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PART II:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service

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MEDICAL ASSISTANCE PROGRAMS

Home Health Services

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[45 CFR Part 249]

MEDICAL ASSISTANCE PROGRAM

Home Health Services

Notice is hereby given that the regulations set forth in tentative form below are proposed by the Administrator, Social and Rehabilitation Service, with the approval of the Secretary of Health, Education, and Welfare. The purpose of the proposed regulations is to remove certain restrictions and ambiguities in current regulations which have prevented full realization of the benefits of home health services in State Medicaid programs (title XIX, Social Security Act).

In light of the statutory requirement under title XIX to provide home health services to all individuals entitled to skilled nursing facility services under a State's Medicaid plan, the Department's efforts to develop alternatives to institutional care, and Congressional interest in expanding the use of home health care, the following revisions are proposed in order to increase the availability of such services and encourage their use in appropriate cases:

1. Currently, participation under Medicaid as a home health service provider is restricted to those agencies which meet the statutory Medicare requirements, i.e., they must provide skilled nursing services and one other service. This has meant that agencies such as small visiting nurse associations are unable to participate because they cannot offer the second service (there are approximately 500–700 VNAs which have been prevented from participating because of this requirement). It has also served to deter creation of new agencies. Since there is no similar statutory requirement in Medicaid, the problem can be alleviated by expanding the types of agencies qualified to provide services. Under the proposal, the limitation would be removed and agencies offering nursing or home health aide services may qualify if they meet the prescribed standards. The standards are basically those used under Medicare, appropriately adapted to reflect inclusion of additional provider types.

A major additional change with respect to provider participation is removal of the current limitation which restricts proprietary agencies from qualifying as home health providers unless the State licenses such agencies. This is a statutory provision for Medicare. In the proposed regulation, such agencies may participate in Medicaid if they are certified to meet the prescribed standards and execute a provider agreement with the State Medicaid agency. The Department believes that this change will further the goal of expansion of services and that proper enforcement of standards and monitoring of performance will provide adequate safeguards against abuse. (§ 249.150)

2. The existing regulation is ambiguous as to the minimum set of home health services which States must provide under their State plans. It has been interpreted that the States are required to provide only one of the specified services (nursing, home health aide, supplies and equipment), when it fact it was intended that all of these were required to be available. The proposal now clarifies that States must make available, as determined necessary by the recipient's physician and included in the plan of care, nursing services, home health aide services, and medical supplies, equipment and appliances suitable for use in the home. At State option, physical, occupational or speech therapy may be provided to home health patients whether or not they are generally provided to all recipients under the State plan. (§ 249.10(b)(7))

3. Limitations on use of the services have also resulted from the practice of some States of adopting Medicare requirements specifying that the patient must be in need of skilled nursing or other professional services. Thus, a person who does not require "skilled" services but for example, only home health aide services, would not be eligible for home health services. Some States have also limited eligibility by applying inappropriate requirements of post-hospitalization. The proposed revision clarifies recipient eligibility by incorporating an explanation of entitlement previously issued as policy interpretation. (§ 249.10(a)(4))

4. In addition to specifying the standards which agencies must meet in order to qualify under the expanded regulation, the procedures for certification by the State agency and provisions relating to provider agreements with the State title XIX agency are also set forth. (§ 249.151)

In summary, then, the proposed revisions:

permit certain types of qualified health service agencies, in addition to those which meet Medicare standards, to provide home health services under State Medicaid programs;

prescribe the standards which those agencies must meet, which parallel those for Medicare but are appropriately adjusted for differing needs under Medicaid;

permit proprietary agencies to participate if they meet the standards, whether or not the State has a licensing law;

clarify that States must make available under the State plan the three main types of services needed in home care: nursing, home health aide, and supplies and equipment, and also permit them to provide various therapies as home health services;

clarify the Medicaid recipients to whom home health services must be available, specify the requirements for a physician's determination of medical needs recorded in a plan of care and periodically reviewed, and clarify that Medicare requirements relating to need for "skilled" care or to post-hospitalization do not apply under Medicaid.

Prior to the adoption of the proposed regulations, consideration will be given to written comments, suggestions, or objections thereto addressed to the Administrator, Social and Rehabilitation Service, Department of Health, Education, and Welfare, P.O. Box 2366, Washington, D.C. 20013, and received on or before September 22, 1975. Comments are particularly solicited on the potential for cost increases that might result from adoption of the proposed regulations.

Such comments will be available for public inspection in Room 5223 of the Department's offices at 330 C Street, SW., Washington, D.C., beginning approximately two weeks after publication of this Notice in the FEDERAL REGISTER, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (area code 202–245–0950).

AUTHORITY: Section 1102, 49 Stat. 647 (42 U.S.C. 1302). (Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

It is hereby certified that the economic and inflationary impacts of this proposed regulation have been carefully evaluated in accordance with OMB Circular A–107.

Dated: August 4, 1975.

JOHN A. SVAHN,
Acting Administrator, Social and Rehabilitation Service.

Approved: August 8, 1975.

CASPAR W. WEINBERGER,
Secretary.

Chapter II, Title 45, Code of Federal Regulations, is amended as follows:

1. Section 249.10 is amended by revising paragraphs (a)(4) and (b)(7) to read as set forth below:

§ 249.10 Amount, duration, and scope of medical assistance.

(a) * * *

* * * * *

(4) Provide for the inclusion of home health services which, as a minimum, shall include nursing services, home health aide services, and medical supplies, equipment and appliances as specified in paragraph (b)(7) of this section. Under this requirement, home health services must be provided to all categorically needy individuals 21 years of age or over; to all categorically needy individuals under 21 years of age if the State plan provides for skilled nursing facility services for such individuals; and to all corresponding groups of medically needy individuals to whom skilled nursing facility services are available under the plan. Eligibility of any individual to receive home health services available under the plan shall not depend upon his need for, or discharge from, institutional care.

* * * * *

(b) * * *

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(7) *Home health services.* (i) This term means the following services and items provided to a recipient in his place of residence. Such residence does not include a hospital, skilled nursing facility or intermediate care facility, except that

these services and items may be furnished as home health services to a recipient in an intermediate care facility if they are not furnished by the facility as intermediate care services. Any such service or item provided to a recipient of home health services must be ordered by his physician as part of a written plan of care which is reviewed by his physician at least every 90 days. Those services listed in paragraphs (A), (B) and (C) are required to be made available by the State as home health services; those listed in paragraph (D) may be provided as home health services at State option.

(A) Nursing service, as defined in the State Nurse Practice Act, provided by a qualified agency or, in the case where no such agency is available to provide nursing services, by a registered nurse or licensed practical nurse who is currently licensed to practice in the State and who is under the direction of the patient's physician.

(B) Home health aid services provided by a qualified agency.

(C) Medical supplies, equipment and appliances suitable for use in the home.

(D) Physical therapy, occupational therapy or speech therapy provided by a qualified agency or by a facility licensed by the State to provide medical rehabilitation services.

(ii) In order to participate under a State title XIX plan as an agency qualified to provide home health services, such agency must meet the conditions and standards set forth in § 249.150 of this chapter, as determined in accordance with the applicable provisions for the certification and execution of valid provider agreements under § 249.151 of this chapter.

2. A new § 249.150 is added to Part 249, as set forth below:

§ 249.150 Standards for agencies qualified to provide home health services.

(a) *Type of agencies qualified to provide home health services.* The requirement to provide home health services under State plans for medical assistance is specified in § 249.10(a)(4) of this chapter; the services included are defined in § 249.10(b)(7). This section describes the agencies which qualify to provide the nursing, home health aide and therapy services specified in § 249.10(b)(7).

(1) Home health services may be provided under the title XIX State plan by any agency which is certified under title XVIII of the Act to provide such services and which executes a valid provider agreement with the title XIX State agency.

(2) Home health services may also be provided under the title XIX State plan by a public or private agency or subdivision thereof (e.g., the home care unit of a hospital) which is primarily engaged in providing medical or health care services, of which one must be nursing, or home health aide services, and which meets the standards set forth in this section; and which executes a valid provided agreement with the title XIX agency.

(3) Therapy services may be provided as home health services by an agency specified in paragraph (a)(1) or (2) of this section, or by a facility licensed by the State to provide medical rehabilitation services, and which meets the other conditions set forth in this paragraph. Such a rehabilitation facility must be operated under competent medical supervision and is one which provides therapy services for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of (i) medical evaluation and services, and (ii) psychological, social, or vocational evaluation and services. The major portion of the required evaluation and services must be furnished within the facility and the facility must be operated either in connection with a hospital or as a facility in which all medical and related health services are prescribed by, or are under the general direction of, persons licensed to practice medicine or surgery in the State.

(b) *Compliance with Federal, State and local laws.* An agency providing home health services under paragraph (a)(2) of this section must be in compliance with all applicable Federal, State, and local laws and regulations. If State or local law requires licensure of agencies but exempts certain types (e.g., public agencies) from the licensure requirement, the exempted agencies must meet the licensure standards even though a license is not actually issued. This determination must be made by the State survey agency and recorded in writing.

(c) *Organization, services, administration.*—(1) *Delegation of responsibility.* Organization, services provided, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be clearly set forth in writing and readily identifiable. Administrative and supervisory functions shall not be delegated to another agency or organization. Services performed by subunits of the agency shall be monitored and controlled by the agency and appropriate administrative records shall be maintained for each subunit.

(2) *Subcontracting.* Patient care services may be subcontracted except that the agency shall provide at least one patient care service directly. All services not provided directly shall be monitored and controlled by the primary agency (the agency responsible for the service rendered to patients and for implementation of the plan of care). (See also paragraph (c)(7) of this section for provisions relating to personnel under contract.)

(3) *Governing body.* The governing body or designated person so functioning shall, at each local administrative level,

(i) Have full legal authority and responsibility for the operation of the home health program;

(ii) Appoint a qualified administrator;

(iii) Arrange for the establishment and continuing operation of an advisory committee;

(iv) Adopt and periodically review written bylaws or an acceptable equivalent;

(v) Oversee the management and fiscal affairs relating to home health services;

(vi) Supply full and complete information to the survey agency as to the identity:

(A) Of each person who has any direct or indirect ownership interest of 10 percentum or more in the agency or who is the owner (in whole or in part) of any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the agency or by any of the property or assets of the agency;

(B) Of each officer and director of the corporation if the agency is organized as a corporation;

(C) Of each partner if the agency is organized as a partnership; and promptly report any changes to the State survey agency which would affect the current accuracy of the information supplied under this paragraph.

(4) *Administrator or director of home health services.* The administrator or director shall be a licensed physician, a registered nurse, or a person with training and experience in health service administration and at least one year of supervisory or administrative experience in home health care or related health programs. The administrator or director shall be appointed by the governing body or the designated person so functioning and shall:

(i) Organize and direct the agency's ongoing operation with respect to home health services;

(ii) Maintain ongoing liaison among the governing body, the professional advisory committee (see paragraph (d) of this section), and the staff;

(iii) Employ only personnel who meet the qualifications prescribed in 20 CFR 405.1202 (k), (l), (q), and (r) and 405.1101 (m), (n), (q), (r), (s), and (t), in the occupational categories defined in such sections;

(iv) Provide for and evaluate ongoing inservice training for all staff;

(v) Ensure the accuracy of public information materials and activities; and

(vi) Implement an effective budgeting and accounting system.

(5) *Supervising physician or registered nurse.* The home health services provided shall be under the supervision and direction of a physician or a registered nurse. This person, or a supervisory staff member of another discipline, shall be available at all times during operating hours and shall participate in all activities relevant to the professional services provided, including the developing of qualifications and assignments of personnel.

(6) *Personnel policies.* Personnel practices and patient care shall be supported by appropriate, written personnel policies. Personnel records shall include job descriptions, qualifications, licensure, performance evaluations, and health examinations, and shall be kept current.

(7) *Personnel under hourly or per visit contracts.* If personnel under hourly or per visit contracts are utilized by the agency to provide home health services, there shall be a written contract between such personnel and the agency clearly designating:

(i) That patients are accepted for care only by the agency,

(ii) The services to be provided,

(iii) The necessity to conform to all applicable agency policies including personnel qualifications,

(iv) The responsibility for participating in developing individual plans of care.

(v) The manner in which services will be controlled, coordinated, and evaluated by the agency,

(vi) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation, and

(vii) The procedures for determining charges and reimbursement.

(8) *Coordination of patient services.* All personnel providing home health services shall maintain liaison with each other to assure that their efforts effectively complement one another and support the objectives outlined in the plan of care. The clinical record or minutes of case conferences shall establish that effective interchange, reporting, and coordinated patient evaluation does occur. A written summary report for each patient shall be sent to his physician at least every 90 days.

(d) *Advisory committee.* (1) An advisory committee shall be established which shall include at least one physician, one registered nurse (preferably a public health nurse), one representative of a therapy discipline (if the agency offers any therapy as a home health service), and one representative of recipients. The majority of members shall be neither owners nor staff members of the agency.

(2) The committee shall annually evaluate the agency's policies including services offered to home health patients, admission and discharge, medical supervision, plans of care, emergency care, clinical records personnel qualifications, and standards of professional service. Results of the evaluation in the form of recommendations shall be reported for appropriate action to the governing body and to the State survey agency.

(3) The committee shall meet at least quarterly to advise the agency on professional issues, participate in evaluation of the agency's program, and assist the agency in maintaining liaison with other health care providers in the community and in its community information program. Its meetings shall be documented by dated minutes.

(e) *Acceptance of patients, plan of care, medical supervision*—(1) *General.* Patients shall be accepted for treatment on the basis of a reasonable expectation that the patient's health needs can be met adequately by the agency in the patient's place of residence. In all cases, an initial home evaluation visit shall be made by a registered nurse. Care shall follow a written plan established and reviewed at least every 90 days by the patient's physician and shall continue under the physician's supervision.

(2) *Development and content of plan.* The plan of care developed in consultation with appropriate agency staff shall cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care which cannot be completed until after the evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Orders for therapy services shall include the specific procedures and modalities to be used and the amount, frequency, and duration of such therapy services.

(3) *Periodic review of plan.* The total plan of care shall be reviewed by the patient's physician and agency personnel as often as the patient's condition requires, but at least once every 90 days. Agency professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care.

(4) *Conformance with physician's orders.* Drugs and treatments shall be administered by agency staff only as ordered by the physician. The nurse or therapist shall immediately record and sign such recording of oral orders and obtain the physician's countersignature in a manner consistent with good medical practice. Agency staff shall check all medicines a patient may be taking to identify possibly ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication, and promptly report any problems to the physician.

(f) *Registered nurse services.* As appropriate, registered nurses providing home health services shall: (1) Make the initial evaluation visit, (2) regularly reevaluate the patient's health needs, (3) initiate the plan of care and necessary revisions, (4) provide those services requiring substantial specialized nursing skill, (5) initiate appropriate preventive and rehabilitative nursing procedures, (6) prepare clinical and progress notes, (7) coordinate services, (8) inform the physician and other personnel of changes in the patient's condition and needs, (9) counsel the patient and family in meeting the patient's nursing and related needs, (10) participate in inservice programs, and (11) supervise and teach other nursing personnel.

(g) *Licensed practical nurse services.* Licensed practical nurses providing home health services shall be under the supervision of a registered nurse. As appropriate, they shall: (1) Provide routine nursing services, (2) prepare clinical and progress notes, (3) assist the physician and/or registered nurse in performing specialized procedures, (4) prepare equipment and materials for treatments observing aseptic technique as required, (5) assist the patient in learning appropriate self-care techniques, and (6) participate in in-service programs.

(h) *Therapy services.* (1) As appropriate, physical, occupational or speech therapists performing home health services shall: (i) Assist the physician in evaluating level of function, (ii) help to develop the plan of care (revising as necessary), (iii) prepare clinical and progress notes, (iv) advise and consult with the family and other agency personnel, and (v) participate in inservice programs.

(2) Services may be provided by a qualified physical therapist assistant or qualified occupational therapy assistant under the supervision of a qualified physical or occupational therapist. A physical therapist assistant or occupational therapy assistant shall perform services planned, delegated, and supervised by the therapist, assist in preparing clinical notes and progress reports, and participate in educating the patient and family, and in inservice programs.

(3) Speech therapy services may be provided only by or under supervision of a qualified speech pathologist or audiologist.

(i) *Home health aide services*—(1) *Assignment and duties.* The home health aide shall be assigned to a particular patient by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse or therapist as appropriate. Duties shall include the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's conditions and needs, and completing appropriate records.

(2) *Supervision.* (i) *Standard: Supervision.* The registered nurse, or appropriate professional staff member, if therapy services are provided, shall make a supervisory visit to the patient's residence at least monthly, alternating the visits when the aide is present and not present to assess relationships and determine whether goals are being met.

(3) *Training.* All home health aides shall receive basic orientation and training consisting of not less than 40 hours. The training will include as a minimum content in each of the following areas:

(i) Basic techniques of personal care such as the activities of daily living;

(ii) Health and hygiene;

(iii) Food preparation and nutrition;

(iv) Interpersonal relationships meeting the social, emotional, and physical needs of patients;

(v) Basic household management;

(vi) Child care.

(4) *In-service education.* There shall be continuing in-service programs on a regularly scheduled basis with on-the-job training during supervisory visits and more often as needed.

(j) *Records*—(1) *Clinical records.* A clinical record containing pertinent past and current findings in accordance with accepted professional standards shall be

maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes (clinical notes shall be written the day service is rendered and incorporated within a week of such service); copies of summary reports sent to the physician; and a discharge summary.

(2) *Retention of records.* Clinical records shall be retained for a period of 3 years (as described and qualified by part 74, subpart D, of this title, "Retention and Custodial Requirements for Records"), after completion of services. When a patient is transferred from care of the agency, a copy of the record or abstract shall be sent to the accepting agency or facility.

(3) *Protection of records.* Clinical record information shall be safeguarded in accordance with the requirements of § 205.50 of this chapter.

(4) *Clinical record review.* At least quarterly, appropriate agency health professionals shall review a 10 percent randomly selected sample of both active and closed clinical records to assure that established policies are followed in providing services (direct services as well as services under contract or arrangement).

(k) *Utilization control.* The agency shall participate in a program of utilization control of services as prescribed by the title XIX State agency pursuant to § 250.18 of this chapter which, as a minimum, shall include provisions for:

(1) Review of patient records by a team of professional persons (at least a physician, public health nurse and one additional health professional) not involved in the direct care of the individual patient, for each 90-day period of service with respect to any patient receiving continued services during such period, in order to make recommendations to the agency providing service as to the necessity for continued service, the adequacy of the plan of care and the appropriateness of continued service; and

(2) A continuing program of home health evaluation studies by a team of professional persons (which may be the same team as specified in paragraph (k)(1) of this section), which shall identify and analyze trends, problems and patterns of care and make recommendations to the State title XIX agency for improvement of the quality of home health care.

(l) *Determination of qualifications.* The determination that an agency providing home health services meets the conditions and standards for participation shall be made in accordance with the applicable provisions for certification and the execution of valid provider agreements set forth in § 249.151 of this chapter.

3. A new § 249.151 is added to Part 249 as set forth below:

§ 249.151 Home health agencies: Requirements for agencies qualifying as home health service providers.

(a) *Certification of agencies not participating under title XVIII.* Prior to the execution of a provider agreement and participation in the title XIX program as a provider of home health services, the State survey agency designated under § 250.100 of this chapter shall survey the home health agency and certify as to whether it is found to be in compliance with the conditions and standards set forth in § 249.150 (a)(2) and (b)–(1).

(1) The findings of the State survey agency with respect to each of the standards shall be adequately documented. Where the State survey agency certifies that a provider agency is not in compliance with the standards, such documentation shall include, in addition to the description of the specific deficiencies which resulted in the agency's finding, a report of all consultation which has been undertaken in an effort to assist the provider to comply with the standards, a report of the provider's responses with respect to the consultation, and the State agency's assessment of the prospects for such improvements as to enable the provider to achieve compliance with the standards within a reasonable period of time.

(2) If a provider is certified by the State survey agency to be in compliance with the standards or to be in compliance except for deficiencies not adversely affecting the health and safety of patients the following information will be incorporated into the finding:

(i) A statement of the deficiencies which were found, and

(ii) A description of further action which is required to remove the deficiencies, and

(iii) A time-phased plan of correction developed by the provider and concurred in by the State survey agency, and

(iv) A scheduled time for a resurvey of the agency to be conducted by the State survey agency within 90 days following the completion of the survey.

(3) If, on the basis of the State certification that an agency meets standards, and such other information as it possesses, the State title XIX agency executes a provider agreement with the provider agency, the information described in paragraph (a)(2) of this section will be incorporated into a notice to the provider.

(4) Initial certifications and recertifications by the State survey agency to the effect that a provider is in compliance with all the standards will be for a period of 12 months. State survey agencies may visit or resurvey providers more frequently where necessary to evaluate correction of deficiencies, ascertain continued compliance, or accommodate to periodic or cyclical survey programs. The State survey agency shall evaluate such reports as may pertain to the health and safety requirements and, as necessary, take appropriate action to achieve compliance or certify to the State title XIX agency that compliance has not been achieved. A State finding and certification that a provider is no longer in compliance will supersede the State's previous certification.

(5) The State survey agency will certify that a provider is not or is no longer in compliance with the standards where the deficiencies are of such character as to substantially limit the provider's capacity to render adequate care or which adversely affect the health and safety of patients.

(6) If a provider is found to be deficient with respect to one or more of the standards, it may participate in the State title XIX program only if the provider has submitted an acceptable plan of correction for achieving compliance within a reasonable period of time acceptable to the State survey agency. The existing deficiencies noted either individually or in combination must neither jeopardize the health and safety of patients nor be of such character as to seriously limit the provider's capacity to render adequate care.

(7) If it is determined during a survey that a provider is not in compliance with one or more of the standards in accordance with paragraph (a)(6), it will be granted a reasonable time to achieve compliance. The amount of time will depend upon the nature of the deficiency and the State survey agency's judgment as to the provider's capabilities to provide adequate and safe care. Ordinarily a provider will be expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies but the State survey agency may grant additional time in individual situations, if in its judgment it is not reasonable to expect compliance within 60 days, e.g., a provider must obtain the approval of its governing body, or engage in competitive bidding.

(b) *Execution of provider agreements with all agencies providing home health services.* (1) The State agency shall not execute a provider agreement, under this section, with an agency providing home health services unless the agency is certified to provide such services under title XVIII of the Act, or is certified as meeting the standards specified in § 249.150 of this chapter in accordance with the applicable provisions of this section.

(2) (i) The term of an agreement may not exceed a period of one year and the effective date of such agreement may not be earlier than the date of certification. (ii) Execution of a provider agreement shall be for the term and in accordance with the provisions of certification determined by the survey agency, except that the single State agency for good cause based on adequate and documented evidence may elect to execute a provider agreement for a term less than the full period of certification, or may elect not to execute a provider agreement, or may

cancel a provider agreement for participation by an agency certified under the State plan. (iii) Notwithstanding the provisions of this paragraph the single State agency may extend such term for a period not exceeding two months where the survey agency has notified the single State agency in writing prior to the expiration of a provider agreement that the health and safety of the patients will not be jeopardized thereby, and that such extension is necessary to prevent irreparable harm to such agency or hardship to the individuals being furnished items or services or that it is impracticable within such provider agreement period to determine whether such agency is complying with the provisions and requirements under the program. An extension of the provider agreement for more than two months may be granted if it is necessary to implement the State survey agency's determination under paragraph (a)(7) of this section to allow the provider additional time to correct deficiencies.

(iv) Any agency whose agreement has been cancelled or otherwise terminated may not be issued another agreement until the reasons which caused the cancellation or termination have been removed and reasonable assurance provided the survey agency that they will not recur.

(3) With respect to home health agencies certified to participate under title XVIII of the Act, the term of a provider agreement between such agency and the State title XIX agency shall be subject to the same terms and conditions and be coterminous with the period of participation specified by the Secretary under title XVIII. Upon notification that an agreement with an agency under title XVIII has been terminated or cancelled, the State title XIX agency will take the same action under title XIX as of the effective date of the title XVIII action.

(c) *Disallowance of Federal financial participation when agency is found not to meet all requirements for certification.* A provider agreement between the title XIX State agency and an agency specified in § 249.150(a)(2) of this chapter shall not be considered valid evidence that such agency meets all requirements for certification pursuant to § 249.150, if the Secretary establishes on the basis of on-site validation surveys, other Federal reviews, State certification records, or such other reports as he may prescribe, that:

(1) The survey agency failed to apply the Federal standards for the certification of such agency as required under § 249.150 of this chapter;

(2) The survey agency failed to follow the rules and procedures for certification set forth under § 249.151 of this chapter;

(3) The survey agency failed to use the Federal standards and such forms, methods and procedures as are established under § 250.100(c)(1) of this chapter; or

(4) The terms and conditions of a provider agreement do not meet the requirements of this section.

States upon request shall receive a reconsideration of any disallowances of Federal financial participation resulting from the Secretary's determination under these provisions, in accordance with section 1116(d) of the Act, and § 201.14 of this chapter.

[FR Doc.75-21698 Filed 8-20-75;8:45 am]