

(i) Pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(ii) Does not vary the rates for a provider based on the utilization of that provider's services; and

(iii) Does not restrict enrollees' choices among providers that are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment.

(b) *Multiple plans.* Under its contract, an M+C organization may offer multiple plans, regardless of type, provided that the M+C organization is licensed or approved under State law to provide those types of plans (or, in the case of a PSO plan, has received from CMS a waiver of the State licensing requirement). If an M+C organization has received a waiver for the licensing requirement to offer a PSO plan, that waiver does not apply to the licensing requirement for any other type of M+C plan.

[63 FR 35068, June 26, 1998, as amended at 65 FR 40315, June 29, 2000]

#### § 422.6 Application requirements.

(a) *Scope.* This section sets forth application requirements for entities that seek a contract as an M+C organization offering an M+C plan.

(b) *Completion of an application.* (1) In order to obtain a determination on whether it meets the requirements to become an M+C organization and is qualified to provide a particular type of M+C plan, an entity, or an individual authorized to act for the entity (the applicant) must complete a certified application, in the form and manner required by CMS, including the following:

(i) Documentation of appropriate State licensure or State certification that the entity is able to offer health insurance or health benefits coverage that meets State-specified standards applicable to M+C plans, and is authorized by the State to accept prepaid capitation for providing, arranging, or paying for the comprehensive health care services to be offered under the M+C contract; or

(ii) Federal waiver as described in subpart H of this part.

(2) The authorized individual must describe thoroughly how the entity and M+C plan meet, or will meet, the requirements described in this part.

(c) *Responsibility for making determinations.* CMS is responsible for determining whether an entity qualifies as an M+C organization and whether proposed M+C plans meet the requirements of this part.

(d) *Resubmittal of application.* An application that has been denied by CMS may not be resubmitted for 4 months after the date of the notice from CMS denying the application.

(e) *Disclosure of application information under the Freedom of Information Act.* An applicant submitting material that he or she believes is protected from disclosure under 5 U.S.C. 552, the Freedom of Information Act, or because of exceptions provided in 45 CFR part 5 (the Department's regulations providing exceptions to disclosure), should label the material "privileged" and include an explanation of the applicability of an exception described in 45 CFR part 5.

#### § 422.8 Evaluation and determination procedures.

(a) *Basis for evaluation and determination.* (1) CMS evaluates an application for an M+C contract on the basis of information contained in the application itself and any additional information that CMS obtains through on-site visits, public hearings, and any other appropriate procedures.

(2) If the application is incomplete, CMS notifies the contract applicant and allows 60 days from the date of the notice for the contract applicant to furnish the missing information.

(3) After evaluating all relevant information, CMS determines whether the contract applicant's application meets the applicable requirements of § 422.6.

(b) *Use of information from a prior contracting period.* If an M+C organization, HMO, competitive medical plan, or health care prepayment plan has failed to comply with the terms of a previous year's contract with CMS under title XVIII of the Act, or has failed to complete a corrective action plan during the term of the contract, CMS may deny an application from a contract

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applicant based on the contract applicant's failure to comply with that prior contract with CMS even if the contract applicant meets all of the current requirements.

(c) *Notice of determination.* CMS notifies each applicant that applies for an M+C contract under this part of its determination and the basis for the determination. The determination may be approval, intent to deny, or denial.

(d) *Approval of application.* If CMS approves the application, it gives written notice to the contract applicant, indicating that it meets the requirements for an M+C contract.

(e) *Intent to deny.* (1) If CMS finds that the contract applicant does not appear to meet the requirements for an M+C organization and appears to be able to meet those requirements within 60 days, CMS gives the contract applicant notice of intent to deny the application for an M+C contract and a summary of the basis for this preliminary finding.

(2) Within 60 days from the date of the notice, the contract applicant may respond in writing to the issues or other matters that were the basis for CMS's preliminary finding and may revise its application to remedy any defects CMS identified.

(f) *Denial of application.* If CMS denies the application, it gives written notice to the contract applicant indicating—

(1) That the contract applicant does not meet the contract requirements under part C of title XVIII of the Act;

(2) The reasons why the contract applicant does not meet the contract requirements; and

(3) The contract applicant's right to request reconsideration in accordance with the procedures specified in subpart N of this part.

(g) *Oversight of continuing compliance.* (1) CMS oversees an M+C organization's continued compliance with the requirements for an M+C organization.

(2) If an M+C organization no longer meets those requirements, CMS terminates the contract in accordance with § 422.510.

[65 FR 40315, June 29, 2000]

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### § 422.10 Cost-sharing in enrollment-related costs (M+C user fee).

(a) *Basis and scope.* This section implements that portion of section 1857 of the Act that pertains to cost-sharing in enrollment-related costs. It sets forth the procedures that CMS follows to determine the aggregate annual “user fee” to be contributed by M+C organizations and to assess the required user fees for M+C plans offered by M+C organizations.

(b) *Purpose of assessment.* Section 1857(e)(2) of the Act authorizes CMS to charge and collect from each M+C plan offered by an M+C organization its pro rate share of fees for administering section 1851 of the Act, relating to dissemination of enrollment information; and section 4360 of the Omnibus Budget Reconciliation Act of 1990, relating to the health insurance counseling and assistance program.

(c) *Applicability.* The fee assessment also applies to those demonstrations for which enrollment is effected or coordinated under section 1851 of the Act.

(d) *Collection of fees.* (1) *Timing of collection.* CMS collects the fees over 9 consecutive months beginning with January of each fiscal year.

(2) *Amount to be collected.* The aggregate amount of fees for a fiscal year is the lesser of—

(i) The estimated costs to be incurred by CMS in that fiscal year to carry out the activities described in paragraph (b) of this section; or

(ii) For fiscal year 2000, \$100 million and for fiscal year 2001 and each succeeding year, the M+C portion (as defined in paragraph (e) of this section) of \$100 million.

(e) *M+C portion.* In this section, the term “M+C portion” means, for a fiscal year, the ratio, as estimated by the Secretary of the average number of individuals enrolled in M+C plans during the fiscal year to the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year.

(f) *Assessment methodology.* (1) The amount of the M+C portion of the user fee each M+C organization must pay is assessed as a percentage of the total Medicare payments to each organization. CMS determines this percentage rate using the following formula: