Health Care Reform’s Impact on Hospitals

Earlier this week, President Obama signed the Patient Protection and Affordable Care Act - P.L. 111-148 (the “Act”). Central to this wide-ranging reform of the nation’s health care system are significant expansions of health coverage to the uninsured. During the health care reform negotiations, policymakers sought concessions from a number of stakeholder groups to assist in financing the reform’s coverage expansions. Last summer, the American Hospital Association, the Federation of American Hospitals, and the Catholic Health Association agreed to significant savings from reduced Medicare and Medicaid payments to hospitals. Yet, even after accounting for the significant reductions in reimbursements — primarily through reductions in market basket/productivity updates and cuts to Disproportionate Share Hospitals (DSH) — the Act’s coverage expansions create opportunities for the hospital industry.

It is possible that the Act will be amended by the Health Care & Education Affordability Reconciliation Act (H.R. 4872), which was passed by the House of Representatives on March 21, 2010 and by the Senate, with an amendment, on March 25, 2010. In this Alert, we have identified those potential modifications in italics. This Alert is intended as a summary only and is not to be relied upon for drawing legal conclusions or advising clients about specific issues.

New Federal Funding for Insurance Coverage

According to the Congressional Budget Office (CBO), the Act will expand coverage to 31 million Americans (15 million through Medicaid and 25 million through the new exchanges, with 9 million fewer covered through employer-sponsored insurance and in the individual market). To achieve these new coverage levels, the Act finances massive new expenditures on health coverage.

• Between 2014 (when the exchanges are up and running, the individual/employer responsibility requirements take effect, and the Medicaid expansions are fully enacted) and 2019, the federal government will spend $443 billion on exchange subsidies;
• Between 2014 (when the Medicaid/CHIP expansions are fully enacted) and 2019, the federal government will spend $379 billion on Medicaid/CHIP; and
• Between 2010 and 2019, small employers will receive $40 billion in federal tax credits to provide insurance for their employees.

Medicare Market Basket Reductions and Productivity Improvements

Under existing Medicare laws, reimbursements to inpatient hospitals, skilled nursing facilities, hospice care, and other facilities are updated yearly and generally increase between 3 to 4 percent to match inflation and the increased costs of providing Medicare services. According to the CBO, the Act’s market basket
reductions and productivity adjustments will result in $156 billion in cuts to providers between 2010-2019. The Reconciliation bill would further decrease these reimbursements by approximately $10 billion.

**Medicare DSH Payments**

Beginning in 2015, hospitals will receive only 25 percent of their scheduled DSH payments. These reductions are based on the assumption that with the expansion of coverage, there will be fewer uninsured and less uncompensated care. These reduced DSH payments will be adjusted upward to take into account the persistence of uninsured populations and uncompensated care in certain communities and hospitals. The CBO has estimated that these changes will decrease DSH payments by $25.1 billion. If enacted, the Reconciliation bill would make two key changes to the Act. First, the 25 percent DSH cut will begin in 2014 rather than 2015. Second, the formula for the increased payments is adjusted. The net impact of these two changes is a $3 billion reduction in the DSH cuts.

**Medicaid DSH Payments**

Beginning in 2015, states' Medicaid DSH allotments would be reduced depending on their use of allotments between 2004 and 2008, whether they are low DSH states, and the rate of uninsured. Under the Reconciliation bill, reductions would begin in 2014, but the level of DSH cuts would decline from $18.1 billion to $14.1 billion. In addition, the Secretary of Health and Human Services would be required to develop a methodology for reducing federal DSH allotments to all states in order to achieve the mandated reductions.

**Physician Ownership Interests in Hospitals**

The Act effectively dismantles the so-called whole hospital exception to the physician self-referral law known as the Stark law. This exception allows physicians to own and invest in whole hospitals if their ownership interest complies with certain terms and conditions. Going forward, physicians may not own interests in hospitals to which they refer unless those hospitals are operating and have a Medicare provider number by August 1, 2010. Also, existing hospitals with physician ownership may not expand capacity unless they meet certain conditions, which include applying to the Secretary of the Health and Human Services, undergoing a waiting period for community input, and meeting certain population and patient metrics.

This prohibition on physician ownership affects hospitals wholly owned by physicians (so-called physician-owned hospitals) as well as hospitals where physician owners or investors own less than 100 percent. Such hospitals may not increase the aggregate percentage of ownership interest held by physicians as of the date of the Act's passage. Additionally, physicians who refer to hospitals in which they hold ownership interests must give patients prior disclosure as to their level of ownership in the hospital.

If enacted, the Reconciliation bill would extend the deadline for ownership interests until December 31, 2010. Also, it would provide a limited exception to the prohibition on growth of physician-owned hospitals if the hospital (a) treats the highest percentage of Medicaid patients in its county and (b) is not the only hospital in the county.
Federal Matching Funds for Increased Medicaid Costs

The Act provides a permanent level of 100 percent in federal matching Medicaid funds to Nebraska to cover the costs of newly eligible Medicaid patients. *The Reconciliation bill would strike this provision and replace it with one expanding these federal matching funds for new Medicaid patients to all fifty states and the District of Columbia. The level of federal matching would start at 100 percent in 2014-2016 and slowly decrease thereafter.*

Frontier States Amendment

Beginning in FY 2011, the Act establishes a hospital wage index and geographic practice expense floor for hospitals in states where 50 percent of counties are frontier counties. This provision would apply to hospitals in North Dakota, South Dakota, Montana, Utah, and Wyoming. The CBO has estimated that this provision will cost the federal government $2 billion over 10 years.

False Claims Act Amendments

Effective date of enactment, the Act amends the jurisdictional bar against qui tam actions based on publicly available information. Instead, claims will only be dismissed if not opposed by the government. Furthermore, the amendments limit the types of cases to which the public disclosure bar applies.

$400 million for Low Reimbursement Counties

The Reconciliation bill provides $400 million in funding for hospitals in counties where spending for benefits under Medicare Parts A and B is within the lowest quartile of spending. While the legislation does not identify these counties, the Dartmouth Atlas has identified Medicare reimbursements per enrollee by state and puts 14 states into the lowest quintile of spending — Washington, Idaho, Montana, Wyoming, Utah, New Mexico, North Dakota, South Dakota, Nebraska, Minnesota, Iowa, Wisconsin, Virginia and Maine. It is likely that many of the counties eligible for this funding will be clustered in these states.

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