HONIGMAN

Eastern Michigan Chapter of HFMA
58th Fall Conference
Medicare Payment Principles Related To Transactions

Southfield, Michigan
October 6, 2011

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TOPICS

- Importance Of Planning
- What Is A Change of Ownership Transaction ("CHOW")?
- What Are The CHOW Implications?
  - Assignment Of Provider Agreement/Successor Liability
  - Certification
  - Payment
  - Hospital-Specific Reimbursement

THE IMPORTANCE OF PLANING

- The time to determine if a transaction is CHOW is *before* the transaction closes.
- If the operational folk are not familiar with the CHOW implications, failure to plan can result in adverse, unintended consequences.
  - Finance/Reimbursement = The “Messenger”

HOW DO I IDENTIFY A CHOW?

Does the person/entity with ultimate

Responsibility for or ownership of the provider change?

If yes, the transaction likely is a CHOW.

- **Sale of All/Substantially All Assets**
- **Merger Of Provider With and Into Another Corporation**
- **Consolidation Of Two Providers With and Into a New Corporation**

But **not a CHOW if sale of corporate stock (or sale of corporate membership) or a donation**

WHAT ABOUT OTHER TRANSACTION TYPES?

- Lease

  Usually not a CHOW if no change in entity with operational responsibility

- Management Agreement

  Possible a CHOW if the owner gives up all operational / management responsibility

WHERE CAN I GET GUIDANCE?

Regulation:

- **42 C.F.R.§ 413.89**

CMS Manuals:

- ***Medicare State Operations Manual***
  §§ 3210.1-3210.5
- ***Provider Reimbursement Manual, Part I*:**
  §§ 1500.1-1500.8
- **Discuss With CMS OR MAC**
- **Discuss With Internal or External Legal**

WHY DO I CARE?

- Certification

  *Provider Agreement/Enrollment

  Including Medicaid, BCBSM, MCO
- *Reimbursement

  Substantive Payment
- Licensure/CON

WHAT HAPPENS TO THE PROVIDER AGREEMENT IN A CHOW?

(c) *Assignment of agreement*.—

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*

42 C.F.R.§ 413.89(c)

SUPPOSE THE TRANSACTION IS NOT A CHOW?

If a transaction is not a CHOW, it is still necessary to file the applicable CMS Form 855 for informational purposes

WHAT HAPPENS IF THE PROVIDER AGREEMENT IS ASSIGNED?

- **The Acquiring Entity Steps Into The Shoes Of The Prior Owner**
- **Medicare Rights, Obligations, Sanctions, Penalties All Become The Responsibility Of The New Owner, *e.g*,**
  - **Overpayments**
  - **Receivables, Proceeds of Pending Appeals**

TO ASSIGN OR NOT TO ASSIGN?

Recognize The Tradeoff:

- If accept assignment, assume seller's liabilities (and rights), but become certified and eligible for Medicare payment as of the closing date of the transaction
- If do not assign, avoid seller's liabilities (and rights) but experience delay in certification and eligibility for Medicare payment

WHAT IF THE PARTIES AGREE NOT TO TRANFER LIABILITY?

- Liability Follows The Agreement
  - *E.g., US v Vernon Home Health*, CCH ¶42,424 (Purchaser liable for overpayment.)
- The Seller Can Agree To Indemnify The Purchaser Against Liability
  - *If* the Seller has the financial resources
  - *If* the Seller remains in existence

CAN I AVOID ASSIGNMENT OF THE PROVIDER AGREEMENT?

- To avoid the automatic assignment:
  - Purchaser and Seller must agree that the Seller retains the provider agreement.
- But there's a catch ….
  - There may be a delay in issuance of a new provider agreement, resulting in a gap between the transaction effective date and the effective date of the new agreement.

SO WHAT TO I DO TO AVOID AUTO ASSIGNMENT?

- **Advance Planning!!**
- **See The State Operations Manual, Chapter 3, § 3210.5.**
  - **– In writing, signed by the new owner**
  - **– Forwarded to the CMS Regional Office (RO) at least 45 days prior to the transaction effective date**
- **Enrollment Effect: The old owner voluntarily terminates as of the closing and the new owner enrolls as an initial enrollment**
- **Earliest date of enrollment of new owner: date that the RO determines all Federal requirements are satisfied**
  - **Enroll with the FI (855)**
  - **Undergo Office Civil Rights review/clearance**
  - **Initial survey**
    - **– Impact of Accreditation**

WHAT OTHER PAPERWORK IS INVOLVED?

- **Send a notice of the transaction as early as possible so that discussions can be had with CMS RO, FI and SA regarding the effect of the transaction.**
  - **– As noted, if purchase is not accepting automatic assignment, must give 45 day notice.**
- **Submit "new owner" CMS Form 855 as soon as possible**
  - **– Range: 30-90 days pre-closing (depending on provider/supplier) to 30 days post-closing**
- **Submit "old owner" 855 as soon as possible**
  - **– Should be within 14 days of each other**
- **FI reviews and makes recommendation to Regional Office**
- **RO makes final determination**

WHAT ABOUT ENROLLMENT RULES

- April 2006: CMS issued final enrollment rules-42 C.F.R. § 424.500 et seq.
- Provisions affecting CHOWs:
  - Reporting requirements (424.520(b)): change of information (90 days); "change of ownership or control" (30 days)
    - Query: Is a stock transaction a change of information or control?
    - Failure to comply: deactivation or revocation
  - Prohibits the sale or transfer of billing privileges (424.550)
    - Requires both the current owner and the new owner to submit 855s
    - Failure of current owner to do so can result in penalties post-closing of the CHOW
    - Failure of the new owner to do so can result in deactivation of the Medicare billing numbers
  - Clarification of Effective Date for Reimbursement Purposes (424.510(b))
  - Providers & suppliers that require survey, certification or accreditation - 42 C.F.R. § 489.13
  - Non-surveyed, certified or accredited suppliers--42 C.F.R. § § 424.5 & 424.44)
  - DMEPOS suppliers-42 C.F.R. § 424.57

IS THERE A SPECIAL RULE FOR A HOME HEALTH AGENCY?

- **<u>Regulation: 42 C.F.R. 424.502</u>**
  If there is a change of majority ownership within 36 months of the HHA's Medicare enrollment, the provider agreement and Medicare billing privileges will not be conveyed to the new owner.

- **The new owner must re-enroll as a new HHA, and obtain new survey or accreditation.**

- **See CMS Transmittal 318 (December 18, 2009) instructs contractors to determine upon receipt of a CMS-855A for a HHA whether the transfer date listed on the transfer agreement (as opposed the CMS 855A) occurred within 36 months of either the provider's Medicare enrollment or the effective date of the last change of ownership for that provider.**

COST REPORT: OUTGOING PROVIDER

- **The seller must file a final cost report within 45 days of termination date**
  - **– Note terminating date must be consistent on 855 and cost report**
  - **– Note potential cost impacts:**
    - **Gains/losses on disposals (although BBA eliminated gains/loss on sale)**
    - **Depreciation**
    - **Start-up and organizational costs**
    - **Self Insurance**
    - **Administrative costs post provider termination**

COST REPORT: INCOMING PROVIDER

- Choose fiscal year end
  - May file with no fewer than 1 month, no more than 13 months of data
- Cost report due five months after reporting year end
- Costs to consider:
  - Depreciable assets
  - Start-up and organization costs that were purchased from previous owner and unamortized
- Can generally change prior statistic elections, however must notify FI/MAC prior to effect
- Assignment of FI/MAC

HOW IS CASH FLOW IMPACTED?

- **Medicare will continue to pay the old owner until the RO approves the CHOW (*i.e.*, tie-in notice)**
- **Process may take several weeks or months after the closing date**
- **Usually cannot redirect payments during processing of CHOW**
- **PPS payment are made to the legal owner on the date of discharge.**

  – Parties may reach their own agreement regarding the allocation of payment for transfer/discharges that straddle the transaction date
- **Other payments, such as cost-reimbursed capital payments, direct medical education, certain anesthesia services, organ acquisitions and bad debt are made to the owner of the provider at the time the service is provided.**

ALLOCATION OF PAYMENT

When a hospital's ownership changes, as described in §489.18 of this chapter, the following rules apply: (a) Payment for the operating and capital-related costs of inpatient hospital services for each patient, including outlier payments, as provided in §412.112, and payments for hemophilia clotting factor costs under §412.115(b), are made to the entity that is the legal owner on the date of discharge.

42 CFR §412.125 :

REIMBURSEMENT IMPACT

If Providers Combine:

Hospital-specific payment variables will change

Best Practice:

If as a result of the CHOW two providers are combined, run a pro forma cost report to identify how the hospital-specific payment variables will interact

REIMBURSEMENT: MEDICAL EDUCATION

If a merger, an asset purchase or other transaction where the purchaser assumes the provider agreement:

IME/GME FTE Cap: Merged

GME Per Resident Amount: Weighted Averaged

IME Available Beds: Merged

REIMBURSEMENT: DSH

If a merger, an asset purchase or other transaction where the purchaser assumes the provider agreement:

The DSH adjustment will be impacted by combining the statistics of the two providers, which could be beneficial or adverse.

REIMBURSEMENT: SUBPROVIDERS

If a merger, an asset purchase or other transaction where the purchaser assumes the provider agreement:

Size and status of sub provider

Changes as of first day of cost reporting period (not as of transaction date)

A provider cannot have more than one of each type of subprovider

REIMBURSEMENT: COST TO CHARGE RATIO

- **Cost to Charge Ratio**

  – In a merger situation, will use the surviving entity's CCR

  – CHOWs occurring prior to January 1, 2007 where new owner does not take assignment, use the old owner's CCR

    - **Could request statewide CCR**

  – CHOWs occurring on or after January 1, 2007 where new owner does not take assignment, use the default statewide CCR

REIMBURSEMENT: OTHER HOSPITAL - SPECIFIC VARIABLES

Hospital Within Hospital
Wage Index
"New" Provider Status (Capital/Med Ed)
Sole Community Hospital Status
Rural Referral Center Status
ESRD Rate
    Potential Related Party Implications
Outlier Payment
Bad Debt Collection Policy
Other Hospital-Specific Rates Or Status
Discretionary Elections (E.g., cost finding)

Q & A

Questions?

Comments?

Experience To Share?

About Ken Marcus

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Admitted Michigan Federal Courts, Sixth Circuit Court of Appeals, D.C. District Court, D.C. Court of Appeals, Tenth Circuit Court of Appeals

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