§ 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.

[76 FR 9512, Feb. 18, 2011

§ 489.57 Reinstatement after termination.

When a provider agreement has been terminated by CMS under § 489.53, or by the OIG under § 489.54, a new agreement with that provider will not be accepted unless CMS or the OIG, as appropriate, finds—

(a) That the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and

(b) That the provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

[51 FR 24493, July 3, 1986]

Subpart F—Surety Bond Requirements for HHAs

SOURCE: 63 FR 313, Jan. 5, 1998, unless otherwise noted.

§ 489.60 Definitions.

As used in this subpart unless the context indicates otherwise—

Assessment means a sum certain that CMS may assess against an HHA in lieu of damages under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Assets includes but is not limited to any listing that identifies Medicare beneficiaries to whom home health services were furnished by a participating or formerly participating HHA.

Civil money penalty means a sum certain that CMS has the authority to impose on an HHA as a penalty under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Participating home health agency means a ''home health agency'' (HHA), as that term is defined by section 1861(o) of the Social Security Act, that also meets the definition of a ''provider'' set forth at § 400.202 of this chapter.

Rider means a notice issued by a Surety that a change in the bond has occurred or will occur.

Surety bond means one or more bonds issued by one or more surety companies under 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225, provided the bond otherwise meets the requirements of this section.

Unpaid civil money penalty or assessment means a civil money penalty or assessment imposed by CMS on an HHA under Titles XI, XVIII, or XXI of the Social Security Act, plus accrued interest, that, after the HHA or Surety has exhausted all administrative appeals, remains unpaid (because the civil money penalty or assessment has not been paid to, or offset or compromised by, CMS) and is not the subject of a written arrangement, acceptable to CMS, for payment by the HHA. In the event a written arrangement for payment, acceptable to CMS, is made, an *unpaid civil money penalty or assessment* also means such civil money penalty or assessment, plus accrued interest, that remains due 60 days after the HHA's default on such arrangement.

Unpaid claim means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that, 90 days after the date of the agency's notice to the HHA of the overpayment, remains due (because the overpayment has not been paid to, or recouped or

compromised by, CMS) and is not the subject of a written arrangement, acceptable to CMS, for payment by the HHA. In the event a written arrangement for payment, acceptable to CMS, is made, an *unpaid claim* also means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that remains due 60 days after the HHA's default on such arrangement.

[63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998]

§ 489.61 Basic requirement for surety bonds.

Except as provided in § 489.62, each HHA that is a Medicare participating HHA, or that seeks to become a Medicare participating HHA, must obtain a surety bond (and furnish to CMS a copy of such surety bond) that meets the requirements of this subpart F and CMS's instructions.

§ 489.62 Requirement waived for Government-operated HHAs.

An HHA operated by a Federal, State, local, or tribal government agency is deemed to have provided CMS with a comparable surety bond under State law, and CMS therefore waives the requirements of this subpart with respect to such an HHA if, during the preceding 5 years the HHA has—

(a) Not had any unpaid claims or unpaid civil money penalties or assessments; and

(b) Not had any of its claims referred by CMS to the Department of Justice or the General Accounting Office in accordance with part 401 of this chapter.

[63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998]

§ 489.63 Parties to the bond.

The surety bond must name the HHA as Principal, CMS as Obligee, and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as Surety.

§ 489.64 Authorized Surety and exclusion of surety companies.

(a) An HHA may obtain a surety bond required under § 489.61 only from an authorized Surety.

(b) An authorized Surety is a surety company that—

(1) Has been issued a Certificate of Authority by the U.S. Department of the Treasury in accordance with 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225 as an acceptable surety on Federal bonds and the Certificate has neither expired nor been revoked; and

(2) Has not been determined by CMS to be an unauthorized Surety for the purpose of an HHA obtaining a surety bond under this section.

(c) CMS determines that a surety company is an unauthorized Surety under this section—

(1) If, upon request by CMS, the surety company fails to furnish timely confirmation of the issuance of, and the validity and accuracy of information appearing on, a surety bond an HHA presents to CMS that shows the surety company as Surety on the bond;

(2) If, upon presentation by CMS to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond, the surety company fails to timely pay CMS in full the amount requested, up to the face amount of the bond; or

(3) For other good cause.

(d) Any determination CMS makes under paragraph (c) of this section is effective immediately when notice of the determination is published in the FEDERAL REGISTER and remains in effect until a notice of reinstatement is published in the FEDERAL REGISTER.

(e) Any determination CMS makes under paragraph (c) of this section does not affect the Surety's liability under any surety bond issued by a surety company to an HHA before notice of such determination is published in accordance with paragraph (d) of this section.

(f) A determination by CMS that a surety company is an unauthorized Surety under this section is not a debarment, suspension, or exclusion for the purposes of Executive Order No. 12549 (3 CFR, 1986 comp., p. 189).

§ 489.65 Amount of the bond.

(a) *Basic rule.* The amount of the surety bond must be $50,000 or 15 percent of the Medicare payments made by