

**§ 417.407 Requirements for a Competitive Medical Plan (CMP).**

(a) *General rule.* To qualify as a CMP, an entity must be organized under the laws of a State and must meet the requirements of paragraphs (b) through (f) of this section.

(b) *Required services*—(1) *Basic rule.* Except as provided in paragraph (b)(2) of this section, the entity furnishes to its enrollees at least the following services:

- (i) Physicians' services performed by physicians.
- (ii) Laboratory, x-ray, emergency, and preventive services.
- (iii) Out-of-area coverage.
- (iv) Inpatient hospital services.

(2) Exception for Medicaid prepayment risk contracts. An entity that had, before 1970, a Medicaid prepayment risk contract that did not include provision of inpatient hospital services is not required to provide those services.

(c) *Compensation for services.* The entity receives compensation (except for deductibles, coinsurance, and copayments) for the health care services it provides to enrollees on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any enrollee.

(d) *Source of physicians' services.* The entity provides physicians' services primarily through—

- (1) Physicians who are employees or partners of the entity; or
- (2) Physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity to provide physicians' services.

(e) *Assumption of financial risk.* The rules set forth in §417.120(b) for HMOs apply also to CMPs except that reference to "basic services" must be read as reference to the required services listed in paragraph (b) of this section.

(f) *Protection of enrollees.* The entity provides adequately against the risk of insolvency by meeting the requirements of §§ 417.120(a) and 417.122 for protection of enrollees against loss of benefits and liability for payment of any fees that are the legal responsibility of the entity.

[60 FR 45675, Sept. 1, 1995]

**§ 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 that it meets the requirements for either a risk or reasonable cost contract or only for a reasonable cost contract.

(2) If the HMO or CMP is dissatisfied with a determination that it meets the requirements only for a reasonable cost contract, it may 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.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38078, July 15, 1993; 60 FR 45676, Sept. 1, 1995]

**§ 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.

## § 417.412

(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;
- (2) Has at least 5,000 enrollees or 1,500 enrollees if it serves a primarily rural area as defined in § 417.413(b)(3);
- (3) Has at least 75 Medicare enrollees or has an acceptable plan to achieve this Medicare membership within 2 years;
- (4) Satisfies CMS that it can bear the potential losses of a risk contract; and
- (5) Has not previously terminated or failed to renew a risk contract within the preceding 5 years, unless CMS determines that circumstances warrant special consideration.

(f) *Requirements for a reasonable cost contract.* An HMO or CMP may enter into a reasonable cost contract if it meets one of the following:

- (1) The HMO or CMP qualifies for a risk contract, but chooses a reasonable cost contract.
- (2) The HMO or CMP meets the conditions for entering into a risk contract specified in paragraph (e) of this section except that CMS does not judge the HMO or CMP capable of bearing the potential losses of a risk contract.

(g) Regulations on reasonable cost and risk reimbursement are set forth in subparts O and P of this part.

[50 FR 20570, May 17, 1985, as amended at 58 FR 38078, July 15, 1993; 60 FR 45676, Sept. 1, 1995]

## 42 CFR Ch. IV (10–1–24 Edition)

### § 417.412 Qualifying condition: Administration and management.

The HMO or CMP must demonstrate that it—

- (a) Has sufficient administrative capability to carry out the requirements of the contract; and
- (b) Does not have any agents or management staff or persons with ownership or control interests who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social service programs under title XX of the Act.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 45676, Sept. 1, 1995]

### § 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.

(c) *Standard: Enrollment and operating experience for HMOs or CMPs to contract on a cost basis.* To be eligible to contract on a reasonable cost basis, an HMO or CMP must currently have enrollees sufficient in number to provide a reasonable basis for entering into a contract, as follows:

(1) At least 1,500 enrollees.

(2) At least 75 Medicare enrollees, or a plan acceptable to CMS for achieving—

(i) A Medicare enrollment of 75 within 2 years from the beginning of its initial contract period; and

(ii) At least 250 Medicare enrollees by the beginning of its fourth contract period.

(d) *Standard: Composition of enrollment—(1) Requirement.* Except as specified in paragraphs (d)(2) and (e) of this section, not more than 50 percent of an HMO's or CMP's enrollment may be Medicare beneficiaries.

(2) *Waiver of composition of enrollment standard.* CMS may waive compliance with the requirements of paragraph (d)(1) of this section if the HMO or CMP has made and is making reasonable efforts to enroll individuals who are not Medicare beneficiaries and it meets one of the following requirements:

(i) The HMO or CMP serves a geographic area in which Medicare beneficiaries and Medicaid beneficiaries constitute more than 50 percent of the population. (CMS does not grant a waiver that would permit the percentage of Medicare and Medicaid enrollees to exceed the percentage of Medicare beneficiaries and Medicaid beneficiaries in the population of the geographic area.)

(ii) The HMO or CMP is owned and operated by a government entity. The waiver may be for a period up to three

years after the date the HMO or CMP first enters into a contract under this subpart, and may not be extended.

(iii) The HMO or CMP requests waiver of the composition rule because it is in the public interest. The organization provides documentation that supports one of the following:

(A) The organization serves a medically underserved rural or urban area.

(B) The organization demonstrates a long-term business and community service commitment to the area.

(C) The organization believes that a waiver is necessary to promote managed care choices in an area with limited or no managed care choices.

(3) *Waiver granted on or before October 21, 1986.* An HMO or CMP (or a successor HMO or CMP) that as of October 21, 1986, had been granted an exception, waiver, or modification of the requirements of paragraph (d)(1) of this section, but that does not meet the requirements of paragraph (d)(2) of this section, must make (and throughout the period of the exception, waiver, or modification continue to make) reasonable efforts to meet scheduled enrollment goals, consistent with a schedule of compliance approved by CMS.

(i) If CMS determines that the HMO or CMP has complied, or made significant progress toward compliance, with the approved schedule, and that an extension is in the best interest of the Medicare program, CMS may extend the waiver of modification.

(ii) If CMS determines that the HMO or CMP has not complied with the approved schedule, CMS may apply the sanctions described in paragraphs (d)(6) and (d)(7) of this section.

(4) *Basis for application of sanctions.* CMS may, as an alternative to contract termination, apply the sanctions specified in paragraph (d)(6) of this section if CMS determines that the HMO or CMP is not complying with the requirements in paragraphs (d)(1), (d)(2), or (d)(3) of this section, as applicable.

(5) *Notice of sanction.* Before applying the sanctions specified in paragraph (d)(6) of this section, CMS sends a written notice to the HMO or CMP stating the proposed action and its basis. CMS gives the HMO or CMP 15 days after