

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 413, 440, 441, and 489

[HCFA-1152-FC]

RIN 0938-AI31

Medicare and Medicaid Programs; Surety Bond and Capitalization Requirements for Home Health Agencies

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule with comment period.

SUMMARY: The Balanced Budget Act of 1997 (BBA '97) requires each home health agency (HHA) to secure a surety bond in order to participate in the Medicare and Medicaid programs. This requirement applies to all participating Medicare and Medicaid HHAs, regardless of the date their participation began. This final rule with comment period requires that each HHA participating in Medicare must obtain from an acceptable authorized Surety a surety bond that is the greater of \$50,000 or 15 percent of the annual amount paid to the HHA by the Medicare program, as reflected in the HHA's most recently accepted cost report. The BBA '97 also requires that provider agreements be amended to incorporate the surety bond requirement; this rule deems such agreements to be amended accordingly. The BBA '97 prohibits payment to a State for home health services under Medicaid unless the HHA has furnished the State with a surety bond that meets Medicare requirements. This final rule with comment period requires that, in order to participate in Medicaid, each HHA must obtain from an acceptable authorized Surety, a surety bond that is the greater of \$50,000 or 15 percent of the annual Medicaid payments made to the HHA by the Medicaid agency for home health services for which Federal Financial Participation (FFP) is available.

In addition to the surety bond requirement, an HHA entering the Medicare or Medicaid program on or after January 1, 1998 must demonstrate that it actually has available sufficient capital to start and operate the HHA for the first 3 months. Undercapitalized providers represent a threat to the quality of patient care.

DATES: *Effective Date:* January 1, 1998.

Comment Period: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on March 6, 1998.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-1152-FC, P.O. Box 26688, Baltimore, MD 21207-0488.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 309-G, Hubert H. Humphrey Building, 00 Independence Avenue, SW, Washington, DC 20201, or Room C5-09-26, 7500 Security Boulevard, Baltimore, MD 21244-1850.

In commenting, please refer to file code HCFA-1152-FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690-7890).

FOR FURTHER INFORMATION CONTACT: Ralph Goldberg (410) 786-4870 (Medicare Surety Bond Provision); John Eppinger (410) 786-4518 (Medicare Capitalization Provision); Mary Linda Morgan (410) 786-2011 (Medicaid Provisions).

SUPPLEMENTARY INFORMATION: On September 15, 1997, the Department of Health and Human Services (HHS) issued a press release announcing that HHS was halting Medicare certification of new home health agencies (HHAs) and, during the interim, would be developing new regulations to fight home health fraud and abuse. In this final rule with comment period we implement the statutory requirement in the Balanced Budget Act of 1997 (BBA '97), (Public Law 105-33), enacted August 5, 1997, that requires an HHA to post a surety bond as a condition of its approval as a Medicare provider or Medicaid provider of home health services. Also, on the basis of authority found in sections 1861(o)(8), 1866(b)(2), and 1891(b), of the Social Security Act (the Act), we institute a requirement that a new HHA, under the terms of its provider agreement, must have enough funds on hand to operate for the first 3 months. The purpose of both requirements is to establish the financial stability of home health providers. The discussion below deals with both provisions.

I. Background: Surety Bonds

Home health agencies (HHAs) that meet certain requirements are approved

to be paid for medical and other services furnished to Medicare and Medicaid beneficiaries. Section 1861(o) of the Social Security Act (Act) defines the term "home health agency" under the Medicare program and thereby establishes certain conditions and requirements that an HHA must meet in order to participate in Medicare. As a Medicare participating provider of services, HHAs also must comply with applicable requirements for provider agreements and supplier approval located in our regulations at 42 CFR part 489.

Sections 1902(a)(10)(D) and 1905(a)(7) of the Act provide for the coverage of home health services as medical assistance under an approved State Medicaid plan. Implementing regulations for these statutory provisions are located at 42 CFR 440.70 and 441.15. Section 440.70(d) specifies that a home health agency under Medicaid is an agency that meets the requirements for participating in Medicare. Section 441.15 specifies State plan requirements for home health services.

Section 4312(b)(1) of BBA '97 amended section 1861(o) of the Act to require each HHA, on a continuing basis, to furnish us with a surety bond in a form we have specified and in an amount that is not less than \$50,000. The BBA '97 provides for a waiver of this requirement, which we discuss below. This provision is to be implemented effective for services furnished to Medicare beneficiaries on or after January 1, 1998. However, our regulations do not currently contain such a requirement. This change affects our regulations at 42 CFR part 489. Section 4312(b)(2) of BBA '97 amended the definition of "reasonable cost" in section 1861(v)(1)(H) of the Act to provide that the cost of a surety bond is not included as an allowable Medicare cost. This change affects our regulations at 42 CFR part 413, subpart F, which concern specific categories of Medicare costs.

Section 4724(b) of BBA '97 also amended section 1903(i) of the Act by adding a new paragraph (18) to prohibit Federal financial participation (FFP) in payments under Medicaid for home health services unless the HHA provides the State Medicaid agency, on a continuing basis, a surety bond in a form that we have specified for Medicare participation and in an amount that is not less than \$50,000 or some other comparable surety bond under State law. This change affects our regulation at 42 CFR Part 441.

II. Surety Bond Requirements for HHAs Under Medicare

A. Scope of Requirement

In general, every HHA that participates or that seeks to participate in the Medicare program must obtain a surety bond. The surety bond must name the HHA as Principal, HCFA as Obligee, and the surety company as Surety. The statute permits us to waive the requirement of a surety bond in the case of an agency or organization that provides a comparable surety bond under State law. We are not, as a general matter, implementing the full scope of this waiver authority at this time, because we are still considering what standards and criteria would be appropriate to implement such a waiver. If a State has a comparable bond requirement, we can waive the Medicare bond requirement with respect to those HHAs that furnish us with a bond in compliance with that State's law. At the moment, we are only aware that Florida has a bond requirement which is for \$50,000, whereas our requirement begins at \$50,000 and is higher under certain circumstances. We believe that this is consistent with the intent of the Congress that established \$50,000 as the minimum amount of the bond.

Although we have been apprised that other States are considering legislation, we are not aware that any of this legislation has been enacted into law. As a result, we are seeking public comment on what States currently require in order for HHAs to be in compliance with State law. We are also seeking public comment with respect to comparable experiences in the private sector on the establishment of surety bond requirements for HHAs. In addition, we are seeking public comment on the impact of our not choosing to waive the Medicaid bond required in the case of an agency or organization that provides a comparable surety bond under State law. We are, however, waiving the requirement for an HHA operated by a Federal, State, local, or tribal government agency if, during the preceding 5 years, the HHA has not incurred long-term unpaid debts owed to us based on unrecovered Medicare overpayments or on unpaid civil money penalties or assessments, and none of its claims have had to be referred by us to the Department of Justice or the General Accounting Office because of nonpayment. A government-operated HHA that does not qualify for waiver must submit a surety bond.

We are waiving the surety bond requirement for government-operated HHAs only to the extent such HHAs have a good history of paying their

Medicare debts. Our anecdotal experience suggests that such HHAs timely pay their Medicare debts. The basis for this waiver is principally that because government-operated HHAs are a component of government, and because a government has the power to tax, it is unlikely such HHAs will be unable to pay their Medicare debts. Thus, government-operated HHAs, by their public nature, furnish a comparable or greater guarantee of payment as would be afforded us by a surety bond issued by a private surety company. Nevertheless, government-operated HHAs with a poor history of paying their Medicare debts, if there are any such HHAs, are subject to the surety bond requirement. We solicit comments on appropriate criteria we may use for waiving other HHAs from the requirement to purchase a surety bond.

B. Relationship to Provider Agreements

Section 4312(f)(2) of BBA '97 specifies that the surety bond requirement must be incorporated into existing Medicare provider agreements by January 1, 1998. Inasmuch as this mandate would require the modification of over 10,000 HHA provider agreements by the January 1, 1998 deadline, we are implementing these modifications by this rule. Therefore, this rule deems such agreements to be modified so as to incorporate the surety bond requirement effective January 1, 1998.

We will verify that each HHA has obtained a bond in the correct amount and that the bond otherwise conforms to the specifications we establish. If an HHA fails to timely file a surety bond that meets the requirements of our rules, we may terminate a participating HHA's existing provider agreement or refuse to enter into a provider agreement with an HHA that seeks to participate in Medicare. The surety bond requirement will be incorporated into participating HHAs' existing provider agreements and all new HHA provider agreements effective January 1, 1998.

C. What Constitutes a Surety Bond

The "surety bond" in this final rule with comment period is an instrument obtained by an HHA from a surety company in which the surety company, acting as Surety, guarantees that it will be responsible for unrecovered debts owed to us by an HHA.

We are requiring that the bond be obtained from a company that has been issued a Certificate of Authority by the U. S. Department of Treasury (which has issued generally applicable regulations governing the surety bond industry with respect to Federal agencies, thereby creating a well-

regulated market). Such companies are listed in the Department of Treasury's Circular Number 570 "Companies Holding Certificates of Authority as Acceptable Sureties on Federal Bonds and as Acceptable Reinsuring Companies." We limit the purchase of a bond from a company listed on the Department of Treasury's list of approved companies that have been issued a "Certificate of Authority" to ensure that a Surety we rely on meets certain minimum standards. Also, the company must not have been determined by us to be an unauthorized surety for the Medicare program.

We will determine a surety company to be unauthorized if:

- The surety company fails to furnish us, upon request, timely confirmation of the issuance of, and the validity and accuracy of information appearing on, a surety bond.
- The surety company fails to pay us timely after we have presented to the surety a proper claim for payment and sufficient evidence to establish the surety company's liability on the bond.
- The surety company, by other similar action, furnishes us with good cause to determine that the company is not acceptable as a surety for the Medicare program.

A determination that a surety company is not an authorized source for surety bond for Medicare will be effective immediately upon publishing a notice of the determination in the **Federal Register** and remains in effect until we publish a notice of reinstatement in the **Federal Register**. However, any such determination does not affect any surety bond issued by the surety company to an HHA before the effective date of the determination.

If a Surety is determined to be an unauthorized surety company, we will also determine whether and how such a determination will affect HHAs that have obtained a current bond from the now unauthorized company. We may require that HHAs obtain replacement bonds. A determination by us that a surety company is an unauthorized surety company for the purposes of this rule is not a debarment, suspension, or exclusion for the purposes of Executive Order 12549.

D. Surety Company Obligations

The surety company must guarantee to pay us, up to the face amount of the bond, the full amount of any unpaid Medicare overpayment, plus accrued interest, based on payments we made to the HHA during the term of the bond. Also, the surety company must guarantee to pay us, up to the face amount of the bond, the full amount of

any unpaid civil money penalty or assessment we have imposed on the HHA during the term of the bond based on an authority under Title XI, Title XVIII, or Title XXI of the Act, plus any accrued interest. When the term of the surety bond expires, the Surety remains liable for any claims that are not timely paid that have been or will be identified based on Medicare payments made during the term of the bond and for civil money penalties or assessments that were determined during the term of the bond and are not timely paid. We will demand payment from a Surety when the Surety becomes liable under a bond even if we have available to us alternative legal means to pursue collection of the monies due us.

Additional requirements for obtaining a surety bond are addressed in order to specify the conditions under which the surety company becomes liable to us.

E. HHA Surety Bond Purchase Requirements

Except for an HHA operated by a Federal, State, local, or tribal government agency determined by us to meet the waiver criteria for this requirement, every other participating HHA must submit to us by February 27, 1998 a surety bond that is effective beginning January 1, 1998 through the end of the HHA's current fiscal year. Thereafter, a participating HHA must submit to us, on an annual basis, a new surety bond to be effective for the HHA's fiscal year. The HHA must submit the bond to us not later than 30 days before the start of the fiscal year. (For an HHA whose fiscal year begins February 1, 1998 or March 1, 1998 the submission of the second bond would not be due until March 31, 1998.) We require each HHA to obtain a new surety bond each year in lieu of a multiple-year bond or continuous bond. We believe neither a multi-year bond nor a continuous bond gives the Medicare Trust Funds the level of protection of a one-year bond. In addition, a one-year bond makes it easier to administratively tie a particular bond with a particular year's Medicare payments. Also, if the Surety's liability is renewed each year up to the limit of the surety bond, any penalties and assessments have a greater opportunity of being repaid by the HHA. If a one-year bond is required, it is easier to link the Surety's liability with a particular term of the bond and the fiscal year.

An HHA that seeks to participate in Medicare for the first time must submit a surety bond to us with its enrollment application (form HCFA-855, OMB approval number 0938-0685) but no later than the completion date of its

certification survey. An HHA that seeks to become a participating HHA through the purchase or other transfer of the ownership interest of a participating HHA must also ensure that the surety bond is effective from the date of the purchase or transfer of the ownership interest.

For an HHA that undergoes a change of ownership, the 15 percent is computed on the basis of Medicare payments made by us to the HHA for the most recently accepted cost report.

F. Amount of Surety Bond

We are establishing a flat rate to determine the amount of the bond that will be used in combination with a \$50,000 minimum bond. The flat rate is related to the volume of business a HHA does with Medicare. The bond amount is the maximum amount for which a surety company would be liable to HCFA. The flat rate is generally 15 percent of the annual amount paid to the HHA by the Medicare program as reflected in the HHA's most recently accepted cost report. However, if an HHA's payments have increased or decreased by 25 percent for the first 6 months of the HHA's current fiscal year, we will determine the amount of the bond required for the next fiscal year based on such payments and notify the HHA of the required bond amount based on the annualized amount of such payments. In either case, the amount of the surety bond and the premium paid by the HHA for the surety bond are directly tied to the amount of Medicare payments received by the HHA.

We believe a bond amount tied to 15 percent of an HHA's Medicare payments is needed to ensure that we will recover on most uncollectible overpayments. In 1993, Medicare overpayments were 4 percent of total Medicare payments made to all HHAs. In 1996, Medicare overpayments had grown to 7 percent of total Medicare payments made to all HHAs. Thus, the industry-wide ratio of overpayments to payments has risen dramatically (nearly doubling). Also, although the industry percentage was only 7 percent in 1996, the overpayments of a particular HHA, as a percentage of that HHA's Medicare payments could greatly exceed the percentage of overpayments of all HHAs.

We also believe that generally the 15 percent is a reasonable percentage on which to base the amount of the bond, since it would not be too high as to be a barrier for small companies, yet high enough to provide the Trust Funds with a reasonable ability to recover debts owed to the program. In determining

this percentage amount, we consulted with an insurance industry trade group.

For HHAs currently participating in Medicare, the amount of the initial surety bond (i.e., the bond effective from January 1, 1998) is to be based on the HHA's most recently accepted cost report. For an HHA that seeks to participate in the Medicare program on or after January 1, 1998 and purchases the assets or ownership interest of a participating (or formerly participating) HHA, the amount of the initial surety bond will be based on the total amount of Medicare payments to the participating (or formerly participating) HHA in the most recently accepted cost report. For an HHA that seeks to participate in the Medicare program on or after January 1, 1998 and has not purchased the assets or ownership interest of a participating (or formerly participating) HHA, the amount of the initial surety bond will be \$50,000. The amount of each subsequent surety bond will be based on the annual total amount of Medicare payments made to the HHA in the most recently accepted cost report.

If an HHA's overpayment for the most recently accepted cost report exceeds 15 percent of annual payments, Medicare may require the HHA to secure a bond up to or equal to the amount of the overpayment, provided the amount of the bond is not less than \$50,000.

G. Cost of Surety Bonds

We have been advised by surety industry sources that well-operated and sufficiently capitalized companies can expect to incur costs, on average, of approximately \$10 per thousand dollars of the face amount of the bond. Thus, on average, a \$50,000 bond will cost an HHA approximately \$500. As noted earlier, under section 4312(b)(2) of BBA'97 the cost of surety bonds is not to be reimbursed by Medicare. The costs associated with obtaining surety bonds is further discussed in the regulatory impact analysis section of this preamble.

III. Surety Bond Requirements Under Medicaid

Section 4724(b) of BBA '97 amended section 1903(i) of the Act to prohibit Federal Financial Participation (FFP) to a State for home health services under Medicaid unless the home health agency furnishing the services provides the State with a surety bond that meets the requirement established by section 1861(o)(7) of the Act. This provision is effective for services furnished on or after January 1, 1998. This change affects our regulations at 42 CFR part 441.

In general, every HHA that participates or that seeks to participate in the Medicaid program must obtain a surety bond. The statute requires that the Medicaid surety bond must be in the form specified by the Secretary for surety bonds under the Medicare program. Therefore, in general, the requirements for surety bonds for HHAs in the Medicare program, discussed in section II of this preamble, also apply to HHAs participating in the Medicaid program. However, certain differences between the Medicare and Medicaid programs require that the surety bond requirement be tailored to fit the Medicaid program. Medicare reimbursement for services furnished by participating HHAs is provided through fiscal intermediaries based on claims submitted directly to HCFA. Payment for home health services under Medicaid is made to the HHA by the State Medicaid agency. The State Medicaid agency submits a quarterly expenditure report to HCFA in order to claim Federal matching funds, usually at the 50 percent rate, for home health services provided under Medicaid by participating HHAs.

In general, we are adopting for the Medicaid program the surety bond requirements set forth in the Medicare program, as provided for under the BBA '97. Appropriate changes are made to establish that the HHA participating in the Medicaid program must submit the surety bond to the State Medicaid agency, rather than HCFA, and that the State Medicaid agency must take the applicable actions with regard to compliance with the statutory and regulatory requirements in order to receive FFP for home health services. For these reasons, we are allowing the State Medicaid agency to specify any other requirements for the HHA that it deems necessary to ensure that it receives a surety bond from an authorized surety company. Surety bonds must be submitted to the Medicaid agency by February 27, 1998, and carry an effective date of January 1, 1998. The term of the bond must be 1 year and the amount of the bond must be \$50,000 or 15 percent of the amount paid to the HHA by the State Medicaid program for the most recent annual period for which data are available, whichever is greater. As in Medicare, the Medicaid agency may require a bond greater than 15 percent of annual payments if the HHA's overpayments exceed that percentage of payments.

The Medicaid agency, rather than HCFA, is the obligee for surety bonds required under the Medicaid program. We are specifying that each State will make the determination that a surety

company has met a condition to cause it to be unauthorized for Medicaid purposes in its State. Since each State will be making this determination, we are allowing the State to establish its own requirements for notifying the HHAs and the public that a surety company is not authorized for Medicaid purposes in the State. Each State is provided the flexibility to set the annual period for which bonds in their State will apply.

The surety bond under Medicaid is for unpaid overpayments only, not for civil money penalties or assessments, as is the case under Medicare. Civil money penalties against HHAs are not authorized under the Medicaid statute and neither HCFA nor the States can impose assessments to HHAs similar to those assessments imposed by HCFA under Medicare.

IV. Capitalization Requirements for HHAs

A. Background

One potential difficulty with many small businesses is that they are often undercapitalized. That is, they do not have adequate capital, or up-front funds, with which to operate the business pending development of an adequate and reliable stream of revenue.

Even under ideal conditions, a business must incur costs before any revenues are realized. Costs of planning and organizing the business are incurred before any services can be rendered or goods can be sold. Afterwards, once the business has begun to operate, there is a period of time when services are rendered or goods are sold before any revenues from these activities actually will begin to flow into the business. Until that happens, the business must have other funds available to operate in order to pay employee salaries, to pay rent, to pay costs of heat, light and power, and so forth.

Under less than ideal conditions, the need for adequate up-front operating funds is even more critical. For example, the demand for the services or goods may not be as great as anticipated; a temporary (or longer) downturn in the market may depress sales; the normal turn-around in billing and receiving payment may be longer than anticipated; or particular customers may lag in paying for goods and services.

New HHAs generally are small businesses and have the same need for adequate capitalization as have other small businesses which are just starting. As with other small businesses, a lack of funds in reserve to operate the business until a stream of revenues can be established can seriously threaten the

viability of the business. In addition, for new HHAs, which are in business to render patient care services, any condition threatening the viability of the new business can adversely affect the quality of care to their patients and, in turn, the health and safety of those patients. That is, if lack of funds forces an HHA to close its business, to reduce staff, or to skimp on patient care services because it lacks sufficient capital to pay for the services, the overall well-being of the HHA's patients could be compromised. In fact, there could be the risk of serious ill effects as a result of patients not receiving adequate services.

The level of services provided to an HHA's patients is of serious concern to us for the following reason. The process by which an HHA participates in the Medicare program is one that involves a survey by HHS or an accrediting organization. This survey is essentially a snapshot of the agency's activities. For a new agency that is undercapitalized, it may be unable to sustain the level of services it is able to provide at the time of the survey over the period of time necessary for it to begin receiving a steady stream of revenue from Medicare. The period in question could last as long as two or even three months. Since a survey has already been conducted, the new HHA's services are not routinely inspected during this period and so there is increased danger that lack of operating funds could result in inadequate care that is not discovered.

B. Effects of Threatened Financial Viability

To assure quality of care to patients who receive care from a new HHA, we are establishing initial capitalization requirements for new HHAs in order to increase the likelihood of their viability and to minimize situations that could adversely affect the health and safety of their patients. These requirements will be effective January 1, 1998.

We believe that these requirements are urgently needed, particularly in light of the findings of the Office of Inspector General (OIG) regarding undercapitalized or bankrupt HHAs and the adverse impact such HHAs have on the Medicare program and public monies. In its July 1997 report, "Home Health: Problem Providers and Their Impact on Medicare" (OEI-09-96-00110), the OIG stated, in part:

If it were not for Medicare accounts receivable, problem agencies would have almost nothing to report as assets. Agencies tend to lease their office space, equipment, and vehicles. They are not required by Medicare to own anything, and they are almost always undercapitalized. On average,

cash on hand and fixed assets amount to only one-fourth of total assets for HHAs, while Medicare accounts receivable frequently equal 100 percent of total assets. These agencies are almost totally dependent on Medicare to pay their salaries and other operating expenses. For a home health agency, there are virtually no startup or capitalization requirements. In many instances, the problem agencies lease everything without collateral. They * * * do not even have enough cash on hand to meet their first payroll.

We agree that it is unacceptable that an HHA can enter the Medicare program in many cases with little or no reserves with which to operate pending receipt of reimbursement from Medicare (and other payers). To do business in this manner sets a new HHA up for potential problems from the beginning and exposes Medicare to unnecessary risk. Accordingly, we believe it is imperative that Medicare set capitalization requirements for new HHAs promptly.

Section 1891(b) of the Act states that it is "the duty and responsibility of the Secretary to assure that the conditions of participation and requirements specified in or pursuant to section 1861(o) and subsection (a) of this section and the enforcement of such conditions and requirements are adequate to protect the health and safety of individuals under the care of a home health agency and to promote the effective and efficient use of public moneys." Section 1861(o)(8) itself authorizes the Secretary to establish "such additional requirements * * * as the Secretary finds necessary for the effective and efficient operation of the program."

Section 1866(b)(2) provides that the Secretary may refuse to enter into an agreement under section 1866 after determining "that the provider fails to comply substantially with the provisions of the agreement" or "with the provisions of [Title 18] and regulations thereunder" or "that the provider fails substantially to meet the applicable provisions of section 1861."

It is on the basis of these authorities that we are, by regulation, establishing this new requirement that an HHA must have a certain minimum amount of capital necessary to assure the financial success of the business and, thus, to minimize the possibility of quality problems or financial loss to the Medicare program as a result of shortfalls in business revenue.

C. Capitalization Requirements

For an HHA that seeks to participate in the Medicare or Medicaid program beginning on or after January 1, 1998, we will determine whether the HHA has sufficient capitalization, that is, the

initial reserve operating funds that the HHA will need to operate for the first three months as a participating Medicare or Medicaid provider. Capitalization is required for all HHAs that are seeking, for the first time, to participate in Medicare, including new HHAs as a result of a change of ownership if the change of ownership results in a new provider number being issued.

These capitalization requirements apply to Medicaid HHAs as well as Medicare HHAs. As provided in 42 CFR 440.70(d), a home health agency for the Medicaid program means a public or private agency or organization, or part of an agency or organization, that meets requirements for participating in Medicare. Most HHAs participate in both the Medicare and Medicaid programs. However, even those HHAs that participate solely in Medicaid but not in Medicare must meet the Medicare requirements. Therefore, the following discussion, which is directed to Medicare HHAs, must be read to apply also to HHAs that seek participation in both programs or only in the Medicaid program. However, in the case of Medicaid-only HHAs, the Medicaid State agency is responsible for determining whether the capitalization requirements set forth in 42 CFR 489.28 are met in the same manner that Medicare intermediaries make the determination for HHAs requesting to enter the Medicare program only or both the Medicare and Medicaid programs.

As discussed further below, through our Medicare intermediaries we will determine the amount of capital that each new HHA is required to have before becoming certified in the Medicare program. This amount is to enable the HHA to operate for three months after becoming certified to participate as a Medicare provider of services. That is, as of the date that the HHA becomes certified in the Medicare program, which sometimes could be retroactive back to the date the HHA met all condition level requirements, it must have available the amount of capital determined by us as sufficient under criteria established by this rule. After the date of certification, it is expected that the HHA will expend some, or in some cases all, of the funds in providing care to its patients, including Medicare beneficiaries, pending developing a stream of patient care revenue from Medicare and other payers.

There may be several ways to structure a capitalization requirement for new HHAs, but we believe the method discussed below is reasonable and likely to meet the objectives of

enhancing the financial viability of the Medicare program. We will determine the sufficiency of the capitalization of an HHA that seeks to participate in the program based on the first-year experience of other HHAs, i.e., on cost data from submitted cost reports for the first full year of operation from at least three other comparable HHAs. Although a number of factors could be relevant in determining an adequate capitalization amount, we believe the following core-approach serves to tailor the capitalization needed by an HHA which is seeking to participate in the Medicare program.

First, the intermediary determines an average cost per visit based on first-year cost report data from the as-filed cost reports for at least three HHAs that it serves that are comparable to the HHA that is seeking to enter the Medicare program, considering such factors as geographic location and urban/rural status, number of visits, provider-based vs. free-standing, and proprietary vs. non-proprietary status. The average cost per visit is determined by dividing the sum of the total reported costs of care for all patients of the HHAs by the sum of their total visits. Then, the intermediary multiplies the average cost per visit by the projected number of visits for *all* patients (Medicare, Medicaid, and all other patients) for the first three months of operation of the HHA that is seeking to enter the program. By developing an average cost per visit using first year cost data from at least three comparable HHAs in the same area, then applying this cost per visit to the new HHA's own projected visits, the initial reserve operating funds so determined should closely approximate the needs of the new HHA.

Finally, if the number of annual visits projected by the HHA seeking to enter the program is less than 90 percent of the average number of annual visits reported by the HHAs from which the average cost per visit was developed (that is, total reported visits divided by the total number of HHAs used), the intermediary will substitute for the HHA's projected visits 90 percent of one calendar quarter of the average reported visits (that is, the average number of visits for three months) for the new HHAs already in the program. This step serves to set a reserve amount for the new HHA in line with the experience of comparable HHAs in the same area and prevents the new HHA from being undercapitalized, and putting the HHA and the Medicare program at risk.

The intermediary also will submit the average cost per visit that it has developed to the HCFA regional office that is involved in certifying the HHA.

We will collect this information and analyze it to determine the feasibility of establishing average per visit costs regionally or centrally or developing some other measure of initial capitalization. Following publication of these new regulations, we will develop program instructions that will describe this process more fully.

The process we have laid out here will work acceptably, we believe, because regional home health intermediaries (RHHs) serving HHAs are limited in number and have both the expertise and recent cost reporting files to estimate the capital requirements laid out in this rule. We recognize, however, that the process relies to some extent on the recent cost reports available to the RHHs and that it could be improved if the capitalization amounts required could be derived from a larger data base and could be computed to a greater degree by provider type. We have recently begun to receive HHA cost reports in an automated system; however, the available reports are limited and additional information from survey and certification files and HHA claims data would be necessary to help develop the data we need. We have begun to look at these data to determine if it is feasible to compute capitalization amounts from them. If so, we will use this data in further developing in the future, the capitalization requirements established in this final rule.

The HHA must provide us sufficient evidence to prove that the initial reserve operating funds are available to it and that at least 50 percent of the amount comprises the HHA's own, non-borrowed funds which are not in any way encumbered. If an owner uses his/her own funds in the business, whether loaned or contributed to the business, the funds are considered the owner's investment in the business and, therefore, those funds are part of the HHA's own funds. (However, if the owner lends funds to the business, any interest the HHA pays the owner would not be allowable as interest under the Medicare program (42 CFR 413.153(c)(1)).

If an organization plans to do business with the Medicare program as a new HHA, we believe it is reasonable that it would have 50 percent of the capitalization requirement as non-borrowed funds. Fifty percent of the requirement in non-borrowed funds demonstrates that the organization is earnest in its attempt to become a financially sound provider of home health services under the Medicare program. And from Medicare's perspective, 50 percent of the capitalization minimizes Medicare's risk

that the HHA will become financially insolvent in the beginning stages of starting its business. At least one State, (the State of New York), which imposes operating capital requirements as part of its certificate-of-need process for HHAs, requires the applying HHA to document that it has contributed at least 50 percent of its own (non-borrowed) funds in meeting the capital requirement.

To support that the HHA has met the requirement, it must provide the intermediary with a copy of the statement(s) of the HHA's savings, checking, or other account(s) which contain(s) the funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available.

Although Medicare generally expects the funds available to be cash funds, in some cases an HHA may have all or part of the initial reserve operating funds in cash equivalents. For the purposes of this section, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. If a cash equivalent is not readily convertible to a known amount of cash as needed *during the initial three month period* for which the initial reserve operating funds are required, the cash equivalent does not qualify in meeting the initial reserve operating funds requirement. Examples of items commonly considered to be cash equivalents are Treasury bills, commercial paper, and money market funds. As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents.

Depending on the elapsed time between the time the HHA originally establishes that it has the funds available and the time needed for us to determine that the HHA has met all other requirements necessary for certification, we later may require the HHA to furnish us with another attestation from the financial institution that the funds remain available upon the HHA's certification into the Medicare program or, if applicable, documentation from the HHA that any cash equivalents remain available.

Also, the officer at the HHA who will be certifying to the accuracy of the information on the HHA's cost report must certify as to the portion of the required initial reserve operating funds that constitutes non-borrowed funds, an amount which must be at least 50 percent of the total required funds.

The remainder of the initial reserve operating funds may be secured through borrowing or line of credit from an

unrelated lender. An unrelated lender is defined in the regulations providing for the reimbursement of allowable interest expense under the Medicare program. In determining whether interest is proper under the Medicare program, 42 CFR 413.153(b)(3) provides that "interest be—(ii) Paid to a lender not related through control or ownership, or personal relationship to the borrowing organization." Funds borrowed from a person or entity contrary to the provisions in § 413.153(b)(3)(ii) do not qualify as funds to meet the initial reserve operating funds requirement.

If borrowed funds are not in the same account(s) as the provider's own funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA, by providing to the intermediary a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available. As with the provider's own funds, we later may require the HHA to furnish another attestation by the financial institution that the funds remain available upon the HHA's certification into the Medicare program.

If the HHA chooses to establish the availability of a portion of the initial reserve operating funds with a line of credit, it must provide the intermediary with a letter of credit from the lender. As with funds in a bank or other financial institution, as discussed above, we later may require the HHA to furnish us with an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

We will not enter into a provider agreement with an HHA until we are satisfied, through the intermediary, that the capitalization requirement has been met, that is, that the HHA has the initial reserve operating funds available as discussed above.

V. Provisions of the Final Rule With Comment Period

A. Surety Bond Requirements Under Medicare

We are adding a new Subpart F to 42 CFR part 489, consisting of §§ 489.60 through 489.73, to establish the surety bond requirements that pertain to HHAs under Medicare.

In § 489.60 ("Definitions") we specify the meaning of the terms "assessment", "assets", "civil money penalty", "participating home health agency",

“surety bond”, “unpaid civil money penalty or assessment”, and “unpaid claim” to clarify the meaning of these terms in the context of the surety bond requirements.

We define the terms as follows:

Assessment means a sum certain that HCFA may assess against an HHA in lieu of damages under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Assets includes but is not limited to any listing that identifies Medicare beneficiaries to whom home health services were furnished by a participating or formerly participating HHA.

Civil money penalty means a sum certain that HCFA has the authority to impose on an HHA as a penalty under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Participating home health agency means a “home health agency” (HHA), as that term is defined by section 1861(o) of the Social Security Act, that also meets the definition of a “provider” as set forth at § 400.202 of this chapter.

Surety bond means one or more bonds issued by one or more surety companies under 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225, provided the bond otherwise meets the requirements of this section.

Unpaid civil money penalty or assessment means a civil money penalty or assessment imposed by HCFA on an HHA under Titles XI, XVIII, or XXI of the Social Security Act, plus accrued interest, that, 90 days after the HHA has exhausted all administrative appeals, remains unpaid (because the civil money penalty or assessment has not been paid to, or offset or compromised by, HCFA) and is not the subject of a written arrangement, acceptable to HCFA, for payment by the HHA. In the event a written arrangement for payment, acceptable to HCFA, is made, an *unpaid civil money penalty or assessment* also means such civil money penalty or assessment, plus accrued interest, that remains due 60 days after the HHA’s default on such arrangement.

Unpaid claim means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that, 90 days after the date of the agency’s notice to the HHA of the overpayment, remains due (because the overpayment has not been paid to, or recouped or compromised by, HCFA) and is not the subject of a written arrangement, acceptable to HCFA, for payment by the HHA. In the event a written arrangement for payment, acceptable to HCFA, is made, an *unpaid claim* also means a Medicare overpayment for

which the HHA is responsible, plus accrued interest, that remains due 60 days after the HHA’s default on such arrangement.

In § 489.61 (“Basic requirement for surety bonds”) we stipulate that, in general, each Medicare participating HHA or HHA that seeks to become a Medicare participating HHA must obtain and furnish us with a copy of a surety bond. The BBA ’97 requires that HHAs must obtain a surety bond effective January 1, 1998. In addition, we believe that requiring a HHA to purchase a surety bond will help ensure that we are able to recover overpayments we cannot collect using other methods.

In § 489.62 (“Requirement waived for Government-operated HHAs”) we stipulate that, under certain conditions, government-operated HHAs are deemed to have furnished a comparable surety bond under State law. When the necessary conditions are met, we waive the bond requirement. We believe that government-operated HHAs tend not to use fraudulent or abusive Medicare billing practices and when overpaid almost invariably honor their debts. Our anecdotal experience suggests that such HHAs timely pay their Medicare debts. More importantly, given the taxing authority of the government of which the HHA is a part, such government will generally be able to raise funds to meet its just debts. As such, we believe such taxing power affords us a comparable if not greater level of protection as would a surety bond issued by a private surety company and that any Medicare debt a government-operated HHA might inadvertently incur would be easily collectible. Therefore, we believe that government-operated HHAs represent a minimum risk to Medicare. Consequently, we have waived the surety bond requirement for government-operated HHAs to the extent such HHAs have a good history of paying their Medicare debts. Government-operated HHAs with a poor history of paying their Medicare debts, if there are any such HHAs, will not meet the standard necessary for waiver of the surety bond requirement.

In § 489.63 (“Parties to the bond”) we specify the format of the names of the three entities on the bond. This provides guidance to the HHA as to how to name the three parties to the bond. By specifically naming the parties to the bond in this manner, clarity is provided as to the rights and obligations of each party of this three-party instrument.

In § 489.64 (“Authorized Surety and exclusion of surety companies”) we stipulate that the surety bond must be obtained from an Authorized Surety and

define what conditions must be met for a surety company to be considered an Authorized Surety under this section. We believe that allowing HHAs to obtain bonds only from surety companies that have been issued a Certificate of Authority by the U.S. Department of the Treasury helps ensure that the HHA is obtaining a bond from a company that meets certain minimum standards. To ensure that the HHA has properly fulfilled the surety bond requirement as specified in this rule, we will ask the Surety to furnish timely confirmation of the issuance of, and the validity and accuracy of information appearing on, a bond the HHA has furnished to us. If the Surety fails to comply with our request for such information, we will determine the Surety to be unauthorized as a source of bonds for Medicare purposes, since without such confirmation from the Surety we can not determine if the HHA has properly complied with the surety bond requirements. Similarly, if we demand payment according to the terms of the bond, and the Surety fails without justification to pay us, we may determine that such surety company cannot be relied upon to fulfill its commitments and may then determine the surety company to be unauthorized for future use by any HHA. If a Surety is determined to be an unauthorized surety company, we also determine whether and how such a determination will affect HHAs that have obtained a current bond from the now unauthorized company. We may require that HHAs obtain replacement bonds. A determination by us that a surety company is an unauthorized surety company for the purposes of this rule is not a debarment, suspension, or exclusion for the purposes of Executive Order 12549.

Section 489.65 (“Amount of the bond”) covers the methods of how to calculate the surety bond amount for participating HHAs and HHAs that seek to participate in Medicare. We believe that 15 percent of the annual Medicare payments received by the HHA during its fiscal year is generally a reasonable percentage on which to base the amount of the bond, subject to the statutory minimum of \$50,000. By using 15 percent of the amount of annual Medicare payments, the amount of the surety bond and the premium for the surety bond are directly tied to the amount of Medicare payments received by the HHA. As stated earlier, in 1993 overpayments were 4 percent of total Medicare payments made to all HHAs. In 1996, overpayments were 7 percent of total Medicare payments made to all

HHAs. Of course, the percentage of overpayments to total payments for a particular HHA could be significantly higher. However, we believe that the 15 percent standard is a generally reasonable level and will usually ensure that we recover most uncollectible overpayments. Also, we believe that the 15 percent is a reasonable percentage on which to base the amount of the bond, since it would not be too high as to be a barrier for small companies, yet high enough to provide the Trust Funds with a reasonable ability to recover debts owed to the program. In determining this percentage amount, we consulted with an insurance industry trade group. However, we recognize that the 15 percent standard may be insufficient for HHAs that incur large overpayments. Therefore, instead of applying the 15 percent standard to such HHAs, we may require a bond greater than 15 percent of annual payments if the HHA's overpayments exceed that percentage of payments.

Section 489.66 ("Additional requirements of the surety bond") specifies the bases under which the Surety becomes liable to pay HCFA under the bond, and the conditions under which the Surety's guarantee to HCFA under the bond is not extinguished. Although a surety bond requirement has been implemented in other Federal government agencies, it is new to us as an element of program administration. Therefore, we believe that in order to provide maximum protection to Medicare, it is our obligation to provide specific guidance to the HHAs as to the terms that must be included in the bond.

In § 489.67 ("Submission date and term of the bond") we specify when HHAs must submit their initial and subsequent surety bonds. We believe neither a multi-year bond nor a continuous bond gives Medicare the level of protection of a one-year bond. The Medicare payments received by HHAs change yearly, usually increasing. Thus, a one-year bond makes it easier to administratively tie the required bond amount with a particular year's Medicare payments, helping to eliminate confusion for the HHA, the Surety, and us if we demand payment from the Surety. We chose for an initial term of the bond a period from January 1, 1998 to the close of each HHA's current fiscal year. ("Current" means as of January 1, 1998, and not as the date of the publication of the rule.)

In § 489.68 ("Effect of failure to obtain, maintain, and timely file a surety bond") we state that failure to obtain a surety bond in accordance with this rule is a sufficient basis for us to

terminate an HHA's provider agreement or for us to refuse to enter into such an agreement. Such a policy is an administratively efficient means of enforcing the surety bond requirement while affording participating HHAs and HHAs that wish to participate in Medicare appropriate rights of due process as specified in 42 CFR part 498.

In § 489.69 ("Evidence of compliance") we specify that we may, at any time and in a manner we choose, require an HHA to demonstrate that the HHA is in compliance with the surety bond requirements. We also provide that the failure of the HHA to demonstrate such compliance is sufficient reason to terminate the HHA's provider agreement or refuse to enter into such an agreement. We believe that in order to ensure that an HHA not only obtains a surety bond but also that it does not terminate the bond during the bond's one-year term, it is necessary that we have the ability to make sure the bond is still in effect. In addition, conditions may arise, such as the Surety terminating its business operations, where the bond may become unenforceable. Therefore, in order to safeguard our ability to recover on unpaid debts from HHAs, a method is needed to ascertain the continuing validity of the financial security represented by the bond we have been furnished.

Also, if the Surety's liability is renewed each year up to the limit of the surety bond, any penalties and assessments have a greater opportunity of being repaid by the HHA. If a one-year bond is required, it is easier to link the Surety's liability with a particular term of the bond and the fiscal year.

In § 489.70 ("Effect of payment by the Surety") the payment by the Surety to HCFA on the bond constitutes collection of the unpaid claim or unpaid civil money penalty or assessment owed by the HHA and is a sufficient basis for termination of the HHA's provider agreement. We believe that having to resort to the Surety for payment of a Medicare debt owed by the HHA, and having the Surety acknowledge our demand for payment as valid, is a sufficient basis to conclude that the HHA is not complying with the provisions of Title XVIII and our implementing regulations.

In § 489.71 ("Surety's standing to appeal Medicare determinations") we specify that a Surety has the same appeal rights of the HHA, provided the Surety has paid us under the surety bond, the HHA has assigned its right of appeal to the Surety, and the Surety satisfies all jurisdictional and procedural requirements that applied to

the HHA. By extending appeal rights to the Surety in this manner, we are further protecting it from improper financial loss in those cases where the HHA did not exercise the HHA's appeal rights and our demand for and receipt of payment under the bond was erroneously determined.

In § 489.72 ("Effect of review reversing HCFA's determination") we specify that if a Surety has paid HCFA on the basis of a Medicare debt incurred by an HHA and the HHA (or the Surety) successfully appeals HCFA's determination that was the basis of the debt (and the Surety's payment), then HCFA will refund to the Surety the amount that the Surety paid to HCFA to the extent such amount relates to the successful appeal, provided all review, including judicial review, has been completed on the matter. We believe this provision protects the Surety from undue financial loss due to error on our part.

In § 489.73 ("Incorporation into existing provider agreements") we specify that the requirements of Subpart F of Part 489 are deemed incorporated into existing HHA provider agreements effective January 1, 1998. Due to the BBA '97, we must incorporate the HHA surety bond requirement into all HHA provider agreements by January 1, 1998. Given that the BBA '97 was enacted in August 1997, we find that the only practicable means to accomplish this task in timely fashion is by our regulatory authority.

In new § 413.92 we specify that the costs incurred by a HHA to obtain a surety bond are not included as allowable Medicare costs. This provision implements section 4312(b)(2) of the BBA '97 which amended section 1861(v)(1)(H) of the Act to exclude the cost of these surety bonds as a reimbursable cost under Medicare.

B. Surety Bonds Requirements Under Medicaid

We have established a new § 441.16 (the previous § 441.16 is redesignated as § 441.17) to specify the prohibition on FFP in expenditures for home health services unless the HHA meets the surety bond requirements. In this section, we also include the surety bond requirements specific to Medicaid.

As discussed earlier, generally, we are adopting the surety bond requirements under Medicare for the requirements under Medicaid. However, there are program differences that require changes to the Medicare program requirements and are reflected in the discussion below of the changes to the Medicaid regulations.

In § 441.16(a) we define the terms “assets”, “participating home health agency”, “surety bond”, and “uncollected overpayment” as these terms apply to Medicaid. Section 441.16(b) contains the prohibition on FFP provision. Section 441.16(c) includes the basic requirement for the HHA to obtain a surety bond and furnish a copy of the bond to the Medicaid agency.

Section 441.16(d) allows government-operated HHAs, under certain conditions, to be exempt from the surety bond requirements under Medicaid as we have allowed them under Medicare except that we have not included provisions for unpaid civil money penalties or assessments and having claims referred to the Department of Justice or the General Accounting Office (which are not applicable under Medicaid). In § 441.16(e), we define the parties to the bond.

Under paragraph (f)(1) of § 441.16, we stipulate that an HHA may obtain a surety bond only from an authorized surety. We have expanded the Medicare provision on the definition of an authorized surety for Medicaid purposes to allow the Medicaid agency to include any other conditions that the Medicaid agency considers necessary for the proper and efficient administration of the program. We also have included the Medicare criteria for determining an unauthorized surety under paragraph (f)(2).

Under paragraph (f)(3) of § 441.16, we have allowed the Medicaid agency to specify the manner by which public notification of a determination of an unauthorized Surety is given and the effective date of the determination instead of the determination being published in the **Federal Register**.

In § 441.16(g), we stipulate that the amount of the bond must be \$50,000 or 15 percent of the annual Medicaid payments made to the HHA by the State Medicaid agency for home health services furnished for which FFP is available, whichever is greater. The computation of the 15 percent for participating HHAs is to be done by the State Medicaid agency on the basis of Medicaid payments made to the HHA for the most recent annual period for which information is available as specified by the State Medicaid agency. Likewise, the computation of 15 percent for an HHA that seeks to become a participating HHA by obtaining assets or ownership interest is computed using the most recent annual period as specified by the State Medicaid agency. The 15 percent computation does not apply to an HHA that seeks to become a participating HHA without obtaining

assets or ownership interest. However, we recognize that the 15 percent standard may be insufficient for HHAs that incur large overpayments. Therefore, instead of applying the 15 percent standard to these HHAs, we are providing that the State Medicaid agency may require a bond greater than 15 percent of annual payments if the HHA's overpayments exceed that percentage of payments.

In paragraph (h) of § 441.16 we include the same Medicare provisions on the surety's liability for full and timely payment of the HHA's unpaid overpayments, up to the stated amount of the bond, plus accrued interest, as applicable, for which the HHA is responsible. However, we do not include provisions relating to unpaid civil money penalties or assessments, which are not imposed by us or the States with respect to Medicaid. This section also includes the conditions under which the Surety's liability is not extinguished.

In paragraph (h)(1) we have specified the submission dates and terms of the bond. For all participating HHAs, we have made the initial term of the bond to be effective from January 1, 1998 through a date specified by the State Medicaid agency. For subsequent terms, we have provided that the State may specify the date by which a bond must be submitted, and that the term will be effective for an annual period as specified by the Medicaid agency. We require that an HHA that seeks to become a participating HHA must submit a surety bond before a provider agreement under § 431.107 of the Medicaid regulations can be entered into. An HHA that experiences a change of ownership (as “change of ownership” is defined by the State Medicaid agency) must submit a surety bond effective the date of the change of ownership for a term through a date specified by the State Medicaid agency. We also require that a government-operated HHA that does not qualify for waiver submit a surety bond. In addition, we require that an HHA that obtains a replacement surety bond from a different surety to cover the remaining term of a previously obtained bond must submit the new surety bond to the State Medicaid agency within 60 days (or such earlier date as the State Medicaid agency may specify) of obtaining it from the new Surety for an annual term specified by the State Medicaid agency.

Section 441.16(j) specifies the effect of an HHA's failure to obtain, maintain, and timely file a surety bond. Section 441.16(k) specifies that the State Medicaid agency may require an HHA to furnish further evidence of

compliance with the surety bond requirement and also specifies actions the Medicaid agency may take if the HHA fails to furnish it with such evidence of compliance. Section 441.16(l) allows the Medicaid agency to establish procedures for granting or denying appeal rights to sureties since the Medicare appeal procedures would not be applicable for State agencies.

C. Capitalization

We are adding new § 489.28 to establish an initial reserve operating fund requirement for HHAs that are seeking, for the first time, to participate in the Medicare program on or after January 1, 1998. Under this requirement, HCFA, through its intermediaries, will determine the amount of reserve funds that each new HHA is required to have before becoming certified in the Medicare program. We are also revising the Medicaid regulations at § 440.70(d), which already apply the Medicare HHA requirements for participation to Medicaid, to reference the Medicare capitalization requirement in § 489.28. This initial reserve operating fund requirement is to ensure that the HHA will be able to operate for three months after becoming certified to participate as a Medicare provider of services. The required amount is based on the average cost per visit of comparable new HHAs, using data from submitted cost reports from those HHAs for the first full year of operation. The HHA must provide proof that it has the funds to meet the requirement, with no more than 50 percent of the funds being borrowed funds, and that the funds are immediately available.

The purpose of this requirement is to establish the financial stability of HHAs newly entering the Medicare program and thus to assure quality of care to the HHA's patients, including Medicare beneficiaries. The requirement is being established in order to increase the likelihood of the viability of an HHA entering the program and to minimize situations that could adversely affect the health and safety of its patients. Lack of adequate initial reserve operating funds, that is, undercapitalization, sets up a new HHA for potential problems from the beginning, exposes Medicare to unnecessary risk, and can adversely affect the quality of care to the HHA's patients. We are establishing the requirement now because we believe it is urgently needed, particularly in light of the findings of the Office of Inspector General that problem HHAs entering the Medicare program are almost always undercapitalized—often with not even

enough cash on hand to meet the first payroll.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are, however, requesting an emergency review of this final rule with comment period. In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we are submitting to the Office of Management and Budget (OMB) the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR part 1320, to ensure compliance with section 4312(b) and 4724(b) of BBA '97 which requires Medicare and Medicaid participating HHAs to secure a surety bond, as of January 1, 1998, in order to continue participation in the Medicare and Medicaid programs. We cannot reasonably comply with normal clearance procedures because public harm is likely to result if the agency cannot enforce the capitalization requirement to prevent undercapitalized HHAs from entering the Medicare program or cannot enforce the surety bond requirements of the BBA '97 in order to protect the Federal government (especially the Medicare Trust Funds) from losses due to uncollectible debts incurred by HHAs.

HCFA is requesting OMB review and approval of this collection within 3 working days from the date of publication of this regulation, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by

the individuals designated below within 2 working days from the date of publication of this regulation.

During this 180-day period, we will publish a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. We will submit the requirements for OMB review and an extension of this emergency approval.

We are soliciting public comment on each of these issues for the provisions summarized below that contain information collection requirements:

Section 441.16 Home health agency requirements for surety bonds. Section 441.16(h)(3)(i) requires that a Surety must furnish the Medicaid agency with notice of any action by the HHA or the Surety to terminate or limit the scope or term of the bond and that such notice must be furnished not later than 10 days after the date of notice of such action by the HHA, or not later than 60 days before the effective date of the action by the Surety.

The burden associated with this requirement is the time required for a Surety to provide a State Medicaid agency with a notice no later than 10 days after any action by the HHA or the Surety to terminate or limit the scope or term of the bond. HCFA met with surety bond industry representatives to discuss the time and effort associated with furnishing a notice to terminate or limit the scope or term of a bond. It is estimated that less than 1 percent (80 entities) of all 8,062 participating HHAs will terminate or limit the scope or term of a bond. It is also estimated that it will take a surety company 5 minutes to generate and furnish a notice of such action (80 entities * 5 minutes = 400 minutes or 7 hours).

Section 441.16(i) requires each participating HHA that is not exempted by paragraph (d) of this section to submit to the Medicaid agency an initial surety bond by February 27, 1998, effective for the term January 1, 1998, through a date specified by the State Medicaid agency and for subsequent terms annually thereafter by a date as the Medicaid agency may specify, effective for an annual period specified by the Medicaid agency.

The burden associated with this requirement is the time required for each participating HHA to furnish the Medicaid agency a copy of a surety bond with original signatures on an annual basis. It is estimated that it will take 8,062 providers 5 minutes for an annual burden of 40,310 minutes = 672 hours.

Section 441.16(i)(2)(i) requires that HHAs seeking to become a Medicaid

participating HHA must submit a surety bond before a provider agreement described under § 431.107 of this subchapter can be entered into.

The burden associated with this requirement is the time required for each HHA seeking Medicaid participation to furnish the State agency with a copy of a surety bond with original signatures. It is estimated that it will take 900 new providers 5 minutes for an annual burden of 4,500 minutes that is 75 hours.

Section 441.16(i)(3) requires an HHA that undergoes a change of ownership to furnish the State agency with a copy of a surety bond with original signatures effective from the date of the change of ownership.

The burden associated with this requirement is the time required for each participating HHA that undergoes a change in ownership to furnish the Medicaid agency a copy of a surety bond with original signatures. It is estimated that it will take 287 providers 5 minutes for an annual burden of 1,435 minutes, that is 24 hours.

Section 441.16(i)(4) requires that a government-operated HHA, that as of January 1, 1998 meets the criteria for waiver of the requirements of this section but thereafter is determined by the Medicaid agency to not meet such criteria, must submit a surety bond within 60 days after it receives notice from the Medicaid agency that it no longer meets the criteria for waiver.

The burden associated with this requirement is the time required for each government-operated HHA that no longer meets the criteria for waiver to furnish the State agency a copy of a surety bond with original signatures. It is estimated that on an annual basis less than 10 entities will be required to comply with this information collection.

Section 441.16(i)(5) requires that an HHA that obtains a replacement surety bond from a different Surety to cover the remaining term of a previously obtained bond must submit the new surety bond to the Medicaid agency within 60 days (or such earlier date as the Medicaid agency may specify) of obtaining it from the new Surety for a term specified by the Medicaid agency.

The burden associated with this requirement is the time required for each HHA that obtains a replacement surety bond to furnish the State agency with a copy of a surety bond with original signatures. It is estimated that it will take 80 providers 5 minutes for an annual burden of 400 minutes, that is, 7 hours.

Section 489.28 Required proof of availability of initial reserve operating funds. In summary, the information

collection requirements for capitalization referenced in § 489.28 requires that an HHA seeking to participate in the Medicare and/or Medicaid program on or after January 1, 1998, must demonstrate that it has sufficient capital, that is, "initial reserve operating funds," to operate for the initial three months of its participation in the program. In particular, the HHA must provide HCFA or the State Medicaid agency a copy of the statement(s) of the HHAs savings, checking, or other account(s) which contain the funds, (e.g. cash, cash equivalents, borrowed funds or line of credit) accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available.

We estimate that the annual number of HHAs submitting this information to be 900, based on the average number of new HHAs entering the Medicare and/or Medicaid program from 1994 through 1996. An HHA, whether it requests participation in both Medicare and Medicaid, or in one program only, will have to submit this information only once. We estimate this activity to take approximately 900 entities 30 minutes for an annual burden of 450 hours.

Section 489.66 Additional requirements of the surety bond. *Section 489.66 (c)(1)* provides that the Surety's liability on the bond is not extinguished unless, in the event the HHA or the Surety takes any action to terminate or limit the scope or term of the bond, the Surety furnishes us with notice of such action not later than 10 days after receiving notice of such action by the HHA, or not later than 60 days before the effective date of such action by the Surety.

The burden associated with this requirement is the time required for a Surety to provide Medicare with a notice no later than 10 days after any action by the HHA or the Surety to terminate or limit the scope or term of the bond. It is estimated that less than 1 percent (80 entities) of all 8,062 participating HHAs will terminate or limit the scope or term of a bond. It is also estimated that it will take a surety company 5 minutes to generate and furnish a notice of such action (80 entities at 5 minutes = 400 minutes or 7 hours).

Section 489.67 Submission date and term of the bond. *Section 489.67(a)* requires each participating HHA that does not meet the criteria for waiver under § 489.62 must submit to HCFA, in such a form as HCFA may specify, a surety bond by February 27, 1998, effective for the term beginning January 1, 1998, through the end of the HHA's fiscal year and for subsequent terms not later than 30 days before the HHA's fiscal year, effective for a term concurrent with the HHA's fiscal year.

The burden associated with this requirement is the time required for each Medicare participating HHA to furnish HCFA a copy of a surety bond with original signatures on an annual basis. It is estimated that it will take 8,062 providers 5 minutes for an annual burden of 40,310 minutes = 672 hours.

Section 489.67(b)(1) requires that an HHA seeking to become a participating HHA must submit a surety bond with its enrollment application (Form HCFA-855, OMB number 0938-0685).

The burden associated with this requirement is the time required for each HHA seeking Medicare participation to furnish us a copy of a surety bond with original signatures. It is estimated that it will take 900 new providers 5 minutes for an annual burden of 4,500 minutes that is 75 hours.

Section 489.67(c) requires an HHA that undergoes a change of ownership to furnish HCFA a copy of a surety bond with original signatures effective from the date of the change of ownership.

The burden associated with this requirement is the time required for each participating HHA that experiences a change of ownership to furnish HCFA a copy of a surety bond with original signatures. It is estimated that it will take 287 providers 5 minutes for an annual burden of 1,435 minutes, that is, 24 hours.

Section 489.67(d) requires that a government-operated HHA, that as of January 1, 1998 meets the criteria for waiver under § 489.62 but thereafter is determined by HCFA to not meet such criteria, must submit a surety bond within 60 days after it receives notice from HCFA that it no longer meets the criteria for waiver.

The burden associated with this requirement is the time required for each government-operated HHA that no

longer meets the criteria for waiver to furnish HCFA a copy of a surety bond with original signatures. It is estimated that on an annual basis less than 10 entities will be required to comply with this information collection.

Section 489.67(e) requires that an HHA that obtains a replacement surety bond from a different Surety to cover the remaining term of a previously obtained bond must submit the new surety bond to HCFA within 30 days of obtaining it from the new Surety.

The burden associated with this requirement is the time required for each HHA that obtains a replacement surety bond to furnish HCFA a copy of a surety bond with original signatures. It is estimated that it will take 80 providers 5 minutes for an annual burden of 400 minutes, that is, 7 hours.

As a note, the provider/supplier enrollment forms HCFA-855, HCFA-855C, HCFA-855R, and related instructions, which are currently approved under OMB Approval No. 0938-0685, are in the process of being revised to incorporate the relevant HHA surety bond requirements reflected in this regulation. In particular, an emergency clearance of these information collection requirements was also requested by HCFA. A notice was published in the **Federal Register** on December 18, 1997, requesting that OMB approve the revised collection by December 31, 1997. In that notice the public was given from the date of the notice's publication, until December 29, 1997 to comment on the proposed collection. It should be noted that these emergency clearances sought by HCFA would have a maximum approval period of 6 months from the date of OMB approval. Also, the addendum to this regulation displays the revised HCFA-855, HCFA-855R, HCFA-855C, and related instructions that will implement the surety bond requirements, which were submitted to OMB for emergency approval. We continue to solicit comment on these forms and instructions.

The table below indicates the annual number of responses for each regulation section in this proposed rule containing information collection requirements, the average burden per response in minutes or hours, and the total annual burden hours.

ESTIMATED ANNUAL BURDEN

CFR section	Responses	Average burden per response (minutes)	Annual burden hours
441.16(h)(3)(i)	80	5	7

ESTIMATED ANNUAL BURDEN—Continued

CFR section	Responses	Average burden per response (minutes)	Annual burden hours
441.16(i)	8,062	5	672
441.16(i)(2)(i)	900	30	75
441.16(i)(3)	287	5	24
441.16(i)(5)	80	5	7
489.28	900	5	450
489.66(c)(1)	80	5	7
489.67(a)	8,062	5	672
489.67(b)(1)	900	5	75
489.67(c)	287	5	24
489.67(e)	80	5	7
Total	2,020

We have submitted a copy of this final rule with comment to OMB for its review of the information collection requirement. These requirements are not effective until they have been approved by OMB. A notice will be published in the **Federal Register** when approval is obtained.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2-26-17, 7500 Security Boulevard, Baltimore, MD 21244-1850, Attn: John Burke HCFA-1152-FC Fax number: (410) 786-1415

and,

Office of Information and Regulatory Affairs, Office of Management and Budget Room 10235, New Executive Office Building Washington, D.C. 20503, Attn.: Allison Herron Eydt, HCFA Desk Officer Fax numbers: (202) 395-6974 or (202) 395-5167.

VII. Impact Analyses

A. Regulatory Impact Analyses

We have examined the impacts of this final rule with comment period under Executive Order (E. O.) 12866, the Unfunded Mandate Reform Act of 1995, and the Regulatory Flexibility Act. E.O. 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits. In addition, a Regulatory Impact Analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more annually).

The Unfunded Mandate Reform Act of 1995 requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before proposing any rule that may result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million. The rule has no consequential effect on State, local, or tribal governments. The impact on the private sector is well below the \$100 million threshold.

Consistent with the Regulatory Flexibility Act, we prepare a Regulatory Flexibility Analysis (RFA) unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The RFA is to include a justification of why action is being taken, the kinds and number of small entities which the proposed rule will affect, and an explanation of any considered meaningful options that achieve the objectives and would lessen any significant adverse economic impact on the small entities. For purposes of the RFA, HHAs with annual revenues of \$5 million or less and non-profit organizations are considered to be small entities. Because of the scope of this rule, all HHAs will be affected, but we do not expect that effect to be significant. Nonetheless, we have prepared the following analysis, which in conjunction with other material provided in this preamble, constitutes an analysis under the Regulatory Flexibility Act.

The following regulatory impact analysis is divided into three parts to discuss separately the Medicare surety bond requirement, the Medicaid surety bond requirement, and the capitalization requirement.

1. Medicare Surety Bond Regulatory Impact Analysis

Section 4312(b) of BBA'97 contains a requirement that HHAs obtain a surety bond in an amount not less than \$50,000. In addition to using the statutory minimum amount of the bond as a floor, we link the required amount of the surety bond to the amount of Medicare payments we make to the HHA each year by establishing that the bond amount equal 15 percent of such payments. However, if that amount is not sufficient, we may link the required amount of the bond to Medicare overpayments. We believe that tying the amount of the bond to the amount of annual payments or, when necessary, the amount of Medicare overpayments will better protect the Trust Funds from losses due to uncollectible debts incurred by HHAs. Although we generally require a bond in an amount that equals 15 percent of annual Medicare payments, we recognize the 15 percent standard may be insufficient for HHAs that incur very large overpayments. Therefore, instead of applying the 15 percent standard to such HHAs, we may require a bond greater than 15 percent of annual payments if the HHA's overpayments exceed that percentage of payments.

We believe one effect of our rule will be to encourage inefficient or poorly managed HHAs to reform their billing practices. Also, to the extent some HHAs are intent on providing excessive or inappropriate services or defrauding the Medicare program, this rule may discourage such HHAs from continuing to participate in the Medicare program. We expect to have a "significant impact" on an unknown number of such entities, effectively preventing some of them from repeating their past aberrant billing activities. The majority of HHAs will not be significantly affected by this rule. In addition, we believe this rule

reinforces the behavior of HHAs that are not currently billing inappropriately, by encouraging them to continue billing only for appropriate Medicare services. We expect reduction in unrecovered program overpayments as a result of this rule either by having debts guaranteed by a surety company, or by high risk businesses being unable to obtain surety bonds and, thus, being unable to comply with their provider agreements.

Because of the large influx of HHAs (nearly 450 additional HHAs come into the Medicare program each year) and because HHAs will be able to furnish services to additional beneficiaries, we do not expect an adverse effect on Medicare beneficiaries. However, we do not know precisely how many HHAs will not enter the Medicare program because of these requirements. As a result, we are soliciting comments on these foregoing assertions and assumptions.

a. Rationale and purposes. We believe an HHA is an essential link in the chain of health care providers needed by Medicare beneficiaries to achieve optimum health. However, some HHAs consistently bill Medicare inappropriately and incur significant Medicare overpayments. Some of these overpayments, amounting to hundreds of millions of dollars, are never recovered. This rule will provide better protection of Medicare funds by establishing a mechanism, the surety bond, to replenish the Medicare Trust Funds from the losses incurred by unpaid debts. In addition, an HHA's failure to comply with the surety bond requirement will provide a basis for us to refuse to enter into or to terminate a Medicare provider agreement. We believe that such HHAs as are unable or unwilling to obtain a surety bond are the most likely HHAs to be unable or

unwilling to repay their Medicare debts. We expect this rule to deter HHAs from abusive billing practices and from defrauding the Medicare program and, to the extent certain HHAs are not deterred, the surety bond required by this rule furnishes us with greater assurance that we may recover on Medicare debts. Fraudulent practices include billing the Medicare program for services that were not furnished, not furnishing services as billed, or not furnishing services in accordance with Medicare policies.

Table 1 illustrates the total claims paid to HHAs from 1993 through 1996 and associated overpayment information for those years. This table illustrates that uncollected overpayments have been rising significantly both in absolute dollar amounts and as a percentage of the original amount of overpayment.

TABLE 1.—OVERPAYMENTS

Year	Annual HHA claims paid to date	Original amount of overpayments	Overpayment percentage of claims paid	Current uncollected overpayments	Percent of overpayments uncollected
1993	\$9,710,473,021	\$360,987,031	4	\$17,976,042	5
1994	12,683,597,818	567,570,313	4	25,827,042	5
1995	15,430,623,631	794,637,131	5	98,646,416	12
1996	14,357,504,894	1,061,157,961	7	153,628,056	14

b. Costs. According to a home health industry source, Medicare accounts for approximately 49 percent of the average HHA's revenue. (The approximate percentage amounts for other revenue sources are: private insurance—4 percent, Medicaid—24 percent, and consumer's out-of-pocket—22 percent.)

Table 2 shows the number of participating HHAs by Medicare reimbursement ranges and demonstrates that approximately 94 percent of all HHAs were paid \$5 million or less by Medicare in 1996. Because Medicare accounts for approximately only 49 percent of the average HHA's total revenue, we estimate that approximately 84 percent of these HHAs would qualify as small entities under the Regulatory Flexibility Act. We estimate that these HHAs would have a total annual bond cost of approximately \$9.5 million and an average annual cost per HHA of approximately \$1200.

TABLE 2.—TOTAL NUMBER OF HHAS ARRANGED BY MEDICARE PAYMENT [Dates of Service—January to December 1996]

Dollars reimbursed	Number of HHAs
>50,000	744
50,001–100,000	452
100,001–200,000	735
200,001–334,000	767
334,001–1,000,000	2854
1,000,001–2,499,000	2406
2,500,000–5,000,000	939
5,000,001–10,000,000	415
10,000,001–20,000,000	103
20,000,001–30,000,000	20
30,000,001–40,000,000	6
40,000,001–50,000,000	2
50,000,001–150,000,000	0
>150,000,001	1
Totals	9444

There were approximately 2800 non-profit HHAs during the time period specified in Table 2. We estimate that all but 150 of them were reimbursed less than \$5 million and are already part of the cost estimate developed for small businesses. By including these 150 in the small business category there would

not be any significant change to the cost estimates already developed.

This rule will require an HHA to have a surety bond in an amount that is the greater of \$50,000 or 15 percent of Medicare payments made to the HHA in the most recent fiscal year for which a cost report is accepted, or if payments in the first six months of the current fiscal year differ from such an amount by more than 25 percent, then the amount of the bond is 15 percent of such payments projected on an annualized basis. However, if an HHA's overpayment in the most recently accepted annual cost report exceeds 15 percent, Medicare may require the HHA to secure a bond up to or equal to the amount of the overpayment, provided the amount of the bond is not less than \$50,000. We believe that any additional cost attributable to the percentage of the Medicare reimbursement calculation does not represent a significant economic impact on most HHAs that will be required to purchase a surety bond in an amount greater than \$50,000. Moreover, those HHAs that will incur a substantial cost for obtaining a surety bond are those few HHAs that generate Medicare billings in the tens of millions of dollars or more. In order to have some

reasonable assurance of being able to recover a significant portion of otherwise unrecoverable Medicare debts, we believe that using a percentage of total annual Medicare payments to determine surety bond amounts above \$50,000 is both reasonable and necessary. Thus, we have chosen alternatives that we believe are cost effective and will ensure that HHAs have bonds in appropriate amounts. Moreover, we believe that for most HHAs the cost of obtaining a surety bond will be outweighed by the benefits gained by participating in the Medicare program. Thus, the surety bond requirement should not result in substantial changes in the number of well-managed and appropriately-billing HHAs. Nonetheless, we are soliciting comments on surety bond amounts that would strengthen protection to the Medicare program and be cost effective.

We believe that 15 percent is a reasonable percentage on which to base the amount of the bond since it would not be too high as to be a barrier to entry

for small entities, yet high enough to provide the Medicare Trust Fund with some recourse for compensation for debts owed to the program. We are interested in comments about the reasonableness of the 15 percent amount. However, if an HHA's overpayments in the most recently accepted annual cost report exceeds 15 percent of payments, Medicare may require the HHA to secure a bond up to or equal to the amount of the overpayment, provided the amount of the bond is not less than \$50,000. We solicit comments on this approach.

A surety company charges its underwriting fee based on the amount of the bond. We have been advised by the Surety Association of America that for this type of surety bond the surety industry usually has an underwriting charge that ranges between \$2 to \$30 per thousand dollars of the face amount of the bond. However, we have also been advised by the Surety Association of America that, for such a bond as is required by this rule, the average cost is

likely to be approximately \$10 per thousand. Based on this average cost, Table 3 indicates the average cost of a surety bond in relation to the HHA's annual Medicare revenue.

Table 3 also indicates that the total costs of bonds would be approximately \$22.5 million if all Medicare participating HHAs in 1996, including government-operated HHAs, purchased surety bonds. However, as stated earlier, the requirement is waived for an HHA operated by a Federal, State, local, or tribal government agency if, during the preceding 5 years, the HHA has not had any unrecovered Medicare overpayments or unpaid civil money penalties or assessments, and has not had any HCFA claims referred to the Department of Justice or the General Accounting Office because of nonpayment. Therefore the total cost of the surety bond requirement based on the number of HHAs in calendar year 1996 is approximately \$18.4 million as illustrated in Table 4.

TABLE 3.—COST OF SURETY BOND

Dollars reimbursed	Number of HHAs	Reimbursement by range	Average reimbursement per HHA	Average amount of bond	Average cost of bond	Total cost of bonds
<50,000	744	14,801,083	19,894	50,000	1 500	372,000
50,001-100,001	452	33,825,800	74,836	50,000	1 500	226,000
100,001-200,000	735	107,909,794	146,816	50,000	1 500	367,500
200,001-334,000	767	202,035,624	263,410	50,000	1 500	383,500
334,001-1,000,000	2854	1,827,498,253	640,329	96,049	960	2,741,247
1,000,001-2,499,000	2406	3,810,798,797	1,583,873	237,581	2,376	5,716,198
2,500,000-5,000,000	939	3,256,036,561	3,467,558	520,134	5,201	4,884,055
5,000,001-10,000,000	415	2,827,979,666	6,814,409	1,022,161	10,222	4,241,969
10,000,001-20,000,000	103	1,356,573,414	13,170,616	1,975,592	19,756	2,034,860
20,000,001-30,000,000	20	462,520,233	23,126,012	3,468,902	34,689	693,780
30,000,001-40,000,000	6	207,852,076	34,642,013	5,196,302	51,963	311,778
40,000,001-50,000,000	2	95,830,624	95,830,624	14,374,594	143,746	287,492
50,000,001-150,000,000	0	0	0	0	0	0
>150,000,001	1	153,842,969	153,842,969	23,076,445	230,764	230,764
Totals	9444	14,357,504,894	1,520,278	228,042	2,280	22,491,145

¹ These costs represent the cost of the minimum bond required by BBA '97, section 4312(b).

Table 4 illustrates that there are approximately 1382 government-operated HHAs. If a government-operated HHA does not qualify for a waiver, it must obtain a surety bond and submit it to us. It is estimated

government-operated HHAs would account for approximately \$4 million of the Medicare surety bond program cost. If government-operated HHAs are waived then their surety bond costs are removed. The net cost to the industry is

then approximately \$18.4 million as illustrated in Table 4. We request comment on the accuracy of these estimates.

TABLE 4.—SURETY BOND COST BY WAIVING REQUIREMENT FOR GOVERNMENT-OPERATED HHAS

Total number of HHAs	Number of Govt. HHAs	Number of HHAs subject to bond	Total reimbursement of HHAs subject to bond	Average reimbursement per HHA	Average amount of bond	Average cost of bond	Total cost of bonds
9444	1382	8062	\$12,256,481,236	\$1,520,278	\$228,042	\$2,280	\$18,384,722

We realize that surety bonds represent a new cost of approximately \$18.4 million to HHAs that furnish services to Medicare beneficiaries. In addition, we note that the use of a percentage of the Medicare reimbursement method adds approximately \$13.7 million more to the cost of bonds as compared to the cost that would be incurred by HHAs if they were subject only to the \$50,000 minimum amount required under the law. However, we believe that the benefits to the Medicare program and Medicare beneficiaries outweigh these additional costs. Our fiscal intermediaries report that, currently, uncollected overpayments total over \$150 million (based on 1996 data per Table 1). These funds are at risk of not being recovered because the HHAs responsible for these uncollected overpayments may be unwilling to repay these debts or may go (or may have already gone) out of business. We believe that if each HHA obtains a surety bond in an amount proportional to the amount of Medicare payments it receives, the Medicare program will increase its recoveries of uncollected overpayments, thereby reducing losses to the Trust Funds.

We project that there will not be any savings to the Trust Funds in fiscal year 1998 or 1999 because of the lengthy process of determining overpayments. In fiscal years 2000, 2001, and 2002, we estimate direct savings of \$10 million, \$20 million, and \$20 million, respectively. Uncollected overpayments represented about .185 percent of total HHA payments in fiscal year 1993. We consider .185 percent the most reliable estimate because of the time lag discussed in collecting overpayments. We are estimating that the savings for each year is only half of this percentage because we do not know whether or not 15 percent of an agency's payments would cover all of their uncollectable overpayments. In addition, we believe that the sentinel effect of the surety bond, although indeterminable with any specificity, is likely to result in much higher savings to the Medicare Trust Funds beginning in fiscal year 1998.

c. Discussion of alternatives. We believe it was the Congress' intent to strengthen HHA standards to protect beneficiaries and the Medicare program from fraudulent and abusive billing practices, and to protect the Trust Funds from growing losses due to unrecoverable Medicare debts incurred by HHAs. Therefore, we did not choose the alternative of requiring, across-the-board, a surety bond in the minimum statutory amount of \$50,000. Instead of relying on this amount for all HHAs, we have tied the bond amount to a

percentage of each HHA's annual Medicare payments. We realize this policy choice increases the cost of obtaining a bond for all HHAs that receive more than \$334,000 in Medicare payments annually. However, this policy choice also increases the protection the surety bond requirement gives to the Medicare Trust Funds. We solicit comments on this approach.

Although we are authorized to waive the surety bond requirement if an HHA provides a comparable surety bond under State law, with the exception of government-operated HHAs, we have not implemented that waiver authority in this rule. The limited amount of time available to us between the enactment of BBA '97 and the effective date of the surety bond requirement did not permit us sufficient time to effectively analyze the potential specifications of a general waiver provision. However, we are mindful that some States may already have, or may be considering implementing, surety bond requirements that could affect HHAs. Moreover, section 4724 of BBA '97 establishes a Medicaid surety bond requirement that the States will be implementing. We do not want to add unnecessary costs to HHAs that may be required to obtain multiple surety bonds. However, our principal concern is to safeguard the Medicare Trust Funds from the losses resulting from dramatically increasing unrecovered Medicare debts for which a growing number of HHAs are responsible. We solicit comments on useful standards and criteria for implementing a waiver of our surety bond requirements that would, nonetheless, maintain the same or a greater level of protection of the Medicare Trust Funds achieved by this rule.

Because of the short duration between when BBA '97 became law and the effective date of its surety bond provision, we had little time available to develop a surety bond rule. As such, we did not attempt to also develop and secure approval for a surety bond form to accompany this rule. Instead, as described previously, we have specified certain minimum requirements of an acceptable surety bond. However, our present intention is to develop such a form and to seek approval from the Office of Management and Budget for its use. The development of such a form may eliminate the need to state in regulation some of the various requirements of a surety bond for Medicare purposes and would furnish to HHAs, the surety industry, and our own fiscal intermediaries an unambiguous standard with respect to the required format of a Medicare surety

bond. We solicit comments on the advisability of mandating the use of a HCFA-designed surety bond form. In addition, we solicit recommendations regarding the format and other features of a HCFA-designed surety bond form.

We have established that the Surety would be liable for unpaid civil money penalties, assessments imposed by us and for Medicare overpayments. We also considered including within the scope of the Surety's potential liability a guarantee of payment for unpaid civil money penalties and assessments that were imposed by the Office of the Inspector General. However, because of the short time period between when the BBA '97 was enacted and the effective date of the Surety bond provision, we were unable to fully consider this option. In addition, because of our unfamiliarity with surety bonds as a component of program administration, we believed that we did not fully understand how best to implement this option. We solicit comments on the advisability of including within the scope of the Surety's potential liability unpaid Office of Inspector General-imposed civil money penalties and assessments.

2. Medicaid Surety Bond Regulatory Impact Analysis

Section 4724(b) of the BBA '97 contains a requirement that HHAs obtain a surety bond in a minimum amount of \$50,000. In addition to using the statutory minimum amount of the bond as a floor, we link the required amount of the surety bond to the amount of estimated Medicaid payments made to the HHA each year. We follow the same rationale used for tying the amount of the bond to Medicaid payments as Medicare uses for tying the amount of the bond to Medicare payments. Likewise, we believe that the effect of our rule will mirror the justification used for imposition of the bond requirement on participating Medicare HHAs.

This rule requires an HHA participating in Medicaid to have a surety bond in an amount that is the greater of \$50,000 or 15 percent of annual Medicaid payments made to the HHA. However, we recognize the 15 percent standard may be insufficient for HHAs that incur large overpayments. Therefore, instead of applying the 15 percent standard to such HHAs, we may require a bond in a greater amount if the HHA's overpayments exceed that percentage of payments. In examining the impact that this final rule with comment period will have on Medicaid participating HHAs, we followed the same rationale and methodology that

was used for the determination of the impact of the surety bond requirement on Medicare participating HHAs. Likewise, we expect this rule to encourage some inefficient HHAs to reform their billing practices and to deter other HHAs from abusive billing practices and from defrauding the Medicaid program. Our analysis is based on the information that there are virtually the same number of HHAs participating in Medicaid as there are in Medicare and that in 1995 total Medicaid payments for home health services amounted to approximately \$1.9 billion.

We have estimated the average amount of Medicaid payment per HHA and on this amount have based the total cost of surety bonds for Medicaid participating HHAs. After excluding

costs associated with government-operated HHAs that meet our waiver requirements, we estimate the total cost of surety bonds for Medicaid-participating HHAs to be approximately \$4.8 million. Unlike the Medicare program, the Medicaid program savings are indeterminable because there is no data comparable to the overpayment data used to produce the Medicare estimates. However, combined with the sentinel effect, we believe the Medicaid savings will equal or exceed the modest cost estimated for the bonds.

Using the latest data available, the following tables show the total number of HHAs arranged by Medicaid payment, the total cost of surety bonds if all HHAs in the Medicaid program obtain a surety bond, and the cost of surety bonds if only non-government-

operated HHAs in the Medicaid program had obtained a surety bond.

TABLE 1.—TOTAL NUMBER OF HHAS ARRANGED BY MEDICAID PAYMENT

Dollars paid	Number of HHAs
<50,000	2964
50,001–100,000	1750
100,001–150,000	1244
150,001–200,000	834
200,001–334,000	1217
334,001–1,000,000	1190
1,000,001–2,500,000	214
2,500,001–5,000,000	27
5,000,001–10,000,000	3
10,000,001–20,000,000	1
Totals	9444

TABLE 2.—COST OF SURETY BOND

Dollars reimbursed	Number of HHAs	Reimbursement by range	Average reimbursement	Average bond	Average cost	Total cost of bonds
>50,000	2964	\$58,990,371	\$19,902	\$50,000	\$500	\$1,482,000
50,001–100,000	1750	129,314,787	73,894	50,000	500	875,000
100,001–150,000	1244	152,441,149	122,541	50,000	500	622,000
150,001–200,000	834	144,767,688	173,582	50,000	500	417,000
200,001–334,000	1217	310,906,680	255,470	50,000	500	608,500
334,001–1,000,000	1190	647,061,386	543,749	81,562	816	970,592
1,000,001–2,500,000	214	298,295,160	1,393,903	209,085	2,091	447,443
2,500,001–5,000,000	27	87,119,660	3,226,654	483,998	4,840	130,679
5,000,001–10,000,000	3	17,578,870	5,859,623	878,944	8,789	26,368
10,000,001–20,000,000	1	20,000,000	20,000,000	3,000,000	30,000	30,000
Totals	9444	1,866,475,751	197,636	59,400	594	5,609,582

TABLE 3.—EFFECT ON TOTAL COST OF BONDS BY WAIVING REQUIREMENT FOR GOVERNMENT-OPERATED HHAS

Total number of HHAs	Number of Govt HHAs	HHAs subject to bond	HHAs subject to bond reimbursement	Average reimbursement per HHA	Average amount of bond	Average cost of bond	Total cost of bonds
9444	1382	8062	\$1,593,341,432	\$197,636	\$59,400	\$594	\$4,788,697

In our discussion of the Medicare surety bond requirement, we identified and invited comments on several alternative courses of action. These alternatives also apply to Medicaid, and we solicit comments on their application in that context.

3. Capitalization Regulatory Impact Analysis

The effect of the capitalization requirement in this rule will be to prevent HHAs that are undercapitalized from participating in the Medicare program. Also, as provided in 42 CFR 440.70(d), a home health agency for the Medicaid program means a public or private agency or organization, or part of an agency or organization, that meets requirements for participation in

Medicare. Most HHAs participate in both the Medicare and Medicaid programs. However, even those HHAs that participate in Medicaid but not Medicare must meet the Medicare requirements. Therefore, the following discussion, which is directed to Medicare HHAs, must be read to apply to HHAs that seek participation in both programs or only in the Medicaid program.

We do not know if the capitalization requirement will have a significant economic impact on a substantial number of small entities. However, we believe that it will not adversely affect an HHA that is properly capitalized, that is, has sufficient operating funds to see it through the early months of operation until it develops a stream of

revenue from Medicare, Medicaid, and other payers. An organization that is earnest in its attempt to be a financially sound provider of home health services under the Medicare program will already be properly capitalized without the need for Medicare to require such capitalization. Furthermore, the capitalization requirement is structured to minimize significant economic impact on new HHAs. Amounts that will be required for capitalization will be derived from actual experiences of new HHAs under Medicare, so we are confident that HHAs coming into the program should be incurring the same level of expenditures independently of our requirement. Therefore, the regulation simply captures as an entry requirement the amount of capital that

actual HHAs need to operate.

Accordingly, its impact on an HHA that plans to succeed with due regard for appropriate quality of patient care and without resorting to fraudulent or abusive billing practices is negligible because the HHA would need to raise this much capital despite Medicare's requirement.

To the extent that any of the funds are not needed in operating the business during the first three months, the funds simply remain with the HHA.

Furthermore, any possible impact that this requirement may have on HHAs entering the Medicare program is more than offset by savings to the Trust Funds in situations in which HHAs go out of business due to undercapitalization, leaving the program unable to recover overpayments.

Second, the requirement should not disproportionately affect small HHAs because the amount of capitalization is based on the new HHA's projected number of visits. Therefore, in determining the capitalization for three months, HCFA will expect that an HHA that projects 25,000 visits in the first year will need only one quarter of the capitalization of an HHA projecting 100,000 visits. Of course, if HCFA determines that a new HHA has underprojected its visits, HCFA will base the capitalization on the number of visits of other new HHAs in the program that are of comparable size to the HHA seeking to enter the program.

Finally, it is important to be clear that the need for this requirement is not solely related to financial concerns. Paramount to Medicare's concerns is the need for an HHA to provide quality care to its patients, including its Medicare patients. A lack of funds in reserve to operate the business until a stream of revenues can be established can seriously threaten the viability of the business. For a new HHA, any condition threatening the viability of the new business can adversely affect the quality of care to its patients and, in turn, the health and safety of those patients. That is, if lack of funds forces an HHA to close its business, to reduce staff, or to skimp on patient care services because it lacks sufficient capital to pay for the services, the overall well-being of the HHA's patients could be compromised. In fact, there could be the risk of serious ill effects as a result of patients not receiving adequate services. This capitalization requirement serves to greatly minimize that possibility.

If a new HHA for some reason cannot raise the capital necessary to meet Medicare's requirement and, therefore, is not permitted to enter the Medicare program, that clearly has an economic

impact on the HHA. However, we believe that such an economic impact is necessary. If the HHA cannot raise the capital, the HHA is not beginning its business on a sound financial footing. In such a case, we find the likelihood of the HHA's being forced to reduce its patient care due to reduced patient care staff or even to go out of business too great for the Medicare program, and a risk that Medicare does not want to take. Quality care is too important to risk on an HHA that may perform poorly or go out of business due to undercapitalization.

We believe that many HHAs have recently entered the Medicare program undercapitalized and that, absent this rule, more would do so. As discussed above, this requirement will prevent that situation.

We believe that there is no reasonable alternative to this requirement. If an HHA is to provide quality care, it must be properly capitalized to do so.

B. Rural Hospital Impact Statement

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds. We are not preparing a rural impact statement since we have determined, and certify, that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this rule was reviewed by the Office of Management and Budget.

VIII. Waiver of Proposed Rulemaking

A. Surety Bond Rules

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite prior public comment on proposed rules. The notice of proposed rulemaking can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and it incorporates a statement of the finding and its reasons in the rule issued. We find good cause to waive the notice-and-comment procedure with respect to this rule because it is impracticable to employ such a procedure in this instance with respect to both the Medicare and Medicaid regulations, because it is

unnecessary with respect to the Medicare regulations, and because the delay in promulgating both the Medicare and the Medicaid regulations would be contrary to the public interest.

Issuing a proposed rule with a comment period before issuing a final rule would be impracticable because the Congress has established a statutory deadline of January 1, 1998 for the implementation of the surety bond requirement (BBA '97, sections 4312(f)(2) and 4724(b)(2)). We cannot publish a proposed rule, followed by a final rule, and meet this statutory deadline. The urgency of the Congress to have us implement this requirement was underscored by its further mandate that HHA Medicare participation agreements must be amended by January 1, 1998. Further, because Federal Financial Participation (FFP) will not be available to States after January 1, 1998 for Medicaid home health services unless the surety bond requirement is met by Medicaid HHAs, and because it is necessary to tailor the requirement to the Medicaid program to address the differences between Medicare and Medicaid, it is necessary to issue a Medicaid rule by the statutory deadline. However, it would be impracticable to employ notice-and-comment procedures and accomplish these results. The only practical means of amending the Medicare participation agreements by the statutory deadline is by issuing this rule now as a final rule with comment period and deeming such agreements to be amended as of January 1, 1998 to incorporate the surety bond requirement. Similarly, the only practical means of tailoring the surety bond requirement to the Medicaid program so as to make FFP available for home health services by January 1, 1998 is by issuing this rule now as a final rule with comment period. Therefore, notice-and-comment procedures are impracticable for this rule with respect to both the Medicare and Medicaid surety bond regulations.

Issuing a proposed rule prior to issuing a final rule is also unnecessary with respect to the Medicare surety bond regulation because the Congress has provided that a Medicare rule need not be issued as a proposed rule before issuing a final rule if, as here, a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the enactment of the statute in which the deadline is contained (42 U.S.C. 1395hh(b)(2)(B), section 1871(b)(2)(B) of the Social Security Act). BBA '97 was enacted on August 5, 1997, less than 150 days from the statute's effective date for the surety bond requirement of

January 1, 1998. Therefore, notice-and-comment procedures are not necessary for the Medicare rule.

Issuing a notice of proposed rule before issuing a final rule would also be contrary to the public interest with respect to both the Medicare and Medicaid surety bond regulations because it would prevent us from complying with the statutory deadline imposed by the Congress, would delay significantly the implementation of an effective gatekeeping device to deter undercapitalized and unscrupulous home health operators from participating in the Medicare or Medicaid program, would delay significantly the implementation of fiscal guarantees on potentially hundreds of millions of dollars of Medicare and Medicaid overpayments, and would delay significantly the issuance of essential guidance to the home health industry, the surety industry, and the State Medicaid agencies. Conversely, if notice-and-comment procedures were employed in issuing this final rule with comment, the delay would leave the Medicare Trust Funds and other Federal Government funds vulnerable to a variety of fraudulent and abusive activities at a time when certain unscrupulous operators appear to have targeted the home health industry as a means to improperly obtain Medicare and Medicaid payment. (See, e.g., Department of Health and Human Services, Office of Inspector General report—Home Health: Problem Providers and Their Impact on Medicare, OEI-09-96-00110.) Therefore, for the foregoing reasons we find that, with respect to both the Medicare and Medicaid surety bond regulations, employing notice-and-comment procedures would be contrary to the public interest.

For these reasons, we find good cause to waive publishing a proposed rule and to issue this final rule with comment period. We invite written comments on this final rule and will consider comments we receive by the date and time specified in the **DATES** section of this preamble. Although we cannot respond to comments individually, if we change this rule as a result of our consideration of timely comments, we will respond to such comments in the preamble of the amended rule.

B. Capitalization

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite prior public comment on proposed rules. The notice of proposed rulemaking can be waived, however, if an agency finds good cause

that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and it incorporates a statement of the finding and its reasons in the rule issued. We find good cause to waive the notice-and-comment procedure with respect to the capitalization requirements of this rule because the delay in promulgating this rule would be contrary to the public interest.

Issuing a notice of proposed rulemaking before issuing a final rule would be contrary to the public interest because to do so would permit HHAs that are undercapitalized, and therefore not adequately financially prepared to do business, to continue to enter into the Medicare and Medicaid programs. Preventing the participation in Medicare and Medicaid of undercapitalized HHAs will have an immediate positive effect in ensuring that a lack of capital will not affect care and will have an immediate sentinel effect on preventing further losses to the Medicare Trust Funds and other Federal funds due to the undercapitalization. The immediacy of this problem and the urgent need to correct it has been well documented.

In its July 1997 report, "Home Health: Problem Providers and Their Impact on Medicare" (OEI-09-96-00110), the OIG found that entrepreneurs are able to open and operate HHAs without fixed assets or startup costs, relying almost exclusively on Medicare for income and assets. It stated, in part:

If it were not for Medicare accounts receivable, problem agencies would have almost nothing to report as assets. Agencies tend to lease their office space, equipment, and vehicles. They are not required by Medicare to own anything, and they are almost always undercapitalized. On average, cash on hand and fixed assets amount to only one-fourth of total assets for HHAs, while Medicare accounts receivable frequently equal 100 percent of total assets. These agencies are almost totally dependent on Medicare to pay their salaries and other operating expenses. For a home health agency, there are virtually no startup or capitalization requirements. In many instances, the problem agencies lease everything without collateral. They * * * do not even have enough cash on hand to meet their first payroll.

It is unacceptable that an HHA currently can enter the Medicare or Medicaid program with little or no reserves with which to operate. An HHA inadequately prepared to do business runs the risk of having to reduce staff or of going out of business pending receipt of a regular and continuous stream of patient care revenues. With this comes the risk of the HHA's providing inadequate care to its patients due to lack of staff or being forced to stop

rendering patient care altogether. Equally importantly, a cash poor HHA limping along to provide patient care or an HHA that has gone out of business exposes Medicare and Medicaid to the risk of being unable to recover payments to the HHA which are later determined to be overpayments, resulting in a drain on the Medicare Trust Funds and other Federal funds.

Publishing this final rule with comment period requiring adequate capitalization for new HHAs prevents HHAs which are not financially prepared to do business from entering the Medicare or Medicaid program, thereby greatly reducing the attendant risk of inadequate care to patients and misuse of the Medicare Trust Funds and other Federal Government funds. Employing notice of proposed rulemaking procedures, on the other hand, would continue to permit financially ill-prepared HHAs to enter these programs. Permitting a situation to continue that can result in inadequate health care to an HHA's patients, thus potentially threatening the health and safety of those patients, as well as a situation that can result in the improper disbursement of monies from the Medicare Trust Funds and other Federal funds, is contrary to the public interest. Moreover, although there is currently a moratorium in effect on the entry of new HHAs into the Medicare program, a prolonged moratorium could, itself, eventually create a threat of reduced access to home health services in some markets. Therefore, ending the moratorium timely is also in the public interest. However, ending the moratorium before the capitalization requirement is established would be counterproductive. Therefore, the capitalization requirement should be implemented without significant delay, an objective not achievable if notice and comment procedures are employed. Therefore, HCFA believes that it would be contrary to the public interest to employ notice and comment procedures to implement the capitalization requirement.

For these reasons, we find good cause to waive notice and comment procedures and to issue this final rule with comment period. We invite written comments on this final rule and will consider comments we receive by the date and time specified in the **DATES** section of this preamble.

IX. Waiver of 30-Day Interim Period Before Rule Is Effective

We ordinarily make the effective date of a final rule at least 30 days after the publication of the rule in the **Federal Register**. However, the 30-day interim

period can be waived if an agency finds good cause for making the effective date of the rule earlier than 30 days after the publication of the rule and the agency publishes a brief statement with the rule of its findings and the reasons therefore.

We find good cause to make both the surety bond and the capitalization provisions of this rule effective January 1, 1998. For the reasons discussed above in VIII of this preamble "Waiver of Proposed Rulemaking," i.e., because we find that making the rule effective after January 1, 1998 would be impracticable, unnecessary, and contrary to the public interest, we find good cause to waive the 30-day interim period for this rule. Therefore, we have made the effective date of this rule January 1, 1998.

Although we have waived the 30-day interim period, we invite written comments on this final rule with comment period. We will consider comments we receive by the date and time specified in the DATES section of this preamble.

X. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments received by the date and time specified in the DATES section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

List of Subjects

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 440

Grant programs-health, Medicaid

42 CFR Part 441

Family planning, Grant programs-health, Infants and children, Medicaid, Penalties, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Chapter IV is amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

A. Part 413 is amended as follows:

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1861(v), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v), and 1395hh).

2. Section 413.92 is added to read as follows:

§ 413.92 Costs of surety bonds.

Costs incurred by a provider to obtain a surety bond required by part 489, subpart F of this chapter are not included as allowable costs.

PART 440—SERVICES: GENERAL PROVISIONS

B. Part 440 is amended as follows:

1. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. In § 440.70, paragraph (d) is revised as follows:

§ 440.70 Home health services.

* * * * *

(d) "Home health agency" means a public or private agency or organization, or part of an agency or organization, that meets requirements for participation in Medicare, including the capitalization requirements under § 489.28 of this chapter.

* * * * *

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

C. Part 441 is amended as follows:

1. The authority citation for part 441 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 441.10 is amended by redesignating paragraphs (h) through (k) as paragraphs (i) through (l), respectively and adding a new paragraph (h) to read as follows:

§ 441.10 Basis.

* * * * *

(h) Section 1903(i)(18) for the requirement that each home health agency provide the Medicaid agency with a surety bond (§ 441.16).

3. In § 441.15 a new paragraph (d) is added to read as follows:

§ 441.15 Home health services

* * * * *

(d) The agency providing home health services meets the capitalization requirements included in § 489.28 of this chapter.

§ 441.16 [Redesignated as § 441.17]

4. Section 441.16 is redesignated as § 441.17.

5. A new § 441.16 is added to read as follows:

§ 441.16 Home health agency requirements for surety bonds; Prohibition on FFP.

(a) *Definitions.* As used in this section, unless the context indicates otherwise—

Assets includes but is not limited to any listing that identifies Medicaid recipients to whom home health services were furnished by a participating or formerly participating HHA.

Participating home health agency means a "home health agency" (HHA) as that term is defined at § 440.70(d) of this subchapter.

Surety bond means one or more bonds issued by one or more surety companies under 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225, provided the bond otherwise meets the requirements of this section.

Uncollected overpayment means an "overpayment," as that term is defined under § 433.304 of this subchapter, plus accrued interest, for which the HHA is responsible, that has not been recouped by the Medicaid agency within a time period determined by the Medicaid agency.

(b) *Prohibition.* FFP is not available in expenditures for home health services under § 440.70 of this subchapter unless the home health agency furnishing these services meets the surety bond requirements of paragraphs (c) through (l) of this section.

(c) *Basic requirement.* Except as provided in paragraph (d) of this section, each HHA that is a Medicaid participating HHA or that seeks to become a Medicaid participating HHA must—

(1) Obtain a surety bond that meets the requirements of this section and instructions issued by the Medicaid agency; and

(2) Furnish a copy of the surety bond to the Medicaid agency.

(d) *Requirement waived for Government-operated HHAs.* An HHA operated by a Federal, State, local, or tribal government agency is deemed to have provided the Medicaid agency with a comparable surety bond under State law, and is therefore exempt from

the requirements of this section if, during the preceding 5 years, the HHA has not had any uncollected overpayments.

(e) *Parties to the bond.* The surety bond must name the HHA as Principal, the Medicaid agency as Obligee, and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as Surety.

(f) *Authorized Surety and exclusion of surety companies.* An HHA may obtain a surety bond required under this section only from an authorized Surety.

(1) An authorized Surety is a surety company that—

(i) Has been issued a Certificate of Authority by the U.S. Department of the Treasury in accordance with 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225 as an acceptable surety on Federal bonds and the Certificate has neither expired nor been revoked;

(ii) Has not been determined by the Medicaid agency to be an unauthorized Surety for the purpose of an HHA obtaining a surety bond under this section; and

(iii) Meets other conditions, as specified by the Medicaid agency.

(2) The Medicaid agency may determine that a surety company is an unauthorized Surety under this section—

(i) If, upon request by the Medicaid agency, the surety company fails to furnish timely confirmation of the issuance of, and the validity and accuracy of information appearing on, a surety bond that an HHA presents to the Medicaid agency that shows the surety company as Surety on the bond;

(ii) If, upon presentation by the Medicaid agency to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond, the surety company fails to timely pay the Medicaid agency in full the amount requested up to the face amount of the bond; or

(iii) For other good cause.

(3) The Medicaid agency must specify the manner by which public notification of a determination under paragraph (f)(2) of this section is given and the effective date of the determination.

(4) A determination by the Medicaid agency that a surety company is an unauthorized Surety under paragraph (f)(2) of this section—

(i) Has effect only within the State; and

(ii) Is not a debarment, suspension, or exclusion for the purposes of Executive Order No. 12549 (3 CFR 1986 Comp., p. 189).

(g) *Amount of the bond.*

(1) *Basic rule.* The amount of the surety bond must be \$50,000 or 15 percent of the annual Medicaid payments made to the HHA by the Medicaid agency for home health services furnished under this subchapter for which FFP is available, whichever is greater.

(2) *Computation of the 15 percent: Participating HHA.* The 15 percent is computed by the Medicaid agency on the basis of Medicaid payments made to the HHA for the most recent annual period for which information is available as specified by the Medicaid agency.

(3) *Computation of 15 percent: An HHA that seeks to become a participating HHA by obtaining assets or ownership interest.* For an HHA that seeks to become a participating HHA by purchasing the assets or the ownership interest of a participating or formerly participating HHA, the 15 percent is computed on the basis of Medicaid payments made by the Medicaid agency to the participating or formerly participating HHA for the most recent annual period as specified by the Medicaid agency.

(4) *Computation of 15 percent: Change of ownership.* For an HHA that undergoes a change of ownership (as "change of ownership" is defined by the State Medicaid agency) the 15 percent is computed on the basis of Medicaid payments made by the Medicaid agency to the HHA for the most recent annual period as specified by the Medicaid agency.

(5) *An HHA that seeks to become a participating HHA without obtaining assets or ownership interest.* For an HHA that seeks to become a participating HHA without purchasing the assets or the ownership interest of a participating or formerly participating HHA, the 15 percent computation does not apply.

(6) *Exception to the basic rule.* If an HHA's overpayment in the most recent annual period exceeds 15 percent, the State Medicaid agency may require the HHA to secure a bond in an amount up to or equal to the amount of the overpayment, provided the amount of the bond is not less than \$50,000.

(h) *Additional requirements of the surety bond.* The surety bond that an HHA obtains under this section must meet the following additional requirements:

(1) The bond must guarantee that, upon written demand by the Medicaid agency to the Surety for payment under the bond and the Medicaid agency furnishing to the Surety sufficient evidence to establish the Surety's liability under the bond, the Surety will

timely pay the Medicaid agency the amount so demanded, up to the stated amount of the bond.

(2) The bond must provide that the Surety's liability for uncollected overpayments is based on overpayments that arise from Medicaid payments that are made by the Medicaid agency to the HHA during the term of the bond, regardless of when the overpayments are determined by the Medicaid agency or when the overpayments become uncollected overpayments.

(3) The bond must provide that the Surety's liability to the Medicaid agency is not extinguished by any of the following:

(i) Any action by the HHA or the Surety to terminate or limit the scope or term of the bond unless the Surety furnishes the Medicaid agency with notice of such action not later than 10 days after the date of notice of such action by the HHA to the Surety, or not later than 60 days before the effective date of the action by the Surety.

(ii) The Surety's failure to continue to meet the requirements of paragraph (f)(1) of this section or the Medicaid agency's determination that the surety company is an unauthorized surety under paragraph (f)(2) of this section.

(iii) Termination of the HHA's provider agreement described under § 431.107 of this subchapter.

(iv) Any action by the Medicaid agency to suspend, offset, or otherwise recover payments to the HHA.

(v) Any action by the HHA to—

(A) Cease operation;

(B) Sell or transfer any assets or ownership interest;

(C) File for bankruptcy; or

(D) Fail to pay the Surety.

(vi) Any fraud, misrepresentation, or negligence by the HHA in obtaining the surety bond or by the Surety (or by the Surety's agent, if any) in issuing the surety bond, except that any fraud, misrepresentation, or negligence by the HHA in identifying to the Surety (or to the Surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the Surety's liability to the Medicaid agency to exceed the amount of the bond.

(vii) The HHA's failure to exercise available appeal rights under Medicaid or to assign such rights to the Surety (provided the Medicaid agency permits such rights to be assigned).

(4) The bond must provide that actions under the bond may be brought by the Medicaid agency or by an agent that the Medicaid agency designates.

(i) *Submission date and term of the bond.*

(1) Each participating HHA that is not exempted by paragraph (d) of this

section must submit to the Medicaid agency a surety bond as follows:

(i) *Initial term.* By February 27, 1998, effective for the term January 1, 1998, through a date specified by the State Medicaid agency.

(ii) *Subsequent terms.* By a date as the Medicaid agency may specify, effective for an annual period specified by the Medicaid agency.

(2) *HHA that seeks to become a participating HHA.*

(i) An HHA that seeks to become a participating HHA must submit a surety bond before a provider agreement described under § 431.107 of this subchapter can be entered into.

(ii) An HHA that seeks to become a participating HHA through the purchase or transfer of assets or ownership interest of a participating or formerly participating HHA must also ensure that the surety bond is effective from the date of such purchase or transfer.

(3) *Change of ownership.* An HHA that undergoes a change of ownership (as "change of ownership" is defined by the State Medicaid agency) must submit the surety bond to the State Medicaid agency by such time and for such term as is specified in the instructions of the State Medicaid agency.

(4) *Government-operated HHA that loses its waiver.* A government-operated HHA that, as of January 1, 1998, meets the criteria for waiver of the requirements of this section but thereafter is determined by the Medicaid agency to not meet such criteria, must submit a surety bond to the Medicaid agency within 60 days after it receives notice from the Medicaid agency that it does not meet the criteria for waiver.

(5) *Change of Surety.* An HHA that obtains a replacement surety bond from a different Surety to cover the remaining term of a previously obtained bond must submit the new surety bond to the Medicaid agency within 60 days (or such earlier date as the Medicaid agency may specify) of obtaining the bond from the new Surety for a term specified by the Medicaid agency.

(j) *Effect of failure to obtain, maintain, and timely file a surety bond.*

(1) The Medicaid agency must terminate the HHA's provider agreement if the HHA fails to obtain, file timely, and maintain a surety bond in accordance with this section and the Medicaid agency's instructions.

(2) The Medicaid agency must refuse to enter into a provider agreement with an HHA if an HHA seeking to become a participating HHA fails to obtain and file timely a surety bond in accordance with this section and instructions issued by the State Medicaid agency.

(k) *Evidence of compliance.*

(1) The Medicaid agency may at any time require an HHA to make a specific showing of being in compliance with the requirements of this section and may require the HHA to submit such additional evidence as the Medicaid agency considers sufficient to demonstrate the HHA's compliance.

(2) The Medicaid agency may terminate the HHA's provider agreement or refuse to enter into a provider agreement if an HHA fails to timely furnish sufficient evidence at the Medicaid agency's request to demonstrate compliance with the requirements of this section.

(l) *Surety's standing to appeal Medicaid determinations.* The Medicaid agency may establish procedures for granting or denying appeal rights to sureties.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

D. Part 489 is amended as follows:

1. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 489.1 is amended by adding a new paragraph (e) to read as follows:

§ 489.1 Statutory basis.

* * * * *

(e) Section 1861(o)(7) of the Act requires each HHA to provide HCFA with a surety bond.

3. In § 489.10, new paragraphs (e) and (f) are added to read as follows:

§ 489.10 Basic requirements.

* * * * *

(e) In order for a home health agency to be accepted, it must also meet the surety bond requirements specified in subpart F of this part.

(f) In order for a home health agency to be accepted as a new provider, it must also meet the capitalization requirements specified in subpart B of this part.

4. A new § 489.28 is added to read as follows:

§ 489.28 Special capitalization requirements for HHAs

(a) *Basic rule.* An HHA entering the Medicare program on or after January 1, 1998, including a new HHA as a result of a change of ownership, if the change of ownership results in a new provider number being issued, must have available sufficient funds, which we term "initial reserve operating funds," to operate the HHA for the three month

period after its Medicare provider agreement becomes effective, exclusive of actual or projected accounts receivable from Medicare or other health care insurers.

(b) *Standard.* Initial reserve operating funds are sufficient to meet the requirement of this section if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of three or more similarly situated HHAs in their first year of operation (selected by HCFA for comparative purposes) multiplied by the number of visits projected by the HHA for its first three months of operation—or 22.5 percent (one fourth of 90 percent) of the average number of visits reported by the comparison HHAs—whichever is greater.

(c) *Method.* HCFA, through the intermediary, will determine the amount of the initial reserve operating funds using reported cost and visit data from submitted cost reports for the first full year of operation from at least three HHAs that the intermediary serves that are comparable to the HHA that is seeking to enter the Medicare program, considering such factors as geographic location and urban/rural status, number of visits, provider-based versus free-standing, and proprietary versus non-proprietary status. The determination of the adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs' total reported visits. The resulting average cost per visit is then multiplied by the projected visits for the first three months of operation of the HHA seeking to enter the program, but not less than 90 percent of average visits for a three month period for the HHAs used in determining the average cost per visit.

(d) *Required proof of availability of initial reserve operating funds.* The HHA must provide HCFA with adequate proof of the availability of initial reserve operating funds. Such proof, at a minimum, will include a copy of the statement(s) of the HHA's savings, checking, or other account(s) that contains the funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and that the funds are immediately available to the HHA. In some cases, an HHA may have all or part of the initial reserve operating funds in cash equivalents. For the purpose of this section, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that

present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial three month period for which the initial reserve operating funds are required does not qualify in meeting the initial reserve operating funds requirement. Examples of cash equivalents for the purpose of this section are Treasury bills, commercial paper, and money market funds. As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. HCFA later may require the HHA to furnish another attestation from the financial institution that the funds remain available, or, if applicable, documentation from the HHA that any cash equivalents remain available, until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization. The officer of the HHA who will be certifying the accuracy of the information on the HHA's cost report must certify what portion of the required initial reserve operating funds is non-borrowed funds, including funds invested in the business by the owner. That amount must be at least 50 percent of the required initial reserve operating funds. The remainder of the reserve operating funds may be secured through borrowing or line of credit from an unrelated lender.

(e) *Borrowed funds.* If borrowed funds are not in the same account(s) as the HHA's own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA, by providing, at a minimum, a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds, accompanied by an attestation from an officer of the bank or other financial institution that the funds are in the account(s) and are immediately available to the HHA. As with the HHA's own (that is, non-borrowed) funds, HCFA later may require the HHA to establish the current availability of such borrowed funds, including furnishing an attestation from a financial institution or other source, as may be appropriate, and to establish that such funds will remain available until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization.

(f) *Line of credit.* If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide HCFA with a letter of credit from the lender. HCFA later may require the HHA to furnish an attestation from the

lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

(g) *Provider agreement.* HCFA does not enter into a provider agreement with an HHA unless the HHA meets the initial reserve operating funds requirement of this section.

5. A new subpart F is added to read as follows:

Subpart F—Surety Bond Requirements for HHAs

Sec.

- 489.60 Definitions.
- 489.61 Basic requirement for surety bonds.
- 489.62 Requirement waived for Government-operated HHAs.
- 489.63 Parties to the bond.
- 489.64 Authorized Surety and exclusion of surety companies.
- 489.65 Amount of the bond.
- 489.66 Additional requirements of the surety bond.
- 489.67 Submission date and term of the bond.
- 489.68 Effect of failure to obtain, maintain, and timely file a surety bond.
- 489.69 Evidence of compliance.
- 489.70 Effect of payment by the Surety.
- 489.71 Surety's standing to appeal Medicare determinations.
- 489.72 Effect of review reversing HCFA's determination.
- 489.73 Incorporation into existing provider agreements.

Subpart F—Surety Bond Requirements for HHAs

§ 489.60 Definitions.

As used in this subpart unless the context indicates otherwise—

Assessment means a sum certain that HCFA may assess against an HHA in lieu of damages under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Assets includes but is not limited to any listing that identifies Medicare beneficiaries to whom home health services were furnished by a participating or formerly participating HHA.

Civil money penalty means a sum certain that HCFA has the authority to impose on an HHA as a penalty under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Participating home health agency means a "home health agency" (HHA), as that term is defined by section 1861(o) of the Social Security Act, that also meets the definition of a "provider" set forth at § 400.202 of this chapter.

Surety bond means one or more bonds issued by one or more surety companies under 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225, provided

the bond otherwise meets the requirements of this section.

Unpaid civil money penalty or assessment means a civil money penalty or assessment imposed by HCFA on an HHA under Titles XI, XVIII, or XXI of the Social Security Act, plus accrued interest, that, 90 days after the HHA has exhausted all administrative appeals, remains unpaid (because the civil money penalty or assessment has not been paid to, or offset or compromised by, HCFA) and is not the subject of a written arrangement, acceptable to HCFA, for payment by the HHA. In the event a written arrangement for payment, acceptable to HCFA, is made, an *unpaid civil money penalty or assessment* also means such civil money penalty or assessment, plus accrued interest, that remains due 60 days after the HHA's default on such arrangement.

Unpaid claim means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that, 90 days after the date of the agency's notice to the HHA of the overpayment, remains due (because the overpayment has not been paid to, or recouped or compromised by, HCFA) and is not the subject of a written arrangement, acceptable to HCFA, for payment by the HHA. In the event a written arrangement for payment, acceptable to HCFA, is made, an *unpaid claim* also means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that remains due 60 days after the HHA's default on such arrangement.

§ 489.61 Basic requirement for surety bonds.

Except as provided in § 489.62, each HHA that is a Medicare participating HHA, or that seeks to become a Medicare participating HHA, must obtain a surety bond (and furnish to HCFA a copy of such surety bond) that meets the requirements of this subpart F and HCFA's instructions.

§ 489.62 Requirement waived for Government-operated HHAs.

An HHA operated by a Federal, State, local, or tribal government agency is deemed to have provided HCFA with a comparable surety bond under State law, and HCFA therefore waives the requirements of this section with respect to such an HHA if, during the preceding 5 years the HHA has—

(a) Not had any unpaid claims or unpaid civil money penalties or assessments; and

(b) Not had any of its claims referred by HCFA to the Department of Justice or the General Accounting Office in

accordance with part 401 of this chapter.

§ 489.63 Parties to the bond.

The surety bond must name the HHA as Principal, HCFA as Obligee, and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as Surety.

§ 489.64 Authorized Surety and exclusion of surety companies.

(a) An HHA may obtain a surety bond required under § 489.61 only from an authorized Surety.

(b) An authorized Surety is a surety company that—

(1) Has been issued a Certificate of Authority by the U.S. Department of the Treasury in accordance with 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225 as an acceptable surety on Federal bonds and the Certificate has neither expired nor been revoked; and

(2) Has not been determined by HCFA to be an unauthorized Surety for the purpose of an HHA obtaining a surety bond under this section.

(c) HCFA determines that a surety company is an unauthorized Surety under this section—

(1) If, upon request by HCFA, the surety company fails to furnish timely confirmation of the issuance of, and the validity and accuracy of information appearing on, a surety bond an HHA presents to HCFA that shows the surety company as Surety on the bond;

(2) If, upon presentation by HCFA to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond, the surety company fails to timely pay HCFA in full the amount requested, up to the face amount of the bond; or

(3) For other good cause.

(d) Any determination HCFA makes under paragraph (c) of this section is effective immediately when notice of the determination is published in the **Federal Register** and remains in effect until a notice of reinstatement is published in the **Federal Register**.

(e) Any determination HCFA makes under paragraph (c) of this section does not affect the Surety's liability under any surety bond issued by a surety company to an HHA before notice of such determination is published in accordance with paragraph (d) of this section.

(f) A determination by HCFA that a surety company is an unauthorized Surety under this section is not a debarment, suspension, or exclusion for the purposes of Executive Order No. 12549 (3 CFR, 1986 comp., p. 189).

§ 489.65 Amount of the bond.

(a) *Basic rule.* The amount of the surety bond must be \$50,000 or 15 percent of the Medicare payments made by HCFA to the HHA in the HHA's most recent fiscal year for which a cost report has been accepted by HCFA, whichever is greater.

(b) *Computation of the 15 percent: Participating HHA.*

The 15 percent is computed as follows:

(1) For the initial bond—on the basis of Medicare payments made by HCFA to the HHA in the HHA's most recent fiscal year as shown in the HHA's most recent cost report that has been accepted by HCFA. If the initial bond will cover less than a full fiscal year, the computation of the 15 percent will be based on the number of months of the fiscal year that the bond will cover.

(2) For subsequent bonds—on the basis of Medicare payments made by HCFA in the most recent fiscal year for which a cost report has been accepted. However, if payments in the first six months of the current fiscal year differ from such an amount by more than 25 percent, then the amount of the bond is 15 percent of such payments projected on an annualized basis.

(c) *Computation of 15 percent: An HHA that seeks to become a participating HHA by obtaining assets or ownership interest.* For an HHA that seeks to become a participating HHA by purchasing the assets or the ownership interest of a participating or formerly participating HHA, the 15 percent is computed on the basis of Medicare payments made by HCFA to the participating or formerly participating HHA in the most recent fiscal year that a cost report has been accepted.

(d) *Change of ownership.* For an HHA that undergoes a change of ownership the 15 percent is computed on the basis of Medicare payments made by HCFA to the HHA for the most recently accepted cost report.

(e) *An HHA that seeks to become a participating HHA without obtaining assets or ownership interest.* For an HHA that seeks to become a participating HHA without purchasing the assets or the ownership interest of a participating or formerly participating HHA, the 15 percent computation does not apply.

(f) *Exception to the basic rule.* If an HHA's overpayment in the most recently accepted cost report exceeds 15 percent of annual payments, HCFA may require the HHA to secure a bond in an amount up to or equal to the amount of overpayment, provided the amount of the bond is not less than \$50,000.

§ 489.66 Additional requirements of the surety bond.

The surety bond that an HHA obtains under this subpart must meet the following additional requirements:

(a) The bond must guarantee that within 30 days of receiving written notice from HCFA of an unpaid claim or unpaid civil money penalty or assessment, which notice contains sufficient evidence to establish the Surety's liability under the bond, the Surety will pay HCFA, up to the stated amount of the bond—

(1) The full amount of any unpaid claim, plus accrued interest, for which the HHA is responsible; and

(2) The full amount of any unpaid civil money penalty or assessment imposed by HCFA on the HHA, plus accrued interest.

(b) The bond must provide that the Surety's liability for unpaid claims and unpaid civil money penalties and assessments is based on—

(1) Medicare overpayments that arise from Medicare payments that are made by HCFA to the HHA during the term of the bond, regardless of when the overpayments are determined by HCFA or when the overpayments become unpaid claims; and

(2) Civil money penalties and assessments that HCFA imposes on the HHA during the term of the bond regardless of when it is determined that the civil money penalties or assessments are unpaid.

(c) The bond must provide that the Surety's liability to HCFA under the bond is not extinguished by any action of the HHA, the Surety, or HCFA, including but not necessarily limited to any of the following actions:

(1) Any action by the HHA or the Surety to terminate or limit the scope or term of the bond unless the Surety furnishes HCFA with notice of such action not later than 10 days after receiving notice of such action by the HHA, or not later than 60 days before the effective date of such action by the Surety.

(2) The Surety's failure to continue to meet the requirements of § 489.64(a) or HCFA's determination that the surety company is an unauthorized Surety under § 489.64(b).

(3) Termination of the HHA's provider agreement.

(4) Any action by HCFA to suspend, offset, or otherwise recover payments to the HHA.

(5) Any action by the HHA to—

(i) Cease operation;

(ii) Sell or transfer any asset or ownership interest;

(iii) File for bankruptcy; or

(iv) Fail to pay the Surety.

(6) Any fraud, misrepresentation, or negligence by the HHA in obtaining the surety bond or by the Surety (or by the Surety's agent, if any) in issuing the surety bond, except that any fraud, misrepresentation, or negligence by the HHA in identifying to the Surety (or to the Surety's agent) the amount of Medicare payments upon which the amount of the surety bond is determined will not cause the Surety's liability to HCFA to exceed the amount of the bond.

(7) The HHA's failure to exercise available appeal rights under Medicare or to assign such rights to the Surety.

(d) The bond must provide that actions under the bond may be brought by HCFA or by HCFA's fiscal intermediaries.

§ 489.67 Submission date and term of the bond.

(a) Each participating HHA that does not meet the criteria for waiver under § 489.62 must submit to HCFA, in such a form as HCFA may specify, a surety bond as follows:

(1) *Initial term:* By February 27, 1998, effective for the term beginning January 1, 1998 through the end of the HHA's fiscal year.

(2) *Subsequent terms:* Not later than 30 days before the HHA's fiscal year, effective for a term concurrent with the HHA's fiscal year.

(b) *HHA that seeks to become a participating HHA.*

(1) An HHA that seeks to become a participating HHA must submit a surety bond with its enrollment application (Form HCFA-855, OMB number 0938-0685). The term of the initial surety bond must be effective from the effective date of provider agreement as specified in § 489.13 of this part. However, if the effective date of the provider agreement is less than 30 days before the end of the HHA's current fiscal year, the HHA may obtain a bond effective through the end of the next fiscal year, provided the amount of the bond is the greater of \$75,000 or 20 percent of the amount determined from the computation specified in § 489.65(c) as applicable.

(2) An HHA that seeks to become a participating HHA through the purchase or transfer of assets or ownership interest of a participating or formerly participating HHA must also ensure that the surety bond is effective from the date of such purchase or transfer.

(c) *Change of ownership.* An HHA that undergoes a change of ownership must submit the surety bond to HCFA not later than the effective date of the change of ownership and the bond must be effective from the effective date of the

change of ownership through the remainder of the HHA's fiscal year.

(d) *Government-operated HHA that loses its waiver.* A government-operated HHA that, as of January 1, 1998, meets the criteria for waiver under § 489.62 but thereafter is determined by HCFA to not meet such criteria, must submit a surety bond to HCFA within 60 days after it receives notice from HCFA that it no longer meets the criteria for waiver.

(e) *Change of Surety.* An HHA that obtains a replacement surety bond from a different Surety to cover the remaining term of a previously obtained bond must submit the new surety bond to HCFA within 30 days of obtaining the bond from the new Surety.

§ 489.68 Effect of failure to obtain, maintain, and timely file a surety bond.

(a) The failure of a participating HHA to obtain, file timely, and maintain a surety bond in accordance with this subpart F and HCFA's instructions is sufficient under § 489.53(a)(1) for HCFA to terminate the HHA's provider agreement.

(b) The failure of an HHA seeking to become a participating HHA to obtain and file timely a surety bond in accordance with this Subpart F and HCFA's instructions is sufficient under § 489.12(a)(3) for HCFA to refuse to enter into a provider agreement with the HHA.

§ 489.69 Evidence of compliance.

(a) HCFA may at any time require an HHA to make a specific showing of being in compliance with the requirements of this Subpart F and may require the HHA to submit such additional evidence as HCFA considers sufficient to demonstrate the HHA's compliance.

(b) If requested by HCFA to do so, the failure of an HHA to timely furnish sufficient evidence to HCFA to demonstrate compliance with the requirements of this Subpart F is sufficient for HCFA to terminate the HHA's provider agreement under § 489.53(a)(1) or to refuse to enter into a provider agreement with the HHA under § 489.12(a)(3), as applicable.

§ 489.70 Effect of payment by the Surety.

A Surety's payment to HCFA under a bond for an unpaid claim or an unpaid civil money penalty or assessment, constitutes—

(a) Collection of the unpaid claim or unpaid civil money penalty or assessment (to the extent the Surety's payment on the bond covers such unpaid claim, civil money penalty, or assessment); and

(b) A basis for termination of the HHA's provider agreement under § 489.53(a)(1).

§ 489.71 Surety's standing to appeal Medicare determinations.

(a) A Surety shall have standing to appeal any matter that the HHA could appeal provided that:

(1) The Surety has made payment of all amounts owed to HCFA by the HHA, up to the amount of the bond.

(2) The HHA has assigned its right of appeal to the Surety.

(3) The Surety satisfies all jurisdictional and procedural requirements that would otherwise have applied to the HHA.

(b) Any assignment of appeal rights by the HHA to the Surety must be in writing and must include the right to appeal all issues contested with respect to the specified cost reporting period.

§ 489.72 Effect of review reversing determination.

In the event a Surety has paid HCFA on the basis of liability incurred under a bond obtained by an HHA under this subpart F, and to the extent the HHA that obtained such bond (or the Surety under § 489.71) is subsequently successful in appealing the determination that was the basis of the unpaid claim or unpaid civil money penalty or assessment that caused the Surety to pay HCFA under the bond, HCFA will refund to the Surety the amount the Surety paid to HCFA to the extent such amount relates to the matter that was successfully appealed by the HHA (or by the Surety), provided all review, including judicial review, has been completed on such matter. Any additional amounts owing as a result of the appeal will be paid to the HHA.

§ 489.73 Incorporation into existing provider agreements.

The requirements of this subpart F are deemed to be incorporated into existing HHA provider agreements effective January 1, 1998.

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Hospital Insurance Program, and Program No. 93.778, Medical Assistance Program)

Dated: December 1, 1997.

Nancy-Ann Min DeParle,
Administrator, Health Care Financing Administration.

Dated: December 24, 1997.

Donna E. Shalala,
Secretary.

Note: The attached addendum will not appear in the Code of Federal Regulations.



Medicare And Other Federal Health Care Programs General Enrollment

Health Care Provider/Supplier Application

Privacy Act Statement

The Health Care Financing Administration (HCFA) is authorized to collect the information requested on this form in order to ensure that correct payments are made to providers and suppliers under the Medicare program established by Title XVIII of the Social Security Act. See sections 1814 and 1815 of the Social Security Act for payment under Part A of Title XVIII [42 U.S.C. §§ 1395f(a)(1) and 1395g(a)] and section 1833(e) [42 U.S.C. § 1395(e)] for payment under Part B. In addition, HCFA is required to ensure that no payments are made to providers or suppliers who are excluded from participation in the Medicare program under section 1128 of Title XVIII [42 U.S.C. § 1320a-70] or who are prohibited from providing services to the federal government under section 2455 of the Federal Acquisition Streamlining Act of 1994, (P.L. 103-355) [31 U.S.C. § 6101 note]. This information must, minimally, clearly identify the provider and its place of business as required by the Budget Reconciliation Act of 1985 (P.L. 99-272) [42 U.S.C. § 9202(g)] and provide all necessary documentation to show they are qualified to perform the services for which they are billing.

The Debt Collection Improvement Act (DCIA) of 1996 (P.L. 104-134) [31 U.S.C. §§ 3720B-3720D] requires agencies to collect the Taxpayer Identification Number (either the Social Security Number or the Employer Identification Number) from all persons or business entities doing business with the federal government. Under section 31001(i)(1) of the DCIA [31 U.S.C. § 7701(c)(1)], the taxpayer identification number will be used to collect (including collection through use of offset) and report any delinquent amounts arising out of the business relationship with the Government. Therefore, collection of this data element is mandatory.

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in administration of the Medicare program and other Federal and State health care programs. All information on this form is required, with the exception of those sections marked as optional on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in the Federal Register in Vol. 61, no. 89, May 7, 1996), or the National Provider Identifier (NPI) System (OMB approval 0938-0684 (R-187)). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances, to:

- (1) Contractors working for HCFA to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
- (2) A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
- (3) The Railroad Retirement Board for purposes of administering provisions of the Railroad Retirement or Social Security Acts;
- (4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
- (5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information. (6) To the Department of Justice for investigation and prosecuting violations of the Social Security Act to which criminal penalties attach;
- (7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
- (8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
- (9) Other Federal agencies who administer a Federal health care benefits program to enumerate/enroll providers of medical services or to detect fraud or abuse;
- (10) State Licensing Boards for review of unethical practices or nonprofessional conduct;
- (11) States for the purpose of administration of health care programs; and/or
- (12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider/supplier's health care claims.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988, (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected on this form are protected from public disclosure by Federal law 5 U.S.C. 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by HCFA under 5 U.S.C. § 552(b)(4) and/or (b)(6), respectively.



**MEDICARE AND OTHER FEDERAL
HEALTH CARE PROGRAMS
PROVIDER/SUPPLIER ENROLLMENT
APPLICATION INSTRUCTIONS
General Application - HCFA 855**

Upon completion, return this application and all necessary documentation to:

General

This application must be completed by all providers and suppliers of medical and other health services for enrollment in the Medicare or any other federal health care program.

Some applicants may also need to be surveyed and/or certified by the appropriate State Agency or Regional Medicare Office when required to meet Medicare conditions of enrollment. In this case, those applicants must initially contact the State Agency or Regional Medicare Office prior to completion and submission of this application.

If you need assistance or have any questions concerning the completion of this application, contact your local Medicare or other federal health care contractor.

A separate application must be submitted for each classification of provider/supplier type (e.g., physician in private practice, physician in group practice) even if the different types of services are furnished within the same organization or entity (e.g., hospitals and all affiliated units).

Each entity of an organization must submit a separate application (e.g., hospital based skilled nursing facility, hospices, outpatient clinics, etc.). Each entity of a chain organization must submit a separate application.

Providers and/or suppliers enrolling in the Medicare or any other federal health care program as a group member, partner, or individual contractor who reassigns their Medicare or other federal health care program benefits to the enrolling applicant must also complete HCFA Form 855R (Individual Reassignment of Benefits Application).

Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies must enroll in the Medicare or any other federal health care program using HCFA Form 855S (DMEPOS Supplier Enrollment Application) instead of this application.

Note: Any changes in the information reported in this application must be reported to the Medicare or other federal health care contractor within 30 calendar days of said change.

Definitions

Authorized Representative: The appointed official who has the authority to enroll the entity in Medicare or other federal health care programs as well as to make changes and/or updates to the applicant's status, and to commit the provider/supplier to Medicare laws and regulations.

Chain Organization: Multiple providers and/or suppliers (chains) are owned, leased or through any other devices, controlled by a single business entity. The chain organization must consist of two or more health care facilities. The controlling business entity is called the chain "Home Office." Each entity in the chain may have a different owner (generally chains are not owned by the "Home Office").

Typically, the chain "Home Office:"

-maintains uniform procedures in each facility for handling admissions, utilization review, preparation and processing admission notices and bills;

-maintains and controls centrally, individual provider/supplier cost reports and fiscal records and a major part of the Medicare audit for each component can be performed centrally.

Examples of provider types that would typically be chain organizations are: Certified Outpatient Rehabilitation Facilities (CORFs); Skilled Nursing Facilities (SNFs); and Home Health Agencies (HHAs).

Clinical Laboratory Improvement Amendments (CLIA) Number: This number is assigned to laboratories who are certified by the Health Care Financing Administration (HCFA) under the Clinical Laboratory Improvement Amendments.

Note: Any laboratory soliciting or accepting specimens for laboratory testing is required to hold a valid certificate issued by the Secretary of the United States Department of Health and Human Services or hold a license from a CLIA exempt State.

Consolidated Cost Report: A cost report compiled for multiple facilities joined together and filed under the parent facility's Medicare Identification Number.

Contractor: Any individual, entity, facility, organization, business, group practice, etc., receiving an Internal Revenue Service (IRS) Form 1099 for services provided to this applicant (e.g., independent contractor, subcontractor).

Distinct Part Unit [of a facility]: A separate psychiatric, rehabilitation, or skilled nursing unit that is attached to a hospital paid under the Prospective Payment System (PPS) but which is paid on a cost reimbursement or other non-PPS basis. It must be a clearly identifiable unit, such as an entire ward, wing, floor, or building, including all the beds and related services in the unit, that meets all the requirements for a type of facility other than the one in which it is located, **and** houses all the beneficiaries and recipients for whom payment is made under Medicare for services in the other type of facility.

Food and Drug Administration Number (FDA): This is the certification number assigned by the FDA for equipment used in mammography screening and diagnostic services.

Group Member: A physician or non-physician practitioner who renders services in a group practice and who reassigns benefits to the group.

Independent Diagnostic Testing Facility (IDTF) (formerly Independent Physiological Laboratories (IPL's)): An entity independent of a hospital or physician's office in which diagnostic tests are performed by licensed, certified non-physician personnel under appropriate physician supervision (e.g., free standing cardiac catheterization facility, imaging center, etc.).

Legal Business Name: The legal name of the individual or entity applying for enrollment. This name should be the same name the applicant uses in reporting to the Internal Revenue Service.

Medicaid Number: This number uniquely identifies the applicant as a Medicaid provider and/or supplier in a given State.

Medicare Identification Number: This number uniquely identifies the applicant as a Medicare provider and/or supplier and is the number used on claim forms. The Medicare Identification Number is also known as Medicare Provider Number and Provider Identification Number (PIN). Examples of Medicare Identification Numbers are the UPINs, OSCAR numbers, and NSC numbers.

Note: if the applicant is enrolling in the Medicare or other federal health care programs for the first time, the applicant will receive a Medicare or other federal health care program identification number upon enrollment.

National Provider Identifier (NPI): This number is assigned using the National Provider System to identify health care providers and/or suppliers. In the future, it will replace the Medicare Identification Number.

National Supplier Clearinghouse Number (NSC): This number uniquely identifies the applicant as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It is the number used by DMEPOS suppliers on claim forms.

On-Line Survey Certification and Reporting System (OSCAR): National database used for maintaining and retrieving survey and certification data for certified providers and/or suppliers that are approved to participate in the Medicare, Medicaid and CLIA programs. OSCAR numbers are assigned by the Regional Medicare office.

Other Affiliated Units: Entities that are either a Provider Based Facility, a Distinct Part Unit, or file a consolidated cost report.

Provider Based Facility: Entities operating under the control of a parent organization (e.g., hospital based End Stage Renal Disease Unit, Skilled Nursing Facility, etc.).

Reassignee: An individual or organization that allows another organization to bill Medicare or other federal health care programs on their behalf for services rendered.

Unique Physician Identification Number (UPIN): This number is assigned to physicians, non-physician practitioners and groups to identify the referring or ordering physician on Medicare claims.

APPLICATION COMPLETION INSTRUCTIONS

Furnish all requested information in its entirety. If a field is not applicable, write N/A in the field. If entire section is not applicable, check the box at the beginning of the section indicating the entire section is not applicable. Any section of the application that does not have a check box at the beginning of the section indicating the entire section is not applicable must be completed by applicant.

Check Type of Business: (For administrative purposes only)

Check appropriate box indicating how applicant's business is structured. The answer to this item will not affect the amount of reimbursement or enrollment status.

Note: If applicant's business structure is a partnership, applicant must provide a copy of its partnership agreement signed by all parties and identifying the general partner (if any) and attest that the partnership meets all State requirements. Partnerships see group instruction.

Check "Applicant Enrolling As" Type: (For administrative purposes only) The answer to this item will not affect the amount of reimbursement or enrollment status.

See the instructions below that identify which sections the applicant is responsible for completing.

Individual: An individual person enrolling as a physician, supplier or non-physician practitioner (e.g., physician, nurse, midwife, etc.).

Note: An individual who is registered as a business is considered a sole proprietor for the purpose of completing this application and should not check this box.

Individuals complete sections 1a, 1d, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 14, 15, 17, and 18.

Sole Proprietor: An individual person registered as a business and issued a tax identification number from the IRS and rendering services under the business name.

Sole Proprietors complete sections 1a, 1b, 1d, 2, 3, 4, 5, 6, 7, 8, 9, 12, 13, 14, 15, 17 and 18.

Organization: A company, not-for-profit entity, governmental agency (Federal, State, or Local) or a qualified health care delivery system which renders medical care (e.g., pharmacy, equipment manufacturer, hospital, Public Health Clinic, laboratory, skilled nursing facility, Ambulance Service Supplier, Independent Diagnostic Testing Facility, etc.).

Organizations complete sections 1b, 1d, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18.

Ambulance Service Suppliers must also complete Attachment 1.

Independent Diagnostic Testing Facilities must also complete Attachment 2.

Home Health Agencies must also complete Attachment 3.

Group: Two or more physicians, non-physician practitioners or other health care providers/suppliers who form a practice together (as authorized by State law) and bill Medicare or other federal health care programs as a single unit. This excludes contracted physicians, contracted non-physician practitioners and other contracted health care providers/suppliers. A group has individual practitioners. The individual members must be enumerated and enrolled in the Medicare or other federal health care program as individuals in order to enroll as members of the group.

Only those health care practitioners who are authorized to bill Medicare or other federal health care programs directly in their individual capacities are allowed to form a group. A group can only be enrolled if it can meet the conditions for reassignment (see instructions for the Reassignment of Benefits section).

The above definition of a group is to be used for Medicare or other federal health care programs' enrollment purposes only. It is not the group definition described in section 1877(h) of the Social Security Act.

Groups/Partnerships complete sections 1c, 1d, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17 and 18.

All group member/partners must complete HCFA Form 855R.

Note: PARTNERSHIPS: For purposes of this application, partnerships should check that they are "enrolling as" a group.

Note: RURAL HEALTH CLINICS: Rural Health Clinics that meet the definition of a group, should also submit HCFA Form 855R (Individual Reassignment of Benefits Application) for each member of the group. This is not applicable to those Rural Health Clinics that are provider based.

Mass Immunization Biller Only: A health care provider/supplier who roster bills Medicare or other federal health care programs solely for mass immunizations.

Mass Immunization/Roster Billers complete sections 1a, 1b, 1d, 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 17 and 18.

Note: Applicants enrolling in the Medicare or other federal health care program as mass immunization/roster billers cannot bill the Medicare or other federal health care program for any other services. The applicant agrees to accept assignment of the influenza/pneumococcus benefit as payment in full and cannot "balance bill" the beneficiary.

For those who are only applying to enroll in the Medicare or other federal health care program to roster bill for mass immunization, enter "Roster" under primary speciality in Section 1A if applicant is an individual, or enter "Roster" under type of facility in Section 1B if applicant is an organization.

Check appropriate federal health care program:

If applicant is enrolling in a federal health care program other than Medicare, check the appropriate box. Check only one box. For each federal health care program in which the applicant wishes to enroll, the applicant must complete a separate enrollment application and submit it to that federal health care program.

Check Application For:

Initial Enrollment: Applicant is enrolling in the Medicare or other federal health care programs for the first time, or re-activating a prior Medicare billing number.

Enrollment of Additional Location(s): Currently enrolled provider/supplier is applying to enroll a new practice location.

Re-certification: Currently enrolled provider/supplier is completing application to comply with mandatory periodic re-survey and/or re-certification through the State agency or Regional Medicare Office.

Change of Ownership (CHOW): This term applies to certain limited circumstances as defined in 42 CFR § 489.18 as described below.

A new or prospective new owner must complete this application to report new or prospective new ownership. In addition, the applicant must also submit an Individual Reassignment of Benefits Application (HCFA Form 855R) identifying all individuals who will reassign their benefits to the applicant.

A change of ownership is defined as:

- In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law;
- In the case of an unincorporated sole proprietorship, transfer of title and property to another party;
- In the case of a corporation, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation (transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership); and
- In the case of leasing, the lease of all or part of a DMEPOS supplier facility constitutes a change of ownership of the leased portion.

Note: A currently enrolled provider/supplier who is reporting new information on the current owners (i.e., addition(s) or deletion(s) of owner(s)) which is not expected to result in a CHOW as defined above, must make the appropriate changes using the ownership information section of this application. This action is considered a change of information (see below).

Change of Information: Currently enrolled provider/supplier is completing applicable sections of the application to report a change in information other than a CHOW as defined above. Currently enrolled provider/suppliers can use HCFA Form 855C (Change of Information Form) to report changes in name, specialty, e-mail address, practice location address, billing agency address, pay to address, surety bond changes/renewals, mailing address, pricing locality, telephone number(s), fax number(s), deactivation of Medicare or other federal health care billing number(s), addition or deletion of authorized representatives, and potential termination of current ownership.

Changes not listed above must be reported using this application.

When using this application to notify the Medicare or other federal health care program that a practice location(s), owner(s), or various personnel are no longer associated with this entity, check the appropriate deletion box in the applicable section(s) and identify the practice location and/or personnel.

All changes must be reported in writing and have an original signature. For individuals, the applicant must sign and for organizations and group practices, an "Authorized Representative" must sign to confirm the requested change(s). Faxed or photocopied signatures will not be accepted.

Check Where Applicant Will Be Submitting Bills:**MEDICARE APPLICANTS ONLY**

Fiscal Intermediary: Applicant will be enrolled to bill the fiscal intermediary only. The fiscal intermediary is generally known as the Part A Medicare Contractor. The applicant will generally be a hospital or other health care facility.

Carrier: Applicant will be enrolled to bill the carrier only. The carrier is generally known as the Part B Medicare Contractor. The applicant will generally be a physician or non-physician practitioner.

Both: Applicant's application will automatically be forwarded to bill both the fiscal intermediary and the carrier for enrollment consideration.

Regional Home Health Intermediary: Applicant will be enrolled to bill the regional home health intermediary.

Check other federal health care program(s) where applicant is currently enrolled:

If applicant is currently enrolled in any other federal health care program(s), check all appropriate boxes.

1. Applicant Identification**A. Individuals Only**

Complete all items in this section if applicant plans to bill the Medicare or other federal health care program as an individual practitioner.

If an individual or sole proprietorship, complete applicant's full name (this is the name payment will be made in), date and place of birth (county and/or city). If applicant has previously practiced or operated a business under another name, including applicant's maiden name, supply that name under Other Name.

If applicant is a resident or intern at a hospital, check appropriate box.

If applicant is enrolling as an individual or sole proprietor, furnish the applicant's primary speciality (e.g. cardiologist, pathologist, nurse practitioner, etc.). Designation of a secondary speciality is optional.

Gender and Race/Ethnicity information is optional. This data will only be used to assist HCFA in uniquely identifying the applicant.

**A. Individuals Only (continued)**

If applicant is employed by an entity that will receive payments for the applicant's services, applicant must complete and sign the HCFA Form 855R (Individual Reassignment of Benefits Application).

B. Organizations Only

Complete this section if applicant is a sole proprietor of the business or if applicant is a publicly or privately held business entity.

Complete all items in this section. For Legal Business Name, supply the name that the business, organization or group practice reports to the IRS (this is the name payment will be made in). For Type of Facility give the classification that designates the entity (e.g., hospital, skilled nursing facility, home health agency, ambulance company, etc.), and check whether this facility is accredited or non-accredited.

Note: Clinical laboratories and independent diagnostic testing facilities should annotate this section "LABORATORY" (LAB).

All organizations must identify if they are considered a Provider Based Facility, a Distinct Part Unit, or file a consolidated cost report under another provider/supplier Medicare identification number. If an organization is a Distinct Part Unit, then the organization also falls under the broader category of Provider Based Facility.

If the organization is a:

- Provider Based Facility;
- Distinct Part Unit;
- or files a consolidated cost report,

then the organization must provide the name and Medicare identification number of their parent provider.

Note: The final determination as to whether an entity is truly a Provider Based Facility will be made by HCFA prior to completion of the enrollment process.

In addition to the parent provider relationship described above, the organization must identify how many Provider Based Facilities, Distinct Part Units, Branches, or Multi-campus sites the organization is responsible for. For each of those locations identified, the Practice Location(s) section of this application must be completed.

If applicant receives payment from Medicare or any other federal health care agency for any services rendered by a contractor, when permitted by Medicare or other federal health care program requirements, the contractor must complete and sign the HCFA Form 855R (Individual Reassignment of Benefits Application).

C. Physician and Non-Physician Practitioner Groups Only

Complete all items in this section. Furnish the group's legal business name. This should be the legal name used in reporting to the IRS. Furnish the group's primary specialty (the primary specialty of the majority of the group's members). Designation of a secondary specialty is optional. All group members who the group will be billing the Medicare or other federal health care program in their behalf, must be individually enrolled in the given Medicare or other federal health care program.

Note:The group's members must be enrolled within the same federal health care program as the group enrollment. Otherwise, the group member must enroll separately as an individual in the group's federal health care program prior to becoming a member of that group practice.

Each group member must complete and sign the HCFA Form 855R (Individual Reassignment of Benefits Application).

Note: PARTNERSHIPS: When completing this section, provide legal business name of partnership, date partnership was incorporated, and the State where the partnership is incorporated. Place "n/a" in the specialty block.

D. All Applicants

Provide applicant's mailing address. This is where the applicant can receive correspondence and bulletins from Medicare or other federal health care program contractors. This address may be the applicant's home address or a Post Office Box. Applicant must supply fax number and e-mail address if available. If applicable, provide applicant's previously assigned Medicare Identification Number(s) and the name(s) of the Carrier and/or Fiscal Intermediary to which applicant most recently submitted bills using this number. If applicable, provide applicant's most recent Medicaid number and the State in which it was issued. Applicant must provide his/her Social Security Number and when applicable, his/her Employer Identification Number(s).

Note: All applicants must provide either their Social Security Number and/or, when applicable, their Employer Identification Number (EIN). **If applicant uses more than one EIN, list all, starting with the EIN(s) currently used or to be used for tax reporting purposes relating to this application. Attach a copy of IRS Form CP 575 to verify the applicant's EIN.**

Applicant must answer all questions related to criminal activity. Answering "yes" to any of these questions will not automatically deny enrollment into Medicare or other federal health care programs. For purposes of these questions related to criminal activity, an "immediate family member" of the applicant is defined as:

- a husband or wife;
- the natural or adoptive parent, child or sibling;
- the stepparent, stepchild, stepbrother or stepsister;
- the father, mother, daughter, son, brother or sister;
- parent-in-law, brother-in-law or sister-in-law;
- the grandparent or grandchild; and
- the spouse of a grandparent or grandchild.

For purposes of these questions related to criminal activity, "member of household" with respect to the applicant is defined as any individual sharing a common abode as part of a single family unit with the applicant, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.

2. Professional and Business License, Certification, and Registration Information

All applicants are required to furnish information on all Federal, State and local (city/county) professional and business licenses, certifications and/or registrations required to practice as applicant's provider/supplier type in applicant's State (e.g. State medical license for physician, State certification and/or registration for Nurses, Federal DEA number, Business Occupancy License, local business license, etc.). The local Medicare or other federal health care contractor will supply specific credentialing requirements for applicant's provider/supplier type upon request.

Notarized or "certified true" copies of the above information are optional, but will speed the processing of this application.

Notarized: A notarized copy of an original document that will have a stamp which states "Official Seal" along with the name and signature of the notary public, State, County, and the date the notary's commission expires.

Certified True: This is a copy of the original document obtained from where it originated or is stored, and it has a raised seal which identifies the State and County in which it originated or is stored.

In lieu of copies of the above requested documents, the applicant may submit a notarized or "certified true" Certificate of Good Standing from the applicant's State licensing/certification board or other medical association. This certificate cannot be more than 30 days old.

Non-physician practitioners who must meet Medicare or other federal health care program requirements for professional experience should submit evidence of practice and the dates of employment.

If applicant's enrollment requires a State survey and/or certification, the applicant is required to forward copies of State survey and/or certification documents to the Medicare or other federal health care contractor once they are received from the State agency or Regional Medicare Office.

Note: Temporary licenses are acceptable submissions with this application. However, once received, a copy of the applicant's permanent license must be forwarded to the Medicare or other federal health care program contractor within 30 days of receipt.

If applicant's State licensure is dependent upon State survey and/or certification, check applicable box and furnish information on all other required licensing information.

Note: A business license is required for each practice location.

If applicant had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice(s) with this application, if applicable.

3. Professional School Information (Individuals Only)

If applicable, supply information about the educational institution from which applicant received medical, professional, or related degree or training as required by applicant's State. Enclose copies of diploma, degree or evidence of qualifying course work.

Non-physician practitioners who must meet HCFA or other federal health care program requirements for education must provide documentation of courses or degrees taken that satisfy Medicare or other federal health care program requirements. Contact the local Medicare or other federal health care program representative for requirements needed for applicant's provider/supplier type.

4. Board Certification

If applicant is Board Certified, furnish requested information for each Board Certification obtained by the applicant.

5. Exclusion/Sanction Information

Supply all requested information, and, if applicable, attach a clear copy of the applicant's reinstatement letter(s).

6. Practice Location(s)

Provide all information requested for each location where applicant will render services to Medicare or other federal health care program beneficiaries.

Individual practitioners should include all hospitals and/or other health care facilities where they render service or have privileges to treat patients. Individual practitioners who only render services in the patient's home (house calls) should supply his/her home address in this section. If individual practitioners render services in retirement or assisted living communities, complete this section using the names and addresses of these communities.

Hospitals must list all off-site clinics, distinct part units, and provider based facilities (e.g., skilled nursing facility, rural health clinic, etc.) and multi-campus sites.

Home health agencies and hospices must list all branches.

Note: Listing the facilities, clinics, units, and multi-campus sites controlled by a hospital or other entity does not automatically enroll them in the Medicare or other federal health program. The HCFA Form 855 (General Enrollment Application) must also be completed for each of these entities.

Post Office boxes and drop boxes are **not** acceptable as practice location addresses. The phone number must be a number where patients and/or customers can reach the applicant to ask questions or register complaints.

Furnish the "Pay To" address for payment of services rendered at this practice location. Payments will be made in the legal business name that the individual, organization, or group/partnership uses to report to the IRS, as reported in Section 1 of this application. In most circumstances, payment will be made in the name of the individual who furnished the service unless a valid Reassignment of Benefits Statement has been completed. The "Pay To" address may be a Post Office box.

Furnish the name and social security number of the primary managing/directing employee of this practice location.

If applicable, provide the CLIA number or FDA certification number associated with each piece of equipment at each practice location and submit a copy of the most current certification.

6. Practice Location(s) (continued)

Indicate whether patient records are kept on the premises. If not, supply the name of the storage facility/location and the physical address where the records are maintained. Post Office boxes and drop boxes are **not** acceptable as the physical address where patient records are maintained.

7. Prior Practice Information**FOR MEDICARE ENROLLMENT ONLY**

If applicant has previously billed Medicare or Medicaid, supply requested information about the prior practice. Indicate whether applicant was a participating or non-participating provider/supplier in the prior practice.

8. Ownership Information

Complete this section for all individuals and/or entities who have an ownership or control interest in the applicant's business/entity. If owner is an individual, complete owner name, social security number and employer identification number. If applicant is owned by another entity, complete legal business name and employer identification number. Entities with ownership interest must provide their legal business name(s).

A person or entity with an ownership or control interest is one that:

- has an ownership interest totaling 5 percent or more in the provider/supplier;
- has a direct, indirect, or combination of direct and indirect ownership interest equal to 5 percent or more in the provider/supplier, where the amount of an indirect ownership interest is determined by multiplying the percentages of ownership in each entity (for example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the provider/supplier, A's interest equates to an 8 percent indirect ownership interest in the provider/supplier and must be reported);
- owns an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the provider/supplier if that interest equals at least 5 percent of the value of the property or assets of the provider/supplier;
- is an officer or director of a provider/supplier that is organized as a corporation; and/or
- is a partner in a provider/supplier that is organized as a partnership.

Supply all requested information about the owner's past and present billing relationships with Medicare. Furnish past history for the last 10 years. If data is not known or is incomplete, check the appropriate box.

Supply all requested sanction information, and, if applicable, attach a clear copy of the owner's reinstatement letter(s).

Attach a copy of the applicant's IRS Form CP 575 pertaining to this business. The IRS Form CP 575 will be used to verify the employer identification number (EIN). In lieu of the IRS Form CP 575, the applicant may use any official correspondence, such as the quarterly tax payment coupon, from the IRS showing the name of the entity as shown on this application and the EIN.

9. Managing/Directing Employees

Complete this section for all managing and/or directing employees, employed by the applicant. This section should include, but is not limited to, general manager(s), business manager(s), administrator(s), director(s), or other individuals who exercise operational or managerial control over the provider/supplier, or who directly or indirectly conduct the day-to-day operations of the applicant.

Note: This section **is not** to be completed with information about billing agency or management service organization employees. If applicant uses a billing agency or management service organization, complete the appropriate section of this application.

Note: Non-profit organizations should complete this section with information about the members on the Board of Directors and the managing and/or directing employees and submit a copy of the 501(C)(3) approval notification from the IRS.

Note: For large business organizations, furnish only the top 20 compensated managing and/or directing personnel. Social security numbers **must** be provided for all persons listed in this section.

Applicant must include all managing and/or directing employees for each practice location. Organizations must also complete this section for all corporate officers. Include the name(s) and address(es) of all practice location(s) where this employee manages and/or directs.

Supply all requested information about the managing and/or directing employee's past and present billing relationships with Medicare or other federal health care programs.

Supply all requested information about other entities this managing and/or directing employee managed or directed that previously billed or are presently billing the Medicare or other federal health care programs. Furnish past history for the last 10 years. If data is not known or is incomplete, check the box indicating this.

Supply all requested information about other entities this managing and/or directing employee had ownership interest in that previously billed or are presently billing the Medicare or other federal health care programs. Furnish past history for the last 10 years. If data is not known or is incomplete, check the appropriate box.

Supply requested sanction information, and if applicable, attach a copy of the managing and/or directing employee's reinstatement letter(s).

10. Parent/Joint Venture or Subsidiary Information

If applicant is a subsidiary (wholly or partially owned by another organization or business), or a joint venture (equally owned by another individual(s), organization(s) or business(s)), complete all information requested in this section **about the parent company or joint venture**. Attach a copy of the parent company's or other owner's IRS Form CP 575 pertaining to this business.

11. Chain Organization Information

When applicable, this section to be completed by Medicare Part A institutional provider/suppliers ONLY. This includes all institutional chain provider/suppliers that bill fiscal intermediaries (e.g., Home Health Agencies and Skilled Nursing Facilities).

11. Chain Organization Information (continued)

If applicant is in a chain organization, check appropriate action block for this chain, then supply all information requested about the chain home office.

12. Contractor Information (Business Organizations)

This section is to be completed with information about any business organization that the applicant contracts with that:

- provides medical or diagnostic services or medical supplies for which the cost or value is \$10,000 or more in a 12 month period; OR
- will reassign benefits to the applicant, regardless of annual cost or value of medical or diagnostic services or supplies provided.

Note: Individual contractors with whom the applicant does business and who will reassign benefits to the applicant must complete the HCFA Form 855R (Individual Reassignment of Benefits Application).

Provide all requested information about the contractor's past and present billing relationships with Medicare or Medicaid.

Furnish all requested sanction information about the contractor(s), and, if applicable, attach a clear copy of the contractor's reinstatement letter(s).

If a business or group contractor will be reassigning Medicare benefits to the applicant, an authorized representative must complete and sign the Reassignment of Benefits section. For additional information concerning Federal requirements for reassignment see instructions below.

If a currently enrolled provider/supplier is obtaining the services of a new contractor that will be reassigning their benefits, complete only the Application Identification section, the Contractor Information section and the Reassignment of Benefits Statement.

13. Reassignment of Benefits Statement

In general, Medicare and other federal health care programs make payment only to the beneficiary or the individual or entity that directly provides the service.

If the applicant receives payment on behalf of other business organizations for services provided, that other business organization must complete and sign the Reassignment of Benefits Statement. Failure to do so will cause a delay in processing the application and limit the Medicare or other federal health care program contractor's ability to make payment.

Note: The reassignee is permitted by Federal law to reassign Medicare benefits to an employer, the facility in which the reassignee provides services, or to a health care delivery system. For further information on Federal requirements on reassignment of benefits the applicant should contact the local Medicare or other federal health care program contractor before signing the application.

Any individual practitioner, including individual contractors and group members, who reassign Medicare or other federal health care program benefits to the applicant must complete the HCFA Form 855R.

Individual practitioners who are contracted by the applicant, but do not reassign their benefits to the applicant do not need to complete the HCFA Form 855R.

14. Billing Agency/Management Service Organization Address

A Billing Agency is a company contracted by the applicant to furnish all claims processing functions for the applicant's practice.

A Management Service Organization is a company contracted by the applicant to furnish some or all administrative, clerical and claims processing functions of the applicant's practice.

If the applicant currently uses or will be using a billing agency and/or management service organization to submit bills, complete all requested information and attach a current copy of the signed contract between the applicant and the billing agency or management service organization.

Note: If applicant uses a billing agency and/ or management service organization but no written contract exists between applicant and billing agency and/or management service organization, a contract must be written and furnished with this application.

Any change in the contract between the applicant and the billing agency and/or management service organization must be reported to the Medicare or other federal health care program contractor within 30 calendar days of said change.

15. Electronic Claims Submission Information

If applicant plans to submit bills electronically, or would like information about electronic billing, supply a contact name and phone number. The Medicare or other federal health care program contractor will be in contact with further instructions about qualifying for electronic billing submissions.

Note: Electronic Funds Transfer can only be made into an account controlled exclusively by the applicant.

16. Surety Bond Information

If applying to the State Medicaid program, do not complete this section for submission of Medicaid surety bond information.

Complete all requested information.

Annual surety bond renewals must be reported to the Medicare or other federal health care program contractor using HCFA Form 855C (Change of Information Form).

An original copy of the surety bond must be submitted with this application. Failure to submit a copy of the surety bond will prevent the processing of this application. In addition, the applicant must obtain and submit a certified copy of the agent's Power of Attorney with this application, if the bond is issued by an agent.

17. Contact Person

Provide the full name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application.

18. Certification Statement

This statement includes the minimum standards to which the applicant must adhere to be enrolled in Medicare or other federal health care programs. Read these statements carefully.

By signing the certification statement, the applicant agrees to adhere to all the conditions listed and is aware that the applicant may be denied entry to or revoked from the program if any conditions are violated. The certification statement must contain an original signature. Faxed or photocopied signatures will not be accepted.

Note: If applicant is applying as an individual or sole proprietor, **applicant** must sign and date the Certification Statement. If applicant is applying as an organization or as a group practice, **an authorized representative of the organization/group practice** must sign the Certification Statement. If applicant has more than one authorized representative, furnish the names and signatures of those authorized representatives who will be directly involved with the Medicare or other federal health care contractors.

Attachment 1 Ambulance Service Suppliers

This attachment is to be completed by the applicant for each ambulance service company being enrolled in the Medicare or other federal health care program.

1. State License Information

If applicant is currently State licensed and certified to operate as an ambulance service supplier, complete this section and attach copy(s) of all State licenses and documents.

A copy of applicant's current license or certificate must be attached to this form. The effective date and expiration date must be stated on the license or certificate. Claims will be paid based on these dates. The applicant must provide this office with a copy of the renewal license in order to receive payment after the expiration date.

2. Description of Vehicle(s)

Applicant must identify the type (e.g., automobile, aircraft, boat) of each vehicle, and furnish year, make, model, and vehicle identification number.

The applicant's vehicle(s) must be specially designed and equipped for transporting the sick or injured. It must have customary patient care equipment including, but not limited to, a stretcher, clean linens, first aid supplies and oxygen equipment, and it must have all other safety and lifesaving equipment as required by State and local authorities. If the ambulance will supply Advanced Life Support services, list all the necessary equipment and provide documentation of certification from the authorized licensing and regulation agency for applicant's area of operation.

Vehicles must be regularly inspected and recertified according to applicable State and local licensure laws. Evidence of recertification must be submitted to the Medicare or other federal health care program contractor on an ongoing basis, as required by State or local law.

Note: Air Ambulance

To qualify for air ambulance, the following is required:

- a written statement that gives the name and address of the facility where the aircraft is hangared signed by the President, Chief Executive Officer, or Chief Operating Officer of the airport; and
- proof that the air ambulance applicant or its leasing company possess a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the air medical transportation company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the applicant's name on this enrollment application. If the air medical transportation company leases the aircraft, a copy of the lease agreement must accompany this enrollment application. The name of the company leasing the aircraft must be the same as the applicant's name on this enrollment application.

3. Qualification of Crew

The ambulance crew must consist of at least two members. Those crew members charged with the care or handling of the patient must include one individual with adequate first aid training, (i.e., training at least equivalent to that provided by the basic and advanced Red Cross first aid courses). If the ambulance crew will provide ALS services, they must list their ALS training courses.

Training "equivalent" to the basic and advanced Red Cross first aid courses include ambulance service training and experience acquired in military service and/or successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization.

Applicant must enclose a certificate(s) showing that crew members have successfully completed the required first aid training, or give a description of the equivalent military training, where and when it was received. Crew must continue to pursue and complete continuing education requirements in accordance with State and local licensure laws. Evidence of recertification must be submitted to the Medicare or other federal health care program contractor on an ongoing basis, as required by State and local law.

4. Billing Method**FOR MEDICARE ENROLLMENT ONLY**

Answer all applicable questions regarding billing methods. Supply the name of the Medical Director and the geographic area the applicant services.

Note: Paramedic Intercept Services:

- A basic life support (BLS) ambulance supplier may arrange with a paramedic/Emergency Medical Technician (EMT) organization or another advanced life support (ALS) ambulance supplier to provide the advanced life support services while it provides for the transportation component. The BLS would bill for the ALS services and make arrangement to pay the organization providing the ALS services. As an alternative, the BLS could arrange for the organization providing the ALS to be its billing agent.
- If this arrangement exists, applicant must complete the Billing Agency/Management Service Organization and Reassignment of Benefits section and submit a copy of the signed contract.

Check the appropriate box indicating if applicant bills for nautical miles or statute miles.

If applicant is not enrolling in the Medicare program skip this section.

5. Exclusion/Sanction Information

If applicable, supply all requested information for the company or any owner or employee of the company and attach a clear copy of the reinstatement form(s).

Attachment 2 **Independent Diagnostic Testing Facilities (IDTFs)**

Formerly known as Independent Physiological Laboratories.

This attachment is to be completed by the applicant for each Independent Diagnostic Testing Facility being enrolled in the Medicare or other federal health care program.

Definition:

Independent Diagnostic Testing Facility (IDTF): An entity independent of a hospital or physician's office in which diagnostic tests are performed by licensed, certified non-physician personnel under appropriate physician supervision (e.g., free standing cardiac catheterization facility, imaging center).

Note: A cardiac catheterization facility which is a physician's office is not an IDTF. The term "free standing" means that the cardiac catheterization facility, whether office or IDTF, is independent of a hospital.

1. Identification of Practice Location

Indicate whether this practice location is operating as a mobile unit. If so, provide vehicle identification number and expiration date of vehicle license. If operating mobile units, the vehicles must be regularly inspected and recertified according to State and local licensure laws. Evidence of recertification must be submitted to the Medicare or other federal health care program contractor on an ongoing basis, as required by State and local law.

Identify practice location of IDTF for which this attachment is being completed. If this is a mobile unit, furnish the address where the vehicle is stored.

If applicable, complete all information concerning applicant's practice location.

2. Identification of Supervising/Directing Physician(s)

The information in this section is required only if applicant's State requires that a supervising physician be associated with all IDTFs. Supervising physicians must perform their duties as described by State requirements. Each supervising/directing physician is required to be enrolled as an individual practitioner in Medicare or other federal health care program for which the applicant is applying.

3. Service Performance

List all Current Procedural Terminology, Version 4 (CPT-4) and HCFA Common Procedure Coding System (HCPCS) codes this IDTF or its contractors intend to perform, supervise, interpret, or bill. Describe the setting where the service will be rendered, and identify each physician who will be performing, supervising, and/or interpreting the test results.

4. Referral Records

Explain how referral records, physician's written order and the name of the technician who rendered the service are maintained.

5. Signature of Supervising/Directing Physician(s)

Each supervising/directing physician identified in Section 2 of this attachment must complete and sign this attachment.

Attachment 3 **Home Health Agencies (HHAs)**

This attachment is to be completed by all Home Health Agencies for enrollment in the Medicare or other federal health care program.

Each owner listed in the Ownership Information section who has an ownership interest in or controls other related businesses (as defined below) must complete this attachment.

This attachment must also be completed with other related business interests in which the HHA itself has an ownership or control interest.

Copy and submit a separate Attachment 3 for the HHA and each owner, as applicable.

Definitions:

Related to the Provider: Related to the provider (HHA) means that the provider (HHA), to a significant extent, is associated or affiliated with or has control of or is controlled by an organization furnishing services, facilities, or supplies to the provider.

Common Ownership: Common ownership exists if an individual or individuals possess significant ownership or equity in the provider (HHA) and the institution or organization serving the provider (HHA).

Control Interest: Control exists if an owner of the HHA has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution furnishing services, facilities, or supplies to the provider (HHA).

1. Other Related Business Interests

All owners of the enrolling Home Health Agency are required to furnish identifying information about all other related businesses in which they have an ownership and/or control interest.

In general, businesses that furnish services, facilities, and supplies to the provider (HHA) that are related to the provider (HHA) by common ownership or control interest are to be listed in this attachment.

Supply all requested information about the related businesses.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated at 1 1/2 - 3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

MEDICARE/FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION
General Application

PLEASE CHECK APPLICABLE BOX

Type of Business: Individual Corporation Partnership Other (specify) _____

PLEASE CHECK APPLICABLE BOX

Applicant Enrolling As: Individual Sole Proprietor Organization Group Mass Immunization Biller Only

Check the appropriate box listed below if applicant is completing this application for enrollment in a federal health care program other than Medicare. (Check only one program box.)

Railroad Retirement Board State Medicaid CHAMPUS Indian Health Service
 Public Health Service CHAMPVA Other (specify) _____

PLEASE CHECK APPLICABLE BOX

Application For: Initial Enrollment Re-certification Change of Ownership (CHOW)
 Enrollment of Additional Location(s) Change of Information

MEDICARE APPLICANTS ONLY:

Where will applicant be submitting billings? Fiscal Intermediary Carrier Both (OR) Regional Home Health Intermediary

Is the applicant currently enrolled in another federal health care program? YES NO

IF YES, check all the appropriate federal programs listed below.

Medicare State Medicaid CHAMPUS Indian Health Service
 Railroad Retirement Board Public Health Service CHAMPVA Other (specify) _____

I. Applicant Identification

A. Individuals ONLY

Check here only if this entire section does not apply to the applicant.

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Other Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.

Residency Status (if applicable) resident intern

Name of Facility Where Resident or Intern:

Are services rendered in the above setting part of the applicant's requirements for graduation from a formal residency program? YES NO

Primary Specialty (e.g. pathology, cardiology, nurse practitioner, etc.)(required)	Secondary Specialty (if applicable)
--	-------------------------------------

Gender (optional) male female

Race/Ethnicity (optional) Asian or Asian American or Pacific Islander Hispanic Black (not Hispanic) or African-American North American Indian or Alaska Native White (not Hispanic)

Date of Birth (MM/DD/YYYY)	County of Birth	State of Birth	Country of Birth
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B. Organizations ONLY

Check here only if this entire section does not apply to the applicant.

Legal Business Name	Fiscal Year End Date (MM/DD)	Incorporation Date (if applicable) (MM/DD/YYYY)
---------------------	------------------------------	---

Type of Facility (e.g., hospital, nursing home, clinical laboratory, roster biller, etc.) Accredited Non-Accredited

State Where Incorporated:	Date Business Established at This Location (MM/DD/YYYY)	All other states in which applicant does business:
---------------------------	---	--

Is this a organization a Provider Based Facility? Yes No Is this organization a Distinct Part Unit? Yes No

Does this organization file a consolidated cost report under another Medicare provider's number? Yes No

IF YES to any of the above three questions, furnish name of parent provider. Parent Medicare Provider Number

Does this organization operate other affiliated units, off-site clinics, or have multi-campus sites or branches? Yes No

If Yes, how many of each? _____ other affiliated units _____ off-site clinics _____ multi-campus sites _____ branches

Complete Section 7 for each unit, clinic, site, and/or branch operated.

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1. Applicant Identification (continued)

C. Physician and Non-Physician Practitioner Groups ONLY (For each group member, complete form HCFA 855R.)
 Check here only if this entire section does not apply to the applicant.

Legal Business Name	Incorporation Date (if applicable) (MM/DD/YYYY)	State Where Incorporated
Group's Primary Specialty (required)		Group's Secondary Specialty (if applicable)

D. All Applicants

Mailing Address Line 1

Mailing Address Line 2

City	County	State	ZIP Code + 4
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Telephone Number ()	Fax Number ()	E-mail Address
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Employer Identification Number (if applicable)	Social Security Number (if applicable)	Medicare Identification Number(s) (if applicable)
--	--	--

Does applicant now have or has applicant ever had a Medicare or Medicaid provider number in this or any other State?
 Yes No IF YES, supply all current and prior information requested below.

Current Carrier Name (if applicable)	Current Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
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Prior Carrier Name (if applicable)	Prior Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)
------------------------------------	---	---

Current CLIA Number (if applicable)	Prior CLIA Number (if applicable)
-------------------------------------	-----------------------------------

Has applicant ever been convicted of any health care related crime? Yes No

Has applicant ever been convicted of a felony under Federal or State law? Yes No

Has any family and/or household member(s) of the applicant who has ownership or control interest in the enrolling business or entity ever been convicted, assessed, or excluded from the Medicare program due to fraud, obstruction of an investigation, or a controlled substance violation?
 Yes No IF YES, furnish name and relationship of relative/household member(s) below.

Name:	First	Middle	Last	Jr., Sr., etc.	Relationship
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Does the applicant have any outstanding overpayments with Medicare? Yes No

2. Professional and Business License/Certification/Registration Information

Attach a copy of each required Federal, State, and/or local city/county business and/or professional license, certification or registration. Notarized or "certified true" copies are optional but will speed the processing of this application.

Check here if applicant's State licensure is pending upon completion of State survey and/or certification.

Has applicant ever had any Federal, State, and/or local city/county business and/or professional business license, certification or registration revoked or suspended? Yes No
 IF YES, explain below and attach copy of reinstatement letter if applicable.

3. Professional School Information (Individuals only)

Check here only if this entire section does not apply to the applicant.

Attach a copy of each degree or certificate. Notarized or "certified true" copies are optional but will speed processing of application.

School Name	Graduation Year (YYYY)	
City	State	Country

4. Board Certification

Check here only if this entire section does not apply to the applicant.

If applicant is Board Certified in his/her primary specialty complete the following information.

If applicant is Board Certified in more than one specialty, copy this section and complete the following information for each.

Certification Board Name		
Certification Number	Effective Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)

5. Exclusion/Sanction Information

A. Has the applicant ever been sanctioned from the Medicare/Medicaid program, or debarred, suspended, or excluded from any other Federal agency or program? Yes No IF YES, supply the following information.

Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY)	Date(s) of Reinstatement (Attach copy(s) of the Reinstatement letter(s)) (MM/DD/YYYY)
--	--

B. Have civil monetary penalties ever been levied against the applicant by the Medicare or Medicaid program or any Federal agency or program? Yes No
 IF YES, has penalty been paid? Yes No

6. Practice Location(s)

Check here if deleting this practice location.

A. How many practice locations does applicant utilize? _____ For each additional practice location, copy and complete this section.

B. "Doing Business As" name for this location Medicare Identification Number for this location (if applicable)

Business Street Address Line 1

Business Street Address Line 2

City	County	State	ZIP Code + 4
Telephone Number ()	Fax Number ()	E-mail Address	

Is this location an off site clinic? distinct part unit? multi-campus site? branch?
 a location that files a consolidated cost report? provider based facility? or none of these?

Date applicant began practicing at this location? (MM/DD/YYYY)	If applicable, date applicant ceased practicing at this location? (MM/DD/YYYY)
---	---

Does the applicant own or lease this practice location? Yes No

C. "Pay To" address for this practice location. If same as practice location in section 6 B., check here and skip to section 6 D.

Check here if applicant wants all practice location payments listed in this application sent to address furnished in Section 6 C.

Mailing Address Line 1

Mailing Address Line 2

City	State	ZIP Code + 4	Telephone Number ()	
D. Name of managing/directing employee for this location?	First	Middle	Last	Social Security Number

E. CLIA Number for this location (if applicable) FDA Mammography Certification Number(s) at this location (if applicable)

F. Are all patient records stored at this practice location? Yes No IF NO, supply storage location below.

Name of Storage Facility/Location	Telephone Number ()	Fax Number ()
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Street Address Line 1

Street Address Line 2

City	County	State	ZIP Code + 4
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7. Prior Practice Information

Check here only if this entire section does not apply to the applicant.
 If applicant has previously billed the Medicare or Medicaid programs, furnish requested prior practice information below.
 For each additional prior practice, copy and complete this section.

Type of Practice	Status <input type="checkbox"/> Inactive IF INACTIVE, supply date of termination (MM/DD/YYYY) <input type="checkbox"/> Active
Legal Business Name	Doing Business As Name
Medicare Identification Number(s)	Medicaid Number/State Telephone Number ()
Business Street Address Line 1	
Business Street Address Line 2	
City	County State ZIP Code + 4
Was applicant a <input type="checkbox"/> participating or <input type="checkbox"/> non-participating provider/supplier in this prior practice?	

8. Ownership Information

Check here if deleting this owners' association with this entity.
 Effective date of deletion? (MM/DD/YYYY)
 How many owners have 5 percent or more ownership interest in this entity? (maximum of 20)
 For each additional owner, copy and complete this section.
 Applicants must submit a copy of the entity's IRS form CP 575.

A. Identifying Information

Owner Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Other Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Date of Birth (MM/DD/YYYY)	County of Birth	State of Birth	Country of Birth	
Legal Business Name				

"Doing Business As" Name	Effective Date of Ownership (MM/DD/YYYY)
Social Security Number	Employer Identification Number Medicare Identification Number (if applicable)

B. Does this owner now have or has this owner ever had a Medicare or Medicaid provider number in this or any other State?
 Yes No IF YES, supply all current and prior information requested below.

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

C. Has this owner ever managed or directed other organizations that have billed or are currently billing Medicare for services?
 Yes No IF YES, how many? _____
 Copy and complete the following for each organization this owner managed or directed in the last 10 years.
 If this list is incomplete, check here indicating that some information for the last 10 years is missing.

Organization's Legal Business Name		
Employer Identification Number	Medicare Identification Number	Date Associated TO -- FROM (MM/DD/YYYY)
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

8. Ownership Information (continued)

D. Has this owner ever had ownership in other organizations that have billed or are currently billing Medicare for services?
 Yes No IF YES, how many? _____

Copy and complete the following for each organization this owner has had ownership in during the last 10 years.
 If this list is incomplete, check here indicating that some information for the last 10 years is missing.

Organization's Legal Business Name _____

Employer Identification Number	Medicare Identification Number	Date Associated TO --- FROM (MM/DD/YYYY)
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

E. Has this owner ever been sanctioned from the Medicare/Medicaid program or debarred, suspended, or excluded from any other Federal agency or program? Yes No IF YES, supply the following information.

Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY) _____ Date(s) of Reinstatement (Attach a copy(s) of the Reinstatement letter(s)) (MM/DD/YYYY) _____

F. Have civil monetary penalties ever been levied against this owner by the Medicare or Medicaid program or any Federal agency or program? Yes No
 IF YES, has penalty been paid? Yes No Date(s) of Penalty (MM/DD/YYYY) _____

G. Has this owner ever been convicted of any health care related crime? Yes No
 Has this owner ever been convicted of a felony under Federal or State law? Yes No

9. Managing/Directing Employees

If applicant is the sole owner and the sole managing/directing employee, skip this section.

Check here if deleting this managing/directing employee's association with the applicant.

Effective date of deletion? _____ (MM/DD/YYYY)

What is the total number of managing/directing employees for all location(s) listed in this application? _____ (Maximum of 20)

For each additional managing/directing employee, copy and complete this section.

A. Identifying Information

Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Title/Position
Social Security Number	Employer Identification Number (if applicable)	Medicare Identification Number (if applicable)			
Date of Birth (MM/DD/YYYY)	County of Birth	State of Birth	Country of Birth		
Legal Name of Business	Where This Person Manages/Directs				
"Doing Business As" Name	Where This Person Manages/Directs				

B. Has this Managing/Directing employee ever had a Medicare or Medicaid provider number in this or any other State?
 Yes No IF YES, supply all current and prior information requested below.

If additional space is needed, copy and complete this section.

Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

C. Has this managing/directing employee ever managed or directed other organizations that have billed or are currently billing Medicare for services? Yes No IF YES, how many? _____

Copy and complete the following for each organization this managing/directing employee managed or directed in the last 10 years.
 If this list is incomplete, check here indicating that some information for the last 10 years is missing.

Legal Business Name	Medicare Identification Number	Employer Identification Number
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

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9. Managing/Directing Employees

D. Has this managing/directing employee ever had ownership interest in other organizations that have billed or are currently billing Medicare for services? Yes No IF YES, how many? _____

Copy and complete the following for each organization this managing/directing employee managed or directed in the last 10 years.

If this list is incomplete, check here indicating that some information for the last 10 years is missing.

Legal Business Name	Medicare Identification Number	Employer Identification Number
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)

E. Has this managing/directing employee ever been sanctioned from the Medicare/Medicaid program or debarred, suspended, or excluded from any other Federal agency or program? Yes No IF YES, supply the following information.

Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY)	Date(s) of Reinstatement (Attach copy(s) of the Reinstatement letter(s)) (MM/DD/YYYY)
--	--

F. Have civil monetary penalties ever been levied against this managing/directing employee by the Medicare/Medicaid program or any Federal agency or program? Yes No
 IF YES, has penalty been paid? Yes No

Date(s) of Penalty
(MM/DD/YYYY)

10. Parent/Joint Venture Information

Check here only if this entire section does not apply to the applicant.

Check if this entity is a subsidiary company or joint venture. Subsidiary Company Joint Venture

Complete the information below about the PARENT company or JOINT venture.

Attach a copy of parent company's or other owner's IRS form W-9 pertaining to this DMEPOS supplier/provider/business/entity.

Legal Business Name

"Doing Business As" Name		Effective Date of Affiliation (MM/DD/YYYY)
Employer Identification Number	Medicare Identification Number	
Current Carrier Name (if applicable)	Current Fiscal Intermediary Name (if applicable)	Current Medicaid Number/State (if applicable)
Prior Carrier Name (if applicable)	Prior Fiscal Intermediary Name (if applicable)	Prior Medicaid Number/State (if applicable)
Business Street Address Line 1		
Business Street Address Line 2		
City	State	ZIP Code + 4
Telephone Number ()	Fax Number ()	E-mail Address

11. Chain Organization Information

This section to be completed by Medicare Part A institutional provider/suppliers ONLY.

Check here only if this entire section does not apply to the applicant.

Does the applicant need to register a chain action? (see list below) Yes No

- IF YES, check the appropriate action:
- Applicant in chain for first time
 - Applicant in a different chain since last report
 - Applicant dropped out of all chains
 - Applicant in same chain under new chain name

11. Chain Organization Information (continued)

Complete the following information about the chain Home Office:

Name of Home Office				Effective Date of Linkage (MM/DD/YYYY)	
Name of Home Office	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Administrator or CEO:					
Title of Home Office Administrator					
Home Office Business Street Address Line 1					
Business Street Address Line 2					
City		County		State	
Telephone Number ()		Fax Number ()		E-mail Address	
Chain Number		Name of Home Office Intermediary			
Applicant's Affiliation to Chain:					
<input type="checkbox"/> Joint Venture/Partnership		<input type="checkbox"/> Managed/Related		<input type="checkbox"/> Leased	
<input type="checkbox"/> Operated/Related		<input type="checkbox"/> Wholly Owned		<input type="checkbox"/> Other	
Fiscal Year End Date of this Chain (MM/DD)			Do all the providers of the chain use the same Part A fiscal intermediary? <input type="checkbox"/> Yes <input type="checkbox"/> No		

12. Contractor Information (Business Organizations)

A. Does the applicant contract with a business organization for any medical or diagnostic services or supplies for which the cost or value is \$10,000 or more in a 12 month period? Yes No

IF YES, how many of the above business organizations does the applicant contract with? _____

For each of these business organizations, complete this section. If more than one contractor, copy and complete this section.

B. Will the applicant be billing and receiving payment (reassigned benefits) for medical or diagnostic services or medical supplies rendered by any other business organization, (excluding individuals), regardless of cost or value? Yes No

IF YES, how many of the above business organizations reassign benefits to the applicant? _____

For each business organization (excluding individuals) that will reassign benefits to the applicant, complete this section and the Reassignment of Benefits Statement section. If more than one reassignee, copy and complete these sections.

Check here if deleting (no longer using) this contractor.

Legal Business Name			
Doing Business As Name			Effective Date of Relationship/Reassignment (MM/DD/YYYY)
Business Street Address Line 1			
Business Street Address Line 2			
City		State	
ZIP Code + 4			
Telephone Number ()		Fax Number ()	
E-mail Address			
Employer Identification Number		Medicare Identification Number (if applicable)	
C. Does this contractor now have or has this contractor ever had a Medicare or Medicaid provider number in this or any other state? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, supply all current and prior information requested below.			
Current Carrier Name (if applicable)		Current Fiscal Intermediary Name (if applicable)	
Current Medicaid Number/State (if applicable)			
Prior Carrier Name (if applicable)		Prior Fiscal Intermediary Name (if applicable)	
Prior Medicaid Number/State (if applicable)			

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12. Contractor Information (Business Organizations) (continued)

D. Has this contractor ever been sanctioned from the Medicare/Medicaid program or debarred, suspended, or excluded from any other Federal agency or program? Yes No **IF YES, supply the following information.**

Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY)	Date(s) of Reinstatement (Attach copy(s) of contractor's Reinstatement letter(s)) (MM/DD/YYYY)
--	---

E. Have civil monetary penalties ever been levied against this contractor by the Medicare or Medicaid program or any Federal agency or program? Yes No **IF YES, has penalty been paid?** Yes No

Date(s) of Penalty (MM/DD/YYYY)

13. Reassignment of Benefits Statement

Check here only if this entire section does not apply to the applicant.

Medicare law prohibits payment for services to entities other than the provider/supplier who provided the services unless the provider/supplier specifically authorizes another entity (employer, facility, health care delivery system, or agent) to bill for its services, per Federal Regulation 42 CFR 424.80. This Reassignment of Benefits Statement authorizes an entity to receive Medicare payments on your behalf.

This contract must be in compliance with HCFA regulations. The Reassignment of Benefits Statement must be signed by all providers/suppliers who allow an employer, facility, health care delivery system, or agent to receive payment for the provider/supplier's services.

I acknowledge that, under the terms of my contract,
(Legal Business Name of Entity)

is entitled to claim or receive any fees or charges for my services.

Reassignee Name (printed) First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Reassignee Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

14. Billing Agency/Management Service Organization Address

Check here if deleting (no longer using or changing) this billing agency/service management organization.

Check here only if this entire section does not apply to the applicant.

Complete this section if applicant will be using a billing agency or management service organization.

Applicant MUST submit a copy of the applicant's current signed billing agreement/contract with this application.

Name of Billing Agency/Management Service Organization				Employer Identification Number	
Agency/Organization First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	
Contact Person Name:					
Business Street Address Line 1					
Business Street Address Line 2					
City		State	ZIP Code + 4		
Telephone Number ()		Fax Number ()	E-mail Address		

15. Electronic Claims Submission Information

Check here only if this entire section does not apply to the applicant.

Furnish a contact person in this section if the applicant would like to submit claims electronically.

Contact Person Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	
Mailing Address Line 1					
Mailing Address Line 2					
City		State	ZIP Code + 4		
Telephone Number ()		Fax Number ()	E-mail Address		

16. Surety Bond InformationCheck here only if this entire section does not apply to the applicant.

Name of Surety Bond Company

Agent's Name:	First	Middle	Last	Jr., Sr., etc.
Telephone Number ()	Fax Number ()			
Amount of Surety Bond \$	Effective Date of Surety Bond (MM/DD/YYYY)	Bond for Tax Year (YYYY)	Annual Bond Renewal Date (MM/DD/YYYY)	

17. Contact Person

Furnish the name and telephone number of a person who can answer questions about the information furnished in this application.

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Telephone Number ()	Fax Number ()			E-mail Address	

Penalties for Falsifying Information on the Medicare Health Care Provider/Supplier Enrollment Application.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. § 3571. Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program."

The offender is subject to fines of up to \$25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:

- knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
- knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
- conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of \$5,000 to \$10,000 per violation, plus 3 times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency. . . a claim. . . that the Secretary determines is for a medical or other item or service that the person knows or should know:

- was not provided as claimed; and/or
- the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to \$10,000 for each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.

18. Certification Statement

I, the undersigned, certify to the following:

- 1.) I have read the contents of the application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare or other federal health care program contractor of this fact immediately.
- 2.) I authorize the Medicare or other federal health care program contractor to verify the information contained herein. I agree to notify the Medicare or other federal health care program contractor of any changes in this form within 30 days of the effective date of the change. I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application.
- 3.) I am familiar with and agree to abide by the Medicare or other federal health care program laws and regulations that apply to my provider/supplier type. The Medicare laws and regulations are available through the Medicare Contractor.
- 4.) Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under the Medicare or Medicaid program or debarred, suspended, or excluded under any other Federal agency or program, or otherwise is prohibited from providing services to Medicare or other federal health care program beneficiaries.
- 5.) I agree that any existing or future overpayment to me by the Medicare or other federal health care program(s) may be recouped by Medicare or the other federal health care program(s) through withholding future payments.
- 6.) I understand that only the Medicare or other federal health care program(s) billing number for the provider/supplier who performed the service or to whom benefits were reassigned under current Medicare or other federal health care program(s) regulations may be used when billing Medicare or other federal health care program(s) for services.
- 7.) I understand that any omission, misrepresentation or falsification of any information contained in this application or contained in any communication supplying information to Medicare or other federal health care program(s) to complete or clarify this application may be punishable by criminal, civil, or other administrative actions including revocation of Medicare or other federal health care program(s) billing number(s), fines, penalties, damages, and/or imprisonment under Federal law.
- 8.) I further certify that I am the individual practitioner who is applying for the billing number, or in the case of a business organization, I am an officer, chief executive officer, or general partner of the business organization that is applying for the Medicare or other federal health care program(s) billing number.

Applicant Name (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Applicant Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

FOR GROUPS AND ORGANIZATIONS: (Please list all "Authorized Representatives" for this group/organization)

Check here if deleting this representative from this entity.

Authorized Representative Name (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Title/Position
Social Security Number	Medicare Identification Number (if applicable)					
Authorized Representative Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)		

Check here if deleting this representative from this entity.

Authorized Representative Name (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Title/Position
Social Security Number	Medicare Identification Number (if applicable)					
Authorized Representative Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)		

ATTACHMENT 1

Ambulance Service Suppliers

1. State License Information

Is applicant licensed as a Supplier of Ambulance Services by applicant's State? Yes No
 IF YES, complete this section, attach a copy of the applicant's current State license, and skip sections 2 and 3.

License Number	Issuing State	Effective Date (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)
----------------	---------------	--------------------------------	---------------------------------

2. Description of Vehicle (Copy and complete this section as needed for additional vehicles.)

For each vehicle, attach copy of the vehicle registration.

1. Type (automobile, aircraft, boat, etc.)		Vehicle Identification Number
Make	Model	Year (YYYY)

Does this vehicle have the following:

- | | | | |
|---------------------|--|-------------------------------------|--|
| first aid supplies? | <input type="checkbox"/> Yes <input type="checkbox"/> No | other safety/life saving equipment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| oxygen equipment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | two-way telecommunications radio? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| warning lights? | <input type="checkbox"/> Yes <input type="checkbox"/> No | mobile communication? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| sirens? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

List other medical equipment this vehicle has.

_____	_____
_____	_____
_____	_____

Does this vehicle provide:

- | | | | |
|------------------------------|--|-------------------|--|
| basic life support (BLS)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | land ambulance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| advanced life support (ALS)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | air ambulance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| emergency runs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | marine ambulance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| non-emergency runs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

How many crew members accompany this vehicle on runs?

2. Type (automobile, aircraft, boat, etc.)		Vehicle Identification Number
Make	Model	Year (YYYY)

Does this vehicle have the following:

- | | | | |
|---------------------|--|-------------------------------------|--|
| first aid supplies? | <input type="checkbox"/> Yes <input type="checkbox"/> No | other safety/life saving equipment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| oxygen equipment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | two-way telecommunications radio? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| warning lights? | <input type="checkbox"/> Yes <input type="checkbox"/> No | mobile communication? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| sirens? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

List other medical equipment this vehicle has.

_____	_____
_____	_____
_____	_____

Does this vehicle provide:

- | | | | |
|------------------------------|--|-------------------|--|
| basic life support (BLS)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | land ambulance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| advanced life support (ALS)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | air ambulance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| emergency runs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | marine ambulance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| non-emergency runs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

How many crew members accompany this vehicle on runs?

OMB Approval No. 0938-0685

3. Qualification of Crew (Copy and complete this section as needed for additional crew.)

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Social Security Number
-------	-------	--------	------	----------------	------------------	------------------------

List training completed by this crew member (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____	_____
_____	_____
_____	_____

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Social Security Number
-------	-------	--------	------	----------------	------------------	------------------------

List training completed by this crew member (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____	_____
_____	_____
_____	_____

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Social Security Number
-------	-------	--------	------	----------------	------------------	------------------------

List training completed by this crew member (i.e., First Aid, CPR, ACLS, etc.) and attach copy(s) of training certificate(s).

_____	_____
_____	_____
_____	_____

4. Billing Method

A. Certified Basic Life Support (BLS) companies complete the following:

Contact the local Medicare contractor for information on the billing method that applies in the State where applicant will operate.

- Does company bill Method 1 (an all-inclusive base rate)? Yes No
- Does company bill Method 2 (base rate plus a separate charge for mileage)? Yes No
- Does company bill Method 3 (base rate plus a separate charge for supplies)? Yes No
- Does company bill Method 4 (separate charges for services, mileage, and supplies)? Yes No
- Is company certified to perform defibrillation? (IF YES, attach certification.) Yes No

Does company provide Advanced Life Support (ALS) Services under contract with a paramedic or Emergency Medical Technician (EMT) organization or an Advanced Life Support (ALS) ambulance supplier? Yes No

IF YES, submit a copy(s) of the signed contractual agreement(s).

If the company provides Paramedic Intercept Service, does the contract allow the supplier of the life support service to submit the Medicare claim for the paramedic service and the transport on the company's behalf under the company's provider number? Yes No

AIR AMBULANCE ONLY: Do you bill nautical mileage or statute mileage ?

Medical Director Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Social Security Number
------------------------	-------	--------	------	----------------	------------------	------------------------

What geographic area does company serve?

4. Billing Method (continued)

B. Certified Advanced Life Support (ALS) companies complete the following:

Contact the local Medicare contractor for information on the billing method that applies in the State where applicant will operate.

- Does company bill Method 1 (an all-inclusive base rate)? Yes No
- Does company bill Method 2 (base rate plus a separate charge for mileage)? Yes No
- Does company bill Method 3 (base rate plus a separate charge for supplies)? Yes No
- Does company bill Method 4 (separate charges for services, mileage, and supplies)? Yes No
- Does company have a contract with any municipality? Yes No
- If Yes, submit copy(s) of the signed contractual agreement(s). Yes No
- Is company certified to perform defibrillation? (IF YES, attach certification.) Yes No

AIR AMBULANCE ONLY: Do you bill nautical mileage or statute mileage ?

Medical Director Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Social Security Number
------------------------	-------	--------	------	----------------	------------------	------------------------

What geographic area does company serve?

5. Exclusion/Sanction Information

Copy and complete this section as needed for additional owners and/or employees.

A. Has the company, any owner, or employee ever been sanctioned from the Medicare/Medicaid program, or debarred, suspended or excluded from any other Federal agency or program Yes No **IF YES, supply the information below.**

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number			Employer Identification Number		
Date(s) of Sanction, Debarment, etc. (MM/DD/YYYY)			Date(s) of Reinstatement (Attach a copy(s) of the Reinstatement letter(s)) (MM/DD/YYYY)		

B. Have civil monetary penalties ever been levied against the company, any owner, or employee by the Medicare or Medicaid program or any Federal agency or program? Yes No **Date(s) of Penalty (MM/DD/YYYY)**

IF YES, who was the civil monetary penalty levied against?

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number			Employer Identification Number		

Has penalty been paid? Yes No

ATTACHMENT 2

OMB Approval No. 0938-0685

Independent Diagnostic Testing Facility (IDTFs)

This attachment must be completed for each IDTF owned and /or operated by the applicant.

1. Identification of Practice Location

A. Is this practice location a mobile unit? YES NO

IF YES, please list the vehicle(s) identification number(s) and the expiration date of the license for all mobile units and submit copies of all vehicle(s) registration(s).

Vehicle Identification Number

Expiration Date of License (MM/DD/YYYY)

1 _____
 2 _____
 3 _____

If this practice location is a mobile unit, complete practice location address below with the address where the mobile unit is stored.

B. "Doing Business As" Name of This Practice Location

Business Street Address Line 1

Business Street Address Line 2

City	County	State	ZIP Code + 4
------	--------	-------	--------------

C. Are all diagnostic tests/services performed at the business/practice location? YES NO
IF NO, complete the Contractor section with information on where the diagnostic tests/services are performed.

D. Is the practice location used for any other purpose? YES NO

IF YES, please answer the following questions:

Is the practice location used for another type of business? YES NO

IF YES, what type? _____

Is the practice location used for residential purposes? YES NO

IF YES, explain reason for dual use as residence. _____

If above two questions are both answered "no", please explain the other uses for the practice location.

2. Identification of Supervising/Directing Physician(s)

List all Supervising/Directing Physicians affiliated with this facility.

For each additional Supervising/Directing Physician or Contractor, copy and complete this section.

Name: First		Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number	Medicare Identification Number	Current Medicaid Number/State (if applicable)		Prior Medicaid Number/State (if applicable)	
Name: First		Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number	Medicare Identification Number	Current Medicaid Number/State (if applicable)		Prior Medicaid Number/State (if applicable)	

3. Service Performance (For each additional CPT-4 or HCPCS code, copy and complete this section.)

List all Current Procedural Terminology, Version 4 (CPT-4) codes or HCFA Common Procedure Coding System codes (HCPCS), equipment, and model number which this facility or its contractors intend to perform, supervise, interpret, or bill.

CPT-4 or HCPCS Code	Equipment	Model Number
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____

Where will these services be rendered? (Check all that apply.) Physician's Office Skilled Nursing Facility Hospital
 Other (Explain.) _____

Will this facility be billing for both the technical and professional components? YES NO

IF YES, fill out the following information for each physician who will be performing the interpretations:

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Title	Social Security Number			Medicare Identification Number	
Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Title	Social Security Number			Medicare Identification Number	

Will tests be taken by employees or contractors who are licensed or approved by the State in:

X-Ray Technology, YES NO Nursing, or YES NO
 Other YES NO (IF YES to "Other", explain and give qualifications below.)

IF YES to any of the above, provide the following information for each employee/contractor licensed or approved:

Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number	License Number			License Issue Date (MM/DD/YYYY)	
Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number	License Number			License Issue Date (MM/DD/YYYY)	

4. Referral Records

Does applicant maintain records of:

the name of the attending or consulting physician who ordered the test(s)? YES NO
 a copy of the physician's written order(s) for the test(s)? YES NO
 the name(s) of the technician(s) who rendered the service(s)? YES NO

IF YES to any of the above, explain how the referral records are maintained (e.g., electronic, paper, by patient name, or by physician name, etc.).

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5. Signature of Supervising/Directing Physician(s)

**Each Supervising/Directing Physician must sign the following statement:
For additional Supervising/Directing Physician signatures, copy and complete this section.**

I hereby acknowledge that I have agreed to provide the (IDTF Name) _____ with general supervisory and/or directing responsibilities for tests performed by this facility. If I terminate my relationship with the aforementioned IDTF, I will report the date of termination to the Medicare Contractor within 30 days of termination.

Supervising/Directing Physician Name (printed):	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Title/Position
Signature of Supervising/ Directing Physician					(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	
					Date (MM/DD/YYYY)	

I hereby acknowledge that I have agreed to provide the (IDTF Name) _____ with general supervisory and/or directing responsibilities for tests performed by this facility. If I terminate my relationship with the aforementioned IDTF, I will report the date of termination to the Medicare Contractor within 30 days of termination.

Supervising/Directing Physician Name (printed):	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.	Title/Position
Signature of Supervising/ Directing Physician					(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	
					Date (MM/DD/YYYY)	

ATTACHMENT 3

Home Health Agencies (HHAs)

1. Other Related Business Interests (Control and/or Ownership)

For each owner listed in the Ownership section, as well as the home health agency (HHA) itself, complete the following information about all other businesses that each owner or the HHA has an ownership and/or control interest.

For each owner, and/or when additional space is needed, copy and complete this attachment.

Check here if this entire attachment does not apply to the Home Health Agency or any of it's owners.

Owner Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
-------------------	--------	------	----------------	------------------

A. Legal Business Name of Related Business	Employer Identification Number
--	--------------------------------

"Doing Business As" Name	Effective Date of Ownership (MM/DD/YYYY)
--------------------------	--

Business Street Address Line 1

Business Street Address Line 2

City	State	ZIP Code + 4
------	-------	--------------

Telephone Number ()	Fax Number ()	E-mail Address
----------------------	----------------	----------------

B. Legal Business Name of Related Business	Employer Identification Number
--	--------------------------------

"Doing Business As" Name	Effective Date of Ownership (MM/DD/YYYY)
--------------------------	--

Business Street Address Line 1

Business Street Address Line 2

City	State	ZIP Code + 4
------	-------	--------------

Telephone Number ()	Fax Number ()	E-mail Address
----------------------	----------------	----------------

C. Legal Business Name of Related Business	Employer Identification Number
--	--------------------------------

"Doing Business As" Name	Effective Date of Ownership (MM/DD/YYYY)
--------------------------	--

Business Street Address Line 1

Business Street Address Line 2

City	State	ZIP Code + 4
------	-------	--------------

Telephone Number ()	Fax Number ()	E-mail Address
----------------------	----------------	----------------

D. Legal Business Name of Related Business	Employer Identification Number
--	--------------------------------

"Doing Business As" Name	Effective Date of Ownership (MM/DD/YYYY)
--------------------------	--

Business Street Address Line 1

Business Street Address Line 2

City	State	ZIP Code + 4
------	-------	--------------

Telephone Number ()	Fax Number ()	E-mail Address
----------------------	----------------	----------------



Medicare

And Other Federal Health Care Programs

Individual Reassignment of Benefits Enrollment

Health Care Provider/Supplier Application

Privacy Act Statement

The Health Care Financing Administration (HCFA) is authorized to collect the information requested on this form in order to ensure that correct payments are made to providers and suppliers under the Medicare program established by Title XVIII of the Social Security Act. See sections 1814 and 1815 of the Social Security Act for payment under Part A of Title XVIII [42 U.S.C §§ 1395(a)(1) and 1395g(a)] and section 1833(e) [42 U.S.C. § 1395(e)] for payment under Part B. In addition, HCFA is required to ensure that no payments are made to providers or suppliers who are excluded from participation in the Medicare program under section 1128 of Title XVIII [42 U.S.C. § 1320a-7] or who are prohibited from providing services to the federal government under section 2455 of the Federal Acquisition Streamlining Act of 1994, (P.L. 103-355) [31 U.S.C. § 6101 note]. This information must, minimally, clearly identify the provider and its place of business as required by the Budget Reconciliation Act of 1985 (P.L. 99-272) [42 U.S.C § 9202(g)] and provide all necessary documentation to show they are qualified to perform the services for which they are billing.

The Debt Collection Improvement Act (DCIA) of 1996 (P.L. 104-134) [31 U.S.C. §§ 3720B-3720D] requires agencies to collect the Taxpayer Identification Number (either the Social Security Number or the Employer Identification Number) from all persons or business entities doing business with the federal government. Under section 31001(i)(1) of the DCIA [31 U.S.C. § 7701(c)(1)], the taxpayer identification number will be used to collect (including collection through use of offset) and report any delinquent amounts arising out of the business relationship with the federal government. Therefore, collection of this data element is mandatory.

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in administration of the Medicare program and other Federal and State health care programs. All information on this form is required, with the exception of those sections marked as optional on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in the Federal Register in Vol. 61, no. 89, May 7, 1996), or the National Provider Identifier (NPI) System (OMB approval 0938-0684 (R-187)). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances, to:

- (1) Contractors working for HCFA to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
- (2) A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
- (3) The Railroad Retirement Board for purposes of administering provisions of the Railroad Retirement or Social Security Acts;
- (4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
- (5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information. (6) To the Department of Justice for investigation and prosecuting violations of the Social Security Act to which criminal penalties attach;
- (7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
- (8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
- (9) Other Federal agencies who administer a Federal health care benefits program to enumerate/enroll providers of medical services or to detect fraud or abuse;
- (10) State Licensing Boards for review of unethical practices or nonprofessional conduct;
- (11) States for the purpose of administration of health care programs; and/or
- (12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider/supplier's health care claims.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988, (P.L. 100-503) amended the Privacy Act, U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected on this form are protected from public disclosure by Federal law 5 U.S.C. 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by HCFA under 5 U.S.C. § 552(b)(4) and/or (b)(6), respectively.



**MEDICARE AND OTHER FEDERAL
HEALTH CARE PROGRAMS
PROVIDER/SUPPLIER ENROLLMENT
APPLICATION INSTRUCTIONS
Individual Reassignment of Benefits Application
HCFA 855R**

Upon completion, return this application and all necessary documentation to:

General

This form is to be completed for any individual who will reassign their benefits to an eligible entity.

THE REASSIGNMENT OF BENEFITS APPLICATION MUST BE COMPLETED FOR THE FOLLOWING SITUATIONS:

Initial Enrollment: A newly enrolling entity will list all individuals who will be reassigning their Medicare or other federal health care program benefits to the enrolling entity.

NOTE: All entities and individuals must be currently enrolled or concurrently enrolling in the Medicare or other federal health care program.

Adding a Reassignment: An individual practitioner is currently enrolled in Medicare or another federal health care program(s) and will reassign benefits to an entity that is currently in the Medicare or the same other federal health care program(s).

Deleting a Reassignment: An individual that has been reassigning benefits to an entity is terminating that reassignment. No reassigned claims will be paid to the entity for dates of service after the effective date of deletion.

Changing Status of an Individual: An individual reporting a change in the type of income tax withholding or the practice locations with which he or she is associated.

Changes of Ownership (CHOW): This application is to be completed by all individual contractors, physicians, and other non-physician practitioners who will be reassigning their Medicare or other federal health care benefits to a new or a prospective new owner due to the occurrence or potential occurrence of a CHOW.

Definitions

Authorized Representative: The appointed official whose signature legally binds the entity.

Change of Ownership (CHOW): This term applies to certain limited circumstances as defined in 42 CFR § 489.18 as described below.

A change of ownership is defined as:

- In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law;
- In the case of an unincorporated sole proprietorship, transfer of title and property to another party;
- In the case of a corporation, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation (transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership); and
- In the case of leasing, the lease of all or part of a provider/supplier facility constitutes a change of ownership of the leased portion.

Entity: A business organization (e.g., group practice, hospital, clinic, health care delivery system) that is eligible to receive reassigned benefits as permitted under 42 CFR 424.80.

Individual: A physician or other individual practitioner eligible to receive Medicare or other federal health program benefits who is permitted to reassign their benefits to an eligible entity.

Medicare Identification Number: This number uniquely identifies individuals and entities as Medicare providers/suppliers and is the number used on claim forms. The Medicare Identification Number is also known as Medicare Provider Number and Provider Identification Number (PIN). Examples of Medicare Identification Numbers are the UPIN, OSCAR number, NSC number, etc.

National Provider Identifier (NPI): This number is assigned using the National Provider System to identify health care provider/suppliers. In the future, it will replace the Medicare Identification Number.

APPLICATION COMPLETION INSTRUCTIONS

Check the box indicating the reason this application is being completed.

1. Entity Identification

Complete information identifying the entity to whom Medicare or other federal health care program benefits are being reassigned to and the type of action being reported.

Note: This form may be used to add or delete an individual who reassigned his or her benefits to the entity.

The legal business name of the entity must be the same name the entity uses in reporting to the Internal Revenue Service (IRS).

2. Individual Identification

Complete this section for each individual who is reassigning Medicare or other federal health care benefits to the entity shown in the Entity Identification section.

3. Practice Location(s)

Complete all information requested for each location where the individual will render services to Medicare or other federal health care program beneficiaries on behalf of the entity identified in the Entity Identification section. The entity must have enrolled, or be in the process of enrolling, all of these practice locations using the HCFA 855 General Enrollment Application.

4. Billing Agency/Management Service Organization Address

A Management Service Organization is a company contracted by the applicant to furnish some or all administrative, clerical and claims processing functions of the applicant's practice.

Complete this section if the entity shown in the Entity Identification section currently uses a billing agency/management service organization to submit bills.

5. Reassignment of Benefits Statement

In general, Medicare and other federal health care programs only make payments to the beneficiary or the individual or entity that directly provides the service. However, an individual or entity may reassign benefits to an eligible entity as defined in 42 CFR 424.80. The individual making this reassignment must sign a reassignment of benefits statement. Failure to complete the statement will cause a delay in processing the application and limit the Health Care Financing Administration's or other federal health care program's ability to make payment.

Note: For further information on Federal requirements on reassignment of benefits, the applicant should contact his/her Medicare or other federal health care contractor before signing the application.

6. Contact Person

Provide the full name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application.

7. Attestation Statement

The Authorized Representative of the entity that will receive payments must sign and date this form, attesting to the accuracy of the information provided and certifying that the entity applying to receive payments is eligible to receive reassigned benefits.

SEE PAGE ONE OF THESE INSTRUCTIONS FOR THE ADDRESS TO RETURN THIS COMPLETED APPLICATION.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

MEDICARE/FEDERAL HEALTH CARE PROVIDER/SUPPLIER ENROLLMENT APPLICATION
Individual Reassignment of Benefits Application

THIS FORM IS TO BE COMPLETED FOR ANY INDIVIDUAL WHO WILL REASSIGN THEIR BENEFITS TO AN ELIGIBLE ENTITY.

Check box indicating the reason this application is being completed. (Note: definitions of the following terms are found in the instructions.)

- | | |
|--|---|
| <input type="checkbox"/> Initial Enrollment | <input type="checkbox"/> Adding a Reassignment |
| <input type="checkbox"/> Deleting a Reassignment | <input type="checkbox"/> Changing Status of an Individual |
| <input type="checkbox"/> Changes of Ownership (CHOW) | |

1. Entity Identification

Legal Business Name

"Doing Business As" Name

Entity Employer Identification Number

Entity Medicare Identification Number

Adding or Listing Individual

Date Individual Reassigned Benefits (required)
(MM/DD/YYYY)

Deleting Individual

Date Individual Terminated Reassignment (if applicable)
(MM/DD/YYYY)

2. Individual Identification

Name: First Middle Last Jr., Sr., etc. M.D., D.O., etc.

Social Security Number

Medicare Identification Number

Date of Birth
(MM/DD/YYYY)

Individual Primary Speciality

Individual Secondary Speciality (optional)

What income reporting form does this individual receive from the entity or the Internal Revenue Service at the end of the calendar year?

W-2 1099 1065-K1 Other _____

3. Practice Location(s)

List all entity locations where individual will render services.

At how many entity locations does this individual render services? _____

If more space is needed, copy page and attach to application.

Legal Business Name For This Location

Doing Business As Name For This Location

Business Street Address Line 1

Business Street Address Line 2

City

County

State

ZIP Code + 4

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4. Billing Agency/Management Service Organization Address

Check here only if this entire section does not apply to the applicant.

Complete this section if entity is using a billing agency or management service organization.

Name of Billing Agency/Management Service Organization				Employer Identification Number	
Agency/Organization	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Contact Person Name:					
Business Street Address Line 1					
Business Street Address Line 2					
City		State		ZIP Code + 4	
Telephone Number ()		Fax Number ()		E-mail Address	

5. Reassignment of Benefits Statement

Medicare law prohibits payment for services to entities other than the practitioner who provided the services unless the practitioner specifically authorizes another entity (employer, facility, health care delivery system, or agent) to receive payment for his or her services, per Federal Regulation 42 CFR 424.80. By signing the Reassignment of Benefits Statement below, you are authorizing an entity to receive Medicare payments on your behalf.

This contract must be in compliance with HCFA regulations. The Reassignment of Benefits Statement must be signed by all providers, suppliers, and individuals who allow an entity (employer, facility, health care delivery system, or agent) to receive payment for the individual's services.

I acknowledge that, under the terms of my employment or contract,
 (Legal Business Name of Entity) _____
is entitled to claim or receive any fees or charges for my services.

Reassignee Name	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
(printed)					
Reassignee Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date	(MM/DD/YYYY)

6. Contact Person

Please supply the name and telephone number of a person who can answer questions about the information furnished in this application.

Name	First	Middle	Last	Jr., Sr., etc.	Telephone Number
					()

7. Attestation Statement

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal laws. I certify that the entity applying to receive payments is eligible to receive reassigned benefits.

Authorized Representative Name	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
(printed)					
Authorized Representative Title				Date	(MM/DD/YYYY)
Authorized Representative	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)				
Signature					



Medicare And Other Federal Health Care Programs Change of Information

Health Care Provider/Supplier Form

Privacy Act Statement

The Health Care Financing Administration (HCFA) is authorized to collect the information requested on this form to ensure that correct payments are made to providers and suppliers under the Medicare program established by Title XVIII of the Social Security Act. See, sections 1814 and 1815 of the Social Security Act for payment under Part A of Title XVIII [42 U.S.C. §§ 1395(a)(1) and 1395g(a)], section 1833(e) [42 U.S.C. § 1395l(e)] for payment under Part B and section 1833(e) and 1834(j) [42 U.S.C. §§ 1395m(j)] for payment to DMEPOS under Part B of Title XVIII. In addition, HCFA is required to ensure that no payments are made to providers or suppliers who are excluded from participation in the Medicare program under section 1128 of Title XVIII [42 U.S.C. § 1320a-7] or who are prohibited from providing services to the federal government under section 2455 of the Federal Acquisition Streamlining Act of 1994, (P.L. 103-355) [31 U.S.C. § 6101 note]. This information must, minimally, clearly identify the provider and its' place of business as required by the Budget Reconciliation Act of 1985 (P.L. 99-272) [42 U.S.C. § 9202(g)] and provide all necessary documentation to show they are qualified to perform the services for which they are billing.

The Debt Collection Improvement Act (DCIA) of 1996 (P.L. 104-134) [31 U.S.C. §§ 3720B-3720D] requires agencies to collect the Taxpayer Identification Number (either the Social Security Number or the Employer Identification Number) from all persons or business entities doing business with the federal government. Under section 3100010(1) of the DCIA [31 U.S.C. § 7701(c)(1)], the taxpayer identification number will be used to collect (including collection through use of offset) and report any delinquent amounts arising out of the business relationship with the Government. Therefore, collection of this data element is mandatory.

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as providers/suppliers of goods and services to Medicare beneficiaries and to assist in administration of the Medicare program and other Federal and State health care programs. All information on this form is required, with the exception of those sections marked as optional on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into either system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in the Federal Register in Vol. 61, no. 89, May 7, 1996), or the National Provider Identifier (NPI) System (OMB approval 0938-0684 (R-187)). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances, to:

- (1) Contractors working for HCFA to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
- (2) A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
- (3) The Railroad Retirement Board for purposes of administering provisions of the Railroad Retirement or Social Security Acts;
- (4) Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
- (5) To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information. (6) To the Department of Justice for investigation and prosecuting violations of the Social Security Act to which criminal penalties attach;
- (7) To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
- (8) An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
- (9) Other Federal agencies who administer a Federal health care benefits program to enumerate/enroll providers of medical services or to detect fraud or abuse;
- (10) State Licensing Boards for review of unethical practices or nonprofessional conduct;
- (11) States for the purpose of administration of health care programs; and/or
- (12) Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process provider/supplier's health care claims.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988, (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected on this form are protected from public disclosure by Federal law 5 U.S.C. 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by HCFA under 5 U.S.C. § 552(b)(4) and/or (b)(6), respectively.



Upon completion, return this form and all necessary documentation to:

General

This form is for reporting changes in provider/supplier information for the Medicare or any other federal health care program. All changes must be requested in writing and have an original signature. Faxed or photocopied signatures will not be accepted. Changes on this form are those made most frequently and may also be reported using HCFA Form 855, 855R, or 855S, as appropriate. All changes **not** on this form **must** be reported using HCFA Forms 855, 855R, or 855S.

This form is not to be used to report a change of ownership (CHOW) as defined in 42 CFR § 489.18. A change of ownership requires the new owner to submit a completed HCFA Form 855 (General Enrollment Application). However, the current owner should complete the Potential Termination of Current Ownership section of this form to report that a potential change of ownership may occur.

Check Type of Change Being Reported

Check all changes that apply.

1. Provider/Supplier Identification

Complete provider/suppliers' full name and Social Security Number and Employer Identification Number as it is currently on file at the Medicare or other federal health care contractor. The current Medicare or other federal health care program identification number must be provided (e.g. UPIN, NSC, OSCAR, PIN, NPI).

For legal business name, supply the name that the individual or entity uses in reporting to the Internal Revenue Service (IRS), as well as the individual's or entity's Employer Identification Number (EIN) as it is currently on file at the Medicare or other federal health care contractor. If the EIN has changed, a new Enrollment Application (HCFA Form 855 or 855S) must be completed.

2. Name Change Information

If the provider/supplier is reporting a name change, complete applicable changes to the individual, organization or group name, and/or the "doing business as" name in the appropriate section. If an organization or group is requesting a name change, an IRS form W-9 or other official correspondence must be submitted showing the new name and the tax identification number related to the new name.

MEDICARE AND OTHER FEDERAL HEALTH CARE PROGRAMS PROVIDER/SUPPLIER FORM CHANGE OF INFORMATION INSTRUCTIONS

Change of Information Form-HCFA 855C

3. Address/Telephone Number Change Information

Complete provider/supplier's new mailing address. This is where the provider/supplier receives notices from the Health Care Financing Administration or other federal health care programs.

Complete the "Pay To" address section if provider/supplier would like payments to go to an address other than the reported "Pay To" address currently on file. This address may be a Post Office Box.

If the provider/supplier is reporting a billing agency/management service organization address change, complete identifying information for the agency/organization and furnish the new address. If the provider/supplier is reporting a NEW billing agency/management service organization, do not use this form. Provider/supplier must complete HCFA Form 855 (Provider/Supplier Identification and Billing Agency/Management Service Organization Address sections) and submit a copy of the new billing agreement/contract.

If provider/supplier is changing the location of the current practice, complete all information requested for the new location where provider/supplier will render services to Medicare or other federal health care program beneficiaries. If establishing a concurrent location (in addition to the current location), a new HCFA Form 855 must be completed for the new location.

A post office box or drop box is **not** acceptable as a practice location address. The phone number must be a number where patients and/or customers can reach the provider/supplier to ask questions or register complaints.

Indicate whether patient records are kept at the new practice location. If records are not kept at the new practice location, supply the physical address where the records are maintained. A post office box or drop box is **not** acceptable as the physical address where patient records are maintained.

4. Provider/Supplier Specialty

Complete this section if provider/supplier's primary and/or secondary specialty is changing.

5. Medicare or Other Federal Health Care Program Billing Number Deactivation Information

If provider/supplier wishes to deactivate his/her Medicare or other federal health care program billing number, identify the type of Medicare or other federal health care program billing number (e.g. UPIN, NSC, OSCAR, CHAMPUS, CHAMPVA, etc.) and provide the billing number, the effective date of deactivation for that billing number, and the reason for deactivation. Provider/supplier may deactivate any and all Medicare or other federal health care program billing numbers as necessary by listing all applicable numbers, their types, and effective dates of deactivation as outlined above in this section. However, applicant must notify each individual federal agency regarding the deactivation of the number(s) under that agency's control.

6. Addition/Deletion of Authorized Representative

Complete this section if provider/supplier wishes to delete a currently listed authorized representative, or the provider/supplier would like to report a new authorized representative.

The original signature of the new authorized representative is required to add a new authorized representative.

7. Surety Bond Information

This section to be completed by all providers/suppliers for which a surety bond is required.

Annual renewals must be reported to the Medicare contractor using this Change of Information form - HCFA Form 855C.

An original copy of the surety bond must be submitted with this form. Failure to submit an original copy of the surety bond will prevent the processing of this form. In addition, the surety bond company must submit a certified copy of the agent's Power of Attorney with this form.

8. Potential Termination of Current Ownership

When the business/organization is changing ownership, in accordance with the provisions for Change of Ownership (CHOW) as defined in 42 CFR § 489.18, the current owner should furnish name of the potential new owner and the projected effective date of the potential change of ownership.

Note: This section is not to be completed when the existing business/organization is adding or deleting a new owner. Changes of individual owners should be reported using the appropriate sections of HCFA Form 855 (General Application).

9. Effective Date of Change(s)

Report the date all listed changes are effective.

10. Attestation Statement

Sign and date this form attesting to the accuracy of the requested changes. If changes are being reported by the individual provider/supplier, the provider/supplier must sign this form. If the changes are being reported for an organization or group practice, an authorized representative of the organization or group practice must sign this form to confirm the requested change(s).

THIS FORM SHOULD BE RETURNED TO YOUR LOCAL MEDICARE OR OTHER FEDERAL HEALTH CARE PROGRAM CONTRACTOR. SEE THE RETURN ADDRESS AT THE BEGINNING OF THESE INSTRUCTIONS.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

OMB Approval No. 0938-0685

MEDICARE/FEDERAL HEALTH CARE PROVIDER/SUPPLIER FORM
Change of Information Form

Type of Change (Check all that apply.)	<input type="checkbox"/> Name	<input type="checkbox"/> Practice Location Address	<input type="checkbox"/> Mailing Address	<input type="checkbox"/> Telephone Number(s)
	<input type="checkbox"/> Pay To Address	<input type="checkbox"/> Billing Agency Address	<input type="checkbox"/> Specialty	<input type="checkbox"/> Fax Number(s)
	<input type="checkbox"/> E-Mail Address	<input type="checkbox"/> Authorized Representative	<input type="checkbox"/> Deactivation of Medicare Billing Number(s)	
	<input type="checkbox"/> Potential Termination of Current Ownership	<input type="checkbox"/> Surety Bond Change or Renewal Information		

1. Provider/Supplier Identification (Required)

Individual Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Other Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
OR				
Business Name:				
Social Security Number (if applicable)	Employer Identification Number (if applicable)	Medicare Identification Number(s) (if applicable)		

2. Name Change Information

A. Individuals ONLY

Prior Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
New Name: First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Social Security Number (if applicable)	Employer Identification Number (if applicable)	Medicare Identification Number(s) (if applicable)		

B. Organizations or Groups ONLY

New Legal Business Name	Employer Identification Number
-------------------------	--------------------------------

C. "Doing Business As" Name

Under what new name do you conduct business?

3. Address/Telephone Number Change Information

A. Mailing Address

New Mailing Address Line 1			
New Mailing Address Line 2			
New City	New County	New State	New ZIP Code + 4
New Telephone Number ()	New Fax Number ()	New E-mail Address	

B. "Pay To" Address

New Mailing Address Line 1			
New Mailing Address Line 2			
New City	New State	New ZIP Code + 4	New Telephone Number ()

3. Address/Telephone Number Change Information (continued)

C. Billing Agency/Management Service Organization Address

Attach a copy of the most current signed contract with provider's/supplier's billing agency or management service organization.

Name of Billing Agency/Management Service Organization				Employer Identification Number	
Agency/Organization	First	Middle	Last	Jr., Sr., etc.	Title
Contact Person Name:					
New Telephone Number ()		New Fax Number ()		New E-mail Address	
New Business Street Address Line 1					
New Business Street Address Line 2					
New City			New State	New ZIP Code + 4	

D. Practice Location(s) (For each additional location, copy and complete this section.)

New Street Address Line 1					
New Street Address Line 2					
New City	New County	New State	New ZIP Code + 4		
New Telephone Number ()	New Fax Number ()	New E-mail Address			
Are all patient records stored at this new practice location? <input type="checkbox"/> Yes <input type="checkbox"/> No IF NO, supply storage location below.					
Name of New Storage Facility/Location					
New Street Address Line 1					
New Street Address Line 2					
New City	New County	New State	New ZIP Code + 4		
New Telephone Number ()	New Fax Number ()	New E-mail Address			

4. Provider/Supplier Specialty Change Information

New Primary Specialty	New Secondary Specialty
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5. Medicare or Other Federal Health Care Program Billing Number Deactivation Information

Type (OSCAR, UPIN, PIN, etc.)	Medicare/Other Federal Health Care Program Number	Effective Date of Deactivation (MM/DD/YYYY)
Reason for deactivation request?		

6. Addition/Deletion of Authorized Representative

For each additional authorized representative, copy and complete this section.

<input type="checkbox"/> Addition of Authorized Representative			<input type="checkbox"/> Deletion of Authorized Representative		
Effective date (MM/DD/YYYY)			Effective date (MM/DD/YYYY)		
Authorized Representative Name: (printed)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
Authorized Representative Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Title/Position	Date (MM/DD/YYYY)
Social Security Number	Medicare Identification Number(s) (if applicable)		Medicaid Identification Number(s) and State(s) (if applicable)		

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7. Surety Bond Change or Renewal Information**An original copy of the current surety bond must be submitted with this form.****A certified copy of the surety bond agent's Power of Attorney must be submitted with this form.**

Name of Surety Bond Company		Telephone Number () ()		Fax Number () ()	
Agent's Name:	First	Middle	Last	Jr., Sr., etc.	
Amount of Surety Bond \$		Effective Date (MM/DD/YYYY)			
Bond for Tax Year:		Annual Renewal Date (MM/DD/YYYY)			

8. Potential Termination of Current Ownership**Furnish name of potential new owner and projected effective date of change of ownership.**

Individual Name of Potential New Owner:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
OR					
Legal Business Name of Potential New Owner:					
Projected Effective Date of Change of Ownership (MM/DD/YYYY)			Medicare Identification Number of Potential New Owner (if applicable)		

9. Effective Date of Change(s)

This change/these changes are effective as of _____ (MM/DD/YYYY)

10. Attestation Statement

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal laws.

Provider/Supplier Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
(printed)					
Provider/Supplier Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			Date (MM/DD/YYYY)	

or for groups and organizations:

Authorized Representative Name:	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
(printed)					
Authorized Representative Signature	(First, Middle, Last, Jr., Sr., M.D., D.O., etc.)		Title/Position	Date (MM/DD/YYYY)	