''covered person'' as used in this paragraph means one of the following:

(1) All owners of nonrenewal or terminated organizations who are natural persons, other than shareholders who have an ownership interest of less than 5 percent.

(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]

§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) 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.

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

(6) Fails to provide CMS with valid data as required under §422.310.

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

(8) Substantially fails to comply with the prompt payment requirements in §422.520.

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

(10) Fails to comply with the requirements of §422.208 regarding physician incentive plans.

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

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

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

(14) 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.

(15) Has failed to report MLR data in a timely and accurate manner in accordance with §422.2460.

(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 90 days before the intended date of the termination.

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

(iii) The MA organization notifies the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA organization's service area.

(2) *Expedited 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) 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 alternative 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) 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 in accordance with subpart N of this part.

[63 FR 35099, June 26, 1998, as amended at 65 FR 40328, June 29, 2000; 70 FR 52027, Sept. 1, 2005; 72 FR 68723, Dec. 5, 2007; 75 FR 19811, Apr. 15, 2010; 77 FR 22168, Apr. 12, 2012; 78 FR 31307, May 23, 2013]

§ 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