Notice 2011-20

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

May 31, 2011

Internal Revenue Service
SE:T:EO:RA:G (Notice 2011-20)
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice 2011-20 (IRS Guidance and Solicitation of Comments) on ACOs and the Medicare Shared Savings Program

Dear Sirs:

The Texas Medical Association (TMA) appreciates this opportunity to comment on the Internal Revenue Service's (IRS) Notice 2011-20 (i.e., IRS guidance and solicitation of comments regarding tax exempt organizations participating in the Medicare Shared Savings Program through an "accountable care organization.")

TMA is a private voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its mission is to "Improve the health of all Texans." Its almost 46,000 members practice in all fields of medical specialization. It is located in Austin and has 119 component county medical societies around the state.

Consistent with its mission, TMA has a keen interest in advocating for laws and regulations promoting both increased quality and efficiency in the delivery of healthcare. TMA recognizes that accountable care organizations (ACOs) and the Medicare Shared Savings Program (MSSP), as envisioned by Congress, under Section 3022 of the Patient Protection and Affordable Care Act, are directed towards this end.

Many potential challenges, however, are presented in transforming the theory behind ACOs into practice. TMA acknowledges that, among those potential challenges, are considerations regarding the participation of an organization described in Section 501(c)(3) of the Internal Revenue Code in the MSSP.

TMA, therefore, appreciates the IRS' proactive approach in issuing guidance and requesting comments regarding the participation of 501(c)(3) tax-exempt organizations

(primarily tax-exempt hospitals) in ACOs in the MSSP. TMA respectfully offers the following comments on IRS Notice 2011-20.

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

The IRS Notice begins by soliciting comments regarding "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." *See* Notice 2011-20, Page 1. TMA contends that the existing guidance, along with the additional guidance provided in Notice 2011-20, is generally sufficient for 501(c)(3) organizations seeking to participate in the MSSP through an ACO **(with a few exceptions noted infra).**

Beginning with the private inurement/private benefit analysis, the Discussion section states that that "because of CMS regulation and oversight of the MSSP, as a general matter, 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 private party ACO participants where:

- 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. If the tax-exempt organization receives an ownership interest in the ACO, the ownership interest received is proportional and equal in value to its capital contributions to the ACO and all ACO returns of capital, allocations and distributions are made in proportion to ownership interests;

- 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; and

- 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.

A. IRS Proposed Private Inurement/Private Benefit Requirements Regarding Participation in MSSP and Proportional Distributions (Pages 7 – 8)

TMA agrees that, "as a general matter," the elements described above serve as safeguards ensuring a lack of private inurement/private benefit, consistent with Section 501(c)(3) requirements. However, TMA seeks clarification of the second element and strongly urges the IRS to re-examine the third element (in the bullets above). The second bullet states that private inurement/private benefit is unlikely when CMS has accepted the ACO into, and has not terminated the ACO from, the MSSP. While TMA understands that the IRS envisions this criterion as a desirable element due to the CMS oversight provided for MSSP participants and the community focus of ACOs inherent to the MSSP, TMA seeks clarification regarding how the unexpected termination of the ACO from the MSSP may affect the tax-exempt status of the participant organization. Additionally, TMA queries whether such termination results in an immediate private inurement/private benefit concern or whether a grace period/unwinding period may be available to the underlying tax-exempt ACO participant.

Next, TMA is strongly opposed to the third bullet, which requires the tax-exempt organization's share of MSSP payments, ownership interest in the ACO, and other returns/disbursements from the ACO to be proportional to the tax-exempt organization's capital contributions to the ACO. TMA contends that this element will act as a considerable barrier/disincentive to the collaboration of tax-exempt hospitals with independent physician practices in forming ACOs to participate in the MSSP (as envisioned by PPACA). This is true, because it fails to adequately acknowledge the physicians' significant non-capital investments (e.g., services and expertise) in the ACO and will inappropriately constrain disbursement of MSSP payments to physician participants.

The Centers for Medicare and Medicaid Services (CMS) itself estimates the aggregate cost for start-up investment and first year operating expenditures for MSSP ACOs to range from $131 million to $263 million, assuming 75 to 150 ACOs participate in the MSSP. *See* 76 Fed. Reg. 19633. Physician practices are highly unlikely to independently have the financial resources to create an ACO or to offer significant capital investments in ACOs. It is, therefore, likely that hospitals participating in ACOs, including tax-exempt hospitals, will be the primary providers of capital for the start-up costs in ACO formation. Thus, under the IRS guidance as currently drafted, the tax-exempt hospitals will take the lion's share of MSSP payments, despite the considerable non-capital contributions of physicians.

TMA strongly urges the IRS to modify its guidance to permit the ACO's allocation of ownership interest and the distribution of revenues (including MSSP payments) to appropriately recognize the contribution of services and expertise provided by ACO non-exempt professional participants (i.e., physicians and other providers).

B. IRS Proposed Case-by-Case Approach to Private Inurement/Private Benefit Analysis (Page 7)

Next, TMA supports the IRS' stated intent of determining whether prohibited inurement or impermissible private benefit has occurred on a case-by-case basis, using a totality of the circumstances approach. *See* Notice 2011-20, Page 7. Although it is important to provide basic guidance to tax-exempt organizations seeking to participate in an ACO in the MSSP (as is accomplished in Notice 2011-20), TMA believes that the assessment of tax-exempt status must be individualized, given the varying structures and circumstances surrounding ACOs.

TMA notes that the basic purpose of the MSSP is to encourage providers to modify utilization of Medicare services in a fashion that reduces total Medicare cost for the beneficiaries that they treat. TMA acknowledges that tax-exempt hospitals will frequently join with physician practices or other providers in order to provide the full range of services required for successful MSSP performance. The structure and organization of these agreements will vary depending upon many factors, including individual state laws governing the practice of medicine. Because these organizations could take unanticipated forms and because tax-exempt 501(c)(3) status is frequently analyzed on an individualized basis, TMA strongly agrees that IRS determinations regarding private inurement will need to be made on a case-by-case basis. It is possible that satisfaction of the CMS MSSP rules and the additional factors set forth in Notice 2011-20 on pages 7 and 8 alone will not adequately prevent private inurement/private benefit in certain, discrete circumstances. The IRS, therefore, must maintain its ability to appropriately assess such circumstances.

II. Tax Exempt Status for ACOs

Finally, TMA notes that Notice 2011-20 focuses exclusively on the tax-exempt status of an organization, such as a hospital, participating in an ACO under the MSSP. The Notice is silent regarding requirements for the ACO itself (rather than a participant of the ACO) to be granted tax -exempt status and does not solicit comments on this issue.

Although the issue is not raised in this Notice, TMA has serious concerns about potential methods that may be used to grant tax-exempt status to ACO entities themselves. Currently, some physician organizations affiliated with tax-exempt hospitals have been granted derivative tax exempt status by qualifying as a "captive" of the hospital or related exempt entity. *See, generally*, Kenneth L. Levine, "Obtaining 501(c)(3) Status for Professional Medical Corporations," 2 DePaul J. Health Care L. 231 (1998). Physician organizations may qualify as captives by provisions such as: (1) allowing hospitals to control the appointment and removal of the board of directors of the professional corporation, (2) giving hospitals the power to control stock transfers, (3) prohibiting changes in professional corporation bylaws without hospital approval or (4) allowing hospital control of all physician compensation. *Id.*

TMA is vehemently opposed to the use of derivative/integral part/captive test as a mechanism for providing tax-exempt status to an ACO. Application of the derivative status/integral part test with the captive control element is fundamentally incompatible with the unique ACO structure mandated under PPACA from both a legal and a policy standpoint.

First, from a legal standpoint, allowing a tax-exempt organization (such as a hospital) that is a participant in an ACO with non-tax exempt entities (such as physician practices) to control the ACO either directly through all hospital governance of the ACO or indirectly through beneficial ownership or restrictive shareholder control agreement is directly in contravention of the shared governance requirement for ACOs under PPACA. Specifically, 42 USC 1395jjj(b)(1) states that the groups of providers of services and suppliers eligible to participate as ACOs under the MSSP are those that "have established a mechanism for shared governance." If a tax-exempt hospital holds the ACO "captive," by exerting the traditional control mechanisms used for derivative or integral part status, then the ACO has, in practice, a mechanism for *sole* governance by a single ACO participant in place, not *shared* governance. The ACO is, therefore, rendered non-compliant with the shared governance structure mandated by PPACA and, by definition, ineligible for MSSP participation. Thus, TMA contends that the IRS is statutorily prohibited from granting 501(c)(3) status to an ACO under the traditional "captive" analysis.

Second, from a policy standpoint, truly shared governance with the physician participants in an ACO (rather than nominal sharing of governance) is imperative in order to ensure that the improved health and improved care elements of CMS' "triple aims" are achieved through ACO implementation. ACOs participating in the MSSP are charged with the difficult task of simultaneously improving quality of care while reducing costs. This task may, at times, result in tension regarding the appropriate care to be rendered to a particular ACO patient. However, the cost concern should never take precedence over quality patient care. Physician participation and "sharing" in the governance of the ACO ensures that patient care is always paramount.

Importantly, the physician's ethical obligation always resides, first and foremost, with the patient. *See* AMA Principles of Medical Ethics, Principle VIII, stating that "A physician shall, while caring for a patient, regard responsibility to the patient as paramount." In striking contrast, hospitals and other non-professional providers, are not bound by the same ethical obligations to patients. Hospitals have financial duties to their shareholders or their mission, which may sometimes be at odds with appropriate or optimal patient care. Consequently, permitting hospitals to have sole governance of an ACO by making the ACO the "captive" of a tax-exempt hospital creates a situation under which patient care may sometimes be secondary to financial concerns. In order to minimize this potential and to ensure that the ACO is sufficiently patient-centric, physicians must be actively engaged in the ACO's design, governance, implementation, monitoring, and evaluation.

It is important to note that physicians and other ACO professionals will face significant pressure in the MSSP to (1) reduce the utilization frequency of services or to (2) substitute lower cost services for higher cost services for Medicare beneficiaries. Reducing utilization frequency or intensity may pose a risk that Medicare beneficiaries fail to receive services that are of benefit to them. In an attempt to assure that clinically useful services are not reduced or eliminated, the MSSP requires reporting and compliance with quality performance standards, which will include a limited number of process and outcome measures. *See* 42 USC 1395jjj(b)(3). However, additional physician oversight through physician ACO governance roles is necessary to provide patient protection for the entire universe of patient care, which is simply too vast for CMS to measure or oversee. Simply put, the traditional paradigm of physician control of medical decisions should not be disturbed for the purpose of granting tax-exempt status to an ACO.

Based upon the foregoing, TMA strongly contends that the terms and conditions that qualify an ACO as "captive" of a tax-exempt organization (e.g., hospital) are directly in conflict with the "shared governance" requirement of PPACA for the MSSP. Additionally, the terms and conditions that qualify an ACO as "captive" of a tax-exempt organization may interfere with the critical authority of physicians in the ACO to make quality of care decisions that serve patient interests, which may sometimes be at odds with the tax-exempt hospital's interests. Therefore, TMA urges the IRS to take efforts to ensure that tax law does not conflict with the "shared governance" requirement of PPACA or create conditions or incentives that interfere with clinical decisions about patient care quality.

To that end, TMA recommends that the IRS not permit the use of the derivative/integral part/captivity test as a standard for granting tax-exempt status to an ACO participating in the MSSP. Instead, TMA recommends that the IRS permit the ACO to demonstrate its own community benefit with departures/modifications from traditional IRS guidance to accommodate the "shared governance" structure mandated by PPACA and other requirements mandated under PPACA. Such flexibility should be permitted in granting tax-exempt status to ACOs participating in the MSSP, since such ACOs are subject to significant federal oversight via the MSSP and are supposed to be inherently community-oriented with the numerous patient-centric requirements of the MSSP, such as requirements regarding patient engagement and measures of patient experience of care. *See, e.g.*, 42 USC 1395jjj(b)(2)(G) and (b)(3)(A)(ii).

III. Conclusion

Once again, TMA thanks you for the opportunity to provide these comments. If you should have any questions or need any additional information, please do not hesitate to contact me or the following staff of the Texas Medical Association: Lee A. Spangler, JD, TMA Vice President, Division of Medical Economics; Donna B. Kinney, CPA, TMA Director, Research and Analysis; or Kelly Walla, JD, LLM, TMA Associate General Counsel at TMA's main number 512-370-1300.

Sincerely,

Asa C. Lockhart, MD, MBA, Chair
Ad Hoc Committee on Accountable Care Organizations