American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

BY ELECTRONIC MAIL & HAND DELIVERY

May 31, 2011

SE:T:EO:RA:G (Notice 2011-20)
Courier's Desk
Sarah Hall Ingram
Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

RE: Notice 2011-20; Request for Comments Regarding Participation by Tax-Exempt Hospitals in Accountable Care Organizations

Dear Commissioner Ingram:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and the nearly 200,000 employed physicians within those organizations, the American Hospital Association (AHA) is pleased to offer comments in response to Notice 2011-20 (Notice) issued by the Internal Revenue Service (IRS or Service). In the Notice, the Service asks for comments regarding participation of tax-exempt hospitals in an accountable care organization (ACO), which is an entity described in §1899(b)(1) of the *Patient Protection and Affordable Care Act of 2010* (ACA), enacted March 23, 2010.

To summarize our comments, we respectfully request that IRS issue:

- A clear statement for tax-exempt hospitals that participating in an eligible ACO will not result in impermissible inurement and private benefit and will not generate unrelated business income tax (UBIT), so long as the ACO complies with regulations promulgated by the Centers for Medicare & Medicaid Services (CMS).
- A clear statement indicating whether the Service will consider granting tax-exempt status to ACOs.
- Clear guidance that the Service will extend its existing joint-venture precedents to other clinically integrated organizations that do not choose to participate in the ACO program, but provide similar benefits, and do so in a flexible manner that recognizes that such

organizations may take a variety of forms in their efforts to provide accountable care to diverse communities.

BACKGROUND

The ACA established the Medicare Shared Savings Program (ACO Program), which promotes the voluntary formation and operation of ACOs[1] to coordinate and improve care for Medicare beneficiaries, beginning January 1, 2012. ACOs that meet certain quality and other standards will be eligible to share in savings that result from their efforts. On March 31, CMS released proposed regulations for the new program.

Also on March 31, three other government agencies, in a coordinated effort, released additional information related to ACO development: CMS and the HHS Office of Inspector General published a notice on fraud and abuse waivers; the Department of Justice and the Federal Trade Commission issued a "Proposed Statement of Antitrust Enforcement Policy," and the IRS published Notice 2011-20.

NOTICE 2011-20

In Notice 2011-20, the Service addressed two primary concerns for tax-exempt hospitals that participate in an ACO. First, the Service considered whether participation by a tax-exempt hospital in the ACO Program through an ACO is consistent with the organization's tax-exempt status under Section 501(c)(3). The Service concluded that a tax-exempt hospital's participation through an ACO would generally further the charitable purposes of lessening the burdens of government and promoting health. However, the Service advised that a tax-exempt hospital must ensure its participation in an ACO will be structured to avoid prohibited inurement and impermissible private benefit. Although the Service anticipates evaluating possible instances of inurement or private benefit on a case-by-case basis, the Service stated that a tax-exempt hospital will generally not run afoul of these restrictions if the ACO participants observe a series of rules listed in the Notice.

Second, the Notice addressed whether a tax-exempt organization's share of the payment received from participation in an ACO would be subject to UBIT. The Service explained that, so long as an ACO meets all the eligibility requirements established by CMS for participation in the ACO Program, and absent inurement or impermissible private benefit, any payments received by a tax-exempt hospital from an ACO would be deemed to be derived from activities that are substantially related to the performance of the hospital's charitable purpose. Such charitable purpose includes lessening the burdens of government. Because the federal government considers providing Medicare to be its burden, the ACO's function in promoting quality

[1] Unless otherwise indicated, ACO here refers to those organizations participating in the Medicare Shared Savings Program, not to other integrated organizations providing accountable care.

improvements and cost savings will reduce the government's burden in providing Medicare benefits.

In the Notice, the Service also acknowledged that a tax-exempt organization may participate in an ACO that conducts activities unrelated to the ACO Program. Some of those activities may lessen burdens on the government and thereby align with a tax-exempt's charitable purpose, while other activities may not. The IRS provided as an example of a "non-charitable" activity negotiating with private health insurers on behalf of unrelated parties, regardless of whether the agreement negotiated involves a program aimed at achieving cost savings in health delivery. On the other hand, the IRS cites participation in shared savings arrangements with Medicaid as an example of an activity that would advance a tax-exempt's charitable purpose.

Finally, the Service requested comments regarding two issues:

- what additional guidance is necessary to facilitate participation by a tax-exempt organization in the ACO Program; and
- how would a tax-exempt organization's participation in activities outside the ACO Program further or be substantially-related to an exempt purpose.

DISCUSSION OF RECOMMENDATIONS

IRS Should Issue Guidance Assuring Hospitals Participating in an ACO Will Retain Their Tax-Exempt Status

Notice 2011-20 appears to assure tax-exempt participants in a properly structured ACO that, if the ACO meets CMS criteria, the tax-exempt participants will neither jeopardize their tax-exempt status nor generate UBIT. However, in the same paragraph the Service cautions that it will evaluate all ACO arrangements on a case-by-case basis, based on all facts and circumstances, to determine if prohibited inurement or impermissible private benefit has occurred. The Service suggests that even if an ACO complies with all the CMS terms to be an ACO eligible to participate in the ACO Program, it may still risk violating the prohibition on private inurement and private benefit. The threat to tax-exempt hospitals of losing their exempt status is unnecessary and could deter hospitals from joining ACOs.

To encourage participation, the Service should provide an unequivocal statement that tax-exempt hospitals participating in an eligible ACO will not be engaging in inurement or impermissible private benefit. The Service has previously provided a similar assurance to tax-exempt hospitals with respect to electronic health records (EHRs) in a memorandum from the Director of Exempt Organizations, dated May 11, 2007. The Service disseminated the memorandum after the Department of Health and Human Services issued final regulations that permitted hospitals to provide, within specific parameters, EHR software and technical support services to staff physicians without violating the federal anti-kickback law. The memorandum addressed cases in which Section 501(c)(3) hospitals provided staff physicians financial assistance to acquire and implement software used to create, maintain and transmit EHRs for patients. Responding to concerns regarding inurement and private benefit, the Service stated:

> "We will not treat the benefits a hospital provides to its medical staff physicians as impermissible private benefit or inurement in violation of Section 501(c)(3) of the Code if the benefits fall within the range of Health IT Items and Services that are permissible under the HHS EHR Regulations…."

Analogously, the Service should issue a clear statement for tax-exempt hospitals that participating in an eligible ACO will not result in impermissible inurement and private benefit and will not generate UBIT, so long as the ACO complies with regulations promulgated by CMS.

Tax-Exempt Status for ACOs

In the Notice, the Service lists groups of service providers that may form an ACO, including:

- physicians and other health care practitioners in a group practice;
- a network of individual practices;
- a partnership or joint-venture arrangement between hospitals and ACO professionals; and
- a hospital employing ACO professionals.

The Service, however, does not suggest whether any of the entities may be granted tax-exempt status. **The AHA recommends that the IRS address specifically the potential for tax-exempt status for the ACO itself.** Granting ACOs tax-exempt status will encourage participation by tax-exempt hospitals and ensure that ACOs' activities further a charitable purpose.

The Service has previously granted tax-exempt status to similar groups of health care providers that participated in regional health information organizations (RHIOs). RHIOs were established to facilitate access to EHRs and coordinate exchange of information among hospitals, physicians and insurers, in an effort to reduce health care costs and improve outcomes for patients. The Service granted RHIOs tax-exempt status in recognition of the fact that they will promote health, benefit the community at large and generate only an incidental amount of private benefit. Additionally, tax-exempt status was granted to RHIOs to encourage participation in RHIOs by tax-exempt hospital organizations that possessed resources necessary to establish a successful RHIO.

The rationale for granting tax-exempt status to RHIOs applies equally to ACOs. The purpose of an ACO is to improve accountability for care of Medicare beneficiaries, improve coordination of Medicare fee-for-service items and services and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery. ACOs will be promoting health of the large section of the community, similar to RHIOs.

Participation in a Clinically Integrated Organization That is Not an ACO Should Not Affect a Hospital's Tax-Exempt Status

Definition of an "ACO". The discussion regarding participation by tax-exempt organizations in clinical integration activities outside the Medicare program is confusing. The Service appears to confuse (Medicare) ACOs and other types of clinically integrated organizations. Simply put, an ACO is not the only means for providers to come together to coordinate care. There are many

other types of clinically integrated organizations that engage in the same type of accountable, coordinated care activities as ACOs.

The Service appears also to confuse the activities of a legitimate clinically integrated organization with that of a sham arrangement that involves only joint pricing among competitors, but does not provide the benefits of improved quality and coordinated care activities that are the hallmarks of clinical integration. Investigating and prosecuting sham arrangements is the province of two federal agencies – the Federal Trade Commission (FTC) and the Department of Justice (DOJ) (collectively, the Antitrust Agencies). To the extent that a clinically integrated arrangement is a sham, the Antitrust Agencies provide sufficient oversight.

Joint-Venture Guidance. To evaluate whether a tax-exempt hospital's participation in a clinically integrated organization furthers a charitable purpose, the Service may rely on precedents involving joint ventures between tax-exempt organizations and private persons. The Service has issued numerous Revenue Rulings and Private Letter Rulings discussing joint ventures between tax-exempt organizations and private individuals or for-profit entities. Previous guidance has highlighted several factors that the Service evaluates to determine whether the venture will advance a charitable purpose, including:

- If the venture includes a tax-exempt hospital, the Service requires that the venture promote health among a broad spectrum of the community;

- The amount of control the tax-exempt organization exerts over the venture, which may be evidenced either by the number of votes the exempt organization possesses on the board of the joint venture, the power that is granted to the exempt organization by the venture's governing documents, or the operational role of the exempt organization in the venture;

- Management of the entity consistent with tax-exempt purposes, evidenced by provisions in the organizational documents of the venture and also in the management of the venture by parties unrelated to the for-profit member;

- Limitations on investment made by the tax-exempt organization and the exempt organization's ownership interests in the venture relative to its investment;

- Distributions received and whether they are consistent with the parties' economic interests in the venture; and

- Expertise that an exempt organization obtains from the venture, which may not be otherwise available to it.

Relying on the foregoing factors, the Service has approved joint ventures between tax-exempt hospitals and for-profit entities, provided the joint ventures furthered the charitable purpose of promoting health among the broad spectrum of the community. The Service has cited control of the joint venture by the tax-exempt entity as one factor that indicates the joint venture is

advancing health in the community. Although in Rev. Rul. 98-15, the Service approved a joint venture primarily because the tax-exempt hospital could appoint a majority of the board members, the Ruling focused specifically on a whole-hospital joint venture and the Service has since enabled tax-exempt organizations to demonstrate control in other ways. For instance, in Rev. Rul. 2004-51 the Service concluded that a university continued to qualify for exemption under Section 501(c)(3) when it contributed and operated part of its facilities through an LLC formed with a for-profit corporation, even though the tax-exempt and for-profit members could appoint an equal number of directors to the board. The Service relied on other indicia of control, such as the governing documents of the venture, which granted the exempt organization control over key decisions of the venture and ensured that the venture will not engage in any activities that may jeopardize the tax-exempt member's Section 501(c)(3) status.

Because a clinically integrated organization is essentially a joint venture, the Service may use the foregoing joint venture guidance to assess whether its activities further a charitable purpose. In doing so, however, the Service needs to be mindful that like ACOs, clinically integrated organizations are testing ways to improve the quality and coordination of care using different arrangements among the participants. Therefore, application of the joint-venture guidance needs to take the need for various types of arrangements into account.

The rulings discussed below indicate that the Service has, and has used its discretion in evaluating arrangements such as clinically integrated organizations, that promote health, benefit the community at large and generate only an incidental amount of private benefit.

- In the Notice the Service listed several factors it will evaluate to determine whether a tax-exempt hospital's participation in an ACO will result in private inurement or impermissible private benefit. For instance, the Service will evaluate the terms of the ACO's written agreement, the economics of the arrangement, and the transactions entered into by the parties. Such factors reflect those used by the Service to assess the activities of joint ventures in which tax-exempt organizations participate and thus should provide a sufficient framework for evaluating whether the activities of a clinically integrated organization furthers the charitable purpose of promoting health for a broad section of the community.

- Even if private individuals derive an incidental benefit from the activities of a clinically integrated organization, that factor alone should not prevent the organization from furthering a charitable purpose. In Rev. Rul. 97-2,1 the Service considered whether a tax-exempt hospital that provided recruitment incentives to physicians violated the prohibition on private inurement and benefit contained in Section 501(c)(3). Recruitment incentives encompassed payment of physicians' liability insurance, home mortgage guarantees, reimbursement of moving expenses and subsidized office space. The Service concluded that these incentives would not cause a tax-exempt hospital to fail the inurement and private benefits prohibitions of 501(c)(3), so long as a hospital can objectively demonstrate that such recruitment incentives allow it to reasonably promote and protect the health needs of the surrounding community.

- The Service confirmed in PLR 200601030 that financial incentives can be provided to individuals who achieve goals established by the tax-exempt organization, without violating the prohibitions on inurement and private benefit. The PLR discusses a 501(c)(3) educational institution that established an incentive program for employees who made key contributions to the organization enabling it to advance its tax-exempt purpose. The Service, relying on Rev. Rul. 97-21, stated that the incentive program will not adversely affect the organization's tax-exempt status. Analogously, a clinically integrated organization will offer incentives to physicians who follow evidence-based medical protocols and provide other benefits to patients. Based on the PLR, such payments should not compromise a tax-exempt hospital's Section 501(c)(3) status. Therefore, according to Rev. Rul. 97-21 and PLR 200601030, incidental benefit to private parties that accrues as a result of activities of a clinically integrated organization should not compromise a tax-exempt hospital's Section 501(c)(3) status, so long as it furthers the charitable purpose of promoting health for a broad spectrum of the community.

Oversight by FTC and DOJ. To the extent the Service is concerned about oversight over clinically integrated arrangements, to assure that they are legitimate and not shams, we believe that it may rely on the Antitrust Agencies. The Antitrust Agencies have explained that their indicia for evaluating legitimate clinical integration, as reflected in the DOJ/FTC *Statements of Antitrust Enforcement Policy in Health Car*e, are similar to those CMS employs for ACOs.

Specifically, oversight of clinically integrated organizations by the Antitrust Agencies involves several issues. First, they consider whether an organization has sufficient clinical and/or financial integration to achieve substantial efficiencies in delivering care as reflected by improved quality and lower costs. Among the factors that are considered by the Antitrust Agencies are the following:

- Selectively choosing program physicians who are likely to further the program's efficiency objectives by applying extremely selective participation criteria tied to quality, cost-control and other efficiency measures;

- Establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care by disseminating clinical protocols among members, collecting and analyzing data regarding providers' performance and establishing a process for providing feedback to providers; and

- Investing capital, both monetary and human, in the necessary infrastructure to realize efficiencies by providing tools and processes that help doctors improve their care and working with providers so they can understand the program's goals.

Significantly, many of these activities are aimed at providing tax-exempt hospitals with the ability to work more closely with physicians and other providers to coordinate care in and outside of the hospital setting.

Second, the Antitrust Agencies must address whether any joint negotiations with health plans are reasonably necessary to achieve the efficiencies and legitimate goals they seek to accomplish. The standard the Antitrust Agencies use in evaluating joint negotiations is whether they are subordinate and reasonably necessary to achieve high quality, efficiently delivered health care. To the extent the Antitrust Agencies find that such negotiations do not meet these standards, they will challenge the organization. See N. Tex. Specialty Physicians v. Fed. Trade Comm'n, 528 F.3d 346 (5th Cir. 2008); "FTC Settles Price-Fixing Charges Against Two Separate Doctors' Groups," FTC Press Release, Dec. 24, 2008 (describing settlements with physicians groups in Modesto, CA, and Boulder, CO). Together, oversight and enforcement by the FTC and DOJ provide an adequate framework to ensure that a clinically integrated organization will promote health for a broad spectrum of the community and further exempt purposes.

We look forward to working with the Service on guidance that assists in the development of ACOs and other clinically integrated organizations. In that regard, we respectfully request a meeting to discuss our comments and the next steps in the implementation process. If you have any questions, please contact me at mhatton@aha.org or (202) 626-2336.

Sincerely,

_____/S/_____
Melinda Reid Hatton
Senior Vice President & General Counsel