



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Division of Survey and Certification, Region VI

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October 14, 2004

**REGIONAL SURVEY AND CERTIFICATION LETTER NO. 04-09**

**TO:** All State Survey Agencies (Action/Information)  
All Title XIX Single State Agencies (Action/Information)

**SUBJECT:** NEW CHANGE OF OWNERSHIP PROCEDURE FOR SKILLED NURSING FACILITIES AND SKILLED NURSING FACILITIES/NURSING FACILITIES  
(**ACTION-** Effective Immediately)

The purpose of this memorandum is to modify the process for Medicare Change of Ownership (CHOW) procedures. Based on recommendations from the Office of General Counsel (OGC), CMS is directing State Agencies (SA) to give formal notice of assignment to Medicare certified long term care providers requesting a change of ownership at the time of the provider's request. OGC's recommendation is based on a legal opinion stating written notice should be given to the new owner/lessee, as soon as the new owner/lessee indicates they have or will take over an existing Medicare provider.

According to the State Operations Manual 3210.5, *"The owner can refuse to accept assignment of the previous owner's provider agreement, in a letter initiated by the prospective owner or can be indicated in response to a letter sent to the new owner by the RO of the SA that is designed to document the new owner's desire to continue program participation."*

To achieve this procedural change, CMS requests the SA to provide notice to the potential provider and include the following language:

*We have been notified that effective (Effective Date of CHOW) your organization became the new owner and operator of (Name of Facility) when a change of ownership occurs, the existing Medicare provider agreement is automatically assigned to the new owner. See 42 C.F.R. §489.18(b).*

*The Medicare provider agreement between the Federal government and the prior operator, lessee, or facility that will be automatically assigned to you is subject to all applicable statutes and regulations and to the terms and conditions under which the agreement was originally*



*issued. These terms and conditions include, but are not limited to, repayment of all pre-assignment Medicare monetary liabilities, as well as correction of any outstanding deficiencies. See 42 C.F.R. §489.18(d).*

*Should you decide not to accept the terms of the Medicare provider agreement, you have the option to:*

- *Apply for a new provider number or,*
- *Withdraw from the Medicare program.*

*Should you choose not to accept the terms of the Medicare provider agreement, please notify the State Agency in writing within forty-five (45) days of receipt of this letter. To expedite the process please respond in writing with your choice, otherwise, the State Agency will not forward the packet for processing to CMS until 45 days have passed.*

When sending the provider packet to CMS for approval of the CHOW, the SA will include a copy of the notice and the provider's response to the notice. CMS will not accept any CHOW packet unless the 45 days is completed or the provider's written acceptance is forwarded in the packet.

Attached is a sample form used by the State of Texas indicating the provider understands the Medicare assignment agreement and the provider's choice.

If you have any questions, you may contact Susana Cruz at (214) 767-4415 or [scruz@cms.hhs.gov](mailto:scruz@cms.hhs.gov).

Thank you for your assistance and cooperation.

Sincerely,

/S/

David R. Wright, Chief  
Long Term Care Branch  
Division of Survey and Certification

Attachment

## Prospective Owner Intentions Regarding Medicare Certification

A Provider who is contemplating or negotiating a change of ownership must notify the Centers for Medicaid and Medicare Services (CMS). (**42 CFR Part 489.18 (b)**). Please indicate if the prospective owner will participate in the Medicare program by checking the appropriate sections below.

\_\_\_\_\_ **Prospective Owner has read Section 3210.5 of the State Operations Manual and understands options. (Included in packet)**

\_\_\_\_\_ Prospective Owner does **not** intend to participate in Medicare program.

\_\_\_\_\_ Prospective Owner **intends** to participate in Medicare program.

\_\_\_\_\_ Prospective Owner **accepts** assignment of the previous owner's provider agreement

\_\_\_\_\_ Prospective Owner wishes to apply for **new** provider agreement.

Legal Entity \_\_\_\_\_

Name of Facility \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Authorized Signatory \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_

Please mail form **ASAP** to: State Agency Address