Home Health Agency 2011 Rate Update Implements Key Health Reform Provisions for Home and Hospice Care

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The Centers for Medicare and Medicaid Services' Final 2011 Home Health Agency Prospective Payment System update significantly clarifies the application of the 36-month change of ownership rule for home health agencies and exceptions to that rule. The update also clarifies home health agency capitalization and enrollment requirements, as well as patient face-to-face encounter requirements for home health agencies and hospices, effective January 1, 2011.

The Centers for Medicare & Medicaid Services (CMS) published its final Home Health Agency (HHA) Prospective Payment System (PPS) Rate Regulation, effective January 1, 2011 (the Final Rule), in the November 17, 2010, *Federal Register*. The Final Rule adds checkpoints requiring newly enrolling HHAs to document they have sufficient funds available to operate the HHA during the enrollment process, including a provision permitting the Medicare contractor to revoke newly issued billing privileges, after the HHA receives them, for failure to meet capitalization requirements. Based on comments to the proposed rule, the Final Rule changes the proposed exceptions to the controversial rule that prohibits the sale or transfer of HHA billing privileges where there is a sale or transfer of the HHA within 36 months after the effective date of the HHA's initial enrollment in Medicare, or within 36 months after the HHA's most recent change in majority ownership. The Final Rule also clarifies that indirect changes of ownership (*i.e.*, changes at the parent or holding company level) are exempt from the 36-month rule.

As the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) authorized, the Final Rule 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 very long-stay patients, the Final Rule implements the Affordable Care Act 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.

This newsletter discusses notable provisions of the Final Rule.

I. Changes to HHA Capitalization and Enrollment Requirements

Prompted by concerns that newly enrolling HHAs, generally as small businesses, were under-capitalized and thus unable to sustain the level of services provided at the time of the certification survey over the period of time necessary for it to begin receiving a steady Medicare revenue stream, CMS adopted a rule in January 1998 requiring proof that HHAs have "initial reserve operating funds" sufficient to operate the HHA for the three-month period after its provider agreement became effective. The initial reserve operating fund 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 Medicare contractors have been carrying out the 1998 rule, it 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 Final Rule added checkpoints to assure the adequate capitalization of HHAs in the enrollment process, including an added provision permitting the Medicare contractor to cite inadequate capitalization as grounds for revocation of billing privileges within three months past the conveyance of those privileges.

Specifically, the Final Rule requires a prospective HHA to submit verification of adequate capitalization 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 and within three months immediately following the issuance of the Medicare billing privileges.

Under the Final Rule, 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. 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.

II. Changes in Indirect Ownership Interests Will not Trigger the 36-Month Rule

The 36-month rule applies to any change in majority ownership, which occurs when an individual or organization acquires (via asset sale, stock transfer, merger and consolidation) *more than a 50 percent direct ownership interest* in an HHA, within 36 months after the effective date of the HHA's initial enrollment in Medicare or the HHA's most recent change in majority ownership. The new owner must enroll in Medicare as a new HHA and obtain a state survey or accreditation from an approved organization unless one of the four exceptions discussed below applies.

In the Final Rule, CMS clarified that *indirect* ownership changes, *i.e.*, changes to the ownership of a holding company that owns and operates HHAs through subsidiaries, are not subject to the 36-month rule. This provision is arguably beneficial to the overall financial stability of an HHA because it permits added resources and capitalization at the holding or parent company level. However, unless an exception applies, the transfer of a majority ownership interest of an HHA's stock to a holding company is subject to the 36-month rule because it is a direct ownership change to the HHA.

III. Exceptions to the 36-Month Rule on Changes of Ownership

In the Final Rule, CMS substantially revised the exceptions set forth in the proposed rule. In particular, several commenters expressed concern over the proposed exception for publicly traded companies as both providing an unfair advantage to publicly traded firms and creating an undue burden by requiring submission of five consecutive years of cost reports. To address these concerns, CMS expanded the exception to public or private HHAs and reduced the number of consecutive years of full cost reports (not including low- or no-utilization cost reports) from five to two. CMS also eliminated the five-year cost report submission requirement from the exception for an HHA parent company undergoing a corporate restructuring. The Final Rule provides four exceptions to the 36-month rule:

- An HHA submitted two consecutive years of full cost reports
- An HHA's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation
- The owners of an existing HHA are changing the HHA's existing business structure (*e.g.*, from a corporation to a partnership [general or limited], from an LLC to a corporation, or from a partnership [general or limited] to an LLC) and the owners remain the same

- An individual owner of an HHA dies

IV. Home Health "Face-to-Face" Encounter Requirements

The Affordable Care Act 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 nonphysician practitioner (*e.g.*, nurse practitioner, clinical nurse specialist), has had a face-to-face encounter. The Affordable Care Act 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 nonphysician practitioners to perform the face-to-face encounter with the patient in lieu of the certifying physician and to 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 nonphysician practitioners performed the face-to-face encounter.

In implementing the Affordable Care Act provision, CMS revised the time frames described in the proposed rule to allow the face-to-face encounter to occur up to 90 days prior to the start of care, if the reason for the encounter is related to the reason the patient comes to need home care. If no such encounter has occurred, CMS will allow the encounter to occur up to 30 days after the start of care. CMS revised the Final Rule to remove the requirements concerning the physician's own medical record documentation.

The Final Rule imposes the same restrictions on a physician's financial interest in the HHA to nonphysician practitioners who perform the face-to-face encounter, as currently apply to certifying physicians.

V. Final Rule Requirements for Hospice Certifications and Recertifications

In a measure directed at hospices that tend to enroll very long-stay patients, and in conjunction with existing statutory requirements that a physician must certify and recertify a patient's terminal illness, the Affordable Care Act requires, on and after January 1, 2011, a hospice physician or nurse practitioner to have a face-to-face visit with patients prior to the 180th day recertification and prior to each subsequent recertification, and to attest that such a visit took place. CMS' proposed regulation implementing this requirement drew extensive public comments.

CMS addresses those comments at considerable length in the Final Rule. As to a number of comments, CMS notes simply that the hospice face-to-face requirements are Affordable Care Act requirements, which CMS must implement as written. For example, CMS cannot permit face-to-face encounters by physician assistants because the law limits the performance of the face-to-face encounter to physicians and nurse practitioners.

The CMS commentary in the Final Rule is guidance, however, on how the mandate is to be implemented. CMS changed the regulatory text of the Final Rule to clarify that CMS is counting a beneficiary's time across all hospices based upon benefit periods rather than on actual days of hospice care, eliminating the 180-day reference used in the proposed rule. That is, hospice patients are allowed two 90-day benefit periods followed by an unlimited number of 60-day benefit periods, so every 60-day benefit period is by definition beyond the 180-day recertification. Thus, a face-to-face encounter will be required prior to the third benefit period recertification and each recertification thereafter. CMS clarified that the hospice physician or nurse practitioner is not required to go to the patient for the face-to-face encounter, but that the patient is allowed to travel to the hospice physician or nurse practitioner when medically appropriate. CMS also changed the regulatory text of the Final Rule so that hospice physicians or nurse practitioners will have up to 30 calendar days prior to the third benefit period recertification, and up to 30 calendar days prior to each recertification thereafter, to have the face-to-face encounter.

Another helpful clarification is that the Final Rule does not require hospices to have a face-to-face encounter with existing patients who entered the third or later benefit period in 2010 and were recertified in 2010. The Final Rule does require that patients who enter the third or later benefit period in 2011 have the face-to-face encounter, with CMS noting the statutory language did not give CMS flexibility to "grandfather" in existing patients. CMS believes that by extending the time frame for the face-to-face encounter from 15 to 30 calendar days, hospices will have the flexibility to meet this requirement for patients who will enter the third or later benefit periods in 2011. CMS also stated that to address certain commenters' concerns, CMS will expand on particular requirements in manual guidance or that standing manual guidance is available.

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