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Notice 2011-20

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VHA

Results are just the beginning

Submitted Electronically

May 27, 2011

Mr. Douglas Shulman
Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Mr. Joseph Grant
Acting Commissioner
Tax Exempt and Government Entities
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Re: COMMENTS OF VHA INC. IN RESPONSE TO IRS NOTICE 2011-20

Dear Commissioners Shulman and Grant:

VHA Inc. ("VHA") appreciates the opportunity to submit comments on the participation of tax-exempt organizations in the Medicare Shared Savings Program ("MSSP") through an accountable care organization ("ACO").

Based in Irving, Texas, VHA is a national healthcare alliance serving more than 1,400 nonprofit, community-based hospitals and more than 23,000 non-acute care organizations. VHA helps its members deliver safe, effective and cost-efficient health care through both national and local support. VHA has 16 regional offices covering 47 states as well as offices in Washington, D.C. Founded in 1977 as Voluntary Hospitals of America, VHA is dedicated to the success of nonprofit, community-based health care.

Notice 2011-20

On March 31, 2011, the IRS released Notice 2011-20. This notice set forth the IRS's views on tax-exempt organizations participating in the MSSP through an ACO. The notice indicated that the IRS is soliciting comments in two main areas:

- Whether existing guidance relating to the Code provisions governing tax-exempt organizations is sufficient for those tax-exempt organizations planning to participate in the MSSP through an [ACO] and, if not, what additional guidance is needed.

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- Whether guidance is needed regarding the tax implications for tax-exempt organizations participating in activities unrelated to the MSSP, including shared savings arrangements with commercial health insurance payers, through ACOs.

VHA appreciates the opportunity to comment and submits the following.

1. Participation in the MSSP Through ACOs by Tax-Exempt Organizations

IRS Notice 2011-20 states that the IRS "anticipates" that tax-exempt organizations will participate in the MSSP through ACOs with private parties, including some that might be considered "insiders" with respect to the tax-exempt participant.[1] The IRS further anticipates that tax-exempt organizations' participation in ACOs might take a variety of forms, including membership in a nonprofit corporation, ownership of shares in a corporation, ownership of an interest in a partnership or LLC, and contractual arrangements with the ACO and/or its other participants. However, the IRS does not "expect" such participation to result in inurement or impermissible private benefit if the following five conditions are satisfied:

- The terms of the tax-exempt organization's participation in the MSSP through the ACO (including its share of MSSP payments or losses and expenses) are set forth in advance in a written agreement negotiated at arm's length.
- CMS has accepted the ACO into, and has not terminated the ACO 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.[2]
- 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.

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[1] Code Section 501(c)(3) provides that corporations organized and operated for charitable purposes are exempt from taxation if, among other requirements, no part of the net earnings inure to the benefit of any person. Private inurement generally involves a non-arm's length transaction between the exempt organization and "insiders" (those in a position of control or influence over the organization). Violating the private inurement prohibition can result in the loss of the organization's tax-exempt status.

[2] Under this condition, if the tax-exempt organization receives an ownership interest in the ACO, the ownership interest received must be proportional and equal in value to its capital contributions to the ACO and all ACO returns of capital, allocations and distributions must be made in proportion to ownership interests.

Comments on MSSP Participation Through ACOs by Tax-Exempt Organizations

VHA believes that the five conditions set forth above are a step in the right direction toward ensuring that tax-exempt organizations avoid private inurement and private benefit when participating in an ACO. At the same time, VHA believes that additional and more definitive IRS guidance is needed.

Specifically, VHA requests that the IRS issue a revenue procedure (or other similar guidance) stating that satisfaction of these five conditions would provide tax-exempt ACO participants a safe harbor from private inurement and private benefit. The IRS has successfully employed this guidance model in the past (*e.g.*, in Revenue Procedure 2003-14, the IRS set forth eight requirements (one with five subparts) the satisfaction of which enabled a particular type of trust to avoid the tax consequences of the constructive receipt and economic benefit doctrines).

A "safe harbor" approach would provide the nonprofit community with certainty and reduce the IRS's administrative burden, as it would free the IRS from having to issue numerous private letter rulings that likely contain similar, basic facts. In addition, it would also be consistent with the Obama Administration's policy of streamlining government regulation and reducing related paperwork burdens. Furthermore, it would enable nonprofit healthcare organizations to move more quickly into the ACO model without facing unnecessary uncertainty regarding the impact on their tax-exempt status.

While VHA believes that satisfying the five conditions stated above are generally appropriate, additional IRS guidance is needed to clarify how the third and fifth conditions (proportionate economic benefits and fair market value terms) should be applied in the ACO context.

The third condition requires that the tax-exempt organization's share of economic benefit derived from the ACO be proportionate to the contributions and benefits it has provided to the ACO. However, the IRS's approach to proportionality of gains and losses in the joint venture context has traditionally been determined by ownership interests, which, in turn, is determined by the capital contributions of the respective owners. This approach must be reconciled with the CMS approach taken in its Notice of Proposed Rule Making, which appears to contemplate the distribution of significant portions of the shared savings based on medical providers' contributions towards quality performance and attainment of savings goals--irrespective of ownership interests.[3]

> *Example of the potential conflict between traditional IRS approach and CMS approach: Hospital A contributes $60 in capital to the ACO, while Medical Practice Group B contributes $40. Accordingly, their initial ownership interests are 60 percent for Hospital A and 40 percent for Medical Practice Group B. If the Medical Practice Group is 75 percent responsible for the cost savings and*

[3]76 Fed. Reg. 19528, 19536 (providing very broad guidance on the requirements for forming an ACO but leaving open the issue of how to share bonus payments based on providing high quality care).

high quality of care, does the IRS expect that savings will be shared strictly in proportion to capital contributions?

Thus, it would be helpful to have further guidance on the sharing of savings in the joint venture context, particularly where the joint venture owners are also service providers.

Further guidance on how the fair market value terms requirement will apply in the ACO context would also be helpful. Many hospitals contemplating the formation of ACOs have reason to believe that physicians will need tangible incentives to participate in the new reimbursement/payment structures. In some cases, hospitals anticipate that the ACOs will be able to furnish such incentives through the provision of discounted ACO-related services, such as practice management services, clinical case management and coordination services, clinical decision support services, discharge planning services and/or other information technology services. Hospitals further anticipate that CMS may be willing to approve such incentives as eligible for federal anti-kickback and physician self-referral law waivers so long as they are made available to all participating providers without regard to the volume or value of their referrals. In 2007, the IRS promulgated guidance assuring hospitals that their provision of financial incentives to staff physicians with respect to electronic health records capability would not be treated as impermissible private benefit or private inurement so long as such subsidies met requirements in HHS regulations allowing electronic health records software and technical support to be provided to medical staff physicians without violating federal anti-kickback and physician self-referral laws. *See* May 11, 2007 Memorandum from Lois Lerner, Director, Exempt Organizations, Internal Revenue Service, regarding Hospitals Providing Financial Assistance to Staff Physicians Involving Electronic Health Records. A similar approach should be taken with respect to the provision of discounts or subsidies that may be needed to facilitate physician participation in ACO structures, and that are offered by an exempt organization either pursuant to a specific waiver issued by HHS (or its Office of Inspector General) with respect to such arrangement, or that are offered by the exempt organization in compliance with any other guidance that may be issued by CMS or HHS (or its Office of Inspector General) with respect to ACO-related service arrangements.

In addition, there is no reason why a safe harbor approach to private inurement and private benefit should not be employed more broadly in the ACO context. IRS guidance should explicitly state that serving non-Medicare patients through an ACO operated in compliance with the applicable safe harbor conditions will not violate the private benefit or private inurement rules. While formal CMS program approval would not be applicable in the context of a non-governmental cost saving program, all of the other safe harbor conditions (advance written agreement, proportionate economic benefits, proportionate economic losses, and fair market terms) would be applicable and would be sufficient to guard against private inurement and private benefit.

2. Relationship of Exempt Organizations' MSSP Activities to Charitable Purpose

IRS Notice 2011-20 states that the IRS "expects" that any MSSP payments received by a tax-exempt organization from an ACO would derive from activities that are "substantially related" to the performance of the charitable purpose of "lessening the burdens of government," so long as the ACO meets the eligibility requirements established by CMS for participation in the MSSP.

Comments Regarding MSSP ACO Activities and Charitable Purpose Test

VHA agrees with the IRS's conclusion that MSSP payments are derived from activities substantially related to the charitable purpose of lessening the burdens of government. However, for the same reasons stated above, it would be helpful to have this IRS "expectation" re-phrased as a safe harbor for tax-exempt organizations participating in the MSSP through an ACO.

3. Exempt Organizations' Conduct of Non-MSSP ACO Activities

IRS Notice 2011-20 states that some ACOs will conduct activities "unrelated" to the MSSP, including operating under shared savings agreements with non-governmental health insurers. The IRS anticipates that these activities are "unlikely" to lessen the burdens of government within the meaning of Treas. Reg. 1.501(c)(3)-1(d)(2) (*i.e.*, for purposes of satisfying the charitable purpose requirement imposed on 501(c)(3) organizations). However, the IRS concedes that "certain non-MSSP activities may further or be substantially related to an exempt purpose." As an example, the IRS cites ACO's possible participation in shared savings arrangements with Medicaid, which it recognizes "may further the charitable purpose of relieving the poor and distressed or the underprivileged." IRS then asks for comments on "what guidance, if any, is necessary or appropriate regarding a tax-exempt organization's participation in non-MSSP activities through an ACO."

Comments on Conduct of non-MSSP ACO Activities

VHA agrees with the IRS's conclusion that "certain non-MSSP activities may further or be substantially related to an exempt purpose." While non-MSSP activities undertaken by an ACO are not "per se" exempt, they could be viewed as furthering an exempt purpose in several respects. First of all, even non-governmental ACO activities should help reduce health care cost generally, thus reducing the need for government subsidies. Second, if the ACO is an integral part of a tax-exempt hospital's community-based integrated delivery system, it should be recognized as furthering an exempt purpose. As noted above, the IRS has recognized health care that furthers relief of the poor as a charitable purpose (*e.g.*, participation in a Medicaid ACO). However, IRS guidance needs to go beyond the easy case of participation in a Medicaid shared savings program or arrangement and look at other situations in which a charitable purpose could be served.

The concept of treating the activities of subsidiaries or affiliates as furthering the exempt purpose of a community-based nonprofit health system is not new, particularly where the tax-exempt

parent effectively controls the affiliate and ensures that its activities achieve an identifiable community benefit. Thus, the IRS should issue guidance setting forth the circumstances in which a tax-exempt hospital's sponsorship of an ACO participating in non-governmental (as well as governmental) shared saving programs is deemed to be related to the charitable purpose of promoting health for the benefit of the community. Even where such an ACO is a joint venture between a nonprofit hospital and for-profit medical providers, and/or where the ACO is not formed pursuant to the MSSP and serves patients covered by non-governmental health insurance, effective control over the ACO's activities should be sufficient to ensure that such activities serve a tax-exempt purpose.

Conclusion

The IRS should issue a revenue procedure containing a safe harbor from private benefit and private inurement with respect to a tax-exempt organization's participation in the MSSP through an ACO. Such guidance would provide certainty to tax-exempt organizations and reduce the IRS's administrative burden. Any safe harbor should include the five conditions set forth above, but should clarify that the third and fifth conditions (relating to proportionate economic benefits and fair market value terms) will not be applied too strictly. In addition, the revenue procedure should explicitly state that serving non-Medicare patients through an ACO satisfying the applicable conditions will not violate the private benefit or private inurement rules.

VHA appreciates IRS's recognition that an exempt organization's participation in the Medicare program satisfies the charitable purpose requirement by virtue of lessening the burdens of government. The same rationale should apply to participation in a Medicaid shared savings program, which would also satisfy the additional charitable purpose of relieving the poor and distressed.

IRS also needs to issue guidance regarding when a tax-exempt organization's participation in a shared savings program with respect to non-governmental insurance will be regarded as an activity substantially related to its tax-exempt purpose. VHA believes that when the ACO conducting such activities is effectively controlled by one or more tax-exempt hospitals, the ACO's activities should be treated as furthering a charitable purpose.

For further information regarding any of the topics discussed herein, please contact Cidette Perrin, Senior Director, Governmental Relations at (202) 354-2608 or cperrin@vha.com.

Sincerely,

Edward N. Goodman

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Vice President, Public Policy

cc: Kathleen M. Nilles, Esq.
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