Community Mental Health Centers

2250 - Community Mental Health Centers (CMHC) - Citations and Descriptions

(Rev. 1, 05-21-04)

2250A - General

(Rev. 1, 05-21-04)

Section 4162 of P.L. 101-508 (OBRA 1990) amended §1861(ff)(3)(A) and §1832(a)(2)(J) of the Act to include CMHCs as entities that are authorized to provide partial hospitalization services under Part B of the Medicare program, effective October 1, 1991. The regulations are found at 42 CFR Chapter IV, Parts 400, 410, 424, and 489.

2250B - Special Requirements

(Rev. 1, 05-21-04)

Section 1866(e)(2) of the Act and 42 CFR Part 489.2(c)(2) recognize CMHCs as providers of services for purposes of provider agreement requirements, but only with respect to providing partial hospitalization services.

2250C - Community Mental Health Centers

(Rev. 1, 05-21-04)

1 - A CMHC, in accordance with §1861(ff)(3)(B)(ii) of the Act, is an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located; and

2 - In accordance with §1861(ff)(3)(B)(i) of the Act, §1913 (c)(1) of the Public Health Service Act (PHSA), and the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA), a CMHC must provide all of the following core services to meet the statutory definition of a CMHC. However, effective March 1, 2001, in the case of an entity operating in a State that by law precludes the entity from providing the screening services, the entity may provide for such service by contract with an approved organization or entity (as determined by the Secretary) that, among other things, meets applicable licensure or certification requirements for CMHCs in the State in which it is located. Pursuant to 42 CFR Part 410.110, a CMHC may receive Medicare reimbursement for partial hospitalization services only if it demonstrates that it provides such services. The core services include:

- Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility;

- 24 hour-a-day emergency care services;

- Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and

- Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission.

2250D - Partial Hospitalization Program (PHP)

(Rev. 1, 05-21-04)

A PHP, for Medicare purposes, is a program that is furnished by a hospital to its outpatients or by a CMHC that provides partial hospitalization services.

2250E - Partial Hospitalization Services Provided by CMHCs or by Others Under Arrangements With the CMHC

(Rev. 1, 05-21-04)

In accordance with 42 CFR Parts 410.2 and 410.43, partial hospitalization services for Medicare purposes, means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care and that furnishes services that:

1. Are reasonable and necessary for the diagnosis or active treatment of the individual's condition;

2. Are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization;

3. Include any of the following:

    - Individual and group therapy with physicians or psychologists or other mental health professionals authorized or licensed by the State in which they practice (e.g., licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors);

    - Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy must be a component of the physician's treatment plan for the individual;

- Services of other staff (social workers, trained psychiatric nurses, and others) trained to work with psychiatric patients;

- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR Part 410.29);

- Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals;

- Family counseling, the primary purpose of which is treatment of the patient's condition;

- Patient training and education, to the extent that training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition; and

- Medically necessary diagnostic services.

NOTE: Since the word "any" could be misinterpreted, we want to be clear that we would not consider delivery of an instance of any one of these services to itself constitute a covered partial hospitalization service. PHPs are intensive, active treatment programs that offer a combination of services and a multi-disciplinary team approach to address each patient's symptoms and functional level.

A program comprised primarily of diversionary activity, social activity, or recreation therapy does not constitute a partial hospitalization program.

The following services are excluded from the scope of partial hospitalization services defined in §1861(ff) of the Act:

- Services to hospital inpatients;

- Meals, self-administered medications, transportation; and

- Vocational training.

2250F - Definitions of Core Services

(Rev. 1, 05-21-04)

The CMS defines the CMHC core services as follows:

- **Outpatient Services** are separate from partial hospitalization services and contain the elements of diagnosis, treatment, and follow-up (as appropriate). Screening and referral do not constitute the provision of outpatient services.
    - Specialized outpatient services to children - In this context; “children” are defined as persons through the age of 21 years.
    - Specialized outpatient services to the elderly - In this context, “elderly” are defined as persons aged 62 years and older.
    - Specialized outpatient services to the chronically mentally ill - Chronic mental illness should be evidenced by a psychiatric diagnosis as defined by the current edition of the American Psychiatric Association’s Diagnostic and Statistical Manual.
    - Specialized outpatient services to patients discharged from a mental health facility - Such services must be supported by evidence of a prior psychiatric inpatient hospitalization.
- **24 hour Emergency Care Services** must be available through a system that provides for access to a clinician and appropriate disposition with follow-up documentation of the emergency in the patient’s CMHC medical record. A psychiatric emergency may occur at any time, and a patient must have access to evaluation and stabilization services after normal business hours. A range of emergency interventions may be necessary and should be available to the patient, including a face-to-face interview, medication evaluation, and hospitalization. While hot lines, beepers and answering services may be facets of emergency services, they may not constitute their totality.
- **Day Treatment or Other Partial Hospitalization Services, or Psychosocial Rehabilitation Services** are structured day programs (less than 24 hours per day) that use a multidisciplinary team approach to develop treatment plans that vary in intensity of services and the frequency and duration of services provided based on the needs of the patient.

Partial hospitalization programs are to provide intensive psychiatric care of an acute nature, utilizing the clinically recognized therapeutic items and services identified in §1861(ff) of the Act. The treatment program of a PHP is:

1. Similar to that of a highly structured, short-term hospital inpatient program;

2. At a level more intense than outpatient day treatment or psychosocial rehabilitation;

3. Active treatment that incorporates an individualized treatment plan which describes a coordination of services wrapped around the particular needs of the patient;

4. Provided through a multi-disciplinary team approach to patient care under the direction of a physician, who certifies the patient's need for PHP services;

5. The program reflects a high degree of structure and scheduling;

6. In accordance with current practice guidelines, the treatment goals developed for each partial hospitalization patient should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission.

To be covered by Medicare, PHPs must be distinct from other outpatient, day treatment, or psychosocial rehabilitation programs.

The Medicare statutory requirements applicable to PHP are set forth in §1861(ff) of the Act. Based on that section, the term "partial hospitalization services" means the items and services that are prescribed by a physician provided under a program under the supervision of a physician pursuant to an individualized written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate PHP staff), which sets forth the physician's diagnosis, the type, amount, frequency, and duration of services provided under the PHP treatment plan and the goals for treatment.

- Screening for Patients Being Considered for Admission to State Mental Health Facilities to Determine the Appropriateness of Such Admission -Constitutes the performance of at least one of the steps in a process by which an individual is clinically evaluated, pursuant to State law, for the appropriateness of admission to a State mental health facility by an entity that has both the appropriate clinical personnel, and authorization under State law, to perform all of the steps in the clinical evaluation process except those required to be provided by a 24-hour facility

NOTE: Some State laws allow only certain entities to perform this type of screening. When a situation is discovered where the State limits screening to specific entities, the RO should discuss the matter with the Regional Attorney before denying entry to the CMHC applicant or terminating existing CMHCs because they are unable to conduct screening because of the State requirements. (See §2252.H below for changes to this requirement that resulted from the passage of BIPA.)

As a result of BIPA amendments to the Act (See §2250 C), a CMHC that is precluded by State law from providing the core service related to screening described in

§1913(c)(1)(E) of the Public Health Service Act (PHSA) may provide the screening under a contract with an approved organization or entity that is determined to be acceptable by CMS on behalf of the Secretary. Thus, effective March 1, 2001, screening may be performed by a CMHC via a contract in spite of the State law preclusion. The BIPA language applies to both those CMHCs participating currently in the Medicare program as well as new applicants requesting participation in the program.

It is important to distinguish the term "contract" used in the BIPA amendments and the term "under arrangement" defined in §2250 of the SOM and in the Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-1, Chapter 5, §10.3. A CMHC may provide one or more core services "under arrangement" with another entity if the service is authorized by State law, the CMHC retains full legal responsibility, and a written agreement is in place as explained in §2250 of the SOM. All requirements for performing a core service either directly or "under arrangement" remain intact and unaffected by the BIPA amendments.

The BIPA amendments allow a CMHC to provide screening by "contract" in the limited circumstance when the CMHC has not been given the authority to provide the service itself under State law. For purposes of §1861(ff)(3)(B), we believe a "contract" ought to provide the following:

1. The name, address, and provider number, if applicable, of the contractor(s);

2. That the contractor meet applicable licensing or certification requirements in the State in which the CMHC is located to conduct screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission;

3. That the contractor must provide the CMHC with the results of the screening for the patient(s) for which the CMHC requested screening;

4. The date the contract became effective, the term of the contract, and the manner of the contract's termination or renewal; and

5. A statement that the contract will be made available to CMS, the State survey agency, the CMHC's Medicare fiscal intermediary (FI) and the onsite contractor upon request.

The CMS regional office, on behalf of the Secretary, may approve an entity or organization as a contractor for the purpose of the BIPA screening provision if the organization's or entity's contract with the CMHC meets all of the terms of the contract as described above. The CMS will not grant a "blanket approval" for an entity or organization to conduct screening under a contract with a CMHC, but instead, must review each contract to ensure that it meets the prescribed contract terms. A contractor may contract with more than one CMHC to provide screening, and a CMHC may contract with more than one entity or organization to provide screening.

Although the State, the FI or the onsite contractor may recommend to CMS that the CMHC's contract to conduct screening in accordance with §1861(ff)(3)(B)(i)(II) be approved, CMS itself must determine if the screening is with an approved organization or entity. The CMHC must maintain documentary evidence that screening occurred in a particular case and provide a copy of the contract for screening to CMS upon request.

The BIPA amendments make no substantive changes to the PHSA/CMS requirement that the CMHC must provide the core services described in section 1913(c)(1) of the PHSA (including screening) and not just be capable of providing the services. Therefore, the "Threshold and Service Requirements" contained in the SOM must continue to be followed.

When screening is going to be provided under contract, under the newly revised terms of §1861(ff)(3)(B), the CMHC must maintain and provide documentary evidence to CMS that the screening occurred even though the CMHC may not be legally responsible for the screening results. Providing a service under contract does not mean merely referring an individual to another organization or entity.

- **Core Services Provided Under Arrangement** -A CMHC may provide one or more core services under arrangement with another individual, group, or entity only when the following criteria are met:

    - **Service Authorized by State Law** - In no case may a CMHC provide a service under arrangement when the CMHC has not been given authority to provide the service itself directly under State statute, licensure, certification, or regulation. However, as a result of the BIPA provisions, and under the circumstance described previously, a CMHC or proposed CMHC may provide screening via a contract.

    - **Full Legal Responsibility** - A CMHC that provides a core service under arrangement with another entity remains the legally responsible authority through which comprehensive mental health services are provided. It is not sufficient for the arrangement to be a referral process where the CMHC does not assume overall management responsibility for the provision of core services by a separate individual, group, or entity. The CMHC must retain complete accountability for the services provided under arrangement. The CMHC must retain legal, professional, and administrative responsibility to coordinate care, supervise and evaluate the services, and ensure the delivery of high quality mental health treatment.

    - **Written Agreement** - If a CMHC provides services under arrangement with another party or person, there must be a written agreement or contract between the two parties that specifies the services to be rendered, and the manner in which the CMHC exercises its legal, professional and administrative responsibility for these services. Furthermore, for the

agreement to serve as the vehicle through which the CMHC meets the requirement to provide one or more of the core services, the terms of the agreement must be adhered to in practice. The provider's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The provider must accept the patient for treatment in accordance with its admission policies, and maintain a complete and timely clinical record on the patient, which includes diagnoses, medical history, physician's orders, and progress notes relating to all services received, and must maintain liaison with the attending physician regarding the progress of the patient and the need for revised orders. In order to verify the nature of the relationship between the CMHC and the other party, the agreement must be accessible to CMS or its agents, and the documentation for all services rendered under arrangement must be maintained by the CMHC at the site identified in the provider agreement.

2250G - Threshold and Service Requirements for CMHCs

(Rev. 1, 05-21-04)

The statute requires that an applicant CMHC be providing the core services at the same time of certification, not at some future point in time. Accordingly, CMS will look for evidence that the applicant is already providing the core services as a pre-condition for certification. For example, CMS will look to see that the applicant:

- Is fully operational for one entire business quarter;

- Has served, as evidenced by complete, onsite medical record documentation from within three months of the date of the initial Medicare application for new applicants or the date of sale for changes of ownership, a sufficient number of persons to enable us to be reasonably assured that the facility is, in fact, complying with basic program requirements. We believe, that to achieve this objective, a facility should have served at least ten non-Medicare patients, including:

    - A minimum of three patients for which medical records demonstrate that the CMHC has

        - The legal capacity under State law to provide screening services for admission to State mental health facilities (or provides screening under a contract with an approved organization or entity, see §2252.H),

        - The capability and clinical expertise to provide such screening services (or provides screening under a contract with an approved organization or entity, see §2252.H); and,

- Provided screening services for the specific purpose (e.g., reason for referral) of assessing the patient's need for admission to a State mental health facility. Where there are State requirements for the completion of required forms, court documents or any other required documentation in response to the screening request, these documents would be evidence of providing the service. Otherwise, evidence in the screening assessment must include a clinical decision regarding the appropriate level of care and follow-up placement (or provides screening under a contract with an approved organization or entity, see §2252.H);

- A minimum of three-day treatment or other partial hospitalization or psychosocial rehabilitation for patients (this is group treatment and three patients is the smallest number the CMHC could justify as a group); and

- At least one patient from each of the four outpatient categories:

    - Children;

    - Elderly;

    - Chronically mentally ill; and

    - Residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility.

NOTE: At this time, there are no prior service requirements regarding the following core service: 24-hour a day emergency care services. However, please be aware that the CMHC must be able to demonstrate that it can provide 24-hour emergency care services. If a CMHC is approved for Medicare participation, it is expected to continue to provide the core services at §1913(c)(1). Providing the services described at §1913(c)(1) of the PHSA is ongoing and not a one time qualifying event for Medicare participation.

2250H - Revisions to the Core Service Screening Requirements as the Result of the Passage of BIPA

(Rev. 1, 05-21-04)

As a result of the passage of BIPA, there have been changes to the Act with respect to CMHCs. Section 431 of BIPA amended §1861(ff)(3)(B) of the Act concerning the qualifications that must be met by some CMHCs to participate in Medicare. This section is quoted below:

(i) "(B) for purposes of sub paragraph (A), the term "community mental health center" means any entity that

(ii) (1) provides the mental health services described in §1913(c)(1) of the Public health Service Act; or (II) in the case of an entity operating in a State that by law precludes the entity from providing itself the service described in subparagraph (E) of such section, provides for such service by contract with an approved organization or entity (as determined by the Secretary);

(iii) Meets applicable licensing or certification requirements for community mental health centers in the State in which it is located; and

(iv) Meets such additional conditions as the Secretary shall specify to ensure (I) the health and safety of individuals being furnished such services, and (II) the effective and efficient furnished such services, and (III) the compliance of such entity with the criteria described in §1931(c)(1) of the Public Health Service Act."

NOTE: The reference in the BIPA provision relating to §1931(c)(1) of the PHSA is a transposition error and should be read as 1913(c)(1) of the PHSA.

Thus as a result of BIPA amendments to the Act, a CMHC that is precluded by State law from providing the core services related to screening described in §1913(c)(1)(e) of the Public Health Service Act (PHSA) may provide the screening under a contract with an approved organization or entity that is determined to be acceptable by CMS on behalf of the Secretary. Consequently, effective March 1, 2000, screening may be performed by a CMHC via a contract in spite of State law preclusion, and any prior conflicting guidance is superseded.

For example, several of the Model letters contained in the SOM Exhibits referencing a denial of a CMHC's request for Medicare participation or termination of a CMHC because of a service being precluded under State law must be amended before usage to reflect the change made by the BIPA provision. The BIPA language applies to both those

CMHCs participating currently in the Medicare program as well as new applicants requesting participation in the program.

It is important to distinguish the term "contract" used in the BIPA amendments and the term "under arrangements" defined in SOM, §2250, and in the Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-1, Chapter 5, §10.3. A CMHC may provide one or more core services "under arrangement" with another entity if State law authorizes the service, the CMHC retains full legal responsibility, and written agreement or contract is in place as explained in SOM §2250. All requirements for performing a core service either directly of "under arrangement" remain intact and unaffected by the BIPA amendments.

The BIPA amendments allow a CMHC to provide screening by "contract" in the limited circumstances when the CMHC has not been given the authority to provide the service itself under State law. For purposes of §1861(ff)(3)(B) of the Act, we believe a "contract" ought to provide the following:

1. The name, address, and provider number, if applicable, of the contractor(s);

2. That the contractor meet applicable licensing or certification requirements in the State in which the CMHC is located to conduct screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission;

3. That the contractor must provide the CMHC with the results of the screening for the patient(s) for which the CMHC requested screening;

4. The date the contract became effective, the term of the contract, and the manner of the contract's termination or renewal; and

5. A statement that the contract will be made available to CMS, the State survey agency, the CMHC's FI and the RO upon request.

The CMS RO, on behalf of the Secretary, may approve an entity or organization as a contractor for the purpose of the BIPA screening provision if the organization or entity's contract with the CMHC meets all of the terms of the contract as described in the memorandum. The CMS will not grant a "blanket approval" for an entity or organization to conduct screening under a contract with a CMHC, but instead, must review each contract to ensure that it meets the prescribed contract terms. A contractor may contract with one or more than one entity or organization to provide screening

Although the State or the FI may recommend to CMS that the CMHC's contract to conduct screening in accordance with §1861(ff)(3)(B)(I)(II) of the Act be approved, CMS itself must determine if the screening is with an approved organization or entity. The CMHC must maintain documentary evidence that screening occurred in a particular case and provide a copy of the contract for screening to CMS upon request.

The BIPA amendments make no substantive change to the PHSA/CMS requirement that the CMHC must provide the core services described in §1913(c)(1) of the PHSA (including screening) and not just be capable of providing the services. Therefore, the "Threshold and Service Requirements" contained in the SOM must continue to be followed.

When screening is going to be provided under contract, under the newly revised terms of §1861(ff)(3)(B) of the act, the CMHC must maintain and provide documentary evidence to CMS that the screening occurred even though the CMHC may not be legally responsible for the screening results. Providing a service under contract does not mean merely referring an individual to another organization or entity.

The BIPA provision in §431 which added a new paragraph relating to "additional conditions as the Secretary shall specify…" will require consideration by CMS to determine whether there is a need to establish additional conditions.

The FIs and contractors who conduct CMHC site visits will also be notified of these changes.

2252 - Certification Process

(Rev. 1, 05-21-04)

2252A - General

(Rev. 1, 05-21-04)

The fiscal intermediary (FI) will verify enrollment information on the Form CMS-855A submitted by CMHCs seeking initial enrollment or undergoing changes of ownership (CHOWs). Once the FI has completed their review and recommended that the enrollment application or that the CHOW be approved, the FIs will forward any request for a site visit to the appropriate CMS Regional Office (RO), Division of Medicaid and State Operations (DMSO) who will then conduct the site visit.

The CMS ROs are responsible for approving or denying CMHCs for Medicare participation and for notifying CMHCs and the appropriate SA of the approvals or denials based on the Fiscal Intermediary (FI) certification recommendations, information gained from an onsite visit to the CMHC by the RO. As part of the process to approve or deny CMHC applications, ROs are responsible for conducting the site visit including medical records, the completed Site Visit Assessment Tool, and the completed Site Visit Summary. The purpose of the RO's site visit is to ensure that CMHC applicants provide the required core services, as well as meet the threshold and service requirements before allowing those applicants to enter into the Medicare program.

2252B - Request to Participate

(Rev. 1, 05-21-04)

CMHCs that wish to participate in the Medicare program for the purpose of providing partial hospitalization services must request application materials from the fiscal intermediary (FI), and must complete and submit the Form CMS-855A - Application for Health Care Providers that will Bill Medicare Fiscal Intermediaries (see §2003), and a separate statement over a penalty clause attesting that they meet the requirements for CMHCs contained in the Social Security Act and CMS Regulations (See Exhibit 275).

The CMHCs require an on-site visit prior to enrollment. Follow FIs should follow current procedures for provider enrollment, including communicating and sharing information with the State agencies (SAs) (or for FIs in RO IX, your RO) regarding enrollment up to and including verification of the Form CMS-855A. If the Form CMS-855A cannot be verified, follow current procedures for recommending denial of enrollment.

In addition to the FI's current provider enrollment procedures, check for a completed and signed CMHC attestation statement from the SA (or for FIs in RO IX, your RO). If the CMHC has not filed a completed attestation statement with the SA (or for FIs in RO IX, your RO), follow current procedures for recommending denial, and file a recommendation for denial.

If the Form CMS-855A has been verified, and the CMHC has filed a completed attestation statement, the FI should send a copy of the Form CMS-855A to the SA (or for FIs in RO IX, your RO) for retention, and issue their recommendation for approval. Using the form Attachment B below "Community Mental Health Center Site Visit Request Form," the FI should contact the appropriate CMS RO, DMSO via e-mail to initiate a site visit of the CMHC applicant. The FI should send carbon copies of the request to the SA, and the appropriate RO provider enrollment contact.

Once the site visit is completed, the RO DMSO will contact the FI via the provider agreement tie-in notice to inform them of the outcome of the site visit review process and the effective date of Medicare participation, if applicable.

2252C - Information to be Sent to CMHC Applicant

(Rev. 1, 05-21-04)

The SA mails copies of the following to applicant CMHCs, including those undergoing a change of ownership:

- The statutory requirements for CMHCs including the revised PHSA, §1913(c)(1). Also send a copy of the applicable CMS CMHC regulations.

- Exhibit 282. Model letter explaining participation in Medicare as a CMHC (including threshold and service requirements). The CMHC's response to this letter serves as its Medicare application.

- Exhibit 131. CMHC Crucial Data Extract (CDE).

- Exhibit 276. Provider Agreement

- Exhibit 275. Attestation Statement

- The CMHC will download a copy of the Form CMS-855A from the CMS Web site at http://www.cms.hhs.gov/providers/enrollment/forms.

2252D - Processing CMHC Requests, FI Role

(Rev. 1, 05-21-04)

The FI follows these steps when processing applications from CMHCs for Medicare participation and non-assigned provider agreement CMHC changes of ownership. If the provider agreement is not assigned, the new owner can only gain entry into the Medicare program as an initial applicant.

- The FI forwards concurrently to the SA and the RO, the CMHC's completed Form CMS-855A along with the CMHC's response to the model letter (application) and a copy of the signed attestation statement. The application must contain at least the following information:

    - The name and address of the facility;

    - The name of the facility's responsible agent, including the agent's address and telephone number;

    - The facility's Medicare provider number, if it is already participating in the Medicare program as a part of another type of provider;

    - The identification of all locations where the facility proposes to operate, if it plans to operate at other alternative sites in the community it serves through its provider agreement;

    - The Medicare provider number of the other entity, if the facility is operated as part of and under control of another entity that is participating in the Medicare program (provider based);

    - The services provided, with the number of full-time equivalent employees;

    - The type of ownership or control (i.e., nonprofit, Government);

- o A signed attestation statement over a penalty clause (separate from the application) indicating that the facility complies with all of the Federal requirements in §1861(ff) of the Act, the Medicare regulations, and specifically with the requirements contained in §1913(c)(1) of the PHSA;

- o A completed and signed Form CMS-855A; and

- o A signed Form CMS-1561, Provider Agreement. (The SA should never indicate or suggest to the CMHC that it is approved and/or that it may begin providing partial hospitalization services to Medicare beneficiaries, because until the RO determines that all requirements are met, it will not sign off on the provider agreement.) The date the RO signs off on the provider agreement will be the CMHC's effective date.

The FI's primary role with respect to CMHC applicants is to verify the information provided on the Form CMS-855A and recommend to the RO and SA approval or denial of the enrollment application. Also, the FI will contact the RO to verify that the applicant CMHC or CMHC undergoing change of ownership has the legal capacity to provide screening services for admission to State mental health facilities. (See §2250.H.) However, the FI will not request the RO to conduct an onsite visit until it has completed its review and verified the information provided on the Form CMS-855A, because there is no point in conducting an onsite visit if the CMHC is denied enrollment based on the Form CMS-855A review, or the CMHC has not provided all of the information necessary to make an enrollment decision. When making an on-site visit, the RO will copy medical records to confirm the provision of the core services, record its findings on the CMHC Site Visit Assessment Tool and the CMHC Site Visit Summary and then forward these documents to the SA.

The FI will make a recommendation to the RO, and the SA, of approval or denial of the CMHC's request for Medicare enrollment/participation based on its review of the Form CMS-855A. The FI should not indicate in any way to the CMHC that it might begin to provide partial hospitalization services to Medicare beneficiaries at any point in the enrollment process. The provider's effective date (in the case of approvals), or application denial will be determined by the RO.

2252E - Processing CMHC Requests, SA Role

(Rev. 1, 05-21-04)

In particular, CMS looks to the SA to evaluate whether the applicant CMHC meets applicable licensing or certification requirements for CMHCs in the State in which it is located, develop any provider based-issues, and comment on the CMHC's plan to operate an alternative site (the proposed alternative site must be a part of the community where the applicant intends to locate the CMHC that is seeking Medicare approval). (See §2252.I.) The SA should also comment on any reason it has to believe or disbelieve that

the CMHC applicant is providing the core services or, in change of ownership cases, has moved from its original service area. For example, if the SA knows that State law precludes the CMHC from performing the core service requirement related to screening, it should make the RO aware of this. In fact, if the SA knows that the CMHC does not meet State licensure or certification requirements, it should forward all application materials, including Form CMS-855A to the RO for a denial of the request to participate in Medicare. The SA will process CMHC certifications pursuant to applicable instructions in §§2760-2776 and the following SOM sections. This includes completing the appropriate blocks of Part I and Part II of the Form CMS-1539 and completing the CMHC Crucial Data Extract based on the information provided by the CMHC

2252F - Processing CMHC Requests, RO Role

(Rev. 1, 05-21-04)

The RO will adjudicate the CMHC's request to be a provider of partial hospitalization services, or in cases where the CMHC is already in the Medicare program, will determine if the CMHC meets all applicable requirements to remain in the Medicare program and conduct a site visit that focuses on whether the CMHC meets or continues to meet core service requirements. The RO will evaluate the CMHC's application and the recommendations of the SA and FI, the materials collected by the site visit (the Site Visit Assessment Tool, the CMHC Site Visit Summary and the medical records), as well as the applicable sections of the Act, CMS Regulations, PHSA, and the guidance contained in the SOM, as a part of its decision. If there are issues of provider-based, alternative sites, or operating across State lines, these should be resolved concurrently with a decision to approve or deny the CMHC for Medicare participation. At the request of the FI, at the time of Medicare enrollment, the RO will also consult with its Regional Attorney regarding State screening laws to determine their applicability to applicant CMHCs and those undergoing change of ownership. (See §2250.H.) The RO will then provide to the FI verification, based on State law or other designation, as to whether the applicant CMHC or CMHC undergoing change of ownership has the legal capacity to provide screening services for admission to State mental health facilities. In addition, if the RO is determining if an existing CMHC should remain in the Medicare program, then the RO should note whether the CMHC (including any alternative sites) has moved from the community it originally was approved to serve, and terminate the provider agreements of those CMHCs that have moved to a different community where they have not been approved to operate as a CMHC. The RO should also consider the following in making its decision:

- Whether the CMHC applicant has reasonably demonstrated to CMS that it is providing the core PHSA services. To substantiate the provision of 24-hour emergency services, the RO may invoke unconventional measures such as calling the CMHC after hours to assess the response to, and management of, emergency calls;

The RO will not approve an entity as a CMHC unless and until the CMHC has reasonably demonstrated that it has provided the core services to a sufficient number of patients in accordance with §2250.G. Additional records aside from those that were collected as part of the onsite visit that show provision of the core services by the CMHC must be sent to CMS upon request and must be available at the site for which the CMHC is requesting Medicare approval. This includes records for patient services provided by a CMHC under an arrangement, because the CMHC is responsible for those patients the same as if the services were provided directly by the CMHC. In cases where there is doubt about the validity of medical records submitted by a CMHC during the onsite visit to substantiate the delivery of core services, the RO may also contact the beneficiaries (or their representatives) whose medical records are in question to validate the services cited in the medical records (if necessary, contact CMS' Office of Financial Management, Program Integrity Group, Division of Provider and Supplier Enrollment for further guidance on handling beneficiary interviews or if you require additional assistance or support in making the interviews);

- Whether, based on information collected during the onsite visit, the CMHC applicant has reasonably demonstrated to CMS that it has met all of the service and threshold requirements required of all new CMHCs, per §2250.G;

- Whether the facility is providing all of the core services with the exception of one that you determine it cannot provide due to preclusion under State law. Consult with your Regional Attorney before issuing a denial of the applicant's request for Medicare approval based on an issue of State law; and

- That an entity applying as a CMHC does not have to receive block grant funds in order to meet Medicare requirements as a CMHC.

The RO should also be aware that to preserve the consistency of information being released to the public, it will serve as the contact point for inquires regarding Medicare CMHC applicants. However, as always, press inquiries should be referred to the CMS Press Office.

2252G – Onsite Visit to the CMHC

(Rev. 1, 05-21-04)

The RO will make an onsite visit to an applicant CMHC, complaint visits to participating CMHCs and other necessary visits to CMHCs.

2252H - Facility Alleges it is Provider-Based

(Rev. 1, 05-21-04)

Medicare coverage of partial hospitalization services provided by a hospital to its outpatients became effective December 22, 1987, under §1861(ff) of the Act. Hospital

outpatient departments do not need to qualify as CMHCs to initially provide or continue to provide partial hospitalization services. Although the statute does not preclude CMS' approval of hospital-based CMHCs, an entity, for the purposes of providing partial hospitalization services, can qualify under Medicare either as a hospital outpatient department OR a CMHC that is hospital-based. An entity does not have the option to qualify as both a hospital outpatient department and a hospital-based CMHC to provide partial hospitalization services. Allegations of provider-based, whether alleged initially by the applying CMHC, or subsequent to CMS approval as a CMHC, will be developed using the guidelines contained in §2004.

2252I - Facility Requests an Alternative Site to be Approved Initially or Subsequent to Approval

(Rev. 1, 05-21-04)

In accordance with §1913(c)(1) of the PSHA, CMHCs are required to provide mental health services principally to individuals who reside in a defined geographic area (service area). The service area means the geographic territory that includes a community that is served or proposed to be served by an existing or proposed CMHC. A service area may be delineated by factors such as population distribution, natural geographic boundaries, and transportation accessibility. Specific examples of a service area may include townships, school districts and municipalities. A CMHC must be able to serve persons in or near where the CMHC is, or is to be, situated. Therefore, CMHCs must service a distinct and definable community. If the CMHC intends to operate outside the community, it must have a separate Medicare provider agreement/number. Some CMHCs will propose to serve at an alternative site to its primary location. The RO determines the confines of the community in the event that the CMHC requests to operate such an alternative site. In making this judgment, the RO will consider the actual demonstrated transportation patterns of the CMHC clients within the community to assure that all core services and partial hospitalization services are available from each alternative site within the community. Also, the RO, with any necessary assistance from the SA, will determine if the proposed alternative site is permissible or whether the entity must seek a separate provider agreement/number for the proposed alternative site because it serves a different community. If a CMHC operates a CMS-approved alternative site, the site is not required to provide all of the core PHSA services. However, a patient must be able to access and receive the services he/she needs at the approved primary site, or at an alternative site that is within the distinct and definable community served by the CMHC. Approvals of such alternative sites should be very limited, because CMHCs must serve a distinct and definable community, and also because CMS has not limited the number of CMHCs an entity may submit for Medicare approval as long as these proposed CMHCs serve different communities. Each case considered for an alternative site will be based on its own merits. The following guidelines also apply when making determinations relating to alternative sites of CMHCs:

- An applicant CMHC must identify for CMS the site where it intends to operate the CMHC as well as any proposed alternative sites where it intends to provide

partial hospitalization services. This information is specifically requested on the Form CMS-855A. The RO will inform the CMHC if it determines that the proposed alternative site must be separately approved because it is not a part of the community where the CMHC is located;

- CMHCs are required to notify CMS if, after approval and issuance of a provider agreement, they propose to add or delete an alternative site (SOM §3224). Reporting such a change is also a part of the CMS enrollment process (§2005.D.1);

- The PHSA core service records, as well as the partialization hospitalization records of the primary site and any other approved alternative sites within the CMHC's community, must be available for review at the primary site; and

- When the onsite visit is made to a CMHC subsequent to its approval, the RO conducting the visit will request the CMHC to identify any and all alternative sites it may have operating and requesting payment through the approved provider agreement/number, and completed Site Visit Assessment Tool. Assuming that the RO was aware of the alternative sites, it may re-evaluate its previous decision under these guidelines and determine if these locations may continue to be approved under the existing provider agreement or must be approved as a separate CMHC. The RO may also give this consideration to those CMHCs that failed to notify CMS of the alternative site. In either situation, if the RO determines that these locations are not located within the CMHC's distinct and definable community, it will inform the CMHC that if it has not requested approval for the site(s) as CMHCs within 60 days of RO notification to the CMHC, the RO will request the FI to deactivate the CMHC's billing number until such time as the CMHC either ceases to provide services at the unauthorized alternative site or until the alternative site requests and receives a billing number of its own as a CMHC. If the CMHC does not request approval of the outside-the-community operation that it has been told must have its own provider agreement/number, and does not notify CMS of its intentions with respect to this location, the RO may terminate the CMHC's provider agreement if it determines that the CMHC is not providing services principally in the original service area for which it was approved.

2252J - RO Approval of CMHC Request for Medicare Approval

(Rev. 1, 05-21-04)

If the RO approves a CMHC for Medicare participation, it assigns the CMHC a provider number from the series 1400-1499, 4600-4799, and 4900-4999 (§2779), and determines the effective date of the provider agreement. The effective date of Medicare participation is the date the RO signs the provider agreement, after determining that all Medicare requirements, including enrollment, are met (§2004). A CMHC that only receives Federal funds through Medicare Part B is not required to comply with various civil rights

statutes enforced by the Department of Health and Human Services (DHHS), Office for Civil Rights. However, if the CMHC participates in the Medicaid Program or receives any other financial assistance such as grants from DHHS, it must comply with all applicable civil rights statutes.

The RO will notify the applicant CMHC of its decision. The notice will also address any related issues such as approval/disapproval of the CMHC as provider-based and approval/disapproval of additional offices, as appropriate. The RO will send copies of its notification to the FI and the SA.

2252K - RO Denial of CMHC Request for Medicare Approval

(Rev. 1, 05-21-04)

If the RO determines that a CMHC applicant's request for Medicare must be denied, the reason will usually relate to the applicant's failure to provide the core PHSA services or the applicant's failure to meet threshold and service requirements. Use the Model Denial Letter for CMHC Applicants, Failure to Provide Core Services, if you determine that the applicant fails to provide one or more of the core PHSA services. Model Denial Letter for CMHC Applicants, State Restriction on Screening, is designed for use when an application for participation as a CMHC in the Medicare program is being denied SOLELY because the CMHC is precluded by State law or regulation from providing the core service of screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission. Be mindful of the BIPA provision that allows a CMHC to contract for screening (see §2250.C.).

Model Denial Letter for CMHC Applicants, Failure to Meet Threshold and Service Requirements, should be sent when the RO determines that the CMHC applicant does not meet the minimum threshold and service requirements. All model letters provide the applicant with an opportunity for a reconsideration of the decision to deny the application. If the applicant is being denied for another reason under 42 CFR Part 489.12(a), you must develop a notice to advise the applicant CMHC of the reason for the denial. When the onsite visit is made to the CMHC, and the CMHC cannot be located, deny the application.

If the applicant CMHC requests a timely reconsideration, examine any evidence submitted by the applicant CMHC as to why it believes the initial determination was incorrect. If you determine that the denial must be affirmed, provide the CMHC with an adequate explanation of your findings of non-compliance for each of the unmet core service requirements. Specifically address any new evidence submitted via Statement of Findings and/or via Statement of Threshold and Service Requirement Findings. Offer the denied applicant an opportunity for an Administrative Law Judge (ALJ) hearing.

2252L - Approved Provider Changes Ownership

(Rev. 1, 05-21-04)

CMHCs undergoing a Change of Ownership (CHOW) are treated as other providers (See SOM §§3210-3210.5, and §2005.F.) with the following exceptions:

2252L1 - Provider Agreement is Assigned, FI Role

(Rev. 1, 05-21-04)

The provider is required to report the CHOW to the FI and submit a Form CMS-855A as soon as possible. If this reporting is not done, or not done timely, the provider agreement is automatically assigned. (If the CHOW is reported to the SA or RO, the FI or RO will forward the CHOW to the FI to initiate the CHOW.) The FI will send the new owner a copy of all of the materials under §2252.C and follow the instructions in SOM §3210.5 for an assigned provider agreement. The new owner must obtain a copy of the Form CMS-855A from the CMS Web site http://www.cms.hhs.gov/medicare/enrollment/forms and submit the completed form to the FI. The FI upon receipt of the requested materials (attestation, pertinent application information about the new owner, Form CMS-855A, Assigned Provider Agreement), the FI:

- Will verify and process the Form CMS-855A in accordance with current procedures. If the Form CMS-855A cannot be verified, follow current procedures for issuing are commendation for denial.

- Check for a completed and signed CMHC attestation statement from the SA (or for FIs in RO IX, their RO). If the CMHC buyer applicant has not filed a completed attestation statement with the SA (or for FIs in RO IX, your RO), follow current procedures found in the Medicare Program Integrity Manual (PIM), Chapter 10, §14.3, for recommending denial, file a recommendation for denial, citing the reason.

- Check to ensure that the CMHC has not changed its address. If the CMHC has changed its address, notify the RO in writing. Use the form in Attachment A, to do so. Continue to process the application according to the time frame established in the PIM, Chapter 10, §15. If the RO DMSO does not approve the change of address, follow current procedures found in the PIM, Chapter 10, §14.3, for recommending denial and file a recommendation for denial, citing the reason.

- If the Form CMS-855A is verified, the CMHC buyer applicant has filed a completed attestation statement, and has not changed its address, send a copy of the Form CMS-855A back to the SA (or for FIs in RO IX, their RO) for retention, and issue the recommendation for approval.

- Three months after the Form CMS-855A verification, or sooner if the CMHC buyer applicant is suspect but enrollment cannot be denied based solely on the information provided on the Form CMS-855A, using the form is, contact the RO DMSO via e-mail to initiate a site visit of the CMHC. Send copies of the request to the SA (or for FIs in RO IX, their RO), and the appropriate RO provider enrollment contact. The RO DMSO may contact FI prior to the site visit for information about the CMHC prior to and after the CHOW, including:

    - o Any significant cost report audit information;
    - o Any significant medical review information;
    - o Any significant fraud information;
    - o HCIS data from the two most recent completed data years on the CMHC to be visited; and
    - o Any information regarding overpayments from the overpayments database.

Provide this information upon request or as soon as possible. The FI may also provide this information with their request for the site visit. Direct all calls and correspondence regarding the CMHC site visit process to the appropriate RO DMSO address.

Once the site visit has been completed, the RO DMSO will contact the FI with the outcome of the site visit review process. In addition, the RO DMSO may determine that the results of the site visit warrant action such as payment suspension.

2252L2 - Provider Agreement is Assigned, SA Role

(Rev. 1, 05-21-04)

If the SA is aware that the CMHC does not meet the core service screening requirement at §1913(c)(1) of PHSA because it is not among the entities that may conduct screening in the State or does not have a contract with and approved entity or organization to provide screening; (See §2250.H .); or it does not meet applicable State licensing or certification requirement for CMHCs, or the new owner has moved the CMHC to a new community without notifying CMS, the SA will provide this information directly to the FI and the RO for an involuntary termination of the provider agreement.

In the absence of any of the above situations that may result in a termination of the provider agreement, once the FI receives the application materials and has completed its review of those materials and finds no issue with the CHOW, the FI contacts the RO to initiate a site visit within 6 months.

2252L3 - Provider Agreement is Assigned, RO Role

(Rev. 1, 05-21-04)

The RO will follow SOM §§3210-3210.5 and §2000.F in initially processing CHOW unless the RO is aware that the screening State licensure or State certification requirements are not met by the CMHC, absent the on-site visit (see §2250.H). If there are requirements that are not met, the RO should follow procedures to terminate the provider agreement. The RO should also ascertain if the CMHC has moved to a different community from that for which it was originally approved as a CMHC. If so, the RO may terminate the assigned provider agreement because the CMHC has moved, without notification to and subsequent approval from the RO, to a different community than the one it was approved to serve. If the CMHC does not meet any of the termination criteria, after 6 months, a site visit will be conducted of the new owner. (Follow procedures in §2252.F for reviewing site visit materials.) If it is determined from the site visit that the new CMHC owner is not in compliance with all Federal and State requirements and/or has moved since the CHOW to a new community, consider terminating the provider agreement. In some instances the site visit documentation may not yield enough substantial evidence to justify termination of the new CMHC owner's provider agreement. However, there may be sufficient cause to investigate the matter further.

If after the site visit the RO has determined that the CMHC has not moved from its community and meets all applicable State and Federal requirements, it should indicate this determination to the FI and SA. The RO should note that if the CMHC does not report the CHOW timely, the provider agreement is automatically assigned to the new owner. Note that the effective date for all CHOWs is the date of the sale.

NOTE: If a potential purchaser of a CHOW should ask the SA, FI or RO prior to consummating a CHOW, about what will happen if he/she buys a CMHC that is not permitted to do screening in the State, or has a State licensure or certification problem with respect to licensure or certification for CMHCs, or if he/she intends to relocate the CMHC to another community, he/she should be forewarned about the possibility of termination of the provider agreement. The RO should check with the State to determine if, under the State law, provision of screening extends to the new owner.

2252L4 - Approved Provider Changes Ownership, Provider Agreement Is Not Assigned

(Rev. 1, 05-21-04)

If the CMHC buyer does not or will not be accepting assignment, the CMHC seller must submit the Form CMS-855A to apprise the FI of the CHOW as soon as possible. The CMHC buyer should submit a new Form CMS-855A and be treated as an initial applicant, in accordance with the PIM, Chapter 10, §10, and all other applicable instructions and procedures for initial applicants, with one exception: the FI should

contact the RO DMSO three months after the date of the CMHC sale/CHOW to initiate the site visit.

Before initiating a site visit, the FI must check to ensure that the CMHC has not changed its address. If the CMHC has changed its address, notify the RO in writing. Use the form in Attachment A, "Community Mental Health Center Notification and Approval of Address Change," to do so. Continue to process the application according to the time frame established in the PIM, Chapter 10, §15. If the RO DMSO does not approve the change of address, follow current procedures found in the PIM, Chapter 10, §14.3, for recommending denial and file a recommendation for denial citing the reason.

Once a site visit has been completed, the RO will terminate the CMHC seller's provider agreement effective with the date of the CMHC sale. In addition, the RO should note that in checking the new CMHC owner's compliance with the threshold and service requirements, the date of the sale is the first day of the new owner's first business quarter. If all Federal and State requirements are met, the RO will issue a new provider agreement to the new CMHC owner. If the CMHC does not meet all necessary requirements, the RO will issue a notice of that determination to the FI and SA. Note that the effective date of all CHOWs is the date of sale.

2252M - Voluntary Termination

(Rev. 1, 05-21-04)

A Medicare participating CMHC may voluntarily terminate its provider agreement at any time. The RO will follow the guidance in SOM §§3046, 3047, and 3048 in processing the termination. Also, if you are unable to locate the CMHC at the site approved for entry into the Medicare program, and you have exhausted all reasonable attempts to locate the CMHC, including a contact with the FI to ascertain if the CMHC has been billing Medicare, you should process an involuntary termination. (See "Model Letter for CMHC that has Ceased Operating," Exhibit 281.)

2252N - Involuntary Termination

(Rev. 1, 05-21-04)

An involuntary termination of a CMHC's provider agreement will usually be based on an onsite visit in which it is discovered that the participating CMHC is not providing one or more of the core services. The onsite visit may have resulted from a complaint, a periodic revalidation of the provider or because the CMHC met the most egregious criteria discussed in §2252.O. Following a review of the site visit findings and any other relevant information, if the RO determines that a termination is in order, it will use the Model Letters, "Notice of Termination of Provider Agreement," Exhibit 280, and "Notice of Findings of Non-Compliance," Exhibit 279 in notifying the CMHC of the termination. If the CMHC provides additional documentation of having provided the core services subsequent to the notification of Findings of Non-Compliance, work closely with your

Regional Attorney in making a determination of whether to continue with the termination. If the CMHC moves from the approved site issued by the Provider Agreement/Number to a different community, this should be treated as an involuntary termination (see §2252.M).

2252O - Identifying the "Most Egregious" CMHCs for Termination Action

(Rev. 1, 05-21-04)

Since there are no Conditions for Participation for CMHCs, many participating CMHCs have never had an onsite visit and are in the Medicare program solely because their attestation of compliance with the Federal requirements has never been challenged. The CMS has developed criteria as a way of identifying CMHCs that may be among the worst program offenders in terms of not meeting Federal requirements for CMHCs. The criteria are as follows:

- **History of Inappropriate Billing Data** - Inappropriate billing is any one of the following circumstances:
  - Unusual pattern of billed charges per patient per CMHC which significantly deviates from the State or national CMHC payments per patient (as determined by RO review of HCIS data for a recent 6-month period);
  - Denial of 50 percent or more of services reviewed (after focused medical review by the FI (e.g., 15 percent of total charges submitted));
  - Overpayment in excess of 15 percent of the CMHC's total Medicare payments (identified by FI);
  - CMHC's cost report shows no other services rendered other than services reimbursed by Medicare or no charges/services paid for by personnel needed to render all of the required core services. (RO or FI to refer to Worksheet S, Part II, lines 14 through 23, and worksheet C, lines 29-38.)

NOTE: When a cost report shows Medicare as the sole source of income, the RO should request documentation from the CMHC to determine if core services are being provided. If documentation is not provided or is inadequate, termination of the Provider Agreement should be considered and recommended for review by the Regional Attorney.

- Failure of CMHC to provide two or more of the core services described in §1913(c)(1) of the PHSA as determined by:
  - RO review of onsite inspection findings; or

- o RO review of documentation voluntarily provided from any source, including a CMHC, SA, or FI, or any documentation requested for review by the RO.

- **The RO Review of Any Relevant Documentation or Information** - The RO should review the CMHC's inappropriate billing data obtained from the FI that indicates that the CMHC may not meet the Federal requirements in the Act, including those provisions that are cross-referred to the PHSA. If an onsite visit is necessary, the RO, considering the recommendation of the national site visit contractor, will determine whether the CMHC meets the requirements in §1861(ff) of the Act with specific attention given to the PHSA core service provisions and other regulatory requirements such as whether physicians' orders and plans of care exist for the Medicare partial hospitalization billings.

A final determination that a CMHC meets the "most egregious" criteria will be based on a full review of all relevant facts, and not solely on issues related to inappropriate billing or failure to provide one of the core services.

- **Deactivation of the CMHC's Medicare Provider Billing Number** - The FI will periodically review CMHC billing records. If the FI observes that for the past 12 months the CMHC has not submitted any claims for partial hospitalization services, it may deactivate the CMHC's billing number rendering the CMHC an inactive Medicare provider. Deactivation is neither a termination of the provider agreement nor a suspension of Medicare payment. It simply means the Medicare provider agreement remains in effect, but the FI will make no further payments to the CMHC until it receives from the CMHC an updated Form CMS-855A that it must verify. The FI will use the "Medicare Provider Billing Number Deactivation Letter," Exhibit 277 when notifying the CMHC of the deactivation. Since this is not a termination, if the CMHC is using its Medicare approval in order to receive Medicaid benefits, it could continue to receive Medicaid. If the FI subsequently learns that the CMHC wants its provider agreement terminated, it will inform the RO.

2252P - For Visits to Existing Medicare CMHCs

(Rev. 1, 05-21-04)

There may be instances, such as a CMHC audit, which may prompt the RO DMSO to conduct a site visit of an existing CMHC. The RO DMSO may contact the FI prior to the site visit for information about the CMHC, including:

- Significant cost report audit information;

- Significant medical review information;

- Significant fraud information;

- CMS Customer Information System (HCIS) data from the two most recent completed data years on the CMHC to be visited; and

- Any information regarding overpayments from the overpayments database.

If possible, the FI should provide this information upon request, or as soon as possible. In instances where a site visit is completed for an existing CMHC that does not have the Form CMS-855A on file, request that the CMHC download and complete the Form CMS-855A. The FI should direct all calls and correspondence regarding the CMHC site visit process to the appropriate RO DMSO address

Attachment A - Community Mental Health Center Notification and Approval of Address Change

(Rev. 1, 05-21-04)

**COMMUNITY MENTAL HEALTH CENTER NOTIFICATION
AND APPROVAL OF ADDRESS CHANGE**

Date_______________

Dear CMS Regional Office, Division of Medicaid and State Operations:

In processing the following Medicare Community Mental Health Center's (CMHC) change of ownership (CHOW) application, it was discovered that the CMHC applicant buyer has undergone a change in address. In order to complete the enrollment process, it is necessary for the fiscal intermediary (FI) to verify with you in writing that the CMHC applicant will still be serving the same community it served before the address change.

Please complete the regional office (RO) Division of Medicaid and State Operations (DMSO) portion of this form and return it to the FI contact person at the address, fax number, or e-mail address listed below within 14 days.

Thank you.

The CMHC applicant has reported the following information on the Form CMS-855A:

FI completes the following for the CMHC applicant

Doing Business as Name:
____

Legal Name:____

Current Address:____

Previous Address:____

Current Phone Number:____

Previous Phone Number:____

Owner(s) Name:____

Managing Employee:____

Contact Person:____

CHOW date:____

FI completes the following for the FI:

FI Name:____

Address:____

Phone Number:____

Fax Number:____

Regional Office, Division of Medicaid and State Operations completes the following:

Date: ____

The address change reported for the CMHC applicant noted above (check one):

____________ **HAS BEEN approved.**

OR

____________ **HAS NOT been approved.**

RO DMSO Contact Person:

____

Phone Number: ____________________

Fax Number: ______________________

E-mail Address: ____________________

Attachment B -Community Mental Health Center Site Visit Request Form

(Rev. 1, 05-21-04)

COMMUNITY MENTAL HEALTH CENTER SITE VISIT REQUEST FORM

Date of request: __________________________

Check type of site visit:

__________ Initial applicant

__________ Change of ownership with assignment

__________ Change of ownership without assignment

__________ Other - (explain reason for visit)
____

Please complete the following for the CMHC applicant requiring a site visit:

Name: ____

Address: ____

Phone Number: _________________________

Owner(s) Name: ____

Managing/Directing Employee: ____

Contact Person: ____

Please complete the following for the fiscal intermediary:

Name:
____

Address: ____

Phone Number: _____________________

Fax Number: _______________________

E-mail Address: ____________________

Contact Person:
____

Corresponding CMS Regional Office:
____

CMS Regional Office Contact:
____