

§ 422.4

42 CFR Ch. IV (10–1–07 Edition)

that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population.

[63 FR 35068, June 26, 1998, as amended at 65 FR 40314, June 29, 2000; 68 FR 50855, Aug. 22, 2003; 70 FR 4714, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005; 70 FR 76197, Dec. 23, 2005]

§ 422.4 Types of MA plans.

(a) *General rule.* An MA plan may be a coordinated care plan, a combination of an MA MSA plan and a contribution into an MA MSA established in accordance with § 422.262, or an MA private fee-for-service plan.

(1) *A coordinated care plan.* A coordinated care plan is a plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS.

(i) The network is approved by CMS to ensure that all applicable requirements are met, including access and availability, service area, and quality.

(ii) Coordinated care plans may include mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care.

(iii) Coordinated care plans include plans offered by health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), regional or local preferred provider organizations (PPOs) as specified in paragraph (a)(1)(v) of this section, and other network plans (except PFFS plans).

(iv) A specialized MA plan for special needs individuals (SNP) includes any type of coordinated care plan that meets CMS'SNP requirements and either—

(A) Exclusively enrolls special needs individuals as defined in § 422.2; or

(B) Enrolls a greater proportion of special needs individuals than occur nationally in the Medicare population as defined by CMS.

(v) A PPO plan is a plan that has a network of providers that have agreed to a contractually specified reimburse-

ment for covered benefits with the organization offering the plan; provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers; and, only for purposes of quality assurance requirements in § 422.152(e), is offered by an organization that is not licensed or organized under State law as an HMO.

(2) *A combination of an MA MSA plan and a contribution into the MA MSA established in accordance with § 422.262.* (i) *MA MSA plan* means a plan that—

(A) Pays at least for the services described in § 422.101, after the enrollee has incurred countable expenses (as specified in the plan) equal in amount to the annual deductible specified in § 422.103(d); and

(B) Meets all other applicable requirements of this part.

(ii) *MA MSA* means a trust or custodial account—

(A) That is established in conjunction with an MSA plan for the purpose of paying the qualified expenses of the account holder; and

(B) Into which no deposits are made other than contributions by CMS under the MA program, or a trustee-to-trustee transfer or rollover from another MA MSA of the same account holder, in accordance with the requirements of sections 138 and 220 of the Internal Revenue Code.

(3) *MA private fee-for-service plan.* An MA private fee-for-service plan is an MA plan that—

(i) Pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(ii) Does not vary the rates for a provider based on the utilization of that provider's services; and

(iii) Does not restrict enrollees' choices among providers that are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment.

(b) *Multiple plans.* Under its contract, an MA organization may offer multiple plans, regardless of type, provided that the MA organization is licensed or approved under State law to provide those types of plans (or, in the case of a PSO plan, has received from CMS a

waiver of the State licensing requirement). If an MA organization has received a waiver for the licensing requirement to offer a PSO plan, that waiver does not apply to the licensing requirement for any other type of MA plan.

(c) *Rule for MA Plans' Part D coverage.*

(1) Coordinated care plans. In order to offer an MA coordinated care plan in an area, the MA organization offering the coordinated care plan must offer qualified Part D coverage meeting the requirements in § 423.104 of this chapter in that plan or in another MA plan in the same area.

(2) *MSAs.* MA organizations offering MSA plans are not permitted to offer prescription drug coverage, other than that required under Parts A and B of Title XVIII of the Act.

(3) *Private Fee-For-Service.* MA organizations offering private fee-for-service plans can choose to offer qualified Part D coverage meeting the requirements in § 423.104 in that plan.

[63 FR 35068, June 26, 1998, as amended at 65 FR 40315, June 29, 2000; 70 FR 4714, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

§ 422.6 Cost-sharing in enrollment-related costs.

(a) *Basis and scope.* This section implements that portion of section 1857 of the Act that pertains to cost-sharing in enrollment-related costs. It sets forth the procedures that CMS follows to determine the aggregate annual "user fee" to be contributed by MA organizations and PDP sponsors under Medicare Part D and to assess the required user fees for each MA plan offered by MA organizations and PDP sponsors.

(b) *Purpose of assessment.* Section 1857(e)(2) of the Act authorizes CMS to charge and collect from each MA plan offered by an MA organization its pro rata share of fees for administering section 1851 of the Act (relating to dissemination of enrollment information), and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program) and section 1860D-1(c) of the Act (relating to dissemination of enrollment information for the drug benefit).

(c) *Applicability.* The fee assessment also applies to those demonstrations

for which enrollment is effected or coordinated under section 1851 of the Act.

(d) *Collection of fees—(1) Timing of collection.* CMS collects the fees over 9 consecutive months beginning with January of each fiscal year.

(2) *Amount to be collected.* The aggregate amount of fees for a fiscal year is the lesser of—

(i) The estimated costs to be incurred by CMS in that fiscal year to carry out the activities described in paragraph (b) of this section; or

(ii) For fiscal year 2006 and each succeeding year, the applicable portion (as defined in paragraph (e) of this section) of \$200 million.

(e) *Applicable portion.* In this section, the term "applicable portion" with respect to an MA plan means, for a fiscal year, CMS's estimate of Medicare Part C and D expenditures for those MA organizations as a percentage of all expenditures under title XVIII and with respect to PDP sponsors, the applicable portion is CMS's estimate of Medicare Part D prescription drug expenditures for those PDP sponsors as a percentage of all expenditures under title XVIII.

(f) *Assessment methodology.* (1) The amount of the applicable portion of the user fee each MA organization and PDP sponsor must pay is assessed as a percentage of the total Medicare payments to each organization. CMS determines the annual assessment percentage rate separately for MA organizations and for PDPs using the following formula:

(i) The assessment formula for MA organizations (including MA-PD plans): C divided by A times B where—

A is the total estimated January payments to all MA organizations subject to the assessment;

B is the 9-month (January through September) assessment period; and

C is the total fiscal year MA organization user fee assessment amount determined in accordance with paragraph (d)(2) of this section.

(ii) The assessment formula for PDPs: C divided by A times B where— A is the total estimated January payments to all PDP sponsors subject to the assessment; B is the 9-month (January through September) assessment period; and C is the total fiscal year PDP sponsor's user fee assessment