

(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]

§417.105 Payment for supplemental health services.

(a) An HMO may require supplemental health services payments, in addition to the basic health services payments, for the provision of each

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.

health service included in the supplemental health services set forth in §417.102 for which subscribers have contracted, or it may include supplemental health services in the basic health services provided its enrollees for a basic health services payment.

(b) Supplemental health services payments may be made in any agreed upon manner, such as prepayment or fee-for-service. Supplemental health services payments that are fixed on a prepayment basis, however, must be fixed under a community rating system, unless the supplemental health services payment is for a supplemental health service provided an enrollee who is a full-time student at an accredited institution of higher education. In the case of an HMO that provided comprehensive health services on a prepaid basis before it became a qualified HMO, the community rating requirement shall not apply to that HMO during the forty-eight month period beginning with the month following the month in which it became a qualified HMO.

(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 50 FR 6175, Feb. 14, 1985. Redesignated at 52 FR 36746, Sept. 30, 1987, as amended at 58 FR 38082, 38083, July 15, 1993]

§417.106 Quality assurance program; Availability, accessibility, and continuity of basic and supplemental health services.

(a) *Quality assurance program.* Each HMO or CMP must have an ongoing quality assurance program for its health services that meets the following conditions:

(1) Stresses health outcomes to the extent consistent with the state of the art.

(2) Provides review by physicians and other health professionals of the process followed in the provision of health services.

(3) Uses systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed change.

(4) Includes written procedures for taking appropriate remedial action

whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that ought to have been furnished have not been provided.

(b) *Availability and accessibility of health care services.* Basic health services and those supplemental health services for which enrollees have contracted must be provided or arranged for by the HMO in accordance with the following rules:

(1) Except as provided in paragraph (b)(2) of this section, the services must be available to each enrollee within the HMO's service area.

(2) *Exception.* If the HMO's service area is located wholly within a non-metropolitan area, the HMO may make available outside its service area any basic health service that is not a primary care or emergency care service, if the number of providers of that basic health service who will provide the service to the HMO's enrollees is insufficient to meet the demand. As used in this paragraph, primary care includes general practice, family practice, general internal medicine, general pediatrics, and general obstetrics and gynecology. An HMO that provides the services covered by these fields through at least a general or family practitioner, or a pediatrician and a general internist, is considered to be providing primary care.

(3) The services must be available and accessible with reasonable promptness to each of the HMO's enrollees as ensured through—

(i) Staffing patterns within generally accepted norms for meeting the projected enrollment needs; and

(ii) Geographic location, hours of operation, and arrangements for after-hours services. (Medically necessary emergency services must be available 24 hours a day, 7 days a week.)

(c) *Continuity of care.* The HMO must ensure continuity of care through arrangements that include but are not limited to the following:

(1) Use of a health professional who is primarily responsible for coordinating the enrollee's overall health care.

(2) A system of health and medical records that accumulates pertinent information about the enrollee's health