

Flow of Funds and Credit Risk Issues for ACOs

Health Care Group

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Scope of Presentation and Agenda

This is the third in a series of teleconferences on Accountable Care Organizations (ACOs). First presentation focused on ACO strategy, organizational options and tax implications. Second presentation discussed governance, decision-making and accountability for ACO functions.

This presentation will discuss:

- Implications of ACOs for Hospitals and Health Systems with Tax-Exempt Debt
- Funds Flow
- Financial Covenant Considerations
- Capitalization and Support for ACO Operations
- Expectations of Creditors, Ratings Agencies and Investors
- Credit and Insolvency Risk
- Board Duties
- People and Issues to Watch

Hospital and Health System Participation in ACOs

- In a recent survey, 73% of hospital financial executives said an accountable care organization is an investment priority⁽¹⁾
- Hospitals have financial resources and credit profile to provide or obtain capital for ACO
- Inpatient care is one of the costliest components of health care costs
- Competitive advantage (or imperative) for physician affiliation and coordinated care delivery
- Risks of not participating – loss of volume and no sharing in savings from lower hospital utilization

⁽¹⁾ Source: “New Incentives for More Efficient Care,” *Wall Street Journal* (Monday, November 29, 2010) (citing a survey conducted by The Advisory Board Co., a health care research firm).

Size of the Hospital Tax-Exempt Debt Market

- In 2009, of the roughly 5,800 hospitals in the U.S., the majority — approximately 50% — were non-governmental, nonprofit hospitals, and approximately 19% were state and local government hospitals⁽¹⁾
- In 2002, non-profit hospitals received \$1.8 billion in tax savings from the preference allowing them to issue tax-exempt debt⁽²⁾
- In 2009, \$41.2 billion of tax-exempt debt was issued for health care institutions⁽³⁾

(1) Source: American Hospital Association, results of 2009 annual survey. Figure for total hospitals includes federal government hospitals and nonfederal psychiatric and long-term care hospitals.

(2) Source: Nonprofit Hospitals and Tax Arbitrage, Congressional Budget Office (December 2006).

(3) Source: SDC/Thomson Financial.

Financial Significance of ACO Model

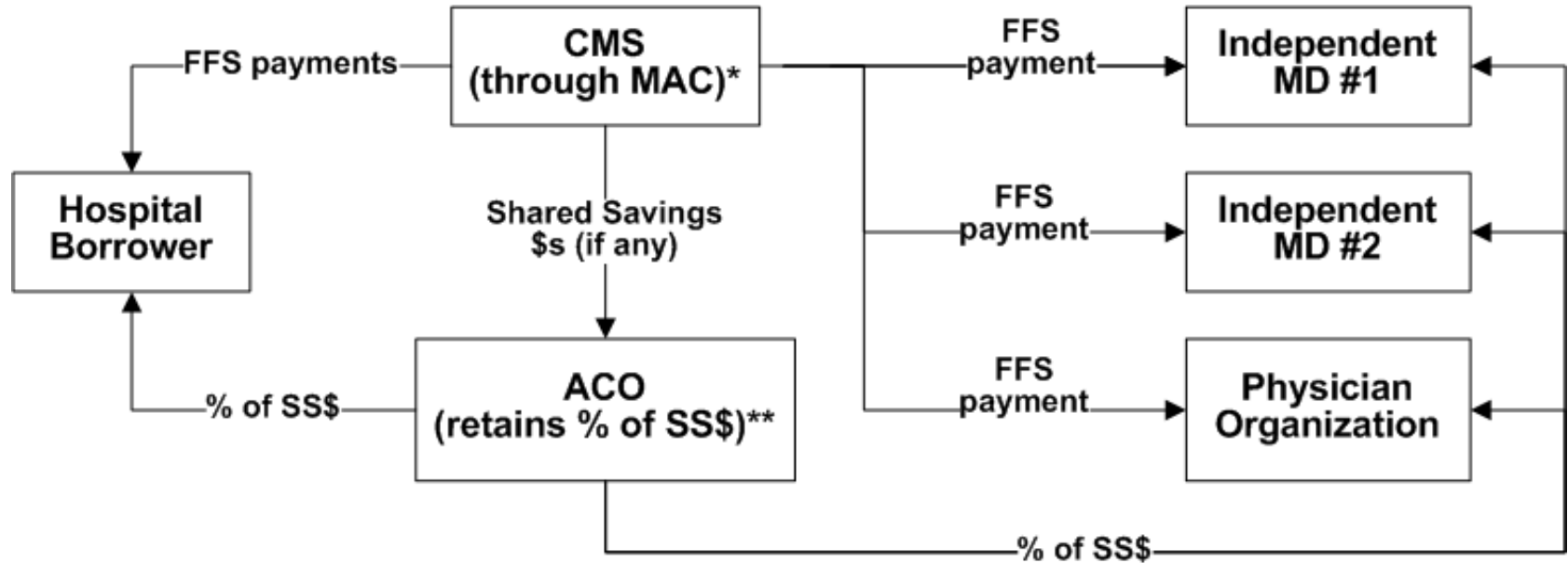
What do we mean when we talk about ACOs?

- Medicare Shared Savings Program – basic fee-for-service “gainsharing”: relatively minimal percentage of patient service revenue at stake
- Other payment models:
 - Possibility that MSSP will use partial capitation
 - Center for Medicare and Medicaid Innovation seeking to promote ACO structures – will fund multiple demonstrations
 - Commercial payor initiatives
 - Pay-for-performance withhold, bundled payments, episode-based payments, partial or global capitation
 - Voluntary Programs → Mandatory Reimbursement Model?

Options for Structuring ACOs

- Separate Entity Controlled by Hospital – single-member LLC or, potentially, single-member tax-exempt corporation (e.g., ACO as Section 509(a) supporting organization)
- Joint Venture with Physician Organization(s)
- Virtual Model
- Challenges in any structure:
 - Balancing need for physician leadership and commitment against requirements for hospital's tax-exempt status
 - Creating a vehicle that effectively promotes collaboration and sharing of revenue with partners without ceding control of hospital revenue stream to another entity

Funds Flow – Medicare Shared Savings Program

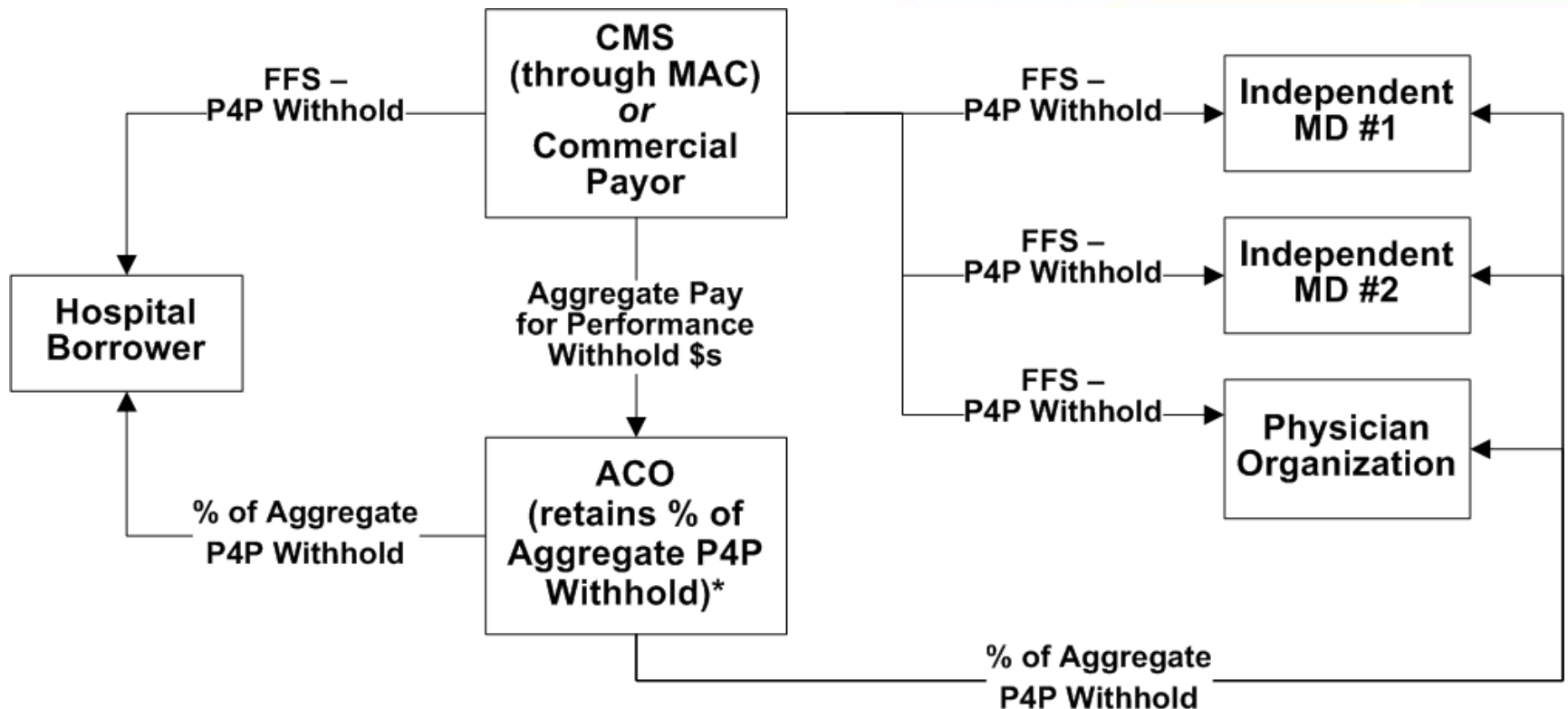


Note: This diagram could be replicated several times within an obligated group consisting of multiple hospitals participating in different ACOs that are responsible for different patient populations.

* CMS may not pay out shared savings directly to the contracting ACOs. These payments might not, like fee-for-service payments, be administered through MACs.

** ACO may retain a portion of shared savings to cover its costs of operation or to invest in systems for care coordination, quality measurement and reporting.

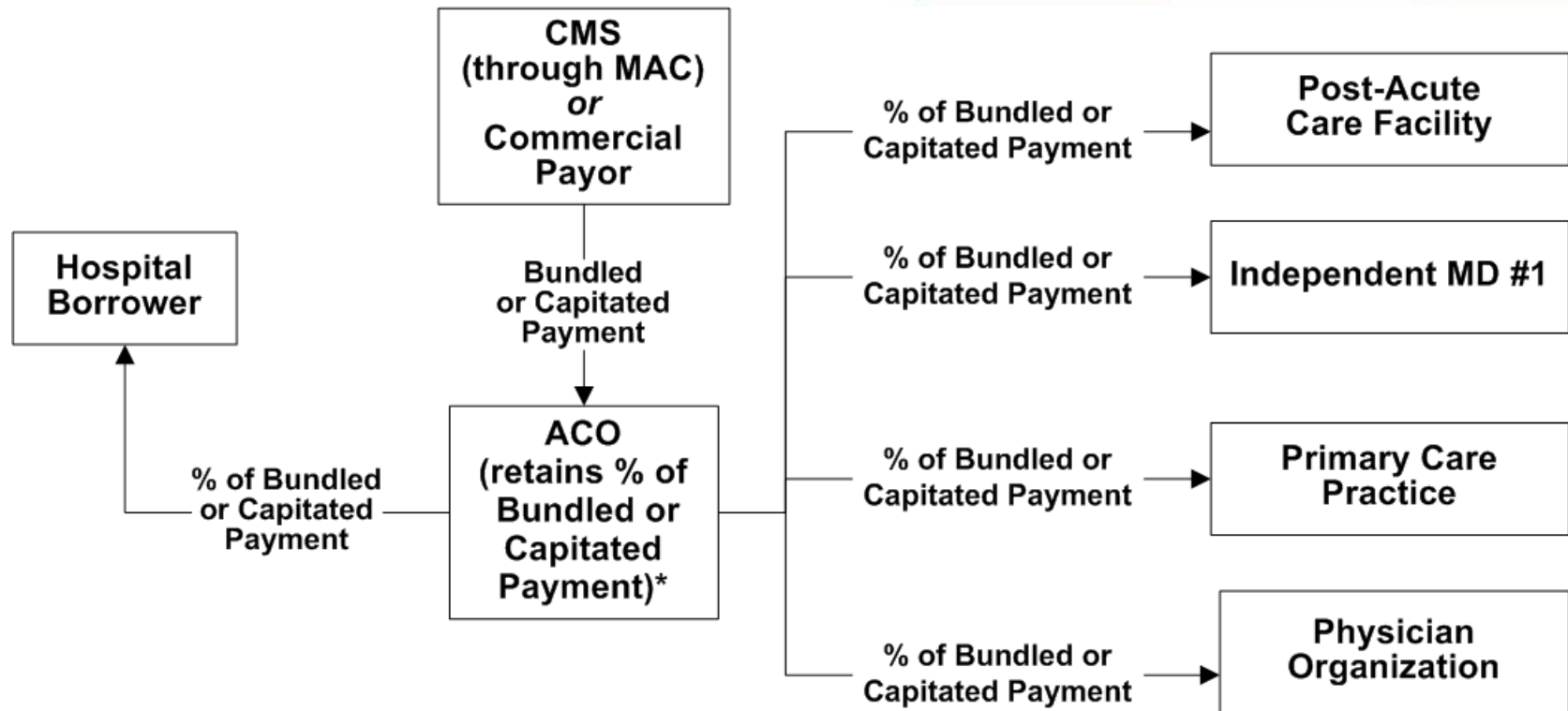
Funds Flow – Medicare (or Commercial Payor) Performance-Based Payments



Note: This diagram could be replicated several times within an obligated group consisting of multiple hospitals participating in different ACOs that are responsible for different patient populations.

* ACO may retain a portion of shared savings to cover its costs of operation or to invest in systems for care coordination, quality measurement and reporting.

Funds Flow – Medicare (or Commercial Payor) Bundled Payments



Note: This diagram could be replicated several times within an obligated group consisting of multiple hospitals participating in different ACOs responsible for different patient populations.

- * ACO may retain a portion of shared savings to cover its costs of operation or to invest in systems for care coordination, quality measurement and reporting. If ACO manages capitated payments and is considered a risk-bearing organization under applicable state law, it may need to retain funds (or be capitalized) to meet reserve requirements.

Key Financial Covenants

As a broad generalization ...

- Security Pledge – gross revenues, gross receivables, mortgage, “negative pledge”
- Debt Service Coverage Ratio – net revenue available for debt service as a percentage of annual debt service
- Days Cash on Hand – cash available to fund average daily operating expenses
- Debt to Capitalization Ratio – long-term debt as percentage of long-term debt plus unrestricted fund balance
- Restrictions on incurring additional debt
- Limitations on asset sales or dispositions

Financial Considerations under Different Payment and Structural Models

- Assumption: ACO will contract with payors for “savings” payments, performance-based payments and, potentially, base reimbursement
- Risks of Medicare Shared Savings Program
 - Savings to be shared will come from utilization reductions
 - Hospital’s share of savings may be less than forgone profit on lost admissions
- Risks of capitation
 - Inadequate rates → reduction in net income
 - Mismatch of revenue and expenses – may not be immediately apparent
 - Liquidity concerns
 - Need for reserves; assumption of insurance risk?
 - Payor offset rights

Financial Considerations under Different Payment and Structural Models

- **ACO as Separate Entity Controlled by Hospital**
 - If single-member LLC, expenses and revenues flow through to hospital and are considered in covenant calculations
 - Incurrence of debt or hospital as guarantor of debt – effect on Debt to Cap Ratio, DSCR
 - Liability to contracting physicians – physicians likely to expect rights to payment; ACO solely controlled by hospital may not meet ACO criteria
 - Value of creating separate entity if it is *not* the locus of capital-intensive activity?
 - Does model provide solution for the loss of inpatient revenue predicted under ACOs? – consequences for DSCR

Financial Considerations under Different Payment and Structural Models

- **ACO as Joint Venture with Physician Organization**
 - If gross revenues are pledged to bondholders and other (actual or potential) creditors (letter of credit banks, bond insurers, interest rate swap counterparties), ACO may not receive and hold substantial portion of hospital patient service revenues, unless on pass-through basis
 - May not be vehicle for substantial number of payor contracts and patient service revenue – IRS guidance on *ancillary* joint ventures: Rev. Ruling 2004-51.
 - Incurrence of debt or hospital as guarantor of debt – effect on Debt to Cap Ratio
- **Virtual Model**
 - Meets requirements for “formal legal structure”?
 - Practical administration of administering virtual arrangement – Number of participants? Who are parties to ACO contract with payors? Revenue management by committee?
 - Contingent rights to revenue and potential for claims and clawbacks by physicians
 - Does model provide solution for the loss of inpatient revenue predicted under ACOs? – consequences for DSCR

Financial Covenant Considerations under Different Structural and Payment Models

- From financial perspective, ACO implementation likely to be the *least* disruptive and uncertain for integrated delivery systems and hospitals that employ (or, by state law, are permitted to employ) physicians
- Potential for Problems
 - ACO is part of obligated group but receives and is responsible for paying out revenue to non-obligated group members
 - ACO is not part of obligated group but is conduit for or has control over obligated group member revenue
 - ACO is not part of obligated group but becomes the focus of hospital investment or the owner/manager of substantial hospital assets

Capitalization and Support for ACO Operations

- **Incurrence of Debt Tests**

- Must meet specified DSCR or Debt to Cap Ratio
- Set capacity for short-term debt and capitalized leases in any fiscal year
- Nonrecourse or unsecured debt typically permitted without limit
- Ability to incur tax-exempt debt for ACO?
- Ability to guarantee ACO obligations: important to analyze definition of “guaranty” in indentures/credit agreements

- **Asset Disposition**

- Basket – specified percentage of total book value of obligated group
- Dispositions in excess of the basket: fair market value sales (leases or licenses), transfers that do not lower the DSCR below stipulated threshold
- Credit agreements may require bank consent for dispositions in excess of specified dollar amount

Capitalization and Support for ACO Operations

- **In-Kind Support – Private Business Use Problem**
 - Assets previously financed with tax-exempt bond proceeds, such as health information technology systems, electronic medical records
 - Can you calculate PBU? Is it less than 3-5%?
 - Allocate costs to equity or remediation – payoff of equivalent portion of outstanding bonds

Credit Risks – Perception of Rating Agencies and Debt Markets

- Early indications from ratings agencies – positive reaction to ACOs mainly as strategy for market share: have not yet analyzed payment models and impacts
- Concern likely to arise if obligated group member revenues are siphoned off to non-obligated group members
- Payment uncertainty – market may want debt service reserve fund or more robust security package
- Protection – partnering with organizations that are strong financially because future ratings analyses may factor in creditworthiness of partners
- Disclosure – Risk Factors section in offering documents will need to address risks of ACOs and new payment models; management’s discussion and analysis will need to identify and describe impacts

Insolvency Risk and Bankruptcy

- ACO creates a new entity with credit risk for participant hospitals, physician groups, others
- Payor Recoupment
 - If all payments (in capitation or bundled payment structure), or substantial payments (in a P4P structure) flow through ACO, each participant takes the risk of Medicare (or other insurance payor) recoupment claims generated from all other participants
- Capitation/Bundled Structure
 - Could this be an insurance company for state law purposes?
 - If so, then it cannot file for federal bankruptcy (same result as some HMOs)
 - State law insolvency regimes are very uncertain, and are typically a receivership where a third party takes control of the insolvent entity
- Insider Preference Risks
 - If a participant believes it has been underpaid by the ACO, it can likely sue to recapture/clawback payments (even unrelated payments) made by ACO to other participants (e.g., hospital) during the prior year
 - This is because the various participants may all be affiliates of the ACO, through their ownership and control of the ACO

ACO Structures – Insolvency Risk and Bankruptcy

- **LLC ACO**
 - If an LLC structure, the ACO is not a nonprofit. In extreme cases, ACO would be subject to an involuntary bankruptcy filing (which nonprofit hospitals are not)
- **Virtual ACO**
 - If virtual structures are allowed for ACOs, the insolvency risks become very complicated and based on contractual framework (bilateral contracts, multiparty contracts)
- **Nonprofit ACO**
 - If ACO is a nonprofit, a bankruptcy could conceivably be used to reject unfavorable contracts (e.g., with an acute care facility or a particular physician practice); threat to counterparty of paying any damages claim at pennies on the dollar

Making Decisions – Board Fiduciary Duties

In face of potential for major restructuring of reimbursement model and funds flow, what are a hospital board's responsibilities?

- Be mindful of duty of care to organization and worst case scenarios
- Document deliberation leading to decisions
- Cardinal rule: in the zone of insolvency, may not take actions that deepen insolvency or hasten bankruptcy
- Institutions in financial distress should be particularly concerned about creditor claims of breach of fiduciary duty

People and Issues to Watch

- CMS: Proposed ACO Regulations – mid-January?
- Center for Medicare and Medicaid Innovation – authorized to test different payment models, including support for states' testing of all-payor payment reforms
- Massachusetts Special Commission on the Health Care Payment System – recommendations for implementation global payment
- Integrated Health Association Bundled Episode Payment Pilot – California hospitals and physicians sharing payment for surgical episode and pre-surgical/post-surgical care
- Dartmouth-Brookings ACO Pilot Sites – five providers (hospitals and multi-specialty physician groups) working with commercial payors
- Premier Implementation and Readiness Collaboratives – numerous hospitals cited by Premier as participants; different hospitals in various stages and degrees of involvement

CLE Information

For CLE credit, complete and return Attorney Affirmation form within 48 hours.

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Thank You For Participating

Time for Questions

- Please submit your questions now to ropesgrayllp@ropesgray.com
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