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served as covered persons for the terminated or non-renewed contract. A “covered person” as used in this paragraph means one of the following:

(i) All owners of 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 or board of trustees of the entity, if the organization is organized as a corporation.

(c) *Notice of determination.* Within timeframes determined by CMS, it notifies each applicant that applies for an MA contract or to be designated a Specialized MA Plan for Special Needs Individuals under this part of its determination and the basis for the determination. The determination is one of the following:

(1) *Approval of application.* If CMS approves the application, it gives written notice to the applicant, indicating that it qualifies to contract as an MA organization.

(2) *Intent to deny.* (i) If CMS finds that the applicant does not appear to be able to meet the requirements for an MA organization or Specialized MA Plan for Special Needs Individuals, CMS gives the applicant notice of intent to deny the application for an MA contract or for a Specialized MA Plan for Special Needs Individuals a summary of the basis for this preliminary finding.

(ii) Within 10 days from the intent to deny, the applicant must respond in writing to the issues or other matters that were the basis for CMS’ preliminary finding and must revise its application to remedy any defects CMS identified.

(iii) If CMS does not receive a revised application within 10 days from the date of the notice, or if after timely submission of a revised application, CMS still finds that the applicant does not appear qualified or has not provided CMS enough information to

allow CMS to evaluate the application, CMS will deny the application.

(3) *Denial of application.* If CMS denies the application, it gives written notice to the contract applicant indicating—

(i) That the applicant is not qualified to contract as an MA organization under Part C of title XVIII of the Act and/or is not qualified to offer a Specialized MA Plan for Special Needs Individuals;

(ii) The reasons why the applicant is not qualified; and

(iii) The applicant’s right to request a hearing in accordance with the procedures specified in subpart N of this part.

[70 FR 4736, Jan. 28, 2005, as amended at 75 FR 19809, Apr. 15, 2010; 76 FR 21568, Apr. 15, 2011; 77 FR 22167, Apr. 12, 2012; 80 FR 7960, Feb. 12, 2015; 83 FR 16733, Apr. 16, 2018]

§ 422.503 General provisions.

(a) *Basic rule.* In order to qualify as an MA organization, enroll beneficiaries in any MA plans it offers, and be paid on behalf of Medicare beneficiaries enrolled in those plans, an MA organization must enter into a contract with CMS.

(b) *Conditions necessary to contract as an MA organization.* Any entity seeking to contract as an MA organization must:

(1) Complete an application as described in § 422.501.

(2) Be licensed by the State as a risk bearing entity in each State in which it seeks to offer an MA plan as defined in § 422.2.

(3) Meet the minimum enrollment requirements of § 422.514, unless waived under § 422.514(b).

(4) Have administrative and management arrangements satisfactory to CMS, as demonstrated by at least the following:

(i) A policy making body that exercises oversight and control over the MA organization’s policies and personnel to ensure that management actions are in the best interest of the organization and its enrollees.

(ii) Personnel and systems sufficient for the MA organization to organize, implement, control, and evaluate financial and communication activities, the furnishing of services, the quality

improvement program, and the administrative and management aspects of the organization.

(iii) At a minimum, an executive manager whose appointment and removal are under the control of the policy making body.

(iv) A fidelity bond or bonds, procured and maintained by the MA organization, in an amount fixed by its policymaking body but not less than \$100,000 per individual, covering each officer and employee entrusted with the handling of its funds. The bond may have reasonable deductibles, based upon the financial strength of the MA organization.

(v) Insurance policies or other arrangements, secured and maintained by the MA organization and approved by CMS to insure the MA organization against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks.

(vi) Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse. The compliance program must, at a minimum, include the following core requirements:

(A) Written policies, procedures, and standards of conduct that—

(1) Articulate the organization's commitment to comply with all applicable Federal and State standards;

(2) Describe compliance expectations as embodied in the standards of conduct;

(3) Implement the operation of the compliance program;

(4) Provide guidance to employees and others on dealing with potential compliance issues;

(5) Identify how to communicate compliance issues to appropriate compliance personnel;

(6) Describe how potential compliance issues are investigated and resolved by the organization; and

(7) Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, au-

ditions and remedial actions, and reporting to appropriate officials.

(B) The designation of a compliance officer and a compliance committee who report directly and are accountable to the organization's chief executive or other senior management.

(1) The compliance officer, vested with the day-to-day operations of the compliance program, must be an employee of the MA organization, parent organization or corporate affiliate. The compliance officer may not be an employee of the MA organization's first tier, downstream or related entity.

(2) The compliance officer and the compliance committee must periodically report directly to the governing body of the MA organization on the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

(3) The governing body of the MA organization must be knowledgeable about the content and operation of the compliance program and must exercise reasonable oversight with respect to the implementation and effectiveness of the compliance programs.

(C)(1) Each MA organization must establish and implement effective training and education for its compliance officer and organization employees, the MA organization's chief executive and other senior administrators, managers and governing body members.

(2) Such training and education must occur at a minimum annually and must be made a part of the orientation for a new employee and new appointment to a chief executive, manager, or governing body member.

(D) Establishment and implementation of effective lines of communication, ensuring confidentiality, between the compliance officer, members of the compliance committee, the MA organization's employees, managers and governing body, and the MA organization's first tier, downstream, and related entities. Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.

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(E) Well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals. These standards must include policies that—

(1) Articulate expectations for reporting compliance issues and assist in their resolution,

(2) Identify noncompliance or unethical behavior; and

(3) Provide for timely, consistent, and effective enforcement of the standards when noncompliance or unethical behavior is determined.

(F) Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the MA organization, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program.

(G) Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.

(1) If the MA organization discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct.

(2) The MA organization must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph (b)(4)(vi)(G)(1) of this section.

(3) The MA organization should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee.

(4)[Reserved]

(5) Not accept new enrollees under a section 1876 reasonable cost contract in

any area in which it seeks to offer an MA plan.

(6) The MA organization's contract must not have been non-renewed under § 422.506 within the past 2 years unless—

(i) During the 6-month period beginning on the date the organization notified CMS of the intention to non-renew the most recent previous contract, there was a change in the statute or regulations that had the effect of increasing MA payments in the payment area or areas at issue; or

(ii) CMS has otherwise determined that circumstances warrant special consideration.

(7) Not have terminated a contract by mutual consent under which, as a condition of the consent, the MA organization agreed that it was not eligible to apply for new contracts or service area expansions for a period of 2 years per § 422.508(c) of this subpart.

(c) *Contracting authority.* Under the authority of section 1857(c)(5) of the Act, CMS may enter into contracts under this part without regard to Federal and Departmental acquisition regulations set forth in title 48 of the CFR and provisions of law or other regulations relating to the making, performance, amendment, or modification of contracts of the United States if CMS determines that those provisions are inconsistent with the efficient and effective administration of the Medicare program.

(d) *Protection against fraud and beneficiary protections.* (1) CMS annually audits the financial records (including data relating to Medicare utilization, costs, and computation of the bid) of at least one-third of the MA organizations offering MA plans. These auditing activities are subject to monitoring by the Comptroller General.

(2) Each contract under this section must provide that CMS, or any person or organization designated by CMS has the right to:

(i) Inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the MA contract;

(ii) Inspect or otherwise evaluate the facilities of the organization when there is reasonable evidence of some need for such inspection; and

(iii) Audit and inspect any books, contracts, and records of the MA organization that pertain to—

(A) The ability of the organization or its first tier or downstream providers to bear the risk of potential financial losses; or

(B) Services performed or determinations of amounts payable under the contract.

(iv) CMS may require that the MA organization hire an independent auditor to provide CMS with additional information to determine if deficiencies found during an audit or inspection have been corrected and are not likely to recur. The independent auditor must work in accordance with CMS specifications and must be willing to attest that a complete and full independent review has been performed.

(e) *Severability of contracts.* The contract must provide that, upon CMS's request—

(1) The contract will be amended to exclude any MA plan or State-licensed entity specified by CMS; and

(2) A separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made.

[63 FR 35099, June 26, 1998, as amended at 65 FR 40327, June 29, 2000. Redesignated at 70 FR 4736, Jan. 28, 2005, and amended at 70 FR 4737, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005; 70 FR 76198, Dec. 23, 2005; 72 FR 68722, Dec. 5, 2007; 75 FR 19809, Apr. 15, 2010; 79 FR 29958, May 23, 2014; 80 FR 7960, Feb. 12, 2015; 83 FR 16733, Apr. 16, 2018]

EDITORIAL NOTE: At 79 FR 29958, May 23, 2014, in § 422.503, paragraph (b)(4)(vi)(G)(5) was revised; however no paragraph (b)(4)(vi)(G)(5) exists, so it cannot be revised.

§ 422.504 Contract provisions.

The contract between the MA organization and CMS must contain the following provisions:

(a) *Agreement to comply with regulations and instructions.* The MA organization agrees to comply with all the applicable requirements and conditions set forth in this part and in general instructions. Compliance with the terms of this paragraph (a) is material to the performance of the MA contract. The MA organization agrees—

(1) To accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit invol-

untary disenrollments, as provided in subpart B of this part.

(2) That it will comply with the prohibition in § 422.110 on discrimination in beneficiary enrollment.

(3) To provide—

(i) The basic benefits as required under § 422.101 and, to the extent applicable, supplemental benefits under § 422.102; and

(ii) Access to benefits as required under subpart C of this part;

(iii) In a manner consistent with professionally recognized standards of health care, all benefits covered by Medicare.

(4) To disclose information to beneficiaries in the manner and the form prescribed by CMS as required under § 422.111;

(5) To operate a quality assurance and performance improvement program and have an agreement for external quality review as required under subpart D of this part;

(6) To comply with all applicable provider and supplier requirements in subpart E of this part, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, limits on physician incentive plans, and the preclusion list requirements in §§ 422.222 and 422.224.

(7) To comply with all requirements in subpart M of this part governing coverage determinations, grievances, and appeals;

(8) To comply with the reporting requirements in § 422.516 and the requirements in § 422.310 for submitting data to CMS;

(9) That it will be paid under the contract in accordance with the payment rules in subpart G of this part;

(10) To develop its annual bid, and submit all required information on premiums, benefits, and cost-sharing by not later than the first Monday in June, as provided in subpart F of this part;

(11) That its contract may not be renewed or may be terminated in accordance with this subpart and subpart N of this part.