(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

with CMS under section 1876 of the Act and subpart L of this part.

Demonstration project means a demonstration project under section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1) or section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b–1 (note)), relating to the provision of services for which payment is made under Medicare on a prospectively determined basis.

Emergency services means covered inpatient or outpatient services that are furnished by an appropriate source other than the HMO or CMP and that meet the following conditions:

(1) Are needed immediately because of an injury or sudden illness.

(2) Are such that the time required to reach the HMO's or CMP's providers or suppliers (or alternatives authorized by the HMO or CMP) would mean risk of permanent damage to the enrollee's health.

Once initiated, the services continue to be considered emergency services as long as transfer of the enrollee to the HMO's or CMP's source of health care or authorized alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable, given the distance and the nature of the medical condition.

Geographic area means the area found by CMS to be the area within which the HMO or CMP furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees.

Medicare enrollee means a Medicare beneficiary who has been identified on CMS records as an enrollee of an HMO or CMP that has a contract with CMS under section 1876 of the Act and subpart L of this part.

New Medicare enrollee means a Medicare beneficiary who—

(1) Enrolls with an HMO or CMP after the date on which the HMO or CMP first enters into a risk contract under subpart L of this part; and

(2) Was not enrolled with the HMO or CMP at the time he or she became entitled to benefits under Part A or eligible to enroll in Part B of Medicare.

Risk contract means a Medicare contract under which CMS pays the HMO or CMP on a risk basis for Medicare covered services.

Risk HMO or CMP means an HMO or CMP that has in effect a risk contract with CMS under section 1876 of the Act and subpart L of this part.

Urgently needed services means covered services that are needed by an enrollee who is temporarily absent from the HMO's or CMP's geographic area and that—

(1) Are required in order to prevent serious deterioration of the enrollee's health as a result of unforeseen injury or illness; and

(2) Cannot be delayed until the enrollee returns to the HMO's or CMP's geographic area.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 51986, Oct. 17, 1991; 58 FR 38072, July 15, 1993; 60 FR 45675, Sept. 1, 1995]

§ 417.402 Effective date of initial regulations.

(a) The changes made to section 1876 of the Act by section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 became effective on February 1, 1985, the effective date of the initial implementing regulations.

(b) No new cost plan contracts are accepted by CMS. CMS will, however, accept and approve applications to modify cost plan contracts in order to expand service areas, provided they are submitted on or before September 1, 2006, and CMS determines that the organization continues to meet regulatory requirements and the requirements in its cost plan contract. Section 1876 cost plan contracts will not be extended or renewed beyond December 31, 2007, where conditions in paragraph (c) of this section are present.

(c) *Mandatory HMO or CMP and contract non-renewal or service area reduction.* CMS will non-renew all or a portion of an HMO's or CMP's contracted service area using procedures in § 417.492(b) and § 417.494(a) for any period beginning on or after January 1, 2013, where—

(1) There were two or more coordinated care plan-model MA regional plans not offered by the same MA organization in the same service area or portion of a service area for the entire previous calendar year meeting the conditions in paragraph(c)(3) of this section; or