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State Moves to Limit Home Health Agencies

In his Health Law column, Francis J. Serbaroli of Greenberg Traurig discusses the moratorium that New York recently imposed on licensed home health care agencies, of which there are more than 1,400 in the state.

By Francis J. Serbaroli | May 21, 2018 | New York Law Journal

In our previous Health Law column ("**A Primer on Home Health Care Services**" NYLJ March 26, 2018), we explained the various types of home health care providers and the services that they can provide in New York. Since that column was published, there have been significant developments affecting licensed home care services agencies (LHCSA) which this column will cover.

Background

As we explained in the earlier column, a LHCSA can arrange or provide, either directly or through contract arrangements, one or more of the following to individuals in their homes:

- Nursing services;
- Home health aide services;

- Other therapeutic and related services including but not limited to: physical therapy; speech therapy; occupational therapy; nutritional services; medical social services; personal care services; homemaker services; housekeeper or chore services.

New York State Public Health Law (PHL) Section 3602(13) and (2).

A LHCSA can provide these services and bill Medicaid, private health insurers, managed care plans (if the LHCSA is an approved provider), and self-pay patients. A LHCSA generally cannot bill Medicare or other federal government health benefit plans, although it can contract to provide services to patients of a certified home health agency (CHHA) that participates in Medicare, and be paid by the CHHA.

According to the New York State Department of Health's (DOH) website **http://profiles.health.ny.gov/home_care/counties_served/type:LHCSA** there are currently 1435 LHCSAs operating in the state. Apparently, this number does not include LHCSAs that have been approved by the state's Public Health and Health Planning Council (PHHPC) but have not received their license or commenced operations. This number represents many more LHCSAs than are needed to provide services to New York's population. It also constitutes a growing burden on Medicaid expenditures, and presents difficulties in maintaining appropriate regulatory oversight. The state has now taken several significant steps in an attempt to stop the proliferation of LHCSAs, to encourage consolidation of existing LHCSAs, and to remove unnecessary LHCSA capacity from the New York marketplace.

Moratorium

As part of the Fiscal Year 2018-19 budget, the Legislature enacted and Gov. Andrew Cuomo signed a new law (Chapter 57 of the Laws of 2018, Part B, Section 9-e) imposing a two-year moratorium on the processing and approval of applications for LHCSA licensure. The moratorium went into effect on April 1, and will expire on March 31, 2020, unless it is extended. The law allows for certain limited exceptions to the moratorium.

Assisted Living Program LHCSA Exception

There is an exception for an application for LHCSA licensure that accompanies an application for licensure of an Assisted Living Program (ALP) pursuant to Social Services Law Section 461-a. The ALP application must have been submitted to and assigned an application number by the DOH. The ownership of the proposed LHCSA must be identical to the proposed ownership of the ALP, and the LHCSA will be limited to providing services only to the residents of the ALP, which the applicant must so attest and acknowledge.

Change of Ownership Exception

A second exception is for an application for approval to transfer or change ownership of an existing LHCSA but only if the LHCSA has been licensed and operating for a minimum of five years for the purposes of consolidating the licenses of two or more LHCSAs. DOH states (**LHCSA Moratorium Guidance**) that LHCSAs to be acquired must be currently operational and have been in operation for at least five years, and the application must include an attestation and statistical report data verifying these requirements. Moreover, the DOH points out:

Only changes in ownership that consolidate two or more LHCSAs may be accepted during the moratorium. Consolidate means reducing the number of LHCSA license numbers, not a reduction in the number of sites operated under a license number.

… The application must include all sites of the to-be-acquired agency.

Lastly, DOH requires that if an existing LHCSA is purchasing one or more LHCSAs, the purchaser itself must be currently operational and providing services, and attest and provide statistical data so verifying.

Exception for Serious Concern

The third exception is for applications seeking licensure of a LHCSA where the applicant demonstrates to the satisfaction of the DOH Commissioner that the application addresses a serious concern, such as a lack of access to home care services in a particular geographic area, or lack of "adequate and appropriate care, language and cultural competence, or special needs services."

In its moratorium guidance, the DOH states that there is a "presumption of adequate access" if there are two or more LHCSAs already approved (i.e., operational, or approved but not yet operational) in the proposed county. In the event there are two or more LHCSAs in the proposed county, the DOH requires the following:

- The applicant must articulate the population to be served for which there is a lack of access to licensed home care services;
- The applicant must submit substantial, data-driven proof of lack of access to the population (demographics, disposition and referral source for targeted patient population, level of care and visits required, payor mix, etc.);
- The applicant must provide satisfactory documentation that no existing LHCSA in the county can provide services to the population;
- If more than one county is requested, the application must include all required material for each county individually; and
- The applicant may request to operate in up to five counties, only.

Need

After the moratorium expires, when the PHHPC resumes considering LHCSA applications, and depending upon the type of health care provider, the PHHPC must consider whether there is a need for the provider in the geographic area to be served. For example, DOH has established a need methodology for renal dialysis services, and calculates how many dialysis stations are needed on a per-county basis. Once there are providers with the requisite number of stations, the PHHPC can deny an application for stations in excess of that number.

Historically, need was not a criterion in the PHHPC's consideration of LHCSA applications, which may have been one of the factors contributing to the proliferation of these agencies. The new law imposing the LHCSA moratorium provides that, as of the end of the moratorium in 2020, all new applicants for LHCSA licensure must demonstrate to the PHHPC public need for the proposed agency's services in the counties in which it proposes to operate.

Registration

The law further requires all existing LHCSAs to register with the DOH on an annual basis. A LHCSA that fails to submit a completed registration on a timely basis will be subject to a fine of $500 per month for every month or partial month that it is not in compliance. LHCSAs that are not registered with the DOH will not be permitted to continue operating after Jan. 1, 2019. Moreover, the DOH may revoke the license of a LHCSA that has failed to register for two annual periods (not necessarily consecutive) or has demonstrated a pattern of failing to register. The DOH's website, which currently lists all LHCSAs in New York, will be updated to include each LHCSA's registration status.

Cost Reports

The moratorium law imposes a new requirement for LHCSAs to submit Medicaid cost reports to the DOH. The DOH is to set the format of the required reports, their frequency, the data to be included, and how the reports are to be certified. The DOH is to notify a LHCSA of any inaccurate or incomplete cost report information, after which the LHCSA has 30 days to submit correct information.

Limits on Contracts

For several years, the Medicaid program in New York has been converting from a largely fee-for-service payment model to a managed care model. The DOH has been migrating Medicaid recipients needing long term care services, such as LHCSA services, to managed long term care plans (MLTCP), private organizations that receive Medicaid funds and then contract with providers to provide covered services to recipients. In the aftermath of this mass migration, MLTCPs have been inundated with requests from LHCSAs to become contracted providers, with some MLTCPs having contracts with 100 or more LHCSAs. The new law authorizes the DOH Commissioner, as of Oct. 1, to limit the number of LHCSAs with which a MLTCP can contract. Factors that will go into the calculation of the maximum number of contracts include the region served by the MLTCP and the number of enrollees in the MLTCP. The DOH Commissioner can increase a MLTCP's maximum number of contracted LHCSAs, on a county by county basis, if the increase is necessary to ensure adequate access to services in the area, including but not limited to special needs services, and services that are culturally and linguistically appropriate, or to avoid disruption of services in the area.

Conclusion

These new budget law requirements clearly seek to encourage a major consolidation among LHCSAs, improvements in the quality and availability of LHCSA services, and cost savings to the Medicaid program. As the DOH issues implementing regulations, and MLTCPs begin reducing their contracted LHCSAs, there are likely to be many more mergers of LHCSAs. Smaller LHCSAs may be forced out of business due to being terminated by MLTCPs, or due to their inability or unwillingness to meet the new cost report and registration requirements.

However, there is some confusion. The wording of the law in one section appears to have the moratorium apply to new applications for licensure, but then included among the three narrow exceptions is a transfer of ownership of an existing LHCSA that has been licensed and operating for a minimum of five years "for the purpose of consolidating ownership of two or more [LHCSAs]." The DOH Moratorium Guidance gives as an example of a nonqualifying change in ownership application: "A partial change in ownership requiring Public Health & Health Planning Council approval." If that is the case, the DOH's interpretation of the law will create significant burdens for the current owners of LHCSAs. PHL Section 3611-a requires PHHPC approval if a LHCSA proposes to transfer, assign or otherwise dispose of 10 percent or more of its

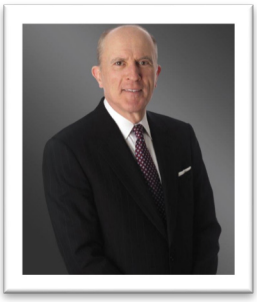
ownership interest. Any proposed transfers of ownership interests of 10 percent or more, unless they occur within the narrow context of the aforementioned merger exception, would thus appear to be prohibited until the moratorium expires. Yet transfers of less than 10 percent only require notice to the PHHPC, although PHL Section 3611-a(1)(c)(ii) gives the PHHPC authority to bar even a less than 10 percent transaction if it gives specific reasons therefor. Are transfers of less than 10 percent barred by the moratorium?

There are other anomalies. According to the DOH moratorium guidance, if an owner dies, the owner's estate will not be able to dispose of the owner's interest until the moratorium expires or "the state takes definitive action to revoke the license," unless the disposition takes place in the context of an excepted merger. If two LHCSAs wish to merge, but each has been in operation for less than five years, the moratorium prohibits such a merger.

The LHCSA landscape is about to undergo significant changes in the near future, and the implementation of this new state policy seeking to consolidate and reduce the number of LHCSAs will present challenges to the DOH, the LHCSA industry, MLTCPs and other payors, and patients. There also will likely be a number of challenges to the law and the DOH's interpretation of the law.

About the Author:

Francis J. Serbaroli is a shareholder at Greenberg Traurig and the former vice-chair of the New York State Public Health Council.



Francis J. Serbaroli
serbarolif@gtlaw.com