§417.494(b) if CMS determines that the HMO or CMP no longer substantially meets the requirements of paragraphs (d)(1), (d)(2), or (d)(3) of this section.

(8) *Termination of composition standard.* The 50 percent composition of Medicare beneficiaries terminates for all managed care plans on December 31, 1998.

(e) *Standard: Open enrollment.* (1) Except as specified in paragraph (e)(2) of this section, an HMO or CMP must enroll Medicare beneficiaries on a first-come, first-served basis to the limit of its capacity and provide annual open enrollment periods of at least 30 days duration for Medicare beneficiaries.

(2) CMS may waive the requirement of paragraph (e)(1) of this section if compliance would prevent compliance with the limitation on enrollment of Medicare beneficiaries and Medicaid beneficiaries (paragraph (d) of this section) or result in an enrollment substantially nonrepresentative of the population of the HMO's or CMP's geographic area. The enrollment would be ''substantially nonrepresentative'' if the proportion of a subgroup to the total enrollment exceeded, by 10 percent or more, its proportion of the population in the HMO's or CMP's geographic area, as shown by census data or other data acceptable to CMS. For purposes of this paragraph, a subgroup means a class of Medicare enrollees as defined in §417.582.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 46570, Sept. 13, 1991; 58 FR 38082, July 15, 1993; 60 FR 45676, Sept. 1, 1995; 63 FR 35066, June 26, 1998]

§417.414 Qualifying condition: Range of services.

(a) *Condition.* The HMO or CMP must demonstrate that it is capable of delivering to Medicare enrollees the range of services required in accordance with this section.

(b) *Standard: Range of services furnished by eligible HMOs or CMPs*—(1) *Basic requirement.* Except as specified in paragraph (b)(3) of this section, an HMO or CMP must furnish to its Medicare enrollees (directly or through arrangements with others) all the Medicare services to which those enrollees are entitled to the extent that they are available to Medicare beneficiaries who reside in the HMO's or CMP's geographic area but are not enrolled in the HMO or CMP.

(2) *Criteria for availability.* The services are considered available if—

(i) The sources are located within the HMO's or CMP's geographic area; or

(ii) It is common practice to refer patients to sources outside that geographic area.

(3) *Exception for hospice care.* An HMO or CMP is not required to furnish hospice care as described in part 418 of this chapter. However, HMOs or CMPs must inform their Medicare enrollees about the availability of hospice care if—

(i) A hospice participating in Medicare is located within the HMO's or CMP's geographic area; or

(ii) It is common practice to refer patients to hospices outside the geographic area.

(c) *Standard: Financial responsibility for services furnished outside the HMO or CMP.* (1) An HMO or CMP must assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services (as defined in §417.401) that are obtained by its Medicare enrollees from providers and suppliers outside the HMO or CMP even in the absence of the HMO's or CMP's prior approval.

(2) An HMO or CMP must assume financial responsibility for services that the Medicare enrollee attempted to obtain from the HMO or CMP, but that the HMO or CMP failed to furnish or unreasonably denied, and that are found, upon appeal by the enrollee under subpart Q of this part, to be services that the enrollee was entitled to have furnished to him or her 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]

§417.416 Qualifying condition: Furnishing of services.

(a) *Condition.* The HMO or CMP must furnish the required services to its Medicare enrollees through providers and suppliers that meet applicable Medicare statutory definitions and implementing regulations. The HMO or CMP must also ensure that the required services, additional services, and any other supplemental services

for which the Medicare enrollee has contracted are available and accessible and are furnished in a manner that ensures continuity.

(b) *Standard: Conformance with conditions of participation, conditions for coverage, and conditions for certification.* (1) Hospitals, SNFs, HHAs, CORFs, and providers of outpatient physical therapy or speech-language pathology services must meet the applicable conditions of participation in Medicare, as set forth elsewhere in this chapter.

(2) Suppliers must meet the conditions for coverage or conditions for certification of their services, as set forth elsewhere in this chapter.

(3) If more than one type of practitioner is qualified to furnish a particular service, the HMO or CMP may select the type of practitioner to be used.

(c) *Standard: Physician supervision.* The HMO or CMP must provide for supervision by a physician of other health care professionals who are directly involved in the provision of health care as generally authorized under section 1861 of the Act. Except as specified in paragraph (d) of this section, with respect to medical services furnished in an HMO's or CMP's clinic or the office of a physician with whom the HMO or CMP has a service agreement, the HMO or CMP must ensure that—

(1) Services furnished by paramedical, ancillary, and other nonphysician personnel are furnished under the direct supervision of a physician;

(2) A physician is present to perform medical (as opposed to administrative) services whenever the clinics or offices are open; and

(3) Each patient is under the care of a physician.

(d) *Exceptions to physician supervision requirement.* The following services may be furnished without the direct personal supervision of a physician:

(1) Services of physician assistants and nurse practitioners (as defined in § 491.2 of this chapter), and the services and supplies incident to their services. The conditions for payment, as set forth in §§ 405.2414 and 405.2415 of this chapter for services furnished by rural health clinics and Federally qualified health centers, respectively, also apply when those services are furnished by an HMO or CMP.

(2) When furnished by an HMO or CMP, services of clinical psychologists who meet the qualifications specified in § 410.71(d) of this chapter, and the services and supplies incident to their professional services.

(3) When an HMO or CMP contracts on—

(i) A risk basis, the services of a clinical social worker (as defined at § 410.73 of this chapter) and the services and supplies incident to their professional services; or

(ii) A cost basis, the services of a clinical social worker (as defined in § 410.73 of this chapter). Services incident to the professional services of a clinical social worker furnished by an HMO or CMP contracting on a cost basis are not covered by Medicare and payment will not be made for these services.

(e) *Standard: Accessibility and continuity.* (1) The HMO or CMP must ensure that the required services and any other services for which Medicare enrollees have contracted are accessible, with reasonable promptness, to the enrollees with respect to geographic location, hours of operation, and provision 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.