

(f) *Arrangements that cause substantial financial risk.* For purposes of this paragraph, *potential payments* means the maximum anticipated total payments (based on the most recent year's utilization and experience and any current or anticipated factors that may affect payment amounts) that could be received if use or costs of referral services were low enough. The following physician incentive plans cause substantial financial risk if risk is based (in whole or in part) on use or costs of referral services and the patient panel size is not greater than 25,000 patients:

(1) Withholds greater than 25 percent of potential payments.

(2) Withholds less than 25 percent of potential payments if the physician or physician group is potentially liable for amounts exceeding 25 percent of potential payments.

(3) Bonuses that are greater than 33 percent of potential payments minus the bonus.

(4) Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula—

$$\text{Withhold} = 0.75 (\text{Bonus } \%) + 25\%.$$

(5) Capitation, arrangements, if—

(i) The difference between the maximum potential payments and the minimum potential payments is more than 25 percent of the maximum potential payments; or

(ii) The maximum and minimum potential payments are not clearly explained in the physician's or physician group's contract.

(6) Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25 percent of potential payments.

(g) *Requirements for physician incentive plans that place physicians at substantial financial risk.* HMOs and CMPs that operate incentive plans that place physicians or physician groups at substantial financial risk must do the following:

(1) Conduct enrollee surveys. These surveys must—

(i) Include either all current Medicare/Medicaid enrollees in the HMO or CMP and those who have disenrolled

(other than because of loss of eligibility in Medicaid or relocation outside the HMO's or CMP's service area) in the past 12 months, or a sample of these same enrollees and disenrollees;

(ii) Be designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

(iii) Address enrollees/disenrollees satisfaction with the quality of the services provided and their degree of access to the services; and

(iv) Be conducted no later than 1 year after the effective date of the Medicare contract and at least annually thereafter.

(2) Ensure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

(i) If aggregate stop-loss protection is provided, it must cover 90 percent of the costs of referral services (beyond allocated amounts) that exceed 25 percent of potential payments.

(ii) If the stop-loss protection provided is based on a per-patient limit, the stop-loss limit per patient must be determined based on the size of the patient panel and may be a single combined limit or consist of separate limits for professional services and institutional services. In determining patient panel size, the patients may be pooled in accordance with paragraph (h)(2) of this section. Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per patient limit. The per-patient stop-loss limit is as follows:

Panel size	Single combined limit	Separate institutional limit	Separate professional limit
1–1000	\$6,000	\$10,000	\$3,000
1,001–5000	30,000	40,000	10,000
5,001–8,000	40,000	60,000	15,000
8,001–10,000	75,000	100,000	20,000
10,001–25,000	150,000	200,000	25,000
>25,000	none	none	none

(h) *Disclosure and other requirements for organizations with physician incentive plans—*(1) *Disclosure to CMS.* Each health maintenance organization or competitive medical plan must provide to CMS information concerning its physician incentive plans as requested.

(2) *Pooling of patients.* Pooling of patients is permitted only if—

(i) It is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group;

(ii) The physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled;

(iii) The terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled;

(iv) The distribution of payments to physicians from the risk pool is not calculated separately by patient category; and

(v) The terms of the risk borne by the physicians or physician group are comparable for all categories of patients being pooled.

(3) *Disclosure to Medicare beneficiaries.* Each health maintenance organization or competitive medical plan must provide the following information to any Medicare beneficiary who requests it:

(i) Whether the prepaid plan uses a physician incentive plan that affects the use of referral services.

(ii) The type of incentive arrangement.

(iii) Whether stop-loss protection is provided.

(iv) If the prepaid plan was required to conduct a survey, a summary of the survey results.

(i) *Requirements related to subcontracting arrangements—(1) Physician groups.* An HMO or CMP that contracts with a physician group that places the individual physician members at substantial financial risk for services they do not furnish must do the following:

(i) Disclose to CMS any incentive plan between the physician group and its individual physicians that bases compensation to the physician on the use or cost of services furnished to Medicare beneficiaries or Medicaid beneficiaries. The disclosure must include the information specified in paragraphs (h)(1)(i) through (h)(1)(vii) of this section and be made at the times specified in paragraph (h)(2) of this section.

(ii) Provide adequate stop-loss protection to the individual physicians.

(iii) Conduct enrollee surveys as specified in paragraph (g)(1) of this section.

(2) *Intermediate entities.* An HMO or CMP that contracts with an entity (other than a physician group) for the provision of services to Medicare beneficiaries must do the following:

(i) Disclose to CMS any incentive plan between the entity and a physician or physician group that bases compensation to the physician or physician group on the use or cost of services furnished to Medicare beneficiaries or Medicaid beneficiaries. The disclosure must include the information required to be disclosed under paragraphs (h)(1)(i) through (h)(1)(vii) of this section and be made at the times specified in paragraph (h)(2) of this section.

(ii) If the physician incentive plan puts a physician or physician group at substantial financial risk for the cost of services the physician or physician group does not furnish—

(A) Meet the stop-loss protection requirements of this subpart; and

(B) Conduct enrollee surveys as specified in paragraph (g)(1) of this section.

(3) For purposes of paragraph (i)(2) of this section, an entity includes, but is not limited to, an individual practice association that contracts with one or more physician groups and a physician hospital organization.

(j) *Sanctions against the HMO or CMP.* CMS may apply intermediate sanctions, or the Office of Inspector General may apply civil money penalties described at §417.500, if CMS determines that an HMO or CMP fails to comply with the requirements of this section.

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§417.480 Maintenance of records: Cost HMOs and CMPs.

A reasonable cost contract must provide that the HMO or CMP agrees to maintain books, records, documents, and other evidence of accounting procedures and practices that—

(a) Are sufficient to—

(1) Ensure an audit trail; and

(2) Properly reflect all direct and indirect costs claimed to have been incurred under the contract; and