Health Care Regulation and Quality Improvement
800 NE Oregon Street, Suite 465
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

This letter is in response to your expression of interest in becoming a provider of home health services under the Medicare program. This letter does not address state licensing requirements. However, home health agencies (HHAs) must be licensed in order to operate in Oregon and prior to participation in the Medicare program.

The Health Care Regulation and Quality Improvement Section of the Oregon Health Authority has an agreement with the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, (CMS) formerly Health Care Financing Administration (HCFA), to assist in determining whether health care facilities meet, and continue to meet, required federal regulations.

You can find the Federal regulations for HHAs, called Conditions of Participation online at: http://www.cms.hhs.gov/GuidanceforLawsAndRegulations/downloads/som107ap_b_hha.pdf. A HHA must comply with these regulations if it desires to be Medicare certified. Medicare certification enables a HHA to receive reimbursement with Medicare monies for services provided to Medicare beneficiaries. In this section you will also find the Interpretive Guidance, which is CMS's official interpretation of the Conditions of Participation.

Upon admission, the patient has the right to be advised of the availability of the toll-free HHA hotline in the state. Oregon's toll free number is 1-800-542-5186. When the agency accepts the patient for treatment of care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of operation (M-F, 8:00am-5:00pm), and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directive requirements.

After reviewing all the regulations, should you desire to participate in the Medicare program, you must return the following forms and documents to this office:

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

2. **HHS 690 - Assurance of Compliance with Title VI of the Civil Rights Act (2 signed original copies required) and the Civil Rights Packet**
   http://www.hhs.gov/forms/HHS690.pdf & http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/formstobecompleted.html & http://www.hhs.gov/ocr/civilrights/clearance/pregrantchecklist.pdf

3. **CMS 1572(a) and (b) - Home Health Agency Survey and Deficiency Report**
   http://www.cms.hhs.gov/cmsforms/downloads/cms1572a.pdf

4. **CMS 855 - Provider/Supplier Enrollment Form will need to be obtained from the fiscal intermediary (FI), National Government Services (866) 590-6724.**

5. **HHA Capitalization Information**

Regarding the HCFA 1561: The person signing the Health Insurance Benefit Agreement must have the authorization of the agency's owners to enter into this agreement.

Regarding the HHS 690: Title VI of the Civil Rights Act of 1964 prohibits discrimination on grounds of race, color, or national origin in any program receiving Federal financial assistance; and age discrimination is prohibited under provision of the Age Discrimination Act of 1975. Please respond, as requested, to the Office for Civil Rights.

Regarding the Intermediary Preference: The fiscal intermediary (FI) is the insurance company, which, under an agreement with CMS, reimburses health care facilities with federal Medicare monies. The CMS designated FI for HHAs in Oregon is National Government Services.

Regarding the CMS 855: If you have any questions relative to the completion of the CMS 855 please call National Government Services at (866) 590-6724.

Regarding the capitalization information: On a separate piece of paper

provide the following information:

- The name of the agency;
- The projected number and type (skilled nursing, physical therapy, etc.) of visits for the first three months of operation;
- The projected number and type of visits for the first year of operation;
- If the agency freestanding or provider (hospital, SNF, etc.) based;
- The geographic location of the agency;
- If the agency proprietary or nonproprietary;
- Any additional information which will enable the FI to properly compare your HHA with other similarly situated and sized agencies.

More specific capitalization information will be requested of you at a later date, after you have provided this preliminary information. If you have any questions relative to the capitalization information, please call National Government Services at (866) 590-6724.

After you have obtained and/or completed all of the required documents and forms, return them to this office WITH A COVER LETTER REQUESTING MEDICARE CERTIFICATION. Return the CMS 855 to National Government Services, and all other documents to this office. This office will begin processing the documents and forms in accordance with CMS's directions. National Government Services will forward the CMS 855 to this office after it has been reviewed, and approved or denied.

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

At the present time the onsite survey will need to be conducted by a CMS-approved accreditation organization (AO), and such accreditation is "deemed" to be equivalent to a recommendation by the SA for CMS certification. To schedule the initial accreditation survey, contact one of the CMS-Approved Accrediting Organizations.

CMS instructs States to place a higher priority on recertification of existing providers, on similar work for existing providers, and on complaint investigations

than for initial surveys of new providers/suppliers seeking Medicare participation.

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

Additionally, a HHA pursuing Medicare certification must **demonstrate** compliance with the Outcome and Assessment Information Set (OASIS) requirements set forth in the Conditions of Participation at CFR 484.20 and CFR 484.55 related to the electronic transmission of patient information to the State Agency (this office). **The HHA must demonstrate electronic connectivity to this office and must be capable of transmitting the OASIS data set information before the onsite survey can occur.**

After you have submitted the application documents previously described, you must contact OHA to reach the OASIS Education Coordinator, to arrange for OASIS guidance and direction. Jason Woolery, the OASIS Automation Coordinator, will provide education to you via the telephone to assist you in setting up your OASIS system.

If your agency is determined to be in compliance at the time of this survey, the AO will communicate its findings to CMS. This office will also need written notification that the agency has successfully completed the initial certification survey by the AO. When documentation of the successful completion of the initial survey and all of the application forms and other documents have been received by this office, they will be transmitted to CMS with a recommendation and CMS will make a final determination.

If certified, the certification date will be determined by CMS and is generally the

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

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

Those institutions and agencies which are denied Medicare certification will be notified and given the reasons for the denial and information about their rights to appeal the decision. If you need to contact CMS, the phone number for CMS-Seattle location is 206-615-2313.

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

Medicare certification also enables a HHA to bill the state Medicaid program for services. If you desire reimbursement for home health services provided to Medicaid clients, you would need to contact the provider enrollment department of the State of Oregon Office of Medical Assistance Programs (OMAP), at 800.422.5047, after you have received notification from CMS that Medicare certification has been approved. A representative from OMAP will inform you of its requirements and procedures for billing and reimbursement.

Additionally, if your agency performs any type of laboratory tests (for example: blood glucose testing) for the purpose of diagnosis and treatment or assessment of individuals' health, you must have and display a current CLIA (Clinical Laboratory Improvement Amendments) license or waiver to do so. For

information, call Oregon Health Authority, Public Health Laboratories, Laboratory Licensing Section, at (503) 693-4125.

As long as the HHA is certified, subsequent recertification surveys of the agency will be conducted on a routine basis to evaluate its continued compliance with the regulations.

Best wishes with your new venture. Please call this office at 971-673-0540 if you have any questions.

Sincerely,

Client Care Surveyor
CMS Representative
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

If you need this information in an alternate format, please call our office at (971)673-0540 or TTY 711

MEDICARE PROVIDER AGREEMENTS AND CHANGES OF OWNERSHIP

NEW OWNER ACCEPTS ASSIGNMENT OF PREVIOUS OWNER'S PROVIDER AGREEMENT

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

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

NEW OWNER REFUSES ASSIGNMENT OF PREVIOUS OWNER'S PROVIDER AGREEMENT

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

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