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Hospital Group Seeks Changes to Tax-Exempt Bond Rules.

The American Hospital Association has urged Treasury to modify the tax-exempt bond rules, noting that the current rules pose a barrier to hospital and medical foundations' use of specific types of arrangements that are encouraged by the Affordable Care Act, such as accountable care organizations, bundled payments, and other shared savings programs.

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Dear Ms. Tsilas and Ms, Som de Cerff:

Thank you for taking the time on May 20th to discuss with me, Mike Rock and representatives from several of the American Hospital Association's hospital members the importance of updating tax-exempt bond rules to accommodate the intent, requirements and incentives of the Affordable Care Act (ACA) for high-quality, cost-effective health services.

As we discussed, current rules as embodied in Rev. Proc. 97-13 present a barrier to hospital and medical foundation use of particular arrangements that are encouraged by the ACA, such as accountable care organizations, bundled payments and other shared savings programs. Furthermore, hospitals face significant penalties tinder readmission reduction and value-based purchasing programs. Rev. Proc. 97-13 prevents the types of arrangements that can effectively align incentives among physicians, hospitals, medical foundations and other health care service providers to meet the goals of the ACA.

During our call, you asked for (1) suggestions on the types of quality measures hospitals or medical foundations use in management contracts to incentivize physicians that should be considered acceptable under the "private business use" standards; and (2) suggested language to allow retroactivity of the new rules after any new guidance is issued (or old agreements that are materially modified or extended after that date).

Quality Measures

A number of third-party organizations develop and evaluate quality measures for the purpose of evaluating and reporting on the performance of health care providers.

Public measure developers include the Center for Medicare and Medicaid Services (CMS), and the Agency for Healthcare Research and Quality (AHRQ). CMS currently uses measures to financially reward providers who are able to deliver better-quality care to beneficiaries at a lower cost. CMS defines quality measures as, "tools that help (us) measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care."

Non-profit, private developers of quality measures include the Joint Commission, which evaluates and accredits more than 20,000 healthcare organizations and programs in the United States, and the National Quality Forum (NQF), a multi-stakeholder organization that endorses consensus standards for performance measurement. The measures they develop are predominantly used by payers in public reporting and provider incentive programs. The NQF, for instance, uses four criteria to assess a measure for endorsement:

(1) Important to measure and report to keep our focus on priority areas, where the evidence is highest that measurement can have a positive impact on healthcare quality.
(2) Scientifically acceptable, so that the measure when implemented will produce consistent (reliable) and credible (valid) results about the quality of care.
(3) Useable and relevant to ensure that intended users — consumers, purchasers, providers, and policy makers — can understand the results of the measure and are likely to find them useful for quality improvement and decision-making.
(4) Feasible to collect with data that can be readily available for measurement and retrievable without undue burden.

It is also important to recognize that pursing quality measures may also have the additional benefit of reducing costs by eliminating unnecessary or duplicative tests, promoting the efficient use of supplies, facilitating coordination with other providers, or reducing length of stay. Management contracts between hospitals or medical foundations and physicians or other providers should not give rise to private use if they base incentive compensation on quality measures including those that have the added benefit of producing gains in the efficiency and effectiveness of care. Further, such compensation should be permitted to be structured on a sliding basis without limit on its frequency. Finally, hospitals or medical foundations should have flexibility in the terms of the management contract in order to ensure the quality measures can be accomplished.

Effective Date

We believe that any new rules should generally apply for new agreements entered into after the new guidance is issued (or old agreements that are materially modified or extended, except under a renewal option, after that date). We also suggest a 90-day delay between the date of publication and the effective date so that healthcare providers with outstanding or proposed tax-exempt bonds have time to digest the rules and won't have to apply them to agreements that have already been negotiated but not yet signed. We also believe flexibility should be provided by allowing healthcare providers with outstanding tax-exempt bonds the option to apply the new rules retroactively to older agreements. The following is our suggested language:

"_. Effective Date

This [revenue procedure] is effective for any agreement entered into, materially modified, or extended (other than pursuant to a renewal option) on or after [DATE THAT IS 90 DAYS AFTER DATE OF PUBLICATION]. In addition, healthcare providers with outstanding tax-exempt bond may apply this revenue procedure to any agreement entered into prior to [DATE THAT IS 90 DAYS AFTER DATE OF PUBLICATION].”

Conclusion

The need to improve the quality and cost-effectiveness of health care delivery requires hospitals and medical foundations to integrate among themselves and with other providers by sharing financial risk through incentives, encouraging the streamlining of management services. Regulatory barriers such as the private use rules related to tax-exempt bond financing constrain the pace of innovation and increase the cost of care. Your efforts to update those rules are vital to the success of the payment and quality reforms of the ACA. Our recommendations aim to ensure that quality incentives would not give rise to private use, and that any new guidance allows healthcare providers with outstanding tax-exempt bonds the option to apply the new rules retroactively to older agreements.

Sincerely,

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