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Healthcare Reform

Final Rule Update: New Enrollment and Payment Suspension Rules Affect All Medicare, Medicaid, and CHIP Providers and Suppliers

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, made significant changes to Medicare, Medicaid, and the Children's Health Insurance Program to reduce fraud, waste, and abuse at the provider enrollment level of program participation. On September 23, 2010, the Centers for Medicare & Medicaid Services issued a proposed rule that implemented the ACA's provisions addressing fraud, waste, and abuse at the enrollment level. The Proposed Rule included new requirements regarding enrollment screening, an enrolling application fee, payment suspension, temporary moratoria on enrollment, compliance programs, and provider and supplier termination. This article summarizes the changes in the final rule with comment period, which was published in the *Federal Register* on February 2, 2011. Continue reading on page 10.

Final Rule Update: CMS Extends Deadlines, Issues Clarifications on Redistribution of Unused Residency Slots Under PPACA

On August 3, 2010, the Centers for Medicare & Medicaid Services published a proposed rule providing proposed guidelines for the redistribution of unused residency slots under Section 5503 of the Patient Protection and Affordable Care Act. On November 24, 2010, CMS published a Final Rule that largely adopted the provisions of the Proposed Rule discussed in our earlier article. However, CMS made several changes in the Final Rule that should be noted. Continue reading on page 17.

Editor's Note:

Continuing our monitoring of healthcare reform implementation, this edition of *The RAP Sheet* again features two articles focusing on some aspect of the implementation of the Patient Protection and Affordable Care Act. Two articles summarize final rules issued to implement pieces of the reform legislation. We expect to include at least one article on healthcare reform in future editions of *The RAP Sheet*.

Initial Enrollments and Changes of Ownership Impacted by Home Health Medicare Enrollment Rule Changes

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In the 2011 Home Health Prospective Payment System Rate Update Rule, the Centers for Medicare & Medicaid Services (CMS) modified home health agency (HHA) Medicare provider enrollment provisions in two important ways. First, it extended the amount of time that a Medicare-certified HHA must meet initial capitalization requirements. Second, it narrowed the scope of business transactions that are subject to the so-called 36-Month Rule, which causes the deactivation of an HHA's Medicare billing entitlements upon the occurrence of certain HHA ownership transfers that occur within three years of the last ownership change.

Overview of the New Rule

HHA Capitalization

Since 1998, HHAs have been required to prove that they have adequate start-up working capital upon initial Medicare enrollment, or when participating in selected change of ownership (CHOW) transactions that result in "a new provider number being issued."[1] The pre-2011 requirement was set forth in an HHA-specific Medicare certification rule that provided that an HHA must prove that it has three months of available working capital at the time of Medicare provider enrollment. Under the new rule, an HHA must satisfy the working capital requirement at the time of enrollment, during the entire initial enrollment process, and for the first three months after enrollment.[2]

CMS' stated rationale for modifying the rule was to address situations in which the HHA has sufficient working capital at the time the HHA submitted its Medicare enrollment application, but did not have these same funds on hand at the time that the Medicare enrollment application was eventually approved some months later.[3] CMS acknowledged the reality that an HHA may have to operate for many months before it has the benefit of a Medicare revenue stream even under the best of circumstances. The purpose of the amendments is to make sure that the HHA can financially survive until its Medicare accounts receivable are being collected and the funds are available to pay the HHA's obligations, such as meeting payroll.

The provider enrollment rules now provide additional tools for Medicare contractors to verify capitalization more than once during the enrollment process, by permitting:

1. The contractor to deny billing privileges to an applicant who does not provide proof that they have the required "initial reserve operating funds" within thirty days of a Medicare or contractor request;[4]
2. The revocation of Medicare billing privileges of any HHA that fails to comply with a CMS or Medicare contractor request to prove that it meets the capitalization requirements at any time during the provider enrollment process and the three months thereafter;[5] and
3. The denial of Medicare billing privileges to an HHA unless the HHA meets the initial working capital requirements.[6]

It is clear in commentary to the new rules that CMS expects (but the rule does not require) Medicare contractors to verify that the working capital funds that were present at the time of submission of the enrollment application are still available to the HHA later on in the enrollment process.

By building in additional enrollment processes, it is likely that the change may extend the amount of time it takes an HHA to successfully enroll in the Medicare program. If the rule, as implemented, causes Medicare contractors processing HHA enrollment applications to verify capitalization more than once, it is likely that enrollment delays will increase an HHA's need for working capital during the HHA's start-up phase because of the longer enrollment period. Before, the HHA could simply include the financial information with its Medicare application, submitted before the HHA commenced operations; now it appears that the HHA should expect the Medicare contractor to request verification again at some later point in the enrollment process and to process this additional information after it is submitted.

The 36-Month Rule

It does appear that the ability to engage in legitimate business transactions got slightly easier for HHAs as a result of changes to the 36-Month Rule. CMS has developed reasonable exceptions to the previous rule, which essentially banned the purchase and sale of Medicare-participating HHAs more frequently than once every three years.

Background—Transactional Structures—Initial Enrollment, CHOW, and Changes of Information[7]

In order to understand and analyze the changes to the 36-Month Rule, it is helpful to understand the way various business transactions are treated for Medicare enrollment purposes, and the different impacts each has on the Medicare provider agreement and the collection of the provider's Medicare accounts receivable.

Initial Enrollment

The "initial enrollment" process is the way new providers get into the Medicare program. In an initial Medicare enrollment, a provider may only submit a Medicare application thirty days prior to the date that the provider is to commence providing services.[8] The Medicare contractor generally takes a minimum of several months (and sometimes many months) to review and approve even a well-packaged application. The provider must then secure a survey by CMS or an accrediting body with deeming authority to complete the enrollment process. Medicare billing privileges commence the date that a successful survey is passed.[9] HHAs that are subject to the 36-Month Rule would be required to use the initial enrollment process.

CHOW

Some sales of Medicare providers constitute Changes of Ownership (CHOWs); others do not. With respect to a corporation, Medicare regulations provide that:

> [t]he merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes a change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.[10]

The importance of whether or not a CHOW has occurred significantly affects the Medicare and Medicaid billing processes for the buyer and seller in the transaction. The operating company's Medicare billing entitlements do not terminate upon the sale of a business that does not constitute a CHOW, such as a sale of all of the outstanding shares of a corporation. Providers that experience a CHOW transaction, however, are able to use the selling provider's Medicare billing entitlements for a period of time after the closing of the business transaction but before the CHOW process has been finally approved by CMS, which occurs sometime after the transaction closes.[11]

Providers experiencing a CHOW that choose not to accept the assignment of the selling provider's Medicare provider agreement will be required to use the "initial enrollment process," which invariably necessitates a gap in the HHA's Medicare billing entitlements and thus an important source of revenue for a period of time until the initial application process has concluded and a survey arranged. For these reasons, business transactions are frequently structured with reference to the Medicare CHOW rules and their impact on the flow of funds into the HHA.

For providers who choose to use the CHOW process, the assignment of the seller's provider agreement to a purchaser occurs on the transfer of the business and the purchaser's billing privileges can commence on that date. Depending on the billing arrangement between seller and buyer, it is possible that there can be only minimal interruptions in the billing privileges of the HHA that experiences a CHOW.[12] There will be no uncompensated Medicare care based on a failure of the HHA to be properly enrolled.

Providers that experience a CHOW but choose not to accept assignment of the seller's provider agreement have all billing entitlements cease on the date that the CHOW occurs.[13] In this situation, an HHA that purchases a business would either discharge Medicare beneficiaries on or before the date of the purchase if this can be done without running afoul of patient abandonment rules or provide uncompensated care to Medicare beneficiaries for an unknown period of time until the date of the Medicare certification survey.

Changes of Information

The "changes of information" process is the required means of reporting changes to a provider's Medicare file that are not CHOWs to CMS.[14] With some exceptions, these changes must be reported within ninety days of the occurrence[15] and simply serve as an update to the Medicare file. As a general rule, they do not routinely impact the flow of Medicare receivables except to the extent that they assist the provider in continuing to meet eligibility for Medicare payment. Transfers of stock in a company (whether 5% of the operating company's stock or 100%) would generally be reported to the Medicare program through this mechanism.

The "Old" 36-Month Rule

The old 36-Month Rule, effective only for 2010, provided that:

> If an owner of a home health agency sells (including asset sales or stock transfers), transfers or relinquishes ownership of the HHA within thirty-six 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.[16]

Under these circumstances, the HHA must engage in an initial Medicare enrollment process, including a new survey.[17] While the heading that preceded the old 36-Month Rule was called "change of ownership," it was clear by its application to stock sales that the 36-Month Rule applied not only to Medicare CHOWs, but also to non-CHOW transactions that previously were subjected to a mere change of information file update that did not affect the HHA's ongoing stream of Medicare receivables.

According to CMS, the 36-Month Rule is in place to prevent the sustenance of HHA "flipping" (e.g., rapidly selling the HHA) or the HHA "certificate mill" process by which organizations, working with brokers, enroll in the Medicare program with the sole purpose of transferring the established Medicare revenue stream and provider agreement to a purchaser after the enrollment occurs.[18] Nonetheless, the effect of the rule on legitimate providers engaging in above-board business transactions cannot be overstated.

The consequence of application of the 36-Month Rule is that the HHA's Medicare billing entitlements are deactivated on the date of the sale transaction and the initial enrollment process is the means by which the HHA can get back into the Medicare program. Medicare applications for initial enrollment cannot be

submitted until thirty days prior to the date that the business will become operational to the new owner. Medicare application processing times can be as few as sixty days after the date that the application is received by the Medicare contractor, but can frequently take many months. The effective date of the provider agreement of an HHA whose Medicare billing entitlements have been deactivated is unpredictable, and is in large part beyond the HHA's control. Instead, this date is within the control of the Medicare contractor reviewing the application and partially dependent upon CMS or accreditation surveyors and the date they are willing to schedule the HHA survey. This process is unpredictable and gives legitimate buyers of an HHA little comfort in the purchase of a business as an ongoing concern. Buyers seeking to sell an HHA within three years of purchase are faced with the unattractive choices of providing Medicare services for some months on an uncompensated basis or arranging for the transfer of patients to providers, if any in the area, and thereby foregoing some of the traditional benefits available in the purchase of a business with an established patient and referral basis. Purchasers dependent upon capital from lenders face particular challenges in using HHAs as sources of collateral given the restrictions on sales and the limitations on lenders needing to foreclose on an outstanding loan.

The old rule initially left open questions such as the threshold for triggering the 36-Month Rule—would a minor sale of stock (e.g., 5%) trigger the application of the rule and thus deactivate a provider's Medicare billing privileges if it occurred within three years of any other similar transfer? CMS ultimately released several interpretations to the old 36-Month Rule that would have applied the severe rule to situations in which a mere 5% stock or asset sale, or a change request reporting a change in partners, regardless of the percentage of ownership.[19] Backlash against implementation was significant, and these interpretations were rescinded by CMS.

The "New" 36-Month Rule

The new rule has injected several reasonable exceptions to the 36-Month Rule to permit legitimate transactions by established Medicare providers to proceed. First, the modified rule narrows the circumstances in which it applies. The new 36-Month Rule introduces the concept of an HHA "change in majority ownership" (CMO) and specifies that the rule applies only in the event of a CMO. A "CMO" occurs when an "individual or organization acquires more than a 50% direct ownership interest in an HHA during the thirty-six months following the HHA's initial enrollment into the Medicare program or the thirty-six months following the HHA's most recent change in majority ownership (including asset sale, stock transfer, merger, and consolidation."[20] A CMO includes cumulative changes that occur within a thirty-six-month period.[21]

While the CMO is broader than the traditional Medicare CHOW, it is narrower than the old 36-Month Rule in that it applies only to significant (50% or more) transactions, and distinguishes between "direct" and "indirect" ownership transfers. This implies that a CMO applies to stock transactions at the level of the Medicare operating company's shareholders, rather than more remote transfers (e.g., owners of shareholders of a Medicare HHA).

There are several exceptions to the new rule. Under the new rule, the following HHAs are exempt from the 36-Month Rule:

- HHAs that have submitted two consecutive years of full-cost reports;
- HHAs whose parent company experiences an internal corporate restructuring, such as a merger or consolidation;
- An HHA operating company that experiences a legal conversion from one entity type to another (such as conversion of an entity from a corporation to a limited liability company, for example) so that the indirect owners of the operating company did not change; or
- When an individual owner of an HHA dies.[22]

With these new exceptions, it appears HHA transactions got a little easier. Given the great consequences of application of the 36-Month Rule, the HHA community is expected to welcome efforts to narrow its scope.

Conclusion

Consistent with CMS' goals in enacting the new enrollment rules, HHAs seeking enrollment in the Medicare program need to be prepared to stay in business for the long haul. Recent changes to Medicare provider enrollment rules will require that HHAs have larger amounts of capital than ever before. HHAs will continue to be impacted in business transactions by the application of the 36-Month Rule except in very narrow circumstances.

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1 42 C.F.R. § 489.28 (as in effect in 2010).
2 *Id.* § 424.510(d)(9).
3 *Id.* § 489.28.
4 *Id.* § 424.510(d)(9).
5 *Id.* § 424.535(a)(11).
6 *Id.* § 489.28(g).
7 This discussion is limited to the process used by Medicare providers for whom a CHOW process is available, such as HHAs, and does not apply to certain Part B providers such as medical groups.
8 CMS Program Integrity Manual Chapter 15 § 15.8.1.
9 42 C.F.R. § 489.13(b).
10 *Id.* § 489.18.
11 CMS Program Integrity Manual Chapter, § 5.5.2.5.
12 *Id.*
13 *See* CMS State Operations manual Chapter 3 § 3210.5.
14 *See* form CMS 855A, page 6 and 855B, page 5.
15 42 C.F.R. § 424.516(e).
16 *See id.* § 424.550(b)(1) effective January 1, 2010.
17 *Id.*
18 75 Fed. Reg. 70419-70420.
19 CMS Program Integrity Manual Transmittal 318, which has been rescinded; *see also* MLN Matters Number MM6750, also rescinded.
20 *See* new 42 C.F.R. § 424.502.
21 *Id.*
22 *Id.* § 424.550(b)(2)(iv) effective January 1, 2009.