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exceeds the lesser of $25,000 or 5 percent of the total operating expenses of the HMO.

Staff of the HMO means health professionals who are employees of the HMO and who—

(1) Provide services to HMO enrollees at an HMO facility subject to the staff policies and operational procedures of the HMO;

(2) Engage in the coordinated practice of their profession and provide to enrollees of the HMO the health services that the HMO has contracted to provide;

(3) Share medical and other records, equipment, and professional, technical, and administrative staff of the HMO; and

(4) Provide their professional services in accordance with a compensation arrangement, other than fee-for-service, established by the HMO. This arrangement may include, but is not limited to, fee-for-time, retainer or salary.

Subscriber means an enrollee who has entered into a contractual relationship with the HMO or who is responsible for making payments for basic health services (and contracted for supplemental health services) to the HMO or on whose behalf these payments are made.

Supplemental health services means the health services described in § 417.102(a).

Unusual or infrequently used health services means:

(1) Those health services that are projected to involve fewer than 1 percent of the encounters per year for the entire HMO enrollment, or,

(2) Those health services the provision of which, given the enrollment projection of the HMO and generally accepted staffing patterns, is projected will require less than 0.25 full time equivalent health professionals.

Subpart B—Qualified Health Maintenance Organizations: Services

§ 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)(i) 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 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;

(3) Nutritional services, which must include hospital and related facilities, use of intensive care unit and services, x-ray services, laboratory, and other diagnostic services, 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 outside 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) Diagnosis, 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 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 counseling) 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 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;
§ 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 through (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 for the provision of these services, or (v) any combination of staff, medical group or groups, 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, CMS 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 which 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 CMS 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 CMS 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 CMS that the entity is making continuous efforts and progress towards compliance with the requirements of the definition of “medical group,” or