Hospices will have until October 1, 2014 to ensure they conform their coding practices to comply with a “clarification” issued by the Centers for Medicare & Medicaid Services (CMS) in its final fiscal year (FY) 2014 Hospice Wage Index and Payment Rate Update, published in the Federal Register on August 7, 2013. CMS’ policy, as clarified, is that the International Classification of Diseases, Ninth Revision (ICD-9) codes for “adult failure to thrive” and “debility” are not to be used as principal diagnoses on the hospice Medicare claim form when a related definitive diagnosis has been established or confirmed by the provider. Any claims submitted after October 1, 2014 that have debility or adult failure to thrive as the principal diagnosis will be returned to the provider to resubmit with a more-definitive principal diagnosis coding.

CMS first gave notice of this clarification in the Proposed Rule for FY 2014, published in the Federal Register on May 10, 2013. In doing so, CMS asserted that this was not a new proposal. Rather, CMS indicated that this clarification was consistent with ICD-9-CM Coding Guidelines, which provide that “Symptoms, Signs, and Ill-defined Conditions,” including adult failure to thrive and debility, are not to be used as principal diagnoses.

CMS’ motivation for this clarification apparently was the changes in diagnosis patterns over the years. At the beginning of the hospice benefit in 1983, the most commonly reported principal diagnoses for hospice were cancer diagnoses. Over time, non-cancer diagnoses have become more commonly reported. In 2002, adult failure to thrive and debility together accounted for 9% of the top 20 principal diagnoses. Ten years later, these two diagnoses were the first and third most commonly reported diagnoses, accounting for 19% of the top 20. Thus, they captured the attention of CMS and led to the clarification of policy.

CMS’ Justification for Policy Clarification

CMS’ primary justification for this clarification was concern that the use of nonspecific diagnoses of adult failure to thrive and debility, without any other diagnoses, means that Medicare hospice beneficiaries are not being thoroughly assessed in the hospice setting. The use of these diagnoses as principal diagnoses fails to capture the complexity of the hospice beneficiary and the circumstances surrounding their care.

CMS also noted that hospice patients who are primarily or solely managed in the hospice setting, and who do not have any other diagnoses on their hospice claim, are appropriately treated in hospice and do not need to be transferred to another provider for care. The use of these diagnoses as principal diagnoses results in the hospice provider being paid a lower amount of money than if the provider were to use more-definitive diagnoses.

Assessing CMS’ Clarification

CMS’ clarification of the use of adult failure to thrive and debility as principal diagnoses on hospice claim forms is a significant change to hospice coding practices. Hospices will need to reassess their coding practices to ensure compliance with the new CMS policy. In addition, hospices will need to be prepared to resubmit claims that have been returned due to use of these diagnoses as principal diagnoses.

Certification of Compliance

Hospices should also consider the potential impact of the CMS clarification on their certification of compliance with hospice accreditation standards. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires hospice providers to have a comprehensive and accurate coding system for hospice care. The CMS clarification on the use of adult failure to thrive and debility as principal diagnoses may impact hospice providers’ compliance with JCAHO standards.

Conclusion

The CMS clarification on the use of adult failure to thrive and debility as principal diagnoses on hospice claim forms is a significant change to hospice coding practices. Hospices will need to reassess their coding practices to ensure compliance with the new CMS policy. In addition, hospices will need to be prepared to resubmit claims that have been returned due to use of these diagnoses as principal diagnoses. Hospices should also consider the potential impact of the CMS clarification on their certification of compliance with hospice accreditation standards.
assessed and therefore may not be receiving the full range of services the Medicare Hospice benefit envisioned.

More significantly, CMS expressed its concern that use of a nonspecific diagnosis such as adult failure to thrive or debility indicates that the “multiple comorbid conditions” that accompany these diagnoses may not be adequately diagnosed, thereby depriving beneficiaries of an informed understanding of their condition and all of the possible options available to them. CMS said it believes this clarification will encourage hospices to be “more intentional about addressing all of the beneficiary’s identified needs” as the end of life approaches.

CMS acknowledged that, where a patient has multiple coexisting conditions, no one condition, individually, may deem the patient as terminally ill; however, the collective presence of them and the progressive nature of some will contribute to the terminal diagnosis. In such instances, CMS stated that the physician should “select the condition he or she feels is most contributory to the terminal prognosis, based on information in the comprehensive assessment, other relevant clinical information supporting all diagnoses, and his or her best clinical judgment.”

Commenters questioned CMS’ concern with diagnoses, when hospice eligibility is based on the terminal prognosis of a patient and not on diagnosis. CMS confirmed that hospice eligibility is based on a terminal prognosis. However, CMS pointed to the requirements for certifications and recertifications—that clinical information in the medical record must support the medical prognosis, and that the physician include a narrative of the clinical findings supporting the terminal diagnosis. CMS indicated that it is not seeing the level of completeness of diagnosis reporting as is required for the certifications and recertifications. Further, CMS stated that many hospices have been coding “a single terminal diagnosis” when eligibility “should always have been based on the terminal prognosis of the patient, and this prognosis would typically involve more than one diagnosis.”

CMS also discussed what conditions are “related” versus “unrelated” to the terminal illness by quoting the 1983 policy that “hospices are required to provide virtually all the care that is needed by terminally ill patients.” CMS reiterated that “unless there is clear evidence that a condition is unrelated to the terminal prognosis, all services would be considered related. It is also the responsibility of the hospice physician to document why a patient’s medical need(s) would be unrelated to the terminal prognosis.”

Many of the commenters on the Proposed Rule expressed concern that this clarification would limit or prohibit access to hospice care for many Medicare beneficiaries. CMS denied this assertion, noting that certifications for hospice eligibility are based on prognosis, not diagnosis, and are completed no more than 15 days prior to the start of the benefit period. Diagnosis coding on the hospice claim form is not done until after the patient has been informed of his or her choices and accepted into hospice. Similarly, CMS rejected comments saying that this clarification was a change of coverage that should go through the national coverage determination process. CMS denied it was making any changes in coverage or eligibility policies, insisting instead that it was only making a coding clarification “to request more clarity and detail on the hospice claims to reflect a complete picture of the Medicare hospice population and the hospice services rendered.”

CMS supported its decision with an analysis showing that, in 2012, for those beneficiaries with adult failure to thrive or debility reported as the principal hospice diagnosis with no secondary diagnosis, more than 50% of them had seven or more chronic conditions, and 75% of them had four or more chronic conditions. CMS noted that many of these chronic conditions also are terminal conditions or contributory to the terminal prognosis. If multiple conditions are being treated, or if medications have been prescribed to treat or manage them, then CMS said it would be inappropriate to use adult failure to thrive or debility as a principle diagnosis.

As further justification, CMS indicated that it needs more-complete diagnosis information on claims as it moves forward with hospice payment reform. Although the precise terms of hospice payment reform have not yet been proposed, CMS’ more-immediate concern is the trend that some hospice-related drugs used for hospice patients are being charged to Medicare Part D, rather than being covered under the bundled payment of the hospice benefit, causing additional and inappropriate payments to be made. For example, CMS pointed out that nearly 15% of hospice patients in 2010 received analgesic prescriptions through Part D; in total, Medicare hospice beneficiaries receive prescriptions under Part D totaling more than $350 million. This echoes the concerns expressed in the U.S. Department of Health & Human Services, Office of Inspector General Report “Medicare Could be Paying Twice for Prescription Drugs for Beneficiaries in Hospice.”

In response to comments pointing out that many local coverage determinations (LCDs) by home health and hospice Medicare administrative contractors permitted the use of adult failure to thrive or debility as a primary diagnoses, CMS said it would be working with those contractors to ensure all LCDs will reflect these coding clarifications. CMS also noted that LCDs are used to determine eligibility for hospice services, and not to determine the appropriate diagnoses codes on hospice claims.

Although recognizing that this clarification would be a significant change for many hospices, CMS denied that this clarification would require hospices to hire professional coders and create a financial burden. CMS said the clarification was made to assist hospices in complying with long-standing coding policy that these two diagnoses should be reported as principal diagnoses, and pointed the hospices to several coding resources on the CMS website to assist them. CMS noted that the paper UC-04 forms have always had space to list up to 17 additional diagnosis fields, and the electronic claim form has up to 24 additional diagnosis fields.

Delayed Effective Date for Return of Claims to Provider

One positive outcome of the rule making process was CMS’ decision to delay the effective date of this clarification. It was unclear in the Proposed Rule whether this policy clarification would be applied retrospectively to claims already submitted or whether it would have prospective effect. Indeed, some Medicare contractors

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began returning claims to providers prior to the end of the comment period.\textsuperscript{20} In the Final Rule, even though it characterized its statements about failure to thrive and debility as a clarification, CMS acknowledged that this clarification may be a “paradigm shift” for some hospices in the way they have coded claims.\textsuperscript{21} CMS therefore made the clarification effective for claims dated on or after October 1, 2014. As of that date, any claims submitted with adult failure to thrive or debility as the principal diagnosis will be returned to the provider for more-definitive coding of the principal and additional diagnoses.\textsuperscript{22} CMS also expects, however, that hospices will “transition immediately to more thoughtful coding practices in advance of this effective date.”\textsuperscript{23}

### What Hospices Need to Do

- Educate the staff and hospice physicians on this policy clarification:
  - Identify all conditions that contribute to the terminal prognosis.
  - The principal diagnosis should be the diagnosis most contributory to the terminal prognosis, and the one chiefly responsible for the services provided; and
- Make sure edits exist in the billing system to identify any claims where adult failure to thrive or debility are listed as the primary diagnosis. Where these are identified, work with the attending physician to determine if there is a more-specific principal diagnosis contributing to the terminal prognosis.

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**Post-Acute and Long-Term Services**  
**Practice Group Leadership**

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Assessing CMS’ Temporary Moratoria on Enrollment of HHAs and Ambulance Companies in Medicare, Medicaid, and CHIP

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Fraud, waste, and abuse are not distributed equally in the health care industry. With a certain degree of predictability, some provider types and geographic areas have emerged over others on regulators’ radars as particularly susceptible to charges of illegality. This point is well illustrated by the home health industry in South Florida, which has become the focus of intensified antifraud efforts. Statistics from the Centers for Medicare & Medicaid Services (CMS) identify a number of peculiarities that the federal government has interpreted to indicate a “significant risk of fraudulent activity.” According to CMS, Miami-Dade County bears the distinction based on 2012 data of having the highest ratio of home health agencies (HHAs) to Medicare fee-for-service (FFS) beneficiaries and having the highest payments to HHAs among all counties in the United States with at least 200,000 Medicare beneficiaries. CMS has found similar patterns among HHAs in Medicaid in Miami-Dade County, which, compared with other Florida counties based on 2010 data, had a disproportionate supply of HHAs.

Relying on these findings, CMS in July 2013 imposed a drastic regulatory measure: it implemented a six-month moratorium on enrollment of HHAs in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) in two South Florida counties, including Miami-Dade. The notice in which CMS announced the moratorium, however, was limited neither to HHAs nor to South Florida. In the same notice, CMS also imposed a six-month moratorium on enrollment of HHAs in these programs in five counties in the Chicago, IL, region. And in eight counties in the Houston, TX, area, CMS enacted a six-month moratorium on enrollment of ambulance companies.

Notably, these moratoria constitute the first occasion that CMS has invoked its moratorium power since Congress provided the agency with this power in the Affordable Care Act (ACA) of 2010. Under the ACA, the Secretary of the U.S. Department of Health & Human Services (HHS) may impose a temporary moratorium on the enrollment of new providers and suppliers in Medicare, Medicaid, and CHIP “if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse . . . .” Likewise, the ACA gives states the authority to implement enrollment moratoria as well as numerical caps or other limits in Medicaid and CHIP for providers that the HHS Secretary identifies as being at “high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse.”

Now, having finally flexed its regulatory muscle against HHAs and ambulance companies in a select few jurisdictions, CMS (acting on behalf of HHS) has provided a context for understanding a potentially expansive authority. This article discusses the sources of CMS’ and state Medicaid and CHIP agencies’ moratorium power; the moratoria in Florida, Illinois, and Texas; and their implications for future regulatory actions.

The Authority for Medicare, Medicaid, and CHIP Enrollment Moratoria

The ACA provides CMS with a panoply of new tools and resources to crack down on fraud, waste, and abuse in Medicare, Medicaid, and CHIP. Reflecting a push toward preventive enforcement, several of the program integrity measures in the ACA expand CMS’ ability to use the provider and supplier enrollment process as a fraud-fighting mechanism through, among other measures, screening procedures, application fees, and enhanced oversight. Another such measure is enrollment moratoria, barring enrollment altogether. Section 6401 of the ACA allows the HHS Secretary to impose a temporary moratorium on enrollment of new providers and suppliers, including categories of new providers and suppliers, in Medicare, Medicaid, and CHIP “if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse . . . .” To this end, the ACA bars judicial review of a temporary moratorium. Otherwise, the statute does not elaborate on the scope of this power, leaving unanswered how long a “temporary” moratorium might last or how CMS might determine that a moratorium is warranted.

Other provisions of the ACA extend the moratorium authority to the states in administering Medicaid and CHIP. In addition to the authority that it gives to the HHS Secretary, Section 6401 allows a state to implement periods of Medicaid enrollment moratoria, numerical caps, or other limits for providers or suppliers identified by the HHS Secretary as being at “high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse . . . .” The state, however, must ensure that the imposition of any such moratoria, caps, or other limits would not “adversely impact beneficiaries’ access to medical assistance.” Similarly, a state must ordinarily comply with any temporary Medicaid enrollment moratorium that the HHS Secretary imposes under Section 6401, except where the state determines that such moratorium would “adversely impact beneficiaries’ access to medical assistance.”

Another provision of Section 6401 applies these requirements to states in administering CHIP. To fill the gaps in the statutory text, CMS promulgated regulations interpreting the moratorium provisions in the ACA in a 2011 Final Rule that implemented other program integrity provisions in the statute. The regulations are split substantively between a regulation that addresses temporary enrollment moratoria in Medicare and a regulation that addresses temporary enrollment moratoria in Medicaid.
enrollment moratoria in Medicaid.14 Another regulation applies the terms of the Medicaid regulation to CHIP.15

The Medicare regulation builds on the statute by allowing CMS to impose a temporary enrollment moratorium not only on new Medicare providers and suppliers of a particular type, but also on the establishment of new practice locations of a particular provider or supplier type in a specific geographic region.16 To this end, CMS must rely on one of the grounds to act enumerated in the regulation. Chief among them is a finding of a “significant potential for fraud, waste, or abuse with respect to a particular provider or supplier type or particular geographic area or both,”17 CMS would have to base any such finding on its “review of existing data, and without limitation, identification of a trend that appears to be associated with a high risk of fraud, waste, or abuse,” such as a “[h]ighly disproportionate number of providers or suppliers in a category relative to the number of beneficiaries” or a “[r]apid increase in enrollment applications within a category.”18 Alternatively, CMS could impose a moratorium based on the determinations of certain other federal and state agencies, such as federal law enforcement agencies engaged in antifraud initiatives or a state Medicaid agency that has imposed a state-level Medicaid enrollment moratorium.19

In the event that CMS implements a temporary Medicare enrollment moratorium, the moratorium would last for six months initially.20 Subsequently, CMS could extend a moratorium in six-month increments as necessary.21 Once in effect, CMS could lift a moratorium in certain instances, such as where circumstances warranting the moratorium have abated or CMS has implemented “program safeguards to address the program vulnerability,” or where the HHS Secretary determines the moratorium is no longer needed.22 CMS will communicate determinations regarding the imposition, extension, or rescission of a moratorium via notice in the Federal Register.23

With respect to Medicaid and CHIP, the HHS Secretary will consult any affected state Medicaid or CHIP agency about a temporary moratorium on enrollment of providers in those programs prior to imposition of the moratorium.24 If CMS implements a moratorium, the state agency normally would have to comply with the moratorium unless it determines that the moratorium would “adversely affect beneficiaries’ access to medical assistance.”25 In addition to CMS, a state Medicaid or CHIP agency also may impose a temporary enrollment moratorium, numerical caps, or other limits where the state agency has identified a “significant potential for fraud, waste, or abuse . . . .”26 However, prior to implementing the moratorium, caps, or other limits, the state agency must determine that its action would not “adversely impact beneficiaries’ access to medical assistance” and must obtain the HHS Secretary’s concurrence with implementation of the action.27 As with a Medicare enrollment moratorium imposed by CMS, a Medicaid or CHIP enrollment moratorium imposed by a state agency would last for six months initially and then for additional six-month increments as necessary.28

The Temporary Moratoria on Enrollment of HHAs and Ambulance Companies in Medicare, Medicaid, and CHIP

Almost two years after issuing regulations implementing its moratorium power, CMS exercised this power for the first time by notice in the July 31, 2013 Federal Register. The notice announced that effective July 30, 2013 CMS was imposing a six-month moratorium on the enrollment in Medicare, Medicaid, and CHIP of HHAs in Miami-Dade County, FL, and in Cook County, IL, (within which Miami and Chicago are located, respectively) as well as selected surrounding counties—Monroe County in Florida and DuPage, Kane, Lake, McHenry, and Will counties in Illinois.29 The notice also announced that in Harris County, TX (within which Houston is located) and seven surrounding counties—Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and Waller counties—CMS was imposing a six-month moratorium on the enrollment of ambulance suppliers and providers in Medicare, Medicaid, and CHIP.30 Providing insight into CMS’ decision-making process, the notice elaborates on the “qualitative and quantitative factors” that CMS determined were indicative of a high risk of fraud, waste, or abuse and supported the moratoria.31

CMS emphasized that the moratoria were an outgrowth of its long-standing collaborative antifraud efforts with other federal agencies. On this point, CMS noted that the moratoria decisions had been shaped significantly by its experience working with the HHS Office of Inspector General and the U.S. Department of Justice as part of Medicare Fraud Strike Force teams.32 These teams operate in nine cities nationwide and use Medicare claims data and intelligence data to “target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers.”33 CMS underscored that the three target sites for the moratoria—Chicago, Houston, and Miami—are all Strike Force cities, where the federal government has conducted significant criminal prosecutions and administrative investigations with respect to the provider and supplier types subject to the moratoria.34 Through these efforts, CMS and its agency partners have learned that some fraud schemes spread quickly within communities and across geographic areas in response to enforcement activities.35 Accordingly, CMS deemed it necessary to extend the moratoria beyond the target counties to certain bordering counties.36 Based on a somewhat similar rationale, CMS concluded that the moratoria were necessary in Medicaid and CHIP as well as in Medicare because of the “reciprocal risk” that if fraud were pervasive among applicable providers and suppliers in one program, it would be pervasive in all of them.37

To confirm its determination that the temporary enrollment moratoria were warranted, CMS reviewed Medicare and Medicaid enrollment and claims data regarding HHAs and ambulance companies in the applicable target counties in relation to the same data from all counties in the United States with at least 200,000 Medicare beneficiaries.38 With the data from these
comparison counties as a benchmark, CMS analyzed the data from the target counties along certain metrics that it considered “strong indications of potential fraud risk.” These metrics included: (1) the number of providers or suppliers per 10,000 Medicare FFS beneficiaries; (2) the compounded annual growth rate in provider or supplier enrollment; (3) the “churn rate” of providers and suppliers entering and exiting Medicare, as measured by the percent of the provider or supplier community continuously receiving Medicare payments since 2008; and (4) 2012 FFS Medicare payments to providers and suppliers in the target areas based on the average amount spent per beneficiary who used the applicable services.

CMS found that the three areas to which the moratoria apply included the only counties with Strike Force cities that also consistently ranked near the top of the above metrics among counties with at least 200,000 Medicare beneficiaries in 2012. For example, according to 2012 CMS data, Miami-Dade County had the highest ratio of HHAs to Medicare FFS beneficiaries (by 1,960%) and the highest payments to HHAs (by 77%). Similarly, as to ambulance companies, 2012 CMS data revealed that Harrison County had the highest ratio of ambulance suppliers to Medicare FFS beneficiaries (by 1,065%) and the highest number of providers not continuously billing since 2008 (66%). Using Medicaid data from the applicable state for comparison, CMS detected like patterns in Medicaid in all of the target counties.

As further support for the moratoria, CMS claimed that the moratoria would not jeopardize access to care. CMS based this determination on the feedback it received from state agencies, its data on the number of providers and suppliers in the moratoria areas, and recent reports from the Medicare Payment Advisory Commission, an independent agency that advises Congress on beneficiary access and other issues pertaining to Medicare. Nevertheless, CMS indicated that it would continue to monitor for reductions in the number of HHAs and ambulance companies in addition to beneficiary complaints, and would continue to consult state agencies about potential access-to-care issues.

**Assessing the Temporary Moratoria**

CMS’ temporary moratoria on enrollment of HHAs and ambulance companies in Medicare, Medicaid, and CHIP in certain counties in Florida, Illinois, and Texas represent an apparently limited application of an otherwise-broad power. While the full effect of the moratoria remains to be seen, the moratoria provide a context for understanding when, how, and to what extent CMS or its state counterparts may use this power.

The breadth of the moratorium authority lies in its potential to bar entire categories of providers from public payer programs across multiple jurisdictions, regardless of their individual circumstances. While a moratorium could act to stop fraud before it occurs by imposing a barrier to entry on would-be fraudsters, it also could have adverse spillover effects if unconstrained. As evidenced in CMS’ moratoria analysis, reduced access to care is one such potential effect. In essence, a moratorium could impose a quota on certain provider types, even as the applicable beneficiary population may increase. A moratorium also could have a negative impact on the quality and cost of care by shutting out innovative product and service providers. In these respects, a moratorium could actually undermine antifraud efforts by deterring program entry by legitimate providers while insulating already-enrolled fraudsters and incentivizing potential fraudsters to relocate to jurisdictions outside the moratorium range where fraud may not be as prevalent. Citing several of these concerns, commenters in the rule in which CMS finalized the moratorium regulations implored the agency to exercise its authority carefully and sparingly. In the words of one commenter, “a moratorium is a drastic remedy that should be used when CMS can clearly articulate the basis for imposing such an extreme measure.”

The circumstances surrounding CMS’ implementation of the moratoria suggest that CMS is aware of these concerns and will not casually effectuate a moratorium. CMS waited almost two years after releasing the moratorium regulations before imposing the moratoria, even though commenters to the regulations argued that factors were already present at that time to justify moratoria on enrollment of certain providers and suppliers, such as HHAs and hospices. Since issuance of the Final Rule, moreover, several Senators have written multiple letters to CMS noting its inaction and urging it to impose moratoria on specific types of providers and suppliers in particular locations. When CMS finally did impose the moratoria, they were limited in their reach both categorically with respect to the type of provider and supplier and geographically.

Nevertheless, the moratoria give clues to other foreseeable applications of CMS’ moratoria power. Notably, in choosing to implement the moratoria against HHAs and ambulance companies in the specified geographic areas, CMS selected two provider and supplier types that, for purposes of the Medicare application screening scheme that CMS created under the ACA, are considered “moderate” (ambulance service suppliers) and “high” (prospective HHAs) categorical risk. In the Final Rule on the moratorium regulations, CMS gave itself broad leeway to implement moratoria against different provider and supplier types, explaining that “[s]hould there ever be a reason to impose a temporary enrollment moratorium on any category of providers or suppliers, we would need to be able to do so—regardless of the screening level to which they were assigned as part of the provider and supplier screening process . . . .” In addition to the screening level, it is notable that the target sites of the moratoria are all Medicare Fraud Strike Force cities, where CMS and other agencies have concentrated their enforcement activities. Based on the foregoing, one can conceive future moratoria against other providers and suppliers that CMS considers moderate or high risk in other Strike Force cities.

While much of CMS’ rationale for the moratoria hinges on its analysis of Medicare data, the moratoria indicate that CMS will have an important role in the imposition of moratoria on
enrollment in Medicaid and CHIP. CMS’ articulation of the concept of “reciprocal risk” in the moratoria notice suggests that where CMS has determined that an enrollment moratorium in Medicare is appropriate, it will essentially by default determine that the moratorium also is appropriate in Medicaid and CHIP. Although the moratorium regulations allow state Medicaid and CHIP agencies to implement enrollment moratoria on their own, they may do so only with the oversight and concurrence of CMS. Further, the standard by which state Medicaid and CHIP agencies must impose any enrollment moratorium is limited to whether there is a “significant potential for fraud, waste, or abuse . . . .”\(^3\) This appears to mark a departure from state laws that authorize imposition of moratoria for reasons that are not strictly grounded in fraud prevention, as in Florida, whose Medicaid agency may impose a moratorium on pharmacy enrollment “if it is determined that it has a sufficient number of Medicaid-participating providers.”\(^4\)

Ultimately, the measure of the moratoria and any future moratoria may be its impact on the providers and suppliers already enrolled in Medicare, Medicaid, and CHIP, as opposed to those who have not yet enrolled in these programs. As CMS explained in the Final Rule containing the moratorium regulations, imposing moratoria will, among other things, allow [the agency] to review and consider additional programmatic initiatives, including the development of additional regulatory and sub regulatory provisions to ensure that Medicare providers and suppliers are meeting program requirements, beneficiaries receive quality care, and that an adequate number of providers and suppliers exists to furnish services to Medicare beneficiaries.\(^5\)

Providers and suppliers who fall outside the scope of a moratorium because of their pre-moratorium enrollment should recognize that a moratorium will likely spur other enforcement activities and should tailor their operations accordingly.

**Conclusion**

The ACA gives CMS and state agencies broad power to implement temporary enrollment moratoria in Medicare, Medicaid, and CHIP. CMS’ first application of this power against HHAs and ambulance companies in pockets of Florida, Illinois, and Texas was a limited one, suggesting that CMS may take an incremental approach to exercising this power. Until their full impact can be measured, the moratoria imposed by CMS offer a prelude to future moratoria.

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2. Id. at 46343.
3. Id.
10. Id.
14. Id. § 455.470.
15. Id. § 457.990.
16. Id. § 424.570(a)(1)(i).
17. Id. § 424.570(a)(2)(i).
18. Id.
19. Id. § 424.570(a)(2)(ii)-(iv).
20. Id. § 424.570(b).
21. Id.
22. Id. § 424.570(d).
23. Id. § 424.570(a)(1)(ii), (b), (d).
24. Id. § 455.470(a)(1).
25. Id. § 455.470(a)(2)-(3)(i).
26. Id. § 455.470(b)(1).
27. Id. § 455.470(b)(2)-(3).
28. Id. § 455.470(c)(1)-(2).
30. Id. at 46340-46341.
31. Id. at 46340.
32. Id. at 46341.
33. Id.
34. Id.
35. Id.
36. Id.
37. Id. at 46340.
38. Id. at 46341.
39. Id.
40. Id.
41. Id. at 46343.
42. Id. at 46345.
43. Id. at 46343-46345.
44. Id. at 46341-46342.
45. Id.
46. Id. at 46342.
48. Id. at 5921, 5927.
52. 42 C.F.R. § 455.470(b)(1).
Employee compensation certainly affects an employer's bottom line, and unnecessary overtime can put quite a dent in it. Understandably, employers strive to classify as many of their employees as exempt as the law allows to avoid what can sometimes be crippling overtime costs when calculated across the workforce. Determining whether employees are properly classified as exempt can be dicey, however, as the analysis is often incredibly fact specific. Additionally, long-term care (LTC) employers frequently grapple with the proper classification for employees who perform nursing duties, who may or may not qualify for the learned-professional exemption. This analysis may be further complicated in the LTC industry by alternative payment models such as pay-per-visit.

Because of the limited protections afforded exempt employees under the Fair Labor Standards Act (FLSA), employers may be tempted to identify as many employees as possible as exempt. However, exempt employees are the exception, not the rule. And, misclassification may subject employers to U.S. Department of Labor (DOL) audits or private lawsuits on an individual or class-wide basis seeking back wages, liquidated damages, penalties, interest, and/or attorneys' fees. Because the employer bears the burden of proving the exemption is properly applied, defending misclassification claims may be difficult and costly. This article provides LTC employers with general guidelines for analyzing the learned-professional exemption under the FLSA.

How Do I Know if an Employee is a Learned Professional under the FLSA?

The learned-professional exemption under the FLSA is often misunderstood and, thus, misapplied by employers who incorrectly presume that all employees with a professional license (e.g., registered nurses (RNs) or licensed practical nurses (LPNs)) will qualify as exempt. On the contrary, to qualify for this exemption, an employee must meet the learned-professional duties test. The advanced knowledge must be in a field of science or learning, such as law, medicine, nursing, accounting, actuarial computation, engineering, education, and various types of physical, chemical, and biological sciences; and the advanced knowledge must be customarily acquired by a prolonged course of specialized intellectual instruction.

For employers in the LTC industry, RNs generally are exempt; provided, however, that the RNs are: (1) paid on a “salary or fee basis” of at least $455 a week; (2) registered by the appropriate state examining board; and (3) actually perform the general job duties of an RN (i.e., an employee working in housekeeping who happens to be an RN would not be exempt under the learned-professional exemption). On the flip side, LPNs or other similar health care employees generally are not exempt, regardless of work experience and training, because possession of a specialized advanced academic degree is not a standard prerequisite for entry into such occupations.

Employers must keep in mind, however, that whether an exemption applies to a particular position depends entirely on the specific duties being performed and the education required for such performance. It is therefore risky for employers to generalize whether their specific employees meet this test based merely on their job titles or how other similar positions are treated in the industry. Employers should consider consulting with an attorney if there are any questions about whether a particular employee meets the learned-professional duties test.

How Must I Pay Learned Professionals to Maintain the Exemption?

Even if an employee otherwise meets the learned-professional duties test, the employee still must be paid on a “salary or fee basis” to be exempt from the FLSA overtime and other requirements. The current minimum salary required under the FLSA is $455 per week.

An employee is paid on a “salary basis” if he or she regularly receives a set, predetermined amount of compensation that is not subject to reduction because of variations in the quality or the quantity of work performed by the employee. In other words, the employee must receive his or her full salary, regardless of the quality of the employee’s work or the number of days or hours the employee worked.

Of course, there are some exceptions. Generally, an employer can reduce an exempt employee’s salary for an entire workweek in which the employee performed no work without risk of jeopardizing the employee’s exempt status. However, there is a caveat here as well. If the employee is ready, willing, and able to work, deductions may not be made for “downtime” when work is not available due to the employer's operating or business conditions, if the employer has closed the business due to inclement weather, or other such circumstances. There are other possible exceptions where, for example, an employee is absent from work for one or more full days for personal reasons other than sickness or

How Much Can I Deduct from a Learned Professional’s Salary?

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disability; the deduction for one or more full days of absence due to sickness or disability is made in accordance with a bona fide plan or practice of providing compensation for salary lost due to illness; the employee takes unpaid leave under the Family and Medical Leave Act; and for partial weeks during the employee's initial or final week of employment. In sum, employers need to be wary of how their exempt employees are being paid so as not to destroy the exemption through improper salary payments or deductions.

**What if I Pay Employees on a Pay-per-Visit Basis?**

The LTC industry is unique in that some LTC employers, particularly those in the home health sector, have adopted a pay-per-visit model of compensation for home health aides or similar employees. Under this model, employees generally are paid a fixed amount (or a fee) for each visit, which may or may not vary by the type of visit. Employers also may sometimes use different methods to compensate for non-visit-related activities such as training, mandatory meetings, and the completion of administrative paperwork related to the visits. Although the FLSA does permit learned professionals to be paid on either a salary or a fee basis, LTC employers should not presume that any alternative “fee basis” model will suffice.

First, the fee basis must still meet the minimum amount of salary required for an exemption. To test whether the fee meets the requirements, take the fee(s) paid divided by the time worked in a given workweek on the job. The amount per hour must be equivalent to $455 per week, should the employee have worked 40 hours on the task(s) during that workweek. For example, if an employer paid a home health aide $25 each for ten visits that took her an average of two hours (or 20 hours total) to complete, this fee would likely meet the minimum-salary requirement for the learned-professional exemption, because earnings at this rate would generally yield the home health aide $500 if 40 hours were worked. By the same token, had the home health aide taken an average of five hours for each of the visits (or 50 hours total) and was only paid $250 for the ten visits, this likely would not meet the minimum-salary requirement of $455 per week. But meeting the minimum amount of salary required, alone, is not sufficient.

Second, the “fee basis” must be payment of an agreed sum for a single job, regardless of the time required for its completion. Generally, the fee must be paid for the kind of job that is unique, rather than for a series of jobs repeated an indefinite number of times and for which payment on an identical basis is made over and over again. The issue of whether particular tasks qualify as “unique” is, like the duties test, fact specific. For example, in *Fazekas v. The Cleveland Clinic Foundation Health Care Ventures, Inc.*, the Sixth Circuit looked at whether RNs performing home health visits were engaged in “unique” activities. The RNs evaluated each patient's medical condition during the initial visit, devised a treatment plan, made revisions as necessary, and took care of as many as five distinct conditions for each patient. The court found that, on these specific facts, the tasks performed by the RNs were unique, but warned that a slight change in duties could reverse the analysis. Employers therefore must be careful not to presume that all employees providing home health services on a fee basis are engaged in “unique” tasks.

Third, and perhaps most importantly, the fee basis generally must not include any payments based on or derived from the number of hours or days worked, rather than the accomplishment of a given single task. For example, where an employee receives a set dollar amount for each medical task performed, but is paid hourly for filling out patient charts or attending meetings, this hybrid pay structure is unlikely to pass muster under the FLSA. In *Elwell v. University Hospitals Home Care Services*, a home health care nurse brought a claim against her former employer for overtime under the FLSA, alleging that she was improperly classified as an exempt learned-professional employee. The Sixth Circuit agreed with the employee, finding that, although she may have met the duties test to qualify as a learned professional, she was not paid on a “salary or fee basis” as required by the FLSA.

Elwell's primary duty was visiting residents in their homes to administer home health care. She was paid according to a fee schedule that varied by the type of visit. She also was paid an hourly rate for intravenous infusion visits that lasted longer than two hours. Finally, the employer required Elwell to perform on-call services (at a rate of $3 an hour) and to attend regular staff meetings and in-service training (at a rate of $17.65 an hour).

In finding that Elwell was not paid on a fee basis, the Sixth Circuit relied on a DOL regulation requiring that fee payments be made for a completed task “regardless of the time required for its completion,” stating that the “language suggests that a compensation plan will not be considered a fee basis arrangement if it contains any component that ties compensation to the number of hours worked.” The Sixth Circuit then held that, because Elwell was paid at least in part on an hourly basis for some duties (such as the infusion visits longer than two hours, on-call duty, in-service training, and required staff meetings), the hybrid plan did not qualify as a fee-basis arrangement and Elwell was not, therefore, exempt from the FLSA's overtime requirements.

The Sixth Circuit also looked at the argument made by the district court below that even the per-visit rates were based on hourly rates because back-up documentation showed that the rates were arrived at by taking the hourly rate of $17.65, multiplying by 39 hours of work, and then dividing the gross hourly wage by 25, the average productivity number per week. The district court therefore concluded that the “flat per visit fee was really a proxy for hourly compensation.” The Sixth Circuit indicated that, although it was “inclined to agree that a plaintiff could maintain an FLSA claim upon evidence that the employer's use of a fee based compensation plan was nothing more than a proxy for an hourly wage,” it considered this a jury question.
The Sixth Circuit cases of Fazekus and Elwell serve as reminders that courts may be inclined to closely scrutinize compensation schemes to determine if any portion of them is derived from or determined by the time spent by the employee (even if the payment is not directly made by the hour).

Conclusion
In determining whether an LTC employee meets the learned-professional exemption, employers must closely analyze not only the tasks the employee performs, but also how the employee is paid for those tasks. And because the FLSA exemptions are applied on a case-by-case basis, employers should be wary of relying on another employer’s or the industry’s practice when making classification decisions. Should you have questions about whether certain employees are exempt, it is best to consult with your attorney prior to classifying the employee. It is almost always less expensive to ensure proper classification at the get-go than to defend a DOL audit or individual lawsuit.

2 This article does not address any state laws. Many states have their own tests for exemptions, which may be different from the tests under the FLSA. Where differences exist between federal and state laws, employers must follow the law that is most favorable to the worker. Further, an employer’s policies, an employment contract, and/or a collective bargaining agreement (CBA) may provide FLSA-exempt employees certain rights above and beyond those set forth in the FLSA. Employers should therefore conduct the exemption analysis under both federal and applicable state laws and also look to any policies, contracts, or CBAs when conducting their analysis.
4 29 C.F.R. § 541.301(c)(2); see also U.S. Department of Labor, Wage and Hour Division, Fact Sheet #17N: Nurses and the Part 541 Exemptions Under the Fair Labor Standards Act (FLSA), July 2008. The fact sheet is available at www.dol.gov/whd/regs/compliance/fairpay/fs17n_nurses.pdf.
5 Id.
6 29 C.F.R. § 541.300(a)(1).
7 State law may differ from the FLSA in this regard. Employers generally must pay employees whichever minimum salary is higher.
8 29 C.F.R. § 541.602(a).
9 Id.
10 Id.
11 Id. § 541.602(b).
12 Id. § 541.605(a).
13 204 F.3d 673 (6th Cir. 2000).
14 Id. at 678.
15 See Elwell v. Univ. Hosps. Home Care Servs., 276 F.3d 832, 897 (6th Cir. 2002).
16 Elwell, 276 F.3d at 901 (citing 29 C.F.R. § 541.313(b), which is now 29 C.F.R. § 541.605).
17 Id. at 839.
New Federal Regulatory and Enforcement Provisions Become Effective for HHAs

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On November 12, 2012, the Centers for Medicare & Medicaid Services (CMS) published its Final Rule titled “Medicare Program; Home Health Prospective System Rate Update for Calendar Year 2013; Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies.” In addition to announcing home health payment changes for calendar year 2013, the Final Rule implemented several regulatory changes involving the survey and enforcement process for home health agencies (HHAs). These changes were originally enacted in the Omnibus Budget Reconciliation Act of 1987 but were never implemented through regulation until now.

Although the new rule does not expand the conditions of participation (CoPs) for HHAs, it does create new survey standards and provide for an informal dispute resolution (IDR) process for certain deficiencies. In addition, the new rule provides new sanctions for condition-level deficiencies, including civil money penalties (CMPs) and suspension of payments. The effective date for the new CMP and suspension-of-payment provisions and the IDR process will not be until July 1, 2014. The effective date for all other survey and enforcement provisions was July 1, 2013. The rule also includes revisions to the conditions for Medicare payment for HHAs, which will provide some relief for HHAs that were finding it difficult to comply with the Face-to-Face Encounter Rule. The effective date for the revised Face-to-Face Encounter Rule was January 1, 2013.

Survey and Certification Requirements for HHAs

The new Subpart I under 42 C.F.R. Section 488 sets forth new survey and certification requirements for HHAs, which became effective on July 1, 2013. Prior to the enactment of these regulations, state survey agencies would survey HHAs to determine whether the agency met the CoPs. Alternatively, the HHA could elect to undergo an accreditation process through The Joint Commission (formerly known as the Joint Commission on the Accreditation of Healthcare Organizations), the Community Health Accreditation Program (CHAP), or the Accreditation Commission for Health Care (ACHC). An HHA that was accredited by one of these organizations was “deemed” to meet the CoPs and did not have to undergo a certification survey by the survey agency. However, under the new rule, the survey agency is now required to conduct standard surveys.

Standard Surveys

HHAs will now be required to undergo a standard survey conducted by the survey agency at least every 36 months. Standard surveys or abbreviated surveys also are required within two months of a survey agency’s receipt of a significant number of complaints reported against an HHA, and if otherwise directed by CMS, such as in the investigation of a complaint. The survey agency also may conduct a standard or abbreviated standard survey within two months of a change in ownership, administration, or management of an HHA.

In a standard survey, the survey agency reviews only a select number of standards or CoPs to determine the quality of care provided by the agency. To the extent practicable, the standard survey must include at least the following:

- Review of a case-mix stratified sample of individuals to whom the HHA provides services;
- Home visits of sample patients by CMS, but only with consent of the patient, their legal guardian, or legal representative;
- Review of indicators that include outcomes of quality of care and services furnished by the agency as indicated by medical, nursing, and rehabilitative care; and
- Review of compliance with a select number of regulations most related to high-quality care.

As is the case for LTC providers, the regulation specifically states that the failure of a survey agency to follow the procedures for standard surveys will not invalidate otherwise-legitimate determinations that deficiencies exist. In other words, providers will be required to comply with all CoPs, but the survey agencies are not necessarily required to comply with the regulations that govern the survey process.
Partial Extended Surveys

The survey agency will conduct a partial extended survey for CoPs not fully examined during the standard survey if there is an indication that a more-comprehensive review would determine if a deficient practice exists. In the commentary, CMS indicated that a partial extended survey also would be performed where a complaint survey or abbreviated survey identifies issues beyond the initial scope of the survey.

Extended Surveys

An extended survey involves the review of additional CoPs that were not examined during a standard survey. An extended survey must be conducted within 14 days after the completion of the standard survey that found the HHA out of compliance with a CoP. Although an extended survey may be conducted at any time, it must be conducted if the survey agency identifies substandard quality of care during a survey. Substandard quality of care occurs when the survey agency determines that there is noncompliance with one or more CoPs and that the deficiency resulted in or could result in actual harm to HHA patients. Therefore, harm does not need to occur to a patient for a finding of substandard quality of care.

Alternative Sanctions for Findings of Noncompliance

Prior to the enactment of Subpart J of 42 C.F.R. Section 488, the only sanction for noncompliance was termination of the provider agreement. The new regulations now provide for alternative sanctions that may be imposed based on the HHA's noncompliance with one or more CoPs. In addition to termination, CMS will now be able to impose a CMP, suspension of payment for all new admissions, temporary management of the HHA, a directed plan of correction, or directed in-service training. Regardless of which sanction is imposed, a noncompliant HHA must still submit a plan of correction that must be approved by CMS.

If a CMP is imposed on the HHA, the fine could potentially exceed the payment received for an entire episode of care because the minimum daily fine for a condition-level deficiency is $500 per day. “Lower range” penalties are to be imposed for repeat deficiencies and/or condition-level deficiencies that do not constitute an immediate jeopardy and that are related predominantly to structure or process-oriented conditions (such as OASIS submission requirements) rather than patient care. The fine range for “lower range” penalties is $500 to $4,000 per day. “Middle range” penalties are to be issued for repeat deficiencies and/or condition-level noncompliance that do not constitute an immediate jeopardy. The fine range for a “middle range” penalty is $1,500–$8,500 per day. If a condition-level deficiency is cited at an immediate-jeopardy level, the penalty range for the noncompliance will be in the “upper range,” which is $8,500 to $10,000 per day, until compliance is determined on a revisit survey. Per-instance penalties ranging from $1,000 to $10,000 also may be imposed if the noncompliance involves one or more singular events that are corrected during the onsite survey.

Immediate Jeopardy

The regulations now identify specific actions that must be taken when CMS determines that a deficiency poses “immediate jeopardy” to one or more HHA patients. “Immediate jeopardy” is defined as “a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment or death to a patient(s).” If an immediate-jeopardy situation is cited, CMS either may immediately terminate the HHA's provider agreement, or terminate the agreement after the HHA has failed to remove the immediate jeopardy within 23 days of the completion of the survey that identified the immediate jeopardy. In addition to termination, CMS also may impose one or more of the alternative sanctions identified above, but it must give an HHA notice at least two calendar days prior to the effective date for all sanctions other than the imposition of CMPs.

Informal Dispute Resolution

The new regulation provides for an IDR process, which allows the HHA to dispute condition-level survey findings. The HHA will be notified in writing at the time the statement of deficiencies is issued of the opportunity to submit an IDR. The request for an IDR must be submitted in writing within the same ten calendar-day timeframe that the plan of correction is due and must identify the specific deficiencies that are disputed. The regulation includes no timeframe by which a state agency or CMS must review and rule on the IDR, but the rule does state that the failure by CMS or a state agency to timely complete the IDR process does not
postpone or delay the effective date of any enforcement action. Accordingly, the HHA must still submit a plan of correction for those deficiencies for which it submits an IDR.

If the survey findings are revised as a result of the IDR, the statement of deficiencies will be revised accordingly and any enforcement actions imposed solely as a result of the deficiencies modified will be adjusted accordingly. The rule does not identify who is to review the IDR, but under the commentary, CMS stated that the process is an “informal dispute resolution” and not an “independent dispute resolution.” Therefore, the IDR review process will be conducted internally by the state agency (or CMS). The survey agency will be responsible for setting up its own IDR process.

Changes to the Payment Provisions

Changes to the Home Health Face-to-Face Encounter Rule

The Home Health Face-to-Face Encounter Rule has caused compliance concerns for HHAs. As a result, CMS made two changes to this rule that allow for some additional flexibility with meeting this requirement.

The first involves a change in how the certifying physician may obtain verification of a face-to-face encounter. As a condition of payment, prior to certifying a patient’s eligibility for the home health benefit, the certifying physician was required to document that the physician himself/herself or an allowed non-physician practitioner (i.e., physician assistant, nurse practitioner, nurse midwife, etc.) had a face-to-face encounter with the individual to verify homebound status and the need for skilled services. Alternatively, the physician who cared for the individual in the acute care or post-acute care facility could perform the face-to-face encounter and inform the certifying physician (usually the physician in the community), who would then document the face-to-face encounter as part of the certification of eligibility. Compliance with this requirement often resulted in a delay in services because the rule required the HHA to obtain documentation of the face-to-face encounter directly from the physician who treated the patient in the acute-care setting or to coordinate communication between the acute-care physician and the certifying physician so that the certifying physician could document the encounter and certify the need for services.
To help alleviate this burden, the rule has been revised so that the non-physician practitioners working in collaboration with acute and post-acute care physicians will now be permitted to perform the face-to-face encounter and communicate findings to the certifying physician in the community, which should help facilitate getting the information to the certifying physician. The face-to-face encounter information may be provided via the discharge summary, emails, or other exchanges of information or communication.

In implementing this change, CMS reiterated that it is still the responsibility of the certifying physician to document: (1) the date of the face-to-face encounter; (2) that the condition for which the patient was treated in the face-to-face encounter is related to the primary reason the patient requires home health services; and (3) that the clinical findings of the encounter support that the patient is homebound and in need of skilled care or therapy services.

The second change has to do with how the face-to-face encounter must be “titled.” The rule originally required that the face-to-face documentation be “clearly titled, dated and signed by the certifying physician.” In the commentary to the regulation, however, CMS indicated that it only intended that the face-to-face documentation be “clearly titled or clearly identified as such, and that it did not intend for any particular person to title the document. To address this issue, the regulation includes a text change that removes prescriptions that the certifying physician must “date and title” the face-to-face documentation. As a result, if the discharge summary from the hospital is used as documentation of the face-to-face encounter, the certifying physician’s support staff may now date and title or identify the discharge summary as the face-to-face documentation, as long as the summary is signed by the certifying physician and included with the certification as an addendum.

Changes to Therapy Reassessment Requirements

CMS also made two changes in response to practical concerns raised by HHAs regarding the timing of therapy reassessments. Previously, when a qualified therapist missed a reassessment visit, coverage would resume beginning with the first visit after the visit in which the late reassessment was performed. Under the Final Rule, coverage now resumes beginning with the visit in which the late reassessment is performed. Additionally, where multiple therapy disciplines are involved, as long as the remaining therapy disciplines complete timely reassessments, therapy coverage will only be lost for the discipline that fails to meet the reassessment requirement.

CMS also made a small but significant change regarding the timing of required therapy reassessments when multiple disciplines of therapy are involved. Qualified therapists must now complete their reassessment visits during the eleventh, twelfth, or thirteenth visit for the required thirteenth-visit reassessment, and during the seventeenth, eighteenth, or nineteenth visit for the required nineteenth-visit reassessment. CMS provided one exception to this rule change: where the frequency of a discipline does not make it feasible for the reassessment to occur during the timeframe provided by the rule without providing an extra unnecessary visit or delaying a visit, then all qualified therapists must provide all the therapy and functionally reassess the patient during the visit scheduled closest to the fourteenth, but not later than the thirteenth visit for the thirteenth-visit reassessment, and during the visit closest to the twentieth, but not later than the nineteenth visit for the nineteenth-visit reassessment.

Conclusion

The increased regulatory oversight for HHAs is due, in part, to the expectation that more elderly individuals will be receiving home and community-based services (HCBS) waivers in the HHA setting as opposed to a nursing facility. In an effort to control health care costs, the federal government has been implementing regulatory changes that are designed to reduce the number of days an individual receives inpatient services of any kind. Patients are expected to leave the hospital sooner and receive ongoing nursing care in a skilled nursing setting or via home care. Patients who receive skilled nursing services at a long term care facility are expected to be discharged sooner and receive ongoing home care services in their home in the community or in an assisted living setting, resulting in more and more individuals being pushed toward HCBS. With larger numbers of sicker patients being served in their own homes, it appears that the government has decided to increase its oversight and enforcement of the care they will receive from HHAs.

The increased oversight of HHAs may very well result in a reduction in the number of HHAs across the country, as poor or marginal-quality providers may be forced out of business by the increased enforcement scheme. In addition, the high cost of CMPs related to an instance of noncompliance could far exceed the cost of a billing episode, which could drive small providers to sell or consolidate with larger providers more capable of absorbing such costs.

2 42 C.F.R. § 488.715.
3 Id. § 488.720.
4 Id. § 488.810.
5 Id. § 488.845(b).
6 Id. § 488.830.
7 Id. § 488.815.
8 Id. § 488.805.
9 Id. § 488.825.
10 Id. § 488.825(a)(3).
11 Id. § 488.745.
12 Id. § 424.22; see also Q & A response #9, available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Home-Health-Questions-Answers.pdf.
13 42 C.F.R. § 424.22.
14 Id. § 409.44.
15 Id.
The Centers for Medicare & Medicaid Services (CMS) recently issued final regulations that aim to improve communication between hospice providers and long term care facilities. In some respects, the finalized regulations do just that, by requiring greater delineation of responsibilities and formality in this relationship. In other respects, these regulations may muddle the roles of these two providers. What is certain, though, is that the final regulations must be carefully compared to the regulations that have, until now, governed hospices. The differences that emerge are not drastic but are important and can easily be missed.

Attorneys whose practice concerns hospice services will recall that 42 C.F.R. § 418.112 (2008 Rule) sets forth contract and program requirements for hospice providers that provide hospice services in a skilled nursing facility, nursing facility, or intermediate care facility for individuals with intellectual disabilities (herein, LTC Facilities or LTC). By way of overview, the 2008 Rule covers many aspects of the relationship between hospice providers and LTC Facilities. Generally speaking, the 2008 Rule requires: (1) that hospice providers and LTC Facilities have a written agreement in place that addresses the manner of communication, delineation of responsibilities, notification regarding changes in condition, and transfers of residents; (2) that a hospice plan of care be in place that involves LTC input; and (3) that the hospice provider and LTC Facility coordinate care. Of course, the hospice provider “must assume responsibility for professional management of the resident's hospice services provided.”

The 2008 Rule, which primarily focuses on hospice providers, is still in effect. Yet now, under the August 26, 2013 rule (2013 Rule), CMS applies similar requirements to LTC Facilities and focuses on the LTC Facility's responsibilities and communication. Most significantly, perhaps, the LTC Facility now has an oversight responsibility that it did not have before. The LTC Facility must “ensure that the hospice services meet professional standards.
and principles that apply to individuals providing services in the facility, and to the timeliness of the services. The 2008 Rule, by contrast, did not impose directly on an LTC any such oversight responsibility. Concerning “timeliness of services,” CMS indicates that this “means that the LTC facility will be required to ensure that the Medicare-certified hospice will provide services to the resident in a way that meets their needs in a timely manner.” (CMS gives the examples of the LTC Facility “increasing the resident’s pain medication to ensure an optimal comfort level.”)

This change does more than simply mirror the 2008 Rule, which asked that hospice providers ensure services were provided in accordance with the “hospice plan of care.” Now, the LTC Facility arguably must assume additional responsibility. Some have concern that this provision, and others like it, injects confusion as to which provider is ultimately responsible for hospice services provided to patients. Yet, the government has confirmed that “the LTC Facility is responsible for assuring that services and care provided meet the assessed needs of each resident,” and the LTC Facility should be monitoring the delivery of services to assure that professional standards and principles are met.

Another significant change concerns notification of alleged violations. Under the 2008 Rule, the hospice provider needs to report to the LTC Facility within 24 hours of becoming aware of any “alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the [LTC] administrator within 24 hours of the hospice becoming aware of the alleged violation.” By contrast, the 2013 Rule requires that the LTC Facility report those alleged violations “immediately” to the hospice administrator (as well as misappropriation of patient property by hospice personnel). Like the previous rule change, this provision shifts additional responsibility toward the LTC Facility.

Further, the 2013 Rule imposes new requirements on the qualifications of the LTC Facility’s personnel who interact with the hospice provider. Under the 2008 Rule, the hospice provider must designate a member of its interdisciplinary team (IDT) to provide overall coordination of care, including communications between the hospice IDT and the LTC medical director and communications between the LTC Facility and the hospice medical director. Under the 2013 Rule, the LTC Facility must also ensure quality communication. To ensure this communication, the LTC’s IDT member “must have a clinical background, function within their state’s scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.” The government points out that this person need not be a registered nurse. Somewhat surprisingly, the government states, “we are not requiring the person assessing the resident to be on the LTC Facility staff.”

In addition to these substantive changes, the 2013 Rule expands the provisions that must be found in a written agreement between a hospice provider and LTC Facility. First, regarding communication, the 2008 Rule only requires that the contract set forth “[t]he manner in which the [LTC] and the hospice are to communicate with each other and document such communications.” By contrast, the 2013 Rule requires that the agreement set forth “a communication process, including how the communication will be documented.” This provision requires more than mere documentation; it requires a process.

Second, under the 2013 Rule, the agreement imposes new notification requirements upon the LTC Facility. Under the 2008 Rule, the agreement must require the LTC to notify the hospice provider of: (1) changes in condition; (2) changes requiring a change to the hospice plan of care; (3) death; or (4) a need to transfer a patient for continuous or inpatient care necessary “related to the terminal illness and related conditions.” Now, the agreement must require that the LTC Facility notify the hospice provider of “a need to transfer the resident from the facility for any condition.” This more-comprehensive notification requirement is probably positive, and was in fact added by CMS in response to comments.

Ultimately, it is unknown whether these changes will clarify or complicate communication between hospice providers and LTC Facilities. Many providers are already questioning whether these changes will bring increased conflict between hospice staff and LTC staff. Others believe that increased delineation of duties will have a positive effect on communication and patient care. Regardless, providers should take heed of these changes and ensure that their agreements and processes are up to date.

1 See 42 C.F.R. § 483.75(t); see 78 Fed. Reg. 38595.
2 See 42 C.F.R. § 418.112.
3 42 C.F.R. § 418.112(c)-(e).
4 Id. § 418.112.
5 See 42 C.F.R. § 483.75(t); see 78 Fed. Reg. 38595.
6 42 C.F.R. § 483.75(t)(2)(i).
8 Id. at 38596.
9 42 C.F.R. § 418.112(c)(8).
10 42 C.F.R. § 483.75(t)(2)(ii)(D).
11 42 C.F.R. § 418.112(e)(i).
12 42 C.F.R. § 483.75(t)(3).
14 Id.
15 42 C.F.R. § 418.112(c)(1).
16 42 C.F.R. § 483.75(t)(2)(ii)(D) (emphasis added).
17 42 C.F.R. § 418.112(c) (emphasis added).
19 78 Fed Reg. at 38598.
The Long Term Care, Senior Housing, In-Home Care, and Rehabilitation Practice Group (LTC-SIR PG) has a new name. Now known as the “Post-Acute and Long-Term Services Practice Group (PALS PG),” the name change was chosen to better reflect current terminology in the field. Joanne Lax, Chair of the PALS PG, said of the name change: “The Practice Group leadership is very excited to launch ‘Post-Acute and Long-Term Services’ as the new name for the Long Term Care, Senior Housing, In Home Care, and Rehabilitation Practice Group. We believe that our new name is in keeping with current terminology for the industries that we represent, and is more convenient than our old name. We want to welcome all of our Practice Group members to PALS!”
Announcing the New Behavioral Health Task Force

The Behavioral Health (BH) Task Force is committed to advancing the understanding of laws impacting behavioral health, including the delivery of services to those living with mental illness, certain neurological conditions, substance use disorders or developmental disabilities, and reimbursement for such services.

The BH Task Force will serve to raise awareness about how behavioral health laws influence health improvement efforts, and will include collaborative efforts with AHLA’s Public Interest activities.

Interested in volunteering with the BH Task Force? Contact the Practice Groups staff at pgs@healthlawyers.org.
The In-House Counsel Practice Group and General Counsel (GC) Metrics LLC invite you to take part in this year’s staffing, spending, and compensation survey. To participate, access the survey and simply enter your six fiscal year 2012 figures on staffing and spending, and complete the compensation table.

Thank you for your participation!
AHLA’s library of **free** reader- and user-friendly checklists, toolkits, guidebooks, and audio-visual resources educates community leaders, non-attorneys, primary caretakers, social workers, health care providers, emergency preparedness teams, and family members on how best to prepare and/or respond to an emergency and/or challenging health crisis.

**Emergency Preparedness**

- For the Health Care Consumer
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Every resource in the Public Interest Series is available at no cost. It’s our way of giving back to the very communities in which we work and reside. View the entire collection at [www.healthlawyers.org/publicinterest](http://www.healthlawyers.org/publicinterest).