

HOME HEALTH AND HOSPICE TRANSACTIONS: TRAPS FOR THE UNWARY

I. INTRODUCTION

A. What is home health care?

1. Home health care refers to a wide range of health care (i.e., “skilled”) and non-health care (i.e., “private duty”) services that can be provided an individual’s “home.” The type and extent of services provided depends on the patient’s needs and:
 - a. May include skilled nursing services, occupational therapy, physical therapy, speech therapy, and medical social services.
 - b. May involve helping the elderly with activities of daily living such as bathing, dressing, and eating.
 - c. May include assistance with cooking, cleaning, laundry, other housekeeping jobs.
 - d. May include the provision of medical supplies.
 - e. May include monitoring one’s daily regimen of prescription and over-the-counter medications.
2. By often delaying the need for long-term nursing home care, home care helps senior citizens live independently as long as possible.
3. As with facility-based services, skilled home health services typically have a higher profit margin; however, many agencies offer private duty home health services as a possible “feeder” for skilled home health services.

B. What is hospice?

1. Hospice is a program of care and support for individuals who are terminally ill (i.e., generally having less than six (6) months to live) and is a comprehensive program of services that includes skilled nursing services, medical social services; counseling (spiritual, bereavement, and nutritional); physician services, and aide/homemaker services as well as occasional use of occupational therapy, physical therapy, speech therapy, short-term inpatient or respite services, and durable medical equipment, medications and supplies.
2. The focus of hospice is not to cure illness; instead, the goal is to provide comfort care designed to meet an individual’s physical, emotional, social, and spiritual needs, as well as the psychosocial needs of the individual’s family/caregiver(s). A specially trained team and support staff of a variety of disciplines is utilized in any setting the patient calls home.

C. Current Market Conditions Impacting Home Health and Hospice Transactions.

1. The home health and hospice industries are expanding.

a. Home Health.

- (1) In 2011, there were approximately 11,900 Medicare-certified home health agencies (“HHAs”) throughout the country.¹
 - (i) This represents a growth in HHAs of approximately 420 over the prior year and approximately 4,300 since 2000.²
 - (ii) Most new HHAs are concentrated in a few states (i.e., Texas, California, Florida, and Illinois).³
 - (iii) Most Medicare-certified HHAs are for-profit – approximately 16% of HHAs have non-profit ownership (down seven (7) percentage points since 2007), 6% have government ownership (down three (3) percentage points since 2007), and 78% have for-profit ownership (up ten (10) percentage points since 2007).⁴
- (2) In 2011, there were approximately 3.4 million Medicare beneficiaries that received HHA services, which represents a 4% growth in the number of beneficiaries over the prior year and a 36% growth in the number of beneficiaries since 2000.⁵
- (3) In 2010, Medicare, the largest single payer of HHA services,⁶ spent approximately \$19.4 billion on HHA services, which is up from approximately \$8.5 billion in 2000.⁷

b. Hospice.

- (1) In 2010, there were approximately 3,500 Medicare-certified hospice providers throughout the country.⁸
 - (i) This represents an increase in hospice providers of approximately 3% since 2009 and approximately 53% since 2000.⁹

¹ Medicare Payment Advisory Commission’s *Report to the Congress: Medicare Payment Policy* (March 2012).

² *Id.*

³ *Id.*

⁴ Alliance for Advancing NonProfit Health Care, *Basic Facts & Figures: NonProfit Home Health Services* (<http://www.nonprofithealthcare.org/resources/BasicFacts-NonprofitHomeHealthCare.pdf>).

⁵ Medicare Payment Advisory Commission’s *Report to the Congress: Medicare Payment Policy* (March 2012).

⁶ National Association for Home Care & Hospice, *Basic Statistics About Home Care* (Updated 2010) (http://www.nahc.org/facts/10hc_stats.pdf).

⁷ Medicare Payment Advisory Commission’s *Report to the Congress: Medicare Payment Policy* (March 2012).

⁸ *Id.*

⁹ *Id.*

- (ii) For-profit organizations represented approximately 60% of all hospice providers in 2011¹⁰ and have accounted for almost the entire increase in the number of hospice programs over the past decade.¹¹ Specifically, the number of for-profit hospices grew approximately 150% from 2000 to 2010, while the number of non-profits declined approximately 1% and hospices with government or other ownership structures increased approximately 27% during this period.¹²
 - (2) In 2010, more than 1.1 million Medicare beneficiaries received hospice services, up from 0.5 million in 2000.¹³
 - (3) In 2010, approximately 44% of Medicare beneficiaries who died that year used hospice, up from just under 23% in 2000.¹⁴
 - (4) Medicare spending reached approximately \$13 billion in 2010, more than quadrupling since 2000.¹⁵
2. Growth in home health and hospice is fueled by a variety of factors, such as:
- a. ever-increasing number of senior citizens who are living longer;
 - b. public education and enhanced awareness of full spectrum of health care options, including benefits of home health and hospice;
 - c. desire of patients to remain in their homes as long or as much as possible;
 - d. enabling patient to maintain dignity, independence, and control of care;
 - e. more cost effective than institutional care;
 - f. comparatively fewer financial, regulatory, and other barriers to entry for providers; and
 - g. comparatively higher Medicare profit margins.
3. Due to the market factors increasing the need for, and utilization of, home health and hospice services, the number of home health and hospice transactions (sale, purchase, joint venture, start-up) also has increased.
- a. Many buyers are facility-based and for-profit.
 - (1) Diversification of service offerings beyond institutional care – attempt to stay competitive and adapt to trends in health care.

¹⁰ National Hospice and Palliative Care Organization, *NHPCO Facts and Figures: Hospice Care in America* (2012 Edition) (http://www.nhpco.org/files/public/Statistics_Research/2012_Facts_Figures.pdf).

¹¹ Medicare Payment Advisory Commission's *Report to the Congress: Medicare Payment Policy* (March 2012).

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

- (2) Low capital requirements – HHAs and hospices are not as capital intensive as other providers because they do not require extensive physical infrastructure.
 - (3) Following governmental funding and reimbursement trends.
- b. Buyers need to consider whether the service will be “captive” to the acquiring entity, or serve a broader market.
- c. Alternatively, some organizations start their own HHA or hospice, either alone or through a joint venture, due to the unavailability of HHAs and hospice programs at an acceptable purchase price. Relevant considerations include:
 - (1) cost of start-up/initial certification versus acquisition; and
 - (2) certification versus accreditation.
- d. See Exhibit 1 for a comparison of sales price to annual revenue for the period of January 2006 – August 2011 (home health agencies).

D. Traps for the Unwary.

- 1. Many facility-based organizations attempt to apply principles from nursing facility transactions to home health and hospice transactions. This is dangerous, in light of the following considerations:
 - a. HHAs and hospice providers are faced with laws generally not applicable to facility-based providers (e.g., physician self-referral, 36-month rule, and capitalization requirements for HHAs).
 - b. Market competition is generally higher among HHAs and hospice providers.
 - (1) Referring hospitals may have their own HHA and/or hospice program.
 - (2) Marketing practices need to be examined closely PRIOR to closing.
 - c. Due to comparatively low barriers to entry, non-competition agreements need to be given greater consideration than in many nursing home transactions.
 - d. Freedom-of-choice and established relationships will prevent capturing 100% of a nursing facility’s discharges/referrals.
 - e. Nursing facility-hospice relationships are a high priority for the OIG.

2. As a result of these and other unique considerations, the due diligence process for an HHA and hospice transactions must differ from those applied to nursing home transactions.
3. See Exhibit 2 for a due diligence task list (home health agencies).

II. **LEGAL ISSUES UNIQUE TO HOME HEALTH TRANSACTIONS – “36 MONTH RULE”**

A. Background of Rule – HHA “Flipping”.

1. In the 2000s, there was a rising trend in “turn-key” HHA transactions.
 - a. Owners of HHAs were enrolling in Medicare for the sole purpose of immediately selling their Medicare billing privileges and related Medicare provider agreements to third parties (frequently for a significant profit), which would frequently enable the buyers to circumvent the Medicare initial enrollment and survey requirements, ultimately leading to a lack of compliance with HHA conditions of participation.
 - b. Specifically, a provider would apply for Medicare HHA certification, undergo a state survey, and become enrolled in Medicare, but then immediately sell the HHA. Under prior law, the parties to the transaction would then notify the Centers for Medicare and Medicaid Services (“CMS”) of the sale via the Medicare enrollment application after the billing privileges have been transferred when the HHA is sold. Because state surveys that are performed to ascertain compliance with the applicable conditions of participation did not occur in cases of changes of ownership with the frequency that they did when providers initially enrolled in Medicare, there were several instances in which a change of ownership occurred yet the new owner did not undergo a survey. This, therefore, allowed the buyer of an HHA to enter the Medicare program through the back door – via the change of ownership process – without having to undergo a time-consuming and costly survey.
 - c. In such cases, Medicare could not conclusively ascertain whether the HHA, under new ownership, met the required conditions of participation. According to the government, this increased the risk of inadequate care and the submission of inappropriate and potentially fraudulent claims to Medicare.
2. In an effort to combat the growing trend of HHA “flipping” and to ensure that buyers of HHS satisfy the Medicare conditions of participation, CMS adopted the so-called “36-Month Rule,” the final version of which went into effect on January 1, 2011, despite concerns from providers and ancillary business that the 36-Month Rule unduly hinders legitimate transactions and chills new investments in the HHA industry.

B. General Rule.

1. The 36-Month Rule is set forth in 42 CFR § 424.550(b)(1), which reads as follows:

“(1) Unless an exception...applies, if there is a change in majority ownership of a home health agency by sale (including asset sales, stock transfers, mergers, and consolidations) 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 provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA must instead: (i) Enroll in the Medicare program as a new (initial) HHA under the provisions of § 424.510 of this subpart. (ii) Obtain a State survey or an accreditation from an approved accreditation organization.”

C. Exceptions.

1. The 36-Month Rule is not implicated in the event that any of exceptions set forth in the following provisions of 42 CFR § 424.550(b)(2) applies:

“(2)(i) The HHA submitted two consecutive years of full cost reports. For purposes of this exception low utilization or no utilization cost reports do not qualify as full cost reports.

(ii) An HHA’s parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.

(iii) The owners of an existing HHA are changing the HHA’s existing business structure (for example, from a corporation to a partnership (general or limited); from an LLC to a corporation; from a partnership (general or limited) to an LLC) and the owners remain the same.

(iv) An individual owner of an HHA dies.”

D. Consequences of Applicability.

1. The 36-Month Rule can significantly impact the timing and cost requirements of a buyer obtaining Medicare certification for a newly acquired HHA.
2. The process for obtaining Medicare certification in an HHA acquisition, which can take anywhere from two (2) to eighteen (18) months, depends on whether the buyer intends, and is able, to assume the Medicare provider number of the seller.
 - a. If, as in most cases, the buyer intends, and is able to assume the Medicare provider number of the seller (i.e., the 36-Month Rule does not apply to the transaction), then the certification process is generally shorter and less costly.

- (1) A CMS Form 855A application (including all ancillary documents) is completed and filed with the applicable fee-for-service contractor (the “Contractor”) by the buyer and the seller within thirty (30) days of the effective date of the transaction.
 - (2) The Contractor reviews the application and makes a recommendation for approval or denial to CMS and the applicable state Medicare agency. In addition, the buyer submits various forms and documents to such state Medicare agency, including, but not limited to, civil rights policies and notices.
 - (3) If the state Medicare agency approves the materials, it forwards the same, along with a recommendation for enrollment, to CMS for review and processing.
 - (4) If the recommendation for enrollment is accepted by CMS and other requirements are met, CMS will issue a “tie-in notice,” approving the change of ownership.
- b. If, on the other hand, the 36-Month Rule applies, and the buyer is not able to assume the provider number of the seller and, therefore, is required to enroll in Medicare through an “initial enrollment” process, the path to Medicare certification is often more costly and time-consuming. While the application/ processing requirements are similar to what is described above, as indicated below, the initial enrollment process requires a successful survey following the completion of clause (2) above, which often adds significant time, administrative duties, and costs to the enrollment process.
- (1) Due to funding limitations, CMS has issued instructions to state survey agencies to give higher priority to recertification of existing Medicare providers, complaint investigations, and similar work for existing providers than to initial surveys of new providers seeking Medicare certification. In fact, many states have a moratorium on such initial surveys for HHA providers (and hospice providers as well).
 - (2) As a result, in most cases, through the more costly “accreditation option,” HHA providers choose a nationally-recognized accreditation organization whose standards for HHA services are approved by CMS as meeting or exceeding the HHA conditions of participation (i.e., Community Accreditation Program, The Joint Commission, and the Accreditation Commission for Health Care) to conduct the initial survey instead of the applicable state survey agency. This requires that the provider seeks “deemed status” from one of the approved accreditation organizations. “Deemed status” means that the HHA is found to meet the Medicare conditions of participation through the unannounced survey conducted by the accreditation organization in the accreditation process.

- (3) Before the survey is conducted, the HHA must have provided skilled services to at least ten (10) patients within the previous twelve (12) months, and at least seven (7) of those patients must actively be receiving skilled services at the time of the survey. If all applicable requirements are met on the date of the survey, the HHA's new Medicare provider agreement will be effective as of that date. If, on the other hand, all requirements are not met on the date of the survey, then the provider agreement will not be effective until the date on which the HHA is deemed to have met all requirements. In either case, however, reimbursement under Medicare will not be made for any care provided prior to the effective date of certification.

E. Clarifications.

1. Direct vs. Indirect Ownership Changes.

- a. In 42 CFR § 424.502 CMS defines "Change in majority ownership," as used in the 36-Month Rule, as referring a situation in which "an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sale, stock transfer, merger, and consolidation). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period following the HHA's most recent change in majority ownership."
- b. As a result, indirect ownership changes (i.e., changes in ownership solely at the holding company level of an HHA provider entity) are not subject to the 36-Month Rule. Therefore, the key is to evaluate the ownership structure of the HHA provider entity before and after the transaction – if such ownership structure changes, the 36-Month Rule may be implicated, but if only the ownership structure of one or more of the HHA provider entity's owners or holding companies changes, then the 36-Month Rule will not be implicated.

2. Relationship to Change of Ownership Provisions of Other Providers.

- a. The 36-Month Rule is unique to HHAs and does apply to any other Medicare Part A providers.
- b. In general, under the traditional "change of ownership" regulations applicable to all Medicare Part A provider types (42 CFR § 489.18), a transaction is not regarded as a "change of ownership" if there is merely a transfer of corporate stock, or the entity, itself, remains intact and the actual "provider." However, even if an HHA transaction does not fall within the parameters of a "change of ownership" under such regulations

(e.g., in the case of a transfer of corporate stock), it may still fall within the purview of the 36-Month Rule.

- c. Check state laws for Medicaid and licensure requirements.
 - (1) Some states follow Medicare definitions for a “change of ownership.”
 - (2) Other states (e.g., Florida) more broadly define a “change of ownership” to specifically include certain stock purchases and other non-asset transactions.
- d. Also check state law for Certificate of Need requirements.

III. LEGAL ISSUES UNIQUE TO HOME HEALTH TRANSACTIONS – CAPITALIZATION REQUIREMENTS

- (1) Overview. In light of the government’s concern that many HHAs were entering into the Medicare program without sufficient funds, which could have “deleterious consequences on patient care,” as a requirement to obtain and maintain Medicare enrollment, HHAs must have and prove the availability of sufficient initial operating funds.
- (2) Requirements.
 - 1. General Rule. Effective January 1, 2011, an HHA entering the Medicare program (including a new HHA as a result of a change of ownership if the change of ownership results in a new provider number being issued) is required by 42 CFR § 489.28(a) to have available sufficient funds (known as “initial reserve operating funds”), at the time of enrollment application submission and at all times during the enrollment process, to operate the HHA for the three (3) month period after Medicare billing privileges are conveyed to the provider (exclusive of actual or projected accounts receivable from Medicare. This means that, prior to applying for Medicare enrollment, the provider needs to obtain funds sufficient to operate the HHA for a three (3) month period following the conveyance of Medicare billing privileges.
 - 2. Standard of Sufficiency for Initial Operating Funds.
 - a. Initial operating funds are sufficient to meet the requirement of 42 CFR § 489.28(a) if the total amount of funds is equal to or greater than the product of the actual average cost per visit of three (3) or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by the HHA for its first three (3) months of operation – or 22.5% of the average number of visits reported by the comparison HHAs – whichever is greater.

- b. The Contractor determines the amount of the initial reserve operating funds using reported cost and visit data from submitted cost reports for the first full year of operation from at least three (3) HHAs that the Contractor serves that are comparable to the HHA that is seeking to enter the Medicare program. Factors to be used in making this determination shall include: (1) geographic location and urban/rural status; (2) number of visits; (3) provider-based vs. free-standing; and (4) proprietary vs. non-proprietary status.
3. Proof of Initial Reserve Operating Funds.
 - a. Within thirty (30) days of any request of CMS, the HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. Such proof, at a minimum, must include a copy of the statement(s) of the HHA's savings, checking, or other account(s) that contains the funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and that the funds are immediately available to the HHA.
 - b. As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. CMS may later require the HHA to furnish another attestation from the financial institution that the funds remain available, or, if applicable, documentation from the HHA that any cash equivalents remain available, until a date when the HHA will have been surveyed by the state survey agency or by an approved accrediting organization. The officer of the HHA who will be certifying the accuracy of the information on the HHA's cost report must certify what portion of the required initial reserve operating funds constitutes non-borrowed funds, including funds invested in the business by the owner. That amount must be at least 50% of the required initial reserve operating funds. The remainder of the initial reserve operating funds may be secured through borrowing or line of credit from an unrelated lender.
4. Borrowed Funds. If borrowed funds are not in the same account(s) as the HHA's own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA, by providing, at a minimum, a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available to the HHA. As with the HHA's own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds, including furnishing an attestation from a financial institution or other source, as may be appropriate, and to establish that such funds will remain available until a date when the HHA will have been surveyed by the state agency or by an approved accrediting organization.

5. Line of Credit. If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the applicable lender. CMS later may require the HHA to furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.
6. Noncompliance with Capitalization Requirements. Medicare billing privileges for HHA may be denied or revoked for noncompliance with the initial reserve operating fund requirements.

IV. LEGAL ISSUES UNIQUE TO HOME HEALTH TRANSACTIONS – PHYSICIAN SELF-REFERRAL

- A. General Rule. The federal physician self-referral law (aka “Stark Law”), provides that, as a general rule, if a physician has a financial relationship with an entity, or has an immediate family member who has a financial relationship with an entity, then, unless the relationship comes within one of many enumerated exceptions to the prohibition: (a) the physician may not make a referral to the entity for the furnishing of designated health services (“DHS”) for which payment may otherwise be made by Medicare (including HHA services); and (b) the entity may not present or cause to be presented a Medicare claim or bill to any individual, third party payor, or other entity for DHS furnished pursuant to such a referral.
- B. Violations. The Stark Law is a strict liability statute (and not intent-based), and violations of the Stark Law can lead to significant civil fines and penalties, which may even be assessed against successor entities of a provider under the theory of successor liability, along with possible exclusion from federal health care programs.
- C. Applicability to HHA. Home health is a DHS. In the event that a physician refers patients to an HHA with whom the physician (or an immediate family member) has a financial relationship, then the Stark Law is implicated.
- D. Exceptions. The Stark Law contains several exceptions that permit financial relationships that are otherwise prohibited by the plain language of the statute. Accordingly, these so-called “Stark exceptions” determine the permissibility of health care financial relationships under the Stark Law. The Stark exceptions are generally divided into the following categories: (a) those that apply to ownership or investment interests and compensation arrangements; (b) those that apply to ownership or investment interests; and (c) those that apply to compensation arrangements. With respect to HHAs, some relevant Stark exceptions to examine when attempting to determine whether a relationship or arrangement is permissible include the following:
 2. Bona Fide Employment Relationships. The “bona fide employment relationships” Stark exception, which is set forth in 42 CFR § 411.357(c), reads as follows:

“(c) Bona fide employment relationships. Any amount paid by an employer to a physician (or immediate family member) who has a bona fide employment relationship with the employer for the provision of services if the following conditions are met:

(1) The employment is for identifiable services.

(2) The amount of the remuneration under the employment is—

(i) Consistent with the fair market value of the services; and

(ii) Except as provided in paragraph (c)(4) of this section, is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.

(3) The remuneration is provided under an agreement that would be commercially reasonable even if no referrals were made to the employer.

in the form of a productivity bonus based on services performed personally by the physician (or immediate family member of the physician).”

3. Personal Service Arrangements. The “personal service arrangements” Stark exception, which is set forth in 42 CFR § 411.357(d), reads as follows:

“(d) Personal service arrangements. (1) General—Remuneration from an entity under an arrangement or multiple arrangements to a physician or his or her immediate family member, or to a group practice, including remuneration for specific physician services furnished to a nonprofit blood center, if the following conditions are met:

(i) Each arrangement is set out in writing, is signed by the parties, and specifies the services covered by the arrangement.

(ii) The arrangement(s) covers all of the services to be furnished by the physician (or an immediate family member of the physician) to the entity. This requirement is met if all separate arrangements between the entity and the physician and the entity and any family members incorporate each other by reference or if they cross-reference a master list of contracts that is maintained and updated centrally and is available for review by the Secretary upon request. The master list must be maintained in a manner that preserves the historical record of contracts. A physician or family member can “furnish” services through employees whom they have hired for the purpose of performing the services; through a wholly-owned entity; or through locum tenens physicians (as defined at § 411.351, except that the regular physician need not be a member of a group practice).

(iii) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement(s).

(iv) The term of each arrangement is for at least 1 year. To meet this requirement, if an arrangement is terminated during the term with or without cause, the parties may not enter into the same or substantially the same arrangement during the first year of the original term of the arrangement.

(v) The compensation to be paid over the term of each arrangement is set in advance, does not exceed fair market value, and, except in the case of a physician incentive plan (as defined at § 411.351 of this subpart), is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(vi) The services to be furnished under each arrangement do not involve the

counseling or promotion of a business arrangement or other activity that violates any Federal or State law.

(vii) A holdover personal service arrangement for up to 6 months following the expiration of an agreement of at least 1 year that met the conditions of paragraph (d) of this section satisfies the requirements of paragraph (d) of this section, provided that the holdover personal service arrangement is on the same terms and conditions as the immediately preceding agreement.

(2) Physician incentive plan exception. In the case of a physician incentive plan (as defined at § 411.351) between a physician and an entity (or downstream contractor), the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

(i) No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services furnished with respect to a specific individual enrolled with the entity.

(ii) Upon request of the Secretary, the entity provides the Secretary with access to information regarding the plan (including any downstream contractor plans), in order to permit the Secretary to determine whether the plan is in compliance with paragraph (d)(2) of this section.

(iii) In the case of a plan that places a physician or a physician group at substantial financial risk as defined at § 422.208, the entity or any downstream contractor (or both) complies with the requirements concerning physician incentive plans set forth in § 422.208 and § 422.210 of this chapter.”

E. State Law. Check corresponding state law statutes.

V. **2013 OIG WORK PLAN ISSUES FOR HOME HEALTH AND HOSPICE**

A. Role of OIG.

1. The OIG, or the Office of the Inspector General, was created to protect the integrity of the U.S. Department of Health and Human Services (“HHS”) programs and operations and the well-being of beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve economy, efficiency, and effectiveness; and holding accountable those who do not meet applicable program requirements or federal law.
2. Known most notably for its enforcement activities, the OIG conducts audits, evaluations, and investigations; provides guidance to industry; and, when appropriate, imposes civil monetary penalties, assessments, and administrative sanctions.
3. While the OIG oversees operations of more than 300 programs administered by HHS at various governmental agencies, the majority of the OIG’s resources are directed toward safeguarding the integrity of the Medicare and Medicaid programs and the health and welfare of their beneficiaries.

B. Function of OIG Work Plan.

1. In planning its work, the OIG assesses relative risks in the programs for which it has oversight authority to identify the areas in most need of attention. Once those areas are identified, priorities are set for the sequence and proportion of resources to be allocated.
2. Each year, the OIG issues its Work Plan, which summarizes the areas of focus and activities that the OIG plans to pursue with respect to HHS programs and operations during the next fiscal year.

C. Areas of OIG Focus – Home Health.

1. The 2013 OIG Work Plan outlines the following areas of focus specific to HHAs:
 - a. Home Health Face-to-Face Requirement. The OIG will attempt to determine the extent to which HHAs are complying with a statutory requirement that physicians (or certain practitioners working with physicians) who certify beneficiaries as eligible for Medicare HHA services have face-to-face encounters with the beneficiaries.
 - b. Employment of Home Health Aides with Criminal Convictions. The OIG will attempt to determine the extent to which HHAs are complying with state requirements that criminal background checks be conducted with respect to HHA applicants and employees.
 - c. States' Survey and Certification: Timeliness, Outcomes, Follow-up, and Medicare Oversight. The OIG will review the timeliness of HHA recertification and complaint surveys conducted by state survey agencies and accreditation organizations, the outcomes of those surveys, and the follow-up of complaints against HHAs.
 - d. Missing or Incorrect Patient Outcome and Assessment Data. The OIG will review HHAs' Outcome and Assessment Information Set ("OASIS") data to identify payments for episodes for which OASIS data were not submitted or for which the billing codes on the claims are inconsistent with OASIS data.
 - e. Medicare Administrative Contractors' Oversight of Claims. The OIG will review the activities that CMS and its contractors performed to identify and prevent improper home health payments from January to October 2011.
 - f. Home Health Prospective Payment System Requirements. The OIG will review compliance with various aspects of the HHA prospective payment system requirements, including the documentation required in support of the claims paid by Medicare.

- g. Trends in Revenues and Expenses. The OIG will review cost report data to analyze HHA revenue and expense trends under the HHA prospective payment system to determine whether the payment methodology should be adjusted.
- h. Duplicate Payments by Medicare and Medicaid. The OIG will review Medicaid payments by states for Medicare-covered home health services to determine the extent to which both Medicare and Medicaid have paid for the same services.
- i. Screenings of Health Care Workers. The OIG will review health-screening records of Medicaid home health care workers to determine whether the workers were screened in accordance with federal and state requirements.
- j. Provider Compliance and Beneficiary Eligibility. The OIG will review HHA claims to determine whether providers have met applicable criteria to provide services and whether beneficiaries have met eligibility criteria.
- k. Homebound Requirements. The OIG will review CMS policies and practices for reviewing the sections of Medicaid state plans related to eligibility for home health services and describe how CMS intends to enforce compliance with appropriate eligibility requirements for home health services.

D. Areas of OIG Focus – Hospice.

- 1. The 2013 OIG Work Plan outlines the following areas of focus specific to hospice providers:
 - a. Marketing Practices and Financing Relationships with Nursing Facilities. The OIG will review hospices' marketing materials and practices and their financial relationships with nursing facilities. In a recent report, the OIG found that 82% of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements. MedPAC, an independent congressional agency that advises Congress on issues affecting Medicare, has noted that hospices and nursing facilities may be involved in inappropriate enrollment and compensation. MedPAC has also highlighted instances in which hospices aggressively marketed services to nursing facility residents. Accordingly, the OIG has indicated that it will focus its review on hospices that have a high percentage (i.e., at least 2/3) of their beneficiaries in nursing facilities.
 - b. General Inpatient Care. The OIG will review the use of hospice general inpatient care in 2011 and assess the appropriateness of hospices' general inpatient care claims.
 - c. Compliance with Reimbursement Requirements. The OIG will attempt to determine whether Medicaid payments by states for hospice services complied with federal reimbursement requirements.

VI. SURVEY AND ENFORCEMENT PROVISIONS FOR HOME HEALTH

A. Background of Change in Law.

1. On August 2, 1991, CMS (at the time known as Health Care Financing Administration) published the “Survey Requirements and Alternative Sanctions for Home Health Agencies” proposed rule in an effort to establish survey and enforcement requirements, as well as alternative sanctions, for HHAs.
2. While CMS proposed to finalize the proposed rule numerous times since its 1991 publication, sweeping changes in the law, together with the demands of additional improvement efforts, impeded the promulgation of a final rule.
3. In response to the August 2008 OIG report, entitled “*Deficiency History and Recertification of Medicare Home Health Agencies*,” CMS noted that the August 2, 1991 proposed rule would require substantial revisions and republication prior to implementation. As a result, on November 8, 2012, CMS issued a final rule, entitled “Medicare Program; Home Health Prospective System Rate Update for Calendar Year 2012; Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies” (77 Fed. Reg. 67068 (November 8, 2012)), which, among other things, creates new survey standards, provides an informal dispute resolution process, and imposes alternative sanctions for condition-level deficiencies (the “Final Rule”).

B. Summary of Survey Requirements in Final Rule.

1. The Final Rule establishes requirements for standard, partial extended, and extended surveys, all of which shall be unannounced.
 - a. Standard Surveys.
 - (1) Standard surveys shall be conducted no later than 36 months after the date of the previous standard survey.
 - (2) Standard surveys shall review a case-mix stratified sample of individuals to whom the HHA furnishes surveys.
 - (3) The surveyor shall visit homes of sampled patients (with the patients’ consent) and conduct a survey of the quality of services being provided.
 - b. Partial Extended Surveys.
 - (1) Partial extended surveys shall be conducted to determine if deficiencies and/or deficient practices exist that were not fully examined during the standard survey.

- (2) Partial extended surveys shall be conducted when (i) standard-level deficiencies are found during a standard survey and the surveyor determines that a more comprehensive review of the conditions of participation examined under the standard survey would result in condition-level deficiencies; or (ii) it is necessary to determine if standard or condition-level deficiencies are present in the conditions of participation not examined in the standard survey.

c. Extended Surveys.

- (1) Extended surveys can be conducted at any time, but will be conducted no later than 14 days after the completion of a standard survey that found that the HHA furnished substandard care (which is defined as noncompliance with one or more conditions of participation at the condition-level).
 - (2) Extended surveys will review and identify the HHA's policies, procedures, and practices that produced the substandard care, as well as any associated activities that might have contributed to the deficient practice.
2. The Final Rule also gives CMS the authority to conduct surveys as often as necessary to assure delivery of quality home health services by determining whether HHAs are in compliance with conditions of participation or to confirm that HHAs have corrected previous deficiencies.
 3. These provisions shall become effective as of July 1, 2013.

C. Summary of Informal Dispute Resolution Provisions in Final Rule.

1. The Final Rule establishes an informal dispute resolution ("IDR") process to address disputes related to condition-level survey findings following an HHA's receipt of the official statement of deficiencies.
2. The IDR process will provide HHAs an informal opportunity (prior to a formal hearing) to resolve disputes in the survey findings for those HHAs that are seeking recertification for continued participation in Medicare and for those HHAs that are currently under monitoring by the state survey agency (either through a compliant or validation survey).
3. The HHA's request for IDR must be submitted, in writing, should include the specific deficiencies that are disputed, and should be submitted within the same 10 calendar day period that the HHA has for submitting an applicable plan of correction.
4. If any findings are revised or removed based on IDR, the official statement of deficiencies will be revised accordingly and any enforcement actions imposed solely as a result of those revised or removed deficiencies will be adjusted accordingly.
5. These provisions shall become effective as of July 1, 2014.

D. Summary of Sanctions in Final Rule.

1. Under the Final Rule, CMS may choose to apply one or more alternative sanctions (meaning alternative to the termination of the provider agreement) based upon an HHA's noncompliance with one or more conditions of participation found through surveys. The available alternative sanctions include civil money penalties, suspension of payment for new patient admissions, appointment of temporary management, imposition of a directed plan of correction, and directed in-service training.
2. When an alternative sanction is applied, the sanction applies to a parent HHA as well as to its respective branch offices.
3. An HHA will be given written notification of CMS' intent to impose an alternative sanction and must submit a plan of correction upon the imposition of an alternative sanction. An HHA may appeal a determination of noncompliance leading to the imposition of an alternative sanction.
4. The choice of alternative sanctions or termination will reflect the impact on patient care and the seriousness of an HHA's patterns of noncompliance. CMS will consider the following factors in making that determination:
 - a. whether the deficiencies pose "immediate jeopardy" to patient health and safety;
 - b. the nature, incidence, degree, manner, and duration of the deficiencies or noncompliance;
 - c. the presence of repeat deficiencies, the HHA's compliance history in general and specifically with reference to the cited deficiencies;
 - d. whether deficiencies are directly related to a failure to provide quality patient care;
 - e. whether the HHA is part of a larger organization with documented performance problems; and
 - f. whether the deficiencies indicate a system wide failure of providing quality care.
5. The sanction provisions shall become effective as of July 1, 2013, while the provisions related to civil monetary penalties and suspension of payment for new patient admissions shall become effective as of July 1, 2014.

VI. LICENSURE AND CERTIFICATION CONSIDERATIONS

A. Licensure Issues.

1. Many, but not all, states license HHAs and hospice programs – (a) check state requirements; and (b) contact applicable state agency (or agencies) to obtain all applicable licensure application forms and materials.
2. If applicable, identify the mechanism for buyer to obtain new license or assume seller's license.
3. If the buyer will not have a license before closing, and will temporarily operate under seller's license (if permitted by state law), include appropriate indemnification provisions in transactions agreements.
4. The buyer and the buyer's lender need to understand the licensing process so they can be assured the buyer will have all licenses needed as of closing date.
5. Some state agencies are willing to issue a comfort letter which states that the buyer has applied for a license and the agency believes a license will be issued promptly upon closing. Other agencies will simply provide a verbal confirmation that the application appears to be in order, and that a new license will be issued "in the ordinary course of business" without specifying a drop dead date.

B. Certification Issues.

1. Medicaid Enrollment. Medicaid certification of HHAs and hospice programs, as well as the nature and extent of any Medicaid benefits available to Medicaid enrollees, varies from state to state – (a) check state requirements; and (b) contact the applicable state agency to obtain all applicable licensure application forms and materials.
2. Medicare Enrollment. HHAs and hospice programs meeting all applicable enrollment requirements and federal standards, or "conditions of participation," may become a certified under the Medicare program.
 - a. Federal Application. CMS Form 855A is the federal Medicare enrollment application for Part A providers, which is filed with the applicable Contractor.

- (1) The form can be downloaded and filled in, as follows:

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf>

- (2) The applicant for enrollment must obtain a National Provider Identifier (aka "NPI") prior to submission of Form 855A. The NPI is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System. An NPI can be obtained online, as follows:

<https://NPPES.cms.hhs.gov>

- (3) In the case of a change of ownership, both the buyer and the seller are required to file a version of Form 855A with the applicable Contractor.
 - (4) A buyer should try to file Form 855A as soon as possible to reduce delays in the buyer's ability to bill for Medicare services after the closing.
 - (5) Changing Contractors can further complicate and delay the process.
- b. State Application Materials. Contact the applicable state agency to obtain all applicable forms and materials required by the state in connection with Medicare enrollment.
3. Assumption of Provider Agreements.
- a. In a change of ownership should the buyer accept the seller's Medicare provider agreement or not?
- (1) 42 C.F.R. § 489.18(c) states:

“When there is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.”
 - (2) However, the current version of Form 855A specifically asks whether the new provider is accepting assignment of the prior provider's provider agreement – no such question was in the prior forms.
 - (3) Although there are compelling reasons not to accept assignment of a provider agreement, most buyers do so anyway.
 - (4) Benefits to the buyer of accepting assignment of the Seller's provider agreement:
 - (i) streamlined Medicare enrollment application process (*see discussion in section II(D)(2) above*); and
 - (ii) potential ability to obtain Medicare receivables sooner (*see discussion in section VI(B)(4) below*).

- (5) Detriment to the buyer of accepting assignment of the seller's provider agreement:
 - (i) risk of assumption of seller's Medicare liabilities for repayments, civil monetary penalties, and potentially other liabilities (see, for example, *United States v. Vernon Home Health Care, Inc.*, 21 F.3d 693 (5th Cir. 1994) (an overpayment to the prior owner of an HHA could be offset by CMS against Medicare payments to the buyer of the same HHA); and *Deerbrook Pavilion, LLC v. Shalala*, 235 F.3d 1100 (8th Cir. 2000) (civil monetary penalties imposed against prior operator of skilled nursing facility can be asserted against new operator of skilled nursing facility)).
- (6) Benefit to the buyer of **not** accepting the seller's provider agreement:
 - (i) avoiding the liabilities mentioned above.
- (7) Detriments to the buyer of **not** accepting the seller's provider agreement:
 - (i) buyer treated like any other new Medicare provider and go through the initial enrollment process (*see discussion in section II(D)(2) above*); and
 - (ii) cannot bill Medicare for services rendered until the date of certification –
 - (a) the buyer may not be able to afford such a cash flow hit; and
 - (b) even if the buyer is willing, the buyer's lender may not be.

4. Cash Management and Changes of Ownership.

- a. If, in a change of ownership, a buyer elects and is able to assume the Medicare provider number of the seller, once the buyer's Medicare change of ownership application is filed, processed, and approved, it will generally be able to bill Medicare retroactively to the date of the change of ownership (i.e., the closing date of the transaction). In that case, the Medicare receivables will be deposited into the account designated by the buyer in CMS Form 588, Electronic Funds Transfer (EFT) Authorization Agreement. However, until such time, all Medicare payments will continue to be deposited into the bank account currently on file with Medicare for the seller.

- b. Unless the buyer and seller are able to negotiate an arrangement whereby the buyer will be able to bill Medicare using the seller's name, provider number, and tax ID, and collect all post-closing Medicare receivables deposited into the seller's bank account, until the buyer's Medicare change of ownership application is filed, processed, and approved, then the buyer will need to wait potentially several months until after closing before it can bill Medicare and collect Medicare receivables. This gap in payment could result in significant interim cash flow issues for a buyer relying on Medicare receivables to cover operating and other costs. Therefore, given that Medicare is the primary payor and source of revenue for many HHAs and hospice programs, it is vital that a buyer plans for, and addresses, this important issue during negotiations with the seller.
 - c. While CMS has generally permitted the practice of billing through the seller's name, provider number, and tax ID while the buyer's Medicare change of operator application is under review, CMS has cautioned that claims should continue to be submitted by an agent of the seller during this period under the theory that the provider number, tax ID, etc. used to submit claims, and the password to the electronic claims system, belong to the seller and not the buyer. Furthermore, some states do not allow this to occur relative to Medicaid provider numbers and require that the seller terminate their provider number and the buyer reapply for a provider number, which requires impeccable timing relative to a smooth transition for patients under care and coordination of the sale.
 - d. As a result, the parties in some asset transactions utilize a "sale/leaseback," or similar, arrangement in attempt to address this issue. Specifically, for a term beginning upon the closing of the buyer's purchase of the assets of the seller constituting the business, and ending on date that the buyer's Medicare change of ownership application is filed, processed, and approved:
 - (1) the buyer leases back to the seller, and the seller leases from the buyer, the assets purchased by the buyer from the seller, such that the seller technically remains the provider of services;
 - (2) the buyer manages, administers, and operates the business on the seller's behalf, which would include the ability to bill Medicare on the seller's behalf, as an authorized agent of the seller, for services rendered during such sale/leaseback term; and
 - (3) the Medicare receivables paid in connection with post-closing services rendered, after being deposited into the seller's operating account on file with CMS, would be swept into an account designated by the buyer, as compensation for the management, administration, and operation of the business by the buyer.
5. Changes in HHA Operation. It is vital for a buyer to determine in the course of its due diligence investigation whether it intends to make any changes to the operation of the HHA post-closing. If it does intend to make operational changes, the buyer

needs to evaluate whether such changes would jeopardize the ability of the HHA to continue participation in Medicare.

- a. For example, in a 2011 Department of Health and Human Services Departmental Appeals Board (“DAB”) decision (*Caretenders Visiting Services of Columbus, LLC v. Centers for Medicare and Medicaid Services*, Decision No. CR2311 (January 19, 2011), DAB upheld the termination by CMS of a recently-acquired HHA from Medicare due to the buyer’s decision to undertake the following actions, post-closing: (a) temporarily ceasing to operate the HHA, including firing the original staff and discharging patients; and (b) resuming operations of the HHA several months later under the original provider agreement, while serving different patients with a different staff in different geographic locations.
- b. DAB opined that, in light of such actions, the HHA was no longer “primarily engaged” in providing service and, as a result, no longer met the statutory definition of an HHA. Furthermore, even though the HHA did resume services later that year, according to the termination decision, “CMS could not have allowed this entirely new operation to participate in the program without undergoing the certification process” because “the staff were all different; the patients were different, the practice location was different; [and] the service area was different.”
- c. Accordingly, DAB concluded that the existing Medicare number and provider agreement could not be assigned to the buyer, thereby underscoring the importance of thorough pre-acquisition strategic planning.
- e. See Exhibit 3 for a copy of the *Caretenders Visiting Services of Columbus* decision.

LIST OF EXHIBITS:

1. Comparison of sales price to annual revenue for the period of January 2006 – August 2011 (home health agencies).
2. Due diligence task list.
3. *Caretenders Visiting Services of Columbus, LLC v. Centers for Medicare and Medicaid Services*, Decision No. CR2311 (January 19, 2011).