Notice 2011-20

UPMC HEALTH PLAN

Two Chatham Center
Eleventh Floor
112 Washington Place
Pittsburgh, PA 15219
412-434-1200
412-454-7527 (fax)

www.upmchealthplan.com

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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

On behalf of UPMC, we are pleased to submit the following comments in response to the IRS Notice and Request for Comments on Tax Exempt Entities Participating in the Medicare Shared Savings Program through an Accountable Care Organization (the "Notice"). UPMC, a tax-exempt organization (TEO), is and has long been deeply committed to improving the manner in which health care is delivered to its patients, and to offering those patients only the highest-quality, state-of-the-art care and services. UPMC recognizes that, going forward, it, and other premier institutions like it, must play a leading role in transforming the manner in which care is delivered and financed in the United States.

We commend the IRS for its coordinated effort with CMS, the FTC and DOJ to release comprehensive regulations, as well as other guidance, on a multitude of anticipated issues related to ACO formation and operation. The participation of UPMC and other TEOs in the MSSP (and in other CMS demonstration projects and novel commercial cost-reduction and coordinated-care initiatives) is vital to achieving CMS's Triple Aim of better care, better health, and lower per capita costs. The IRS clearly recognizes the challenges that may face TEOs seeking to participate in the MSSP and, by releasing the Notice, has provided them much needed guidance as to how to structure such participation to avoid jeopardizing tax-exempt status. UPMC understands that, while participation by TEOs in ACOs is critical to the success of the Medicare Shared Savings Program, such participation should not pave the way for the evisceration of existing bright-line distinctions between taxable and tax-exempt organizations, or otherwise allow TEOs to ignore the well-established rules and parameters of tax exemption. It is with this support for both participation by tax-exempt entities in ACOs and the integrity of the tax code itself that UPMC respectfully submits the following comments.

We appreciate the IRS's effort to identify a list of criteria/conditions/activities to guide TEOs wishing to preserve tax-exempt status while participating in ACOs. We support "acceptance of the ACO into the MSSP by CMS" as a solid indication that the ACO is indeed structured and

designed to better serve patients by reducing costs and improving quality, and not as a sham to allow a TEO to covertly direct its profits to private parties.

As for the remaining criteria/activities on the list, we believe that more detailed guidance is necessary. First, in theory, we support the requirement that the TEO's participation in the MSSP be memorialized in a written agreement negotiated at "arm's length." Likewise, we support the requirement that all contracts/transactions between TEOs, an ACO and ACO participants be executed for "fair market value." We question, however, the factors that will trigger reviews as to the "arm's length" nature of negotiations or the "fair market value" of contracts/transactions, the criteria upon which determinations will be based, and the entities responsible for conducting such reviews. Because inclusion of smaller ACO participants will be critical to the MSSP's success, and ACO start-up costs will be substantial (the American Hospital Association estimates that start-up costs will be between $11.6 and $26.1 million dollars), better-funded TEOs may be called upon to assume somewhat larger or disproportionate shares of financial and other obligations than would otherwise generally be expected. Whether seemingly lop-sided negotiations, contracts or transactions will be considered "arm's length" or of "fair market value" is an open question of considerable consequence to a TEO. As such, we respectfully request additional guidance on both the standards of review and procedural mechanisms by which these determinations will be made.

Likewise, while we understand and theoretically support the proposition that a TEO's economic benefits, ownership interests and losses be proportionate to the TEO's contributions to an ACO, we have reservations about the practical application of this standard. We understand that, generally, a tax-exempt organization that provides facilities, services or other items for less than fair market-value compensation or subsidizes operating losses without expectation of repayment will be viewed as improperly providing a private benefit or inurement to the recipient. However, improving the clinical and cost outcomes of our current care-delivery system will require a fundamental transformation of that system. Such transformation cannot and will not be achieved effortlessly or without substantial capital and other investments. As such, when a TEO is willing and able to make capital and other investments into an ACO or is able to withstand losses at a level disproportionate to smaller ACO participants, it should be permitted to do so. We believe that, rather than applying a proportionality requirement, the inquiry should instead focus upon whether such investments are made in furtherance of a TEO's exempt purpose and/or the goals of the MSSP, including the promotion of health by lowering medical costs and improving health care quality. When they are made for these purposes or goals, such contributions should not be deemed to constitute an improper inurement or benefit. We respectfully request that the IRS provide guidance articulating this standard.

Further, we note that the promotion of health has long been recognized by the IRS as a charitable purpose, albeit not in all instances. In the Notice, the IRS articulates its position that "negotiating with private health insurers...is not a charitable activity, regardless of whether the

agreement negotiated involves a program aimed at achieving cost savings in health care delivery." We respectfully assert that, in light of the magnitude and scope of continually escalating medical costs in the United States and the fundamental changes that will be necessary to reverse this escalation, this position be reconsidered. The Kaiser Family Foundation's annual report on health care spending found that the United States now spends $7,538 a year on each American. That is at least $2,535 more, or 51 percent higher than the next largest per capita spender (Norway). U.S. health care spending as a portion of gross domestic product (GDP) is also growing faster than that of any other industrialized nation. If this unsustainable trend continues, health care will soon account for more than a quarter of the nation's total GDP.

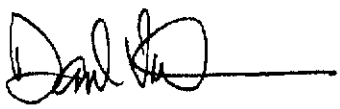
The current cost crisis is certainly not limited to Medicare or Medicaid alone, but cuts across the entire commercial market as well. The looming fiscal crisis therefore cannot be averted without fundamental changes to the manner in which we approach health care financing and delivery in all segments. Just as the problem of growing costs cannot be solved through Medicare alone, the ultimate success of ACOs both inside and outside the MSSP is necessarily linked to all aspects of our healthcare system. Many providers, hospitals in particular, do not provide care to patients with only one type of health insurance coverage. Accordingly, ACOs and ACO participants should not be asked to allocate, attribute or otherwise limit their cost-reduction and quality-improvement efforts to patients from one market segment. On the contrary, encouraging the expansion of MSSP and ACO principles to both Medicaid and the private market will allow the program model to be more thoroughly refined while improving overall patient care. Achieving cost savings through the efficient delivery of high quality health care benefits all Americans (and the community at large) by making coverage more affordable; it simultaneously lessens the government's growing burden of financing coverage for millions of Americans who cannot otherwise afford coverage.

While we understand the importance of maintaining the integrity of long-standing tax-exemption standards, we believe there is room within those standards to recognize the way in which ACO development and improvement can directly contribute to a combined purpose of promoting population and individual health while also reducing health care costs. Accordingly, reducing health care costs should unequivocally be deemed a charitable purpose, particularly when such cost reductions are accompanied by an increase in the quality of the services delivered, as required by the Medicare Shared Savings Program. We respectfully assert that the IRS issue guidance which provides the same.

Finally, the IRS Notice does not indicate whether an ACO could itself be considered a tax-exempt entity. We read nothing to suggest that it could not be – assuming it meets existing requirements to qualify for such tax treatment – but respectfully request clarification in this regard.

Thank you for providing us the opportunity to offer input into the IRS Notice and Request for Comments on Tax Exempt Entities Participating in the Medicare Shared Savings Program through an Accountable Care Organization. We appreciate your consideration of these comments and look forward to working with you in the future.

Sincerely,



Daniel Vukmer, Esq.
Vice President & General Counsel
Chief Compliance Officer
UPMC Insurance Services Division