Changes in Ownership: Medicare Rules and Other Issues

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Introduction

When a healthcare provider or supplier is enrolled in Medicare, certain transactions, including an asset transfer to a new owner, are typically classified by the Centers for Medicare & Medicaid Services ("CMS") as a change of ownership, or CHOW, which requires notification from both seller and buyer, and CMS Regional Office ("RO") approval. Such a transaction often results in formal assignment of the Medicare number and, if applicable, Medicare provider agreement, to the new owner. In comparison, transactions involving stock or member-ship transfers or other reorganizations that do not change the tax identification number ("TIN") on file with CMS typically require the filing of an update of ownership information with CMS. However, CMS will ultimately make the final determination—based on the structure of the transaction—as to whether a CHOW has occurred. Therefore, notification of any changes in ownership information affecting a Medicare provider number is important to ensure that all CMS requirements and approvals are obtained. Failure to timely and properly notify CMS of a CHOW or update of ownership information can lead to deactivation or revocation of a Medicare identification number (also known as a Provider Transaction Number ("PTAN") for Part B and CMS Certification Number ("CCN") for Part A) or Medicare billing privileges.

When initially structuring and negotiating a transaction involving a Medicare provider or supplier, parties to the transaction should review applicable Medicare regulations and CMS guidance to determine whether the proposed transaction is a CHOW or requires only an update of owner-ship information; understand applicable pre- and post-closing filing and notification requirements; determine whether regulations affect the pro-posed structure of the transaction; and identify other legal and business issues that may affect the transaction, such as successor liability and arranging for post-closing payment for Medicare services during the CHOW process.

Providers and Suppliers

When reviewing Medicare requirements relating to CHOWs and ownership updates, it is important to understand that Medicare classifies "providers" and "suppliers" as follows:

1. *Providers* are defined generally to mean: (1) a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility ("CORF"), home health agency, or hospice that has in effect an agreement to participate in Medicare; (2) a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or (3) a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.[1] Providers typically use Form CMS-855A to notify CMS of a CHOW or update of ownership information.
2. *Suppliers* are defined to mean a physician or other practitioner, or an entity other than a provider, that furnishes healthcare services under Medicare.[2] Suppliers include ambulance service providers, ambulatory surgery centers, clinics and group practices, independent clinical laboratories, independent diagnostic testing facilities, and other healthcare services that bill under Medicare Part B. Suppliers typically use Form CMS-855B to notify CMS of a CHOW or update of ownership information. Suppliers of durable medical equipment, prosthetics, orthotics, and supplies ("DME-POS") use Form CMS-855S.[3]

Medicare CHOWs

WHAT ARE MEDICARE CHOWS?

A Medicare change of ownership generally means:

- In the case of a *partnership*, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law.[4]
- In the case of a *sole proprietorship*, transfer of title and property to another party.[5]
- In the case of a *corporation*, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation.[6] An asset transfer of a corporation would be considered a CHOW, whereas the transfer of corporate stock or the merger of another corporation into the provider corporation typically would not.[7]
- Medicare regulations and guide-lines do not specifically address *limited liability corporations* ("LLCs"). CMS recognizes that LLCs have characteristics of both a partnership and corporation and that the members in an LLC are very similar to those of stockholders in corporations.[8] It is common for CMS to view an asset transfer involving an LLC as a CHOW but, similar to transfer of corporate stock, not treat a transfer of a membership interest in an LLC as a CHOW.

Although a CHOW is usually accompanied by a TIN change, this is not always the case. The RO will review the sales agreement closely to definitively determine whether a CHOW has occurred.[9] To identify ownership, the RO will determine which party (whether an individual or legal

entity such as a partnership or corporation) has immediate authority for making final decisions regarding the operation of the provider and bears the legal responsibility for the consequences of the provider's operations.[10]

A CHOW may also occur in certain situations involving leases.[11] Whether the provider's premises are directly owned or rented or leased from a landlord or lessor is immaterial. However, if the owner enters into an agreement that allows the "landlord" to make or participate in decisions about the ongoing operation of the provider enterprise, this indicates that the owner has entered into either a partnership agreement or a management agency agreement instead of a property lease, and such transaction would likely be considered a CHOW.[12] Furthermore, the leasing of all or part of a facility used to render patient care will be considered a CHOW if the leasing affects utilization, licensure, or certification of the entity enrolled in Medicare.[13]

Arrangements between a provider or supplier and a management company do not typically result in CHOWs. A management company that contracts with owners to provide management services, subject to the owners' general approval of operating decisions, is considered an agent of the owners rather than a partner or successor. This is the case even if the management company appears to have wide latitude in making decisions and even if the management fee is based on the net revenue or profit the provider or supplier receives from furnishing services.[14] The only case in which operation under a management agreement would constitute a CHOW is when the owner has relinquished all authority and responsibility for the provider organization.[15]

CHOW NOTIFICATION AND FILING REQUIREMENTS

Providers: When a provider undergoes a CHOW, the current owner (seller) and the prospective new owner (buyer) must complete and submit to the provider's designated Medicare Administrative Contractor ("MAC") a CMS 855-A and other forms and documentation relating to the transaction.[16] To help promote a seamless transaction and faster review, the buyer and seller must submit their applicable CMS-855A forms to the MAC around the same time, but no later than 14 days from each other.[17] The MAC may accept Form CMS- 855A CHOW applications submitted up to 90 calendar days prior to the anticipated date of the ownership change.[18] The MAC will process the CMS-855A forms and forward to the appropriate state survey agency ("SA") its recommendations and final Form CMS-855.19 After the SA concludes its factfinding, it forwards the findings, with supporting documentation, to the RO with its recommendations for determination. The RO will make the final determination regarding whether the transaction qualifies as a CHOW.[20]

Approved Suppliers: The Medicare CHOW provisions apply to Medicare providers and certain Medicare suppliers that require approval through certification survey by the state surveying agency or through accreditation such as portable X-ray suppliers, ambulatory surgery centers, and hospitals with departments that bill for Medicare Part B services.[21] Other types of suppliers, such as a group practice, are not permitted to undergo a CHOW; a new owner must newly enroll as a Part B supplier in the event a transaction that constitutes a CHOW occurs.[22] In anticipation of a CHOW, the new owner of an approved supplier must submit a complete Form 855B and submit a copy of the sales agreement to the MAC. The CHOW must be reported to the MAC within 30 days of the change.[23] However, a CMS-855B CHOW application may be accepted by the MAC up to 90 calendar days prior to the anticipated date of the proposed ownership change.[24] The MAC will review the sales agreement submitted with a CMS-855B application indicating a CHOW to determine whether: (1) the ownership change qualifies as a CHOW under the principles of 42 C.F.R. § 489.18; (2) its terms indicate that the new owner will be accepting assignment of the Medicare assets and liabilities of the old owner; and (3) the information contained in the agreement is consistent with that reported on the new owner's Form CMS-855B (e.g., same names provided).[25] However, the RO—not the MAC—makes the final determination regarding whether a CHOW has occurred.[26]

ASSIGNMENT OF THE PROVIDER AGREEMENT

CMS will automatically assign the existing provider agreement to the new owner unless the new owner rejects assignment in its Form 855 filings.[27] With automatic assignment, the new owner becomes subject to all of the terms and conditions under which the existing agreement was issued, including, but not limited to:

1. Any existing plan of correction.[28] The new owner must meet the time frames for correcting deficiencies cited in the existing plan of correction. A CHOW is not a basis for extending the time given for correction.[29]
2. Compliance with applicable health and safety standards.[30] Assignment of an existing provider agreement assumes that a CHOW will have no adverse effect on patient health and safety. If there is any indication that patient

care has deteriorated following a CHOW, the SA must conduct a survey.[31]

3. Compliance with the ownership and financial interest disclosure requirements applicable to the provider.[32]
4. Compliance with civil rights non-discrimination requirements.[33]

With automatic reassignment, the new owner assumes all penalties and sanctions under the Medicare program, including the repayment of any accrued overpayments, regardless of who had ownership of the Medicare agreement at the time the overpayment was discovered unless, under certain circumstances, fraud was involved.[34] In addition, the new owner receives any benefits of assuming the Medicare provider agreement, such as receiving underpayments discovered after the CHOW.[35] A sales agreement stipulating that the new owner is not liable for overpayments made to the previous owner is not evidence enough for recovery from the new owner to be avoided; however, the parties may privately negotiate indemnification for such losses. Medicare will attempt to recover from the new/current owner regardless of the sales agreement, and it would be up to the new owner to enforce the sales agreement.[36] If CMS is unable to recover an overpayment from the current/new owner, CMS may decide to collect the overpayment from the previous owner.[37]

If the new owner rejects automatic assignment of the seller's existing provider agreement or, if applicable, supplier approval, the existing Medicare provider agreement—including the associated Medicare numbers—is considered voluntarily terminated.[38] The voluntary termination is effective as of the date the acquisition is completed, and, with few exceptions relating to certain providers like skilled nursing facilities, no Medicare payments are made for services to beneficiaries under the rejected (and thus terminated) provider agreement furnished on or after that acquisition date.[39]

The refusal to accept assignment must be put in writing by the prospective new owner and forwarded to the appropriate CMS RO 45 calendar days prior to the CHOW date to allow for the orderly transfer of any beneficiaries that are current patients.[40] If the new owner refuses to accept assignment but also wishes to participate in the Medicare program, the RO will first process the refusal and then treat the new owner as it would any new applicant to the program.[41] The earliest possible effective date of Medicare enrollment for the new owner that refuses automatic assignment is the date the RO determines that all federal requirements have been met. The federal requirements include, in addition to the Conditions of Participation, enrollment and any other special requirements applicable to specific providers. A new Medicare number will be issued at some time after closing, depending on how long it takes to meet all federal requirements. Consequently, if the new owner refuses assignment and applies for a new Medicare number, there will be a gap between the date of the CHOW and the effective date of the new Medicare number.

NEW CERTIFICATION SURVEYS

A certification survey of the provider is generally not required as a result of a CHOW with automatic assignment; however, a CMS RO may exercise its discretion to direct the state survey agency to conduct a survey in individual cases when it has cause for concern about quality of care.[42] Furthermore, if new locations are added or different types of services will be provided, a new survey may be required.[43] In the case of deemed status providers or suppliers, automatic assignment also means that the new owner must notify the applicable accrediting organization ("AO") of the acquisition and agree that accreditation continues until the AO decides whether a resurvey is necessary.[44]

If the new owner rejects automatic assignment, but wishes to participate in the Medicare program, the facility under the new ownership is considered an initial applicant to the Medicare program.[45] For providers subject to certification, this means that, in addition to completing the Form 855 enrollment process, they must also satisfy any other applicable federal Medicare participation requirements, including undergoing an unannounced full survey of the compliance with applicable Medicare requirements.[46] If the seller 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 of the new owner, but 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 based on the time of the accreditation survey and decision.[47] Initial certification surveys are subject to a number of requirements, which result in gaps between the date of an acquisition and the effective date of a Medicare enrollment for a provider or certain types of suppliers that reject automatic assignment. Specifically:

- State survey agencies or AOs must not conduct a survey for initial certification purposes until after the date the acquisition is complete; the survey must be a full, standard survey and must take place when the facility is under its new ownership in order to assess compliance of the new owner.[48]
- The survey cannot be conducted until the applicable MAC has issued a recommendation for approval of the new owner's enrollment application.[49]
- The new owner must be fully operational and providing services before it may be surveyed.[50]
- CMS workload instructions, issued on November 5, 2007, require initial surveys conducted by SAs generally to be the lowest workload priority, particularly in the case of provider or supplier types for which there is an accreditation option.[51] Due to these workload priorities, it may take several years for an SA to conduct an initial accreditation survey.

A buyer that rejects automatic assignment of the seller's Medicare number but wishes to participate in the Medicare program must be aware of the potential gaps in certification and enrollment and the impact on cash flow. The provider or supplier undergoing the CHOW will not be able to bill Medicare or receive payment for services provided during this gap period.

COST REPORTS

When providers that are required to file Medicare cost reports undergo a CHOW, Medicare regulations require the seller to file a final cost report, which should cover the period from the end of the provider's prior cost reporting period to the effective date of the CHOW.[52] The final cost report is due no later than five months following the effective date of the CHOW.[53] Items to be considered in the seller's cost report include: (1) gains and losses on disposal of depreciable assets; (2) accelerated depreciation; (3) involuntary conversion losses; (4) demolition and abandonment losses; (5) lease-purchase agreements/ rental charges; (6) start-up and organization costs; (7) self-insurance; (8) insurance purchased from a limited-purpose insurance company; (9) administrative costs incurred after change of ownership; (10) tentative retroactive adjustment; (11) carryover of reasonable cost not reimbursed due to the "lower of reasonable cost or customary charges" provision; and (12) cost to related organizations.[54]
The new owner can designate its cost reporting year.[55] In a CHOW, the new owner is considered to be a new provider in the program and may file its initial cost report covering a period of at least one month of provider operations, but the cost report cannot exceed 13 months of operations under the program.[56] A change in provider ownership may have an immediate effect on the manner in which the new or incoming provider is reimbursed for Medicare services. Some of the reimbursement areas requiring special treatment on the new provider's cost report include: (1) basis of depreciable assets; (2) donated assets; (3) involuntary conversion losses; (4) demolition and abandonment losses; (5) recovery of accelerated depreciation; (6) startup costs; and (7) organizational costs.[57]

PAYMENT ISSUES ASSOCIATED WITH A CHOW

When a CHOW involving automatic reassignment is pending, Medicare will continue to pay the previous owner (seller) until the CHOW is approved by the CMS RO and a final tie-in notice is issued.[58] When a CHOW is pending, any application from the old or new owner to change the electronic funds transfer ("EFT") account or special payment address to that of the new owner will be rejected by the MAC.[59]

CMS advises that it is ultimately the responsibility of the old and new owners to work out any payment arrangements between themselves while the MAC and CMS RO are processing the CHOW.[60] Therefore, if the buyer wishes to continue billing Medicare under the existing Medicare number while a CHOW is pending approval, the parties to the transaction should negotiate terms for handling the funds received by the seller during this transition period. Parties to a transaction involving a provider that bills under the Prospective Payment System ("PPS") should also be aware of billing requirements relating to patients whose episode of care straddles between buyer and seller.[61] Payment is determined by date of discharge, and CMS does not prorate payment between buyer and seller. Other payments for cost-reimbursed capital payments, direct medical education, certain anesthesia services, organ acquisition, and bad debt are made to the buyer and seller in accordance with the principles of reasonable cost reimbursement.[62] Parties to a CHOW should be aware of these payment implications when negotiating the terms of the purchase agreement or other agreements ancillary to the transaction.

Medicare Updates of Information

Not all transactions involving a Medicare provider or supplier result in a CHOW. For example, stock transfers in a corporation, even if such transfer involves 100 percent of

the stock ownership, typically do not result in a CHOW.[63] Instead, such transactions require an update of the ownership information on file with CMS for the current Medicare number. This update is accomplished by filing a Form CMS-855A, CMS-855B, or CMS-855S with the applicable MAC. Updates of ownership information may be filed by some suppliers, such as a group practice, that are not permitted to undergo a CHOW.

Most changes to a provider's or supplier's enrollment information must be filed with the MAC within 90 days of the change.[64] Medicare regulations specify that providers and suppliers (other than physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dieticians or nutritional professionals, and organizations [e.g., group practices] consisting of any of the categories of the preceding individuals) must report a "change of ownership or control, including changes in authorized official(s) or delegated official(s)" within 30 days.[65] CMS's reference to a change of "control" leaves some uncertainty as to whether providers and suppliers must report a stock transfer, or similar change of information relating to control, within 30 or 90 days. Historically, a transaction that does not qualify as a CHOW has been treated as an update of information, for which updates must be filed within 90 days. However, DMEPOS suppliers must report any changes in information supplied on the enrollment application, including a change of ownership information that does not change the current TIN, within 30 days of the change to the National Supplier Clearinghouse ("NSC").[66]

Once an "855" update of ownership or control information is filed with the MAC, the MAC will send the update to the RO for approval. However, if the transaction is a stock transfer, the MAC may not send the transaction to the SA/RO if the following three conditions are met: (1) the contractor is confident that the transaction is merely a transfer of stock and not a CHOW; (2) the RO in question (based on the contractor's past experience with this RO) does not treat stock transfers as potential CHOWs; and (3) the contractor knows that the particular SA/RO in question does not review, approve, or deny this type of transaction.[67]

Failure to Report a CHOW or Update of Ownership Information

Failure to file a CHOW or change of information within the applicable 90-day or 30-day reporting period may result in deactivated billing privileges[68] or revocation of the provider's or supplier's Medicare number.[69] If an incomplete enrollment application is submitted, CMS may also deactivate the Medicare billing number based upon material omissions in the submitted enrollment application, or based on preliminary information received or determined by CMS that makes CMS question whether the new owner will ultimately be granted a final transfer of the provider agreement.[70]

Additional Considerations for Certain Providers/ Suppliers

HOME HEALTH AGENCIES

Under the home health "36-month rule," which applies to home health agency transactions effective on or after January 1, 2011, if a majority ownership of a home health agency changes by sale (including stock transfers, mergers, consolidations and transfers) within 36 months of the home health agency's Medicare enrollment or prior change of majority ownership, the provider agreement and Medicare billing privileges will not be conveyed to the new owner.[71] The prospective provider/owner of the home health agency must instead enroll in the Medicare program as a new (initial) home health agency and obtain a state survey or accreditation from an approved AO.

There are four primary steps to follow to determine whether the 36-month rule applies to a home health transaction:

1. Determine whether a change in direct ownership has occurred. The 36-month rule does not apply to "indirect" ownership changes.[72]
2. Determine whether the change involves a party assuming a greater than 50 percent ownership interest in the home health agency. For purposes of the 36-month rule, a "change in majority ownership" occurs when an individual or organization acquires more than a 50 percent direct ownership interest in a home health agency during the 36 months following the home health agency's initial enrollment in the Medicare program or the 36 months following the home health agency's most recent change in majority ownership (including 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 home health agency's most recent change in majority ownership).[73]
3. Determine whether the effective date of the transfer is within 36 months after the effective date of the home

health agency's initial enrollment in Medicare or most recent change in majority ownership. If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the 36-month rule does not apply.[74]

4. Determine whether any of the following exceptions apply: (1) if the home health agency submitted two consecutive years of full cost reports (low utilization or no utilization cost reports do not qualify as full cost reports); (2) a home health agency's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation; (3) the owners of an existing home health agency are changing the home health agency's existing business structure (for example, from a corporation to a partnership [general or limited]; from an LLC to a corporation; from a partnership [general or limited] to an LLC) and the owners remain the same); or (4) the individual owner of a home health agency dies, regardless of the percentage of ownership the person had in the home health agency.[75]

If a change in majority ownership has occurred within the previous 36 months and none of the exceptions apply, the home health agency must enroll as a new entity in Medicare if the parties move forward with the transaction.[76] As previously discussed, new enrollment for the home health agency would require filing a CMS 855-A for initial enrollment and a new certification survey and deemed accreditation, which cannot occur prior to the transaction or before the MAC processes the initial enrollment application.

SUBUNITS

Providers that have subunits and undergo a CHOW may need to file multiple CMS-855 forms to transfer the subunits to the new owner. Any subunit that has a separate provider agreement (e.g., home health agency subunits) must report its CHOW on a separate Form CMS-855A rather than using the main provider's CMS-855A.77 However, if the subunit has a separate Medicare provider number but not a separate provider agreement (e.g., hospital psychiatric unit, home health agency branch), the CHOW can be disclosed on the main provider's Form CMS-855A because the subunit is treated as a practice location of the main provider and not a separately enrolled entity.[78]

SUBTYPES

On occasion, a CHOW may occur in conjunction with a change in the facility's provider subtype. This can happen when a hospital undergoes a CHOW and changes from a general hospital to another type of hospital, such as a psychiatric hospital. Although a change in hospital type is considered a change of information, all information (including the change in hospital type) should be reported on the CHOW application, and the entire application will then be processed as a CHOW.[79] However, if the facility is changing from one main provider type to another (e.g., hospital converting to a skilled nursing facility) and also undergoing a CHOW, the provider must submit its application as an initial enrollment.[80]

DMEPOS SUPPLIERS

Updates of information and CHOWs involving a DMEPOS supplier are processed by the NSC. All updates of ownership information or CHOWs must be reported to the NSC within 30 days. Failure to timely report such changes to the NSC within the required 30-day period will lead to a revocation action.[81]

If a DMEPOS supplier undergoes a CHOW, the buyer must obtain accreditation that covers all of the supplier's locations.[82] If the seller has such an accreditation, the buyer can be enrolled as of the date of sale if the accreditor determines that the accreditation should remain in effect as of the date of sale.[83] If the buyer submits an application without evidence that the accreditation is still in effect for the buyer, CMS has instructed the NSC to reject the application.[84]

Effective May 4, 2009, DMEPOS suppliers submitting an enrollment application to change the ownership of an existing supplier are also required to obtain and submit a copy of that supplier's required surety bond to the NSC with the CMS-855S enrollment application. The surety bond must be in an amount of not less than $50,000 and is predicated on the National Provider Identifier ("NPI"), not the TIN.[85] Thus, if a supplier has two separately enrolled DMEPOS locations, each with its own NPI, a $50,000 bond must be obtained for each site.[86] Ownership changes that do not involve a change in the status of the legal entity (as evidenced by no change in the TIN), or changes that result in the same ownership at the level of individuals (corporate reorganizations and individuals incorporating) are not considered to be "changes of owner-ship" for purposes of the May 4, 2009 effective date.[87]

DMEPOS SUPPLIERS PARTICIPATING IN COMPETITIVE BIDDING

DMEPOS suppliers participating in the Competitive Bidding Program have additional CHOW filing requirements relating

to their contracts. A DMEPOS supplier that is negotiating a CHOW must notify CMS at least 60 days before the anticipated date of the change.[88] Contract suppliers that do not notify CMS of a CHOW are in breach of their contract.[89]

A CHOW does not automatically grant contract supplier status of the new owner; however, CMS may permit the transfer of a competitive bidding contract to an entity that merges with or acquires a competitive bidding contract supplier if the new owner assumes all rights, obligations, and liabilities of the competitive bidding contract. CMS divides filing requirements relating to a CHOW into two groups: one for "successor" entities and the other for "new" entities. A *successor entity* is an existing entity that merges with or acquires a contract supplier and continues to exist after the CHOW as it existed before the transaction. A *new entity* is an entity that is formed as a result of merger or acquisition and did not exist prior to the transaction.

CMS may award a contract to the new or successor entity if: (1) the entity meets all requirements applicable to contract suppliers for competitive bidding program(s) to which the contract supplier's contract applies; and (2) the entity submits to CMS documentation needed to substantiate compliance with basic eligibility requirements, quality standards, accreditation requirements, and financial standards.[90]

The parties must also prepare a novation agreement that is signed by all parties involved in the contract transfer, including CMS. CMS will review all novation agreements and will only accept those that assign all applicable contract supplier obligations to the purchaser. An acceptable novation agreement should include a number of provisions specified by CMS through guidance.[91] A sample novation agreement can be found at 42 C.F.R. § 42.1204. If the transaction involves a successor entity, an executed novation agreement must be submitted to CMS at least 30 calendar days before the anticipated effective date of the change of ownership.[92] If a CHOW involves a new entity, the existing contract supplier must submit its final draft of a novation agreement to CMS at least 30 days before the anticipated effective date of the CHOW. The new entity must submit an executed novation agreement to CMS within 30 days after the effective date of the CHOW.[93]

In the event of a CHOW or even a change of ownership interest of at least five percent (including a stock transfer), DMEPOS suppliers participating in the Competitive Bidding Program will have reporting obligations to the Competitive Bidding Implementation Contract ("CBIC") as well as the NSC. For example, for stock purchases that result in five percent or more ownership transfers, the seller must notify the CBIC by mailing or faxing all pertinent information regarding the transaction and include all information sent to the NSC.[94]

Conclusion

When engaging in an acquisition involving a Medicare provider or supplier that results in a CHOW, buyer and seller parties should address various Medicare requirements to ensure that appropriate and timely filings are made to assign or obtain a Medicare number, and should also plan for how the transaction may affect post-closing Medicare payments. Buyers must consider whether to accept assignment of the seller's Medicare number and, if not, the business impact involved with enrolling as a new provider or, if applicable, supplier. For transactions that qualify as updates of information, rather than CHOWs, it is also important for the parties to ensure that ownership updates are appropriately and timely filed. Failure to properly handle CHOWs or updates of information could result in deactivated billing privileges or revocation of the provider or supplier Medicare number.

This article is adapted from the ABA Health Law Section's new book, What is …CHOW? The book provides readers with a general understanding of the regulatory and other processes involved when a healthcare provider or supplier under-goes a change in ownership. For more information, go to www.shopABA.org.

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End Notes

[1] 42 U.S.C. § 1395x(u); 2 C.F.R. § 400.202.
[2] 42 U.S.C. § 1395x(d); 2 C.F.R. § 400.202.
[3] Centers for Medicare & Medicaid Services, PROGRAM INTEGRITY MANUAL ch. 15, § 15.1.2 ["CMS PROGRAM INTEGRITY MANUAL"].
[4] 42 C.F.R. § 489.18(a)(1); Centers for Medicare & Medicaid Services, CMS MANUAL SYSTEM PUB. 100-07 STATE OPERATIONS MANUAL, ch. 3, § 3210.1.D.2 ["CMS STATE OPERATIONS MANUAL"].
[5] 42 C.F.R. § 489.18(a)(2); CMS STATE OPERATIONS MANUAL § 3210.1.D.1.
[6] 42 C.F.R. § 489.18(a)(3); CMS STATE OPERATIONS MANUAL § 3210.1.D.3.
[7] 42 C.F.R. § 489.18(a)(3); CMS PROGRAM INTEGRITY MANUAL § 15.1.1.
[8] CMS PROGRAM INTEGRITY MANUAL § 15.2(C).
[9] CMS PROGRAM INTEGRITY MANUAL § 15.7.7.1.2.
[10] CMS STATE OPERATIONS MANUAL § 3210.1A.
[11] 42 C.F.R. § 489.18(a)(4).
[12] *Id.*
[13] *Id.*
[14] CMS STATE OPERATIONS MANUAL § 3210.1.D.5.
[15] *Id.*
[16] 42 C.F.R. § 424.550(b).
[17] CMS PROGRAM INTEGRITY MANUAL § 15.7.7.1.3.
[18] *Id.*
[19] CMS STATE OPERATIONS MANUAL § 3210; CMS PROGRAM INTEGRITY MANUAL § 15.7.7.1.3.
[20] CMS PROGRAM INTEGRITY MANUAL § 15.7.7.1.
[21] See 42 C.F.R. §§ 424.550(c), 489.13; CMS PROGRAM INTEGRITY MANUAL §§ 15.7.8.3, 15.7.8.3.1.
[22] 42 C.F.R. § 424.550(c).
[23] See 42 C.F.R. § 424.540(a)(2).
[24] CMS PROGRAM INTEGRITY MANUAL § 15.7.8.3.1
[25] *Id.*
[26] CMS PROGRAM INTEGRITY MANUAL § 15.7.8.3.
[27] 42 C.F.R. § 489.18(c).
[28] Id. at § 489.18(d).
[29] CMS STATE OPERATIONS MANUAL § 3210.
[30] 42 C.F.R. § 489.18(d).
[31] CMS STATE OPERATIONS MANUAL § 3210.
[32] See 42 C.F.R. §§ 420.200420.206.
[33] 42 C.F.R. § 489.18(c)(d); see 45 C.F.R. pts. 80, 84, and 90.
[34] CMS STATE OPERATIONS MANUAL § 3210; Centers for Medicare & Medicaid Services, CMS MANUAL SYSTEM PUB. 100-06, FINANCIAL MANAGEMENT MANUAL, ch. 3, § 130.
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] CMS STATE OPERATIONS MANUAL, § 3210.5A.
[39] CMS, Letter to State Survey Agency Directors, "Acquisitions of Providers/ Suppliers with Rejection of Automatic Assignment of the Medicare Provider Agreement: Implications for Timing of Surveys and Participation Effective Date" (Sept. 6, 2013) ["CMS State Survey letter"].
[40] CMS STATE OPERATIONS MANUAL § 3210.5A.
[41] *Id.*
[42] CMS State Survey letter.
[43] CMS STATE OPERATIONS MANUAL § 3210.1B1.
[44] Id. at § 3210.1C.
[45] CMS STATE OPERATIONS MANUAL § 3210.
[46] Id.
[47] CMS State Survey letter; 42 C.F.R. § 489.13.
[48] CMS State Survey letter; 42 C.F.R. § 489.13.
[49] CMS State Survey letter; 42 C.F.R. § 489.13; CMS STATE OPERATIONS MANUAL § 2008A.
[50] CMS State Survey letter; 42 C.F.R. § 489.13; CMS STATE OPERATIONS MANUAL § 2008A.
[51] Department of Health & Human Services, Centers for Medicare & Medicaid Services, Letter to State Survey Agency Directors, "Initial Surveys for New Medicare Providers" (Nov. 5, 2007).
[52] Providers required to file Medicare Cost Reports include hospitals, home health agencies, hospices, CORFs, independent renal dialysis facilities, skilled nursing facilities, independent rural health clinics, and federally qualified health centers ("FQHCs").
[53] Centers for Medicare & Medicaid Services, MEDICARE PROVIDER REIMBURSEMENT MANUAL, Part 2, Ch. 1, § 104B ["CMS MEDICARE PROVIDER REIMBURSEMENT MANUAL"]; 42 C.F.R. § 413.24(f)(2).
[54] CMS MEDICARE PROVIDER REIMBURSEMENT MANUAL, pt. 1, ch. 15, § 1503.
[55] CMS STATE OPERATIONS MANUAL § 3210.1.B1; CMS MEDICARE PROVIDER REIMBURSEMENT MANUAL, pt. 2, ch. 1, § 102.3.
[56] CMS MEDICARE PROVIDER REIMBURSEMENT MANUAL § 102.2.
[57] CMS MEDICARE PROVIDER REIMBURSEMENT MANUAL, pt. 1, ch. 15, § 1504.
[58] CMS PROGRAM INTEGRITY MANUAL § 15.7.7.1.5.
[59] *Id.*
[60] *Id.*
[61] *See* 42 C.F.R. § 412.125.
[62] 42 C.F.R. § 412.113.
[63] 42 C.F.R. § 489.18(a)(3).
[64] 42 C.F.R. § 424.516(d), (e); 42 C.F.R. § 410.33(g).
[65] 42 C.F.R. § 424.516(e); CMS PROGRAM INTEGRITY MANUAL § 15.10.1.
[66] 42 C.F.R. § 424.57(c)(2).
[67] CMS PROGRAM INTEGRITY MANUAL § 15.7.7.1.6.
[68] 42 C.F.R. § 424.540(b), 42 C.F.R. § 424.535(a) (1), (a)(9); 42 C.F.R. § 424.540(a)(2).
[69] CMS PROGRAM INTEGRITY MANUAL §§ 15.8, 15.8.2, and 15.8.4.
[70] 42 C.F.R. § 424.540(b).
[71] 42 C.F.R. § 424.550(b)(1); CMS PROGRAM INTEGRITY MANUAL § 15.26.1.
[72] CMS PROGRAM INTEGRITY MANUAL § 15.26.1.
[73] 42 C.F.R. § 424.502; CMS PROGRAM INTEGRITY MANUAL § 15.1.1.
[74] CMS PROGRAM INTEGRITY MANUAL § 15.26.1.
[75] 42 C.F.R. § 424.550(b)(2); CMS PROGRAM INTEGRITY MANUAL § 15.26.1.
[76] 42 C.F.R. § 424.518; CMS PROGRAM INTEGRITY MANUAL § 15.19.2.3.
[77] CMS PROGRAM INTEGRITY MANUAL § 15.7.7. 1.3(E).
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] CMS PROGRAM INTEGRITY MANUAL § 15.21.1.
[82] 42 C.F.R. § 424.57(d)(1)(i); CMS PROGRAM INTEGRITY MANUAL § 15.21.1.
[83] CMS PROGRAM INTEGRITY MANUAL § 15.21.1.
[84] See 42 C.F.R. § 424.525; CMS PROGRAM INTEGRITY MANUAL § 15.21.1(C)(1)(a).
[85] 42 C.F.R. § 424.57(d)(2).
[86] CMS PROGRAM INTEGRITY MANUAL § 15.21.7.
[87] *Id.*
[88] 42 C.F.R. § 414.422(d)(1).
[89] 42 C.F.R. § 414.422(g).
[90] 42 C.F.R. § 414.422(d)(2); 42 C.F.R. § 414.414 (b)(d); Centers for Medicare & Medicaid Services, CMS MANUAL SYSTEM PUB. 100-04, MEDICARE CLAIMS PROCESS MANUAL, ch. 36, § 30.7 ["CMS CLAIMS PROCESS MANUAL"].
[91] See Centers for Medicare & Medicaid Services, *Change of Ownership Guidelines and Responsibilities* (April 2016), https://dmecompetitive bid.com/ Palmetto/Cbicrd2Recompete.Nsf/files/23_R2RC_Fact_Sheet_CHOW.pdf/ $File/23_R2RC_Fact_Sheet_CHOW.pdf.
[92] 42 C.F.R. § 414.422(d)(2)(i)(C); CMS CLAIMS PROCESS MANUAL § 36.7.
[93] 42 C.F.R. § 414.422(d)(2)(ii)(B).
[94] *See id.*