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With the Benefit Comes the Burden: CMS Clarifies Effects of Rejecting Assignment of Medicare Agreements

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On September 6, 2013 the Survey and Certification Group of the Centers for Medicare & Medicaid Services (CMS) issued a policy memorandum to clarify its policies regarding the effects of rejecting assignment of a provider agreement in connection with the change of ownership of a Medicare-participating provider.[1] The policy memorandum, which became effective upon publication, highlights a number of issues with respect to the timing and conduct of surveys by state survey agencies and accreditation organizations following the rejection of assignment, as well as several other matters prospective purchasers of health care facilities should consider carefully. In doing so, CMS provides further incentives for purchasers of Medicare-participating providers to accept automatic assignment of provider agreements.

Automatic Assignment of Medicare Provider Agreements

Pursuant to CMS regulations, when a change of ownership of a Medicare-participating provider occurs, the existing Medicare provider agreement is automatically assigned to the new owner.[2] The automatic assignment of a Medicare provider agreement has two major effects. First, the acquired provider continues participation in the Medicare program under the new ownership without interruption, and no survey is required as a result of the acquisition and assignment, although the CMS regional office may direct the state survey agency to conduct a survey in certain cases. Second, by accepting automatic assignment, the new owner becomes subject to all applicable statutes and regulations and to the terms and conditions under which the previous owner's provider agreement was issued, including any requirements to adjust payments to account for prior overpayments (and underpayments) and to collect for civil monetary penalties. In effect, any existing liabilities of the provider agreement remain with it. CMS has emphasized the importance of this tool in safeguarding the Medicare trust funds by providing continuity in the ability to recover outstanding overpayments.[3]

The new owner may choose to reject automatic assignment of the existing Medicare provider agreement. If the new owner chooses to reject automatic assignment, the provider agreement will terminate effective as of the date the acquisition is completed. The termination of the provider agreement generally means that the new owner will not have any successor liability for Medicare overpayments under the previous owner's provider agreement. However, if

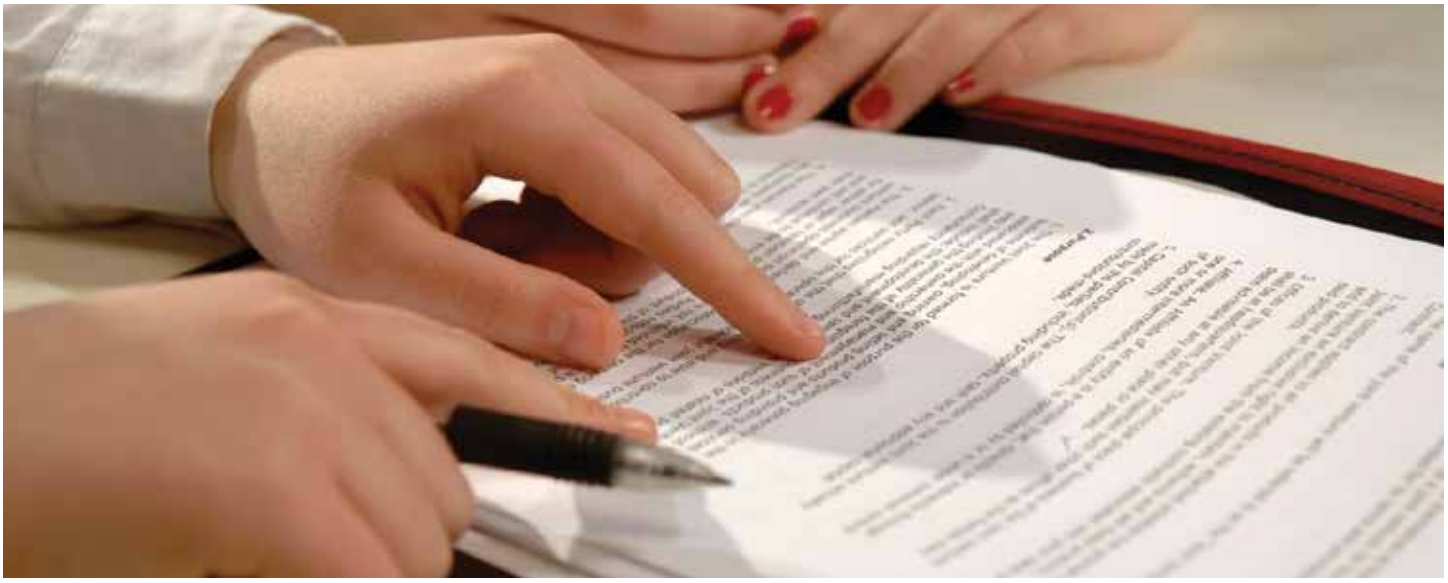
the new owner seeks to participate in the Medicare program, it will be treated as an initial applicant and, therefore, be subject to the provider enrollment process and other participation requirements, including an unannounced full survey of the provider's compliance with applicable Medicare requirements. In addition, if the facility was previously deemed to comply with the applicable Medicare requirements by virtue of being accredited by a CMS-approved accreditation organization (such as The Joint Commission), the accreditation organization may not extend its accreditation to the new owner; rather, the accreditation organization must conduct a full initial accreditation survey following the consummation of the transaction.

CMS regulations provide that the effective date of the new owner's Medicare provider agreement will be the date on which all applicable federal requirements are met, including satisfactory completion of a survey.[4] Typically, the successful completion of an on-site survey is the final federal requirement before a new owner is issued a Medicare provider agreement. However, there may be other federal requirements, such as the submission of acceptable compliance documentation to the U.S. Department of Health & Human Services, Office for Civil Rights, that remain outstanding following a survey showing substantial compliance.[5] As a result, one practical consequence of rejecting automatic assignment is that there is a period of time between the voluntary termination of the previous owner's provider agreement and the effective date of the new owner's provider agreement during which the new owner will not receive payment from Medicare.

Policies Regarding Timing of Surveys Following Rejection of Automatic Assignment

In its policy memorandum, CMS notes that "the incentives to accept automatic assignment are weakened by [state survey agency] or [accreditation organization] practices that deviate from CMS policy requiring unannounced surveys and shorten the typical [. . .] timeframes for surveying initial applicants."[6] Essentially, if state survey agencies and accreditation organizations permit new owners who have rejected assignment of the previous owners' provider agreements to jump ahead in the survey line, the severity of the potential cash flow issues associated with rejecting assignment will be mitigated, and, according to CMS, future buyers may be encouraged to reject assignment.

To clarify that the benefit does not come without the burden, CMS specifies that state survey agencies and accreditation organizations must adhere to several long-standing policies concerning initial surveys for Medicare certification. First, the full survey for initial certification purposes may only take place after the acquisition is complete and after the applicable Medicare administrative contractor has issued a recommendation for approval of the new owner's enrollment application. Second, before the facility may be surveyed, it must be fully operational and providing services to patients, meaning it must: (1) have opened its doors to admissions; (2) be furnishing all services required of the facility's particular Medicare provider or supplier type; and (3) demonstrate the "operational capability of all facets of its operations."[7] Importantly, in order to be "fully operational," the facility must be serving a sufficient number of patients so as to allow the surveyor to determine whether the facility complies with all applicable requirements. Third, the survey must be unannounced. While the requirement that the survey be unannounced is not new, CMS adds new texture to this requirement in its policy memorandum. CMS observes that the occurrence of an initial survey shortly after a change of ownership suggests that the state survey agency or accreditation organization may have discussed the timing of the survey with the new owner. Although each situation is to be assessed on a case-by-case basis, the policy memorandum notes that any survey that takes place within 14 days after the effective date of an acquisition (where automatic assignment of the provider agreement is rejected by the new owner) "warrants closer review" by the CMS regional office.[8] While the 14-day timeframe is offered as an example, it may be interpreted by state survey agencies and accreditation organizations as a de facto rule. Because the survey must be unannounced, it may be the case that state survey agencies and accreditation organizations steer far wide of the 14-day timeframe.



The CMS policy memorandum also makes clear that, in general, initial surveys are, and should remain, the lowest workload priority for state survey agencies, particularly for initial applicants that have the option of being accredited by a CMS-approved accreditation organization. To ensure compliance with this standard, CMS notes that when a state survey agency conducts an initial certification survey of an applicant that acquired a Medicare-participating provider but rejected assignment of the existing provider agreement, the CMS regional office must review the facts of the case carefully to determine whether the agency deviated from its workload priorities or its typical practices with initial applicants. The occurrence of a survey inconsistent with these workload priorities and practices would raise concern as to whether the survey was, in fact, unannounced.

Acquisition of a Hospital and Conversion to Provider-Based Location

CMS also uses the policy memorandum as an opportunity to clarify its policies regarding the situation in which one Medicare-participating hospital acquires another and operates the acquired hospital as a provider-based location in accordance with the Medicare provider-based regulations.[9] According to the policy memorandum, some hospitals, state survey agencies, and accreditation organizations "appear to be unclear" as to when it is permissible for the acquiring hospital to bill for Medicare services at the newly acquired location immediately following the closing of the transaction.[10] In particular, CMS notes that where the acquiring hospital has rejected assignment of the acquired hospital's Medicare provider agreement, it may not treat the acquisition of the hospital as the mere addition of a site of service and begin billing Medicare as of the acquisition date. Instead, CMS will automatically assign the acquired hospital's provider agreement to the acquiring hospital. Since the acquired hospital is operated as a provider-based location of the acquiring hospital, there will not be a separate Medicare provider number or agreement for the acquired hospital; however, the acquired hospital's provider agreement will be subsumed under or incorporated into the provider agreement of the acquiring hospital. That is, any successor liability for Medicare overpayments under the acquired hospital's provider agreement will be incorporated into the acquiring hospital's provider agreement. The benefit is that the acquiring hospital may begin to bill Medicare for services provided at its new provider-based location immediately upon closing.

As in any change of ownership, the acquiring hospital may choose to reject assignment of the acquired hospital's Medicare provider agreement. By doing so, the provider agreement will terminate effective as of the date the acquisition is completed and, in general, the acquiring hospital will not have any successor liability for Medicare overpayments under the acquired hospital's provider agreement. However, the acquiring hospital will not be able to bill Medicare for services at its new provider-based location until such time as the location has been subject to the same sort of process as described above for an initial applicant. In other words, the provider-based location must undergo a full survey of all applicable Medicare hospital conditions of participation, and the acquiring hospital's accreditation organization may not extend accreditation to the provider-based location until it has completed a full survey of that site. The same timing considerations described above would apply in this scenario—i.e., there would be a period of time during which the acquiring hospital would not be able to bill Medicare for services rendered at the provider-based location.

Practical Considerations

The CMS policy memorandum makes clear that purchasers of Medicare-participating providers cannot avoid Medicare successor liability by rejecting assignment without being made subject to the same cumbersome enrollment and certification requirements as any other initial applicant to the Medicare program. It also sends a clear message to state survey agencies and accreditation organizations that CMS is serious about scrutinizing the timing and conduct of surveys. In response to the policy memorandum, state survey agencies and accreditation organizations may push surveys of new owners who have rejected assignment to the very bottom of the pile out of an abundance of caution.

While prospective purchasers who plan to accept assignment may mitigate the risk of Medicare successor liability through thorough due diligence and effective indemnification and escrow arrangements, prospective purchasers who plan to reject assignment should consider the potential cash flow conundrum associated with rejection and ensure they have access to adequate capital to survive the period pending receipt of a new provider number. Purchasers who reject assignment also should allocate appropriate resources to ensure that their facilities are fully prepared for certification surveys so as to minimize any delay in the effective date of the facilities' new provider agreements. In addition, hospitals seeking to acquire and convert nearby hospitals into provider-based locations should understand that even if the acquired hospital's Medicare provider number is "retired," the successor liability associated with it will be baked into the acquiring hospital's provider agreement if the acquiring hospital accepts assignment.

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1 *See* CMS Survey and Certification Letter 13-60-ALL (Sept. 6, 2013), *available at* www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-60.pdf (hereinafter CMS Policy Memorandum). For ease of reference, the term "provider" is used throughout this article. Please be advised, however, that by its terms, the CMS Policy Memorandum applies to both Medicare-participating providers and those institutional suppliers subject to certification requirements.

2 42 C.F.R. § 489.18(c).

3 *See* CMS, Fiscal Year 2011 Hospital Inpatient Prospective Payment System Final Rule, 75 Fed. Reg. 50042, 50401 (Aug. 16, 2010).

4 42 C.F.R. § 489.13.

5 *See* CMS Policy Memorandum at 6-7. Please note that the CMS Policy Memorandum provides further detail regarding the calculation of the effective date of Medicare provider agreements for non-long term care applicants where the initial survey requires further action.

6 *Id.* at 3.

7 *Id.* at 4.

8 *Id.*

9 *See* 42 C.F.R. § 413.65.

10 CMS Policy Memorandum at 5.