



Missouri Alliance for HOME CARE

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1. MO General Assembly Leaves for Spring Break

As the General Assembly leaves Jefferson City for a week break, most of the decisions about home care programs are still being debated. The perpetually declining budget continues to be the overriding problem and all legislation is being looked at through a lens of no money is available!

In-Home and CDS programs are being hit hard by several new cost cutting initiatives from the administration and GA. First, the one piece of good news is that the proposed cap on the maximum number of hours in-home and CDS clients/consumers could receive a month has been dropped. The governor decided to withdraw his proposal to cap services at 100 hours per month. However, the other cost cutting initiatives are still on the table. The most concerning is the idea of contracting with a private 3rd party vendor to conduct all of the assessments for home and community based services. Other new cost cutting initiatives include mandated telephony systems, reducing the APC rate to PC, and creating review teams who will look at clients/consumers who use more than the normal amount of services. For more detail on these issues go to:

<http://www.homecaremissouri.org/members/documents/FederalIssuesUpdate.pdf>

Or

<http://www.homecaremissouri.org/members/documents/associationsjointpositions.pdf>

Some of the information in these older documents may no longer applicable, however, they will give you a good idea of the issues.

We will be working hard to advocate for home care programs and those who receive the services you provide. You can help by contacting your state senator and state representative while they are back at home to express your concern about these cost cutting initiatives. They need to hear from people in their district. If you are not sure who your state representative and senator are click here: (you will need to know your zip code Plus 4) http://www.senate.mo.gov/llookup/leg_lookup.aspx

2. **NAHC: MedPAC Report to Congress Contains Serious Data Omissions, Skewed Analysis; Fails to Consider Value of Home Health** (excerpts from NAHC Report)

The Medicare Payment Advisory Commission (MedPAC) released its 2010 Report to Congress containing recommendations for Medicare payments to home health agencies and other health care providers as well as its evaluation and analysis of payments for home health services. MedPAC's recommendations were finalized in January, and the report is the annual formal display of the recommendations and the rationale put forth for them.

As it has in prior years, MedPAC recommends significant reductions in the basic payment rate for Medicare home health services through a freeze in 2011 payment rates and a rebasing of those rates. While MedPAC also recommends that Medicare take steps to reform the payment model to protect beneficiary access to care, that step is suggested to occur only after across-the-board rate reductions are in place.

In a closer examination of MedPAC's reasoning for the recommendations set out in the report, "the flaws are magnified and our concerns are greatly heightened," asserted Halamandaris. MedPAC's report contains serious data omissions, analytical prejudices, and no consideration of the value that home care brings to an ever-costlier Medicare program in terms of preventing hospitalizations and re-hospitalizations, nor its value in avoiding more costly institutional care. "The analysis is devoid of any necessary evaluation of the recommendations' consequences on patients' access to quality care. Further, the report does not even note that Congress is presently considering massive Medicare reforms in home health services payment as part of the health care reform deliberations," he explained.

"One of the insights gained in the health care reform debate is that home and community-based care offers the means to address runaway Medicare costs and the growing needs of people afflicted by chronic illness," Halamandaris noted. "Home care is the most sensible solution in chronic care management and post-acute care."

Val Halamandaris, President of NAHC, called attention to a number of flaws in MedPAC's analysis:

1. There is no evaluation of what the payment recommendations would do to access to care. Instead, MedPAC simply portrays the financial status of providers under current reimbursement levels. Even a basic trend analysis is not presented. In reality, the data MedPAC used from Medicare cost reports show that reducing the payment rates in the crude across-the-board fashion MedPAC suggests would result in nearly 70% of all home health agencies getting paid less than the cost of care they provide. MedPAC merely reviews current average margins for all agencies, rather than considering that there is a very wide range today leading to unsustainable rate reductions to the significant number of providers below the average.
2. In contrast to the MedPAC review of other health care sectors, the analysis continues the decades-long flaw of excluding the over 1,600 home health agencies that are part of a hospital. These home health providers are utterly disregarded, despite the fact that many of them are the primary source of home health care in their communities. That exclusion puts those communities in jeopardy while also skewing the calculations of Medicare margins.
3. In its focus on Medicare margins, MedPAC ignores legitimate costs of providing home health services. These costs include certain patient care technologies; the services of nutritionists, dieticians, and respiratory therapists; federal tax payments; and common business costs such as marketing. As a result, MedPAC again vastly overstates home health profit margins. Further, necessary guidance on rate rebasing to consider these costs and other normal business operating costs is absent.
4. No consideration is given to the impact of the rate recommendations on the large professional and paraprofessional workforces providing Medicare home health services. Approximately 80% of home health costs are the wages and employment benefits of the nearly one million nurses, therapists, and home health aides. The U.S. Department of Labor projects that home care in coming years will remain one of the fastest growing areas of employment in the nation -- arbitrary rate reductions will only serve to stifle that growth.
5. The vast majority of home health agencies use Medicare "profits" to cover the unmet costs of Medicaid patients and others. The current overall financial margin for home health agencies is approximately 3%. With the MedPAC recommendations, agencies will need to eliminate services to Medicaid patients or face certain bankruptcy.
6. The future of U.S. health care depends on a stable home care delivery system. The recommended Medicare cuts would destroy any chance at financial stability and eliminate most of these vital care providers. Congress already recognizes that home care is needed to solve the crisis in health care spending. MedPAC continues looking at home health care as if it operated in a silo and ignores the health system-wide ramifications of its recommendations.

7. The evidence clearly demonstrates that growth in Medicare spending and high profit margins is extremely isolated and concentrated in certain providers and geographic locations. The untargeted MedPAC recommendations actually would result in support for providers that engage in questionable practices while penalize those that do not manipulate the system for financial gain.

3. **36-Month Rule': Restrictions on Transfer of Home Health Agency Medicare Provider Numbers Pose Significant**

Challenges. By William T. Cuppett, CPA (Reprinted with permission from NAHC Report)

Very quietly and without much notice by the home health industry, the U.S. Department of Health and Human Services (HHS) modified 42 CFR §424.550 in its final rule dated Nov. 10, 2009, updating the Medicare home health prospective payment system rates. Initially, very few recognized the potential implications of the new rule -- but those involved with mergers/acquisitions in the home health industry immediately recognized the problems relating to implementation of this rule, which has become known as the "36-month rule."

In the regulatory impact analysis provided in the final rule, HHS stated that it believes the number of ownership changes will be less than 2,000 (approximately 15% of all home health providers). HHS also speculated that some entities and individuals may be reluctant to sell or buy a Medicare-enrolled home health agency (HHA) if they know that the HHA will have to undergo an initial Medicare enrollment and survey. Furthermore, HHS stated specifically that the changes "are necessary to ensure that currently enrolled and prospective HHAs are billing for the services provided and are in compliance with the conditions of participation in 42 CFR Part 484, and all other Medicare requirements."

:: The language of the so-called "36-month rule" states:

"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 Medicare 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 §424.510, and

(ii) Obtain a State Survey or an accreditation from an approved accreditation organization."

Effective Jan. 1, 2010 an HHA may not undergo a CHOW (change in ownership) pursuant to 42 CFR §489.18 if the ownership occurs within 36 months after:

- The effective date of the provider's enrollment in Medicare, or
- The effective date of the most recent ownership change for the provider.

On Nov. 10, 2009, I sent a letter to the Centers for Medicare & Medicaid Services (CMS) posing a series of questions related to the rule's implementation and initiated several conversations with Bill Dombi at the National Association for Home Care & Hospice (NAHC). To date, no response has been received from CMS to the letter.

On Dec. 18, 2009, CMS issued Transmittal 318 implementing 42 CFR § 424.540(b). The transmittal goes further to define an "ownership change" as a CHOW; acquisition/merger; consolidation; change request (that would be filed on CMS 855A) reporting a 5% or greater ownership change (e.g., stock transfer or asset sale); or a change request reporting a change in partners, regardless of the percentage of ownership involved. Prior to these changes, stock transfers were not filed as a CHOW on the CMS 855A, but rather as a change in information because the company was deemed the owner, not the respective individuals holding the ownership interest in the company.

This changed definition only adds to the confusion regarding the applicability of the rule and provides little, if any, clarification of the issues at hand. In addition, Transmittal 318 as originally issued applies to all applications (CMS Forms 855A) that are pending on, or received on or after Jan. 1, 2010, regardless of the date of the ownership change. On Feb. 18, 2010, CMS issued a bulletin modifying Transmittal 318 by adding a note that the 36-month rule is applicable only to CMS 855A applications received on or after Jan. 1, 2010 (NAHC Report, 2/25/10).

NAHC has been working to obtain additional clarification from CMS and communicate concerns about the extent of the impact that the rule is having on the industry. Even with these efforts, our experience indicates a general lack of understanding across the home health industry regarding what impact the rule and its implementation will have on the ability to transfer home health agencies to new owners and the inability of home health agencies to modify their ownership and equity interests.

:: The following are recently encountered examples of how the new rule and lack of guidance has affected home health agencies:

Example 1: A home health agency wanted to purchase the interests of a minority shareholder who was not active in the business and subsequently sell a substantial portion of the agency to another entity who would invest substantially in the agency to facilitate additional services and growth. The other owners are to remain active in the agency after the second transaction. Fortunately, the first transaction with the minority shareholder (an owner of more than 5%) was caught in time and abandoned. Had it not been, the second transaction would have triggered the need to secure a new provider number. Regardless, the inability to purchase the interests

from the minority shareholder as planned has significantly affected the nature of the second transaction.

Example 2: An entity with three provider numbers entered into a letter of intent to sell all three providers to an existing home health agency that has been in the business for over 20 years. During the due diligence process, a change in ownership of 5% between existing owners of one of the providers had occurred in 2007 that did not appear to have ever been reported to CMS. Even though the owners had never changed (only a change in the interests held by each of them), the transaction has been placed on hold pending additional research and, hopefully, clarification of the 36-month rule.

Example 3: A home health agency that was Medicare certified over 20 years ago has been transferring ownership interests to children of the owners who are working in the business on a regular basis as part of their estate and financial planning. The interests being transferred exceeded 5% in 2008. This agency must now proceed very cautiously with any additional transfers to avoid having to secure a new Medicare certification in the future.

There is little doubt that the 36-month rule is an effort by CMS to limit the growth of the home health industry in its attempts to serve the growing need and demand for home health services. We believe there are many unintended consequences of the 36-month rule that must be rectified. I raised many of these issues in my Nov. 10, 2009 letter to CMS. At this point, the potential implications of the rule for tax-exempt providers have not been examined closely, and I believe many tax-exempt home health agencies are unfamiliar with the rule and the impact its implementation could have on them in the future.

The 36-month rule, as it is now being implemented, will cost Medicare providers substantial amounts of money and resources in their attempts to meet organizational objectives that would best serve their patient populations. Future transactions may require the incorporation of management agreements or other arrangements facilitating a transfer of control without a transfer of ownership pending completion of the 36-month period from any previous ownership transfer.

Regardless, it is imperative that home health providers, representative organizations, consultants, and legal counsel be keenly cognizant of the 36-month rule, ongoing implementation guidance, and other information released by CMS and, to the best of their ability, provide guidance in any equity transaction to their home health agency clients and those looking to acquire interests in home health agencies. It is equally important that elected representatives be made aware of the (we hope) unintended impact of the 36-month rule.

William T. Cuppett, CPA, is a member and home health/hospice niche leader with Dixon Hughes PLLC.

4. **The CLASS Act – Two Perspectives** (info taken from these organization's web)

The CLASS Act. – According to the Democratic Policy Committee: The CLASS Act will provide a lifetime cash benefit that offers people with disabilities some protection against the costs of paying for long term services and supports, and helps them remain in their homes and communities. Individuals qualify to receive benefits when they need help with certain activities of daily living, have paid premiums for five years, and have worked at least three of those five years. Beneficiaries receive a lifetime cash benefit based on the degree of impairment, which is expected to average roughly \$75 a day or more than \$27,000 per year. Benefits can be used to maintain independence at home or in the community, and should be sufficient to cover typical costs of home care services or adult day care.

The CLASS Act. – According to the Heritage Foundation: The CLASS Act is intended to pay for itself with collected premiums. The premiums would produce positive revenues for the government for the first 10 years, appearing to reduce the federal deficit during this time. However, the CBO points out, while "the program's cash flows would show net receipts for a number of years, [this would be] followed by net outlays in subsequent decades." [14] Thus, the CLASS Act appears self-sufficient for the first 10 years but starts running a deficit soon thereafter.

5. **Electronic Health Record Rule**

As part of the HITECH Act in 2009, CMS administers the Electronic Health Record (EHR) incentive programs under Medicare and Medicaid. CMS prepared a proposed rule on the EHR incentive programs for public comment. This proposed rule includes the definition of meaningful use and other requirements for qualifying for incentive payments. The comment period for this proposed rule closes on March 15, 2010. CMS welcomes your comments which may be submitted through <http://www.regulations.gov>. For additional information on the proposed rule, visit http://www.cms.hhs.gov/Recovery/11_HealthIT.asp on the web. Here you will find fact sheets, presentation materials summarizing the proposed rule, and links to the proposed rule itself.

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Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

6. **Northwest Rural Nurse Residency: Transition-to-Practice - Improving Retention, Clinical Performance, and Job Satisfaction**

June 2010 Enrollment:

Rural nurses are required to have a breadth and depth of knowledge unparalleled in other specialty nursing fields. The immense generalist role of the rural nurse often leads to early burnout and high turnover rates when compared with more urban nurse roles (up to 65% in the first year of practice). Residency or Transition-to-Practice programs have been shown to be an effective means of reducing the turnover of new and transitioning nurses, improving their job satisfaction, and hastening critical thinking skills.

And so, it is with great excitement that Idaho State University (ISU) developed the Northwest Rural Nurse Residency (NWRNR) program. Participants receive all of their training (64-hours of seminars and a 104-hour supervised clinical experience) 'at home' in their own facilities and communities from top-notch rural nurse experts. Using new technologies like web-conferencing and high tech simulation make it possible for the program to be offered at no cost to participants. Program faculty and staff provide a support and information for preceptors, residents and nurse administrators to help ensure a flexible, locally adapted, successful completion of the 12-month program.

The next sessions begins in June 2010. Applications are accepted on a first-come, first-served basis, so apply today! Be one of the first facilities in your area to boast the employment of rural nurse specialists while enjoying the benefits of improved clinical performance and lower nurse turnover. To learn more about the NWRNR please call the ISU Office of Professional Development at (208) 282-2982, email at nurseopd@isu.edu or visit the NWRNR website at <http://www.isu.edu/nursing/opd/nwrnr.shtml>