

(vi) Pediatric and adult immunizations, in accord with accepted medical practice.

(b) In addition, an HMO may include a health service described in § 417.102 as a supplemental health service in the basic health services that it provides or arranges for its enrollees for a basic health services payment.

(c) To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of an HMO results in the facilities, personnel, or financial resources of an HMO being unavailable to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of §§ 417.101 through 417.106 and §§ 417.168 and 417.169, the HMO is required only to make a good-faith effort to provide or arrange for the provision of the service, taking into account the impact of the event. For purposes of this paragraph, an event is not within the control of an HMO if the HMO cannot exercise influence or dominion over its occurrence.

(d) The following are not required to be provided as basic health services:

(1) Corrective appliances and artificial aids;

(2) Mental health services, except as required under section 1302(1)(D) of the PHS Act and paragraph (a)(4) of this section;

(3) Cosmetic surgery, unless medically necessary;

(4) Prescribed drugs and medicines incidental to outpatient care;

(5) Ambulance services, unless medically necessary;

(6) Care for military service connected disabilities for which the enrollee is legally entitled to services and for which facilities are reasonably available to this enrollee;

(7) Care for conditions that State or local law requires be treated in a public facility;

(8) Dental services;

(9) Vision and hearing care except as required by sections 1302(1)(A) and 1302(1)(H)(vi) of the PHS Act and paragraphs (a)(1) and (a)(8) of this section;

(10) Custodial or domiciliary care;

(11) Experimental medical, surgical, or other experimental health care procedures, unless approved as a basic

health service by the policymaking body of the HMO;

(12) Personal or comfort items and private rooms, unless medically necessary during inpatient hospitalization;

(13) Whole blood and blood plasma;

(14) Long-term physical therapy and rehabilitation;

(15) Durable medical equipment for home use (such as wheel chairs, surgical beds, respirators, dialysis machines); and

(16) Health services that are unusual and infrequently provided and not necessary for the protection of individual health, as approved by HCFA upon application by the HMO.

(e) An HMO may not offer to provide or arrange for the provision of basic health services on a prepayment basis that do not include all the basic health services set forth in paragraph (a) of this section or that are limited as to time and cost except in a manner prescribed by this subpart.

[45 FR 72528, Oct. 31, 1980. Redesignated at 52 FR 36746, Sept. 30, 1987, and amended at 58 FR 38077, July 15, 1993]

§ 417.102 Health benefits plan: Supplemental health services.

(a) An HMO may provide to its enrollees any health service that is not included as a basic health service under § 417.101(a). These health services may be limited as to time and cost.

(b) An HMO must determine the level and scope of supplemental health services included with basic health services provided to its enrollees for a basic health services payment or those services offered to its enrollees as supplemental health services.

[45 FR 72528, Oct. 31, 1980, as amended at 47 FR 19339, May 5, 1982. Redesignated at 52 FR 36746, Sept. 30, 1987, as amended at 58 FR 38082, 38083, July 15, 1993]

§ 417.103 Providers of basic and supplemental health services.

(a)(1) The HMO must provide that the services of health professionals that are provided as basic health services will, except as provided in paragraph (c) of this section, be provided or arranged for through (i) health professionals who are staff of the HMO, (ii) a medical group or groups, (iii) an IPA or

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IPAs, (iv) physicians or other health professionals under direct service contracts with the HMO for the provision of these services, or (v) any combination of staff, medical group or groups, IPA or IPAs, or physicians or other health professionals under direct service contracts with the HMO.

(2) A staff or medical group model HMO may have as providers of basic health services physicians who have also entered into written services arrangements with an IPA or IPAs, but only if either (i) these physicians number less than 50 percent of the physicians who have entered into arrangements with the IPA or IPAs, or (ii) if the sharing is 50 percent or greater, HCFA approves the sharing as being consistent with the purposes of section 1310(b) of the PHS Act.

(3) After the 4 year period beginning with the month following the month in that an HMO becomes a qualified HMO, an entity that meets the requirements of the definition of medical group in § 417.100, except for subdivision (3)(i) of that definition, may be considered a medical group if HCFA determines that the principal professional activity (over 50 percent individually) of the entity's members is the coordinated practice of their profession, and if the HMO has demonstrated to the satisfaction of HCFA that the entity is committed to the delivery of medical services on a prepaid group practice basis by either:

(i) Presenting a reasonable time-phased plan for the entity to achieve compliance with the "substantial responsibility" requirement of subdivision (3)(i) of the definition of "medical group" in § 417.100. The HMO must update the plan annually and must demonstrate to the satisfaction of HCFA that the entity is making continuous efforts and progress towards compliance with the requirements of the definition of "medical group," or

(ii) Demonstrating that compliance by the entity with the "substantial responsibility" requirement is unreasonable or impractical because (A) the HMO serves a non-metropolitan or rural area as defined in § 417.100, or (B) the entity is a multi-speciality group that provides medical consultation upon referral on a regional or national basis, or (C) the majority of the resi-

dents of the HMO's service area are not eligible for employer-employee health benefits plans and the HMO has an insufficient number of enrollees to require utilization of at least 35 percent of the entity's services.

(b) HMOs must have effective procedures to monitor utilization and to control cost of basic and supplemental health services and to achieve utilization goals, which may include mechanisms such as risk sharing, financial incentives, or other provisions agreed to by providers.

(c) Paragraph (a) of this section does not apply to the provision of the services of a physician:

(1) Which the HMO determines are unusual or infrequently used services; or

(2) Which, because of an emergency, it was medically necessary to provide to the enrollee other than as required by paragraph (a) of this section; or

(3) Which are provided as part of the inpatient hospital services by employees or staff of a hospital or provided by staff of other entities such as community mental health centers, home health agencies, visiting nurses' associations, independent laboratories, or family planning agencies.

(d) Supplemental health services must be provided or arranged for by the HMO and need not be provided by providers of basic health services under contract with the HMO.

(e) Each HMO must:

(1) Pay the provider, or reimburse its enrollees for the payment of reasonable charges for basic health services (or supplemental health services that the HMO agreed to provide on a prepayment basis) for which its enrollees have contracted, which were medically necessary and immediately required to be obtained other than through the HMO because of an unforeseen illness, injury, or condition, as determined by the HMO;

(2) Adopt procedures to review promptly all claims from enrollees for reimbursement for the provision of health services described in paragraph (e)(1) of this section, including a procedure for the determination of the medical necessity for obtaining the services other than through the HMO; and

(3) Provide instructions to its enrollees on procedures to be followed to secure these health services.

(Sec. 215 of the Public Health Service Act, as amended, 58 Stat. 690, 67 Stat. 631 (42 U.S.C. 216); secs. 1301-1318, as amended, Pub. L. 97-35, 95 Stat. 572-578 (42 U.S.C. 300e-300e-17)

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§ 417.104 Payment for basic health services.

(a) *Basic health services payment.* Each HMO must provide or arrange for the provision of basic health services for a basic health services payment that:

(1) Is to be paid on a periodic basis without regard to the dates these services are provided;

(2) Is fixed without regard to the frequency, extent, or kind of basic health services actually furnished;

(3) Except as provided in paragraph (c) of this section, is fixed under a community rating system, as described in paragraph (b) of this section; and

(4) May be supplemented by nominal copayments which may be required for the provision of specific basic health services. Each HMO may establish one or more copayment options calculated on the basis of a community rating system.

(i) An HMO may not impose copayment charges that exceed 50 percent of the total cost of providing any single service to its enrollees, nor in the aggregate more than 20 percent of the total cost of providing all basic health services.

(ii) To insure that copayments are not a barrier to the utilization of health services or enrollment in the HMO, an HMO may not impose copayment charges on any subscriber (or enrollees covered by the subscriber's contract with the HMO) in any calendar year, when the copayments made by the subscriber (or enrollees) in that calendar year total 200 percent of the total annual premium cost which that subscriber (or enrollees) would be required to pay if he (or they) were enrolled under an option with no copayments. This limitation applies only if the subscriber (or enrollees) dem-

onstrates that copayments in that amount have been paid in that year.

(b) *Community rating system.* Under a community rating system, rates of payment for health services may be determined on a per person or per family basis, as described in paragraph (b)(1) of this section or on a per group basis as described in paragraph (b)(2) of this section. An HMO may fix its rates of payment under the system described in paragraph (b)(1) or (b)(2) of this section or under both such systems, but an HMO may use only one such system for fixing its rates of payment for any one group.

(1) A system of fixing rates of payment for health services may provide that the rates will be fixed on a per person or per family basis and may vary with the number of persons in a family. Except as otherwise authorized in this paragraph, these rates must be equivalent for all individuals and for all families of similar composition. Rates of payment may be based on either a schedule of rates charged to each subscriber group or on a per-enrollee-per-month (or per-subscriber-per-month) revenue requirement for the HMO. In the former event, rates may vary from group to group if the projected total revenue from each group is substantially equivalent to the revenue that would be derived if the schedule of rates were uniform for all groups. In the latter event, the payments from each group of subscribers must be calculated to yield revenues substantially equivalent to the product of the total number of enrollees (or subscribers) expected to be enrolled from the group and the per-enrollee-per-month (or per-subscriber-per-month) revenue requirement for the HMO. Under the system described in this paragraph, rates of payment may not vary because of actual or anticipated utilization of services by individuals associated with any specific group of subscribers. These provisions do not preclude changes in the rates of payment that are established for new enrollments or re-enrollments and that do not apply to existing contracts until the renewal of these contracts.

(2) A system of fixing rates of payment for health services may provide