

## § 417.598

(1) Offer without charge the supplemental services it provides to its Medicare enrollees under the provisions of § 417.440 (b)(2) or (b)(3); or

(2) Refinance prior contract period losses or to avoid losses in the upcoming contract period.

(d) *Form of payment.* Payment of monies withdrawn from a benefit stabilization fund is made, in equal parts, as an additional amount to the monthly advance payment made to the HMO or CMP under § 417.584 during the period of the contract.

[58 FR 38075, July 15, 1993, as amended at 60 FR 46233, Sept. 6, 1995]

## § 417.598 Annual enrollment reconciliation.

CMS's payment to an HMO or CMP may be subject to an enrollment reconciliation at least annually. CMS conducts this reconciliation as necessary to ensure that the payments made do not exceed or fall short of the appropriate per capita rate of payment for each Medicare enrollee of the HMO or CMP during the contract period. The HMO or CMP must submit any information or reports required by CMS to conduct the reconciliation.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46233, Sept. 6, 1995]

## Subpart Q—Beneficiary Appeals

### § 417.600 Basis and scope.

(a) *Statutory basis.* (1) Section 1869 of the Act provides the right to a redetermination, reconsideration, hearing, and judicial review for individuals dissatisfied with a determination regarding their Medicare benefits.

(2) Section 1876 of the Act provides for Medicare payments to HMOs and CMPs that contract with CMS to enroll Medicare beneficiaries and furnish Medicare-covered health care services to them.

(3) Section 234 of the MMA requires section 1876 contractors to operate under the same provisions as MA plans where two plans of the same type enter the cost plan contract's service area.

(b) *Applicability.* (1) The rights, procedures, and requirements relating to beneficiary appeals and grievances set

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forth in subpart M of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(2) In applying those provisions, references to section 1852 of the Act must be read as references to section 1876 of the Act, and references to MA organizations as references to HMOs and CMPs.

[60 FR 46233, Sept. 6, 1995, as amended at 62 FR 23374, Apr. 30, 1997; 70 FR 4713, Jan. 28, 2005]

## Subpart R—Medicare Contract Appeals

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

### § 417.640 Determinations subject to appeal.

This subpart establishes the procedures for making and reviewing the following initial determinations:

(a) A determination that an HMO or CMP is not qualified to enter into a contract with CMS under section 1876 of the Act.

(b) A determination that an HMO or CMP is qualified only for a reasonable cost contract.

(c) A determination to terminate, or to refuse to renew, a contract with an HMO or CMP because—

(1) The HMO or CMP has failed substantially to carry out the terms of the contract;

(2) The HMO or CMP is carrying out the contract in a manner that is inconsistent with the efficient and effective administration of section 1876 of the Act;

(3) The HMO or CMP no longer meets the applicable conditions necessary to qualify as an HMO or CMP under section 1876 of the Act and this subpart; or

(4) The HMO or CMP has failed to comply with the composition of enrollment requirements specified in § 417.413(d).

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 46572, Sept. 13, 1991; 58 FR 38080, July 15, 1993]