§ 417.2 Basis and scope.

(a) Subparts B through F of this part pertain to the Federal qualification of HMOs under title XIII of the Public Health Service (PHS) Act.

(b) Subparts G through R of this part set forth the rules for Medicare contracts with, and payment to, HMOs and competitive medical plans (CMPs) under section 1876 of the Act.

(c) Subpart U of this part pertains to Medicare payment to health care prepayment plans under section 1833(a)(1)(A) of the Act.

(d) Subpart V of this part applies to the administration of outstanding loans and loan guarantees previously granted under title XIII of the PHS Act.

§ 417.101 Health benefits plan: Basic health services.

(a) An HMO must provide or arrange for the provision of basic health services to its enrollees as needed and without limitations as to time and cost other than those prescribed in the PHS Act and these regulations, as follows:

(1) Physician services (including consultant and referral services by a physician), which must be provided by a licensed physician, or if a service of a physician may also be provided under applicable State law by other health professionals, an HMO may provide the service through these other health professionals;

(2) Outpatient services, which must include diagnostic services, treatment
services and x-ray services, for patients who are ambulatory and may be provided in a non-hospital based health care facility or at a hospital;

(ii) Inpatient hospital services, which must include but not be limited to, room and board, general nursing care, meals and special diets when medically necessary, use of operating room and related facilities, use of intensive care unit and services, x-ray services, laboratory, and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and administration of whole blood and blood plasma;

(iii) Outpatient services and inpatient hospital services must include short-term rehabilitation services and physical therapy, the provision of which the HMO determines can be expected to result in the significant improvement of a member’s condition within a period of two months;

(3) Instructions to its enrollees on procedures to be followed to secure medically necessary emergency health services both in the service area and out of the service area;

(4) Twenty outpatient visits per enrollee per year, as may be necessary and appropriate for short-term evaluative or crisis intervention mental health services, or both;

(5) Diagnostic, medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs:

(i) Diagnosis and medical treatment for the abuse of or addiction to alcohol and drugs must include detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis, whichever is medically determined to be appropriate, in addition to the other required basic health services for the treatment of other medical conditions;

(ii) Referral services may be either for medical or for nonmedical ancillary services. Medical services must be a part of basic health services; nonmedical ancillary services (such as vocational rehabilitation and employment counselling) and prolonged rehabilitation services in a specialized inpatient or residential facility need not be a part of basic health services;

(6) Diagnostic laboratory and diagnostic and therapeutic radiologic services in support of basic health services;

(7) Home health services provided at an enrollee’s home by health care personnel, as prescribed or directed by the responsible physician or other authority designated by the HMO; and

(8) Preventive health services, which must be made available to members and must include at least the following:

(i) A broad range of voluntary family planning services;

(ii) Services for infertility;

(iii) Well-child care from birth;

(iv) Periodic health evaluations for adults;

(v) Eye and ear examinations for children through age 17, to determine the need for vision and hearing correction; and

(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
§ 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.


§ 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 by (i) health professionals who are staff of the HMO, (ii) a medical group or groups, (iii) an IPA or IPAs, (iv) physicians or other health professionals under direct service contracts with 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.