

§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 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.

§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