

(3) The facility which has not achieved substantial compliance re-assumes management control. In this case, CMS or the State initiates termination of the provider agreement and may impose additional remedies.

(d) In the case of a civil money penalty imposed for an instance of non-compliance, the remedy is the specific amount of the civil money penalty imposed for the particular deficiency.

(e) If the facility can supply documentation acceptable to CMS or the State survey agency that it was in substantial compliance and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that CMS or the State can 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 time-frame 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 fa-

cility 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.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

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

SOURCE: 45 FR 22937, Apr. 4, 1980, unless otherwise noted.

Subpart A—General Provisions

§ 489.1 Statutory basis.

This part implements section 1866 of the Social Security Act. Section 1866 specifies the terms of provider agreements, the grounds for terminating a

provider agreement, the circumstances under which payment for new admissions may be denied, and the circumstances under which payment may be withheld for failure to make timely utilization review. The following other sections of that Act are also pertinent.

(a) Section 1861 defines the services covered under Medicare and the providers that may be reimbursed for furnishing those services.

(b) Section 1864 provides for the use of State survey agencies to ascertain whether certain entities meet the conditions of participation.

(c) Section 1871 authorizes the Secretary to prescribe regulations for the administration of the Medicare program.

(d) Although section 1866 of the Act speaks only to providers and provider agreements, the effective date rules in this part are made applicable also to the approval of suppliers that meet the requirements specified in § 489.13.

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

[45 FR 22937, Apr. 4, 1980, as amended at 51 FR 24492, July 3, 1986; 62 FR 43936, Aug. 18, 1997; 63 FR 312, Jan. 5, 1998]

§ 489.2 Scope of part.

(a) Subpart A of this part sets forth the basic requirements for submittal and acceptance of a provider agreement under Medicare. Subpart B of this part specifies the basic commitments and limitations that the provider must agree to as part of an agreement to provide services. Subpart C specifies the limitations on allowable charges to beneficiaries for deductibles, coinsurance, copayments, blood, and services that must be part of the provider agreement. Subpart D of this part specifies how incorrect collections are to be handled. Subpart F sets forth the circumstances and procedures for denial of payments for new admissions and for withholding of payment as an alternative to termination of a provider agreement.

(b) The following providers are subject to the provisions of this part:

- (1) Hospitals.
- (2) Skilled nursing facilities (SNFs).
- (3) Home health agencies (HHAs).