If an organization participates in joint ventures, Form 990 (2013), Part VI, Line 16b asks whether the organization has adopted a written policy or procedure requiring evaluation of its participation in joint ventures and taken steps to safeguard the organization's exempt status with

[26] Any management contract for affiliate of for-profit should be limited to five years, with no automatic renewal, nonprofit may terminate for cause before end of term. See St. David's Healthcare, *supra*; Rev. Rul. 98-15, *supra*.

[27] Code § 512(c)(1); Rev. Rul. 98-15, 1998-1 C.B. 718.

respect to such joint ventures. The Instructions describe the joint venture policy or procedure as one "that requires the organization to negotiate, in its transactions and arrangements with other members of the venture or arrangement, such terms and safeguards as are adequate to ensure that the organization's exempt status is protected." A non-exclusive list of examples of such safeguards in the Instructions includes:

- Control over the venture or arrangement sufficient to ensure that the venture furthers the exempt purpose of the organization.
- Requirements that the venture or arrangement give priority to exempt purposes over maximizing profits for the other participants.
- The venture or arrangement does not engage in activities that would jeopardize the organization's exemption (such as political intervention or substantial lobbying for a section 501(c)(3) organization[, inurement or repeated or substantial excess benefit]).
- All contracts entered into with the organization are on terms that are at arm's length or more favorable to the organization.[28]

Additional elements that may be appropriate in a joint venture policy include: (1) a requirement to address in any governance presentation the reporting effect of the joint venture under revised Form 990 and Instructions; (2) documentation of the purpose for the joint venture; (3) outlining the organization's position on control of the joint venture; (4) manner of determining whether the joint venture represents a substantial activity of the organization (thus potentially raising an exemption issue); (5) tying support services to the organization's duties as a partner/member (which may bolster arguments against a finding of unrelated business income); (6) other indicia of related, charitable activity (e.g., Medicare/Medicaid, charity care, community needs assessment, new provider, renovations, financing, retain needed services, improve quality/efficiency/cost, etc.); and (7) dealing with use of bond-financed space.

Finally, in analyzing a joint venture, hospitals and other tax-exempt organizations should consider the interplay of tax and business ramifications and the organization's risk tolerance. Although majority control and mandated charity care may provide the simplest route to avoiding UBI and the least complex documents, it is not clearly required in all cases under current law and regulations. Relying on the facts and circumstances approach to demonstrate that the activities of the joint venture are substantially related can provide more deal-making flexibility but may be more time consuming (at least) to defend on audit. There is no bright line safe harbor for which combinations of factors the IRS will accept on audit and the answer may vary from one audit team to the next given the current moratorium on both exemption and UBI rulings on for-

[28] Form 990 (2013), Instructions, Core Form, Part VI, Line 16b, p, 24; see also Form 990 (2013), Instructions, Appendix F, p. 81.

profit/nonprofit joint ventures outside of an application for exemption or perhaps a request for technical advice.[29]

C. Fair Market Value Terms

Regardless of substantiality of activities, if the terms of participation in the joint venture are not consistent with fair market value, it raises potential issues of prohibited private inurement or excess benefit (if any of the participants or their owners is an insider or disqualified person) or more than incidental private benefit. Service contracts, recruitment agreements, leases and asset sales involving a joint venture typically will be evaluated by the same standards of fair market value and reasonableness that apply to direct transactions between hospitals and physicians.

Two particular scenarios tend to arise frequently in a joint venture setting—in-kind payments (including so-called "sweat equity") and contribution of an existing business line (including a de facto noncompete by voluntarily discontinuing a service line or location). Where these features are present in a proposed transaction, they often (though not universally) flow one way – with "sweat equity" earned by physicians for their time and effort (but not that of hospital personnel) and the hospital discontinuing one or more service lines or locations when the joint venture becomes operational. Although distribution of share savings through CIOs can raise its own challenging issues regarding fair market value and reasonableness, the valuation analysis is no different in theory than with quality incentives and other performance metrics in physician employment and service contracts. Valuation considerations for distributions of shared savings and other performance incentives are discussed in Section VII of this outline.

1. Contribution of Existing Business

The IRS has indicated, in the FY2002 CPE Text, that failure to credit the nonprofit hospital with the fair market value of the contributed business (including the income generated by the business) may result in more than incidental private benefit and, if the other parties are insiders/disqualified persons, may constitute inurement and an excess benefit transaction that jeopardizes exemptions and triggers the 225% excise tax under Section 4958.[30] The FY2002 CPE Text discussion was likely a response to comments on a 2001 private letter ruling wherein the IRS approved participation by a tax-exempt entity in an ASC joint venture with a group of individual physicians. The ruling referred to capital contributions by the nonprofit sufficient to acquire a 70% ownership interest, without any reference to valuing the existing ASC business owned and operated by the nonprofit and effectively contributed to the venture when it was discontinued.[31] The agreement by a tax-exempt hospital to exclusive participation terms in an ACO or CIO could be viewed as analogous in many ways to contribution of a service line. In the

[29] *See* Rev. Proc. 2014-4, 2014-1 I.R.B. 125, § 6.12. The no rule position on for-profit/nonprofit joint ventures has been in effect since 2006. See Rev. Proc. 2006-4, 2006-1 C.B. 132, §§ 2.02 & 6.11.

[30] L. Brauer, M.J. Salins & R. Fontenrose, "Update on Health Care," Exempt Organizations Continuing Professional Education Technical Instruction Program (FY2002), Ch. D, pp. 162-63; see also Rev. Rul. 98-15 (partnership interests in proportion to value of assets contributed to the joint venture).

[31] PLR 200118054 (Feb. 7, 2001).

typical ACO/CIO both the hospital and physicians agree to exclusivity and arguably are creating a new service. Whether an ACO/CIO also may be viewed as replacing an existing service line depends on factors such as whether its activities are substituted for other gainsharing or risk sharing arrangements with payors and physicians—more likely to be a potential issue for second generation ACO/CIO structures.

If there is an in-kind contribution of an existing business to be valued, it is also worth noting that the IRS will give more credence to an independent third party appraisal of value.[32] Moreover, following the procedure in the Section 4958 "dash 6" regulations for establishing a rebuttable presumption of value protects board members and management from the 10% excise tax for approving an excess benefit transaction.[33]

Although the Section 4958 regulations do not define independence for appraisers, the temporary regulations indicated an intent to follow the qualified appraisers standard under Section 170.[34] Those standards in part mirror the Section 4958 regulations by requiring that the appraiser hold itself out to the public as performing valuations, regularly performs such valuations and has the qualifications to do so. The Section 170 regulations, however, also provide that the qualified appraiser must perform a majority of such evaluations for parties unrelated to the exempt organization seeking the appraisal.[35]

Legal counsel generally does not opine on fair market value, but they do opine on process and often rely on valuations or fairness opinions. In rendering legal opinions, if attorneys intend to rely on a valuation or fairness opinion or assumptions of fair market value or other assumptions of fact, that reliance must be reasonable and some due diligence may be required.[36] Potential issues on the face of an appraisal that may trigger a duty to investigate further and seek a reasonable explanation would include internal inconsistencies that appear to be material (e.g., different discount rates in different portions of the valuation); changes in the Stark Law or other fraud and abuse laws that may affect the ability of certain physicians to refer to the joint venture and thus potentially lowering total revenues;[37] dated appraisals not reflecting intervening sales or changes in the market;[38] omitted assets such as failure to account for effect of award of

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[32] See Rev. Rul. 76-91, 1976-1 C.B. 149 (sale of a hospital); see also Treas. Reg. § 53.4958-6(c)(2) (appropriate data on comparability required as part of establishing a rebuttable presumption of reasonableness of fair market value).

[33] Treas. Reg. § 53.4958-1(c)(4)(iv).

[34] 66 Fed. Reg. 2144, 2146 (Jan. 10, 2001).

[35] Treas. Reg. § 1.170-13(c)(5)(i)(C) & (iv); Treas. Reg. § 53.4958-4(c)(4)(iii)(C).

[36] See, e.g., Weiss v SEC, No. 06-1001 (D.C. Cir. 2006).

[37] See C. Kaiser, P. Haney & T.J. Sullivan, IRS FY1995 CPE Text, Ch. L, "Integrated Delivery Systems and Joint Venture Update," p. 176.

[38] TAM 9130002; Anclote Psychiatric Center v. Commissioner, T.C. Memo. 1998-273, aff'd sub nom., 190 F.3d 541 (11th Cir. 1999); TAM 200244028 (June 21, 2002).

certificates of need;[39] changes in reimbursement;[40] changes in pay scale for staff of joint venture facility;[41] board ignoring recommendations of a valuation expert;[42] lack of a control premium or minority discount where exempt organization ends up with a minority position in the joint venture, i.e., with no or limited veto rights and no initiation rights.[43] A marketability discount also may be appropriate for a hospital or physician buying a minority interest in a joint venture.[44]

2. "Sweat Equity"

Sweat equity, if earned, likely goes both ways. One of the more common pitfalls of recognizing sweat equity in hospital-physician transactions is a tendency to view it as a means of incentivizing physicians to become "invested" in a project by crediting their capital accounts, or compensating physicians, for time spent in developing the joint venture or serving on joint venture governing boards or committees. It is also typical for hospital management to devote a significant amount of time to development and operation of joint ventures with physicians. If that time and effort is not adequately compensated consistent with fair market value but the physicians are credited for sweat equity, questions may arise as to the extent to which it benefits private physicians. On the other hand, such questions likely do not raise serious concerns if each partner is simply participating in joint venture development and governance to protect its own investment, generating neither taxable income nor a deduction.[45] Assuming the private benefit issue can be overcome in a particular circumstance, questions may arise as to how the sweat equity can be quantified accurately and what value should be assigned to it (or more accurately, how the value can be shown to comport with a reasonable, market-based amount from comparable arrangements). To the extent participants choose to compensate board or committee members, it may be more appropriate to provide compensation to both the hospital's representatives and the physician participants.

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[39] Anclote, *supra*; Caracci v Commissioner, 118 T.C. 389 (2002), rev'd, 98 AFTR 2d 2006-5264 (5th Cir. 2006).

[40] C. Kaiser & A. Henchey, IRS FY1996 CPE Text, Ch. Q, "Valuation of Medical Practices," pp. 15-16.

[41] FY1996 CPE Text, *supra*.

[42] TAM 9451001 (April 14, 1994).

[43] See, e.g., GCM 39444 (July 18, 1985) (proportionality of distributions and equity contributions); Ahmanson Foundation v U.S., 48 AFTR 2d 81-6317 (9th Cir. 1981) (control premium not justified absent showing that voting control of holding company created economic benefits warranting a premium such as by virtue of the ability to use control "in such a way to assure an increased economic advantage worth paying a premium for"; taxpayer presented testimony indicating that in the highly regulated savings and loan industry "there are numerous legal restraints which protect against exploitation of corporate assets through such self-dealing"); Caracci, *supra* (taxpayer's expert argued minority discount normally would apply where no one shareholder had a controlling interest but was not appropriate for a loss corporation); S. Pratt, et al., Valuing a Business: The Analysis and Appraisal of Closely Held Companies, pp. 48-54 (4th Ed.).

[44] See S. Pratt, *supra*; Kelley's Estate v Commissioner, 90 TCM (CCH) 369 (2005).

[45] See, e.g., R.V.J. Cezar Corp., T.C. Memo. 2010-173 (taxpayers did not include any sweat equity I income for work they did themselves for their construction company); Palmer, T.C. Memo. 1987-106 (denied deduction for sweat equity for labor "invested in a hydroponic greenhouse operation"); Cox, T.C. Memo. 1982-667 (federal tax laws do not recognize a sweat equity component to the tax basis of property).

In other situations, some hospitals rely on elaborate "sweat equity" formulas to encourage active physician participation in the development and implementation of care management protocols and other quality improvement initiatives necessary to establish an extended track record of coordinated activities to improve care in order to achieve clinical integration for antitrust purposes. Other hospitals, developing Medicare ACOs, rely on sweat equity to demonstrate a meaningful commitment by physicians to the mission and ongoing operations of the ACO as required by CMS rules.[46] One aspect of such "sweat equity" models is essentially an emotional appeal based on the perception of ownership that the term "equity" implies. More substantively, however, some hospitals may attempt to tie enhanced benefits, such as the extent of incentive pool participation, funding for the incentive pool or reduction in service payments to the hospital. To the extent sweat equity provides a financial benefit to the physicians, it also may result in taxable income under the broad scope of Section 61.

D. Management and Services Agreements

The IRS may argue that management and administrative services ("M&A services") provided to joint ventures are not charitable activities but are a form of UBI.[47] Where services are charged at cost, the IRS may attempt to impute a profit margin under Section 482. The technical support, however, generally favors the taxpayer if the joint venture itself furthers exempt purposes. If the distributive share of income/loss from the joint venture is not UBI, then M&A services should not be a form of UBI if they are either (1) necessary to operationalize an exempt purpose joint venture (this argument may be strengthened if the services are required by the operating agreement or partnership agreement as opposed to/in addition to a separate contract),[48] (2) relate to patients of the hospital member,[49] or (3) at a minimum, limited to the extent of the exempt organization's percentage interest in the joint venture.[50] In addition, other special circumstances may indicate that the services are substantially related to exempt purposes, such as services to support critical access hospitals that provide needed expertise to continue their operations in isolated areas otherwise lacking in hospital services (particularly if the vending tax-exempt hospital also provides professional medical services at each of those hospitals).

II. Clinically Integrated Organizations (CIOs)

Accountable Care Organizations ("ACOs") have been featured prominently in discussions about health care reform and ways in which to improve the quality and cost of health care services – both for Medicare and potentially commercial payors. ACOs may be organized in a variety of structures, including limited liability companies ("LLCs"), partnerships and

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[46] See 42 C.F.R. § 425.108(d)(1) (demonstrating meaningful commitment through "human investment (for example, time and effort)"; 76 Fed. Reg. 67802, 67824-67825 (Nov. 2, 2011) (preamble commentary).

[47] *See* Rev. Rul. 72-369.

[48] *See, e.g.*, Rev. Rul. 78-41.

[49] *See, e.g.*, Rev. Rul. 68-375, Rev. Rul. 68-376.

[50] PLR 9323030 (a percentage of payments for M&A services equal to nonprofit's percentage ownership interest not treated as UBI).

corporations. Physician participation may take the form of contractual arrangements, equity ownership or both. A number of ACOs are organized as physician-owned organizations with hospital participation by contract only. As the healthcare market evolves, it remains to be seen how the IRS will apply existing standards to new types of organizations, such as ACOs.

To the extent that a hospital owned or co-owned ACO negotiates or administers contracts for the benefit of physicians, the IRS may conclude that it provides more than an incidental amount of private benefit to the physicians and thus (a) does not qualify for exempt status, and (b) if organized as an LLC or partnership, results in unrelated business income for any tax-exempt partner or member.[51] ACOs, however, may be viewed differently than Physician-Hospital Organizations ("PHOs") and Independent Practice Associations ("IPAs") if the ACO has an active role in improving quality, reducing costs or other community benefit activities (e.g., prevention and disease management).

A. Physician Hospital Organizations

Limited guidance exists on PHOs (i.e., the main source is a Continuing Professional Education ("CPE") Text from 1996[52]), their structure and operations are often quite different from an ACO. A typical PHO is often jointly controlled by both the hospital and the physicians as owners and focuses on marketing, dealing with third party payers, credentialing and related administrative services but does not control the operations of the hospital or the physicians. According to the IRS, a "PHO generally will not qualify for exemption under Code 501(c)(3) because negotiating managed care contracts for the member-physicians furthers their private interests more than incidentally," functions also performed by a typical IPA which the IRS has found does not qualify for exemption as a Section 501(c)(4) or (c)(6) organization due to the primary private benefit to physicians receiving such contracts.[53] However, the CPE Text goes on to explain the example of a unique scenario under which a PHO can meet the requirements for exemption under 501(c)(3) where the PHO is controlled by a related organization that is exempt under Code Section 501(c)(3), in particular an academic medical center, where the PHO serves to supply a continuum of patients with diverse medical problems to the faculty and teaching hospital in order to perform their exempt function of educating the medical students.[54] Tax-exempt hospitals should also note that, under certain circumstances, they may be able to

[51] *See, e.g.*, Rev. Rul. 86-98, 1986-2 C.B. 74 (IPA did not qualify as 501(c)(4) or 501(c)(6) organization where its primary purpose was to negotiate contracts with HMOs); C. Kaiser & T.J. Sullivan, FY1996 EO Continuing Professional Education Text, Chapter P: Integrated Delivery Systems and Health Care Update, 16-19 (PHOs organized as corporations generally are not tax-exempt unless as an integral part of a related organization such as a PHO established for a tax-exempt teaching hospital and its 501(c)(3) practice plan, and if organized as an LLC or division of the hospital, may result in unrelated business income depending on whether the services provided relate to physicians' treatment of patients of the hospital vs. private practice patients).

[52] IRS EO CPE Text (1996), Charles F. Kaiser and T.J. Sullivan, Integrated Delivery Systems and Health Care Update, *available at* http://www.irs.gov/pub/irs-tege/eotopicp96.pdf.

[53] *Id.*; *see also* Rev. Rul. 86-98 (organizations failed to qualify for exemption under lesser requirements of Code Sections 501(c)(4) and 501(c)(6)).

[54] IRS EO CPE Text (1996), Charles F. Kaiser and T.J. Sullivan, Integrated Delivery Systems and Health Care Update, *available at* http://www.irs.gov/pub/irs-tege/eotopicp96.pdf.

participate in a PHO that is not itself tax-exempt without jeopardizing the tax-exempt hospital's status.[55]

B. Medicare Shared Savings Program ACO Guidance

Although ACOs are still too new to have been addressed in detail on audit yet, we do have guidance from the IRS on how it will view Medicare ACOs established pursuant to authority found in amendments to Section 1899 of the Social Security Act made by the Patient Protection and Affordable Care Act establish the Medicare Shared Savings Program ("MSSP"). Under this program, groups of service providers meeting criteria established by the Centers for Medicare and Medicaid Services ("CMS") can work together through an ACO. The ACO must meet performance standards and show that it has achieved savings in line with standards provided by CMS. If an ACO does this, it can receive a payment from CMS equivalent to a portion of the savings to Medicare. Although no federal income tax regulations have been published dealing with participation by charitable organizations in the MSSP through an ACO, taxpayers should note that IRS Notice 2011-20 and Fact Sheet 2011-11 explain how existing guidance may affect such organizations.[56]

Notice 2011-20 provides a five factor test for determining whether a tax-exempt entity's participation in an ACO will result in private inurement, more than incidental private benefit or UBI: (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.

The IRS modified the five factor test, for MSSP ACOs only, in Fact Sheet 2011-11. As modified, it will not be necessary for an exempt organization to meet all five factors to avoid inurement or private benefit and no one factor is determinative. The Fact Sheet places heavy reliance on MSSP safeguards and CMS oversight for avoiding inurement, private benefit, and UBI. Although the Fact Sheet maintains that control is relevant to whether an ACO furthers the charitable purposes of its exempt member(s), it defers to CMS' oversight and MSSP rules for Medicare ACOs. Perhaps most significantly, the IRS conceded that ownership interests need not be directly proportional to capital contributions nor must shared savings necessarily be distributed in proportion to ownership interests, rather the IRS will consider other economic benefits and in-kind contributions. There is, however, no requirement to specify an exact share or amount of distributions to the tax-exempt participant so long as the written agreement includes the methodology for determining each party's allocable portion of shared savings. Fact Sheet 2011-11, Q. 19.

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[55] *Id.*; *see also* IRS EO CPE Text (1995) at 154-57. However, the 1996 CPE Text goes on to state that the hospital's exempt status will be jeopardized if "the participation in the PHO is merely a device to distribute its earnings to the physician participants. The hospital participant is required to ensure that the PHO is structured so that it is not providing impermissible benefits to the physician participants."

[56] Notice 2011-20, 2011-16 I.R.B. 652 (April 18, 2011); IRS Fact Sheet 2011-11 (Oct. 20, 2011).

An MSSP ACO may qualify for Section 501(c)(3) status if it is treated as a corporation for federal tax purpose, limits its activities to the MSSP and meets the other generally applicable requirements for obtaining Section 501(c)(3) status. Fact Sheet 2011-11, Q. 16. Exemption, however, may require at least indirect control similar to friendly or captive PC model (which some physician advocates have suggested is contrary to the provider-focused governance structure described in CMS' MSSP rules. Other FAQs in the Fact Sheet suggest that a dual Medicare/Medicaid ACO also may qualify for 501(c)(3) status. Fact Sheet 2011-11, Q. 12 & 17. Termination of an ACO's MSSP participation agreement does not automatically jeopardize a tax-exempt participant's exempt status. Rather, participation would be analyzed on a facts and circumstances basis as participation in a non-MSSP ACO. Fact Sheet 2011-11, Q. 20

It is important to note that the MSSP ACO waivers only apply to the MSSP ACO activities of the ACO and do not extend directly to other activities, even if conducted directly by the MSSP ACO. In the Fact Sheet, the IRS left open the question of UBI from non-MSSP ACOs but noted that some non-MSSP ACO activities may be substantially related to charitable purposes; did not address private use issues. Other specific exclusions under Code 512(b) may apply, including payment of dividends, and, subject to limits for controlled entities, interest and rent of real property and an insubstantial amount of personal property. Factors the IRS would consider in determining whether participation in a non-MSSP ACO jeopardizes exempt status (Fact Sheet 2011-11, Q. 11-14) include: (1) whether participation furthers a charitable purpose (e.g., Medicaid ACO relieving poor and distressed; however, not all activities that promote health further charitable purposes);[57] (2) whether the activities of the ACO are attributed to the tax-exempt participant (e.g., partnership vs. corporation); (3) whether the ACO activities represent an insubstantial part of the tax-exempt participant's total activities; unclear how measured; and (4) whether or not the ACO's activities result in inurement or impermissible private benefit. A stronger showing on charitable purpose may be required than with an MSSP ACO, including oversight equivalent to that in the MSSP, quality and cost improvements instead of mere contracting activity, including persuading the IRS that benefits to payors, employers and physicians as opposed to Medicare are not the primary purposes of the non-MSSP ACO.

C. Regional Health Information Organizations (RHIOs)

A key activity of a CIO is to collect, analyze and share health information. Regional Health Information Organizations ("RHIOs") have been formed in many states, often on a regional if not statewide basis, to facility the exchange of electronic medical records among providers. After struggling with the issues for a few years, the IRS developed an approach that would allow a RHIO to qualify for Section 501(c)(3) status. The IRS adopted a lessening the burdens of government theory for RHIOs, similar to the position taken in the Fact Sheet with respect to MSSP ACOs discussed above.

[57] This factor may require a stronger showing for a commercial ACO/CIO than with an MSSP ACO, including oversight equivalent to what CMS provides in extent and independence, with a strong emphasis on quality and cost improvements vs. mere provider contracting functions. One particular challenge will be a potential focus on benefits to commercial payors, employers and physicians, rather than patients, the community at large or governmental health programs.

Although guidance to date on RHIOs is scarce, in one private letter ruling issued after clearing the way for exemption, the IRS approved an arrangement which bears some resemblance to the objectives of many ACOs. Specifically, the IRS held that a RHIO (described in Section 501(c)(3) and formed to support the activities of nine charitable or governmental health care organizations and three tax-exempt associations) collaborating which another tax-exempt organization on the development of a clinical database was furthering charitable and educational purposes. The database included information on medical and drug claims, patient prescription medications, lab and other test results, and "clinical messaging data."

Importantly, the program also included provisions for merit-based compensation payments from participating health plans to participating physicians, provided clinical quality reports to participating health plans and physicians and access to the clinical quality database for the physicians (who used the data for diagnoses and preventive care and as a reminder system for scheduling procedures or office visits). The quality payments included a minimum payment for initial continuous one year participation in the program and incentives for achieving at least 50% of the evidence-based clinical and quality measures developed by the RHIO's "Measures Committee" (based on national benchmarks) for the program. Other minimum requirements for the quality incentive compensation program were set by the RHIO's "Program Administration Committee." Any benefit to the health plans in terms of reduced indemnity expenses or to the physicians from the quality incentive payments realized as a result of the program was merely incidental and did not constitute private inurement or an impermissible level of private benefit or result in UBI for the RHIO.[58] The ruling further notes that the program "promotes the purposes of the [American Recovery and Reinvestment Act of 2009] by using health information technology to reduce healthcare costs."[59]

D. Tax-exempt MSSP ACO

On August 7, 2014, the IRS released what likely is the first exemption ruling for an ACO.[60] Although this is a boilerplate 501(c)(3) ruling, it shows that there is a legitimate shot at exemption for MSSP ACOs. It does not, however, necessarily change the caution with which the IRS would approach an application from a commercial or combined purpose ACO. The additional facts in the summary below not reflected in the letter itself were gleaned from the ACO's website.[61]

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[58] PLR 201250025 (Sept. 21, 2012) (the ruling does not describe the membership of the committees). Brief FAQs from the IRS regarding RHIOs are available online at http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/Regional-Health-Information-Organization-(RHIO)-Frequently-Asked-Questions (last accessed April 26, 2014); see also INFO 2010-0178 (July 8, 2010) (meaningful use payments direct to physicians are gross income within Code § 61 but they may be able to deduct certain expenses incurred in implementing the system either in the year incurred or over the useful life of the system for tax purposes, depending on the nature of the expenses).

[59] PLR 201250025, *supra*.

[60] Methodist Patient Centered ACO (Aug. 7, 2014) (Dallas).

[61] http://www.methodisthealthsystem.org/aco.

The ACO involved, Methodist Patient Centered ACO, participates in the Medicare Shared Savings Program. The ACO was formed by a nonprofit hospital system, which is the sole corporate member; however, the ACO is governed by a majority physician board comprised of 15 directors (13 of whom are physicians, including 12 ACO Participants and 1 system employee, 1 Ph.D. representing the system, and one Medicare Beneficiary). Although the IRS hinted at the possibility of exemption for ACOs in its MSSP guidance released in 2011 (Notice 2011-20 and Fact Sheet 2011-11), this appears to be the first example of the IRS actually approving exemption for an ACO. Although this is a positive development, the IRS has not yet provided clear guidance on whether or under what circumstances it would be willing to recognize a solely or combined purpose commercial ACO as a Section 501(c)(3) organization.

E. Community Health Improvement Organizations

In a recent adverse determination, the IRS denied Section 501(c)(3) status to an organization formed by an insurer, an association and a medical research organization.[62] This determination may not bode well for exemption or UBI rulings for commercial ACOs, though it also may be a direct result of the control of the entity by non-charitable organizations.

The purpose for which the organization was formed resembled at some level the objectives of many commercial ACOs. The stated purposes of the organization were to:

> . . . collaborate with [the] Founders and other healthcare organizations and government agencies to improve healthcare in your state. Your first project is to reduce preventable hospital readmissions in partnership with an exempt organization in your region. You will focus on reducing readmission for patients with specific medical conditions. You plan to help hospitals identify areas of improvement in their discharge process, implement evidence-based practices to identify and correct common gaps in the discharge process, provide expertise and support to hospital staff and community partners, and help hospitals and communities develop transition strategies.[63]

Despite the purpose to promote the health of the community-in a manner similar to the goals of MSSP and commercial ACOs—the IRS concluded that the organization failed to establish that it would be operated exclusively for an exempt purpose. In that regard, the IRS noted that not every organization that promotes health is charitable, but rather such activities also may be commercial in nature.[64] The organization itself did not provide medical care "but rather conduct research and training and collect data for members of the healthcare industry." The IRS concluded that the research to be conducted by the organization would primarily benefit insurers and physicians (by reducing the insurer's expenses for readmissions and improving physician reimbursement), and patients who are in more stable health on discharge, rather than the

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[62] PLR 201436050 (June 12, 2014) (no protest filed).

[63] Id.

[64] Federation Pharmacy Services, 72 T.C. 687, 692 (1979), *aff'd*, 625 F.2d 804 (8th Cir. 1980) (selling pharmaceuticals at market rates).

community at large.[65] The potential for substantial benefits to the for-profit insurer, a purpose the IRS does not view as charitable, also may have been a factor in the negative analysis.

In addition to not meeting the organizational test,[66] the IRS found prohibited private inurement and more than incidental private benefit from its governance structure, which allowed the two non-charitable founders to have voting control of the board (4 of 6 or 4 of 7 directors, with the 7th elected by the other directors), plus additional non-voting seats for the founders' CEOs.[67] Only the founder appointing a director can remove him or her from office, and each of the directors may have personal financial interests through employment or other relationships with the founders, "increasing their loyalty to non-charitable goals over your charitable ones." There was no charitable purpose override in the governing documents to require the board to give priority to charitable purposes when in conflict with commercial ones. None of the directors or officers represented the broader interests of the community. The organization also had no employees of its own and depended entirely on its founders for staffing as well as funding of its operations, which gives the founders "the opportunity to manage the exempt organization for the financial benefit."[68] In short, there were not protections to prevent the founders from choosing the focus of research, directing how it is conduct, and preparing training that results in benefits to their private financial interests.

F. Medical Foundation Model Example

Physician control of the board of a CIO may preclude tax exempt status for the ACO. In a exemption denial also involving questions of physician control, the IRS issued a proposed denial to a medical foundation originally formed with a physician-lead board. Although the foundation participated in Medicare and Medicaid and had a charity care policy that applied to all of its clinics, the IRS expressed concerns about private control of the organization. The affiliated tax-exempt hospital and the physicians had the right to appoint an equal number of directors, and those directors would elect one independent director. The hospital's board appointment rights, however, would last only so long as it continued to fund the organization. The IRS also rejected a proposed compromise for the hospital to appoint a bare majority, but with super majority vote (or physician veto) required for certain major actions including debt, management agreements and significant corporate actions and a broad delegation of authority to an Executive Committee on which the hospital held only 1 of 3 seats. The day-to-day activities of the organization also were managed by a physician-owned entity, which arranged all HMO contracts.

The IRS ultimately approved exemption for the organization after significant organizational changes, including:

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[65] PLR 201436050 (*citing* American Campaign Academy, 92 T.C. 1053 (1989)).

[66] Treas. Reg. § 1.501(c)(3)-1(d)(1)(i) & (ii).

[67] PLR 201436050 (*citing* Redlands, supra; Rev. Rul., 98-15, 1998-1 C.B. 718).

[68] Id. (*citing* Harding Hospital v. U.S., 505 F.2d 1068 (6th Cir. 1974); Lowry Hospital Association v. Commissioner, 66 T.C. 850, 859-60 (1976)).

- Hospital as sole member with unconditional right to appoint and remove a voting majority of board; eliminated supermajority rights
- Hospital representatives must be a voting majority on all committees
- Charitable purposes override of fiduciary/other duties
- Strengthened conflict of interest policy
- Provided documentation to support fair market value of all transactions with physician groups
- Hospital approval required for any director/committee compensation
- Terminated physician entity management agreement
- Eliminated exclusive for physician entity in managed care contracting
- Future funding of the foundation would be in the hospital's discretion

III. Antitrust Considerations

Note that in addition to addressing clinical integration and other antitrust considerations, it is necessary to ensure that the ACO or CIO complies with the Stark Law and the Anti-kickback Statute. A discussion of those laws is beyond the scope of this session.

A. Clinical Integration

From an antitrust perspective, establishing clinical integration is essential to permit joint contracting on behalf of otherwise unrelated physicians (sometimes described as single signature contracting). In this context, clinical integration is a term of art that goes beyond data sharing. The term clinical integration is not precisely defined but rather one has to glean its meaning from various FTC staff/advisory opinions and speeches. For antitrust purposes, it also includes various elements intended to improve efficiency and quality of care, such as development of and adherence to clinical practice guidelines and protocols, outcomes measurement and performance improvement goals or metrics covering a substantial portion of the providers' patient base and medical costs and a broad range of diagnoses (though some successful programs have been more focused), with the ability to reward or penalize based on performance (which includes some mechanism for monitoring performance), and a demonstration of why collaborative action is necessary to achieve the quality of care and other performance goals, why additional incentives are needed (especially for employed physicians), and why joint contracting is necessary to achieve those goals.

Typically, an extended track record of coordinated activities to improve care is required before the FTC will approve joint contracting by otherwise unrelated physicians; these networks, if done right, typically do not start with joint contracting day one.[69] Prior to joint contracting (single signature), networks may use a messenger model if structured appropriately to avoid agreement on price by competing providers, and use of non-exclusive contracting also may help.[70]

B. Determining Participants in an Accountable Care Organization ("ACO")

The manner in which participating physicians are selected/join and the sheer number of physicians in a specialty participating in an ACO (or other CIO) can impact the degree of tax (and regulatory) risk posed by the venture. For example, under federal antitrust law, naked price fixing or allocating markets among competitors is regarded as *per se* illegal; however, joint pricing agreements among providers that are either financially or clinically integrated are analyzed under a rule of reason if the joint pricing agreement is reasonably necessary to achieve the precompetitive benefits of the affiliation. The rule of reason balances likely anticompetitive effects against the potential precompetitive efficiencies of the arrangement. In the FTC and DOJ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations, the agencies indicated that they would apply a rule of reason analysis to ACOs that meet certain conditions.[71]

The agencies also indicated that clinical integration, which may be relevant for ACOs expanding into managed care contracting, "can be evidenced by the joint venture implementing an active and ongoing program to evaluate and modify practice patterns by the venture's providers and to create a high degree of interdependence and cooperation among the providers to control costs and ensure quality." They have not, however, previously prescribed how clinical integration may occur or identified specific criteria to be used in determining whether providers are clinically integrated, recognizing instead that such decisions must be based on the totality of the circumstances.[72] In the ACO guidance, the agencies noted that CMS' eligibility criteria for participation in the MSSP "are broadly consistent with the indicial of clinical integration" in prior healthcare antitrust guidance from the agencies, and that ACOs meeting those eligibility requirements are likely to be bona fide arrangements intended to improve quality and reduce costs of healthcare services through the joint efforts of the participants. Moreover, the agencies noted that CMS' collection and evaluation of cost, utilization and quality metrics will help the agencies determine whether the MSSP eligibility criteria do in fact require a sufficient level of

[69] See California Pacific Medical Group, Inc., d/b/a Brown & Toland Medical Group ("BTMG"), Preliminary Approval 4/5/2005 (consent order); Advocate Health Partners ("Advocate"), No Determination at this Time 12/29/2006 (consent order); FTC Staff Advisory Opinions Suburban Health Organization, Inc. ("SHO") (rejected 3/28/2006); MedSouth, Inc. ("MedSouth") (approved 6/18/2007); Greater Rochester IPA, Inc. ("GRIPA") (approved 9/17/2007); TriState Health Partners, Inc. ("TriState") (approval 4/13/2009); Norman Physician Hospital Organization ("Norman PHO") (approved 2/13/2013).

[70] See FTC Staff Advisory Opinion – Bay Area Preferred Physicians (Sept. 23, 2003).

[71] 76 Fed. Reg. 67026 (Oct. 28, 2011).

[72] 76 Fed. Reg. at 67027.

clinical integration to produce the intended efficiencies (i.e., cost savings and quality improvements). Given the anticipated benefits of clinical integration and monitoring by CMS, the agencies also indicated they would treat negotiations by MSSP ACOs with private payors as reasonably necessary to the ACO's primary purpose of improving healthcare delivery and apply a rule of reason analysis, provided that the ACO uses the same governance and leadership structures and the same clinical and administrative processes across both its MSSP and commercial business.[73]

In addition to promising a rule of reason analysis of ACOs, Section A of the antitrust guidance provides an antitrust safety zone for certain MSSP ACOs – arrangements which the agencies deem highly unlikely to raise significant competitive concerns and thus will not be challenged by the antitrust agencies "absent extraordinary circumstances" (e.g., collusion or improper sharing of pricing information or other competitively sensitive information related to the sale of competing services outside of the ACO. Determining eligibility for the safety zone requires an ACO to evaluate its share of services in each ACO participant's primary service area ("PSA") for physician specialties, major diagnostic categories for inpatient services, and outpatient categories. The PSA is defined using the Stark Law definition of "geographic area served by the hospital," a 75% zip code test, determined separately for each participant providing physician, inpatient and outpatient services and a separate PSA for each of those services if an entity, such as a hospital, provides more than one.[74] To fall within the safety zone, independent ACO participants providing "the same service (a 'common service') must have a combined share of 30 percent or less of each common service in each participant's PSA, wherever two or more ACO participants provide that service to patients from that PSA."[75] In order for a hospital or ASC to qualify for the safety zone it must be non-exclusive to the ACO, i.e., free to contract with payors individually, through other ACOs or via analogous collaborations.[76]

An ACO that exceeds the 30 percent threshold for common services may still fit within the safety zone if the reason it exceeds the threshold is the inclusion of hospitals or physicians in rural areas, so long as the ACO includes only one physician or physician group per rural area and one hospital per rural area, each on a non-exclusive basis. Where there are non common services, the 30 percent threshold does not apply; however, the ACO is subject to the dominant participant limitation. Under that limitation, "any ACO that includes a participant with a greater than 50 percent share in its PSA of any service that no other ACO participant provides to patients in that PSA, … the ACO participant must be non-exclusive to the ACO for the ACO to fall within the safety zone." In addition, to qualify for the safety zone, an ACO with a dominant participant also cannot impose exclusivity on any private payor by requiring the payor "to contract exclusively

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[73] 76 Fed. Reg. at 67027-67028.

[74] See 42 C.F.R. § 411.357(e)(2)(i) ("the area composed of the lowest number of contiguous zip codes from which the hospital draws at least 75 percent of its inpatients"). The antitrust agencies, however, omitted "contiguous" from the quoted definition. 76 Fed. Reg. at 67028.

[75] 76 Fed. Reg. at 67028.

[76] 76 Fed. Reg. at 67028-67029.

with the ACO or otherwise restrict a private payer's ability to contract or deal with other ACOs or provider networks."[77]

Similarly, if physicians are selected for participation in, or rewarded through shared savings with respect to, a commercial ACO in a manner that is related to the volume or value of referrals, that selection or calculation may implicate the Anti-kickback Statue and/or the Stark Law.[78] For its part, the IRS guidance largely defers to CMS oversight of the MSSP and a traditional joint venture analysis without focusing on market concentration or ability to refer.[79] In prior guidance regarding hospital subsidies for physician implementation of electronic health records, however, the IRS originally took the position that the software and technical support offered must be made available to all medical staff members, and provide "the same level of subsidy to all of its medical staff physicians or [vary] the level of subsidy by applying criteria related to meeting the healthcare needs of the community."[80] The IRS later clarified that access may be rolled out over time rather than provided simultaneously to all physicians if the timing of the rollout is based on "criteria related to meeting the health care needs of the community."[81]

IV. Unrelated Business Income

A. Overview

The tax-exempt hospital participant would prefer to treat payments it receives for services and its distributions from a CIO as not subject to tax. Under Section 501(a) of the Code, an organization described in Section 501(c) is subject to tax under Section 511(a) on its "unrelated business taxable income" as defined in Section 512. In this regard, Section 512(a)(1) defines "unrelated business taxable income" as the gross income derived by an organization from any unrelated trade or business (as defined in Section 513) regularly carried on by it less the deductions allowed, both computed with the modifications provided in Section 512(b). An unusual, non-recurring activity, however, will not be deemed "regularly carried on" and thus will not be subject to UBI, such as the isolated sale of a hospital facility.[82] In addition, Section 512(c) provides that, for purposes of determining unrelated business taxable income, a tax-exempt organization that is partner in a partnership is considered to be directly carrying on its proportionate share of the partnership's activities and must, subject to the exceptions, additions, and limitations contained in Section 512(b), include in unrelated business taxable income its

[77] 76 Fed. Reg. at 67029.

[78] 76 Fed. Reg. 67992, 68006 (Nov. 2, 2011).

[79] IRS Notice 2011-20, 2011-16 I.R.B. 652 (April 18, 2011); IRS Fact Sheet FS-2011-11(Oct. 20, 2011).

[80] Memorandum regarding "Hospitals Providing Financial Assistance to Staff Physicians Involving Electronic Health Records" (May 11, 2007) (the "EHR Directive"), available online at http://www.irs.gov/file_source/pub/irs-tege/ehrdirective.pdf.

[81] Q&A on Hospitals' Health IT Subsidy Arrangements with Medical Staff Physicians, Q.6., available online at http://www.irs.gov/file_source/pub/irs-tege/ehr_qa_062007.pdf.

[82] *See* Ohio Farm Bureau Federation, Inc. v. Commissioner, 106 T.C. 222 (1996) (one-time payment for noncompete was not an activity "regularly carried on" by the taxpayer).

share (whether or not distributed) of the gross income of the partnership from the unrelated trade or business and its share of the partnership deductions directly connected with that gross income. This pass-through approach would apply to any CIO organized as an LLC and treated as a partnership for federal tax purposes (and single member LLCs would be disregarded, leading to the same result if the member is an exempt organization).

In general, subject to certain specific exceptions for specific activities, Section 513(a) defines the term "unrelated trade or business" as any trade or business the conduct of which is not substantially related (aside from the need of the organization for income or funds or the use it makes of the profits derived) to the exercise or performance by the organization of its charitable, educational, or other purpose or function constituting the basis for its exemption under Section 501(a). Note that the substantial relationship is specific to the particular exempt purposes of the organization carrying on the activity, which would be different for a hospital than for a museum. In this regard, the Treasury Regulations provide that a trade or business is "related" to an organization's exempt purposes only if the conduct of the business activities has a causal relationship to the achievement of exempt purposes (other than through the production of income).[83] A trade or business is "substantially related" for purposes of Section 513(a), only if the causal relationship is a substantial one. Thus, to be substantially related, the activity "must contribute importantly to the accomplishment of [exempt] purposes."[84] Section 513(a), therefore, focuses on "the manner in which the exempt organization operates its business" to determine whether it contributes importantly to the organization's charitable or educational function.[85]

The regulations further provide that dual use (or dual purpose) expenses, such as from facilities or personnel used in both related and unrelated trades or businesses, "shall be allocated between the two uses on a reasonable basis."[86] The regulations also state that "[t]he portion of any such item so allocated to the unrelated trade or business activity is proximately and primarily related to that business activity, and shall be allowable as a deduction in computing unrelated business taxable income in the manner and to the extent permitted by section 162, section 167, or other relevant provisions of the Code."[87] In other words, any reasonable methodology is acceptable so long as the expenses themselves are of a type that is deductible under the Code. If dual use expenses are allocated using a reasonable methodology, then the expenses so allocated "are by definition 'proximately and primarily related' to the business. They are therefore 'directly connected with' the unrelated business activity and expressly made deductible by the regulation."[88] Allocations that merely follow the Medicare cost report without adjustments to reflect the differences between cost accounting and tax accounting are likely to be challenged by

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[83] Treas. Reg. § 1.513-1(d)(2)

[84] Treas. Reg. § 1.513-1(d)(2).

[85] U.S. v. American College of Physicians, 475 U.S. 834, 849 (1986).

[86] Treas. Reg. § 1.512(a)-1(c).

[87] *Id.*

[88] Rensselaer Polytechnic Institute v. Commissioner, 732 F.2d 1058 (2nd Cir. 1984), *aff'g*, 79 T.C. 967 (1982); *see also* Treas. Reg. § 1.512(a)-1(c); Disabled American Veterans v. U.S., 704 F.2d 1570 (Fed. Cir. 1983).

the IRS.[89] Although the regulations also provide that "allocations based on dollar receipts from various exempt activities will generally not be reasonable since such receipts are usually not an accurate reflection of the costs associated with activities carried on by exempt organizations," that provision only applies to certain advertising activities and not to UBI activities in general.[90]

Where UBI is derived from an activity that exploits the intangible assets (such as goodwill) derived from an exempt activity of the organization and the exempt activity involved "is a type of activity normally conducted by taxable organizations in pursuance of such [unrelated trade or] business," the usual allocation rules do not apply.[91] In that event, the income remains taxable as UBI but the associated expenses, depreciation and similar items are allocable to the unrelated trade or business only to the extent that the aggregate of all such items exceeds the amount of any income "derived from or attributable to the exempt activity;" and allocating that excess to the activity producing UBI "does not result in a loss from such unrelated trade or business activity" (including a loss carryover or carryback).[92] In applying this special allocation rule, all such items are required to be allocated first to the exempt activity to the extent of any income derived from the exempt activity and only the excess is potentially allocable to the unrelated trade or business. In addition, the expenses cannot be allocated to other trades or businesses that do not exploit the same exempt activity.[93]

Common areas of potential UBI include management services provided to unrelated parties,[94] and lab or pharmacy items or services provided to anyone who is not a patient of the hospital.[95] Some of those items relate to tax accounting methods, particularly for depreciation and bad debt. For management services, there is a reasonable argument that if they are provided to another exempt organization with which the hospital is structurally and financially integrated, or to a joint venture the activities of which are substantially related to exempt purposes, that the management and administrative services needed to operationalize the joint venture also should be substantially related to exempt purposes and not produce UBI.[96] That argument may be strengthened where the services are provided by the exempt organization in its capacity as a managing member or general partner.[97] There are also a variety of exclusions from UBI

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[89] GCM 39843 (April 5, 1991).

[90] Treas. Reg. § 1.512(a)-1(f)(6).

[91] Treas. Reg. § 1.512(a)-1(d)(1) & (2).

[92] Treas. Reg. § 1.512(a)-1(d)(2).

[93] Id.

[94] *See, e.g.*, Rev. Rul. 72-369, 1972-2 C.B. 245.

[95] For examples of whether or not a patient will be viewed as a patient of the hospital for UBI purposes, see Carle Foundation v. U.S., 611 F.2d 1192 (7th Cir. 1979); St. Luke's Hospital of Kansas City v. U.S., 494 F. Supp. 85 (W.D. Mo. 1980); Rev. Rul. 85-110, 1985-2 C.B. 166; Rev. Rul. 85-109, 1985-2 C.B. 165; Rev. Rul. 68-376, 1968-2 C.B. 246; Rev. Rul. 68-374, 1968-2 C.B. 242.

[96] *See, e.g.*, Rev. Rul. 78-41, 1978-1 C.B. 148; TAM 200151045 (July 26, 2001); PLRs 9623011-013 (Feb.. 29, 1996); PLR 9204048 (Oct. 30, 1991).

[97] TAM 200218037 (March 27, 2001).

including for substantially all services in the activity are performed by volunteers,[98] activities conducted for the convenience of patients,[99] dividends,[100] and for royalties, rent, interest and annuities received from other than controlled entities.[101]

Additional rules apply to debt-financed property of exempt organizations under Section 514; however, most ACOs tend not to be debt financed. Section 482 gives the IRS authority to reallocate income and adjustments thereto (i.e., credits, deductions or allowances) among related organizations, trades or businesses as "necessary in order to prevent evasion of taxes or clearly to reflect the income of any of such organizations, trades, or businesses." The Section 482 rules apply to the unrelated trade or business activities of exempt organizations in the same manner as they apply to non-exempt entities. In essence, Section 482 generally requires services to be priced consistent with what would be charged in an arm's length commercial transaction.[102] Use of Section 482 in audits of exempt organizations became more prevalent in the mid-90s. In the event that it is not possible to reach a reasonable resolution with the audit team on transfer pricing issues it may be an appropriate area for technical advice or going to appeals depending on the dollars involved.

B. Expense Allocations

In computing UBI, tax-exempt hospitals may need to determine which hospital expenses should be allocated to the CIO and other operations. Although allocations may be challenged on audit, taxpayers have a fair amount of flexibility in making such allocations on an ongoing basis if they can provide sufficient documentation of their approach. In that regard, the regulations clearly state that dual use expenses, such as from facilities or personnel used in both related and unrelated trades or businesses, "shall be allocated between the two uses on a reasonable basis."[103] The regulations go on to state that "[t]he portion of any such item so allocated to the unrelated trade or business activity is proximately and primarily related to that business activity, and shall be allowable as a deduction in computing unrelated business taxable income in the manner and to the extent permitted by section 162, section 167, or other relevant provisions of the Code."[104] These standards have been interpreted by the courts in a manner that provides some flexibility to

[98] Code § 513(a)(1).

[99] Code § 513(a)(2).

[100] Code § 512(b)(1).

[101] Code § 512(b)(1)-(3) & (13).

[102] With respect to rental arrangements, the Regulations provide that "an arm's length rental charge shall be the amount of rent which was charged, or would have been charged for the use of the same or similar property, during the time it was in use, in independent transactions with or between unrelated parties under similar circumstances considering the period and location of the use, the owner's investment in the property or rent paid for the property, expenses of maintaining the property, the type of property involved, its condition, and all other relevant facts." Treas. Reg. § 1.482-2(c)(2)(i). Section 482 rental amounts also may be reduced for any Section 514 debt financed property.

[103] Treas. Reg. 1.512(a)-1(c) (emphasis added).

[104] *Id.*

taxpayers in developing a reasonable allocation methodology. If dual use expenses are allocated using any reasonable methodology, then the expenses so allocated "are by definition 'proximately and primarily related' to the business. They are therefore 'directly connected with' the unrelated business activity and expressly made deductible by the regulation."[105]

Arguments that the IRS has raised on audit regarding expense allocation methodologies include whether the Section 512 regulations require exempt organizations, in computing UBI, to exclude all or a portion of costs of personnel who do not work on any unrelated business activity on Sundays or other specific days or shifts. Following such approach would require a detailed position-by-position, day-by-day and perhaps hour-by-hour review of activities of dual use personnel and facilities. The regulations and technical guidance, however, do not require an hour-by-hour accounting. Moreover, the argument for such a micro-level allocation may incorrectly assume, among other things, that (1) unrelated activities (e.g., non-patient lab tests) are conducted on particular days or shifts, and (2) personnel costs are the same on weekends (when in fact pay grades tend to be lower and staffing leaner).

Because UBI is computed on the basis of a full tax year, the relevant question should be whether the items or services for which expenses being allocated are of the same type that are used at any point during the tax year in connection with an unrelated trade or business of the taxpayer. Accordingly, questions of whether expenses for weekend or evening shifts should be counted in determining unrelated business taxable income is a question of allocation – not a question of whether they should be included but how much is sufficiently related to the UBI activities.

For further support, taxpayers may cite federal case law and IRS advice and rulings holding that prior to making a reasonable allocation, the taxpayer is not required to first establish that the expense would not have been incurred in the absence of the unrelated business activity.[106] The courts also have clearly approved the use of relative amounts of gross revenues, from related and unrelated businesses, as a means of allocating dual use expenses.[107]

The regulations also expressly provide for allocation of dual use expenses between related and unrelated business activities, and the only limitations on what comprises the pool of deductible dual use expenses are that they must be the type of expenses that are otherwise deductible under the Code (e.g., Section 162 business expenses) and they must be for items or services used at least in part to further or support an unrelated trade or business of the taxpayer.

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[105] Rensselaer Polytechnic Institute v. Commissioner, 732 F.2d 1058 (2nd Cir. 1984), aff'g, 79 T.C. 967 (1982); *see also* Treas. Reg. 1.512(a)-1(c); Disabled American Veterans v. U.S., 704 F.2d 1570 (Fed. Cir. 1983)). Although the Medicare cost report is not necessarily an acceptable allocation for tax purposes, the IRS has acknowledged it may be the starting point for such calculations, subject to adjustments necessary to reflect the different purposes of the tax laws. Specifically, the hospital must demonstrate that the relevant Medicare costs "(1) are allowable deductions under the Internal Revenue Code, (2) are directly connected to [the] unrelated trade or business (i.e., bear a proximate and primary relationship) and (3) clearly reflect income. GCM 39843 (April 5, 1991).

[106] *See* Rensselaer Polytechnic Institute v. Commissioner, 732 F.2d 1058 (2nd Cir. 1984); Field Service Advice 658 (April 1, 1992); PLR 9837031 (Sept. 11, 1998).

[107] *See* Disabled American Veterans v. U.S., 704 F.2d 1570 (Fed. Cir. 1983); Portland Golf Club v. Commissioner, 497 U.S. 154 (1990).

Beyond that, however, a taxpayer is permitted to apply any reasonable method of allocation to the pool of dual use expenses and the resulting allocation should by definition be deemed to be proximately and primarily related to the unrelated business activity. Neither the Code, nor the regulations, nor any case law or IRS ruling require a more specific line item by line item scrutiny of what expenses may be counted in the pool (e.g., no requirement to scrutinize each shift of each employee to assess the amount of UBI-related activity).

Other issues with expense allocations that the IRS may raise on audit include: (1) extent to which purported UBI services were provided to medical staff, retirees, and volunteers which may be considered substantially related to exempt purposes; (2) differences in reporting, expense tracking and discounts among different locations of the taxpayer; and (3) ability to track and document patient classifications (as patient/non-patient of the hospital).[108]

V. Risk Bearing Entities

A. Commercial-Type Insurance

The actual nature and scope of a typical CIO's services are evolving. Some services now performed by CIOs historically were performed by insurers, and some CIOs may be moving toward accepting risk for the costs of care where permitted by state law. Section 501(m) of the Code provides that an organization that provides commercial-type insurance as a substantial part of its activities is disqualified from 501(c)(3) or (c)(4) status.[109] Now withdrawn HMO audit guidelines on Section 501(m) included a 15% safe harbor for activities that would not be considered substantial, which is consistent with case law defining "substantial" in other contexts.[110] Other organizations providing an insubstantial amount of commercial-type insurance are taxed on the affected income as UBI with the tax determined as if it were an insurance company under Subchapter L of the Code (which includes special rules regarding the tax treatment of reserves). These rules are subject to certain exceptions, such as for incidental health insurance provided by HMOs.[111]

The IRS has taken the position that point of service products offered by HMOs constitute commercial-type insurance and do not fit within the incidental health insurance exception;[112] however, the current HMO audit guidelines are silent on the treatment of point of service products, merely noting them as one benefit option and method of compensating providers.[113] In

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[108] For further discussion of expense allocation issues, see J. Bloom, "Offsetting Expenses Against UBI Can Be an Allocation Headache for Tax-Exempts," Taxation of Exempts (July/Aug. 1996).

[109] *See* GCM 39829 (Aug. 24, 1990).

[110] Internal Revenue Manual Chapter 27, [7.8.1] 27.10.1 (05-25-1999); *see also* . Haswell v. U.S., 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"); Rev. Rul. 71-529, 1971-2 C.B. 234 (less than 15% was not "substantial").

[111] Code § 501(m)(3)(B).

[112] *See* GCM 39829 (Aug. 24, 1990); TAM 200033046 (April 27, 2000).

[113] Internal Revenue Manual 4.76.31.2(2) & 4.76.31.3.1.1(2)(E) (May 15, 2003).

other respects, "commercial type insurance" is also broadly defined as any type of insurance available to the public from any carrier without reference to specific features of a custom policy.[114] The IRS has not yet issued regulations under Section 501(m) despite it being on the books since 1986. Detailed audit guidelines under Section 501(m) provided some guidance, but they were withdrawn when a regulations project was announced.[115] That withdrawal was precipitated by a Supreme Court decision that called into question whether HMO arrangements could be viewed as purely pre-payment for services, the underlying rationale for much of the prior 501(m) guidance.[116] The current HMO audit guidelines do little more than restate Section 501(m) of the Code in summary fashion.[117] Other guidance issued to date is arguably inconsistent.

In analyzing whether an HMO is engaged in commercial-type insurance activity, the IRS has focused on the physician compensation methodology, particularly for primary care "gatekeeper" physicians, looking for indicia that significant risk has been transferred to the providers such as through capitation, substantial discounts and substantial withholds, with a realistic possibility of losing a substantial portion or all of the at-risk compensation.[118] For example, in two different cases, the IRS found that (a) providers receiving capitated payments were simply receiving prepayment for services and did not assume insurance-type risk,[119] and (b) an HMO paying providers on a capitated basis did not retain any insurance-type risk.[120] Although such guidance as exists on Section 501(m) is minimal and arguably inconsistent, the IRS has since relied on Section 501(m) to deny or revoke tax-exempt status – though it is not possible to tell from those public rulings how effectively the IRS position was contested, if at all.[121]

B. HMO Exemption

Even apart from application of Section 501(m), the IRS position appears to continue to be in flux regarding exemption for HMOs. A CIO that evolves to the point of being a risk bearing entity that employs physicians and operates medical facilities should qualify for 501(c)(3) status (assuming no disqualifying issues such as inurement or more than incidental private benefit).[122]

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[114] Paratransit Insurance Corp., 102 T.C. 745 (1994).

[115] *See* Notice 2003-31, 2003-21 I.R.B. 948.

[116] Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002).

[117] Internal Revenue Manual 4.76.31.9 & 4.76.31.10 (May 15, 2003).

[118] *See, e.g.*, GCM 39829 (Aug. 24, 1990); TAM 9412002.

[119] PLR 200044039 (Aug. 3, 2000). *See also* PLR 9246004 (July 22, 1992); Rev. Rul. 68-27, 1968-1 C.B. 315; Jordan v. Group Health Association, 107 F.2d 239 (1939).

[120] TAM 200033046 (April 27, 2000).

[121] *See, e.g.*, PLR 201218017 (Feb. 8, 2012); PLR 201022029 (March 8, 2010); PLR 200941038 (July 14, 2008); PLR 201321036 (April 4, 2007).

[122] See Sound Health Association v. Commissioner, 71 T.C. 158 (1979); Rev. Rul. 69-545, *supra*.

Other managed care organizations affiliated with hospitals, and with significant patient overlap as well as Medicare and Medicaid business, have failed to qualify for 501(c)(3) status in recent years either based on their own activities or as an integral part of the hospital or health system.[123] Nevertheless, they generally have been able to qualify for 501(c)(4) status,[124] with one exception that is arguably an aberration and operated as more of a loose discount network.[125] For an in-depth discussion of the exemption criteria for Section 501(c)(4) HMOs and similar organizations, please refer to the materials for Session F. – How the IRS Assesses HMOs for 501(c)(4) Status Today (we think!).

C. Accountable Care Organizations

The manner of accomplishing shared financial risk through an ACO may also raise exemption concerns (for the ACO itself or for exempt organizations participating in an ACO) under Section 501(m), which precludes 501(c)(3) or (c)(4) status for any organization engaged in substantial commercial-type insurance activity.[126] As explained above, the term "commercial-type insurance" has been broadly defined to mean coverage of the type available on the commercial market regardless of particular terms or program features,[127] or cost differentials in coverage.[128] On the other hand, there appears to be strong public policy in favor of ACOs, and the IRS has not been very active in attempting to apply Section 501(m) to health care organizations, perhaps given the lack of any implementing regulations despite the law being on the books for 25 years. (For a discussion of one MSSP ACO recognized by the IRS as a Section 501(c)(3) organization, please see Section II.D above.)

VI. Tax-exempt Bonds

A. Private Use

Most nonprofit hospitals and certain nonprofit HMOs and clinics are beneficiaries of tax-exempt bond financing or are part of an obligated group or similar financing structure that issues or benefits from tax-exempt bonds. In order to maintain the exemption from federal income tax for interest on "qualified 501(c)(3) bonds" issued after 1986, private use generally must be limited to no more than five (5%) percent (measured over the life of the bonds), and all private

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[123] Geisinger Health Plan v. Commissioner, 985 F.2d 1210, 1291 (3rd Cir. 1993); IHC Health Plans v. Commissioner, 325 F.3d 1188 (10th Cir. 2003).

[124] See, e.g., GCM 39830, nn. 8 & 9 (Aug. 24, 1990); GCM 39829 (Aug. 24, 1990); Exemption Ruling for IHC Health Plans, Inc. (Nov. 1, 2005) and Exemption Ruling for IHC Care, Inc. (Nov. 1, 2005), reprinted in, Daily Tax Report (BNA), No. 219 (Nov. 15, 2005).

[125] Vision Service Plan v. U.S., 101 AFTR 2d 2008-656, 265 Fed. Appx. 650 (9th Cir. 2008).

[126] Note, however, that if the ACO participates in the MSSP, even in a risk bearing model, existing IRS guidance discussed in Section II.B likely trumps any 501(m) concern.

[127] *See* Florida Hosp. Trust Fund v. Commissioner, 103 T.C. 140 (1994), *aff'd on other grounds*, 71 F.3d 808 (11th Cir. 1996).

[128] *See* Paratransit Ins. Corp. v. Commissioner, 102 T.C. 745 (1994).

uses are aggregated for purposes of applying the 5% limit (which typically includes 2% for costs of issuance leaving only 3% for other private uses).[129] Private use may arise out of an ownership interest or lease of bond-financed facilities or equipment, a management or incentive payment contract and certain other arrangements (potentially including certain non-governmentally sponsored research) with any person or entity that is not a qualified user. The IRS generally takes the position that service contracts with for-profit physician groups providing professional medical services involving the use of bond financed property constitute private use.[130] On the other hand, the mere granting of staff privileges, use by the general public, use by agents of the qualified user and certain incidental or temporary uses are not private use.[131]

The laws that exempt interest on bonds from most federal income taxation thus distinguish between use of the bond-financed facilities by a "qualified user" and use by a "nonqualified user." A "qualified user" is (1) a state or political subdivision of a state or (2) a 501(c)(3) organization (which could include a tax-exempt clinic, hospital or HMO as long as it is a 501(c)(3) and not a 501(c)(4) organization) so long as the facilities in question are not used in an unrelated trade or business.[132] A "nonqualified user" means any other individual or entity (excluding use as part of the general public).[133] For example, use of bond-financed property by a hospital's taxable clinic subsidiary or hospital-physician imaging center joint venture or under contract with a medical group, and use by their respective employed or contract physicians, may constitute private use unless it is within a safe harbor or fits within the 5% *de minimis* exception for all private use in the aggregate or certain incidental uses.

B. Management Contract Safe Harbors

Revenue Procedure 97-13 sets out various safe harbors for management and other service contracts related to the operation of an entire hospital or a department that includes bond-financed space. In general terms, compensation must be reasonable and it must not be based in whole or in part on a share of net profits from the operation of the facility, and the parties must not be related in a manner that would tend to restrict the qualified user's ability to exercise its termination rights under the contract.[134] In addition, the contracts must fit certain term and termination parameters that vary based on the compensation methodology used in the contract. Fees may be subject to an automatic adjustment to match changes in the consumer price index (CPI).[135] The following table summarizes the compensation, term and termination elements of the safe harbors. Generally speaking, the higher the proportion of compensation that is

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[129] Code §§ 103, 141, 145; Treas. Reg. §§ 1.141-3(g) & 1.145-2.

[130] Treas. Reg. § 1.141-3(b); Rev. Proc. 97-13, 1997-1 C.B. 632, § 2.01.

[131] Treas. Reg. § 1.141-3(b)(4)(iii), (c) & (d).

[132] Rev. Proc. 97-13, 1997-1 C.B. 632, § 3.07; Rev. Proc. 2007-47, 2007-29 I.R.B. 108, § 3.02.

[133] *See, e.g.*, TAM 200006049 (Oct. 22, 1999); Code § 7701(a) (definition of "person").

[134] Treas. Reg. § 1.141-3(b)(4)(i); Rev. Proc. 97-13, 1997-1 C.B. 632 § 5.01.

[135] Rev. Proc. 97-13, 1997-1 C.B. 632, §§ 3.02, 3.05 & 3.06, *amended by*, Rev. Proc. 2001-39, 2001-2 C.B. 38.

represented by a fixed fee the longer the term the contract may have as illustrated in the summary table:

Compensation	**Maximum Term**	**Minimum Termination Rights**
95% or more is a fixed fee (*i.e.*, set dollar amount per unit of time such as $X per month that may increase automatically based on a "specified, objective, external standard" such as changes in the CPI) plus one-time incentive fee payment	Lesser of 15 years or 80% of useful life of financed property	N/A
80% or more is a fixed fee plus one-time incentive fee payment	Lesser of 10 years or 80% of useful life of financed property	N/A
50% or more is a fixed fee, 100% capitated, or a combination of a capitation fee and a fixed fee	5 years	On reasonable notice at end of 3rd year
100% per unit fee (*e.g.*, per read) or a combination of a fixed fee and a per unit fee; this includes "bill and collect" contracts where the PC bills patients or third parties directly	3 years	On reasonable notice at end of 2nd year
100% based on percentage of fees charged or a combination of a per unit fee and a percentage of revenue or expense (not both) fee	2 years	On reasonable notice at end of 1st year
During a start-up period only, compensation may be based on a percentage of either gross revenues, adjusted gross revenues, or expenses of a facility.	2 years	On reasonable notice at end of 1st year

Contracts that may result in private use but do not fit within the terms of a safe harbor must be analyzed on a facts and circumstances basis. Absent clear guidance from the IRS such as in a private letter ruling,[136] bond counsel may insist on approaching the IRS for a private letter ruling as to the treatment of such contracts under the private use rules.

[136] See, e.g., PLR 201338031 (May 28, 2013) (compensation methodology for management of a hotel); PLR 201338026 (May 13, 2013) (compensation methodology for medical group management services); PLR 201228029 (March 30, 2012) (compensation methodology for management of an electric transmission and distribution system); PLR 201145005 (Aug. 4, 2011) (compensation methodology for management of a convention center); PLR 200926005 (March 17, 2009) (physician professional services agreements).

Private use also may result from certain research contracts involving the conduct of research at bond-financed facilities or with bond-financed equipment. The IRS has issued two safe harbors for avoiding private use from "basic research" (i.e., for general scientific knowledge rather than specific commercial objectives – for example, testing the sponsor's products would not be basic research) funded by outside sponsors.[137] First, certain corporate-sponsored research will be excluded from private use where the sponsor pays a fair market value rate for a license of the resultant technology (including taking into account the value of an exclusive license). Second, industry or federally-sponsored research that is directed by the qualified user who retains title to any resulting patent or other product and grants the sponsor(s) no more than a nonexclusive, royalty free license, and the arrangement is subject to the "march-in rights" and other rights of the federal government under the Bayh-Dole Act.[138]

C. Application of Private Use Rules to CIOs

To date, the IRS has not provided any specific guidance on the potential application of the private use rules to ACOs and other CIOs. Based on existing guidance in other areas, however, there are four possible arguments on private use, particularly if the activity results in UBI.

First, if the ACO/CIO is itself a 501(c)(3) organization or if it is operated as a division or single member LLC of the tax-exempt hospital, there would be no private use as long as the ACO's operations are not an unrelated trade or business as to the hospital.[139] The extent to which non-MSSP ACOs and CIOs qualify for exempt status or constitute an unrelated trade or business for the affiliated nonprofit hospitals, however, remain open questions.

Second, it is at best debatable whether the intended activities of an ACO or CIO would actually constitute use of the hospital. Mere ownership of an interest in an ACO or CIO by the hospital does not constitute private use. Although private use may be through ownership, it is ownership of, not by, the tax-exempt hospital that creates a private use issue.[140] If the ACO or CIO has a physical office, it may be possible to locate it outside of bond-financed space, perhaps in an MOB owned by a private developer or physician group rather than a formal or de facto lease of space in a hospital or other bond-financed space.[141] At present, the typical ACO or CIO does not manage any patient care service line of the affiliated hospitals. An ACO or CIO may have control or significant influence over patient care protocols for the hospital's medical staff or a significant portion thereof; however, the IRS has long taken the position that holding medical

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[137] Rev. Proc. 2007-47, 2007-29 I.R.B. 108.

[138] 35 U.S.C. § 200 *et seq*.

[139] See, e.g., Determination Letter for Methodist Patient Centered ACO (Aug. 7, 2014) (Dallas); GCM 39830, n. 9 (IRS recognized that a hospital operating a non-staff model HMO as a division likely would not have UBI from its activities even thought they are not substantially related to the performance of its charitable activities because the HMO activities may be described in Section 501(c)(4)).

[140] Treas. Reg. § 1.141-3(b)(2); Rev. Proc. 97-13, § 2.01(3) & (4).

[141] Treas. Reg. § 1.141-3(b)(3) (leases as private use).

staff privileges (which by definition includes following hospital procedures and protocols applicable to a department or the entire staff) does not alone constitute private use.[142] Likewise, if the hospital's only obligation is to reimburse the ACO/CIO for costs paid to third parties, it likely would not constitute private use.[143]

Third, if there is private use, the amount of private use may fit within a *de minimis* exception for private use (e.g., 5% less issuance costs). Private use is measured over the life of the bonds. There may be more restrictive covenants, however, in the applicable bond documents. For example, it is not unusual for the issuer to either preclude reliance on the *de minimis* exception (given the small margin for error) or require a favorable opinion from bond counsel confirming that the proposed private use does not jeopardize the tax-exempt status of interest on the bonds.

Fourth, it may be possible to structure all contractual commitments between the hospital and the ACO/CIO to fit within the management contract safe harbors described above. The length of the permitted term will depend on the compensation methodology, though funding ACO/CIO losses may not fit neatly in any of the safe harbors.

The Priority Guidance Plan for 2014-2015 includes two items that when finalized may resolve the question of how the private use rules and safe harbors apply to ACOs and other CIOs, guidance under Section 141 regarding ACOs and updating the Rev. Proc. 97-13 management contract safe harbors.[144]

VII. Compensation and Distribution Plans

A. Acquisition and Sale of CIOs

At this point in time, it is too early in the life cycle of most ACOs and CIOs to have any significant sale transactions involving these organizations, i.e., no or only minimal market data. Such transactions, however, are likely not that far in the future as the health care market continues to evolve. When the ACO or CIO is sold by or to an exempt organization, or has an exempt organization as an owner/member, it will be important to ensure that the sale price is consistent with fair market value as defined for federal tax purposes—just as it is critical to ensure that ongoing financial relationships between an exempt organization and a commercial ACO or CIO are consistent with fair market value.

For federal tax purposes, fair market value is generally defined as the price at which a willing buyer and a willing seller would agree to transfer property, neither being under any compulsion to buy or sell and both having a reasonable knowledge of the relevant facts.[145] The

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[142] Treas. Reg. § 1.141-3(b)(4)(iii)(B).

[143] Treas. Reg. § 1.141-3(b)(4)(iii)(D).

[144] Department of Treasury 2014-2015 Priority Guidance Plan, p. 26, Tax-Exempt Bonds ¶¶ 4 & 5, available online at http://www.irs.gov/file_source/pub/irs-utl/2014-2015_pgp_initial.pdf.

[145] Rev. Rul. 59-60, 1959-1 C.B. 237.

excess benefit regulations provide that appropriate data as to comparability for determining reasonableness and fair market value for property includes, but is not limited to, "current independent appraisals of the value of all property to be transferred; and offers received as part of an open and competitive bidding process."[146]

Generally when an organization purchases tangible and intangible assets from an independent third party in arm's-length negotiations, there is a presumption that the negotiated price represents fair market value. Where the seller, however, is in a position to exercise influence or control over the purchaser at the time of the sale and the transaction is not at arm's length, that presumption does not apply and the value of the assets must be established by independent appraisal.[147] In the IRS' view, when a hospital acquires the practices of staff physicians and retains them to provide professional services after the acquisition, "the existence of arm's length bargaining may be questionable."[148] In those circumstances, the IRS notes that "the best determinant of fair market value is a properly performed, unbiased valuation appraisal of the medical practice."[149] Further, intangible assets should be purchased only for a use directly and substantially related to exempt purposes.[150]

The IRS prefers that appraisals include consideration of three common approaches as cross-checks: *income* (cash flow available for distribution, discounted to present value), *market* (comparable sales), and *cost* (reproduction or replacement cost, less deterioration or obsolescence). The IRS generally prefers the income approach for practice acquisitions, using discounted cash flow determined on an after-tax basis with realistic assumptions of revenue growth and market supportable discount rates.[151] There may be insufficient comparables to use a market approach, and the cost approach generally does not include a value for intangibles, but they can be used as comparisons for reasonableness of the income approach.[152] Earnings before depreciation, interest, taxes, and amortization ("EBDITA") is a common method of comparing business investments, although, consistent with its preference for after-tax valuations, the IRS adds back a tax factor.[153]

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[146] Treas. Reg. § 53.4958-6(c)(2)(i).

[147] *See* Rev. Rul. 76-91, 1976-1 C.B. 150.

[148] C.F. Kaiser and A. Henchey, *Chapter Q: Valuation of Medical Practices, in* IRS EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM FOR FY 1996, 408, available online at http://www.irs.gov/pub/irs-tege/eotopicq96.pdf (hereafter, "FY1996 CPE Text, Ch. Q").

[149] Id.

[150] *See* Rev. Rul. 76-91, 1976-1 C.B. 150.

[151] *See* C.F. Kaiser, P.D. Haney & T.J. Sullivan, *Chapter L: Integrated Delivery Systems and Joint Venture Dissolutions Update, in* IRS EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM FOR FY 1995, 162-69 (hereafter, "FY1995 CPE Text, Ch. L"); Exemption Ruling for Harriman Jones Medical Foundation (Feb. 3, 1994).

[152] Key points of a discounted cash flow analysis are outlined in more detail in the FY 1996 CPE Text, Chapter Q. Kaiser and Henchey, "FY1996 CPE Text, Ch. Q," *supra*.

[153] See FY 1996 CPE Text, Chapter Q, Exhibit A.

Obtaining an independent appraisal that on its face supports the purchase price as being fair market value will not always be sufficient even to protect tax-exempt status. Examples of where the IRS or the courts have disregarded the conclusions in independent appraisals include:

- Unreasonable assumptions as to discount rate, future revenue or expenses (e.g., failure to account for change in pay scale);[154]
- Overly optimistic projections after an extended history of losses and alleged evidence of an intent to overpay to secure referrals;[155]
- Omitting key assets or relying on a stale appraisal;[156]
- Changes in law that are likely to affect future revenues or prohibiting the current owners from continuing to hold an interest in the business.[157]

B. Compensation from Exempt Organizations

It is important to assess payments from an ACO/CIO to physicians, especially when the ACO/CIO is funded by a hospital or other tax-exempt organization. In determining whether salaries paid to physicians are reasonable, the IRS and courts will consider not only the duties and responsibilities of the physician, but also the amounts received by physicians having similar responsibilities and holding comparable positions at similar organizations.[158] It should be emphasized, however, that to qualify for tax-exempt status under Section 501(c)(3) of the Code an organization not only must establish that compensation paid to its employed and contracted physicians are reasonable, but also that the employed and contracted physicians' compensation are not merely a disguised distribution of the organization's profits but are in fact paid in return for valuable services.[159] Accordingly, compensation should relate to services performed, and an arrangement will be suspect if it rewards physicians for the financial performance of a department or activity for which they perform no significant personal or supervisory services.[160]

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[154] C.F. Kaiser and A. Henchey, *Chapter Q: Valuation of Medical Practices, in* IRS EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM FOR FY 1996, 408, available online at http://www.irs.gov/pub/irs-tege/eotopicq96.pdf.

[155] Letter of Revocation (LAC Facilities Inc., f/k/a Modern Health Care Services, Inc.) (June 16, 1994), published in Daily Tax Rep. (BNA), L-2 – L-3 (Nov. 2, 1994); TAM 9451001 (April 14, 1994).

[156] *See* Anclote v. Commissioner, *supra* (omitted approved CON for additional beds and ignored three more recent comparable transactions, appraisal report was delivered 18 months prior to the sale).

[157] See C.F. Kaiser, P.D. Haney & T.J. Sullivan, Chapter L: Integrated Delivery Systems and Joint Venture Dissolutions Update, in IRS EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM FOR FY 1995, 162, 176-81 (attempts to unwind a physician-hospital joint venture may themselves raise private inurement concerns if valuations do not take into account changes in referral patterns to comply with the Stark Law), available online at http://www.irs.gov/file_source/pub/irs-tege/eotopicl95.pdf.

[158] *See, e.g.*, Rev. Rul. 69-383, 1969-2 C.B. 280; B.H.W. Anesthesia Found. v. Commissioner, 72 T.C. 681 (1979); University of Maryland Physicians, P.A. v. Commissioner, 41 T.C.M. (CCH) 732 (1981).

[159] *See* Sonora Community Hosp. v. Commissioner, 46 T.C. 519, 525-26 (1966), *aff'd per curiam*, 397 F.2d 814 (9th Cir. 1968); Lorain Avenue Clinic v. Commissioner, 31 T.C. 141 (1958); GCM 38394 (June 2, 1980).

[160] *See Sonora Community Hospital*, 46 T.C. 519.

Prohibited private inurement or more than incidental private benefit may be present where there is a high degree of correlation between (1) fees generated by the physicians and their total compensation, with a higher percentage of return suggesting the private practice of medicine for profit rather than a charitable activity;[161] or (2) a physician's compensation and the ratio of the physician's individual fees to the revenues of the venture.[162]

The excess benefit regulations provide that appropriate data as to comparability for determining reasonableness and fair market value with respect to compensation for services includes, but is not limited to:

> . . . compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions; the availability of similar services in the geographic area of the applicable tax-exempt organization; current compensation surveys compiled by independent firms; and actual written offers from similar institutions competing for the services of the disqualified person.[163]

To date, the IRS has not provided express guidance on when distributions of shared savings from an ACO or other CIO may result in inurement, more than incidental private benefit or an excess benefit. Existing guidance for incentive compensation generally, however, provides a useful framework for the analysis. In that regard, private inurement and more than incidental private benefit to physicians and other employees or contractors, including executives, may be alleged to result from any compensation formula which is determined to be a means of sharing the profits or net earnings of the exempt organization with the private party. However, it will not be an "excess benefit" unless the private party is a disqualified person and the compensation exceeds fair market value of the service or is not properly reported or documented as compensation.[164] The IRS has repeatedly concluded that percentage-based incentive compensation is permissible for exempt organizations so long as total compensation is reasonable and the incentive arrangement is not a disguised distribution of profits.[165] In that regard, the common safeguards the IRS looks for in incentive compensation arrangements are:

1. The employee receiving the compensation has no participation in management or control of the organization and his or her relationship with the organization is completely arm's length.

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[161] *See* GCM 38394.

[162] *See Lorain Avenue Clinic*, 31 T.C. 141; University of Massachusetts Medical School Group Practice v. Commissioner, 74 T.C. 1299 (1980); *acq.*, AOD 1980-176, 1980-2 C.B. 2 (where member-physician salaries bear no relation to fees generated by the individual member and the total compensation is reasonable, the salary plan did not result in inurement or more than incidental private benefit).

[163] Treas. Reg. § 53.4958-6(c)(2)(i).

[164] *See* Rev. Rul. 69-383, 1969-2 C.B. 280; Treas. Reg. §§ 53.4958-4(a)(1) & (5 (reserved)).

[165] This view is reiterated in the Hospital Audit Guidelines as to recruiting incentives. Announcement 92-83, 1992-22 I.R.B. 22, § 333.3(5).

2. The contingent payment serves a real and discernible business purpose of the exempt organization independent of any purpose to operate the organization for the direct or indirect benefit of the employee (*e.g.*, the organization may want to achieve maximum efficiency and economy in operations by shifting away the principal risk of operating costs to the service provider to reduce the organization's need to carry large insurance-type reserves).

3. The amount of compensation is dependent upon the accomplishment of the objectives of the compensatory contract and is not dependent principally upon incoming revenue of the exempt organization (*e.g.*, the success of the exempt organization and the service provider in keeping actual expenses within the limits of projected expenses upon which the ultimate prices of charitable services are based).

4. A review of the actual operating results reveals no evidence of abuse or unwarranted benefits (*e.g.*, through manipulation of receipts and expenditures or other showing that charges and costs do not compare favorably with those of similar organizations), or safeguards exist to prevent such abuse (*e.g.*, provisions of the governance documents of the exempt organization, or the written compensation agreement).

5. There is a ceiling or reasonable maximum amount that avoids the possibility of a windfall benefit to the employee based upon factors bearing no direct relationship to the level of service provided.[166]

The IRS has applied a substantially similar approach to gainsharing programs in two unpublished private letter rulings and one Information Letter.[167] INFO 2002-0021 related to a CMS gainsharing demonstration program for Cardiovascular and Orthopedic services. The program involved payment of a global fee that would be allocated between the hospital and physician participants. The upside and downside risk to the physicians was capped at 25% of a Medicare fee for service payment. Incentive payments were based on a share of aggregate cost savings of Medicare patients discharged under the same DRG (diagnosis related group) or group of related DRGs, and receipt of any savings was conditioned on the hospital and physician

[166] GCM 38322 (March 24, 1980) (Section 501(c)(9) organization); *see also* GCM 32453 (Nov. 30, 1962) (Section 501(c)(4) organization); GCM 38905 (June 11, 1982) (Section 501(c)(3) organization); GCM 39674 (June 17, 1987) (Section 501(c)(3) organization); People of God Community v. Commissioner, 75 T.C. 127, 132 (1980) (minister's compensation equal to 69 – 86% of gross contributions with no cap on total compensation – held, inurement); Klamath Medical Service Bureau v. Commissioner, 261 F.2d 842 (9th Cir. 1958) (distributions in excess of 100% of billings *per se* unreasonable under Section 23(a) of 1939 Code); H.R. 104-506 at n. 4 (July 30, 1996) (legislative history of Section 4958, citing favorably GCM 38283, 38905 and 39674). Setting a cap on total compensation is also important for purposes of establishing a rebuttable presumption of reasonableness for non-fixed payments. *See* Treas. Reg. § 53.4958-6(d)(2)(ii).

[167] See INFO 2002-0021 (Jan. 9, 2002), available online at http://www.irs.gov/pub/irs-wd/02-0021.pdf; B. Yuill, Government Officials Discuss Gainsharing; IRS 'Reluctant' to Issue Favorable Rulings, Daily Tax Rep. (BNA), at G-3 (Aug. 4, 1999). Neither the unpublished rulings nor INFO 2002-0021 specifically addressed the application of the private use rules and related safe harbors to gainsharing arrangements.

meeting the quality standards of the program, with quality performance monitored by CMS.[168] Patients were informed of the program upon admission and provided with information regarding the incentive plan and annual distributions upon request. All staff physicians at the hospital with the appropriate privileges and licensure were included in the incentive plan, including both hospital-employed physicians and independent medical staff. The Information Letter explained that in examining physician incentive compensation arrangements, the IRS has generally considered the following factors:

1. Whether the compensation was approved by an independent board of directors or compensation committee that is subject to a "substantial conflicts of interest policy";

2. Whether the plan results in total compensation that is reasonable;

3. Whether there is an arm's length relationship between the hospital and the physician or whether the physician is in a position to manage or control the organization in a manner that affects his or her compensation;

4. Whether there is a cap on total incentive payments "to protect against projection errors or substantial windfall benefits";

5. Whether the incentive plan has the potential for reducing charity care;

6. Whether the plan takes into account data measuring quality of care and patient satisfaction;

7. Whether any net revenue based component is directly related to ensuring that the hospital furthers its charitable purposes, such as by controlling expenses where expenses affect fees charged to patients;

8. Whether the plan has the result of transforming the principal activity of the hospital into a joint venture with physicians;

9. Whether the plan is merely a device to distribute profits to insiders;

10. Whether the plan serves a real and discernible business purpose, such as improving efficiencies and economy of operation, that is independent of any purpose to operate the organization in a manner that impermissibly benefits the physicians;

11. Whether the incentive plan results in abuse or unwarranted benefits or has effective e safeguards to avoid basing incentives on increased fees to patients and to guard against unnecessary utilization; and

[168] In this respect, the program provided the IRS with comfort similar to that derived from CMS' role in the MSSP ACO program. See Notice 2011-20, *supra*; Fact Sheet 2011-11, *supra*.

12. Whether the plan only rewards a physician based on his or her personally performed services.

It should be noted that the Information Letter represents a recitation of what the IRS considers to be settled law for incentive compensation arrangements in general. It does not, however, apply those principles to any specific program, even the gainsharing program it references.

Finally, although defectively structured percentage compensation arrangements can still result in inurement or private benefit, they will not result in excess benefit as long as the amounts paid constitute reasonable compensation for the services provided. Treasury has the authority under Section 4958(c)(4) to expand the definition of excess benefit to include revenue sharing arrangements that constitute inurement by promulgating regulations that define inurement in this context. Treasury proposed a revenue sharing rule in the original proposed regulations under Section 4958;[169] however, that provision was omitted from both the temporary and final regulations. Moreover, absent such regulations, it may be difficult for the IRS to argue that an isolated instance of defectively structure revenue sharing arrangements constitutes inurement or more than incidental private benefit.[170]

C. Deductibility

In order for a taxable company to deduct compensation payments under Section 162 of the Code the payments must be reasonable.[171] Determinations of what constitutes reasonable compensation for purposes of Section 162 are similar to standards applied to tax-exempt organizations under Section 4958.[172] For publicly held companies, Section 162(m) of the Code also limits deductibility of employee compensation in excess of $1 million per year. There are exceptions to that $1 million limit for commission payments, certain performance-based compensation, pre-existing binding written contracts in effect on February 17, 1993, and certain benefits including non-taxable benefits.[173]

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[169] 63 Fed. Reg. 41486, 41503 (Aug. 4, 1998) (Prop. Reg. § 53.4958-5); 66 Fed. Reg. 2144, 2167 (Jan. 10, 2001); 67 Fed. Reg. 3076, 3095 (Jan. 23, 2002).

[170] Caracci v. Commissioner, 118 T.C. 379 (2002), reversed and rendered, 456 F.3d 444 (5th Cir. 2006) (IRS did not appeal the portion of the Tax Court opinion overturning revocation of 501(c)(3) status of home health agencies); H. Rept. 104-506 at 59 n. 15 (1996), 1996-3 C.B. 49, 107 ("In general, the intermediate sanctions are the sole sanction imposed in those cases in which the excess benefit does not rise to a level where it calls into question whether, on the whole, the organization functions as a charitable or other tax-exempt organization").

[171] Treas. Reg. § 1.162-7.

[172] Treas. Reg. § 53.4958-4(b)(1)(ii)(A).

[173] Code § 162(m); Treas. Reg. § 1.162-27; Rev. Rul. 2008-13, 2008-10 I.R.B. 518; Rev. Rul. 2008-32, 2008-27 I.R.B. 6.

D. Quality Based Payment Models

Application of the foregoing principles to new payment models for physician services is an evolving area. Historically, physician incentive compensation models have been driven primarily by revenues or RVUs (or wRVUs) generated by the physicians from their personal services, or where permitted by health care regulatory laws (Stark, Anti-kickback, etc.), production of the group or physician extenders. Both revenues and wRVUs are objectively verifiable and typically readily quantifiable, with a wealth of market data to support the payment rates, including publicly available in-depth compensation and productivity surveys. The ACA highlights the change in emphasis in health care payment to a more quality-based system to further the "triple aims" of the MSSP ACO program of better care for individuals, better health for individuals and lower growth in health care costs.[174] Translating these goals into incentive plans for physicians has been described succinctly as reducing the cost of care without reducing quality, or improving quality without increasing costs.[175] These goals are consistent with the application of the community benefit standard to physician financial relationships, a standard which contemplates improvement in cost, quality of and access to care.[176]

Payment models designed to achieve these goals include various bundled payment mechanisms with discounted rates that include both the facility and professional components to be allocated between the hospital and physicians, inpatient stay and all related services within a specific time window (e.g., 30 – 90 days), all post-acute care services, or the inpatient stay and all physician services including readmissions within a specific time window (e.g., 30 days). There is a wide range in the market of how those bundled payments are allocated among the participating providers, including 50/50 splits in approved gainsharing programs, up to 60% in certain Medicare programs, and even more provider favorable splits in commercial programs where the providers also accept downside risk (in some instances subject to safeguards such as a minimum patient population, or retaining some initial portion of savings to cover start-up costs).[177] For primary care physicians, the patient-centric medical home models provide a modest base fee for managing population health, a productivity bonus based on personally performed RVUs, a bonus based on size of the panel (to build the necessary physician infrastructure), and a quality bonus tied to achieving certain quality metrics that tend to lead to reduced costs (e.g., readmission rate, adverse events/malpractice expense, and compliance with available, recognized quality measures).[178]

Another alternative preferred by many hospitals as a physician integration and alignment mechanism is a co-management arrangement. The theory of co-management arrangements is to involve the physicians directly in the management of the clinical service line in which they

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[174] 76 Fed. Reg. 67802, 67803 (Nov. 2, 2011).

[175] C. Bernstein & A. Carty, "Compensating Employed Physicians Under New Reimbursement Models," In-House Counselor, p. 3 (AHLA, March 2014).

[176] See GCM 39862 (Nov. 21, 1991).

[177] C. Bernstein, et al., "Compensating Employed Physicians," *supra* at pp. 4-5.

[178] Id. at pp. 5-6.

provide professional services. Co-management is implemented by delegating management authority over the outpatient and/or inpatient service line to a co-management company (typically an LLC co-owned by the hospital and a physician group) or through service contracts with the physician group. The incentives of hospital and physicians are aligned through the incentive component of compensation. Specifically, the physicians are rewarded through payment of a base fee (to cover costs and perhaps a modest return) and an incentive fee tied to improvement in specific performance standards in the service line, including quality of care and financial performance—benchmarks that may closely resemble those use to determine the amount of distributions in ACOs and CIOs. The reasonableness of the base fee component of co-management compensation packages is often assessed by computing a market rate based on the estimated hours to provide the required services (which may imply a need to document the services rendered such as through time records, time studies or specific deliverables) multiplied by a fair market value hourly rate based on survey data for management and administrative compensation (the "hourly build-up method," which may be described as a cost approach for services).[179]

The incentive component of co-management compensation plans also may be based on the hourly build-up method subject to hitting specific performance thresholds, or on the value in the market of achieving pre-defined performance thresholds. One potential deficiency in practice of the hourly build-up method is that it can be difficult to project the hours that will be required to achieve particular metrics. The latter market approach may be based on a database of comparable components in other co-management arrangements or comparable components of management and administrative services provided by nonphysician vendors. The performance metrics may be based on achieving a particular quality metric threshold (e.g., specific percentage of reduced morbidity and mortality for a patient admitted with a particular diagnosis), operational goal (e.g., developing and implementing clinical protocols for specific diagnoses), or, where permitted for health care regulatory purposes, financial goals. In fact, regulatory concerns may preclude assessing the reasonableness/fair market value of incentive plans based on an income approach because of the risk that such a methodology may be deemed to take into account the volume or value of referrals.[180] Hospitals may cap the incentive component at 50% of the total to fit within the fixed fee management contract safe harbor where the co-management agreement covers the operations of a bond-financed facility (inpatient or outpatient). Compensation consultants also have concluded that a 50/50 split between base and incentive compensation may be reasonable, a higher proportion of base compensation (e.g., 80%) "would seem to diminish the ideals of achieving the pre-established performance objectives."[181]

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[179] *See* A. Brandt, et al., "Valuation of Co-Management Arrangements: Achieving Operational and Quality Improvements Through Hospital/Physician Partnerships," Health Lawyers Weekly (AHLA, Sept. 21, 2007).

[180] Id. There have been several recent cases involving allegations that physician compensation violated the Stark Law or Anti-kickback Statute by taking into account the volume or value of referrals. See, e.g., U.S. ex rel. Drakeford v. Tuomey Healthcare System Inc., 675 F.3d 394, 399 (4th Cir. 2012); U.S. ex. rel. Elin Baklid-Kunz v. Halifax Hospital Medical Center, No. 09-1002 (M.D. Fla. No. 09-1002, Second Amended Complaint filed 2/18/11); U.S. ex rel. Dilbagh v. Bradford Regional Medical Center, 752 F. Supp. 2d 602 (W.D. Pa. 2010).

[181] A. Brandt, et al., "Valuation of Co-Management Arrangements," *supra* at p. 2.

E. "Takes Into Account"

Multiple Stark Law exceptions require that a compensation arrangement with a physician not "take into account" the volume or value of referrals or the value of any referrals or other business generated between the parties, including a wide array of "designated health services" (or "DHS").[182] In other words, the services themselves must have the value paid for, and that value should not exceed what would be paid to obtain the services from an independent source that does not make and is not in a position to make referrals to (or accept referrals from) the purchaser of the services.

Although the Stark regulations do permit an entity providing DHS to mandate referrals related to the scope of the physician's services pursuant to the employment agreement or service contract, this provision is subject to a number of conditions, including that total compensation must be set in advance and that it must be consistent with fair market value for services performed by the physician and "not take into account the volume or value of anticipated or required referrals."[183] The regulations provided specific examples of compensation arrangements that will be deemed not to take into account the volume or value of referrals, including a time-based or per unit of service rate which is fair market value for the items or services actually provided and which does not vary during the term of the agreement in any manner that takes into account referrals of DHS.[184] Court opinions in two recent cases and court filings by the government in two others (including one that recently settled) indicate that the meaning of "takes into account" is potentially far broader than anticipated outside of these safe zones. These recent developments serve as a cautionary note on overly aggressive valuations and bad historical documents that may color a court's perception of a valuation or the terms of the deal itself.

Bradford. In one case, the court concluded that any price that "takes into account" the volume or value of referrals is not fair market value, even if it is a fixed, negotiated amount and even if referrals are not mandated.[185] Factors that caused the court to conclude that the financial terms took into account the volume or value of referrals included (a) considering the financial impact on the hospital of the physicians developing a competing nuclear imaging service in establishing the financial terms of a joint venture, covenant not to compete or other transaction; (b) basing a joint venture valuation on an assumed increase in revenues to the hospital projected to result from referrals by the physician investors; (c) purchasing property (nuclear imaging

[182] 42 C.F.R. § 411.351 et seq.

[183] 42 C.F.R. § 411.354(d)(4).

[184] 42 C.F.R. § 411.354(d)(2). This is a somewhat circular definition with no specific examples provided. Although locking in the rate may be the safest course if for a reasonable duration (generally two or three years with a consultant opinion), it seems apparent that if changes are limited to changes in market value and applied across the board to all employed physicians regardless of referrals it would be difficult in most cases for the government or a relator to successfully argue that the change "takes into account" the volume or value of referrals. Possible measures of changes in market value may include, for example, changes in proportion to changes in the relevant percentile wRVU rate in an independent published physician compensation survey, changes in Medicare or other third party physician fee schedules or changes in the Consumer Price Index related to healthcare services.

[185] U.S. ex rel. Dilbagh v. Bradford Regional Medical Center, 752 F. Supp. 2d 602 (W.D. Pa. 2010).

camera inadequate for hospital's long-term needs) at a substantial price with no intention to use it long term or re-sell it at a profit; (d) basing the billing and collection fee paid to the physicians on a percentage of collections for business they refer; and (e) considering projected profits to the hospital, including from business that would be referred by the physicians. The court noted that simply because the parties negotiated the payment amounts does not by definition establish fair market value. There were, however, no allegations that any of the agreements expressly required the physicians to refer to the hospital; however, there were no other competing facilities in the area.

Several lessons for valuation scenarios are apparent from a review of the opinion in Bradford and the underlying valuation. First, considering the amount of business physicians refer to the hospital in deciding whether to enter into a business transaction is taking into account volume or value of referrals, even if the compensation is limited to expense reimbursement and fixed periodic fees if the total exceeds fair market value (i.e., excess over fair market value potentially takes into account the volume or value of referrals absent another appropriate reason for the excess).[186] Likewise, valuing a noncompete based on anticipated lost revenue to the hospital may be viewed as "taking into account" the volume or value of referrals. A compensation arrangement also may be found to "take into account" the volume or value of referrals even if referrals are not mandated (especially where the hospital is a sole community provider). Under the reasoning of Bradford, other indications that a compensation formula "takes into account" the volume or value of referrals would include (a) considering potential lost revenue to the hospital; basing a determination of value on incremental revenues from referrals anticipated from the contracting physicians; and leasing equipment (or space) that is not needed or will not be used for the duration of the lease.

Tuomey. One solution followed by many hospitals when a traditional recruitment package is not viable (e.g., because the physicians are already practicing in the area and on the medical staff), is to provide part-time work for the physicians to help supplement their income so that the physicians' total compensation from their practices is at a reasonable level. In one case, the relator and the government alleged that the amount of compensation and full-time benefits that the hospital paid to nineteen physicians in various specialties for part-time services as employees at the hospital's outpatient surgery center exceeded fair market value, was not commercially reasonable and impermissibly took into account the volume or value of referrals.

Troublesome aspects of the contract in *Tuomey* included terms of up to ten years, that the physicians remained separately employed for their office practices and inpatient surgeries (though employment by multiple employers is not per se prohibited), basing fair market value off of the physicians' charges rather than collections, the generous nature of the benefits package (full-time benefits for part time work, by contrast, other workers did not receive full-time benefits unless they worked at least 35 hours per week), and a compensation formula that was so favorable it virtually guaranteed that the hospital would lose money on the physician services unless one took into account the value of the technical component generated by the physicians (e.g., the facility fee). The government's expert also disputed the propriety of using

[186] 752 F. Supp. 2d at 625-26 (citing U.S. ex rel. Solinger v. Villafane, 543 F. Supp. 2d 678, 693 (W.D. Ky. 2008).

compensation as a percentage of gross charges as the benchmark for determining fair market value compensation, allegedly attributing value to referrals in valuing the noncompete clauses in the contracts, and the long-term nature of the contract as at least double the norm. The relator alleged that the compensation offered to these physicians was, on average, 131% of their net collections.[187] Note, however, that in some specialties it may be far more common for compensation in the market to be above the amount of professional fee collections (e.g., Cardiovascular Surgery, Medical Oncology). Moreover, The hospital asserted that but for the part-time contracts, a number of the physicians would have left the area thereby exacerbating an already acute physician shortage.

The Fourth Circuit noted that: "It stands to reason that if a hospital provides fixed compensation to a physician that is not based solely on the value of the services the physician is expected to perform, but also takes into account additional revenue the hospital anticipates will result from the physician's referrals, that such compensation by necessity takes into account the volume or value of such referrals." The government also alleged that Tuomey disregarded adverse legal and valuation advice, choosing instead to rely on one favorable opinion and a conclusory four page valuation that included no rationale and failed to even mention the value of the benefits package. The court did note, however, that a determination of whether the contracts "take into account" the volume or value of referrals is a question of fact for the jury to decide from the face of the contract and remanded the case for retrial.[188] Following the second trial, another jury found that Tuomey had submitted over $39 million in false claims, for which the government received a judgment for in excess of $237 million in damages pursuant to the False Claims Act, including penalties ranging from $5,500 to 11,000 per false claim and treble the amount of the underlying claims. For comparison, the hospital's Form 990 for the year ended September 30, 2011 reflected net assets of approximately $124 million. The hospital filed a notice of appeal of the second verdict on October 1, 2013.

Several points of caution emerge from the proceedings to date in ***Tuomey***. First, paying physicians amounts in excess of the value of the services they actually provide to the payor as a means of making them whole and retaining them in the market runs the risk of a Stark Law violation even if the physician's total practice income is still reasonable (*i.e.*, the hospital arguably is subsidizing a below market private practice with above market compensation for services to the hospital). Second, if a hospital-owned physician practice is guaranteed to generate losses by virtue of the compensation formula – including noncash items such as benefits – there needs to be a clearly identifiable, supportable justification unrelated to the volume or value of any technical or ancillary fees generated by the physicians. Third, the more unusual the terms of the contract the more difficult it may be to defend the terms as commercially reasonable without regard to referrals. Fourth, if there are questions about the level of disclosure of relevant facts to counsel or indications of opinion shopping, a defense of reliance on advice of counsel may be

[187] Complaint, ¶¶ 68 & 76, U.S. ex rel. Drakeford v. Tuomey, No. 3:05-CV-2858-MJP (D.S.C., filed Dec. 21, 2007).

[188] 675 F.3d at 407, n. 22 & 409.

weakened. Fifth, to the extent that legal or consulting opinions are revised or disregarded, that approach should be based on verifiable changes in or mistakes of fact or law.[189]

Halifax. Whether physician compensation took into account anticipated referrals was also at the heart of a case in a federal court in Florida, which ultimately settled. This case involved referrals from ten physicians employed on a full-time basis by a wholly owned affiliate of the hospital. The government alleged that all ten of the physicians made referrals to the hospital for DHS. For every professional service performed at the hospital by these physicians there was a related facility fee generated for the hospital. In perhaps its broadest approach yet to defining "takes into account" for Stark purposes, in Halifax the government argued that this connection alone shows that the compensation for the physicians took into account the volume or value of referrals or other business generated by the physicians and thus, by definition, the compensation could not be fair market value. In a court order on a Motion for Partial Summary Judgment, the court agreed that the compensation took into account the volume or value of referrals and, as such, the arrangement could not satisfy the Stark bona fide employment relationship exception.

Infirmary Health. Allegations of tracking referrals are also included in another recently filed case, though arguments for an indirect compensation arrangement appear to be based more on common management and alleged failure to follow the terms of written agreements or to make any reasonable effort at compliance with the Stark Law or the Anti-kickback Statute.[190]

[189] Though as one commentator noted, CMS has indicated that any commercially reasonable method should be acceptable for valuations. 72 Fed. Reg. 51012, 51015 (Sept. 5. 2007); A. Hutzler, "Tuomey – Another Verdict – FMV Boxing Match Continues," ABA Health eSource (Sept. 2013).

[190] U.S. ex rel. Heesch v. Infirmary Health System, Inc., No. 11-364-KD-B (S.D. Ala., filed Aug. 7, 2013), complaint available online at http://freepdfhosting.com/e189c3d1f0.pdf.