

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;