(2) There were two or more coordinated care plan-model MA local 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.

(3) *Minimum enrollment requirements.* With respect to any service area or portion of a service area that is within a Metropolitan Statistical Area (MSA) with a population of more than 250,000 and counties contiguous to the MSA that are not in another MSA with a population of more than 250,000, 5000 enrolled individuals. If the service area includes a portion in more than one MSA with a population of more than 250,000, the minimum enrollment determination is made with respect to each such MSA and counties contiguous to the MSA that are not in another MSA with a population of more than 250,000.

[63 FR 35066, June 26, 1998, as amended at 65 FR 40314, June 29, 2000; 67 FR 13288, Mar. 22, 2002; 70 FR 4713, Jan. 28, 2005; 73 FR 54248, Sept. 18, 2008; 76 FR 21560, Apr. 15, 2011; 76 FR 54633, Sept. 1, 2011]

§417.404 General requirements.

(a) In order to contract with CMS under the Medicare program, an entity must—

(1) Be determined by CMS to be an HMO or CMP (in accordance with §§117.142 and 417.407, respectively); and

(2) Comply with the contract requirements set forth in subpart L of this part.

(b) CMS enters into or renews a contract only if it determines that action would be consistent with the effective and efficient implementation of section 1876 of the Act.

[60 FR 45675, Sept. 1, 1995]

§417.406 Application and determination.

(a) *Responsibility for making determinations.* CMS is responsible for determining whether an entity meets the requirements to be an HMO or CMP.

(b) *Application requirements.* (1) The application requirements for HMOs are set forth in §417.143.

(2) The requirements of §417.143 also apply to CMPs except that there are no application fees.

(c) *Determination.* CMS uses the procedures set forth in §417.144(a) through (d) to determine whether an entity is an HMO or CMP.

(d) *Oversight of continuing compliance.* (1) CMS oversees an entity's continued compliance with the requirements for an HMO as defined in §417.1 or for a CMP as set forth in §417.407.

(2) If an entity no longer meets those requirements, CMS terminates the contract of that entity in accordance with §417.494.

[60 FR 45675, Sept. 1, 1995]

§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