(16) Health services that are unusual and infrequently provided and not necessary for the protection of individual health, as approved by CMS upon application by the HMO.

(e) An HMO may not offer to provide or arrange for the provision of basic health services on a prepayment basis that do not include all the basic health services set forth in paragraph (a) of this section or that are limited as to time and cost except in a manner prescribed by this subpart.


§ 417.102 Health benefits plan: Supplementary health services.

(a) An HMO may provide to its enrollees 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 supplementary health services included with basic health services provided to its enrollees for a basic health services payment or those services offered to its enrollees as supplemental health services.


§ 417.103 Providers of basic and supplementary 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 arranged for through (i) health professionals 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 contracts with the HMO for the provision of these services, or (v) any combination of staff, medical group or groups, IPA or IPAs, or physicians or other health professionals under direct service 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 arrangements with an IPA or IPAs, but only if either (i) these physicians number less than 50 percent of the physicians who have entered into arrangements with the IPA or IPAs, or (ii) if the sharing is 50 percent or greater, CMS approves the sharing as being consistent with the purposes of section 1310(b) of the PHS Act.

(3) After the 4 year period beginning with the month following the month in that an HMO becomes a qualified HMO, an entity that meets the requirements of the definition of medical group in § 417.100, except for subdivision (3)(i) of that definition, may be considered a medical group if CMS determines that the principal professional activity (over 50 percent individually) of the entity’s members is the coordinated practice of their profession, and if the HMO has demonstrated to the satisfaction of CMS that the entity is committed to 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-specialty 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 supplementary health services and to achieve utilization goals, which may include mechanisms such as risk sharing, financial