NEWSSTAND

Healthcare Update - Healthcare News from Capitol Hill and the Department of Health and Human Services

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CMS PUBLISHES FINAL 36-MONTH RULE:

As we reported to you in our September 27 update (please visit www.eapdhealthcarereform.com to view this and other previous updates), several dozen comments associated with CMS's proposed rule for the Medicare Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year 2011 addressed the so-called "36-month rule" for home health agencies (HHAs) that went into effect in January 2010.

Under the 36-month rule, the provider agreement and Medicare billing privileges do not convey to a new owner if an HHA owner sells, transfers or relinquishes ownership within 36 months after the effective date of Medicare enrollment. Exemptions were proposed by CMS in response to concerns that the rule would have the unintended consequence of harming the business of legitimate HHAs and potentially affecting financing to the industry. Such exemptions included:

- A publicly-traded company is acquiring another HHA and both entities have submitted cost reports to Medicare for the previous five years;
- An HHA parent company is undergoing an internal corporate restructuring, such as a merger or consolidation, and the HHA has submitted a cost report to Medicare for the previous five years;
- The owners of an existing HHA decide to change the existing business structure (e.g., partnership to a limited liability company or sole proprietorship to subchapter S corporation), the individual owners remain the same, and there is no change in majority ownership (i.e., 50 percent or more ownership in the HHA); and
- The death of an owner who owns a 49 percent or less interest in an HHA (where several individuals and/or organizations are co-owners of an HHA and one of the owners dies).

In response to the comments received in September, CMS revised its exemptions in the final HH PPS rule – which was published in the November 17 Federal Register – to clarify the following:

- The publicly-traded company exception was expanded to include both public and private HHAs, and the time period for submitting cost reports was reduced to two consecutive years (down from five in the proposed rule);
- The cost report requirement in the internal corporate restructuring exemption has been eliminated;
- When an existing HHA's business structure is changed, there is no longer a requirement that there be no change in majority ownership to meet the exemption; and
- The death of owner exemption will apply to any owner and will not be based on the above ownership percentage.

CMS also addressed concerns over access to capital and the belief that the 36-month rule would block new investments in the home health industry, therefore causing the costs of the rule to outweigh its benefits to Medicare beneficiaries. In response to such comments, CMS stated, "We disagree with the assertion that the costs of the proposed rule outweigh its benefits. Beyond the issue of 'certificate mills' and HHAs' 'flipping' ownership to a third-party, we remain concerned about: (1) The sale or transfer of HHAs that have little or no enterprise value except the Medicare billing number, and (2) new owners entering Medicare without the HHA having to undergo a State survey."

REDUCTIONS IN HEALTH SPENDING RECOMMENDED BY BIPARTISAN PANEL:

Also on November 17, the Bipartisan Policy Center's Debt Reduction Task Force released a report to address the growing federal debt that included a proposed $756 billion cut in national healthcare spending by 2020. The report recommended various steps to achieve this reduction in spending, including Medicare premium increases and substantial changes to Medicaid.

In the short term, the task force proposed raising Medicare Part B premiums from 25 percent to 35 percent over five years, while also using the federal program's significant buying power in order to increase rebates from drug companies, updating benefits packages and bundling post-acute care payments. Long term, the task force proposed that in 2018 Medicare would move to a premium support system that limits growth in federal support per-beneficiary.

For the Medicaid program, the task force's report recommended the application of managed care principles to Supplementary Security Income (SSI) beneficiaries in all states in order to rein in costs in the short term. Long term, the report recommended a one percent cut in annual per-beneficiary cost growth beginning in 2018, and proposed strategies for achieving such a goal.

Further, the task force's report recommended a permanent fix for Medicare's physician reimbursement system and reforms to the medical malpractice system.

The Bipartisan Policy Center is a non-profit entity that was established in 2007 by a bipartisan group of former leaders of the U.S. Senate. The Center's Debt Reduction Task Force is made up of 19 members, including former Members of Congress, former White House officials, former Governors, economists, budget experts and leaders from the business and labor communities.

NEXT STEPS:

As the lame-duck congressional session moves forward and congressional leaders prepare for the 112th Congress, we continue to follow news from Capitol Hill. In addition, we continue to monitor HHS and other agencies, as the implementation of healthcare reform progresses and other related matters arise. We will provide timely updates as such developments occur.

Edwards Angell Palmer & Dodge LLP is pleased to provide regular updates on issues affecting the Healthcare industry. Our lawyers not only provide sophisticated legal services to a broad array of clients in the healthcare industry, we also monitor and analyze federal and state legislative and regulatory processes to ensure that our clients are informed of government actions and initiatives.

Should you have any questions on the content of this advisory, or wish to discuss any other healthcare related

issue, please contact those listed below or call the Edwards Angell Palmer & Dodge LLP attorney responsible for your affairs.

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