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Accountable Care Organizations: Tax Consequences to Tax-Exempt Healthcare Organizations in Joint Ventures

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The recently enacted Patient Protection and Affordable Care Act[1] states that the federal government will establish a program not later than January 1, 2012, that promotes accountability for a patient population by establishing criteria for groups of professionals and health practices to set up accountable care organizations (ACOs). These organizations will provide an infrastructure to coordinate patient care among the members of the ACOs, with a goal of increasing overall quality performance. The legislation[2] sets forth the requirements for each of these organizations, specifying that the ACO must be an organization that is "willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it." In addition, the ACO must agree to participate in the program for no less than three years, have a formal legal structure, and serve not fewer than 5,000 beneficiaries. Any savings from streamlined care will be shared among the ACO members.

This newly amended section 1899 of the Social Security Act (SSA) provides that an ACO must have a formal legal structure so that it can receive and distribute payments for shared savings, as determined annually under the statute. Section 1899 also sets forth examples of organizations with shared governance:

> (A) ACO professionals in group practice arrangements;
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> (B) networks of individual practices of ACO professionals;
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> (C) partnerships or joint venture arrangements between hospitals and ACO professionals;
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> (D) hospitals employing ACO professionals; and
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> (E) such other groups of providers of services and suppliers as the Secretary determines appropriate.[3]

This article focuses on the structure set forth in item (C). An ACO partnership or other type of joint venture, such as a limited liability company, is likely to include one or more tax-exempt entities. Thus, the article will analyze tax issues and added complexities that a tax-exempt healthcare organization may face when entering into a legal structure as a participant in an ACO, as well as analyze the sometimes conflicting legal standards that have been created by recent legislation. As discussed below, any savings from streamlined care going to tax-exempt healthcare organizations in an ACO is likely to be used to engage tax professionals to ensure compliance with the new complexities found in section 501(r) of the Internal Revenue Code and Schedule H of Form 990, "Return of Organization Exempt From Income Tax."

Regulatory Background

On March 31, 2011, the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), issued a notice of proposed rulemaking[4] (NPRM) implementing section 3022 of the Affordable Care Act.[5] These comprehensive proposed rules have been eagerly anticipated by healthcare organizations and their advisers. The new Medicare Shared Savings Program (MSSP) is designed to promote accountability for a patient population by establishing criteria for groups of professionals and health practices to enable them to set up an ACO.

The CMS, in its NPRM, set forth the following definition:

> Accountable care organization (ACO) means a legal entity that is recognized and authorized under applicable State law, as identified by a Taxpayer

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[1]P.L. 111-148, 124 Stat. 395 (Mar. 23, 2010) (Affordable Care Act); section 3022, the Medicare Shared Savings Program, amending the Social Security Act, Section 1899, 42 U.S.C. 1395 et seq.

[2]42 U.S.C. section 1899(b)(2).

[3]42 U.S.C. section 1899(b)(1).

[4]42 CFR Part 425 [CMS-1345-P], RIN 0938-AQ22; *available at* http://www.nephronline.com/uploaded/acorules.pdf.

[5]P.L. 111-148, Patient Protection and Affordable Care Act, 124 Stat. 395 (Mar. 23, 2010).

Identification Number (TIN), and comprised of an eligible group . . . of ACO participants that work together to manage and coordinate care for Medicare fee-for-service beneficiaries and have established a mechanism for shared governance that provides all ACO participants with an appropriate proportionate control over the ACO's decision-making process.[6]

The NPRM specifies there will be shared governance of the ACO and that membership of the governing body must comprise ACO participants, with each participant allocated appropriate proportionate control over governing body decision-making.[7]

While it is anticipated that each ACO will be a unique legal entity, included among the members of many ACOs will necessarily be tax-exempt healthcare organizations. Thus, also on March 31, 2011, the IRS issued Notice 2011-20,[8] providing guidance for nonprofit healthcare service providers that may form, or be a member of, an ACO. In the notice the IRS addresses private inurement, private benefit, and the unrelated business income tax. The IRS has requested that all comments on the notice be submitted on or before May 31.

Inurement or Private Benefit

An ACO organized as a partnership and joint venture between a tax-exempt hospital and ACO professionals may result in inurement or private benefit to the private-party ACO participants. However, the IRS has provided a relatively safe harbor in Notice 2011-20. The tax-exempt healthcare organization can expect to be safe from an allegation of inurement or private benefit as long as the following criteria are met:

- Terms of the tax-exempt organization's participation in the MSSP through the ACO are set forth in a written agreement negotiated at arm's length. This also must include the organization's share of the MSSP payments or losses and expenses.
- The ACO has been accepted by CMS into the MSSP, and the ACO has not been terminated from the MSSP.
- The tax-exempt organization's share of economic benefits derived from the ACO (including its share of MSSP payments) is proportional to the benefits or contributions the tax-exempt organization provides to the ACO.
- If the tax-exempt organization receives an ownership interest in the ACO, the ownership interest is proportional and equal in value to the tax-exempt organization's capital contributions.
- The tax-exempt organization's share of the ACO's losses (including its share of MSSP losses) does not exceed the share of ACO economic benefits to which the tax-exempt organization is entitled.
- All contracts and transactions entered into by the tax-exempt organization with the ACO and the ACO's participants, and by the ACO with the ACO's participants and any other parties, are at fair market value.

Assuming these criteria are met, the ''IRS expects that it will not consider a tax-exempt organization's participation in the MSSP through an ACO to result in inurement or impermissible private benefit to the private party ACO participants.''[9]

Thus, the tax-exempt organization must enter into written agreements establishing the ACO. The agreements must be at arm's-length fair market value by ensuring that the tax-exempt organization's proportional shares of profits and losses are clearly stated. If they are, the tax-exempt organization should be protected from allegations of inurement to persons who are considered insiders within the tax-exempt organization. The tax-exempt organization also should be protected from allegations that it provided private benefit to unrelated third parties.

Unrelated Business Income

Although not an enumerated charitable purpose in section 501(c)(3), the IRS has long recognized the promotion of health as charitable.[10] This determination has been made case by case, depending mostly on the community benefit provided by the organization.[11] Further, the IRS recognizes that the federal government considers the provision of Medicare to be the government's burden.[12] Accordingly, the IRS states in Notice 2011-20 that absent inurement or impermissible private benefit, any MSSP payments received by the tax-exempt organization will be classified as substantially related to the organization's charitable purpose of lessening the burdens of government.[13] However, to the extent the tax-exempt organization participates in activities unrelated to the MSSP, such as entering into shared savings arrangements with other types of health insurance payers, the IRS anticipates there will be unrelated business income because it does not think these non-MSSP activities will lessen the burdens of government.

Recognizing that a tax-exempt organization's participation in non-MSSP activities through an ACO may further its exempt purpose of providing healthcare (for example, shared savings arrangements with healthcare funded by Medicaid), the IRS has requested comments regarding a rationale to define unrelated and related activities. Presumably, until that rationale is developed and guidance published, the generic consideration of all facts and circumstances will continue to be used to

[6]NPRM section 425.4.

[7]NPRM section 425.5(d)(8)(iv).

[8]*Available at* http://www.irs.gov/pub/irs-drop/n-11-20.pdf.

[9]Notice 2011-20, p. 7.

[10]''The promotion of health has long been recognized as a charitable purpose.'' Rev. Rul. 98-15, 1998-1 C.B. 718; *Restatement (Second) of Trusts*, sections 368, 372 (1959); 4A Austin W. Scott and William F. Fratcher, *The Law of Trusts*, sections 368, 372 (4th ed. 1989).

[11]*See, e.g.*, Rev. Rul. 69-545, 1969-2 C.B. 117.

[12]Rev. Rul. 81-276.

[13]Reg. section 1.501(c)(3)-1(d)(2).

determine whether these non-MSSP activities further the tax-exempt organization's exempt purpose, or whether the activities result in UBIT.

The long-established principles of joint ventures found in Rev. Rul. 98-15 and Rev. Rul. 2004-51 are cited in Notice 2011-20 and will continue to be followed by the IRS to determine whether the tax-exempt partner retains sufficient control over the partnership or LLC to generally avoid UBIT or a threat to the organization's exempt status. These rules also must be coordinated with the new hospital requirements in section 501(r) of the code, namely, the completion of the community health needs assessment and establishment of a financial assistance policy. Also, as discussed above, the NPRM requires members of an ACO joint venture to retain proportional control over the joint venture. These overlapping requirements create much complexity for the healthcare industry, but with careful planning and transparency, the tax-exempt entities should be in a good position to protect their exemptions and minimize UBIT.

Section 501(r)

Section 501(r) was added to the code by section 9007(a) of the Patient Protection and Affordable Care Act.[14] Section 501(r) adds four requirements for hospitals to continue to be described as tax exempt as described under section 501(c)(3). Section 501(r) now requires hospitals to conduct a community health needs assessment (CHNA) once every three years, establish a financial assistance policy, and establish policies equalizing charges for hospital services for the privately insured, Medicare and Medicaid patients, and the uninsured. Finally, a tax-exempt hospital must not engage in extraordinary collection actions until it has made reasonable efforts to determine whether the individual is eligible for assistance within the mandated financial assistance policy. (The four requirements are collectively referenced herein as the section 501(r) community benefit requirements.)[15] In addition, section 4959 imposes a $50,000 excise tax on hospitals that fail to perform the CHNA once every three years.[16] This excise tax seems to apply annually until the CHNA requirement is fulfilled.

The questions that arise for a tax-exempt hospital regard the overlap of the ACO requirements, the section 501(r) community benefit requirements, and the more general and well-established joint venture requirements found in Rev. Rul. 98-15 and the cases following that ruling.[17] Since the focus of the ACO will be Medicare patients, and the focus of the section 501(r) community benefit requirements will encompass a review of policies for all patients, the tax-exempt healthcare organization will need to balance all requirements and develop policies and measurements that work for insured and uninsured patients in order to survive in this new healthcare environment.

In joint ventures it is essential that both the for-profit partner and the tax-exempt partner are aware of the section 501(r) requirements and include language in the partnership documents reflecting compliance with section 501(r). There should also be a recognition that the section 501(r) standards may change as new guidance from the IRS, Treasury, Congress, and the courts will most certainly be released as these complex and overlapping provisions are put into practical use.

Reporting Standard: Aggregate or Individual?

While the exempt status of a hospital system is generally the focus of inquiry when analyzing the governance and operation of a tax-exempt healthcare entity or joint venture, under section 501(r)(2)(B), an organization with more than one hospital facility must meet the section 501(r) requirements separately for each facility. If one facility in a hospital system does not meet the requirements, the organization will not be treated as a section 501(c)(3) entity with respect to the noncompliant facility.[18] Thus an organization's tax-exempt status could be bifurcated between two different categories of exemption. Schedule H makes this reporting scheme evident by requiring aggregate reporting for most purposes, with a separate Part V, section B to be completed for each hospital operated by the organization, whether the facility is operated directly or indirectly through a disregarded entity or joint venture treated as a partnership. As noted by the American Hospital Association, the Healthcare Financial Management Association, and VHA Inc. and the associations' member hospitals, this has resulted in redundancy and onerous new reporting requirements for tax-exempt hospitals.[19]

The IRS also requested comments on the application of the requirements of section 501(r).[20] The American Bar Association Section of Taxation and Health Law Section submitted comments January 20.[21] The ABA members said they were troubled by the provision in section 501(r)(1)(A) that a hospital organization shall not be treated as a tax-exempt organization unless it meets the

[14] P.L. 111-148, section 9007(a), 124 Stat. 119, 855 (2010).

[15] Section 501(r)(3) through (r)(6).

[16] Note that section 501(r)(3) and the requirement for a periodic CHNA is not effective until tax years beginning after March 23, 2012. Section 4959 and the $50,000 excise tax for failure to satisfy the CHNA requirements under section 501(r)(3) is effective for failures occurring after March 23, 2010. Therefore, the CHNA should be completed by the end of an organization's 2012 fiscal year so that the CHNA can relate back to the 2010 and 2011 fiscal years. *See* Notice 2010-39 (June 14, 2010).

[17] *See St. David's Health Care System v. United States*, 349 F.3d 232 (5th Cir. 2003); *Redlands Surgical Services v. Commissioner*, 113 T.C. 47, 83-4 (1999), *aff'd* 242 F.3d 904 (9th Cir. 2001).

[18] Section 501(r)(2)(B).

[19] Schedule H comment letter dated April 20, 2011, to Sarah Hall Ingram, commissioner of the IRS Tax-Exempt and Government Entities Division; *available at* http://www.aha.org/aha/letter/2011/110420-cl-schedh.pdf.

[20] Notice 2010-39, 2010-24 IRB 756.

[21] "ABA Section of Taxation and Health Law Section Comments on Requirements for Tax-Exempt Hospitals," *EO Tax Today*, *2011 EOTT 13-1*, Jan. 11, 2011.

enumerated community benefit requirements for each hospital. If one of the exempt partner's hospitals does not comply with section 501(r), the tax-exempt partner would lose exemption, according to the statute. As discussed at length in the ABA comments, this provision causes numerous complications and harsh consequences to the tax-exempt hospital that loses exemption, which may not be commensurate with the totality of the facts and circumstances of the charitable activities of the tax-exempt healthcare organization. This could also affect the ACO classification, if the loss of treatment as a section 501(c)(3) organization affects the Medicare patients. Also, if the tax-exempt organization has tax-exempt financing, severe consequences to the financial structure of the tax-exempt entities could result.

The ABA comments suggest that if a hospital does not meet the section 501(r) community benefit standards, the tax-exempt parent should be partially recognized instead under section 501(c)(4) with regard to the noncompliant hospital. If that interpretation were adopted, organizations would still be exempt from tax and file Form 990, but they could only partially take advantage of the section 501(c)(3) benefits of tax-exempt financing and tax-deductible charitable donations.

An alternative interpretation of this provision is to classify any net income from a hospital that does not meet the requirements of section 501(r) as subject to UBIT.[22] Although the parent organization would still be recognized under section 501(c)(3), the net income from the hospital not meeting the section 501(r) community benefit standards would be subject to tax. In this manner, tax-exempt financing would not be at risk, although the parent organization would be subject to section 150(b)(3) and denial of some benefits of tax-exempt financing.[23]

However, if the number of hospitals not complying with the section 501(r) requirements become a majority or otherwise overwhelm the exempt activities of the tax-exempt parent, the parent's tax exemption could be revoked. While that may be a more logical outcome than bifurcating a tax-exempt organization under sections 501(c)(3) and 501(c)(4), imposing federal tax on a hospital for which tax payments are not historically a part of its budget may affect the ACO cost benefit calculations. Again, identifying these issues in the planning process will help alleviate any unforeseen results.

Whole Hospital Joint Venture Analyzed as an ACO Subject to Section 501(r)

To illustrate these principles, assume the whole hospital joint venture is a fifty-fifty partnership between a section 501(c)(3) healthcare organization and a for-profit healthcare corporation. Assume further that the joint venture qualifies as an ACO. An analysis of the impact of these new requirements to established nonprofit law reveals some potential conflicts.

As set forth in Rev. Rul. 98-15, a section 501(c)(3) organization may form and participate in a partnership and meet the operational test if (1) participation in the partnership furthers a charitable purpose, and (2) the partnership 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.[24] The appellate court in *St. David's Health Care System v. United States*[25] expanded this two-part test into a three-prong control test and indicated that the ''non-profit can demonstrate control by showing some or all'' of the three factors:

1. the founding documents of the partnership expressly state that it has a charitable purpose and that the charitable purpose will take priority over all other concerns;

2. the partnership agreement gives the nonprofit organization a majority vote in the partnership's board of directors; and

3. the partnership is managed by an independent company (an organization that is not affiliated with the for-profit entity).[26]

The first issue is whether satisfaction of the first prong will also comply with the NPRM's requirement that each member of the ACO have proportionate control. While the governing documents of the partnership may be in compliance and expressly state a charitable purpose for the joint venture, the purpose of the ACO is to be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it. This is not incompatible with section 501(r). However, there is a cost inherent in providing financial assistance to patients not eligible for Medicare. Thus, if a tax-exempt hospital is providing a large percentage of charity care and financial assistance to patients not eligible for Medicare to the detriment of its Medicare patients, it is questionable whether the hospital would also qualify as an ACO.

The emphasis on Medicare patients in the ACO organizational structure may be incompatible at some level with the community benefit standards and charity care. This balancing act will be very important for hospitals and healthcare systems to be aware of and to address in planning the level of financial assistance to non-Medicare patients.

Satisfaction of the second prong may raise issues if the joint venture also initially qualified as an ACO. While a fifty-fifty joint venture is not going to give the nonprofit entity majority vote, according to the appellate court in

[22]While the language indicates the organization will not be treated as a 501(c)(3) organization as to that hospital, it could be interpreted that the offending hospital is thus unrelated to the 501(c)(3) organization's charitable purpose and subject to UBIT.

[23]Section 150(b)(3) provides that the amount of gross income attributable to the unrelated activity shall not be less than the fair rental value of the facility that is financed by the qualified bonds. Additionally, deductions for accrued interest on financing are denied during the period the facility is treated as being used in an unrelated trade or business.

[24]Rev. Rul. 98-15, 1998-1 C.B. at 732.

[25]*St. David's Health Care System v. United States*, 349 F.3d 232, 239 (5th Cir. 2003).

[26]349 F.3d at 239.

St. David's, because actions of the board require a majority vote, St. David's can effectively veto any actions that are contrary to its exempt purpose by a tie vote. However, the reverse is also true: The for-profit partner could block charitable activities through a tie vote.[27] The court noted that the level of control by the nonprofit partner was undetermined, so there remained a material fact to be decided.[28]

As long as the procedures for dealing with a gridlocked board favor the nonprofit interests, the requirement that the nonprofit organization retain a majority vote should be achievable by a fifty-fifty nonprofit/for-profit joint venture. The relevant inquiry is the method for resolving an evenly split board and whether that resolution favors the nonprofit partner or the for-profit partner. If it favors the nonprofit partner, this control test from Rev. Rul. 98-15 should be satisfied. If not, and the for-profit partner retains control over a gridlocked board, the nonprofit partner may lose exempt status. Proportional control required by the NPRM also will have to be addressed carefully in the joint venture documents so that the voting control provisions balance the need for the nonprofit partner to control the activities in furtherance of its exempt purpose while still allowing proportional control to the for-profit partner.

Regarding a joint venture in which the nonprofit has less than a 50 percent interest, the nonprofit partner would not have a majority vote if it has proportionate control under the NPRM and ACO requirements. Nor would the nonprofit partner have any type of overriding veto power, given the requirements that partners retain proportionate control. Thus, the joint venture ACO would almost certainly cause the nonprofit partner to incur UBIT or lose its exempt status.

The third requirement, that a management company be independent, serves all parties well, and its fulfillment should lead to compliance with all statutes, notices, and proposed rules. However, if the management company is aligned with the nonprofit partner, care must be taken so that the for-profit entity retains proportionate control over the partnership in order to comply with the NPRM.

Section 501(r) and Joint Ventures

The applicability of section 501(r) to joint venture arrangements between tax-exempt and for-profit healthcare entities is largely unknown. The statute is silent regarding its application to joint ventures and whether the standards apply to all hospitals within the joint venture partnership or just those that are proportional to the tax-exempt partner's interest. Certainly the reporting requirements now set forth in Schedule H treat activities of a joint venture as activities that must be reported by the tax-exempt organization, but only to the extent of the tax-exempt organization's proportionate share in the partnership. Therefore, in a fifty-fifty partnership, the tax-exempt organization would only report 50 percent of the aggregate numbers from the joint venture's activities.

Schedule H requires that the tax-exempt hospital list all hospitals owned by the tax-exempt entity, whether operated directly or indirectly by a disregarded entity or joint venture. The Schedule H instructions, in connection with reporting the tax-exempt organization's financial assistance policies, also known as charity care policies, require the organization to report the policies that apply to the hospital in the joint venture that has the greatest number of patients.

Regarding the reporting of income limits for recipients of financial assistance, the IRS states: "If the organization does not operate its own hospital facility, [report] the largest number of patients of a hospital facility operated by a joint venture in which the organization has an ownership interest. For example, if the organization has two hospital facilities, use the financial assistance eligibility criteria used by the hospital facility which has the most patient contacts or encounters during the tax year."[29] This requirement will provide skewed results, however, in a joint venture in which the tax-exempt organization holds only a minority interest, reports the activity from that hospital or joint venture as unrelated to its exempt purpose, and thus pays tax on any net income.

Section 512(c) requires a tax-exempt organization to report any unrelated trade or business regularly carried on by a partnership, to the extent of the tax-exempt organization's share of partnership gross income and partnership deductions directly connected with the gross income. Accordingly, it is logical that a tax-exempt organization's proportionate share of the aggregate numbers from each of the hospitals in the partnership will have to be reported on Schedule H as set forth in the corresponding instructions. However, the statutory language is silent on that issue, unlike the explicit language found in section 512(c). It is possible that regulations will eventually be published to address this issue.

There is a potential conflict among the appellate court's ruling in *St. David's*, the control test of Rev. Rul. 98-15, section 501(r), and the ACO requirements found in the NPRM. Both the appellate court and Rev. Rul. 98-15 require an analysis of the partnership's activities in operating the joint venture as a whole to determine whether the tax-exempt organization retained control over all the partnership's activities. Section 501(r) requires the tax-exempt organization to satisfy the community benefit and financial assistance policies for each hospital. Schedule H of Form 990 specifies that the tax-exempt partner in a joint venture must list all hospitals and report activities for all hospitals for most purposes, with financial information reported only to the extent of the tax-exempt organization's proportionate

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[27]*See Redlands Surgical Services v. Commissioner*, 113 T.C. 47, 83-4 (1999), *aff'd* 242 F.3d 904 (9th Cir. 2001) ("This long-term management contract with an affiliate of [the for-profit entity] is a salient indicator of [the non-profit's] surrender of effective control over the [partnership's] operations"), as quoted in *St. David's*, 349 F.3d at 242.

[28]The summary judgment motion in favor of the government was vacated and the case remanded for further litigation. Ultimately, the appellate court did not decide the control issue. The jury, not focused on the control issue, found in favor of St. David's.

[29]Schedule H, Form 990, instructions at p. 2.

share. The ACO requires that control by each ACO member over the ACO be proportional to profit/loss interests, with all agreements negotiated at arm's-length fair market value.

Additionally, if the for-profit hospital facility in the joint venture has the most patient contacts, its financial assistance policy will be reported on the nonprofit partner's Schedule H as the joint venture's financial assistance policy. It is questionable whether the large for-profit hospital will be able to satisfy the section 501(r) financial assistance policy charitable standards immediately after the joint venture is established. Those policies should be addressed as part of the joint venture negotiations.

Although these tests can be satisfied through careful planning and reporting, there are traps for the unwary when trying to satisfy simultaneously all the various tests and requirements of section 501(r), Rev. Rul. 98-15, and the *St. David's* appellate opinion.[30] When the ACO requirements are imposed as well, the tax-exempt organization must be careful to structure the ACO in a way that also will satisfy the NPRM. Although it is not impossible to do so, it will require careful planning and close attention to situations in which the activities of the joint venture as a whole are reported, the situations in which the joint venture is analyzed through data from each hospital, and the control over the ACO joint venture, whether it satisfies the ACO proportional control test or favors the tax-exempt organization as required by Rev. Rul. 98-15. If it favors the for-profit partner, the ACO proportional test may not be met in a fifty-fifty partnership, the Rev. Rul. 98-15 control test will not be met, and the section 501(r) requirements will need further scrutiny. Obviously, if the joint venture fails the Rev. Rul. 98-15 control test and is revoked on that basis, section 501(r) is no longer relevant. If the joint venture also loses its ACO status, the consequences will be costly.

[30]*St. David's Health Care System v. United States*, 349 F.3d 232 (5th Cir. 2003).

Congress has debated whether there are real differences between for-profit healthcare organizations and tax-exempt healthcare organizations.[31] Those in the industry know that the charitable mission is of utmost importance to the nonprofit community and that charitable hospitals fill a great societal need, as contrasted with the emphasis prevalent in for-profit hospitals to provide profits in the form of dividends to shareholders.

However, this latest statutory and regulatory assault seems destined to send charitable hospitals running for cover to escape the regulatory, statutory, and reporting complexities that have been imposed on them. Health reform may fail because of the complexity and burdens placed on the industry by these often conflicting standards. While the ACO concept was brilliant in its goal of encouraging economies of scale and encouraging joint operations among various components of the healthcare industry to realize efficiencies, the burdens imposed by Congress and the IRS through the enactment of section 501(r), the reporting required in Schedule H, and the continued enforcement of the historic joint venture standards are all counterproductive to the apparent intent of ACOs.

CMS, in its NPRM, stated, "Our intent is to encourage participation by not-for-profit, community-based organizations."[32] If the labor costs required to unravel the complexities of all these provisions, plus the labor costs required to satisfy all of the reporting requirements, are added to total costs and figured into the cost of the ACO, the shared savings will be hard to find.

[31]*See* http://grassley.senate.gov/releases/2007/07182007.pdf; *available at* http://grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=25912.

[32]42 CFR Part 425 [CMS-1345-P], RIN 0938-AQ22, p. 52; *available at* http://www.nephronline.com/uploaded/acorules.pdf.