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January 14, 2015

*Submitted electronically to notice.comments@irscounsel.treas.gov*  
(Notice 2014-67)

Internal Revenue Service  
CC:PA:LPD:PR (Notice 2014-67)  
P.O. Box 7604  
Ben Franklin Station  
Washington, DC 20044

***Re: Response to IRS Request for Comments in Notice 2014-67***

Ladies and Gentlemen:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, the American Hospital Association (“AHA”) respectfully submits the following comments with respect to IRS Notice 2014-67 (the “Notice”), which provides interim guidance with respect to private business use of tax-exempt bond finance facilities, focusing in particular on (i) participation by governmental persons and 501(c)(3) organizations in the Medicare Shared Savings Program (“MSSP”) under the Patient Protection and Affordable Care Act (“ACA”) through “accountable care organizations” (“ACOs”) that include private persons or entities, and (ii) management contracts with nongovernmental persons to provide health care services that will take into account the quality performance standards and Medicare fee-for-service expenditures relevant to participation in the MSSP.

The AHA appreciates both the effort of the Department of the Treasury and the Internal Revenue Service in the promulgation of the Notice as well as the request for and consideration of public comments on this important topic. Updating the tax-exempt bond rules to accommodate the intent, requirements and incentives of the ACA will be essential to its successful implementation. While the Notice represents a positive step in that direction, the AHA believes that modifications to the guidance are necessary in order to ensure that the tax-exempt bond rules are not an impediment to the successful achievement of the ACA’s goals and objectives.



Expand Scope of MSSP-ACO Guidance to Cover Comparable Arrangements with Private Payers

Section 3.01 of the Notice provides that the participation of a qualified user (as defined in Rev. Proc. 97-13) in the MSSP through an ACO in itself will not result in private business use of a tax-exempt bond financed facility if all of the following conditions are satisfied:

- The terms of the qualified user's participation in the MSSP through the ACO (including its share of MSSP payments or losses and expenses) are set forth in a written agreement negotiated at arm's length.
- The Center for Medicare & Medicaid Services ("CMS") has accepted the ACO into, and has not terminated the ACO from, the MSSP.
- The qualified user's share of economic benefits derived from the ACO (including its share of MSSP payments) is proportional to the benefits or contributions the qualified user provides to the ACO. If the qualified user 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 qualified user's share of the ACO's losses (including its share of MSSP losses) does not exceed the share of the ACO economic benefits to which the qualified user is entitled.
- All contracts and transactions entered into by the qualified user 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.
- The qualified user does not contribute or otherwise transfer the property financed with tax-exempt bonds to the ACO unless the ACO is an entity that is a governmental person, or in the case of qualified 501(c)(3) bonds, either a governmental person or a 501(c)(3) organization.

While this guidance is helpful, it is limited to ACOs that serve Medicare patients through the MSSP, and does not address the fact that an important element of the ACA is to promote the development of ACO-type arrangements with non-Medicare payers. While ACOs participating in the MSSP is an important element of the ACA, it is clear that another objective of the ACA is to promote the development of similar arrangements involving private payers rather than just Medicare. As stated by Senate Finance Committee Chairman Max Baucus in his 2009 white paper entitled "Reforming America's Health Care System: A Call to Action":

Many of the proposals in the plan are based in the Medicare program because of its unique ability to lead the way for system-wide changes. The expectation, however, is that public and private insurers will follow and continue to innovate as well.

Similarly, HHS Secretary Sebelius said the following on December 7, 2010 in her remarks at the Institute for Healthcare Improvement:

We recently announced the creation of the CMS Innovation Center, an important new effort to stretch the boundaries of the existing systems of payment and care delivery to find new ways to improve the quality and affordability of care. While the center will be focused on Medicare and Medicaid, the combined purchasing power of those two programs will help the rest of the American health care system improve at the same time. And we are also making sure these efforts align with those of States and private payers.

And the following was said by Jonathan Blum, Director of the Center for Medicare Management, in his testimony before the Senate Committee on Health, Education, Labor and Pensions on November 10, 2011:

CMS has established initiatives to ensure that Medicare patients get the right care, in the right place, at the right time. A key part of CMS' work in this area is a multi-part initiative built around Accountable Care Organizations (ACOs), which bring together doctors, hospitals and other health care providers to better coordinate care for patients. ACOs are an innovative service delivery model being used by CMS and in the private sector and communities across the country.

Moreover, while the ACA does not provide rewards for successful shared savings programs other than the MSSP and does not mandate ACO-type structures for non-Medicare payers, standards to be developed under the ACA indicate that private health insurance payers either will be required to adopt elements that are found in MSSP ACOs or will be measured and rated by whether they adopt such elements. For example, within two years of the ACA's enactment health plans must report on, and are encouraged to have, "health care provider reimbursement structures that improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives." [ACA §1001, enacting § 2717(a) of the Public Health Service Act, 42 U.S.S. § 300gg-17(a).]

The evolution of ACO-type arrangements with non-Medicare payers will further the goals of the ACA by transforming the health care delivery system into something that is more affordable, available, efficient, and quality oriented, regardless of who is providing the reimbursement. Accordingly, we urge that the comfort provided by the Notice for qualified users participating in the MSSP through an ACO be extended to cover similar ACO-type arrangements with non-Medicare payers. To the extent that Treasury and the IRS are concerned about the lack of CMS oversight of ACOs outside of those participating in the MSSP, we believe that imposing requirements for ACOs involving private payers similar to those imposed by the Notice (excluding acceptance by the MSSP) will provide adequate safeguards to ensure that private parties are not being improperly benefitted. The tax-exempt bond rules should not distinguish between comparable ACO-type arrangements solely on the basis of whether the payer is Medicare or a private insurer.

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We thank you in advance for your consideration of these comments, and would be happy to meet with you to discuss these important issues.

Sincerely,

/ s /

Melinda Reid Hatton  
Senior Vice President and General Counsel