

(2) For enrollees who are in an inpatient facility on the date of insolvency, until they are discharged from the facility.

§ 417.124 Administration and management.

(a) *General requirements.* Each HMO must have administrative and managerial arrangements satisfactory to CMS, as demonstrated by at least the following:

(1) A policymaking body that exercises oversight and control over the HMO's policies and personnel to ensure that management actions are in the best interest of the HMO and its enrollees.

(2) Personnel and systems sufficient for the HMO to organize, plan, control and evaluate the financial, marketing, health services, quality assurance program, administrative and management aspects of the HMO.

(3) At a minimum, management by an executive whose appointment and removal are under the control of the HMO's policymaking body.

(b) *Full and fair disclosure*—(1) *Basic rule.* Each HMO must prepare a written description of the following:

(i) Benefits (including limitations and exclusions).

(ii) Coverage (including a statement of conditions on eligibility for benefits).

(iii) Procedures to be followed in obtaining benefits and a description of circumstances under which benefits may be denied.

(iv) Rates.

(v) Grievance procedures.

(vi) Service area.

(vii) Participating providers.

(viii) Financial condition including at least the following most recently audited information: Current assets, other assets, total assets; current liabilities, long term liabilities; and net worth.

(2) *Requirements for the description.* (i) The description must be written in a way that can be easily understood by the average person who might enroll in the HMO.

(ii) The description of benefits and coverage may be in general terms if reference is made to a detailed statement of benefits and coverage that is

available without cost to any person who enrolls in the HMO or to whom the opportunity for enrollment is offered.

(iii) The HMO must provide the description to any enrollee or person who is eligible to elect the HMO option and who requests the material from the HMO or the administrator of a health benefits plan. For purposes of this requirement, "administrator" (of a health benefits plan) has the meaning it is given in the Employment Retirement Income Security Act of 1974 (ERISA) at 29 U.S.C. 1002(16)(A).

(iv) If the HMO provides health services through individual practice associations (IPAs), the HMO must specify the number of member physicians by specialty, and a listing of the hospitals where HMO enrollees will receive basic and supplemental health services.

(v) If the HMO provides health services other than through IPAs, the HMO must specify, for each ambulatory care facility, the facility's address, days and hours of operation, and the number of physicians by specialty, and a listing of the hospitals where HMO enrollees will receive basic and supplemental health services.

(c) *Broadly representative enrollment.*

(1) Each HMO must offer enrollment to persons who are broadly representative of the various age, social, and income groups within its service area.

(2) If an HMO has a medically underserved population located in its service area, not more than 75 percent of its enrollees may be from the medically underserved population unless the area in which that population resides is a rural area.

(d) *Health status and enrollment.* (1) The HMO may not, on the basis of health status, health care needs, or age of the individual—

(i) Expel or refuse to reenroll any enrollee; or

(ii) Refuse to enroll individual members of a group.

(2) For purposes of this paragraph, a "group" is composed of individuals who enroll in the HMO under a contract or other arrangement that covers two or more subscribers. Examples of groups are employees who enroll under a contract between their employer and the HMO, or members of an organization

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that arranges coverage for its membership.

(3) Nothing in this subpart prohibits an HMO from requiring that, as a condition for continued eligibility for enrollment, enrolled dependent children, upon reaching a specified age, convert to individual enrollment, consistent with paragraph (e) of this section.

(e) *Conversion of enrollment.* (1) Each HMO must offer individual enrollment to the following:

- (i) Each enrollee (and his or her enrolled dependents) leaving a group.
- (ii) Each enrollee who would otherwise cease to be eligible for HMO enrollment because of his or her age, or the death or divorce of an enrollee.

(2) The individual enrollment offered must meet the conditions of subpart B of this part and this subpart C.

(3) The HMO is not required to offer individual enrollment except to the enrollees specified in this paragraph.

(4) The HMO must offer the enrollment on the same terms and conditions that it makes available to other nongroup enrollees.

(f) [Reserved]

(g) *Grievance procedures.* Each HMO must have and use meaningful procedures for hearing and resolving grievances between the HMO’s enrollees and the HMO, including the HMO staff and medical groups and IPAs that furnish services. These procedures must ensure that:

- (1) Grievances and complaints are transmitted in a timely manner to appropriate HMO decisionmaking levels that have authority to take corrective action; and
- (2) Appropriate action is taken promptly, including a full investigation if necessary and notification of concerned parties as to the results of the HMO’s investigation.

(h) *Certification of institutional providers.* Each HMO must ensure that its affiliated institutional providers meet one of the following conditions:

- (1) In the case of hospitals, are either accredited by the Joint Commission on Accreditation of Health Care Organizations, or certified by Medicare.
- (2) In the case of laboratories, are either CLIA-exempt, or have in effect a valid certificate of one of the following types, issued by CMS in accordance

with section 353 of the PHS Act and part 493 of this chapter:

- (i) Registration certificate.
- (ii) Certificate.
- (iii) Certificate of waiver.
- (iv) Certificate of accreditation.

(3) In the case of other affiliated institutional providers, are certified for participation in Medicare and Medicaid in accordance with part 405, 416, 418, 488, or 491 of this chapter, as appropriate.

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§ 417.126 Recordkeeping and reporting requirements.

(a) *General reporting and disclosure requirements.* Each HMO must have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information with respect to the following:

- (1) The cost of its operations.
- (2) The patterns of utilization of its services.
- (3) The availability, accessibility, and acceptability of its services.
- (4) To the extent practical, developments in the health status of its enrollees.
- (5) Information demonstrating that the HMO has a fiscally sound operation.
- (6) Other matters that CMS may require.

(b) *Significant business transactions.* Each HMO must report to CMS annually, within 120 days of the end of its fiscal year (unless for good cause shown, CMS authorizes an extension of time), the following:

- (1) A description of significant business transactions (as defined in paragraph (c) of this section) between the HMO and a party in interest.
- (2) With respect to those transactions—
 - (i) A showing that the costs of the transactions listed in paragraph (c) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or