provider's change of ownership. Accordingly, we are proposing to revise the regulation text at § 413.134(f)(1) to clarify our longstanding policy that Medicare does not recognize a provider's gain or loss on the sale or scrapping of an asset that occurs on or after December 1, 1997, regardless of whether the asset is sold incident to a provider's change of ownership or is otherwise sold or scrapped as an asset of a Medicare participating provider.

XI. Proposed Changes Relating to Survey and Certification Requirements

A. Proposed Revisions to the Application and Re-Application Procedures for National Accrediting Organizations (AOs), Provider and Supplier Conditions, and Posting of Survey Reports and Acceptable Plans of Corrections (PoCs)

1. Background

Health care facilities must demonstrate compliance with the Medicare conditions of participation (CoPs), conditions for coverage (CfCs), or conditions for certification (depending on the type of facility) to be eligible to receive Medicare payments. Section 1865 of the Act allows health care facilities that are "provider entities" to demonstrate this compliance through accreditation by an accreditation program of a private, national accrediting organization (AO) that is approved by the Secretary. An AO must demonstrate the ability to effectively evaluate a facility's compliance using accreditation standards that meet or exceed the applicable Medicare conditions, as well as survey processes that are comparable to those survey methods, procedures, and forms required by CMS for conducting Federal surveys for the same health care facility type, which are generally outlined in regulations and specified in the State Operations Manual (SOM).

Section 1865(a)(2) of the Act requires that the Secretary base its decision to approve or deny the Medicare accreditation program application of an accrediting organization after considering at least the following factors: (a) program requirements for the accreditation program to meet or exceed Medicare requirements; (b) survey procedures that are comparable to those of Medicare; (c) the ability to provide adequate resources for conducting surveys; (d) the capacity to furnish information for use by CMS in enforcement activities; (e) monitoring procedures for providers or suppliers identified as being out of compliance with conditions or requirements; and (f) the ability to provide the necessary data for validation surveys to the Secretary. In addition, section 1865(a)(2) of the Act specifies that the Secretary shall consider other factors with respect to determining the AOs ability to meet or exceed applicable conditions, therefore meaning that CMS has the ability to determine "other factors" when considering an AO for deemed status.

CMS has responsibility for oversight and approval of AO accreditation programs used for Medicare certification purposes, and for ensuring that providers and suppliers that are accredited under an approved AO accreditation program meet the quality and patient safety standards required by the Medicare conditions and requirements. The Medicare regulations at 42 CFR 488.5 set forth the detailed requirements that a national AO must satisfy in order to receive approval, and maintain recognition, of a Medicare accreditation program. Section 488.5 also details the procedures that CMS follows in reviewing applications from AOs.

The results of surveys conducted by State Survey Agencies of a facility's compliance with Medicare conditions and requirements of CMS-certified facilities are reported using the CMS Form 2567, "Statement of Deficiencies and Plan of Correction" (OMB No. 0938-0391). These reports describe any findings of noncompliance with Federal requirements (also referred to as "deficiencies") that the surveyors may have found. If there are cited deficiencies, a facility must submit an acceptable plan of correction (PoC) for achieving compliance to CMS describing how and when, within a reasonable timeframe, it will correct them. Failure to correct deficiencies will lead to the facility's termination from Medicare participation.

CMS makes survey reports and acceptable PoCs publicly available through a variety of settings as part of the Department's commitment to transparency, and to providing all health care consumers and the general public with access to quality and safety information. CMS began posting redacted CMS Form 2567 survey data for skilled nursing facilities and nursing facilities on its *Nursing Home Compare* website in July 2012. In March 2013, CMS began posting on its website the CMS Form-2567 surveys reports based on complaint investigations for short-term acute care hospitals and critical access hospitals (CAHs).[504] In addition, two websites owned by private entities also publish the public CMS survey data of nursing homes, short-term acute care hospitals, and CAHs, based on the CMS survey information. The *ProPublica* website[505] and the Association for Health Care Journalist (AHCJ) websites, respectively, provide search

[504] Survey & Certification Policy Memorandum (SC-13-21-ALL). Available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-21.pdf.
[505] ProPublica (2016) Website: http://projects.propublica.org/nursing-homes/.

engines that refer back to the CMS Form 2567 data that CMS has made available. These websites enable all health care consumers and the general public across the country to learn about the performance of these providers in order to make more informed decisions about where to get health care. We also believe that release of this information encourages these health care providers to improve the quality of care and services they provide. Such information can also be obtained by the public directly from State Survey Agencies.

AOs perform their own accreditation surveys and issue their own survey reports which provide information on accredited facilities' compliance with Federal standards. These facilities include: hospitals, psychiatric hospitals, CAHs, home health agencies (HHAs), hospices, ambulatory surgery centers (ASCs), outpatient physical therapy and speech-language pathology services (OPTs), and rural health clinics (RHCs).[506] These facilities participate in Medicare based on their accreditation from a CMS-approved AO and are not subject to routine surveys from State survey agencies.

By contrast, AOs currently do not make their survey reports and accompanying PoCs publicly available. We believe it is important to continue to lead the effort to make information regarding a health care facility's compliance with health and safety requirements found in survey reports publicly available through our various provider and supplier *Compare* sites, including hospital and home health *Compare* sites to increase transparency. CMS recognizes, based on the above references to CMS *Compare* sites and other resources which make survey reports publically available, that these survey

[506] Note that other types of facilities may also participate in Medicare via an approved accreditation program, but to date, no AO has sought and received approval for any of these additional facility types.

reports vary in the type of information accessible to the public (complaint) based on the provider or supplier type. For example, the current CMS Survey and Certification site for hospital 2567 downloads (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals.html) only contains complaint surveys; no recertification survey reports are posted. In addition, there has been an increasing concern in terms of AO disparity rates based on the AO deficiency findings compared to serious, condition-level deficiencies found by the State Survey Agencies. For example, in FY 2015, the disparity rates increased by 1 percent to 39 percent for hospitals and decreased by 6 percent to 69 percent for psychiatric hospitals, from FY 2014. This continued trend of high disparity rates from FY 2012 to FY 2015 raises serious concerns regarding the AOs' ability to appropriately identify and cite health and safety deficiencies during the survey process. Therefore, we believe that posting AO survey reports and acceptable PoCs would address some of the concerns of reporting hospital information from both CMS and AOs, as well as the disparity between serious deficiency findings, and provide a more comprehensive picture to health care consumers and the public in general.

As the number of health care facilities participating in Medicare by virtue of their accreditation and deemed status increases, the number of survey reports and acceptable PoC available to health care consumers decreases. The table below illustrates that 40 percent of Medicare-participating providers or suppliers with an accreditation option participate in Medicare via accreditation and deemed status. In addition, 89 percent of hospitals and psychiatric hospitals across the country participate in Medicare via

accreditation and deemed status. This represents a significant number of hospital and other health care facility survey reports and acceptable PoCs that are currently not available to health care consumers. This information is not available to assist health care consumers in their decision making when selecting a health care facility in which to receive care for themselves or a loved one. Therefore, we believe that it is critical that accrediting organizations with CMS-approved accreditation programs make available publicly all survey reports and acceptable plans of correction on their websites.

Total Medicare Participating Facilities – FY 2015
Deemed Versus Non-Deemed

Program Type	Deemed* (percentage)	Non-Deemed** (percentage)	Total
Hospital	3,500 (89)	432 (11)	3,932
Psychiatric Hospital	424 (89)	53 (11)	477
CAH	420 (32)	887 (68)	1,307
HHA	4,450 (47)	5,008 (53)	9,458
Hospice	1,694 (40)	2,573 (60)	4,267
ASC	1,499 (27)	3,973 (73)	5,472
OPT	175 (8)	1,957 (92)	2,132
RHC	253 (6)	3,862 (94)	4,115
Total	**12,415 (40)**	**18,745 (60)**	**31,160**

* As reported by accrediting organizations.
** Surveyed by a State survey agency for compliance with Medicare conditions.

2. Proposed Regulation Changes

In an effort to increase transparency, in this proposed rule, we are proposing to require AOs with CMS-approved accreditation programs to post final accreditation survey reports and acceptable PoCs on public facing website designated by the AO. All current AOs with CMS-approved accreditation programs have websites that inform the general public about their organization. Therefore, we are proposing to require AOs to have their final accreditation survey reports and acceptable PoCs available on their websites.

Establishing the standard for posting both accredited and nonaccredited provider and supplier survey reports, which would include initial and recertification surveys, and acceptable PoCs would expand transparency even further. Disclosure of survey findings protects both patient health and safety, in which public disclosure of findings currently only shows the subset of complaint activity. Expanding these requirements through the posting of all survey reports and acceptable PoCs would allow for a more comprehensive way to show a provider's or supplier's compliance with all health and safety requirements.

Therefore, we are proposing to revise § 488.5 of the regulations to incorporate this proposed requirement. We are proposing to add a new standard at § 488.5(a)(21) to require that each national AO applying or reapplying for CMS-approval of its Medicare provider or supplier accreditation program provide a statement acknowledging that it agrees to make all Medicare provider or supplier final accreditation survey reports (including statements of deficiency findings) as well as acceptable PoCs publicly

available on its website within 90 days after such information is made available to those facilities for the most recent 3 years. This provision would include all triennial, full, follow-up, focused, and complaint surveys, whether they are performed onsite or offsite.

In addition, pursuant to section 1834(e) of the Act, State Survey Agencies do not evaluate suppliers of the technical component of advanced diagnostic imaging services. CMS-approved advanced diagnostic imaging AOs are the only source of compliance data for suppliers of the technical component of advanced diagnostic imaging services. Therefore, we believe it is critical that these AOs also be required to post survey reports and acceptable PoCs on their websites. Otherwise, it will not be possible to provide health care consumers with compliance information about Medicare-participating suppliers of advanced diagnostic imaging services. We are proposing to amend our regulations at 42 CFR 414.68 governing imaging accreditation under Medicare by redesignating paragraphs (c)(7) through (c)(14) as paragraphs (c)(8) through (c)(15), respectively, and adding a new paragraph (c)(7) to require that each national advanced diagnostic imaging AO that applies or reapplies for CMS approval of its Medicare advanced diagnostic imaging accreditation program must provide a statement acknowledging that it agrees to make all Medicare advanced diagnostic imaging final accreditation survey reports as well as acceptable PoCs publicly available on its website within 90 days after such information is made available to the supplier of advanced diagnostic imaging services for the most recent 3 years. This provision would apply to all full, follow-up, focused, and complaint surveys, regardless of whether they are performed onsite or offsite.

We are inviting public comments on these proposals.

B. Proposed Changes to Termination Public Notice Requirements for Certain Providers and Suppliers

1. Background

Under the provisions of sections 1866(b)(2) of the Act and implementing regulations at 42 CFR 489.53, the Secretary may terminate an agreement with a provider of services if it is determined that the provider is not in substantial compliance with applicable requirements governing provider agreements. For instance, CMS must determine that the provider:

- Is not complying substantially with the terms of the agreement, the provisions of title XVIII, or regulations promulgated thereunder;
- Has failed to supply information necessary to determine whether payments are or were due and the amounts of such payments;
- Refuses to permit examination of fiscal and other records (including medical records) necessary for the verification of information furnished as a basis for claiming payment under the Medicare program; or
- Refuses to permit photocopying of any records or other information necessary to determine or verify compliance with participation requirements.

Sections 1866(b)(1) and (2) of the Act require reasonable public notice, as prescribed in regulations, of both voluntary and involuntary terminations of Medicare and Medicaid participating providers and suppliers. Various existing regulations specify the requirements of public notice for voluntary and involuntary terminations prior to

termination of a provider or supplier agreement. Specifically, for voluntary terminations, providers at 42 CFR 489.52(c)(2), RHCs at 42 CFR 405.2404(d), FQHCs at 42 CFR 405.2442, ASCs at 42 CFR 416.35(d), and OPOs at 42 CFR 486.312(e) are required to publish termination notices in the local public newspaper.

2. Basis for Proposed Changes

The existing regulations requiring termination notices to be published in local newspapers have become outdated over time as the public and beneficiaries increasingly turn to the Internet and other electronic forums for information. Currently, rural health centers (RHCs), Federally qualified health centers (FQHCs), ambulatory surgical centers (ASCs), and organ procurement organizations (OPOs) are required to publish public notices of voluntary and involuntary termination of participation in the Medicare and Medicaid programs in one or more local newspapers. Providers and suppliers that voluntarily terminate their participation agreement must give notice to the public at least 15 days before the effective date of termination and the notice must be published in one or more local newspapers. The use of hard copy local newspaper through time has become less effective, as a large majority of the public uses alternate sources such as websites or other online news and resources.

According to national studies, approximately 23 percent of the general public continues to read print newspapers.[507] Many individuals have turned to digital platforms to read news rather than print news, which continues to decline on an annual basis, therefore, limiting the effectiveness of publishing termination notices in local

[507] PewResearchCenter (2012) *Number of Americans Who Read Print Newspapers Continues Decline*. Available at: http://www.pewresearch.org/daily-number/number-of-americans-who-read-print-newspapers-continues-decline/

newspapers. In light of the public's increased access to the Internet and other electronic forums for information and the decline of print newspaper readership, in this proposed rule, we are proposing changes in the existing regulations noted earlier regarding newspaper publication of termination notices to allow CMS Regional Offices and providers and suppliers more media platforms in which to publish termination notices, both voluntary and involuntary, with the intent of making these notices more visible and effective.

3. Proposed Changes to Regulations

In this proposed rule, we are proposing to remove the regulatory language specifying public notice of terminations for FQHCs, RHCs, ASCs, and OPOs to be exclusively in newspapers to allow for more flexibility for both the CMS Regional Offices and providers and suppliers. Specifically, we are proposing changes to the regulations for RHCs at 42 CFR 405.2404(d), for FQHCs at 42 CFR 405.2442(a) and (b), for ASCs at 42 CFR 416.35(d), and for OPOs at 42 CFR 486.312(e) to remove the reference to publication in newspapers as the means for notifying the community of involuntary and voluntary terminations from participation in Medicare and Medicaid programs. This proposal for termination notices to the public for RHCs, FHQCs, ASCs, and OPOs would align with the termination notices CMS currently has set forth for all other providers and suppliers. For example, under 42 CFR 488.456(c) (enforcement procedures for long-term care facilities), CMS must notify the public of a termination of a nursing home's provider agreement, but the regulation does not specify through which public forum this notice is to be given. Similarly, 42 CFR 489.53(d)(5) also does not

specify the method of public notification required for terminations. Through this proposed change, RHCs, FQHCs, ASCs, and OPOs would have the same requirement for the notice to the public as under 42 CFR 489.53(d)(5), where there is a termination by CMS in which public notice is required but the method for these providers or suppliers for providing public notice is not specified, to allow for flexibility.

In addition, we are proposing to revise 42 CFR 489.52(c)(2) to remove the requirement to publish notice in one or more local newspapers in circumstances of the termination of a provider agreement by a provider and instead to allow providers to inform the community via public notice, without specifying the method used for public notice. We believe that these proposed changes will ensure that the community continues to be aware of terminations of Medicare and Medicaid participating providers and suppliers.

The method for delivering the required public notice is no longer being specified by removing the word "newspaper" from the regulations for RHCs, FQHCs, ASCs, and OPOs. Instead, we are proposing to allow for flexibility for the CMS Regional Offices and the providers or suppliers to post public notices through a manner in which the maximum number of community individuals and beneficiaries would be informed. This may include, but is not limited to State website postings, facility websites, or local news and social media channels. It also would not preclude publication in local newspapers. Through this proposed rule, we will continue to fulfill the regulatory requirement to publically post involuntary termination notices. We are also operationally considering allowing voluntarily terminating providers and suppliers the same public notice platform

used for involuntary notices in order to meet their regulatory public notice requirements. This could include media venues such as website postings and press releases through the use of CMS Regional press officers.

We are inviting public comments on our proposals. In addition, we are seeking suggestions from the public on sufficient mechanisms to provide public information, other than local newspapers, for posting Medicare and Medicaid participating provider and supplier termination notices.

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