

MEMORANDUM

Texas Department of Aging and Disability Services

TO: Regulatory Services Division
Regional Directors and State Office Managers

FROM: Dana McGrath, Unit Manager
Policy, Rules and Curriculum Development Unit
State Office MC E-370

SUBJECT: Regional Survey and Certification (RS&C) Letter No. 12-01

DATE: February 10, 2012

The referenced Region VI Centers for Medicare and Medicaid Services (CMS) Regional Survey and Certification (RS&C) Letter was issued on November 17, 2011. This letter, which was distributed by e-mail on February 7, 2012 is being provided to you for information and action purposes and should be shared with all professional staff.

- RS&C Letter No. 12-01 – Voluntary Termination and Related Processes

If you have any questions, please contact a policy program specialist in the Policy, Rules and Curriculum Development Unit at (512) 438-3161.

Attachment



Division of Survey and Certification, Region VI

REGIONAL SURVEY AND CERTIFICATION LETTER NO. 12-01

Date: November 17, 2011

To: All State Survey Agencies

Subject: Voluntary Termination and Related Processes

The purpose of this letter is to clarify the types of voluntary termination from Medicare participation and to provide references and procedures for processing each type of voluntary termination. In addition, this letter will provide clarification regarding application to all Medicare providers and suppliers that voluntarily withdraw or terminate from the Medicare program.

The State Survey Agency (SA) submits the recommendation for voluntary termination to the Regional Office (RO) via the CMS 1539 and the supporting documents. The RO will review and then approve or disapprove the recommendation. If approved, the RO will notify the provider/supplier of the voluntary termination via letter, with a copy to the SA via ASPEN Central Office and to the Accrediting Organization, if applicable. The RO will send a CMS-2007, Tie-in notice, to the Medicare Administrative Contractor (MAC) or Fiscal Intermediary. If disapproved, the RO will communicate with the SA regarding the recommendation in order to clarify.

The following process definitions are applied in determining certification actions:

- **Voluntary Termination (withdrawal or closure):** This occurs when the owner of the Medicare provider agreement decides it no longer wishes to participate in the Medicare program and notifies the MAC, SA, and/or CMS. For a voluntary termination based on withdrawal, the facility is still operating and providing care but does not accept/bill Medicare. For a voluntary termination based on closure, the facility completely stops operations, is no longer providing care/services to any recipients, and has discharged all current recipients. (SOM 2005F, 3046-3049) See the “Cessation of Business” section below regarding situations where the provider/supplier does not inform CMS, the SA or the MAC of the termination of services.
- **Voluntary Termination under a Threat of Involuntary Termination:** This occurs when the facility is requesting a voluntary withdrawal from the Medicare program while CMS is taking action to terminate for non-compliance. The effective date for withdrawal from Medicare must be before the involuntary termination date. However, the facility will still have to meet reasonable assurance prior to re-entering the program. (SOM 2016D) even though it voluntarily withdrew from the Medicare program.(SOM 2016)

In situations where involuntary termination is imminent and written notification from the facility to voluntarily withdraw from the Medicare program is received, there are usually negotiations between the facility and the RO. During that time, a CMS-1539 will not be generated by the State Agency. The SA may enter a CMS-1539 later to allow the action to be completed in ASPEN.

- **Cessation of Business:** In this instance, the facility is found to be non-operational by the SA. This can usually be discovered when a survey is attempted. The surveyor determines that the facility is no longer open for business and has stopped providing services to the community; however, no notice has been given to CMS or SA.

The SA provides to the RO the supporting documentation and recommendation for a voluntary cessation of business. Supporting documentation must include a written report of the findings of the attempted onsite survey. Some examples of questions to be answered are: Is the facility closed? Is it locked? Is there signage? Is the phone still in service? The SA and RO should determine what evidence is necessary on a case by case basis.

A facility may be operational and not have patients/clients/residents at the time the SA conducts a survey or at any point in time. Failure to admit patients can be a trigger for CMS to determine if cessation of business has occurred. However, care should be taken to ensure a facility has indeed ceased business prior to recommending termination. (42 CFR 489.52(b)(3))

Cessation of business may also be determined related to revocation of state licensure. If State law requires licensure of a provider/supplier, the State should ensure the license is in place. CMS understands the licensure process varies by State as does the process for a provider/supplier to request review or reinstatement of a license. If the provider/supplier's license is no longer in place, the State should, after exhausting the regular courses of action (e.g., pending revocations or grace periods for license renewals) inform CMS of the recommendation of termination based on cessation of business.

- **Relocation Resulting in Cessation of Business:** In this case, the facility relocates to another community, hires new staff, discharges patients, and/or is serving patients/clients/residents in a new service area. This could be determined as a result of a SA survey, provider notification, change of address, or a change of ownership. (SOM 2702B, 3210.1B5)

The SA should provide the following supporting documentation, along with the CMS 1539:

- Previous location and current location
- Distance of move
- Prior and current staffing and services
- Were patients discharged?

Note: Critical Access Hospitals have specific guidance at SOM 2256 and S&C letter 07-35.

- **Deactivation:** The facility's billing privileges may be deactivated by the MAC due to inactivity of the certification number for billing purposes. Deactivation is not a voluntary termination. Deactivation means that the providers or suppliers billing privileges were stopped, but can be restored upon the submission of updated information (42 CFR 424.502). The reasons for deactivation of Medicare billing privileges may be found at 42 CFR 424.540.

No action is necessary unless additional information is received which suggests there is a question of whether or not the facility is still open.

- **Temporary Closure:** A request by the facility to temporarily stop providing services to the community may result in a temporary closure. Each request will be evaluated on a case by case basis relative to the length of time the entity is requesting to be closed, applying the following criteria:
 - For a temporary closure of 30 days or less, no review by the RO is required.
 - For a time frame of 30-90 days, the provider/supplier should establish benchmarks as approved by the SA and/or RO. The provider/supplier must notify the SA prior to re-opening.
 - For a time frame of 90-180 days, the provider/supplier should follow the process described for 30-90 days. In addition, the SA and/or RO may require a survey prior to reopening.

In all cases, once the facility is ready to reopen the SA will determine that the facility is operational.

Procedural notes:

The SA should follow SOM 3049 to submit the recommendation of voluntary termination to the RO, in consideration of these points:

- The SA should forward the following documents to the RO for recommendation of voluntary termination:
 - CMS 1539
 - Evidence of voluntary termination or cessation of business, which may include written notice from the provider/supplier.
 - MAC letter acknowledging withdrawal and CMS 855A or 855B, if available.
 - Facility's newspaper notice published 15 days prior to the effective date, if available.
- If the RO receives a letter directly from the facility or the MAC, the RO will forward to the SA for processing of a recommendation.
- The discharge date of patients is not necessarily the actual termination date. The provider should determine the effective date of voluntary termination. If the facility does not select an effective date, CMS will set a date that will not be more than 6 months from the date on the provider's notice of intent. (42 CFR 489.52(b)(1))
- Providers should be directed to SOM 2005F, SOM 3046 and 42 CFR 489.52(a)(1) and (2) when requesting information about voluntary termination from the Medicare program.

On occasion a provider may indicate, after receiving the RO's notice of voluntary termination or cessation of business letter that they did not intend to terminate. These situations are processed on a case by case basis by the Regional Office. (SOM 3046B)

If you have questions, please contact Jann Caldwell at 214-767-4401 or email to jann.caldwell@cms.hhs.gov.

Sincerely,

Ginger Odle
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Dallas Division of Survey and Certification