

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

(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 residents 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))

[45 FR 72528, Oct. 31, 1980; 45 FR 77031, Nov. 21, 1980, as amended at 47 FR 19339, May 5, 1982; 50 FR 6174, Feb. 14, 1985. Redesignated at 52 FR 36746, Sept. 30, 1987, as amended at 58 FR 38082, 38083, July 15, 1993]

§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) demonstrates 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 that the rates will be fixed for individuals and families by groups. Except as otherwise authorized in this paragraph, such rates must be equivalent for all individuals in the same group and for all families of similar composition in the same group. If an HMO is to fix rates of payment for individuals and families by groups, it must:

(i) Classify all of the enrollees of the organization into classes based on factors that the HMO determines predict the differences in the use of health services by the individuals or families in each class and which have not been disapproved by CMS,

(ii) Determine its revenue requirements for providing services to the enrollees of each class established under paragraph (b)(2)(i) of this section, and

(iii) Fix the rates of payment for the individuals and families of a group on the basis of a composite of the organization's revenue requirements determined under paragraph (b)(2)(ii) of this section for providing services to them as members of the classes established under paragraph (b)(2)(i) of this section. CMS will review the factors used by each HMO to establish classes under paragraph (b)(2)(i) of this section. If CMS determines that any such factor may not reasonably be used to predict the use of the health services by individuals and families, CMS will disapprove the factor for that purpose.

(3)(i) Nominal differentials in rates may be established to reflect differences in marketing costs and the different administrative costs of collecting payments from the following categories of potential subscribers:

(A) Individual (non-group) subscribers (including their families).

(B) Small groups of subscribers (100 subscribers or fewer).

(C) Large groups of subscribers (over 100 subscribers).

(ii) Differentials in rates may be established for subscribers enrolled in an HMO: (A) Under a contract with a governmental authority under section 1079 (“Contracts for Medical Care for Spouses and Children; Plans”) or section 1086 (“Contracts for Health Benefits for Certain Members, Former Members and their Dependents”) of title 10 (“Armed Forces”), United States Code; or (B) under any other governmental program (other than the health benefits program authorized by chapter 89 (“Health Insurance”) of title 5 (“Government Organization and Employees”), United States Code; or (C) under any health benefits program for employees of States, political subdivisions of states, and other public entities.

(4) An HMO may establish a separate community rate for separate regional components of the organization upon satisfactory demonstration to CMS of the following:

(i) Each regional component is geographically distinct and separate from any other regional component; and

(ii) Each regional component provides substantially the full range of basic health services to its enrollees, without extensive referral between components of the organization for these services, and without substantial utilization by any two components of the same health care facilities. The separate community rate for each regional component of the HMO must be based on the different costs of providing health services in the respective regions.

(c) *Exceptions to community rating requirement.* (1) In the case of an HMO that provided comprehensive health services on a prepaid basis before it became a qualified HMO, the requirement of community rating shall not apply to the HMO during the forty-eight month

period beginning with the month following the month in which it became a qualified HMO.

(2) The requirement of community rating does not apply to the basic health services payment for basic health services provided an enrollee who is a full-time student at an accredited institution of higher education.

(d) *Late payment penalty.* HMOs may charge a late payment penalty on accounts receivable that are in arrears.

(e) *Review procedures for evaluating the community rating by class system under paragraph (b)(2).*¹ An HMO may establish a community rating system under paragraph (b)(2) of this section or revised factors used to establish classes after it receives written approval of the factors from CMS. CMS 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 CMS, listing the factors to be used in the community rating by class system under paragraph (b)(2) of this section.

(2) CMS 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 CMS will notify the HMO of its decision within 30 days from the date of receipt of this information or data; or

(iii) CMS needs additional time to review the written request and the HMO will be notified of CMS’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]

¹Further information entitled “Guidelines for Rating by Class” may be obtained from the Office of Prepaid Health Care, Division of Qualification Analysis, HHS Cohen Bldg., room 4360, 330 Independence Ave. SW., Washington, DC 20201.