Subpart E—Termination of Agreement and Reinstatement After Termination

§ 489.52 Termination by the provider.

(a) *Notice to CMS.* (1) A provider that wishes to terminate its agreement must send CMS written notice of its intent.

(2) The notice may state the intended date of termination which must be the first day of a 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 be published in one or more local newspapers and 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.

§ 489.53 Termination by CMS.

(a) *Basis for termination of agreement with any provider.* CMS may terminate the agreement with any provider if CMS finds that any of the following failings is attributable to that provider:

(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) It 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 Medicare 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 no longer meets the conditions for coverage, conditions of participation and requirements set forth 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) It refuses to permit photocopying 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 to § 424.535 of this chapter.

(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) *Notice of termination*—(1) *Timing: Basic rule.* Except as provided in paragraph (c)(2) 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) *Hospital with emergency department.* If CMS finds that a hospital with an emergency department is in violation of § 489.24, paragraphs (a) through (e), 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.

(3) *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.

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

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

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§ 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