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, nonrenewal, 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 Age Discrimination Act of 1975 (regulations at 45 CFR part 91).

(f) *Requirements for advance directives.* The HMO or CMP must meet all the requirements for advance directives at § 417.436(d).

(g) *Authority to waive conflicting contract requirements.* Under section 1876(i)(5) of the Act, CMS is authorized to administer the terms of this subpart without regard to provisions of law or other regulations relating to the making, performance, amendment, or modification of contracts of the United States if it determines that those provisions are inconsistent with the efficient and effective administration of the Medicare program.

(h) *Collection of fees from risk HMOs and CMPs.* (1) The rules set forth in §422.10 of this chapter for M+C plans also apply to collection of fees from risk HMOs and CMPs.

(2) In applying the part 422 rules, references to ''M+C organizations'' or ''M+C plans'' must be read as references to ''risk HMOs and CMPs''.

(i) The HMO or CMP must comply with the requirements at §422.152(b)(5).

(j) All coordinated care contracts (including local and regional PPOs, contracts with exclusively SNP benefit packages, private fee-for-service contracts, and MSA contracts), and all cost contracts under section 1876 of the Act, with 600 or more enrollees in July of the prior year, must contract with approved Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendors to conduct the Medicare CAHPS satisfaction survey of Medicare plan enrollees in accordance with CMS specifications and submit the survey data to CMS.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 57 FR 8202, Mar. 6, 1992; 58 FR 38079, July 15, 1993; 60 FR 45680, Sept. 1, 1995; 63 FR 35067, June 26, 1998; 75 FR 19802, Apr. 15, 2010]

§417.474 Effective date and term of contract.

(a) *Effective date.* The contract must specify its effective date, which may not be earlier than the date it is signed by both CMS and the HMO or CMP.

(b) *Term.* The contract must specify the duration of its term as follows:

(1) For the initial term, at least 12 months, but no more than 23 months.

(2) For any subsequent term, 12 months.

[60 FR 45680, Sept. 1, 1995]

§417.476 Waived conditions.

If CMS waives any of the qualifying conditions required under subpart J of this part, the contract must specify the following information for each waived condition:

(a) The specific terms of the waiver.

(b) The expiration date of the waiver.

(c) Any other information required by CMS.

[60 FR 45680, Sept. 1, 1995]

§417.478 Requirements of other laws and regulations.

The contract must provide that the HMO or CMP agrees to comply with—

(a) The requirements for QIO review of services furnished to Medicare enrollees as set forth in subchapter D of this chapter;

(b) Sections 1318(a) and (c) of the PHS Act, which pertain to disclosure of certain financial information;

(c) Section 1301(c)(8) of the PHS Act, which relates to liability arrangements to protect enrollees of the HMO or CMP; and

(d) The reporting requirements in §417.126(a), which pertain to the monitoring of an HMO's or CMP's continued compliance.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38079, 38082, July 15, 1993]

§417.479 Requirements for physician incentive plans.

(a) The contract must specify that an HMO or CMP may operate a physician incentive plan only if—

(1) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and

(2) The stop-loss protection, enrollee survey, and disclosure requirements of this section are met.

(b) *Applicability.* The requirements in this section apply to physician incentive plans between HMOs and CMP and individual physicians or physician groups with which they contract to provide medical services to enrollees. The requirements in this section also apply to subcontracting arrangements