§ 422.210 Assurances to CMS.

(a) Assurances to CMS. Each organization will provide assurance satisfactory to the Secretary that the requirements of § 422.208 are met.

(b) Disclosure to Medicare Beneficiaries. Each MA organization must provide the following information to any Medicare beneficiary who requests it:

1. Whether the MA organization uses a physician incentive plan that affects the use of referral services.
2. The type of incentive arrangement.
3. Whether stop-loss protection is provided.

§ 422.212 Limitations on provider indemnification.

An MA organization may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify the organization against any civil liability for damage caused to an enrollee as a result of the MA organization’s denial of medically necessary care:

(a) A physician or health care professional.
(b) Provider of services.
(c) Other entity providing health care services.
(d) Group of such professionals, providers, or entities.

§ 422.214 Special rules for services furnished by noncontract providers.

(a) Services furnished by non-section 1861(u) providers. (1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

(2) Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an MA plan also apply to the payment described in paragraph (a)(1) of this section.
Centers for Medicare & Medicaid Services, HHS § 422.216

(b) Services furnished by section 1861(u) providers of service. Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under §§ 412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direct medical education costs.)


§ 422.216 Special rules for MA private fee-for-service plans.

(a) Payment to providers—(1) Payment rate. (i) The MA organization must establish payment rates for plan covered items and services that apply to deemed providers. The MA organization may vary payment rates for providers in accordance with § 422.4(a)(3).

(ii) Providers must be reimbursed on a fee-for-service basis.

(iii) The MA organization must make information on its payment rates available to providers that furnish services that may be covered under the MA private fee-for-service plan.

(2) Noncontract providers. The organization pays for services of noncontract providers in accordance with § 422.100(b)(2).

(5) Services furnished by providers of service. Any provider of services as defined in section 1861(u) of the Act does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA private fee-for-service plan must receive, and accept as payment in full, at least the amount (less any payments under §§ 412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare.

(b) Charges to enrollees—(1) Contract providers. (i) Contract providers and “deemed” contract providers may charge enrollees no more than the cost-sharing and, subject to the limit in paragraph (b)(1)(ii) of this section, balance billing amounts that are permitted under the plan, and these amounts must be the same for “deemed” contract providers as for those that have signed contracts in effect, unless access requirements with respect to a particular category of health care providers are met solely through § 422.114(a)(2)(ii) and the MA organization imposes higher beneficiary copayments as permitted under § 422.114(c). (ii) The organization may permit balance billing no greater than 15 percent of the payment rate established under paragraph (a)(1) of this section.

(iii) The MA organization must specify the amount of cost-sharing and balance billing in its contracts with providers and these amounts must be the same for “deemed” contract providers as for those that have signed contracts in effect, unless access requirements with respect to a particular category of health care providers are met solely through § 422.114(a)(2)(ii) and the MA organization imposes higher beneficiary copayments as permitted under § 422.114(c).

(iv) The MA organization is subject to intermediate sanctions under § 422.752(a)(7), under the rules in subpart O of this part, if it fails to enforce the limit specified in paragraph (b)(1)(i) of this section.

(2) Noncontract providers. A noncontract provider may not collect from an enrollee more than the cost-sharing established by the MA private fee-for-service plan as specified in § 422.256(b)(3), unless the provider has opted out of Medicare as described in part 405, subpart D of this chapter.

(c) Enforcement of limit—(1) Contract providers. An MA organization that offers an MA fee-for-service plan must enforce the limit specified in paragraph (b)(1) of this section.

(2) Noncontract providers. An MA organization that offers an MA private fee-for-service plan must monitor the amount collected by noncontract providers to ensure that those amounts do not exceed the amounts permitted to be collected under paragraph (b)(2) of