

(c) *Construction.* Nothing in paragraph (b) of this section may be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(d) *Sanctions.* An M+C organization that violates the prohibition of paragraph (a) of this section or the conditions in paragraph (b) of this section is subject to intermediate sanctions under subpart O of this part.

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000]

**§ 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.

*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.

*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 M+C 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 M+C organization must meet the following requirements:

(1) The M+C 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 M+C 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, and conduct periodic surveys in accordance with paragraph (h) of this section.

(3) For all physician incentive plans, the M+C organization provides to HCFA 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 M+C fee-for-service plans*. An M+C fee-for-service plan may not operate a physician incentive plan.

(f) *Stop-loss protection requirements*—

(1) *Basic rule*. The M+C 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) Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per patient deductible limit. The per-patient stop-loss deductible limits are as follows:

Panel size	Single combined deductible	Separate institutional deductible	Separate professional deductible
1-1,000 .....	\$6,000	\$10,000	\$3,000
1,001-5,000 .....	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 .....	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )

<sup>1</sup> None.

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(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 M+C 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) *Periodic surveys of current and former enrollees.* An M+C organization must conduct periodic surveys of current and former enrollees where substantial financial risk exists. These periodic surveys must—

(1) Include either a sample of, or all, current Medicare/Medicaid enrollees in the M+C organization and individuals disenrolled in the past 12 months for reasons other than—

(i) The loss of Medicare or Medicaid eligibility;

(ii) Relocation outside the M+C organization's service area;

(iii) For failure to pay premiums or other charges;

(iv) For abusive behavior; and

(v) Retroactive disenrollment.

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

(3) Measure the degree of enrollees/disenrollees' satisfaction with the quality of the services provided and the degree to which the enrollees/disenrollees have or had access to the services provided under the M+C organization; and

(4) Be conducted no later than 1 year after the effective date of the M+C organization's contract and at least annually thereafter.

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

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000]

§ 422.210 Disclosure of physician incentive plans

(a) *Disclosure to HCFA—(1) Basic requirement.* Each M+C organization must provide to HCFA descriptive information about its physician incentive plan in sufficient detail to enable HCFA to determine whether that plan complies with the requirements of § 422.208. Reporting should be on the HCFA PIP Disclosure Form (OMB No. 0938–0700).

(2) *Content.* The information must include at least the following:

(i) Whether services not furnished by the physician or physician group are covered by the incentive plan.

(ii) The type or types of incentive arrangements, such as, withholds, bonus, capitation.

(iii) The percent of any withhold or bonus the plan uses.

(iv) Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection.

(v) The patient panel size and, if the plan uses pooling, the pooling method.

(vi) If the M+C organization is required to conduct enrollee surveys, a summary of the survey results.

(3) *When disclosure must be made to HCFA.* An M+C organization must disclose annually to HCFA the physician incentive arrangements that are effective at the start of each year. In addition, HCFA does not approve an M+C organization's application for a contract unless the M+C organization discloses the physician incentive arrangements effective for that contract.

(b) *Disclosure to Medicare beneficiaries—Basic requirement.* An M+C organization must provide the following information to any Medicare beneficiary who requests it: