24th Annual Health Sciences Tax Conference

Issues in population health management and clinical integration networks, including accountable care organizations

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Agenda

- Population health management: an overview
  - Accountable care organizations (ACOs)
  - Clinically integrated networks (CINs)
- Structuring considerations for ACOs and CINs
- Tax considerations for participants in ACOs and CINs
  - Internal Revenue Service (IRS) Notice 2011-20
  - Tax exemption
  - Unrelated business income (UBI)
  - Private benefit use (PBU) considerations
  - Taxable corporations
  - Joint operating agreements (JOAs)
Population health management: an overview
Accountable care model drives Coordinated Care Networks

Health care works best when stakeholders work together

- Payors, who are increasingly embracing the accountable care organization model, which rewards providers for health outcomes rather than procedure volume, are pushing health care stakeholders to embrace Coordinated Care Networks.
- Robust communication between patient and caregiver and amongst caregivers ensures that all parties are equipped with the information to drive the best possible health outcomes at the lowest cost.

Firms that are upgrading their technology and forming strategic partnerships with other health care providers will be in the best position to capitalize on the shift to Coordinated Care Networks.
Accountable care organization

- Current Centers for Medicare & Medicaid Services (CMS) accountable care initiatives
  - Medicare Shared Savings Program (MSSP)
    - Promoting accountability for the care of Medicare Fee for Service (FFS) beneficiaries
    - Requiring coordinated care for all services provided under Medicare FFS
    - Encouraging investment in infrastructure and redesigned care processes
    - CMS provides financial incentives to ACOs that reduce costs and improve quality for a group of Medicare patients
  - Currently 338 MSSP ACOs (CMS website)
Accountable care organization

► Advanced payment ACO model
  ► Must be participating in the Medicare Shared Savings Program
  ► Generally for physician based and rural providers that have a lack of access to capital to establish infrastructure to develop ACO
  ► ACO will receive monthly advances based on the expected savings to be earned by the ACO
    ► An up-front, fixed payment – Each ACO will receive a fixed payment.
    ► An up-front, variable payment – Each ACO will receive a payment based on the number of its historically assigned beneficiaries.
    ► A monthly payment of varying amount depending on the size of the ACO – Each ACO will receive a monthly payment based on the number of its historically assigned beneficiaries.
  ► Currently 35 advanced payment ACOs exist (CMS website)
Accountable care organization

► Pioneer model ACO
  ► Population-based payment model
  ► Higher levels of shared savings and risk than with the MSSP
  ► Started three years ago with 32 pioneer ACOs; currently 19 remain (CMS website)
Clinically integrated networks

- Goal to contain the cost of health care while:
  - Improving population health
  - Improving quality of care
- Significant focus on effective management of chronic conditions
- Requires substantial investment of capital and personnel resources to establish infrastructure required
Clinically integrated networks

Components of a CIN

- Structure and governance
- Infrastructure and funding
- Participation criteria
- Performance objectives
- Physician leadership
- Health information exchange
- Distribution of funds
- Contracting

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Structuring considerations

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Choice of legal entity

The IRS and CMS do not dictate a particular structure.

- Single-member limited liability company (LLC) with exempt health system member
- Partnership with physician and exempt owners
- State law taxable nonprofit corporation
- Charitable organization under Internal Revenue Code (IRC) Section 501(c)(3)
- For-profit corporation

Considerations

- Patient populations to be managed
- Control by physicians versus exempt organizations (EOs)
- Shared savings distributions and other contracts
Hospital subsidiary structure

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Joint venture CIN structure

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Independent physician association (IPA) CIN structure

Physicians

Hospital
Participation agreement

IPA
Participation agreement

Payers

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Tax considerations for exempt participants in ACOs and CINs
IRSI RS guidance on Notice 2011-20: general principles

- Participation in the MSSP through an ACO furthers tax-exempt purposes by lessening the burdens of government.
- Control by EO partners is not required in order for an ACO that participates in the MSSP to further its charitable purposes.
- Shared savings income of EO participants from an ACO’s participation in the MSSP will not be UBI.
- Serving Medicaid or indigent populations through an ACO will further charitable purposes of relief for the poor and distressed.
IRS guidance on Notice 2011-20: avoiding private benefit and private inurement

- The Notice identifies five factors to be considered:
  - Terms of the EO’s participation in the MSSP through the ACO must be set forth in advance in a written agreement negotiated at arm’s length.
  - The CMS has accepted the ACO into, and has not terminated the ACO from, the MSSP.
  - The EO’s share of economic benefits derived from the ACO is proportional to the benefits or contributions the EO provides to the ACO (including capital contributions).
  - The EO’s share of the ACO’s losses does not exceed its share of the ACO’s economic benefits.
  - All contracts and transactions entered into by the EO 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.
Exemption considerations for exempt organizations participating in CINs and ACOs

- General principles applicable to other IRC Section 501(c)(3) organizations apply to CINs and ACOs seeking tax exemption.
  - Substantial non-exempt activities will jeopardize exemption
  - Prohibition on private benefit and private inurement
  - Joint venture guidance in Revenue Rulings 98-15 and 2004-51
UBI considerations for exempt organizations participating in ACOs and CINs

- When established as a joint venture, the IRS is likely to follow typical flow-through analysis to the income received by the CIN.
  - Control by the exempt organization member
  - May consider patient versus non-patient analysis
  - Triggers for earning shared savings distributions (e.g., quality measures)

- Other considerations for UBI subject to taxation include:
  - Services provided by a CIN and ACO to physicians and other taxable parties
  - Services provided by exempt parent to a taxable CIN and ACO
  - Section 512(b)(13) tax on interest, annuity, royalty or rent
ACOs conducting non-MSSP activities

- Notice 2011-20 does not address whether non-MSSP activities through an ACO will be consistent with IRC Section 501(c)(3) exemption or not result in UBI.
  - ACO enters into shared savings arrangements with other types of health insurance payers.
  - This is unlikely to lessen the burdens of government.
  - Negotiating with private health insurers on behalf of unrelated parties generally is not a charitable activity regardless of whether the agreement negotiated involves a program aimed at achieving cost savings in health care delivery.
  - Promotion of health has been recognized as a charitable purpose; however, not every activity that promotes health supports tax exemption under IRC Section 501(c)(3).
Unanswered questions for ACOs conducting non-MSSP activities

- IRS requests comments regarding how a tax-exempt organization’s participation in non-MSSP activities through an ACO furthers an exempt purpose.
  - How does a tax-exempt organization’s participation in non-MSSP activities through an ACO substantially relate to or further an exempt purpose?
- What criteria requirements or safeguards need to be present in non-MSSP activities in the absence of safeguards similar to those present for MSSPs?
  - MSSPs have regulatory requirements imposing quality performance standards.
  - MSSPs have oversight and monitoring by a government agency – the CMS.
Private business use guidance for EOs participating in ACOs

- Notice 2014-67 provides interim guidance on whether an EO will have PBU due to participation in an ACO.

- The guidance provides six factors to avoid PBU and mirrors the criteria identified in Notice 2011-20 for an EO to avoid private inurement and excess private benefit from its participation in a MSSP ACO.

- Additionally, Notice 2014-67 provides an update to Revenue Procedure (Rev. Proc.) 97-13 regarding conditions under which management contracts do not result in private use.

- The Notice is effective for bonds sold on or after January 22, 2015, but it may also apply to those bonds that were sold before that date.
Notice 2014-67 criteria to avoid private business use

- The terms of the EO’s participation in the MSSP are set forth in advance in a written agreement negotiated at arm’s length.
- CMS has accepted the ACO into the MSSP.
- The EO’s share of economic benefits derived from the ACO is proportional to the benefits or contributions the EO provides to the ACO.
- The EO’s share of the ACO’s losses does not exceed the share of ACO economic benefits to which the EO is entitled.
- All contracts and transactions entered into by the EO with the ACO and the ACO’s participants are at fair market value.
- The EO does not contribute or otherwise transfer the property financed with exempt bonds to the ACO, unless the ACO is an IRC Section 501(c)(3) entity or a governmental person.
Private business use considerations from management contracts

- Notice 2014-67 further provides that management contracts must be structured to avoid PBU where the EO is participating in the MSSP through an ACO.
- The Notice amplifies permitted productivity rewards and types of permissible arrangements described in Rev. Proc. 97-13 that do not result in PBU.
Private business use considerations from management contracts

- Notice 2014-67 specifies that productivity rewards for services in any annual period during the term of the contract generally will not cause the compensation to be based on a share of net profits of the facility if:
  - The eligibility for the rewards is based on quality of services under the management contract and not charges in facility revenues or expenses.
  - The amount of the award is a stated, periodic fixed, or tiered amount based solely on the level of performance.
Private business use considerations from management contracts

  - Compensation for services must be based on a stated amount, periodic fixed fee, a capitation fee, a per unit fee or a combination of the preceding.
  - It may include a percentage of gross revenues, adjusted gross revenues or expenses of the facility, but not both revenues and expenses.
  - The term of the contract cannot exceed five years, including renewal options, but does not need to be terminable prior to the end of the term.
- The Notice is effective for management contracts entered into, materially modified or extended (other than under a renewal option) on or after January 22, 2015.
Tax timing differences for taxable ACO corporation: revenue recognition

- ACO’s recognition of income occurs in year all events have occurred that fix the taxpayer’s right to receive income and the amount of income can be determined with reasonable accuracy (Reg. Sections 1.446-(c)(1)(ii) and 1.451(a)).
  - However, advance payments for prepaid services to be performed in a later year generally require the payment to be included in gross income in the year the payment is received.
  - There is a limited exception under Rev. Proc. 2004-34 to defer recognition of income for an advance to the following year of prepayment if an agreement exists for such services to be rendered at end of year two.
  - Advance payments received by ACO from payers and providers promoting ACO may be accelerated into taxable income in the year payment is received.
**Tax timing differences for taxable ACO corporation: expense deduction**

- ACO deductions for savings payments to participants may generally be deducted in the year when services are rendered by ACO participants or when payments to participants are made if it can be reasonably expected that the services will be performed by ACO participants within three and a half months of payment.

  - All events test – A taxpayer may not deduct an expense until the year in which all events have occurred which determine the fact of the liability and the amount of such liability can be determined with reasonable accuracy (IRC Section 461(h)).

  - Economic performance generally occurs when property or service is provided or, in certain situations, when payment is made (Reg. Sections 1.461-4(d)(2) and 1.461-4(d)(6)(ii)).
Tax timing differences for taxable ACO corporation: expense deduction

- IRC Section 404(d) and Treas. Reg. Section 1.404(b)-1T
  - An accrual-basis taxpayer may not generally deduct accrued expenses payable to an independent contractor unless the compensation is paid within 2.5 months of the taxpayer’s year-end in which the services were performed.
    - Cash-basis provider (i.e. independent physicians)
  - Amounts are deductible for the taxable year in which an amount attributable to the compensation is includible in the gross income of the independent contractor
Tax timing differences for taxable ACO corporation: whipsaw potential

- ACO intended to be an entity with zero net income over time
- ACO advance payments causing accelerated income recognition coupled with deferral of deductions to ACO participants
- Equals unwanted tax liability
- Problem if NOLs are created after carryback period is expired and not allowed
Other tax considerations for taxable ACO corporations

- Transfer pricing
  - Fair market value fees for services performed to assist taxable ACO corporations are generally required to ensure arm’s length transactions.
  - Certain low-margin and non-integral services may be charged at cost without generating UBI.
Joint operating agreements re-emerging in the market

- JOAs between or among tax-exempt entities must substantially further the entities’ tax-exempt purposes to avoid UBI and/or jeopardizing their tax-exempt status.

- Goals
  - Clinically integrated networks
  - Coordination to improve patient care
  - Increase efficiencies
  - Avoiding duplicative services
  - Conduct joint venture activities

- Arrangements are either contractual where integration occurs by agreement or structural where a super parent is created.
General characteristics of exempt JOA arrangements with Newco parent

- Public Letter Rulings (PLRs) 9609012, 9623011 and 19944046 provide examples of arrangements that further exempt purposes.

- Newco parent is created to establish certain governance, administrative, financial and consulting services to the hospitals in the network.

- Newco parent’s board is sole governance authority over the network, and appoints the board, senior executives and medical staff of underlying network hospitals.

- No more than 20% of the members of Newco parent are physicians.

- JOA provides for the operation but not the ownership of the network facilities.
Benefits of exempt Newco parent JOA arrangements

► It allows the hospitals to share the financial risks and rewards of providing key health care services to the community and otherwise develop a closely integrated regional health care delivery network.

► Network participants effectively accomplish financial integration through annual payments between and among hospitals based on a weighted average of ratios specified in the JOA (example metrics: net assets, net income, net cash flow and/or capital expenditures).

► JOA will not alter the bond obligations for any of the underlying hospital facilities, and the bonds for each facility continue to qualify as “qualified hospital bonds” under Section 145(c).
Benefits of exempt Newco parent JOA arrangements

- Newco parent organization may be considered to be carrying out an integral part of the activities of the network hospitals (and the parts of the hospital systems that are completely financially integrated) under all the facts and circumstances.

- Under the integral part basis for exemption:
  - Newco parent performs essential services for an exempt organization and the services, if performed by the exempt organization directly, would not be an unrelated trade or business.
  - Newco parent exercises sufficient control and close supervision, based on all facts and circumstances, to establish the equivalent of a parent and subsidiary relationship.
UBI considerations for other contractual JOA arrangements

Where Newco parent entity is formed, and hospitals create a JOA on a less-formal contractual basis, UBI may be incurred or prohibited private benefit may be generated in several ways, including the following:

- Provision of managed care contracting services, consulting or administrative services to a third party (e.g., physician groups or other providers in the network) by a tax-exempt hospital
- Fees charged by one tax-exempt hospital to another tax-exempt hospital for management services that do not qualify under the exception of Section 513(e) for small rural hospitals
Questions?

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