



**News Flash** – As a result of the Affordable Care Act, claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For full details, see the MLN Matters® article, MM6960, at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6960.pdf> on the Centers for Medicare & Medicaid Services website.

MLN Matters® Number: MM7256

Related Change Request (CR) #: 7256

Related CR Release Date: December 17, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R362PI

Implementation Date: January 1, 2011

## Implementation of Home Health Agency (HHA) Payment Safeguard Provisions

**Note:** This article was updated on September 4, 2012, to reflect current Web addresses. All other content remains the same.

### Provider Types Affected

HHAs submitting claims to Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and A/B Medicare Administrative Contractors (A/B MACs) are affected by this article.

### Provider Action Needed

This article advises HHAs that Change Request (CR) 7256 directs Medicare contractors to implement the provisions related to HHAs regarding: (1) changes in majority ownership, and (2) capitalization. These provisions were implemented in the Centers for Medicare & Medicaid Services's (CMS) final rule, entitled: "CMS-1510-F: Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices."

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2009 American Medical Association.

You are urged to review these new policies in the section below, entitled “What You Need to Know.”

CR7256 also explains that the provisions in Section 27.1, regarding HHA deactivations, have been in effect since January 1, 2010, and are merely being inserted into the Medicare Program Integrity Manual, Pub.100-08, chapter 15.

Be sure to inform your staffs of these changes.

## What You Need to Know

---

The final rule, CMS-1510-F, provides the following policies for HHAs that are undergoing a change in ownership:

### 1. Changes in Majority Ownership

#### a. General Provisions

Effective January 1, 2011, and in accordance with 42 Code of Federal Regulations (CFR), Section 424.550(b)(1), if there is a change in majority ownership of an HHA by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA's initial enrollment in Medicare or within 36 months after the HHA's most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA must instead:

- Enroll in the Medicare program as a new (initial) HHA under the provisions of Section 424.510; and
- Obtain a State survey or an accreditation from an approved accreditation organization.

For purposes of Section 424.550(b)(1), a “change in majority ownership” (as defined in Section 424.502) occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

**There are several exceptions to these provisions.** The requirements of Section 424.550(b)(1) do not apply if:

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2009 American Medical Association.

- The HHA has submitted two consecutive years of full cost reports. (For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports.)
- The HHA's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.
- The HHA is changing its existing business structure – such as from a corporation, a partnership (general or limited), or an LLC to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.
- An individual owner of the HHA dies, regardless of the percentage of ownership the person had in the HHA.

In addition, Section 424.550(b)(1) does not apply to “indirect” ownership changes.

**Note:** If none of the above exceptions apply, the new owner must enroll as a new provider, and the Medicare contractor will send a letter to the HHA, notifying them. In addition, if the sale has already occurred, the HHA's billing privileges will be deactivated..

#### b. Effective Date

These provisions apply only to HHA ownership transactions whose effective date is on or after January 1, 2011. However, the provisions can apply irrespective of when the HHA first enrolled in Medicare. Consider the following illustrations:

**Example 1** – Smith HHA initially enrolls in Medicare effective July 1, 2009. Smith undergoes a change in majority ownership effective September 1, 2011. The provisions of § 424.550(b)(1) apply to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.

**Example 2** – Jones HHA initially enrolls in Medicare effective July 1, 2007. Jones undergoes a change in majority ownership effective February 1, 2011. Section 424.550(b)(1) does not apply to this transaction because it occurred more than 36 months after Jones's initial enrollment. Suppose, however, that Jones undergoes another change in majority ownership effective February 1, 2012. Section 424.550(b)(1) **does** apply to this transaction because it took place within 36 months after Jones's most recent change in majority ownership (i.e., on February 1, 2011).

**Example 3** – Johnson HHA initially enrolls in Medicare effective July 1, 2006. It undergoes a change in majority ownership effective October 1, 2010. This transaction is not affected by Section 424.550(b)(1) – as enacted in CMS-6010-F – because: (1) its effective date was prior to January 1, 2011, and (2) it occurred more than 36 months after the effective date of Johnson's initial enrollment.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2009 American Medical Association.

Johnson undergoes another change in majority ownership effective October 1, 2012. This change **is affected** by Section 424.550(b)(1) because it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on October 1, 2010).

**Example 4** – Davis HHA initially enrolls in Medicare effective July 1, 1999. It undergoes its first change in majority ownership effective February 1, 2011. This change is not affected by Section 424.550(b)(1) because it occurred more than 36 months after Davis's initial enrollment. Davis undergoes another change in majority ownership effective July 1, 2014. This change, too, is unaffected by Section 424.550(b)(1), as it occurred more than 36 months after the HHA's most recent change in majority ownership (i.e., on February 1, 2011). Davis undergoes another majority ownership change on July 1, 2016. This change **is impacted** by Section 424.550(b)(1), since it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on July 1, 2014).

## 2. Capitalization

Effective January 1, 2011, and pursuant to 42 CFR Sections 489.28(a) and 424.510(d)(9), an HHA entering the Medicare program - including a new HHA as a result of a change of ownership if the change of ownership results in a new provider number being issued - must have available sufficient funds, which we term "initial reserve operating funds," at (1) the time of application submission, and (2) all times during the enrollment process, to operate the HHA for the 3-month period after Medicare billing privileges are conveyed by the Medicare contractor (exclusive of actual or projected accounts receivable from Medicare). This means that the HHA must also have available sufficient initial reserve operating funds during the 3-month period following the conveyance of Medicare billing privileges.

## Additional Information

---

The official instruction, CR7256, issued to your FI, RHHI or A/B MAC, regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R362PI.pdf> on the CMS website.

If you have any questions, please contact your FI, RHHI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website. The CMS final rule, entitled: "CMS-1510-F: Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices," may be found at <http://edocket.access.gpo.gov/2010/pdf/2010-27778.pdf> on the CMS website.

### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2009 American Medical Association.