

## § 417.418

of after hours service. Medically necessary emergency services must be available twenty-four hours a day, seven days a week.

(2) The HMO or CMP must maintain a health (including medical) record-keeping system through which pertinent information relating to the health care of its Medicare enrollees is accumulated and is readily available to appropriate professionals.

(3) The HMO or CMP must meet network adequacy standards specified in § 422.116 of this chapter.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 63 FR 20130, Apr. 23, 1998; 85 FR 33901, June 2, 2020]

### § 417.418 Qualifying condition: Quality assurance program.

(a) *Condition.* The HMO or CMP must make arrangements for a quality assurance program that meets the requirements of this section.

(b) *Standard.* An HMO or CMP must have an ongoing quality assurance program that meets the requirements set forth in § 417.106(a).

[58 FR 38072, July 15, 1993]

## Subpart K—Enrollment, Entitlement, and Disenrollment under Medicare Contract

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

### § 417.420 Basic rules on enrollment and entitlement.

(a) *Enrollment.* Eligible individuals who are entitled to benefits under both Part A and Part B of Medicare or only Part B may elect to receive those benefits through an HMO or CMP that has in effect a contract with CMS under subpart L of this part.

(b) *Entitlement.* If a Medicare beneficiary enrolls with an HMO or CMP, CMS pays the HMO or CMP on his or her behalf for the services to which he or she is entitled.

(c) *Beneficiary liability.* (1) The HMO or CMP may require payment, in the form of premiums or otherwise, from individuals for services not covered under Medicare, as well as deductible

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and coinsurance amounts attributable to Medicare covered services.

(2) As described in § 417.448, Medicare enrollees of risk HMOs or CMPs are liable for services that they obtain from sources other than the HMO or CMP, unless the services are—

(i) Emergency or urgently needed; or

(ii) Determined, on appeal under subpart Q of this part, to be services that should have been furnished by the HMO or CMP.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38078, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 80 FR 7958, Feb. 12, 2015]

### § 417.422 Eligibility to enroll in an HMO or CMP.

Except as specified in §§ 417.423 and 417.424, an HMO or CMP must enroll, either for an indefinite period or for a specified period of at least 12 months, any individual who meets all of the following:

(a) Is entitled to Medicare benefits under Parts A and B or under Part B only.

(b) Lives within the geographic area served by the HMO or CMP.

(c) Is not enrolled in any other HMO or CMP that has entered into a contract under subpart L of this part.

(d) During an enrollment period of the HMO or CMP, completes the HMO's or CMP's application form or another CMS-approved election mechanism and gives whatever information is required for enrollment.

(e) Agrees to abide by the HMO's or CMP's rules after they are disclosed to him or her in connection with the enrollment process.

(f) Is not denied enrollment by the HMO or CMP under a selection policy, if any, that has been approved by CMS under § 417.424(b).

(g) Is not denied enrollment by the HMO or CMP on the basis of any of the administrative criteria concerning denial of enrollment in § 417.424(a).

(h) Is a United States citizen or an individual who is lawfully present in the United States as determined in 8 CFR 1.3.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38078, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 77 FR 22166, Apr. 12, 2012; 80 FR 7958, Feb. 12, 2015]