§ 417.408 Contract application process.

(a) Contents of application. (1) The application for a contract must include supporting information in the form and detail required by CMS. (2) Whenever feasible, CMS exempts the HMO or CMP from resubmittal of information it has already submitted to CMS in connection with a determination made under the provisions of § 417.406.

(b) Approval of application. (1) If CMS approves the application, it gives written notice to the HMO or CMP indicating—
   (i) That it does not meet the contract requirements under section 1876 of the Act;
   (ii) The reasons why the HMO or CMP does not meet the contract requirements; and
   (iii) The HMO’s or CMP’s right to request reconsideration in accordance with the procedures specified in subpart R of this part.

(c) Denial of application. If CMS denies the application, it gives written notice to the HMO or CMP indicating—

   (1) That it does not meet the contract requirements under section 1876 of the Act;
   (2) The reasons why the HMO or CMP does not meet the contract requirements; and
   (3) The HMO’s or CMP’s right to request reconsideration in accordance with the procedures specified in subpart R of this part.

§ 417.410 Qualifying conditions: General rules.

(a) Basic requirement. In order to qualify for a contract with CMS under this subpart, an HMO or CMP must demonstrate its ability to enroll Medicare beneficiaries and other individuals and groups and to deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to its Medicare enrollees.

(b) Other qualifying conditions. An HMO or CMP must meet qualifying conditions that pertain to operating experience, enrollment, range of services, furnishing of services, and a quality assurance program.

(c) Standards. Generally, each qualifying condition is interpreted by a series of standards that are used in surveying an HMO or CMP to determine its qualifications for a Medicare contract.

(d) Application of standards. Application of the standards enables the surveyor to determine—

   (1) The HMO’s or CMP’s activities;
   (2) The extent to which the HMO or CMP complies with each condition;
   (3) The nature and extent of any deficiencies; and
   (4) The need for improvement if CMS should enter into a contract with the HMO or CMP.

(e) Requirements for a risk contract. An HMO or CMP may enter into a risk contract with CMS if it—

   (1) Meets all the applicable requirements in the statute and regulations;
§ 417.413 Qualifying condition: Operating experience and enrollment.

(a) Condition. The HMO or CMP must demonstrate that it has operating experience and an enrolled population sufficient to provide a reasonable basis for establishing a prospective per capita reimbursement rate or a reasonable cost reimbursement rate, as appropriate.

(b) Standard: Enrollment and operating experience for HMOs or CMPs to contract on a risk basis. To be eligible to contract on a risk basis—

(1) A nonrural HMO or CMP must currently have the following:

(i) At least 5,000 enrollees; and

(ii) At least 75 Medicare enrollees or a plan acceptable to CMS for achieving a Medicare enrollment of 75 within 2 years from the beginning of its initial contract period.

(2) A rural HMO or CMP must currently have—

(i) At least 1,500 enrollees; and

(ii) At least 75 Medicare enrollees or a plan acceptable to CMS for achieving a Medicare enrollment of 75 within 2 years from the beginning of its initial contract period.

(3) For purposes of this paragraph, an HMO or CMP is considered rural if at least 50 percent of its enrollees reside in nonmetropolitan areas. A nonmetropolitan area is an area—

(i) No part of which is within a metropolitan statistical area (MSA) as designated by the Executive Office of Management and Budget; and

(ii) That does not contain a city whose population exceeds 50,000 individuals.

(4) A subdivision or subsidiary of an HMO or CMP that meets the requirements of paragraph (b)(1) or (b)(2) of this section need not demonstrate that it meets those requirements as an independent unit if the HMO or CMP assumes responsibility for the financial risk, and adequate management and supervision of health care services furnished by its subdivision or subsidiary.