EXHIBIT 196
(Rev. 117, Issued: 06-06-14)

MODEL LETTER ANNOUNCING TO DEEMED *STATUS* PROVIDER/SUPPLIER AFTER A VALIDATION SURVEY THAT IT DOES NOT COMPLY WITH ALL *MEDICARE* CONDITIONS
90-Day Termination Track:

Use after the following types of surveys when there are findings of condition-level noncompliance:

- *Sample Validation Survey;*
- *Substantial Allegation (Complaint) Validation Survey when the RO does not require a subsequent full survey*
- *Full Survey After a Substantial Allegation Validation Survey*

Do Not Use:

- When *an i*mmediate *jeopardy exists and was not removed before the survey team exited the facility (See Exhibit 195); or*
- *In the case of a Substantial Allegation Validation Survey when the RO requires a subsequent full survey (See Exhibit 199*)

(**Date**)
Name/*Title of Hospital Administrator, CEO, or Responsible Individual*
Facility Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear _____:

Section 1865 of the Social Security Act (the Act) and *Centers for Medicare & Medicaid Services (CMS)* regulations provide that a provider or supplier accredited by *a CMS-approved Medicare accreditation program of* **(name of *accrediting* organization)** will be "deemed" to meet all of the Medicare ***(*Conditions of Participation (CoPs) or for Coverage or for Certification (CfCs), as applicable)** for **(type of provider/supplier**. *In accordance with* Section 1864 of the Act *State Survey Agencies may* conduct *at CMS's direction surveys of deemed status providers/suppliers* on a selective sampling basis*, in response to a substantial allegation of noncompliance, or when CMS determines a full survey is required after a substantial allegation survey identifies substantial noncompliance. CMS uses such surveys as a means of validating the accrediting organization's survey and accreditation process.*

(In the case of a full survey after a complaint survey, add the following:** Your deemed status was removed on **(date)** as a result of findings of substantial noncompliance resulting from a substantial allegation validation survey.)* A ***(for full survey after a

complaint, insert: *follow-up full)* survey conducted by the **(State agency)** at (**name of facility**) on (**date**) found that the facility was not in *substantial* compliance with the *following* (**CoPs or CfCs**) for **(type of facility)**.

(List CoPs or CfCs with condition-level deficiencies)

(Except in the case of a full survey which was conducted after a complaint validation survey, add the following: *As a result, effective* ***(date)*** *your deemed status has been removed and survey jurisdiction has been transferred to the* ***(State agency).)***

A listing of all deficiencies found is enclosed (Form CMS-2567, Statement of Deficiencies and Plan of Correction.).

When a **(type of provider/supplier)**, regardless of *whether it has deemed* status, is found to be out of compliance with the **(CoPs or CfCs)**, a determination must be made that the facility no longer meets the requirements for participation as a provider or supplier of services in the Medicare program. Such a determination has been made in the case of (**facility name**) and accordingly, the Medicare agreement between (**facility name**) and *CMS* is being terminated.
The date on which the *Medicare* agreement terminates is (**date**).

(Add, in the case of a hospital or CAH: The Medicare program will not make payment for services furnished to patients who are admitted on or after (**date of termination**). For inpatients admitted prior to (**date of termination**), payment may continue to be made for a maximum of 30 days of inpatient services furnished on or after (**date of termination**). You should submit as soon as possible, a list of names and Medicare claim numbers of beneficiaries in your facility on (**date of termination**) to the (**name and address of the RO involved**) to facilitate payment for *services to* these individuals.**)**

We will publish a public notice in the (**local newspaper**) *at least fifteen days prior to the termination date*. **[Public notice language is optional]**

Termination can only be averted by correction of the deficiencies*, through submission of an acceptable plan of correction (PoC) and subsequent verification of compliance by (* ***State Agency)****. The Form CMS 2567 with your POC and dated and signed by your facility's authorized representative must be submitted to* ***(State Agency)*** *no later than* ***(enter date that is 10 calendar days after the date of this notice)****. Please indicate your corrective actions on the right side of the Form CMS-2567 in the column labeled "Provider Plan of Correction", keying your responses to the deficiencies on the left. Additionally, indicate your anticipated completion dates in the column labeled "Completion Date".*

An acceptable PoC must contain the following elements:

1. The plan for correcting each specific deficiency cited;

2. The plan *for* improving the processes that led to the deficiency cited*, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practice;*

3. The procedure for implementing the PoC*, if found acceptable,* for each deficiency cited;

4. A completion date for correction of each deficiency cited;

5. The monitoring and tracking procedures *that will be implemented* to ensure *that* the PoC is effective and that *the* specific deficien*(*cies*)* cited remain corrected and in compliance with the regulatory requirements; and

6. The title of the person*(s)* responsible for implementing the acceptable PoC.

Copies of the Form CMS-2567, including copies containing the facility's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 CFR 401.133(a). As such, the PoC should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names. It must, however, be specific as to what corrective action the hospital will take to achieve compliance, as indicated above.

Your facility will be revisited to verify necessary corrections. If CMS determines that the reasons for termination remain, you will be so informed in writing, including the effective date of termination. If corrections have been made and your facility is in substantial compliance, the termination procedures will be halted, and you will be notified in writing.

If your Medicare agreement is terminated and you wish to be readmitted to the program, you must demonstrate to the (**State agency**) and CMS that you are able to maintain compliance. Readmission to the program will not be approved until CMS is reasonably assured that you are able to sustain compliance.

If *your Medicare agreement is terminated and* you do not believe this termination decision is correct, you may request a hearing before an Administrative Law Judge (ALJ) of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in regulations at 42 CFR 498.40 et. seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of *the final notice of termination*. Such a request may be made to (***name, title,*** **address** ***of RO ARA***). We will forward your request to the Chief Administrative Law Judge in the Office of Hearing and Appeals.

At your option you may instead submit a hearing request directly (accompanied by a copy of this letter) to the following address.

Departmental Appeals Board, Civil Remedies Division

Room G-644-Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201
Attn: Director, Departmental Appeals Board

Send a copy of your request to this office also.
A request for a hearing should identify the specific issues, the findings of fact, and conclusions *of law, if applicable, with which you disagree*. You may be represented by counsel at a hearing at your own expense.

Sincerely yours,

Regional Office DSC

Enclosure:
CMS Form-2567 Statement of Deficiencies

cc: *State Survey Agency*
Accrediting Organization