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Long-Term Acute Care Hospital Legal Alert

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What the Supreme Court Decision on the Affordable Care Act Could Mean for LTACHs

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Since it was signed into law by President Obama on March 23, 2010, the Patient Protection and Affordable Care Act ("PPACA")[1] (*i.e.*, the health reform law) has begun to alter the healthcare landscape in numerous ways. But PPACA's constitutionality was immediately challenged by a series of lawsuits that have culminated in a historic set of cases before the United States Supreme Court ("Court"). A decision is expected this June. Among the possible results, the Court could (1) decide that it is premature to rule on the law; (2) uphold the entire law; (3) strike the individual mandate to purchase health insurance (with or without related provisions); (4) strike the Medicaid expansion; or (5) strike the entire law (because parts ruled invalid are deemed not severable). If the entire law is struck down, the Medicare parts will be invalidated and the Department of Health & Human Services ("HHS"), Centers for Medicare & Medicaid Services ("CMS") will be forced to unwind or assert other authority for changes made pursuant to the law. This legal alert examines the favorable and unfavorable aspects of PPACA that impact LTACHs and how they may fare after the Supreme Court rules.

Please feel free to reach us at the phone number or email address to the left if you have questions about how the Supreme Court decision will impact your business.

Issues Before the Supreme Court. The Supreme Court granted certiorari to consider four issues raised by three appellate decisions.[2] The first two issues focus on the minimum coverage provision (also called the "individual mandate"). The Court must decide whether it has jurisdiction to rule on the constitutionality of the minimum coverage provision, even though the penalty for non-coverage has not yet taken effect.[3] Assuming there is jurisdiction, the Court must then decide whether the minimum coverage provision is constitutional.[4] If the Court finds that the minimum coverage provision is unconstitutional, it must then decide whether PPACA must be struck down in its entirety or whether the provision is severable.[5] Last, the Court must consider

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whether PPACA imposes such significant changes to the Medicaid federal-state partnership that it violates the principles of federalism and dual sovereignty.[6]

Immediate Effects of Decision. Many Court watchers believe that the Supreme Court will invalidate the individual mandate but allow the rest of PPACA to stand. If that occurs, all of the Medicare provisions will remain in effect, including the LTACH provisions. However, if the Supreme Court invalidates PPACA in its entirety, the immediate aftermath would be chaotic. Many of the changes and programs mandated by PPACA have been implemented or are in progress. Some of these programs are based upon demonstrations, policies, or processes that pre-date PPACA. Health care providers, including LTACHs, must assume that the Secretary Sebelius will attempt to salvage as many of these programs as possible, especially those that do not require funding beyond what has already been allocated.

The logic behind invalidating the whole bill – that the Court cannot invalidate part of it without effectively creating a new law – would also preclude the Court from crafting some kind of transitional framework. Given the current political landscape, Congress would almost certainly be unable to pass any replacement legislation this year.[7] In the absence of legislative action, the logistics of disentangling PPACA from the remainder of the Medicare and Medicaid landscape would fall to the Secretary. On April 12, 2012, *Politico* reported that the Secretary told the National Action Network[8] that the Department is *not* working on a contingency plan, adding, "that isn't where conversations are headed right now, and I'm confident that it is constitutional."[9] She also has not discussed contingency plans in recent testimony before Congressional committees. This, of course, doesn't mean that HHS is without contingency plans, only that the agency's focus is on implementation of the law and that is the message it wants to convey.

Whether HHS has a contingency plan or not, regulations promulgated as a result of PPACA would remain in force, at least temporarily. Likewise, contracts entered into by the Secretary, funding previously authorized, and hiring decisions to carry out the agency's myriad duties under PPACA would not be immediately unwound. The Secretary would likely assert other statutory or regulatory authority for as many parts of an invalidated PPACA as possible. The Secretary could use emergency rulemaking and/or program memoranda to minimize the immediate disruption and maintain the status quo while these determinations are made, citing her executive authority to administer the Medicare and Medicaid programs. Any activity by HHS to further the PPACA agenda at that point would almost assuredly elicit a negative response from Congressional Republicans and is likely to spawn more lawsuits.

Impact on LTACH Moratoriums and Regulatory Relief. The Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA") imposed a 3-year moratorium on the establishment or classification of new LTACH facilities and increases in LTACH beds.[10] It also provided relief for 3 years from the very short stay outlier policy ("VSSO"), the one-time budget neutrality adjustment ("one-time BNA"), and froze percentage levels under the "25% Rule" patient threshold payment adjustment. Section 3106 of PPACA extended these 3-year periods under MMSEA to five years, with the moratoriums and all regulatory relief expiring this year.

A ruling that invalidates PPACA in its entirety would immediately remove the statutory authority for the 2-year extension of the MMSEA moratoriums and regulatory relief. However, the implementing regulations would still be in effect. CMS has stated recently that it is "supportive of a statutory extension of these moratoria as we anticipate potential payment policy changes to the LTACH PPS as a result of CMS' research initiatives." This indicates that the agency may be reluctant to assert other regulatory authority for the same provisions. However, we note that CMS has such authority. The VSSO policy and one-time BNA are purely regulatory creations – they are not required by statute. But in the recent LTACH PPS FY 2013 proposed rule, CMS has proposed allowing both of those policies to be restored, subject to public comments. CMS could clarify in the final rule due by August 1 that these two policies will take effect sooner, such as the October 1 start of the fiscal year. In order to implement these policies sooner, the regulations relating to each would need to be changed as they currently prohibit action prior to December 29, 2012.[11] With regard to the moratoriums on new LTACHs and LTACH beds, CMS has relatively new regulatory authority to impose a temporary moratorium if necessary to prevent or combat fraud, waste, and abuse under the Medicare programs. However, this authority is derived from PPACA as well, making it equally susceptible to elimination.[12] Accordingly, CMS may take time to consider the issue, in which case it will fall on Medicare payment contractors and the CMS Regional Offices to make individual determinations as to whether new LTACH applicants or bed increases are permitted. CMS's recent proposal to offer an additional one year of relief from the 25% Rule would not be affected. CMS intends to use the one-year extension of 25% Rule relief as a bridge to replacement payment policies currently being studied.

Impact on Market Basket & Productivity Adjustments. Section 3401(c) of PPACA amended the Social Security Act ("SSA") to include reductions in the LTACH PPS standard Federal rate beginning in rate year 2010 through fiscal year 2019. It also created an additional reduction described as a "productivity adjustment" beginning in fiscal year 2012. These reimbursement cuts were used to help pay for PPACA with the expectation that LTACHs would benefit from new patients due to program expansions. CMS has implemented these changes by regulation.[13] If

PPACA is invalidated, the rate reductions and productivity adjustments would no longer be authorized by any authority granted to the Secretary. CMS would likely back these two reductions out of the calculation of the standard Federal rate in the upcoming fiscal year 2013 final rule. CMS could issue an interim final rule or program memorandum to increase the current year rate by the amount of the fiscal year 2012 reductions, which is 1.1%.

Impact on Quality Reporting Measures. Section 3004 of PPACA amended the SSA to require LTACHs to submit data on certain quality reporting measures. Penalties for failing to report begin in rate year 2014, and include a non-cumulative two percentage point reduction in the standard Federal rate for that year.[14] CMS identified three measures in the fiscal year 2012 final rule - "urinary catheter-associated urinary tract infections" or "CAUTI," "central line catheter-associated bloodstream infection" or "CLABSI," and new or worsening pressure ulcers.[15] CMS proposed to begin collecting data on these three measures on October 1, 2012, and these measures will be used to determine whether payment penalties will be applied during rate year 2014.[16] Five additional quality measures have been proposed for reporting beginning in fiscal year 2016.

The authority to adjust payments for failure to meet certain quality measures is entirely created by Section 3004 of PPACA. In the past, Congress explicitly limited quality reporting requirements and payment reductions to "subsection (d) hospitals," and other providers.[17] Until PPACA, the statute clearly did not apply to LTACHs. CMS could look for other authority to continue an LTACH quality reporting program, such as a general authority to monitor Medicare providers' quality of care and collect information relating to quality of care. However, the authority to use that information to adjust payment rates for non-compliant LTACHs would no longer be available if PPACA is invalidated by the Supreme Court.

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029.

2. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, No. 11-393 (2012), *cert. granted* 565 U.S. ___, 2011 WL 5515163 (severability issue only); *Dept. of Health & Human Servs. v. Florida*, No. 11-398 (2012) *cert. granted* 565 U.S. ___, 2011 WL 5515163 (Anti-Injunction Act and individual mandate issues); *Florida v. Dept. of Health & Human Servs.*, No. 11-400 (2012) *cert. granted* 565 U.S. ___, 2011 WL 5515163 (severability and Medicaid issues).

3. *See* 565 U.S. ___, 2011 WL 5515163.

4. *Id.*

5. *Id.*

6. *Id.*

7. For example, the House of Representatives passed the Repealing the Job-Killing Health Care Law Act, H.R. 2, on January 19, 2011, but the Senate did not consider it. The bill sought to repeal PPACA entirely. The Congressional Budget Office, using an effective date of October 1, 2011, projected that repeal would result in a $210 billion increase in

the federal deficit across the 2012 to 2021 budgets. *See CBO and Joint Committee on Taxation Letter to Speaker John Boehner,* CBO Pub. 22027, (Feb. 18, 2011). The CBO's projection "incorporates an assessment of the extent to which repeal" would affect already promulgated regulations. *Id.* at 14.

8. A civil rights organization founded by Rev. Al Sharpton.

9. J. Lester Feder, *Kathleen Sebelius: We don't have a health care backup plan*, POLITICO, April 12, 2012.

10. Medicare, Medicaid, and SCHIP Extension Act of 2007, § 114, Pub. Law No. 110-173, 121 Stat. 2492, 2501-06.

11. *See* 42 C.F.R. §§ 412.523(d)(3) (one time BNA), 412.529(c)(3) (VSSO payments).

12. The Secretary has broad moratorium authority under SSA § 1866(j)(7), but it was also created by PPACA.

13. *See* 42 C.F.R. § 412.523.

14. SSA § 1886(m)(5)(A) to (C).

15. 76 Fed. Reg. 51476, 51743-56 (Aug. 18, 2011).

16. 76 Fed. Reg. at 51751-56.

17. *See e.g.* SSA § 1886(b)(3)(B)(viii), codified at 42 U.S.C. § 1395ww(b)(3)(B)(viii).

About Us

The Law Offices of Jason M. Healy PLLC is a health care law firm that focuses exclusively on legal issues affecting health care providers. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations. We also represent health care providers in reimbursement audits, appeals, and litigation. Located in Washington, DC, we are well positioned to provide legal support for advocacy efforts. Our principal, Jason M. Healy, is a health care lawyer with over 14 years of experience with the array of legal issues facing health care providers.