



Optimizing External Opportunities for Agency Growth and Expansion



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Pandemic Recovery Series

<http://www.hc-link.com/pandemic-recovery-webinar-series>

- Session 1 (7.2.20)
 - Navigating the Economic Incentives
- Session 2 (7.9.20)
 - Promoting Agency Success with Emergency Preparedness Plans, Infection Control, and Quality Programs
- Session 3 (7.16.20)
 - Identifying Operational Efficiencies During Pandemic Recovery
- Session 4 (7.23.20)
 - Getting Prepared for the Next Round, Financial Considerations

Pandemic Recovery Series

- Session 5 (7.30.20)
 - FFCRA – Emergency Paid Sick Leave & Expanded Family Medical Leave
- Session 6 (8.6.20)
 - Legal Aspects of Pandemic Recovery
- Bonus Session (8.11.20)
 - PPP Loan Forgiveness – Form 3508EZ Application Training
- Session 7 (8.13.20)
 - Addressing Pandemic Psychosocial Impacts While Rebuilding Agency Operations
- Session 8 (8.20.20)
 - Optimizing External Opportunities for Agency Growth and Expansion

Agenda: Session 8

- Introductions
- Clinical and Clinical Operations Due Diligence
- Accounting Best Practices to Prepare for External Opportunities
- Home Care Market Assessment
- Preparing for Mergers & Acquisitions as a Buyer or Seller
- Q&A



Clinical and Clinical Operations Due Diligence Activities



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HealthCare ConsultLink



Preparation of Regulatory Diligence

- May be requested by the buyer or seller
 - Buyer: Often in the event a target agency has been specifically identified
 - Seller: Often in advance of intent to sell to identify potential weak areas
- Purpose is to provide information that helps to determine the following:
 - The valuation of the target company
 - The risk of repayments/recoupments
 - The risk level of a corporate integrity agreement
 - The risk level of a qui tam/whistleblower lawsuit
 - The risk of regulatory enforcement actions
 - The overall compliance health of the target company
 - The ability and timeline for integrating policies and procedures that address the identified issues and establish and/or maintain a culture of compliance

Clinical Record Review

- Goal is to identify benchmark data for the applicable service line
 - Hospice examples: Principal diagnosis mix, level of care changes, live discharges, average and median length of stay
 - Home health examples: Establishment of eligibility (including face-to-face requirement), average length of stay, documentation compliance measures related to Medicare Conditions of Participation (CoPs)
 - Other agency type examples: Client hours, compliance with Individualized Service Plan (ISP), coordination of care and supervision compliance

Clinical Record Review

- Sample of records should be completed by qualified individual(s)
 - Random sample of active and discharged patients/clients
 - Usually a minimum of 20% of the current active agency census; may vary with larger census entities
 - Comprehensive audit tool should be utilized for consistent record review and tracking of results
 - Results should be compiled into an aggregated report to identify trends
 - Allows for classification of risk areas by appropriate categories
 - Additional records may be reviewed if specific areas of concern or trends are identified through the process

Clinical Record Review

- Review of billing documents
 - Review of documents for the specific records reviewed
 - Compare services provided with services billed
 - Use to determine technical errors and other areas of non-compliance for risk of payment adjustments (full and partial) and/or potential recoupment
 - Compliance with specific billing-related requirements (e.g., Pre-Claim Review for home health agencies)
- The due diligence process once a buyer/seller relationship has been established will likely also involve a more in-depth review of agency's comprehensive billing records, including accounts receivable, billing patterns, etc.

Review of Agency Audit Activities

- Internal audit activities to be reviewed
 - Frequency of monitoring and reporting of audit results [e.g., routine auditing, Quality Assessment Performance Improvement (QAPI) compilation, targeted/focused audits]
 - Trends identified
 - Corrective actions needed
 - Performance improvement plans (establishment and tracking of progress)

Review of Agency Audit Activities

- External audit activities to be reviewed
 - Medicare Administrative Contractor (MAC) activities [e.g., Additional Documentation Requests (ADRs), Targeted Probe and Educate (TPE)]
 - Initial and recertification surveys
 - State license and relicensure surveys
 - Complaint surveys
 - Focused infection control surveys
 - PEPPER reports
 - STAR and COMPARE reports
 - All related corrective action plans related to external audits

Common Findings

- Common findings that negatively impact regulatory diligence include the following:
 - Missing and/or insufficient documents
 - Plans of care
 - Physician orders
 - Election of benefits/consents
 - Signed acknowledgments of required regulatory information
 - Supportive clinical documents for eligibility of services
 - Supportive clinical documents for billing (e.g., hospice higher level of care, appropriate home health coding support, etc.)
 - Clinical assessments

Common Findings

- Technical claims errors that negatively impact regulatory diligence include the following:
 - Missing signatures
 - Missing dates
 - Invalid consents or admission documents
 - Missing or untimely face-to-face encounters; includes insufficient documentation of encounters that did occur
 - Missing or insufficient hospice physician narratives

Recommendations

- Consider all components of the regulatory review both as a buyer OR seller
 - Create checklists for program regulatory requirements (audit tools)
 - Incorporate risk areas into agency audit process
 - Organize all documents prior to review
 - Upload all documents into the EMR and file them specifically to the patient/client
 - For internal staff doing routine reviews, ensure competency and understanding of regulatory requirements
 - Consider outsourcing QAPI in advance of a sale to ensure program compliance with all regulatory requirements
 - Provide ongoing staff education regarding compliance and regulatory requirements
 - Document education and hold staff accountable for compliance with expectations

Recommendations

- Consider all components of the regulatory review both as a buyer OR seller
 - Complete a mock survey from an external source to determine risk areas
 - Review results with staff
 - Implement corrective action plans
 - Completion of a mock survey in advance of selling your agency can show proactive steps to identify and correct problem areas that might otherwise impact a buyer
 - Be aware of the most common deficiency areas and monitor as potentially vulnerable areas impacting the value of the agency in an acquisition scenario
 - In preparation for a purchase (buyer) or sale (seller) of an agency, identify a qualified external firm to complete record reviews that may impact negotiations
 - Buyers: Can help to identify areas of potential financial risk or additional investment post-close to bring agency to compliance
 - Sellers: Can allow for proactively addressing weak areas that could concern a buyer and result in a reduced offer price

Regulatory Due Diligence Summary

- Buyers and sellers will benefit from completing clinical and clinical operations due diligence in advance of a business sale transaction
- Even if the transaction is not executed, identifying areas for improvement offers opportunities to move the business forward
- Any improvement to agency operations should yield a positive outcome in patient/client-focused care and meeting the goals for an agency's primary goal: PROVIDE EXCELLENT CARE WITH COMPLIANT OPERATIONS

Polling Question 1





Accounting Best Practices to Prepare for External Opportunities



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Back Office Best Practices

- Even if acquiring an agency or selling is not on your agenda, follow best practices so that if/when it does arise, you and your agency are ready
- Do not wait until you are ready to make a move to decide to get your back office in order; this takes time
- If selling your agency, the due diligence process may require that you review up to three (3) years worth of financial records
 - Good habits need to be practiced well before you are ready to exit

Back Office Best Practices

- Establish well-defined accounting policies
 - All accounting should be done monthly at a bare minimum
 - Reconciliation of all bank and credit card accounts must be done monthly
 - Utilize segregation of duties: The staff member who handles incoming and outgoing checks and payroll should not handle the banking reconciliation
 - Ensure financials are set up appropriately for the industry
 - An outside accounting firm should review and produce monthly financial statements
 - Ask this question: Is your back office using current technology to increase efficiencies and scale virtually?
- All cost report and tax filings should stay current
- Outsource your payroll: This better ensures compliance and saves you time

Back Office Best Practices

- Ensure all company or management changes are properly reported to the appropriate agencies; this must always be done properly
- Diversify your referral sources
- Owner involvement: Stay involved with your agency
 - Do not leave it to someone else to run and expect that they will run it with the same passion that you will



Home Care Market Assessment



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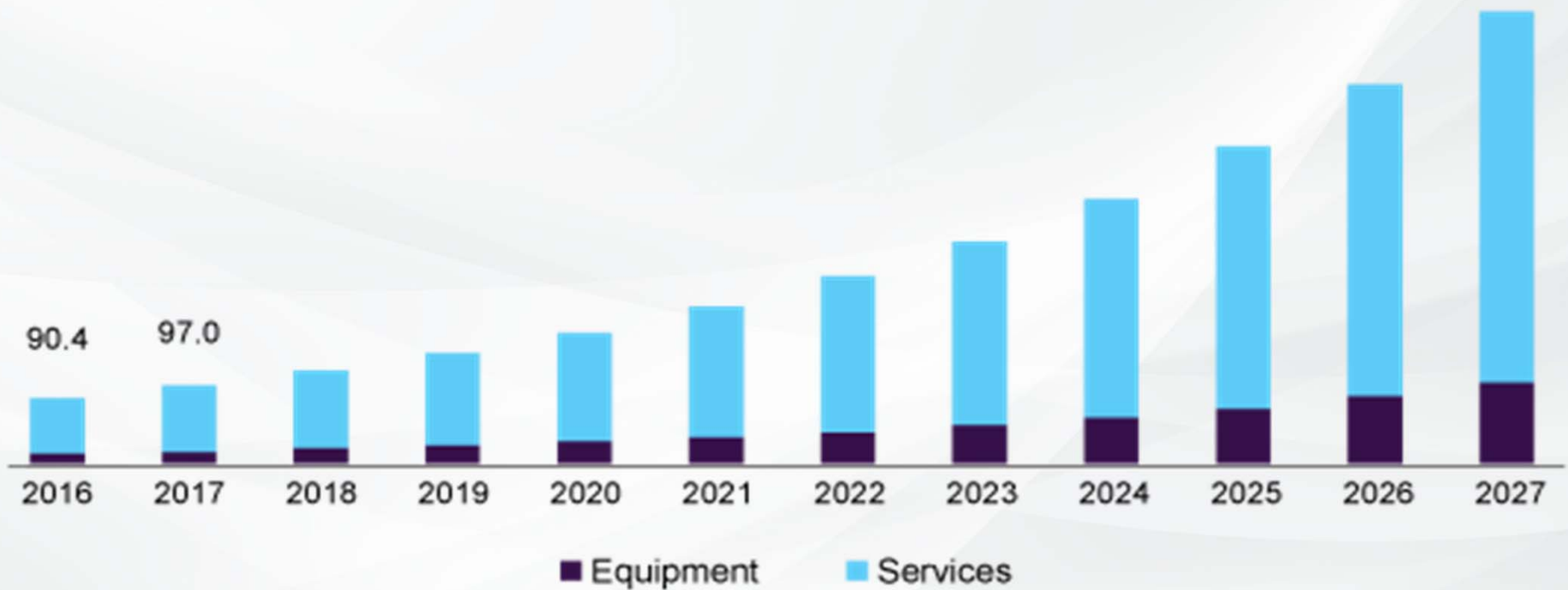
Deal Climate for Home Care

- According to Home Health Care News, “It’s business as usual”
- The Braff Group, a leading mergers and acquisitions advisory firm, stated, “Due diligence is still going on for the deals that I’m working on. We are still looking to achieve targeted closing deadlines” in reference to the home health care industry.
- For deal-making to remain stable, banks and other financial entities will need to stay engaged and open for business
- Banks are proactively calling and using this time to position themselves as being available to continue to help buy businesses
- However, the longevity of COVID-19 still remains a long-term threat

Home Health: Growing Market?

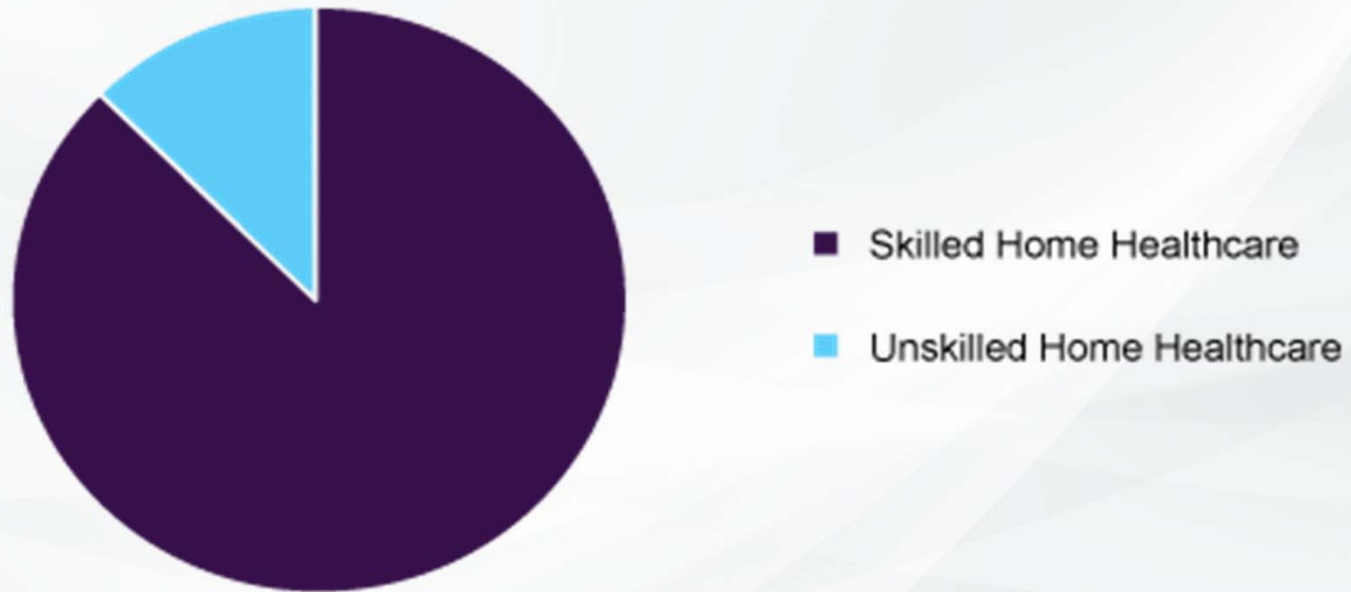
- The global home healthcare market size was valued at USD \$281.8 billion in 2019
- Expected to grow at a compound annual growth rate (CAGR) of 7.9% from 2020 to 2027
- The Bureau of Labor Statistics states that a growing workforce pertaining to healthcare service translates to the increasing demand for home health and personal healthcare aides; more than 4 million jobs only in the home healthcare sector

U.S. home healthcare market size, by component, 2016 - 2027 (USD Billion)



Source: www.grandviewresearch.com

Global home healthcare market share, by service, 2019 (%)



Source: www.grandviewresearch.com

Important Factors

- Market: What is the market?
- Market capitalization (aka “market cap”): The total dollar market value of a company's shares of stock; calculated by multiplying the total number of a company's shares by the current market price of one share
- Buyer Power Ratio (BPR): The ratio of the size of the buyer/buyer market cap to the size of the transaction/purchase price
- Bigger ratio = more leverage for buyer; smaller ratio = more leverage for the seller
- This impacts the behavior of the seller (e.g., disclosures) and buyer in a deal



Mergers and Acquisition Processes



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Polling Question 2



Road Map of a Transaction

1. Prospective buyer expresses interest: General discussion of deal points
2. Preliminary due diligence
3. Letter of Intent: Outlines the overall deal points and creates a guide
4. Non-disclosure agreement (NDA)
5. Due Diligence: Buyer issues due diligence request (e.g., checklist); includes clinical, financial, legal, insurance, employment, tax, corporate structure, intellectual property, state regulatory/licenses, payor sources, etc.
6. Purchase Agreement: Stock or asset purchase? Know the difference and the regulatory and legal impacts of each.
7. Disclosures
8. Negotiation points in the purchase (e.g., indemnification, representations and warranties, escrow/hold back)
9. Concurrent filings: Medicare and state license filings
10. Closing and funding
11. Post-closing issues: Reconciliations, funding to appropriate accounts receivable, litigation

Change of Ownership (CHOW) Overview

- Transaction: Proposed new operator attempting to secure the license and Medicare certification to lawfully operate a home care agency
- Texas Department of Health & Human Services (HHS) oversees licensure CHOW process for Home and Community Support Services Agencies (HCSSA)
- **BEFORE:** A CHOW involved (a) a change of 50% or more in the ownership of the business organization or sole proprietorship that is licensed to operate the agency; or (b) a change in the federal taxpayer identification number
- **NOW (Effective October 6, 2017):** A CHOW is a change in the federal taxpayer identification number

What is NOT a Texas License CHOW?

- Change of Information (CHOI): A change in location, phone number(s), operator hours, entity name, and/or most of all, no federal taxpayer ID change
- Others include the following: Certification status, management personnel (administrator, alternate administrator, or chief financial officer), and/or category of service
- Expired license: A CHOW is not allowed in this situation

CHOWs and CHOI's are Time-Sensitive

- CHOWs: Must notify HHS 30 days before the effective date of the ownership change. Otherwise, there is a \$250 late fee per license.
- CHOI's: There is a notification time frame ranging from five (5) days (e.g., change in certification status) to 30 days (e.g., change in physical location). There is a \$30 standard fee associated with the submission of a CHOI, plus a \$100 late fee, if applicable.
- An agency must respond within 30 days with the correct and complete information to address deficient items within the license application; HHS will approve or deny the application within 45 days, unless an activity is pending (e.g., survey).

Transaction Structure

- Acquisition: One entity buys another (target or seller). There are three basic forms of acquisitions:
 - i.) Stock purchase; ii.) Merger and; iii.) Asset purchase
- **Stock Purchase:** A party buys units, shares, or equity of the seller. Sale proceeds from the sale of stock, minus liabilities, are distributed to selling equity owners. Buyers become new equity owners or shareholders of the seller. There are concerns with liabilities (e.g., accounts payable (AP), litigation, leases, vendors, licenses, certifications, etc.).
- **Merger:** Two entities are merged into one. Either the buyer or seller can be the surviving entity; the key is that one entity is remaining.

Transaction Structure, cont'd.

- **Asset Purchase:** Buyer acquires all or some seller's assets. This happens because the buyer does not want to acquire all of seller's assets or the seller only wants to sell a specific line/division or stock purchase liabilities (e.g., avoid successor liabilities).

BEWARE: Courts have upheld buyer liability when licenses or Medicare provider numbers are purchased, even if the seller agree to retain liabilities for prior acts

- **Joint Venture (JV):** Used when providers want to collaborate but do not want to acquire or merge. When two or more parties agree to pursue a common purpose. JV parties remain independent entities and is created by contract or forming a new entity and each JV party jointly owns the new entity.

Medicare and Medicaid

- **CHOW:** Change in operator or ownership of operator certified to participate in Medicare or Medicaid
- Medicare Administrative Contractors (MACs) are involved, and each has its own way of handling CHOWs
- Takes 90-120 days following a closing to complete a CHOW under Medicare and to receive the notice: TIE-IN NOTICE. This permits the new operator to start billing Medicare for services rendered since the date of the closing.
- Medicaid is a state and federally funded program but is state-administered. In Texas, it is managed by Texas Medicaid & Healthcare Partnership (TMHP) under the Texas Health & Human Services Commission (HHSC).
- **CHOWs Impact Cash Flow / Revenue:** Understand the Medicare/Medicaid agreement, determine the need for a Medicare/Medicaid provider agreement or take the auto assignment, determine if the buyer/seller can bill under the other's Medicare/Medicaid number until new number or tie-in notice is provided, and determine if there are any additional notices needed

Medicare and Medicaid

- CMS maintains oversight for compliance with Medicare health and safety standards for HHAs
- The survey (inspection) for this determination is done on behalf of CMS by HHS under the agreements in Section 1864 of the Social Security Act (the Act) (“certification process”)
- CMS publishes annual Mission and Priority Document (MPD), outlining guidance of HHAs applying for initial certification

Buyer and Seller Tips

- Both seller and buyer need to be aware of how to properly address the CHOW process and each party's obligations
- **Seller:** Require buyer to file its CHOW application by a specified date and obligate buyer to be diligent with completion. Seller should dictate timing on notices to the state agency and require status updates on CHOW.
- **Buyer:** Ensure the agreement sets a realistic deadline for filing the CHOW application. Buyer must require seller to provide notices as required by law and on a timeframe that does not delay the buyer's CHOW application. Buyer must hold seller accountable and be cooperative to provide due diligence information and required information for the CHOW application. Make sure undue delay caused by seller's lack of diligence does not cause a breach of the agreement.

We're here to help

- We are always available to assist agencies with consulting and advisory services, but especially through this public health emergency

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- HealthCare ConsultLink

<http://hc-link.com>

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- For any questions regarding the website, call 888.258.1894 or email info@hc-link.com. These complimentary recordings and materials will remain active until further notice.

Questions?

