



Center for Clinical Standards and Quality/Survey & Certification Group

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TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Acquisitions of Providers/Suppliers with Rejection of Automatic Assignment of the Medicare Provider Agreement: Implications for Timing of Surveys and Participation Effective Date

Memorandum Summary

- ***The Centers for Medicare & Medicaid Services (CMS) Encourages New Owners of a Provider/Supplier to Accept Automatic Assignment of the Seller's Medicare Agreement:***
 - 42 CFR 489.18(c) provides for automatic assignment of the current Medicare agreement to a new owner. However, new owners have the option to reject automatic assignment, resulting in termination of the prior Medicare agreement in accordance with 42 CFR 489.52.
 - If the new owner rejects assignment, the facility must be treated as an initial applicant if it seeks to participate in Medicare. Like all initial applicants the facility will experience a period (of uncertain duration) with no Medicare payments. This policy also applies in the case of hospitals that acquire another hospital, reject assignment, and make the acquired hospital a provider-based campus.
- ***State Survey Agency (SA) & Accreditation Organization (AO) Surveys Must Be Unannounced:***
 - All surveys conducted for Medicare certification purposes must be unannounced in accordance with Section 2700A of the State Operations Manual (SOM).
 - If an initial survey of an applicant that acquired a provider/supplier but rejected assignment is conducted shortly after the acquisition date, it raises significant doubts that the survey was unannounced. At a minimum, the appearance is created that the SA or AO collaborated with the new owner on the timing of the survey.
 - CMS may refuse to accept a survey for certification purposes if the survey timing creates reasonable doubt that the survey was unannounced.
- ***SAs Must Prioritize Initial Surveys in Accordance with CMS Workload Priorities:***
 - Unless the CMS Regional Office (RO) directs the SA to conduct an initial certification survey as soon as possible, SAs must not conduct initial surveys unless they are able to complete their higher priority workload. For initial applicants that have an accreditation option, initial certification surveys are the lowest SA priority.
 - When an SA conducts an initial certification survey of an applicant that acquired a provider/supplier but rejected assignment, the RO must review the facts of the case carefully to determine whether the SA deviated from CMS workload priorities as well as the SA's typical practice for initial applicants. Such deviation may raise reasonable doubt that the survey was unannounced.
- ***Determination of the Medicare Agreement Effective Date:*** ROs determine the effective date of each Medicare provider agreement or supplier approval in accordance with 42 CFR 489.13. While the effective date can be the last day of an initial Medicare survey conducted by the SA or AO as part of the certification process, this is not always the case. SAs and AOs must not speculate to prospective providers/suppliers on what the likely effective date will be.
- ***Non-Long Term Care Survey Procedures When An Initial Survey Finds Substantial Noncompliance:*** We are reiterating the existing policy and process to be followed when an initial certification survey of a non-long term care applicant results in condition-level deficiency citations.

Background

Each year there are a number of acquisitions of Medicare-participating providers and institutional suppliers subject to certification requirements. In accordance with 42 CFR 489.18(b), an owner contemplating or negotiating a sale of a Medicare-participating provider or supplier must notify CMS. Further, under 42 CFR 424.516(e)(a), CMS must be notified within thirty days of a change of ownership or control of a participating provider or supplier. Both the seller and buyer accomplish these required notifications by submitting the appropriate Medicare enrollment form, Form CMS 855A or Form CMS 855B (collectively referred to hereafter as the “855”), to their Medicare Administrative Contractor (MAC). Consistent with SOM Section 2005E1, the seller indicates that it is terminating ownership of the provider or supplier.

Automatic Assignment of Medicare agreement

Under 42 CFR 489.18(c), when an acquisition has occurred, CMS automatically assigns the existing Medicare provider agreement or supplier approval to the new owner. Automatic assignment means uninterrupted participation of the acquired provider or supplier in the Medicare program. There is also no required survey of the provider or supplier as a result of the acquisition and assignment, although the RO may exercise its discretion to direct the SA to conduct a survey in individual cases when it has cause for concern about quality of care. In the case of deemed status providers/suppliers, automatic assignment also means, in accordance with Section 3210.1C, that the new owner must notify the AO of the acquisition, and that accreditation continues until the AO decides whether a resurvey is necessary.

Acceptance of automatic assignment also means the buyer is subject to all applicable statutes and regulations and to the terms and conditions under which the assigned agreement was originally issued. These include, but are not limited to, Medicare requirements to adjust payments to account for prior overpayments and underpayments, even if they relate to a pre-acquisition period (successor liability), and to adjust payments to collect civil monetary penalties.

Rejection of Automatic Assignment

New owners have the option of indicating on the 855 application they submit to the MAC that they are rejecting the automatic assignment of the existing provider agreement or supplier approval. Generally, rejecting assignment precludes the buyer from having successor liability for Medicare overpayments or underpayments. However, it also means that there has been a voluntary termination of the existing Medicare provider agreement or supplier approval, including its associated CMS Certification Number (CCN), in accordance with 42 CFR 489.52. The voluntary termination is effective as of the date the acquisition is completed. There will be no Medicare payments for services to beneficiaries under the rejected (and thus terminated) provider agreement furnished on or after that acquisition date. The only exception to this rule provides for a continuation, up to thirty days, of payments for hospital or critical access hospital (CAH) inpatients, home health agency (HHA) or hospice patients, or skilled nursing facility (SNF) residents who were admitted prior to the acquisition date.

When a new owner rejects automatic assignment of the existing provider agreement/supplier approval, but wishes to participate in the Medicare program, the facility under the new ownership is considered an initial applicant to the Medicare program. *See U.S. v. Vernon Home*

Health, Inc., 21 F. 3d 693, 695 (5th Cir. 1994), *cert denied*, 513 U.S. 1015 (1994). Also see *SOM section 3210*. For providers or suppliers subject to certification this means that, in addition to completing the 855 enrollment process, they must also satisfy any other applicable Federal Medicare participation requirements, including undergoing an unannounced full survey of their compliance with the applicable Medicare requirements (skilled nursing facilities (SNFs)), Conditions of Participation (providers), Conditions for Coverage (most institutional suppliers) or Conditions for Certification (rural health clinics).

Further, if the new owner of a healthcare facility rejects the existing provider agreement/supplier approval, and that facility previously was deemed to meet the applicable conditions based on its accreditation under a CMS-approved Medicare accreditation program, the AO may not “extend” its prior accreditation to the new owner. Instead, the AO must conduct a full initial accreditation survey after the acquisition date. The effective date of the new owner’s Medicare provider agreement or supplier approval is calculated in accordance with the provisions of 42 CFR 489.13.

In 75 *Fed. Reg.* 50,401-02 (August 16, 2010) CMS reiterated that the policy of automatic assignment of the existing provider agreement/supplier approval to a new owner is an important tool in protecting the Medicare Trust Funds. The policy provides continuity in the ability of CMS to recover outstanding overpayments to the provider/supplier.

The effectiveness of this tool can be undermined, however, if the incentives to accept automatic assignment are weakened by SA or AO practices that deviate from CMS policy requiring unannounced surveys and shorten the typical SA or AO timeframes for surveying initial applicants. When such atypical practices have the effect of significantly shortening the period during which no Medicare payments will be made, they reduce the impact on new owners of rejecting assignment, and may encourage new owners in the future to likewise reject assignment. Under such a scenario, a new owner could potentially begin receiving Medicare payments almost immediately, but would not be responsible for any pre-acquisition liabilities. This could 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. CMS is aware that the new owner likely has an interest in having as short a gap as possible between the voluntary termination date of the seller’s Medicare agreement and the effective date of the new Medicare agreement. However, this interest of the buyer is not consistent with CMS’s obligation to protect the Medicare Trust Funds by creating incentives to accept the automatic assignment of the seller’s Medicare agreement.

Timing of Initial Surveys after a Rejection of Assignment

SAs and AOs must adhere to the following long-standing CMS policies concerning all initial certification surveys:

1. SAs and AOs must not conduct a survey for initial certification purposes until after the date the acquisition is complete (date of sale); the survey must be a full, standard survey (consistent with the requirements at 42 CFR 489.10) and must take place when the facility is under its new ownership in order to assess the facility’s compliance under that new owner. Any survey conducted prior to the completion of the acquisition is a survey of the seller, under the seller’s provider agreement or supplier approval, and has no relevance once that

provider agreement/supplier approval has been terminated as a result of the new owner's rejection of assignment.

2. Consistent with SOM Section 2003B, SAs and AOs must not conduct an initial survey until the applicable MAC has issued a recommendation for approval of the new owner's enrollment application. CMS will be clarifying with the MACs that, in the case of an acquisition where the new owner rejects automatic assignment of the Medicare provider agreement or supplier approval, the MAC should not complete its review of the new owner's 855 and issue its recommendation to the SA and the RO until after the MAC has verified that the acquisition has been completed.
3. Consistent with SOM Section 2008A, the applicant must be fully operational and providing services to patients/residents before it may be surveyed. This means that at the time of survey, the facility must have opened its doors to admissions, be furnishing all services necessary to meet the applicable provider or supplier definition, and demonstrate the operational capability of all facets of its operations. To be considered "fully operational," initial applicants must be serving a sufficient number of patients or residents so that compliance with all requirements can be determined.
4. Section 2700A of the SOM requires all surveys of providers and suppliers (other than clinical laboratories) to be unannounced. This requirement applies to AO as well as SA surveys. An unannounced survey provides an opportunity to assess how the provider or supplier typically operates. On the other hand, if a provider or supplier knows the exact or approximate date of a survey, it may temporarily adjust its typical practices to enhance its compliance at the time of the survey. In doing so, it presents an unrepresentative picture to surveyors of the quality of care typically provided to its patients or residents. It is therefore in the best interest of patients and residents that surveys be unannounced.

Given the lead time normally required to schedule and prepare for a full survey, if an initial survey takes place shortly after the acquisition date, such timing suggests discussion with the new owner prior to the acquisition date to arrange the timing of the survey to occur shortly thereafter, compromising the requirement that the survey be unannounced. We understand that the new owner, like any other initial applicant to the Medicare program, will be expecting to be surveyed at some point, but there must be some degree of uncertainty about just when that survey will occur, in order to permit an assessment of compliance when the facility is operating in a typical manner.

Each case must be assessed based on the facts specific to it and such facts may warrant further review by the RO at any time; however, any survey that takes place, for example, within fourteen days after the effective date of an acquisition that involves rejection of assignment of the provider agreement warrants closer review by the RO of the circumstances of the case and the timing of the survey.

5. Consistent with S&C-08-03, issued November 5, 2007, as updated by CMS's annual workload instructions, initial surveys conducted by SAs are generally the lowest workload priority, particularly in the case of provider or supplier types for which there is an accreditation option. Longstanding CMS policy makes complaint investigations, recertifications, and other core work for existing Medicare providers and suppliers a higher

priority than certification of new Medicare providers and suppliers. SAs must be able to demonstrate that they can complete all of their higher priority workload and that initial certification surveys are conducted in addition to this higher priority work, rather than instead of it. We reiterate that a prospective provider or supplier whose new owner has rejected assignment of the existing Medicare agreement is a new applicant and must be treated like any other initial applicant. Further, it is not acceptable for an SA to conduct an initial survey at SA expense if it only does so for one or more initial applicants whose new owner(s) rejected automatic assignment of the existing Medicare agreement.

If an SA conducts an initial certification survey of an applicant that acquired a previously enrolled provider or supplier but rejected assignment, the RO must review the facts of the case carefully to determine whether the SA deviated from CMS workload priorities as well as the SA's typical practice for initial applicants. Such deviation may raise reasonable doubt that the survey was unannounced.

Hospital Acquisition Followed by Combination Into One Hospital

In accordance with the provider-based rules at 42 CFR 413.65, a hospital may operate one or more of the following under one Medicare provider agreement and associated CCN: (1) one or more off-campus outpatient departments; and/or (2) one or more inpatient campuses (with one being the "main" campus and the other(s) called either "remote locations" or "satellites," depending on the type of hospital). (This is also true for CAHs, although the statutory limit on CAH bed size makes it less likely that a CAH will provide inpatient services at multiple campuses.) The remote location or satellite must be the same type of hospital as the main campus. For example, a short-term acute care hospital cannot have a provider-based long term care hospital satellite. However, a short-term acute care hospital can have an Inpatient Prospective Payment System (IPPS)-excluded unit of that hospital at a remote location – for example, a short-term acute care hospital may have a unit providing IPPS-excluded inpatient psychiatric services at a remote location.

Therefore, under the provider-based rules, it is possible for the owner of an existing Medicare-participating hospital (Hospital A) to acquire another Medicare-participating hospital (Hospital B) and make the acquired Hospital B a remote location or second campus of Hospital A. For purposes of this example, the acquired hospital is now called Hospital A-Campus 2. Hospital A-Campus 2 would be covered by Hospital A's Medicare provider agreement and CCN number. Some hospitals, SAs, and AOs appear to be unclear as to the circumstances in which it is permissible for Hospital A to bill for Medicare services at the newly acquired Hospital A-Campus 2 as soon as the acquisition is completed. To continue our example, there have been cases where Hospital A has rejected assignment of the Hospital B Medicare provider agreement, but has assumed it could nevertheless treat the acquisition of Hospital B as the addition of a service location and begin billing as of the acquisition date. This is incorrect. We are, therefore, clarifying the rules which apply to a hospital acquisition-combination scenario as follows:

1. CMS will automatically assign the Hospital B's existing provider agreement to Hospital A. Under this scenario, since Hospital B becomes Hospital A-Campus 2, there cannot be a separate provider agreement and CCN for this campus. However, Hospital B's provider agreement is **not** terminated; instead it is subsumed under/incorporated into the provider agreement of Hospital A. The CCN associated with Hospital B's provider agreement is

“retired” and no longer used. Hospital A may begin to bill Medicare for services provided at Hospital A-Campus 2 as soon as the acquisition is completed. There is no interruption in the participation of Hospital A-Campus 2 in Medicare.

2. As in any acquisition, Hospital A also has the option to reject assignment of Hospital B’s existing Medicare provider agreement. If it does so, Hospital B’s provider agreement is terminated, and Hospital A is not eligible for Medicare payment for services at the new Hospital A-Campus 2 until it has completed a process analogous to that applied to an initial applicant for Medicare enrollment. This is the case even though Hospital A-Campus 2 will not be separately enrolled in Medicare.
 - a) Hospital A must notify CMS that it is rejecting assignment of the Hospital B provider agreement, and that it is creating a provider-based Hospital A-Campus 2. It is **not** permissible for Hospital A to treat this transaction merely as a change of information on Hospital A’s 855, to provide notice to CMS of its addition of a new practice location at the campus of Hospital A-Campus 2.
 - b) Hospital A-Campus 2 must have a full certification survey of all applicable Medicare Hospital Conditions of Participation in the same way as would a prospective hospital applying for initial enrollment in Medicare. If Hospital A is deemed to meet the requirements through accreditation, its AO may **not** extend the accreditation of Hospital A to its new Hospital A-Campus 2, but must instead conduct a full accreditation survey of that campus.
 - i) The survey by the SA or AO may not be scheduled and conducted until the acquisition is complete, the MAC has completed its review of the Form 855A and made a recommendation for approval to the RO, and the campus is fully operational and providing services to patients.
 - ii) The effective date for participation of the new campus and payment for any Medicare services which are provided there is calculated under the same procedure that would have been used if the new owner had not combined Hospital B into Hospital A.

Medicare Participation Effective Date after Rejection of Assignment

The effective date for Medicare participation of the facility under its new owner is established in the same manner as for any initial applicant, that is, after a prospective provider/supplier (or newly acquired hospital/CAH campus) demonstrates it meets all Federal requirements per 42 CFR §§ 489.10 and 489.13. The effective date is **not** the date of the acquisition of the provider or supplier. Rather, the effective date of the Medicare agreement is the date when the **last** applicable Federal requirement has been met, and not earlier.

The finding of substantial compliance via an onsite survey is typically the final Federal requirement completed before a prospective provider or supplier is issued a Medicare agreement. However, this is not always the case. There may be other Federal requirements outstanding after the initial survey is completed. For example, the applicant:

- may have neglected to submit the appropriate Office of Civil Rights compliance documentation prior to the accreditation survey by the AO; or
- might be seeking to enroll as a rehabilitation hospital, but might not have submitted the required attestation to the SA.

Non-long Term Care Post-Initial Survey Scenarios for Effective Date Calculation

As specified in 42 CFR 489.13, the survey findings from the initial full survey may require further actions before the applicant may be certified and the Medicare agreement may be effective. Although this regulation applies to both SNFs and non-long term care providers and suppliers, there are some differences in terms of post-initial survey actions. **In the scenarios which follow we are considering only non-long term care applicants. The scenarios assume that:**

- all applicable Federal requirements, *other than* the survey requirements, have been met prior to the survey; *and*
- the RO accepts the survey findings and recommendations of the SA or the AO.

Cases in which either or the above conditions are not met will be more complicated than the scenarios which follow.

1. Scenario #1 – the initial survey by the SA or AO finds compliance with all health and safety conditions and standards, i.e., no deficiencies are cited at any level. The effective date of the Medicare agreement, and thus participation, is the date when the SA survey concluded or the date of the AO's positive accreditation decision.
2. Scenario #2 - the initial survey by the SA or AO finds standard-level deficiencies, but no condition-level deficiencies:
 - a. The prospective provider or supplier applicant must submit an acceptable plan of correction (POC) for the identified noncompliance to the SA or AO. Information regarding the requirements for an acceptable POC is found in SOM section 2728.
 - b. If the POC is *not* acceptable, the prospective provider/supplier must submit a revised POC.
 - c. The SA recommends certification to the RO as of the date the SA receives an acceptable POC. Where a POC was not acceptable and required revision, the date the SA recommends is the date the revised acceptable POC was received.
 - d. Likewise, the AO may award accreditation as of the date it receives an acceptable POC and recommend to the RO deemed status as of that accreditation date. Where a POC was not acceptable and required revision, the AO may not issue a positive accreditation decision that is effective prior to the date the revised acceptable POC was received.

- e. The submission of revised POCs is not an open-ended process. If a second POC remains unacceptable and requires more than minor revisions, the SA or AO should consider recommending denial of certification to the RO. If the RO agrees with the SA's or AO's recommendation concerning the POC, then the RO must deny the application for certification by issuing a formal denial letter.
 - i. The prospective provider/supplier applicant must request a new initial certification survey and be re-surveyed if it would like to be certified as a Medicare provider or supplier.
 - ii. In accordance with SOM section 2005A2, the applicant may reapply for certification without having to complete another 855 or other applicable documents if the applicant requests another initial survey and the survey is completed within 90 calendar days of the date of the RO's denial letter. There is no prescribed form for the applicant to use to apply for a new initial survey within this 90-day timeframe – the applicant may provide an informal oral or email notification to the SA or AO that it is ready to be resurveyed.
 - iii. Consistent with SOM section 3054A, an applicant that has requested a formal reconsideration of the denial of its initial certification pursuant to 42 CFR 498.22 – 498.25 must withdraw the reconsideration request in order for the SA or AO to conduct another initial survey.
 - iv. The SA or AO must conduct an unannounced resurvey, which means a full, standard initial survey, not a focused revisit survey.
 - v. If the applicant is not resurveyed within 90 calendar days of the denial of certification, the RO must notify the MAC that certification and enrollment were denied. SAs and AOs are encouraged to communicate with ROs in a timely manner if they expect to complete a survey before the end of the 90 days, but their certification recommendation or accreditation decision, as applicable, will be made later. If the applicant has not been resurveyed and seeks Medicare participation 90 or more calendar days after the date of the denial letter, it must submit a new 855 and begin the enrollment and certification processes all over again.
3. Scenario #3 - the initial survey by the SA or AO finds one or more condition-level deficiencies:
- a. In accordance with SOM section 2005 the RO must deny the application for certification by issuing a formal denial letter.
 - i. The prospective provider/supplier applicant must request a new initial certification survey and be re-surveyed if it would like to be certified as a Medicare provider or supplier. The applicant does *not* submit any POC in this scenario.

- ii. In accordance with SOM section 2005A2, the applicant may reapply for certification without having to complete another 855 or other applicable documents if the applicant requests another initial survey and the survey is completed within 90 calendar days of the date of the RO's denial letter. There is no prescribed form for the applicant to use to apply for a new initial survey within this 90-day timeframe – the applicant may provide an informal oral or email notification to the SA or AO that it is ready to be resurveyed.
- iii. Consistent with the SOM section 3054A, an applicant that has requested a formal reconsideration of the denial of its initial certification pursuant to 42 CFR 498.22 – 498.25 must withdraw the reconsideration request in order for the SA or AO to conduct another initial survey.
- iv. The SA or AO must conduct an unannounced resurvey, which means a full, standard initial survey, not a focused revisit survey.
- v. If the applicant is not resurveyed within 90 calendar days of the denial of certification, the RO must notify the MAC that certification and enrollment were denied. SAs and AOs are encouraged to communicate with ROs in a timely manner if they expect to complete a survey before the end of the 90 days, but their certification recommendation or accreditation decision, as applicable, will be made later. If the applicant has not been resurveyed and seeks Medicare participation 90 or more calendar days after the date of the denial letter, it must submit a new 855 and begin the enrollment and certification processes all over again.

As indicated above, it is current CMS policy that the resurvey which takes place after the RO has issued a formal written denial of certification must be a full, standard initial survey and not a focused revisit survey. CMS is reviewing this policy to determine whether a more focused revisit survey would be sufficient. However, until such time as CMS provides notice via future guidance of a policy change, all initial surveys of prospective providers/suppliers seeking certification (including any resurveys after a denial of certification) must be unannounced, full standard surveys.

For questions relating to this memorandum please send inquiries to: hospitalscg@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management