

§417.442 Risk HMO's and CMP's: Conditions for provision of additional benefits.

(a) *General rule.* Except as provided in paragraph (b) of this section, a risk HMO or CMP must, during any contract period, provide to its Medicare enrollees the additional benefits described in §417.440(b)(4) if its ACRs (calculated in accordance with §417.594) are less than the average per capita rates that CMS pays for the Medicare enrollees during the contract period.

(b) *Exceptions—(1) Reduced payment election.* An HMO or CMP is not obligated to furnish additional services under paragraph (a) of this section if it has requested a reduction in its monthly payment from CMS under §417.592(e), and it—

(i) Elects to receive reduced payment so that there is no difference between the average of its per capita rates of payment and its ACR; or

(ii) Elects to receive partially reduced payment and furnish Medicare enrollees with additional benefits described in §417.440 (b)(4) so that the combined value of benefits and reduced payment is equivalent to the difference between the average of its per capita rates of payment and its ACR.

(2) *Benefit stabilization fund.* An HMO or CMP may elect to have a part of the value of the additional benefits it must provide under paragraph (a) of this section withheld in a benefit stabilization fund as described in §417.596.

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§417.444 Special rules for certain enrollees of risk HMOs and CMPs.

(a) *Applicability.* This section applies to any Medicare enrollee of a risk HMO or CMP who meets the following conditions:

(1) On February 1, 1985, was enrolled—

(i) In an HMO or CMP that had in effect a cost contract entered into under section 1876 of the Act in accordance with regulations in effect before February 1, 1985; or

(ii) In an HCPP that was being reimbursed on a reasonable cost basis under section 1833(a)(1)(A) of the Act.

(2) Has continued enrollment in the same entity without interruption or disenrolled after February 1, 1985, and later reenrolled in the same entity.

(b) *Retention of nonrisk status—(1)* A “nonrisk” enrollee is a Medicare beneficiary who meets the conditions of paragraph (a) of this section and is enrolled in an entity that enters into a risk contract as an HMO or CMP. A “nonrisk” enrollee may retain nonrisk status indefinitely unless CMS determines under paragraph (c)(1) of this section, that the enrollee’s status must be changed, or the enrollee requests the change, as provided in paragraph (c)(2) of this section.

(2) A nonrisk enrollee of a risk HMO or CMP is not entitled to additional benefits under §417.442.

(c) *Conversion to risk status—(1) Conversion based on CMS determination.* If CMS determines that, for administrative reasons or because there are fewer than 75 current nonrisk Medicare enrollees remaining in the HMO or CMP, all of its nonrisk Medicare enrollees must be covered under the risk provisions of the contract, the conversion process is as follows:

(i) CMS notifies each affected enrollee of the decision at least 90 days prior to the effective date.

(ii) The nonrisk Medicare enrollees complete and sign forms stating that they understand and accept the new rules and benefits that will be applicable to them.

(iii) The HMO or CMP notifies each affected enrollee, in writing, at least 30 days in advance, of the date upon which his or her coverage under the risk portion of the contract takes effect.

(2) *Conversion based on enrollee’s request.* A nonrisk Medicare enrollee requests, using a form identical or similar to the form described in paragraph (c)(1) of this section, that he or she be covered under the risk portion of the contract.

(d) *Notification.* An HMO or CMP converting from a cost contract to a risk contract must, within 60 days of signing the risk contract, inform nonrisk enrollees of their right to remain nonrisk Medicare enrollees or to convert to risk enrollment at any time in