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Is Obamacare the **Right Prescription** For Insolvent Hospitals?

BY ADAM C. ROGOFF AND ANUPAMA YERRAMALLI

In the wake of the U.S. Supreme Court's decision[1] upholding the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Reconciliation Act (collectively, ACA), healthcare providers are attempting to gauge the effect of the new law on operations. Of particular interest is the impact upon financially stressed providers. The ACA will result in 32 million additional insureds through (i) broader Medicaid eligibility, and (ii) mandating that virtually every citizen obtain health insurance and establishing healthcare exchanges. The ACA also requires Medicare reimbursement reductions, reductions in aid to hospitals that treat uninsured patients, and lower reimbursements for hospitals failing to comply with the ACA's quality mandates and reporting requirements.

Given that community-based hospitals—often those operating on a standalone basis and not part of a larger system—face existing operational deficiencies, the ACA could impose greater costs upon hospitals that need to meet certain levels of patient care to avoid decreases in reimbursement revenues.

The ACA contains a number of provisions having an acute effect on the liquidity of distressed hospitals. The American Hospital Association and other hospital groups publicly support the law because it promises to create a large pool of additional insured individuals hopefully resulting in substantially increased revenues. In fact, several for-profit hospitals' stocks rose when the Supreme Court upheld the ACA.[2] However, many community hospitals with a high Medicaid and uninsured patient population have expressed reservations regarding their ability to operate successfully after the ACA is

Mr. Rogoff is a partner in the Corporate Restructuring and Bankruptcy Department of Kramer Levin Naftalis & Frankel LLP in New York. Mr. Rogoff has over two decades' experience in representing companies in Chapter 11 and out of court restructurings. He has extensive experience representing hospitals in bankruptcy serving as debtor's counsel for Bayonne Medical Center and Saint Vincents Catholic Medical Centers of New York and its affiliates in their chapter 11 cases ("SVCMC"). Ms. Yerramalli is an associate in Kramer Levin's Corporate Restructuring and Bankruptcy Department and also represented SVCMC. In addition, Benjamin Wolf, also an associate in Kramer Levin's Corporate Restructuring and Bankruptcy Department assisted in the preparation of this article. The authors appreciate the comments and suggestions made by Jason Horowitz, a Senior Vice President of Cain Brothers & Company LLC, to this article.

fully implemented.[3] This article explains the key provisions of the ACA that may affect distressed hospitals.

Positive Impact on Liquidity

The Individual Mandate. The ACA is estimated to require health coverage for an additional 32 million previously uninsured individuals by 2019. The mandate will be enforced by a tax penalty, though it is unclear how many of those subject to the mandate will acquire health insurance given the size of the tax penalty and since the IRS is precluded from using certain enforcement mechanisms.[4]

The biggest advantage of the ACA for hospitals is the dramatic increase in the insured patient population. According to one estimate, by the time the ACA is fully implemented in 2019, the newly insured individuals will generate approximately $40 billion in new revenue for hospitals.[5] A hospital's healthcare mission is also furthered since patients may no longer avoid visits due to lack of insurance.

Value-Based Purchasing. One aspect of the ACA with the potential to increase hospitals' liquidity is its establishment of a value-based purchasing (VBP) program for Medicare and Medicaid payments based on certain quality measures. However, the VBP program imposes additional reporting requirements. When a hospital meets its required performance standard, it is eligible for an increased reimbursement rate.

Concomitantly, reimbursements decrease if services fall below an expected standard.[6] It is unclear, however, whether distressed hospitals' potentially increased payments for meeting performance goals will be offset by the costs of complying with the performance and reporting obligations (discussed below). This is noteworthy, as liquidity-constrained providers may also be the ones in the greatest need of operational improvements and new capital investment to meet quality and patient care standards.

Expanded Medicaid Eligibility. The ACA also provides for the expansion of the Medicaid program to cover individuals and families earning 133 percent of the federal poverty level.[7] This broadening of Medicaid's eligibility requirements is expected to result in approximately 15 million additional insured individuals.[8] While these additional insured individuals should result in more revenue-generating patients for hospital,[9] the additional covered patients will be insured by Medicaid, whose reimbursement rates are currently far below those of Medicare (which itself is below market);[10] therefore, the cost of treating these individuals may outpace Medicaid revenues for many hospitals.[11] To improve the bottom line, the volume of government-payor patients must increase or new partnerships must be sought with other hospitals that have higher reimbursement rates.

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Liquidity-Decreasing Provisions

While the policy goal of mandating insurance coverage and improving quality of care and patient outcomes align with the charitable mission of hospitals, the increased costs of implementing the ACA, in addition to the reimbursement reductions set forth therein, impose financial burdens on healthcare systems to implement the goals of the ACA.

Reduction in Aid for Charity Care. The federal government currently spends approximately $20 billion (of which $2.84 billion goes to New York hospitals) to assist mostly poor urban and rural hospitals (known as disproportionate share hospitals) with the treatment of uninsured patients, including undocumented immigrants. Undocumented immigrants are estimated to constitute approximately 40 percent of the uninsured patients in New York City's public hospitals.[12]

The federal government plans to cut the $20 billion allocated to disproportionate share hospitals to $10 billion by 2019 based on the assumption that the number of uninsured patients will decrease by at least half and broaden Medicaid eligibility after the ACA is fully implemented.[13] However, this reduction does not account for the fact that a large number of uninsured patients are ineligible for Medicare or Medicaid because they are undocumented immigrants, particularly in urban areas. Since hospitals cannot turn away those in need of emergency care, hospitals will still be required to treat their share of the over 11 million out-of-status individuals from other countries as well as the other recipients of indigent care. The substantial cut in aid available to disproportionate share hospitals will further strain a hospital's liquidity.[14]

Reduced Reimbursement Rates. The ACA also provides for reductions in hospitals' mar ket basket update[15] (a higher reimbursement rate than the standard federal rate) from 2012 till 2019. According to some estimates, this reduction will result in approximately $20 billion less revenue for hospitals relative to current levels.[16] However, some argue that this reduction will be more than offset by increased revenues due to the increased number of insured patients resulting from the implementation of the ACA.[17]

Long-term care hospitals and inpatient rehabilitation facilities may face additional reductions in their market basket update in connection with the ACA's new increased quality reporting requirements. If they fail to comply with such quality reporting requirements, they face a reduction from their annual market basket update to their standard federal rate.[18] Hospitals could therefore be strained not only by potential reductions in their market basket update, but also as a result of the additional administrative costs associated with the quality reporting requirements. New partnership and strategic alliances are likely to increase as the synergies achieved from shared services amongst health systems will be required to offset the reduced reimbursement rates.[19]

Accountable Care Organizations. The ACA also offers certain incentives in the form of savings-sharing programs, to health care providers organized as accountable care organizations,[20] which may have the effect of incentivizing physicians participating in such organizations to reduce hospital admissions, thus potentially drawing a larger share of the increased insured population away from hospitals, including distressed hospitals.[21] On the other hand, to the extent hospitals seek accountable care organization status, they could share in such savings. Hospitals participating in accountable care organizations striving to meet quality benchmarks will likely have expenditures to oversee and report on the services to receive the shared savings.

Value Based Purchasing. As noted above, the VBP program implemented by the ACA creates the opportunity for higher reimbursement rates for hospitals that meet certain quality benchmarks. However, this may require an increase in quality of care. Additionally, administrative burden will be imposed on hospitals in meeting the VBP reporting requirements with reductions in reimbursement rates if hospitals are unable to satisfy the requirements of the program.

Under the VBP program, the Medicare policy of penalizing hospitals if patients come down with certain "hospital acquired conditions" will now be extended to Medicaid.[22] When a patient suffers from a "hospital acquired condition," the hospital is

penalized with a 1 percent reduction in the otherwise-applicable reimbursement rate. Unfortunately, the definition of a "hospital acquired condition" is only vaguely defined by the ACA, leaving such definition to the discretion of the Secretary of Health and Human Services. Hospitals are largely in the dark as to the ultimate impact of this provision on their revenues.

In addition, under the VBP program, hospitals will be penalized if patients return to the same hospital from which they were discharged or another hospital in a "preventable readmission."[23] Initially, there are only three conditions that qualify for the "preventable readmissions" designation: (i) acute myocardial infarction, (ii) heart failure, and (iii) pneumonia. Beginning in 2015, four more conditions will also qualify as preventable readmissions: (i) chronic obstructive pulmonary disease, (ii) coronary artery bypass graft, (iii) percutaneous transluminal coronary, and (iv) other vascular procedures. Reduced reimbursement rates for preventable readmissions under the VBP program are calculated by reference to certain ratios for hospital readmissions within a certain period of time after a patient was discharged.

Distressed hospitals will necessarily incur additional labor and capital costs to improve operations and administrative costs associated with compliance with the substantive requirements of the VBP program and related reporting requirements in order to avoid reductions in Medicare payments.

Additional Requirements for Not-for-Profit Hospitals. The ACA also obligates nonprofit 501(c)(3) tax exempt hospitals to conduct a "community health needs assessment" and draft an implementation strategy to address the identified needs every three years.[24] If any not-for-profit hospital fails to file such an assessment, it will face a $50,000 tax.[25] The ACA will also require such not-for-profit hospitals to establish a written financial assistance policy, which includes, among other things, (1) the criteria for patient eligibility for financial assistance, (2) the basis for calculating amounts charged to patients, and (3) what steps the hospital will take in the event of nonpayment, which steps must include reasonable efforts to discern whether such patient may qualify for financial assistance.

In addition, the ACA imposes a limit on the amount such hospitals can charge for emergency or other medically necessary care to the amounts generally billed to insured individuals and a prohibition against the use of "gross charges." Hospitals will necessarily incur additional administrative costs in preparing the required community needs assessment and implementation plan and will face lower revenues based on the billing limitations imposed by the law. Distressed not-for-profit hospitals already face significantly constrained liquidity, and increased reporting requirements will further limit critical operating cash flow.

Increased Reporting Requirements. The ACA also imposes increased reporting requirements by requiring any federally supported health care program (including hospitals that accept Medicare and Medicaid) to collect and collate a variety of data on patients.[26] In addition, for-profit hospitals will incur additional administrative costs because they will now have to issue 1099 forms to all individuals or corporations from whom they buy more than $600 worth of goods or services. In the past, such forms have only been required for independent contractors.[27]

Capital Expenditure for Implementation. Some hospitals will be required to invest in capital expenditures to improve patient care standards and implement the ACA. To meet the reporting, administrative efficiency, and quality control requirements, distressed hospitals likely have to revamp their technology infrastructures, such as migration to electronic medical reporting. Liquidity-constrained hospitals may lack the available cash for these projects. The advent of private equity investment in healthcare systems may better facilitate ACA's implementation that also may occur with healthcare systems conversion from non-profit to for-profit systems[28]—but only in states that allow for-profit entities to operate hospitals. The financing capability of stronger health systems or private equity funds would facilitate operational, technological and clinical improvements to align with ACA as it is being implemented over the next several years.[29]

Conclusion

The ACA could increase distressed hospitals' liquidity by decreasing the uninsured population, which will mean that (i) many uninsured patients covered by disproportionate share hospitals will now be insured and (ii) many uninsured individuals who previously never sought hospital care or delayed or avoided medical treatment will now seek treatment. On the other hand, the ACA (i) imposes many additional reporting and quality-of-care related requirements, (ii) cuts Medicaid reimbursement rates, (iii) financially penalizes hospitals that fail to satisfy all reporting and quality requirements, and (iv) significantly cuts aid to disproportionate share hospitals for charity care without regard for the proportion of such hospitals' patients who remain uninsured.

To account for the various reimbursement cuts and additional reporting and compliance costs, hospitals will have to adopt additional efficiencies to ensure compliance with the ACA's additional requirements is economical and should continue to work with the Secretary of the Department of Health and Human Services to implement the ACA in a common-sense and economical manner while preventing an undue burden on already struggling hospitals.

1. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (June 28, 2012).
2. Andrew Pollack and Katie Thomas, "In Health Care Ruling, Investors See a Mixed Blessing," *New York Times*, June 28, 2012.
3. Milt Freudenheim, "Hospital Groups Assess Health Care Law," New York Times Blog, March 25, 2011, available at http://prescriptions.blogs.nytimes.com/2011/03/25/hospital-groups-assess-health-care-law/.
4. ACA, Pub. L. No. 111-148, §1501(g) 124 Stat. 119, 242-46 (2010).
5. Robert Berenson and Stephen Zuckerman, "How Will Hospitals Be Affected by Health Care Reform?, Timely Analysis of Immediate Health Policy Issues," at 1, The Urban Institute, July 2010.
6. ACA at §3001.
7. Id. at §2001.
8. See Freudenheim, supra note 3.
9. Id.
10. Richard A. McGrath, "Healthcare Reform Will Hurt Hospitals," McGrath Insurance Group, available at http://www.mcgrathinsurance.com/node/47.
11. Id.
12. Nina Bernstein, Hospitals Fear Cuts in Aid for Care to Illegal Immigrants, *The New York Times*, July 26, 2012.
13. ACA at §3133.
14. See Bernstein, supra note 12.
15. Hospital market basket is the cost of purchasing the goods and services needed to provide care as compared to a base period that may be adjusted for inflation and reflects changes in costs and payments. See "Market Basket Definitions and General information," found at www.cms.gov.
16. See Berenson and Zuckerman, supra note 5
17. Id.
18. ACA at §3004.
19. See Vanguard Health Systems Form 10-K, at 9.
20. Accountable Care Organizations are groups of providers and suppliers coordinating patient care for Medicare beneficiaries where providers will share and receive information about the patient eliminating disorganized care and miscommunication. See "Accountable Care Organizations: Improving Care Coordination for People with Medicare," http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html.
21. ACA at §10307.
22. Id. at §§3008, 10302.
23. Id. at §§3025.
24. Id. at §9007.
25. Id. at §4959.
26. Id. at §3101.
27. Id. at §9001.
28. See Kathleen Roney, "Despite Distressed Assets, Private Equity Firms See Value in Healthcare," Becker's Hospital Review (Feb. 13. 2012). See, e.g., Ascension Health Care System, a joint venture between Oak Hill Capital Partners and Ascension Health, a Catholic healthcare system in New Jersey; Vanguard Health Partners' sponsors are affiliated with The Blackstone Capital Group and Metalmark Capital.
29. See Vanguard Form 10-K at 16 for references to this hospital system's efforts to transition to requirements of ACA, including quality of care initiatives, expansion of outpatient facilities and strengthening of managed care relationships.