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CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12393	**Date: December 7, 2023**
	Change Request 13333

SUBJECT: Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08 - Home Health Prospective Payment System (HH PPS) Final Rule

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 10 of CMS Pub. 100-08 with instructions regarding the implementation of certain provider enrollment regulatory provisions in the Calendar Year (CY) 2024 HH PPS final rule.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/Table of Contents
R	10/10.1/10.1.1/Definitions
R	10/10.2/10.2.1.6/Home Health Agencies (HHAs)
R	10/10.2/10.2.1.6.1/Reserved for Future Use
R	10/10.4/10.4.8/Deactivations
R	10/10.4/10.4.8.1/Deactivation Rebuttals
R	10/10.6/10.6.1.1/Changes of Ownership (CHOWs) – Transitioned Certified Providers and Suppliers
N	10/10.6/10.6.1.1.5/HHA and Hospice Ownership Changes
R	10/10.6/10.6.7.2/Individual Owning and Managing Information
R	10/10.6/10.6.15/Risk-Based Screening
R	10/10.7.5/10.7.5.1/Part A/B Certified Provider and Supplier Letter Templates – Post-Transition
R	10/10.7/10.7.12/Deactivation Model Letter

NOTE: There are 73 total pages to this CMS Manual System. The pages in shown are pages 1, 9, and 28-33 of 74 respectively and only.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 12393	Date: December 7, 2023	Change Request: 13333

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I. GENERAL INFORMATION

A. Background: The CY 2024 HH PPS final rule (88 Federal Register 77676) contains provisions concerning Medicare provider enrollment. These include, but are not limited to: (1) Expanding the home health agency "36-month rule" to include hospice changes in majority ownership; and (2) Moving hospices into the "high" level of categorical risk-screening. Except for the provisions concerning prohibitions against ordering, certifying, etc. (which CMS will address in separate guidance to the contractors), this CR will update Chapter 10 of CMS Pub. 100-08 with instructions regarding these regulatory provisions.

B. Policy: CY 2024 HH PPS final rule.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13333.1	The contractor shall observe the clarification of the definition of "managing employee" in Section 10.1.1 in Chapter 10 of CMS Pub. 100-08.	X		X						
13333.2	The contractor shall observe the regulatory change in 42 Code of Federal Regulations (CFR) § 424.540(a)(1) reducing the	X	X	X						NPEAST, NPWEST

- **Not Actionable:** Rebuttal is no longer actionable (moot) because the basis for the deactivation has been resolved (e.g. deactivation was rescinded).
- **Favorable:** (to provider/supplier) Contractor has determined that an error was made in the implementation of the deactivation. Therefore, the initial determination was overturned and the enrollment record has been placed in approved status.
- **Unfavorable:** (to provider/supplier) Contractor upholds the initial determination resulting in the enrollment remaining deactivated.
- **Dismissed:** The rebuttal submission does not meet the rebuttal submission requirements (e.g. missing proper signature and did not timely respond to development request).
- **Withdrawn:** Provider/supplier/representative has submitted written notice of its intent to withdraw its rebuttal before the contractor issued a determination and the contractor has acknowledge the withdrawal.
- **In Process:** A final decision has not been issued. The Contractor is still processing the submission.

- **Column K:** The response in Column K labelled, "Comments," shall include any information related to the deactivation, rebuttal submission, or rebuttal determination that provides context for CMS in reporting the rebuttal and outcome. This column may be left blank if no additional information is necessary.

10.6.1.1 – Changes of Ownership (CHOWs) – Transitioned Certified Providers and Suppliers

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

(Until further notice from CMS, the instructions in sections 10.6.1.1 through 10.6.1.1.4 apply only to certified provider and certified supplier types that have officially "transitioned" as part of the transition of various certification activities from the SOG Location to the states, the contractors, and PEOG. These provider/supplier types include SNFs, HHAs, CMHCs, CORFs, Part A OPT/OSP, ASCs, and PXRSs. The contractor shall continue to use the existing CHOW instructions--now in section 10.6.22 of this chapter—for all non-transitioned certified provider/supplier types.

When executing the instructions in sections 10.6.1.1 through 10.6.1.1.4, the contractor can disregard directives that obviously do not apply to the provider/supplier type in question (e.g., references to home health agencies do not apply to SNFs).

Except as otherwise noted, the term "CHOW" as used in section 10.6.1.1 et seq. includes CHOWs, acquisitions/mergers, and consolidations. Though the Change of Ownership (CHOW) Information section of the Form CMS-855A separates the applicable transactions into CHOWs, acquisition/mergers, and consolidations for ease of disclosure and reporting, they fall within the general CHOW category under 42 CFR § 489.18 (e.g., an acquisition/merger is a type of CHOW under § 489.18).

Note that the CHOW instructions in 10.6.1.1 through 10.6.1.1.4 apply to HHA *and hospice* CHOWs taking place under 42 CFR § 489.18. For changes in majority ownership under 42 CFR § 424.550(b), see section 10.2.1.6.1 of this chapter.

10.6.1.1.5 – HHA and Hospice Ownership Changes

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

A. Background – 36-Month Rule

1. General Principles

In accordance with 42 CFR § 424.550(b)(1), if there is a change in majority ownership of an HHA or hospice by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA's or hospice's initial enrollment in Medicare or within 36 months after the HHA's or hospice most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA or hospice must instead:

- *Enroll in the Medicare program as a new (initial) HHA or hospice under the provisions of § 424.510, and*

- *Obtain a state survey or an accreditation from an approved accreditation organization.*

For purposes of § 424.550(b)(1), a "change in majority ownership" (as defined in 42 CFR § 424.502) occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA or hospice during the 36 months following the HHA's or hospice's initial enrollment into the Medicare program or the 36 months following the HHA's or hospice's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA or hospice through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's or hospice's most recent change in majority ownership.

2. Exceptions

There are several exceptions to § 424.550(b)(1). Specifically, the requirements of § 424.550(b)(1) do not apply if:

- *The HHA or hospice has submitted 2 consecutive years of full cost reports since initial enrollment or the last change in majority ownership, whichever is later. (For purposes of this exception, low utilization or no utilization cost reports do not quality as full cost reports.)*

- *The HHA's or hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.*

- *The HHA or hospice is changing its existing business structure – such as from a corporation, a partnership (general or limited), or a limited liability company (LLC) to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.*

- *An individual owner of the HHA or hospice dies.*

In addition, § 424.550(b)(1) does not apply to "indirect" ownership changes.

3. Timing of 36-Month Period for Hospices

The provisions of 42 CFR § 424.550(b)(1) and (2) with respect to hospices (as enacted in "CMS-1780-F, Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2024") became effective January 1, 2024. This means these provisions impact only those hospice ownership transactions whose effective date is on or after January

1, 2024. However, the provisions can apply irrespective of when the hospice first enrolled in Medicare. Consider the following illustrations:

- *Example 1 – Smith Hospice initially enrolled in Medicare effective February 1, 2022. Smith undergoes a change in majority ownership effective February 1, 2024. The provisions of § 424.550(b)(1) apply to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.*

- *Example 2 – Jones Hospice initially enrolled in Medicare effective February 1, 2016. Jones undergoes its first change in majority ownership effective February 1, 2024. Section 424.550(b)(1) does not apply to this transaction because it occurred more than 36 months after Jones's initial enrollment. Suppose, however, that Jones undergoes another change in majority ownership effective February 1, 2025. Section 424.550(b)(1) applies to this transaction because it took place within 36 months after Jones's most recent change in majority ownership (i.e., on February 1, 2024).*

- *Example 3 – Davis HHA initially enrolled in Medicare effective February 1, 2012. It underwent its first change in majority ownership effective February 1, 2016. This change was not affected by § 424.550(b)(1) because it occurred more than 36 months after Davis's initial enrollment. Davis underwent another change in majority ownership effective February 1, 2023. This change, too, was unaffected by § 424.550(b)(1), for it occurred more than 36 months after the HHA's most recent change in majority ownership (i.e., on February 1, 2016). Davis underwent another majority ownership change on February 1, 2025. This change is impacted by § 424.550(b)(1), since it occurred within 36 months of the HHA's most recent change in majority ownership (i.e., on February 1, 2023).*

B. Determining the 36-Month Rule's Applicability

If the contractor receives a Form CMS-855A application reporting an HHA or hospice ownership change (and unless a CMS instruction or directive states otherwise), it shall undertake the following steps:

Step 1 – Change in Majority Ownership

The contractor shall determine whether a change in direct majority ownership has occurred. Through its review of the transfer agreement, sales agreement, bill of sale, etc., the contractor shall verify whether:

- *The ownership change was a direct ownership change and not a mere indirect ownership change, and*

- *The change involves a party assuming a greater than 50 percent ownership interest in the HHA or hospice.*

Assumption of a greater than 50 percent direct ownership interest can generally occur in one of three ways. First, an outside party that is currently not an owner can purchase more than 50 percent of the business in a single transaction. Second, an existing owner can purchase an additional interest that brings its total ownership stake in the business to greater than 50 percent. For instance, if a 40 percent owner purchased an additional 15 percent share of the HHA or hospice, this would constitute a change in majority ownership. This is consistent with the verbiage in the aforementioned definition of "change in majority ownership" regarding the "cumulative effect" of asset sales, transfers, etc. Another example of a change in majority ownership would be if a 50 percent owner obtains any additional amount of ownership (regardless of the percentage) and hence becomes a majority owner; thus, for

instance, if a 50 percent owner were to acquire an additional .001 percent ownership stake, he or she becomes a majority owner and the transaction involves a change in majority ownership.

If the transfer does not qualify as a change in majority ownership, the contractor can process the application normally (which will typically be as a change of information under 42 CFR § 424.516(e)). If it does qualify, the contractor shall proceed to Step 2:

Step 2 – 36-Month Period

The contractor shall determine whether the effective date of the transfer is within 36 months after the effective date of the HHA's or hospice's (1) initial enrollment in Medicare or (2) most recent change in majority ownership. The contractor shall verify the effective date of the reported transfer by reviewing a copy of the transfer agreement, sales agreement, bill of sale, etc., rather than relying upon the date of the sale as listed on the application. It shall also review its records – and, if necessary, request additional information from the HHA or hospice – regarding the effective date of the HHA's or hospice's most recent change in majority ownership, if applicable.

If the effective date of the transfer does not fall within either of the aforementioned 36-month periods, the contractor may process the application normally; specifically, the contractor shall, as applicable and depending upon the facts of the case, process the application as a change of information under 42 CFR § 424.516(e) or as a potential change of ownership under 42 CFR § 489.18.

If the transfer's effective date falls within one of these 36-month timeframes, the contractor shall proceed to Step 3.

Step 3 – Applicability of Exceptions

If the contractor determines that a change in majority ownership has occurred within either of the above-mentioned 36-month periods, the contractor shall determine whether any of the exceptions in § 424.550(b)(2) apply. As alluded to earlier, the exceptions are as follows:

i. The HHA or hospice has submitted 2 consecutive years of full cost reports.

(A) For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports. (See 42 CFR § 413.24(h) for a definition of low Medicare utilization.)

(B) The cost reports must have been: (1) consecutive, meaning that they were submitted in each of the 2 years preceding the effective date of the transfer; and (2) accepted by the contractor.

ii. The HHA's or hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.

iii. The HHA or hospice is changing its existing business structure – such as from a corporation, a partnership (general or limited), or an LLC to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.

(A) If the HHA or hospice is undergoing a change in business structure other than those which are specifically mentioned in this exemption (e.g., corporation to an LLC), the contractor shall contact its PEOG Business Function Lead (BFL) for guidance.

(B) For the exemption to apply, the owners must remain the same.

iv. An individual owner of the HHA or hospice dies – regardless of the percentage of ownership the person had in the HHA or hospice.

Step 4 - Determination

If the contractor concludes that one of the aforementioned exceptions applies (and unless a CMS instruction or directive states otherwise), it may process the application normally; specifically, the contractor shall, as applicable and depending upon the facts of the case, process the application as a change of information under 42 CFR § 424.516(e) (via the instructions in section 10.6.1.2 of this chapter) or as a potential change of ownership under 42 CFR § 489.18 (via the instructions in section 10.6.1.1 of this chapter).

If no exception applies, the contractor shall refer the case to its PEOG BFL for review. Under no circumstances shall the contractor apply the 36-month rule to the HHA or hospice and require an initial enrollment based thereon without the prior approval of PEOG. If PEOG agrees with the contractor's determination:

(1) PEOG will terminate the seller in ASPEN.

(2) The contractor shall identify the voluntary termination action in PECOS as a deactivation ---- and hence shall deactivate the HHA's or hospice's billing privileges pursuant to § 424.540(a)(8) --- with a status reason of "Voluntarily Withdrawal from the Medicare Program." Per § 424.540(d)(1)(ii)(E), the effective date of the deactivation shall be the date of the sale.

(3) The contractor shall send to the HHA or hospice the "36-Month Rule Voluntary Termination Letter" in section 10.7.5.1. This letter will include, among other things, rebuttal rights regarding the deactivation as well as language stating that, as a result of § 424.550(b)(1), the HHA or hospice must:

- *Enroll as an initial applicant; and*
- *Obtain a new state survey or accreditation survey after it has submitted its initial enrollment application and the contractor has made a recommendation for approval to the state.*

(In preparing this letter, the contractor may, if applicable to the situation, change any reference therein to "HHA" or "home health agency" to "hospice.")

(4) The HHA or hospice need not submit a Form CMS-855A voluntary termination application.

Providers and/or their representatives (e.g., attorneys, consultants) shall contact their local MAC with any questions concerning (1) the 36-month rule in general and (2) whether the rule and/or its exceptions apply in a particular provider's case.

C. Additional Notes

The contractor is advised of the following:

1. If the contractor learns of an HHA or hospice ownership change by means other than the submission of a Form CMS-855A application, it shall notify its PEOG BFL immediately.

2. If the contractor determines, under Step 3 above, that one of the § 424.550(b)(2) exceptions applies, the ownership transfer still qualifies as a change in majority ownership for purposes of the 36-month clock. To illustrate, assume that an HHA initially enrolled in Medicare effective July 1, 2010. It underwent a change in majority ownership effective February 1, 2012. The contractor determined that the transaction was exempt from § 424.550(b)(1) because the HHA submitted full cost reports in the previous 2 years. On February 1, 2014, the HHA underwent another change in majority ownership that did not qualify for an exception. The HHA thus had to enroll as a new HHA under § 424.550(b)(1) because the transaction occurred within 36 months of the HHA's most recent change in majority ownership - even though the February 2012 change was exempt from § 424.550(b)(1).

10.6.7.2 – Individual Owning and Managing Information

(Rev. 12393; Issued: 12-07-23; Effective: 01-01-24; Implementation: 01-02-24)

A. Owning and Managing Individuals Who Must Be Listed in this Section

All individuals who have any of the following must be listed in this section:

(i) Ownership - A 5 percent or greater direct or indirect ownership interest in the provider.

(ii) Mortgage/Security Interest - A 5 percent or greater mortgage or security interest in the provider.

(iii) Partnership Interests

- Any general partnership interest in the provider, regardless of the percentage. This includes (1) all interests in a non-limited partnership and (2) all general partnership interests in a limited partnership.

- Limited partnerships - For the CMS-855A, any limited partnership interest that is 10 percent or greater. For the Form CMS-855B, CMS-855S and CMS-20134, any limited partnership interest, regardless of the percentage.

(iv) Managing Control of the Provider - For purposes of enrollment, such a person is considered to be a "managing employee." A managing employee is any individual, including a general manager, business manager, office manager or administrator, who exercises operational or managerial control over the provider's business, or who conducts the day-to-day operations of the business. A managing employee also includes any individual who is not an actual W-2 employee but who, either under contract or through some other arrangement, manages the day-to-day operations of the business.

(v) Corporate Officers and Directors/Board Members

Officers and directors/board members must be listed in the Individual Ownership and/or Managing Control section if – and only if - the applicant is a corporation. (For-profit and non-profit corporations must list all of their officers and directors. If a non-profit corporation has "trustees" instead of officers or directors, these trustees must be listed in this section of the Form CMS-855A, CMS-855B, CMS-855S and CMS-20134.)

Only the enrolling provider's officers and directors must be reported. Board members of the provider's indirect owners need not be disclosed to the extent they are not otherwise required to be reported (e.g., as an owner or managing employee) in this section. However, there may be situations where the officers and directors/board members of the enrolling provider's corporate owner/parent also serve as the enrolling provider's officers and directors/board