Centers for Medicare & Medicaid Services, HHS

§ 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).

(b) Services furnished by 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.

(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)(i) 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 this section.
this section, unless the provider has opted out of Medicare as described in part 405, subpart D of this chapter. The MA organization must develop and document violations specified in instructions and must forward documented cases to CMS.

(d) Information on enrollee liability—(1) General information. An MA organization that offers an MA fee-for-service plan must provide to plan enrollees, for each claim filed by the enrollee or the provider that furnished the service, an appropriate explanation of benefits. The explanation must include a clear statement of the enrollee’s liability for deductibles, coinsurance, copayment, and balance billing.

(2) Advance notice for hospital services. In its terms and conditions of payment to hospitals, the MA organization must require the hospital, if it imposes balance billing, to provide to the enrollee, before furnishing any services for which balance billing could amount to not less than $500—

(i) Notice that balance billing is permitted for those services;

(ii) A good faith estimate of the likely amount of balance billing, based on the enrollee's presenting condition; and

(iii) The amount of any deductible, coinsurance, and copayment that may be due in addition to the balance billing amount.

(e) Coverage determinations. The MA organization must make coverage determinations in accordance with subpart M of this part.

(f) Rules describing deemed contract providers. Any provider furnishing health services, except for emergency services furnished in a hospital pursuant to §489.24 of this chapter, to an enrollee in an MA private fee-for-service plan, and who has not previously entered into a contract or agreement to furnish services under the plan, is treated as having a contract in effect and is subject to the limitations of this section that apply to contract providers if the following conditions are met:

(1) The services are covered under the plan and are furnished—

(i) To an enrollee of an MA fee-for-service plan; and

(ii) Provided by a provider including a provider of services (as defined in section 1861(u) of the Act) that does not have in effect a signed contract with the MA organization.

(2) Before furnishing the services, the provider—

(i) Was informed of the individual’s enrollment in the plan; and

(ii) Was informed (or given a reasonable opportunity to obtain information) about the terms and conditions of payment under the plan, including the information described in §422.202(a)(1).

(3) The information was provided in a manner that was reasonably designed to effect informed agreement and met the requirements of paragraphs (g) and (h) of this section.

(g) Enrollment information. Enrollment information was provided by one of the following methods or a similar method:

(1) Presentation of an enrollment card or other document attesting to enrollment.

(2) Notice of enrollment from CMS, a Medicare intermediary or carrier, or the MA organization itself.

(h) Information on payment terms and conditions. Information on payment terms and conditions was made available through either of the following methods:

(1) The MA organization used postal service, electronic mail, FAX, or telephone to communicate the information to one of the following:

(i) The provider.

(ii) The employer or billing agent of the provider.

(iii) A partnership of which the provider is a member.

(iv) Any party to which the provider makes assignment or reassigns benefits.

(2) The MA organization has in effect a procedure under which—

(i) Any provider furnishing services to an enrollee in an MA private fee-for-service plan, and who has not previously entered into a contract or agreement to furnish services under the plan, can receive instructions on how to request the payment information;

(ii) The organization responds to the request before the entity furnishes the service; and

(iii) The information the organization provides includes the following:
(A) Billing procedures.
(B) The amount the organization will pay towards the service.
(C) The amount the provider is permitted to collect from the enrollee.
(D) The information described in § 422.202(a)(1).

(3) Announcements in newspapers, journals, or magazines or on radio or television are not considered communication of the terms and conditions of payment.

(i) Provider credential requirements. Contracts with providers must provide that, in order to be paid to provide services to plan enrollees, providers must meet the requirements specified in §§ 422.204(b)(1)(1) and (b)(3).

§ 422.220 Exclusion of services furnished under a private contract.

An MA organization may not pay, directly or indirectly, on any basis, for services (other than emergency or urgently needed services as defined in § 422.2) furnished to a Medicare enrollee by a physician (as defined in section 1861(r)(1) of the Act) or other practitioner (as defined in section 1842(b)(18)(C) of the Act) who has filed with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts under section 1802(b) of the Act with the beneficiaries. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner who has not signed a private contract with the beneficiary.

Subpart F-Submission of Bids, Premiums, and Related Information and Plan Approval

§ 422.250 Basis and scope.

This subpart is based largely on section 1854 of the Act, but also includes provisions from section 1853 and section 1856 of the Act. It sets forth the requirements for the Medicare Advantage bidding payment methodology, including CMS’ calculation of benchmarks, submission of plan bids by Medicare Advantage (MA) organizations, establishment of beneficiary premiums and rebates through comparison of plan bids and benchmarks, and negotiation and approval of bids by CMS.

§ 422.252 Terminology.

Annual MA capitation rate means a county payment rate for an MA local area (county) for a calendar year. The terms “per capita rate” and “capitation rate” are used interchangeably to refer to the annual MA capitation rate.

MA local area means a payment area consisting of county or equivalent area specified by CMS.

MA monthly basic beneficiary premium means the premium amount an MA plan (except an MSA plan) charges an enrollee for benefits under the original Medicare fee-for-service program option (if any), and is calculated as described at § 422.262.

MA monthly basic MSA premium means the premium amount an MA plan charges an enrollee for benefits under the original Medicare fee-for-service program option (if any), and is calculated as described at § 422.262.

MA monthly basic beneficiary premium means the premium amount an MA plan charges an enrollee for benefits under the original Medicare fee-for-service program option (if any), and is calculated as described at § 422.262.

MA monthly basic MSA premium means the premium amount an MA plan charges an enrollee for benefits under the original Medicare fee-for-service program option (if any), and is calculated as described at § 422.262.

MA monthly basic beneficiary premium means the premium amount an MA plan charges an enrollee for benefits under the original Medicare fee-for-service program option (if any), and is calculated as described at § 422.262.

MA monthly basic MSA premium means the premium amount an MA plan charges an enrollee for benefits under the original Medicare fee-for-service program option (if any), and is calculated as described at § 422.262.