

the changes to CMS in accordance with § 417.428(a)(3), and notify its Medicare enrollees of the changes at least 30 days before the effective date of the changes.

(d) *Advance directives.* (1) An HMO or CMP must maintain written policies and procedures concerning advance directives, as defined in § 489.100 of this chapter, with respect to all adult individuals receiving medical care by or through the HMO or CMP and are required to:

(i) Provide written information to those individuals concerning—

(A) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives. Providers are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. Such information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law; and

(B) The HMO's or CMP's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the HMO or CMP cannot implement an advance directive as a matter of conscience. At a minimum, this statement should:

(1) Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

(2) Identify the state legal authority permitting such objection; and

(3) Describe the range of medical conditions or procedures affected by the conscience objection.

(ii) Provide the information specified in paragraphs (d)(1)(i) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an ad-

vance directive, the HMO or CMP may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The HMO or CMP is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

(iii) Document in the individual's medical record whether or not the individual has executed an advance directive;

(iv) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(v) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives;

(vi) Provide for education of staff concerning its policies and procedures on advance directives; and

(vii) Provide for community education regarding advance directives that may include material required in paragraph (d)(1)(i)(A) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the HMO or CMP. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An HMO or CMP must be able to document its community education efforts.

(2) The HMO or CMP—(i) Is not required to provide care that conflicts with an advance directive.

(ii) Is not required to implement an advance directive if, as a matter of conscience, the HMO or CMP cannot implement an advance directive and

State law allows any health care provider or any agent of such provider to conscientiously object.

(3) The HMO or CMP must inform individuals that complaints concerning non-compliance with the advance directive requirements may be filed with the State survey and certification agency.

[58 FR 38072, July 15, 1993, as amended at 59 FR 49843, Sept. 30, 1994; 60 FR 33292, June 27, 1995]

§417.440 Entitlement to health care services from an HMO or CMP.

(a) *Basic rules.* (1) Subject to the conditions and limitations set forth in this subpart, a Medicare enrollee of an HMO or CMP is entitled to receive health care services and supplies directly from, or through arrangements made by, the HMO or CMP as specified in this section and §§417.442–417.446.

(2) A Medicare enrollee is also entitled to receive timely and reasonable payment directly (or have payment made on his or her behalf) for services he or she obtained from a provider or supplier outside the HMO or CMP if those services are—

(i) Emergency services or urgently needed services as defined §417.401;

(ii) Services denied by the HMO or CMP and found (upon appeal under subpart Q of this part) to be services the enrollee was entitled to have furnished by the HMO or CMP.

(b) *Scope of services*—(1) *Part A and Part B services.* Except as specified in paragraphs (c), (d), and (e) of this section, a Medicare enrollee is entitled to receive from an HMO or CMP all the Medicare-covered services that are available to individuals residing in the HMO's or CMP's geographic area, as follows:

(i) Medicare Part A and Part B services if the enrollee is entitled to benefits under both programs.

(ii) Medicare Part B services if the enrollee is entitled only under that program.

(2) *Supplemental services elected by an enrollee.* (i) Except as provided under paragraph (b)(2)(ii) of this section, a Medicare enrollee of an HMO or CMP may elect to pay for optional services that are offered by the HMO or CMP in

addition to the covered Part A and Part B services.

(ii) An HMO or CMP may elect to provide qualified prescription drug coverage (as defined at §423.104 of this chapter) as an optional supplemental service in accordance with the applicable requirements under part 423 of this chapter, including §423.104(f)(4) of this chapter.

(iii) The HMO or CMP may not set health status standards for those enrollees whom it accepts for these optional supplemental services.

(3) *Supplemental services imposed by a risk HMO or CMP.* (i) Subject to CMS's approval, a risk HMO or CMP may require Medicare enrollees to accept and pay for services in addition to those covered by Medicare. (ii) If the HMO or CMP elects this option, it must impose the requirement on all Medicare enrollees, without regard to health status. (iii) CMS approves supplemental benefits of this type if CMS determines that imposition of the requirements will not discourage other Medicare beneficiaries from enrolling in the risk HMO or CMP.

(4) *Additional benefits from risk HMOs or CMPs required by statute.* Subject to the conditions stated in §417.442, a new Medicare enrollee or a current nonrisk Medicare enrollee who converts to risk reimbursement under §417.444 is eligible to receive, in addition to the covered Part A and Part B benefits for which he or she is eligible, benefits consisting of one or both of the following:

(i) A reduction in the HMO's or CMP's premium rate or in other charges for services furnished to Medicare enrollees.

(ii) Provision of health benefits or services beyond the required Part A and Part B coverage.

(5) *Special supplemental benefits.* Under conditions described in §417.444(c), current nonrisk Medicare enrollees who are not converted to the risk portion of the contract, may enroll in a special supplemental plan, if offered by the HMO or CMP, for some or all of the additional benefits described in paragraph (b)(4) of this section.

(c) *Limitation on hospice care*—(1) *Extent of limitation*—(i) *Basic rule.* Except as provided in paragraph (c)(1)(ii) of