GG. Not Just for Geeks: Why You and Your Client’s Executives Need to Understand Medicare’s Change of Ownership ("CHOW") Rules

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Not Just for Geeks: Why You and Your Client’s Executives Need to Understand Medicare’s Change of Ownership (CHOW) Rules

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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 and Human Services, the Office of the General Counsel, or the Centers for Medicare & Medicaid Services

Claire’s Comments:
Why Are CHOW Rules Important?

• Failure to understand CHOW rules can result in unanticipated:
  – Revenue Loss
  – Cash Flow Interruption
  – Successor Liability

• CHOWs potentially impact future Medicare reimbursement rates. For example, consider:
  – Excluded units
  – Cost-to-charge ratios for outlier payments
  – DSH
  – GME Payments – FTE Cap and Per Resident Amount
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 Rules Apply To:

- Suppliers that have category-specific agreements with the Secretary (or that must file cost reports). SOM § 3210.1.A; see 42 C.F.R. § 489.13(a).
  - Rural Health Clinics (RHC)
  - Ambulatory Surgical Centers (ASC)
  - Federally Qualified Health Centers (FQHC)
  - End-Stage Renal Disease Facilities (ESRD)
Claire’s Comments:
Change of Ownership Considerations for Part B Suppliers

• “CHOW” Rules technically apply only to Part A providers (and certain certified or cost report-filing suppliers)

• Generally, a new owner of a Part B supplier must file for initial enrollment upon any change of ownership.

• What if a new owner of a physician group already has a Part B number for a physician group?

• What if a new owner of an IDTF or DMEPOS supplier already has a Part B number for these types of suppliers?

Claire’s Comments: Change of Ownership Considerations for Part B Suppliers, Cont’d.

• What about the “hybrid” world of certified suppliers such as ASCs?
  
  — ASCs actually have two numbers, a CMS certification number (CCN) and a provider transaction access number (PTAN) issued by the MACs for Part B billing purposes
  
  — Even if the new owner accepts assignment, a new PTAN will be issued

• CMS also mandates the issuance of a new CCN in certain instances for ESRDs and RHCs that change from hospital-based to freestanding or vice versa
I. Is the Change a CHOW Situation?

II. Making the Choice to Accept or Reject Automatic Assignment of the Existing Provider Agreement

III. Medicare Notification, Filing Requirements and Responsible Parties as a Result of a CHOW

IV. Handling Licensure and Payment Issues in the CHOW Processing Period

V. Complex Transactions

VI. Due Diligence Issues to Consider when Entering into a CHOW

I. Is the Change a CHOW Situation?  
(Did the responsible legal entity* change?)

* A provider is the party having ultimate responsibility and liability for the operational decisions of the institution. SOM § 2012
Examples of CHOW Situations

- A corporation acquires all or most of the (provider-related) assets from another corporation.
- It is irrelevant whether the transfer was a sale, or some other transaction (i.e., the reversion of the provider to the landlord under a lease agreement).
- A provider corporation acquires the assets of another provider, intending to establish the acquired assets as provider-based to the provider it already owns.

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 Corporation 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.
Examples of CHOW Situations

• 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.

Claire’s Comments:
Other CHOW Situations

• Partnerships and LLCs

• Management Agreements

• Hospital Sub-Units

• One Hospital Acquiring Another in a CHOW
  – Option 1: Operating both campuses as a single provider
  – Option 2: Operating campuses as separate providers

• Relocation in connection with CHOW
NON-CHOWs

When the responsible legal entity does not change, there can be 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 X (which does not own a provider) into Corporation Y, which owns a provider. There is no CHOW, because Corporation Y remains responsible for care at the provider.

42 C.F.R. § 489.18(a)(3).

Miscellaneous Transactions

• The change of “members” in nonprofits is treated the same way as a change of stock ownership. There is no CHOW.

• The transfer of a non-profit to another non-profit IS a CHOW situation (even if the two entities are related).

• If a corporation converts to an LLC, it is not a CHOW if the state laws at issue treat the converted LLCs as the same organization, rather than a legally new or distinct organization.
Simple CHOW – Complex Transaction

• ABC, Inc. is Medicare-enrolled ambulatory surgical center
• ABC establishes XYZ, LLC. ABC, Inc. contributes ASC assets to XYZ, LLC
• XYZ Hospital, LLC purchases 51% of XYZ, LLC from ABC, Inc.
• Is this a CHOW Situation?

WHO’S ON FIRST? USE A CHART TO DETERMINE WHETHER A CHOW OCCURRED
The provider should construct a simple “before and after” ownership diagram of the legal relationships among the owning entities and providers involved.
SOM 3210.1E.

The Before/After Chart shows that the ASC was transferred from ABC, Inc. to XYZ, LLC. Therefore, this is CHOW situation.
II. Making the Choice to Accept or Reject Automatic Assignment of the Existing Provider Agreement

Buyer Must Choose

• Choice # 1:
  – Accept automatic assignment (CHOW) of existing provider agreement:
    • Benefit - Continuous Medicare participation; most provider and payment statuses retained
    • Burden - Successor liability for overpayments and CMPs that relate to the pre-transfer period
    • Retain Quality History
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).

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).
Main Benefits of Automatic Assignment (Hospitals)

- Hospital Inpatient Prospective Payment System (IPPS)-excluded statuses continue *(as long as other requirements are met)*
- Special payment treatment/classifications continue *(as long as other requirements are met)*
- Provider-Based or Medicare-Related Status retained
- Data for IPPS calculation retained
- Grandfathering retained

Main Burden of Automatic Assignment: Successor Liability


- 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. *Deerbrook Pavilion v. Shalala*, 235 F.3d 1100 (8th Cir. 2000).
Main Burden of Automatic Assignment: Successor Liability


Claire’s Comments:

**Case Study: The Long Arm of an Inherited Poor Quality History**

- See, e.g., Department Appeals Board Case *Savoy Nursing & Rehabilitation Center*, Decision No. CR3521 (Dec. 18, 2014)

- CMS imposed a civil monetary penalty after a resident fell from a second-story window in 2013

- The facility had experienced a similar incident in 2006, under prior ownership, when another resident had eloped through a window. A plan of correction (POC) was instituted at that time

- The current owner acquired the facility in 2011, five years later, and stated that it was unaware of the POC

- DAB held: “An assigned provider agreement is subject to ... any existing plan of correction.” Therefore, the new owner “had a reasonable basis to foresee that the windows in its facility could serve as an exit route for a resident seeking to elope.”
Buyer Must Choose

• Choice # 2:
  — Affirmatively reject assignment:
    • Benefit - avoid successor liability.
    • Burden - Existing provider agreement terminates.
      — If the new owner wants the facility to participate in Medicare, it must file as an initial applicant.
      — The facility will never receive payment for any services it may provide before CMS determines that it meets all Medicare requirements for a new provider, including successful enrollment and a successful full initial survey.

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 that are associated with the provider agreement that it refuses. FMM Chapter, § 130.

• The new owner does not have the quality history associated with the provider agreement it refuses.
Refusing Automatic Assignment = Voluntary Termination

CMS policy permits a new owner to refuse *(i.e., reject)* automatic assignment of the provider agreement or Part B Agreement.  
SOM §§ 2003B, 2005A4, 2202.17, 2308, 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 § 3258.

Main Burdens of Refusing Automatic Assignment - Break in Certification

- Refusal of automatic assignment means that the existing provider agreement terminates effective with the date ownership changes.  
- CMS treats this as a voluntary termination under 42 C.F.R. § 489.52(a)(3) based on the cessation of the seller’s business.  
  SOM § 3258.
- Deemed Medicare certification status for that location/facility is lost.
Main Burdens of Refusing Automatic Assignment - Break in Eligibility to Receive Medicare Payment

• If the new owner wants the facility/location to participate in Medicare, it must file as an initial applicant, and meet all current requirements for any special status. 75 Fed. Reg. 50,042, 50,401 (Aug. 16, 2010); SOM § 2003B, 2003C.

• The initial applicant 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). 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 for Medicare participation as an initial applicant. 75 Fed. Reg. 50,042, 50,401 (Aug. 16, 2010).

Main Burdens of Refusing Automatic Assignment - Hospitals

• Hospital IPPS-excluded statuses terminate for the entire hospital and for hospital units
• Special payment treatment/classifications terminate
• Provider-Based or Medicare-Related Organization Status terminates
• Former provider’s data irrelevant to IPPS calculation
• Grandfathering terminates
Claire’s Comments:
Special Rules for Home Health Agencies (HHAs)

• If there is a “change in majority ownership” within
  – 36 months of initial Medicare enrollment, or
  – 36 months following the most recent “change in majority ownership,” then

• Unlike other CHOW situations, the provider agreement of the old owner does NOT automatically transfer to the new owner, and the new owner has no option to accept assignment of the provider agreement.

• Instead the new owner must do an initial enrollment in the Medicare program and obtain a state survey or an accreditation.

• Feb. 2, 2015 Federal Register: CMS has extended the temporary moratoria on enrollments of new HHAs in certain metropolitan areas of FL, IL, MI, NJ, PA and TX.

Claire’s Comments:
Special Rules for HHAs, Cont’d.

• What is a “change in majority ownership?”
  – Acquisition of more than a 50 percent direct ownership interest
  – Includes assets sales, mergers, consolidations, and even stock transfers that would not otherwise be a “CHOW”
  – But note the emphasis on “direct” ownership interest. Can the use of holding companies avoid the 36-month rule?

• CMS has stated that it will look to the cumulative effect of transactions within the applicable 36-month period.

• Exceptions to the 36-month rule?
  – HHA’s parent organization is undergoing an internal restructuring
  – HHA has submitted two consecutive years of full cost reports
  – Existing owners remain the same but change the business structure
  – Individual owner of HHA dies
Claire’s Comments: Making the Call as to Accept or Reject

• Your diligence process should help you assess the overall risk and, therefore, the attractiveness of accepting the provider number.

• If diligence shows an overall risk profile that may be too scary, consider:
  – Can you possibly expedite the initial survey?
  – Can you withstand the lost revenue?

III. Medicare Notification, Filing Requirements and Responsible Parties as a Result of a CHOW
Claire’s Comments:
If the New Owner **DOES Accept Assignment**, What are the Medicare Filing Requirements and Responsible Parties?

- Both new owner and old owner must submit 855As
  - The notices do not have to be filed pre-closing, but parties may wish to do so
  - 30–90 days pre-closing may be possible
  - In any event, the mandatory post-closing deadline under the enrollment rules is 30 days after a “change of ownership or control”
  - The “new owner” 855A should be submitted within 14 days of the “old owner’s” 855A

- MAC reviews and makes recommendations to Regional Office (RO); RO makes final determination. **Effective date of CHOW for reimbursement purposes**: 12:01 am on date of closing of transaction

- Remember that, even if you do not have a CHOW, you will still likely have a change of information that must also be filed with CMS within designated time frames

Claire’s Comments:
If the New Owner **DOES NOT Accept Assignment**, What are the Medicare Filing Requirements and Responsible Parties?

- New owner must file refusal with RO **at least 45 days prior to the CHOW date**

- New owner **files an 855A initial enrollment** with MAC as of the closing

- Old owner voluntarily terminates as of the closing

- **Earliest date of enrollment of new owner**: Date that RO determines all Federal requirements are satisfied (i.e., enroll with MAC, undergo OCR clearance, and pass initial survey or “deemed status” accreditation survey)
Trying to Have it Both Ways *

*reject automatic assignment/
minimize break in Medicare payment

Refusing Automatic Assignment:
Requirements for Initial Survey

• Timing

  – State Survey Agencies (SAs) and CMS Approved
    Accreditation Organizations (AOs) must not conduct an
    initial survey until the applicable MAC has recommended
    approval of the new owner’s enrollment application. SOM
    2003B & 2003C.

  – MAC should issue such a recommendation only after the
    acquisition is complete. S&C 13-60 at 4, ¶ 2.

  – CMS policy has long provided that initial certification
    surveys of Medicare applicants have a lower priority than
    mandated surveys for existing providers. SOM § 2003B.
Refusing Automatic Assignment: Requirements for Initial Survey

• **Survey must be Unannounced.** SOM §§ 2003B, 2700A.
  
  – CMS may reject a compliance recommendation from the SA or the AO if the survey timing creates doubt that the survey was unannounced. SOM § 2003B.
  
  – Cases are assessed on their facts. However, if the survey takes place within 14 days “after the effective date of an acquisition that involves rejection of assignment of the provider agreement,” CMS may review the situation closely to verify that the survey was unannounced. *Id.*
  
  – However, even if the survey takes place more than 14 days after the effective date of acquisition, the facts may indicate that the survey was announced, and that CMS should not accept its findings. *Id.*

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

• If the prospective provider has condition-level citations, CMS will issue a denial letter. SOM § 2005.A.2.
  – The prospective provider may appeal this denial. 42 C.F.R. § 488.24 (b),(c).
  – The prospective provider may re-apply for certification – must successfully complete a full initial survey.

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)(ii), see SOM § 2728 re: POCs.

• The effective date will be the date on which CMS or the State survey agency receives a POC which is determined to be acceptable. SOM § 2728.B (this may not be the first POC submitted)
CMS Makes Certification Decision

• Neither MACs Nor AOs ever have authority to make CHOW or other certification decisions

• CMS has inherent authority to assure itself that a prospective provider can comply with the patient protection requirements before making a determination on a certification recommendation. See Big Bend Hospital Corp, supra.

• CMS makes an independent determination to either grant or deny the application for Medicare certification. See 42 U.S.C. § 1395aa(a).

CMS Has the Authority to Reject Survey Results

• Concerns which might trigger a new initial survey include:
  – Not all applicable CoPs 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 § 2003C; SOM Appendices.
CMS Has the Authority to Validate Survey Results

• *Apollo Behavioral Health Hospital, DAB No. 2561 (2014).*
  
  – CMS’s decision to order validation surveys was not subject to review under 42 C.F.R. § 498.3. *Id.* at 5-6.
  
  – CMS’s decision not to accept a plan of correction for undisputed standard-level deficiencies in state agency surveys is not an initial determination subject to review. *Id.* at 9.

IV. Handling Licensure and Payment Issues in the CHOW Processing Period
Claire’s Comments:
Handling Licensure and Payment Issues in the CHOW Processing Period

• Remember that “CHOW” rules are just for Medicare

• **State licensure laws** and **State Medicaid programs** will likely have additional notice and filing requirements for “changes of ownership,” which may be defined differently than under Medicare CHOW rules

• A transaction, such as a stock transaction, which is not a “CHOW” for Medicare could be a “change of ownership” for purposes of these other rules

• Most important state licensure task: Make sure that your new license can be retro-dated to the date of closing

Claire’s Comments:
Handling Licensure and Payment Issues in the CHOW Processing Period, Cont’d.

• A CHOW is not effective until the Regional Office (RO) issues the tie-in notice, which is typically well after closing.

• CMS continues to pay the old owner until the tie-in notice. New owner either:
  - Holds claims from and after closing date (cash flow issue), or
  - Submits claims on behalf of old owner pursuant to purchase agreement and conducts sweep of old owner’s bank account (and abides by reassignment rules)
Claire’s Comments: Payment During CHOW Processing

• 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. See PIM § 15.7.7.1.5.

• 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 CHOW processing period, and will not change its standard procedures to effectuate the terms of any such agreement.

Buyer is Responsible for Overpayments During CHOW Processing


• Buyer accepted assignment, but no agreement on claim submission during CHOW process. Id.

• Seller and Buyer both submitted claims during CHOW processing period (to different fiscal intermediaries) both were paid. Id. at 9.

• Court held that Buyer had successor liability, and must recover excess from Seller. Id. at 20-22.
Claire’s Comments: Allocation of Straddle Payments

• Some Medicare payments are made to the entity that is the legal owner on **the date of service** and some are made to the entity that is the legal owner on the **date of discharge**

  — **PPS payments**, including outlier payments, are made to the entity that is the legal owner on the **date of discharge**.

  — **Other payments**, such as direct medical education, certain anesthesia services, organ acquisitions and bad debt are made in accordance with the principles of reasonable cost reimbursement, which may mean to the entity that is the legal owner of the provider at the time the service is provided.

• Medicare will not prorate payments or change the “pay to” parties in these situations, but the parties to a transaction may reach their own agreement regarding the allocation of these payments, **once received from Medicare**, with respect to transfer/ discharge that straddle the transaction date. Again, remember to observe reassignment rules.

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.*
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 § 3210.1.E.

• Clauses that purport to sell Medicare assets without Medicare liabilities are not binding on CMS. FMM Chapter 3, § 130.

Claire’s Comments:
When Is It NOT Possible to Receive Payment During CHOW Processing?

• If the new owner rejects automatic assignment of the provider agreement

• If, as a result of the CHOW, one or more provider agreements will be terminated or discontinued, e.g., in a merger/acquisition or consolidation. In these situations, the new owner should not bill under discontinued provider numbers (even though the MAC might otherwise continue to pay until the tie-in notice)

• What about situations where the new owner accepts the provider agreement but, due solely to quirks of Medicare rules, a new provider number is issued? E.g., ASCs
Claire’s Comments: Cost Reports

- **Old owner final cost report:**
  - Final cost report is due **no later than five months** after the effective date of the CHOW (if provider agreement is accepted due to automatic assignment) or termination of the provider agreement (if automatic assignment is rejected).
  - **NOTE:** Old guidance used to contain 45-day deadline

- **New owner cost report:**
  - New owner selects reporting year end
  - Can no longer select MAC

V. Complex Transactions
New Owners Trying to Obtain the Benefits of a CHOW While Avoiding its Burdens

• Allowing Buyer to “Use” Prior Owner’s Provider Agreement Without Assignment.

• Sale With Lease-Back and/or Management Agreement.

• Combining Acquired Medicare Provider with Existing Provider.

“Using” Existing Provider Agreement Without Assignment Impermissible

• In a chain bankruptcy case, the debtor asked the court to approve a stipulation with its landlord to reject its sublease of a nursing home, and permit the landlord to “use” its Medicare provider number and agreement until the landlord obtained its own provider numbers and agreements.

• After CMS objection, debtor rejected the lease, but assumed & assigned the Medicare provider agreement.
Sale/Leaseback

• Seller enters into asset purchase agreement for hospital with Buyer. It also entered into a leaseback-management agreement which became effective on the effective date of the purchase, under which Seller is manager.

• For Medicare purposes, the Seller is the provider until after the management agreement expires. This is because the Seller is the responsible legal entity while the agreement is in effect.

• If the Buyer refuses assignment of the Medicare provider agreement, the existing agreement terminates when the management agreement expires. The Buyer must apply to Medicare for this hospital as an initial applicant. The survey cannot take place until after the management agreement expires.

Sale/Leaseback

Application of Certification Rules to Facts

• If all the same facts were present, but the Buyer had ultimate responsibility for hospital care during the management agreement, then the existing provider agreement would terminate on the effective date of the asset purchase agreement.

• No matter how the agreement is structured, the initial survey of a new owner happens only after the responsible legal entity has changed.
Acquisition/Combinations of Providers Require Decision on Assignment of Existing Provider Agreement

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 § 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 RO [S&C staff] make the final determination as to whether a CHOW has occurred PIM § 15.7.7.1; SOM § 2005E1.
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 §§ 2005E1, 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 (combination).
  - 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.

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*Mission Regional Hospital Medical Center*

DAB CR2458 (2011) (Facts)

- Petitioner owned a Medicare-certified acute care hospital.

- Petitioner declined assignment of the acquired hospital’s provider agreement, and instead sought to “add it as a new practice location to its existing hospital.”

- CMS advised that the effective date of new certification for the acquired hospital was March 18, 2010, the date the AO completed a full survey. The new owner was not entitled to Medicare payment for any services provided at the acquired hospital for over seven months.
Mission Regional Hospital Medical Center (ALJ Decision)

• Summary judgment for CMS. DAB CR2458 (2011).

• Rejects argument that CMS is bound by contractor’s statement that petitioner could receive Medicare reimbursement on the date of acquisition. States that 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) the ALJ is not authorized to order payment contrary to law based on equitable grounds.

Mission Regional Hospital Medical Center (Appellate Division)

• Upholds ALJ’s grant of summary judgment to CMS. Appellate Decision at 1. DAB No. 2459 (May 21, 2012).

• Mission did not dispute that the provider agreement “did not transfer over.” Id.

• There was no longer a provider agreement covering the Laguna Beach campus as of July 1, 2009.

• Mission could bill for the Laguna Beach Campus only after going through the survey and certification process. Id.
Mission Hosp. Regional Medical Ctr. v. Sebelius
2013 WL 7219511

• The District Court affirmed the DAB’s decision, and rejected Petitioner’s request for $1.4 million in reimbursement for services billed in the 3 months after acquisition.

• Case is on appeal to the Ninth Circuit. No. 8:12-cv-01171-AG-JPR (9th Cir.). Briefs filed; no decision as yet.

VI. Due Diligence Issues to Consider when Entering into a CHOW
Claire’s Comments:
Due Diligence Considerations

• CHOW considerations can affect your look-back period. If you assume provider agreement, for example, you’ll inherit all prior POCs

• Make sure in any CHOW that Medicare enrollment profiles of the parties are up to date prior to processing CHOW.
  
  – See helpful CMS FAQ issued 10/27/14

  – This FAQ indicates (in the context of revalidations) that CMS does not plan to penalize those who update enrollment profiles past the regulatory 30- and 90-day windows

Claire’s Comments:
Due Diligence Considerations, Cont’d.

• Research payment effects, e.g.:
  – Geographic reclassification
  – GME/IME
  – DSH
  – Cost-to-charge ratio for outlier payments
  – Excluded units

• Allocate payments and risk in transaction documents
  – Escrow/Indemnification
  – Payments during CHOW processing period?
  – Straddle patients
  – Abide by reassignment rules
Not Just for Geeks –
Why You and Your Client’s Executives Need to Understand Medicare’s Change of Ownership (CHOW) Rules

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   3. Skilled nursing facilities (SNFs)
   4. Home health agencies

B. Suppliers that have category-specific agreements with the Secretary (or that must file cost reports). State Operations Manual (SOM), CMS Publ. 100-07, § 3210.1.A; *see* 42 C.F.R. § 489.13(a).
   1. Rural Health Clinics (RHC) - 42 C.F.R. § 405.2403, 42 C.F.R., Part 491
   2. Ambulatory Surgical Centers (ASC) - 42 C.F.R., Part 416, Subparts B, C
   3. Federally Qualified Health Centers (FQHC) - 42 C.F.R., Part 491; 42 C.F.R. § 405.2434
II. Is the Change a CHOW Situation? - (Did the responsible legal entity change?) A provider is the party having ultimate responsibility and liability for the operational decisions of the institution. SOM § 2012.

A. Examples of CHOW Situations

1. A corporation acquires all or most of the (provider-related) assets from another corporation.

2. It is irrelevant whether the transfer was a sale or some other transaction (i.e., the reversion of the provider to the landlord under a lease agreement).

3. A provider corporation acquires the assets of another provider, intending to establish the acquired assets as provider-based to the provider it already owns. See Part VI-C, infra.

4. 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).

   a) Example: Corporation X owns a Medicare provider. Corporation X merges into corporation Y. This is a CHOW situation, because Corporation Y replaces Corporation X as the corporate entity responsible for care at the provider.

   b) Example: Corporation X owns a Medicare provider. Corporation X and Corporation Y are consolidated into Corporation Z. This is a CHOW situation, because Corporation Z replaces Corporation X as the corporate entity responsible for care at the provider.

5. 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 SNF 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 situation, because Corporation Y replaces Corporation X as the corporate entity responsible for care at the provider.

B. NON-CHOWS

1. When the responsible legal entity does not change, there can be no CHOW:

   a) Stock transfer (but see 42 C.F.R. § 424.550 for enrollment provisions governing home health agencies undergoing a change in majority ownership).

   b) The merger of Corporation X (which does not own a provider) into Corporation Y, which owns a provider. There is no CHOW, because Corporation Y remains responsible for care at the provider.

42 C.F.R. § 489.18(a)(3).

C. Miscellaneous Transactions

1. The change of “members” in a non-profit is treated the same way as a change of stock ownership. There is no CHOW.

2. The transfer of a non-profit to another non-profit IS a CHOW situation (even if the two entities are related).

3. If a corporation converts to an LLC, it is not a CHOW if the state laws at issue treat the converted LLCs as the same organization, rather than a legally new or distinct organization.

D. Complex Transaction - Simple CHOW

1. ABC, Inc. is Medicare-enrolled ambulatory surgical center

2. ABC establishes XYZ, LLC, and contributes ASC assets to XYZ, LLC

3. XYZ Hospital, LLC purchases 51% of XYZ, LLC from ABC, Inc.

4. USE A CHART TO DETERMINE WHETHER A CHOW OCCURRED
a) The provider should construct a simple “before and after” ownership diagram of the legal relationships among the owning entities and providers involved. SOM 3210.1E.

The Before/After Chart shows that the ASC was transferred from ABC, Inc. to XYZ, LLC. Therefore, this is CHOW situation.
III. Making the Choice to Accept or Reject Automatic Assignment of the Existing Provider Agreement.

A. Choice # 1: Receive automatic assignment (CHOW) of existing provider agreement:

1. In a CHOW, the existing provider agreement is automatically assigned to the new owner. 42 C.F.R. § 489.18(c)

2. 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).

3. MAIN CHOW BENEFIT - Continuous Medicare participation; most provider and payment statuses retained

4. MAIN CHOW BURDEN - Successor liability for overpayments and CMPs that relate to the pre-transfer period

5. MAIN CHOW BURDEN - Retain Quality History

B. Choice # 2 – Affirmatively Reject Assignment

1. Refusing Automatic Assignment = Voluntary Termination

2. CMS policy permits a new owner to refuse (i.e., reject) automatic assignment of the provider agreement or Part B Agreement. SOM §§ 2003B, 2005A4, 2202.17, 2308, 3210.5A.

3. This is not a “CHOW,” since there is no automatic assignment of the existing provider agreement.

4. 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).
5. CMS treats this as a voluntary termination under 42 C.F.R. § 489.52(a)(3) based on the cessation of the seller’s business. SOM § 3258.


7. **MAIN REJECTION BURDEN** - existing provider agreement terminates.

   a) *If the new owner wants the facility to participate in Medicare, it must file as an initial applicant.*

   b) *The facility will never receive payment for any services it may provide before CMS determines that it meets all Medicare requirements for a new provider, including successful enrollment and a successful full initial survey.*

C. **Transfer Agreement**

1. The parties’ agreement can distribute obligations:

   a) *Can provide for the seller to indemnify the buyer for pre-CHOW overpayments and CMPs. See CMS Financial Management Manual (FMM), CMS Publ. 100-06, Chapter 3, § 130.*

   b) *Alternatively, the agreement can provide that some of the purchase price be placed into escrow pending resolution of pre-transfer cost years (e.g., when seller is in bankruptcy).*

   c) *Provide for a lower purchase price due to expected overpayment determinations and recoupment.*

2. The Parties’ Transfer Agreement Cannot Bind Medicare

   a) *Clauses that purport to sell Medicare assets without Medicare liabilities are not binding on CMS, which is not a party to the agreement. FMM Chapter 3, § 130.*

   b) *Clauses that treat the Medicare provider agreement as property do not bind CMS. The manual clearly states that the provider agreement and CCN, also called the “provider number,” are not the “property” of the owner which can be sold. SOM § 3210.1E.*
D. Notify CMS Which Option Chosen

The new owner should notify the CMS regional office, S&C Branch (RO), 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 §§ 3210.1.B.1, 3210.5.A.

E. Enrollment – Buyer of Part A Provider Should Notify the Medicare Administrative Contractor (MAC) of Its Choice via CMS Form 855A


2. The new owner should indicate on the 855A that this is a transfer, and that it is accepting or refusing assignment of the existing provider agreement, so that the enrollment documentation is consistent with the certification documents.

   a) Accepting Automatic Assignment-855A (7/11)

      (1) The new owner should select the submittal reason: “[t]here has been a change of ownership (CHOW) of the Medicare-enrolled provider.” 855A at 6, §1.A (5th Box).

      (2) The new owner indicates on the 855A that it is accepting assignment of the existing provider agreement (Yes). 855A at 13, § 2.F.

   b) Refusing/Rejecting Automatic Assignment.

      (1) If the new owner indicates on the 855A at 13, § 2.F that it is not accepting (i.e., refusing) assignment of the existing provider agreement (No), the 855A should be submitted as an initial enrollment.

      (2) The new owner should indicate on the 855A (7/11) that it is a new enrollee in Medicare. CHOW (855A at 6, §1.A - 1st Box).
F. Enrollment - Buyer of Certain Part B Suppliers Should Notify the MAC of Its Choice via CMS Form 855B

The new owner should indicate on the 855A that this is a CHOW or a new enrollment, so that the enrollment documentation is consistent with the certification documents.

1. The 855B (7/11) provides check boxes for “new enrollee” (at 5-refusing automatic assignment) and for a “change of ownership”) (at 7–accepting automatic assignment), which applies only to hospitals, ambulatory surgical centers, or portable X-ray suppliers undergoing a change of ownership (CHOW) in accordance with the principles outlined in 42 C.F.R. 489.18 (at 4).

2. The 855B currently has no location on which the new owner can indicate that it is accepting or refusing automatic assignment – CMS expects that a draft revision that includes this choice will be available in 4-6 months.

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

A. Benefits of Automatic Assignment

1. No break in Medicare participation (no survey required for continued Medicare participation).

2. Provider receives any underpayments (including those related to reimbursement appeals), even if they relate to the pre-transfer period. FMM, Chapter 3, § 130.

3. Benefits of Automatic Assignment – Hospitals

   a) Hospital Inpatient Prospective Payment System (IPPS) - excluded statuses continue (as long as other requirements are met - see 42 C.F.R. §§ 412.22 - 412.29), including:

   (1) Psychiatric Hospital (entire hospital or unit);

   (2) Rehabilitation Hospital (entire hospital or unit);

   (3) Children’s Hospital
(4) Cancer Hospital
(5) Long-Term Care Hospital

b) Special payment treatment/classifications continue (as long as other requirements are met), including (all in 42 C.F.R, Part 412):

(1) Sole Community Hospital - 412.92
(2) Rural Referral Center – 412.96
(3) Medicare Dependent Hospital – 412.108
(4) Renal Transplant Centers – 412.100
(5) Geographic reclassification – 412.102-412.103
(6) Indirect Graduate Medical Education Costs - 412.105
(7) Disproportionate Share Hospitals – 412.106
(8) Essential Access Community Hospitals – 412.109

c) Provider-Based or Medicare-Related Status Retained, 42 C.F.R. § 413.65. If a new owner acquires both Medicare entities and accepts assignment of both agreements (and does not seek to combine the hospital with another hospital), it will retain the provider-based or related organization status of:

(1) Provider-based RHC (provider-based entity)
(2) Hospital-based ESRD (related organization)
(3) ASC operated by a hospital (related organization)

d) Data for IPPS calculation retained:

(1) To calculate Medicare Disproportionate Share Hospital payment. 42 C.F.R. § 412.106.
(2) To calculate cost to charge ratio (CCR) for outlier payment. 42 C.F.R. § 412.84(i)(3)(i).
(3) Retention of IPPS “base period” for payment and cost reporting history. 42 C.F.R., Part 412.
(4) GME residency slots retained. 42 C.F.R. § 413.79(h)(2).


(6) Electronic Health Record Incentive Payments. 42 C.F.R. § 495.104(c).

e) Grandfathering retained, including:

(1) Hospital within a hospital - 42 C.F.R. § 412.22(f).

(2) Satellite - 42 C.F.R. § 412.22(h), 412.25(e).

(3) Provider-based – 42 C.F.R § 413.65(b)(2), (b)(5).

(4) CAH necessary provider determinations – 42 C.F.R. § 485.610(c).

(5) CAH co-location – 42 C.F.R § 485.610(e).

(6) CAH provider-based distance from another hospital – 42 C.F.R § 485.610(e)(2).

B. Burden of Automatic Assignment: Successor Liability

1. The new owner is responsible for the former owner’s Medicare liabilities, including any Medicare overpayments. SOM § 3210.1B1. 

   a) 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.

   b) 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.

2. 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. Deerbrook Pavilion v. Shalala, 235 F.3d 1100 (8th Cir. 2000).

   a) In August 1999, Sun Healthcare Group (Sun) entered into transfer agreements with plaintiffs for five SNFs; on 10/14/99, Sun filed for bankruptcy. Id. at 41.

   b) On May 18, 2000, CMS processed Eagle’s CHOW application and assigned Sun’s Medicare Provider Agreements for the five SNFs to Eagle with an effective date of 12/1/99. Id.

   c) Global Sun settlement agreement effected mutual release of claims through October 13, 1999, but explicitly excluded transferees of Sun provider agreements from the benefits of the Global Settlement. Id. at 42.

   d) Three years after Sun Global Settlement Agreement, Medicare contractor notified Eagle of pre-sale overpayments, and recouped them. Id. at 42.

   e) PRRB dismissed Eagle’s request for hearing because regulations preclude it from reviewing CMS actions to compromise an overpayment claim. Id. at 43.

   f) District Court affirmed PRRB decision.

C. CHOW Rules & Part B Entities

   Full initial enrollment and survey required when buyer rejected automatic assignment for Part B hospital-based end-stage renal disease (ESRD) facilities. Four months of services not eligible for Medicare reimbursement. **Tenet Health System Philadelphia, Inc. v. HCFA**, DAB CR633 at 7 (2000).

D. Payment during CHOW Processing

   1. A CHOW is effective at 12:01 a.m. on date of transaction. SOM § 3210.1.E.

   2. 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.
3. 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.

4. 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. See PIM § 15.7.7.1.5.

5. 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 CHOW processing period, and will not change its standard procedures to effectuate the terms of any such agreement.


1. Mariner did not timely cease operations in January 2004. After litigation, Triad began operating them on December 1, 2006. Id. at 8.

2. Triad accepted assignment of the provider agreement, even though Triad and Mariner did not have an agreement regarding claim submission during CHOW process. Id.

3. CHOW processing was completed in April 2007.

4. Mariner and Triad both submitted claims during the CHOW processing period (to different fiscal intermediaries); both were paid. Id. at 9.

5. Court held that Triad had successor liability, and must recover excess from Mariner. Id. at 20-22.
A. Benefits of Refusing Automatic Assignment

Because the existing provider agreement terminates, the new owner:

1. Is not responsible for overpayments that are associated with the provider agreement that it refuses. FMM Chapter, § 130.

2. Does not have the quality history associated with the provider agreement it refuses.

B. Burdens of Refusing Automatic Assignment - Break in Certification

1. 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).

   a) CMS treats this as a voluntary termination under 42 C.F.R. § 489.52(a)(3) based on the cessation of the seller’s business. SOM § 3258.

   b) Deemed Medicare certification status for that location/facility is lost.

C. Burdens of Refusing Automatic Assignment – Termination of Hospital Classifications and Special Payment Statuses

1. Hospital IPPS-excluded statuses terminate for the entire hospital and for hospital units, including:

   a) Psychiatric Hospital (entire hospital or unit)

   b) Rehabilitation Hospital (entire hospital or unit)

   c) Children’s Hospital

   d) Cancer Hospital

   e) Long-Term Care Hospital
2. Special payment treatment/classifications terminate, including:
   a) Sole Community Hospital status
   b) Rural Referral Center status
   c) Medicare Dependent Hospital
   d) Transplant Center Certification
   e) Geographic reclassification
   f) Indirect Medical Education Costs
   g) Disproportionate Share Hospitals

3. Provider-Based or Medicare-Related Organization Status terminates.
   a) RHC Provider-based to a Hospital
   b) Hospital-based ESRD
   c) ASC operated by a Hospital
   d) The relationship may be able to be re-established depending on whether the hospital’s buyer also buys the other organization and whether the buyer also accepts assignment of the other entity’s provider agreement.

4. Former provider’s data irrelevant to IPPS calculation:
   a) To calculate Medicare Disproportionate Share Hospital payment
   b) To calculate cost to charge ratio (CCR) for outlier payment
   c) Loss of IPPS "base period" for payment and cost reporting history
   d) Graduate Medical Education residency slots redistributed - 42 C.F.R. § 413.79(h).
   e) Wage index reclassification lost
   f) Electronic Health Record Incentive Payment
5. Grandfathering terminates, including:
   a) *Hospital within a hospital*
   b) *Satellite*
   c) *Provider-based*
   d) *Whole hospital exception*
   e) *CAH necessary provider determinations*
   f) *CAH co-location*
   g) *CAH provider-based distance from another hospital*

D. Prospective Provider Must File Initial Application to Participate in Medicare

1. If the new owner wants the facility/location to participate in Medicare, it must file as an initial applicant, and meet all current requirements for any special status. 75 Fed. Reg. 50,042, 50,401 (Aug. 16, 2010); SOM § 2003B, 2003C.

2. The initial applicant is not eligible for Medicare payments for services it provides before the date that the provider meets all Medicare requirements (as determined by CMS RO). 42 C.F.R. §§ 489.10, 489.13.

3. The effective date is not the date of acquisition.

4. In this situation, Medicare will never pay the prospective provider for services it provides before the date on which the provider qualifies for Medicare participation as an initial applicant. 75 Fed. Reg. 50,042, 50,401 (Aug. 16, 2010).

5. A successful onsite full initial survey is usually the last federal requirement completed.

6. 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 MAC recommends the initial 855 for approval. See also 75 Fed. Reg. 50,042, 50,400-01 (Aug. 16, 2010); SOM §§ 2003B; 3210.5A.
E. Refusing Automatic Assignment: Requirements for Initial Survey

1. Facility must be Fully Operational
   
a) Before survey, the prospective provider (applicant) must be fully operational and furnishing services to patients/residents. SOM §§ 2005A2, 2008.A. It must:
      (1) Have its doors open to admissions
      (2) Furnish all services necessary to meet the applicable provider definition
      (3) Demonstrate the operational capability of all facets of its operations
      (4) Serve a sufficient number of patients (inpatients for hospitals) or residents to verify compliance with all requirements

2. Timing of the Survey
   
a) Survey must take place when the facility is under its new ownership in order to assess the facility’s compliance under that new owner. Any earlier survey is a survey of the seller, and has no relevance to new owner's compliance. SOM § 2005.A.2.

b) State Survey Agencies (SAs) and CMS Approved Accreditation Organizations (AOs) must not conduct an initial survey until the applicable MAC has recommended approval of the new owner’s enrollment application. SOM §§ 2003B & 2003C.

c) MAC should issue such a recommendation only after the acquisition is complete. S&C 13-60 at 4, ¶ 2.

3. Survey must be Unannounced:
   
a) All SA and AO surveys (except clinical laboratories) must be unannounced. SOM §§ 2003B, 2700A.

b) CMS policy has long provided that initial certification surveys of Medicare applicants have a lower priority than mandated surveys for existing providers. SOM § 2003B.
c) CMS may reject a compliance recommendation from the SA or the AO if the survey timing creates doubt that the survey was unannounced. SOM § 2003B.

d) Cases are assessed on their facts. However, if the survey takes place within 14 days “after the effective date of an acquisition that involves rejection of assignment of the provider agreement,” CMS may review the situation closely to verify that the survey was unannounced. Id.

e) Even if the survey takes place more than 14 days after the effective date of acquisition, the facts may indicate that the survey was announced, and that CMS should not accept its findings. Id.

F. New owners should not count on obtaining Medicare certification effective on the date of the first initial survey. For non-SNFs, if all other federal requirements for Medicare participation have been met, the effective date of Medicare participation will be:

1. 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 (the last day of the survey). 42 C.F.R. § 489.13(b).

2. 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)(ii), see SOM § 2728 re: POCs.

   a) If CMS determines that the provider’s POC is not acceptable, the prospective provider will revise and resubmit the POC. SOM § 2728.E.

   b) The effective date will be the date on which CMS or the SA receives a POC which is determined to be acceptable. SOM § 2728.B.
3. If the prospective provider has condition-level citations:

a) 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).

b) CMS will issue a denial letter. SOM § 2005.A.2.

c) The prospective provider may appeal this denial. 42 C.F.R. § 488.24 (b), (c).

d) Once the prospective provider has implemented systemic corrections, it must reapply for certification. SOM § 2005A2.

(1) The prospective provider may submit no more than two reapplications for certification in connection with one enrollment application;

(2) After the prospective provider has reapplied, there will be a new initial survey (also called a “resurvey”) of all applicable Conditions of Participation (CoPs) (which is not the same as a “revisit” survey for a SNF. 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).

(3) If the prospective provider fails to demonstrate compliance within six months of the RO’s first denial of certification, the RO will recommend that the prospective provider’s enrollment application be closed out as denied.

G. Effective Date for Initial Certification after Refusing Automatic Assignment (SNFs)

1. 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.

2. If the SNF 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.
3. 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 SA may accept written evidence of correction to confirm substantial compliance in lieu of an onsite revisit. However, the SA always has the discretion to conduct an onsite revisit to determine if corrections have been made. SOM § 7300.3.

4. If the noncompliance is at the F level with a finding of substandard quality of care, or above, the SA must conduct an onsite revisit to determine substantial compliance after the facility submits an acceptable POC. *Id.*

**H. ONLY CMS is Authorized to Make the Certification Decision (not the SA or AO).**

1. 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 (as those terms are defined in [42 U.S.C. 1395x]) may be treated as such by the Secretary”).

2. "The RO (this refers to RO 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.

3. “[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).
4. *Apollo Behavioral Health Hospital - DAB No. 2561 (2014).* CMS may require validation survey.

   a) While CMS was processing AO-recommended certification for psychiatric hospital, the SA received a complaint from former hospital patient. CMS put certification in abeyance, and told the SA to investigate the complaint and perform full survey.

   b) State survey showed one condition-level, multiple standard-level deficiencies. Id.

   c) AO performed another survey in January 2013, and recommended certification on 2/8/13. CMS accepted.

   d) Hospital wanted 8/20/12 certification date.

   e) Board found that CMS’s decision to order validation surveys was not subject to review under 42 C.F.R. § 498.3. Id. at 5-6.

   f) Well-settled under DAB case law that CMS’s decision not to accept a plan of correction for undisputed standard-level deficiencies in state agency surveys is not an initial determination subject to review. Id. at 9.

5. CMS May Reject SA or AO’s Survey Recommendation

If CMS has concerns about whether an initial survey was properly conducted by an SA, an AO or a contract survey team, it may reject the survey recommendation and deny certification. In that situation, a subsequent initial survey would be conducted to determine whether the provider meets Medicare certification standards. SOM §§ 2003B, 2005A2. 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).

6. Concerns which might trigger a new initial survey include:

   a) *Not all applicable CoP were surveyed*

   b) *Inadequate sample size*

   c) *Not a full survey of all provider locations*

   d) *Citations do not reflect the facts recorded in the survey report*
e) 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 § 2003C; SOM Appendices.

VI. Buyers Cannot Avoid Eligibility Gap via Complex Transactions

A. “Using” Existing Provider Agreement without Assignment

1. Example in Chain Bankruptcy Case

   a) The debtor asked the court to approve a stipulation with its landlord to reject its sublease of a nursing home, and permit the landlord to “use” its Medicare provider number and provider agreement for up to ninety days, or until the landlord obtained its own provider numbers and agreements.

   b) CMS objected to the stipulation on the ground that a Debtor cannot lawfully permit another entity to “use” its provider number or provider agreement unless or until Debtor assumes such agreement and it is assigned in accordance with Medicare law.

   c) In the end, debtor rejected the lease, but assumed & assigned the Medicare provider agreement.

B. Sale/Leaseback/Management Agt. Cannot Give Benefits of Assignment Without Burdens

1. “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).

2. “The provider agreement will be assigned to the lessee only to the extent of the leased portion of the facility.” 42 C.F.R. § 489.18(e).

3. Sale/Leaseback: Facts

   a) Seller entered into asset purchase agreement for hospital with Buyer. It also entered into a leaseback-management agreement which became effective on the effective date of the purchase.
b) Under that agreement: (1) Seller was to sublease the hospital facilities from Buyer; and (2) Buyer was to become the manager for Seller. During the term of the management agreement, the Seller was to retain responsibility for the hospital. The management agreement was to expire 5 days after the Buyer obtained its own state license.

4. Sale/Leaseback: Certification Rules

a) The survey of new owner cannot take place until transfer is complete.

b) The survey of new owner cannot take place until the MAC has determined that the enrollment application is complete.

c) Any survey performed does not apply to the new owner until transaction is complete and the new owner is ultimately responsible for care.

d) For Medicare purposes, the Seller is the provider until after the management agreement expires. This is because the Seller is the responsible legal entity while the agreement is in effect.

e) If the Buyer refuses assignment of the Medicare provider agreement, the existing agreement terminates when the management agreement expires. The Buyer must apply to Medicare for this hospital as an initial applicant. The survey cannot take place until after the management agreement expires.

f) If all the same facts were present, but the Buyer had ultimate responsibility for hospital care during the management agreement, then the existing provider agreement would terminate on the effective date of the asset purchase agreement.

g) No matter how the agreement is structured, the initial survey of a new owner happens only after the responsible legal entity has changed.

C. Acquisition/Combinations of Providers Require Decision on Assignment of Existing Provider Agreement

1. 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 §§ 2005E1, 3210.

(1) 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 (acquisition/combination).

(2) 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.

2. Provider A’s Owner Accepts Assignment of Acquired Provider B’s Provider Agreement.

   a) All the benefits of a CHOW apply.

   b) No break in Medicare participation (the AO for both providers may extend Medicare deemed status).

   c) Special payment statuses and grandfathering continue (as long as other conditions are met).

   d) After CHOW & combination, Hospital B’s agreement is subsumed and its CCN is “retired.”

   e) 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.

3. Provider A’s Owner Refuses Assignment of Acquired Provider B’s Provider Agreement.

   a) The existing provider agreement terminates; and any deemed status is lost.

   b) That facility/location is no longer eligible under the terminated provider agreement for payment for any services it provides.
c) The new owner cannot bill for services at the acquired facility/location B using Provider A’s CCN or National Provider Identifier.

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

a) 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.

b) 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."

c) 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 RO [S&C staff] makes the determination as to whether a CHOW has occurred.” PIM § 15.7.7.1; SOM § 2005E1.

D. Provider A’s Owner Refuses Assignment of Acquired Provider B’s Provider Agreement.

1. The new owner must apply for initial certification of the acquired location.

2. The SA or AO cannot conduct an initial certification survey to determine that the facility/location meets all applicable CoPs at the acquired campus until after:

   a) The effective date of the acquisition, and

   b) The MAC notifies the RO that the initial 855 is recommended for approval.

   SOM §§ 2003B, 2003C.

3. Provider A’s Owner Refuses Assignment of Acquired Provider B’s Provider Agreement
a) When the new owner rejects assignment of the existing provider agreement and that agreement terminates, the AO may NOT extend “deemed status” of former provider to the acquired facility/location because its Medicare participation has been terminated. SOM § 2005A4.

b) The AO also may not extend the deemed status from Provider A to the acquired facility/location.

E. Mission Regional Hospital Medical Center, DAB CR2458 (2011) (Facts)

1. Petitioner owned a Medicare-certified acute care hospital (Mission Viejo).

2. 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.

3. Before the acquisition date, Petitioner submitted an 855A to its MAC to “add” South Coast as a new practice location effective July 1, 2009.

4. 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.

5. South Coast submitted an 855A that reported its acquisition by Mission. It appeared that South Coast was voluntarily terminating its provider agreement.

6. Petitioner expressly declined to assume the liabilities under South Coast’s existing Medicare provider agreement.

7. 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 SA or AO completed a full Medicare certification survey, and CMS determined that all applicable Medicare requirements had been met.
8. 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.

9. 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.

F. Mission Regional Hospital Medical Center, DAB CR2458 (2011) (ALJ Decision)

1. Grants summary judgment to CMS.

2. Cites S&C Letter 09-08.

   a) "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)
b) Quotes preamble to revised 42 C.F.R. § 489.13 in which CMS re-affirmed its policy and intent, as follows:

A CHOW “means that the new owner receives the assets and liabilities associated with that agreement or approval. This has proven to be an important tool in protecting the Medicare Trust Funds through continuity in the ability to recover outstanding overpayments.

Under that policy, if a buyer of a Medicare-participating facility chooses not to accept assignment of the provider agreement or supplier approval, the provider agreement or supplier approval terminates. Then, the new owner must be treated as an initial applicant to the Medicare program. In this situation, Medicare will not reimburse the provider or supplier for services it provides before the date on which the provider or supplier qualifies as an initial applicant.

Any requirement to make payments retroactive to the date of a State survey or accreditation decision, despite the fact that all other Federal requirements may not yet have been met, could provide an incentive for more buyers to refuse assumption of the seller's provider agreement or supplier approval, because there would potentially be no break in payments. Therefore, effectively, a buyer who does not accept assignment of the seller's active provider agreement could potentially begin receiving Medicare payments immediately (assuming it meets all the requirements), but not be responsible for any existing liabilities of the provider agreement. This would also be an incentive for existing providers or suppliers with civil money penalties or overpayments to sell their facilities in order to escape any financial responsibility to the Medicare program.”

c) ALJ rejects arguments that statements by contractor about effective date are binding. States that 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) the ALJ is not authorized to order payment contrary to law based on equitable grounds.

G. Mission Regional Hospital Medical Center, DAB No. 2459 (May 21, 2012) (Appellate Division)

1. Upholds ALJ’s grant of summary judgment to CMS. Appellate Decision at 1.

2. Because Mission did not assume the provider agreement, it did not take automatic assignment. Id. at 6.

3. Mission did not dispute that the provider agreement “did not transfer over.” Id.

4. There was no longer a provider agreement covering the Laguna Beach campus as of July 1, 2009.

5. 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.

6. It could bill for the Laguna Beach Campus only after going through the survey and certification process. Id.
VII. CONCLUSION

A. Automatic Assignment was created to benefit providers.

B. I personally recommend spending your time formulating a contract that properly apportions financial obligations and benefits between the parties in a CHOW, rather than taking the risk of rejecting the provider agreement in an attempt to “have it both ways.”

VIII. CONTACT INFORMATION

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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 and Human Services, the Office of the General Counsel, or the Centers for Medicare & Medicaid Services.

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