

MA organization for pre-approval of further post-stabilization care services;

(iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—

(A) The MA organization does not respond to a request for pre-approval within 1 hour;

(B) The MA organization cannot be contacted; or

(C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met; and

(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

(3) *End of MA organization's financial responsibility.* The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—

(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(ii) A plan physician assumes responsibility for the enrollee's care through transfer;

(iii) An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or

(iv) The enrollee is discharged.

[65 FR 40322, June 29, 2000, as amended at 70 FR 4723, Jan. 28, 2005]

§ 422.114 Access to services under an MA private fee-for-service plan.

(a) *Sufficient access.* (1) An MA organization that offers an MA private fee-

for-service plan must demonstrate to CMS that it has sufficient number and range of providers willing to furnish services under the plan.

(2) CMS finds that an MA organization meets the requirement in paragraph (a)(1) of this section if, with respect to a particular category of health care providers, the MA organization has—

(i) Payment rates that are not less than the rates that apply under original Medicare for the provider in question;

(ii) Contracts or agreements with a sufficient number and range of providers to furnish the services covered under the MA private fee-for-service plan; or

(iii) A combination of paragraphs (a)(2)(i) and (a)(2)(ii) of this section.

(b) *Freedom of choice.* MA fee-for-service plans must permit enrollees to obtain services from any entity that is authorized to provide services under Medicare Part A and Part B and agrees to provide services under the terms of the plan.

(c) *Contracted network.* Private fee-for-service plans that meet network adequacy requirements for a category of health care professional or provider by meeting the requirements in paragraph (a)(2)(ii) of this section may provide for a higher beneficiary copayment in the case of health care professionals or providers of that same category who do not have contracts or agreements to provide covered services under the terms of the plan.

[63 FR 35077, June 26, 1998, as amended at 70 FR 4723, Jan. 28, 2005]

§ 422.118 Confidentiality and accuracy of enrollee records.

For any medical records or other health and enrollment information it maintains with respect to enrollees, an MA organization must establish procedures to do the following:

(a) Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. The MA organization must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify—