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§ 422.208 Physician incentive plans: requirements and limitations.

(a) *Definitions*. In this subpart, the following definitions apply:

Bonus means a payment made 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) paid to 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.

Combined Stop-Loss Insurance Deductible Table (Table PIP–1) means the table described and developed using the methodology in paragraph (f)(2)(iv) of this section.

Global capitation means a specific type of ''capitation'' that includes both professional and institutional services. Services covered by global capitation may also include prescription drug benefits and supplemental benefits as well as basic benefits (as those terms are defined in § 422.100(c)). For purposes of Tables PIP–1 and PIP–2 global capitation includes all Parts A and B services except hospice.

Net benefit premium means the total amount of stop-loss claims (90 percent of claims above the deductible) for that panel size divided by the panel size. It is determined for each panel size and shown in Table PIP–1, described in paragraph (f)(2)(iv) of this section. It is then used in Table PIP–2, described in paragraph (f)(2)(vi) of this section, to identify all separate institutional and separate professional deductible combinations that meet the stop-loss requirements for multi-specialty physician groups participating in PIPs.

Non-Risk Patient Equivalents (NPE) means the estimate of annual claims for physician rendered services for non-risk patients served by the physician or physician group divided by what the PMPY capitation for physician rendered services would be if the beneficiary were part of the risk arrangement. Both Medicare and non-Medicare patients are included in this calculation.

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

Physician incentive plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.

Potential payments means the maximum payments possible to physicians or physician groups including payments for services they furnish directly, and additional payments based on use and costs of referral services, such as withholds, bonuses, capitation, or any other compensation to the physician or physician group. Bonuses and other compensation that are not based on use of referrals, such as quality of care furnished, patient satisfaction or committee participation, are not considered payments in the determination of substantial financial risk.

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. This is set at 25 percent risk.

Separate Stop-Loss Insurance Deductible Table (Table PIP–2) means the table described and developed using the methodology in paragraph (f)(2)(vi) of this section.

Substantial financial risk, for purposes of this section, means risk for referral services that exceeds the risk threshold.

Withhold means a percentage of payments or set dollar amounts deducted 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.

(b) *Applicability.* The requirements in this section apply to an MA organization and any of its subcontracting arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Subcontracting arrangements may include an intermediate entity, which includes but is not limited to, an individual practice association that contracts with one or more physician groups or any other organized group such as those specified in § 422.4.

(c) *Basic requirements.* Any physician incentive plan operated by an MA organization must meet the following requirements:

(1) The MA organization makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

(2) If the physician incentive plan places a physician or physician group at substantial financial risk (as determined under paragraph (d) of this section) for services that the physician or physician group does not furnish itself, the MA organization must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with paragraph (f) of this section.

(3) For all physician incentive plans, the MA organization provides to CMS the information specified in § 422.210.

(d) *Determination of substantial financial risk*—(1) *Basis.* Substantial financial risk occurs when risk is based on the use or costs of referral services, and that risk exceeds the risk threshold. Payments based on other factors, such as quality of care furnished, are not considered in this determination.

(2) *Risk threshold.* The risk threshold is 25 percent of potential payments.

(3) *Arrangements that cause substantial financial risk.* The following incentive arrangements cause substantial financial risk within the meaning of this section, if the physician's or physician group's patient panel size is not greater than 25,000 patients, as shown in the table at paragraph (f)(2)(iii) of this section:

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

(ii) 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.

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

(iv) 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—Withhold % = -0.75 (Bonus %) + 25%.

(v) Capitation arrangements, if—

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

(B) The maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group.

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

(e) *Prohibition for private MA fee-for-service plans.* An MA fee-for-service plan may not operate a physician incentive plan.

(f) *Stop-loss protection requirements*—(1) *Basic rule.* The MA organization must assure 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:

(2) *Specific requirements.* (i) Aggregate stop-loss protection must cover 90 percent of the costs of referral services that exceed 25 percent of potential payments.

(ii) For per-patient stop-loss protection if the stop-loss protection provided is on a per-patient basis, the stop-loss limit (deductible) per patient must be determined based on the size

of the patient panel and may be a combined policy or consist of separate policies for professional services and institutional services. In determining patient panel size, the patients may be pooled in accordance with paragraph (g) of this section.

(iii)(A) Stop-loss protection must cover at least 90 percent of costs of referral services above the deductible or an actuarial equivalent amount of the costs of referral services that exceed the per-patient deductible limit. The single combined deductible for the required stop-loss protection for the various panel sizes for contract years beginning on or after January 1, 2019 is determined using the Combined Stop-Loss Insurance Deductible Table (Table PIP–1). For panel sizes not shown on Table PIP–1 and for values not shown on Table PIP–2, linear interpolation (between the table values) may be used to identify the maximum deductible(s) for the required stop-loss coverage. Tables PIP–1 and PIP–2 apply to only multi-specialty physician groups in global capitation arrangements with per-patient stop-loss insurance. For all other physician incentive plan arrangements, the MA organization must assure that the physician or physician group entering into the physician incentive plan arrangement is covered by actuarially equivalent stop-loss protection that meets the requirements of this regulation.

(B) Using Table PIP–1, the deductible is identified for the panel size that is the number of risk patients plus non-risk patient equivalents. Non-risk patient equivalents may add a maximum of $100,000 to the deductible. The deductible for the stop-loss insurance required to be provided for the physician or physician group is then based on the lesser of:

(*1*) The deductible for the risk patient panel size plus $100,000; and

(*2*) The deductible for the panel size that is the total of the number of risk patients plus non-risk patient equivalents.

(iv) Table 1 is developed and updated by CMS using the methodology in this paragraph. CMS publishes Table PIP–1 in guidance (such as an attachment to the Rate Announcement issued under section 1853(b) of the Act) in advance of the bid due date for the upcoming year if CMS determines that an update would be prudent for that year.

(A) The stop-loss tables are calculated using claims data for a statistically valid sample of beneficiaries enrolled in Fee-for-Service Medicare Parts A and B from the most available recent year. The sample includes only claims for beneficiaries eligible for both Part A and Part B for whom Medicare is the primary insurer and excludes hospice claims. The estimate of medical group income is derived from payments for all Part A and Part B services (excluding hospice) in the sampled claims data (to emulate a multi-specialty practice). The central limit theorem is used to obtain the distribution of claim means for a multi-specialty group of any given panel size. The distribution of claim means is used to obtain, with 98 percent confidence, the point at which a multi-specialty group of a given panel size would, through referral services, lose no more than 25 percent of potential payments. This point is the deductible in Table PIP–1 for the given panel size.

(B) The 'net benefit premium' (NBP) column in Table PIP–1 is not used for computation of combined insurance but is used to determine the separate deductibles for professional services and institutional services in the *Separate Stop-Loss Insurance Deductible Table* (Table PIP–2).

(C) The NBP is computed by dividing the total amount of stop loss claims (90 percent of claims above the deductible) for that panel size by the panel size.

(v)(A) Insurance using separate deductibles for professional and institutional claims is permissible so long as the separate deductibles for institutional services and professional services are determined using Table 2 as described in paragraph (f)(2)(vi)(B) of this section. Table PIP–2 is developed and updated by CMS using the methodology in paragraph (f)(2)(vi). CMS publishes Table PIP–2 in guidance (such as an attachment to the Rate Announcement issued under section 1853(b) of the Act) in advance of the bid due date for the upcoming year if CMS determines that an update would be prudent for that year.

(B) The maximum deductibles for each category of services (institutional and professional claims) are identified by using the net benefit premium (NBP) determined in Table PIP–1 as the starting point in Table PIP–2. Any combination of institutional and professional attachment points for which the NBP in Table PIP–2 is greater than the NBP determined in Table PIP–1 is permissible. Interpolation may be used to find the NBP values in Table PIP–2 that are closest to the NBP identified in Table PIP–1.

(vi) Table PIP–2 is developed using a methodology similar to that for Table PIP–1.

(A) Claims data are obtained as described in paragraph (f)(2)(iv)(A).

(B) Professional and institutional claims are defined and categorized based on industry standards and based on payments for Part A and Part B services.

(C) The central limit theorem is used to obtain the distribution of claim means and deductibles are obtained at the 98 percent confidence level.

(3) *Special insurance.* If there is a different type of stop-loss policy obtained by the physician group, it must be actuarially equivalent to the coverage shown in Tables PIP–1 and PIP–2. Actuarially equivalent deductibles are acceptable if the insurance is actuarially certified by an attesting actuary who fulfills all of the following requirements:

(i) Develops the deductibles to be actuarially equivalent to those coverages in the Tables.

(ii) Makes the computations in accordance with generally accepted actuarial principles and practices.

(iii) Meets the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

(g) *Pooling of patients.* Any entity that meets the pooling conditions of this section may pool commercial, Medicare, and Medicaid enrollees or the enrollees of several MA organizations with which a physician or physician group has contracts. The conditions for pooling are as follows:

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

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

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

(4) The distribution of payments to physicians from the risk pool is not calculated separately by patient category.

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

(h) *Sanctions.* An MA organization that fails to comply with the requirements of this section is subject to intermediate sanctions under subpart O of this part.

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§ 422.210 Assurances to CMS.

(a) Assurances to CMS. Each organization will provide assurance satisfactory to the Secretary that the requirements of § 422.208 are met.

(b) Disclosure to Medicare Beneficiaries. Each MA organization must provide the following information to any Medicare beneficiary who requests it:

(1) Whether the MA organization uses a physician incentive plan that affects the use of referral services.

(2) The type of incentive arrangement.

(3) Whether stop-loss protection is provided.

[70 FR 52026, Sept. 1, 2005]

§ 422.212 Limitations on provider indemnification.

An MA organization may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify the organization against any civil liability for damage caused to an enrollee as a result of the MA organization's denial of medically necessary care: