# CMS Manual System

## Pub. 100-16 Medicare Managed Care

**Department of Health & Human Services (DHHS)**
**Centers for Medicare & Medicaid Services (CMS)**

**Transmittal 69** | **Date: September 2, 2005**

**SUBJECT: Revisions to Chapter 12, "Effect of Change of Ownership," and Chapter 14, "Contract Determination and Appeals"**

**I. SUMMARY OF CHANGES:** This revision changes requirements in Chapter 12 relating to change of ownership, and Chapter 14 relating to contract determinations and appeals. Throughout this instruction M+C was changed to MA, and Medicare+Choice was changed to Medicare Advantage.

**NEW/REVISED MATERIAL - EFFECTIVE DATE: September 2, 2005**

***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.***

**II. CHANGES IN MANUAL INSTRUCTIONS: (R = REVISED, N = NEW**

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| R | 12/Effect of Change of Ownership. |
| R | 12/10.1/What Constitutes a Change of Ownership |
| R | 12/20.4/Address for Sending Notifications to CMS |
| R | 12/30.1/When a Novation Agreement is Required |
| R | 12/30.3/Acceptable Novation Agreements |
| R | 12/30.3/Exhibit 1/Model Novation Agreement |
| R | 14/10.1.1/Contract Determination Notice |
| R | 14/10.1.3/Postponement of the Contract Determination's Effective Date |
| R | 14/10.2/Reconsiderations |
| R | 14/10.2.1/Time Frames for Filing a Reconsideration Request |
| R | 14/10.3.4/Parties to the Hearing |
| R | 14/10.3.7/Conduct and Record of a Hearing |
| R | 14/20/Reopening of Contract Reconsidered Determination or Decision of a Hearing Officer or the Administrator |

## III. ATTACHMENTS:

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| | **Business Requirements** |
| **X** | **Manual Instruction** |
| | **Confidential Requirements** |
| | **One-Time Special Notification** |

**Chapter 12**

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## 10.1 - What Constitutes a Change of Ownership

***(Rev. 69, Issued: 09-02-05, Effective: 09-02-05)***

The following situations usually constitute a change of ownership:

- *Asset transfer* - transfer of title and property to another party;
- Partnership - the removal, addition, or substitution of a partner (unless the partners agreed otherwise as permitted by applicable State law); or
- Corporation - the merger of the contracting corporate entity which holds the Medicare contract into another corporate entity; or the consolidation of the corporate entity which holds the Medicare contract with one or more other corporations, resulting in a new corporate body.

**NOTE:** The transfer of corporate stock or the merger of another corporation into the corporation that holds a contract with CMS does not ordinarily constitute a change of ownership.

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## 20.4 - Address for Sending Notifications to CMS

***(Rev. 69, Issued: 09-09-05, Effective: 09-09-05)***

All notifications to CMS required in §20.1, §20.3, and §30.1 (below) should be mailed to:

*Division of Plan Management*
*Medicare Advantage Group*
*Center for Beneficiary Choices*
*Centers for Medicare and Medicaid Services*
*Mail Stop C4-23-07*
7500 Security Boulevard
Baltimore, MD 21244-1850

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## 30.1 - When a Novation Agreement is Required

***(Rev. 69, Issued: 09-02-05, Effective: 09-02-05)***

A Novation Agreement is required to transfer the rights and obligations under the Medicare managed care contract. Novation agreements are only required when there has been a change of ownership (as defined in §10.1). In the absence of a Novation Agreement, a change of ownership shall invalidate a Medicare contract except to the extent that the managed care organization receives capitation payments from CMS. In

this circumstance, the new entity or organization may be required to file a new application, demonstrate eligibility, and be determined an eligible entity, in order to contract with CMS.

CMS recommends that organizations that anticipate a change in ownership submit a Novation Agreement to CMS at least 60 days prior to the effective date of change of ownership. *Organizations are required to submit such an agreement no later than 30 days prior to the effective date of change of ownership.* Organizations should submit three (3) copies of the Novation Agreement with the additional information requested in subpart 20.2. Organizations MUST receive CMS approval of the Novation Agreement prior to the effective date of change in ownership in order to assume an existing contract with CMS. If a Novation Agreement is not completed before the effective date of the change of ownership, the Medicare Advantage contract will be terminated as of that date. Medicare members enrolled under the terminated contract will be disenrolled and provided notice of their remaining Medicare coverage options in accordance with existing statute, regulations, and policies

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## 30.3 - Acceptable Novation Agreements

***(Rev. 69, Issued: 09-02-05, Effective: 09-02-09)***

Exhibit 1 contains a Model Novation Agreement. This Agreement is intended to serve only as a guide in preparing a novation agreement. Contracting managed care organizations may need to revise the model, as necessary or appropriate, to conform to the circumstances of a particular transaction involving a change of ownership. In order to be accepted, the Novation Agreement must include the following:

- The new owner must assume all obligations under the Medicare managed care contract;
- The new entity must be an eligible organization;
- The entity's previous owner must waive its right to reimbursement for covered services furnished during the rest of the then current contract period;
- The previous owner must guarantee that the new owner will carry out the terms of the contract or the new owner must *guarantee* the new owner's performance of contract responsibilities; and
- The previous owners must agree to make its books and records and any other necessary information available to the new owner and to CMS in order to permit an accurate determination of costs for the final settlement of the contract period.

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**EXHIBIT 1**
**MODEL NOVATION AGREEMENT**

**(Name of Medicare Managed Care Plan or Medicare Advantage Organization being sold/merged)** (Transferor), d.b.a. **(Where applicable, the d.b.a. name),** a corporation, partnership, sole proprietorship, etc., duly organized and existing under the laws of the State of **(indicate the State under which the Transferor is formed or organized to operate)** with its principal office in**; (Name of owner) (Transferee)**, a corporation, partnership, sole proprietorship, etc. duly organized and existing under the laws of the state of**,** with its principal office in and the *Centers for Medicare & Medicaid Services (CMS*) enter into this Agreement:

**(A) RECITALS:**

(1) CMS has entered into certain contract(s) with the Transferor, namely:

**(Indicate Medicare Managed Care Plan or Medicare Advantage Organization contract type)**

**(Indicate Medicare contract number/H#s)**

The term "the contract(s)" as used in this Agreement, means the above contract(s) including all modifications, made between CMS and the Transferor before the effective date of this Agreement (whether or not performance and payment have been completed) and releases executed if CMS or the Transferor has any remaining rights, duties, or obligations under these contract(s). Included in the term "the contract(s)" are also all modifications made under the terms and conditions of these contract(s) between CMS and the Transferee, on or after the effective date of this Agreement.

(2) As of **(date change of ownership is effective),** the Transferor has transferred to the Transferee all the assets of the Transferor by virtue of a **(indicate the type of transfer, i.e., a merger, corporate reorganization, or an agreement and purchase of the sale of assets)** between the Transferor and the Transferee.

(3) The Transferee has assumed all the assets of the Transferor by virtue of the above transfer.

(4) The Transferee has assumed all the obligations of the Transferor under the contract(s) by virtue of the above transfer.

(5) The Transferee has indicated a desire to assume the obligations of the Transferor under the contract(s) and to fully perform all obligations that may exist under the contract(s).

**(B) IN CONSIDERATION OF THESE FACTS THE PARTIES AGREE AS FOLLOWS:**

(1) The Transferor confirms the transfer of the contract to the Transferee, and waives any claims and rights against CMS that it now has or may have in the future in connection with the contract(s).

(2) From and after the date of the change of ownership in § (A)(2), above, the Transferee agrees to be bound by and to perform all the duties and responsibilities of Transferor in

each contract in accordance with the conditions contained in the contract(s). The Transferee also assumes all obligations and liabilities of, and all claims against the Transferor under the contract(s) incurred from and after the effective date of the change of ownership in §(A)(2), above.

(3) The Transferee ratifies all previous actions taken by the Transferor with respect to the contract(s) with the same force and effect as if the action had been taken by the Transferee.

(4) CMS recognizes the Transferee as the Transferor's successor in interest in and to the contracts. From and after the date of the change of ownership the Transferee by this Agreement becomes entitled to all rights, title, and interests of the Transferor in and to the contract(s). Following the effective date of this Agreement, the terms "Organization" and "Contractor" as used in the contract(s) shall refer to the Transferee.

(5) Except as expressly provided in this Agreement, nothing in it shall be construed as a waiver of any rights of CMS against the Transferor. Notwithstanding any other provision of this Agreement, Transferor remains liable for all acts constituting a breach of the contract(s) occurring or arising before the effective date of the change of ownership, to the fullest extent of applicable laws and regulations.

(6) All payments and reimbursements previously made by CMS to the Transferor shall be considered to have discharged CMS's obligations under the contract(s). All payments and reimbursements made by CMS after the effective date of this Agreement in the name of or to the Transferee, shall have the same force and effect as if made to the Transferor, and shall constitute a complete discharge of CMS's obligations under the contract(s) to the extent of the amounts paid or reimbursed.

(7) The Transferor and the Transferee agree that CMS is not obligated to pay or reimburse either of them for, or otherwise give effect to, any costs, taxes, or other expenses, or any related increases, directly or indirectly arising out of or resulting from this Agreement other than those that CMS in the absence of this Agreement would have been obligated to pay or reimburse under the terms of the contract(s).

(8) The Transferor guarantees payment of all liabilities and the performance of all obligations that the Transferee (i) assumes under this Agreement or (ii) may undertake in the future should these contracts be modified under their terms and conditions. The Transferor waives notice of, and consents to, any such future modifications.

(9) The contract(s) shall remain in full force and effect except as modified by this Agreement. Each party has executed this Agreement which is effective as of the date signed below by the Centers for Medicare & Medicaid Services.

(10) Each party certifies and warrants that it has full power and authority to enter into this Agreement.

(11) Each person executing this Agreement on behalf of a party certifies and warrants that he or she is authorized to enter into this Agreement on behalf of such party.

Centers for Medicare & Medicaid Services

By ________________________________Date__________

Director, Medicare Managed Care Group

Centers for Medicare & Medicaid Services

(Name of Transferee)

By ________________________________Date___________

Title____________________________________________

(Name of Transferor)

By ________________________________Date____________

Title____________________________________________

**Chapter 14**

## 10.1.1 - Contract Determination Notice

***(Rev. 69, Issued: 09-02-05, Effective: 09-02-05)***

CMS sends a written notice for every contract determination. The notice includes:

- The reasons for the contract determination;
- The right to request reconsideration of the contract determination; and
- Instructions on how to request a reconsideration.

*For CMS-initiated terminations, CMS mails the notice at least 90 days before the anticipated effective date of the termination. For terminations based on initial determinations described at 42 CFR 422.510(a)(5), however, where the health of enrollees is at imminent and serious risk, CMS immediately notifies the MA organization of its decision to terminate the MA organization's contract*. When CMS determines that it will not renew its contract with an organization, CMS will notify the organization by May 1 of the current contract year.

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## 10.1.3 - Postponement of the Contract Determination's Effective Date

***(Rev. 69, Issued: 09-02-05, Effective: 09-02-05)***

The MA contract termination date, as stated in the notice to terminate an MA contract, is postponed if the organization requests a review of the hearing decision by the CMS Administrator. Written notice is issued by the Administrator notifying the organization of the Administrator's decision. The administrator may uphold, reverse, or modify the hearing officer's decision.

*If the contract determination (termination) is based on 42 CFR 422.510(a)(5), concerning the imminent and serious health risk to enrollees, the effective date cannot be postponed even if the MA organization requests a review by the Administrator.*

The effective date of a contract determination to non-renew an MA contract may be extended by CMS if CMS finds that a contract extension is consistent with the purpose of Title XVIII of the Social Security Act (the Act) and for as long as CMS and the organization agree with the extension.

## 10.2 - Reconsiderations

***(Rev. 69, Issued: 09-02-05, Effective: 09-02-05)***

Reconsideration is the first step for a contract applicant/MA organization to appeal contract determinations described at §10 of this chapter. *A reconsideration determination is a new determination that affirms, reverses, or modifies an initial contract determination.* This reconsideration process must be completed before the contract applicant/MA organization has a right to a hearing under §10.3 of this chapter. CMS bases the reconsideration determination on the evidence and findings used to make the contract determination and any other written evidence the applicant/organization submits to CMS before CMS mails its response to the request for reconsideration to the MA organization.

*Only an authorized official of the applicant/organization that was the subject of the contract determination may file a request for reconsideration of a contract determination. The request must be in writing and the official may send the request to any CMS office.*

## 10.2.1 - Time Frames for Filing a Reconsideration Request

***(Rev. 69, Issued: 09-02-05, Effective: 09-02-05)***

An organization or MA contract applicant must file the request for reconsideration in writing within 15 days from the date of the initial MA contract determination notice. Only an authorized official of the contract applicant or MA organization that is a subject of a contract determination may file a request for reconsideration.

***NOTE:*** *Notice of any redetermination favorable to the MA organization applicant, including those resulting from a hearing or Administrator review conducted under 42 CFR Part 422, Subpart N, must be issued by July 15 for the contract in question to be effective on January 1 of the following year.*

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## 10.3.4 - *Parties to the Hearing*

***(Rev. 69, Issued: 09-02-05, Effective: 09-02-05)***

The parties to a hearing are:

- A contract applicant that has been determined in a reconsidered determination to be unqualified to enter into a contract with CMS under Part C of the Act;
- A MA organization whose contract with CMS has been terminated or has not been renewed as a result of a contract determination; and
- The Centers for Medicare and Medicaid Services.

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## 10.3.7 - Conduct *and Record* of a Hearing

*(Rev. 69, Issued: 09-02-05, Effective: 09-02-05)*

The hearing is open to the parties and the public. The hearing officer will inquire into all the matters at issue, receives in evidence the testimony of witnesses, and any documents that are relevant and material. If any party objects to the inclusion of any document as evidence, the hearing officer hears the objections. The hearing officer also decides the order in which the evidence and the arguments of the parties are presented and the conduct of the hearing.

A complete record of the proceedings at the hearing is made and transcribed, and made available to all parties upon request. A party requesting the transcribed record must pay for its transcription and reproduction.
The record may not be closed until a hearing decision has been issued.

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## 20 - Reopening of Contract or Reconsidered Determination or Decision of a Hearing Officer or the Administrator

*(Rev. 69, Issued: 09-02-05, Effective: 09-02-05)*

A reopening is not an appeal right. It is an administrative procedure that permits reexamination of an existing determination for a specific reason. If an applicant or MA organization believes it has a basis for reopening a decision, it may request that the decision-maker reopen the matter. The decision whether to act on such a request, however, is committed to the decision-maker's discretion, and is not subject to appeal or further review of any kind. This policy is consistent with our general policies on reopening decisions, as discussed in Federal Regulations at 42 CFR Part 405, Subpart R, *Provider Reimbursement Determinations and Appeals*.

CMS may reopen and revise an initial or reconsidered determination upon its own motion within one year of the date of the notice of determination. A decision of a hearing officer may be reopened and revised by another hearing officer designated by CMS within one year of the notice of the hearing decision if the hearing officer who issued the initial decision is unavailable. A decision by the Administrator that is otherwise final may be reopened and revised by the Administrator upon the Administrator's own motion within one year of the notice of the Administrator's decision.