

(3) The notice may state the intended date of termination which must be the first day of the month.

(b) *Termination date.* (1) If the notice does not specify a date, or the date is not acceptable to CMS, CMS may set a date that will not be more than 6 months from the date on the provider's notice of intent.

(2) CMS may accept a termination date that is less than 6 months after the date on the provider's notice if it determines that to do so would not unduly disrupt services to the community or otherwise interfere with the effective and efficient administration of the Medicare program.

(3) A cessation of business is deemed to be a termination by the provider, effective with the date on which it stopped providing services to the community.

(c) *Public notice.* (1) The provider must give notice to the public at least 15 days before the effective date of termination.

(2) The notice must—

- (i) Specify the termination date; and
- (ii) Explain to what extent services may continue after that date, in accordance with the exceptions set forth in § 489.55.

[45 FR 22937, Apr. 4, 1980, as amended at 76 FR 9512, Feb. 18, 2011; 81 FR 68872, Oct. 4, 2016; 82 FR 38516, Aug. 14, 2017]

§ 489.53 Termination by CMS.

(a) *Basis for termination of agreement.* CMS may terminate the agreement with any provider if CMS finds that any of the following failings is attributable to that provider, and may, in addition to the applicable requirements in this chapter governing the termination of agreements with suppliers, terminate the agreement with any supplier to which the failings in paragraphs (a)(2), (13) and (18) of this section are attributable:

(1) It is not complying with the provisions of title XVIII and the applicable regulations of this chapter or with the provisions of the agreement.

(2) The provider or supplier places restrictions on the persons it will accept for treatment and it fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medi-

care beneficiaries the same as to all other persons seeking care.

(3) It no longer meets the appropriate conditions of participation or requirements (for SNFs and NFs) set forth elsewhere in this chapter. In the case of an RNHCI, it no longer meets the conditions for coverage, conditions of participation and requirements set forth elsewhere in this chapter. In the case of an OTP, it no longer meets the requirements set forth in this section and elsewhere in this chapter.

(4) It fails to furnish information that CMS finds necessary for a determination as to whether payments are or were due under Medicare and the amounts due.

(5) It refuses to permit examination of its fiscal or other records by, or on behalf of CMS, as necessary for verification of information furnished as a basis for payment under Medicare.

(6) It failed to furnish information on business transactions as required in § 420.205 of this chapter.

(7) It failed at the time the agreement was entered into or renewed to disclose information on convicted individuals as required in § 420.204 of this chapter.

(8) It failed to furnish ownership information as required in § 420.206 of this chapter.

(9) It failed to comply with civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

(10) In the case of a hospital or a critical access hospital as defined in section 1861(mm)(1) of the Act that has reason to believe it may have received an individual transferred by another hospital in violation of § 489.24(d), the hospital failed to report the incident to CMS or the State survey agency.

(11) In the case of a hospital requested to furnish inpatient services to CHAMPUS or CHAMPVA beneficiaries or to veterans, it failed to comply with § 489.25 or § 489.26, respectively.

(12) It failed to furnish the notice of discharge rights as required by § 489.27.

(13) The provider or supplier refuses to permit copying of any records or other information by, or on behalf of, CMS, as necessary to determine or verify compliance with participation requirements.

(14) The hospital knowingly and willfully fails to accept, on a repeated basis, an amount that approximates the Medicare rate established under the inpatient hospital prospective payment system, minus any enrollee deductibles or copayments, as payment in full from a fee-for-service FEHB plan for inpatient hospital services provided to a retired Federal enrollee of a fee-for-service FEHB plan, age 65 or older, who does not have Medicare Part A benefits.

(15) It had its enrollment in the Medicare program revoked in accordance with § 424.535 of this chapter.

(16) It has failed to pay a revisit user fee when and if assessed.

(17) In the case of an HHA or hospice program, it failed to correct any deficiencies within the required time frame.

(18) The provider or supplier fails to grant immediate access upon a reasonable request to a state survey agency or other authorized entity for the purpose of determining, in accordance with § 488.3, whether the provider or supplier meets the applicable requirements, conditions of participation, conditions for coverage, or conditions for certification.

(b) *Termination of agreements with certain hospitals.* In the case of a hospital or critical access hospital that has an emergency department, as defined in § 489.24(b), CMS may terminate the provider agreement if—

(1) The hospital fails to comply with the requirements of § 489.24 (a) through (e), which require the hospital to examine, treat, or transfer emergency medical condition cases appropriately, and require that hospitals with specialized capabilities or facilities accept an appropriate transfer; or

(2) The hospital fails to comply with § 489.20(m), (q), and (r), which require the hospital to report suspected violations of § 489.24(e), to post conspicuously in emergency departments or in a place or places likely to be noticed by all individuals entering the emergency departments, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments, (that is, entrance, admitting area, waiting room, treatment area), signs specifying

rights of individuals under this subpart, to post conspicuously information indicating whether or not the hospital participates in the Medicaid program, and to maintain medical and other records related to transferred individuals for a period of 5 years, a list of on-call physicians for individuals with emergency medical conditions, and a central log on each individual who comes to the emergency department seeking assistance.

(c) *Termination of agreements with hospitals that fail to make required disclosures.* In the case of a physician-owned hospital, as defined at § 489.3, CMS may terminate the provider agreement if the hospital failed to comply with the requirements of § 489.20(u) or (w). In the case of other participating hospitals, as defined at § 489.24, CMS may terminate the provider agreement if the participating hospital failed to comply with the requirements of § 489.20(w).

(d) *Notice of termination—(1) Timing: basic rule.* Except as provided in paragraphs (d)(2) and (d)(3) of this section, CMS gives the provider notice of termination at least 15 days before the effective date of termination of the provider agreement.

(2) *Timing exceptions: Immediate jeopardy situations—(i) Hospitals.* If CMS finds that a hospital is in violation of § 489.24(a) through (f), and CMS determines that the violation poses immediate jeopardy to the health or safety of individuals who present themselves to the hospital for emergency services, CMS—

(A) Gives the hospital a preliminary notice indicating that its provider agreement will be terminated in 23 days if it does not correct the identified deficiencies or refute the finding; and

(B) Gives a final notice of termination, and concurrent notice to the public, at least 2, but not more than 4, days before the effective date of termination of the provider agreement.

(ii) *Skilled nursing facilities (SNFs).* For an SNF with deficiencies that pose immediate jeopardy to the health or safety of residents, CMS gives notice at least 2 days before the effective date of termination of the provider agreement.

(iii) *Home health agencies (HHAs)*. For an HHA with deficiencies that pose immediate jeopardy to the health and safety of patients, CMS gives notice to the HHA at least 2 days before the effective date of termination of the provider agreement.

(3) *Notice of LTC facility closure*. In the case of a facility where CMS terminates a facility's participation under Medicare or Medicaid in the absence of immediate jeopardy, CMS determines the appropriate date for notification.

(4) *Content of notice*. The notice states the reasons for, and the effective date of, the termination, and explains the extent to which services may continue after that date, in accordance with § 489.55.

(5) *Notice to public*. CMS concurrently gives notice of the termination to the public.

(e) *Appeal by the provider*. A provider may appeal the termination of its provider agreement by CMS in accordance with part 498 of this chapter.

[51 FR 24492, July 3, 1986]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 489.53, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

§ 489.54 Termination by the OIG.

(a) *Basis for termination*. (1) The OIG may terminate the agreement of any provider if the OIG finds that any of the following failings can be attributed to that provider.

(i) It has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application or request for payment under Medicare.

(ii) It has submitted, or caused to be submitted, requests for Medicare payment of amounts that substantially exceed the costs it incurred in furnishing the services for which payment is requested.

(iii) It has furnished services that the OIG has determined to be substantially in excess of the needs of individuals or of a quality that fails to meet professionally recognized standards of health care. The OIG will not terminate a provider agreement under paragraph (a) if CMS has waived a disallowance with respect to the services in question on

the grounds that the provider and the beneficiary could not reasonably be expected to know that payment would not be made. (The rules for determining such lack of knowledge are set forth in §§ 405.330 through 405.334 of this chapter.)

(b) *Notice of termination*. The OIG will give the provider notice of termination at least 15 days before the effective date of termination of the agreement, and will concurrently give notice of termination to the public.

(c) *Appeal by the provider*. A provider may appeal a termination of its agreement by the OIG in accordance with subpart O of part 405 of this chapter.

(d) *Other applicable rules*. The termination of a provider agreement by the OIG is subject to the additional procedures specified in §§ 1001.105 through 1001.109 of this title for notice and appeals.

[51 FR 24492, July 3, 1986, as amended at 51 FR 34788, Sept. 30, 1986]

§ 489.55 Exceptions to effective date of termination.

(a) Payment is available for up to 30 days after the effective date of termination for:

(1) Inpatient hospital services (including inpatient psychiatric hospital services) and post hospital extended care services (except as specified in paragraph (b) of this section with respect to LTC facilities) furnished to a beneficiary who was admitted before the effective date of termination; and

(2) Home health services and hospice care furnished under a plan established before the effective date of termination.

(b) The Secretary may, as the Secretary determines is appropriate, continue to make payments with respect to residents of a long-term care facility that has submitted a notification of closure as required at § 483.70(1) of this chapter during the period beginning on the date such notification is submitted and ending on the date on which the residents are successfully relocated.

[76 FR 9512, Feb. 18, 2011, as amended at 78 FR 16805, Mar. 19, 2013; 81 FR 68872, Oct. 4, 2016]