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

Re: Change of ownership-Hospice

This letter is in response to your notification of a change of ownership for a hospice. The Health Care Regulation and Quality Improvement section of the Oregon Health Authority 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 facilities meet, and continue to meet, required Conditions of Participation.

Please complete and return to this office the following change of ownership forms, which may be found online at:

(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
www.hhs.gov/forms/HHS690.pdf & www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/formstobecompleted.html & www.hhs.gov/ocr/civilrights/clearance/pregrantchecklist.pdf

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

(4) A new licensure application must be filled out and signed by the new owner. www.healthoregon.org/hcrqi

(5) A letter from the buyer *and* a letter from the seller with effective date of change.

The CMS 855A form can either be obtained from the Fiscal Intermediary

(United Government Services (805) 384-7063) or at the CMS website (http://www.cms.hhs.gov). If you have any questions relative to the CMS 855A completion, please call your fiscal intermediary, United Government Services, (805) 384-7063.

After you have completed the form, send it back 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.

In addition to the necessary forms and accompanying instructions, there are federal regulations covering all requirements of the Medicare program, including the standards, which must be met in regard to the care of patients and the principles of reimbursement for provider costs. 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.

For your information, Appendix M, Interpretive Guidelines for Hospices, is available online at:

http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-19.pdf

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. Under separate cover, you will receive a packet of forms and informational material. Please respond, as requested, to the Office for Civil Rights.

Also, if your facility performs laboratory tests for the purpose of diagnosis and treatment or assessment of individuals' health, you must have and display a current Oregon license to do so. For information, call Health Services, Center for Public Health Laboratories, Laboratory Licensing Section, at (503) 229-5853.

You are required to notify this office if in the future you plan to transfer ownership to another owner, 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 recoup from the buyer even when a sales agreement specifically states that the buyer will not accept the liability of the seller. The enclosed document has been prepared to outline the effect of a new owner's acceptance or refusal of assignment of an existing Medicare provider agreement.

Once it is determined that all requirements of Medicare are met, you will receive written notification from CMS that the hospice's continued Medicare certification under the new ownership has been approved.

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.

As long as the hospice is certified, subsequent, routine surveys will be conducted to evaluate its continued compliance with the regulations. Please do not hesitate to call this office at 971-673-0540 if you have any questions.

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.