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Accountable Care NEWS

IRS Ruling Poses Dilemmas for Dual-Purpose ACOs

by Matthew Amodeo

A recent IRS decision[1] that denied tax-exempt status to an accountable care organization (ACO) that is affiliated with a not-for-profit health system may pose legal and practical dilemmas for ACOs that have been formed to participate in both the Medicare Shared Savings Program (MSSP) and commercial ACO arrangements—so called "dual-purpose ACOs."

The ACO that was the focus of the IRS's April 8 adverse determination was formed by a non-profit health system solely for contracting with commercial payors; it did not participate in MSSP. The ACO was comprised of a roughly equal mix of health system–affiliated providers and non-affiliated, community-based ones.

In reaching its decision to deny the ACO tax status, the IRS focused heavily on the fact that it did not participate in MSSP and therefore, could not rely on (among other things) "lessening of the government's burden" as a basis for establishing a charitable mission. The determination confirmed the IRS's position originally articulated in Notice 2011-20,[2] in which ACOs that do not participate in MSSP could face an uphill battle in qualifying for tax-exempt status.

For non-profit health systems hoping to secure tax-exempt status for their ACOs, a seemingly obvious inference to be drawn from the IRS's decision is that the system should strongly consider participating in MSSP by using a dual-purpose ACO; however, there are potential legal concerns under both the July 2015 ACO Final Rule[3] and Federal antitrust rules that could limit a health system's ability to implement such a strategy.

The concerns arise in connection with MSSP requirements applicable to members of an ACO's governing body, specifically the fiduciary duty owed by the members, which, under the Final Rule, must be exclusive to the ACO.

MSSP regulations require that an ACO's governing body be the same as the legal entity that is the ACO.[4] For example, if a health system were to form a new independent practice association (IPA) or to use one of its existing IPAs to function as an MSSP ACO, the IPA's board and the ACO's board must be identical. In sub-regulatory guidance, CMS states that "[t]his legal entity must have a legal structure with a governing body that has a fiduciary responsibility to the ACO *alone* and not to any other individual or entity."[5]

CMS further states: "In summary, the ACO's governing body decisions must be independent from influence of interests that may conflict with the ACO's interests, including the interests of group practices that are not participating in the ACO but continue to be represented by the IPA for other purposes, including commercial contracting."

While the 2015 ACO Final Rule does not specifically prohibit opt-out clauses in dual-purpose IPA provider agreements, the exclusive duty of loyalty requirement for ACO governing body members may not be met if IPA providers are permitted to opt out of commercial arrangements. The governing body members would have potentially conflicting loyalties related to those providers in the IPA, who have chosen to opt out of certain commercial ACO arrangements versus those who have elected to participate in both MSSP and commercial arrangements. In other words, in order for ACO governing body members to have an exclusive duty of loyalty to an ACO, all providers in the IPA would need to participate in all of the IPA's payor arrangements.

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To the extent the MSSP exclusive duty of loyalty requirement can be construed as a *defacto* "all products" requirement, this raises additional legal concerns—in particular antitrust concerns—for dual-purpose ACOs that are engaged in joint contracting activities with commercial payors. Under general antitrust principles, provider networks, such as IPAs and ACOs, may not negotiate rates with payors on behalf of otherwise unrelated providers in the IPA/ACO unless providers are either financially or clinically integrated.

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Financial integration generally requires that providers in the network assume a certain degree of financial withholds or capitation) under an entity's arrangements with third-party payors. Clinical integration requires significant provider investment and commitment of practice resources to a clinical integration network's (CIN) coordinated care delivery, clinical quality and health improvement missions, among other things.

To minimize antitrust risk, until an IPA or ACO is able to meet one or both of these integration thresholds, they generally employ what is known as a "messenger model" for joint contracting. Under this model, the IPA/ACO separately communicates the pertinent participation and payment criteria of proposed payor arrangements to each provider, and a provider is afforded the option of opting in or out of an arrangement. As discussed above, however, ACOs that participate in MSSP might not be able to allow their providers to opt out of either MSSP or commercial payor arrangements.

Health systems that participate in MSSP using a dual-purpose ACO are therefore faced with weighing the increased antitrust risk posed by using all-products clauses in their participation agreements versus potential violations of MSSP rules by not using them.

Health systems, which use dual-purpose ACOs that have already entered into commercial payor arrangements using the messenger model (or other opt-out methods), could face significant practical challenges in restructuring those arrangements to reduce regulatory risk.

These include the following:

- Amending participating provider agreements to eliminate any opt-out provisions. Depending on how the agreement is worded, this may require the provider's consent which, for non-health system-affiliated providers, could be difficult to obtain.
- Recontracting with its provider network using a newly formed ACO for commercial contracting only. Again, unless an agreement is unilaterally assignable by an ACO to a new ACO entity without a provider's consent, this might be problematic for non-health system-affiliated providers.
- For ACOs and CINs that have not yet achieved a level of clinical or financial integration sufficient to significantly reduce antitrust risk, the new ACO would need to recontract with commercial payors for its commercial ACO arrangements. This might open up unwelcome renegotiations with commercial payors looking for more favorable terms and/or rates.
- The ACO would likely have to disclose its failure to meet MSSP fiduciary requirements as a "material change" under 42 CFR 425.214.[6] This could result in one of many disciplinary actions available to CMS under MSSP regulations, including submission of a corrective active plan, termination and reapplication into MSSP or the ACO's complete termination from MSSP.

In summary, non-profit health systems should not interpret the IRS's recent adverse determination to encourage the use of dual-purpose ACOs as a means to increase the likelihood of obtaining a favorable tax-exemption determination. To the contrary, given the apparent and potentially irreconcilable tension between MSSP requirements and antitrust principles, health systems might be better served by establishing a separate legal entity that is devoted exclusively to participation in MSSP.

[1] "TEGE Appeals Program." Internal Revenue Service. Jan. 15, 2016.

[2] "Notice 2011-20." Internal Revenue Service. Apr. 18, 2011.

[3] "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations." Centers for Medicare & Medicaid Services. June 9, 2015.

[4] "Additional Guidance for Medicare Shared Savings Program Accountable Care Organization (ACO) Applicants." Centers for Medicare & Medicaid Services. Mar. 16, 2012.

[5] *Ibid*.

[6] "425-214—Managing Changes to the ACO During the Agreement Period." U.S. Code of Federal Regulations. Govregs.com. Mar. 1, 2016.

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