

determine what constitutes a substantive versus a nonsubstantive change to a measure's specifications on a case-by-case basis.

(b) *Substantive changes.* CMS will continue to use rulemaking to adopt substantive updates to measures in the ASCQR Program.

(c) *Nonsubstantive changes.* If CMS determines that a change to a measure previously adopted in the ASCQR Program is nonsubstantive, CMS will use a subregulatory process to revise the ASCQR Program Specifications Manual so that it clearly identifies the changes to that measure and provide links to where additional information on the changes can be found. When a measure undergoes subregulatory maintenance, CMS will provide notification of the measure specification update on the QualityNet Web site and in the ASCQR Program Specifications Manual, and will provide sufficient lead time for ASCs to implement the revisions where changes to the data collection systems would be necessary.

#### **§ 416.330 Reconsiderations under the ASCQR Program.**

(a) *Reconsiderations of ASCQR Program decisions.* An ASC may request reconsideration of a decision by CMS that it has not met the requirements of the ASCQR Program for a particular payment determination year. An ASC must submit a reconsideration request to CMS by no later than the first business day on or after March 17 of the affected payment year.

(b) *Requirements for reconsideration requests.* A reconsideration request must contain the following information:

- (1) The ASC CCN and related NPI(s);
- (2) The name of the ASC;
- (3) The CMS-identified reason for not meeting the requirements of the ASCQR Program for the affected payment determination year as provided in any CMS notification to the ASC;

(4) The ASC's basis for requesting reconsideration. The ASC must identify its specific reason(s) for believing it met the ASCQR Program requirements for the affected payment determination year and should not be subject to the reduced ASC annual payment update;

(5) The ASC-designated personnel contact information, including name, email address, telephone number, and mailing address (must include physical mailing address, not just a post office box); and

(6) A copy of all materials that the ASC submitted to comply with the requirements of the affected ASCQR Program payment determination year. With regard to information on claims, ASCs are not required to submit copies of all submitted claims, but instead may focus on the specific claims at issue. For these claims, ASCs should submit relevant information, which could include copies of the actual claims at issue.

(c) *Reconsideration process.* Upon receipt of a request for reconsideration, CMS will do the following:

(1) Provide an email acknowledgment, using the contact information provided in the reconsideration request, notifying the ASC that the request has been received; and

(2) Provide a formal response to the ASC contact using the information provided in the reconsideration request notifying the ASC of the outcome of the reconsideration process.

(d) *Final ASCQR Program payment determination.* For an ASC that submits a timely reconsideration request, the reconsideration determination is the final ASCQR Program payment determination. For an ASC that does not submit a timely reconsideration request, the CMS determination is the final payment determination. There is no appeal of any final ASCQR Program payment determination.

## **PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS**

### **Subpart A—General Provisions**

Sec.

417.1 Definitions.

417.2 Basis and scope.

### **Subpart B—Qualified Health Maintenance Organizations: Services**

417.101 Health benefits plan: Basic health services.

**Pt. 417**

- 417.102 Health benefits plan: Supplemental health services.
- 417.103 Providers of basic and supplemental health services.
- 417.104 Payment for basic health services.
- 417.105 Payment for supplemental health services.
- 417.106 Quality assurance program; Availability, accessibility, and continuity of basic and supplemental health services.

**Subpart C—Qualified Health Maintenance Organizations: Organization and Operation**

- 417.120 Fiscally sound operation and assumption of financial risk.
- 417.122 Protection of enrollees.
- 417.124 Administration and management.
- 417.126 Recordkeeping and reporting requirements.

**Subpart D—Application for Federal Qualification**

- 417.140 Scope.
- 417.142 Requirements for qualification.
- 417.143 Application requirements.
- 417.144 Evaluation and determination procedures.

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

- 417.150 Definitions.
- 417.151 Applicability.
- 417.153 Offer of HMO alternative.
- 417.155 How the HMO option must be included in the health benefits plan.
- 417.156 When the HMO must be offered to employees.
- 417.157 Contributions for the HMO alternative.
- 417.158 Payroll deductions.
- 417.159 Relationship of section 1310 of the Public Health Service Act to the National Labor Relations Act and the Railway Labor Act.

**Subpart F—Continued Regulation of Federally Qualified Health Maintenance Organizations**

- 417.160 Applicability.
- 417.161 Compliance with assurances.
- 417.162 Reporting requirements.
- 417.163 Enforcement procedures.
- 417.164 Effect of revocation of qualification on inclusion in employee's health benefit plans.
- 417.165 Reapplication for qualification.
- 417.166 Waiver of assurances.

**Subparts G–I [Reserved]**

**42 CFR Ch. IV (10–1–23 Edition)**

**Subpart J—Qualifying Conditions for Medicare Contracts**

- 417.400 Basis and scope.
- 417.401 Definitions.
- 417.402 Effective date of initial regulations.
- 417.404 General requirements.
- 417.406 Application and determination.
- 417.407 Requirements for a Competitive Medical Plan (CMP).
- 417.408 Contract application process.
- 417.410 Qualifying conditions: General rules.
- 417.412 Qualifying condition: Administration and management.
- 417.413 Qualifying condition: Operating experience and enrollment.
- 417.414 Qualifying condition: Range of services.
- 417.416 Qualifying condition: Furnishing of services.
- 417.418 Qualifying condition: Quality assurance program.

**Subpart K—Enrollment, Entitlement, and Disenrollment Under Medicare Contract**

- 417.420 Basic rules on enrollment and entitlement.
- 417.422 Eligibility to enroll in an HMO or CMP.
- 417.423 Special rules: ESRD and hospice patients.
- 417.424 Denial of enrollment.
- 417.426 Open enrollment requirements.
- 417.427 Extending MA and Part D program disclosure requirements to section 1876 cost contract plans.
- 417.428 Marketing activities.
- 417.430 Application procedures.
- 417.432 Conversion of enrollment.
- 417.434 Reenrollment.
- 417.436 Rules for enrollees.
- 417.440 Entitlement to health care services from an HMO or CMP.
- 417.442 Risk HMO's and CMP's: Conditions for provision of additional benefits.
- 417.444 Special rules for certain enrollees of risk HMOs and CMPs.
- 417.446 [Reserved]
- 417.448 Restriction on payments for services received by Medicare enrollees of risk HMOs or CMPs.
- 417.450 Effective date of coverage.
- 417.452 Liability of Medicare enrollees.
- 417.454 Charges to Medicare enrollees.
- 417.456 Refunds to Medicare enrollees.
- 417.458 Recoupment of uncollected deductible and coinsurance amounts.
- 417.460 Disenrollment of beneficiaries by an HMO or CMP.
- 417.461 Disenrollment by the enrollee.
- 417.464 End of CMS's liability for payment: Disenrollment of beneficiaries and termination or default of contract.

**Subpart L—Medicare Contract Requirements**

- 417.470 Basis and scope.
- 417.472 Basic contract requirements.
- 417.474 Effective date and term of contract.
- 417.476 Waived conditions.
- 417.478 Requirements of other laws and regulations.
- 417.479 Requirements for physician incentive plans.
- 417.480 Maintenance of records: Cost HMOs and CMPs.
- 417.481 Maintenance of records: Risk HMOs or CMPs.
- 417.482 Access to facilities and records.
- 417.484 Requirement applicable to related entities.
- 417.486 Disclosure of information and confidentiality.
- 417.488 Notice of termination and of available alternatives: Risk contract.
- 417.490 Renewal of contract.
- 417.492 Nonrenewal of contract.
- 417.494 Modification or termination of contract.
- 417.496 Cost plan crosswalk.
- 417.500 Intermediate sanctions for and civil monetary penalties against HMOs and CMPs.

**Subpart M—Change of Ownership and Leasing of Facilities: Effect on Medicare Contract**

- 417.520 Effect on HMO and CMP contracts.

**Subpart N—Medicare Payment to HMOs and CMPs: General Rules**

- 417.524 Payment to HMOs or CMPs: General.
- 417.526 Payment for covered services.
- 417.528 Payment when Medicare is not primary payer.

**Subpart O—Medicare Payment: Cost Basis**

- 417.530 Basis and scope.
- 417.531 Hospice care services.
- 417.532 General considerations.
- 417.533 Part B carrier responsibilities.
- 417.534 Allowable costs.
- 417.536 Cost payment principles.
- 417.538 Enrollment and marketing costs.
- 417.540 Enrollment costs.
- 417.542 Reinsurance costs.
- 417.544 Physicians' services furnished directly by the HMO or CMP.
- 417.546 Physicians' services and other Part B supplier services furnished under arrangements.
- 417.548 Provider services through arrangements.
- 417.550 Special Medicare program requirements.
- 417.552 Cost apportionment: General provisions.

- 417.554 Apportionment: Provider services furnished directly by the HMO or CMP.
- 417.556 Apportionment: Provider services furnished by the HMO or CMP through arrangements with others.
- 417.558 Emergency, urgently needed, and out-of-area services for which the HMO or CMP accepts financial responsibility.
- 417.560 Apportionment: Part B physician and supplier services.
- 417.564 Apportionment and allocation of administrative and general costs.
- 417.566 Other methods of allocation and apportionment.
- 417.568 Adequate financial records, statistical data, and cost finding.
- 417.570 Interim per capita payments.
- 417.572 Budget and enrollment forecast and interim reports.
- 417.574 Interim settlement.
- 417.576 Final settlement.

**Subpart P—Medicare Payment: Risk Basis**

- 417.580 Basis and scope.
- 417.582 Definitions.
- 417.584 Payment to HMOs or CMPs with risk contracts.
- 417.585 Special rules: Hospice care.
- 417.588 Computation of adjusted average per capita cost (AAPCC).
- 417.590 Computation of the average of the per capita rates of payment.
- 417.592 Additional benefits requirement.
- 417.594 Computation of adjusted community rate (ACR).
- 417.596 Establishment of a benefit stabilization fund.
- 417.597 Withdrawal from a benefit stabilization fund.
- 417.598 Annual enrollment reconciliation.

**Subpart Q—Beneficiary Appeals**

- 417.600 Basis and scope.

**Subpart R—Medicare Contract Appeals**

- 417.640 Applicability.

**Subparts S–T [Reserved]****Subpart U—Health Care Prepayment Plans**

- 417.800 Payment to HCPPs: Definitions and basic rules.
- 417.801 Agreements between CMS and health care prepayment plans.
- 417.802 Allowable costs.
- 417.804 Cost apportionment.
- 417.806 Financial records, statistical data, and cost finding.
- 417.808 Interim per capita payments.
- 417.810 Final settlement.
- 417.830 Scope of regulations on beneficiary appeals.
- 417.832 Applicability of requirements and procedures.

## § 417.1

## 42 CFR Ch. IV (10–1–23 Edition)

- 417.834 Responsibility for establishing administrative review procedures.
- 417.836 Written description of administrative review procedures.
- 417.838 Organization determinations.
- 417.840 Administrative review procedures.

### Subpart V—Administration of Outstanding Loans and Loan Guarantees

- 417.910 Applicability.
- 417.911 Definitions.
- 417.920 Planning and initial development.
- 417.930 Initial costs of operation.
- 417.931 [Reserved]
- 417.934 Reserve requirement.
- 417.937 Loan and loan guarantee provisions.
- 417.940 Civil action to enforce compliance with assurances.

AUTHORITY: 42 U.S.C. 1302 and 1395hh, and 300e, 300e–5, and 300e–9, and 31 U.S.C. 9701.

### Subpart A—General Provisions

#### § 417.1 Definitions.

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

*Basic health services* means health services described in § 417.101(a).

*Community rating system* means a system of fixing rates of payments for health services that meets the requirements of § 417.104(a)(3).

*Comprehensive health services* means as a minimum the following services which may be limited as to time and cost:

- (1) Physician services (§ 417.101(a)(1));
- (2) Outpatient services and inpatient hospital services (§ 417.101(a)(2));
- (3) Medically necessary emergency health services (§ 417.101(a)(3)); and
- (4) Diagnostic laboratory and diagnostic and therapeutic radiologic services (§ 417.101(a)(6)).

*Direct service contract* means a contract for the provision of basic or supplemental health services or both between an HMO and (1) a health professional other than a member of the staff of the HMO, or (2) an entity other than a medical group or an IPA.

*Enrollee* means an individual for whom an HMO, CMP, or HCPP assumes the responsibility, under a contract or agreement, for the furnishing of health care services on a prepaid basis.

*Full-time student* means a student who is enrolled for a sufficient number of credit hours in a semester or other academic term to enable the student to

complete the course of study within not more than the number of semesters or other academic terms normally required to complete that course of study on a full-time basis at the school in which the student is enrolled.

*Furnished*, when used in connection with prepaid health care services, means services that are made available to an enrollee either directly by, or under arrangements made by, the HMO, CMP, or HCPP.

*Health maintenance organization (HMO)* means a legal entity that provides or arranges for the provision of basic and supplemental health services to its enrollees in the manner prescribed by, is organized and operated in the manner prescribed by, and otherwise meets the requirements of, section 1301 of the PHS Act and the regulations in subparts B and C of this part.

*Health professionals* means physicians (doctors of medicine and doctors of osteopathy), dentists, nurses, podiatrists, optometrists, physicians' assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists, and other professionals engaged in the delivery of health services who are licensed, practice under an institutional license, are certified, or practice under authority of the HMO, a medical group, individual practice association, or other authority consistent with State law.

*Individual practice association (IPA)* means a partnership, association, corporation, or other legal entity that delivers or arranges for the delivery of health services and which has entered into written services arrangement or arrangements with health professionals, a majority of whom are licensed to practice medicine or osteopathy. The written services arrangement must provide:

- (1) That these health professionals will provide their professional services in accordance with a compensation arrangement established by the entity; and
- (2) To the extent feasible, for the sharing by these health professionals of health (including medical) and other records, equipment, and professional, technical, and administrative staff.