

# Summary of Medicare Shared Savings Program Final Rule on Accountable Care Organizations

On November 2, 2011, the Centers for Medicare and Medicaid Services (“CMS”) published a Final Rule implementing the Medicare Shared Savings Program (“MSSP”) established under Section 3022 of the Patient Protection and Affordable Care Act (the “Final Rule”). The Final Rule signals CMS’s strong desire to encourage widespread formation of accountable care organizations (“ACOs”). By addressing many of the most significant objections raised by industry stakeholders in response to the proposed rule that was released last spring (the “Proposed Rule”), the Final Rule is likely to stimulate the formation of ACOs during 2012 and 2013. The regulatory analysis supporting the release of the Final Rule indicates that CMS assumes 1 to 5 million Medicare beneficiaries will align with between 50 and 270 ACOs during the first four years of the program.

A summary of the Final Rule is provided below.

## Who Is Eligible to Be a Participant in an ACO?

The following entities are eligible to form an ACO:

- ACO professionals<sup>1</sup> in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals<sup>2</sup> employing ACO professionals
- Critical Access Hospitals (“CAHs”) that bill under Method II<sup>3</sup>
- Federally Qualified Health Centers (“FQHCs”)
- Rural Health Clinics (“RHCs”)

**Broadening the list of entities eligible to form an ACO to include FQHCs increases the likelihood that dual eligibles and less affluent Medicare beneficiaries will participate in Medicare ACOs.**

Other entities may provide services through an ACO but may not form their own. ACOs may not participate in the MSSP if they include a participant involved in other shared savings initiatives.

<sup>1</sup> ACO professional means a physician (defined as a doctor of medicine or osteopathy), or a practitioner (defined as a physician assistant, nurse practitioner, or clinical nurse specialist).

<sup>2</sup> Hospital means an acute care hospital paid under Medicare’s hospital inpatient prospective payment system.

<sup>3</sup> Under Method II, a CAH bills for both facility and professional services. CAH eligibility is limited to those billing under Method II because it is the only billing method that provides CMS with the data it needs to perform various programmatic functions (e.g., assign beneficiaries to each ACO).

## What Is the Time Frame for Participation in the MSSP?

CMS will begin accepting applications “shortly after January 1, 2012.” Information on the application process will be included in a Notice of Intent CMS will post at <https://www.cms.gov/sharesavingsprogram.com>. If accepted, an ACO must enter into a participation agreement with CMS for at least three years.

For 2012, applicants may choose to have either April 1, 2012 or July 1, 2012 as the start date of their participation agreements. For applicants approved to participate in 2013 and all subsequent years, the start date will be January 1. Beginning with participation agreements effective in 2013, the term of the agreement will be three years. ACOs may add or remove participants and providers or suppliers during the agreement period but must notify CMS of the change within 30 days.

## What Type of Legal Structure Must an ACO Establish?

An ACO must be a legal entity, formed under applicable state, federal, or tribal law, that is authorized to conduct business in each state in which it operates for purposes of (i) receiving and distributing shared savings; (ii) repaying shared losses or other monies determined to be owed to CMS; (iii) establishing, reporting, and ensuring provider compliance with health care quality criteria, including quality performance standards; and (iv) fulfilling other ACO functions. An ACO formed by two or more otherwise independent participants must be a legal entity separate from any of its participants.

## What Type of Governance Structure Must an ACO Maintain?

An ACO must maintain an identifiable governing body with authority to execute the functions of the ACO, including, but not limited to, the definition of processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care. An ACO must provide for meaningful participation in the governing body by the ACO’s participants or their designated representatives. Subject to certain exceptions, participants must control at least 75% of the ACO’s governing body. Each ACO must also appoint a beneficiary representative to the governing body. If the ACO’s governing body does not meet the 75% control threshold or include a beneficiary representative, the ACO may request a waiver and describe to CMS why it does not meet these requirements and how the ACO will involve participants and beneficiaries in governance.

### Key Changes in Final Rule

- ▶ **ACOs have flexibility to propose governance structures that do not meet the 75 % participant control test or include a beneficiary representative.**
- ▶ **It is no longer required that each ACO participant have proportionate control of the governing body.**

## What Type of Leadership and Management Structure Must an ACO Employ?

An ACO’s operations must be managed by an executive, officer, manager, or general partner whose appointment and removal are under the control of the organization’s governing body and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve efficiency, processes, and outcomes. Clinical management and oversight must be managed by a senior-level medical director who is one of the ACO’s physicians, is physically present on a regular basis in an established ACO location, and is a board-certified physician and licensed in one of the states in which the ACO operates.

## How Will Beneficiaries Be Assigned to an ACO?

CMS will employ a “preliminary prospective assignment methodology with final retrospective reconciliation.” This means that CMS will provide to the ACO a list of beneficiaries likely to receive care from the ACO’s participants based on primary care utilization during the most recent periods for which adequate data are available. During the performance year, CMS will update the list quarterly based on the most recent 12 months of data. At the end of each performance year, CMS will reconcile the list to reflect beneficiaries who actually met the criteria for assignment.

**Early identification of participating beneficiaries through a preliminary prospective assignment methodology – combined with the ability to receive claims data for participating beneficiaries – should drive the creation of care management programs necessary for success under the MSSP.**

After identifying all patients that received a primary care service (defined as the set of services identified by the following HCPCS codes: 99201 through 99215, 99304 through 99340, and 99341 through 99350, G0402, G0438 and G0439) from a physician who is a provider/supplier in the ACO, CMS will engage in a two-step process. Under the first step, a beneficiary is assigned to an ACO if the beneficiary received the plurality of his or her primary care services from PCPs within the ACO. The second step considers only beneficiaries who have not had a primary care service furnished by any PCP. In this step, a beneficiary is assigned to an ACO if the beneficiary received a plurality of his or her primary care services from physicians (including specialist physicians) and certain nonphysician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the ACO.

To operationalize this process, CMS will identify an ACO as a collection of Medicare-enrolled taxpayer identification numbers (“TINs”). An ACO will have to report to CMS the TINs of the ACO and its participants, as well as a list of participating Medicare providers’ and suppliers’ national provider identifiers (“NPIs”). Each ACO participant TIN upon which beneficiary assignment is dependent must be exclusive to one ACO for purposes of Medicare beneficiary assignment. ACO participant TINs upon which beneficiary assignment is not dependent are not required to be exclusive. CMS clarified that individual provider NPIs are not exclusive to one ACO. When providers whose services are the basis of assignment bill under multiple TINs, each TIN would be exclusive to only one ACO but the provider would not be required to be exclusive to one ACO.

CMS will deem an ACO to have a sufficient number of primary care professionals if the number of beneficiaries historically assigned to the ACO’s participants in each of the three years before the start of the agreement period is 5,000 or more.

## What Type of Care Management and Health IT Initiatives Must an ACO Undertake?

As in the Proposed Rule, CMS does not identify specific care management criteria that ACOs must satisfy. Rather, CMS simply requires an ACO to document in its application its plans to define, establish, implement and periodically update its processes.

CMS eliminated the requirement that at least 50% of the ACO’s PCPs engage in meaningful use. Instead, the Final Rule includes the following quality measure: “Percent of PCPs who successfully qualify for an EHR Incentive Program Payment” which will be weighted twice that of any other measure for scoring purposes. CMS left largely intact its requirements for an ACO to document in its application its plans to (i) promote evidence-based medicine; (ii) promote beneficiary engagement; (iii) report internally on quality and cost metrics; and (iv) coordinate care. However, CMS removed some of the specific requirements it included in the Proposed Rule, including those related to health information technology.

CMS also removed a proposed regulatory provision requiring that ACOs “have a process in place (or clear path to develop such a process) to exchange summary of care information when patients transition to another provider or setting of care, both within and outside the ACO. For providers participating in the electronic exchange of information, this process must be consistent with meaningful use requirements under the Medicare electronic health record Incentive Program.”

## **How Will CMS Share Data With ACOs?**

At the start of its agreement period and every quarter thereafter, CMS will provide an ACO with de-identified, aggregated reports on beneficiary use of health care services. At the beginning of the agreement period, during each quarter, in conjunction with the annual reconciliation, and at the beginning of each performance year, CMS will provide an ACO, upon request, with information regarding the preliminarily prospectively assigned beneficiaries whose data was used to generate the aggregate reports. The information will be limited to beneficiary name, date of birth, sex and beneficiary health insurance claim number. CMS will also, upon request, provide an ACO with a standardized data set consisting of patient identifiable claims data generated under Medicare Parts A, B and D. CMS will provide the data set on a monthly basis. The data set will not include information protected under federal alcohol and drug abuse confidentiality regulations at 42 CFR Part 2.

Before requesting claims data about a particular beneficiary, the ACO must inform the beneficiary of the request and give the beneficiary a 30-day period to opt out. An ACO must also provide beneficiaries with a form explaining their right to opt out of data sharing as part of the beneficiary’s first primary care service visit with an ACO participant upon whom assignment is based.

## **How Will Beneficiaries Be Notified of Their Assignment to an ACO?**

ACO participants must notify beneficiaries at the point of care of their participation in an ACO by posting signs in their facilities and making available to beneficiaries standardized written notices developed by CMS. All beneficiary notification and signage are included in the definition of “marketing materials and activities.”

The Final Rule establishes a “file and use” approach under which an ACO may use marketing materials or commence marketing activities 5 business days following submission of such materials to CMS if the ACO certifies compliance with all MSSP marketing requirements and CMS does not disapprove the materials or activities within the 5-day period. CMS may issue written notice of disapproval of marketing materials or activities at any time, including after the expiration of the initial 5-day review period, at which time the use of such marketing materials or the marketing activities must be discontinued. Marketing materials and activities must: i) use template language developed by CMS, if available; ii) not be used in a discriminatory manner or for discriminatory purposes; iii) comply with requirements related to beneficiary inducements; and, iv) not be materially inaccurate or misleading. CMS also modified its definition of permissible marketing materials to specifically include social media such as Twitter and Facebook.

## **On What Grounds May an ACO’s Participation in the MSSP Be Terminated?**

CMS may terminate a participation agreement with an ACO when an ACO, ACO participants, ACO providers/suppliers or other individuals or entities performing functions or services related to ACO activities fail to comply with any of the requirements of the MSSP. If CMS concludes that termination of an ACO is warranted, it may but is not required to provide a warning notice to the ACO regarding noncompliance with one or more program requirements; request a corrective action plan from the ACO; or place the ACO on a special monitoring plan. CMS must notify an ACO in writing of its decision to terminate the participation agreement.

An ACO may terminate its participation agreement by providing at least 60 days' advance written notice to CMS and its ACO participants of its decision to terminate. An ACO will not share in any savings for the performance year during which it notifies CMS of its decision to terminate the participation agreement.

## How Will ACOs Participate in Shared Savings?

**Two Tracks.** The Final Rule offers two models of risk sharing. First, there is the one-sided model, where the ACO shares only in savings if the ACO spends less compared to what Medicare would have spent without the ACO. Second, there is the two-sided model, in which the ACO also shares in losses if the ACO spends more compared to what Medicare would have spent without the ACO. In Track One, ACOs will participate in the savings-only model for all three years of their initial participation agreement with CMS. Under Track Two, the two-sided model applies for all three years of the ACO's participation agreement.

**Determining the Benchmark.** To determine whether an ACO saved the Medicare program money, CMS must estimate what Medicare would have paid for the care of the beneficiaries attributed to the providers in the ACO (the "benchmark"). The benchmark spending data includes all Part A and Part B expenditures. Catastrophic claims (above the 99th percentile and approximately \$100,000 per patient per year) are capped at the 99th percentile. The expected claims costs will be risk-adjusted based on health status (under the same method as utilized by Medicare Advantage). CMS will then apply trend factors to adjust for growth in health care expenditures for each of the beneficiary categories during the three years of the participation agreement. The Final Rule eliminates certain payments, including indirect medical education ("IME") and disproportionate share hospital ("DSH") payments from the benchmark. CMS will also calculate the benchmark using population-specific expenditures for each of the following categories of beneficiaries: (1) End Stage Renal Disease ("ESRD"), (2) disabled, (3) aged, dually eligible individuals, and (4) aged, non-dually eligible individuals (collectively, "beneficiary categories").

### Key Changes in Final Rule

- ▶ **ACOs have the option to avoid all downside risk throughout the entire three-year term of their participation agreement.**
- ▶ **ACOs will also share in first dollar savings if the minimum savings threshold is satisfied.**

**The ACO's Share of Savings.** CMS will compare actual expenditures to the benchmark after applying a "minimum savings rate," which reflects fluctuations so small that they likely are not due to the ACO's efforts. Under the one-sided model, the minimum savings rate ranges from 2% for large ACOs to 3.9% for small ACOs. Under the two-sided model, the minimum savings rate is 2% for all ACOs. All ACOs are entitled to receive 50% of the savings under the one-sided model. Payments of savings are contingent upon meeting the quality scores set forth in the ACO's participation agreement. For example, if the ACO attains an 80% quality score, the ACO then is entitled to 80% of the 50% shared savings that are available. An ACO's sharing rate in all participation agreements with downside risk will be 60%. Under both models, all ACOs, regardless of size, will be eligible to share in the first dollar of savings. Under the one-sided model, there is a maximum shared savings payment to the ACO of 10% of the benchmark. Under the two-sided model, the cap is 15%.

**The ACO's Share of Losses.** There is a similar 2% corridor from the benchmark where the ACO will not be responsible for losses. The shared loss rate for an ACO is 1 minus the ACO's shared savings rate, up to a maximum shared loss rate of 60%. For example, an ACO with a shared savings rate of 60% is responsible for 40% of the losses. An ACO's shared losses may not exceed 5% of the benchmark in its first year in the two-sided model, 7.5% of the benchmark in its second year, and 10% of the benchmark in its third year.

**Financial Security.** All applicants participating in Track Two and some applicants participating in Track One will be required to demonstrate financial resources to absorb possible losses. ACOs may demonstrate their ability to repay losses in many ways, including by demonstrating sufficient cash reserves, arrangements with insurers, or assurances from providers within the ACO. The Final Rule eliminates the 25% withhold by CMS of any shared savings payments, which would be applied to future shared losses.

## What Are the Differences Between the One-Sided and Two-Sided Models?

Design Element	One-Sided Model	Two-Sided Model
Threshold Savings to Trigger Shared Savings	Between 2% and 3.9% based on number of assigned beneficiaries	2% regardless of ACO size
Savings Eligible for Sharing	First dollar of savings	First dollar of savings
Maximum Share of Savings	50%	60%
Maximum Sharing Cap	10% of benchmark	15% of benchmark
Threshold Losses to Trigger Shared Losses	N/A	2%, regardless of ACO size
Losses Eligible for Sharing	N/A	First dollar of losses
Share of Losses	N/A	40%-60% depending on quality score
Maximum Loss Cap	N/A	Year 1: 5%; Year 2: 7.5%; Year 3: 10%

## What Type of Quality Standards Will Be Applied to ACOs?

The Final Rule focuses on measures that directly assess the overall quality of care furnished to beneficiaries with a preference for National Quality Forum-endorsed measures. The Final Rule substantially reduces the number of quality measures – from 65 to 33 – on which ACOs are scored. CMS also sought to align the measures with those used in other programs and initiatives. The Final Rule does not include hospital patient safety measures; however, claims-based hospital measures will be monitored by CMS.

**ACOs that do not align their IT requirements and workflows with quality measure goals will be significantly challenged to hit their targets and pull down their full shared saving allotments.**

As in the Proposed Rule, each measure is pay-for-reporting in an ACO's first performance year. In year two, 25 of the 33 measures are pay-for-performance. In year 3, all measures are pay-for-performance, with the exception of Measure Seven (health status/functional status). Twenty two measures will be collected using the Group Practice Reporting Option ("GPRO") tool, prepopulated for a sample of assigned beneficiaries. Seven

**ACO participants choosing the one-sided model will not need to retain reserves to cover unanticipated ACO program financial losses.**

**States that regulate risk-bearing organizations may need to consider whether these one-sided ACOs require risk-bearing regulatory oversight.**

measures will be collected via the Consumer Assessment of Healthcare Providers and Systems (“CAHPS”) patient survey that CMS will pay to administer in the first two years in order to ensure standardized administration. Three measures will be collected via claims data and one measure will be collected through the EHR incentive program.

CMS will require ACOs to achieve the quality performance standard on 70% of the measures within each domain. To calculate the standard, the points earned for each domain’s measures will be added up and divided by the total available points. This will result in a domain score, which will then be added up and divided by four (the total number of domains) to reach the final shared savings rate.

Calculating the quality performance standard will indicate whether an ACO has sufficiently met goals that would qualify it for shared savings. ACOs will be able to earn a maximum of two points per measure (except for the EHR meaningful use measure, which is worth four points) under both the one-sided and two-sided models.

CMS finalized its proposal to establish the minimum attainment level for a measure at a national flat 30% or, where applicable, the national 30th percentile level of performance of FFS or Medicare Advantage (“MA”) quality rates. CMS also finalized its proposal to establish national, as opposed to regional, benchmarks for quality measures. The benchmarks will use a national sample of Medicare FFS claims data, MA quality data, or a flat percentage of FFS claims if MA quality data are not available.

ACO Performance Level (Percentile FFS / MA Rate or %)	Quality Points (Except EHR)	EHR Measure Points
90+	2 points	4 points
80+	1.85	3.7
70+	1.7	3.4
60+	1.55	3.1
50+	1.4	2.8
40+	1.25	2.5
30+	1.1	2.2
<30	No Points	No Points

## What Protection From Antitrust Laws Will Be Granted to ACOs?

The Final Statement of Antitrust Enforcement Policy on ACOs issued by the federal antitrust enforcement agencies – the Department of Justice (“DOJ”) and Federal Trade Commission (“FTC”) – is both broader and simpler than the agencies’ original proposal. The Final Statement now applies to collaborations among otherwise independent providers and provider groups that are eligible and intend to participate in the MSSP, even if they were formed prior to March 23, 2010.

### Key Change in Final Rule

**CMS eliminated mandatory antitrust reviews for ACOs with PSA shares above 50%.**

**Clinical Integration: Applicability to Commercial Markets.** The agencies note that an ACO that meets the CMS eligibility criteria will also meet the criteria to conduct joint negotiations with private sector payers in the commercial market. To serve those patients in the commercial market, however, the ACO must use the same governance and leadership structures as well as the same clinical and administrative processes it uses in the MSSP.

**Regulatory Review Process: The “Safety Zone.”** The Final Statement eliminates the formerly proposed mandatory antitrust review for certain collaborations as a condition of entry into the MSSP, but still maintains an antitrust “safety zone” as well as offering additional guidance for antitrust compliance for ACOs. The “safety zone” closely tracks the “safety zone” of the same name in the 1996 Enforcement

Statements issued by the FTC and DOJ, which is frequently referenced in the Final Statement. The new “safety zone” applies to ACOs with market shares of 30% or less in each “common service.” A “service” for these purposes is based upon each primary specialty for physicians, each MDC for inpatient facilities, and each outpatient category for outpatient facilities. The Final Statement continues to use a 75% PSA as a relevant geographic area for these calculations. As before, additional requirements govern the use of exclusivity provisions. Exceptions are made to allow rural facilities to have at least one relevant provider in each category without breaching the safety zone and to allow dominant providers to participate on a nonexclusive basis. An Appendix to the Statement explains how to calculate the PSA shares of “common services.” In contrast to the Proposed Rule, there is no mandatory antitrust review of ACOs that have PSA shares above 50%.

**Guidance for ACOs Outside the “Safety Zone.”** The Statement offers additional guidance to help assure antitrust compliance in ACO operations by identifying various types of conduct and contracting practices most likely to lead to antitrust violations. The conduct and practices to avoid generally include anything that might prevent payers from reducing costs, such as anti-steering provisions, most favored nations clauses and restrictions on the dissemination of useful information with enrollees, as well as unnecessary exclusivity or tying of services.

**Voluntary Expedited Review for New ACOs.** Any “newly formed ACO” (i.e., one which has not signed or jointly negotiated any contracts with private payers or participated in the MSSP as of March 23, 2010) can seek expedited 90-day review from the antitrust agencies. Request for such a review should be made on a form available on the agencies’ websites, with the specified supplemental information potentially including: i) business plans and documents discussing the level and nature of competition among participants in the ACO; ii) information on the “current competitive significance of the ACO” or its participants, including the participants’ PSAs; iii) information on the largest commercial health plans or other private payers for the ACO’s services; and iv) any “substantial precompetitive justification” for the ACO.

## How Will ACOs Be Protected From the Fraud and Abuse Laws?

Concurrent with the Final Rule, CMS and OIG issued an Interim Final Rule with comment period (the “Interim Final Rule”) that establishes waivers of the Federal Physician Self-Referral Law (the “Stark Law”) and the Federal Anti-Kickback Statute (the “AKS”) as well as the provisions of the Federal Civil Monetary Penalties Law prohibiting inducements to physicians to limit services to beneficiaries and prohibiting inducements to beneficiaries (the “Gainsharing CMP” and the “Beneficiary Inducements CMP”).

In a joint notice issued earlier this year, the agencies had proposed waivers that were fairly limited in scope - a waiver for distribution of shared savings and a waiver for arrangements complying with a Stark Law exception. The Interim Final Rule includes the proposed waivers as well as three new waivers developed in response to industry concern that the proposed waivers were too narrow:

- An “ACO pre-participation” waiver of the Stark Law, the AKS, and the Gainsharing CMP for ACO-related start-up arrangements in anticipation of participation in the MSSP. The waiver is subject to certain restrictions, including limits on the duration of the waiver and the types of parties covered, and compliance with certain governing body approval, documentation, and public disclosure requirements.

**The broadened fraud and abuse waivers extend exemptions to commercial ACOs. However, some ACOs may face more restrictions on how they profit and incent patients than outlined in these waivers due to state anti-kick-back or gainsharing laws.**



- An “ACO participation” waiver of the Stark Law, the AKS, and the Gainsharing CMP for ACO-related arrangements during the term of the ACO’s participation agreement and for a specified time thereafter, subject to certain conditions similar to those established for pre-participation waivers.
- A “shared savings distributions” waiver of the Stark Law, AKS, and Gainsharing CMP for distributions and uses of shared savings payments earned under the Shared Savings Program (even if the actual distribution or use occurs after the expiration of the participation agreement), provided certain conditions are met.
- A “compliance with the Stark Law” waiver of the Gainsharing CMP and the AKS for ACO arrangements that implicate the Stark Law and meet an existing Stark exception, that would apply during the term of the ACO’s participation agreement.
- A “patient incentive” waiver of the Beneficiary Inducements CMP and the AKS for medically related in-kind incentives offered by ACOs in the Shared Savings Program to beneficiaries to encourage preventive care and compliance with treatment regimes, subject to certain conditions. The waiver would apply during the term of the ACO’s participation agreement, although a beneficiary could receive the remainder of any service initiated and keep items received before the expiration or termination of the agreement.

CMS and OIG note that the waivers apply uniformly to each ACO, ACO participant, and ACO provider/supplier in the MSSP, and are self-implementing - no special action is required in order to be covered by a waiver. The agencies also caution that they will closely monitor ACOs entering the MSSP in 2012 through June 2013, and plan to narrow the waivers accordingly in response to abusive or fraudulent conduct.

## How Will ACOs Be Protected From the Tax Exemption Laws?

In Notice 2011-20 dated March 31, 2011, the Internal Revenue Service (“IRS”) set forth the IRS’s “expectation” of the principal elements of guidance that it ultimately would provide on the subject of the participation by Section 501(c)(3) organizations in the MSSP through ACOs. Following the release of the Final Rule, the IRS issued a fact sheet dated October 20, 2011, that brings the “expectations” of Notice 2011-20 up to date (the “Fact Sheet”). Neither the notice nor the Fact Sheet constitutes final, binding guidance, but as a general rule, final guidance tends to materially conform to issuances such as the notice and the fact sheet.

**This guidance ostensibly enables non-profits to participate in ACOs without threatening their non-profit status, even when they lack significant control over the ACO venture.**

The Fact Sheet confirms the IRS’s three key conclusions of importance for Section 501(c)(3) organizations: (i) participation in the MSSP through an ACO generally furthers charitable purposes, (ii) Section 501(c)(3) organizations need not have control of an ACO that is a partnership for tax purposes, and (iii) a Section 501(c)(3) organization’s share of payments from an ACO generally is not taxable as “unrelated business taxable income” (“UBTI”).

Regarding the first conclusion, the IRS was careful to note that any particular ACO may be structured so that it has terms or features that cause the ACO to result in “private inurement” or “private benefit” in favor of non-Section 501(c)(3) participants. Therefore, each ACO agreement must be examined independently to confirm that the charitable purpose is unaffected by those possibilities.

The second conclusion is possibly the most interesting. Historically, the IRS has been skeptical of ventures between Section 501(c)(3) organizations and other organizations, and has tended to require that Section 501(c)(3) organizations have total or significant control over the venture to ensure furtherance of

tax-exempt purposes. In the case of the MSSP, the IRS has helpfully determined that the CMS regulations and oversight of the program inherently ensure furtherance of charitable purposes without the control requirement.

The third conclusion essentially follows from the first: If an ACO has a charitable purpose and avoids “private inurement” and “private benefit,” payments from the ACO necessarily escape the tax on UBTI.

Both the notice and the Fact Sheet acknowledge that ACOs may engage in activities that are not part of the MSSP, and the conclusions of the notice and Fact Sheet do not necessarily apply in such cases. Therefore, any ACO that engages in broader activities is advised to consult its own tax counsel to consider the implications of such other activities.

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