



an informational series for hospital leaders

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ACCOUNTABLE CARE ORGANIZATIONS: ISSUES IN GOVERNANCE & TAX EXEMPTION

As hospitals consider whether to participate in Accountable Care Organizations (ACOs), two key questions include: What legal structure should be used to house the Accountable Care Organization? Should a separate legal entity be created? Two considerations for resolving this issue involve the proposed governance structure of Accountable Care Organizations and the tax treatment of payments under the Shared Savings Program.

An ACO needs to be a legal entity organized under state law and have a federal Tax ID Number in order to allow the ACO to receive and distribute payments to participating service providers and suppliers. The Centers for Medicare and Medicaid Services (CMS) has said that an existing hospital employing physicians could qualify as an ACO. But, there are several considerations for going this route, especially in regard to some fairly strict requirements on ACO governance and management in the proposed rule.

Governance and Management in the Proposed ACO Rule

Governance

Under the proposed rule, the governing body of a qualifying ACO must:

- Include participating ACO providers and suppliers (“ACO participants”) with 75% control over the ACO’s financial and clinical operations.
- Give “appropriate proportionate control” to the ACO participants in decision making.
- Include Medicare beneficiaries to ensure patient-centered decision-making.

One of the governing body’s core fiduciary duties will be quality oversight. Each and every ACO board member will need to understand his or her role in supporting a system-wide, integrated approach to quality and safety. The duty to support quality is evident by the proposed rule’s emphasis on participant collaboration and patient-centered care, even at the governing level.

Today, many hospital boards do not include a large representation of physicians, in part, because tax-exempt hospitals have had to avoid any conflicts of interest

between fiduciary decision-making and insiders (see the note below on tax-exemption.) Many hospital boards have only recently formed quality committees, so the culture of a hospital's governing body may not yet be ready for the huge paradigm shift to a patient-centered model. And if a hospital wants to keep more diverse expertise on its board, it may be necessary to create a new legal entity for the ACO.

Management

The proposed rule also has specific leadership and management requirements to foster integration of clinical and financial management. The proposed standards require:

- Executive leadership under the control of the governing body with a leadership team capable of directing clinical practice to achieve ACO goals;
- Senior-level medical director for clinical management and oversight;
- ACO participants with enough financial and/or human investment in the ACO's operations to ensure its success;
- Physician-directed quality assurance and process improvement committee that holds ACO participants accountable for meeting performance standards;
- Evidence-based clinical practice guidelines for delivering care consistent with the goals of better care for individuals, better health for populations, and lower growth in expenditures; and
- Information technology that enables the ACO to collect and evaluate data and provide feedback to the ACO participants.

Questions to Consider: CMS believes that these requirements promote efficiency in the delivery of care. But these infrastructure requirements may present many challenges to existing hospital management. A hospital will need to consider, within the framework of its own unique culture, whether these management requirements present significant barriers to ACO activity within its existing structure. Some considerations include:

- The proposed rule requires physician leadership in the ACO's management structure, which is unlike the traditional hospital structure where a self-governing medical staff is separate and distinct from hospital management;
- ACO leaders must have direct influence over clinical compliance with system-wide quality initiatives, which could require a financial officer's involvement on the quality committee; and

- Financial incentives to ACO participants could exacerbate already existing “turf battles” among physicians and other providers.

CMS suggests that it will be flexible in the types of organizations that may qualify as ACOs and the manner in which they are governed. In addition, CMS is willing to consider and adopt alternative management strategies to complement and advance the objectives of the Medicare Shared Savings Program (MSSP).

Hospitals are urged to share specific examples for their envisioned structures with CMS so CMS can consider alternatives that better fit other models of governance and management. Send comments to CMS by June 6, 2011.

Tax Exemption

A tax-exempt hospital must not permit its net earnings to benefit private “insiders,” in order to maintain tax-exempt status as a charitable organization under Section 501(c)(3) of the Internal Revenue Code. Net earnings refers to almost any gain and, in the case of ACOs, ACO participants would normally be considered insiders. But the IRS has said it will not consider a tax exempt organization’s participation in an MSSP to result in impermissible private benefit to 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.

Unrelated Business Income Tax (UBIT)

The IRS also expects that, absent impermissible private benefit, payments from an ACO to a tax-exempt organization would be substantially related to the

organization's charitable purpose and therefore not subject to UBIT. However, the IRS guidance indicates that a tax-exempt hospital participating in shared savings arrangements with commercial health insurance payers may generate UBIT as those payments do not necessarily lessen the burdens of government.

Questions to Consider: Most MSSP payments to ACO participants will further a hospital's tax exempt purpose, traditionally viewed as "promoting health for the benefit of the community." Other non-MSSP activities may promote health and result in cost savings in health care delivery, but the gains may result in UBIT. To determine whether a non-MSSP activity furthers or is substantially related to an exempt purpose, consider the following questions found relevant by several federal courts:

- Does the product or service provide a benefit to a broad cross section of the community?
- Is the product or service provided free or below-cost?
- Does the service advance a government endeavor (i.e., treat Medicare or Medicaid patients?);
- Are surplus funds used for research or educational programs? and
- Does the board composition represent the broader community?

Note that in the traditional view, for tax exempt purposes, courts favor a board with broad community representation. But, under the proposed ACO rule, three quarters of an ACO board must be ACO participants. This is the kind of apparent inconsistency that the CMS and IRS must reconcile before CMS adopts final ACO rules.

The Internal Revenue Service is providing the healthcare community with opportunities to comment on IRS guidance for tax-exempt organizations planning to participate in the Medicare Shared Savings Program.

The IRS seeks comments by May 31, 2011 as to:

- Whether the existing guidance governing tax-exempt organizations is sufficient for those organizations planning to participate in the MSSP through an ACO; and
- Whether guidance is needed regarding the tax implications for a tax-exempt organization participating in activities unrelated to the MSSP, including shared savings arrangements with commercial health insurance payers, through ACOs.

For questions regarding the content of this memo, please contact IHA Legal Department at 630-276-5464.

Hospitals submitting comments to CMS or the IRS are encouraged to send copies to IHA.