



**American Hospital  
Association®**

800 10th Street, NW  
Two CityCenter, Suite 400  
Washington, DC 20001-4956  
(202) 638-1100 Phone  
[www.aha.org](http://www.aha.org)

May 16, 2016

*Submitted electronically via [www.regulations.gov](http://www.regulations.gov)*

John Koskinen  
Commissioner  
Internal Revenue Services  
1111 Constitution Ave., N.W.  
Washington, DC 20224

Mark J. Mazur  
Assistant Secretary (Tax Policy)  
Department of the Treasury  
1500 Pennsylvania Ave., N.W.  
Washington, DC 20220

***Re: IRS Notice 2016-26: Priority Guidance Plan 2016-2017; Tax Exemption for Accountable Care Organizations***

Dear Commissioner Koskinen and Assistant Secretary Mazur:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) is writing in response to the position taken by the Internal Revenue Service (IRS) in a recent ruling denying tax exemption to an accountable care organization (ACO)<sup>1</sup>. We are seriously concerned that the IRS has adopted a ruling position that means non-profit hospitals risk losing their tax exemption if they pursue a modern approach to clinically integrated health care that holds the greatest promise for improving outcomes and reducing costs.

In its recent ruling, IRS denied tax-exempt status to an ACO not participating in the Medicare Shared Savings Program (MSSP), the exact opposite of the result it would have received if it were an MSSP ACO. The IRS concluded that the ACO generated impermissible private benefit to physicians without any discussion of how the community benefits from coordinated care and better management of health care costs.

---

<sup>1</sup> PLR 201615022



The IRS ruling is in conflict with the direction that the Department of Health and Human Services (HHS) has given to the hospital field. HHS Secretary Burwell has been very clear about the importance of all types of ACOs in furthering our national health policy goals. In January 2015, when she announced the goal of basing 90 percent of Medicare payments on quality and value by 2018 through use of ACOs or alternative payment models, she said:

Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people. Today's announcement is about improving the quality of care we receive when we are sick, while at the same time spending our health care dollars more wisely. We believe these goals can drive transformative change, help us manage and track progress, and create accountability for measurable improvement.<sup>2</sup>

ACOs (MSSP and non-MSSP) are among the prime mechanisms for meeting the goals articulated by Secretary Burwell. We respectfully request that IRS recognize that, when hospitals integrate with physicians and other providers in their community to reward coordinated patient care, the hospitals are promoting health for the benefit of the community and, therefore, operating as section 501(c)(3) organizations should. **To make that clear, it is imperative that IRS publish guidance affirming that hospitals may participate in ACOs without generating a tax cost or incurring the catastrophic loss of their tax-exempt status. Such guidance will remove what appears to be a serious obstacle for nonprofit hospitals striving to coordinate care for their communities and make other improvements in delivering population health.**

Nonprofit hospitals and health systems qualify for exemption as section 501(c)(3) organizations based on their promotion of health for the benefit of the communities they serve. Promotion of health is necessarily a dynamic function. Hospitals must respond to medical advances and changing public health needs with new activities, programs and structures. They also must respond to the economic challenges and demands not only of the Medicare and Medicaid programs but also the coordinated care models expected by innovative private payers.

To meet the community's health needs and respond to the economic imperatives, many non-profit hospitals have expanded beyond fee-for-service acute care inpatient facilities to models that integrate inpatient and outpatient care, recruit physicians to meet community needs, and enter into joint ventures with for-profit and nonprofit health care providers with complementary skills. Case law and IRS guidance have recognized that non-profit hospitals pursue these activities in order to promote health for the benefit of the community as a whole. Therefore, as long as the activities and programs have been structured to avoid giving private parties a profit-like interest and to make returns on investment proportional to the resources invested, non-profit hospitals have been able to innovate and adapt in their relationships with other providers while remaining confident that they retain their tax-exempt status.

---

<sup>2</sup> Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value, HHS News Release, January 26, 2015.

Our national health care system has shifted the paradigm for promoting community health. Historically, the health care system was built to deliver hands-on care to patients after they became sick or injured. The hands-on approach has, however, become unsustainable. The focus of health care has shifted to improving health status and outcomes by increasing preventive services, encouraging healthy behaviors and coordinating care among providers to improve outcomes and reduce the cost of care. ACOs are an important innovation through which this transformational shift is accomplished.

ACOs, whether formed as corporations, partnerships or LLCs, are designed to promote better health and better care at a lower cost for a defined population of people. ACOs pursue that goal by offering financial incentives to physicians, hospitals and other health care providers to coordinate and improve care for patients and avoid unnecessary hospitalizations. The ACO puts the incentives in place by contracting with payers. For MSSP ACOs, the payer is Medicare. For non-MSSP ACOs, the payers are private insurers and self-insured plans. Some ACOs may blend MSSP and non-MSSP arrangements. Whatever the payment arrangement, the ACO makes the providers accountable for the care they provide. ACOs succeed when individuals stay healthier. When the ACOs manage costs, the shared savings are available to fund the financial incentives.

Unfortunately, the recent IRS denial letter tells non-profit hospitals seeking to form or participate in ACOs outside of the MSSP that they are risking their tax exemption. If they join with physicians in their community – beyond the physicians they employ or accept on their medical staff – to contract with payers or perform the analytics necessary to track where interventions can be made to improve health at lower cost, the ruling says that the ACO would be operating for the benefit of the physicians not the community.

IRS issued guidance making clear that MSSP ACOs are furthering charitable purposes because they are lessening the burdens of government. That is certainly true, but just as important, non-MSSP ACOs are promoting health for the benefit of the community as a whole. What they are doing reflects an evolution in American health care, a fundamental change that, as Secretary Burwell said, is vital to the public interest. We must reward hospitals and physicians for keeping patients healthier and managing costs. To achieve that goal, we must recognize modern health care relies on coordination and cooperation amongst the providers who care for a community, regardless of whether they are all affiliated with the same hospital or health system. The IRS should recognize this welcome paradigm shift with clear and effective guidance permitting tax-exempt hospitals to participate in all ACOs to serve their communities.

John Koskinen and Mark Mazur

May 16, 2016

Page 4 of 7

Thank you for your consideration. We ask that you make guidance on participation in ACOs by non-profit hospitals an immediate priority. The AHA would welcome the opportunity to meet with you to discuss our concerns. Please feel free to contact me with any questions or comments at [mhatton@aha.org](mailto:mhatton@aha.org) or (202) 626-2336.

Sincerely,

/s/

Melinda Reid Hatton  
Senior Vice President and General Counsel

CC:

Sunita Lough – Commissioner, Tax Exempt and Government Entities

Tammy Ripperda – Director, Exempt Organizations

William J. Wilkins – Chief Counsel

Kyle Brown – Division Counsel, Tax Exempt and Government Entities

Victoria Judson – Associate Chief Counsel, Tax Exempt and Government Entities

Thomas West, Tax Legislative Counsel

## Technical Appendix

The American Bar Association's Section of Taxation and Health Law Section submitted comprehensive detailed comments to the IRS in response to Notice 2011-20 and the specific questions raised in that notice about non-MSSP ACO activities: (1) do these activities further the exempt purpose of the promotion of health; and (2) do these activities comply with the private inurement and private benefit doctrines. We commend these comments for their thorough review of the existing law and explanation of how the answers to these questions follow from the law. We join their call for published guidance.

We offer these additional technical points to be taken into consideration.

- Participation in the Medicare version of ACOs cannot be essential for the ACO activity to further exclusively charitable purposes. As Rev. Rul. 69-545, 1969-2 C.B. 117, and Rev. Rul. 83-157, 1983-2 C.B. 94, each say, participation in Medicare and Medicaid is a factor but not a requirement for a hospital to be operated in furtherance of exclusively charitable purposes. Non-MSSP ACOs can satisfy the same factors articulated in Notice 2011-20 for establishing an MSSP ACO whose activities further exclusively charitable purposes, with the exception of approval into the MSSP program by CMS. While CMS acceptance of an ACO arrangement may provide a simple safe harbor, the relevant legal question is whether ACO activities further an exclusively charitable purpose.
- The relevant legal standard is whether activities promote health *for the benefit of the community as a whole*. Pointing to cases about health plans and pharmacies for the proposition that not every activity that promotes health necessarily supports exemption (IHC Health Plans, Inc. v. Commissioner, 325 F.3d 1188, 1197 (10th Cir. 2003), and Federation Pharmacy Services, Inc. v Commissioner, 72 T.C. 687 (1979), *aff'd*, 625 F.2d 804 (8th Cir. 1980)) does not add anything to the analysis. ACOs are not selling health care products or services to individual consumers. ACOs and other forms of clinical integration, by definition, are focused on the health of a population. They function on a system basis to promote the health of the community *as a whole*, and as such, they are charitable.
- The community, for purposes of the community benefit standard, can take many forms beyond geographic ones. For example, children's hospitals serve children, and specialty cancer or eye hospitals serve patients with particular health needs who may live far away from the hospital itself (Cf. Rev. Rul. 83-157, 1983-2 C.B. 94). Both MSSP and non-MSSP ACOs serve communities of thousands of people. These communities are defined by a combination of geography and source of coverage.
- Since 1996, IRS has recognized that hospitals and physicians would create organizations as a vehicle through which they would work together to benefit their community.

Spiraling increases in health care costs have spawned innovative solutions to reduce the price, increase the quality, enhance the efficiency, and

improve the availability of medical services. The integration of hospitals and physicians into single organizations with the common goal of benefiting the community is part of this movement (IRS Training text on integrated delivery systems and health care for exempt organizations personnel, 1996).

ACOs are a contemporary approach to addressing the same concern. In the same way that formation of an integrated delivery system promotes health for the community as a whole, so does an ACO promote health for the community as a whole. IRS recognized that integration furthered the participating hospital's exempt purpose, and focused on the financial terms in evaluating the arrangement. In the context of an ACO, the focus is on metrics for health care improvement and cost containment. The attention to economics is similarly appropriate for an ACO. So long as the metrics for health care improvement and cost containment are sound and evidence-based, payments based on those metrics are necessarily tied to achievement of an exempt purpose. If the use of metrics and standards in the MSSP as a basis for payment is appropriate, then use of other metrics and standards that are backed by substantial research and analysis in ACOs outside of MSSP should similarly be appropriate.

- IRS already recognized that functions performed by an ACO are the promotion of health that merit exemption. In Rev. Rul. 81-276, 1981-2 C.B. 128, IRS recognized that a professional standards review organization is promoting the health of the beneficiaries of governmental health care programs by preventing unnecessary hospitalization and surgery. Similarly, an ACO also promotes health by using evidence-based medicine and population health analytics to achieve improved outcomes for patients and reduce unnecessary health care expenditures.
- If MSSP ACOs serve a charitable purpose through achieving better care and better health for the Medicare beneficiary community as a whole, so too do non-MSSP ACOs serve a charitable purpose through achieving better care and better health for the communities they serve. When MSSP ACOs lessen the burden on government, they do so not just through cost savings but through an improvement and strengthening of health care for Medicare beneficiaries. The same is true outside of the MSSP: the cost savings is one part of a fundamental improvement to the health care system for the community.
- IRS has further recognized that payments based on quality of services using MSSP criteria is incidental private benefit to the physician (Notice 2014-67, 2014-46 I.R.B. 822). IRS allowed private physicians to perform services in tax-exempt, bond-financed facilities and receive payments without engaging in impermissible private use of the facility. This safe harbor acknowledges that meeting the needs of a patient requires both the facilities of the hospital and the care of the physician. Therefore, any private benefit to the physician is incidental to the accomplishment of the hospital's exempt health care purpose. Similarly, hospitals and physicians need to work together in assuming responsibility for the health of the population in their community – improving quality, outcomes, and reducing the cost of health care. The ACO is like the hospital facility. The hospital may have the size and resources to assemble

the network, but the hospital and the physicians both need the ACO to pursue the ultimate goal of promoting health for the benefit of the community.

We urge IRS to issue guidance quickly affirming that non-profit hospitals may participate in ACOs without generating a tax cost or incurring the catastrophic loss of their tax-exempt status. We believe the public policy goals articulated by Congress and the Department of Health and Human Services, and IRS's established precedents properly applied support the following conclusions:

- ACOs organized and operated to promote better health and better care at a lower cost for a defined population of people serve a charitable purpose.
- Any private benefit to the participating physicians or for-profit health care providers can be established as incidental to the furthering of charitable purpose using the same five-factor analysis the IRS has made applicable to MSSP ACOs, in which no particular factor must be satisfied in all circumstances.
- ACO incentives do not result in inurement where they do not give a physician or provider an equity-like interest in the ACO.