include in its notice the reasons for the termination.

(2) The HMO or CMP must notify its Medicare enrollees of the termination at least 60 days before the termination date. Risk HMOs or CMPs must also provide a written description of alternatives available for obtaining Medicare services after termination of the contract. The HMO or CMP is responsible for the cost of these notices.

(3) The HMO or CMP must notify the general public of the termination at least 30 days before the termination date.

(4) The contract is terminated effective 60 days after the HMO or CMP mails the notice to Medicare enrollees as required in paragraph (c)(2) of this section.

(5) CMS's liability for payment ends as of the first day of the month after the last month for which the contract is in effect.

[50 FR 1346, Jan. 10, 1985, as amended at 52 FR 22322, June 11, 1987; 56 FR 46571, Sept. 13, 1991; 58 FR 38079, 38082, July 15, 1993; 60 FR 45681, Sept. 1, 1995; 75 FR 19803, Apr. 15, 2010]

§ 417.500 Intermediate sanctions for and civil monetary penalties against HMOs and CMPs.

(a) Except as provided in paragraph (c) of this section, the rights, procedures, and requirements related to intermediate sanctions and civil money penalties set forth in part 422 subparts O and T of this chapter also apply to Medicare contracts with HMOs or CMPs under sections 1876 of the Act.

(b) In applying paragraph (a) of this section, references to part 422 of this chapter must be read as references to this part and references to MA organizations must be read as references to HMOs or CMPs.

(c) In applying paragraph (a) of this section, the amounts of civil money penalties that can be imposed are governed by section 1876(i)(6)(B) and (C) of the Act, not by the provisions in part 422 of this chapter.

[75 FR 19803, Apr. 15, 2010]

Subpart M—Change of Ownership and Leasing of Facilities: Effect on Medicare Contract

§ 417.520 Effect on HMO and CMP contracts.

(a) The provisions set forth in subpart L of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(b) In applying these provisions, references to ''M+C organizations'' must be read as references to ''HMOs and CMPs''.

(c) In § 422.550, reference to ''subpart K of this part'' must be read as reference to ''subpart L of part 417 of this chapter''.

(d) In § 422.553, reference to ''subpart K of this part'' must be read as reference to ''subpart J of part 417 of this chapter''.

[63 FR 35067, June 26, 1998]

Subpart N—Medicare Payment to HMOs and CMPs: General Rules

§ 417.524 Payment to HMOs or CMPs: General.

(a) *Basic rule.* The payments that CMS makes to an HMO or CMP under this subpart and subparts O and P of this part for furnishing covered Medicare services are in place of any payment that CMS would otherwise make to a beneficiary or the HMO or CMP under sections 1814(b) and 1833(a) of the Act.

(b) *Basis of payment.* (1) CMS pays the HMOs or CMPs on either a reasonable cost basis or a risk basis depending on the type of contract the HMO or CMP has with CMS.

(2) In certain cases a risk HMO or CMP also receives payments on a reasonable cost basis for certain Medicare enrollees who retain nonrisk status, as provided in § 417.444, after the HMO or CMP enters into a risk contract.

[60 FR 46229, Sept. 6, 1995]

§ 417.526 Payment for covered services.

Subpart O of this part set forth the principles that CMS follows in determining Medicare payment to an HMO