Institute on Medicare and Medicaid Payment Issues, March 2013

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Healthcare Transactions & Medicare's Change of Ownership (CHOW) Rules

AHLA Medicare & Medicaid Payment Institute
March 20-22, 2013
Baltimore, MD

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Why are CHOWs Important?

- Impacts Your Provider Agreement
  - Automatic Assignment
  - Successor Liability v. New Enrollment
- Impacts Your Medicare Certification
  - May require a new survey
  - Requires a filing of final cost report
- Potentially Impacts Medicare Payment
  - May affect both seller and owner's reimbursement (i.e., cost report issues)
  - May affect new owner's future payment—excluded units, costs to charge ratios, etc.

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One Deal-Multiple CHOW Determinations

- CHOW for Medicare purposes
  - Main Provider
  - Sub-Providers
- CHOW for state licensure purposes
  - Often includes stock deals (or change of control)
- CHOW for CON purposes
  - If CHOW, may require a CON
  - Even if not a CHOW, may require a determination that not a CON event
- CHOW for State Medicaid purpose
  - Often ill defined by state law
  - May or may not follow Medicare

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What Do We Mean By A CHOW?

- Basic Principle: If the person/entity with ultimate responsibility for the provider changes, typically a CHOW results
- General Rules set forth at 42 C.F.R. §489.18 and at SOM, Chapter 3, § 3210.1-3210.5.
- Medicare CHOW determinations generally require
  - An examination of the nature of the transaction; and
  - An examination of the nature of the provider.

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What Do We Mean By a CHOW?

- Look at the nature of the transaction to determine if a CHOW occurs:
  - **Partnership**: Will the transaction result in the dissolution of the partnership? If so, a CHOW.
  - **Sole Proprietorship**: Is the sole proprietorship selling the enterprise to another? If so, a CHOW.

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What Do We Mean By A CHOW?

- Corporations
  - Will the corporate entity that owns the provider stay in existence post-closing of the transaction and remain responsible for the provider? If so, a CHOW.
  - Stock transactions: Not a CHOW because the same corporate entity is responsible for the provider both before and after the closing. If the transaction is simply changing shareholders, then no CHOW. Note: Uncertainty regarding HHA's and stock transfers.
  - Asset sales: Although not specifically mentioned in the regulations, asset sales always result in a CHOW because the responsible entity changes. Addressed in SOM and case law.
  - Mergers: It depends. Will the corporate entity that owns the provider stay in existence?

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Quasi-Transactions

- Lease Agreements
  - Typically, not a CHOW
  - However, if change in party with operational responsibility can result in a CHOW to lessee
  - If landlord shares operational responsibility, may be treated as a partnership or a management agreement
- Management Agreements
  - Typically, not a CHOW so long as owner retains ability to approve operational authority
  - Will result in a CHOW "when the owner has relinquished all authority and responsibility for the provider organization."
- Cessation of Operations

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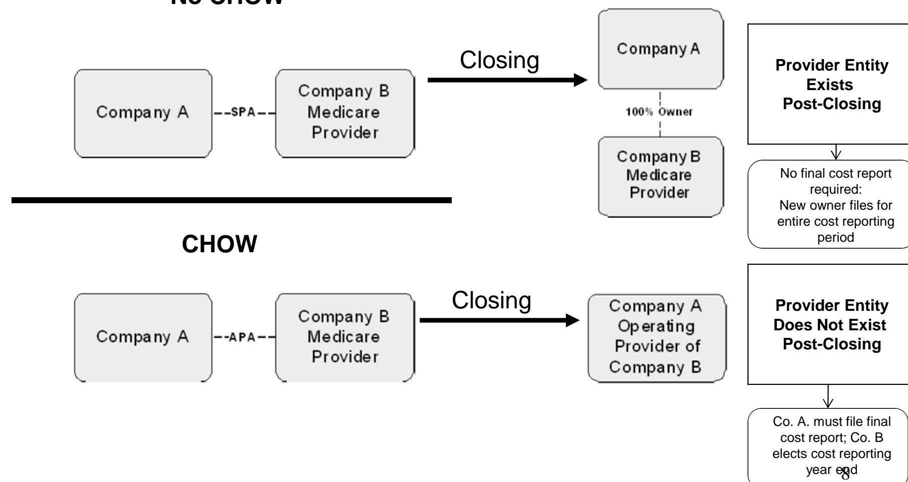
CHOWs of Corporations



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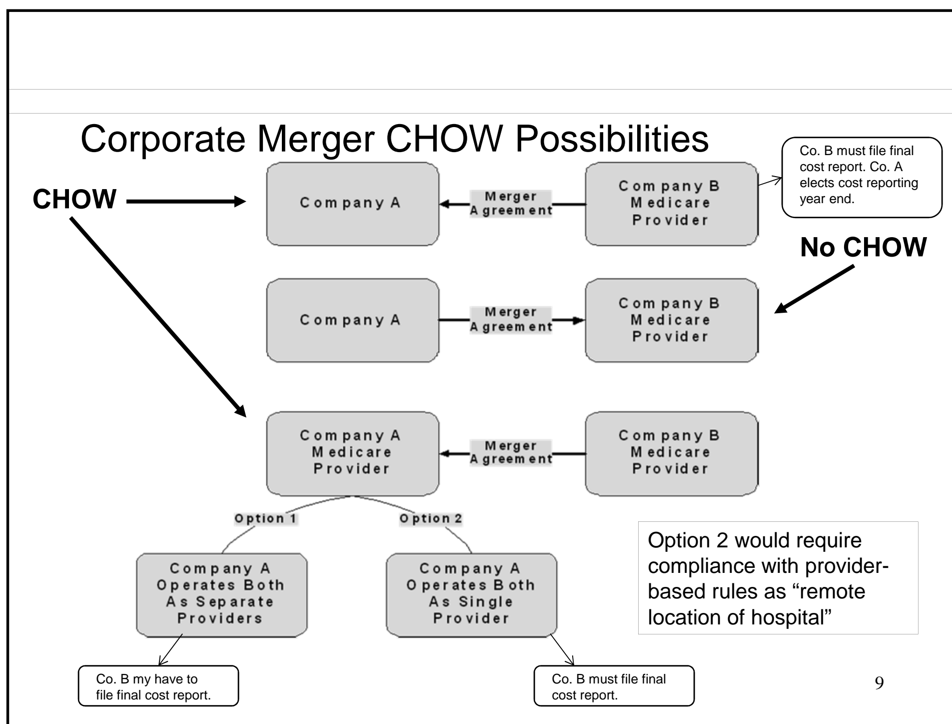

Broader CHOW Definition for HHA's

- <u>**36-Month Rule (42 C.F.R. § 424.550(b)(1))**</u> :

  If majority ownership of a HHA changes by sale (*including stock transfers, mergers, consolidations, transfers, etc.*), within 36 months of the HHA's Medicare enrollment or prior change of majority ownership, the provider agreement and Medicare billing privileges will not be conveyed to the new owner.

- **The new owner must re-enroll as a new HHA, obtaining a new survey or accreditation.**

- **CMS does recognize exceptions in the following situation:**
  - **HHA's parent organization is undergoing an internal corporate restructuring;**
  - **HHA has submitted two consecutive years of <u>full</u> cost reports;**
  - **Existing owners changing business structure; or**
  - **Individual owner of HHA dies.**

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The Difference Between Suppliers & Providers

- "**Provider of services**" generally means a hospital, CAH, SNF, CORF, HHA, or hospice.
- "**Supplier**" means physician, practitioner or facility that furnishes items or services reimbursable by Medicare Part B.
- **Importance**: 42 C.F.R. § 489.18 only applies to providers.
- The problem of suppliers subject to survey or certification.
  - 855B requires hospitals, ASCs and portable x-ray suppliers to submit
  - Enrollment rules tend to divide the world into providers and suppliers covered by 42 C.F.R., part 489 and other suppliers.

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Importance of Designation

- Provider
  - Company A purchases Hospital B through an asset purchase
  - CHOW for Medicare purposes
  - Auto assignment of provider agreement
- Supplier (Not Certified)
  - Company A purchases Imaging Center B through asset purchase
  - Not a CHOW for Medicare purposes
  - New Owner submits 885B for initial enrollment—effective as of the date Owner can show in compliance with coverage criteria (CMS has indicated that later of date of application or above standard)
- Certified Supplier
  - Company A purchases ASC B through asset purchase
  - File 855B for CHOW
  - New provider number
  - New provider agreement?

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Distinguishing between Provider Agreement and Provider Number

- Provider Number now a CCN (CMS Certification Number)
- Generally used interchangeably
- There are, however, situations where the Medicare agreement can be assigned but a new provider number issued
  - ASCs
  - ESRD clinic that changes status (hospital based to freestanding) as a result of a CHOW
- CMS (and especially its contractors) have not been very good about clarifying the distinctions or clearly stating the effect of such distinction
- *Query*: If CMS has not clearly stated that successor liability arises and new owner is given new provider number, should new owner have successor liability?

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Lessons Learned

- Make sure operational people understand whether a CHOW or not
- Use "before and after" diagrams in dealing with regulators
- If a sub-unit has its own Medicare agreement, then you must submit a separate 855
- Distinguish between changing provider types (requires initial enrollment) and provider sub-types (can be part of a CHOW)
- Tax Identification Numbers should not always control the determination but they often do
- A word of caution about NPIs
- New Issues – impact on participation in ACOs, impact on meaningful use dollars, etc.

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CHOW Process-New Owner's Perspective

- Give notice of a transaction as early as possible so that discussions can be had with CMS RO, FI and SA regarding the effect of the transaction.
  - If not accepting automatic assignment, must give 45 day notice.
- Submit "new owner" 855 as soon as possible
  - Range: 30-90 days pre-closing (depending on provider/supplier) to 30 days post-closing
- Submit "old owner" 855 as soon as possible
  - Should be within 14 days of each other
- FI reviews and makes recommendation to Regional Office
- RO makes final determination

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Be Aware of the Enrollment Rules

- Medicare enrollment rules-42 C.F.R. § 424.500 et seq.
- Provisions affecting CHOWs:
  - Reporting requirements (424.520(b)): change of information (90 days); "change of ownership or control" (30 days)
    - Query: Is a stock transaction a change of information or control?
    - Failure to comply: deactivation or revocation
  - Prohibits the sale or transfer of billing privileges (424.550)
    - Requires both the current owner and the new owner to submit 855s
    - Failure of current owner to do so can result in penalties post-closing of the CHOW
    - Failure of the new owner to do so can result in deactivation of the Medicare billing numbers
  - Clarification of Effective Date for Reimbursement Purposes (424.510(b))
    - Providers & suppliers that require survey, certification or accreditation - 42 C.F.R. § 489.13
    - Non-surveyed, certified or accredited suppliers--42 C.F.R. § § 424.5 & 424.44)
    - DMEPOS suppliers-42 C.F.R. § 424.57

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Automatic Assignment: Lost Revenue v. Successor Liability

How Much Are You Willing to Pay for a Clean Slate?

The Downside of Auto-Assignment

- New Owner becomes liable for the Old Owner's
  - Plans of Correction
  - Health and Safety Standards
  - Ownership and Financial Disclosure Requirements
  - Compliance with Civil Rights Requirements
- CMS asserts
  - New Owner liable for all Medicare sanctions and penalties
  - Except for "fraud" by prior owner—unless corporate fraud & stock deal
- Courts have held:
  - Medicare Overpayments of Old Owner—Vernon Home Health & Triad
  - CMP of Old Owner—Deerbrook Pavilion (8th Cir.) & Loess Nursing Home
- Settlements:
  - St. Francis (2004): Settled $9.5 million based upon billing & documentation errors found by the purchaser and self-reported
  - Fresenius (2000): Settled $468 regarding lab billing problems associated with NMC, which Fresenius acquired through merger

Can I Avoid Auto-Assignment?

- *Yes*, but you need to plan ahead.
- State Operations Manual, Chapter 3, § 3210.5.
  - Refusal must be in writing by the new owner and forwarded to the Regional Office at least 45 days prior to the CHOW date
  - Suggests that can be done post-closing
  - From an enrollment perspective, the old owner voluntarily terminates as of the closing and the new owner enroll as an initial enrollment
  - Earliest date of enrollment of new owner: date that the RO determines all Federal requirements are satisfied
    - Enroll with the FI (855)
    - Undergo OCR clearance
    - Initial survey
      - Impact of Accreditation

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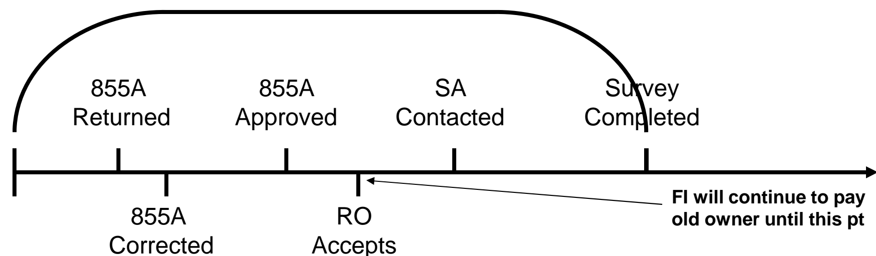
The Benefit of Auto-Assignment

- New Owner becomes eligible for Medicare payment upon the closing of the CHOW event—payment delay
- If New Owner refuses automatic assignment, New Owner will typically not become eligible for Medicare reimbursement until after a survey



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Finding a Balance

- Can you approximate the overall risk in due diligence?
  - Surveys, denied claims, recoupment and set-offs, documentation review, previously filed cost settlements, etc.
- Can you allocate risk via the Purchase Agreement?
  - Escrow, indemnification, etc.
- Can you coordinate with CMS RO, FI, and SA to reduce the amount of time for initial survey?
- Can you withstand the lost revenue?
- My experience is that most parties end up taking automatic assignment.

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The Consequences of a CHOW

Final Cost Report

- Per PRM-I § 1502, Old owner must file a final cost report within 45 days of termination date
- Per PRM-II § 104, cost reports are due no later than five months following the effective date of termination of a provider agreement or change of ownership. These changes supersede the PRM-I § 1502 guidelines.

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Final Cost Report

- Terminating date must be consistent on 855 and cost report
- Costs to consider:
  - Gains/losses on disposals
  - Depreciation
  - Start-up and organizational costs
  - Self Insurance
  - Administrative costs post provider termination
  - Medicare Bad Debts (Kindred vs. WPS)
- Terminating cost report will not be tentatively settled

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New Owner Cost Report

- New owner selects reporting year end
  - Can file on no less than 1 month, no more than 13 months of data
- Cost report due five months after reporting year end
- Costs to consider:
  - Depreciable assets
  - Start-up and organization costs that were purchased from previous owner and unamortized
- Can generally change prior statistic elections, however must notify FI/MAC prior to effect
- Assignment of FI/MAC

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Payment Issues Associated with CHOW

- Medicare will continue to pay the old owner until the RO approves the CHOW (i.e., tie-in notice)
- This will typically be several weeks (months) after the closing date so that the parties need to make determinations as to AR (reassignment issues)
- Will not typically redirect payments during processing of CHOW
- The regulations provide for payment for capital and related costs of inpatient hospital services, including outlier payments, are made to the legal owner on the date of discharge.
  - Be aware of the transfer/discharge issue relevant to straddle patients
- Other payments for cost-reimbursed capital payments, direct medical education, certain anesthesia services, organ acquisitions and bad debt are made to the owner of the provider at the time the service is provided.

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Is it a CHOW for reimbursement purposes?

- Keep in mind: This is a separate determination than the certification determination.
- For most CHOWs, this is less of an issue today than in the past.
- However, even today, CHOWs can have unintended consequences on payment/reimbursement so need to consider the issues.
- Also, need to look at the reimbursement effect on both the seller and the new owner.

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Payment Implications of CHOWs

Avoiding Surprises in the CHOW Context

Payment Implications of CHOWs

- Merger/Acquisitions & Consolidations may impact the following payments to Hospitals:
  - Direct GME (note change in treatment as of 10-1-06)
  - Indirect Medical Education Adjustment
  - DSH
  - Capital PPS
  - Geographic Reclassification
- In addition, if payment is in transition, a CHOW may speed up the transition.

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Avoiding Surprises in CHOWs

- Excluded Units (IPF and IRFs)
  - Can only change status to excluded/increase square footage or number of beds at beginning of cost reporting period
    - Revised Aug. 5, 2011. Can now expand bed size or square footage at any time during the cost reporting period.
  - Can only have one of each type of excluded unit

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HEALTHCARE TRANSACTIONS & MEDICARE'S CHANGE OF OWNERSHIP RULES

By: Thomas E. Bartrum, Esq.

I. What constitutes a change of ownership ("**CHOW**") for Medicare purposes?

A. As a preliminary matter, to determine whether a CHOW results from a particular transaction, it is important to make a few preliminary inquires:

1. What is the nature of the transaction? and

2. What is the nature of the Medicare provider/supplier that is the subject of the transaction?

B. The nature of the transaction is important because CMS guidance on what constitutes a CHOW primarily relates to the nature of the particular transaction. CHOWs "are officially defined and governed by 42 C.F.R. § 489.18 and State Operations Manual (Pub. 100-07), Chapter 3, §§ 3210-3210.5.C. The Regional Office generally makes the final determination as to whether a CHOW has in fact occurred." Medicare Program Integrity Manual (Pub. 100-08), Chapter 15, § 15.7.7.1, (Rev. 423, Issued: 6-01-12, Effective: 07-02-12, Implementation: 07-02-12). While this section of the Medicare Program Integrity Manual references the possible delegation of the CHOW determination by the Regional Office ("**RO**"), an attorney with the Office of the General Counsel of the Department of Health and Human Services has advised that they were not aware of any instances in which the RO had actually delegated this authority to the FI/carrier; thus, for practical purposes, the applicable RO would be the ultimate decision maker as to whether a transaction will constitute a CHOW.

C. CMS' position regarding CHOWs can best be understood by understanding why CMS believes the CHOW is necessary:

1. For program participants that have Health Benefit Agreements or Provider Agreements with the Medicare program (hospital, SNF, HHA, hospice, CORF, OTPT/SP providers and CMHC), a CHOW is important because it must be determined who the responsible party is under the agreement.

2. CMS has similar concerns with respect to participating suppliers that have category-specific agreements with the Secretary (RHC, ASC, and FQHCs) or that must file cost reports (e.g., ESRD facilities).

3. For other supplier types (i.e., supplier types without agreements or cost report requirements (e.g., PXR)), the CHOW process is generally to ensure compliance with the statutory requirement for ownership disclosure and to ensure that the program has current, accurate records regarding such participants.

D. CMS offers the following guidance as to whether a transaction results in a CHOW:

1. In the context of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by state law, constitutes a CHOW. 42 C.F.R. § 489.18(a)(1). Hence, the addition of a new partner to a partnership will typically constitute a CHOW; however, if the partnership agreement expressly provides that an additional partner can be added to the partnership without resulting in the dissolution of the partnership and state law governing the partnership allows such result, the addition of a new partner to an existing partnership will not result in a CHOW. State Operations Manual (Pub. 100-07), Chapter 3, § 3210.1.D.2.

2. In the context of an unincorporated sole proprietorship, any transfer of title or property (related to the supplier or provider) of the enterprise constitutes a CHOW. 42 C.F.R. § 489.18(a)(2); see also State Operations Manual (Pub. 100-07), Chapter 3, § 3210.1.D.1.

3. In the context of a corporation, the merger of the provider corporation into another corporation or the consolidation of two or more corporations resulting in the creation of a new corporation constitutes a CHOW. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a CHOW. 42 C.F.R. §489.18(a)(3); see also State Operations Manual (Pub. 100-07), § 3210.1.D.3.

4. Although the regulations do not address asset purchases in the context of corporations, CMS takes the position that an asset purchase of a provider constitutes a CHOW. See Provider Reimbursement Manual, Part I, §1500.7. This position has been upheld by the Fifth Circuit in the Vernon Home Health case. U.S. v. Vernon Home Health, Inc., 21 F.3d. 693 (5th Cir.), cert. den., 513 U.S. 1015 (1994).

5. The leasing of all or part of a provider constitutes a CHOW with respect to the leased portion. 42 C.F.R. §§ 489.18(a)(4) & (e). Here, the issue is not whether the owner owns or leases the real estate or premises but whether the "landlord" makes or participates in decisions regarding the ongoing operations of the provider enterprise. If so, CMS would treat the arrangement as a partnership or management situation, and a CHOW would result. State Operations Manual (Pub. 100-07), Chapter 3, § 3210.A.

6. In the bankruptcy context, if the debtor continues to operate the provider post-filing of bankruptcy (i.e., debtor in possession), no CHOW, for reimbursement purposes. If the trustee operates the provider post-filing of bankruptcy, a CHOW is recognized for reimbursement purposes. Provider Reimbursement Manual, Part I, §1500.7.

7. Management agreements will not typically result in a CHOW for Medicare certification purposes so long as the owner of the provider retains the ability to approve the operating decisions even if substantial authority is given to the manager as an agent of the owners. The State Operations Manual provides that a management agreement would result in a CHOW only "when the owner has relinquished all authority and responsibility for the provider organization." State Operations Manual (Pub. 100-07), §3210.1.D.5.

8. With respect to franchise relationships, CMS will first determine between the franchisee or franchisor who has responsibility to Medicare as a provider. Then, CMS will

process the CHOW based upon the basic principle as to whether the responsible entity has changed as a result of the transaction. State Operations Manual (Pub. 100-07), §3210.1.D.6.

9. Increasingly, provider entities are being set up as limited liability companies. As such, the entity has certain characteristics of a partnership and certain characteristics of a corporation. There is a letter, from 1999, from the CMS Administrator, that finds that LLCs should generally be analyzed under the partnership standards. Unlike partnerships, however, LLCs rarely provide for dissolution upon the addition of a new member of the departure of a member. Accordingly, the issue is generally whether the transaction results in a different legal entity being responsible for the provider.

10. Although the issue of whether a transaction constitutes a CHOW for Medicaid purposes is beyond the scope of this presentation, there is additional statutory guidance with respect to the effect of a CHOW on assignment of the Medicaid agreement for NFs and SNFs. 42 C.F.R. § 442.14(b).

10. Additionally, November 10, 2009, CMS adopted new regulatory language that complicates the change of ownership analysis where home health agencies are concerned. 74 Fed. Reg. 58078, 58134 (discussion regarding CMS' rationale for the change at74 Fed. Reg. 58078, 58118). 42 C.F.R. § 424.550(b)(1) provides: "if an owner of a home health agency sells (including asset sales or stock transfers), transfers or relinquishes ownership of the HHA within 36 months after the effective date of the HHA's enrollment in Medicare, the provider agreement and Medicare billing privileges do not convey to the new owner." 42 C.F.R. § 424.550(b)(1)(i) and (ii) require the new owner to enroll as a new HHA provider and either obtain a new State survey or "accreditation from an approved accreditation organization." Id. Because stock transfers are not transactions constituting changes of ownership pursuant to 42 C.F.R. §489.18(a)(3), there is some uncertainty regarding the application of the new regulation with respect to stock transfers of companies that own HHAs. However, Transmittal 318 (Dec. 18, 2009) instructs Medicare Administrative Contractors, Fiscal Intermediaries and Regional Home Health Intermediaries to determine upon receipt of a CMS-855A for a HHA whether the transfer date listed on the transfer agreement (as opposed the CMS 855A) occurred within 36 months of either the provider's Medicare enrollment or the effective date of the last change of ownership for that provider. If the sale of the HHA is already past, the contractor is instructed to deactivate the HHA's billing privileges.

E. The nature of the provider/supplier is important because, by its own terms, the CHOW regulation only applies to "providers". See 42 C.F.R. § 489.18 ("Effect on provider agreement"). Technically, CMS distinguishes between "providers" and "suppliers" for Medicare purposes:

1. A "**supplier**" is a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services. 42 U.S.C. §1395x(d).

2. A "**provider of services**" means a hospital, CAH, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, in certain situations, a fund. 42 U.S.C. § 1395x(u). This definition is expanded somewhat by 42 U.S.C. § 1395n(a)(2), which includes a clinic, rehabilitation agency, or public health agency to

the extent that such is furnishing outpatient physical therapy or speech pathology services. The regulations further define provider of services at 42 C.F.R. §§ 400.202 & 489.2(b). In order to bill Medicare for services, the provider must have a provider agreement with Medicare. 42 U.S.C. § 1395cc(a)(1). The State Operations Manual differentiates between providers and suppliers by noting that providers care for patients awaiting, receiving or recuperating from treatment by intervening practitioners. State Operations Manual (Pub. 100-7), Chapter 2, § 2002.

3. Medicaid does not recognize the definitional distinction between provider and supplier. Compare 42 C.F.R. § 400.202 (Medicare definitions) with 42 C.F.R. § 400.203 (Medicaid definitions).

4. Nonetheless, despite the plain meaning of 42 C.F.R. § 489.18, CMS clearly attempts to impose certain CHOW standards and responsibilities beyond providers to those suppliers that must be surveyed, certified or accredited. The new CMS 855B form, however, only requires the reporting of CHOW information for hospitals, portable x-ray suppliers and ambulatory surgery centers ("**ASCs**").

5. The State Operations Manual recognizes the following special treatments for suppliers undergoing a CHOW:

a. ASCs and portable x-ray suppliers must receive a State survey and formal RO approval before they are enrolled in Medicare. Technically, suppliers do not undergo CHOWs (in that they must enroll as a new supplier when a CHOW event occurs). CMS, however, will allow assignment of a provider agreement for an ASC but, in doing so, will issue a new CCN.

b. If a hospital undergoes a CHOW and wants to continue billing for practitioner services, it should indicate this on the 855B. State Operations Manual (Pub. 100-07), Chapter 3, § 3210.

F. In addition to distinguishing between CHOWs and non-CHOW transactions, CMS now distinguishes between "standard" CHOWs, Acquisitions/Mergers, and Consolidations. See Medicare Program Integrity Manual (Pub. 100-08), Chapter 15, § 15.7.7.1.1.

1. A "standard" CHOW occurs when a provider agreement (and CCN number) is transferred to another entity as a result of such entity's purchase of a Medicare-enrolled provider. For example, Company A, which owns and operates a Medicare provider, is acquired by Company B through an asset purchase resulting in a CHOW. Technically, this is an acquisition but considered a "standard" CHOW for Medicare purposes. See id. § 5.5.2.1.

2. CMS defines an "acquisition/merger" as a transaction that results in two or more Medicare providers combining so that one provider agreement remains in effect at closing. Id. For instance, if two companies, each of which own a Medicare enrolled hospital, merge (i.e., so that only one company remains), the transaction would be treated as an acquisition/merger by CMS, if as a result of the merger, the two hospitals would continue to be operated under the single Medicare number of the surviving entity.

3. For enrollment purposes, CMS further distinguishes consolidations from "standard" CHOWs and merger/acquisitions. A consolidation occurs when two or more providers consolidate their operations (and provider agreements) into a new entity resulting in a new entity, a new tax-identification number and, presumably, a new provider agreement. CMS distinguishes from a "merger/acquisition" situation in that there is no surviving entity in the consolidation situation.

4. To summarize, from an enrollment perspective, there are five possible outcomes with respect to a particular transaction: (1) the transaction does not result in a CHOW; (2) the transaction results in a CHOW with automatic assignment; (3) the transaction results in a CHOW without automatic assignment; (4) the transaction results in a merger/acquisition with the elimination of one or more provider numbers; or (5) the transaction results in a consolidation with the creation of a new entity. See Medicare Program Integrity Manual (Pub. 100-08), Chapter 10, §5.5C.

G. CMS sets forth the following general rules regarding CHOW analysis:

1. Medicare determination of whether a CHOW has occurred is separate from the state licensing decision;

2. The cessation of operations results in a termination of the provider agreement and a CHOW cannot follow such cessation;

3. The Medicare provider number will generally follow the Medicare provider agreement and cannot be sold or otherwise assigned;

4. It is helpful to construct a "before and after" chart;

5. Medicare will typically recognize a CHOW at 12:01 am on the date of the closing (unless another date is given in the sales agreement); and

6. CMS will not process a CHOW prior to the effective date (but FIs will begin the review up to 90 days prior to closing). See State Operations Manual (Pub. 100-07), Chapter 3, § 3210.1.E. Note that the submission of a CHOW application prior to three (3) months for "providers" or thirty (30) days for suppliers before the closing date will result in an automatic return of the 855 application. Medicare Program Integrity Manual (Pub. 100-08), Chapter 10, § 3.2A. (Rev. 289, issued 04-15-09; effective 01-01-09).

H. For purposes of CHOW determinations, it is also important to distinguish between the "provider agreement" and the "provider number." Although CMS does not do a very good job of making such a distinction (and the terms are often used interchangeably by the population at large (and the FIs)), CMS clearly recognizes that certain CHOWs require the issuance of a new provider number. See State Operations Manual (Pub. 100-07), Chapter 3, § 3210.4C. It is, however, unclear whether such an arrangement would result in successor liability.

I. There are a number of issues that can further complicate a CHOW analysis and change how CMS treats the transaction:

1. Relocation of the provider/supplier concurrent with the CHOW;

2. The presence of provider-based locations;

3. The presence of sub-units with separate provider agreements from the main provider;

4. CHOW of either a host hospital or a hospital within a hospital;

5. Expansion of services concurrent with the CHOW; and

6. Change in the type of enrollment of the provider as a result of a CHOW (e.g., conversion from a psychiatric hospital to a general acute care hospital). See generally State Operations Manual (Pub. 100-07), Chapter 3, § 3210 et seq.

II. The Effect of a CHOW

A. From CMS' perspective, a proposed transaction results in two types of program reviews: (a) a determination of whether the transaction results in a CHOW for Medicare certification and provider agreement purposes and (b) a determination of whether the transaction results in a CHOW for Medicare reimbursement purposes. Medicare Intermediary Manual, § 4501. Further, these reviews may arrive at different results. That is, a CHOW may result for one purpose but not the other purpose. For instance, although an operational lease will result in a CHOW for certification purposes, it will not result in a CHOW for reimbursement purposes because the lessee has not acquired a non-depreciable asset (i.e., leasehold interests are not depreciable). See Medicare Intermediary Manual, § 4502.B.

B. If a transaction results in a CHOW for certification and Medicare provider agreement purposes, the following results:

1. The Medicare provider agreement is automatically assigned to the new owner. 42 C.F.R. § 489.18(c).

a. The new owner takes the provider agreement subject to all terms and conditions under which the provider agreement was originally issued, including: (a) any existing plans of correction; (b) compliance with applicable health and safety standards; (c) compliance with ownership and financial interest disclosure requirements (See 42 C.F.R. §§ 420.205 & 420.206); and (d) compliance with the civil rights compliance requirements of Title 45, Parts 80, 84, & 85. 42 C.F.R. § 489.18(d).

b. In the Manual provisions, CMS supplements the language of the regulations taking the position that: "With assignment, the new owner assumes all penalties and sanctions under the Medicare program, including the repayment of any accrued overpayments, regardless of who had ownership of the Medicare agreement at the time the overpayment was discovered unless fraud was involved."

c. In addition, there have been a number of court cases that have used 42 C.F.R. §489.18(d) as the basis for holding the new owner responsible for the following liabilities of the prior owner:

(i) Medicare overpayments (U.S. v. Vernon Home Health, Inc., 21 F.3d. 693 (5th Cir.), cert. den., 513 U.S. 1015 (1994); Triad v. Blue Cross Blue Shield of Georgia, PRRB Decision 2009-D21 (Apr. 17, 2009)).

(ii) Civil Monetary Penalties ("**CMPs**") (Deerbrook Pavilion, LLC v. Shalala, 235 F.3d 1100 (8th Cir. 2000); Loess Hills Nursing and Rehabilitation Center v. CMS, HHS DAB Civil Remedies Div., Dec. No. C-01-578, C-01-751 (Dec. 6, 2001) (landlord took possession from tenant for nine days).

(iii) False Claims Act Liability (no cases but a few settlements); and

(iv) Criminal liability (AKS, etc.) (no cases).

d. Further, the courts and CMS take the position that successor liability follows the provider agreement regardless of how the parties address the issue in the transactional documents or how state law would resolve the issue.

e. If the new owner does not want automatic assignment of the provider agreement, the new owner must take affirmative action to reject automatic assignment. Section 3210.5A of the State Operations Manual appears to be the only method to clearly avoid assignment of the old owner's provider agreement. Specifically, the burden is placed on the new owner to put its refusal to accept assignment in writing to the RO at least 45 calendar days prior to the effective date of the CHOW. In such instance, the new owner will have to enroll as an "initial enrollment" in Medicare and the effective date of such enrollment will be the date on which the RO determines that all of the requirements

f. 42 C.F.R. § 488.414(d)(3)(i) provides that "[a] facility may not avoid a remedy on the basis that it underwent a change of ownership."

2. Per the Provider Reimbursement Manual, Part I, § 1502, a final cost report must be filed by the prior owner within 45 days of the closing of the CHOW. Per PRM-II § 104, cost reports are due no later than five months following the effective date of termination of a provider agreement or change of ownership. These changes supersede the PRM-I § 1502 guidelines.

3. Historically, the new owner was allowed to designate its preferred Fiscal Intermediary ("**FI**"). However, this provision of the law sunset in 2005 and providers no longer have the ability to designate their preferred FI. See Transmittal 24 (January 26, 2007). If the transaction results in a CHOW and the new owner take assignment, the new owner will be assigned to the old owner's FI. State Operations Manual, Chapter 3, § 3210.4A. If the new owner does not take assignment, the new owner will be assigned to the local designated FI.

Chain organizations can still elect the chain FI. State Operations Manual (Pub. 100-07), Chapter 3, § 3210.3 (except CMS has changed its position on this several times over the last couple of years).

4. Both the buyer and the seller must complete and submit an 855 for the CHOW. See also 42 C.F.R. § 424.540(a)(2) (setting forth reasons for deactivation of Medicare billing privileges, which include the failure to notify the RO and FI of a change of information (within 90 days post-change) and a "change of ownership or control" (30 days post-change). The Medicare Integrity Manual instructions (and new 855A forms) further distinguish between "standard" CHOW obligations, merger/acquisition obligations and consolidation obligations.

5. Generally, a CHOW does not require a special survey by the State Survey Agency ("**SA**"). There are, however, a number of exceptions. For instance, if a new location is added or different types of services will be offered post-closing, the SA may conduct a survey. On November 2, 2011, the Departmental Appeals Board decided in the case of a hospital that acquired the assets of another hospital but declined to accept the liabilities, operating the newly acquired hospital as a separate campus of the acquiring hospital, that CMS would only reimburse for those charges back to the date of the extension survey of the new campus, which was completed by the Joint Commission some eight and a half months after the CHOW date. Because the acquiring hospital did not assume the liabilities of the target hospital, CMS treats the acquisition as termination of the acquired campus's participation agreement, which required a full Medicare certified survey prior to billing Medicare, based on a CMS Survey and Certification Memorandum issued in 2008. Mission Viejo Hosp. Med. Ctr. v. Ctrs. for Medicare and Medicaid Serv., Docket No. C-11-446, Decision No. CR2458 (Nov. 2, 2011)(citing Ctrs. for Medicare and Medicaid Serv. Survey and Certification Group Memorandum, "Accreditation and its Impact on Various Survey and Certification Scenarios", Ref. S&C-09-08 (Oct. 17, 2008)). CMS's analysis hinges on their concern that if providers are allowed to decline to assume the assets of a target and but retrospectively bill back to the acquisition date, it could provide incentive for providers to sell their facilities when significant liabilities exist to "escape the financial responsibility to the Medicare program."

6. The new owner is allowed to designate its cost reporting year. State Operations Manual (Pub. 100-07), Chapter 3, § 3210.1.B1.

7. With respect to payment issues, parties to a CHOW should be cognizant of the following:

a. In a CHOW situation, CMS has instructed intermediaries to continue to pay the old owner until it receives the tie-in notice from the RO. Further, it has instructed the FI to not process any requests from either the old or new owner to change pay to accounts during the CHOW process. Medicare Program Integrity Manual (Pub. 100-08), Chapter 10, § 5.5.2.5. If the transaction is well planned, it may be possible to change the pay to account prior to the submitting the CHOW application. .

b. Nonetheless, if as a result of the CHOW, one or more provider agreements will be terminated or discontinued, the new owner should consider the risks associated with using those provider numbers in the interim between the CHOW and the

issuance of the provider tie-in notice. That is, even though the FI will continue to pay in merger/acquisition or consolidation cases, the new owner should not bill under discontinued provider numbers. The OIG has taken the position that "[a]ny use of the [the merged entity'] provider number for patient services after [the closing] date was improper. OIG, Office of Audit Services' "Review of Compliance with Medicare Regulations Related to the Consolidation of University Hospital and the Medical Center of Louisiana at New Orleans" (CIN: A-06-02-00012) (June 2003). The OIG's position is consistent with CMS' regulations regarding who is entitled to PPS payment for in-patient hospital services. See 42 C.F.R. § 412.125 (a) (discussed below).

c. Medicare regulations provide for the allocation of payments between a buyer and seller in a CHOW. Under the PPS regulations, payment for the capital and related costs of inpatient hospital services, including outlier payments, are made to the entity that is the legal owner of the provider on the date of discharge. 42 C.F.R. § 412.125 (a) Thus, Medicare payments will not be prorated between the buyer and the seller, even when the patient stay straddles the date of the transaction. Inappropriate billing in these types of situations has been a focus of the OIG in recent years.

d. Other payments for cost-reimbursed capital payments, direct medical education, certain anesthesia services, organ acquisition, and bad debt are made to the owner of the provider at the time the relevant services were provided. 42 C.F.R. § 412.125 (b).

e. Nonetheless, these payments can be allocated among the buyer and seller in the purchase agreement.

C. If a transaction results in a CHOW for reimbursement purposes, one must consider the reimbursement effect on both the seller and the new owner. Many of these issues have become less important recently as provider's move away from cost-based reimbursement and as Congress and CMS attempt to limit providers from gaming the system so as inflate costs to CMS. See, e.g., Balanced Budget Act of 1997, Section 4404 (eliminating Medicare recognition of losses on sales or scrapping of assets occurring on or after December 1, 1997).

D. A CHOW has certain reimbursement effects for the seller; mainly, the seller provider must make adjustments in its final cost report for: gains and losses on the disposition of depreciable assets (for transactions occurring before December 1, 1997), accelerated methods of depreciation, allowable losses from involuntary conversions exceeding $5,000 in any cost reporting period, losses resulting from demolition or abandonment, rental charges from lease-purchase agreements, start-up and organization costs, self-insurance, insurance purchased from a limited purpose insurance company, and certain administrative costs incurred after the CHOW. Furthermore, the intermediary will not make a tentative retroactive adjustment on the basis of a final cost report. Provider Reimbursement Manual, § 1503.

1. The most significant of these adjustments is for gains and losses on the disposition of depreciable assets. Under the Medicare program, providers have received cost reimbursement for depreciation on buildings and equipment used in the provision of patient care. Accordingly, a provider that, within one year after the CHOW, sold assets that were depreciated under the Medicare program had to recognize a gain or loss on the disposition of the assets. 42

C.F.R. § 413.134. The Balanced Budget Act of 1997 eliminated this recognition of gain or loss for transactions occurring on or after December 1, 1997. 42 U.S.C. § 1395x(v)(1)(O)(i). Congress was concerned "with providers which may be gaming the system by creating specious 'losses' in order to be eligible for additional Medicare payments." H. Rep. No. 105-149 (1997).

2. For transactions occurring on or after December 1, 1997, recognition for gain or loss is at the historical cost of the asset less depreciation allowed. 42 U.S.C. § 1395x(v)(1)(O)(i).

3. Program Memorandum (Transmittal No. A-00-76) issued on October 19, 2000 "clarifies" regulations regarding Medicare payment for gains or losses arising from transactions involving nonprofit corporations that occurred before December 1, 1997. Specifically, when two unrelated nonprofit entities merge and the surviving entity's board is comprised of equal representation of the two former entities' boards, Medicare will deem even previously unrelated parties to be related organizations as a result of the transaction. Furthermore, when nonprofit entities combine assets and liabilities on the merged or consolidated entity's books, or where the sale price is merely the assumption of debt by the new entity, Medicare does not consider this a bona fide sale for the purpose of gains and losses. Finally, when a sale price is only sufficient to cover the current assets sold, and there is minimal or no portion of the sales price attributable to the fixed assets (under the cost approach), Medicare will not deem this a bona fide sale. An interesting argument exists as to whether CMS had the authority to make this change via a Program Transmittal since the statute still provides for retroactive adjustments to previous payments. See Robert E. Mazer, Medicare Reimbursement May be Available for Post-12/97 CHOW Losses. The author is not aware of any court that has considered this argument.

4. Another significant cost to consider is the inclusion of Medicare bad debts claimed on the seller's final cost report. 42 CFR 413.8(e) provides the criteria that providers must meet in order to be reimbursed for bad debts under Medicare. Furthermore, 42 CFR 413.80(f) states, "The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed worthless." The Provider Reimbursement Review Board (PRRB) and the Administrator of CMS have continually held that allowable Medicare bad debts are only recognized in the period in which they are deemed worthless, regardless of which provider's service incurred the debt, Palms of Pasadena v. Sullivan, 932 F.2d 982(D.C. 1991); Kindred HealthCare v. Wisconsin Physician Services, PRRB Decision 2009-D10 (Feb. 27, 2009), rev'd CMS Adm'r Dec. (May 1, 2009).

E. A CHOW may have the following possible reimbursement effects on the manner in which the new provider is reimbursed for services rendered to program beneficiaries. Some of the reimbursement areas CMS identified as requiring special treatment on the new provider's cost report include: basis for depreciable assets acquired from the old provider or donated to the new provider, valuation of acquisition costs, involuntary conversion losses, demolition and abandonment losses, recovery of accelerated depreciation, and start-up and organization costs. PRM § 1504. Given capital PPS, these reimbursement effects are time-limited.

F. Providers are entitled to make certain elections that affect their Medicare payments (i.e., cost finding methods, useful life, bases of allocation, etc.). When a CHOW

occurs, the new owner generally can change prior elections. However, in instances where the change of ownership has been among related organizations, some intermediaries have refused to allow a change in elections. Furthermore, in some instances, there are limits on how many times certain elections may be changed. See 42 C.F.R. § 413.134(d)(2) regarding changes in depreciation methods. If a prospective surviving provider wants to change any of its elections after a merger, the provider should notify its intermediary of its desire prior to the effectuation of the merger.

III. The CHOW Process

A. A provider that is contemplating or negotiating a CHOW must notify CMS (one presumes that FI or RO office notification would be acceptable). 42 C.F.R. §489.18(b). Although no pre-closing time limit is imposed on such notice, any notice of a change of persons having an ownership or control interest in a supplier, must "report also within 35 days, on its own initiative, any changes in the information that it previously supplied." 42 C.F.R. §420.206(b)(3). Failure to provide such notice may result in revocation of the supplier's billing number. Id. § 420.206(c)(2). The Provider Reimbursement Manual requires notice to the FI and RO within 15 days after the closing of the CHOW. Provider Reimbursement Manual, Chapter 15, §1501.

B. The new enrollment rules, 42 C.F.R. §424.540(a)(2), provide for deactivation of Medicare billing privileges upon failure to report a change of information within 90 days and a "change of ownership or control" within 30 days.

1. CMS' use of the phrase "change of ownership or control" is unfortunate because it further confuses this area of the law. For instance, would a stock transaction of a provider result in a change of information (requiring reporting within 90 days) or a "change of control" (requiring reporting within 30 days).

2. Historically, such a transaction would have been treated as a change of information but such a result is unclear now. See previous discussion regarding CMS' 2009 changes to regulations regarding stock transfers of HHAs (Section I.D.10).

3. Further, given the fact that a failure to comply with the reporting requirements can result in the deactivation of the provider's billing authority, this is a real uncertainty that should be addressed more clearly by CMS.

C. Both seller and new owner submit 855A to the FI. See Medicare Integrity Manual (Pub. 100-08), Chapter 10; see also 43 C.F.R. §424.520(b).

D. FI reviews and confirms the 855A and then submits its recommendations, along with the 855A, to the state survey agency.

E. The state survey agency engages in any necessary fact finding and forwards its recommendations along with its findings to the Regional Office.

F. The Regional Office makes the final determination as to the acceptance of the CHOW.

IV. Certain Payment Effects of Certain CHOW Transactions

A. This section deals with issues where two providers merge or consolidate so that you have existing payment criteria for two different providers that must be taken into account for the surviving entity (in the case of a merger) or the new entity in the case of a consolidation.

B. A merger of hospitals, may impact the amount of payment of Graduate Medical Education ("**GME**") to the surviving entity. Specifically, the merger can impact both the FTE cap and the per resident amount.

1. Effect on FTE Cap:

a. When two hospitals merge, the surviving hospital's FTE cap will be an aggregate of the each hospital's FTE cap. See 67 Fed. Reg. at 50080 (Aug. 1, 2002) ("A merger of the two hospitals would aggregate the two hospitals' individual FTE caps into a merged FTE cap under the main hospital's provider number, and would require recalculation of the hospital's PRA and a merging of these entities' respective Medicare utilization, resulting in a level of Medicare GME payment to the merged hospital that could exceed the sum of the payments that would be made to each hospital as separate entities."). See also 63 Fed. Reg. at 26,328 (May 12, 2002).

b. With respect to the merger of a hospital subject to IPPS and a hospital excluded from hospital IPPS, 42 C.F.R. §412.105(f) (xiv) provides that "if the surviving hospital is a hospital subject to the hospital inpatient prospective payment system and no hospital unit that is excluded from the hospital inpatient prospective payment system is created as a result of the merger, the surviving hospital's number of FTE residents for payment purposes is equal to the sum of the FTE resident count of the hospital that is subject to the hospital inpatient prospective payment system as determined under paragraph (f)(1)(ii)(B) of this section and the limit on the total number of FTE residents for the excluded hospital as determined under paragraph (f)(1)(xiii) of this section."

2. Effect on per resident amount:

a. For mergers taking effect prior to October 1, 2006, the per resident amount for the surviving entity will be based on the weighted average of each hospital's per resident amount. See 67 Fed. Reg. at 50080 (Aug. 1, 2002); 63 Fed. Reg. at 26,328 (May 12, 2002).

b. For mergers taking effect after October 1, 2006, CMS has adopted a three step process (71 Fed. Reg. at 48,073):

(i) Per resident amount data from the most recently settled cost report for each hospital will be updated to the midpoint of the surviving hospital's cost report for the year preceding the merger;

(ii) Each hospital's per resident amount will be multiplied by its respective number of resident as reported in its most recently settled cost report; and

(iii) The sum of these products will be divided by the total number of residents for the merging hospitals to determine the per resident amount.

C. A merger of hospitals, may impact the amount of the Indirect Medical Education ("**IME**") adjustment applicable to the surviving entity. That is, the adjustment is based upon the ratio of interns and residents to beds and all of those components are likely to change in a merger or consolidation. See 42 C.F.R. §412.105.

D. A merger of hospitals also impacts TEFRA limits. A merger results in the surviving provider keeping its old TEFRA limit.

E. The disproportionate share ("**DSH**") percentage of a merged provider may differ from the percentage previously assigned to either providers due to the differences in the services provided and patient populations serviced.

F. With respect to capital PPS payments, the regulations provide that purchasers in a CHOW receive the Medicare capital payments under the same methodology and rates as the previous owner. PRM § 2807.9. However, in the merger or consolidation context, the regulations provide that a new revised Hospital Specific Rate ("HSR") is calculated using a weighted average of the hospitals' base period HSR's. This revised HSR is applicable to the combined facility as of the date of the CHOW. For a hospital paid under the hold harmless methodology after a merger, no additional payments will be made for newer capital costs – even during the transition period. 42 C.F.R. § 412.331.

G. A merger or consolidation will impact geographic reclassifications. See 57 Fed. Reg. at 39,779 (Sept. 1, 1992).

V. Avoiding Surprises in CHOW Transactions

A. Will the transaction result in a "new provider" that may have a payment effect on the new owner?

1. This was a big issue in the SNF world when SNFs were reimbursed on a cost basis subject to routine services cost limits. There are a number of court decisions as well as administrative decisions as to what constitutes a "new provider" for purposes of that exemption. Although these cases have pretty much run their course given the adoption of PPS for SNFs as of July 1, 1998, these cases are still instructive with respect to how CMS will resolve the issue as it converts other providers to a PPS.

2. For instance, with respect to Inpatient Psychiatric Facilities ("**IPFs**") PPS, CMS defines a new IPF as a facility that has not received TEFRA payments for IPF services under either the current or previous owners prior to the effective date of IPF PPS (i.e., January 1, 2005). 42 C.F.R. § 412.402. Accordingly, even if a target facility is not currently reimbursed under IPF, it is necessary to look at its prior reimbursement history to determine if the facility will be treated as new IPF.

3. With respect to Inpatient Rehabilitation Facility Units ("**IRF Units**"), an IRF unit that has undergone a CHOW is not considered to have participated previously in the Medicare program. State Operations Manual, Section 140.1.7C.

4. New hospitals that open during the transition period are exempt from capital PPS payment for their first two (2) years of operations. However, this new hospital exemption does not apply if the hospital is building a replacement facility at the same or a new location (even if a CHOW is involved).

B. Will the transaction negatively impact the provider's existing favorable reimbursement?

1. A CHOW may impact average length of stay for long term acute care hospitals ("**LTACs**") resulting in exclusion from PPS reimbursement for LTACs. See 42 C.F.R. §412.23(e)(3)(iii). Specifically, if a hospital has undergone a CHOW at the start of a cost reporting period or at anytime within the preceding 6 months, CMS will look back at the prior ownership period to determine if the hospital has the required Medicare average LOS, continuously operated as a hospital and continuously participated as a hospital in Medicare.

2. This is often an issue with PPS exempt facilities and units.

a. CMS limits hospitals to one of each type of exempt units. 42 C.F.R. § 412.25(d).

b. Per 42 C.F.R. § 412.25(b) & (c), CMS will only allow a change in status to exempt increases in square footage or increases in beds in exempt units at the beginning of the cost reporting period. This regulation was revised in ¶ 189,010. *Final Rule*, 76 FR 47836, August 5, 2011. Since IRFs and IPFs are now paid under PPS, bed size and square footage are no longer relevant in determining payment. Under revised regulations, §412.25 (b), an IRF or IPF can change (increase/decrease) its bed size or square footage at one time at any point in a given cost reporting period as long as it notifies the CMS RO at least 30 days in advance of the date of the proposed change, and maintains the information needed to accurately determine costs that are attributable to the excluded units.

c. Hence, in a merger or consolidation situation, it may be necessary to plan the closing to fully effectuate the parties' intentions.

3. Another possibility is that refusing to take automatic assignment of a provider agreement could result in a loss of favorable payment provisions of the seller. For instance, CMS provides that "a change of ownership of any of the facilities (either the CAH or the existing collocated facility) with a co-location arrangement that was in effect before January 1, 2008, will not be considered to be a new co-location arrangement. If a change of ownership should occur in a CAH with a grandfathered co-location arrangement on or after January 1, 2008, the provider agreement will be assigned to the new owner unless the new owner rejects assignment of the provider agreement. Grandfathered necessary provider CAH status, including grandfathered co-location arrangements, would not transfer to a new CAH owner who does not assume the provider agreement from the previous owner. To obtain CAH designation, the new provider would have to comply with all the CAH designation requirements, including the

location requirements relative to other providers, that is, more than a 35-mile drive (or 15 miles in areas of mountainous terrain or secondary roads)." 72 Fed. Reg. at 66,832 (Nov. 27, 2007).

C. Will the transaction result in CMS automatically assigning any payment variables to the new owner?

1. Medicare outlier payment is driven in large part by applying the hospital's cost to charge ratio ("**CCR**") to its actual charges to determine its costs in providing care. Tenet's manipulation of CCR eventually lead to CMS adopting rules to reduce the time lag in determining CCR and to eliminate gaming of CCR to increase outlier payments.

a. With respect to CCR for HOPPS, the Medicare Claims Processing Manual, Chapter 4, §10.13.4 provides the following guidance:

(i) In the event of a merger, the surviving entity's CCR will be used.

(ii) In the event of a CHOW but the new owner refuses to take automatic assignment, if the transaction occurs on or after January 1, 2007, use the default statewide CCR until the new owner submits a cost report.

(iii) In the event of a CHOW but the new owner refuses to take automatic assignment, if the transaction occurs prior to January 1, 2007, use the prior hospital's CCR. If, for instance, the prior owner had manipulated its charges to increase outlier payments, this could potentially result in significant outlier overpayment to the new owner.

Healthcare Transactions & Medicare's Change of Ownership (CHOW) Rules

AHLA Medicare & Medicaid Payment Institute
March 20-22, 2013
Baltimore, MD

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* The views expressed herein are those of the author and do not necessarily reflect the official policy or position of the U.S. Department of Health & Human Services, the Office of the General Counsel, or the Centers for Medicare & Medicaid Services.

1

CHOW Rules (42 C.F.R. § 489.18 and related manual provisions) apply to:

- All providers (42 C.F.R. § 489.2): *e.g.*,
  - Hospitals (including critical access hospitals and long term care hospitals).
  - Hospices
  - Skilled nursing facilities
  - Home health agencies
- CHOW processing is necessary for supplier participants that have category-specific agreements with the Secretary (or that must file cost reports). SOM § 3210.1A.
  - Rural Health Clinics - 42 C.F.R. § 405.2403
  - Ambulatory Surgical Centers - 42 C.F.R., Part 416, Subpart C.
  - Federally Qualified Health Centers, 42 C.F.R., Part 491; 42 C.F.R. § 405.2434.
  - End Stage Renal Disease Facilities - 42 C.F.R. § 413.198.

2

I. Is the Change a CHOW Situation?

II. The Benefits and Burdens of Accepting Automatic Assignment of the Existing Medicare Provider Agreement.

III. The Benefits and Burdens of Refusing Automatic Assignment of the Existing Medicare Provider Agreement.

IV. All Acquisition/Combinations of Providers Require a Decision by the Buyer to Accept or Refuse Assignment of the existing Provider Agreement.

3

I. Is the Change a CHOW Situation?

(Did the responsible legal entity change?)

4

Examples of CHOW Situations

- A corporation acquires all or most of the (provider-related) assets from another corporation.
- A provider corporation acquires the assets of another provider, intending to establish the acquired assets as provider-based to the provider it already owns. For example, the owner of Hospital A acquires Hospital B, and wants it to be a provider-based psychiatric wing of Hospital A. This is a CHOW situation, because the acquiring entity must decide whether to accept or refuse assignment of Hospital B's existing Medicare provider agreement.

5

Examples of CHOW Situations

- A merger or consolidation of two corporations which results in a different legal entity being ultimately responsible for care at the provider. 42 C.F.R. § 489.18 (a)(3).
  - Example: Corporation X owns a Medicare provider. Corporation X merges into corporation Y. This is a CHOW, because Y replaces Corporation X as the corporate entity responsible for care at the provider.
  - Example: Corporation X owns a Medicare provider. Corporation X and Corporation Y are consolidated into Corporation Z. This is a CHOW, because Corporation Z replaces Corporation X as the corporate entity responsible for care at the provider.
- The lease of all or part of a provider facility constitutes change of ownership of the leased portion. 42 C.F.R. § 489.18(a)(4).
  - Example: Corporation X owns both a Medicare skilled nursing provider and the building in which care is provided. Corporation X sells the Medicare provider to Corporation Y, but continues to own the building, and leases it to Corporation Y. This is a CHOW, because Corporation Y replaces Corporation X as the corporate entity responsible for care at the provider.

6

Transactions which are not CHOWs for Survey and Certification Purposes

When the responsible legal entity does not change, there is no CHOW:

- Stock transfer (*but see* 42 C.F.R. § 424.550 for enrollment provisions governing home health agencies undergoing a change in majority ownership).
- The merger of Corporation A (which does not own a provider) into Corporation B, which owns a provider. There is no CHOW, because Corporation B remains responsible for care at the provider.

42 C.F.R. § 489.18(a)(3).

7

CHOW = Automatic Assignment of the Existing Provider Agreement

- In a CHOW, the existing provider agreement is automatically assigned to the new owner. 42 C.F.R. § 489.18(c).
- *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Any existing plan of correction [*or outstanding citations]*.
(2) Compliance with applicable health and safety standards.
(3) Compliance with the ownership and financial interest disclosure requirements.
(4) Compliance with civil rights requirements.

42 C.F.R. § 489.18(d).

8

Refusing Automatic Assignment = Voluntary Termination

CMS policy permits a new owner to refuse automatic assignment of the provider agreement. SOM § 3210.5A.

- This is not a "CHOW," since there is no automatic assignment of the existing provider agreement.
- Refusal of automatic assignment means that the existing provider agreement terminates effective with the date ownership changes. SOM § 3210.5A, 75 Fed. Reg. 50,042, 50,401 (Aug. 16, 2010). CMS treats this as a voluntary termination under 42 C.F.R. § 489.52.

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II. The Benefits and Burdens of Accepting Automatic Assignment of the Existing Provider Agreement.

10

Main Benefits of Automatic Assignment

- No break in Medicare participation (no survey required for continued Medicare participation).
- Provider receives any underpayments (including those related to reimbursement appeals), even if they relate to the pre-transfer period. Medicare Financial Management Manual, CMS Publication 100-06, Chapter 3, § 130 (FMM).

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Main Benefits of Automatic Assignment

- Hospital IPPS-excluded statuses continue (*as long as other requirements are met - see* 42 C.F.R. §§ 412.22 - 412.29), including:
  - Psychiatric Hospital (entire hospital or unit);
  - Rehabilitation Hospital (entire hospital or unit);
  - Children's Hospital
  - Cancer Hospital
  - Long-Term Care Hospital

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Main Benefits of Automatic Assignment

- Special payment treatment/classifications continue (*as long as other requirements are met*), including (all in 42 C.F.R, Part 412):
  - Sole Community Hospital. 412.92
  - Rural Referral Center – 412.96
  - Medicare Dependent Hospital – 412.108
  - Renal Transplant Centers – 412.100
  - Geographic reclassifications - 412.102-103.
  - Indirect Graduate Medical Education Costs - 412.105
  - Disproportionate Share Hospitals – 412.106
  - Essential Access Community Hospitals. 412.109

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Main Benefits of Automatic Assignment

- Provider-Based Status or Medicare Relationships Retained - 42 C.F.R. § 412.25; 413.65.

  For hospitals and CAHs, if a new owner acquires the provider and accepts assignment of the provider agreement (and does not seek to combine it with another hospital), it will retain the provider-based status of:
  - Provider-based RHC
  - Hospital based ESRD
  - Hospital-operated ASC

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Main Benefits of Automatic Assignment

- Data for IPPS calculation retained:
  - To calculate Medicare Disproportionate Share Hospital (DSH) payment. 42 C.F.R. § 412.106.
  - To calculate charge-to cost ratios (CCRs) for outlier payment. 42 C.F.R. § 412.84(i)(3)(i).
  - Retention of IPPS "base period" for payment and cost reporting history. 42 C.F.R., Part 412.
  - GME residency slots retained. 42 C.F.R. § 413.79(h)(2).
  - Wage index reclassification retained. 42 C.F.R. § 412.230.
  - Electronic Health Record Incentive Payment. 42 C.F.R. § 495.104(c).

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Main Benefits of Automatic Assignment

- Grandfathering retained, including:
  - Hospital within a hospital - 42 C.F.R. § 412.22(f).
  - Satellite - 42 C.F.R. § 412.22(h), 412.25(e).
  - Provider-based – 42 C.F.R § 413.65(b)(2), (b)(5).
  - CAH necessary provider determinations – 42 C.F.R § 485.610(c).
  - CAH co-location – 42 C.F.R § 485.610(e).
  - CAH provider-based distance from another hospital - 42 C.F.R § 485.610(e).

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Main Burdens of Automatic Assignment

- The new owner is responsible for the former owner's Medicare liabilities, including any Medicare overpayments. SOM § 3210.1B1.
  - Because the provider remains the same, Medicare payments to the provider will continue to be adjusted to account for prior overpayments under 42 U.S.C. § 1395g(a), including those relating to pre-CHOW periods.
  - With assignment, the new owner assumes . . . the repayment of any accrued overpayments, regardless of who had ownership of the Medicare agreement at the time the overpayment was discovered. FMM Chapter 3, § 130.
- The new owner will be responsible for the quality history of the provider and any unpaid civil money penalties resulting from quality of care deficiencies.

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Transfer/Sales Agreement Can Reduce or Eliminate CHOW Financial Burdens

The parties' agreement:

- Can provide for the seller to indemnify the buyer for pre-CHOW overpayments, *see* FMM, Chapter 3, § 130. Alternatively the agreement can provide that some of the purchase price be placed into escrow pending resolution of pre-transfer cost years.
- Can provide for buyer to pay pre-CHOW underpayments to seller. *Id.*

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Transfer/Sales Agreement Can Reduce or Eliminate CHOW Financial Burdens

The parties' agreement:

- Should not purport to sell the provider agreement or CCN, which are not the "property" of the owner. SOM § 3210.1E.
- Clauses that purport to sell Medicare assets without Medicare liabilities are not binding on CMS. FMM Chapter 3, § 130.

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Payment During CHOW Processing

- A CHOW is effective at 12:01 a.m. on date of transaction. SOM § 32101E.
- In a CHOW, no payment goes to the new owner's bank account until the contractor receives and implements the tie-in notice confirming that CMS has approved the CHOW. Until that process is complete, payments to the provider will continue to go to the prior owner's bank account. *See* PIM § 15.7.7.1.5.
- If the new owner wants all payments for services it provides after the CHOW date to go to its own bank account, it bills only **after** CMS notifies it that the CHOW processing is complete. CMS strongly encourages providers to use this process. *See* PIM § 15.7.7.1.5.

20

Payment During CHOW Processing

- However, in their sales or other transfer agreement, the parties may provide that the new owner will bill during the CHOW processing period. In that case, payments will continue to go to the prior owner's bank account until CHOW processing is complete. It is up to the parties to ensure the proper distribution of these payments during the CHOW processing period.
- **The new owner proceeds at its own risk if it decides to bill during the CHOW processing period**. The parties' agreement cannot change CMS procedures. CMS is not responsible for enforcing the agreement of the parties as to the ultimate distribution of payments during the processing period, and will not change its standard procedures to effectuate the terms of any such agreement.

21

III. The Benefits and Burdens of Refusing Automatic Assignment of the Existing Provider Agreement.

22

Main Benefits of Refusing Automatic Assignment

Because the new owner applies for initial certification to the Medicare program and obtains a new provider agreement:

- It is not responsible for overpayments which were made to the prior provider. FMM Chapter , § 130.
- The new owner does not have the quality history associated with the provider agreement it refuses.

23

Main Burdens of Refusing Automatic Assignment - Break in Certification

- CMS policy permits a new owner to refuse automatic assignment of the provider agreement. SOM § 3210.5A.
  - This is not a "CHOW," since there is no automatic assignment of the existing provider agreement.
  - Refusal of automatic assignment terminates the existing provider agreement effective with the date ownership changes. SOM § 3210.5A, 75 Fed. Reg. 50,042, 50,401 (Aug. 16, 2010). CMS treats this as a voluntary termination under 42 C.F.R. § 489.52.

24

Main Burdens of Refusing Automatic Assignment

- Refusing assignment terminates the existing provider agreement and CMS Certification Number (CCN) (formerly know as the "provider number"). SOM § 3210.5A
- Deemed Medicare certification status for that location/facility is lost.
- All special payment statuses terminate.
- All grandfathering statuses are lost (*e.g.*, hospital within a hospital).

25

Main Burdens of Refusing Automatic Assignment - Break in Certification

- No survey can take place until after: (1) the former owner's provider agreement is terminated; (2) the new owner has ownership and control of the facility; and (3) the Medicare Administrative Contractor recommends the initial 855 for approval. *See also* 75 Fed. Reg. 50,042, 50,400-01 (Aug. 16, 2010); Survey and Certification Memorandum S&C 09-08 at 11 (10/17/08).
- If the survey determines condition-level noncompliance, that survey cannot be used to establish the effective date of Medicare participation. 42 C.F.R. §§ 489.10(a), 489.12(a).

26

Main Burdens of Refusing Automatic Assignment - Break in Certification

- If the new owner wants the facility/location to participate in Medicare, it must file for initial certification, and meet all current requirements for any special status. 75 Fed. Reg. 50,042, 50,401 (Aug. 16, 2010).
- The new provider is not eligible for Medicare payments for services it provides before the date that the provider meets all Medicare requirements (as determined by CMS Regional Office). *See also* 42 C.F.R. § 489.13.
- In this situation, Medicare will **never** pay the provider for services it provides before the date on which the provider qualifies as an initial applicant. 75 Fed. Reg. 50,042, 50,401 (Aug. 16, 2010).

27

Main Burdens of Refusing Automatic Assignment

- Hospital IPPS-excluded statuses terminate for the entire hospital and for hospital units, including:
  - Psychiatric Hospital (entire hospital or unit)
  - Rehabilitation Hospital (entire hospital or unit)
  - Children's Hospital
  - Cancer Hospital
  - Long-Term Care Hospital

28

Main Burdens of Refusing Automatic Assignment

- Special payment treatment/classifications terminate, including:
  - Sole Community Hospital status
  - Rural Referral Center status
  - Medicare Dependent Hospital
  - Transplant Center Certification
  - Geographic reclassifications.
  - Indirect Medical Education Costs
  - Disproportionate Share Hospitals

29

Main Burdens of Refusing Automatic Assignment

- Provider-Based Status or Medicare Relationships Terminate - 42 C.F.R. § 412.25; 413.65.
  - Provider-based RHC
  - Hospital based ESRD
  - Hospital-operated ASC

30

Main Burdens of Refusing Automatic Assignment

- Former provider's data irrelevant to IPPS calculation:
  - To calculate Medicare Disproportionate Share Hospital (DSH) payment.
  - To calculate charge-to cost ratios (CCRs) for outlier payment.
  - Retention of IPPS "base period" for payment and cost reporting history.
  - GME residency slots retained.
  - Wage index reclassification retained.
  - Electronic Health Record Incentive Payment.

Main Burdens of Refusing Automatic Assignment

- Grandfathering terminates, including:
  - Hospital within a hospital
  - Satellite
  - Provider-based
  - Start "whole hospital exception"
  - CAH necessary provider determinations
  - CAH co-location
  - CAH provider-based distance from another hospital

Effective Date for Initial Certification After Refusing Automatic Assignment

- Prospective provider must meet all Medicare requirements. 42 C.F.R. § 489.13.
- The onsite full initial survey is usually the final federal requirement completed.
- New owners should **not** count on obtaining Medicare certification effective on the date of the first initial survey.

33

Effective Date for Initial Certification After Refusing Automatic Assignment (Non-SNFs)

- If all other federal requirements for Medicare participation have been met, the effective date of Medicare participation will be:
  - If the prospective provider is in full compliance (no citations of noncompliance), then its effective date of certification will be the date of the survey. 42 C.F.R. § 489.13(b).

34

Effective Date for Initial Certification After Refusing Automatic Assignment (Non-SNFs)

- If the prospective provider has only standard-level deficiencies, then its effective date will be the date on which CMS receives an acceptable Plan of Correction (POC). 42 C.F.R. § 489.13(c)(2), *see* SOM § 2728 re: POCs.
  - If CMS determines that the provider's POC is not acceptable, the prospective provider will revise and resubmit the POC. SOM § 2728E.
  - The effective date will be the date on which CMS or the State survey agency receives a POC that is determined to be acceptable. SOM §§ 2016E, 2728B.

35

Effective Date for Initial Certification After Refusing Automatic Assignment (Non-SNFs)

- If the prospective provider has condition-level citations:
  - The survey cannot be used to establish the effective date of Medicare participation. 42 C.F.R. § 489.10(a). If condition-level deficiencies exist, the regulations do not permit initial certification based on a Plan of Correction. *National Hospital for Kids in Crisis*, DAB No. 1600 at 10 (1996); *Ultra-X Imaging*, DAB CR2066 at 2 (2010).
  - CMS will issue a denial letter. SOM § 2005A2.
  - The prospective provider may appeal this denial. 42 C.F.R. § 488.24 (b),(c).

36

Effective Date for Initial Certification After Refusing Automatic Assignment (Non-SNFs)

- Condition-Level Citations
  - Once the prospective provider has implemented systemic corrections, it must reapply for certification. SOM § 2005.A2.
  - If the State agency surveys the applicant within three months of the date of the denial letter, then the enrollment process does not have to be repeated. SOM § 2005.A2.
  - This will be a new initial survey (also called a "resurvey") of all applicable Conditions of Participation (which is not the same as a "revisit" survey). *See Big Bend Hospital Corp*., DAB No. 1814 at 23 (2002), *aff'd, Big Bend Hospital Corp. v. Thompson*, 88 F.App'x 4 (5th Cir. 2003).

37

Effective Date for Initial Certification After Refusing Automatic Assignment (SNFs)

- The effective date of initial certification is the date on which the SNF is in substantial compliance with the requirements for participation. 42 C.F.R. §§ 489.13(c)(1), 488.301.
- If the skilled nursing facility is in substantial compliance, the State certifies and recommends that the regional office and/or State Medicaid Agency enter into an agreement with the facility. SOM § 7300.3.

38

Effective Date for Initial Certification After Refusing Automatic Assignment (SNFs)

- If the initial survey of prospective provider finds noncompliance at the D or E level, or the F level without substandard quality of care, the State survey agency may accept written evidence of correction to confirm substantial compliance in lieu of an onsite revisit. However, the State survey agency always has the discretion to conduct an onsite revisit to determine if corrections have been made.
- If the noncompliance is at the F level with a finding of substandard quality of care, or above, the State survey agency must conduct an onsite revisit to determine substantial compliance after the facility submits an acceptable POC.

SOM § 7300.3.

39

CMS Has the Authority to Validate Survey Results

- "[T]he statutory and regulatory scheme reserves an inherent authority in CMS to take steps to assure itself that a prospective provider is able to comply with the requirements in place to protect patients before making a determination on a certification recommendation. *See Big Bend Hospital Corp*., DAB No. 1814 at 9 (2002), *aff'd, Big Bend Hospital Corp. v. Thompson*, 88 F. App'x 4 (5th Cir. 2003).
- CMS makes an **independent** determination to either grant or deny the application for Medicare certification. *See* 42 U.S.C. § 1395aa(a) ("To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, home health agency, or hospice program").

40

CMS Has the Authority to Validate Survey Results

- If CMS has concerns about the reliability of a survey by conducted by a State survey agency, an approved accrediting organization, or a contract survey team, it may conduct a comparative survey within 60 days of the state survey to assess the State survey agency's performance in the interpretation, application, and enforcement of Federal requirements. SOM § 4157.D1. *See Big Bend Hospital Corp.*, DAB No. 1814 at 2, 7, n.2 (2002), *aff'd, Big Bend Hospital Corp. v. Thompson*, 88 F. App'x 4 (5th Cir. 2003).
- Concerns which might trigger a validation/comparative survey include:
  - Not all applicable CoP were surveyed.
  - Inadequate sample size
  - Not a full survey of all provider locations
  - Citations do not reflect the facts recorded in the survey report.
  - The survey was not "unannounced" (*i.e.*, the day of or very soon after the effective date of acquisition).

  42 C.F.R. §§ 488.3, 488.4, 488.6, 488.26(c)(4); SOM Appendices.

41

IV. Acquisition/Combinations of Providers Require Decision on Accepting or Rejecting Provider Agreement.

42

NOTE: For Certification Purposes, the Terms “Merger” and “Consolidation” Apply only to Corporations

- The survey and certification regulation at 42 C.F.R. § 489.18 (a)(3) states that the merger or consolidation of two corporations which results in a different entity being ultimately responsible for care at the provider is a CHOW.
- The definitions of the terms: (1) “Standard“ CHOW; (2) Consolidations; and (3) Acquisition/Merger in the Medicare in § 15.7.7.1.1 of the PIM are "for purposes of provider enrollment only.”
- The PIM recognizes that ”Changes of ownership (CHOWs) are officially defined and governed by 42 CFR § 489.18 and Publication 100-07, chapter 3, §§ 3210 through 3210.5(C). The ROs [survey and certification staff] make the final determination as to whether a CHOW has occurred (unless this function has been delegated).” PIM § 15.7.7.1.

43

Combining Acquired Provider B With Currently Owned Provider A Under A’s Medicare Provider Agreement/CCN

- For certification purposes, **whenever** a new owner acquires a Medicare-certified provider, the provider agreement is automatically assigned unless the new owner affirmatively refuses assignment. SOM § 3210.
  - This rule applies equally when the owner of a provider seeks to combine an acquired provider with its existing provider under the existing provider’s provider agreement/CCN.
  - This rule applies regardless of how the transaction is described, *e.g.*, an acquisition/merger; adding a new campus, practice location or satellite location to Provider A; acquiring Provider B’s assets and operating them as part of Provider A; seeking a Medicare subprovider CCN, etc.

44

Provider A's Owner Accepts Assignment of Acquired Provider B's Provider Agreement.

- **All the benefits of a CHOW apply.**
  - No break in Medicare participation (the approved accrediting organization for both providers may extend Medicare deemed status).
  - Special payment statuses and grandfathering continue (as long as other conditions are met).
- After CHOW & merger, Hospital B's agreement is subsumed and its CCN is "retired."
- Note: there cannot be a CHOW when a new owner purchases a unit of a hospital (*e.g.*, seeking to buy its excluded status), because a hospital unit does not have its own provider agreement which can be assigned. In this situation, the new owner must seek initial certification for the unit.

45

Provider A's Owner Refuses Assignment of Acquired Provider B's Provider Agreement.

- The existing provider agreement terminates; and any deemed status is lost.
- That facility/location is no longer eligible for Medicare payment for any services it provides (and cannot later bill for those services)
- The new owner cannot bill for services at the acquired facility/location B using Provider A's provider number or NPI.

46

Provider A's Owner Refuses Assignment of Acquired Provider B's Provider Agreement

- The new owner must apply for initial certification of the acquired location.
- The State survey agency or approved accrediting organization (AO) cannot take action to schedule an initial certification survey to determine that the facility/location meets all applicable Conditions of Participation at the acquired campus until after:
  - The effective date of the acquisition, and
  - The MAC notifies the RO that the initial 855 is recommended for approval.

47

Provider A's Owner Refuses Assignment of Acquired Provider B's Provider Agreement

- When the new owner rejects assignment of the existing provider agreement and that agreement terminates, the AO may NOT extend "deemed status" of acquired facility/location through the termination.
- The AO also may not extend the deemed status from Provider A to the acquired facility/location.

48

Neither Contractors nor Accreditation Agencies Ever Have Authority to make CHOW or other Certification Decisions.

- "The RO (this refers to the CMS Regional office survey and certification staff) has the delegated authority for making the determination if a CHOW actually exists . . . . Upon review of all documents, the RO will make the decision as to whether or not a CHOW has occurred." SOM § 2005E1.
- Although this provision also states that the RO may delegate this responsibility to the State survey agency, I am aware of no such delegation at this time.

49

Survey and Certification Memorandum 09-08 (10/17/08)

- "If a Medicare participating hospital . . . whether deemed or non-deemed, acquires a provider that already participates in Medicare but does not assume that provider's Medicare provider agreement, then **a survey of the new location is required after the acquisition** and before payment for services begins at the new location. In such a case involving acquisition by an accredited, deemed provider without assumption of the provider agreement, an AO [accrediting organization] may not extend the new owner's deemed status accreditation to the newly–acquired facility."
- **Survey and Certification Memorandum S&C 09-08 at 11 (10/17/08)** http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter09-08.pdf

50

Mission Regional Hospital Medical Center DAB CR1248 (2011) (Facts)

- Petitioner owned a Medicare-certified acute care hospital (Mission Viejo).
- On 6/30/09, petitioner acquired assets of a second Medicare-certified acute care hospital, South Coast Medical Center (South Coast), located in Laguna Beach.
- Before the acquisition date, Petitioner submitted an 855A to its MAC to "add" South Coast as a new practice location effective July 1, 2009.

51

Mission Regional Hospital Medical Center DAB CR1248 (2011) (Fact)

- Petitioner then sought to treat the Laguna Beach facility as a separate campus of Mission Viejo, and billed for services rendered at the Laguna Beach location under Mission Viejo's Medicare provider number effective on the acquisition date.
- South Coast submitted an 855A that reported its acquisition by Mission. It appeared that South Coast was voluntarily terminating its provider agreement.

52

Mission Regional Hospital Medical Center DAB CR1248 (2011) (Facts)

- Petitioner expressly declined to assume the liabilities under South Coast's existing Medicare provider agreement.
- On February 10, 2010, CMS notified petitioner that, since it did not assume the existing provider agreement, the agreement was voluntarily terminated. CMS stated that the new owner could not bill for services at the new location until the State survey agency or AO completed a Medicare certification survey, and CMS determined that all applicable Medicare requirements had been met.

53

Mission Regional Hospital Medical Center DAB CR1248 (2011) (Facts)

- The AO completed a survey for the Laguna Beach campus effective March 18, 2010. CMS advised that the effective date of the new Laguna Beach campus for certification and reimbursement was March 18, 2010.
- The owner was not entitled to Medicare payment for any services provided at the Laguna Beach location between 7/1/09 and 3/18/10.

54

Mission Regional Hospital Medical Center DAB CR1248 (2011) (ALJ Decision)

- Grants summary judgment to CMS.
- Cites S&C Letter 09-08 and preamble to revised 42 C.F.R. § 489.13, quoted above.
- Rejects arguments that statements by contractor are binding.

> Petitioner's argument amounts to a claim of equitable estoppel. Federal case law and Board precedent establish: (1) estoppel cannot be the basis to require payment of funds from the federal fisc; (2) estoppel cannot lie against the government, if at all, absent a showing of affirmative misconduct, such as fraud; and (3) I am not authorized to order payment contrary to law based on equitable grounds."

55

Mission Regional Hospital Medical Center DAB No. 2459 (May 21, 2011) (Appellate Division)

- Upholds ALJ's grant of summary judgment to CMS. Appellate Decision at 1.
- Because Mission did not assume the provider agreement, it did not take automatic assignment. *Id.* at 6.
- Mission did not dispute that the provider agreement "did not transfer over." *Id.*

56

Mission Appellate Decision

- There was no longer a provider agreement covering the Laguna Beach campus as of July 1, 2009.
- Therefore, Mission could not obtain Medicare billing privileges for the Laguna Beach campus merely by submitting an enrollment application seeking to add it as a new practice location.
- It could bill for the Laguna Beach Campus only after going through the survey and certification process. *Id.*

57

Notification for Certification Purposes

- The new owner should notify the CMS regional office, survey and certification branch, 45 days in advance, whether it will accept automatic assignment (CHOW) or refuse it (termination). 42 C.F.R. §§ 489.18(b), 489.52; SOM § 3210.1B1.
- The new owner should indicate on the 855A that this is a CHOW, and that it is accepting or refusing assignment of the existing provider agreement, so that the enrollment documentation is consistent with the certification documents.

NOTE: There are also enrollment requirements for CHOW and termination notification. *See* regulations at 42 C.F.R. Part 424, and the Program Integrity Manual.

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CONCLUSION

Automatic Assignment was created to benefit providers.

I personally recommend spending your time formulating a contract that properly apportions financial obligations and benefits between the parties, rather than taking the risk of trying to "have it both ways."

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