DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Clinical Standards and Quality

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DATE: December 23, 2021

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Transitioning Certification Functions for Changes of Ownership, Administrative Changes, and Initial Enrollment Performed by the CMS Survey and Operations Group

Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS) will be transitioning certain certification enrollment functions performed by the CMS SOG Locations (formerly CMS Regional Offices) to CMS' Center for Program Integrity (CPI) Provider Enrollment Oversight Group (PEOG) and the Medicare Administrative Contractors (MACs).
- CMS has already streamlined certain certification work, such as voluntary termination (July 27, 2020) and Federally Qualified Health Centers (FQHCs) enrollment (March 22, 2021).
- The State Operations Manual (SOM) and Program Integrity Manual (PIM) will be updated accordingly to reflect these changes at a later time.
- The attached standard operating procedure (SOP) related to changes of ownership (CHOWs), administrative changes, and initial certification enrollment work is attached and CMS will implement these processes in calendar year (CY) 2022, commencing with Skilled Nursing Facilities (SNFs).

Background and General Overview

To improve efficiency in the enrollment process for Medicare-participating certified providers and suppliers, CMS is transitioning certain certification enrollment functions performed by the CMS Locations to CMS' CPI/PEOG and the MACs. The transition of workload will continue to occur with implementation rollouts projected throughout CY2022.

The SOP provides a general overview of processing instructions for:

- Changes of Ownership (CHOW);
- Administrative Changes (such as address changes, name changes, additional service locations, relocations, etc.); and,
- Initial Certification.

The SOP identifies processing instructions and highlights the applicability of all providers/suppliers impacted which will be transitioned, **this process will commence with Skilled Nursing Facilities (SNFs) on January 3, 2022, and the remaining providers/suppliers at a later time in 2022**. The SOP also includes the SNF addendum which offers additional guidance for the transition actions specifically related to SNFs. This guidance applies to applications received or recommendations for approval or denials made on or after January 3, 2022.

For all final determinations related to CHOWs, Administrative Changes, and Initial certifications, the CMS Locations will be copied on communications between the State Agency (SA), Accrediting Organization (AO), and MAC for three months or unless otherwise notified. The CMS Locations and CPI/PEOG will work together to transition this work and process by provider and supplier types to ensure consistency by the SAs and MACs.

CHOWs- Part I of the SOP

A CHOW occurs when the responsible legal entity that was a party to the Medicare provider agreement ("Seller") has changed, and the responsible new legal entity ("Buyer") receives/accepts automatic assignment of the existing provider agreement (see 42 CFR 489.18). The responsible legal entity is the party having ultimate responsibility and liability for the operational decisions of the institution. A CHOW may involve any transfer of a provider or supplier even if no money changes hands – the terms "Seller" and "Buyer" are used for convenience.

A CHOW (i.e., when there is an automatic assignment to the new owner of the existing Medicare agreement), per se, does not require a survey. A buyer is generally assigned the existing provider/supplier agreement and its corresponding CMS Certification Number (CCN) if the buyer purchases a participating provider organization and accepts automatic assignment of the existing agreement.

In a CHOW situation, the new owner/buyer may also reject the automatic assignment of the existing Medicare agreement, in which case, the seller's agreement, and CCN would be voluntarily terminated, and the new owner/buyer would need to complete an initial enrollment application.

Administrative Changes- Part II of the SOP

Many enrollment certification actions are not CHOWs. These situations are generally when a provider/supplier changes names, not due to a CHOW or an administrative update to the provider agreement. The SOP provides a general overview of what CMS categorizes as administrative changes for this certification transition to CPI/PEOG and the MAC.

Administrative changes may include:

- Address changes (not relocations);
- Adding/Removing a Branch Location;
- Additional Practice Locations/Sites;
- Adding Additional Services;
- Cessation of Business;
- Expansions/Removal and Change in Modalities and Services (ESRD only)*;
- Extension Locations;

- Multiple Locations; and,
- Name Changes.

*Does not require a CMS-855.

These administrative changes require verification of items, such as ensuring that quality of care continues within these settings, patient populations are served based on a set of criteria the SA follows, and also requires updates to the CMS-855A or CMS-855B (except ESRD change in modalities) as well as potential updates to the national database system. Often, CHOWs may also include a change in address, location, or adding additional services.

Additionally, a significant function of certification work includes relocations. A change in a location outside of the primary approved site or change in a location outside of the existing geographical area is considered a relocation of a provider/supplier. A relocation request must also ensure that patients/residents will continue to receive uninterrupted service during the relocation. The general SOP outlines the responsibilities of the SA and AO (for deemed facilities) and CPI/PEOG and the MAC for relocations. While not all relocations require the SA or AO to conduct a survey, relocations often mirror administrative changes, or administrative changes may be determined to be a relocation.

We note, for deemed facilities, the SA will be responsible for updating the facility information in the national database system based on the recommendations of the AO and the final approval letters issued by the MAC.

Initial Certification and Enrollment- Part III of the SOP

Except for Federally Qualified Health Centers (FQHCs), which was transitioned in March 2021 (see Admin-Info 21-06-ALL), all providers and suppliers are surveyed for compliance with the Medicare conditions of participation, conditions for coverage, or requirements. Initial certification and enrollment require a multistep process that already includes CPI/PEOG and MAC involvement related to enrollment activities and the CMS 855A or CMS 855 B processing when a provider/supplier has been approved to participate in the Medicare Program. In short, the MAC receives the prospective provider/supplier CMS 855A or CMS 855, recommends approval to the SA, which in turn conducts the applicable health survey and as applicable Life Safety Code (LSC) survey, and forwards the completed application package and recommendation to the MAC for approval. We have streamlined the initial enrollment and certification activities within this SOP into a general process for the SA, CPI/PEOG, and the MAC.

We note, for deemed facilities, the SA will be responsible for updating the facility information in the national database system based on the recommendations of the AO and the final approval letters issued by the MAC.

Certification & Enrollment Activities Not Included

CMS **will not be changing the current** enrollment and certification activities for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Psychiatric Residential Treatment Facilities (PRTFs), and Nursing Facilities (NFs) as these providers are Medicaid-only, and therefore will continue to follow the existing processes. The SA will communicate directly with the State Medicaid Agency (SMA) for dually-certified facilities. At this time, we are also not transitioning enrollment and certification activities for Critical Access Hospitals (CAHs), Religious nonmedical health care institutions (RNHCIs), Organ Procurement Organizations (OPOs), or rural health clinics (RHCs). Any potential change to enrollment and certifications

activities of these providers/suppliers will be communicated in the future. We do not include Special Purpose Renal Facilities (SPRDF) as these are used in emergencies/disasters only.

Additionally, for U.S. Territories (American Samoa; the Commonwealth of the Northern Marianas Islands; Guam and the U.S. Virgin Islands), the CMS Locations will act as the State Survey Agency.

Accrediting Organizations

For CHOWs, AOs will be copied on all communications between the provider/supplier, the SA, CPI/PEOG, and the MAC. There will be no direct involvement from the AOs in recommending approval or denial of a CHOW.

For administrative changes, the MAC will provide the initial approval to the SA and AO (if applicable). The AO will determine survey needs and recommend approval or denial directly to the MAC, copying in the SA. SA surveys are scheduled based on the Mission & Priority Document. For AO surveys, the AOs are not held to the MPD requirements. However, the AO must communicate intent to survey to the SA generally within 30 business days.

For providers and suppliers seeking deemed status through a CMS-approved AO, the provider/supplier will still process their CMS-855 through the general enrollment requirements. However, the AO will conduct the initial survey. An AO may not conduct an initial certification survey of a prospective provider or supplier for Medicare certification purposes until the MAC has completed its initial review of the enrollment application and has made a recommendation for deemed status to CMS. The SAs will be responsible for entering information on the 'Deemed' tab within the certification kit in the national survey database system only for those initial applicants seeking deemed status based on accreditation under a CMS-approved Medicare accreditation program.

Finally, we note that if a facility drops accreditation status, the AO must notify the SA and copy in the CMS Location. In the event of withdrawal of accreditation status or when a facility changes from one AO to another, the SA will be responsible for updating the national database to reflect the accreditation status.

We also note that for facilities withdrawing AO accreditation status or AO denials of accreditation (therefore, the facility would be under the SA jurisdiction), notifications of these changes should be sent directly to the SA, copying in the CMS Locations. The SA will be responsible for updating the national database system for changes in accreditation status. This is not considered a voluntary termination and does not require any action from the MAC or CPI/PEOG.

Conclusion

The existing process of enrollment and certification actions primarily follows the following process:
Provider/Supplier > MAC > SA > SOG > SA (and AO if applicable) > MAC >Provider/Supplier

With the streamlined initiative and the successful transition of these enrollment and certification activities, the process will be:
Provider/Supplier > MAC > SA (and AO if applicable) > MAC/PEOG >Provider/Supplier

We believe this will provide a more timely response to the needs of providers and suppliers and

reduce unnecessary burdens. **The SOP outlines the general processing instructions for all parties involved, and the addendums cover the provider/supplier differences and specific information. The SA is to continue to utilize the Form CMS-1539 (or comparable form for the AO) as the transmittal form for communicating recommendations to the MAC.**

Training

The streamlined enrollment and certification work outlined in this memorandum and SOP was provided on October 28, 2021. CMS recorded the training and distributed the training slides and recording through the Association of Health Facility Survey Agencies (AHFSA) for the SAs. Aforementioned, the CMS Locations will continue to remain copied for three months post-implementation to ensure a smooth transition and provide technical assistance to CPI/PEOG and the MAC.

Resources

CMS has developed a SOP attached to assist all involved parties in processing SNF certification transactions. The SOM updates will be updated according to the SOP later once the transition of the enrollment and certification processes has been completed for all applicable provider/supplier types. **An updated Form CMS-1539 transmittal and contact information** for the SAs, AOs, and MACs are available on the Quality, Safety and Oversight Group (QSOG) website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc

Contact: For questions or concerns relating to enrollment, please contact ProviderEnrollment@cms.hhs.gov. For questions or concerns relating to certification and the standard operating procedures within this memorandum, please contact QSOG_Certification@cms.hhs.gov.

Effective Date: Immediately. This information should be communicated with all survey and certification staff, their managers, and the State/CMS Location training coordinators within 30 days of this memorandum.

/s/

Karen L. Tritz Director, Survey & Operations Group	David R. Wright Director, Quality, Safety & Oversight Group

Attachments –
1- CMS Standard Operating Procedures- CHOW, Administrative Changes, Relocations & Initials
2- Skilled Nursing Facility Addendum to the Standard Operating Procedures

Attachment 1:
CMS Standard Operating Procedure (SOP) for
Enrollment and Certification Activities

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Purpose: The intent behind this Standard Operating Procedure (SOP) is to provide direction to the Survey Operations Group (SOG) (later referred to as CMS Locations), State Survey Agencies (SAs), Accrediting Organizations (AOs), and the Center for Program Integrity (CPI)/Provider Enrollment Oversight Group (PEOG) and the Medicare Administrative Contractors (MAC) as it relates to the processing of changes of ownership (CHOWs), administrative changes (name, address, branch locations, additional services, relocations, etc.), and initial surveys and enrollment.

We will not be changing the existing enrollment and certification activities for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Psychiatric Residential Treatment Facilities (PRTFs), and Nursing Facilities (NFs) as these providers are Medicaid-only and will continue to follow the existing processes. The SA will communicate directly with the State Medicaid Agency (SMA) for dually-certified facilities. This SOP also does not apply to non-certified providers/suppliers.
We are also not transitioning enrollment and certification activities for Critical Access Hospitals (CAHs), Religious nonmedical health care institutions (RNHCIs), Organ Procurement Organizations (OPOs), rural health clinics (RHCs), or Special Purpose Renal Facilities (SPRDF) as these are used in emergencies/disasters only. Any potential change to enrollment and certification activities of these providers/suppliers will be communicated in the future.

Additionally, the CMS Locations will continue to act as the SA for U.S. Territories (American Samoa; the Commonwealth of the Northern Marianas Islands; Guam and the U.S. Virgin Islands).

For all final determinations related to CHOWs, Administrative Changes, and Initial certifications, the CMS Locations will be copied on communications between the SA, AO, and MACs for **three months** or unless otherwise notified.

Background: CMS continues to conduct activities to simplify the enrollment and certification work. Specifically, CMS is streamlining some enrollment and certification functions for certified providers/suppliers to the CPI/ PEOG and the MAC. The process to date has consisted of streamlining the processing of voluntary terminations and cessations of business on July 27, 2020 (see Admin-Info 20-08-ALL-Revised), as well as enrollment of Federally Qualified Health Centers (FQHCs) on March 15, 2021 (see Admin-Info 21-06-ALL).

This SOP outlines general procedures in a standardized format for processing these activities. Enrollment aspects of the CHOW process are governed by the Medicare Program Integrity Manual (PIM), Chapters 10 and 15. **The MAC will continue to follow the timeframes and guidance specified in the PIM.**

Effective Date: The transition of certification enrollment work related to the processing of CHOWs, administrative changes, relocations, and initial certification will be released in segmented phases by provider/supplier type. The first segment will commence on January 3, 2022, for Skilled Nursing Facilities (SNFs). CMS will release subsequent provider/supplier types addendums at a later time. This guidance applies to applications received or recommendations for approval or denials made on or after January 3, 2022.

Appeals and Reconsiderations: If the SA determines for any of the enrollment and/or survey and certification activities in this SOP that the provider/supplier is determined not to be in compliance with Medicare requirements, the SA will notify the MAC. The MAC will take the appropriate action on the provider's enrollment and notify CPI/PEOG so that appropriate action may be taken with respect to the Provider's Agreement or other contract. **The MAC will be**

responsible for issuing one letter to the provider/supplier noting the appeal/reconsideration rights for the Provider Agreement and Provider Enrollment actions. (Refer to Part IV of this SOP for additional information).

Enforcement: The SA and CMS Locations will be responsible for processing any enforcement actions and any potential reconsiderations as the result of a denial based on non-compliance with the Medicare requirements.

National Database Updates: The SA and AO (if applicable) must use the CMS Form 1539 as a transmittal document to the MAC regardless of use of national database system (e.g. iQIES or ASPEN). *Note: iQIES does not have the CMS Form 1539. SAs and AOs should use the form provided with this SOP.*

PART I- CHANGES OF OWNERSHIP (CHOWs)

Applicability of CHOWs

The requirements related to CHOWs apply to the below listed providers and suppliers. Providers to which CHOW rules apply include (see 42 CFR 489.2):

- Hospitals;
- Skilled nursing facilities (SNFs);
- Home health agencies (HHAs);
- Hospices;
- Comprehensive outpatient rehabilitation facilities (CORFs);
- Clinics, rehabilitation agencies, and public health agencies (only for furnishing outpatient physical therapy and speech pathology services)- referred to as OPT/OSP;
- Community mental health centers (CMHCs) (only to furnish partial hospitalization services);

The CHOW requirements also apply to suppliers, which are subject to survey and certification provisions in 42 CFR Part 488. CMS processes CHOWs for supplier participants that have category- specific supplier agreements with the Secretary and/or for suppliers who file cost reports (ESRD facilities). Specifically:

- Ambulatory surgical centers (ASCs) - section 1832(a)(2)(F)(i) of the Act;
- Federally qualified health centers (FQHCs)- 42 CFR 405.2434
- End-stage renal disease facilities (ESRDs)– 42 CFR 413.198 (Cost Reports).

Portable X-Ray (PXR) suppliers and Transplant Programs are also included within these CHOW activities.

Changes of Ownership (CHOW) General Overview:

A change of ownership (CHOW) occurs when the responsible legal entity that was a party to the Medicare provider agreement (“Seller”) has changed, and the responsible new legal entity (“Buyer”) receives/accepts automatic assignment of the existing provider agreement (see 42 CFR 489.18). The responsible legal entity is the party having ultimate responsibility and liability for the operational decisions of the institution.
A CHOW may involve any transfer of a provider or supplier even if no money changes hands – the terms “Seller” and “Buyer” are used for convenience. The MAC determines if the transaction is a potential CHOW.

A CHOW (i.e. when there is automatic assignment to the new owner of the existing Medicare agreement), per se, does not require a survey. See additional information under the CHOW checklist related to identifying CHOW versus initial certification.

A Buyer is assigned the existing provider/supplier agreement and its corresponding CCN if the Buyer purchases a participating provider organization and **does not reject** automatic assignment of the existing agreement. A CCN cannot be sold. A CCN is not the "property" of any individual or legal entity. The CCN is issued by the Medicare program and is under the control of the Secretary of DHHS, subject to law, regulation, and program policy (See Section II of the SOP for buyers who do not reject automatic assignment; Section III provides details if the automatic assignment is rejected).

SECTION I- General Processing Instructions (If a New Owner Does Not Reject Automatic Assignment)

A provider or supplier contemplating or negotiating a CHOW transaction must notify CMS, which should be within 60 days prior to a planned transaction. See 42 CFR 489.18 or 42 CFR 424.550 for prohibition on the sale/transfer of billing privileges. A notice of intent of a CHOW (separate from the formal submission of the Form CMS-855) does not trigger the general process and steps noted below under this section. The following steps are taken once the CMS-855 form is submitted **and after the legal transaction has taken place**.

Step #1: A CHOW situation begins with the respective Buyer (new owner) accepting receiving assignment of the provider agreement submits the CMS-855 to the MAC. The CMS-855 may be submitted by both the Seller and Buyer either online through PECOS or the appropriate paper CMS-855 no earlier than 90 days prior to the anticipated legal transaction. In effect, therefore, this means that the provider should submit its CHOW application between 30 and 90 days prior to the effective date. In accordance with 42 CFR 424.516(e)(1), the enrollment application must be submitted within 30 days of the change, or CMS may impose penalties on the provider or supplier. In the event the MAC only receives the Buyer's CMS-855, the MAC can proceed without the Seller's documentation. Note, the MAC cannot proceed with only the Seller's documentation as the MAC should ascertain that the Buyer does not reject automatic assignment.

Step #2: The MAC will review the CMS-855 for completeness in accordance with PIM instructions.

Step #3: Once the MAC determines that the CMS-855 is accurate based on enrollment criteria, the MAC will provide its recommendation via email to the SA and the AO (if applicable) and include the PECOS Application Data Report (ADR) or paper CMS-855, including the legal documentation (Bill of Sale, etc.) of the CHOW and any additional documentation provided by the Buyer/Seller. **The recommendation and documentation should only be sent to the SA and the AO (if applicable) after the CHOW transaction has occurred and the legal documentation is complete and signed by both parties.**

> **NOTE:** The MAC will verify deemed status and identify the AO based on the information listed on Section D of the CMS-855A (Section E for CMS-855B) to provide communication to the AO when applicable. However, AOs will not be directly involved in the processing of CHOW situations unless contacted by the SA for a need for a survey as part of the CHOW package.

Step #4: Once the SA receives the MAC enrollment recommendation, the SA will review the CHOW package within 30 days of receipt from the MAC. The CHOW Package must include the following:

- Legal Documentation of CHOW- the legal documents that governed the CHOW transaction, sale, or transfer of the Medicare-participating facility from the seller to the buyer, as applicable to the federal CHOW process (separate from any additional licensure requirements).
- Evidence of the provider's successful electronic submission of the Form HHS-690 through the Office of Civil Rights (OCR)* portal, as applicable.
- Provider's signed CMS-1561, CMS-1561A, or CMS-370, as applicable.
- Request for certification in the Medicare program, appropriate to provider/supplier type (i.e., CMS-1572, CMS-377, CMS-3427, CMS-29, CMS-671, etc.).
- The National Provider Identifier (NPI) number (may be directly on the CMS-855, however should include the proof of documentation that this number was issued).
- Other applicable provider/supplier specific documents as outlined in Section V.

IMPORTANT NOTES:

- If any of the above documentation is missing from the CHOW package, **it is the responsibility of the SA to obtain the required documents from the provider/supplier.**

- **OCR*:** Before an agreement is executed with a provider to participate in the Medicare program or with a provider undergoing CHOW, there must be a determination of compliance with civil rights requirements. OCR conducts necessary investigations and makes determinations related to compliance with the requirements. For OCR attestation, a prospective provider that applies for initial certification in the Medicare program or a buyer of a provider undergoing a CHOW must receive a clearance from OCR noting compliance with the requirements under 42 CFR 489.10(b). To process CHOW requests, the buyer of a current Medicare provider undergoing a CHOW must send a copy of the electronic verification from the OCR to the SA, or if this is a CHOW of an IHS or Tribal-owned provider, the buyer must send a copy of the electronic verification from the OCR to its CMS Location.

- **CHOW and Additional Changes**: In situations where a buyer (new owner) wishes to add additional services (or relocate) as part of the CHOW, the SA must identify if a survey is to be conducted **prior to** sending their recommendation for approval of the CHOW to the MAC. For additional information on relocations, refer to Part II of this SOP.

Step #5: After the SA has completed its review, the SA will either:

1) Recommend approval of the CHOW (Step #5A to end); or
2) Recommend denial/non-approval (Step #5B only).

Step #5A: If the SA recommends approval, the SA will send the CHOW package (documents listed above via email) to the MAC with their recommendation to proceed via the CMS-1539. The SA is expected to complete its review within 90 days from receipt of the MAC documentation. If there are circumstances in which the SA would exceed 90 days, the SA is responsible for notifying the MAC of the delay.

The SA must also confirm that the CHOW package identifies if there are any associated changes related to the services provided or the location of the buyer as part of the review. This information is captured on the applicable request for certification in the Medicare program (i.e., specific provider/supplier forms- CMS-1572, CMS-377, CMS-3427, CMS-29, CMS-671, etc.).

Step #5B: **If the SA DOES NOT recommend approval**, the SA will notify the MAC via the CMS-1539 (including justification for non-approval). The MAC will notify CPI/PEOG, who will review the CMS-1539. CPI/PEOG will make the final determination and notify the MAC, who will then provide the notification to the Seller/Buyer. The notification should include a copy to the SA, MAC, and AO (if applicable).

> **NOTE:** If the SA recommends denial, this usually is because the transaction was not considered to be CHOW situation.

Step #6: Once the MAC receives **the SA recommendation for approval of the CHOW,** which confirms that the request is a CHOW, the MAC will provide the approval recommendation and copy of the draft provider letter to CPI/PEOG.

CPI/PEOG will sign the provider/supplier agreement or attestation statement (see provider-specific addendums for specific documentation) and return the information to the MAC to finalize the application. The MAC will send the provider approval letter to the SA and AO (if applicable).

> **NOTE:** The CMS-1539 replaces the tie-in-notice.

Step #7: The CPI/PEOG will update the national database to reflect the new ownership information based on the MAC notification letter (Step #6).

SECTION II- General Processing Instructions (If a New Owner Rejects Automatic Assignment)

General Instructions for Providers/Suppliers

A new owner (Buyer) may timely reject automatic assignment of the existing provider or supplier agreement, which means that the existing provider or supplier agreement of the Seller is voluntarily terminated effective on the date of ownership transfer. This is not a CHOW.

In these circumstances, if the Buyer wants to be certified to participate in Medicare or Medicaid programs, the Buyer must enroll as an initial applicant, which will follow the procedures outlined under Part IV- Initial Enrollment. The MAC will notify the Buyer that it is the responsibility of the new owner (Buyer) to submit an application for enrollment/initial certification. There is no appeal process for a voluntary termination if the buyer rejects automatic assignment of the agreement.

Additionally, the Seller would be processed using the Voluntary Termination SOP. The Seller would need to submit the CMS-855 to the MAC to have the provider or supplier agreement terminated. The MAC will notify the Seller that the provider agreement has been voluntarily terminated and copy the SA, the CMS Location, CPI/PEOG, and the AO (as applicable) via email.

SECTION III- General Information

The below outlines general information related to actions in CHOW situations; however, there may be additional information in the by-provider addendums.

A. Deemed Providers and Suppliers & CHOWs

Currently, the majority of CHOW situations within facilities do not require compliance surveys, and the SA is required to verify state licensure and other information per Step #4 (and by-provider addendums). Therefore, AOs will be copied on communications of approval/denial from the MAC to the provider/supplier **(per Part I, Section I, Step #6).** The MAC should verify the AO either directly from the CMS-855.

B. Situations which May or May Not require a Survey

In a CHOW situation where the new Owner/Buyer does not reject (i.e. accepts) assignment, generally, no survey would be conducted as the new Owner/Buyer is accepting the organization "as is" (which would result in no changes to staff, building, operations, etc.). However, if the SA or AO determines there are quality of care or other concerns or in the event the CHOW includes staff or building changes, this may trigger a survey to be conducted.

The SA or AO (if applicable) determines the need for survey in a CHOW situation upon receipt of the MAC recommendation and during its review (Step #4). For deemed facilities, the AO would conduct a survey for compliance after the CHOW occurs. **AOs will now be copied on all communications by the MAC and SA. The AO may survey its accredited facility at any time without impact to the CHOW process. If the SA determines quality concerns may be present during the CHOW review, it may reach out to the AO to survey and/or survey the facility itself.**

The MACs do not make the determination on survey needs. The MAC must wait until it receives the recommendation from the SA or AO (if applicable), per Part I, Section I, Step #5B or 6.

Surveys are at the discretion of the SA or AO (if applicable) for CHOW situations. Situations in which a survey may be conducted include but are not limited to the following:

- Relocation associated with a CHOW situation (including Part II, Sections II & III of the SOP-Administrative Changes);
- Merger/Acquisitions;
- Facility history of non-compliance;
- SA concerns that the quality of care has/may decline.

C. CHOWs versus Provider Agreement Termination

- In a CHOW situation, the provider agreement is automatically assigned to the new owner/Buyer (see Part I, Section I). The Buyer is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued (42 CFR 489.18(d)).
- However, the Buyer has the option to reject the automatic assignment of the agreement (see Part I, Section II) and may choose to enroll in Medicare as an initial applicant and seek initial certification. If the Buyer makes that choice, then the old owner's/Seller's enrollment application must be processed as a voluntary termination of the existing Medicare provider agreement effective the date of the transaction/sale/transfer of ownership or operations.
    - o In this circumstance, the Seller will be required to submit a CMS-855 voluntary termination application which will be processed by the MAC. In the event the

Buyer rejects automatic assignment, and the MAC does not receive the Seller's CMS-855, the MAC must reach out to the Seller for this information. The voluntary termination will be effective the date the transaction (legal date of transaction) occurred.

- It is critical the SA be involved in the event patients require transfers in order to ensure necessary transfers are conducted prior to the effective date of the voluntary termination of the Seller.

D. Acquisitions & Mergers

An acquisition occurs when a currently enrolled Medicare provider is purchasing another enrolled Medicare provider and then makes the acquired provider a part of the acquiring provider. Often termed a "merger," this is an acquisition-combination of Medicare providers, defined below (see SOM Chapter 3, section 3210).

Acquisition-Combination of Medicare Providers - When the direct owner or entity in direct control of existing Medicare Provider A purchases or otherwise acquires direct control of a second Medicare Provider B and then seeks to combine the two providers under Provider A's Medicare provider agreement and CCN. In order for an acquisition-combination to take place, the providers must meet the specific rules for that provider type and must integrate into a single entity under a single Medicare provider agreement. The change in the direct owner or legal entity in control of Medicare Provider B will be a CHOW situation for Medicare Provider B.

These transactions involve at least two distinct, certified facilities (e.g. two hospitals). In an acquisition-combination of two certified facilities, one CCN will be retired, and that location will usually become a practice location for the surviving CCN. The surviving facility, Medicare Provider A in the example above, must accept the assignment of Medicare Provider B's provider agreement. Medicare Provider B's CCN is retired, and its provider agreement is subsumed into that of the new owner, Medicare Provider A. Only Medicare Provider A's CCN and tax identification number remain.

In short, if the two facilities are originally owned by two different legal entities, a CHOW must occur first because there must be common ownership before a combination can occur.

If two facilities already have the same owner, the combination can occur because there is already common ownership. This is not a CHOW, just a combination of two providers into one.

> **NOTE**: If Medicare Provider A rejects assignment of Medicare Provider B's Medicare agreement, then Medicare Provider B is considered to be voluntarily terminated from the Medicare program. A survey of the terminated location (by the SA or AO, if applicable) is required before Medicare Provider A can be reimbursed for services provided at that location.

E. Relocation versus CHOW (See Part II –Administrative Change- of this SOP for additional information)

- A new owner (buyer) may propose to relocate the provider/supplier concurrent with the CHOW.

- In the event the MAC identifies that the new owner (buyer) wishes to relocate as part of the CHOW (e.g. CMS-855), the MAC will provide this information to the SA (via email)

and AO (if applicable) to make a determination on whether or not a survey is required; or whether a CHOW package can be approved without survey. The SA or AO (if applicable) may determine this by reviewing the documentation and asking the following questions, at a minimum:
    - Is the facility serving the same population (i.e. mileage range, same geographic area, etc.)?
    - Is the facility utilizing the same personnel?
    - Is the facility providing the same or similar services?

- **If one or more of above questions are answered "yes,"** then this would be considered a CHOW and relocation determined by the SA. Generally, if the same population, same personnel, same services, etc., exists, the SA or AO (if applicable) may be able to approve the relocation without an onsite survey. In this case, the SA will follow the steps outlined in Part I, Section II above related to processing CHOWs AND include both the approval recommendation for the CHOW and for the relocation (Part II, Section II of the SOP) in the package to the MACs. This will only occur if the new owner (Buyer) **does not reject** automatic assignment of the provider agreement. It is the SA's responsibility to provide both the CHOW and relocation approval recommendation to the MAC at the same time on one CMS-1539 form. The SA must ensure the CMS-1539 clearly states that the CHOW included a relocation that is approved as part of the CHOW.

- **If any answer to the questions above is "no" or "unknown,"** the SA will request additional documentation from the provider/supplier, potentially schedule a survey, and/or recommend denial to the MAC.

SECTION IV- CMS Certification Numbers (CCNs) & Effective Dates

A. CMS Certification Number (CCN) - General Guidance

For CHOWs in which the new owner/buyer receives automatic assignment of the provider agreement, the CCN will generally remain the same. **CPI/PEOG is required to verify the additional CHOW information and update the national database system** with any other administrative changes (e.g. name change; address change; etc.).

CCN's are "smart numbers," which indicate the type of provider or supplier to which they are assigned. If that status changes as a result of the CHOW, then the CCN will also have to change.

For ownership transfers in which the new owner/buyer **rejects** the automatic assignment and the MAC is notified by the SA (See Part I, Section II), the MAC will process this in accordance with existing guidelines on Voluntary Termination in the PIM. For additional information, please refer to the Voluntary Termination SOP.

B. Effective Dates- General Guidance

- In general, a CHOW recognized by the Medicare program is considered to have taken place at 12:01 a.m. on the date specified (i.e., in the first minute of the 24-hour day). Legal responsibility and the right to payment changes over when the clock moves past midnight into the CHOW effective date. (See TDL-210006 *Processing Medicare Part A Provider CHOWs and Terminations,* issued to the MACs on 10-05-2020)

- Providers/Suppliers must provide notice to CMS related to a prospective CHOW. In every case, the SA and MAC must wait to process the CHOW until after the legal transaction of the CHOW has taken place. **The MAC should follow existing guidance on setting the effective dates (refer to PIM, Chapter 10).**

- If the new owner rejects assignment, the CCN that is associated with the rejected agreement (the Seller's) also terminates effective on the date of the ownership transfer.

SECTION V- By-Provider/Suppliers Differences

The below provides the general overarching guidance and forms related to specific providers and suppliers. We note additional information will be found in each addendum.

NOTE: For all Questionable Transactions, the MAC should send/coordinate with the SA and/or CMS (CPI/PEOG).

A. **Ambulatory Surgical Centers (ASCs):**
For ASCs, the CHOW package includes the following documents: CMS-855B - Enrollment Application; Legal Documentation of CHOW; CMS-377 - ASC Request for Certification in the Medicare Program; CMS-370 - ASC Benefits Agreement.

B. **Comprehensive Outpatient Rehabilitation Facilities (CORF)**
For CORFs, the CHOW package includes the following documents: CMS-855A - Enrollment Application; Legal Documentation of CHOW; CMS-359 - CORF Report for Certification to Participate in the Medicare Program; CMS-1561 - Benefits Agreement; and confirmation of eOCR Submission.

C. **Community Mental Health Centers (CMHCs)**
For CMHCs, the CHOW package includes the following documents: CMS-855A - Enrollment Application; Legal Documentation of CHOW.

D. **End-Stage Renal Disease (ESRD) Facilities**
For ESRD facilities, the CHOW package includes the following documents CMS-855A - Enrollment Application; Legal Documentation of CHOW; CMS-3427 - ESRD Application/Notification and Survey & Certification Report. The MAC will also need to verify the number of In-Center Hemodialysis Stations and modalities (In-Center Hemodialysis; In-Center Peritoneal Dialysis; Training and Support for Home Hemodialysis; Training and Support for Home Peritoneal Dialysis (CAPD/CCPD)).

E. **Hospitals**
For hospitals, the MAC must verify that the CHOW package includes the following documents: CMS-1539 - Certification & Transmittal; CMS-855A - Enrollment Application; Legal Documentation of CHOW; CMS-1561 - Benefits Agreement; Confirmation of eOCR Submission. The CHOW package must also identify if the Hospital has Excluded Units (Rehabilitation Unit; Psychiatric Unit; Swing Beds) or a Transplant program. Note: Transplant programs are included as part of a hospital CHOW. Transplant programs cannot undergo a CHOW outside of the hospital, as it's not a separate provider; it's a service of the hospital.

F. **Home Health Agencies (HHA)**
For HHAs, the MAC must verify that the CHOW package includes the following documents: CMS-1539 - Certification & Transmittal; CMS-855A - Enrollment Application; Legal Documentation of CHOW; CMS-1572 - Home Health Agency Survey

& Deficiencies Report; CMS-1561 - Benefits Agreement and confirmation of eOCR Submission. The CHOW package must also identify if the HHA provides any of the following services: Skilled Nursing; Physical Therapy; Speech Therapy; Occupational Therapy; Medical Social Services and Home Health Aide Services (see Form CMS-1572).

NOTE: For HHAs, unless an exception under 42 CFR 424.540(b)(2) applies, CHOWs may only occur 36 months after the effective date of the HHA's initial enrollment or most recent change to majority ownership. HHAs may not undergo a CHOW (the provider agreement and billing privileges do not convey to the new owner) within 36 months of their initial enrollment. Additionally, for HHAs with branches that fall under the parent's Medicare provider agreement and CCN, **if a new owner rejects automatic assignment** of the existing Medicare agreement, the HHA, including its branches, is terminated. (Refer to the HHA addendum for additional information).

G. Hospice

For Hospices, the MAC must verify that the CHOW package includes the following documents: CMS-1539 - Certification & Transmittal; CMS-855A - Enrollment Application; Legal Documentation of CHOW; CMS-417 - Hospice Request for Certification in the Medicare Program; CMS-643 - Hospice Survey & Deficiencies Report; CMS-1561 - Benefits Agreement and confirmation of eOCR Submission.

NOTE: For Hospices, multiple locations fall under the parent Hospice's Medicare provider agreement and CCN. The provider agreement of the hospice, including its multiple locations, terminates **if a new owner rejects automatic assignment** of the existing Medicare agreement.

H. Skilled Nursing Facilities (SNF)- Long- Term Care

SNF CHOWs often take the form of a new operator. The documentation of the CHOW transaction is the operating transfer agreement, from the old operator to the new operator. This is still a CHOW. Even though the operator does not own the building, it is still the entity with legal responsibility for the operation of the nursing home provider itself.

For SNFs, the MAC must verify that the CHOW package includes the following documents: CMS-1539 - Certification & Transmittal; CMS-855A - Enrollment Application; Legal Documentation of CHOW; CMS-671; CMS-1561 - Benefits Agreement and confirmation of eOCR Submission; Patient Transfer Agreement that shows the buyer as a party to the agreement and outlines procedures for a hospital to admit the nursing home residents when they need acute care (§ 483.70 (j)).

I. Federally Qualified Health Centers (FQHCs)

For FQHC's, the MAC must verify that the CHOW package includes the following documents: CMS-855A - Enrollment Application; Supporting Legal Documentation that a CHOW occurred. The CHOW Package should also include HRSA Grant Information (HRSA Grant should have the name of the new grantor/new Buyer).
The following constitutes an FQHC CHOW (42 CFR § 405.2444):

(1) Incorporation. The incorporation of an unincorporated FQHC constitutes a CHOW.
(2) Merger. The merger of the FQHC corporation into another corporation, or the consolidation of two or more corporations, one of which is the FQHC corporation, resulting in the creation of a new corporation, constitutes a CHOW. (The merger of another corporation into the FQHC corporation does not constitute a CHOW.)

(3) Leasing. The lease of all or part of an entity constitutes a CHOW of the leased portion.
NOTE: For FQHCs, no CMS-1539 will accompany the CHOW package as there is no SA involvement. Once the MAC has conducted the initial review of the FQHC CHOW, CPI/PEOG will conduct the final review and make the final determination.

J. Portable X-Ray (PXR)
For PXR, the MAC must verify that the CHOW package includes the following documents: CMS-1539 - Certification & Transmittal; CMS-855B - Enrollment Application; Legal Documentation of CHOW; CMS-1880 - Request for Certification as a Supplier of PXR Services under the Medicare Program.

K. Outpatient Physical Therapy/Speech Pathology (OPT/SP)
For OPT/OSPs, the MAC must verify that the CHOW package includes the following documents: CMS-1539 - Certification & Transmittal; CMS-855A - Enrollment Application; Legal Documentation of CHOW; CMS-1856 - Request for Certification in the Medicare and/or Medicaid Program to Provide Outpatient Physical Therapy and/or Speech Pathology Services; CMS-1561 - Benefits Agreement and confirmation of eOCR Submission.

OPT/OSP providers often have extension sites. Refer to the specific addendum.

SECTION VI- Important Reminders

- General Rule: CMS does not allow parties to use complex legal agreements to circumvent the CHOW rules, which apply to all providers and those suppliers subject to survey and certification. Specifically, a new owner may not both reject assignment of the provider/supplier agreement and its responsibilities yet still obtain the uninterrupted Medicare participation provided by a CHOW.

- In the event of a cessation of business (generally over 30 days of closure), the SA will review and consult as needed with the SOG location. There can be no CHOW, i.e., transfer of Medicare certification, assignment of the provider agreement, and transfer of the CCN if there is no functioning provider enterprise in existence. If a provider ceases operations, it is considered a cessation of business and would be treated as a voluntary termination. Cessation of business situations will be reviewed and managed on a case-by-case basis by the SA.

- Temporary Closures will be reviewed by the SA and SOG Locations on a case-by-case basis. If a provider anticipates more than 180 days on their initial request of a temporary closure, the SOG location will generally deny the temporary closure and advise the provider to submit a voluntary termination. For requests greater than 30 days, a Tie-Out Notice is submitted to the Medicare Administrative Contractor (MAC), authorizing the anticipated time-period the Provider will be non-operational. Submitting the Tie-Out notice prevents claims from being filed in error when the provider is non-operational.

- A provider sometimes experiences an addition or deletion of personnel, not under a partnership, but a CHOW does not occur. In these instances, the MAC will generally process the changes without SA involvement, per Chapter 10 of the PIM.

- In a CHOW, no payment goes to the new owner's bank account until CMS has approved the CHOW. Until that process is complete, payments to the provider will continue to go to the prior owner's bank account. The parties to a sales or other transfer agreement must provide for the distribution of payments issued during the CHOW processing period for services after the effective date of the CHOW. If the new owner wants all payments to go to its own bank account, it should begin submitting claims after the MAC notifies it that the CHOW processing is complete. See PIM, Chapter 10.

- For U.S. territories, the steps outlined under the processing section for Section I and Section II above still apply, however the CMS Locations will be responsible for processing CHOWs with the MAC and CPI/PEOG in lieu of the SAs.

Part II –Administrative Changes

Section I- General Information

Many enrollment and certification actions are not CHOWs. These situations are generally when a provider/supplier changes names, not due to a CHOW, or there is an administrative update to the provider agreement. All of these activities, with the exception of ESRD additional services/modalities, will require submission of the CMS-855.

The MAC currently processes address changes (not relocations) and name changes without requiring review/recommendation for approval by the SA and AO (if applicable). **The MACs use existing practices for making determinations for actions that do not require SA or AO involvement. In cases where uncertainty exists for address changes or name changes, the MAC should consult with the SA or AO, as applicable.** In general, for these two administrative changes, the MAC will process the transactions without involvement from the SA or AO unless the request appears to have additional associated changes listed in Section II below. In these instances, the MAC must copy the SA and AO (if applicable) in any communications or approval (as licensure information may need to be updated). For approvals issued by the MAC, the SA will be responsible for updating the national database, and AOs will update ASSURE as required.

- **Address Change (Not Relocation):** An address change which is not a relocation may be as a result of street name changes; zip code changes; suite number changes, but not a change to physical location.

- **Name Changes**: Name changes of an organization may occur that are not as a result of a CHOW, but rather changes of Owners (see Part I, Section I.B.). These may be changes to the owner's information or the organization name as a whole.

Section II- Defining Administrative Changes

As CMS streamlines some of the activities to CPI/PEOG and the MAC, these administrative changes will be captured within each provider/supplier type addendum as it applies. There are specific processes for these changes, which will be highlighted in the provider/supplier addendum. The below provides only a general overview of administrative changes, which are not CHOWs (Part I) or Initial Certification/Enrollment (Part III). For the below activities, which the MAC will not automatically process, the MACs will send a recommendation for approval to the SA or AO. Recommendations of approval by the MAC require SA or AO action as outlined below within Part II of this SOP.

Adding/Removing Sites, Services, or Locations:

- **Additional Sites (Practice Locations)**: CORF, HHAs, Hospitals, Hospices, PXRs, and OPT/OSPs may request additional practice locations. Additional locations of these providers and suppliers are part of the parent company/organization but are at another location. Additional services are usually added when a provider/supplier requests an additional location/site or extension location but may also arise at the parent/primary site. An organization may apply to CMS for approval of another location near the primary/parent site for the purpose of providing additional access to care.
  NOTE: For provider/suppliers who "drop" or wish to close an additional location or site, the provider/supplier would send the request to the MAC in a CMS-855, or the SA may advise the MAC by completing the CMS-1539. For deemed providers/suppliers, communications may also be from the AO to the MAC (copying in the SA) via a comparable CMS-1539 notification. (Generally, closure/dropped locations will be processed as voluntary terminations of the location- **but not the entire CCN/provider**).

- **Branch Location for HHAs:** A branch office is an approved location or site from which an organization provides services within a portion of the total geographic area serviced by the parent organization. These branch locations are required to furnish information on the form CMS 855A identifying the geographic area(s) where health care services are rendered. There will be circumstances in which a branch office/location will need to be added or removed.

- **Extension Locations (Extension Sites) for OPT/OSPs:** These locations are additional practice locations; however, they are only applicable to rehabilitation agencies. These locations are defined in 42 CFR 485.703. Note, for OPT/OSP, these are similar to the branch locations but are called extension sites.

- **Multiple Locations for Hospices:** When an existing Hospice intends to add a multiple location, it must notify the SA and submit a CMS 855A. Multiple locations for Hospices are similar to HHA branches.

- **Expansions/Removal and Change in Modalities and Services for ESRD Facilities:** These changes are only applicable to ESRD facilities. When an ESRD facility wishes to increase the number of its approved in-center dialysis stations or add a modality/service, it must submit a new Form CMS-3427 ESRD Application and Survey and Certification Report to the applicable SA. The dialysis facility must specify the service requested or the number of additional stations requested and include evidence that adequate space is available for the stations in consideration of safety and infection control and a summary explanation of any building renovations that will be necessary for the addition of stations. (See SOM Chapter 2, Section 2280 - ESRD Survey Activities).
  - This is the only administrative change that does not require a CMS-855 to be sent to the MAC. The provider/supplier will be required to submit the CMS 3427 form to the SA and AO (if applicable) who will review, determine survey needs, and recommend approval/denial to the MAC. (The steps will follow the general SOP guidance in Part II, Section III, but begin at Step #5 once the SA and AO (if applicable) receives the ESRD facility request). The SA and AO (if applicable) will need to notify the MAC of a change in modalities and services via the CMS-1539 (comparable for AO).

- The MACs need to update relevant information for billing purposes, therefore will send the final approval/denial letter to ESRD facility consistent with the steps below.

Cessation of Business:
There are instances in which surveyors may arrive at a facility to conduct a re-certification survey and find that there are no patients or the organization is no longer at the location on the CMS-855. If a provider relocates and is no longer the same provider (different staff, services, patients), then it is a cessation of business (voluntary termination).

Change in Location/Relocation:
A change in location or relocation that is outside of the primary approved site or change in a location outside of the existing geographical area is considered a relocation of a provider/supplier. A relocation request must ensure that patients will continue to receive uninterrupted service during the relocation. A relocation may or may not need a survey.
NOTE:

- If a provider/supplier requests a change in a location that is out-of-state, this is not a relocation but must be processed as a voluntary termination, and the provider/supplier would need to be processed as an initial applicant (initial enrollment).
- As part of the steps outlined in Part IV, if the SA is denying the relocation of a main site, this is considered a termination. If it's an additional site denial (extension, branch, and multiple location), then there's no termination. **The MAC will follow PIM guidance in Chapter 10 related to denials.**

The following "Administrative Changes" will remain a responsibility of the CMS Locations and SAs to review and process

- **Conversions:** Provider conversions such as Hospital to CAH; RHC to FQHCs, or OPTs to CORFs will remain the responsibility of the CMS Locations and SAs.

- **Temporary Closure**: If the organization undergoes a temporary closure, due to repairs, remodeling, or facility emergency for a period of time; it must notify the SA in writing. A temporarily closed facility may not retain its Medicare participation indefinitely. At the time of the temporary closure, the facility provides a projected date for resumption of services. The projected time frame for closure must be consistent with the repairs, renovation, or any other information supporting a "temporary" closure. Depending on the duration, closure may be viewed as a cessation of business (voluntary termination of the Medicare CCN). The facility may be asked to submit periodic progress reports to the SA as to whether the projected re-opening remains the same. Temporary closures will be reviewed by the SA and CMS Location. **AOs may not approve temporary closures. In the event of a deemed facility requesting temporary closure, the provider/supplier must be redirected to the SA.**

Section III- General Processing Instructions for CMS

While some documentation may vary based on the type of administrative request, the steps below provide a general overview on how the documentation will be processed by the responsible parties (SA, AO (if applicable), CPI/PEOG, and the MAC). Additional information for these actions will be outlined in the applicable provider/supplier addendums.

Step #1: An "administrative change" situation begins with the respective provider/supplier submitting a revised Form CMS-855A or CMS- 855B to the MAC. The CMS-855 is commonly

submitted online through PECOS, there are still times in which the application comes in paper-based. In the majority of administrative changes, the submission of the Form CMS-855 occurs after the change has been completed by the provider/supplier, with exception of adding stations/modalities (ESRD).

> **NOTE:** For ESRDs, a request for Removal and Change in Modalities and Services is completed via the CMS-3427 Form, not the CMS-855 (refer to ESRD addendum, when released). For this change, the communication will start from the provider to the SA or AO (if applicable).

Step #2: The MAC will review any applicable enrollment requirements per PIM Chapter 10 and then the CMS-855 for completeness.

Step #3: Once the MAC determines that the CMS-855 is accurate based on enrollment criteria, the MAC will provide its recommendation to the SA and the AO (if applicable) and include the CMS-855 with the package. The MAC will determine the AO based on the information listed in Section D of the CMS-855A (Section E for CMS-855B).

Step #4: Once the SA (or AO for deemed facilities) receives the MAC recommendation, the SA or AO will review the package within 30 business days to determine if the request is an administrative change.

Each of these requests requires that the CMS-855A or CMS-855B is submitted to the MAC (with the exception of temporary closures and ESRD removal and change in modalities and services). Additional documentation for each administrative change is further outlined in the applicable by-provider/supplier addendums, as transitioned.

Step #5: Upon initial review, the SA or AO (if applicable) will either:

> **5a) Schedule a survey** to determine if the administrative change meets the requirements (Follow Steps #6A to end);
>
> **5b) Proceed with a recommendation of approval without a survey** (Follow Steps #6B to end); or
>
> **5c) Recommend denial** of the administrative change (Step #6C only). **AOs must copy the CMS Location and SAs in their recommendation for denial directly to the MACs.**
> Denials recommended by either the SA or AO would generally be based on non-compliance with the Medicare conditions or issues related to licensure. (See Step #6C for additional information)
>
> **NOTE:** If the MAC receives the CMS-855 application from the provider/supplier but has not received the SA's or AO's recommendation within 90 business days, the MAC will process the application and make a recommendation of approval or denial to the SA. While the MAC has received the CMS-855 from the provider/supplier directly or via the SA (Step #1), it will still be required to wait for the SA or AO approval or denial before processing any of these administrative changes, unless it is a name change or address change directly reported to the MAC.

Step #6A: **If the SA or AO concludes that circumstances DO warrant a survey**, the SA or AO (if applicable) will schedule an onsite survey and will make no further findings until a survey has been completed (Follow Steps #6A to end).

NOTE: SA surveys are scheduled based on the Mission & Priority Document. For AO surveys, the AOs are not held to the MPD requirements. However, **the AO must communicate *intent* to survey to the SA and CMS Location within 30 business days.**

Step #6B: **If the SA or AO concludes that circumstances DO NOT warrant a survey but recommends approval**, the SA or AO will send their recommendation and any relevant information provided by the provider/supplier to the MAC via the CMS-1539 (or comparable form for AOs) within 30 business days. For deemed facilities, the AO must copy the SA on communications to the MAC. (Follow Steps #6B to end). The CMS Locations retain the authority to review AO certification recommendations at any time.

Step #6C: If the SA or AO recommends denial, the SA or AO will provide the MAC with the denial recommendation. The MAC will process the application denial in accordance with PIM guidance. For deemed facilities, the AO must copy the SA and CMS Location on communications to the MAC. The CMS Locations retain the authority to review AO certification recommendations at any time.

> **NOTE:** If the administrative change was not approved for reasons related to lack of documentation, findings of non-compliance, etc., the SA or AO will follow up with the MAC, who will follow PIM procedures regarding denials.
>
> A denial of an administrative change may be a denial of a certification action. For example, if the SA/AO recommends denial of the relocation because the provider/supplier is not serving the same community/population, it would be considered a cessation of business and would be processed as a voluntary termination.

No changes are required in the national database system until the voluntary termination has been processed.

(Steps #7 through end do not apply to denials)

Step #7: The SA will send the recommendation of approval to the MAC via the CMS-1539. For deemed facilities, the AO will send the recommendation of approval to the MAC via a comparable CMS-1539 form, copying the SA.

Once the MAC receives the recommendation of approval from the SA or AO (if applicable), the MAC will review the documentation in accordance with the requirements in the PIM.

Step #8: The MAC will notify the CPI/PEOG, who will update the national database system. The CPI/PEOG should enter all applicable information into the national survey data system simultaneously with the release of the approval letter. (See Part II, Section V- National Database Updates, CMS Certification Numbers (CCNs) & Effective Dates)

Step #9: The MAC will then send the provider/supplier the approval letter and forward a copy of the approval letter to the appropriate SA, AO if applicable, and CPI/PEOG. The approval letter to the provider/supplier must include the assigned Federal branch ID number if this is part of a Branch or Extension site, which the MAC will obtain from CPI/PEOG.

Section III- Determining Survey Needs (SA and AO (if applicable) Responsibility)

Upon receipt of a provider's/supplier's request of an administrative change, the SA and AO (if applicable) will review and make a determination on whether or not a survey is required prior to sending any information or recommendations to approve the transaction to the MAC (see step-by-step process). The SA or AO (if applicable) may consider at a minimum the following for determining a survey based on the requested change:

- Is the change within the same geographical area?
- Does the change impact beneficiaries?
- Is the change purely administrative, such as name change?
- If adding or removing locations or there is a cessation of business, what is the impact to beneficiaries?
- Are there new services being provided?
- Is the same staff used?
- What is the facility's past compliance history?;
- Any open enforcement actions against the provider/supplier?
- Are the modalities appropriate for the needs of the patients it accepts for service?

NOTE: The SA and AO may have additional criteria for determining survey needs.
For U.S. Territories: The steps outlined under the processing section (Section II above) still apply, however the CMS Locations will be the responsible for processing administrative changes with the MAC and CPI/PEOG in lieu of the SAs. If the provider/supplier is deemed by a CMS-approved AO, the AO will coordinate with the CMS Locations in lieu of the SAs.
For Accrediting Organizations: For providers and supplier which are deemed (Hospitals, CAHs*, ESRD facilities, HHAs, Hospices, RHCs*, OPTs, ASCs) by a CMS-approved accrediting organization (AO), the provider/supplier will request an administrative change following the same process as outlined above.

The MAC will include the AO on recommendation communications to the SA. The AO will communicate recommendations for approval or denial directly with the MAC; however, they will **copy the SA on all communications. For recommendations of denials, the AO must copy the CMS Location on all communications. It is the responsibility of the SAs to update the national database system as applicable/needed for deemed activities once copied by the AO.** The SA may contact the CMS Locations in the event there is any uncertainty on an AO's recommendation of approval or denial. **The CMS Locations retain the authority to review AO certification recommendations at any time.**

We are also requesting that all AOs use a comparable form (per 488.5(a)(4)) to the SA Form CMS-1539 for communications to the MAC, SA, and CMS Locations for a consistent and streamlined process.

AOs may have additional requirements (exceeding SA processes) in which they determine survey needs. It is the responsibility of the AO to communicate to the SA, copying the CMS Location. **The AO must communicate *intent* to survey to the SA and CMS Location within 30 business days per the step-by-step instructions.**

SECTION V- National Database Updates, CMS Certification Numbers (CCNs) & Effective Dates

For most administrative changes such as name/ownership changes that are not a CHOW, the CCN will remain under the existing/approved CCN. No change is required by CMS CPI/PEOG. In most circumstances, if a facility relocates within the same state, CMS will determine if the

facility will retain its Medicare agreement and CCN. **CPI/PEOG is responsible for updating the following fields in the national database: 1) Initial Certification Date; 2) Termination Date; 3) Action Code; 4) Determination Approval Date; 5) Receipt Date; and 6) CCN's and Branch IDs (and NPI for ASCs and PXR suppliers)**. NOTE: For CHOWs as outlined in Part I of this SOP, CPI/PEOG will be responsible for also entering the CHOW Effective Date into the national database system.

The SAs will be responsible for updating the national database for all associated other information, including updates for deemed recommendations which the SA is copied on.

Important Nuances for National Database Entries and CCN issuance:

CPI/PEOG will be assigning the CCNs. The CCNs will remain unchanged for administrative changes, except in the following circumstances listed below. Additionally, the below captures general information on who (CPI/PEOG or SAs) will update the national database system.

Name & Address Change (Not Relocation): The SA will update the national database system after receiving the MAC's approval. This would include updating the legal entity/name and a change in the DBA. Note: The SA will be responsible for updating any licensure requirements as needed.

Adding/Removing Sites, Services, or Locations:

- For CORF, HHA, Hospital, Hospice, PXR, and OPTs: The location information, Branch IDs, and CCNs will be issued by CPI/PEOG. CPI/PEOG will update the national database system. For HHAs and OPTs, CPI/PEOG will be responsible for also issuing or removing the branch ID or extension site identifier. Do not remove/terminate the parent CCN in a branch removal.
- For ESRD expansions/removal and change in modalities/services, the SA will be responsible for updating the national database system.

Change in Location/Relocation: The SA will update the national database system.

Cessation of Business: CPI/PEOG will update the national database system. The CCN will be terminated along with the provider agreement after the provider/supplier has been notified. The MAC will first attempt to contact the owner to ensure that the cessation of business is not due to a change in location in which the provider has failed to notify the SA and MAC via CMS Form 855.

- **NOTE:** A temporarily closed facility may not retain its Medicare participation indefinitely. At the time of the temporary closure, the facility provides a projected date for resumption of services. The projected period of closure must be consistent with the repairs or renovation required. Depending on the duration, closure may be viewed as a cessation of business (voluntary termination of the Medicare CCN). The facility may be asked to submit periodic progress reports to the SA as to whether the projected re-opening remains the same. The SA will make these determinations in consultation with the CMS Location and notify the MAC.

Temporary Closure: No changes are required for temporary closures.

Please refer to the applicable by-provider/supplier addendums based on transition phases.

Effective Dates for Extension Locations, Additional Sites, and Change in Address (Not Relocation):

- Letters of approval must include the approval decision for the added practice (extension) location and the date that the SA/AO determined the added practice location met all appropriate CoPs. The effective date of coverage for services provided from the extension location is the date the SA/AO determines that the extension location meets all Federal requirements. This date will be included in the CMS notice letter sent by the MAC.
- The organization should not begin providing services at the newly added practice location until it receives a CMS notice from the MAC with an approval or denial of the new location.
- Reasons for denial if the request was denied and date of determination.

Part III –Initial Certification and Enrollment

Section I- General Information

SAs (or AOs as applicable) perform initial surveys certification of providers and certain suppliers, with the exception of FQHCs, which self-attest to being compliant. This part of the SOP outlines the roles and responsibilities for completing the initial certification activities for providers and certain suppliers.

NOTE: Transition of initial certification/enrollment for FQHC has been implemented. Please refer to the FQHC Transition SOP.

Section II- Overview Initial Certification

Initial certifications of providers or suppliers involve several steps, including enrollment and being surveyed to confirm their compliance and eligibility to participate in the Medicare program. Only CMS makes the determination to approve or deny a provider or for participation in the Medicare program. The SA transmittal of its findings is a recommendation for the certification action. The SA certification is used as the primary item of evidence to support decisions to approve or deny Medicare provider participation or coverage of provider or supplier services.

The SA reviews the appropriate provider documents (CMS-855A or CMS-855B; written recommendation; state licensure information, etc.) to distill essential information from the survey report for input into the national data system by CPI/PEOG. Before an agreement is executed with a provider to participate in the Medicare program, they must submit evidence of successful electronic submission of the Form HHS-690 through the Office of Civil Rights (OCR) portal before an initial survey may be conducted, or the CHOW may be processed. OCR conducts necessary investigations and makes determinations related to compliance with their requirements.

The SA completes all pertinent documentation relating to certification actions for each provider/supplier or action category and updates the national database system. The SA will forward their certification to the MAC no later than 45 calendar days after the initial certification survey.

U.S. Territories: For U.S. territories, the steps outlined under the processing section III still apply; however, the CMS Locations will be the responsible for processing initial certification

actions with the MAC and CPI/PEOG in lieu of the SAs. If the provider/supplier is seeking deemed status by a CMS-approved AO, the AO will coordinate with the CMS Locations in lieu of the SAs.

For Accrediting Organizations: For providers and suppliers which are seeking deemed status through a CMS-approved accrediting organization (AO), the provider/supplier must still submit their CMS-855 and be processed through the general enrollment requirements (as outlined in Part III, Section III), however, the AO (not the SA) will conduct the initial survey. An AO may not conduct an initial certification survey of a prospective provider or supplier for Medicare certification purposes until the MAC has completed its initial review of the enrollment application and has made a recommendation for approval to CMS. An AO must wait until the MAC has made its recommendation before it conducts an initial certification survey. CMS requires AOs with CMS-approved programs to employ a survey process that is comparable to the process required for a SA.

For certification purposes, CMS considers only accreditation under a CMS-approved Medicare accreditation program where the AO has recommended deemed status of a provider/supplier after the initial survey has been completed. The SAs will be responsible for entering information into Deemed tab within the certification kit in the national survey data system only for those initial applicants that are seeking deemed status prior to the AO survey on the basis of accreditation under a CMS-approved Medicare accreditation program and finalize the Deemed tab information upon completion of the survey.

Section III- General Processing for All Providers/Suppliers (except for FQHCs)

Step #1: When an entity seeks to participate in Medicare, it must first complete and submit an enrollment application. Information on enrollment as well as applicable forms and instructions may be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html. Entities subject to survey and certification file either a CMS Form 855A -- Medicare Enrollment Application for Institutional Providers, or a CMS Form 855B--Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers.

Medicare Part A providers will be required to sign an attestation of their compliance with all applicable civil rights laws enforced by the HHS Office of Civil Rights (OCR). This attestation is referred to as an "Assurance of Compliance" (form HHS-690), and it can be found on the HHS website. New applicants will be responsible for submitting this attestation electronically to OCR via OCR's online Assurance of Compliance portal at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf. They must submit evidence of successful electronic submission of the attestation (Form HHS-690) through the OCR portal before an initial survey may be conducted. SAs must include this link with their initial certification packages.

NOTE: If the prospective provider/supplier is seeking deemed status through a CMS-approved AO, it must still contact the SA for Medicare and/or Medicaid certification materials for their provider/supplier type.

Step #2: Once a prospective provider/supplier has submitted the initial enrollment application to the MAC, the MAC will review for enrollment.
Prospective providers and suppliers should be aware that the initial review of the Form CMS-855A or Form CMS-855B by the MAC and its recommendation for approval must occur before the on-site initial certification survey is conducted.

Step #3: When the MAC completes its review of the application, it either:

1) sends the SA and AO (if applicable) its recommendation via email (Step #4A) (including recommendations of approval for prospective providers/suppliers seeking deemed status);

or,

2) denies the application based on enrollment criteria and notifies the applicant (Step #4B).

Step #4A: **If the MAC recommends approval,** the SA or AO (if applicable) receives the Form CMS-855A or Form CMS-855B along with the approval recommendation from the MAC and will prepare the initial survey kit of the provider/supplier in the national database system (including for those providers/suppliers seeking deemed status). **NOTE:** The AO may not survey prior to receiving approval from the SA (See Part III, Section IV below).

Step #4B: If the MAC denies the application, based on enrollment criteria, the MAC will notify the provider/supplier in accordance with the PIM. The provider/supplier would need to resubmit, and no action would be required from the SA, AO (as applicable), the MAC, or CPI/PEOG. See also Part IV of this SOP related to the appeals/denial process.

Step #5: If the SA and AO (if applicable) receives the MAC recommendation for approval per step #4A, **the SA (or AO if applicable) surveys** the prospective provider/supplier and either:

1) **Certifies or recommends Medicare approval** if it determines that the applicant is in compliance with all conditions of participation/coverage/certification or requirements, as applicable. The SA will notify the MAC of the applicant's recommendation for approval for participation in the Medicare program by sending the Form CMS-1539 via email within 10 business days after the date of the survey.

For prospective providers/suppliers who are seeking deemed status, the SA will receive the recommendation from the AO, review for concurrence with the findings, and process the initial certification kit. The AO does not directly communicate with the MAC.

OR;

2) **Determines the applicant is not in compliance** with the conditions of participation, coverage, certification, or requirements, as applicable. If an initial denial is determined, the SA forwards recommendations for initial denials (including the AO's recommendation of denial of deemed status) to the MAC within 10 business days after the date of the survey via the CMS Form-1539. The MAC will send the provider/supplier a denial letter, copying in the SA, CMS Location, and AO, as applicable per Part IV of this SOP.

NOTE: If the applicant is issued a denial letter for noncompliance with the conditions of participation/coverage/certification, the applicant may correct the deficiencies and reapply for certification.

The SA finalizes the initial certification kit in the national survey data system. For deemed facilities, the SA finalizes the certification kit once the AO's recommendation has been received.

Step #6: Once the MAC receives the SAs recommendation (including the recommendations the AO provided for their respective deemed facility) via the CMS- 1539 for approval and all Federal requirements have been met, the MAC processes the provider or supplier's Medicare enrollment certification and notifies CPI/PEOG.

Step #7: The CPI/PEOG will issue a provider or supplier agreement with an effective date and issue the CMS Certification Number (CCN). The MAC sends a copy of the applicant's approval letter (and signed agreement) to the provider/supplier and copies the SA and AO (if applicable). CPI/PEOG will complete the remaining fields in the initial certification kit and upload.

SECTION IV- Survey Priorities & Accrediting Organizations

Reminder Scheduling Surveys: Initial certification survey scheduling will vary based on the provider/supplier type as outlined within the Mission and Priority Document (MPD). For MAC and CPI/PEOG awareness, there will be varying times based on the Tier levels for each provider/supplier type. The SA or AO (if applicable) must not perform a survey of an initial applicant until it has received notice from the MAC that the information provided on the enrollment application has been verified and that the MAC is recommending approval of the application.

For Accrediting Organizations: If the provider/supplier intends to be deemed, the SA does not conduct a survey to initially certify or recertify compliance with the applicable Medicare CoPs, CfCs, or requirements. Rather, such providers or suppliers are under the jurisdiction of the AO, not the SA. **The AO will recommend approval/denial of deemed status based on their initial survey findings to the SA, copying in the CMS Location.** An AO may not conduct an initial certification survey of a prospective provider or supplier for Medicare certification purposes until the MAC has completed its initial review of the enrollment application and has made a recommendation for approval to SA/AO. **The SA is responsible for updating the deemed certification kit in the national database system.** The CMS Locations retain the authority to review AO certification recommendations at any time.

SECTION V- CMS Certification Numbers (CCNs) & Effective Dates

CMS Certification Number (CCN) - General Guidance:

The CPI/PEOG will assign the CCN based on the provider/supplier-specific information included in the Addendums as the transition work proceeds.

The CCN for providers and suppliers paid under Medicare Part A has 6 digits. The first 2 digits identify the State in which the provider is located. The last 4 digits identify the type of facility. CMS PEOG will assign the CCN based on the existing guidance outlined in SOM Chapter 2, Section 2779A1 – CCN for Medicare Providers. CCNs are issued based on the last issued CCN in the sequence.

Effective Date: In accordance with 42 CFR 489.13, the effective date of participation in the Medicare program, i.e., the effective date indicated on the provider or supplier agreement issued by the CPI/PEOG via the MAC, may not be earlier than the date on which CMS determines that the provider or supplier meets all applicable federal requirements.

Part IV –Appeals and Reconsiderations

Reminder: All enforcement action processes remain unchanged and are the responsibility of the CMS Locations and the SA.

Appeals and reconsiderations for the purposes of this SOP may be based on two separate parts, either a determination that is based on the provider's/supplier's non-compliance with the Conditions for Participation (CoPs), Conditions for Coverage (CfCs) or requirements for LTC

facilities; or 2) based on enrollment determinations. This section applies to both CHOWs and Administrative changes.

Procedures/Guidance for Termination of Provider Agreement upon Revocation:
Revocation of a provider's billing privileges in the Medicare program automatically results in termination of the associated provider agreement. In the event the MAC revokes the provider/supplier based on enrollment criteria, the MAC will notify CPI/PEOG if the revocation determination is not appealed within 150 business days from the date of the notification. CPI/PEOG will terminate the Provider Agreement in the national database system.

The MAC will be responsible for issuing one letter to the provider/supplier noting the reconsideration/appeal rights for the Provider Agreement terminations and separately Provider Enrollment revocations. Formal written notice must include the right for reconsiderations and/or appeal and is issued by the MAC in accordance with the PIM.

The following information is included in the formal notice:

- The date of the notice;
- The decision and reason for it (cite provisions of the law or regulations not met); this may be reflected in two parts:
  - Specific information related to MAC revocation due to enrollment, and/or;
  - Specific information related to revocation based on certification (e.g. Provider Agreement terminations).
- The right to request participation in the future; and
- The procedures to follow for requesting a reconsideration and hearing before an administrative law judge (ALJ).

NOTE: This guidance supersedes previously issued S&C: 12-16-ALL.

Both the provider/supplier agreement or attestation effective date and provider enrollment effective date will be noted separately in a single approval letter.
Initial Denial of Participation and Enrollment: An initial denial is made when, after evaluating the evidence the SA certifies that the requirements of law and regulation (conditions of participation (CoPs)) are not met (including those recommendations/findings provided from the AO to the SA). The SA forwards recommendations for initial denials to the MAC within 10 business days after the date of survey via the CMS Form-1539. **The MAC will follow the processes as outlined in the PIM for sending one consolidated letter to the provider/supplier.**

Reasonable Assurance: The CMS SOG Locations will continue to process all enforcement activities, including reasonable assurance determinations for terminated providers/suppliers who wish to reenter the Medicare program.

A Medicare provider terminated under 42 CFR 489.53 and reinstated under 42 CFR 489.57 is required to operate for a certain period of time without recurrence of the deficiencies, which were the basis for the termination. The reasonable assurance concept also applies to terminated Medicare suppliers such as ASCs (42 CFR 416.35(e)), FQHCs (42 CFR 405.2440), and ESRD facilities (42 CFR 405.2180(c)). The length of this "reasonable assurance" period is determined by the CMS SOG Locations after an evaluation of the provider or supplier's previous compliance history. The reasonable assurance decision is an administrative action (not an initial determination) and is not subject to the appeals process at 42 CFR Part 498.3(d)(5).

Part V –Important Reminders & Resources

The CMS Form 2007 is being phased out for the provider/supplier types discussed in this SOP. The SAs will communicate with the MACs using the Form CMS 1539.

Additional Resources

- Enrollment aspects of the CHOW process are addressed in the Medicare Program Integrity Manual, Chapters 10, 15.
- The Medicare Financial Management Manual, CMS Publication 100.06, Chapters 3 and 4, address overpayment and other financial issues related to acquisitions and/or CHOWs of Medicare-participating providers.
- The Provider Reimbursement Manual, CMS Publication 15-1 and 15-2, at section § 4502.B explains when a "CHOW" has occurred for Medicare reimbursement purposes.

Attachment 2:
SKILLED NURSING FACILITIES ADDENDUM

Purpose: The intent behind the Standard Operating Procedure (SOP) is to provide direction to the Survey Operations Group (SOG) (later referred to as CMS Locations), State Survey Agencies (SAs), and the Center for Program Integrity (CPI)/Provider Enrollment Oversight Group (PEOG) and the Medicare Administrative Contractors (MAC) as it relates to the processing of changes of ownership (CHOWs), administrative changes (name, address, branch locations, additional services, relocations, etc.), and initial surveys and enrollment.

Scope: The SOP covers multiple parts to include 1) CHOWs; 2) Administrative Changes and 3) Initial Certification and Enrollment. The SAs, CPI/PEOG, and the MACs will follow the general guidance provided in the main SOP, however **this Skilled Nursing Facilities (SNFs) Addendum covers provider differences, nuances, and areas specific to Long-Term Care Facilities. NOTE: Only SNFs are part of the simplified the enrollment and certification activities with the MAC and CPI/PEOG.**

NOTE: For SNFs, there are no CMS-approved Accrediting Organizations (AOs). Deeming authority for SNFs is not available. No AO involvement.

General Information & Background

Definitions (42 CFR 488.301):

- **Dually Participating Facility** means a facility that has a provider agreement in both the Medicare and Medicaid programs.
-
- **Facility** means a skilled nursing facility or nursing facility, or a distinct part of a skilled nursing facility or nursing facility, in accordance with 42 CFR 483.5. (See §7008 for entities that qualify as skilled nursing facilities and nursing facilities.)
- **Nursing facility (NF)** means a Medicaid nursing facility.
- **Skilled nursing facility (SNF)** means a Medicare-certified nursing facility that has a Medicare provider agreement.

Participation & Survey/Certification Requirements:

The State (SA) has the responsibility for certifying a SNF's or NF's compliance or noncompliance, except in the case of State-operated facilities. However, the State's certification for a SNF is subject to CMS's approval. "Certification" of compliance means a determination made by SAs that providers and suppliers are in compliance with the applicable conditions of participation, conditions of coverage, conditions for certification, or requirements (42 CFR 488.1).

The following entities are responsible for surveying and certifying a SNF's or NF's compliance or noncompliance with Federal requirements:

- **State-Operated Skilled Nursing Facilities (SNFs) or Nursing Facilities (NFs) or State-Operated Dually Participating Facilities** - The State conducts the survey and

certifies compliance or noncompliance and determines whether a facility will participate in the Medicare or Medicaid programs. Note: **There is no CPI/PEOG and MAC involvement for Medicaid-only (NF) participation**. In dually participating facilities, CPI/PEOG and the MAC will receive directions for processing certification actions by the SA, unless open enforcement activities exist.

- **Non-State Operated Skilled Nursing Facilities (SNFs)** - The State conducts the survey and certifies compliance or noncompliance. The SA will determine whether a facility is eligible to participate in the Medicare program and provide certification and enrollment recommendations to CPI/PEOG and the MAC.

- **Non-State Operated Nursing Facilities (NFs)** - The State conducts the survey and certifies compliance or noncompliance. The State's certification is final. **The State Medicaid Agency determines whether a facility is eligible to participate in the Medicaid program.** Note: **There is no CPI/PEOG and MAC involvement.**

- **Non-State Operated Dually Participating Facilities (Skilled Nursing Facilities/Nursing Facilities)** - The State conducts the survey and certifies compliance or noncompliance. The State's certification of compliance or noncompliance is communicated to the State Medicaid Agency for the nursing facility and to the CPI/PEOG and the MAC for the skilled nursing facility.

CMS Certification Numbers for SNFs:

Use the following CCN ranges for the facility types indicated:

5000-6499	Skilled Nursing Facilities
6990-6999	Numbers Reserved (formerly Christian Science Sanatoria (Skilled Nursing Services)

PART I- Changes of Ownership (CHOWs)

Skilled nursing facilities (SNFs) are subject to the CHOW rules as noted in 42 CFR 489.2(b)(2). See Part I of the SOP for a general overview of CHOWs.

CHOWs - Skilled Nursing Facilities (SNF)- Long- Term Care:

- If a buyer/new owner does not reject automatic assignment, Part I, Section I of the main SOP would be followed, however the SA's and MACs must review the specific information below related to supporting documentation prior to finalizing a CHOW for a SNF.

- If a buyer/new owner rejects automatic assignment, it is not a CHOW. It is an initial certification requiring initial enrollment for the new owner. In that case, Part I, Section II of the SOP would be followed.

- SNF CHOWs often take the form of a new operator. The documentation of the CHOW transaction is the operating transfer agreement from the old operator to the new operator.

This is still a CHOW, even though the operator does not own the building, it is still the entity with legal responsibility for the operation of the nursing home provider itself.

- If the State is concerned that a CHOW, management firm, administrator, or Director of Nursing may have caused a decline in the quality of care or services furnished by a skilled nursing facility or nursing facility, it may conduct a standard or abbreviated standard survey within 60 days of the change. The SA will make the determination once it receives the CHOW package from the MAC for the initial review and recommendation of approval or denial.

- The MAC may obtain only part of these documents during the initial request, however the SA may need to follow up with the provider to obtain the remaining documentation. The final CHOW package supporting documentation should include the documents listed below:
  - The CMS-855 provided from the MAC
  - The provider agreement (CMS-1561);
  - CMS-671 (LTC Facility Application for Medicare/Medicaid)
  - CMS-672 Resident Census
  - The Office of Civil Rights (OCR) attestation confirmation (Providers must complete online at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf);
  - SA completed CMS-1539 and written recommendation for approval of the CHOW;
  - Verification that the Nurse Aide Training & Competency Evaluation Program (NATCEP) is being carried out by facility;
    - **NOTE:** The SA is required to have their process for their state's NATCEP program, this may include but not be limited to, review of the facility curriculum, qualifications of instructors, etc.
  - A copy of transfer agreement(s) with acute care hospital(s). The new owner must be a party to the transfer agreement, not the old owner.
    - **NOTE**: Per the regulations at 483.70(j)(2), the facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.
    - There may be cases in which the SNF provides evidence that they attempted to obtain a transfer agreement but was unable to do so. The SA will determine if adequate information was obtained support approval of the CHOW without a formal transfer agreement.

- Supporting Documentation to be submitted to the MAC by the SA must include:
  - CMS-855A;
  - Recommendation of Approval CMS-855A BUYER Medicare Enrollment Application;
  - CMS-1539 C&T: SA Recommendation of approval prepared and submitted to the MAC with entire application (all documents listed above)

Distinct Part SNF's and CHOWs: Understanding the term "distinct part" SNF or NF is important. This refers to a portion of an institution or institutional complex (e.g., a nursing home or hospital) that is certified to provide SNF services. The distinct part can be a wing, separate building, a floor, a hallway, or one side of a corridor. The beds in the certified distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located.

A composite distinct part is a distinct part consisting of two or more non-contiguous components that are not located within the same campus, as defined in §413.65(a)(2).

A distinct part SNF could occur in situations in which a hospital has a distinct part SNF. Generally, this is seen where a hospital that has a distinct-part SNF and either the hospital, the SNF, or both undergo a change in owners and the new owners accept assignment of existing Medicare agreements. In this case, if a change in ownership situation results in the hospital and the distinct-part SNF having different owners, and **the existing SNF Medicare agreement continues**, the SNF is no longer certified as a distinct-part SNF, but **its CCN would remain unchanged**. The loss of distinct-part status would be noted in the national survey data system.

The SA will be responsible for notifying the MACs if a distinct part situation occurred during a CHOW and there was a loss of distinct part status. If two or more institutions (each with a distinct part SNF or NF) undergo a change of ownership, CMS must approve the existing SNFs or NFs as meeting the requirements before they are considered a composite distinct part of a single institution. In making such a determination, CMS considers whether its approval or disapproval of a composite distinct part promotes the effective and efficient use of public monies without sacrificing the quality of care. If there is a change of ownership of a composite distinct part SNF or NF, the assignment of the provider agreement to the new owner will apply to all of the approved locations that comprise the composite distinct part SNF or NF.

Part II –Administrative Changes

Many enrollment certification actions are not CHOWs. These situations are generally when a provider/supplier changes names not due to a CHOW, or there is an administrative update to the provider agreement.

Administrative Changes - Skilled Nursing Facilities (SNF)- Long- Term Care:

In accordance with the steps under Part II – Administrative Changes of the main SOP, the SA will be responsible for confirming the type of administrative request and providing the recommendation for approval to the MAC once a survey has or has not been conducted based on the criteria outlined. In rare occasions, administrative changes occur in SNFs which are not considered CHOWs. These generally are:

- **Address Change (Not Relocation):** Ordinarily an on-site survey is not necessary for a change of address unless the location is outside the approved geographic area.

- **Name Changes**: Name changes of an organization may occur that are not as a result of a CHOW, but rather changes of Owners (see Part I, Section III.B.). These may be changes to the owner's information or the organization name as a whole. SAs must receive the CMS-855A Change of Information (CHOI) recommendation of approval from the MAC before the SA may change the facility name in the National Database; CMS-1539 C&T: SA Recommendation of approval prepared and submitted to the MAC with copy of the CMS-855A CHOI.

- **Change in Location/Relocation:** A change in location or relocation is outside of the primary approved site or change in location outside of the existing geographical area is generally considered a relocation of a provider/supplier. A relocation request must also ensure that patients will continue to receive uninterrupted service during the relocation. A

relocation may or may not need a survey. **Prior to approval of a SNF relocation, the SA performs a Life Safety Code Survey of the new building or location and requires the CMS-855A to be approved before the facility may relocate/transfer residents to the new location.** As part of the steps outlined in Part IV of the main SOP, note that if the SA recommends denying the relocation of a main site, this is considered a termination.

In rare occasions, relocations may occur in SNFs which are not considered CHOWs. Relocations in SNFs are generally only the result of:

1) Enforcement- The facility is being terminated and must transfer residents (involuntary termination);
2) Emergencies- Relocating residents based on temporary closure due to an emergency.

In either case, the SA will follow the existing processes and termination/enforcement will continue to be processed by the SA and applicable CMS SOG Location per SOM Chapter 7, Section 7552 - Transfer of Residents and Transfer of Residents with Closure of Facility.

- **Distinct Part**- Refer to above explanation of distinct part. **A distinct part is not an administrative change, but may be seen as part of the SA submission of a CMS-1539. One CCN is assigned and only one Form CMS-1539 prepared for the SNF/NF with a SNF or NF distinct part; and with a NF distinct part.**

In the event the SNF decides to voluntarily terminate, the SA, CPI/PEOG and the MACs will follow the procedures outlined in the Voluntary Termination SOP.

Part III –Initial Certification and Enrollment

Initial Enrollment for SNFs will follow Part IV, Section III of the SOP. For SNFs specifically, the SA determines whether a prospective provider is in substantial compliance with the nursing home participation requirements upon initial survey of the facility. The SA also ensures that part of the initial survey includes the LSC survey. The initial survey cannot take place until the SA receives the Form CMS-855A along with the approval recommendation from the MAC per Part IV, Section III of the SOP.

The SA will review:

- All documents listed above for a CHOW are also collected from the provider and required for an Initial Certification Application;
- Some SAs will also request a Floor Plan with all resident room numbers clearly indicated;
- Some SAs will also require a bed listing form (generally a state document);
- The CMS-855A recommendation of approval from the MAC before the SA can conduct the initial certification survey, and subsequently, the facility must have achieved compliance with the requirements for participation in the Medicare program demonstrated through the survey process.

After the initial survey is completed by the SA, the following will apply:

For APPROVALS: If the facility is in substantial compliance, the State certifies and recommends approval to CPI/PEOG and the MAC and/or State Medicaid Agency enter into an agreement with the facility.

NOTE: In the event an initial survey results in standard-level/minimal harm deficiencies, the SA will request a plan of correction (PoC). Only once the SA receives an acceptable PoC, will the SA make its determination of substantial compliance and send their recommendation to the MAC.

CMS-1539 C&T within initial certification survey kit: SA Recommendation of approval prepared and submitted to the MAC with entire application (all documents listed above) by SA.

For DENIALS: If the facility is not in compliance, the SA will recommend denial to the MAC, CMS Location and/or State Medicaid Agency, and follow the existing SOM guidance and main SOP. For additional information, SAs will refer to existing guidance under 42 CFR 431.153 and 42 CFR 498.3(b) and SOM Chapter 2 and 7, §2005 and §7203.

Part IV –Important Reminders & Resources

Important Reminders Resources

- Some providers such as OPT/OSPs might provide services in a SNF and a CORF and be established on the premises of another health entity even though the other entity is currently approved under Medicare as a provider or supplier of services. For example, a SNF owner might rent space within the SNF to the CORF or OPT/OSP. **These are considered separate provider/supplier actions and are not applicable to these certification transition actions specific to SNFs.**

Additional Resources

- CHOW, Administrative Changes; Relocations & Initials- General SOP
- SOM Chapter 2
- SOM Chapter 7
- SOM Appendix P & PP (Surveyor Guidance)