

§ 417.2

tracts, or other geographic measurements, that is the area, as determined by CMS, within which the HMO furnishes basic and supplemental health services and makes them available and accessible to all its enrollees in accordance with § 417.106(b). Facilities in which individuals are incarcerated are not included in the geographic service area of an HMO or CMP plan.

Significant business transaction means any business transaction or series of transactions during any one fiscal year of the HMO, the total value of which 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

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will require less than 0.25 full time equivalent health professionals.

[45 FR 72528, Oct. 31, 1980, as amended at 47 FR 19338, May 5, 1982; 52 FR 22321, June 11, 1987. Redesignated at 52 FR 36746, Sept. 30, 1987. Redesignated and amended at 56 FR 51985, Oct. 17, 1991; 58 FR 38067, July 15, 1993; 60 FR 34887, July 5, 1995; 60 FR 45674, Sept. 1, 1995; 79 FR 29955, May 23, 2014]

§ 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 and 8 U.S.C. 1611.

(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.

[56 FR 51985, Oct. 17, 1991, as amended at 60 FR 45675, Sept. 1, 1995; 80 FR 7958, Feb. 12, 2015]

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