

HMO applicant seeking Federal qualification of one of its regional components as an HMO is charged the same amount, unless the amount of the fee has been changed under paragraph (f) of this section.)

(d) *Application fee amounts.* The application fee amounts for applications completed on or after July 13, 1987 are as follows:

(1) \$18,400 for an entity seeking qualification as an HMO or qualification of a regional component of an HMO.

If, in the case of an HMO seeking qualification of a regional component, CMS determines that there is no need for a site visit, \$8,000 will be returned to the applicant.

(2) \$6,900 for an HMO seeking expansion of its service area.

(3) \$3,100 for a CMP seeking qualification as an HMO.

(e) *Refund of an application fee.* CMS refunds an application fee only if the entity withdraws its application within 10 working days after receipt by CMS. Application fees are not returned in any other circumstance, even if qualification or certification is denied.

(f) *Procedure for changing the amount of an application fee.* If CMS determines that a change in the amount of a fee is appropriate, CMS issues a notice of proposed rulemaking in the FEDERAL REGISTER to announce the proposed new amount.

(g) *New application after denial.* An entity may not submit another application under this subpart for the same type of determination for four full months after the date of the notice in which CMS denied the application.

(h) *Disclosure of application information under the Freedom of Information Act.* An applicant submitting material that he or she believes is protected from disclosure under 5 U.S.C. 552, the Freedom of Information Act, or because of exceptions provided in 45 CFR part 5, the Department's regulations providing exceptions to disclosure, should label the material "privileged" and include an explanation of the applicability of an exception described in 45 CFR part 5.

[52 FR 22321, June 11, 1987. Redesignated at 52 FR 36746, Sept. 30, 1987, as amended at 58 FR 38077, July 15, 1993]

§ 417.144 Evaluation and determination procedures.

(a) *Basis for evaluation and determination.* (1) CMS evaluates an application for Federal qualification on the basis of information contained in the application itself and any additional information that CMS obtains through on-site visits, public hearings, and any other appropriate procedures.

(2) If the application is incomplete, CMS notifies the entity and allows 60 days from the date of the notice for the entity to furnish the missing information.

(3) After evaluating all relevant information, CMS determines whether the entity meets the applicable requirements of §§ 417.142 and 417.143.

(b) *Notice of determination.* CMS notifies each entity that applies for qualification under this subpart of its determination and the basis for the determination. The determination may be granting of qualification, intent to deny, or denial.

(c) *Intent to deny.* (1) If CMS finds that the entity does not appear to meet the requirements for qualification and appears to be able to meet those requirements within 60 days, CMS gives the entity notice of intent to deny qualification and a summary of the basis for this preliminary finding.

(2) Within 60 days from the date of the notice, the entity may respond in writing to the issues or other matters that were the basis for CMS's preliminary finding, and may revise its application to remedy any defects identified by CMS.

(d) *Denial and reconsideration of denial.* (1) If CMS denies an application for qualification under this subpart, CMS gives the entity written notice of the denial and an opportunity to request reconsideration of that determination.

(2) A request for reconsideration must—

(i) Be submitted in writing, within 60 days following the date of the notice of denial;

(ii) Be addressed to the CMS officer or employee who denied the application; and

(iii) Set forth the grounds upon which the entity requests reconsideration, specifying the material issues of

fact and of law upon which the entity relies.

(3) CMS bases its reconsideration upon the record compiled during the qualification review proceedings, materials submitted in support of the request for reconsideration, and other relevant materials available to CMS.

(4) CMS gives the entity written notice of the reconsidered determination and the basis for the determination.

(e) *Information on qualified HMOs*—(1) **FEDERAL REGISTER notices.** In quarterly **FEDERAL REGISTER** notices, CMS gives the names, addresses, and service areas of newly qualified HMOs and describes the expanded service areas of other qualified HMOs.

(2) *Listings.* A cumulative list of qualified HMOs is available from the following office, which is open from 8:30 a.m. to 5 p.m., Monday through Friday: Office of Managed Care, room 4360, Cohen Building, 400 Independence Avenue SW., Washington, DC 20201.

[59 FR 49837, Sept. 30, 1994]

Subpart E—Inclusion of Qualified Health Maintenance Organizations in Employee Health Benefits Plans

SOURCE: 45 FR 72517, Oct. 31, 1980, unless otherwise noted. Redesignated at 52 FR 36746, Sept. 30, 1987.

§417.150 Definitions.

As used in this subpart, unless the context indicates otherwise—

Agreement means a collective bargaining agreement.

Bargaining representative means an individual or entity designated or selected, under any applicable Federal, State, or local law, or public entity collective bargaining agreement, to represent employees in collective bargaining, or any other employee representative designated or selected under any law.

Carrier means a voluntary association, corporation, partnership, or other organization that is engaged in providing, paying for, or reimbursing all or part of the cost of health benefits under group insurance policies or contracts, medical or hospital service agreements, enrollment or subscription

contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier.

Collective bargaining agreement means an agreement entered into between an employing entity and the bargaining representative of its employees.

Contract means an employer-employee or public entity-employee contract, or a contract for health benefits.

Designee means any person or entity authorized to act on behalf of an employing entity or a group of employing entities to offer the option of enrollment in a qualified health maintenance organization to their eligible employees.

Eligible employee means an employee who meets the employer's requirements for participation in the health benefits plan.

Employee means any individual employed by an employer or public entity on a full-time or part-time basis.

Employer has the meaning given that term in section 3(d) of the Fair Labor Standards Act of 1938, except that it—

(1) Includes non-appropriated fund instrumentalities of the United States Government; and

(2) Excludes the following:

(i) The governments of the United States, the District of Columbia and the territories and possessions of the United States, the 50 States and their political subdivisions, and any agencies or instrumentalities of any of the foregoing, including the United States Postal Service and Postal Rate Commission.

(ii) Any church, or convention or association of churches, and any organization operated, supervised, or controlled by a church, or convention or association of churches that meets the following conditions:

(A) Is an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1954.

(B) Does not discriminate, in the employment, compensation, promotion or termination of employment of any personnel, or in the granting of staff and other privileges to physicians or other health personnel, on the grounds that the individuals obtain health care through HMOs, or participate in furnishing health care through HMOs.