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2011 Home Health Prospective Payment System Final Rule: CMS Clarifies Change of Ownership Provisions and Implements New Legislative Requirements

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On November 17, 2010, the Centers for Medicare and Medicaid Services ("**CMS**") published the 2011 Home Health Prospective Payment System ("**2011 HH PPS**") final rule.[1] A number of significant issues are addressed in this rule and are effective January 1, 2011. Specifically, the 2011 HH PPS final rule addresses: (1) the rules regarding a change in ownership within 36 months after the effective date of a home health agency's ("**HHA**'s") initial enrollment or within 36 months following the HHA's most recent change in majority ownership; (2) new legislative requirements regarding face-to-face encounters with providers related to home health and hospice care; (3) a 3.79 percent reduction to rates for calendar year ("**CY**") 2011; and (4) the national standardized 60-day episode rates, the national per-visit rates, the non-routine medical supply ("**NRS**") conversion factors, and the low utilization payment amount add-on payments. This Client Alert will provide an overview of these changes.

HHA Change of Ownership Provisions ("36-Month Rule")

The 36-Month Rule first appeared as part of the 2010 Home Health Perspective Payment System ("**2010 HH PPS**") final rule, stating that:

> If an owner of a home health agency 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. The prospective provider/owner of the HHA must instead: (i) Enroll in the Medicare program as a new HHA under the provisions of §

[1] 75 Fed. Reg. 70,372 (Nov. 17, 2010).

424.510, and (ii) Obtain a State survey or an accreditation from an approved accreditation organization.[2]

On July 23, 2010, CMS issued proposed regulations ("**Proposed 2011 Rule**") clarifying the 36-Month Rule and allowing for public comment on the proposed changes. As reflected in the comments submitted to the Proposed 2011 Rule – which included EpsteinBeckerGreen's submission entitled "Comments Concerning Transfer of Provider Agreement Within 36 Months of Initial Enrollment or Other Change In Ownership"– stakeholders expressed concern that the 36-Month Rule was overly broad, prevented a number of legitimate business transactions, deprived HHAs of access to capital, and would not resolve the primary issues that CMS was attempting to address. Although the 2011 HH PPS final rule retains many of the main elements of the 36-Month Rule as articulated in the Proposed 2011 Rule, in response to the concerns expressed by commenters, CMS offered further clarification of the rule's applicability and expanded its exceptions.

Background

Under traditional change of ownership ("**CHOW**") rules, providers and suppliers could not transfer their Medicare billing privileges to any individual or entity, except pursuant to the Medicare program's CHOW procedures.[3] Notably, the traditional definition of a CHOW in the corporate context specifically excepted stock transfers or mergers of another corporation into a provider corporation.[4]

However, with the implementation of the 36-Month Rule in January 1, 2010, transactions involving HHAs were to begin to be treated differently than transactions involving other providers and suppliers. CMS justified this differential treatment of HHAs on the basis of the need to: (1) eliminate owners establishing HHAs and obtaining Medicare billing privileges for the specific purpose of selling the enrolled HHA to a third party that is able to circumvent the initial enrollment survey requirement (referred to by CMS as "flipping" or establishing an HHA "certificate mill"); and (2) ensure provider compliance with the Conditions of Participation under 42 C.F.R. Part 484 ("**COPs**"), particularly, in light of the program integrity issues prevalent in the HHA community.[5]

Initial Clarifications of the 36-Month Rule

Prior to the 36-Month Rule's initial effective date, CMS issued Transmittal CR 6750, which expanded the application of the 36-Month Rule to a broad array of transactions.[6]

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[2] 74 Fed. Reg. 58,078, 58,134 (Nov. 10, 2009), *amending* 42 C.F.R. §424.550(b)(1).

[3] *See* 42 C.F.R. § 424.550(b). *See also* 42 C.F.R. § 489.18.

[4] *See* 42 C.F.R.§ 489.18(a)(3).

[5] *See* 75 Fed. Reg. 70,372, 70,419-420 (Nov. 17, 2010), *quoting* 74 Fed. Reg. 40,948, 40,971 (Nov. 10, 2009).

[6] *See* Change Request 6750, *available at* http://www.cms.gov/Transmittals/2009Trans/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=descending&itemID=CMS1231771&intNumPerPage=10.

Following widespread industry concerns over this expansion of the 36-Month Rule, CMS rescinded the Transmittal in May 2010, and instructed stakeholders to apply the 36-Month Rule only to those transactions that would constitute a CHOW under the traditional definition.[7] Furthermore, in regards to stock transfer transactions that would close on or before December 31, 2010, informal guidance from CMS indicated that only 100 percent transfers would be subject to the 36-Month Rule.

On July 23, 2010, CMS issued its Proposed 2011 Rule, which included several significant changes to the 36-Month Rule. First, the Proposed 2011 Rule provided that the 36-Month Rule would apply only to changes in ***majority*** ownership, defined as . . .

> when an individual or organization acquires more than [a] 50 percent interest in an HHA during the 36 [months] following the initial enrollment into the Medicare program or a change of ownership (including asset sale, stock transfer, merger or consolidation). This 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.[8]

Second, as noted in this definition, the Proposed 2011 Rule would make the 36-Month Rule applicable to changes in ownership occurring not only during the 36 months following an HHAs initial enrollment in Medicare, but also within 36 months following a change of ownership.

The Proposed 2011 Rule also provided the following exceptions to the 36-Month Rule:

- A publicly traded company is acquiring another HHA and both entities have submitted cost reports to Medicare for the previous 5 years.

- An HHA's 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 5 years.

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[7] In an email dated May 4, 2010, to certain home health industry representatives, CMS stated as follows:

> Good evening everyone – As a follow up to the discussions we have had with you and your respective organizations about the implications of the home health 36 month rule change of ownership provisions, we wanted to notify you of some changes CMS will be making based on those discussions. Specifically, CMS is in the process of: (1) immediately rescinding CR 6750, and (2) instructing the Medicare contractors to apply the provisions of 42 C.F.R. 424.550(b)(1) only to those ownership changes that fall under the definition of "change of ownership" identified in 42 CFR §489.18. We are also considering future rulemaking regarding the provisions set forth in 42 CFR 424.550(b)(1). Thank you all for your input on this issue and please let Jim Bossenmeyer or I know if you have any questions.

[8] 75 Fed. Reg. 43,236, 43,282 (July 23, 2010).

- The owners of an existing HHA decide to change the existing business structure (for example, a partnership to a limited liability corporation or a sole proprietorship to a subchapter S corporation), the individual owners remain the same, and there is no change in majority ownership.

- The death of an owner who owns 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).[9]

2011 Final Rule

Reemphasizing its concerns over flipping and the need to certify HHA compliance with applicable COPs, CMS largely adopted the 36-Month Rule as proposed.[10] However, the most significant change made by CMS in the 2011 HH PPS final rule was to accept the recommendation made by some commenters – including EpsteinBeckerGreen – to clarify that the 36-Month Rule applies only to changes in ***direct*** ownership.[11] In other words, CMS has taken the position that the 36-Month Rule applies only in situations in which there is a change of majority ownership of the HHA itself and not a parent of the HHA. The 2011 HH PPS final rule also confirmed that the 36-Month Rule applies to changes in ownership occurring within 36 months following a HHA's most recent change of ownership.

As mentioned above, the comments to the Proposed 2011 Rule reflected a concern among a variety of stakeholders that the 36-Month Rule would unnecessarily restrict legitimate business transactions. In response to such commentary, CMS expanded its exceptions to the 36-Month Rule.[12] One of the most significant changes to the exceptions was that the "publicly traded exception" was revised to include any HHA, whether public or private. CMS was swayed by comments highlighting that the publicly traded exception would give an unfair advantage to publicly traded companies, and that there is no evidence to suggest that a transaction by a privately held HHA is any less legitimate than one involving a publicly held company.[13] CMS also agreed with commenters that a two-year period for cost report submissions was sufficient.[14] With respect to the exception for an HHA parent company undergoing internal restructuring,

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[9] *Id.*

[10] *See* 75 Fed. Reg. 70,372, 70,426-427 (Nov. 17, 2010).

[11] *See id.* at 70,424, 70,426. Although CMS does not define "indirect ownership" in the 2011 HH PPS final rule, the Medicare Program Integrity Regulations provide a definition of "indirect ownership" as "any ownership interest in an entity that has an ownership interest in the disclosing entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity." 42 C.F.R. § 420.201.

[12] *See* 75 Fed. Reg. 70,372, 70,426-427 (Nov. 17, 2010).

[13] *See id.* at 70,424-425.

[14] *See id.* at 70,426.

CMS eliminated the five-year period for cost report submissions. CMS also removed language from the exception for situations in which the HHA itself is changing business structure. Lastly, CMS concurred with commenters and revised the death of an owner exception to apply regardless of the ownership percentage held by the deceased owner.[15]

EpsteinBeckerGreen and other commenters recommended that CMS establish an exception to permit a qualifying bank or other legitimate lending institution to foreclose on a defaulted loan and to permit the lender to, in turn, sell the HHA to an accredited buyer. This exception was suggested out of concern that failure to do so will curtail the ability of HHAs to secure financing, since banks will be reluctant to loan money to HHAs if, should the HHA collapse financially, the bank would be unable to foreclose on the business. Although the exceptions articulated in the 2011 HH PPS final rule may not go as far as many had hoped, CMS did state that it would "be compelled to follow a court order approving the sale of an HHA."[16]

The exceptions to the 36-Month Rule adopted in the final 2011 HH PPS rule are as follows:

- 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.

- 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 their 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.

- An individual owner of an HHA dies.[17]

The 2011 HH PPS final rule adopts important clarifications to the 36-Month Rule that limit its scope to changes in direct, majority ownership. These changes, combined with CMS' expanded exceptions should relieve some of the chilling effect on bona fide transactions that many in the home health industry have reported. The 2011 HH PPS final rule does allow for future HHA transactions to be structured in such a way as to comply with the 36-Month Rule without having to undergo the Medicare re-enrollment process. Nonetheless, the 2011 HH PPS final rule did not do as much as the home health industry had hoped to alleviate its concerns. In the end, as CMS repeated

[15] *See id.* at 70,425.

[16] *Id.*

[17] *See id.* at 70,465.

throughout the 2011 HH PPS final rule, CMS felt compelled to balance industry concerns against the need to discourage flipping and to ensure new owners comply with the home health COPs.

Face-to-Face Encounters

Background
As a condition of Medicare payment to HHAs for home health care services, Section 6407 of the Patient Protection and Affordable Care Act ("**PPACA**") mandates that, prior to certifying a patient's eligibility for the home health benefit, the physician must document that the physician or a permitted non-physician practitioner ("**NPP**") has had a face-to-face encounter with the patient. PPACA allows the Secretary of Health and Human Services to determine a reasonable timeframe for the encounter to occur.

In the Proposed 2011 Rule, CMS stated that it would require the encounter to occur within the 30 days preceding the start of home health care if the reason for the encounter is related to the primary reason the patient requires home care.[18] If no such encounter occurred prior to the start of home health care, CMS proposed that the encounter would need to occur within two weeks after the start of care. CMS added that the physician must document on the initial certification for eligibility for the Medicare home health benefit how the clinical findings of the encounter support the eligibility requirements that a patient be homebound and need intermittent skilled nursing or therapy. CMS also proposed that a NPP performing the face-to-face encounter with a patient cannot be employed by the HHA providing care, consistent with current policy that precludes a physician who certifies a patient's home health eligibility from having a financial relationship with the HHA.

Final Rule
In response to concerns that the increased burden of requiring a face-to-face visit with a physician could lead to delays or decreased access to care, CMS revised the timeframes described in the Proposed 2011 Rule to allow the encounter to occur up to 90 days prior to the start of home health care, if the reason for the encounter is related to the reason the patient comes to need home health care. If no such encounter has occurred, CMS will allow the encounter to occur up to 30 days after the start of care.[19]

CMS also stated that, if a patient's clinical condition changes significantly between the time of the encounter and the start of home health care such that the physician's or NPP's ability to accurately assess eligibility and care plan would be at risk, a more current encounter would be necessary in order to meet the goals of the statutory requirement. CMS plans to expand on this ambiguous requirement in manual guidance but did not say when the guidance would be forthcoming.[20]

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[18] *See* 75 Fed. Reg. 43,236, 43,266 (July 23, 2010).

[19] *See* 75 Fed. Reg. 70,372, 70,464 (Nov. 17, 2010).

[20] *See id.* at 70,429.

Commenters also expressed concern about potential financial risk to the HHA if the face-to-face encounter does not occur or is not documented properly by the certifying physician. CMS clarified that it is "not holding the HHA responsible for the physician's own medical record documentation associated with the encounter,"[21] and removed from the adopted 2011 HH PPS final rule the requirements concerning the physician's own medical record documentation.[22] CMS also revised the regulation text so that the same financial restrictions apply to NPPs who perform the face-to-face encounter as currently apply to certifying physicians.[23]

Case-Mix for 2011 and 2012

Background
CMS' analysis of Home Health Prospective Payment System claims ("**HH PPS**") from 2000 to 2008 shows total average case-mix grew at a rate of about 1 percent each year from 2000 to 2007, with 4 percent growth in 2008. The total amount of case-mix growth unrelated to real changes in patient severity (nominal case-mix) was 17.45 percent between 2000 and 2008. In each of the years 2008, 2009, and 2010, CMS reduced payment rates by 2.75 percent as recoupment for this nominal case-mix change. According to CMS, a payment-rate reduction of 7.43 percent would be needed to account for the outstanding amount of nominal case-mix change CMS intends to recoup based on the real case-mix change analysis updated through 2008.

In the Proposed 2011 Rule, CMS indicated that it would increase the planned 2.71 percent HH PPS payment-rate reduction in CY 2011 to 3.79 percent, and to make another 3.79 percent reduction in CY 2012.

Final Rule
CMS is moving forward with phasing in case-mix reductions and will be applying a 3.79 percent reduction to the HH PPS rates in CY 2011. In response to comments received on the case-mix model and its measurement of real case-mix, CMS is not finalizing the proposed 3.79 percent reduction to the HH PPS rates for CY 2012 at this time. CMS plans to perform a review of the case-mix and NRS models, and address any reductions to the CY 2012 HH PPS payments in next year's rulemaking.[24]

The 3.79 percent case-mix adjustment applicable to the national standardized 60-day episode rates in the 2011 HH PPS will result in a $700 million cut in Medicare payments to HHAs. Another $490 million in Medicare payments will be cut due to the 2.5 percent

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[21] *See id.* at 70,431.

[22] *See id.* at 70,433, 70,464.

[23] *See id.*

[24] *See id.* at 70,374, 70,389.

reduction in outlier payments required by Section 3131(b) of PPACA. Specifically, Section 3131(b) of PPACA requires the following outlier policy: (1) reduce the estimated total payments by 5 percent; (2) target to pay no more than 2.5 percent of estimated total payments for outliers; and (3) apply a 10 percent agency-level outlier cap.[25]

These payment reductions, totaling $1.190 billion, are offset by payment increases of $230 million. The payment increases reflect a $20 million increase due to the updated wage index and a $210 million increase due to the 1.1 percent home health market basket update. Overall, this results in a reduction in Medicare payments of $960 million in CY 2011. Rural agencies will receive an additional 3 percent rural add-on to their payments, which is intended to help offset the case-mix reductions.

Hypertension Codes

Background
In the Proposed 2011 Rule, CMS stated its concern about the increase in reporting of unspecified hypertension and benign hypertension diagnosis codes.[26] CMS asserts that this is due, in part, to revised classification of blood pressure and new guidelines for hypertension by the National Heart, Lung, and Blood Institute in 2003, as well as coding behavior changes in 2008 when the hypertension codes were included in the HH PPS case-mix system. Therefore, as a nominal coding change rather than a real change in the treatment of more resource intensive patients, CMS stated that these codes should be eliminated from the home health case-mix system to ensure the accuracy of the case-mix model.

In the Proposed 2011 Rule, CMS proposed to delete ICD-9-CM code 401.9, Unspecified Essential Hypertension, and ICD-9-CM code 401.1, Benign Essential Hypertension, from the HH PPS case-mix model's hypertension group.

Final Rule
CMS did not remove the two hypertension diagnosis codes from the HH PPS case-mix system, and is allowing their continued use. CMS plans to analyze patient severity and resource use for hypertension codes 401.1 and 401.9, while controlling for patient characteristic differences, and also to compare the resource usage of patients with these codes to the resource usage of patients with other hypertension diagnosis codes. CMS is deferring removal of the hypertension codes from the case-mix model pending completion of this analysis.[27]

[25] *See id.* at 70,398.

[26] *See* 75 Fed. Reg. 43.236, 43,244 (July 23, 2010).

[27] *See* 75 Fed. Reg. 70,372, 70,388 (Nov. 17, 2010).

Non-Routine Medical Supplies

Background
In the Proposed 2011 Rule, CMS applied the case-mix weight change adjustment to the NRS conversion factor for CY 2011.[28] Payment for NRS is no longer part of the national standardized 60-day episode rate but, rather, is computed by multiplying the relative weight for an episode, assigned to one of six severity levels based on the patient's clinical condition, by the NRS conversion factor that represents the mean estimated NRS costs for each group.[29]

Final Rule
CMS dropped the application of the 3.79 percent cut to the NRS conversion factor.[30] CMS stated that coding practice changes have affected the case-mix assignment for the NRS payment level, which is intended to reflect the patient severity and resource use associated with non-routine medical supplies.[31] However, since the nominal case-mix change measure was designed to apply to the episode case-mix system, the nominal case-mix change measure may not directly apply to the NRS case-mix model.

CMS will conduct an independent review of the case-mix and NRS models. CMS will defer the application of the case-mix reduction to the NRS payment amounts until a review of the nominal case-mix change methodology and its applicability to the NRS model can be performed.[32]

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*This Client Alert was authored by **Emily E. Bajcsi**, **Julia E. Loyd**, and **Lesley R. Yeung**. For additional information about the issues discussed in this Client Alert, please contact one of the authors or the EpsteinBeckerGreen attorney who regularly handles your legal matters.*

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[28] *See* 75 Fed. Reg. 43,236, 43, 260-261 (July 23, 2010).

[29] *See* 75 Fed. Reg. 70,372, 70,414 (Nov. 17, 2010).

[30] *See id.* at 70,389, 70,414.

[31] *See id.* at 70,387.

[32] *See id.* at 70,389.

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