



### WHAT HAPPENED TO THE VALUE OF YOUR HOME HEALTH AGENCY?

Effective May 16, 2005, the value of your home health agency probably decreased. In the short term this decrease may be significant.

The home health market has seen significant merger and acquisition activity for the past several years. The ability to project home health revenues and expenses under PPS has provided stability to home health values that had been missing since the announcement and implementation of the Interim Payment System (IPS), when the value of agencies eroded to almost nothing.

The attitudes of potential buyers must now be tempered with the unknown potential of PPS payment reductions looming in 2007 or 2008. Potential buyers must include the following in any assessment of value:

- 1) Extent of PPS episodes exceeding therapy thresholds,
- 2) Percentage of episodes representing subsequent episodes rather than initial episodes, and
- 3) Performance outcomes reported.

These are expected to be key to upcoming PPS payment changes. Until the proposed rule is issued by CMS, potential buyers are operating blindly with regard to the nature and extent of the payment modifications. (See "Medicare Home Health PPS Changes to Be Announced" in this issue of Home Health News:In Context.)

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**TAX- EXEMPT AGENCIES  
NEED TO WATCH FOR ANY  
ACTIONS FROM THE U.S.  
GOVERNMENT RELATING  
TO OUTGROWTH OF  
SARBANES-OXLEY**

The U.S. Senate Finance Committee is looking into reporting by tax-exempt entities. Preliminary proposals being studied include:

- Audits of all tax-exempt entities meeting certain revenue thresholds
- Establishment of audit committees
- Review of tax-exempt status on a periodic basis (every three years)
- Making audits available for public inspection
- Mandatory review of executive compensation by Board of Directors
- Sign-off of audited financial statements by Executive Director
- Enhanced penalties for late filings of information tax returns and new penalties for inaccurate filings

Although legislation is not expected this year, conversations continue regarding increased accountability by tax-exempt organizations. Some states have created legislation and others are looking at legislation designed to improve reporting and public accountability.

**MEDICARE HOME HEALTH PPS CHANGES  
TO BE ANNOUNCED**

On May 16, 2005, the Centers for Medicare & Medicaid Services announced its intention to release a proposed rule concerning the first major modification to the home health prospective payment system (PPS). The proposed rule scheduled for December 2005 would announce those changes to be effective in 2007.

Most informed observers expect the changes to include the following:

- Refining case-mix (HHRG) categories
- Modifying therapy threshold
- Addressing medical supplies
- Modifying reimbursement for subsequent episodes

Overall, agencies can expect payments to decline. The ability to secure an additional reimbursement approaching \$2,000 by merely increasing therapy visits from nine to ten is certain to be modified.

Additionally, subsequent episodes are expected to provide less reimbursement than an initial episode. It is also quite possible that payments, or a portion of the payments, may be modified based on patient outcome performance.

Given the announcement, agencies can reasonably expect current payments to remain unaltered other than annual updates until 2007, and possibly 2008, given the clearance and approval process that changes must undergo. As additional information becomes available, we will make it available to you.

**Importance of Attendance at Trade Association Meetings**

National and state associations will begin discussing upcoming changes and posing potential scenarios relating to such changes at their regular and special meetings between now and the issuance of the proposed rule. We encourage all agencies to seriously consider attending such programs to enhance preparation for any changes that may occur.

Upcoming scheduled programs of the National Association for Home Care & Hospice include:

***2005 Financial Management Conference and HOMECAREExpo***

July 20-22, 2005 – Sheraton San Diego Hotel and Marina, San Diego

***2005 Annual Meeting and HOMECAREExpo***

October 22-26, 2005 – Washington State Convention & Trade Center, Seattle

Dixon Hughes will have representatives at both of these meetings—stop by our booth and visit us while you're there.

## ABN AND TERMINATION NOTICES – DO YOU HAVE THEM UNDER CONTROL?

If you do, please share it with the rest of the industry.

On May 6, 2005, CMS issued the new Advance Beneficiary Notice (ABN) and its instructions in conjunction with a Federal Register Notice. The scheduled effective date for the new ABN is July 1, 2005; however, even CMS expects the final implementation date to be delayed. Regardless, the new termination notice is mandated for implementation by the Benefit Improvement and Protection Act for July 1, 2005.

The ABN must be issued at initiation of services, reduction in services and termination of services, whereas the termination notice applies primarily to services being terminated.

Under the revised ABN, agencies must estimate the cost of services; the patient can be provided with three options from which to choose:

- “I don’t want the items and/or services listed above. I understand that I won’t be billed for the items and/or services and that I have no appeal rights since I will not receive any items and/or services.”
- “I want the items and/or services listed above, and I agree to pay for the items and/or services myself. I don’t want a claim submitted to Medicare or any other insurance I have. I understand that I have no appeal rights since a claim won’t be submitted to Medicare.”
- “I want the items and/or services listed above and I want a claim submitted to \_\_\_\_ Medicare / \_\_\_\_ Other Insurance.”

Sometimes, agencies will issue a terminating notice and an ABN to the same patient. If Medicare-covered services are being terminated, the patient may receive a termination notice and an ABN to continue providing services under separate financial arrangements inasmuch as the services being provided would not be paid by the Medicare program unless appealed.

### **Will You Charge Up Front? Better Yet, Will the Patient Pay Up Front?**

The ABN will inform the patient, “You may have to pay the full cost at the time you get the items and/or services. If Medicare or your other insurance pays for all or part of the items and/or services that you have already paid for, you will receive a refund for the appropriate amount.”

Whether agencies will solicit payment up front and whether the patient makes the payments are undetermined issues. Of course, as a CPA firm, we recognize that there are a variety of accounting and refund issues associated with these collections—as well as the difficulties smaller agencies will face.

## HOME CARE NEWS: IN CONTEXT

Home Care News: In Context is a quarterly publication intended for administrators, CEOs, CFOs, accounting personnel, compliance officers and clinical management personnel for home care agencies. The publication is intended to:

- Highlight current developments relating to financial and compliance matters for agencies
- Address cost reporting issues for agencies
- Notify agencies of educational offerings for home care personnel
- Provide informative, although limited, discussion of topics of interest in home care agency management

The newsletter is intended to benefit all types of home care agencies. Other facilities that deal regularly with home care agencies, such as nursing homes, hospice providers, physicians or hospitals, may also find the newsletter of benefit to them.

Board members and others responsible for oversight of home care agencies may also benefit from this newsletter. If you want others to receive a copy of this newsletter, do not hesitate to contact us.

Your comments regarding this newsletter, including ideas for future topics, are also appreciated.



## LOCATIONS

### Alabama

Birmingham . . . . . 205.212.5300

### Georgia

Atlanta . . . . . 404.575.8900

### North Carolina

Asheville . . . . . 828.254.2254

Boone . . . . . 828.262.0997

Burnsville . . . . . 828.682.2876

Charlotte - Southpark . . . . 704.367.7020

Charlotte - Uptown . . . . . 704.334.3600

Durham . . . . . 919.484.0630

Greensboro . . . . . 336.275.4578

Greenville . . . . . 252.321.0505

Hendersonville . . . . . 828.692.9176

High Point . . . . . 336.889.5156

Raleigh . . . . . 919.876.4546

Rockingham . . . . . 910.895.4014

Salisbury . . . . . 704.636.9090

Sanford . . . . . 919.776.0555

Southern Pines . . . . . 910.692.8555

Sylva . . . . . 828.586.6200

Thomasville . . . . . 336.889.5156

Winston-Salem . . . . . 336.714.8100

### South Carolina

Greenville . . . . . 864.288.5544

Spartanburg . . . . . 864.583.5800

### Tennessee

Memphis . . . . . 901.684.2277

Brentwood/Nashville . . . . 615.312.8272

### Texas

Dallas/Fort Worth . . . . . 817.276.4100

### West Virginia

Clarksburg . . . . . 304.622.0804



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## MEDICAID FUNDING CUTS AND HOME HEALTH SERVICES

Several states have notified providers of cuts to Medicaid reimbursement for home health services as a way of reducing Medicaid expenditures. Doing so may cause many agencies, especially tax-exempt and governmental providers, to re-examine the services they provide to Medicaid recipients. At the present time, several states provide woefully inadequate reimbursement to home health providers for home health services. Further reductions or limited increases in those payments may cause even more agencies to cease services to Medicaid recipients.

Agencies serving Medicaid beneficiaries should consider the following:

- 1) As a way to monitor services, include in internal financial reporting a comparison of costs incurred to serve Medicaid beneficiaries with the costs of providing these services.
- 2) Disclose in external financial statements the extent of the subsidy as part of the community benefit provided by the agency.
- 3) Federal and state legislative efforts are necessary to preserve the integrity of the home health benefit to Medicaid-eligible individuals, especially with the continued limitation on alternative care settings (skilled and long-term care).

Inadequate Medicaid reimbursement coupled with the increasing percentage of home health services being offered through for-profit providers (many of which already have ceased services to Medicaid beneficiaries) does not bode well for home health service availability to Medicaid and uninsured populations. States who have identified the dilemma will face difficult funding choices.

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Ted Cuppett will be a featured speaker at the upcoming HEALTHCARE INDUSTRY MERGERS & ACQUISITIONS INSTITUTE, to be held July 21 – 22 in the AICPA Boardroom in New York City. Register toll-free at 866.265.1975 or online at [www.northstarconferences.com](http://www.northstarconferences.com). Seating is limited, so register today.