Selected Issues in Home Health and Hospice Transactions

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Presentation Agenda

1. Transactional Landscape for Home Health and Hospice
2. Home Health and Hospice Reimbursement Models
3. Preparing to Sell
4. Key Due Diligence Issues Encountered

Transaction Landscape for Home Health and Hospice

IN-HOME HEALTHCARE HAS MULTIPLE INDUSTRY TRENDS SUPPORTING GROWTH

Post-acute Care Providers are Situated to Benefit from the Healthcare Continuum Shifting Focus to the Home

- Hospice and home health are a cost-effective alternatives to facility-based care for patients during end-of-life and recovering from illness or injury
- Providers have been targets of consolidation due to high industry fragmentation
- Healthcare systems and home health and hospice operators are beginning to transition toward integrated delivery models that can address patients' needs in home care settings; palliative care utilization expected to further increase demand for hospice services
- Industry has benefitted from numerous macroeconomic trends, driving revenue growth, enhancing profitability, and leading to multiple expansion
- Numerous providers are entering into joint venture relationships and beginning to transition into value-based payment arrangement payments

1 Care Transitioning to Lower-Cost Settings

- Hospice is a critical tool in bending the cost curve, saving Medicare $2,000+ per beneficiary in the final year of their life
- Care settings and acuity are more accurately matched to patient needs, enabled by monitoring and equipment

2 Providers Taking More Risk

- Significant shift of payment methodology to value-based care and capitated risk from FFS
- Proactive patient management rewarded and lack of it penalized
- Quality scores drive increased volumes and reimbursement

3 Care Coordination is Key

- Care quality and value being increasingly tied to reimbursement
- Reform demands care coordination across the entire care continuum
- Analytics is central to targeting treatment and managing care settings

4 Consolidation

- Demand from leading public post-acute providers that continue to scale in hospice
- Market remains highly fragmented, with over 4,600 hospices (largely comprised of "mom and pop" providers)
- Value creation through synergies and multiple arbitrage

Hospice is Well Positioned on the Continuum of Care

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HOME HEALTH AND HOSPICE M&A ACTIVITY

Home Health and Hospice M&A Activity Continues Rapid Growth with 208 Completed M&A Transactions in 2020, Up from 155 in 2019

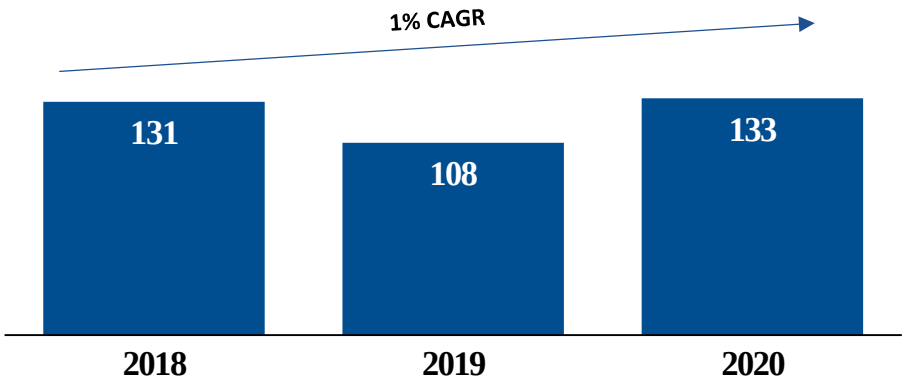
Home Health Care M&A Activity Remains Robust

- Market disruption from PDGM payment reform is driving a unique opportunity for larger home health providers to gain market share or acquire smaller, less sophisticated providers
- Despite brief curtail in M&A activity in Q2 2020 due to COVID-19, the pandemic has added heightened focus on home-based care as payors look for safer, cheaper solutions
- PDGM and COVID-19 will further drive arrangements across the care continuum, enabling more collaborative relationships between institutions and agencies and encouraging increased transaction volume through 2021

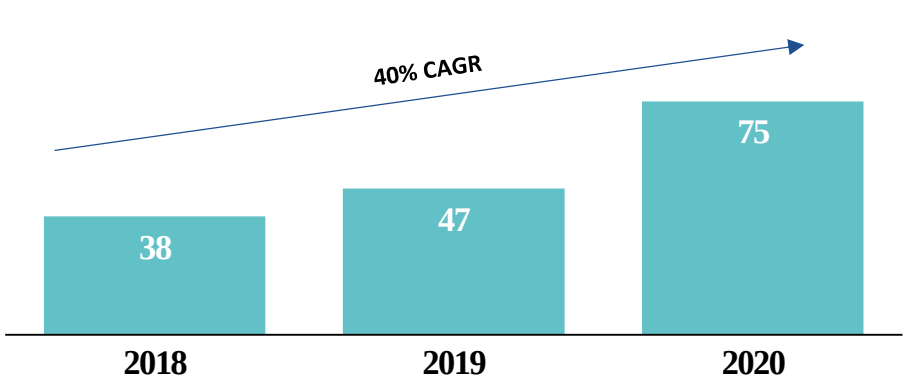
Hospice M&A Activity Recovered from COVID-19

- Despite the overall reduced deal flow due to COVID-19, during 1H 2020 hospice remained the most active vertical within the post-acute care space, with 28 completed transactions
- In Q4 2020, Hospice M&A activity recovered significantly from the pandemic lows with 25 completed transactions, representing year-over-year increase of 10 additional transactions
- Over 56% of the deal activity within the broader Home Health, Hospice and Home Care sector involved assets providing Hospice services in 2020

Consistent Health M&A Volume Growth



Strong Hospice M&A Volume



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RECENT TRANSFORMATIVE TRANSACTIONS

Target	Acquirer	Date	Target Key Stats	Strategic Rationale / Commentary
Brookdale Senior Living	HCA Healthcare	February 2021	57 HH agencies 22 hospice agencies	▪ Expand service offerings and enhance ability to deliver a better experience for patients
Abode Hospice & Home Health	BrightSpring Health Services	February 2021	ADC: ~4,000+	▪ Leading regional hospice provider with large ADC provides for excellent platform to expand current unskilled offering
Seasons Hospice & Palliative Care	AccentCare	December 2020	ADC: ~5,000	▪ Acquired Season's Hospice, the fifth largest U.S. hospice operator, providing entry into 11 new states and further density
Queen City Hospice	ADDUS HomeCare	December 2020	EBITDA: $12M ADC: ~900	▪ Queen City provides high quality hospice services to patients across Southwest Ohio, adds to Hospice Partners acquisition
Simplura Health Group	modivcare (formerly Logisticare)	November 2020	EBITDA: $50M Revenue: $463M	▪ Expands addressable market in high growth adjacency and deepens ModivCare's relationships with managed care and government organizations
Help at Home	Centerbridge / Vistria	October 2020	EBITDA: $110M	▪ Help at Home is a leading home care provider across 13 states, providing quality care to more than 60,000 patients in 150+ locations
CareHospice	Thomas H. Lee Partners	October 2020	EBITDA: $55M	▪ Large regional hospice provider with 60+ sites across 11 states, THL's first hospice investment since selling Curo
St. Croix Hospice	H.I.G. Capital	October 2020	EBITDA: $43.6M ADC: ~2,000	▪ Leading provider of hospice across the Midwest, marks HIG's second hospice asset
Fairview	AccentCare	September 2020	ADC (Hos): 650 ADC (HH): 2,500	▪ AccentCare acquired an 80% stake in Fairview Health Services post-acute business in Minnesota
AseraCare Hospice	amedisys	April 2020	EBITDA: $17.4M ADC: ~2,100	▪ Combined, the two hospice operations include 190 care centers across 35 states with a total ADC of ~14,000
alacare Home Health & Hospice	Encompass Health	July 2019	EBITDA: $14M Revenue: $117M	▪ Addition of Alacare adds 46 Home Health and Hospice locations, expanding their footprint to the Alabama market

Home Health and Hospice Reimbursement Models

Implementation of a New Home Health Payment Model

In January 2020, the Home Health Industry Shifted from Prospective Payment System (PPS) model to the Patient-Driven Groupings Model (PDGM)

HH PPS (Old System)

- Bundles payment for all covered home health services provided in a 60-day episode
- Episodes are grouped into one of 153 total Home Health Resource Groups (HHRGs) based on clinical, functional and service utilization measurements

PDGM (New System)

- Bundles payment for all covered home health services provided in a series of two 30-day episodes
- Episodes are grouped into one of 432 total HHRGs based on admission source, timing, clinical grouping, functional impairment level and comorbidity adjustment

Key Ramifications Impacting Home Health Providers

Intake Considerations & Reimbursement Rates	• Reimbursement structured to incentivize agencies to focus on in-patient patients discharged to home health from an institutional setting and away from community admissions • Payments adjusted for patients who had a prior inpatient stay within 14 days of the beginning of home health services • Rural add-on payment (currently a 3% increase in reimbursement) will be phased out over the next three years
Cash Receipt Delays	• 60-day payment episodes replaced with 30-day periods, reducing upfront collection of Medicare reimbursement by half • Operational changes needed across billing and claims processing going forward to ensure and monitor compliance
Visit & Discipline Utilization	• Eliminated Therapy Thresholds from the case-mix adjustments; scaled providers with a more therapy-dependent patient are seeing their reimbursement decline • New 30-day periods and changes to Low Utilization Payment Adjustments (“LUPA” formerly when four or fewer visits are provided within a 60-day period) methodology will drastically change the episode management approach
Clinical Coding & Documentation	• Heightened requirements for coding of Electronic Medical Records, with greater emphasis on accuracy • Use of incorrect codes result in Questionable Encounters (“QEs” when submitted claims contain primary diagnoses that do not fall into one of the clinical groupings defined by the CMS), which may result in delayed processing and reimbursement • Will require reassessment of knowledge, skills, and abilities of front-end staffing resources to ensure & monitor compliance
Revenue Cycle Complexities	• Adjusted case mix groups (“HHRGs”) from 153 to 432 categories, including updated measurements • LUPA thresholds are no longer four or fewer visits, resulting in additional adjustments (service-specific per-visit rates) • Increased complexity of cash postings expected to require increased staffing levels coupled with productivity decreases

Hospice Payment Model

Hospice Programs are Paid a Daily Rate Based on each Patient's Level of Care

Benefit Periods	• The duration of the episode of care for the beneficiary • Medicare billing consists of two 90-day benefit periods and an unlimited number of 60-day benefit periods • Hospice care is continuous unless the patient revokes the benefit or the physician does not re-certify
Elections	• Patients who choose the benefit are required to sign a Notice of Election (NOE) statement • Billers must submit an NOE for the patient and have a maximum of five days to submit and receive acceptance from the Medicare Administrative Contractor (MAC) • "Provider liable days" apply when the hospice fails to file the NOE within five days
Hospice Cap	• Medicare limits the overall payments made to a hospice annually (aggregate care cap) based on the expected beneficiary period (180 days) (unadjusted for wage index) • The FY 2021 hospice cap amount is $30,684 • At the end of each fiscal year, providers are required to determine their calculated cap (based upon their census throughout the year) and self-report any payments by Medicare in excess of the cap
Covered Services	• Routine Home Care – hospice care in their own home, represents the majority of a provider's service type • Continuous Care – more intense care over the course of an episode (typically at the end of life) that may require full time care; providers are able to bill on an hourly basis (based on length of care) • Inpatient Respite Care – if care cannot be delivered in the home and requires a temporary stay in a hospital or nursing home, the hospice provider is required to pay for these services, but can receive an elevated payment for up to five days • General Inpatient Care – hospice care provided in a hospital, skilled nursing facility or a hospice inpatient facility are paid at the highest of the four levels of care (5x-6x Routine Home Care's daily rate)

Industry Reimbursement Trends & Regulatory Overview

Home Health and Hospice Has Recently Experienced Favorable Reimbursement Trends

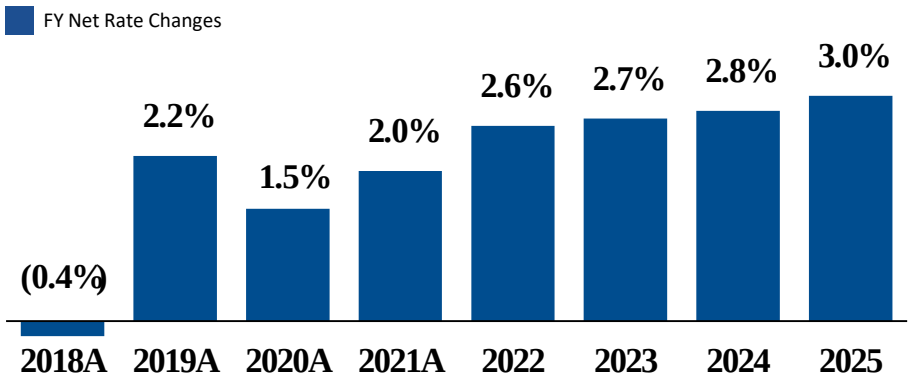
Home Health Regulatory & Reimbursement Dynamics

- Home health reimbursement has rebounded from 2018 to 2021, experiencing a net change of 5.3%
- ~50% increase in the number of Medicare-certified agencies and 40% increase in Medicare spend from 2005 to 2016 has driven heightened regulatory scrutiny by CMS
- PDGM redesign is encouraging value over volume, removing incentives to provide unnecessary care and shifting how agencies view referrals and develop plans of care

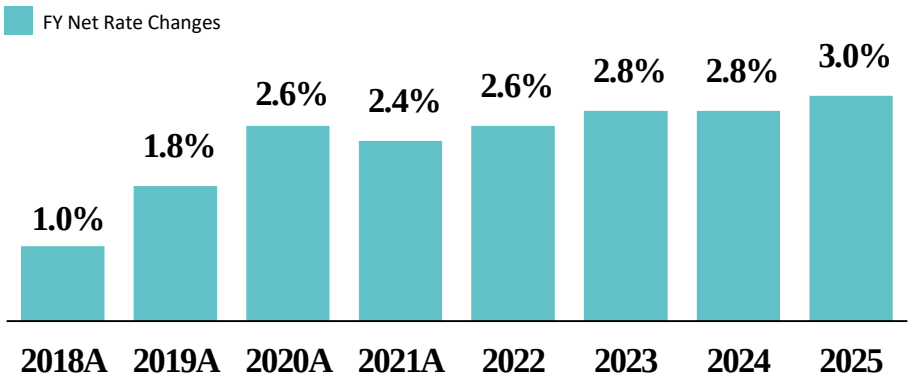
Hospice Regulatory & Reimbursement Dynamics

- Hospice care is a critical tool in bending the cost curve, saving Medicare $2,000+ per beneficiary in the final year of their life
- Hospice has experienced a positive rate increase every year for the past seven years, resulting in a net increase of 12.6%, including a 2.4% increase in 2021
- The hospice industry has experienced tremendous growth over the past 20 years, growing from $2.9B in 2000, to $21B in 2019

Historical and Expected Home Health Rate Changes[1]



Historical and Expected Hospice Rate Changes[1]



Source: CMS, MedPAC, Equity Research, and Press Releases

1. CMS FY 2021 Final Medicare Rate Update; 2022 – 2025 based CMS projected market basket updates as of Q4 2020.

Preparing to Sell

Purpose of Due Diligence

In Addition to Evaluating Risk, Due Diligence Also Evaluates:

- ✓ Organizational culture
- ✓ Other party's willingness to share information/transparency
- ✓ Business acumen and operational/regulatory sophistication
- ✓ Post-transaction expectations and goals
- ✓ Items that will need to be a primary focus post-transaction and the resources needed to address same

Why Self Assessment is Important

Self-Assessment to Identify Issues/Concerns that May Impact Sale

- Identification
- Remediation
- Quantification

Minimize Surprises, as They May…

- Put seller in a defensive position
- Make buyers skittish
- Increase due diligence activities and related cost for both parties
- Impact (decrease) purchase price
- Cause deal to terminate

- ✓ **Assume a HHA is priced at 4x EBITDA**
- ✓ **A business practice, such as incorrect billing, has a $500,000 impact on annual EBITDA, has a $2,000,000 impact on value ($500,000 x 4 = $2,000,000)**
- ✓ **Issue may result in self-disclosures to the CMS, OIG, or MAC**
- ✓ **Issue will also likely impact deal structure via escrow of purchase price, added indemnifications, and possibly additional insurance requirements**

Areas of Self-Assessment

Financial:

- Verify accessibility to, accuracy of, and presentation of financial data
- Especially important if a subset of the business entity is being sold
- Identify potential adjustments to purchase price (or mitigate need for same)
- Sell-side Quality of Earnings (QoE)
- Identify key drivers that will be attractive to buyer

Licensing:

- Ensure meet all licensing standards as well as Medicare Conditions of Participation (CoP)
- Ensure providers licenses, certifications and enrollments are current and accurate

Areas of Self-Assessment – Home Health

Compliance with Governmental Guidelines

- OASIS assessments
- PEPPER reports
- Homebound status

Medical Record Documentation

- Certification/recertifications (Form 485 HOME HEALTH CERTIFICATION AND PLAN OF CARE)
- Face-to-face (F2F) encounters
- Physician orders
- Skilled nursing visit notes
- Home Health aide notes
- OT/PT/ST visit notes
- Support for time-based codes
- Signatures present and legible

Areas of Self-Assessment – Hospice

Compliance with Governmental Guidelines

- OASIS assessments
- PEPPER reports
- Terminal illness requirements
- Special circumstances – ESRD, home health, VA Benefits, SNF

Medical Record Documentation

- Certification/recertifications (Form 485 HOME HEALTH CERTIFICATION AND PLAN OF CARE)
- Face-to-face (F2F) encounters
- Physician orders
- Election statements
- Attending physician designations
- Notice of revocation or transfer

OIG Compliance Program Expectations

Presence of a Robust and Functioning Compliance Program

OIG Areas of Identified Risk

Key Due Diligence Issues Encountered

Specific Issues Identified through Due Diligence

- ✓ Medical director issues
- ✓ Change of ownership/36 Month Rule
- ✓ Compensation of sales force
- ✓ Integrated health system issues
- ✓ Relationships with referral sources
- ✓ Length of stay concerns
- ✓ Certification of terminal illness
- ✓ Face to face encounters
- ✓ Employee/Independent Contractor classification

Length of Stay (LOS) Concerns & Hospice Live Discharge / Revocation Rates

Overview

- Patients mix with length of stay over “X” days
  - Home health / hospice
- Is there a process to review long length of stay patients?
- High rate of live discharge patients?
  - Heightened compliance risk of admitting patients who aren't actually passing

Examples

- The average hospice length of stay for Medicare beneficiaries is 77 days.
- GAO reported that in 2017 more than 22% of Medicare beneficiaries who enrolled in hospice were discharged alive.

Certification of Terminal Illness

Overview

- For a patient to be eligible for the Medicare hospice benefit, the patient must be certified as being terminally ill.
- Critical piece of documentation necessary for Medicare payment for the hospice services you provide.
- Hospice providers must submit the NOE within 5 calendar days after the hospice admission.
- A common reason for hospice certification errors are related to a missing or invalid physician narrative statement.

Examples

- Through a Quality of Earnings chart audit, it is discovered that the Target has numerous certification errors: predating physician(s) certification signatures, no physician(s) signatures, narrative missing and/or incomplete information and or illegible, etc.
- Stated revenue could be in jeopardy as payments from Medicare could be clawed back after a CMS audit.

FACE-TO-FACE ENCOUNTERS

Overview

- The Patient Protection Affordable Care Act mandates that a physician have a face-to-face encounter (in-person visit) for Medicare and Medicaid home health services.
- There is a no standard CMS form for the certification documentation which could lead to issues during a chart audit.

Examples

- Through a Quality of Earnings chart audit, it is discovered that the Target has not complied with face-to-face encounter documentation requirement.
- Stated revenue could be in jeopardy as payments from Medicare and Medicaid could be clawed back after a CMS audit.

Employee / Independent Contractor Classification Issues

Overview

- Worker misclassification
  - Social Security taxes / unemployment insurance (UI) taxes
- Proper classification test
  - Behavioral control / financial control / type of relationship

Examples

- Concentration of staff in a state which is contemplating the passing a “gig economy” legislation making it very difficult to have independent contractor arrangements with staff. Buyer suggests EBITDA overstated given future benefits and tax hits to making staff employees.

Medical Director Issues

- Likely the largest source of FCA liability in home health qui tam lawsuits
- Almost half of reported home health FCA settlements in last five years involved improper medical director payments; much less so for hospice.
- All settlements involved “substantive violations” - payments for referrals
- Watch out for “technical” violations under Stark for home health, which is DHS.
- Common technical violations: Unsigned agreements, expired agreements, minor FMV issues, etc.
- FCA cases in last five years have not focused on technical violations, but sometimes a buyer will require a refund or self-disclosure for technical violations to avoid “Reverse False Claims Act” liability.

The 36 Month Rule

42 CFR Section 424.550

- Applies to Home Health transactions only
- **Rule:** If there is a change in majority ownership of a home health agency by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the agency's initial enrollment in Medicare or within 36 months after the agency's most recent change in majority ownership, the provider must re-enroll in Medicare and be resurveyed re-accredited.

Regulatory Exceptions

- The 36 Month Rule contains several exceptions:
  - The agency has submitted two consecutive years of full cost reports
  - Internal restructurings
  - Change of entity type
  - Death of an owner

Slide 26

1 Combined the 42 CFR/Regulatory Exceptions slides for flow, can split again if preferred.
Unknown, 1/1/1900

THE 36 MONTH RULE: "EXCEPTION" IN THE COMMENTARY

- ✓ The commentary to the final rule indicates that changes of ownership at a parent company level or other indirect ownership changes do not trigger the 36 Month Rule's application.
- ✓ Consider this commentary when organizing home health agencies – add another layer of entity ownership to facilitate later sales.

Compensation of Sale Force

Most sales forces at home health and hospice agencies are paid on a commission basis.

Lawyers wince when they see the terms of the compensation for the sales force.

Look out for Caris problems – pressure to perform resulting in inappropriate admissions.

Agencies rely on the employment exceptions for both AKS and Stark.

Although these exceptions likely "work" to cover commissions, make sure that all commissioned employees are bona fide employees.

Some courts have avoided protection of the exception in egregious cases: see discussion of **Starks** and **Borassi** in outline.

Relationships with Referral Sources

- Home health and hospice agencies often have many, many leases for small amount of space
- Sometimes these leases are with referral sources, such as building partnerships owned by physicians, or with health systems or nursing homes
- Sometimes the real estate relationships are poorly administered, resulting in expired leases, rent increases inconsistent with the escalation clause, missing signatures, missing exhibits, etc.
- Poor administration can raise AKS and Stark issues
- Watch out for FMV issues

Integrated Health System Issues

Purchasing a home health or hospice (or a home health or hospice company) from health system or a chain provider of "upstream" services such as hospitals raises special issues.

Referrals will of course flow from the acute provider its captive home health or hospice unit, which is almost always a separately incorporated unit and always has a distinct enrollment with Medicare. Sometimes the various providers are not wholly owned or wholly controlled by a common parent, as is the case where one of the providers is a joint venture.

Diligence issue to watch out for:

- Is any patient steering from the upstream provider to the agencies too heavy handed to pass muster under the patient choice rules?
- Are the agencies essentially providing free discharge planning to the upstream provider?
- Is PHI being shared inappropriately?

Encountering Qui Tam Litigation or Open Audits in Transactions: Dead Deal or an Escrow?

- Difficulty in complying with the complex regulatory and sub-regulatory structure of the home health and hospice reimbursement systems creates an industry replete with audits by various Medicare contractors.
- UPICs, ADRs and TPE's are common.
- Qui tam actions are common also.
- UPIC and other audits often have a "worst case" scenario that can serve as the basis for determining the size of an escrow.
- Consider paying off the amount claimed in full, stopping the interest accrual, and pursuing a refund by proceeding with appeals as a way of satisfying a buyer.
- In the qui tam context, consider the effect of the Supreme Court's decision in Allina, the so called "Brand Memo" inside the DOJ, and new DOJ policy essentially limiting the pursuit of FCA cases based on "subregulatory" guidance.
- Estimate damages based on an Allina analysis of medical records subject to a qui tam driven civil investigative demand?

Thank you!

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