Certified Providers/Suppliers

Lauren Beard, Business Function Lead, CMS
Diane Gordon, Business Analyst III - Provider Enrollment, CGS

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Healthcare Solutions

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Session Overview

- Initial enrollment process
- Medicare effective date
- Common reasons for development on CMS-588 application
- HHA Capitalization
- Sections 5 & 6 of CMS-855 application
- Ownership changes
- Qualified Chain Provider
- Freestanding/Provider-Based Status

Types of Certified Providers/Suppliers

Certified providers/suppliers that enroll via the CMS-855A:

- Community Mental Health Center (CMHC)
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Critical Access Hospital (CAH)
- End-Stage Renal Disease Facility (ESRD)
- Federally Qualified Health Center (FQHC)
- Histocompatibility Laboratory
- Home Health Agency (HHA)
- Hospice
- Hospital and Hospital Units
- Indian Health Services Facility
- Organ Procurement Organization (OPO)
- Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services (OPT)
- Religious Non-Medical Health Care Initiative
- Rural Health Clinic (RHC)
- Skilled Nursing Facility (SNF)

Types of Certified Providers/Suppliers

Certified suppliers that enroll via the CMS-855B:

- Ambulatory Surgical Center (ASC)
- Portable X-Ray Supplier (PXRS)

Certified Provider/Supplier Initial Enrollment Process

Provider Actions:
- Obtain an NPI
- Contact state agency for certification forms
- Complete CMS-855A and submit it to the MAC serving your state

*** Must be in compliance at time of survey (operational & providing services to patients)*

MAC Actions:
- Screen and validate
- Submit recommendation of approval to State agency, copy to CMS RO

State Survey Agency or Accrediting Organization Actions:
- On-site certification survey
- Makes certification recommendation to CMS RO

CMS RO Actions:
- If Conditions of Participation (COP) are met, RO issues provider agreement and assigns CCN

MAC Actions:
- Processes tie-in
- Updates PECOS and claims systems

Provider Actions

1) Contact state agency for licensure requirements and certification forms
2) Ensure you are able to meet state/federal requirements
3) Obtain NPI
4) Complete applicable CMS-855
5) Respond to questions from state (certification forms) and MAC (855 application)
6) Obtain civil rights clearance from the Office for Civil Rights (OCR) – applicable for all Medicare Part A providers.
7) Be operational and providing services to patients at the time of survey

Accrediting Organizations

Some provider types may elect voluntary accreditation by a CMS-recognized accrediting organization (AO) as an alternative to a state agency survey.

- A health care facility that is accredited for Medicare participation by one of the CMS-recognized AOs is "deemed" by CMS to have satisfied Medicare's health and safety standards.
- The state survey agency does not conduct a survey to certify or recertify the compliance of the facility with Medicare conditions. The facilities remain under the jurisdiction of the AO, not the SA, for oversight of their ongoing compliance.
- Accreditation by an AO is voluntary and not required for Medicare certification or participation in the Medicare program.

State vs. Accrediting Organization

	State	Accrediting Organization
Available to All Provider Types?	Yes*	No
Fees Charged?	No	Yes
Timeframe for Survey	Varies	Varies but is usually faster than state survey if a deeming option is available

*Some states may not offer a survey for some or all provider/supplier types that have the option of deemed status through an accrediting organization.

CMS Approved Accrediting Organizations and Approved Program Types

Accrediting Organization	Hospital	Psych Hospital	CAH	HHA	Hospice	OPT	RHC	ASC
Accreditation Association for Ambulatory Health Care (AAAHC)								X
Accreditation Commission for Health Care, Inc (ACHC)				X	X			
American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)						X	X	X
American Osteopathic Association/ Healthcare Facilities Accreditation Program (HFAP)	X		X					X
Center for Improvement in Healthcare Quality (CIHQ)	X							
Community Health Accreditation Partner (CHAP)				X	X			
DNV GL – Healthcare (DNV GL)	X		X					
Institute for Medical Quality (IMQ)								X
The Compliance Team (TCT)							X	
The Joint Commission (TJC)	X	X	X	X	X			X

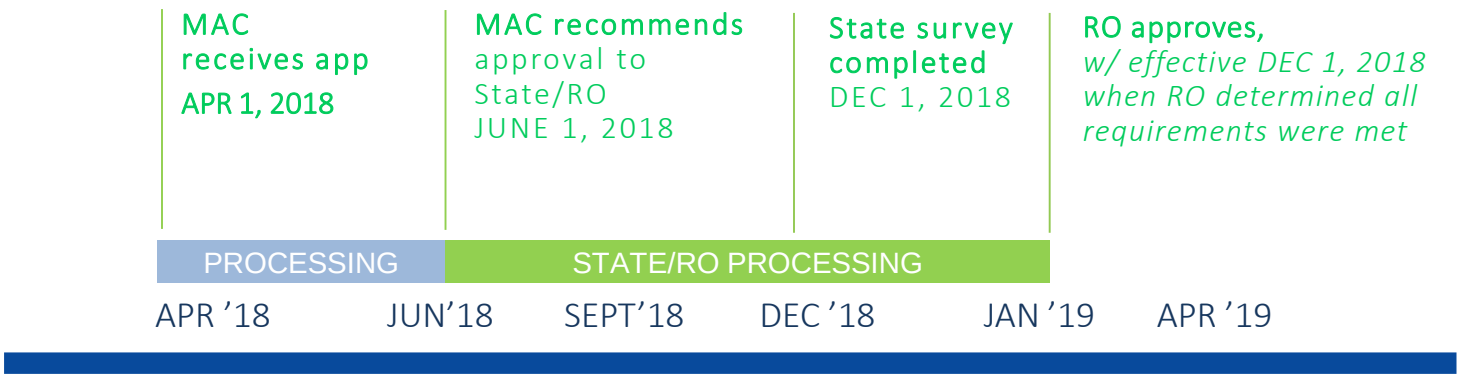
Initial Survey Process

- Survey can't be completed until approval recommendation is received from the MAC.
- All surveys are unannounced.
- Must be fully operational and serving patients.
- Survey results are forwarded to the RO.
  - **In compliance** - the RO proceeds with the provider/supplier's Medicare approval and issues the provider or supplier agreement and assigns a CMS Certification Number (CCN).
  - **Not in compliance** - the RO issues a denial letter. The applicant may correct the deficiencies and reapply for certification and undergo a new survey.

Medicare Effective Date

Provider seeking effective date
SEPT 1, 2018

Hospitals / HHAs / SNFs
can apply up to
180 days prior **



*** Must be in compliance at requested effective date (operational, licensed)*

How Long is Approval Recommendation Valid?

- The MAC's recommendation on the CMS-855 is considered valid regardless of how long it takes for the State to initiate the survey process.
- The provider must submit an updated CMS-855 application to the MAC if the state agency requests it.

Knowledge Check

Questions?

Poll Question

CMS-588 EFT Authorization Agreement

Name on Bank Account can be:

- The provider's legal business name.
- The chain home office legal business name if payment is being made to the chain home office.
- If governmental, doesn't have to match provider's legal business name if required by law to have payments made to a specific account. Must provide copy of statute/regulation supporting this.

CMS-588 EFT Authorization Agreement

Supporting Documents:

- *Pre-printed* voided check or a letter from the bank confirming name on account, account number, and routing number. A deposit slip is not acceptable.
- If payment is being made to the chain home office, a letter authorizing EFT payments due the provider to the chain home office's bank account.

Reminder:

01/17 version of the CMS-588 is the only version being accepted effective 1/1/18.

HHA Capitalization

Factors used to determine initial reserve operating funds:

- Geographic location and urban/rural status
- Average cost per visit comparisons to similar HHAs
- Provider-based versus freestanding status
- Proprietary versus non-proprietary status

HHA Capitalization

Documentation Needed:

- Projected budget
- Document outlining number of anticipated visits for a full year broken out by month
- Copies of current bank statements
- Letter from bank officer attesting that funds are immediately available
- Attestation from the HHA certifying that at least 50% of required funds are non-borrowed
- Audited financial statements if available

HHA Capitalization

Points of Review:

1) Prior to MAC making approval recommendation
2) After approval recommendation but before RO review process is completed
3) After RO review process is completed but before MAC conveys billing privileges
4) During the 3 month period after MAC conveys billing privileges

Authorized and Delegated Officials

AO Authorized Official

Enroll, make changes and ensure compliance with enrollment requirements

- CEO, CFO, partner, chairman, owner, or equivalent appointed by the org
- May sign all applications *(must sign initial application)*
- Approves DOs

DO Delegated Official

Appointed by the AO with authority to report changes to enrollment information

- Ownership, control, or W-2 managing employee
- Multiple DOs permitted
- May sign changes, updates & revalidations *(cannot sign initial application)*

Sections 5 & 6 – Applicable Roles Based on Organizational Structure

Type of Organization	Section 5 and/or 6				Officer	Director	Managing Employee
	5% or > Direct Owner	5% or > Indirect Owner	General Partner	Limited Partner			
Sole Proprietorship	A	N/A	N/A	N/A	N/A	N/A	A
General Partnership	M	M	A	N/A	M	M	A
Limited Partnership	M	M	A	A	M	M	A
Corporation	A	M	N/A	N/A	A	A	A
Limited Liability Company	A	M	N/A	N/A	M	M	A
Non-Profit Organization	M	M	N/A	N/A	A	A	A
Government Owned Entity	A*	N/A	N/A	N/A	M	M	A

A = Applicable & required to include
M = May be applicable; required to include if applicable to your organization
N/A = Not applicable

Sole Proprietorship

Type of Organization	Section 5 and/or 6				Officer	Director	Managing Employee
	5% or > Direct Owner	5% or > Indirect Owner	General Partner	Limited Partner			
Sole Proprietorship	A	N/A	N/A	N/A	N/A	N/A	A

A = Applicable & required to include
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N/A = Not applicable

General Partnership

Type of Organization	Section 5 and/or 6				Officer	Director	Managing Employee
	5% or > Direct Owner	5% or > Indirect Owner	General Partner	Limited Partner			
General Partnership	M	M	A	N/A	M	M	A

A = Applicable & required to include
M = May be applicable; required to include if applicable to your organization
N/A = Not applicable

Limited Partnership

Type of Organization	Section 5 and/or 6				Officer	Director	Managing Employee
	5% or > Direct Owner	5% or > Indirect Owner	General Partner	Limited Partner			
Limited Partnership	M	M	A	A	M	M	A

A = Applicable & required to include
M = May be applicable; required to include if applicable to your organization
N/A = Not applicable

Corporation

Type of Organization	Section 5 and/or 6				Officer	Director	Managing Employee
	5% or > Direct Owner	5% or > Indirect Owner	General Partner	Limited Partner			
Corporation	A	M	N/A	N/A	A	A	A

A = Applicable & required to include
M = May be applicable; required to include if applicable to your organization
N/A = Not applicable

Limited Liability Company (LLC)

Type of Organization	Section 5 and/or 6				Officer	Director	Managing Employee
	5% or > Direct Owner	5% or > Indirect Owner	General Partner	Limited Partner			
Limited Liability Company	A	M	N/A	N/A	M	M	A

A = Applicable & required to include
M = May be applicable; required to include if applicable to your organization
N/A = Not applicable

Non Profit Organization

Type of Organization	Section 5 and/or 6				Officer	Director	Managing Employee
	5% or > Direct Owner	5% or > Indirect Owner	General Partner	Limited Partner			
Non-Profit Organization	M	M	N/A	N/A	A	A	A

A = Applicable & required to include
M = May be applicable; required to include if applicable to your organization
N/A = Not applicable

Government Owned Entity

Type of Organization	Section 5 and/or 6				Officer	Director	Managing Employee
	5% or > Direct Owner	5% or > Indirect Owner	General Partner	Limited Partner			
Government Owned Entity	A*	N/A	N/A	N/A	M	M	A

A = Applicable & required to include
M = May be applicable; required to include if applicable to your organization
N/A = Not applicable

Questions?

Transactions that Require SA/RO Approval

- Initial enrollment
- Change of ownership
- The following types of change of information:
  - Adding locations (all provider types except hospitals)
  - Adding swing-bed, psychiatric, or rehabilitation units to a hospital
  - Adding a transplant center to a hospital
  - Change in type of PPS-exempt unit
  - Conversion of hospital from one sub-type to another
  - Change in practice location address where a survey of the new site is required
  - Stock transfer

Change of Ownership

The assets of the Medicare provider organization are being sold or transferred to another organization through a CHOW, Acquisition/Merger, or Consolidation.

Documentation Needed:

- Copy of final sales/lease agreement.
- Copy of bill of sale.
- Documents must include date and be signed.

Effective date of transfer on 855A application must match the effective date of the sale as noted in the sales agreement or bill of sale.

Examples of CHOWs

- Sale or transfer of assets
- Provider entity merges into another provider entity
- Two provider entities combine to create a new provider entity
- Lease of the provider facility
- Operator of provider facility changes
- Management contract where owner relinquishes all authority and responsibility
- Dissolution of provider entity due to removal, addition, or substitution of a partner/owner

Change of Ownership

Billing During and After CHOW Processing:

- Old and new owners are responsible for working together on claims for services furnished during the CHOW processing period. The bank account will not be updated to buyer's account until the CHOW is approved.

- After CHOW processing is complete, only the Buyer is permitted to submit claims using the existing CCN. MACS no longer have the ability to update the crosswalk in order for the Seller to complete their billing.

Stock Transfers

The stock of the Medicare provider organization is being sold or transferred but the provider's assets and liabilities are still held by the same provider organization.

Documentation Needed:

- MAC may request a copy of the stock transfer agreement.
- Document must include date and be signed.

Effective date of addition/deletion/change for owners in Section 5/6 must match the effective date of the sale in the stock transfer agreement.

Knowledge Check

HHA Change in Majority Ownership

- Occurs when an individual or organization acquires more than a 50% direct ownership interest in a home health agency (HHA) during:
  - The 36 months following the HHA's initial enrollment into the Medicare program
  - The 36 months following the HHA's most recent change in majority ownership

HHA Change in Majority Ownership

- Exceptions
  - The HHA has submitted 2 consecutive years of full cost reports.
  - The HHA's parent company is undergoing an internal corporate restructuring.
  - The HHA is changing its existing business structure and the owners remain the same.
  - An individual owner of the HHA dies.
- If the MAC determines that a change in majority ownership has occurred within either 36-month period and no exception applies, the HHA's billing privileges are deactivated and the HHA must enroll as an initial applicant.

Elimination of HHA Subunits

New HHA Conditions of Participation (CoPs) effective 1/13/2018 no longer contain a definition for HHA subunits.

Options for existing HHA Subunits:

- Elect to become a parent HHA
- Elect to become a branch of its parent HHA
- Elect to terminate it participation in Medicare.

Any HHA subunits that exist on the effective date of the regulations that haven't elected to become a branch or elected to terminate will automatically be converted to parent HHAs.

Qualified Chain Provider (QCP)

Provider types that are eligible to be a qualified chain provider:

- Hospitals
- Skilled nursing facilities
- Critical access hospitals
- ESRDs (Refer to 42 CFR § 421.404(c)(3))

Facilities must be under common ownership or control and meet requirements for number of facilities and number of certified Medicare beds.

CMS must approve all QCP requests.

Qualified Chain Provider (QCP)

A QCP may have all its eligible providers assigned to the MAC that covers the state where the QCP's home office is located.

- If a QCP adds a new eligible provider (a new Medicare provider without any claims history) located outside of the home office MAC jurisdiction, CMS will assign the initial enrollment to the MAC that covers the QCP's home office state.
- If a QCP acquires an eligible provider (an existing Medicare provider ***with*** claims history) located outside of the home office MAC jurisdiction, the provider will remain with the current MAC and ***will not be*** transferred to the MAC that covers the QCP's home office state.

Freestanding/Provider-Based Status

How does this affect provider enrollment?

- RHC & ESRD providers have special numbering based on freestanding/provider-based status. The MAC informs the RO of the applicable status so the correct CCN will be issued.
- HHA & hospice providers enroll with the HHH MAC for the state they are located in if freestanding and with the MAC that services the main provider if provider-based.

Freestanding/Provider-Based Status

Transitioning from freestanding to provider-based or vice versa

- If status is changing due to a CHOW – provider may be assigned to a new MAC. The MAC for the new jurisdiction processes both the buyer's and seller's 855 applications.
- If status is changing and a CHOW is not involved – no updates are made to 855 enrollment, but a tie-in is needed if it changes who completes the Medicare cost report. Contact your MAC for guidance.

Knowledge Check

Questions?

Resources

- ICN 903783 – Medicare Enrollment for Institutional Providers
- Medicare Provider-Supplier Enrollment website
- Medicare Program Integrity Manual – Chapter 15
- Medicare Program Integrity Manual – Chapter 2

Thank You

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