

§ 423.510

42 CFR Ch. IV (10–1–24 Edition)

(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 Part D plan sponsor's contract. This notice is published in one or more newspapers of general circulation in each community or county located in the Part D plan sponsor'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 Part D plan sponsor with notice specifying the Part D plan sponsor'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 Part D plan sponsor 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 Part D plan sponsor 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 Part D plan sponsor;

(ii) The Part D plan sponsor 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 Part D plan sponsor informing it of its termination appeal rights in accordance with subpart N of this part.

(e) *Timely transfer of data and files*. If a contract is terminated under para-

graph (a) of this section, the Part D plan sponsor must ensure the timely transfer of any data or files.

(f) If CMS makes a determination to terminate a Part D sponsor's contract under § 423.509(a), CMS also imposes the intermediate sanctions at § 423.750(a)(1) and (3) in accordance with the following procedures:

(1) The sanction will go into effect 15 days after the termination notice is sent.

(2) The Part D sponsor will have a right to appeal the intermediate sanction in the same proceeding as the termination appeal specified in paragraph (d) of this section.

(3) A request for a hearing does not delay the date specified by CMS when the sanction becomes effective.

(4) The sanction will remain in effect—

(i) Until the effective date of the termination; or

(ii) If the termination decision is overturned on appeal, when a final decision is made by the hearing officer or Administrator.

[70 FR 4525, Jan. 28, 2005, as amended at 72 FR 68733, Dec. 5, 2007; 73 FR 20507, Apr. 15, 2008; 75 FR 19822, Apr. 15, 2010; 76 FR 21575, Apr. 15, 2011; 77 FR 22170, Apr. 12, 2012; 78 FR 31310, May 23, 2013; 79 FR 29965, May 23, 2014; 80 FR 7965, Feb. 12, 2015; 83 FR 16750, Apr. 16, 2018; 89 FR 30838, Apr. 23, 2024]

§ 423.510 Termination of contract by the Part D sponsor.

(a) *Cause for termination*. The Part D plan sponsor may terminate its contract if CMS fails to substantially carry out the terms of the contract.

(b) *Notice of termination*. The Part D plan sponsor 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 Part D sponsor 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 qualified prescription drug coverage within the services area, including alternative PDPs, MA-PDPs, and original Medicare and must receive CMS approval.