

*Payment data* means data submitted by an MA organization to CMS and used for payment purposes, including enrollment data and data submitted under § 422.310.

(b) *Request to correct payment data.* (1) When CMS identifies erroneous payment data submitted by an MA organization (other than an error identified through the process described in § 422.311), CMS may send a data correction notice to the MA organization requesting that the MA organization correct the payment data.

(2) The notice will include or make reference to the specific payment data that need to be corrected, the reason why CMS believes that the payment data are erroneous, and the timeframe for correcting the payment data.

(c) *Payment offset.* (1) If the MA organization fails to submit the corrected payment data within the timeframe as requested in accordance with paragraph (b) of this section, CMS will conduct a payment offset against payments made to the MA organization if—

(i) The payment error affects payments for any of the 6 most recently completed payment years; and

(ii) The payment error for a particular payment year is identified after the applicable reconciliation date for that payment year.

(2) CMS will calculate the payment offset amount using the correct payment data and a payment algorithm that applies the payment rules for the applicable year.

(d) *Payment offset notification.* CMS will issue a payment offset notice to the MA organization that includes at least the following:

(1) The dollar amount of the offset from plan payments.

(2) An explanation of how the erroneous data were identified and used to calculate the payment offset amount.

(3) An explanation that, if the MA organization disagrees with the payment offset, it may request an appeal within 30 days of issuance of the payment offset notification.

(e) *Appeals process.* If an MA organization does not agree with the payment offset described in paragraph (c) of this section, it may appeal under the following three-level appeal process:

(1) *Reconsideration.* An MA organization may request reconsideration of the payment offset described in paragraph (c) of this section, according to the following process:

(i) *Manner and timing of request.* A written request for reconsideration must be filed within 30 days from the date that CMS issued the payment offset notice to the MA organization.

(ii) *Content of request.* The written request for reconsideration must specify the findings or issues with which the MA organization disagrees and the reasons for its disagreement. As part of its request for reconsideration, the MA organization may include any additional documentary evidence in support of its position. Any additional evidence must be submitted with the request for reconsideration. Additional information submitted after this time will be rejected as untimely.

(iii) *Conduct of reconsideration.* In conducting the reconsideration, the CMS reconsideration official reviews the underlying data that were used to determine the amount of the payment offset and any additional documentary evidence timely submitted by the MA organization.

(iv) *Reconsideration decision.* The CMS reconsideration official informs the MA organization of its decision on the reconsideration request.

(v) *Effect of reconsideration decision.* The decision of the CMS reconsideration official is final and binding unless a timely request for an informal hearing is filed in accordance with paragraph (e)(2) of this section.

(2) *Informal hearing.* An MA organization dissatisfied with CMS' reconsideration decision made under paragraph (e)(1) of this section is entitled to an informal hearing as provided for under paragraphs (e)(2)(i) through (e)(2)(v) of this section.

(i) *Manner and timing for request.* A request for an informal hearing must be made in writing and filed with CMS within 30 days of the date of CMS' reconsideration decision.

(ii) *Content of request.* The request for an informal hearing must include a copy of the reconsideration decision and must specify the findings or issues

in the decision with which the MA organization disagrees and the reasons for its disagreement.

(iii) *Informal hearing procedures.* The informal hearing will be conducted in accordance with the following:

(A) CMS provides written notice of the time and place of the informal hearing at least 30 days before the scheduled date.

(B) The informal hearing is conducted by a CMS hearing officer who neither receives testimony nor accepts any new evidence that was not timely presented with the reconsideration request. The CMS hearing officer is limited to the review of the record that was before the CMS reconsideration official when CMS made its reconsideration determination.

(C) The CMS hearing officer will review the proceeding before the CMS reconsideration official on the record made before the CMS reconsideration official using the clearly erroneous standard of review.

(iv) *Decision of the CMS hearing officer.* The CMS hearing officer decides the case and sends a written decision to the MA organization explaining the basis for the decision.

(v) *Effect of hearing officer's decision.* The hearing officer's decision is final and binding, unless the decision is reversed or modified by the Administrator in accordance with paragraph (e)(3) of this section.

(3) *Review by the Administrator.* The Administrator review will be conducted in the following manner:

(i) An MA organization that has received a hearing officer's decision may request review by the Administrator within 30 days of the date of issuance of the hearing officer's decision under paragraph (e)(2)(iv) of this section. The MA organization may submit written arguments to the Administrator for review.

(ii) After receiving a request for review, the Administrator has the discretion to elect to review the hearing officer's determination in accordance with paragraph (e)(3)(iv) of this section or to decline to review the hearing officer's decision.

(iii) If the Administrator declines to review the hearing officer's decision,

the hearing officer's decision is final and binding.

(iv) If the Administrator elects to review the hearing officer's decision, the Administrator will review the hearing officer's decision, as well as any information included in the record of the hearing officer's decision and any written argument submitted by the MA organization, and determine whether to uphold, reverse, or modify the hearing officer's decision.

(v) The Administrator's determination is final and binding.

(f) *Matters subject to appeal and burden of proof.* (1) The MA organization's appeal is limited to CMS' finding that the payment data submitted by the MA organization are erroneous.

(2) The MA organization bears the burden of proof by a preponderance of the evidence in demonstrating that CMS' finding that the payment data were erroneous was incorrect or otherwise inconsistent with applicable program requirements.

(g) *Applicability of appeals process.* The appeals process under paragraph (e) of this section applies only to payment offsets under paragraph (c) of this section.

[79 FR 67031, Nov. 10, 2014]

## Subpart H—Provider-Sponsored Organizations

EDITORIAL NOTE: Nomenclature changes to subpart H of part 422 appear at 63 FR 35098, 35099, June 26, 1998.

### § 422.350 Basis, scope, and definitions.

(a) *Basis and scope.* This subpart is based on sections 1851 and 1855 of the Act which, in part,—

(1) Authorize provider sponsored organizations, (PSOs), to contract as a MA plan;

(2) Require that a PSO meet certain qualifying requirements; and

(3) Provide for waiver of State licensure for PSOs under specified conditions.

(b) *Definitions.* As used in this subpart (unless otherwise specified)—

*Capitation payment* means a fixed per enrollee per month amount paid for contracted services without regard to

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the type, cost, or frequency of services furnished.

*Cash equivalent* means those assets excluding accounts receivable that can be exchanged on an equivalent basis as cash, or converted into cash within 90 days from their presentation for exchange.

*Control* means that an individual, group of individuals, or entity has the power, directly or indirectly, to direct or influence significantly the actions or policies of an organization or institution.

*Current ratio* means total current assets divided by total current liabilities.

*Deferred acquisition costs* are those costs incurred in starting or purchasing a business. These costs are capitalized as intangible assets and carried on the balance sheet as deferred charges since they benefit the business for periods after the period in which the costs were incurred.

*Engaged in the delivery of health care services* means—

(1) For an individual, that the individual directly furnishes health care services, or

(2) For an entity, that the entity is organized and operated primarily for the purpose of furnishing health care services directly or through its provider members or entities.

*Generally accepted accounting principles (GAAP)* means broad rules adopted by the accounting profession as guides in measuring, recording, and reporting the financial affairs and activities of a business to its owners, creditors and other interested parties.

*Guarantor* means an entity that—

(1) Has been approved by CMS as meeting the requirements to be a guarantor; and

(2) Obligates its resources to a PSO to enable the PSO to meet the solvency requirements required to contract with CMS as an MA organization.

*Health care delivery assets (HCDAs)* means any tangible assets that are part of a PSO's operation, including hospitals and other medical facilities and their ancillary equipment, and such property as may be reasonably required for the PSO's principal office or for such other purposes as the PSO may need for transacting its business.

*Insolvency* means a condition in which the liabilities of the debtor exceed the fair valuation of its assets.

*Net worth* means the excess of total assets over total liabilities, excluding fully subordinated debt or subordinated liabilities.

*Provider-sponsored organization (PSO)* means a public or private entity that—

(1) Is established or organized, and operated, by a provider or group of affiliated providers;

(2) Provides a substantial proportion (as defined in § 422.352) of the health care services under the MA contract directly through the provider or affiliated group of providers; and

(3) When it is a group, is composed of affiliated providers who—

(i) Share, directly or indirectly, substantial financial risk, as determined under § 422.356, for the provision of services that are the obligation of the PSO under the MA contract; and

(ii) Have at least a majority financial interest in the PSO.

*Qualified actuary* means a member in good standing of the American Academy of Actuaries or a person recognized by the Academy as qualified for membership, or a person who has otherwise demonstrated competency in the field of actuarial determination and is satisfactory to CMS.

*Statutory accounting practices* means those accounting principles or practices prescribed or permitted by the domiciliary State insurance department in the State that PSO operates.

*Subordinated debt* means an obligation that is owed by an organization, that the creditor of the obligation, by law, agreement, or otherwise, has a lower repayment rank in the hierarchy of creditors than another creditor. The creditor would be entitled to repayment only after all higher ranking creditors' claims have been satisfied. A debt is fully subordinated if it has a lower repayment rank than all other classes of creditors.

*Subordinated liability* means claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all other creditors.

*Uncovered expenditures* means those expenditures for health care services

that are the obligation of an organization, for which an enrollee may also be liable in the event of the organization's insolvency and for which no alternative arrangements have been made 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

## § 422.370

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 demonstrate substantial financial risk in the PSO enterprise.

(1) Agreement by a provider to accept capitation payment for each Medicare enrollee.

(2) Agreement by a provider to accept as payment a predetermined percentage of the PSO premium or the PSO’s revenue.

(3) The PSO’s use of significant financial incentives for its affiliated providers, with the aim of achieving utilization management and cost containment goals. Permissible methods include the following:

(i) Affiliated providers agree to a withholding of a significant amount of the compensation due them, to be used for any of the following:

(A) To cover losses of the PSO.

(B) To cover losses of other affiliated providers.

(C) To be returned to the affiliated provider if the PSO meets its utilization management or cost containment goals for the specified time period.

(D) To be distributed among affiliated providers if the PSO meets its utilization management or cost-containment goals for the specified time period.

(ii) Affiliated providers agree to preestablished cost or utilization targets for the PSO and to subsequent significant financial rewards and penalties (which may include a reduction in payments to the provider) based on the PSO’s performance in meeting the targets.

(4) Other mechanisms that demonstrate significant shared financial risk.

(b) *Determining majority financial interest.* Majority financial interest means maintaining effective control of the PSO.

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

## § 422.370 Waiver of State licensure.

For an organization that seeks to contract to offer an MA plan under this

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subpart, CMS may waive the State licensure requirement of section 1855(a)(1) of the Act if—

(a) The organization requests a waiver no later than November 1, 2002; and

(b) CMS determines there is a basis for a waiver under § 422.372.

[63 FR 25376, May 7, 1998, as amended at 63 FR 35098, June 26, 1998]

## § 422.372 Basis for waiver of State licensure.

(a) *General rule.* Subject to this section and to paragraphs (a) and (e) of § 422.374, CMS may waive the State licensure requirement if the organization has applied (except as provided in paragraph (b)(4) of this section) for the most closely appropriate State license or authority to conduct business as an MA plan.

(b) *Basis for waiver of State licensure.* Any of the following may constitute a basis for CMS’s waiver of State licensure.

(1) *Failure to act timely on application.* The State failed to complete action on the licensing application within 90 days of the date the State received a substantially complete application.

(2) *Denial of application based on discriminatory treatment.* The State has—

(i) Denied the license application on the basis of material requirements, procedures, or standards (other than solvency requirements) not generally applied by the State to other entities engaged in a substantially similar business; or

(ii) Required, as a condition of licensure that the organization offer any product or plan other than an MA plan.

(3) *Denial of application based on different solvency requirements.* (i) The State has denied the application, in whole or in part, on the basis of the organization’s failure to meet solvency requirements that are different from those set forth in §§ 422.380 through 422.390; or

(ii) CMS determines that the State has imposed, as a condition of licensure, any documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, or standards

set forth by CMS to implement, monitor, and enforce §§ 422.380 through 422.390.

(4) *State declines to accept licensure application.* The appropriate State licensing authority has given the organization written notice that it will not accept its licensure application.

[63 FR 35098, June 26, 1998]

**§ 422.374 Waiver request and approval process.**

(a) *Substantially complete waiver request.* The organization must submit a substantially complete waiver request that clearly demonstrates and documents its eligibility for a waiver under § 422.372.

(b) CMS gives the organization written notice of granting or denial of waiver within 60 days of receipt of a substantially complete waiver request.

(c) *Subsequent waiver requests.* An organization that has had a waiver request denied, may submit subsequent waiver requests until November 1, 2002.

(d) *Effective date.* A waiver granted under § 422.370 will be effective on the effective date of the organization's MA contract.

(e) *Consistency in application.* CMS reserves the right to revoke waiver eligibility if it subsequently determines that the organization's MA application is significantly different from the application submitted by the organization to the State licensing authority.

[63 FR 25377, May 7, 1998, as amended at 63 FR 35098, June 26, 1998]

**§ 422.376 Conditions of the waiver.**

A waiver granted under this section is subject to the following conditions:

(a) *Limitation to State.* The waiver is effective only for the particular State for which it is granted and does not apply to any other State. For each State in which the organization wishes to operate without a State license, it must submit a waiver request and receive a waiver.

(b) *Limitation to 36-month period.* The waiver is effective for 36 months or through the end of the calendar year in which the 36 month period ends unless it is revoked based on paragraph (c) of this section.

(c) *Mid-period revocation.* During the waiver period (set forth in paragraph (b) of this section), the waiver is automatically revoked upon—

- (1) Termination of the MA contract;
- (2) The organization's compliance with the State licensure requirement of section 1855(a)(1) of the Act; or
- (3) The organization's failure to comply with § 422.378.

[63 FR 25377, May 7, 1998]

**§ 422.378 Relationship to State law.**

(a) *Preemption of State law.* Any provisions of State law that relate to the licensing of the organization and that prohibit the organization from providing coverage under a contract as specified in this subpart, are superseded.

(b) *Consumer protection and quality standards.* (1) A waiver of State licensure granted under this subpart is conditioned upon the organization's compliance with all State consumer protection and quality standards that—

- (i) Would apply to the organization if it were licensed under State law;
- (ii) Generally apply to other MA organizations and plans in the State; and
- (iii) Are consistent with the standards established under this part.

(2) The standards specified in paragraph (b)(1) of this section do not include any standard preempted under section 1856(b)(3)(B) of the Act.

(c) *Incorporation into contract.* In contracting with an organization that has a waiver of State licensure, CMS incorporates into the contract the requirements specified in paragraph (b) of this section.

(d) *Enforcement.* CMS may enter into an agreement with a State for the State to monitor and enforce compliance with the requirements specified in paragraph (b) of this section by an organization that has obtained a waiver under this subpart.

[63 FR 25377, May 7, 1998]

**§ 422.380 Solvency standards.**

*General rule.* A PSO or the legal entity of which the PSO is a component that has been granted a waiver under

## § 422.382

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§ 422.370 must have a fiscally sound operation that meets the requirements of §§ 422.382 through 422.390.

[63 FR 25377, May 7, 1998]

### § 422.382 Minimum net worth amount.

(a) At the time an organization applies to contract with CMS as a PSO under this part, the organization must have a minimum net worth amount, as determined under paragraph (c) of this section, of:

(1) At least \$1,500,000, except as provided in paragraph (a)(2) of this section.

(2) No less than \$1,000,000 based on evidence from the organization's financial plan (under § 422.384) demonstrating to CMS's satisfaction that the organization has available to it an administrative infrastructure that CMS considers appropriate to reduce, control or eliminate start-up administrative costs.

(b) After the effective date of a PSO's MA contract, a PSO must maintain a minimum net worth amount equal to the greater of—

(1) One million dollars;

(2) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with CMS for up to and including the first \$150,000,000 of annual premiums and 1 percent of annual premium revenues on premiums in excess of \$150,000,000;

(3) An amount equal to the sum of three months of uncovered health care expenditures as reported on the most recent financial statement filed with CMS; or

(4) Using the most recent financial statement filed with CMS, an amount equal to the sum of—

(i) Eight percent of annual health care expenditures paid on a non-capitated basis to non-affiliated providers; and

(ii) Four percent of annual health care expenditures paid on a capitated basis to non-affiliated providers plus annual health care expenditures paid on a non-capitated basis to affiliated providers.

(iii) Annual health care expenditures that are paid on a capitated basis to affiliated providers are not included in the calculation of the net worth re-

quirement (regardless of downstream arrangements from the affiliated provider) under paragraphs (a) and (b)(4) of this section.

(c) *Calculation of the minimum net worth amount*—(1) *Cash requirement.* (i) At the time of application, the organization must maintain at least \$750,000 of the minimum net worth amount in cash or cash equivalents.

(ii) After the effective date of a PSO's MA contract, a PSO must maintain the greater of \$750,000 or 40 percent of the minimum net worth amount in cash or cash equivalents.

(2) *Intangible assets.* An organization may include intangible assets, the value of which is based on Generally Accepted Accounting Principles (GAAP), in the minimum net worth amount calculation subject to the following limitations—

(i) *At the time of application.* (A) Up to 20 percent of the minimum net worth amount, provided at least \$1,000,000 of the minimum net worth amount is met through cash or cash equivalents; or

(B) Up to 10 percent of the minimum net worth amount, if less than \$1,000,000 of the minimum net worth amount is met through cash or cash equivalents, or if CMS has used its discretion under paragraph (a)(2) of this section.

(ii) *From the effective date of the contract.* (A) Up to 20 percent of the minimum net worth amount if the greater of \$1,000,000 or 67 percent of the minimum net worth amount is met by cash or cash equivalents; or

(B) Up to ten percent of the minimum net worth amount if the greater of \$1,000,000 or 67 percent of the minimum net worth amount is not met by cash or cash equivalents.

(3) *Health care delivery assets.* Subject to the other provisions of this section, a PSO may apply 100 percent of the GAAP depreciated value of health care delivery assets (HCDAs) to satisfy the minimum net worth amount.

(4) *Other assets.* A PSO may apply other assets not used in the delivery of health care provided that those assets are valued according to statutory accounting practices (SAP) as defined by the State.

(5) *Subordinated debts and subordinated liabilities.* Fully subordinated

debt and subordinated liabilities are excluded from the minimum net worth amount calculation.

(6) *Deferred acquisition costs.* Deferred acquisition costs are excluded from the calculation of the minimum net worth amount.

[63 FR 25377, May 7, 1998, as amended at 64 FR 71678, Dec. 22, 1999]

**§ 422.384 Financial plan requirement.**

(a) *General rule.* At the time of application, an organization must submit a financial plan acceptable to CMS.

(b) *Content of plan.* A financial plan must include—

- (1) A detailed marketing plan;
- (2) Statements of revenue and expense on an accrual basis;
- (3) Cash-flow statements;
- (4) Balance sheets;
- (5) Detailed justifications and assumptions in support of the financial plan including, where appropriate, certification of reserves and actuarial liabilities by a qualified actuary; and
- (6) If applicable, statements of the availability of financial resources to meet projected losses.

(c) *Period covered by the plan.* A financial plan must—

- (1) Cover the first 12 months after the estimated effective date of a PSO's MA contract; or
- (2) If the PSO is projecting losses, cover 12 months beyond the end of the period for which losses are projected.

(d) *Funding for projected losses.* Except for the use of guarantees, LOC, and other means as provided in § 422.384(e), (f) and (g), an organization must have the resources for meeting projected losses on its balance sheet in cash or a form that is convertible to cash in a timely manner, in accordance with the PSO's financial plan.

(e) *Guarantees and projected losses.* Guarantees will be an acceptable resource to fund projected losses, provided that a PSO—

- (1) Meets CMS's requirements for guarantors and guarantee documents as specified in § 422.390; and
- (2) Obtains from the guarantor cash or cash equivalents to fund the projected losses timely, as follows—

(i) Prior to the effective date of a PSO's MA contract, the amount of the

projected losses for the first two quarters;

(ii) During the first quarter and prior to the beginning of the second quarter of a PSO's MA contract, the amount of projected losses through the end of the third quarter; and

(iii) During the second quarter and prior to the beginning of the third quarter of a PSO's MA contract, the amount of projected losses through the end of the fourth quarter.

(3) If the guarantor complies with the requirements in paragraph (e)(2) of this section, the PSO, in the third quarter, may notify CMS of its intent to reduce the period of advance funding of projected losses. CMS will notify the PSO within 60 days of receiving the PSO's request if the requested reduction in the period of advance funding will not be accepted.

(4) If the guarantee requirements in paragraph (e)(2) of this section are not met, CMS may take appropriate action, such as requiring funding of projected losses through means other than a guarantee. CMS retains discretion to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

(f) *Letters of credit.* Letters of credit are an acceptable resource to fund projected losses, provided they are irrevocable, unconditional, and satisfactory to CMS. They must be capable of being promptly paid upon presentation of a sight draft under the letters of credit without further reference to any other agreement, document, or entity.

(g) *Other means.* If satisfactory to CMS, and for periods beginning one year after the effective date of a PSO's MA contract, a PSO may use the following to fund projected losses—

- (1) Lines of credit from regulated financial institutions;
- (2) Legally binding agreements for capital contributions; or
- (3) Legally binding agreements of a similar quality and reliability as permitted in paragraphs (g)(1) and (2) of this section.

(h) *Application of guarantees, Letters of credit or other means of funding projected losses.* Notwithstanding any other provision of this section, a PSO may use



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guarantees, letters of credit and, beginning one year after the effective date of a PSO's MA contract, other means of funding projected losses, but only in a combination or sequence that CMS considers appropriate.

[63 FR 25378, May 7, 1998, as amended at 63 FR 35098, June 26, 1998; 64 FR 71678, Dec. 22, 1999]

### § 422.386 Liquidity.

(a) A PSO must have sufficient cash flow to meet its financial obligations as they become due and payable.

(b) To determine whether the PSO meets the requirement in paragraph (a) of this section, CMS will examine the following—

(1) The PSO's timeliness in meeting current obligations;

(2) The extent to which the PSO's current ratio of assets to liabilities is maintained at 1:1 including whether there is a declining trend in the current ratio over time; and

(3) The availability of outside financial resources to the PSO.

(c) If CMS determines that a PSO fails to meet the requirement in paragraph (b)(1) of this section, CMS will require the PSO to initiate corrective action and pay all overdue obligations.

(d) If CMS determines that a PSO fails to meet the requirement of paragraph (b)(2) of this section, CMS may require the PSO to initiate corrective action to—

(1) Change the distribution of its assets;

(2) Reduce its liabilities; or

(3) Make alternative arrangements to secure additional funding to restore the PSO's current ratio to 1:1.

(e) If CMS determines that there has been a change in the availability of outside financial resources as required by paragraph (b)(3) of this section, CMS requires the PSO to obtain funding from alternative financial resources.

[63 FR 25378, May 7, 1998, as amended at 64 FR 71678, Dec. 22, 1999]

### § 422.388 Deposits.

(a) *Insolvency deposit.* (1) At the time of application, an organization must deposit \$100,000 in cash or securities (or any combination thereof) into an account in a manner that is acceptable to CMS.

(2) The deposit must be restricted to use in the event of insolvency to help assure continuation of services or pay costs associated with receivership or liquidation.

(3) At the time of the PSO's application for an MA contract and, thereafter, upon CMS's request, a PSO must provide CMS with proof of the insolvency deposit, such proof to be in a form that CMS considers appropriate.

(b) *Uncovered expenditures deposit.* (1) If at any time uncovered expenditures exceed 10 percent of a PSO's total health care expenditures, then the PSO must place an uncovered expenditures deposit into an account with any organization or trustee that is acceptable to CMS.

(2) The deposit must at all times have a fair market value of an amount that is 120 percent of the PSO's outstanding liability for uncovered expenditures for enrollees, including incurred, but not reported claims.

(3) The deposit must be calculated as of the first day of each month required and maintained for the remainder of each month required.

(4) If a PSO is not otherwise required to file a quarterly report, it must file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(5) The deposit required under this section is restricted and in trust for CMS's use to protect the interests of the PSO's Medicare enrollees and to pay the costs associated with administering the insolvency. It may be used only as provided under this section.

(c) A PSO may use the deposits required under paragraphs (a) and (b) of this section to satisfy the PSO's minimum net worth amount required under § 422.382(a) and (b).

(d) All income from the deposits or trust accounts required under paragraphs (a) and (b) of this section, are considered assets of the PSO. Upon CMS's approval, the income from the deposits may be withdrawn.

(e) On prior written approval from CMS, a PSO that has made a deposit under paragraphs (a) or (b) of this section, may withdraw that deposit or any part thereof if—

(1) A substitute deposit of cash or securities of equal amount and value is made;

(2) The fair market value exceeds the amount of the required deposit; or

(3) The required deposit under paragraphs (a) or (b) of this section is reduced or eliminated.

[63 FR 25379, May 7, 1998]

#### § 422.390 Guarantees.

(a) *General policy.* A PSO, or the legal entity of which the PSO is a component, may apply to CMS to use the financial resources of a guarantor for the purpose of meeting the requirements in § 422.384. CMS has the discretion to approve or deny approval of the use of a guarantor.

(b) *Request to use a guarantor.* To apply to use the financial resources of a guarantor, a PSO must submit to CMS—

(1) Documentation that the guarantor meets the requirements for a guarantor under paragraph (c) of this section; and

(2) The guarantor's independently audited financial statements for the current year-to-date and for the two most recent fiscal years. The financial statements must include the guarantor's balance sheets, profit and loss statements, and cash flow statements.

(c) *Requirements for guarantor.* To serve as a guarantor, an organization must meet the following requirements:

(1) Be a legal entity authorized to conduct business within a State of the United States.

(2) Not be under Federal or State bankruptcy or rehabilitation proceedings.

(3) Have a net worth (not including other guarantees, intangibles and restricted reserves) equal to three times the amount of the PSO guarantee.

(4) If the guarantor is regulated by a State insurance commissioner, or other State official with authority for risk-bearing entities, it must meet the net worth requirement in § 422.390(c)(3) with all guarantees and all investments in and loans to organizations covered by guarantees excluded from its assets.

(5) If the guarantor is not regulated by a State insurance commissioner, or other similar State official it must

meet the net worth requirement in § 422.390(c)(3) with all guarantees and all investments in and loans to organizations covered by a guarantee and to related parties (subsidiaries and affiliates) excluded from its assets.

(d) *Guarantee document.* If the guarantee request is approved, a PSO must submit to CMS a written guarantee document signed by an appropriate authority of the guarantor. The guarantee document must—

(1) State the financial obligation covered by the guarantee;

(2) Agree to—

(i) Unconditionally fulfill the financial obligation covered by the guarantee; and

(ii) Not subordinate the guarantee to any other claim on the resources of the guarantor;

(3) Declare that the guarantor must act on a timely basis, in any case not more than 5 business days, to satisfy the financial obligation covered by the guarantee; and

(4) Meet other conditions as CMS may establish from time to time.

(e) *Reporting requirement.* A PSO must submit to CMS the current internal financial statements and annual audited financial statements of the guarantor according to the schedule, manner, and form that CMS requests.

(f) *Modification, substitution, and termination of a guarantee.* A PSO cannot modify, substitute or terminate a guarantee unless the PSO—

(1) Requests CMS's approval at least 90 days before the proposed effective date of the modification, substitution, or termination;

(2) Demonstrates to CMS's satisfaction that the modification, substitution, or termination will not result in insolvency of the PSO; and

(3) Demonstrates how the PSO will meet the requirements of this section.

(g) *Nullification.* If at any time the guarantor or the guarantee ceases to meet the requirements of this section, CMS will notify the PSO that it ceases to recognize the guarantee document. In the event of this nullification, a PSO must—

(1) Meet the applicable requirements of this section within 15 business days; and