

and hospital and other types of provider (for example, nursing home and home health agency) services.

(vii) In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results.

(2) *When disclosure must be made to HCFA.* (i) HCFA will not approve an HMO's or CMP's application for a contract unless the HMO or CMP has provided to it the information required by paragraphs (h)(1)(i) through (h)(1)(v) of this section. In addition, an HMO or CMP must provide this information to HCFA upon the effective date of its contract renewal.

(ii) An HMO or CMP must provide the capitation data required under paragraph (h)(1)(vi) for the previous calendar year to HCFA by April 1 of each year.

(3) *Disclosure to Medicare beneficiaries.* An HMO or CMP 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 HCFA 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 recipients. 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 HCFA 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 recipients. 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.* HCFA may apply intermediate sanctions, or the Office of Inspector General may apply civil money penalties described at § 417.500, if HCFA determines that an HMO or CMP fails to comply with the requirements of this section.

[61 FR 13446, Mar. 27, 1996; 61 FR 46385, Sept. 3, 1996, as amended at 61 FR 69049, Dec. 31, 1996]

#### § 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

(b) Include at least records of the following:

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(1) Ownership, HMO or CMP, and operation of the HMO's or CMP's financial, medical, and other recordkeeping systems.

(2) Financial statements for the current contract period and three prior periods.

(3) Federal income tax or information returns for the current contract period and three prior periods.

(4) Asset acquisition, lease, sale, or other action.

(5) Agreements, contracts, and sub-contracts.

(6) Franchise, marketing, and management agreements.

(7) Schedules of charges for the HMO's or CMP's fee-for-service patients.

(8) Matters pertaining to costs of operations.

(9) Amounts of income received by source and payment.

(10) Cash flow statements.

(11) Any financial reports filed with other Federal programs or State authorities.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 45680, Sept. 1, 1995]

**§ 417.481 Maintenance of records: Risk HMOs and CMPs.**

A risk contract must provide that the HMO or CMP agrees to maintain and make available to HCFA upon request, books, records, documents, and other evidence of accounting procedures and practices that—

(a) Are sufficient to—

(1) Establish component rates of the ACR for determining additional and supplementary benefits; and

(2) Determine the rates utilized in setting premiums for State insurance agency purposes; and

(b) Include at least any records or financial reports filed with other Federal agencies or State authorities.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 45680, Sept. 1, 1995]

**§ 417.482 Access to facilities and records.**

The contract must provide that the HMO or CMP agrees to the following:

(a) HHS may evaluate, through inspection or other means, the quality,

appropriateness, and timeliness of services furnished under the contract to its Medicare enrollees.

(b) HHS may evaluate, through inspection or other means, the facilities of the HMO or CMP when there is reasonable evidence of some need for that inspection.

(c) HHS, the Comptroller General, or their designees may audit or inspect any books and records of the HMO or CMP or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract.

(d) HHS may evaluate, through inspection or other means, the enrollment and disenrollment records for the current contract period and three prior periods, when there is reasonable evidence of some need for that inspection.

(e) In the case of a reasonable cost HMO or CMP to make available for the purposes specified in paragraphs (a), (b), (c), and (d) of this section, its premises, physical facilities, and equipment, its records relating to its Medicare enrollees, the records specified in § 417.480 and any additional relevant information that HCFA may require.

(f) That the right to inspect, evaluate, and audit, will extend through three years from the date of the final settlement for any contract period unless—

(1) HCFA determines there is a special need to retain a particular record or group of records for a longer period and notifies the HMO or CMP at least 30 days before the normal disposition date;

(2) There has been a termination, dispute, fraud, or similar fault by the HMO or CMP, in which case the retention may be extended to three years from the date of any resulting final settlement; or

(3) HCFA determines that there is a reasonable possibility of fraud, in which case it may reopen a final settlement at any time.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

**§ 417.484 Requirement applicable to related entities.**

(a) *Definition.* As used in this section, *related entity* means any entity that is