§ 417.102 Health benefits plan: Supple-
mental health services.

(a) An HMO may provide to its en-
rollees 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 serv-
ices included with basic health services
provided to its enrollees for a basic
health services payment or those serv-
ices offered to its enrollees as supple-
mental health services.

§ 417.103 Providers of basic and sup-
plemental 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 ar-
ranged for through (i) health profes-
sionals 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 con-
tracts with the HMO for the provision
of these services, or (v) any combina-
tion of staff, medical group or groups,
IPA or IPAs, or physicians or other
health professionals under direct serv-
ice 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 service ar-
rangements with an IPA or IPAs, but
only if either (i) these physicians num-
ber less than 50 percent of the physi-
cians who have entered into arrange-
ments with the IPA or IPAs, or (ii) if
the sharing is 50 percent or greater,
CMS approves the sharing as being con-
sistent with the purposes of section
1310(b) of the PHS Act.

(b) HMOs must have effective proce-
dures to monitor utilization and to
control cost of basic and supplemental
health services and to achieve utiliza-
tion goals, which may include mecha-
nisms 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 serv-
ces 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