verify as the date that substantial compliance was achieved and the facility demonstrated that it could maintain substantial compliance, if necessary.

[59 FR 56243, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995, as amended at 64 FR 13361, Mar. 18, 1999]

§ 488.456 Termination of provider agreement.

(a) *Effect of termination.* Termination of the provider agreement ends—

(1) Payment to the facility; and

(2) Any alternative remedy.

(b) *Basis for termination.* (1) CMS and the State may terminate a facility's provider agreement if a facility—

(i) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or

(ii) Fails to submit an acceptable plan of correction within the timeframe specified by CMS or the State.

(2) CMS and the State terminate a facility's provider agreement if a facility—

(i) Fails to relinquish control to the temporary manager, if that remedy is imposed by CMS or the State; or

(ii) Does not meet the eligibility criteria for continuation of payment as set forth in § 488.412(a)(1).

(c) *Notice of termination.* Before terminating a provider agreement, CMS does and the State must notify the facility and the public—

(1) At least 2 calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and

(2) At least 15 calendar days before the effective date of termination for a facility with non-immediate jeopardy deficiencies that constitute noncompliance.

(d) *Procedures for termination.* (1) CMS terminates the provider agreement in accordance with procedures set forth in § 489.53 of this chapter; and

(2) The State must terminate the provider agreement of a NF in accordance with procedures specified in parts 431 and 442 of this chapter.

Subpart G [Reserved]

Subpart H—Termination of Medicare Coverage and Alternative Sanctions for End-Stage Renal Disease (ESRD) Facilities

SOURCE: 73 FR 20475, Apr. 15, 2008, unless otherwise noted.

§ 488.604 Termination of Medicare coverage.

(a) Except as otherwise provided in this subpart, failure of a supplier of ESRD services to meet one or more of the conditions for coverage set forth in part 494 of this chapter will result in termination of Medicare coverage of the services furnished by the supplier.

(b) If termination of coverage is based solely on a supplier's failure to participate in network activities and pursue network goals, as required at § 494.180(i) of this chapter, coverage may be reinstated when CMS determines that the supplier is making reasonable and appropriate efforts to meet that condition.

(c) If termination of coverage is based on failure to meet any of the other conditions specified in part 494 of this chapter, coverage will not be reinstated until CMS finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

§ 488.606 Alternative sanctions.

(a) *Basis for application of alternative sanctions.* CMS may, as an alternative to termination of Medicare coverage, impose one of the sanctions specified in paragraph (b) of this section if CMS finds that—

(1) The supplier fails to participate in the activities and pursue the goals of the ESRD network that is designated to encompass the supplier's geographic area; and

(2) This failure does not jeopardize patient health and safety.

(b) *Alternative sanctions.* The alternative sanctions that CMS may apply in the circumstances specified in paragraph (a) of this section include the following:

(1) Denial of payment for services furnished to patients first accepted for care after the effective date of the

sanction as specified in the sanction notice.

(2) Reduction of payments, for all ESRD services furnished by the supplier, by 20 percent for each 30-day period after the effective date of the sanction.

(3) Withholding of all payments, without interest, for all ESRD services furnished by the supplier to Medicare beneficiaries.

(c) *Duration of alternative sanction.* An alternative sanction remains in effect until CMS finds that the supplier is in substantial compliance with the requirement to cooperate in the network plans and goals, or terminates coverage of the supplier's services for lack of compliance.

§ 488.608 Notice of alternative sanction and appeal rights: Termination of coverage.

(a) *Notice of alternative sanction.* CMS gives the supplier and the general public notice of the alternative sanction and of the effective date of the sanction. The effective date of the alternative sanction is at least 30 days after the date of the notice.

(b) *Appeal rights.* Termination of Medicare coverage of a supplier's ESRD services because the supplier no longer meets the conditions for coverage of its services is an initial determination appealable under part 498 of this chapter.

§ 488.610 Notice of appeal rights: Alternative sanctions.

If CMS proposes to apply an alternative sanction specified in § 488.606(b), the following rules apply:

(a) CMS gives the facility notice of the proposed alternative sanction and 15 days in which to request a hearing.

(b) If the facility requests a hearing, CMS provides an informal hearing by a CMS official who was not involved in making the appealed decision.

(c) During the informal hearing, the facility—

(1) May be represented by counsel;

(2) Has access to the information on which the allegation was based; and

(3) May present, orally or in writing, evidence and documentation to refute the finding of failure to participate in network activities and pursue network goals.

(d) If the written decision of the informal hearing supports application of the alternative sanction, CMS provides the facility and the public, at least 30 days before the effective date of the alternative sanction, a written notice that specifies the effective date and the reasons for the alternative sanction.

Subpart I—Survey and Certification of Home Health Agencies

SOURCE: 77 FR 67164, Nov. 8, 2012, unless otherwise noted.

§ 488.700 Basis and scope.

Section 1891 of the Act establishes requirements for surveying HHAs to determine whether they meet the Medicare conditions of participation.

§ 488.705 Definitions.

As used in this subpart—

Abbreviated standard survey means a focused survey other than a standard survey that gathers information on an HHA's compliance with fewer specific standards or conditions of participation. An abbreviated standard survey may be based on complaints received, a change of ownership or management, or other indicators of specific concern such as reapplication for Medicare billing privileges following a deactivation.

Complaint survey means a survey that is conducted to investigate specific allegations of noncompliance.

Condition-level deficiency means noncompliance as described in § 488.24 of this part.

Deficiency is a violation of the Act and regulations contained in part 484, subparts A through C of this chapter, is determined as part of a survey, and can be either standard or condition-level.

Extended survey means a survey that reviews additional conditions of participation not examined during a standard survey. It may be conducted at any time but must be conducted when substandard care is identified.

Noncompliance means any deficiency found at the condition-level or standard-level.