

(d) *Suspension or termination of contract.* An M+C organization that operates a coordinated care plan or network MSA plan providing benefits through contracting providers must meet the following requirements:

(1) *Notice to physician.* An M+C organization that suspends or terminates an agreement under which the physician provides services to M+C plan enrollees must give the affected individual written notice of the following:

(i) The reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the M+C organization.

(ii) The affected physician's right to appeal the action and the process and timing for requesting a hearing.

(2) *Composition of hearing panel.* The M+C organization must ensure that the majority of the hearing panel members are peers of the affected physician.

(3) *Notice to licensing or disciplinary bodies.* An M+C organization that suspends or terminates a contract with a physician because of deficiencies in the quality of care must give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.

(4) *Timeframes.* An M+C organization and a contracting provider must provide at least 60 days written notice to each other before terminating the contract without cause.

[64 FR 7981, Feb. 17, 1999, as amended at 65 FR 40324, June 29, 2000]

**§ 422.204 Provider selection and credentialing.**

(a) *General rule.* An M+C organization must have written policies and procedures for the selection and evaluation of providers. These policies must conform with the credential and recredentialing requirements set forth in paragraph (b) of this section and with the antidiscrimination provisions set forth in § 422.205.

(b) *Basic requirements.* An M+C organization must follow a documented process with respect to providers and suppliers who have signed contracts or participation agreements that—

(1) For providers (other than physicians and other health care profes-

sionals) requires determination, and redetermination at specified intervals, that each provider is—

(i) Licensed to operate in the State, and in compliance with any other applicable State or Federal requirements; and

(ii) Reviewed and approved by an accrediting body, or meets the standards established by the organization itself;

(2) For physicians and other health care professionals, including members of physician groups, covers—

(i) Initial credentialing that includes written application, verification of licensure or certification from primary sources, disciplinary status, eligibility for payment under Medicare, and site visits as appropriate. The application must be signed and dated and include an attestation by the applicant of the correctness and completeness of the application and other information submitted in support of the application;

(ii) Recredentialing at least every 2 years that updates information obtained during initial credentialing and considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and that includes an attestation of the correctness and completeness of the new information; and

(iii) A process for consulting with contracting health care professionals with respect to criteria for credentialing and recredentialing.

(3) Specifies that basic benefits must be provided through, or payments must be made to, providers and suppliers that meet applicable requirements of title XVIII and part A of title XI of the Act. In the case of providers meeting the definition of “provider of services” in section 1861(u) of the Act, basic benefits may only be provided through these providers if they have a provider agreement with HCFA permitting them to provide services under original Medicare.

(4) Ensures compliance with the requirements at § 422.752(a)(8) that prohibit employment or contracts with individuals (or with an entity that employs or contracts with such an individual) excluded from participation

under Medicare and with the requirements at § 422.220 regarding physicians and practitioners who opt out of Medicare.

[65 FR 40324, June 29, 2000]

**§ 422.205 Provider antidiscrimination rules.**

(a) *General rule.* Consistent with the requirements of this section, the policies and procedures concerning provider selection and credentialing established under § 422.204, and with the requirement under § 422.100(c) that all Medicare-covered services be available to M+C plan enrollees, an M+C organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an M+C organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an M+C organization declines to include a given provider or group of providers in its network, it must furnish written notice to the affected provider(s) of the reason for the decision.

(b) *Construction.* The prohibition in paragraph (a)(1) of this section does not preclude any of the following by the M+C organization:

(1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for M+C private-fee-for-service plans, which may not refuse to contract on this basis).

(2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.

(3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

[65 FR 40324, June 29, 2000]

**§ 422.206 Interference with health care professionals' advice to enrollees prohibited.**

(a) *General rule.* (1) An M+C organization may not prohibit or otherwise re-

strict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under an M+C plan about—

(i) The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;

(ii) The risks, benefits, and consequences of treatment or non-treatment; or

(iii) The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

(2) Health care professionals must provide information regarding treatment options in a culturally-competent manner, including the option of no treatment. Health care professionals must ensure that individuals with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

(b) *Conscience protection.* The general rule in paragraph (a) of this section does not require the M+C plan to cover, furnish, or pay for a particular counseling or referral service if the M+C organization that offers the plan—

(1) Objects to the provision of that service on moral or religious grounds; and

(2) Through appropriate written means, makes available information on these policies as follows:

(i) To HCFA, with its application for a Medicare contract, within 10 days of submitting its ACR proposal or, for policy changes, in accordance with § 422.80 (concerning approval of marketing materials and election forms) and with § 422.111.

(ii) To prospective enrollees, before or during enrollment.

(iii) With respect to current enrollees, the organization is eligible for the exception provided in paragraph (b)(1) of this section if it provides notice of such change within 90 days after adopting the policy at issue; however, under § 422.111(d), notice of such a change must be given in advance.