



**American Hospital
Association**

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May 11, 2012

Douglas H. Shulman
Commissioner
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, DC 20224

Re: *Update of IRS Revenue Procedure 97-13*

Dear Commissioner Shulman:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) respectfully submits the following comments regarding the need to update IRS Revenue Procedure 97-13, 1997-1 C.B. 632 (Rev. Proc. 97-13) in light of the changes that have occurred in the health care field.

Over the past 15 years, market, economic and regulatory forces have led hospitals and physicians to explore new ways to better align their interests and achieve greater integration in order to both reduce costs and improve the quality of care. Most recently, the *Patient Protection and Affordable Care Act (ACA)* was enacted in 2010 with the intent of accomplishing fundamental transformation in the ways that health care is delivered in the United States. A major element of the ACA is to encourage the continued innovation of new ways to structure the relationship between hospitals and service providers, including physicians. Significant hurdles have arisen, however, in these attempts to implement innovative new hospital-physician arrangements as a result of limitations imposed on the use of tax-exempt bond financed facilities under Rev. Proc. 97-13.

As described in further detail below, modifications to Rev. Proc. 97-13 are necessary if the goals of better integration and alignment of interests between hospitals and physicians are to be accomplished in light of the significant amount of governmental and 501(c)(3) health care facilities that have been financed with tax-exempt bonds.

BACKGROUND

Facilities financed with state or local tax-exempt bonds generally are subject to significant restrictions on the amount of “private business use” that can occur in the facilities without jeopardizing the tax-exempt status of the bonds. Rev. Proc. 97-13 provides issuers and



borrowers under state and local tax-exempt bond financings with certain “safe harbors” under which certain management, service, or incentive payment contracts with private service providers will not be treated as resulting in private business use. Although drafted as safe harbors, the provisions of Rev. Proc. 97-13 are often applied by bond counsel as absolute requirements in light of the market requirement that bond counsel render an unqualified opinion that interest on the bonds will be tax-exempt. Bond counsel are rarely willing to provide such an unqualified opinion where there is a management or service contract that does not clearly comply with Rev. Proc. 97-13.

A contract will qualify for a safe harbor under Rev. Proc. 97-13 if it meets each of the following requirements:

- 1) The compensation is reasonable for the services rendered, with no part of the compensation based, in whole or in part, on a share of net profits from operation of the facility. For this purpose, compensation based on a percentage of gross revenues or expenses of a facility (but not both) or a per-unit fee are not considered to be based on a share of net profits. Reimbursement of the service provider for actual and direct expenses paid by the service provider to unrelated parties is not by itself treated as compensation. Also, a productivity award equal to stated dollar amount based on increases in gross revenues or reductions in total expenses (but not both) in any annual period during the term of the contract does not cause compensation to be based on a share of net profits.
- 2) The contract falls within one of the following categories:
 - At least 95 percent of annual compensation is based on a periodic fixed fee ¹ and the term of the contract (which includes any renewal options of the service provider) does not exceed the lesser of 80 percent of the useful life of the financed property or 15 years. For this purpose, a periodic fixed fee may include a one-time incentive award during the term of the contract under which compensation automatically increases when a gross revenue or expense target (but not both) is reached and the award is equal to a single, stated dollar amount.
 - At least 80 percent of annual compensation is based on a periodic fixed fee and the term of the contract does not exceed the lesser of 80 percent of the useful life of the financed property or 10 years. Again, a periodic fixed fee may include a one-time incentive award during the term of the contract under which compensation automatically increases when a gross revenue or expense target (but not both) is reached and the award is equal to a single, stated dollar amount.

¹ For this purposes, a "periodic fixed fee" generally means a stated dollar amount for services rendered for a specified period of time. For example, a stated dollar amount per month is a periodic fixed fee. The stated dollar amount may automatically increase according to an objective, external standard that is not linked to the output or efficiency of the facility. For example, the Consumer Price Index is an objective external standard, as would any similar external index that tracks increases in prices in a geographic area or increases in revenues or costs in an industry.

- At least 50 percent of annual compensation is based on a periodic fixed fee and the term of the contract does not exceed five years and is terminable by the governmental or non-profit owner without penalty or cause at the end of the third year.
 - All compensation is based on a per-unit fee or a combination of a per-unit fee and a periodic fixed fee, and the term of the contract does not exceed three years and is terminable by the governmental or non-profit owner without penalty or cause at the end of the second year.
 - For contracts under which the service provider primarily provides services to third parties (such as physician services to patients) or contracts involving a facility during an initial start-up period for which there have been insufficient operations to establish a reasonable estimate of the amount of the annual gross revenues and expenses, all compensation is based on a percentage of fees charged or a combination of a per-unit fee and a percentage of revenue or expense fee, and the term of the contract does not exceed two years and is terminable by the governmental or non-profit owner without penalty or cause at the end of the first year. During the start-up period, however, compensation may be based on a percentage of either gross revenues, adjusted gross revenues, or expenses of the facility.
- 3) The service provider has no role or relationship with the governmental or non-profit owner that, in effect, substantially limits the governmental owner's ability to exercise its rights under the contract. This requirement is deemed to be met if:
- not more than 20 percent of the voting power on the governmental owner's board is vested in the service provider and its directors, officers, shareholders and employees;
 - overlapping board members do not include the CEO or board chair of either the governmental owner or the service provider; and
 - the service provider and the governmental owner are not related parties.

SPECIFIC ISSUES

Accountable Care Organizations and Similar Arrangements. As noted above, in recent years hospitals have been seeking various ways to reduce health care costs and improve the quality of care by better aligning the incentives of hospitals and physicians. One way to achieve this is to have contractual arrangements under which cost savings are shared with physicians and other service providers. A recent example of such arrangements is "accountable care organizations" (ACOs) established pursuant to provisions of the ACA.

The ACA established the Medicare Shared Savings Program (MSSP), which promotes accountability for care of Medicare beneficiaries, improves the coordination of Medicare fee-for-service items and services, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under the MSSP, groups of providers of services and suppliers that meet criteria established by the Centers for Medicare & Medicaid

Services (CMS) may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through what is referred to as an ACO. If an ACO meets qualify performance standards and demonstrates that it has achieved savings against benchmarks established by CMS, the ACO will be eligible to receive a payment from CMS equal to a portion of the total savings (shared savings). Initially there will be two types of agreements that an ACO may enter into with CMS, one under which the ACO may share in savings but is not at risk for sharing loss, and the other under which the ACO agrees to accept the risk of sharing in losses in exchange for a greater share in savings. All subsequent agreements between ACOs and CMS will be of the second type.

An ACO must be structured as a legal entity separate from its participants, but generally may be structured as either a corporation or as a partnership for federal income tax purposes (or possibly as a disregarded entity if it is an LLC with one owner). An ACO may include both taxable and tax-exempt participants, and may include participants that are issuers or borrowers under tax-exempt bond financings.

In Notice 2011-20, 2011-16 IRB 652, the IRS addressed the issues of the whether participation in an ACO by a 501(c)(3) hospital might result in private inurement or impermissible private benefit, thereby jeopardizing the 501(c)(3) status of the hospital, or might result in unrelated business income to the hospital. The Notice provides that, because of CMS regulation and oversight of the MSSP, the IRS expects that it will not consider a 501(c)(3) hospital's participation in the MSSP through an ACO as resulting in private inurement or impermissible private benefit to the private party participants in the ACO provided that a number of specified factors are present. The Notice further provides that the IRS expects that, absent inurement or impermissible private benefit, any MSSP payments received by a 501(c)(3) hospital from an ACO would be considered to be derived from activities that are substantially related to the performance of an exempt purpose.

It is unclear the extent to which a 501(c)(3) or governmental hospital's participation in an ACO with private for-profit persons or entities may be considered a management contract within the meaning of Rev. Proc. 97-13. If it were, there would be concerns raised that the sharing of savings and of risk of loss might be considered to result in impermissible compensation based on net profits of bond financed facilities, or that the payments received by the for-profit participants might not comply with the very limited types of compensation that service providers are entitled to receive under Rev. Proc. 97-13. In Notice 2011-20, the IRS concluded that the regulation and oversight of ACOs by CMS justified a conclusion that the IRS expected that it would conclude that a 501(c)(3) organization's participation in an ACO would not result in private inurement, impermissible private benefit, or unrelated trade or business activity, provided that certain specified factors are present. We respectfully request that the IRS consider amending Rev. Proc. 97-13 to similarly clarify that a 501(c)(3) borrower or governmental issuer under a tax-exempt bond financing will not be considered to have private business use of its bond financed facilities as a result of its participation in an ACO under the MSSP.

Moreover, we request that such guidance make clear that its principles would apply not only to ACOs created under CMS's bundled payment initiative, but would also apply to ACO-like

organizations that utilize comparable structures. The tax treatment of a particular arrangement should be based on its substance, not on whether the arrangement was formed pursuant to any particular government program or legislative initiative.

Bundled Payments. Another innovative approach to reducing health care costs and improving the quality of care has been the use of bundled payments. This term generally refers to an arrangement whereby multiple providers are reimbursed a single sum of money for all services related to a single episode of care, such as a hospitalization plus a period of post-acute care, rather than each provider being reimbursed for each individual service. It is believed that the use of bundled payment mechanisms promotes a more efficient use of services, in contrast to the more traditional fee-for-service system, under which reimbursement is directly related to the volume of services provided and there is little incentive to reduce unnecessary care.

On August 23, 2011, under authority created under the ACA, the CMS invited health care service providers to apply to test and develop four different models of bundling payments (the Bundled Payment Initiative (BPI)). Medicare historically has made separate payments to each provider for services rendered for a single illness or course of treatment, often resulting in minimal coordination and fragmented care. Under the BPI, CMS would link payments for multiple services that a patient receives in a single episode of care. The entire health care team is compensated with a “bundled” payment that provides incentives to deliver services more efficiently while maintaining or improving the quality of care. Three of the four models involve retrospective arrangements under which providers set a target amount based on historical experience, get paid under the original Medicare fee for service system, and then may be able to share in savings if the fees come in under the target amount. Under the prospective model, CMS would make a single prospectively determined bundled payment, physicians would submit “no pay” Medicare claims and would be paid by the hospital out of the bundled payment. It is anticipated that the BPI will give physicians new incentives to coordinate care, reduce preventable errors, and reduce costs.

The rigid restrictions under Rev. Proc. 97-13 on the types of compensation arrangements that are permitted for services provided in connection with tax-exempt bond financed facilities will make it difficult for issuers and borrowers under tax-exempt bond financings to utilize bundled payments, such as those being promoted under the BPI. Payments under the traditional Medicare fee for service system are generally treated as per-unit fees under Rev. Proc. 97-13, and the safe harbor for such contracts only permits the compensation to be either based on per-unit fees or a combination of per-unit fees and periodic fixed fees. However, a key component of the BPI is the ability to share with providers the savings generated as a result of the BPI. This sharing of savings would presumably result in a type of contingent compensation that is not permitted under the Rev. Proc. 97-13 safe harbor for per-unit fee contracts. Bundled payment arrangements outside of the BPI similarly have problems qualifying under Rev. Proc. 97-13 if the arrangement includes similar incentive provisions.

We recommend that the safe harbors in Rev. Proc. 97-13 be modified to allow greater flexibility in utilizing multiple types of compensation so as not to prevent governmental and 501(c)(3) hospitals from utilizing bundled payment arrangements, such as those being promoted under the

BPI, and achieving the benefits for their patients that are expected to be derived from these arrangements.

Other Affordability or Quality Incentives. In addition to the specific types of arrangements described above, various other contractual arrangements are being considered by hospitals and physicians in furtherance of the trend towards the development of structures that better align the incentives of hospitals and physicians to increase efficiency and improve patient outcomes, such as through greater use of incentive based compensation. The incentives offered under these arrangements can be based on financial targets, such as reducing costs by eliminating unnecessary or duplicative tests, more efficient use of supplies, better coordination with other providers, or shorter length of stay targets. Incentives can also be based on non-financial quality-based targets, such as achieving patient satisfaction benchmarks.

The increased use of affordability and/or quality incentives can result in significant difficulties in attempting to comply with the safe harbors of Rev. Proc. 97-13. First, it must be concluded that the incentive does not result in the payment of compensation based on a share of net profits. Although a fixed incentive payment based on achieving specified decreased cost or increased revenue targets (but not both) would likely not be considered such a net profits based payment, the answer is not as clear where the contract provides for a sliding scale of varying incentive payment amounts based on the amounts by which specified financial benchmarks are achieved. Even if the incentive arrangement is not considered to be based on a sharing of net profits, it still must be determined whether the arrangement fits within one the specific safe harbor arrangements provided in Rev. Proc. 97-13. At a minimum there will be a cap on the percentage of total compensation that may be derived from the incentive payments, with the cap being increasingly lower as the term of the contract gets longer. Moreover, as described above, certain of the Rev. Proc. 97-13 safe harbors limit the ability to combine certain types of compensation in the same agreement, e.g., an agreement that predominantly calls for per-unit fees generally may not be combined with most other types of incentive compensation.

Accordingly, we respectfully request that the IRS consider modifying Rev. Proc. 97-13 to provide greater flexibility in combining multiple types of affordability and quality incentives. We also respectfully request that the IRS modify Rev. Proc. 97-13 to allow for greater use of non-financial quality based incentives (such as those permitted in Priv. Lett. Rul. 201145005). Quality based incentives should not raise the same level of concern regarding private business use as financial based incentives, but can be an important tool for hospitals to encourage the highest level of performance from their providers.

Restrictions on Permitted Term of Agreements. Another way that Rev. Proc. 97-13 is impeding the ability of governmental and non-profit hospitals to effectively deal with the economic and regulatory challenges they are facing is the significant restrictions that Rev. Proc. 97-13 places on the length of the term of an agreement in order to qualify for a safe harbor. The safe harbors that are most used by hospitals generally limit the term of an agreement to either five years, cancellable by the hospital after three years; three years, cancellable by the hospital after two years; or two years, cancellable by the hospital after one year. As a practical matter, the private parties with whom the hospital is contracting will view the date on which the hospital

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may cancel the contract without penalty or cause as the effective term of the contract, resulting in the effective term limits under these safe harbors being three years, two years, and one year. As described above, an essential element of current efforts to reduce health care costs and improve the quality of care is through better integration of hospitals and health care providers and better aligning of interests. It is extremely difficult to achieve these objectives utilizing only the extremely short-term agreements permitted under the safe harbors of Rev. Proc. 97-13. It is very difficult to convince service providers to accept the additional risks that are inherent in many of these arrangements without being able to give them assurance that the relationship will last long enough so that the anticipated returns to the service provider are sufficient to justify the increased risks. Accordingly, we respectfully request that the IRS consider increasing the permitted terms under the safe harbors in Rev. Proc. 97-13 to no shorter than [five] years with no requirement that the hospital have an earlier right to terminate without penalty or cause. We believe that such a limit is reasonable in light of the fact that most tax-exempt bond issues are issued with terms of 20 to 30 years.

Thank you for your attention to this important issue. For more information please contact me at mhatton@aha.org or (202) 626-2336, or Mike Rock at mrock@aha.org or (202) 626-2325. We would be happy to meet with you to discuss these issues.

Sincerely,

/s/

Melinda Reid Hatton

Senior Vice President and General Counsel

cc: James Polfer, Branch Chief, Office of Chief Counsel, IRS
John J. Cross III, Associate Tax Legislative Counsel, Treasury