

ACTION: Final rule; correcting amendment.

SUMMARY: In the November 17, 2010 issue of the **Federal Register**, we published a final rule that set forth an update to the Home Health Prospective Payment System (HH PPS) rates, including: The national standardized 60-day episode rates, the national per-visit rates, the nonroutine medical supply (NRS) conversion factors, and the low utilization payment amount (LUPA) add-on payment amounts, under the Medicare prospective payment system for HHAs. This correcting amendment corrects a technical error identified in the November 17, 2010 final rule.

DATES: Effective Date: This correcting amendment is effective February 18, 2011.

FOR FURTHER INFORMATION CONTACT: Randy Thronset, (410) 786-0131.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2010-27778 (75 FR 70372), the final rule entitled “Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices” (hereinafter referred to as the CY 2011 HH PPS final rule), there was a technical error that is identified and corrected in the regulations text of this correcting amendment. The provisions of this correcting amendment are effective January 1, 2011.

II. Summary of Errors in the Regulations Text

On page 70464 of the CY 2011 HH PPS final rule, we made a technical error in the regulation text of § 424.22(b)(1). That language inadvertently deleted paragraphs (b)(1)(i) and (ii). Accordingly, we are adding those paragraphs in this correcting amendment.

III. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, we can waive this notice and comment procedure if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of

the finding and the reasons therefore in the notice.

Section 553(d) of the APA ordinarily requires a 30-day delay in effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued.

Our policy on timing and signature of recertification for home health services in the calendar year (CY) 2011 final rule has previously been subjected to notice and comment procedures. These corrections are consistent with the discussion of this policy in the CY 2011 final rule and do not make substantive changes to this policy. This correcting amendment merely corrects technical errors in the regulations text of the CY 2011 final rule. As a result, this correcting amendment is intended to ensure that the CY 2011 final rule accurately reflects the policy adopted in the final rule. Therefore, we find that undertaking further notice and comment procedures to incorporate these corrections into the final rule is unnecessary and contrary to the public interest.

For the same reasons, we are also waiving the 30-day delay in effective date for this correcting amendment. We believe that it is in the public interest to ensure that the CY 2011 final rule accurately states our policy on timing and signature of recertification for home health services. Thus delaying the effective date of these corrections would be contrary to the public interest. Therefore, we also find good cause to waive the 30-day delay in effective date.

List of Subjects in 42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

Accordingly, the Centers for Medicare & Medicaid Services corrects 42 CFR part 424 by making the following correcting amendment:

PART 424—CONDITIONS FOR MEDICARE PAYMENT

- 1. The authority citation for part 424 continues to read as follows:

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

- 2. Amend § 424.22 by adding paragraphs (b)(1)(i) and (b)(1)(ii) to read as follows:

§ 424.22 Requirements for home health services.

* * * * *

(b) * * *

(1) * * *

(i) Beneficiary elected transfer; or
(ii) Discharge and return to the same HHA during the 60-day episode.

* * * * *

Authority: (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: February 10, 2011.

Dawn L. Smalls,

Executive Secretary to the Department.

[FR Doc. 2011-3779 Filed 2-17-11; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 483, 488, 489 and 498

[CMS-3230-IFC]

RIN 0938-AQ09

Medicare and Medicaid Programs; Requirements for Long-Term Care (LTC) Facilities; Notice of Facility Closure

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule amends the requirements that a long-term care (LTC) facility must meet in order to qualify to participate as a skilled nursing facility (SNF) in the Medicare program, or a nursing facility (NF) in the Medicaid program. These requirements implement section 6113 of the Affordable Care Act to ensure that, among other things, in the case of a LTC facility closure, individuals serving as administrators of a SNF or NF provide written notification of the impending closure and a plan for the relocation of residents at least 60 days prior to the impending closure or, if the Secretary terminates the facility's participation in Medicare or Medicaid, not later than the date the Secretary determines appropriate.

DATES: *Effective Date:* March 23, 2011.

Comments: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on April 19, 2011.

ADDRESSES: In commenting, please refer to file code CMS-3230-IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the instructions under the "More Search Options" tab.

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-3230-IFC, P.O. Box 8010, Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-3230-IFC, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Kadie Thomas, (410) 786-0468. Mary Collins, (410) 786-3189.

SUPPLEMENTARY INFORMATION: Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Legislative and Regulatory Background

According to the Centers for Medicare and Medicaid Services (CMS) data, as of April 2010, there are 15,713 long-term care (LTC) facilities (commonly referred to as nursing homes) in the U.S. LTC facilities are also referred to as skilled nursing facilities (SNFs) in the Medicare program and as nursing facilities (NFs) in the Medicaid program. For the past decade, CMS Online Survey Certification and Reporting (OSCAR) data have shown a decline in the number of nursing homes, from 17,508 in 1999 to 15,713 in 2010. In 2009, there were 231 nursing home closures. In 2010, there were 191 closures.

LTC facility closures have implications related to access to care, the quality of care, availability of services, and the overall health of residents. Therefore, having an organized process facilities must follow in the event of a nursing home closure would protect residents' health and safety, and make the transition as

smooth as possible for residents, as well as family members and facility staff.

A. Current Regulatory Requirements for Notification of Closure to Residents of LTC Facilities

Currently, requirements for the protection of residents' rights in the case of facility closure are found at 42 CFR 483.12(a), Transfer and Discharge.

Section § 483.12(a)(2), *Transfer and discharge requirements*, prohibits facilities from transferring or discharging a resident from the facility, except under certain circumstances, including cessation of operations.

Section § 483.12(a)(4), *Notice before transfer*, requires that before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident, of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

Section § 483.12(a)(5), *Timing of the notice*, requires facilities to inform residents 30 days before the resident is transferred or discharged, except in the case of certain specific circumstances that include, for example, an immediate transfer or discharge due to a resident's urgent medical needs. In such cases, the notification must be made "as soon as is practicable." State laws regarding notification of LTC facility closures vary, with the majority of States requiring 30 days notice prior to closure. However, there are some States that require up to 90 days notice, such as Vermont, Illinois and Pennsylvania (see (http://www.sph.umn.edu/hpm/nhregsPlus/category_attachments/category_admission_discharge_transfer_rights.pdf#page=1) for information on these States and general background on State regulations pertaining to nursing facility admission, transfer, and discharge rights).

Section § 483.12(a)(6), *Contents of the notice*, specifies what must be included in such notifications, for example the location to which the resident is being transferred or discharged. Finally, § 483.12(a)(7), *Orientation for transfer or discharge*, requires a facility to provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

Section § 488.426 *Transfer of residents, or closure of the facility and transfer of residents*, gives authority to the State in emergency situations. Section 488.426 (a), which is not being revised in this rule, requires that, in an emergency, the State has the authority to—(1) Transfer Medicaid and Medicare residents to another facility; or (2) Close

the facility and transfer the Medicaid and Medicare residents to another facility.

If a facility closes permanently due to an emergency, the administrator is required to provide proper notification. However, if the State temporarily relocates residents during an emergency with the expectation that the residents will return to the facility, we would not regard this situation to be a facility closure and would not require the administrator to provide notification. For example, CMS recently received notification that a facility's air conditioning failed during a heat wave. The State ordered the facility to relocate all of its residents while the problem was being investigated but did not close the facility. Since the States customarily provide notification under § 488.426 for emergency-related closures, CMS is not proposing the administrator be required to provide such notification.

B. Requirements for Notification of Closure to Other Individuals or Entities

Currently, there are no Federal regulations requiring that a LTC facility notify the Secretary or a State's LTC ombudsman prior to closure of a LTC facility and there are no Federal requirements for submission of a plan for closure of a LTC facility to any individual or entity.

C. Legislative Requirements and the Affordable Care Act Amendments

Sections 1819(b)(1)(A) of the Social Security Act (the Act) for SNFs and 1919(b)(1)(A) of the Act for NFs both state that a SNF/NF must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

Sections 1819(c)(2)(A) and 1919(c)(2)(A) of the Act state that in general, with certain specified exceptions, a SNF/NF must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility.

Section 6102 of the Affordable Care Act of 2010 (Pub. L. 111–148, March 23, 2010) added a new section 1128I to the Act to promote greater accountability for LTC facilities (defined as skilled nursing facilities and nursing facilities pursuant to new subsection 1128I(a) of the Act). Section 6113 of the Affordable Care Act added an additional subsection 1128I(h) to the Act, setting forth certain requirements for LTC facility closures, effective March 23, 2011, as follows:

1. Notification of Facility Closure

Section 1128I(h)(1)(A)(i) of the Act, as added by the Affordable Care Act, states

that in general, any individual who is the administrator of the facility must submit to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending facility closure.

For informational purposes, LTC ombudsmen are advocates for residents of nursing homes, board and care homes and assisted living facilities. Ombudsmen provide information about how to find a facility and what to do to get quality care. They are trained to resolve problems, and will assist individuals with complaints; however, unless an ombudsman is given permission, these matters are kept confidential. Under the Federal Older Americans Act, every State is required to have an Ombudsman Program that addresses complaints and advocates for improvements in the LTC system (<http://www.ltcombudsman.org/>).

For voluntary or State-mandated closures, the required written notification must not be later than 60 days prior to the date of such closure. Section 1128I(h)(1)(A)(ii) of the Act states that if the Secretary terminates the facility's participation under this title, notification must be provided no later than the date that the Secretary determines appropriate. Section 1128I(h)(1)(B) of the Act states that the administrator must also ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted.

Finally, section 1128I(h)(1)(C) of the Act states that LTC facilities must include in their closure notices a plan, approved by the State, for the transfer and adequate relocation of residents of the facility by a specified date prior to closure. The notices must also include assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

2. Relocation

Section 1128I(h)(2)(A) of the Act requires a State to ensure, before a facility in the State closes, that all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting. Because this requirement applies to States and not the LTC facility, we have not included it in this rule for LTC facilities. We will implement this statutory requirement through sub-regulatory guidance to be published in the State Operations Manual (SOM) as interpretive guidance

for surveyors. We are requesting comments on the best means of implementing this provision.

Section 1128I(h)(2)(B) of the Act authorizes the Secretary to continue to make payments under this title with respect to residents of a facility that has submitted the required notifications under section 1128I(h)(1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

3. Sanctions

Section 1128I(h)(3) of the Act, as added by the Affordable Care Act, states that any individual who is the administrator of the facility that fails to comply with the requirements set out in the subsection shall be subject to a civil monetary penalty of up to \$100,000, may be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f) of the Act), and shall be subject to any other penalties that may be prescribed by law.

Additionally, Section 1128I(h)(4) of the Act "Procedure," states that the provisions of section 1128A of the Act (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of the Act.

Subsection 6113(c) of the Affordable Care Act requires that the provisions of new subsection 1128I(h) of the Act become effective one year after the date of enactment—that is, March 23, 2011. Therefore, because of the statutory deadline, we are implementing this rule as an interim final rule with comment period.

II. Health Disparities

CMS is committed to developing regulation in a manner that focuses on improving the quality of health care for all persons. Therefore, we believe that it is important in the preamble of regulations to discuss our goal of addressing health care disparities and to solicit comments on how our regulations could be used to address such disparities.

In 1985, the Secretary of the Department of Health and Human Services issued a landmark report that revealed large and persistent gaps in health status among Americans of different racial and ethnic groups and served as an impetus for addressing health inequalities for racial and ethnic minorities in the U.S. This report led to the establishment of the Office of

Minority Health (OMH) within the Department of Health and Human Services (HHS), with a mission to address these disparities. National concern for these differences, termed health disparities, and the associated excess mortality and morbidity have been expressed as a high priority in national health status reviews, including Healthy People 2000 and 2010.

Since that time, research has extensively documented the pervasiveness of racial and ethnic disparities in health care and has led to the acknowledgement of racial and ethnic disparities as a national problem. As a result, more populations have been identified as vulnerable, which has necessitated the development of programs and strategies to reduce disparities for vulnerable populations, as well as the emergence of new leadership to address such disparities. Currently, vulnerable populations can be defined by race/ethnicity, socioeconomic status, geography, gender, age, disability status, sexual orientation, and other populations identified to be at-risk for health disparities. Other populations at risk may include persons with visual or hearing problems, cognitive perceptual problems, language barriers, pregnant women, infants, and persons with disabilities or special health care needs.

Although there has been much attention at the national level to ideas for reducing health disparities in vulnerable populations, we remain vigilant in our efforts to improve health care quality for all persons by improving health care access and by eliminating real and perceived barriers to care that may contribute to less than optimal health outcomes for vulnerable populations. For example, we are aware that immunization rates remain low among some minorities. Despite the long-term implementation of some strategies, such as the use of language translators in hospitals, health literacy and its impact on health care outcomes continues to be in the forefront.

We are always seeking better ways to address the needs of vulnerable populations; therefore, we are specifically requesting comments in regard to how our LTC facility closure requirements could be used to address disparities among facility residents.

III. Provisions of the Interim Final Rule With Comment Period

Based on the provisions of section 1128I(h) of the Act, as added by the Affordable Care Act, we are revising the current requirements for LTC facilities, as discussed below. Under this new

provision the administrator of the facility will be subject to sanctions for failure to provide proper notice according to these new provisions. However, in some cases, an administrator has no control over closure procedures. For instance, an administrator may be hired to oversee a facility's impending closure, although he or she was not present when the decision was made to close, or the administrator was employed fewer than 60 days prior to closure. In regards to LTC facilities, this is the first regulation where civil monetary penalties would be imposed on an individual. CMS considered the impact that this rule would have on an administrator that would be in a facility for an insufficient amount of time to comply with this regulation. We believe that the Congress intended CMS to use sanctions as a method to assure that the requirements in the statute be implemented. The language that the Congress used was "up to \$100,000." They used this language to have a maximum amount, but intended for CMS to determine the amount of the sanctions. Due to the many possible combinations of violations that could be cited gradations would be limited to the number of offenses. Any sanctions that have been levied against an administrator would also be reviewed by the State's licensing agency for possible disciplinary action including suspension and termination of the administrator's license. Because of the unique Federal laws applicable to the operation of IHS and Tribal LTC facilities under the authority of 25 U.S.C. 1621(d), the implementation of this IFC by such facilities will be developed in consultation with the IHS and Tribal programs.

A. Transfer and Discharge § 483.12(a)

We are revising § 483.12(a) by redesignating current paragraph (a)(8) as paragraph (a)(9) and adding a new § 483.12(a)(8) to require that, in the case of a facility closure, any individual who is the administrator of the facility must provide written notification prior to the impending closure to the Secretary, the State LTC ombudsman, the residents of the facility, and the legal representatives of such resident or other responsible parties, as well as provide a plan for the transfer and adequate relocation of the residents, in accordance with new § 483.75(r).

We are also revising § 483.12(a)(5)(i) "Timing of the notice", which allows for exceptions to the 30-day notification requirement for closures. We are adding a statement that newly added paragraph (a)(8), which generally states who must file a notice and plan and to whom the

notice and plan must be filed in the event of impending closure, is also an exception to the timing requirements found in paragraph (a)(5)(i).

B. Facility Closure-Administrator § 483.75(r)

We are adding a new subsection (r) to § 483.75. At § 483.75(r)(1), we are requiring that any individual who is the administrator of the facility must submit to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representative of such residents (or other responsible parties) written notification of an impending closure at least 60 days prior to the date of closure; or, in the case of a facility where the Secretary terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate for such notification.

To understand how the Secretary may determine a date for a notification when the Secretary has terminated the facility's participation in Medicare, Medicaid, or both, we are providing background on facility requirements to participate in these programs. The Secretary may terminate a facility's participation if the facility fails in any area outlined in § 489.53(a)(1) through (a)(15). For instance, at § 489.53(a)(3), failure to continue to meet the appropriate conditions of participation or requirements for SNFs and NFs set forth elsewhere in this chapter would be grounds for termination by CMS. In addition, the timing of the notification of termination by the Secretary may vary based on the justification for the closure. Section 489.53(d)(1) provides the basic timing rule for notice of termination by CMS, which is 15 days before the effective date of termination of the provider agreement. Section 489.53(d)(2)(ii) provides the timing rule for closures that are the result of deficiencies that may pose immediate jeopardy, which is 2 days prior to the effective date of the termination of the provider agreement.

In addition, at § 483.75(r)(2) we are requiring any individual who is the administrator of the LTC facility to ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted to the Secretary, the State LTC ombudsman, and the residents, and/or their representatives or other responsible parties.

At § 483.75(r)(3), we are requiring that any individual who is the administrator of a LTC facility include in the written notice of closure, a plan that has been approved by the State for the transfer

and adequate relocation of the residents of the facility by a date that would be specified prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

We would expect that the closure plan would include sufficient detail to clearly identify the steps the facility would take, and the individual responsible for ensuring the steps are successfully carried out. As an example, the plan might include: (among other things):

- Assessment of residents' care needs and the provision of appropriate services.
- A plan for communicating with staff and/or unions.
- Continuation of appropriate staffing levels and paychecks at the facility.
- Provision of necessary supplies.
- Identification of available facilities to which residents could be transferred, along with an assessment of the quality of care provided by these facilities (for example, Minimum Data Set (MDS) OSCAR data).
- A process for relocation of residents.
- Operation and management of the facility and oversight of those managing the facility.
- The roles and responsibilities of the facility's Administrator or replacement.
- Sources of supplemental funding to assist in keeping a facility open until the residents are transferred.
- A plan for communicating with the Secretary, the State LTC ombudsman, residents and legal representatives of the residents or other responsible parties.

C. Facility Closure § 483.75(s)

We are adding § 483.75(s) to require that the facility have in place policies and procedures that will ensure the administrator's duties and responsibilities involve providing the appropriate notices. While this provision is not explicitly required by section 1128I(h), we believe that it is implicitly authorized by the terms of section 6113 of the Affordable Care Act. Moreover, it is explicitly permitted by the general rulemaking authority of sections 1819(d)(4)(B) and 1919(d)(4)(B) of the Act, which permit the Secretary to issue rules relating to the health, safety and well-being of residents, and rules concerning physical facilities. The facility will not be sanctioned for noncompliance with this rule; however, it will be cited for a deficiency during the survey process.

D. Transfer of Residents, or Closure of the Facility and Transfer of Residents § 488.426

At § 488.426, we are revising paragraph (b) to include a cross-reference to the new requirements at § 483.75(r). We are also adding paragraph (c) *Required notifications when a facility's provider agreement is terminated* to address the required notifications when a facility closes.

E. Administrator Sanctions: Long-Term Care Facility Closures § 488.446

As required by Section 6113 of the Affordable Care Act, new § 488.446 will subject any administrator of a facility that fails to comply with the requirements at § 483.75(r) to sanctions. Such individual—

(1) Would be subject to a civil monetary penalty as follows: A minimum of \$500 for the first offense; a minimum of \$1,500 for the second offense; and a minimum of \$3,000 for the third and subsequent offenses. The three levels of civil monetary penalties (CMPs) represent a minimum amount for each offense; however, an administrator could be subject to higher amounts of CMPs (not to exceed \$100,000) based on criteria that CMS will identify in interpretative guidelines. If it is determined that an administrator of record completely fails to take the necessary and timely actions to adhere to the Notice of Facility Closure thus causing unjustified harm to the resident, family, and visitors, then the administrator could be subject to additional CMPs. For example, the administrator abandons his or her responsibility as set forth in the Notice of Facility Closure for the purpose of personal gain (financial) by devoting his or her energies to keeping the facility open rather than working on a safe and timely closure.

(2) Could be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f) of the Act); and

(3) Would be subject to any other penalties that may be prescribed by law.

F. Period of Continued Payments § 488.450(c)

At § 488.450(c), we are renumbering this section to add paragraphs (1) and (2). Current § 488.450(c) corresponds with new § 488.450(c)(1), and new paragraph (2) provides that the Secretary may, as deemed appropriate, continue to make payments under this title with respect to residents of an LTC facility that has submitted a notification of closure during the period beginning on the date such notification is

submitted and ending on the date on which the resident is successfully relocated.

G. Notice to CMS § 489.52(a)

We are revising § 489.52(a)(1) to provide an exception for SNFs, redesignating paragraph (a)(2) as paragraph (a)(3), and outlining the requirement specific to SNF notifications to CMS in new paragraph (a)(2).

At § 489.52(a)(2), we are requiring that a SNF provider that wishes to terminate its agreement must send CMS written notice of its intent at least 60 days prior to the date of closure, in accordance with § 483.75(r)(1)(i).

H. Skilled Nursing Facility Closure § 489.53(d)(3)

At § 489.53(d)(3), we are revising and redesignating the section to state that when CMS terminates a facility's participation under Medicare or Medicaid, CMS will determine the date of the required notifications. We are also revising § 489.53(d)(1) to reflect this change.

I. Exceptions to Effective Date of Termination § 489.55

When a notification is made as required at § 483.75(r), the new requirements authorize the Secretary to continue to make payments to the SNF or, for a NF, to the State, as the Secretary considers appropriate, during the period beginning at the time the notification is submitted and until the resident is successfully relocated. We renumbered this section to redesignate paragraphs (a) and (b) as paragraphs (1) and (2), and added a new paragraph (b) to implement this requirement.

J. Scope and Applicability § 498.3

We are adding § 498.3(a)(2)(iv) to clarify that CMS may also impose sanctions on NF administrators for noncompliance with § 483.75(r). In addition, we are adding a new subparagraph § 498.3(a)(3)(ii) to indicate that the appeals process applies to NFs as well as SNFs.

We are adding to § 498.3(b) *Initial determinations by CMS*, a new paragraph (18) to indicate that a sanction imposed on a SNF or NF administrator for noncompliance with the requirements set out at § 483.75(r) constitutes an initial determination of the agency.

K. Appeal Rights § 498.5

At § 498.5, we are adding paragraph (m) *Appeal rights of an individual who is the administrator of a SNF or NF* to establish appeal rights for administrator

sanctions for noncompliance with the requirements set out at § 483.75(r).

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the interim final rule in accordance with 5 U.S.C. 553(b) of the Administrative Procedure Act (APA). The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the interim final rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

Section 6113 of the Affordable Care Act, effective March 23, 2011, added new section 1128I(h) of the Act, which requires that the administrator of a facility follow specified procedures prior to closure of a facility. The Act requires any individual who is the administrator to provide written notification to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, of an impending facility closure. As mentioned above, LTC facility closures have implications for access, the quality of care provided, availability of services, and the overall health of residents, necessitating that an organized process be followed in the event of a nursing home closure. The Congress mandated at subsection 6113(c) of the Affordable Care Act that these amendments take effect one year after the date of the enactment of this Act.

We believe that, in mandating a 1 year effective date, the Congress was acknowledging the importance of protecting the vulnerable elderly residents of LTC facilities. Advance notice of facility closure allows a resident and his or her legal representative or interested family

member to prepare for the move to another facility, which can prove very traumatic to the resident. A move uproots a resident from a familiar environment, including a roommate and other residents, as well as assigned care providers, sometimes including the resident's physician. LTC facility closures require critical adjustments and create difficult issues for residents and their families and representatives. The Affordable Care Act under section 1128I(h) mandates specific procedures in the event of a closure of a nursing home. These procedures help protect the resident, the resident's family, and visitors because it requires the facility to provide an organized plan that allows the resident, family, and visitors to make the necessary adjustments within a reasonable time frame. At present, no Federal rule exists for facility closure. Delaying the implementation of the rule would continue to cause unjustified harm to the resident, family, and visitors.

We believe that to publish this rule as a proposed rule would jeopardize the safety of these individuals and the fulfillment of the mandated implementation date of March 23, 2011. Thus, we find that the Congressional directive renders adherence to the normal notice of proposed rulemaking requirements under the APA both impracticable and contrary to the public interest. Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis. We are providing a 60-day public comment period. In accordance with section 1871(a)(3) of the Act, all Medicare interim final rules must be finalized within three years.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the

affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

The revisions at § 483.12(a)(8) require any individual who is the administrator of the facility to submit to the Secretary, the State LTC ombudsman, residents and their legal representatives or other responsible parties, written notification of an impending closure at least 60 days prior to such closure; or not later than the date that the Secretary deems appropriate in the case of a facility where the Secretary terminates the facility's participation under this title.

Current regulations at § 483.12(a)(5) require notification of transfer or discharge to a resident and, if known, a family member or legal representative, in writing. Except in certain specified circumstances, notification must be made at least 30 days prior to transfer or discharge. Facility closure is not a circumstance that permits a facility to make notification in fewer than 30 days. Although the requirement extends the time period for notification from 30 days to 60 days (or a date determined by the Secretary in case of CMS termination of the facility), we do not believe the change in the time period for reporting imposes any additional burden. In addition, notification of transfer or discharge to residents and their representatives is already a usual and customary business practice. Therefore, in accordance with 5 CFR 1320.3(b)(2), we will not include this activity in the ICR burden analysis.

Although there are no existing Federal regulatory requirements for LTC facilities to notify other individuals or entities of an impending closure, according to feedback to CMS from State surveyors for LTC facilities, nearly all States already require LTC facilities to notify the State within 30 to 90 days. Because we have found that notifications of impending closure are a standard business practice for most LTC facilities, we believe that this requirement would impose burden on only a small number of facilities.

Each facility that does not already notify the State and the State LTC ombudsman must develop a process for doing so. We estimate that the burden associated with complying with this requirement would be due to the resources required to develop a process for notifying the State and the State LTC ombudsman and the time it takes to notify those entities. We expect that such a notification process would involve the administrator of the facility

and administrative support person and an attorney to review the plan.

We anticipate that, on average, it will take 7 hours for a total burden of \$5,584,400.16.

The revisions at § 483.75(r)(2) require that the administrator of the facility ensure that the facility does not admit any new residents on or after the date written notification is submitted. We do not anticipate any ICR burden associated with this requirement.

Section 483.75(r)(3) requires the administrator of the facility to include in the notice the plan for the transfer and adequate relocation of the residents of the facility by a date that is specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

Section 483.75(s) requires the facility to have in place policies and procedures to ensure that the administrator's duties and responsibilities include the provision of the appropriate notices in the event of a facility closure.

In our experience, based on feedback to CMS from State surveyors of LTC facilities, most facilities already have plans for transfer of residents, regardless of whether closure of the facility is expected. For example, most facilities have plans for transfer of residents to another facility in the event of an emergency. Also based on our experience, nearly all facilities anticipating closure develop plans for the relocation of residents and other closure-related activities. Many States require such plans. For example, Vermont requires that the State licensing agency and the LTC ombudsman be notified by the administrator of the facility 90 days prior to the proposed date of closure. In addition, the facility administrator is required to provide to the State licensing agency and LTC ombudsman a written transfer plan 60 days prior to closure.

Because we have found that transfer plans are a standard business practice for most LTC facilities, we believe that this requirement would impose burden on only a small number of facilities.

Each facility that does not already have a plan in place must develop a plan for the transfer and adequate relocation of residents of the facility. We estimate that the burden associated with complying with this requirement would be due to the resources required to develop and review a new plan or, if necessary, modify an existing plan for the transfer of residents in the event of

facility closure. We expect that development of such a plan would involve the administrator of the facility, an administrative support person, and an attorney to review the plan.

LTC facilities are currently required to have a plan under § 483.12 for discharge and transfer of residents. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Therefore, we anticipate that, on average, it will take 3 hours to develop the plan, 1 hour to ensure that the administrator's duties include policies and procedures relating to facility closures, 2 hours for an administrative support person to prepare the document(s), and 1 hour for an attorney to review the document(s), for a total estimated burden of 7 hours per facility. We also believe that the burden would remain approximately the same for the first year and beyond.

Currently, there are 15,713 LTC facilities in the U.S. Based on an hourly rate of \$58.17 for a nursing home administrator, we estimate that development of the plan and incorporating facility closure policies and procedures into the administrator's duties would cost \$3,656,100.80 (15,713 facilities × 4 hours per facility) × \$58.17 per hour). Based on an hourly rate of \$20.11 for an administrative assistant, we estimate that preparing the plan documents would cost \$631,976.86 ((15,713 facilities × 2 hours per facility) × \$20.11 per hour). Finally, based on an hourly rate of \$82.50 for an attorney, we estimate that reviewing the plan document would cost \$1,296,322.50 ((15,713 facilities × 1 hour per facility) × \$82.50 per hour). The salary estimates include 33 percent of the mean hourly rate for overhead and fringe benefits (Source: BLS.gov).

If you comment on these information collection and recordkeeping requirements, please submit your comments electronically as specified in the **ADDRESSES** section of this interim final rule.

VII. Regulatory Impact Analysis

A. Statement of Need

Executive Order 13563 directs agencies to consider and discuss qualitatively values that are difficult to quantify, including equity, human dignity, fairness and distributive impacts. This IFC will implement the Affordable Care Act under section 1128I(h) that mandates specific procedures in the event of a closure of a nursing home. LTC facility closure procedures have implications related to access to care, the quality of care, and

the overall health of residents. These procedures help protect the resident, the resident's family, and visitors because it requires the facility to provide an organized plan that allows the resident, family, and visitors to make the necessary adjustments within a reasonable time frame.

B. Overall Impact

1. Executive Order 12866

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rule does not qualify as a major rule as the estimated economic impact. We estimate that these requirements will cost \$355 (5,584,400/15,713) per facility the first year and each year thereafter.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than \$7.0 million to \$34.5 million in any 1 year). For purposes of the RFA, most physician practices, hospitals and other providers are small entities, either by nonprofit status or by qualifying as small businesses under the Small Business Administration's size standards (revenues of less than \$7.0 to \$34.5

million in any 1 year). States and individuals are not included in the definition of a small entity. For details, see the Small Business Administration's Web site at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2465b064ba6965cc1fbd2eae60854b11&rgn=div8&view=text&node=13:1.0.1.1.16.1.266.9&idno=13>. A rule has a significant economic impact on the small entities it affects, if it significantly affects their total costs or revenues. Under statute we are required to assess the compliance burden the regulation will impose on small entities. Generally, we analyze the burden in terms of the impact it will have on entities' costs if these are identifiable or revenues. As a matter of sound analytic methodology, to the extent that data are available, we attempt to stratify entities by major operating characteristics such as size and geographic location. If the average annual impact on small entities is 3 to 5 percent or more, it is to be considered significant.

We estimate that these requirements will cost \$355 (\$5,584,400/15,713 facilities) per facility initially and \$355 (\$5,584,400/15,713 facilities) thereafter. This clearly is much below 1 percent; therefore, we do not anticipate it to have a significant impact. We do not have any data related to the number of LTC facilities that have facility closure plans in place; however, we are aware through our experience with LTC facilities and the survey process that most facilities have a plan for closure either because they are required to have such a plan in place at the State level or because of their understanding that this is a standard business practice.

3. Social Security Act

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For the purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This rule would impact only SNFs and NFs. Therefore, the Secretary has determined that this interim final rule would not have any impact on the operations of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates

require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2010, that threshold is approximately \$135 million. This rule would not have a significant impact on the governments mentioned or on private sector costs. The estimated economic effect of this rule is \$5,584,400 the first year and \$5,584,400 thereafter. These estimates are derived from our analysis of burden associated with these requirements in section IV, "Collection of Information Requirements."

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This rule would not have any effect on State or local governments.

C. Anticipated Effects

1. Effects on LTC Facilities

The purpose of this rule is to ensure that, among other things, in the case of a facility closure, any individual who is the administrator of the facility provide written notification of the closure and the plan for the relocation of residents at least 60 days prior to the impending closure or, if the Secretary terminates the facility's participation in Medicare or Medicaid, not later than the date the Secretary determines appropriate. This would protect residents' health and safety and make the transition to closure as smooth as possible for residents, as well as family members and facility staff.

2. Effects on Other Providers

This rule is expected to allow for a smoother transition when a facility closes. It requires facilities and facility administrators to prepare in advance for closure so, in the event of a closure, the facility is equipped to protect resident rights and continue to provide quality care to residents who must be relocated. This interim final rule would also improve coordination of care between the LTC facility where the residents are transferred from and the LTC facility they are transferred to. We anticipate that only LTC facilities would be affected.

3. Effects on the Medicare and Medicaid Programs

This rule would require that CMS and the State be notified in the case of a facility closure and provides them with the ability to make determinations regarding the timing of termination of

provider agreements and continuation of payments to LTC facilities. This rule would also support efforts directed toward broad-based improvements in the quality of health care furnished by Medicare and Medicaid providers.

D. Alternatives Considered

We considered the effects of not addressing specific requirements for the notification of facility closures in LTC facilities, although these requirements are statutory and only allow limited discretion on the part of the Secretary. However, we do believe that to improve quality and ensure consistency in the provision of care in LTC facilities, it is important to ensure that residents rights are protected in LTC facilities and that they are relocated appropriately, taking into consideration the needs, choice and best interest of each resident should a facility closure take place. We expect that these requirements would result in improvement in the quality of services provided to LTC residents when they need to be involuntarily relocated.

E. Conclusion

This interim final rule ensures that, among other things, in the case of a facility closure, any individual who is the administrator of the facility provide written notification of the closure and the plan for the relocation of residents at least 60 days prior to the impending closure or, if the Secretary terminates the facility's participation in Medicare or Medicaid, not later than the date the Secretary determines appropriate.

It is consistent with the requirements set forth in section 6113 of the Affordable Care Act and the Administration's efforts toward broad-based improvements in the quality of health care furnished by Medicare and Medicaid providers.

This interim final rule clarifies the responsibility of the administrator of a facility, which is to ensure that the specified parties are notified of an impending closure in a specified timeframe and identifies penalties for non-compliance. It also clarifies the responsibility of the administrator of the facility to ensure that no new residents are admitted after written notice is submitted and that the notice of closure must include a plan for transfer and adequate relocation to another facility. These facilities must take into consideration the needs, choices and best interests of each resident.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects**42 CFR Part 483**

Grant programs—Health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

42 CFR Part 488

Administrative practice and procedure, Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR Chapter IV as set forth below:

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

- 1. The authority citation for part 483 is revised to read as follows:

Authority: Secs. 1102, 1128I and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Requirements for Long Term Care Facilities

- 2. Section 483.12 is amended by—
- A. Revising paragraph (a)(5)(i);
- B. Redesignating paragraph (a)(8) as paragraph (a)(9).
- C. Adding a new paragraph (a)(8).

The revisions and additions read as follows:

§ 483.12 Admission, transfer and discharge rights.

(a) * * *

(5) *Timing of the notice.* (i) Except as specified in paragraphs (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

* * * * *

(8) *Notice in advance of facility closure.* In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of the

residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.75(r).

* * * * *

- 3. Section 483.75 is amended by adding a new paragraph (r) and paragraph (s) to read as follows:

§ 483.75 Administration.

* * * * *

(r) *Facility closure-Administrator.*

Any individual who is the administrator of the facility must:

(1) Submit to the Secretary, the State LTC ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure:

(i) At least 60 days prior to the date of closure; or

(ii) In the case of a facility where the Secretary or a State terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the Secretary determines appropriate;

(2) Ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

(3) Include in the notice the plan for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the State prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

(s) *Facility closure.* The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (r) of this section.

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

- 4. The authority citation for part 488 is revised to read as follows:

Authority: Secs. 1102, 1128I and 1871 of the Social Security Act, unless otherwise noted (42 U.S.C. 1302 and 1395hh); Pub. L. 110-149, 121 Stat. 1820.

Subpart F—Enforcement of Compliance for Long-Term Care Facilities With Deficiencies

- 5. Section 488.426 is amended by—
- A. Revising paragraph (b).
- B. Adding a new paragraph (c).

The revisions and additions read as follows:

§ 488.426 Transfer of residents, or closure of the facility and transfer of residents.

* * * * *

(b) *Required transfer when a facility's provider agreement is terminated.* When the State or CMS terminates a facility's provider agreement, the State will arrange for the safe and orderly transfer of all Medicare and Medicaid residents to another facility, in accordance with § 483.75(r) of this chapter.

(c) *Required notifications when a facility's provider agreement is terminated.* When the State or CMS terminates a facility's provider agreement, CMS determines the appropriate date for notification, in accordance with § 483.75(r)(1)(ii) of this chapter.

- 6. Add a new § 488.446 to read as follows:

§ 488.446 Administrator sanctions: long-term care facility closures.

Any individual who is or was the administrator of a facility and fails or failed to comply with the requirements at § 483.75(r) of this chapter—

(a) Will be subject to a civil monetary penalty as follows:

(1) A minimum of \$500 for the first offense.

(2) A minimum of \$1,500 for the second offense.

(3) A minimum of \$3,000 for the third and subsequent offenses.

(b) May be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f) of the Act); and

(c) Will be subject to any other penalties that may be prescribed by law.

- 7. Section 488.450 is amended by revising paragraph (c) to read as follows:

§ 488.450 Continuation of payments to a facility with deficiencies.

* * * * *

(c) *Period of continued payments—*

(1) *Non-compliance.* If the conditions in paragraph (a)(1) of this section are met, CMS may continue payments to a Medicare facility or the State for a Medicaid facility with noncompliance that does not constitute immediate jeopardy for up to 6 months from the last day of the survey.

(2) *Facility closure.* In the case of a facility closure, the Secretary may, as the Secretary determines appropriate, continue to make payments with respect to residents of a long-term care facility that has submitted a notification of closure during the period beginning on the date such notification is submitted to CMS and ending on the date on which the resident is successfully relocated.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

■ 8. The authority for part 489 is revised to read as follows:

Authority: Secs. 1102, 1128I and 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1351i-3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

Subpart E—Termination of Agreement and Reinstatement After Termination

■ 9. Section 489.52 is amended by revising paragraph (a) to read as follows:

§ 489.52 Termination by the provider.

(a) *Notice to CMS.* (1) A provider that wishes to terminate its agreement, except for a SNF as specified in paragraph (a)(2) of this section, must send CMS written notice of its intention in accordance with paragraph (a)(3) of this section.

(2) A SNF that wishes to terminate its agreement due to closure of the facility must send CMS written notice of its intention at least 60 days prior to the date of closure, as required at § 483.75(r) of this chapter.

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

* * * * *

■ 10. Section § 489.53 is amended by—

- A. Revising paragraph (d)(1).
- B. Redesignating paragraph (d)(3) and paragraph (d)(4) as paragraph (d)(4) and paragraph (d)(5).
- C. Adding a new paragraph (d)(3).

The revisions and additions read as follows:

§ 489.53 Termination by CMS.

* * * * *

(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.

* * * * *

(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.

* * * * *

■ 11. Section § 489.55 is revised to read as follows:

§ 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 posthospital 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 § 483.75(r) 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.

PART 498—APPEAL PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/MR AND CERTAIN NFs IN THE MEDICAID PROGRAM

■ 12. The authority citation for part 498 is revised to read as follows:

Authority: Secs. 1102, 1128I and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provisions

- 13. Section 498.3 is amended by—
- A. Adding a new paragraph (a)(2)(iv).
- B. Revising paragraph (a)(3) introductory text and (a)(3)(ii).
- C. Adding a new paragraph (b)(18).

The revisions and additions read as follows:

§ 498.3 Scope and applicability.

(a) * * *

(2) * * *

(iv) CMS's determination to impose sanctions on the individual who is the administrator of a NF for failure to comply with the requirements at § 483.75(r) of this chapter.

(3) The following parts of this chapter specify the applicability of the provisions of this part 498 to sanctions or remedies imposed on the indicated entities or individuals:

* * * * *

(ii) Part 488, subpart E (§ 488.330(e)) and subpart F (§ 488.446)—for SNFs and NFs and their administrators.

* * * * *

(b) * * *

(18) The level of noncompliance found by CMS with respect to the failure of an individual who is the administrator of a SNF to comply with the requirements at § 483.75(r) of this chapter, and the appropriate sanction to be imposed under § 488.446 of this chapter.

* * * * *

■ 14. Section 498.5 is amended by adding a new paragraph (m) to read as follows:

§ 498.5 Appeal rights.

* * * * *

(m) *Appeal rights of an individual who is the administrator of a SNF.* An individual who is the administrator of a SNF who is dissatisfied with the decision of CMS to impose sanctions authorized under § 488.446 of this chapter is entitled to a hearing before an ALJ, to request Board review of the hearing decision, and to seek judicial review of the Board's decision.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 18, 2010.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: February 15, 2011.

Kathleen Sebelius,

Secretary.

[FR Doc. 2011-3806 Filed 2-17-11; 8:45 am]

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