Health Care Regulation and Quality Improvement
800 NE Oregon Street, Suite 305
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

This letter is in response to your expression of interest in becoming a provider of hospice services under the Medicare program. The Health Care Regulation and Quality Improvement Section of the Public Health Division has an agreement with the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS), to assist in determining whether health care agencies and facilities meet, and continue to meet, the required Conditions of Participation.

If you desire to participate, and if you believe your agency substantially meets the required conditions, please complete and return **to this office** the following forms, which we have enclosed:

(1) CMS 1561 - Health Insurance Benefit Agreement (two (2) signed originals required)
http://www.cms.hhs.gov/cmsforms/downloads/cms1561.pdf

(2) HHS 690 - Assurance of Compliance with Title VI, Civil Rights (two (2) signed originals required) and a Civil Rights packet
http://www.hhs.gov/forms/HHS690.pdf &
http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/formstobecompleted.html &
http://www.hhs.gov/ocr/civilrights/clearance/pregrantchecklist.pdf

(3) CMS 417 - Hospice Request for Certification
http://www.cms.hhs.gov/cmsforms/downloads/cms417.pdf

In addition to the necessary forms and accompanying instructions, information is available online at:

(1) Part 418, Conditions of Participation with Interpretive Guidelines for Hospices
http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-19.pdf

Please note: Before any Medicare certification survey can be conducted, an approved CMS 855A Provider/Supplier Enrollment Form must also be received in this office. The initial CMS 855A form can either be obtained from the Fiscal Intermediary (National Government Services) or from the CMS website (http://www.cms.hhs.gov). If you have any questions relative to the CMS 855A completion, please call the fiscal intermediary, National Government Services, at (805) 367-0734.

After you have completed the CMS 855A, send it to the Fiscal Intermediary for review. Once they have determined that your facility meets the requirements for fiscal responsibility, and consequently approves your request to become a provider, they will send a copy of the approved CMS 855A to our office.

To qualify for Medicare payments your facility must be in compliance with the Medicare Conditions of Participation, the requirements for reimbursement including financial solvency, and the requirements of Title VI of the Civil Rights Act of 1964 and the Age Discrimination Act of 1975.

The person signing the Health Insurance Benefit Agreement must have the authorization of the facility's owners to enter into this agreement.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on grounds of race, color or national origin in any program receiving Federal financial assistance; and age discrimination is prohibited under provisions of the Age Discrimination Act of 1975. Please respond, as requested, to the Office for Civil Rights.

Also, if your agency or facility performs laboratory tests for the purpose of diagnosis and treatment or assessment of individuals' health, you must have and display a current license or waiver to do so. For information, call Health Services, Center for Public Health Laboratories, Laboratory Licensing Section, at (503) 693-4125.

After you have obtained and/or completed all of the required documents and forms, return them to this office. We will begin processing the

documents and forms in accordance with CMS's directions.

Certification: Most types of providers, and some suppliers, are required to demonstrate that they are in full compliance with Medicare quality and safety requirements. This demonstration is accomplished during an onsite survey. The CMS-855 must have been approved, all of the required documentation must have been submitted, and the provider fully operational in order for a survey to be conducted.

At the present time the onsite survey will need to be conducted by a CMS-approved accreditation organization (AO), and such accreditation is "deemed" to be equivalent to a recommendation by the SA for CMS certification. To schedule the initial accreditation survey, contact The Joint Commission (630-792-5800) or Community Health Accreditation Program (202-862-3413) or Accreditation Commission for Health Care (919-785-1214).

CMS instructs States to place a higher priority on recertification of existing providers, on similar work for existing providers, and on complaint investigations than for initial surveys of new providers/suppliers seeking Medicare participation.

However, providers may apply by letter to CMS for consideration to grant an exception to the priority assignment of the initial survey if lack of Medicare certification would cause significant access-to-care problems for Medicare beneficiaries served by the provider or supplier. There is no special form utilized to make a priority exception request. However, the burden is on the applicant to provide data and other evidence that effectively establishes the probability of adverse beneficiary health care access consequences if the provider is not enrolled to participate in Medicare. CMS will not endorse any request that fails to provide such evidence and fails to establish the special circumstances surrounding the provider's or supplier's request. Send this letter and the accompanying documentation to this office (SA). The SA will review the documentation for completeness and may choose to make a recommendation before forwarding the request to CMS.

<u>After</u> the application forms and documents have been reviewed and approved, a surveyor from the AO will conduct the onsite survey to evaluate the agency's compliance with the Conditions of Participation for hospices. The survey will include clinical record review as well as home visits and interviews with agency staff and others.

If your agency is determined to be in compliance at the time of this survey, the AO will recommend to CMS that it participate as a Medicare certified provider. This office will also need written notification that the agency has successfully completed the certification survey by the AO. At that time, all of the application forms and documents that have been submitted will be transmitted to CMS for final determination.

If certified, the certification date will be determined by CMS and is generally the date the agency was determined to be in compliance with the all of the regulations, which could be the date of the onsite survey. If deficiencies are identified during the survey, the certification date would be the date the agency submits an acceptable written plan of correction for those deficiencies. In any event, you will not receive Medicare reimbursement for services provided to Medicare beneficiaries prior to your official date of certification.

Once it is determined that all requirements of Medicare and Civil Rights have been met, the Health Insurance Benefit Agreement will be countersigned and a copy returned to you, along with written notification from CMS that your agency has been approved. This written notification will include the identification of your Medicare Provider Number. A copy of the notification will also be forwarded to the NGS. NGS will then contact you with its requirements and procedures for Medicare billing and reimbursement.

Those institutions and agencies which are denied Medicare certification will be notified and given the reasons for the denial and information about their rights to appeal the decision.

You are required to notify this office if in the future you plan to transfer ownership to another individual, ownership group, or to a lessee. Please be advised that the courts have upheld CMS's right to hold new owners responsible for the overpayment of the old owners based on regulations at 42 CFR 489.18. CMS has the right to recover payment from the buyer even when a sales agreement specifically states that the buyer will not accept the liability of the seller. The enclosed chart has been prepared to outline the effect of a new owner's acceptance or refusal of assignment of an existing Medicare provider agreement.

Those institutions and agencies, which are denied certification in the program, will be notified and given the reasons for the denial and information about their rights to appeal the decision.

Sincerely,

[Custom Text Prompt(Surveyor Signatory Name)]
Client Care Surveyor
CMS Representative
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

If you need this information in an alternate format, please call our office at (971) 673-0540 or TTY (971) 673-0372.

MEDICARE PROVIDER AGREEMENTS AND CHANGES OF OWNERSHIP

NEW OWNER ACCEPTS ASSIGNMENT OF PREVIOUS OWNER'S PROVIDER AGREEMENT

Consequences: New owner is given previous owner's provider number and agreement. There is no break in coverage, but new owner becomes liable for all penalties, sanctions, and liabilities imposed on or incurred by previous owner. If, after accepting the assignment, the new owner subsequently elects to terminate its provider agreement, it must (under the provisions of section 1866(b)(1) of the Act) file a written notice of its intention, and follow the procedures for voluntary termination.

- The regulations specify that when there is a change of ownership, the existing Medicare agreement is automatically assigned to the new owner (42 CFR 489.18(c). New owners are not required to accept assignment of the agreement but they must state their refusal in writing.

NEW OWNER REFUSES ASSIGNMENT OF PREVIOUS OWNER'S PROVIDER AGREEMENT

Consequences: The previous owner's provider agreement terminates on the date the previous owner ceased doing business.

- NEW OWNER DOESN'T WANT TO PARTICIPATE IN PROGRAM
  Consequences: New owner has, in effect, purchased only capital assets. The business ceased being a Medicare provider on the last day of business of the previous owner.
- NEW OWNER WANTS TO PARTICIPATE IN PROGRAM
  Consequences: New owner will have to request to participate in the program, undergo an initial survey, meet the participation requirements, and be certified. There will be no Medicare coverage or payments until the provider is certified, and no retroactive payments for the period between the termination of the previous owner's provider agreement and the commencement of the new owner's provider agreement. However, the new owner is free of any penalties, sanctions, or liabilities imposed on or incurred by the previous owner.