

that are acceptable to CMS. They include expenditures for health care services for which the organization is at risk, such as out-of-area services, referral services and hospital services. However, they do not include expenditures for services when a provider has agreed not to bill the enrollee.

[63 FR 18134, Apr. 14, 1998, as amended at 63 FR 25376, May 7, 1998; 63 FR 35098, June 26, 1998]

§ 422.352 Basic requirements.

(a) *General rule.* An organization is considered a PSO for purposes of a MA contract if the organization—

(1) Has obtained a waiver of State licensure as provided for under § 422.370;

(2) Meets the definition of a PSO set forth in § 422.350 and other applicable requirements of this subpart; and

(3) Is effectively controlled by the provider or, in the case of a group, by one or more of the affiliated providers that established and operate the PSO.

(b) *Provision of services.* A PSO must demonstrate to CMS's satisfaction that it is capable of delivering to Medicare enrollees the range of services required under a contract with CMS. Each PSO must deliver a substantial proportion of those services directly through the provider or the affiliated providers responsible for operating the PSO. Substantial proportion means—

(1) For a non-rural PSO, not less than 70% of Medicare services covered under the contract.

(2) For a rural PSO, not less than 60% of Medicare services covered under the contract.

(c) *Rural PSO.* To qualify as a rural PSO, a PSO must—

(1) Demonstrate to CMS that—

(i) It has available in the rural area, as defined in § 412.62(f) of this chapter, routine services including but not limited to primary care, routine specialty care, and emergency services; and

(ii) The level of use of providers outside the rural area is consistent with general referral patterns for the area; and

(2) Enroll Medicare beneficiaries, the majority of which reside in the rural area the PSO serves.

[63 FR 18134, Apr. 14, 1998, as amended at 63 FR 35098, June 26, 1998; 65 FR 40327, June 29, 2000]

§ 422.354 Requirements for affiliated providers.

A PSO that consists of two or more providers must demonstrate to CMS's satisfaction that it meets the following requirements:

(a) The providers are affiliated. For purposes of this subpart, providers are affiliated if, through contract, ownership, or otherwise—

(1) One provider, directly or indirectly, controls, is controlled by, or is under common control with another;

(2) Each provider is part of a lawful combination under which each shares substantial financial risk in connection with the PSO's operations;

(3) Both, or all, providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986; or

(4) Both, or all, providers are part of an affiliated service group under section 414 of that Code.

(b) Each affiliated provider of the PSO shares, directly or indirectly, substantial financial risk for the furnishing of services the PSO is obligated to provide under the contract.

(c) Affiliated providers, as a whole or in part, have at least a majority financial interest in the PSO.

(d) For purposes of paragraph(a)(1) of this section, control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance right of another.

[63 FR 18134, Apr. 14, 1998, as amended at 63 FR 35098, June 26, 1998]

§ 422.356 Determining substantial financial risk and majority financial interest.

(a) *Determining substantial financial risk.* The PSO must demonstrate to CMS's satisfaction that it apportions a significant part of the financial risk of the PSO enterprise under the MA contract to each affiliated provider. The PSO must demonstrate that the financial arrangements among its affiliated providers constitute "substantial" risk in the PSO for each affiliated provider. The following mechanisms may constitute risk-sharing arrangements, and may have to be used in combination to