§ 422.512 Termination of contract by the MA organization.

(a) Cause for termination. The MA organization may terminate the MA contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA organization must give advance notice as follows:

(1) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA organization is requesting contract termination.

(2) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the services area, including alternative MA plans, Medigap options, original Medicare and must receive CMS approval.
(3) To the general public at least 60 days before the termination effective date by publishing an CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA organization’s geographic area.

(c) Effective date of termination. The effective date of the termination is determined by CMS and is at least 90 days after the date CMS receives the MA organization’s notice of intent to terminate.

(d) CMS’s liability. CMS’s liability for payment to the MA organization ends as of the first day of the month after the last month for which the contract is in effect.

(e) Effect of termination by the organization. (1) CMS does not enter into an agreement with an organization that has terminated its contract within the preceding 2 years unless there are circumstances that warrant special consideration, as determined by CMS.

(2) During the same 2-year period specified in paragraph (e)(1) of this section, CMS will not contract with an organization whose covered persons also served as covered persons for the terminating sponsor. A “covered person” as used in this paragraph means one of the following:

(i) All owners of nonrenewal or terminated organizations who are natural persons, other than shareholders who have an ownership interest of less than 5 percent.

(ii) An owner in whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the organization, or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 percent of the total property and assets of the organization.

(iii) A member of the board of directors of the entity, if the organization is organized as a corporation.


§ 422.514 Minimum enrollment requirements.

(a) Basic rule. Except as provided in paragraph (b) of this section, CMS does not enter into a contract under this subpart unless the organization meets the following minimum enrollment requirement—

(1) At least 5,000 individuals (or 1,500 individuals if the organization is a PSO) are enrolled for the purpose of receiving health benefits from the organization; or

(2) At least 1,500 individuals (or 500 individuals if the organization is a PSO) are enrolled for purposes of receiving health benefits from the organization and the organization primarily serves individuals residing outside of urbanized areas as defined in § 412.62(f) (or, in the case of a PSO, the PSO meets the requirements in § 422.352(c)).

(3) Except as provided for in paragraph (b) of this section, an MA organization must maintain a minimum enrollment as defined in paragraphs (a)(1) and (a)(2) of this section for the duration of its contract.

(b) Minimum enrollment waiver. (1) For a contract applicant or MA organization that does not meet the applicable requirement of paragraph (a) of this section at application for an MA contract or during the first 3 years of the contract, CMS may waive the minimum enrollment requirement as provided for below. To receive a waiver, a contract applicant or MA organization must demonstrate to CMS’s satisfaction that it is capable of administering and managing an MA contract and is able to manage the level of risk required under the contract. Factors that CMS takes into consideration in making this evaluation include the extent to which—

(i) The contract applicant or MA organization’s management and providers have previous experience in managing and providing health care services under a risk-based payment arrangement to at least as many individuals as the applicable minimum enrollment for the entity as described in paragraph (a) of this section, or

(ii) The contract applicant or MA organization has the financial ability to bear financial risk under an MA contract. In determining whether an organization is capable of bearing risk, CMS considers factors such as the organization’s management experience as described in paragraph (b)(1)(i) of this section.