CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 362	**Date: December 17, 2010**
	Change Request 7256

SUBJECT: Implementation of Home Health Agency (HHA) Payment Safeguard Provisions

I. SUMMARY OF CHANGES: This change request (CR) implements certain payment safeguard provisions in 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." Specifically, this CR implements the provisions related to HHA: (1) changes in majority ownership, and (2) capitalization.

The provisions regarding HHA deactivations have been in effect since January 1, 2010, and are merely being inserted into the manual.

EFFECTIVE DATE: JANUARY 1, 2011
IMPLEMENTATION DATE: JANUARY 1, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	15/Table of Contents
N	15/26/Special Provisions for HHAs
N	15/26.1/HHA Ownership Changes
N	15/26.2/Capitalization
R	15/27.1/CMS or Contractor Issued Deactivations

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 362	Date: December 17, 2010	Change Request: 7256

SUBJECT: Implementation of Home Health Agency (HHA) Payment Safeguard Provisions

EFFECTIVE DATE: JANUARY 1, 2011
IMPLEMENTATION DATE: JANUARY 1, 2011

I. GENERAL INFORMATION

A. Background: This change request (CR) implements certain payment safeguard provisions in the Centers for Medicare and Medicaid Services" (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." Specifically, this CR implements the provisions related to HHA: (1) changes in majority ownership, and (2) capitalization.

The provisions in Pub. 100-08, chapter 15, section 27.1, of this CR regarding HHA deactivations have been in effect since January 1, 2010, and are merely being inserted.

B. Policy:

1. Changes in Majority Ownership

a. General Provisions

Effective January 1, 2011 – and in accordance with 42 CFR §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 §424.510, and
- Obtain a State survey or an accreditation from an approved accreditation organization.

For purposes of §424.550(b)(1), a "change in majority ownership" (as defined in 42 CFR §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 §424.550(b)(1). Specifically, the requirements of §424.550(b)(1) do not apply if:

- The HHA has submitted 2 consecutive years of full cost reports. (For purposes of this exception, low utilization or no utilization cost reports do not quality 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.

In addition, §424.550(b)(1) does not apply to "indirect" ownership changes.

b. Effective Date

As indicated earlier, the provisions of 42 CFR §424.550(b)(1) and (2) - as enacted in "CMS-6010-F, Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Final Rule" – are effective January 1, 2011. This means that these provisions impact only those 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, than Jones undergoes another change in majority ownership effective February 1, 2012. Section 424.550(b)(1) would 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 §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. Johnson undergoes another change in majority ownership effective October 1, 2012. This change would be affected by §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 §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, would be unaffected by §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 would be impacted by §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 §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 three-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 three-month period following the conveyance of Medicare billing privileges.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7256.1	If the contractor receives a CMS-855A application reporting an HHA ownership change, it shall, as applicable, undertake the steps outlined in business requirements (BR) 7256.2 through BR 7256.5.1 below.	X		X		X					
7256.2	The contractor shall determine whether a change in direct majority ownership has occurred by reviewing the transfer agreement, sales agreement, bill of sale, etc., to verify whether: (a) the ownership change was a direct ownership change and not a mere indirect ownership change, and (b) the change involves a party assuming a greater than 50 percent ownership interest in the HHA.	X		X		X					
7256.2.1	If the transfer does not qualify as a change in direct majority ownership, the contractor can process the application normally; if it does qualify, the contractor shall undertake the steps outlined in BR 7256.3 through BR 3.3.	X		X		X					
7256.3	The contractor shall determine whether the effective date of the ownership transfer is within 36 months after the effective date of the HHA's: (1) initial enrollment in Medicare, or (2) most recent change in majority ownership.	X		X		X					
7256.3.1	The contractor shall verify the effective date of the ownership transfer by reviewing a copy of the transfer agreement, sales agreement, bill of sale, etc., rather than relying upon the date of the sale as listed on the application.	X		X		X					
7256.3.2	The contractor shall review its records – and, if necessary, request additional information from the HHA regarding the effective date of the HHA's most recent change in majority ownership, if applicable.	X		X		X					
7256.3.3	If the effective date of the transfer does not fall within	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	either of the 36 month periods described in BR 7256.3, the contractor may process the application normally; if the date falls within one of these two periods, the contractor shall undertake the activity in BR 7256.4.										
7256.4	If the contractor determines that a change in direct majority ownership has occurred within either of the above-mentioned 36 month periods, the contractor shall also determine whether any of the exceptions in §424.550(b)(2) apply.	X		X		X					
7256.5	If the contractor concludes that one of these exceptions applies, it may process the application normally; if no exception applies, the contractor shall – after first obtaining approval from its Division of Provider and Supplier Enrollment (DPSE) liaison to do so - send a letter to the HHA notifying it that, as a result of §424.550(b)(1), the HHA must: (1) enroll as an initial applicant; and (2) obtain a new State survey or accreditation after it has submitted its initial enrollment application and the contractor has made a recommendation for approval to the State/RO.	X		X		X					
7256.5.1	If the new owner must enroll as a new provider, the contractor shall: (1) deactivate the HHA's billing privileges if the sale has already occurred, or (2) alert the HHA that it must submit a CMS-855A voluntary termination application if the sale has not occurred.	X		X		X					
7256.6	If the contractor learns of an HHA ownership change by means other than the submission of a CMS-855A application, it shall notify its DPSE liaison immediately.	X		X		X					
7256.7	The contractor shall verify that a newly-enrolling HHA meets the required amount of capitalization: (1) prior to making its recommendation for approval; (2) after a recommendation for approval is made but before the RO review process is completed; (3) after the RO review process is completed but before the contractor conveys Medicare billing privileges to the HHA; and (4) during the 3-month period after the contractor conveys Medicare billing privileges to the HHA.	X		X		X					
7256.7.1	If the HHA fails to furnish adequate proof of capitalization and billing privileges have not yet been conveyed, the contractor shall deny the HHA's application pursuant to §424.530(a)(8)(i) or (ii), as applicable.	X		X		X					
7256.7.2	If the HHA fails to furnish adequate proof of	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	capitalization and billing privileges have been conveyed, the contractor shall revoke the HHA's Medicare billing privileges pursuant to §424.535(a)(11).										
7256.7.3	If the contractor determines that it is necessary to verify the HHA's level of capitalization more than once within a given period – e.g., more than once between the time a recommendation is made and the completion of the RO review process – the contractor shall seek approval from its DPSE liaison.	X		X		X					
7256.8	If a deactivated HHA submits a CMS-855A reactivation application and the contractor makes a recommendation for approval to the State, the contractor shall: (1) switch the HHA's Provider Enrollment, Chain and Ownership System (PECOS) record to an "Approval Recommended" status; (2) send a copy of the HHA's application, along with a recommendation letter, to the State agency; (3) explain in its recommendation letter to the State that the application was for a reactivation of billing privileges and that, pursuant to 42 CFR §424.540(b)(3), a State survey or accreditation is required, and (4) notify the HHA (via e-mail or letter) of both the recommendation of approval and the requirement in 42 CFR §424.540(b)(3), and that it must: (a) pass the State/accreditation survey and (b) submit written proof that it did so, to the contractor prior to having its billing privileges reactivated.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7256.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact: Frank Whelan, frank.whelan@cms.hhs.gov, (410) 786-1302
Post-Implementation Contact: Frank Whelan, frank.whelan@cms.hhs.gov, (410) 786-1302

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Program Integrity Manual
Chapter 15 - Medicare Enrollment

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(Rev.362, Issued: 12-17-10)

15.26 – Special Provisions for HHAs
(Rev. 362, Issued: 12-17-10, Effective: 01-01-11, Implementation: 01-01-11)

15.26.1 – HHA Ownership Changes
(Rev. 362, Issued: 12-17-10, Effective: 01-01-11, Implementation: 01-01-11)

A. Background

Effective January 1, 2011, and in accordance with 42 CFR §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 §424.510, and*

- *Obtain a State survey or an accreditation from an approved accreditation organization.*

For purposes of §424.550(b)(1), a "change in majority ownership" (as defined in 42 CFR §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.

B. Exceptions

There are several exceptions to §424.550(b)(1). Specifically, the requirements of §424.550(b)(1) do not apply if:

- *The HHA has submitted 2 consecutive years of full cost reports. (For purposes of this exception, low utilization or no utilization cost reports do not quality 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.*

In addition, §424.550(b)(1) does not apply to "indirect" ownership changes.

C. Effective Date

As indicated earlier, the provisions of 42 CFR §424.550(b)(1) and (2) as enacted in "CMS-6010-F, Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Final Rule" – are effective January 1, 2011. This means that these provisions impact only those 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, than Jones undergoes another change in majority ownership effective February 1, 2012. Section 424.550(b)(1) <u>would</u> 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 §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. Johnson undergoes another change in majority ownership effective October 1, 2012. This change <u>would</u> be affected by §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 §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, would be unaffected by §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 <u>would</u> be impacted by §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).*

D. Section 424.550(b)(1)'s Applicability

If the contractor receives a CMS-855A application reporting an HHA ownership change, it shall undertake the following steps:

1. Step 1 – Change in Majority Ownership

The contractor shall determine whether a change in direct majority ownership has occurred. Through its review of the transfer agreement, sales agreement, bill of sale, etc., the contractor shall verify whether:

- *The ownership change was a direct ownership change and not a mere indirect ownership change, and*

- *The change involves a party assuming a greater than 50 percent ownership interest in the HHA.*

Assumption of a greater than 50 percent direct ownership interest can generally occur in one of two ways. First, an outside party that is currently not an owner can purchase more than 50 percent of the business in a single transaction. Second, an existing owner can purchase an additional interest that brings its total ownership stake in the business to greater than 50 percent. For instance, if a 40 percent owner purchased an additional 15 percent share of the HHA, this would constitute a change in majority ownership. This is consistent with the verbiage in the aforementioned definition of "change in majority ownership" regarding the "cumulative effect" of asset sales, transfers, etc.

If the transfer does not qualify as a change in majority ownership, the contractor can process the application normally. If it does qualify, the contractor shall proceed to Step 2:

2. Step 2 – 36-Month Period

The contractor shall determine whether the effective date of the transfer is within 36 months after the effective date of the HHA's: (1) initial enrollment in Medicare, or (2) most recent change in majority ownership. The contractor shall verify the effective date of the reported transfer by reviewing a copy of the transfer agreement, sales agreement, bill of sale, etc., rather than relying upon the date of the sale as listed on the application. It shall also review its records – and, if necessary, request additional information from the HHA – regarding the effective date of the HHA's most recent change in majority ownership, if applicable.

If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the contractor may process the application normally. If the transfer's effective date falls within one of these timeframes, the contractor shall proceed to Step 3.

3. Step 3 – Applicability of Exceptions

If the contractor determines that a change in majority ownership has occurred within either of the above-mentioned 36-month periods, the contractor shall also determine whether any of the exceptions in §424.550(b)(2) apply. As alluded to earlier, the exceptions are as follows:

a. The HHA has submitted 2 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. As stated in Pub. 15-2 (Provider Reimbursement Manual, Part 2), section 3204, refer to 42 CFR §413.24(h) for a definition of low Medicare utilization.*

- *The cost reports must have been: (1) consecutive, meaning that they were submitted in each of the 2 years preceding the effective date of the transfer, and (2) accepted by the contractor.*

b. The HHA's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.

c. 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.

- *If the HHA is undergoing a change in business structure other than those which are specifically mentioned in this exemption (e.g., corporation to an LLC), the contractor shall contact its DPSE liaison for guidance.*

- *For the exemption to apply, the owners must remain the same.*

d. An individual owner of the HHA dies – regardless of the percentage of ownership the person had in the HHA.

E. Determination

If the contractor concludes that one of the aforementioned exceptions applies, it may process the application normally. If no exception applies, the contractor shall after first obtaining approval from CMS liaison to do so - send a letter to the HHA notifying it that, as a result of §424.550(b)(1), the HHA must:

- *Enroll as an initial applicant; and*

- *Obtain a new State survey or accreditation after it has submitted its initial enrollment application and the contractor has made a recommendation for approval to the State/RO;*

As the new owner must enroll as a new provider, the contractor shall also deactivate the HHA's billing privileges if the sale has already occurred. If the sale has not occurred, the contractor shall alert the HHA that it must submit a CMS-855A voluntary termination application.

F. Additional Notes

The contractor is advised of the following:

1. If the contractor learns of an HHA ownership change by means other than the submission of a CMS-855A application, it shall notify its DPSE liaison immediately.

2. If the contractor determines, under Step 3 above, that one of the §424.550(b)(2) exceptions applies, the ownership transfer still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that an HHA initially enrolled in Medicare effective July 1, 2010. It undergoes a change in majority ownership effective February 1, 2012. The contractor determined that the transaction was exempt from §424.550(b)(1) because the HHA submitted full cost reports in the previous 2 years. On February 1, 2014, the HHA undergoes another change in majority ownership that did not qualify for an exception. The HHA must enroll as a new HHA under §424.550(b)(1) because the transaction occurred within 36 months of the HHA's most recent change in majority ownership - even though the February 2012 change was exempt from §424.550(b)(1).

15.26.2 – Capitalization

(Rev. 362, Issued: 12-17-10, Effective: 01-01-11, Implementation: 01-01-11)

A. Background

Effective January 1, 2011, and pursuant to 42 CFR §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 three-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.

B. Points of Review

At a minimum, the contractor shall verify that the HHA meets the required amount of capitalization:

1. Prior to making its recommendation for approval;

2. After a recommendation for approval is made but before the RO review process is completed;

3. After the RO review process is completed but before the contractor conveys Medicare billing privileges to the HHA; and

4. During the 3-month period after the contractor conveys Medicare billing privileges to the HHA.

The HHA must submit proof of capitalization within 30 calendar days of being requested to do so by the contractor. Should the HHA fail to furnish said proof and billing privileges have not yet been conveyed, the contractor shall deny the HHA's application pursuant to §424.530(a)(8)(i) or (ii), as applicable. If billing privileges have been conveyed, the contractor shall revoke the HHA's billing privileges per §424.535(a)(11).

Should the contractor believe it is necessary to verify the HHA's level of capitalization more than once within a given period, e.g., more than once between the time a recommendation is made and the completion of the RO review process – the contractor shall seek approval from its DPSE liaison.

C. Determining Initial Reserve Operating Funds

Initial reserve operating funds are sufficient to meet the requirement of 42 CFR §489.28(a) if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of 3 or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by the HHA for its first 3 months of operation--or 22.5 percent (one fourth of 90 percent) of the average number of visits reported by the comparison HHAs--whichever is greater.

The contractor shall determine the amount of the initial reserve operating funds using reported cost and visit data from submitted cost reports for the first full year of operation from at least 3 HHAs that the contractor serves that are comparable to the HHA that is seeking to enter the Medicare program. Factors to be used in making this determination shall include:

- *Geographic location and urban/rural status;*
- *Number of visits;*
- *Provider-based versus free-standing status; and*
- *Proprietary versus non-proprietary status.*

The determination of the adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs' total reported visits. The resulting average cost per visit is then multiplied by the projected visits for the first 3 months of operation of the HHA seeking to enter the program, but not less than 90 percent of average visits for a 3-month period for the HHAs used in determining the average cost per visit.

D. Proof of Operating Funds

The HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. Such proof, at a minimum, must include a copy of the statement(s) of the HHA's savings, checking, or other account(s) that contains the funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and that the funds are immediately available to the HHA.

In some cases, an HHA may have all or part of the initial reserve operating funds in cash

equivalents. For the purpose of this section, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial 3-month period for which the initial reserve operating funds are required does not qualify in meeting the initial reserve operating funds requirement. Examples of cash equivalents for the purpose of this section are Treasury bills, commercial paper, and money market funds.

As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. CMS may later require the HHA to furnish another attestation from the financial institution that the funds remain available, or, if applicable, documentation from the HHA that any cash equivalents remain available, until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization. The officer of the HHA who will be certifying the accuracy of the information on the HHA's cost report must certify what portion of the required initial reserve operating funds constitutes non-borrowed funds, including funds invested in the business by the owner. That amount must be at least 50 percent of the required initial reserve operating funds. The remainder of the reserve operating funds may be secured through borrowing or line of credit from an unrelated lender.

E. Borrowed Funds

If borrowed funds are not in the same account(s) as the HHA's own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA, by providing, at a minimum, a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available to the HHA. As with the HHA's own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds, including furnishing an attestation from a financial institution or other source, as may be appropriate, and to establish that such funds will remain available until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization.

F. Line of Credit

If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the lender. CMS later may require the HHA to furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

G. Documents

As part of ensuring the prospective HHA's compliance with the capitalization requirements, the contractor shall obtain the following from the provider:

- *A document outlining the provider's projected budget – preferably, a full year's budget broken out by month*

- *A document outlining the number of anticipated visits - preferably a full year broken out by month*

- *An attestation statement from an officer of the HHA defining the source of funds*

- *Copies of bank statements, certificates of deposits, etc., supporting that cash is available (must be current)*

- *Letter from officer of the bank attesting that funds are available*

- *If available, audited financial statements*

The contractor shall also ensure that the capitalization information in section 12, of the CMS-855A is provided.

15.27.1 – CMS or Contractor Issued Deactivations

(Rev. 362, Issued: 12-17-10, Effective: 01-01-11, Implementation: 01-01-11)

A. General Instructions

The contractor may deactivate a provider or supplier's Medicare billing privileges when:

- A provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period begins on the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim;

- A provider or supplier fails to report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services; or

- A provider or supplier fails to report a change in ownership or control within 30 calendar days.

The deactivation of Medicare billing privileges does not affect a supplier's participation agreement (CMS-460).

Providers and suppliers deactivated for non-submission of a claim are required to complete and submit a Medicare enrollment application to recertify that the enrollment information currently on file with Medicare is correct and must furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation.

Providers and suppliers that fail to promptly notify the contractor of a change (as described above) must submit a complete Medicare enrollment application to reactivate their Medicare billing privileges or, when deemed appropriate, recertify that the enrollment information currently on file with Medicare is correct. Reactivation of Medicare billing privileges does not require a new State survey or the establishment of a new provider agreement or participation agreement. *However, per 42 CFR §424.540(b)(3)(i), and as described in subsection E below, an HHA whose billing privileges are deactivated must undergo a State survey or obtain accreditation prior to having its billing privileges reactivated.*

Each contractor shall forward a copy of the Deactivation Summary Report provided by the Multi-Carrier System (MCS) to its designated DPSE contractor liaison no later than the last calendar day of each month.

B. Special Reactivation Instructions for Part B Suppliers

(This section does not apply to: (1) providers and suppliers that complete the CMS-855A application, and (2) DMEPOS suppliers.)

To ensure that a supplier that has reactivated its Medicare billing privileges does not become subject to a second deactivation for non-billing within 30 days of the reactivation, the contractor shall:

1. End-date the existing PTAN-NPI combination in sections 1 and 4 of PECOS with the non-billing end-date in MCS, and

2. Issue a new Provider Transaction Access Number (PTAN) to the provider or supplier, and associate the new PTAN with the NPI in sections 1 and 4 of PECOS.

For physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, or organizations (e.g., group practices) consisting of any of the aforementioned categories of individuals, the contractor shall establish the reactivation effective date as the later of: (a) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or (b) the date the supplier first started furnishing services at a new practice location.

The exception to this is if the supplier has at least one other enrolled practice location (under the same TIN) for which it is actively billing Medicare; here, the contractor shall establish and enter the effective date as either: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS, whichever is later. To illustrate, if the supplier has only one enrolled practice location and that site is deactivated for non-billing, the effective date is the later of: (a) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or (b) the date the supplier first started furnishing services at a new practice location. On the other hand, suppose the supplier has two enrolled locations – X and Y - under its TIN. Location X is

actively billing Medicare, but Y is deactivated for non-billing. The reactivation effective date for Y would be the later of: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS. This is because the supplier has at least one other location – Location X – that is actively billing Medicare.

For individual and organizational suppliers other than those identified in the beginning of the previous paragraph, the contractor shall enter the effective date as either: (a) the date the supplier first saw a Medicare patient at the location indicated on the CMS-855, or (b) the same date as the non-billing end-date in MCS, whichever is later.

If the supplier's PTAN is only established in MCS, no action is required if the end-dated non-billing number is not in PECOS.

C. DMEPOS Deactivation

The NSC shall require a DMEPOS supplier whose billing privileges are deactivated for non-submission of claims (see CFR 42 CFR §424.540) to submit a new Medicare enrollment application and meet all applicable enrollment criteria, including a site visit, and accreditation when applicable, before an applicant can be approved. The NSC may not establish a retrospective billing date for a DMEPOS supplier whose billing privileges were deactivated due to claims inactivity.

D. Deactivation and Appeals Rights

The Medicare contractor shall not afford a provider or supplier appeal rights when a deactivation determination is made.

E. HHA Reactivations

Pursuant to 42 CFR §424.540(b)(3), if an HHA's billing privileges are deactivated under 42 CFR §424.540(a), the HHA must undergo a State survey or obtain accreditation in order for its billing privileges to be reactivated. If a deactivated HHA submits a CMS-855A reactivation application, the contractor shall process the application normally and either: (1) recommend approval to the State, or (2) deny the application. If a recommendation for approval is made to the State, the contractor shall:

- *Switch the HHA's PECOS record to an "Approval Recommended" status;*

- *Send a copy of the HHA's application, along with a recommendation letter, to the State agency;*

- *Explain in its recommendation letter to the State that the application was for a reactivation of billing privileges and that, pursuant to 42 CFR §424.540(b)(3), a State survey or accreditation is required. (A copy of the letter should be sent to the RO.)*

- *Notify the HHA (via e-mail or letter) of both the recommendation of approval and the requirement in 42 CFR §424.540(b)(3). The contractor shall also alert the HHA that it must: (1) pass the State/accreditation survey and (2) submit written proof that it did so, to the contractor prior to having its billing privileges reactivated.*

NOTE: *The contractor will not receive a tie-in notice or approval letter from the RO. It can switch the PECOS record to "Approved" once the HHA submits the documentation described in item (2) of the previous bullet; the effective date of billing shall be the date on which the contractor switches the PECOS record to "Approved."*