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Dear Ms. Tsilas, Mr. Polfer and Mr. Jones:

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (the "Affordable Care Act" or the "ACA"), into law. One of the ACA's primary goals is to reduce the overall cost of health care, while ensuring quality by reducing fragmentation in the provision of health care and aligning quality and expense-based financial incentives among physicians, hospitals and other health care service providers.

The ACA provides for accountable care organizations ("ACOs"), which can include as participants governmental entities as well as organizations exempt from tax under section 501(c)(3) of the Internal Revenue Code. The participation of governmental entities or 501(c)(3) organizations in an ACO raises questions concerning the tax-exempt status of debt issued by or for the benefit of such organizations. The attached memorandum requests guidance concerning those questions and, in doing so, provides a recommendation.

The National Association of Bond Lawyers (NABL) was incorporated as an Illinois non-profit corporation on February 5, 1979, for the purposes of educating its members and others in the law relating to state and municipal bonds and other obligations, providing a forum for the exchange of ideas as to law and practice, improving the state of the art in the field, providing advice and comment at the federal, state and local levels with respect to legislation, regulations, rulings and other action, or proposals therefore, affecting state and municipal obligations, and providing advice and comment with regard to state and municipal obligations in proceedings before courts and administrative bodies through briefs and memoranda as a friend of the court or agency. More information about NABL is available on its website, www.nabl.org.

The attached memorandum was prepared by an ad hoc committee of the National Association of Bond Lawyers ("NABL") and approved by NABL's Board of Directors. The members of the ad hoc committee are listed in Exhibit 3.

If NABL can be of any further assistance please do not hesitate to contact NABL's Director of Governmental Affairs, Bill Daly, at 202-503-3303 or bdaly@nabl.org.

Sincerely

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National Association of Bond Lawyers
March 29, 2013

Request For Guidance Concerning Private Business Use When a Tax-Exempt Bond Borrower Participates in an Accountable Care Organization

The Affordable Care Act

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (the "Affordable Care Act" or the "ACA"), into law. One of the ACA's primary goals is to reduce the overall cost of health care, while ensuring quality by reducing fragmentation in the provision of health care and aligning quality and expense-based financial incentives among physicians, hospitals and other health care service providers.

Accountable Care Organizations

Section 3022 of the Affordable Care Act amends Title XVIII of the Social Security Act (the "SSA") (42 U.S.C. 1395 et seq.), adding new Section 1899. Section 1899 of the SSA establishes the Medicare Shared Savings Program (the "MSSP"). Under the MSSP, eligible providers, hospitals and suppliers that meet the 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 "accountable care organization" (an "ACO").

An ACO is a health care organization that creates incentives for health care providers to work together to treat patients across care settings by providing financial incentives to reduce health care costs ("shared savings"), while meeting performance standards for quality of care. An ACO involving two or more otherwise independent participants must be a legal entity with a governing body that is distinct and separate from each participant (e.g., a partnership, a corporation or an LLC). An ACO may include both taxable and tax-exempt participants, and the tax-exempt participants may include entities that are issuers or borrowers of tax-exempt bond financings. Examples of groups that may form an ACO include the following: (i) physicians and other health care practitioners ("ACO professionals") in a group practice, (ii) a network of individual practices, (iii) a partnership or joint venture arrangement between a hospital[1] and ACO professionals, and (iv) a hospital employing ACO professionals.[2]

An ACO will have a contractual arrangement with CMS. The initial contractual arrangement will provide for the ACO to receive incentive payments based on a

[1] The ACO creation documents may or may not require the ACO professionals to provide services at the hospital, but any service contract between the hospital and ACO professionals is expected to be contained in a separate document

[2] A hospital employing ACO professionals may be eligible to participate in the MSSP as an ACO under its existing legal structure.

combination of factors that include one or more of the following: quality performance, patient or provider satisfaction, efficiency and expense control. The term of the initial agreement must be at least three years. In addition to sharing in savings, an ACO may also be required to share the burden of failing to satisfy incentive provisions. As a result, ACOs may be required to make payments to CMS if they do not achieve cost savings and/or quality measures. ACO creation documents may simply provide for incentive payments to be distributed among the ACO participants in proportion to each participant's participation in the ACO or based on the percentage of total savings generated by the respective participant. Alternatively, or additionally, the ACO or the hospital may enter into separate contracts with ACO professionals that contain either (i) contractual incentives substantially similar to the incentive provisions contained in the contract between CMS and the ACO, or (ii) contractual provisions designed to enable the ACO to satisfy the incentives in the contract between CMS and the ACO. For example, if the contract between CMS and the ACO includes an incentive based on patient satisfaction and the ACO believes that doctor punctuality is a material factor in patient satisfaction, an incentive provision based on punctuality of the ACO professionals would be designed to enable the ACO to satisfy the quality incentive provisions in the contract between CMS and the ACO.

As referenced above, both hospitals and other health care organizations that benefit from tax-exempt financings (referred to herein as "tax-exempt health care borrowers") and those that do not are eligible and expected to participate in ACOs. Any incentives based on cost savings are based exclusively on savings in operational costs. Thus, a tax-exempt health care borrower's cost of capital (e.g., debt service) has no bearing on such incentives, eliminating the potential transfer of the benefits of tax-exempt financing to ACO professionals. Additionally, none of the incentive provisions will be measured by revenue received by the tax-exempt health care borrowers. Accordingly, the incentives payable to an ACO are not based, directly or indirectly, on the net profits of the participating tax-exempt health care borrowers.

Other Similar Arrangements

As set forth on Exhibit 1, the ACA created a number of other programs aimed at improving the quality and efficiency of health care delivery and the payments therefor, including through insurance. As with ACOs, incentive payments may be made pursuant to such programs in furtherance of these goals. Both tax-exempt health care borrowers and those that do not benefit from tax-exempt financing are eligible and expected to participate. None of the incentives based on cost savings is based on savings in the cost of capital, and none of the incentive provisions is based on revenue received by the tax-exempt health care borrower.

While these types of incentives are initially being implemented via ACA programs, it is important to recognize that these ACA programs reflect changes that are occurring throughout the health care industry, and are likely to migrate to contracts that are not part of ACA programs. Therefore, broad guidance regarding these types of incentives is urgently needed.

Tax-Exempt Bond Rules

Over $362 billion of tax-exempt bonds allocable to the construction, renovation or acquisition of health care facilities have been issued since 2004. The cost of capital is material to determining the overall expenses of a tax-exempt health care borrower. Under the Internal Revenue Code of 1986 (the "Code"), 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 such facilities without jeopardizing the tax-exempt status of the bonds.

"Private business use" is only generally defined in the Code. Pertinent Treasury Regulations identify certain specific arrangements (e.g., ownership, leases, management or service contracts) that result in private business use, and in addition provide that any other arrangement that gives rise to a "special legal entitlement" or "special economic benefit" comparable to the specifically identified arrangements also results in private business use.[3] While it is unlikely that the creation of or participation in an ACO is described in any of the specifically identified arrangements,[4] it is less clear that an ACO is not a "comparable" arrangement. For example, an ACO may provide case management services to coordinate care among the different providers participating in an ACO. Uncertainty as to whether the creation of ACOs and the contractual arrangements expected to be entered into by ACOs and/or the members of ACOs result in private business use will be an impediment to the implementation of health care reform intended by the ACA. Thus, the ability of the ACA to meet at least one of its primary goals will be impeded if, in order to implement the provisions of the Affordable Care Act, tax-exempt health care borrowers know that they will have to take "remedial action" in the form of redeeming or defeasing tax-exempt debt, which could entail substantial cost.[5]

Such a result would be inconsistent with the policy goals of the ACA without furthering the underlying policies of the use-of-proceeds limitations of section 145 of the Code. We urge you to issue guidance to avoid such a result. This approach would be similar to the approach taken in Internal Revenue Service Notice 2011-20, 2011-16 I.R.B. 652, which was designed to provide safe harbor guidance that the implementation of the programs of the Affordable Care Act, particularly participation in an ACO, would not jeopardize the tax-exempt status of health care borrowers as organizations described in Section 501(c)(3) of the Code. Additionally, the issuance of guidance in the context of the private business use rules in response to dramatic change in an industry is not unprecedented. For example, Treasury Regulations Section 1.141-7(g)(ii) was promulgated in response to the proliferation of independent transmission operators throughout the country and provides comfort that certain arrangements between municipal utilities and independent transmission operators do not give rise to private business use of transmission facilities.

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[3] For further detail regarding these rules, see Exhibit 2.

[4] This discussion does not cover situations in which an ACO may enter into a separate arrangement, e.g., a lease to occupy bond financed property.

[5] Additionally, this would mean that tax-exempt health care borrowers would need to forego eligibility for future tax-exempt financing.

Requests

Either by Notice or Regulation, we request that safe harbors be implemented that provide each of the following:

A. **No Private Use via Creation of or Participation in an ACO**

The creation of or participation in an ACO does not give rise to private business use if:

1. The terms of the tax-exempt organization's participation in the MSSP through the ACO are set forth in advance in a written agreement negotiated at arm's length;

2. CMS has accepted the ACO into, and has not terminated the ACO from, the MSSP; and

3. Any incentives based on cost savings are based exclusively on savings in operational costs (as opposed to the cost of capital of the tax-exempt health care borrowers).

B. **Special Safe Harbor for Health Care Service Contracts**

Create a new term of art "Health Care Service Contract" and define it as a management or service contract for health care or services that is between an ACO or qualified user (as defined in Revenue Procedure 97-13) and a medical provider (doctors, nurses, physician assistants, medical directors, service providers at hospices, service providers at rehabilitation facilities, ACO executives, etc.). Agreements between ACOs or qualified users and food service providers, or consultants that do not provide health care, etc., would not be treated as Health Care Service Contracts.

For a "Health Care Service Contract," incentive features based on quality measures, patient or provider satisfaction, and efficiency or expense control, but not increased revenue or volume, will not cause the contract to give rise to private use if, but for these incentives, the contract would meet one of the safe harbors set forth in Revenue Procedure 97-13. Furthermore, for purposes of any requirements in the safe harbors of Revenue Procedure 97-13, regarding the maximum contract term and the ability to terminate a contract without penalty or cause, a Health Care Service Contract will be treated as satisfying such requirements as long as the term of the contract does not exceed the greater of either (a) the term of the agreement signed between the ACO and CMS[6] , or (b) five years.

Ideally, the requested guidance should make clear that this new safe harbor is designed to accommodate health care reform in general, including all programs created by the Affordable Care Act, and should not be limited to contracts associated with ACOs. The guidance should also provide that ACOs and tax-exempt health care borrowers have

[6] See Section 1899(b)(2)(B) of the SSA, providing that the ACO shall enter into an agreement with CMS for not LESS than three years

broad discretion to determine the types of incentives and other arrangements with various parties including providers and insurers that will improve quality, patient or provider satisfaction, efficiency or expense control, and that such determinations by the ACO or tax-exempt health care borrowers will be presumed to be conclusive for the purposes of Internal Revenue Code sections 141 and 145 so long as they do not contain contractual provisions that transfer the benefit of tax-exempt financing or a net profits interest to a private business. Finally, after the adoption of this new guidance, Revenue Procedure 97-13, which currently does not apply to admitting privileges, would also not apply to incentive payments based on quality measures, patient or provider satisfaction, efficiency or expense control. Therefore, the guidance should make clear that a contract that provides for only such incentive payments to a physician with admitting privileges should not be considered to give rise to private business use.

Conclusion

The ACA represents one of the most significant regulatory overhauls of the U.S. health care system since the passage of Medicare and Medicaid in 1965 and has accelerated the restructuring of the payment model for health care services. The creation of ACOs and a dramatic increase in the number of management or service contracts that include incentives based on quality, efficiency, and expense control is a natural result of this overhaul. Such incentives will not transfer the benefit of tax-exempt financing to a private business and will not cause health care providers to be compensated based on a share of net profits. Accordingly, the manner in which such arrangements are treated is not addressed by the general language of Section 141 of the Code, but needs to be addressed by either Treasury Regulations or guidance from Chief Counsel.

We believe that enactment of the guidance requested above would assure that the implementation of the ACA is not unintentionally impeded by the private business use rules as they currently exist.

EXHIBIT 1

1. **Centers for Medicare and Medicaid Services (CMS) Bundled Payments for Care Improvement initiative.** CMS invited health care providers to apply to help test and develop four different models of bundled payments. This Initiative derives from CMS' requirement under Section 3023 of the ACA to better coordinate care among providers. The goal of the initiative is to encourage and incentivize physicians, hospitals and post-acute care providers to better coordinate patient care, both during in-patient hospitalization and upon discharge, for the purpose of increasing quality and efficiency and reducing the costs of care.

2. **Medicare Shared Savings Program.** Section 3022 of the ACA required the Secretary of Health and Human Services to establish a shared savings program, no later than January 1, 2012, that promoted accountability for a patient population and coordinated items and services under Medicare parts A and B, and encouraged investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under the shared savings program, groups of providers of services and suppliers meeting certain criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an Accountable Care Organization ("ACO"). Those ACOs that meet quality performance standards established by the Secretary will be eligible to receive payments or shared savings.

3. **CMS Hospital Readmission Reduction Program.** Section 3025 of the ACA requires the Secretary of Health and Human Services to establish a Hospital Readmissions Reduction Program whereby the Secretary would reduce Inpatient Prospective Payment System payments to hospitals for excess readmissions beginning on or after October 1, 2012 (Fiscal Year 2013).

4. **Physician Quality Reporting System.** Section 3002 of the ACA provides an incentive payment for eligible professionals who satisfactorily report data on quality measures for professional services provided to Medicare beneficiaries.

5. **Hospital Value-based Purchasing (HVBP) Program.** Section 3001 of the ACA establishes a HVBP, or pay-for-performance incentive program, to reward hospitals for meeting certain performance thresholds. Starting in October 2012, Medicare will reward hospitals that provide high quality care for their patients through the new HVBP Program. This program marks the beginning of change in how Medicare pays health care providers and facilities—for the first time, hospitals across the country will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide.

6. **Payment Adjustment for Conditions Acquired in Hospitals.** Beginning in fiscal year 2015, Section 3008 of the ACA requires inpatient hospitals with high volumes of "hospital acquired conditions" to have their payment for discharges reduced to 99% of the amount of payment that would otherwise apply to such discharges.

7. **U.S. Food and Drug Administration Safe Use Initiative** (not part of ACA but raising similar policy concerns). Creating and incentivizing a collaborative process from all parties involved in the medication manufacturing, distribution, and use system to reduce harm from manageable medication risks as the potential for preventable errors can be increased along any point of this complex system.

EXHIBIT 2

The following restrictions on the amount of "private business use" apply to facilities financed with state or local tax-exempt bonds.

The Code

Section 103(a) of the Code provides that gross income does not include interest on any state or local bond. Section 103(b) of the Code, however, provides that Section 103(a) does not apply to a "private activity bond". Section 141(a)(1) of the Code defines "private activity bond" as any bond issued as part of an issue that meets both the private business use and the private security or private payment test. Under section 141(b)(1) of the Code, an issue generally meets the private business use test if more than the lesser of 10% or $15,000,000 of the proceeds of the issue is to be used for private business use. For reasons that are beyond the scope of this letter, we submit that for the substantial majority of bonds issued to finance a tax-exempt health care borrower's facility, the private security or private payment test will be met if the private business use test is met.

Section 141 of the Code was enacted in 1986. The general purpose of the Section 141 of the Code is to ensure that the primary use of bond-financed assets is by the government (or, in the case of the qualified 501(c)(3) bonds, organizations described in Section 501(c)(3) of the Code) or the general public and to limit the volume of tax-exempt bonds that finance the activities of private businesses. "Private business use" is defined in Section 141 of the Code only in a general fashion. Specifically, Section 141(b)(6)(A) of the Code generally defines private business use as direct or indirect use in a trade or business carried on by any person other than a governmental unit. Section 145(a) of the Code also applies the private business use test of section 141(b)(1) of the Code, with certain modifications, including a reduction in the amount of permitted private use to the lesser of 5% or $15,000,000, to qualified 501(c)(3) bonds. The general nature of the definition of "private business use" in the Code has provided Treasury and Chief Counsel's office with broad authority to interpret "private business use" in a flexible manner to further the purpose of Section 141 of the Code.

Accordingly, an extensive body of law interpreting "private business use" was developed by the Treasury pursuant to Treasury Regulations 1.141-1 through 1.141-15 and Chief Counsel through Revenue Procedure 97-13, 1997-1 C.B. 632.[7] Other than a minor modification to Revenue Procedure 97-13 in 2001, the relevant regulations and revenue procedure were all published in 1997 or earlier, and, therefore, existing published guidance is not written in a manner that contemplates structures such as ACOs or incentive payments pursuant to the Affordable Care Act. Uncertainty as to whether the creation of ACOs and the contractual arrangements expected to be entered into by ACOs and/or the members of ACOs will result in private business use will act as an impediment to the implementation of health care reform intended by the Affordable Care Act.

[7] Revenue Procedure 97-13 was the successor to several prior revenue rulings on the subject. See Rev. Proc. 82-14, 1982-1 C.B. 459; Rev. Proc. 82-15, 1982-1 C.B. 460; Rev. Proc. 93-19. 1993-1 C.B. 526.

Current Treasury Regulations

Pursuant to Treasury Regulations Section 1.141-3(b), private business use generally arises only if a nongovernmental person has special legal entitlements to use the financed property under one of the following types of arrangements:

- Ownership;
- Lease;
- A management or service contract with respect to financed property may result in private business use of that property, based on all of the facts and circumstances. A management contract with respect to financed property generally results in private business use of that property if the contract provides for compensation for services rendered with compensation based, in whole or in part, on a share of net profits from the operation of the facility;
- Certain output contracts;
- Certain research agreements; or
- Comparable arrangements.

It is clear that ACOs, arrangements entered into by ACOs, participating hospitals or other health care organizations, and other similar contractual arrangements entered into pursuant to the Affordable Care Act programs listed on Exhibit 1 would not give rise to private business use via ownership, lease, output contracts, or research agreement. While it would seem unlikely that an ACO would itself be treated as a management or service contract, it is less clear whether the ACO could be treated as a comparable arrangement. Further, as referenced under Accountable Care Organizations in the memorandum, the ACO or hospital may, alternatively or additionally, enter into separate contracts with ACO professionals that contain either (i) contractual provisions that contain incentives substantially similar to the incentive provisions contained in the contract between CMS and the ACO, or (ii) contractual provisions designed to enable the ACO to satisfy the incentives in the contract between CMS and the ACO. Guidance from the Treasury or Chief Counsel is needed to avoid the potentially broad reach of an ambiguous regulation from impeding the implementation of Affordable Care Act.

Revenue Procedure 97-13

Revenue Procedure 97-13 provides safe harbors under which a management or service contract will not be treated in resulting as private business use if the terms of the contract satisfy certain requirements set forth therein. The safe harbors of Revenue Procedure 97-13 generally place limitations on the length of the term of a management or service contract and limitations on the methodology for determining compensation under the contract. As referenced above, this Revenue Procedure was drafted long before the Affordable Care Act and ACOs were contemplated. As with the Treasury Regulations

discussed above, Revenue Procedure 97-13 provides that a management or service contract will give rise to private use if compensation is based, in whole or in part, on a share of net profits from operation of the bond financed facility.

Exhibit 3

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