(1) The qualification requirements are changed by Federal law; or

(2) The HMO shows good cause, consistent with the purposes of title XIII of the PHS Act.

(b) *Basis for finding of good cause.* (1) Grounds upon which CMS may find good cause include but are not limited to the following:

(i) The HMO has filed for reorganization under Federal bankruptcy provisions and the reorganization can only be approved with the waiver of the assurances.

(ii) State laws governing the entity have been changed after it signed the assurances so as to prohibit the HMO from being organized and operated in a manner consistent with the signed assurances.

(2) Changes in State laws do not constitute good cause to the extent that the changes are preempted by Federal law under section 1311 of the PHS Act.

(c) *Consequences of waiver.* If CMS waives any assurances regarding compliance with section 1301 of the PHS Act, CMS concurrently revokes the HMO's qualification unless the waiver is based on paragraph (a)(1) of this section.

[59 FR 49842, Sept. 30, 1994, as amended at 61 FR 27288, May 31, 1996]

Subparts G–I [Reserved]

Subpart J—Qualifying Conditions for Medicare Contracts

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

§417.400 Basis and scope.

(a) *Statutory basis.* The regulations in this subpart implement section 1876 of the Act, which authorizes Medicare payment to HMOs and CMPs that contract with CMS to furnish covered services to Medicare beneficiaries.

(b) *Scope.* (1) This subpart sets forth the requirements an HMO or CMP must meet in order to enter into a contract with CMS under section 1876 of the Act. It also specifies the procedures that CMS follows to evaluate applications and make determinations.

(2) The rules for payment to HMOs and CMPs are set forth in subparts N, O, and P of this part.

(3) The rules for HCPP participation in Medicare under section 1833(a)(1)(A) of the Act are set forth in subpart U of this part.

[60 FR 45675, Sept. 1, 1995]

§417.401 Definitions.

As used in this subpart and subparts K through R of this part, unless the context indicates otherwise—

Adjusted average per capita cost (AAPCC) means an actuarial estimate made by CMS in advance of an HMO's or CMP's contract period that represents what the average per capita cost to the Medicare program would be for each class of the HMO's or CMP's Medicare enrollees if they had received covered services other than through the HMO or CMP in the same geographic area or in a similar area.

Adjusted community rate (ACR) is the equivalent of the premium that a risk HMO or CMP would charge Medicare enrollees independently of Medicare payments if the HMO or CMP used the same rates it charges non-Medicare enrollees for a benefit package limited to covered Medicare services.

Arrangement means a written agreement between an HMO or CMP and another entity, under which—

(1) The other entity agrees to furnish specified services to the HMO's or CMP's Medicare enrollees;

(2) The HMO or CMP retains responsibility for the services; and

(3) Medicare payment to the HMO or CMP discharges the beneficiary's obligation to pay for the services.

Benefit stabilization fund means a fund established by CMS, at the request of a risk HMO or CMP, to withhold a portion of the per capita payments available to the HMO or CMP and pay that portion in a subsequent contract period for the purpose of stabilizing fluctuations in the availability of the additional benefits the HMO or CMP provides to its Medicare enrollees.

Cost contract means a Medicare contract under which CMS pays the HMO or CMP on a reasonable cost basis.

Cost HMO or CMP means an HMO or CMP that has in effect a cost contract