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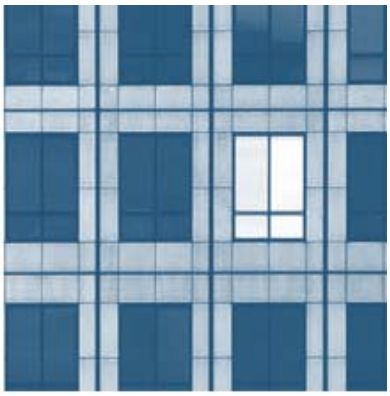
On the Subject



Health Industry Advisory

August 16, 2010

As part of the 2011 update, CMS proposes changes affecting documentation of funding requirements, changes of ownership interests, and face-to-face encounter requirements.

CMS Publishes 2011 Home Health Agency Prospective Payment System Rate Update

The Centers for Medicare and Medicaid Services (CMS) published its Home Health Agency (HHA) Prospective Payment System (PPS) Rate Update effective January 1, 2011 (the 2011 update) in the July 23, 2010, *Federal Register*. As part of the 2011 update, CMS proposes added checkpoints requiring newly enrolling HHAs to document that they have sufficient funds available to operate the HHA during the enrollment process. These checkpoints include a provision permitting the Medicare contractor to revoke newly issued billing privileges within three months after the HHA receives them, and cite failure to meet capitalization requirements as reason for the revocation. The 2011 update further addresses controversial provisions, prompted by program integrity concerns, affecting changes of ownership interests in HHAs within 36 months of initial enrollment or change of ownership. As the Patient Protection and Affordable Care Act of 2010 (PPACA) authorized, the 2011 update addresses timeframes and documentation requirements for the face-to-face encounter required to support a physician certification of a patient's eligibility for the Medicare home care benefit. In a measure directed at hospices that tend to enroll long-stay patients, the 2011 update implements the PPACA provision that a hospice physician or nurse practitioner must have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient prior to the 180-day recertification, and prior to each subsequent recertification. CMS is accepting comments on the proposed 2011 update until September 14, 2010.

Changes to HHA Capitalization and Enrollment Requirements

In January 1998, CMS adopted a rule requiring proof that HHAs have "initial reserve operating funds" (IROF) sufficient to operate the HHA for the three-month period after its provider agreement became effective. This rule was prompted by concerns that newly enrolling HHAs, generally as small businesses, were under capitalized and thus unable to sustain the level of services they provided at the time of the certification survey over the period of time necessary to begin receiving a steady Medicare revenue stream. IROF is determined under a regulatory formula using cost-per-visit information for the first year of operation from cost reports of HHAs similarly situated to the prospective HHAs seeking billing privileges. While CMS observes that Medicare contractors have been carrying out the 1998 rule, CMS remains concerned that a provider may have redirected funds, originally secured exclusively to meet the capitalization requirements, to a purpose other than to operate the business, citing situations where the HHA no longer has sufficient capitalization at the time it signs its Medicare agreement. Where the viability of an HHA can threaten the quality of care and services to HHA patients, and the health and safety of those patients, the 2011 update proposes added checkpoints to ensure the adequate capitalization of HHAs in the enrollment process, including an added provision permitting the Medicare contractor to cite inadequate capitalization, within three months past the conveyance of those billing privileges, as grounds for revocation of those billing privileges.

Specifically, CMS proposes that a prospective HHA be required to submit verification of adequate capitalization at the following points:

- At the time of the submission of the application for Medicare enrollment
- During the period in which a state agency or CMS-approved accreditation organization is making determination as to whether the provider is in compliance with the Conditions of Participation
- Within three months immediately following the issuance of the Medicare billing privileges

Thus, under the 2011 update, if a prospective HHA is determined to be out of compliance with the Medicare enrollment requirements, including not meeting the capitalization requirements at any time prior to the issuance of billing privileges, the Medicare contractor can deny billing privileges, citing the failure of the HHA to meet capitalization requirements as the reason for the denial of the billing privileges. If an enrolled HHA is determined to be out of compliance with the IROF within three months after CMS conveys Medicare billing privileges, then the Medicare contractor can revoke the billing privileges. In either instance, the loss of billing privileges for failing to meet the capitalization requirement would trigger Medicare appeal rights.

Proposed Exemptions to the 36-Month Rule on Changes of Ownership

In the 2010 HHA PPS rule, CMS finalized several home health program integrity provisions. CMS stated that if an owner of an HHA sells (including asset sales or stock transfers), transfers or relinquishes ownership of the HHA within 36 months after the effective date of the HHA's enrollment in Medicare, the provider agreement and Medicare billing privileges do not convey to the new owner. Instead, the new owner is required to enroll in Medicare as a new HHA, and obtain a state survey or an accreditation from an approved accreditation organization. Since the implementation of this provision in January 2010, CMS has received comments regarding the adverse impact of the provision on *bona fide* ownership transactions.

In light of this feedback, the 2011 update proposes exemptions to the 36-month provision by providing exemptions for the following situations:

- 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 Medicare cost report for the previous five years.
- The owners of an existing HHA decide to change the existing business structure (*e.g.*, a partnership to a limited liability corporation, 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 change in majority ownership of the HHA).
- An owner of 49 percent or less interest in an HHA dies (where several individuals and/or organizations are co-owners of an HHA and one of the owners dies).

In proposing these exceptions, CMS remains concerned that HHAs will continue to attempt to participate in a practice referred to as a "certificate mill," whereby entrepreneurs apply for Medicare certification, undergo a survey and become enrolled in Medicare, but then immediately sell or "flip" the agency without having seen a single Medicare beneficiary or hired any employees. This practice allows a purchaser of an HHA from the broker to enter the Medicare program without having to undergo a state survey, which in turn often leads to the new owners selling the business soon thereafter to someone else. CMS states that the regulatory provision is necessary to prevent "flipping" of HHAs to avoid the state survey process.

While the proposed exemptions should be welcomed, the HHA rules continue to present impediments to *bona fide* home health agency transactions and may create new ambiguities. Lenders, for example, pull back from financing, especially financing of acquisitions, faced with uncertainties and timing issues associated with HHA transactions and billing privileges under current rules. The proposed exception, for example, in the case where an "HHA parent company is undergoing an internal corporate restructuring, such as a merger or consolidation" would seem to invite additional clarification. For example, the regulation should permit under the terms "merger" or "consolidation" a change of ownership of the parent company that is beneficial to the financial stability of HHAs operating companies of the parent company, not involving changes in the personnel or operations of those HHAs, but the phrase "internal corporate restructuring" creates ambiguity. Generally, providers, investors and lenders seek a narrowing of, and elimination of confusion about, the application of the rules to *bona fide* HHA transactions, perhaps by limiting them to situations where the HHAs can be shown to have no record of patient intake, or by requiring an affirmative showing of ongoing patient care by prospective investors or their affiliates, as a condition to permitting assumption of billing privileges.

Proposed New Definition of "Change in Majority Ownership"

While the Social Security Act requires that all persons and organizations with a 5 percent or greater ownership interest in the provider, as well as all partners in a partnership if the provider is a partnership, must be reported to CMS, CMS recognizes that in many cases a small change in ownership (*e.g.*, 5 percent) does not result in a fundamental change of ownership by the majority owners and should not necessarily require a new enrollment and state survey, or meet the deemed-accreditation status. However, CMS is concerned that prospective HHA owners could circumvent the regulatory requirements by incrementally increasing their level of ownership to the point where they could effectively assume 51 percent or more ownership of an HHA

without having to enroll as a new provider and undergo a state survey, or meet the deemed-accreditation status. Thus, CMS proposes a definition of "change in majority ownership" in the 2011 update to mean an individual or organization that acquires more than 50 percent interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or a change of ownership (including asset sale, stock transfer, merger or consolidation). This definition includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations and/or mergers during a 36-month period.

Accordingly, any change in majority control and/or ownership during the first 36 months of when the HHA is initially conveyed Medicare billing privileges or the last change of ownership (including asset sale, stock transfer, merger or consolidation) would trigger the enrollment and state survey, or deemed-accreditation requirements, unless one of the exemptions described above is met. The 2011 update invites careful review as to how the changes proposed in the prohibitions on sale or transfer of billing privileges apply to various change of ownership situations, including situations involving a minority owner holding a 5 percent equity interest in an HHA.

Home Health "Face-to-Face" Encounter Requirements

The PPACA amends the Medicare requirement for physician certification of home health services by requiring that, prior to certifying a patient as eligible for home health services, the physician must document that the physician himself or herself, or a specified non-physician practitioner (*e.g.*, nurse practitioner, clinical nurse specialist) has had a face-to face encounter. The PPACA did not amend the statutory requirement that a physician must certify a patient's eligibility for the Medicare home health benefit. Rather the provision allows for specific non-physician practitioners to perform the face-to-face encounter with the patient in lieu of the certifying physician, and inform the physician making the initial certification for eligibility for the Medicare home health benefit. The certifying physician must document the face-to-face encounter regardless of whether the physician or one of the permitted non-physician practitioners performed the face-to-face encounter. In implementing the PPACA provision in the 2011 update, CMS proposes to amend its regulations to require that the certifying physician sign and date the documentation entry into the certification that the face-to-face patient encounter was conducted no more than 30 days prior to the home health start of care date by himself or herself, or by an allowed non-physician practitioner for initial certifications. CMS is proposing that the certifying physician's documentation of the face-to-face encounter be either a separate and distinct area on the certification or an addendum to the certification; be clearly titled, dated and signed by the certifying physician; and include the clinical findings of that encounter.

Physicians with a financial interest in the HHA, unless the interest falls within one of the permitted exceptions, are prohibited from certifying or recertifying home health services. Similarly, non-physician practitioners would be precluded from performing a face-to-face encounter for the purpose of informing the certifying physician of the encounter, if the non-physician practitioner is an employee of the HHA.

Proposed New Requirements for Hospice Certifications and Recertifications

In a measure directed at hospices that tend to enroll long-stay patients, the PPACA requires that on and after January 1, 2011, a physician or nurse practitioner attest that he or she determined continued hospice eligibility through a face-to-face encounter with every hospice patient to determine the eligibility of that patient for continued hospice care, prior to the 180-day recertification, and prior to each subsequent recertification. CMS proposes that the clinical findings gathered by the nurse practitioner or by the physician during the face-to-face encounter with the patient be used in the physician narrative to justify why the physician believes that the patient has a life expectancy of six months or less. Where the PPACA specified that the hospice physician or nurse practitioner attest that such a visit took place in accordance with procedures specified by the Secretary of HHS, the 2011 update proposes the specifics of the procedures, the form of the certification and recertification, and timeframes for the face-to-face encounter.

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