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(2) 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.

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

[63 FR 35099, June 26, 1998, as amended at 75 FR 19811, Apr. 15, 2010; 76 FR 21569, Apr. 15, 2011; 80 FR 7961, Feb. 12, 2015; 83 FR 16734, Apr. 16, 2018]

§ 422.510 Termination of contract by CMS.

(a) *Termination by CMS.* CMS may at any time terminate a contract if CMS determines that the MA organization meets any of the following:

(1) Has failed substantially to carry out the contract.

(2) Is carrying out the contract in a manner that is inconsistent with the efficient and effective administration of this part.

(3) No longer substantially meets the applicable conditions of this part.

(4) CMS may make a determination under paragraph (a)(1), (2), or (3) of this section if the MA organization has had one or more of the following occur:

(i) Based on creditable evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care programs, including submission of false or fraudulent data.

(ii) Substantially failed to comply with the requirements in subpart M of this part relating to grievances and appeals.

(iii) Failed to provide CMS with valid data as required under § 422.310.

(iv) Failed to implement an acceptable quality assessment and performance improvement program as required under subpart D of this part.

(v) Substantially failed to comply with the prompt payment requirements in § 422.520.

(vi) Substantially failed to comply with the service access requirements in § 422.112 or § 422.114.

(vii) Failed to comply with the requirements of § 422.208 regarding physician incentive plans.

(viii) Substantially fails to comply with the requirements in subpart V of this part.

(ix) Failed to comply with the regulatory requirements contained in this part or part 423 of this chapter or both.

(x) Failed to meet CMS performance requirements in carrying out the regulatory requirements contained in this part or part 423 of this chapter or both.

(xi) Achieves a Part C summary plan rating of less than 3 stars for 3 consecutive contract years. Plan ratings issued by CMS before September 1, 2012 are not included in the calculation of the 3-year period.

(xii) Has failed to report MLR data in a timely and accurate manner in accordance with § 422.2460 or that any MLR data required by this subpart is found to be materially incorrect or fraudulent.

(xiii) Fails to meet the preclusion list requirements in accordance with § 422.222 and 422.224.

(xiv) The MA organization has committed any of the acts in § 422.752(a) that support the imposition of intermediate sanctions or civil money penalties under subpart O of this part.

(xv) Following the issuance of a notice to the MA organization no later than August 1, CMS must terminate, effective December 31 of the same year, an individual MA plan if that plan does not have a sufficient number of enrollees to establish that it is a viable independent plan option.

(xvi) Meets the criteria in § 422.514(d)(1) or (2).

(b) *Notice.* If CMS decides to terminate a contract it gives notice of the termination as follows:

(1) *Termination of contract by CMS.*

(i) CMS notifies the MA organization in writing at least 45 calendar days before the intended date of the termination.

(ii) The MA organization notifies its Medicare enrollees of the termination by mail at least 30 calendar days before the effective date of the termination.

(iii) The MA organization notifies the general public of the termination at

least 30 calendar days before the effective date of the termination by releasing a press statement to news media serving the affected community or county and posting the press statement prominently on the organization's Web site.

(iv) In the event that CMS issues a termination notice to an MA organization on or before August 1 with an effective date of the following December 31, the MA organization must issue notification to its Medicare enrollees at least 90 days prior to the effective date of the termination.

(2) *Immediate termination of contract by CMS.* (i) The procedures specified in paragraph (b)(1) of this section do not apply if—

(A) CMS determines that a delay in termination, resulting from compliance with the procedures provided in this part prior to termination, would pose an imminent and serious risk to the health of the individuals enrolled with the MA organization; or

(B) The MA organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists; or

(C) The contract is being terminated based on the grounds specified in paragraph (a)(4)(i) of this section.

(ii) CMS notifies the MA organization in writing that its contract will be terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA organization covering the period of the month following the contract termination.

(iii) CMS notifies the MA organization's Medicare enrollees in writing of CMS's decision to terminate the MA organization's contract. This notice occurs no later than 30 days after CMS notifies the plan of its decision to terminate the MA contract. CMS simultaneously informs the Medicare enrollees of alternative options for obtaining Medicare services, including alter-

native MA organizations in a similar geographic area and original Medicare.

(iv) CMS notifies the general public of the termination no later than 30 days after notifying the plan of CMS's decision to terminate the MA contract. This notice is published in one or more newspapers of general circulation in each community or county located in the MA organization's service area.

(c) *Opportunity to develop and implement a corrective action plan—*(1) *General.* (i) Before providing a notice of intent to terminate the contract, CMS will provide the MA organization with notice specifying the MA organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement a corrective action plan to correct the deficiencies.

(ii) The MA organization is solely responsible for the identification, development, and implementation of its corrective action plan and for demonstrating to CMS that the underlying deficiencies have been corrected within the time period specified by CMS in the notice requesting corrective action.

(2) *Exceptions.* The MA organization will not be provided with an opportunity to develop and implement a corrective action plan prior to termination if—

(i) CMS determines that a delay in termination, resulting from compliance with the procedures provided in this part prior to termination, would pose an imminent and serious risk to the health of the individuals enrolled with the MA organization;

(ii) The MA organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists; or

(iii) The contract is being terminated based on the violation specified in (a)(4)(i) of this section.

(d) *Appeal rights.* If CMS decides to terminate a contract, it sends written notice to the MA organization informing it of its termination appeal rights

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in accordance with subpart N of this part.

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§ 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 may deny an application for a new contract or a service area expansion from an MA organization that has terminated its contract within the preceding 2 years unless there are circumstances that warrant special consideration, as determined by CMS. This prohibition may apply re-

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gardless of the contract type, product type, or service area of the previous contract.

(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.

[63 FR 35099, June 26, 1998, as amended at 67 FR 13288, Mar. 22, 2002; 76 FR 21569, Apr. 15, 2011; 80 FR 7961, Feb. 12, 2015]

§ 422.514 Enrollment requirements.

(a) *Minimum enrollment rules.* 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.