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Transforming Healthcare Together®

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: Comments on IRS Notice 2011-20

Ladies and Gentlemen:

On behalf of the Premier healthcare alliance serving more than 2,500 leading hospitals and health systems and 75,000-plus other healthcare sites, we would like to provide comments to the Internal Revenue Service (Service) regarding the participation by tax exempt organizations in the Medicare Shared Savings Program (MSSP) established under Section 3022 of the Patient Protection and Affordable Care Act of 2010 (PPACA) and payment and service delivery models developed by the Center for Medicare and Medicaid Innovation (Innovation Center) under Section 3021 of PPACA, as well as similar arrangements with commercial payors. Premier, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our member hospitals and health systems, substantially all of which are tax-exempt organizations. As service providers, the members of our alliance have a vested interest in the effective operation of accountable care organizations (ACOs). This is particularly true of the nearly 90 health systems participating in our Accountable Care Collaboratives, launched in May 2010.

BACKGROUND

The Premier healthcare alliance believes that, as a nation, we all must work to rein in spiraling U.S. healthcare costs, expand access, promote wellness and improve the consistency of quality outcomes. We know we need to move from a disjointed, siloed "system" of delivery to one that is better coordinated and aligned to provide real *value* to patients, providers and payors alike. But, this requires a new vision, new culture, and new practice -- none of which are easy to achieve in healthcare.

While still evolving, the concept of ACOs is gaining ground and represents a way to overcome today's challenges without rationing care or dramatically increasing taxes. ACOs are designed to closely connect groups of providers who are willing and able to take responsibility for improving the overall health status, care efficiency and experience for a defined population. Thus ACOs can overcome the fragmentation and volume orientation of our existing fee-for-service system to more appropriately incentivize health and wellness, rather than treatment for illnesses. Achieving these incentives will "bend the cost curve" and revolutionize how care is paid for, provided and received. Nearly 90 member health systems have already started this journey with Premier to accelerate the development of innovative models for delivering care in the private sector with the goal of participating in the Medicare ACO program as soon as it is operational.

Members of the Premier alliance recognize that the concepts of accountable care and reimbursement based on shared savings are entirely new for Medicare, and as such, represent a major regulatory challenge. We strongly support CMS in its efforts to align payment among providers across the continuum of care, as well as the agency's focus on high-quality, people-centered care. We believe that this approach will support greater clinical integration and collaboration among doctors, hospitals and other care providers, and foster alignment of accountable care principles across public and private payors. We also believe the Service is to be commended for working cooperatively with CMS and other agencies that have jurisdiction over parts of the regulatory scheme affecting the development of accountable care, and for the willingness to solicit and consider feedback from providers concerning tax exemption issues. The end result of this unprecedented interagency collaboration will be better, safer and more convenient care delivered at a lower cost for the benefit of healthcare consumers nationwide.

Based on experience in our Accountable Care Collaboratives, Premier believes it is critical that government regulations do everything possible to remove impediments that could derail ACO development, to select strong candidate ACOs and to structure the program to maximize the potential for success.

In Notice 2011-20, 2011-16 I.R.B. 652, the Service indicated that it is considering how existing tax exemption and unrelated business income principles will apply to organizations described in section 501(c)(3) of the Internal Revenue Code (Code) that choose to participate in the MSSP through ACOs, and invited comments on such issues. In addition, the Service also invited comments concerning tax-exempt organizations' participation in ACOs outside of the MSSP context. Premier is pleased to offer its comments on these issues. In addition, we urge the Service to provide guidance regarding the conditions under which an ACO could itself qualify for tax-exempt status under section 501(c)(3).

PARTICIPATION IN THE MSSP BY TAX-EXEMPT ORGANIZATIONS

Premier appreciates the guidance provided by the Service concerning the conditions under which a tax-exempt organization's participation in the MSSP through an ACO will generally not result in inurement or impermissible private benefit to private party ACO participants and not result in recognition of unrelated business income. The objectives of the MSSP and the larger goals of health reform cannot be achieved if tax-exempt organizations, such as Premier's member hospitals and health systems, are unable to participate in this and other transformative programs envisioned under PPACA without jeopardizing their tax exempt status. We urge the Service, however, to consider the following points:

Set in Advance Requirement

The Notice provides that the Service will generally 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 if, among other requirements, the terms of the exempt entity's participation in the MSSP through the ACO (including its share or MSSP payments or losses and expenses) are *set forth in advance* in a written agreement negotiated at arm's length. Premier believes that this requirement can generally be met, since for instance the proposed CMS regulations require ACOs to submit a written description of the methodology to be employed in distributing shared savings among the ACO, ACO participants and ACO providers/suppliers.

The point of a "pay-for-performance" program such as the MSSP is to align incentives between the payor (in this case, Medicare) and providers by creating the opportunity to earn additional reimbursement based on achievement of objectives established by the payor (in this case, measurable improvements in the quality, cost efficiency, and patient and caregiver experience, of care provided to Medicare fee-for-service beneficiaries assigned to the ACO). In order to realize the payor's objectives and thus earn a bonus, the affected providers must align their own incentives so that they are all pulling the oars in the same direction. ACOs are faced with tremendous cultural and business challenges in achieving this realignment of interests. The current siloed, volume-driven delivery system reflects decades of government policies which are now being stood on their head. Premier agrees with most observers that in order to spark the transformation of deeply rooted practices toward an accountable care model, it is likely that most ACOs will establish incentive pools, funded with MSSP payments, to be shared among ACO participants based on their respective efforts at achieving the MSSP objectives. Any residual net income would then be split among the ACO's equity owners (if it is a for-profit entity).

It is important, therefore, for the Service to understand that it will often not be possible (or in fact desirable) to set forth in advance the precise percentages in which each ACO participant will share any pool(s) funded with MSSP payments. Rather, it is preferable that ACOs have the

ability to divide any pool(s) funded from MSSP payments earned by the ACO in proportion to the relative benefits or contributions that each ACO participant provides. Since it can generally be anticipated that ACOs will distribute shared savings payments based on the relative contributions of each provider to achieving the targets set by CMS, it would be possible for an ACO to set in advance only the *methodology* for division of shared savings payments. If the ACO were to set the precise sharing percentages in advance, the individual participating providers would have less motivation to transform their care delivery because they would be guaranteed that set percentage of any MSSP bonus even if they did little or nothing to help earn that bonus.

Premier urges the Service to clarify that the requirement that the terms of the exempt entity's participation in the MSSP through the ACO (including its share or MSSP payments or losses and expenses) be set forth in advance in a written agreement negotiated at arm's length, is satisfied if the written agreement specifies the methodology by which such allocations will be made.

<u>Termination from the MSSP</u>

The Notice provides that the Service will generally 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 if, among other requirements, CMS has accepted the ACO into, and has not terminated the ACO from, the MSSP.

The formation of ACOs will require substantial investment of capital, time and effort on the part of ACO participants. The objective of the MSSP is to promote a radical transformation in the way care is delivered. The outcome of this process is far from certain. The proposed CMS regulation describing the conditions for participation in the MSSP sets a high bar for ACOs. It is likely that some, if not many, ACOs will fail to achieve the measurable improvements in quality, cost efficiency and patient and caregiver satisfaction required under the MSSP. As a result, some of these ACOs may be terminated from the MSSP. Nothing about such termination would necessarily imply, however, that the net earnings of any tax-exempt organizations participating in those ACOs are inuring to the benefit of any private persons or that impermissible private benefit is being conferred on such persons. In fact, the uncertainty created by the specter that the Service could revoke an entity's tax exemption, or impose intermediate sanctions, simply because the ACO in which such organization participants fail to meet all of the MSSP requirements may have a substantial chilling effect on the willingness of tax-exempt entities to participate in ACOs at all.

Premier urges the Service to clarify that termination of an ACO from the MSSP will not jeopardize a tax-exempt participant's exempt status or result in the imposition of

intermediate sanctions, absent extraneous evidence of inurement or impermissible private benefit.

Proportional Returns

The Notice also provides that the Service will generally 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 if, among other requirements, (a) the tax-exempt entity'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 and (b) if the tax-exempt organization has an equity stake in the ACO, its ownership interest 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.

As discussed above, Premier believes that the first part of this test should be deemed to have been met if the ACO specifies in advance the methodology by which economic benefits derived from the ACO will be allocated among the ACO, ACO participants and ACO providers/suppliers based on their relative contributions to achieving those economic benefits.

Premier strongly endorses the second part of this test, but requests that the Service clarify that the use of the terms "allocations and distributions" in this case does not refer to distribution of MSSP payments from the pool(s) under contractual arrangements between the ACO and its providers, but rather to distribution or allocation of the ACO's net income and losses following payment of such expenses. In this regard, it is important to understand that non-equityholders will likely participate in the pool(s) funded from MSSP payments, so the allocation and distribution of those pool(s) will not necessarily mirror the allocation and distribution of net income and losses which Premier agrees should be made in proportion to the ACO's equity ownership percentages.

Sharing Losses

The Notice provides that the Service will generally 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 if, among other requirements, the tax-exempt entity'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 entity is entitled. As discussed above, the ability of ACOs to successfully transform the current care delivery system will be significantly hampered if ACOs are required to divide all MSSP payments and ACO losses in a lock-step fashion (e.g., the hospital and the physicians (as a group) are each allocated 50 percent of any upside or downside). Rather, the goals of the MSSP can better be achieved if ACOs and their

participating providers have flexibility to allocate MSSP payments and ACO losses in a manner that best aligns incentives to achieve program goals.

CMS clearly recognizes this, since the proposed MSSP regulation does not require that an ACO share downside risk with ACO participants and ACO providers/suppliers. Although such risk-sharing may well be a feature of many ACOs, fundamentally the risk of loss properly lies with the owners of the business. Those owners may be all ACO participants or a subset of those providers. As discussed in the preceding section of this letter, non-equityholders will likely participate in the pool(s) funded from MSSP payments, so the allocation and distribution of those pool(s) will not necessarily mirror the allocation and distribution of net income and losses. For example, if a tax-exempt entity that owns 60 percent of an ACO does little to help earn a MSSP payment, the alignment of incentives within the ACO will quickly fall apart if the tax-exempt entity is nonetheless guaranteed 60 percent of the pool(s) funded with MSSP payments earned primarily as a result of the non-exempt participant's efforts.

Premier urges the Service to withdraw the requirement that a tax-exempt organization's share of ACO economic benefits must equal or exceed its share of ACO losses. These are separate issues.

<u>Fair Market Value Requirement</u>

Finally, the Notice provides that the Service will generally 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 if, among other requirements, 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.

As a general proposition, Premier endorses the notion that tax-exempt organizations should engage in fair market value transactions with private parties. However, the inclusion of a fair market value requirement in this context may be unnecessarily restrictive. First of all, as discussed below, Premier urges the Service to provide guidance regarding the conditions under which an ACO could qualify for tax-exempt status. There is no reason why transactions between a tax-exempt hospital and a tax-exempt ACO should be required to be at fair market value, since any difference between the amount paid and fair market value would be considered a charitable contribution. Second, it may not always be possible to determine the fair market value of activities undertaken by ACO participants.

ACOs are very similar to hospital-physician gainsharing arrangements. The Service has previously stated in a 1999 unpublished private letter ruling that a tax-exempt organization's participation in a gainsharing arrangement with non-exempt physicians does not result in

inurement or impermissible private benefit to those private parties. In that situation, the Service recognized that the sharing of cost savings with private parties who helped to generate those savings furthered the hospital's exempt purposes. However, most observers would argue that it is difficult, if not impossible, to determine the fair market value of, for example, physicians' efforts in avoiding hospital readmissions or not opening surgical instrument packs until actually needed. The truth is that while ACO clinical integration and improvement activities would require significant physician involvement, payment would not be based on the value of physicians' services but rather on the savings achieved by the ACO.

As you may be aware, CMS has proposed an exception under the Physician Self-Referral Law for gainsharing arrangements which has not yet been finalized. We would note that the proposed gainsharing exception *does not* include a fair market value requirement, presumably for the reasons stated above. We would also note that the Physician Self-Referral Law was waived for the Medicare gainsharing demonstration.

Premier urges the Service to replace the fair market value requirement with a requirement that such contracts and transactions be commercially reasonably taking into consideration all of the surrounding facts and circumstances.

PARTICIPATION IN INNOVATION CENTER AND MEDICAID ACCOUNTABLE CARE PROGRAMS BY TAX-EXEMPT ORGANIZATIONS

Premier believes that the participation by tax-exempt organizations in other governmental accountable care programs, such as the Pioneer ACO program announced by the Innovation Center and Medicaid ACO arrangements that may be launched by the various states, should be entitled to the same presumptions set forth in the Notice with respect to the MSSP.

Premier urges the Service to provide assurance that the participation by tax-exempt organizations in ACOs or other accountable care programs initiated by the Innovation Center or state Medicaid programs will generally not result in inurement or impermissible private benefit to private party ACO participants and not result in recognition of unrelated business income.

PARTICIPATION IN COMMERCIAL ACO ARRANGEMENTS BY TAX-EXEMPT ORGANIZATIONS

As discussed above in this letter, ACO arrangements are simply "pay-for-performance" arrangements between a payor and a group of providers who are willing to accept collective accountability for achieving targets established by the payor with respect to the quality, cost efficiency, and patient satisfaction with care provided to individuals whose healthcare costs are paid, in whole or in part, by that payor. As such, the participation by a tax-exempt organization

in an accountable care program sponsored by a commercial payor is no different from any of the other types of commercial insurance or HMO arrangements that tax-exempt providers enter into every day. Premier believes that those activities further the exempt purpose of promoting community health and providing indispensable revenue to support a tax-exempt provider's charitable mission. Similarly, commercial ACO arrangements will not result in inurement or impermissible private benefit to any private person.

Premier urges the Service to provide guidance to the effect that it will generally not consider a tax-exempt organization's participation in any commercial payor's accountable care program through an ACO to result in inurement or impermissible private benefit to the payor or private party ACO participants if the ACO satisfies criteria similar to those described by the Service with respect to the MSSP, as modified by our recommendations concerning the MSSP guidance.

AVAILABILITY OF EXEMPTION FOR ACOS

Participation in a Non-MSSP ACO furthers Charitable Purposes

The Service has consistently ruled that providing actual healthcare services is not required to be eligible for tax-exempt status under community benefit standard as an organization described in Section 501(c)(3) of the Code. For example, the following entities were all found to be exempt under the community standard even though none of the entities provided healthcare services: a professional standards review organization (Rev. Rul. 81-26, 1982-2 C.B. 128); a health planning agency (Rev. Rul. 76-455, 1976-2 C.B. 150); an organization that constructed a hospital and leased to a public entity to operate the hospital (Rev. Rul. 80-309, 1980-2 C.B. 150); and, an information retrieval system to facilitate the legal donation of body organs (Rev. Rul. 75-197, 1975-1 C.B. 156). Instead, the key in each ruling was that the organization was serving the healthcare needs of the community and that such public benefit outweighed any impermissible private benefits.

According to the CMS Administrator, Dr. Donald Berwick, the purposes of ACOs are as follows:

> The creation of ACOs is one of the first delivery-reform initiatives that will be implemented under the [PPACA]. Its purpose is to foster change in patient care so as to accelerate progress toward a three-part aim: better care for individuals, better health for populations, and slower growth in costs through improvements in care. Under the law, an ACO will assume responsibility for the care of a clearly defined population of Medicare beneficiaries attributed to it on the basis of their patterns of use of primary care. If an ACO succeeds in both delivering high-quality care

> and reducing the cost of that care to a level below what would otherwise have been expected, it will share in the Medicare savings it achieves. Berwick, D., "Launching Accountable Care Organizations — The Proposed Rule for the Medicare Shared Savings Program," *New England Journal of Medicine,* March 31, 2011.

Premier recognizes that not every activity that promotes health supports tax exemption under section 501(c)(3). For example, selling prescription pharmaceuticals on a commercial basis to the general public certainly promotes health, but pharmacies cannot qualify for recognition of exemption under section 501(c)(3) on that basis alone. Federation Pharmacy Services, Inc. v. Commissioner, 72 T.C. 687 (1979), aff'd, 625 F.2d 804 (8th Cir.1980) (Federation Pharmacy). However, Federation Pharmacy is an extreme example as the organization involved in that case merely operated a commercial pharmacy which, in and of itself, did not provide an independent health benefit to the community other than a discounted price for pharmaceutical products to senior citizens. As clearly articulated by Dr. Berwick in the above quote, ACOs provide discernable and clearly identifiable benefits to the community which directly promotes the general health of the community. Accordingly, the exemption issue should not be whether the activities of an ACO promote the health of the community. CMS has already made such determination. Instead, the issue should be the additional steps, if any, that a tax-exempt ACO must take in order to qualify for exemption.

In reviewing the ability of an ACO to qualify for exemption, the Service must also take into account its previous rulings, both precedential and non-precedential, in areas more directly analogous to ACOs than commercial pharmacies and health maintenance organizations. These additional rulings include the Service's position with respect to activities that facilitate the of adoption of electronic health records (EHR), gainsharing arrangements, physician recruitment activities and certain other healthcare rulings in which activities that improve healthcare for the individual, improve healthcare for the population and reduce costs of healthcare were found to promote health for the benefit of the community within the meaning of section 501(c)(3).

Interestingly, the ACO situation today is not unlike the EHR situation five years ago when Rural Health Information Organizations and similar types of entities designed to encourage the adoption of EHRs were being formed in response to encouragement from the administrations of both President Bush and President Obama. More specifically, in 2005-2006, the Service and the OIG had been preparing guidance with respect to the ability of tax-exempt hospitals to provide financial subsidies to physicians to incentivize such physicians to acquire and implement EHR software that would allow such physicians to connect to the tax-exempt hospitals' EHR systems. The tax-exempt hospitals' purpose for facilitating the adoption of EHRs was to improve the effectiveness and efficiency of medical care in their communities and to reduce medical errors.

On August 6, 2006, the OIG issued final regulations on such issues. By May 2007, however, the Service had not yet finalized its position on such issues. Recognizing that the delay in issuing guidance was harming the affected community, the Service decided to release interim guidance with respect to the ability of tax-exempt hospitals to participate in activities that facilitated the adoption of EHR by physicians. Specifically, on May 11, 2007, the Service issued a "Directive" to tax-exempt hospitals stating that as long as the tax-exempt hospital complied with the OIG regulations, and as long as the hospital's subsidies did not favor specific physicians in an inappropriate manner, financial subsidies provided to such physicians would not be considered proscribed inurement of net earnings or impermissible private benefits. Notably, the ability of a tax-exempt hospital to provide financial incentives to physicians under the Directive was not limited to physicians whose patients were solely comprised of Medicare or Medicaid beneficiaries.

Similar to the position set forth in the Directive, the Service issued an unpublished private letter ruling in 1991, stating that properly structured gainsharing agreements further charitable purposes and do not raise impermissible private benefit or inurement issues. While gainsharing arrangements are somewhat different than ACO arrangements, the concept, *i.e.*, that appropriately crafted arrangements to enhance patient care and reduce healthcare expenses for the community is a charitable purpose, is significantly similar to one of the core purposes of an ACO. This gainsharing ruling, while not precedential, provides useful guidance applicable to the formation of an ACO in which a section 501(c)(3) hospital will participate.

Premier does not believe that Federation Pharmacy and IHC Health Plans are controlling in this instance. Premier agrees that the sale of pharmaceutical supplies to the general public, in and of itself, does not necessarily further charitable purposes. However, an ACO's charitable purposes go far beyond the mere sale of commercially available pharmaceutical products. As noted by Dr. Berwick, an ACO's goal is to provide better care for individuals, to better care for populations, and to slow growth in costs through improvements in care. Further, properly structured ACOs should result in significant integration and coordination of medical services and records for individual patients and, more generally, a better patient experience, all of which further charitable purposes.

Additional community benefits provided by ACOs, that are not provided by pharmacies such as those in Federation Pharmacy include, but are not limited to the following: (a) an ACO's focus is on meaningful care management and quality improvement activities (*i.e.*, if quality of care is not maintained or improved, no shared savings payments are made; (b) an ACO is expressly designed to achieve the goals and objectives of federal healthcare reform which goals are not limited to Medicare and Medicaid beneficiaries; (c) an ACO that is properly structured and operated will improve access to care, provide cost reductions in the provision of healthcare services which will benefit the community, reduce medical errors, promote significant integration of medical services and health records for individual patients, all of which improve

the overall healthcare needs of the community; (d) an ACO will focus on prevention, not just intervention, to improve the health of the general community; and (e) unlike an HMO, community members (i.e., patients) do not pay "membership fees" or premiums to participate in and receive the benefits of the ACO's operations. Instead, all patients within the care of the ACO (which will represent a broad cross section of the community) will receive the benefits of the ACO's charitable activities without additional expenditures of funds by community members in order to receive such benefits.

Premier, like CMS and Dr. Berwick, sees ACOs as a key component of the government's overall healthcare reform, the purpose of which is to improve care for the individual, and improve care and reduce healthcare costs for the community. As such, the activities of an ACO clearly promote the health for the benefit of the community. Further, provided such ACOs are properly structured in a manner similar to those ACOs participating in the MSSP, ACOs pose little risk of private inurement or impermissible private benefit.

Premier urges the Service to provide guidance regarding the conditions upon which ACOs could qualify for tax exemption under section 501(c)(3).

OTHER ISSUES

Joint Venture Issues

Since many ACOs participating in the MSSP will be structured as joint ventures with tax-exempt and taxable participants, as opposed to nonprofit corporations seeking stand-alone exemption, the Service's joint venture position raises potential issues for ACOs. In Rev. Rul. 98-15, the Service strongly suggests that a tax-exempt participant in a joint venture with for-profit participants must retain majority voting control in the joint venture to avoid adverse tax consequences. In 2004, the Service provided additional guidance in this area by clarifying that a tax-exempt entity could participate in a joint venture with for-profits participants, even when the tax-exempt entity didn't have majority voting control, if such tax-exempt participant retained or reserved control over the charitable aspects of the joint venture. See, Rev. Rul. 2004-51.

Many ACOs will be structured as joint ventures with both tax-exempt and for-profit participants, which are not to be controlled by the tax-exempt participant. This will particularly be the case for ACOs participating in the MSSP, unless CMS relaxes the requirement that ACOs have proportional representation from all participating providers.

Premier urges the Service to clarify that as long as a joint venture ACO is structured in compliance with the MSSP requirements, any tax-exempt participant that joint venture

need not control the joint venture's governing board and need not have any special reserved powers over the activities of the ACO.

Clarification on Tax-Exempt Bond Issues

Clarification is also requested regarding the potential private use issues raised by the activities of an ACO, if an entity with outstanding tax-exempt bonds participates in such entity. More specifically, guidance clarifying that ACO arrangements with tax-exempt hospitals do not constitute management or service agreements within the meaning of Rev. Proc. 97-13 and, accordingly, do not raise private use issues. **Premier urges the Service to clarify that ACO arrangements do not constitute proscribed private use of bond financed facilities.**

Sincerely,

Blair Childs
Senior Vice President, Public Affairs