

## § 417.474

Age Discrimination Act of 1975 (regulations at 45 CFR part 91).

(f) *Requirements for advance directives.* The HMO or CMP must meet all the requirements for advance directives at § 417.436(d).

(g) *Authority to waive conflicting contract requirements.* Under section 1876(i)(5) of the Act, CMS is authorized to administer the terms of this subpart without regard to provisions of law or other regulations relating to the making, performance, amendment, or modification of contracts of the United States if it determines that those provisions are inconsistent with the efficient and effective administration of the Medicare program.

(h) *Collection of fees from risk HMOs and CMPs.* (1) The rules set forth in § 422.10 of this chapter for M + C plans also apply to collection of fees from risk HMOs and CMPs.

(2) In applying the part 422 rules, references to “M + C organizations” or “M + C plans” must be read as references to “risk HMOs and CMPs”.

(i) *HMOs and CMPs.* The HMO or CMP must comply with the requirements at § 422.152(b)(5) and (6) of this chapter.

(j) *Coordinated care and cost contracts.* Subject to paragraph (i) of this section, all coordinated care contracts (including local and regional PPOs, contracts with exclusively SNP benefit packages, private fee-for-service contracts, and MSA contracts), and all cost contracts under section 1876 of the Act, with 600 or more enrollees in July of the prior year, must contract with approved Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendors to conduct the Medicare CAHPS satisfaction survey of Medicare plan enrollees in accordance with CMS specifications and submit the survey data to CMS.

(k) All cost contracts under section 1876 of the Act must agree to be rated under the quality rating system specified at subpart D of part 422, and for cost plans that provide the Part D prescription benefit, under the quality rating system specified at part 423 subpart D, of this chapter. Cost contracts are not required to submit data on or be rated on specific measures determined by CMS to be inapplicable to

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their contract or for which data are not available, including hospital readmission and call center measures.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 57 FR 8202, Mar. 6, 1992; 58 FR 38079, July 15, 1993; 60 FR 45680, Sept. 1, 1995; 63 FR 35067, June 26, 1998; 75 FR 19802, Apr. 15, 2010; 83 FR 16721, Apr. 16, 2018; 85 FR 19289, Apr. 6, 2020]

### § 417.474 Effective date and term of contract.

(a) *Effective date.* The contract must specify its effective date, which may not be earlier than the date it is signed by both CMS and the HMO or CMP.

(b) *Term.* The contract must specify the duration of its term as follows:

(1) For the initial term, at least 12 months, but no more than 23 months.

(2) For any subsequent term, 12 months.

[60 FR 45680, Sept. 1, 1995]

### § 417.476 Waived conditions.

If CMS waives any of the qualifying conditions required under subpart J of this part, the contract must specify the following information for each waived condition:

(a) The specific terms of the waiver.

(b) The expiration date of the waiver.

(c) Any other information required by CMS.

[60 FR 45680, Sept. 1, 1995]

### § 417.478 Requirements of other laws and regulations.

The contract must provide that the HMO or CMP agrees to comply with—

(a) The requirements for QIO review of services furnished to Medicare enrollees as set forth in subchapter D of this chapter;

(b) Sections 1318(a) and (c) of the PHS Act, which pertain to disclosure of certain financial information;

(c) Section 1301(c)(8) of the PHS Act, which relates to liability arrangements to protect enrollees of the HMO or CMP; and

(d) The reporting requirements in § 417.126(a), which pertain to the monitoring of an HMO's or CMP's continued compliance.

(e)(1) The prohibitions, procedures and requirements relating to payment

to individuals and entities on the preclusion list, defined in §422.2 of this chapter, apply to HMOs and CMPs that contract with CMS under section 1876 of the Act.

(2) In applying the provisions of §§422.2, 422.222, and 422.224 of this chapter under paragraph (e)(1) of this section, references to part 422 of this chapter must be read as references to this part, and references to MA organizations as references to HMOs and CMPs.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38079, 38082, July 15, 1993; 80 FR 80556, Nov. 15, 2016; 83 FR 16721, Apr. 16, 2018]

**§417.479 Requirements for physician incentive plans.**

(a) The contract must specify that an HMO or CMP may operate a physician incentive plan only if—

(1) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and

(2) The stop-loss protection, enrollee survey, and disclosure requirements of this section are met.

(b) *Applicability.* The requirements in this section apply to physician incentive plans between HMOs and CMP and individual physicians or physician groups with which they contract to provide medical services to enrollees. The requirements in this section also apply to subcontracting arrangements as specified in §417.479(i). These requirements apply only to physician incentive plans that base compensation (in whole or in part) on the use or cost of services furnished to Medicare beneficiaries or Medicaid beneficiaries.

(c) *Definitions.* For purposes of this section:

*Bonus* means a payment an HMO or CMP makes to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withhold.

*Capitation* means a set dollar payment per patient per unit of time (usually per month) that an organization pays a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of services provided.

The services covered may include the physician's own services, referral services, or all medical services.

*Payments* means any amounts the HMO or CMP pays physicians or physician groups for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician group to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of this section.

*Physician group* means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

*Physician incentive plan* means any compensation arrangement between an HMO or CMP and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare beneficiaries or Medicaid beneficiaries enrolled in the HMO or CMP.

*Referral services* means any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish directly.

*Risk threshold* means the maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk.

*Withhold* means a percentage of payments or set dollar amounts that an HMO or CMP deducts from a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.

(d) *Prohibited physician payments.* No specific payment of any kind may be made directly or indirectly under the