

sanction or, if the HMO or CMP timely seeks reconsideration under paragraph (c) of this section, on the date specified in the notice of CMS's reconsidered determination.

(2) *Exception.* If CMS determines that the HMO's or CMP's conduct poses a serious threat to an enrollee's health and safety, CMS may make the sanction effective on a date before issuance of CMS's reconsidered determination.

(3) *Duration of sanction.* The sanction remains in effect until CMS notifies the HMO or CMP that CMS is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

(f) *Termination by CMS.* In addition to or as an alternative to the sanctions described in paragraph (d) of this section, CMS may decline to renew a HMO's or CMP's contract in accordance with § 417.492(b), or terminate the contract in accordance with § 417.494(b).

(g) *Civil money penalties.* If CMS determines that a HMO or CMP has committed an act or failed to comply with a requirement described in paragraph (a) of this section (with the exception of the requirement to limit the percentage of Medicare and Medicaid enrollees described in paragraph (a)(7) of this section), CMS notifies the OIG of that determination. CMS also conveys to the OIG information when it reverses or terminates a sanction imposed under this subpart. In accordance with the provisions of 42 CFR part 1003, the OIG may impose civil money penalties on the HMO or CMP in addition to or in place of the sanctions that CMS may impose under paragraph (d) of this section.

[59 FR 36083, July 15, 1994, as amended at 60 FR 45681, Sept. 1, 1995; 61 FR 13448, Mar. 27, 1996]

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 or CMP that has a reasonable cost contract. Subpart P of this part describes the per capita method of Medicare payment to HMOs or CMPs that contract on a risk basis.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985; as amended at 58 FR 38080, July 15, 1993; 60 FR 46229, Sept. 6, 1995]