

(11) *Supplemental benefits.* Whether the plan offers mandatory supplemental benefits or offers optional supplemental benefits and the premiums and other terms and conditions for those benefits.

[63 FR 35077, June 26, 1998, as amended at 64 FR 7980, Feb. 17, 1999; 65 FR 40321, June 29, 2000]

**§ 422.112 Access to services.**

(a) *Rules for coordinated care plans and network M+C MSA plans.* An M+C organization that offers an M+C coordinated care plan or network M+C MSA plan may specify the networks of providers from whom enrollees may obtain services if the M+C organization ensures that all covered services, including additional or supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the M+C organization must meet the following requirements:

(1) *Provider network.* Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically utilized in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.

(2) *PCP panel.* Establish a panel of PCPs from which the enrollee may select a PCP. If an M+C organization requires its enrollees to obtain a referral in most situations before receiving services from a specialist, the M+C organization must either assign a PCP for purposes of making the needed referral or make other arrangements to ensure access to medically necessary specialty care.

(3) *Specialty care.* Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits (as defined in § 422.2). The M+C organization arranges for specialty care outside of the plan provider network when network providers are un-

available or inadequate to meet an enrollee's medical needs.

(4) *Serious medical conditions.* Ensure that for each plan, the M+C organization has in effect HCFA-approved procedures that enable the M+C organization, through appropriate health care professionals, to—

(i) Identify individuals with complex or serious medical conditions;

(ii) Assess those conditions, and use medical procedures to diagnose and monitor them on an ongoing basis; and

(iii) Establish and implement a treatment plan that—

(A) Is appropriate to those conditions;

(B) Includes an adequate number of direct access visits to specialists consistent with the treatment plan;

(C) Is time-specific and updated periodically; and

(D) Ensures adequate coordination of care among providers.

(5) *Service area expansion.* If seeking a service area expansion for an M+C plan, demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served.

(6) *Credentialed providers.* Demonstrate to HCFA that its providers in an M+C plan are credentialed through the process set forth at § 422.204(a).

(7) *Written standards.* Establish written standards for the following:

(i) Timeliness of access to care and member services that meet or exceed standards established by HCFA. Timely access to care and member services within a plan's provider network must be continuously monitored to ensure compliance with these standards, and the M+C organization must take corrective action as necessary.

(ii) Policies and procedures (coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations.

(iii) Provider consideration of beneficiary input into the provider's proposed treatment plan.

(8) *Hours of operation.* Ensure that—

(i) The hours of operation of its M+C plan providers are convenient to the population served under the plan and do not discriminate against Medicare enrollees; and

(ii) Plan services are available 24 hours a day, 7 days a week, when medically necessary.

(9) *Cultural considerations.* Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

(10) *Ambulance services, emergency and urgently needed services, and post-stabilization care services coverage.* Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services in accordance with § 422.113.

(b) *Rules for all M+C organizations to ensure continuity of care.* The M+C organization must ensure continuity of care and integration of services through arrangements that include, but are not limited to the following—

(1) Policies that specify under what circumstances services are coordinated and the methods for coordination;

(2) Offering to provide each enrollee with an ongoing source of primary care and providing a primary care source to each enrollee who accepts the offer;

(3) Programs for coordination of plan services with community and social services generally available through contracting or noncontracting providers in the area served by the M+C plan, including nursing home and community-based services; and

(4) Procedures to ensure that the M+C organization and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that—

(i) The M+C organization makes a “best-effort” attempt to conduct an initial assessment of each enrollee’s health care needs, including following up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment;

(ii) Each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the M+C organization, taking into account professional standards; and

(iii) There is appropriate and confidential exchange of information among provider network components.

(5) Procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and

(6) Systems to address barriers to enrollee compliance with prescribed treatments or regimens.

[64 FR 7980, Feb. 17, 1999, as amended at 65 FR 40321, June 29, 2000 ]

**§ 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services.**

(a) *Ambulance services.* The M+C organization is financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary’s health.

(b) *Emergency and urgently needed services.—* (1) *Definitions.*

(i) *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(ii) *Emergency services* means covered inpatient and outpatient services that are—

(A) Furnished by a provider qualified to furnish emergency services; and

(B) Needed to evaluate or stabilize an emergency medical condition.

(iii) *Urgently needed services* means covered services that are not emergency services as defined in this section, provided when an enrollee is temporarily absent from the M+C plan’s service (or, if applicable, continuation)