

## § 417.402

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, ac-

## 42 CFR Ch. IV (10-1-06 Edition)

cept 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, 2008, where—

(1) There were two or more coordinated care plan-model MA regional plans 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

(2) There were two or more coordinated care plan-model MA local plans 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.* (i) With respect to any service area or portion of a service area that is within a Metropolitan Statistical Area with a population of more than 250,000 and counties contiguous to the Metropolitan Statistical Area, 5,000 enrolled individuals.

(ii) With respect to any service area or portion of a service area that is not within a Metropolitan Statistical Area described in paragraph (c)(3)(i) of this section, 1,500 individuals.

[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]

### § 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