

(A) Is under common ownership or control of the HMO or CMP that seeks to retain the absent enrollees; or

(B) Has in effect an agreement to furnish services to enrollees who are on an extended absence from the geographic area of the HMO or CMP that seeks to retain them.

(v) When the enrollee returns to the HMO's or CMP's geographic area (even temporarily), the restrictions of §417.448(a) (which limit payment for services not provided or arranged for by the HMO or CMP) apply again immediately.

(vi) If the enrollee fails to return to the HMO's or CMP's geographic area within 1 year from the date he or she left that area, the HMO or CMP must disenroll the beneficiary on the first day of the month following the anniversary of the date the enrollee left that area in accordance with paragraph (f)(1) of this section.

(g) *Failure to convert to risk provisions of Medicare contract*—(1) *Basis for disenrollment.* A risk HMO or CMP must disenroll a nonrisk Medicare enrollee who refuses to convert to the risk provisions of the Medicare contract after CMS determines that all of the HMO's or CMP's nonrisk Medicare enrollees must convert.

(2) *Advance notice requirement.* At least 30 days before it gives CMS notice of disenrollment, the HMO or CMP must give the enrollee written notice of the fact that failure to convert will result in disenrollment.

(h) *Loss of entitlement to Medicare benefits*—(1) *Loss of entitlement to Part A benefits.* If an enrollee loses entitlement to benefits under Part A of Medicare but remains entitled to benefits under Part B, the enrollee automatically continues as a Medicare enrollee of the HMO or CMP and is entitled to receive and have payment made for Part B services, beginning with the month immediately following the last month of his or her entitlement to Part A benefits.

(2) *Loss of entitlement to Part B benefits.* If a Medicare enrollee loses entitlement to Part B benefits, the HMO or CMP must disenroll him or her as a Medicare enrollee effective with the month following the last month of entitlement to Part B benefits. However,

the HMO or CMP may continue to enroll the individual under its regular plan if the individual so chooses.

(i) *Death of the enrollee.* Disenrollment is effective with the month following the month of death.

[60 FR 45678, Sept. 1, 1995]

§417.461 Disenrollment by the enrollee.

(a) *Request for disenrollment.* (1) A Medicare enrollee who wishes to disenroll may at any time give the HMO or CMP a signed, dated request in the form and manner prescribed by CMS.

(2) The enrollee may request a certain disenrollment date but it may be no earlier than the first day of the month following the month in which the HMO or CMP receives the request.

(b) *Responsibilities of the HMO or CMP.* The HMO or CMP must—

(1) Submit a disenrollment notice to CMS promptly;

(2) Provide the enrollee with a copy of the request for disenrollment; and

(3) In the case of a risk HMO or CMP, also provide the enrollee with a statement explaining that he or she—

(i) Remains enrolled until the effective date of disenrollment; and

(ii) Until that date, is subject to the restrictions of §417.448(a) under which neither the HMO or CMP nor CMS pays for services not provided or arranged for by the HMO or CMP.

(c) *Effect of failure to submit disenrollment notice to CMS promptly.* If the HMO or CMP fails to submit timely the correct and complete notice required in paragraph (b)(1) of this section, the HMO or CMP must reimburse CMS for any capitation payments received after the month in which payments would have ceased if the requirement had been met timely.

[60 FR 45679, Sept. 1, 1995]

§417.464 End of CMS's liability for payment: Disenrollment of beneficiaries and termination or default of contract.

(a) *Effect of disenrollment: General rule.* (1) CMS's liability for monthly capitation payments to the HMO or CMP generally ends as of the first day of the month following the month in

§ 417.470

which disenrollment is effective, as shown on CMS's records.

(2) Disenrollment is effective no earlier than the month immediately after, and no later than the third month after, the month in which CMS receives the disenrollment notice in acceptable form.

(b) *Effect of disenrollment: Special rules*—(1) *Fraud or abuse by the enrollee.* If disenrollment is on the basis of fraud committed or abuse permitted by the enrollee, CMS's liability ends as of the first day of the month in which disenrollment is effective.

(2) *Loss of entitlement to Part B benefits.* If disenrollment is on the basis of loss of entitlement to Part B benefits, CMS's liability ends as of the first day of the month following the last month of Part B entitlement.

(3) *Death of enrollee.* If the enrollee dies, CMS's liability ends as of the first day of the month following the month of death.

(4) *Disenrollment at enrollee's request.* If disenrollment is in response to the enrollee's request, CMS's liability ends as of the first day of the month following the month of termination requested by the enrollee.

(c) *Effect of termination or default of contract*—(1) *Termination of contract.* If the contract between CMS and the HMO or CMP is terminated by mutual consent or by unilateral action of either party, CMS's liability for payments ends as of the first day of the month after the last month for which the contract is in effect.

(2) *Default of contract.* If the HMO or CMP defaults on the contract before the end of the contract year because of bankruptcy or other reasons, CMS—

(i) Determines the month in which its liability for payments ends; and

(ii) Notifies the HMO or CMP and all affected Medicare enrollees as soon as practicable.

[60 FR 45680, Sept. 1, 1995]

Subpart L—Medicare Contract Requirements

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

42 CFR Ch. IV (10–1–10 Edition)

§ 417.470 Basis and scope.

(a) *Basis.* This subpart implements those portions of section 1857(e)(2) of the Act pertaining to cost sharing in enrollment-related costs and section 1876(c), (g), (h), and (i) of the Act that pertain to the contract between CMS and an HMO or CMP for participation in the Medicare program.

(b) *Scope.* This subpart sets forth—

(1) Specific contract requirements; and

(2) Procedures for renewal, non-renewal, or termination of a contract.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38079, July 15, 1993; 62 FR 63673, Dec. 2, 1997]

§ 417.472 Basic contract requirements.

(a) *Submittal of contract.* An HMO or CMP that wishes to contract with CMS to furnish services to Medicare beneficiaries must submit a signed contract that meets the requirements of this subpart and any other requirements established by CMS.

(b) *Agreement to comply with regulations and instructions.* The contract must provide that the HMO or CMP agrees to comply with all the applicable requirements and conditions set forth in this subpart and in general instructions issued by CMS.

(c) *Other contract provisions.* In addition to the requirements set forth in §§ 417.474 through 417.488, the contract must contain any other terms and conditions that CMS requires to implement section 1876 of the Act.

(d) *Exemption from Federal procurement regulations.* The Federal Acquisition Regulations and HHS Acquisition Regulations contained in title 48 of the Code of Federal Regulations do not apply to Medicare contracts under section 1876 of the Act.

(e) *Compliance with civil rights laws.* The HMO or CMP must comply with title VI of the Civil Rights Act of 1964 (regulations at 45 CFR part 80), section 504 of the Rehabilitation Act of 1973 (regulations at 45 CFR part 84), and the Age Discrimination Act of 1975 (regulations at 45 CFR part 91).

(f) *Requirements for advance directives.* The HMO or CMP must meet all the requirements for advance directives at § 417.436(d).