Accountable Care Organizations and Tax-Exempt Status: Tax Planning Considerations

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Accountable Care Organization Task Force

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

This member briefing places the denial ruling in context and explains how, with careful tax planning, an ACO entering into and operating substantial shared savings arrangements with private insurers should be able to qualify for tax-exempt status or not jeopardize the tax-exempt status of (or result in UBIT for) its tax-exempt participants.

Background

General Requirements for Exemption and UBIT

In order to be tax-exempt under section 501(c)(3), an organization must engage primarily in activities that accomplish one or more of the exempt purposes specified in that section.\(^1\) An organization will not be considered to be engaged primarily in exempt activities if more than an insubstantial part of its activities furthers purposes other than those described in section 501(c)(3).\(^2\) If a section 501(c)(3) organization is a member or partner in a limited liability company (LLC) or other entity treated as a partnership for

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\(^1\) Treas. Reg. § 1.501(c)(3)-1(c)(1).
\(^2\) Id.
federal tax purposes (henceforth, simply “partnership”), the partnership’s activities are attributed to the section 501(c)(3) organization for purposes of determining whether the organization is engaged primarily in exempt activities. ³

An organization is not described in section 501(c)(3) if its net earnings inure in whole or in part to the benefit of private shareholders or individuals. ⁴ In addition, a section 501(c)(3) organization may not be organized or operated for the benefit of private (as opposed to public) interests. ⁵ Put otherwise, an organization will not qualify for tax exemption under section 501(c)(3) if more than an insubstantial part of its activities confers nonincidental benefit on private interests. ⁶ On the other hand, even substantial private benefit may be consistent with section 501(c)(3) status if it is incidental to the accomplishment of charitable purposes. ⁷

Among the exempt purposes specified in section 501(c)(3) are “charitable” purposes, which include lessening the burdens of government and promoting health for the benefit of the community. ⁸ With respect to the purpose of promoting health, the IRS has repeatedly warned that “not every activity that promotes health supports tax exemption under § 501(c)(3).” ⁹

Although generally exempt from tax, section 501(c)(3) organizations are subject to UBIT on net income derived from any regularly carried on 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

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⁴ IRC § 501(c)(3); Treas. Reg. § 1.501(c)(3)-1(c)(2).
⁶ See, e.g., American Campaign Academy v. Comm’r, 92 T.C. 1053, 1079 (1989) (concluding that because more than an insubstantial part of an organization’s activities furthered the nonexempt purpose of benefitting private interests more than incidentally, the petitioner failed to establish that it operated exclusively for exempt purposes within the meaning of section 501(c)(3)).
⁷ Rev. Rul. 70-186, 1970-1 C.B. 128 (organization formed to preserve a lake as a public recreational facility and to improve the condition of the water in the lake to enhance its recreational features qualified for § 501(c)(3) status because any private benefits derived by the lake front property owners who helped finance the organization was incidental to the accomplishment of its public purpose); Overview of Inurement/Private Benefit Issues in IRC 501(c)(3),” 1990 EO CPE Text, at 11 (“[E]ven substantial private benefit may be tolerated where it is incidental to the accomplishment of charitable purposes.”)
organization of its charitable purpose or function. A partnership’s activities are attributed to its tax-exempt partners for purposes of determining whether the partners have engaged in an unrelated trade or business and therefore are subject to UBIT on their distributive share of the partnership's income.

ACOs and Notice 2011-20

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

In Notice 2011-20 and a related IRS Fact Sheet, the IRS concluded that the participation of tax-exempt hospitals in MSSP activities through an ACO both further and are substantially related to the charitable purpose of lessening the burdens of government, provided that the ACO meets all of the eligibility requirements established by HHS for participation in the MSSP. The IRS reasoned that Congress established the MSSP to be conducted through ACOs in order to promote quality improvements and cost savings, thereby lessening the federal government’s burden associated with providing Medicare benefits. Because MSSP activities were found to further the charitable purpose of lessening the burdens of government, the IRS concluded that an ACO engaged exclusively in MSSP activities could qualify for tax exemption under section 501(c)(3) as long as it met all of the other requirements for tax exemption under

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10 IRC §§ 511(a), 512(a)(1), 513(a).
11 See IRC § 512(c); Rev. Rul. 2004-51.
12 FS-2011-11.
that section (including its not being operated for the benefit of private parties and its net earnings not inuring to the benefit of insiders).

The IRS recognized in Notice 2011-20 that some tax-exempt organizations might participate in ACOs conducting activities unrelated to the MSSP, including entering into and operating under shared savings arrangements with private insurers. In contrast to activities conducted as part of the MSSP, the IRS said that it anticipated that these non-MSSP activities conducted by or through an ACO were unlikely to lessen the burdens of government. The notice also specified that “negotiating with private health insurers on behalf of unrelated parties generally is not a charitable activity, regardless of whether the agreement negotiated involves a program aimed at achieving cost savings in health care delivery.” In the end, however, the notice declined to address whether and under what circumstances an ACO’s entering into and operating under shared savings arrangements with private insurers would be inconsistent with tax exemption or result in UBIT. Although the notice requested comments on this issue, the IRS has yet to issue any additional guidance on this topic.

**PLR 201615022**

In PLR 201615022, the IRS denied exemption under section 501(c)(3) to an ACO entering into and operating under shared savings arrangements with private insurers. The ACO applying for exemption was formed by a section 501(c)(3) health care corporation (called “System” in the ruling) to achieve clinical care integration, coordination, and accountability among both employed and independent physicians practicing throughout System’s affiliated facilities, as well as physicians practicing at other non-System-affiliated hospitals and in other health care systems. The ACO did not participate in the MSSP. The ACO represented that all of its time and resources would be dedicated to the furtherance of the “Triple Aim” health care reform goals established by the Affordable Care Act: namely, reducing the cost of health care for individuals, improving patient access to and the quality of care, and improving population health and the patient experience. The ACO entered into participation agreements with physicians
meeting its eligibility and performance standards and developed and implemented performance measures to assess the care delivery of participating providers. It also developed and implemented financial incentives to motivate the participating providers to achieve improvement, tying payments to their collective success at achieving the Triple Aim goals, as evaluated by the ACO’s performance measures.

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

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

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

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

The summary of the facts and analysis in PLR 201615022 omitted many details relevant to assessing the strength of the ACO’s case for section 501(c)(3) status.

Who Controlled the ACO?

Perhaps most importantly, the denial says nothing about who controlled the ACO. In the context of joint ventures between hospitals and physicians, the IRS and the courts have repeatedly held out control as a central consideration, reasoning that control of a joint venture by a section 501(c)(3) hospital helps ensure that the activities of the joint venture (which would not uncommonly include negotiating with private insurers) will primarily further charitable purposes and only incidentally benefit the physician partners.13

The denial does say that System “formed” the ACO. This and several other aspects of the denial14 suggest that the ACO was, indeed, controlled by System, a section 501(c)(3) health care corporation. This factor should have weighed in favor of granting section501(c)(3) status to the ACO because control by a section 501(c)(3) organization should help ensure that the ACO’s activities (including its negotiation of contracts with private insurers) further charitable purposes and only incidentally benefit the participating physicians.

13 See St. David's Health Care System v. United States, 349 F.3d 232, 237-38 (5th Cir. 2003) (noting that when private individuals or for-profit entities have either formal or effective control over an arrangement, “we presume that the organization furthers the profit-seeking motivations of those private individuals or entities,” while when a non-profit organization enters into an partnership “with a for-profit entity, and retains control, we presume that the non-profit's activities via the partnership primarily further exempt purposes”); Redlands Surgical Services, 113 T.C. 47, 93 (1999), aff'd 242 F.3d 904 (9th Cir. 2001) (concluding that a nonprofit organization impermissibly served private interests in part due to its lack of “formal or informal control” over a joint venture “sufficient to ensure furtherance of charitable purposes”); Rev. Rul. 2004-51; Rev. Rul. 98-15.

14 For example, the denial repeatedly highlights the fact that the ACO’s negotiating activities were on behalf of providers that were not “related” to or “affiliated” with the System, a fact that would seemingly be relevant only as a way of refuting any claim that the ACO might qualify for § 501(c)(3) status as an “integral part” of System. This claim, in turn, could potentially apply only if the ACO were controlled by System because tax exemption as an integral part of a § 501(c)(3) organization (a topic that is beyond the scope of this article) requires control by that § 501(c)(3) organization.
Why Was the Private Benefit Conferred by the Negotiation Activity Not Incidental?

In support of its assertion in the denial that “negotiating with private health insurers on behalf of unrelated healthcare providers is not a charitable activity,” the IRS cited Rev. Rul. 86-98, which denied exemption to an independent practice association (IPA) that negotiated with health maintenance organizations (HMOs). The IPA described in Rev. Rul. 86-98, however, was different from a typical ACO in numerous important respects. First, the IPA was an association of physicians only and did not include a tax-exempt hospital as a member, much less a controlling member. Second, unlike an ACO, the IPA was not developing and negotiating for patient-focused performance measures based on improving patient access to, and the quality of, care and on improving population health and the patient experience and building data infrastructure to track provider performance with respect to these measures. Third, unlike many ACOs, the IPA was not engaged in recognized charitable activities such as electronic health records activities. Fourth, the IPA was negotiating for access to HMOs’ subscribers, which would presumably translate into additional customers for the IPA’s members; an ACO’s negotiation of shared savings arrangements, by contrast, is typically at least loosely based on the patient populations that the ACO’s participants are already serving. Fifth, and perhaps most importantly, the IPA was negotiating for the entire amount the participating physicians would receive from the HMOs for medical services provided to the HMO’s subscribers. By contrast, most ACOs focus their negotiations much more narrowly on performance measures and incentive (shared savings) payments based on those measures, which are the principal mechanisms the ACO uses to promote health.

The IRS does not specify whether the ACO in the denial focused its negotiations with insurers narrowly on the Triple Aim performance measures and incentive payments or instead negotiated more broadly for the entire reimbursement participating providers would receive from the insurers for their health care services. But if the ACO’s negotiations with private insurers were focused narrowly on the Triple Aim performance measures and incentive payments (which would be much more typical), it is difficult to see how the private benefit conferred by such negotiating activity is not incidental to the
ACO’s purpose of achieving the Triple Aim goals, since negotiation and execution of shared savings arrangements is necessary to achieve the Triple Aim goals. If the private benefit conferred by an ACO’s negotiation and execution of shared savings arrangements is incidental to the achievement of the Triple Aim goals, then such activity should be consistent with section 501(c)(3) status provided that achieving the Triple Aim goals, itself, furthers a charitable purpose (a topic addressed in the next section).

Unfortunately, the denial contains no analysis revealing why the IRS concluded that the private benefit conferred on participating providers was primary and the community benefit of the Triple Aim goals was incidental, rather than vice versa. Indeed, the only explanation the denial provides as to why the negotiation activity was “primarily beneficial” to the participating providers and “only indirectly benefi(cial) to the community as a whole” was that this activity provided the participants with “specific long and short term planning information that can be used in their business activities.” The ruling fails to elaborate as to why the provision of long- and short-term planning information should be considered so beneficial to the participating providers as to render incidental the community benefit associated with the Triple Aim goals.

Why Was the ACO’s Promotion of Health Not in Furtherance of Charitable Purposes?

The IRS acknowledges in the denial that the ACO’s Triple Aim goals “generally promot[e] health,” but then adds that the Triple Aim goals “are not coextensive with exempt purposes under § 501(c)(3), and not all activities advancing those goals are necessarily in furtherance of charitable [purposes].” As an example, the IRS notes that, while selling pharmaceuticals promotes health, pharmacies cannot qualify for section 501(c)(3) status on that basis alone. In support of this assertion, the IRS cites Federation Pharmacy Services, Inc. v. Commissioner, a case in which the Tax Court concluded that the pharmacy at issue did not qualify for section 501(c)(3) status because it was operated for a substantial commercial purpose.\(^{15}\) However, the denial contains no indication that the ACO under consideration was operated for a substantial

\(^{15}\) 72 T.C. 687 (1979).
commercial purpose. And, indeed, it does not appear that the ACO was selling any goods or services whatsoever. As a result, the one example provided in the denial to support the proposition that the ACO’s promotion of health was not charitable appears to be inapposite.

Moreover, the fact that the ACO itself was not directly providing medical care or other health care services should not mean that its promotion of health does not further a charitable purpose. Over the years, the IRS has recognized section 501(c)(3) status on the basis of the promotion of health for many organizations that do not directly provide medical care, including professional standards review organizations,16 health planning agencies,17 and organizations operating computerized donor-authorized retrieval systems to facilitate the transplantation of body organs.18

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

Another possible indicator of community benefit that the IRS and courts have recognized as supporting section 501(c)(3) status is serving Medicare and Medicaid beneficiaries.19 Consequently, it is possible that the IRS would have granted section 501(c)(3) status to the ACO if it had entered into and operated under shared savings arrangements not only with private insurers but also with Medicare and/or Medicaid, which would have ensured that the ACO was serving the health needs of a much broader segment of the community.

18 Rev. Rul. 75-197, 1975-1 C.B. 156.
19 See, e.g., Geisinger Health Plan v. Comm’r, 985 F.2d 1210, 1217 (3d Cir. 1993) (“A hospital may also benefit the community by serving those who pay their bills through public programs such as Medicaid or Medicare.”); Rev. Rul. 69-545.
Unfortunately, the IRS did not discuss or analyze any of these issues in the denial, so we do not know why, precisely, the IRS found the ACO’s promotion of health to be insufficiently charitable.

**ACOS, Tax-Exemption, and UBIT**

*ACOs Qualifying for Tax-Exemption*

In the end, whether or not an ACO that enters into and operates shared savings arrangements with private insurers will qualify for section 501(c)(3) status turns on two of the murkiest questions in the law of tax-exempt organizations: whether or not the private benefit is incidental to the accomplishment of a charitable purpose and the amount of “community benefit” necessary for the promotion of health to support tax exemption under section 501(c)(3). However, based on the authorities referenced in the foregoing discussion, ACOs that enter into and operate shared savings arrangements with private insurers and are organized as nonprofit, nonstock corporations should be able to qualify for section 501(c)(3) status if the following conditions are satisfied:

1. The ACO is controlled by a section 501(c)(3) organization.  
2. The ACO focuses its negotiations with private insurers narrowly on performance measures and incentives to achieve these measures (as opposed to more broadly on reimbursements for medical services).

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21 While no authority directly addresses the scope of an ACO’s negotiations, focusing narrowly on performance measures and incentives to achieve them would help distinguish the ACO’s negotiations from that of the IPA described in Rev. Rul. 86-98 and ensure that the private benefit conferred by the negotiating activity would be incidental to the purpose of promoting health through achievement of the Triple Aim goals. (By contrast if an ACO were negotiating on behalf of its participants for the entire reimbursement amount from private insurers, the negotiating would be broader than necessary to achieve the Triple Aim goals.) Even better would be if the ACO independently developed or selected (e.g., by basing them on the MSSP program) its own performance measures and incentives and based its payments on its own measures and incentives to the degree they differed from those under the agreements negotiated with insurers. This would indicate that the ACO’s negotiation and execution of shared savings arrangements would be done on the ACO’s own behalf, based on its own independent assessment of how best to achieve the Triple Aim goals, rather than on behalf of the private practitioners participating in the ACO.
3. The ACO distributes benefits among participating providers in such a manner that no private party\textsuperscript{22} derives a share of economic benefits from the ACO that is greater than the share of total benefits or contributions the private party provides to the ACO. For this purpose, all contributions made by the ACO participants to the ACO in whatever form (loans, leased property,\textsuperscript{23} services, contributions to satisfying the Triple Aim goals) should be taken into account, as should all economic benefits received by ACO participants (including shared savings payments).\textsuperscript{24}

4. The ACO distributes losses among participants in such a manner that no participant derives a share of losses from the ACO that is disproportionate to the share of economic benefits to which the participant is entitled.\textsuperscript{25}

5. All contracts and transactions the ACO enters into with private parties are at fair market value.\textsuperscript{26}

6. The ACO engages in a sufficient amount of other charitable activities indicative of community benefit, such as maintaining electronic health records, participating in shared savings arrangements with respect to Medicare and/or Medicaid beneficiaries, and/or engaging in education or research activities.\textsuperscript{27}

\textsuperscript{22} For purposes of this discussion, the term “private party” is intended to refer to any person other than a § 501(c)(3) entity or a governmental unit.

\textsuperscript{23} In the case of a nonstock corporation, the participating providers would not be making capital contributions, so the only returns they would receive for contributions of cash or property would be in the case of cash they lent or property they leased.

\textsuperscript{24} IRS FS-2011-11, Q21; Notice 2011-20; Rev. Rul. 2004-51; Rev. Rul. 98-15. In weighing benefits received versus contributions made for this purpose, it is possible that a hospital might be able to disregard its contributions that subsidize electronic health records. \textit{See} Conference Report of the American Recovery and Reinvestment Act of 2009 (H. Rept. 111-16, 111th Cong. 1st Sess., Feb. 12, 2009) (providing that private benefit attributable to cost savings realized from the conduct of activities that facilitate the electronic use or exchange of health-related information will be viewed as incidental to the accomplishment of a nonprofit organization’s exempt purposes); Memorandum from the Director of Exempt Organizations to the Directors of EO Examinations and EO Rulings and Agreements on Electronic Health Records (May 1997) (providing that the IRS will not treat the benefits a hospital provides to its medical staff physicians as inurement or impermissible private benefit if (a) the benefits fall within the range of electronic health records software and technical support services that are permissible under certain regulations issued by HHS and (b) the hospital meets certain other specified requirements). The 2011 IRS fact sheet provided that the IRS would continue to follow this 2007 Memo with respect to all hospitals participating in an ACO, IRS FS-2011-11, Q22, but, because that 2007 Memo only addresses benefits to medical staff physicians, it is not clear whether it would also apply to benefits conferred on private parties participating in an ACO other than the hospital’s staff physicians.

\textsuperscript{25} Notice 2011-20.

\textsuperscript{26} Notice 2011-20; Rev. Rul. 2004-51; Rev. Rul. 98-15.

\textsuperscript{27} \textit{Geisinger}, 985 F.2d at 1217; Rev. Rul. 69-545.
The ACO analyzed in PLR 201615022 probably satisfied all of these criteria, with the possible exception of the final criterion relating to sufficient activities indicative of community benefit. The problem with the final criterion—and with the so-called “community benefit test” applicable to tax-exempt hospitals generally—is that the amount of charitable activities indicative of community benefit that the IRS will deem “sufficient” in any particular case is nearly impossible to predict, based on existing authorities. One could reasonably take the position, though, that an ACO that is participating in shared savings arrangements with private insurers is promoting health for the benefit of the community for purposes of section 501(c)(3) provided it is also engaging in robust electronic health records activities (which would be facilitated by the private shared savings arrangements) and participating in the MSSP (which would ensure it would be covering a broad segment of the population), as well as meeting all of the other criteria described above. Such a position would mean that the ACO described in PLR 201615022 would most likely have qualified for section 501(c)(3) status had it also been participating in the MSSP.

If an ACO Does Not Qualify for Exemption, What Are the Consequences for Its Tax-Exempt Participants?

More common than an ACO itself seeking tax-exemption is participation by tax-exempt hospitals (or other exempt healthcare organizations) in an ACO along with other private parties. If the ACO is an organization such as a limited liability company (LLC) or stock corporation in which the private parties have an ownership interest, the ACO cannot itself qualify for tax-exemption. However, tax-exempt organizations participating in such an ACO can still rest assured that their participation in the ACO will not jeopardize their tax-exemption and that the income they derive from the ACO will not be unrelated business taxable income (UBTI) under the right circumstances. One such set of circumstances would be participation in an ACO that satisfies all of the conditions outlined above (other than being a nonprofit, nonstock corporation), such that the

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28 In the case of an ACO in which participants have ownership interests, the ownership interests and capital contributions would be among the benefits and contributions one would have to take into account
ACO could qualify for tax-exemption itself if it were organized as a nonprofit rather than an organization in which private parties have an ownership stake. That participation by a tax-exempt hospital in such an ACO should not jeopardize the hospital’s exemption or generate UBTI is supported by authorities on joint ventures between tax-exempt organizations and private parties, which provide for this result when the tax-exempt organization has control over the joint venture sufficient to ensure that it furthers a tax-exempt purpose and the joint venture’s activities do, in fact, further a tax-exempt purpose.\textsuperscript{29}

If the ACO could not itself qualify for section 501(c)(3) status even if it were organized as a nonprofit, because (1) the ACO is not controlled by one or more section 501(c)(3) organizations; (2) the ACO does not engage in a sufficient amount of other activities recognized as charitable or indicative of community benefit; or (3) the IRS concludes, notwithstanding the arguments presented above that the private benefit conferred by the ACO’s negotiating with private insurers is more than incidental and inconsistent with section 501(c)(3) status, the tax consequences for a tax-exempt organization participating in the ACO are less certain. In the case of such an ACO (referred to as a “non-charitable ACO” in the remainder of this member briefing), the available authorities would give a tax-exempt hospital at least two bases to argue that its participation in the non-charitable ACO should not jeopardize exemption or generate UBTI: (1) the shared savings payments received by the hospital are attributable to the hospital’s patients; or (2) the shared saving payments received by the hospital are not greater than those it would have received directly from the private insurer based on its own performance.

\textit{Shared Savings Payments Attributable to a Hospital’s Patients}

In a 1995 continuing professional education (CPE) text, the IRS addressed physician health organizations (PHOs)—which, as the CPE text put it, are basically IPAs of the

sort described in Rev. Rul. 86-98 (discussed above) with a hospital member—and
collapsed that a PHO could not qualify for section 501(c)(3) status because of the
private benefit conferred by its activities.30 Nonetheless, citing an example in the UBIT
regulations that provides that pharmaceutical sales to hospital patients do not generate
UBTI,31 the CPE text concludes that “income from PHO services performed for the
benefit of [the] hospital and its patients would normally be considered related and would
not be subject to UBIT.”32 By analogy, income that a tax-exempt hospital derives from a
non-charitable ACO that is attributable to the hospital’s patients should be considered
related and not subject to UBIT. And activities that are substantially related to a
hospital’s exempt purpose should not jeopardize the hospital’s tax exemption.

However, while the allocation of payments from PHOs are pretty easily attributable to
the treatment of a participating hospital’s patients, shared savings payments received
from ACOs are not. Shared savings payments are typically based at least in part on
cost reductions that are measured across a designated population that may not be
comprised entirely of individuals who the hospital itself actually treated during the
relevant measurement period. Indeed, cost savings might be achieved as much or more
by the hospital’s not treating individuals—that is, by the individuals’ not being the
hospital’s patients with respect to certain treatments. Moreover, the primary
beneficiaries of the cost reductions would be difficult to trace and would likely involve
persons other than the hospital’s patients. Thus, the UBIT authorities based on a direct
connection to a hospital’s patients may not be a good fit for arguing that shared savings
payments from a non-charitable ACO may be excluded from UBTI. That said, to the
degree a tax-exempt hospital can figure out a way to attribute all or some portion of its
shared saved payments from a non-charitable ACO to its patients (which, at a minimum,

Dissolutions Update,” 1995 EO CPE Text at 3.
31 See Treas. Reg. 1.513-1(b); see also Rev. Ruls. 68-374, -375 and -376, 1968-2 C.B. 242, 245 and 246;
PLR 9739036 (ruling that an LLC’s profits and losses realized from the provision of diagnostic laboratory
services to a patient of any of three member hospitals -- and allocated and distributed to such hospital-- is
not treated as UBTI to the hospitals).
32 1995 EO CPE Text, at 7. By contrast, the 1995 EO CPE Text found that “PHO services provided to
patients in the member physicians’ private practices do not serve the hospital's exempt purposes and
generate unrelated business income.”
should be possible with those portions attributable to patients’ quality of care, health outcomes, and experience), that portion should be excludable from UBTI.

**Shared Saving Payments Equal to or Less Than Those a Hospital Would Have Received Directly from the Private Insurer**

Other authorities suggest that to the extent a non-charitable ACO is simply passing through shared savings payments that it receives from private insurers according to a tax-exempt hospital’s satisfaction of the private insurers’ performance measures, the shared savings payments should not be UBTI to the hospital. In particular, the IRS has ruled that a tax-exempt hospital’s distributive share of income from a purchasing partnership did not result in UBTI to the hospital to the extent the income the hospital received was based on its owned purchases. The purchasing partnership in question negotiated and executed purchase contracts between the partnership and vendors of medical and pharmaceutical supplies on behalf of its limited partners and received management or administrative fees from the vendors based on the purchases of the limited partners. The IRS reasoned that if a tax-exempt hospital were to engage directly in purchasing activities and paid a management or administrative fee by the vendors, such amounts would not be subject to UBIT (as such purchasing activities naturally contribute importantly to the accomplishment of the hospital’s exempt function). “The fact that such activities are carried out through a partnership should result in no different substantive treatment,” the IRS concluded. Thus, if a tax-exempt hospital’s portion of management or administrative fees received were not greater than the fees it would have received based on its actual purchases, the organization would receive no UBTI.

Similarly, a tax-exempt hospital and other private parties could theoretically engage in separate (though conceivably coordinated) negotiations with a private insurer for shared savings payments.

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33 See PLR 9739001.
34 Id.
35 However, if the management and administrative fees allocated to the exempt organization were greater than the fees it would have received based on actual purchases, the IRS concluded that the excess fees would represent income from performing purchasing services not only for itself but also for otherwise unrelated limited partners and such amounts would therefore constitute UBTI.
savings payments rather than have an ACO negotiate on their behalf, and the shared savings payments that the tax-exempt hospital would receive from the private insurer would be excluded from UBTI (just as is any of the other payments streams the tax-exempt hospital receives from private insurers related to its provision of medical care). The fact that such activities are carried out through a partnership (or other joint venture) should not result in a different substantive treatment. Thus, if a tax-exempt hospital’s portion of shared saving payments received from a non-charitable ACO were not greater than the shared savings payments it would have received directly from the private insurer based on its own performance, the shared savings payments should not be UBTI.

How Much UBTI from an ACO Will Jeopardize Exemption?

To the extent a tax-exempt hospital cannot use one or both of the approaches described in in Parts above to exclude all of the income it receives from a non-charitable ACO from UBTI, the tax-exempt hospital should keep in mind that a substantial amount of UBTI (and, in the case of a hospital partner in a ACO that is a partnership, a substantial amount of attributed unrelated business activity) will not necessarily jeopardize the hospital’s tax-exemption. The IRS has permitted tax-exempt organizations to receive almost all of their income in the form of UBTI, provided the organization has a charitable program commensurate in scope with its financial resources. Any tax-exempt hospital will clearly have a charitable program—that is, its treatment of patients in accordance with Rev. Rul. 69-545—commensurate in scope with whatever income it may be receiving from ACOs. Thus, even if participation in a non-charitable ACO results in some UBTI for a tax-exempt hospital, it is difficult to imagine such participation could ever realistically jeopardize the hospital’s section 501(c)(3) status.

36 Rev. Rul. 64-182; 1964-1 C.B. 186; TAM 200021056 (ruling that an unrelated trade or business that constituted, both financially and physically, approximately 66% of an organization's resources did not jeopardize the organization's § 501(c)(3) status); TAM 9636001 (ruling that an unrelated trade or business that generated more than one-half of an organization’s total receipts did not jeopardize the organization’s § 501(c)(3) status).
Conclusion

An ACO’s entering into and executing shared savings arrangements with private insurers should be able to further, or be substantially related to, the charitable purpose of promoting health under the right circumstances, which this article has attempted to summarize. Moreover, even in the case of a non-charitable ACO, tax-exempt hospitals participating in the ACO should be able to argue that at least some portion of the shared saving payments derived from arrangements with private insurers should be excluded from UBTI and that the participation does not jeopardize tax-exempt status.