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

The purpose of this letter is to outline the process you need to complete in order to change the ownership of your rural health clinic.

If you have questions about the rural health clinic program please call Troy Soenen at the Office of Rural Health. His number is 503-494-4450 or you may email him at soenent@ohsu.edu. Information is also available on the Office of Rural Health Website at www.ohsu.edu/oregonruralhealth.

The Health Care Regulation and Quality Improvement Section of the Oregon Health Authority has an agreement with the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS), to assist in determining whether health care facilities meet, and continue to meet, required conditions of participation. Their contact number is 503-693-4100, you may also visit their website at:
http://public.health.oregon.gov/PHD/PHL/Pages/index.aspx

If you wish to change the ownership of your rural health clinic, please complete and return these forms:

(1) HCFA 1561 A - Health Insurance Benefit Agreement (2 signed originals required) available online: http://www.cms.gov/cmsforms/downloads/cms1561a.pdf

(2) HCFA 29 - Request to Establish Eligibility available online: http://www.cms.hhs.gov/cmsforms/downloads/CMS29.pdf

(3) 855A & the FI approval letter for the 855A, information is available online: https://www.noridianmedicare.com/p-meda/contact/contact.html

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

viders/formstobecompleted.html & http://www.hhs.gov/ocr/civilrights/clearance/pregrantchecklist.pdf

***(If the RHC is applying to be provider based)**

In addition to the required forms and accompanying instructions, you can find a copy of the regulations that cover all of the requirements of the Medicare program online at: http://www.cms.hhs.gov/manuals/Downloads/som107ap_g_rhc.pdf.

These requirements include the standards, which must be met in regard to the care of patients and the principles of reimbursement for provider costs. To qualify for Medicare payments your facility must be in compliance with the Medicare conditions of participation and the requirements for reimbursement, including financial solvency.

Please submit these documents with a **written request** to our office. Be advised:

- **A Change of Ownership cannot be completed until we have received approval of your enrollment application (CMS 855A) from the fiscal intermediary (FI) or insurance carrier.** Our office will receive a copy of your 855A form from the FI, however, you must send the original 855A form to your FI.

- **You must have and display a current Oregon license to perform the required laboratory tests for the purpose of diagnosis and treatment or assessment of an individual's health.** For information regarding this license, you may contact the Center for Public Health Laboratories, laboratory Licensing Section.

Once we receive all the required documentation, we will forward it on to CMS. If CMS makes the determination that **all** Medicare requirements have been met, the Health Insurance Benefit Agreement will be countersigned and a copy will be retuned to you, along with the notification that your change of ownership has been approved.

You are required to notify this office if at any time you transfer ownership to another owner, an ownership group, or to a leasee. Please be advised, based on regulations at 42 CFR 489.19 the courts have upheld CMS's right to hold a new owner responsible for overpayment to a previous owner. 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 information has been prepared to outline the effect of a new owner's acceptance or refusal of assignment of an existing Medicare provider agreement.

Those institutions and agencies, which are denied certification in the program, will be notified and given the reasons for the denial and information about their rights to appeal the decision. Please do not hesitate to call this office if you have any questions.

Sincerely,

John Pilmer, RN
Client Care Surveyor
CMS Representative
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

If you need this material in an alternate format, please call our office at (971) 673-0540 or TTY (971) 673-0556.

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.