

including management services, but not including—

(A) Salaries paid to employees for services performed in the normal course of their employment; or

(B) Health services furnished to the HMO's enrollees by hospitals and other providers, and by HMO staff, medical groups, or IPAs, or by any combination of those entities.

(2) *Significant business transaction* means any business transaction or series of transactions of the kind specified in paragraph (c)(1) of this section that, during any fiscal year of the HMO, have a total value that exceeds \$25,000 or 5 percent of the HMO's total operating expenses, whichever is less.

(d) *Requirements for combined financial statements.* (1) The combined financial statements required by paragraph (b)(3) of this section must display in separate columns the financial information for the HMO and each of these parties in interest.

(2) Inter-entity transactions must be eliminated in the consolidated column.

(3) These statements must have been examined by an independent auditor in accordance with generally accepted accounting principles, and must include appropriate opinions and notes.

(4) Upon written request from an HMO showing good cause, CMS may waive the requirement that its combined financial statement include the financial information required in this paragraph (d) with respect to a particular entity.

(e) *Reporting and disclosure under ERISA.* (1) For any employees' health benefits plan that includes an HMO in its offerings, the HMO must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the particular HMO) under the Employee Retirement Income Security Act of 1974 (ERISA).

(2) The HMO must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA.

Subpart D—Application for Federal Qualification

§ 417.140 Scope.

This subpart sets forth—

(a) The requirements for—

(1) Entities that seek qualification as HMOs under title XIII of the PHS Act; and

(2) HMOs that seek—

(i) Qualification for their regional components; or

(ii) Expansion of their service areas;

(b) The procedures that CMS follows to make determinations; and

(c) Other related provisions, including application fees.

[59 FR 49836, Sept. 30, 1994]

§ 417.142 Requirements for qualification.

(a) *General rules.* (1) An entity seeking qualification as an HMO must meet the requirements and provide the assurances specified in paragraphs (b) through (f) of this section, as appropriate.

(2) CMS determines whether the entity is an HMO on the basis of the entity's application and any additional information and investigation (including site visits) that CMS may require.

(3) CMS may determine that an entity is any of the following:

(i) An operational qualified HMO.

(ii) A preoperational qualified HMO.

(iii) A transitional qualified HMO.

(b) *Operational qualified HMO.* CMS determines that an entity is an operational qualified HMO if—

(1) CMS finds that the entity meets the requirements of subparts B and C of this part.

(2) The entity, within 30 days of CMS's determination, provides written assurances, satisfactory to CMS, that it—

(i) Provides and will provide basic health services (and any supplemental health services included in any contract) to its enrollees;

(ii) Provides and will provide these services in the manner prescribed in sections 1301(b) and 1301(c) of the PHS Act and subpart B of this part;

(iii) Is organized and operated and will continue to be organized and operated in the manner prescribed in section 1301(c) of the PHS Act and subpart C of this part;

(iv) Under arrangements that safeguard the confidentiality of patient information and records, will provide access to CMS and the Comptroller General or any of their duly authorized representatives for the purpose of audit, examination or evaluation to any books, documents, papers, and records of the entity relating to its operation as an HMO, and to any facilities that it operates; and

(v) Will continue to comply with any other assurances that it has given to CMS.

(c) *Preoperational qualified HMO.* (1) CMS may determine that an entity is a preoperational qualified HMO if it provides, within 30 days of CMS's determination, satisfactory assurances that it will become operational within 60 days following that determination and will, when it becomes operational, meet the requirements of subparts B and C of this part.

(2) Within 30 days after receiving notice that the entity has begun operation, CMS determines whether it is an operational qualified HMO. In the absence of this determination, the entity is not an operational qualified HMO even though it becomes operational.

(d) *Transitional qualified HMO: General rules—*(1) *Basic requirements.* CMS may determine that an entity is a transitional qualified HMO if the entity—

(i) Meets the requirements of paragraph (d)(2) through (d)(4) of this section; and

(ii) Provides the assurances specified in paragraphs (d)(5) through (d)(7) of this section within 30 days of CMS's determination.

(2) *Organization and operation.* The entity is organized and operated in accordance with subpart C of this part, except that it need not—

(i) Assume full financial risk for the provision of basic health services as required by § 417.120(b); or

(ii) Comply with the limitations that are imposed on insurance by § 417.120(b)(1).

(3) *Range of services.* The entity is currently providing the following services on a prepaid basis:

(i) Physician services.

(ii) Outpatient services and inpatient hospital services. (The entity need not provide or pay for hospital inpatient or outpatient services that it can show are being provided directly, through insurance, or under arrangements, by other entities.)

(iii) Medically necessary emergency services.

(iv) Diagnostic laboratory services and diagnostic and therapeutic radiologic services.

These services must meet the requirement of § 417.101, but may be limited in time and cost without regard to the constraints imposed by § 417.101(a).

(4) *Payment for services—*(i) *General rule.* The entity pays for basic health services in accordance with § 417.104, except that it need not comply with the copayments limitations imposed by § 417.104(a)(4).

(ii) *Determination of payment rates.* In determining payment rates, the entity need not comply with the community rating requirements of §§ 417.104(b) and 417.105(b).

(5) *Contracts in effect on the date of CMS's determination.* The entity gives assurances that it will meet the following conditions with respect to its group and individual contracts that are in effect on the date of CMS's determination, and which are renewed or renegotiated during the period approved by CMS under paragraph (d)(6) of this section:

(i) Continue to provide services in accordance with paragraph (d)(3) of this section.

(ii) Continue to be organized and operated and to pay for basic health services in accordance with paragraphs (d)(2) and (d)(4) of this section, respectively.

(6) *Time-phased plan.* The entity gives assurances as follows:

(i) It will implement a time-phased plan acceptable to CMS that—

(A) May not extend for more than 3 years from the date of CMS's determination; and

(B) Specifies definite steps for meeting, at the time of renewal of each

group or individual contract, all the requirements of subparts B and C of this part.

(ii) Upon completion of this time-phased plan, it will—

(A) Provide basic and supplemental services to all of its enrollees; and

(B) Be organized and operated, and provide services, in accordance with subparts B and C of this part.

(7) *Contracts entered into after the date of CMS's determination.* The entity gives assurances that, with respect to any group or individual contract entered into after the date of CMS's determination, it will—

(i) Be organized and operated in accordance with subpart C of this part; and

(ii) Provide basic health services and any supplemental health services included in the contract, in accordance with subpart B of this part.

(e) *Failure to sign assurances timely.* If CMS determines that an entity meets the requirements for qualification and the entity fails to sign its assurances within 30 days following the date of the determination, CMS gives the entity written notice that its application is considered withdrawn and that it is not a qualified HMO.

(f) *Qualification of regional components.* An HMO that has more than one regional component is considered qualified for those regional components for which assurances have been signed in accordance with this section.

(g) *Special rules: Enrollees entitled to Medicare or Medicaid.* For an HMO that accepts enrollees entitled to Medicare or Medicaid, the following rules apply:

(1) The requirements of titles XVIII and XIX of the Act, as appropriate, take precedence over conflicting requirements of sections 1301(b) and 1301(c) of the PHS Act.

(2) The HMO must, with respect to its enrollees entitled to Medicare or Medicaid, comply with the applicable requirement of title XVIII or XIX, including those that pertain to—

(i) Deductibles and coinsurance;

(ii) Enrollment mix and enrollment practices;

(iii) State plan rules on copayment options; and

(iv) Grievance procedures.

(3) An HMO that complies with paragraph (g)(2) of this section may obtain and retain Federal qualification if, for its other enrollees, the HMO meets the requirements of sections 1301(b) and 1301(c) of the PHS Act and implementing regulations in this subpart D and in subparts B and C of this part.

(h) *Special rules: Enrollees under the Federal employee health benefits program (FEHBP).* An HMO that accepts enrollees under the FEHBP (Chapter 89 of title 5 of the U.S.C.) may obtain and retain Federal qualification if, for its other enrollees, it complies with the requirements of section 1301(b) and 1301(c) of the PHS Act and implementing regulations in this subpart D and subparts B and C of this part.

[59 FR 49836, Sept. 30, 1994]

§417.143 Application requirements.

(a) *General requirements.* This section sets forth application requirements for entities that seek qualification as HMOs; HMOs that seek expansion of their service areas; and HMOs that seek qualification of their regional components as HMOs.

(b) *Completion of an application form.*

(1) In order to receive a determination concerning whether an entity is a qualified HMO, an individual authorized to act for the entity (the applicant) must complete an application form provided by CMS.

(2) The authorized individual must describe thoroughly how the entity meets, or will meet, the requirements for qualified HMOs described in the PHS Act and in subparts B and C of this part, this subpart D, and 417.168 and 417.169 of subpart F.

(c) *Collection of an application fee.* In accordance with the requirements of 31 U.S.C. 9701, Fees and charges for Government services and things of value, CMS determines the amount of the application fee that must be submitted with each type of application.

(1) The fee is reasonably related to the Federal government's cost of qualifying an entity and may vary based on the type of application.

(2) Each type of application has one set fee rather than a charge based on the specific cost of each determination. (For example, each Federally qualified

HMO applicant seeking Federal qualification of one of its regional components as an HMO is charged the same amount, unless the amount of the fee has been changed under paragraph (f) of this section.)

(d) *Application fee amounts.* The application fee amounts for applications completed on or after July 13, 1987 are as follows:

(1) \$18,400 for an entity seeking qualification as an HMO or qualification of a regional component of an HMO.

If, in the case of an HMO seeking qualification of a regional component, CMS determines that there is no need for a site visit, \$8,000 will be returned to the applicant.

(2) \$6,900 for an HMO seeking expansion of its service area.

(3) \$3,100 for a CMP seeking qualification as an HMO.

(e) *Refund of an application fee.* CMS refunds an application fee only if the entity withdraws its application within 10 working days after receipt by CMS. Application fees are not returned in any other circumstance, even if qualification or certification is denied.

(f) *Procedure for changing the amount of an application fee.* If CMS determines that a change in the amount of a fee is appropriate, CMS issues a notice of proposed rulemaking in the FEDERAL REGISTER to announce the proposed new amount.

(g) *New application after denial.* An entity may not submit another application under this subpart for the same type of determination for four full months after the date of the notice in which CMS denied the application.

(h) *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.

[52 FR 22321, June 11, 1987. Redesignated at 52 FR 36746, Sept. 30, 1987, as amended at 58 FR 38077, July 15, 1993]

§ 417.144 Evaluation and determination procedures.

(a) *Basis for evaluation and determination.* (1) CMS evaluates an application for Federal qualification 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 entity and allows 60 days from the date of the notice for the entity to furnish the missing information.

(3) After evaluating all relevant information, CMS determines whether the entity meets the applicable requirements of §§ 417.142 and 417.143.

(b) *Notice of determination.* CMS notifies each entity that applies for qualification under this subpart of its determination and the basis for the determination. The determination may be granting of qualification, intent to deny, or denial.

(c) *Intent to deny.* (1) If CMS finds that the entity does not appear to meet the requirements for qualification and appears to be able to meet those requirements within 60 days, CMS gives the entity notice of intent to deny qualification and a summary of the basis for this preliminary finding.

(2) Within 60 days from the date of the notice, the entity 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 identified by CMS.

(d) *Denial and reconsideration of denial.* (1) If CMS denies an application for qualification under this subpart, CMS gives the entity written notice of the denial and an opportunity to request reconsideration of that determination.

(2) A request for reconsideration must—

(i) Be submitted in writing, within 60 days following the date of the notice of denial;

(ii) Be addressed to the CMS officer or employee who denied the application; and

(iii) Set forth the grounds upon which the entity requests reconsideration, specifying the material issues of

fact and of law upon which the entity relies.

(3) CMS bases its reconsideration upon the record compiled during the qualification review proceedings, materials submitted in support of the request for reconsideration, and other relevant materials available to CMS.

(4) CMS gives the entity written notice of the reconsidered determination and the basis for the determination.

(e) *Information on qualified HMOs*—(1) **FEDERAL REGISTER notices.** In quarterly **FEDERAL REGISTER** notices, CMS gives the names, addresses, and service areas of newly qualified HMOs and describes the expanded service areas of other qualified HMOs.

(2) *Listings.* A cumulative list of qualified HMOs is available from the following office, which is open from 8:30 a.m. to 5 p.m., Monday through Friday: Office of Managed Care, room 4360, Cohen Building, 400 Independence Avenue SW., Washington, DC 20201.

[59 FR 49837, Sept. 30, 1994]

Subpart E—Inclusion of Qualified Health Maintenance Organizations in Employee Health Benefits Plans

SOURCE: 45 FR 72517, Oct. 31, 1980, unless otherwise noted. Redesignated at 52 FR 36746, Sept. 30, 1987.

§417.150 Definitions.

As used in this subpart, unless the context indicates otherwise—

Agreement means a collective bargaining agreement.

Bargaining representative means an individual or entity designated or selected, under any applicable Federal, State, or local law, or public entity collective bargaining agreement, to represent employees in collective bargaining, or any other employee representative designated or selected under any law.

Carrier means a voluntary association, corporation, partnership, or other organization that is engaged in providing, paying for, or reimbursing all or part of the cost of health benefits under group insurance policies or contracts, medical or hospital service agreements, enrollment or subscription

contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier.

Collective bargaining agreement means an agreement entered into between an employing entity and the bargaining representative of its employees.

Contract means an employer-employee or public entity-employee contract, or a contract for health benefits.

Designee means any person or entity authorized to act on behalf of an employing entity or a group of employing entities to offer the option of enrollment in a qualified health maintenance organization to their eligible employees.

Eligible employee means an employee who meets the employer's requirements for participation in the health benefits plan.

Employee means any individual employed by an employer or public entity on a full-time or part-time basis.

Employer has the meaning given that term in section 3(d) of the Fair Labor Standards Act of 1938, except that it—

(1) Includes non-appropriated fund instrumentalities of the United States Government; and

(2) Excludes the following:

(i) The governments of the United States, the District of Columbia and the territories and possessions of the United States, the 50 States and their political subdivisions, and any agencies or instrumentalities of any of the foregoing, including the United States Postal Service and Postal Rate Commission.

(ii) Any church, or convention or association of churches, and any organization operated, supervised, or controlled by a church, or convention or association of churches that meets the following conditions:

(A) Is an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1954.

(B) Does not discriminate, in the employment, compensation, promotion or termination of employment of any personnel, or in the granting of staff and other privileges to physicians or other health personnel, on the grounds that the individuals obtain health care through HMOs, or participate in furnishing health care through HMOs.