



Senate Finance Committee Bill: Highlighting Provisions for Post-Acute Care Providers

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I. Political Overview.

On Wednesday, September 17, 2009, Senator Max Baucus (D-MT) released the long-awaited **Chairman's Mark** of the Senate Finance Committee's proposed health care bill (the "Bill"). The Bill was released without support from Republican members of the "Gang of Six" (Senators Chuck Grassley, Mike Enzi and Olympia Snowe) who have been negotiating the provisions of the Bill, together with Democratic Senators Max Baucus, Kent Conrad and Jeff Bingaman. Senator Baucus, however, remains optimistic that the Bill will receive Republican support. Senator Olympia Snowe has stated that the Bill is moving in the right direction, but that "a number of issues still need to be addressed." Some Democrats have also raised concerns about the Bill, including Democrats who disapprove of the Bill's inclusion of a co-op program rather than a public option plan, and fiscally conservative "Blue Dog" Democrats who remain concerned about the Bill's CBO-scored \$774 billion price tag.



II. Provisions of the Bill Relevant to Post-Acute Care Providers.

The Bill contains a number of provisions that, if enacted, could significantly impact post-acute care service delivery models and Medicare and Medicaid reimbursement to long-term acute care hospitals ("LTACHs"), inpatient rehabilitation facilities ("IRFs"), skilled nursing facilities ("SNFs"), home health agencies ("HHAs") and hospices. This article highlights some of the proposals in the Bill that are most relevant to the post-acute care provider community.

A. Limited Medicaid Bundled Payment Demonstration Project

The Bill (p. 60) would establish a Medicaid bundled payment demonstration project in up to eight states that would begin October 2011. Under the demonstration, the per-discharge payment for acute care hospitals would be expanded to include post-acute care provided in acute care hospitals and non-hospital settings. Acute care hospitals would receive a single bundled payment from Medicaid for such services. Acute care hospitals would then presumably be responsible for discharging patients requiring post-acute care services to the appropriate care setting (i.e., LTACH, IRF, SNF) and compensating post-acute care providers for the delivery of care from the bundled payment. The Secretary of Health and Human Services ("Secretary") would be empowered to waive restrictions imposed by title XI of the Social Security Act, including limitations imposed by the Federal False Claims Act, the Federal Anti-Kickback Statute and the Stark Physician Self-Referral Law.

B. IRF, LTACH and Hospice Quality Reporting

The Bill (p. 81) would require the Secretary to establish quality reporting programs for IRFs, LTACHs and hospices. No such requirement exists in these care settings under current law. The Secretary would be required to select quality measures by Fiscal Year ("FY") 2013 and implement mandatory quality measure reporting programs by FY 2014. Failure to report quality measures would result in reduction of annual market basket updates by 2%. Selected quality measures would cover, to the extent feasible, all dimensions of quality and efficiency of care.

C. HHA and SNF Value-Based Purchasing

The Bill (pp. 82-83) would require the Secretary to submit value-based purchasing implementation plans to Congress for HHAs and SNFs by 2011 and 2012, respectively.

D. Accountable Care Organization (“ACO”)

Post-acute care providers presently face obstacles arising from facility co-location and other rules that prevent the establishment of systems of integrated providers capable of sharing in efficiency gains resulting from the joint responsibility and care of Medicare beneficiaries. As a result, ACOs have not been widely adopted despite the Medicare Payment Advisory Commission’s (“MedPAC”) strong support for such organizations. An ACO is generally defined as a group of providers that are jointly responsible, through shared bonuses or penalties, for the quality and cost of health care services for a beneficiary population. Beginning January 2012, the Bill (p. 88) would enable Medicare to allow groups of providers who voluntarily meet certain organizational criteria and quality measurements to be recognized as ACOs and become eligible to share in the cost-savings they achieve for the Medicare program in the form of an incentive bonus.



E. CMS Innovation Center to Establish New Care and Payment Models

The Bill (pp. 90-92) would require the Secretary to establish an Innovation Center within CMS that would be authorized to test, evaluate, and expand different payment structures and care delivery models with the goals of fostering patient-centered care, improving quality, and slowing the rate of Medicare cost growth. The Center would be required to consider for testing, among others, models that:

- (i) promote broad payment and practice reform in primary care, including patient-centered medical home models;
- (ii) support care coordination of chronically-ill Medicare beneficiaries at high risk of hospitalization through a health IT-enabled network and home tele-health technology;
- (iii) establish physician, nurse practitioner, or physician assistant-led home-based primary care programs with demonstrated experience in serving high-cost beneficiaries with multiple chronic illnesses and functional disability;
- (iv) improve post-acute care through continuing care hospitals that offer LTACH, IRF, SNF, and home health services during an inpatient stay and the thirty days immediately following discharge; and
- (v) offer chronic care management services to Medicare beneficiaries through the use of home health services in cooperation with interdisciplinary teams.

F. National Post-Acute Payment Bundling Pilot Program

Medicare currently pays for most acute care hospital stays and IRF, LTACH, SNF and home health care visits under prospective payment systems (“PPS”) established for each provider type. Under each PPS, a predetermined rate is paid for each unit of service, such as a hospital discharge or a payment classification group (i.e., MS-DRG or LTC-MS-DRG). As Medicare

beneficiaries with complex health conditions and co-morbidities move between hospital stays and a range of post-acute care providers, Medicare makes separate payments to each provider for covered services. MedPAC, among others, has suggested that Medicare test new incentives and payment models to encourage providers to better coordinate across patient episodes of care, including thirty days post-discharge from an acute care hospital.

Beginning in 2013, the Bill (pp. 93-96) would require the Secretary to develop, test and evaluate alternative bundled payment methodologies through a national, voluntary pilot program designed to provide incentives for providers to coordinate patient care across the continuum of care. If the pilot program achieves its goals of improving patient outcomes, reducing costs and improving efficiency, then the Secretary would be required to submit an implementation plan to congress to make the pilot a permanent part of the Medicare program. The Bill does not establish the pilot programs length or propose a date by when the Secretary would be required to submit an implementation plan.



The Secretary would be required to determine what patient assessment instrument (e.g., the C.A.R.E. tool is specifically named) should be used to evaluate a patient's clinical condition for purposes of determining the most clinically appropriate site for post-acute care. The Secretary would be required to work with the Agency for Healthcare Research and Quality and the qualified consensus-based entity defined by the Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA") to develop episode of care quality measures. The Secretary would also be permitted to waive certain regulatory frameworks (i.e., IRF 60% rule, LTACH 25% rule, applicable fraud and abuse laws, etc...).

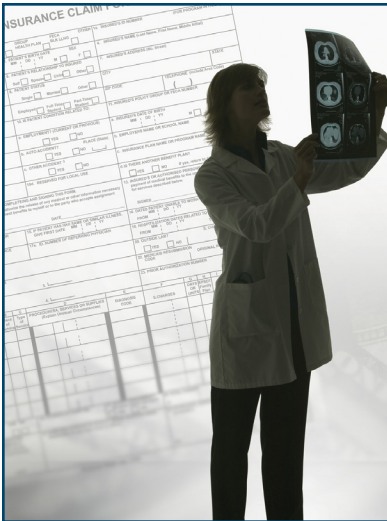
The Secretary would select eight conditions to be included in the pilot program. The pilot's bundled payment would be made to a Medicare provider or other entity comprised of multiple providers to cover the cost of acute care services, physician services and post-acute care. The bundled payment would include the costs of any rehospitalizations that occur during the covered period. Any Medicare provider, including acute care hospitals, physician groups, or post-acute care entities interested in assuming responsibility for the bundled payment would be able to apply to participate in the pilot program. An entity assuming responsibility for the bundled payment would be required to have an arrangement with an acute care hospital for initiation of bundled services.

G. Extension of the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA")

MMSEA Sections 114(c) and (d) provides LTACHs with, among other things, a reprieve from the punitive effects of CMS's "25% Rule" and "very short stay outlier" policy. The MMSEA also established a temporary three-year moratorium on the development of new LTACHs and new LTACH satellites and bed increases. The MMSEA is set to expire on December 28, 2010. The Bill (pp. 113-14) would extend the term of Sections 114(c) and (d) of MMSEA (including the development moratorium) through December 28, 2012, thereby ensuring regulatory and payment stability for the LTACH industry.

H. Restrictions on Physician Hospital Ownership (including LTACHs)

The Bill (pp. 174-76) contains a provision that, like the House's Tri-Committee bill, would restrict further expansion of physician ownership and investment in hospitals by prohibiting physicians from referring patients to hospitals in which they have an ownership or investment interest. The provision is also similar to one contained in the House's version of the State Children's Health Insurance Program ("SCHIP") bill introduced by Senator Grassley earlier this year. Beginning no later than eighteen months after the date of enactment of the Bill, only physician-owned hospitals (including LTACHs) meeting certain conflict of interest, bona fide investment and patient safety requirements described in the Bill, and which have a Medicare provider agreement on November 1, 2009 would be exempt from the ban on physician ownership and self-referral.



III. What's Next.

Amendments to the Bill were due by Friday, September 18, 2009 and the Senate Finance Committee markup of the Bill is scheduled to begin Tuesday, September 22. Further changes to the Bill are certain if and when it is reconciled against the House bill and the full Bill makes its way to the floors of the House and Senate. The text of the Chairman's Mark, which is currently 220 pages, is expected to be expanded into more than one thousand pages of legislative text. We will keep you up-to-date on the rapid developments and shifting changes in legislation. For additional information, please contact any of the authors.

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