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HOME HEALTH AND HOSPICE NEWS

Federal and Texas legal issues affecting home health agencies and hospices, provided as a free service to our clients and friends
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CMS PROHIBITS TRANSFER OF MEDICARE PROVIDER AGREEMENT ON CHOW OF "NEW" HHA: RE-ENROLLMENT REQUIRED

Beginning January 1, 2010, Home Health Agencies (HHA) will be prohibited from transferring their Medicare Provider Agreements and numbers pursuant to a change of ownership (CHOW), when the CHOW occurs **within 36 months** of either the HHA's initial enrollment, or a prior CHOW.

A new regulation adopted by CMS and codified at 42 CFR § 424.550 is aimed at curbing the recent proliferation of start-up HHAs and high turnover rates in HHA ownership, and addressing unusual levels of fraud in certain parts of the country. CMS provided further guidance in an update to the Medicare Program Integrity Manual, Trans. 318, (Dec. 18, 2009).

HHAs whose CHOWs fall within the 36 month window will be required to undergo a new certification or accreditation survey, re-enroll in Medicare and sign a new Provider Agreement. While that process is pending, the HHA will have its billing privileges deactivated.

Mechanically, if the sale occurred on or before 1/1/10 but has not yet been processed by CMS, the FI/MAC will deactivate the HHA's billing privileges. If the sale has not yet occurred, the HHA must voluntarily terminate when the sale occurs (and deactivate its billing privileges), until certification/accreditation is obtained and the FI/MAC "approves" the reactivation. Deactivation does not affect the HHA's participation status but merely suspends claims filing pending approval.

Because of the 2008 CMS workload re-prioritization, state surveys are not an option for most HHAs. They will be required to seek the more costly accreditation, which can often take six months or more.

After obtaining new certification/accreditation, the HHA may apply for reactivation of billing privileges by submitting an 855A. The HHA will be required to sign a new Provider Agreement and EFT authorization. It is unclear whether the HHA will receive a new Provider number or be re-assigned the same number as the prior owner. Once re-activated, billing privileges will date back to the FI/MAC's "approval" date. Notably, the Regional Offices will not be involved and tie-in notices will not be issued.

The rule applies to all CHOWs that are in process as of 1/1/10. CMS's rationale is that it wants HHAs to enroll in Medicare in order to participate in health care delivery, and not to make a quick profit on resale. Further, CMS wants to ensure that new owners are immediately compliant with the HHA Conditions of Participation after a CHOW.

One of the most notable features is the expansion of the definition of a CHOW for certification to include stock transfers of 5 percent or more, where Medicare has historically excluded even 100 percent stock transfers from the definition of a CHOW. Thus, ironically, many HHAs will now undergo CHOWs for *certification* but not for *licensure*.

For transactions in process as of 1/1/10, it is unclear how deactivation will apply to those patients: (1) who are already on service as of the sale date, or (2) for whom a RAP has been submitted or paid but a final claim has not. It is also not clear whether Buyers will be required to demonstrate financial security as if they were *initial* enrollees or entities with new Provider numbers – especially burdensome if the CHOW consists of a mere 5 percent stock transfer.

HHA owners currently in the process of negotiating transactions should carefully review all sale documentation and ancillary agreements to determine whether revisions should (and can) be made. Some may be able to wait out the time until the expiration of 36 months, and thereby avoid the deactivation and re-enrollment process altogether.

While management agreements are an interim option, providers must file an 855A change of information within 90 days, to reflect the new management entity (or individual). The HHA owner/seller will continue to serve as the governing body, and ultimately will be responsible for the legal operation of the HHA, including designating the Administrator, and making all high-level decisions, among other governing body duties .

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