

or revised factors used to establish classes after it receives written approval of the factors from HCFA. HCFA will give approval if it concludes that the factors can reasonably be used to predict the use of health services by individuals and families.

(1) An HMO must make a written request to HCFA, listing the factors to be used in the community rating by class system under paragraph (b)(2) of this section.

(2) HCFA will notify each HMO within 30 days of receipt of the request and application of one of the following:

- (i) The application is approved;
- (ii) Additional information or data are required and HCFA will notify the HMO of its decision within 30 days from the date of receipt of this information or data; or
- (iii) HCFA needs additional time to review the written request and the HMO will be notified of HCFA's decision within 90 days.

(Approved by the Office of Management and Budget under control number 0915-0051)

(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))

[45 FR 72528, Oct. 31, 1980, as amended at 47 FR 19339, May 5, 1982; 50 FR 6175, Feb. 14, 1985. Redesignated at 52 FR 36746, Sept. 30, 1987, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38082, 38083, July 15, 1993]

**§417.105 Payment for supplemental health services.**

(a) An HMO may require supplemental health services payments, in addition to the basic health services payments, for the provision of each health service included in the supplemental health services set forth in §417.102 for which subscribers have contracted, or it may include supplemental health services in the basic health services provided its enrollees for a basic health services payment.

(b) Supplemental health services payments may be made in any agreed upon manner, such as prepayment or fee-for-service. Supplemental health services payments that are fixed on a prepayment basis, however, must be fixed under a community rating system, unless the supplemental health services payment is for a supplemental health

service provided an enrollee who is a full-time student at an accredited institution of higher education. In the case of an HMO that provided comprehensive health services on a prepaid basis before it became a qualified HMO, the community rating requirement shall not apply to that HMO during the forty-eight month period beginning with the month following the month in which it became a qualified HMO.

(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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**§417.106 Quality assurance program; Availability, accessibility, and continuity of basic and supplemental health services.**

(a) *Quality assurance program.* Each HMO or CMP must have an ongoing quality assurance program for its health services that meets the following conditions:

- (1) Stresses health outcomes to the extent consistent with the state of the art.
- (2) Provides review by physicians and other health professionals of the process followed in the provision of health services.
- (3) Uses systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed change.
- (4) Includes written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that ought to have been furnished have not been provided.

(b) *Availability and accessibility of health care services.* Basic health services and those supplemental health services for which enrollees have contracted must be provided or arranged for by the HMO in accordance with the following rules:

- (1) Except as provided in paragraph (b)(2) of this section, the services must