

requirements for that previous period; or

(D) The ACR for the next contract period results in additional benefits that are significantly less in total value than that of the previous contract period.

(iii) *Basis for denial.* HCFA does not approve a request for a withdrawal from a stabilization fund if the withdrawal would allow the M+C organization to refinance prior contract period losses or to avoid losses in the upcoming contract period.

(iv) *Form of payment.* Payment of monies withdrawn from a stabilization fund is made, in equal parts, as an additional amount to the monthly advance payment made to the M+C organization for Medicare beneficiaries electing the M+C plan during the period of the contract.

(d) *Construction.* Nothing in this section may be construed as preventing an M+C organization from providing supplemental benefits in addition to those required under this section and from imposing a premium for those supplemental benefits.

[63 FR 35093, June 26, 1998, as amended at 65 FR 40326, June 29, 2000]

Subpart H—Provider-Sponsored Organizations

EDITORIAL NOTE: Nomenclature changes to subpart H 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 M+C 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 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 HCFA 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 HCFA as an M+C 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 M+C 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 M+C 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 HCFA.

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 HCFA. 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 M+C 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 HCFA's satisfaction that it is capable of delivering to Medicare enrollees the range of services required under a contract with HCFA. 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 HCFA 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