§ 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.

(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 sontract.* 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]

§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