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AUTHORITY: 42 U.S.C. 1302 and 1395hh.

SOURCE: 63 FR 18134, Apr. 14, 1998, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 422 appear at 70 FR 4741, Jan. 28, 2005.

Subpart A—General Provisions

SOURCE: 63 FR 35068, June 26, 1998, unless otherwise noted.

§ 422.1 Basis and scope.

(a) *Basis.* This part is based on the indicated provisions of the following:

(1) The following provisions of the Act:

(i) 1106—Disclosure of information in possession of agency.

(ii) 1128J(d)—Reporting and Returning of Overpayments.

(iii) 1851—Eligibility, election, and enrollment.

(iv) 1852—Benefits and beneficiary protections.

(v) 1853—Payments to Medicare Advantage (MA) organizations.

(vi) 1854—Premiums.

(vii) 1855—Organization, licensure, and solvency of MA organizations.

(viii) 1856—Standards.

(ix) 1857—Contract requirements.

(x) 1858—Special rules for MA Regional Plans.

(xi) 1859—Definitions; enrollment restriction for certain MA plans.

(2) 8 U.S.C. 1611—Aliens who are not qualified aliens ineligible for Federal public benefits.

(b) *Scope*. This part establishes standards and sets forth the requirements, limitations, and procedures for Medicare services furnished, or paid for, by Medicare Advantage organizations through Medicare Advantage plans.

[63 FR 35068, June 26, 1998, as amended at 70 FR 4714, Jan. 28, 2005; 80 FR 7958, Feb. 12, 2015; 81 FR 80556, Nov. 15, 2016]

§ 422.2 Definitions.

As used in this part—

Aligned enrollment refers to the enrollment in a dual eligible special needs plan of full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and: the dual eligible special needs plan's (D-SNP's) MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization. When State policy limits a D-SNP's membership to individuals with aligned enrollment, this condition is referred to as exclusively aligned enrollment.

Arrangement means a written agreement between an MA organization and a provider or provider network, under which—

(1) The provider or provider network agrees to furnish for a specific MA plan(s) specified services to the organization's MA enrollees;

(2) The organization retains responsibilities for the services; and

(3) Medicare payment to the organization discharges the enrollee's obligation to pay for the services.

Attestation process means a CMS-developed RADV audit-related process that is part of the medical record review process that enables MA organizations undergoing RADV audit to submit CMS-generated attestations for eligible medical records with missing or illegible signatures or credentials. The purpose of the CMS-generated attestations is to cure signature and credential issues. CMS-generated attestations do not provide an opportunity for a

provider or supplier to replace a medical record or for a provider or supplier to attest that a beneficiary has the medical condition

Balance billing generally refers to an amount billed by a provider that represents the difference between the amount the provider charges an individual for a service and the sum of the amount the individual's health insurer (for example, the original Medicare program) will pay for the service plus any cost-sharing by the individual.

Basic benefits means all Medicare-covered benefits (except hospice services).

Benefits means health care services that are intended to maintain or improve the health status of enrollees, for which the MA organization incurs a cost or liability under an MA plan (not solely an administrative processing cost). Benefits are submitted and approved through the annual bidding process.

Coinsurance is a fixed percentage of the total amount paid for a health care service that can be charged to an MA enrollee on a per-service basis.

Copayment is a fixed amount that can be charged to an MA plan enrollee on a per-service basis.

Cost-sharing includes deductibles, coinsurance, and copayments.

Downstream entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Dual eligible special needs plan or D-SNP means a specialized MA plan for special needs individuals who are entitled to medical assistance under a State plan under title XIX of the Act that—

(1) Coordinates the delivery of Medicare and Medicaid services for individuals who are eligible for such services;

(2) May provide coverage of Medicaid services, including long-term services and supports and behavioral health services for individuals eligible for such services;

(3) Has a contract with the State Medicaid agency consistent with § 422.107 that meets the minimum requirements in paragraph (c) of such section; and

(4) Beginning January 1, 2021, satisfies one or more of the following criteria for the integration of Medicare and Medicaid benefits:

(i) Meets the additional requirement specified in § 422.107(d) in its contract with the State Medicaid agency.

(ii) Is a highly integrated dual eligible special needs plan.

(iii) Is a fully integrated dual eligible special needs plan.

First tier entity means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Fiscally sound operation means an operation which at least maintains a positive net worth (total assets exceed total liabilities).

Fully integrated dual eligible special needs plan means a dual eligible special needs plan—

(1) That provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Act with the applicable State;

(2) Whose capitated contract with the State Medicaid agency requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a fully integrated dual eligible special needs plan (FIDE SNP) in the State, except as approved by CMS under § 422.107(g) and (h):

(i) Primary care and acute care, and for plan year 2025 and subsequent years including Medicare cost-sharing as defined in section 1905(p)(3)(B), (C), and (D) of the Act, without regard to the limitation of that definition to qualified Medicare beneficiaries;

(ii) Long-term services and supports, including coverage of nursing facility services for a period of at least 180 days during the plan year;

(iii) For plan year 2025 and subsequent years, behavioral health services;

(iv) For plan year 2025 and subsequent years, home health services as defined in § 440.70 of this chapter; and

(v) For plan year 2025 and subsequent years, medical supplies, equipment, and appliances, as described in § 440.70(b)(3) of this chapter;

(3) That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries;

(4) That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement;

(5) For plan year 2025 and subsequent years, that has exclusively aligned enrollment; and

(6) For plan year 2025 and subsequent years, whose capitated contract with the State Medicaid agency covers the entire service area for the dual eligible special needs plan.

Hierarchical condition categories (HCC) means disease groupings consisting of disease codes (currently ICD–9–CM codes) that predict average healthcare spending. HCCs represent the disease component of the enrollee risk score that are applied to MA payments.

Highly integrated dual eligible special needs plan means a dual eligible special needs plan offered by an MA organization that provides coverage of Medicaid benefits under a capitated contract that meets the following requirements—

(1) The capitated contract is between the State Medicaid agency and—

(i) The MA organization; or

(ii) The MA organization's parent organization, or another entity that is owned and controlled by its parent organization;

(2) The capitated contract requires coverage of the following benefits, to the extent Medicaid coverage of such benefits is available to individuals eligible to enroll in a highly integrated dual eligible special needs plan (HIDE SNP) in the State, except as approved by CMS under § 422.107(g) or (h):

(i) Long-term services and supports, including community-based long-term services and supports and some days of coverage of nursing facility services during the plan year; or

(ii) Behavioral health services; and

(3) For plan year 2025 and subsequent years, the capitated contract covers the entire service area for the dual eligible special needs plan.

Institutionalized means, for the purposes of defining a special needs individual and for the open enrollment period for institutionalized individuals at § 422.62(a)(4), an MA eligible individual who continuously resides or is expected to continuously reside for 90 days or longer in one of the following long-term care facility settings:

(1) Skilled nursing facility (SNF) as defined in section 1819 of the Act (Medicare).

(2) Nursing facility (NF) as defined in section 1919 of the Act (Medicaid).

(3) Intermediate care facility for individuals with intellectual and developmental disabilities as defined in section 1905(d) of the Act.

(4) Psychiatric hospital or unit as defined in section 1861(f) of the Act.

(5) Rehabilitation hospital or unit as defined in section 1886(d)(1)(B) of the Act.

(6) Long-term care hospital as defined in section 1886(d)(1)(B) of the Act.

(7) Hospital which has an agreement under section 1883 of the Act (a swing-bed hospital).

(8) Subject to CMS approval, a facility that is not listed in paragraphs (1) through (7) of this definition but meets both of the following:

(i) Furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and

(ii) Whose residents have similar needs and healthcare status as residents of one or more facilities listed in paragraphs (1) through (7) of this definition.

Institutionalized-equivalent means for the purpose of defining a special needs individual, an MA eligible individual who is living in the community but requires an institutional level of care. The determination that the individual requires an institutional level of care (LOC) must be made by—

(1) The use of a State assessment tool from the State in which the individual resides; and

(2) An assessment conducted by an impartial entity and having the requisite knowledge and experience to accurately identify whether the beneficiary meets the institutional LOC criteria. In States and territories that do not have an existing institutional level of care assessment tool, the individual must be assessed using the same methodology that State uses to determine institutional level of care for Medicaid nursing home eligibility.

Licensed by the State as a risk-bearing entity means the entity is licensed or otherwise authorized by the State to assume risk for offering health insurance or health benefits coverage, such that the entity is authorized to accept prepaid capitation for providing, arranging, or paying for comprehensive health services under an MA contract.

MA stands for Medicare Advantage.

MA local area is defined in § 422.252.

MA local plan means an MA plan that is not an MA regional plan.

MA-Prescription drug (PD) plan means an MA plan that provides qualified prescription drug coverage under Part D of the Social Security Act.

MA regional plan means a coordinated care plan structured as a preferred provider organization (PPO) that serves one or more entire regions. An MA regional plan must have a network of contracting providers that have agreed to a specific reimbursement for the plan's covered services and must pay for all covered services whether provided in or out of the network.

MA eligible individual means an individual who meets the requirements of § 422.50.

MA organization means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

MA plan means health benefits coverage offered under a policy or contract by an MA organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of

the MA plan (or in individual segments of a service area, under § 422.304(b)(2)).

MA plan enrollee is an MA eligible individual who has elected an MA plan offered by an MA organization.

Mandatory supplemental benefits means health care services not covered by Medicare that an MA enrollee must accept or purchase as part of an MA plan. The benefits may include reductions in cost sharing for benefits under the original Medicare fee for service program and are paid for in the form of premiums and cost sharing, or by an application of the beneficiary rebate rule in section 1854(b)(1)(C)(ii)(I) of the Act, or both.

MSA stands for medical savings account.

MSA trustee means a person or business with which an enrollee establishes an MA MSA. A trustee may be a bank, an insurance company, or any other entity that—

(1) Is approved by the Internal Revenue Service to be a trustee or custodian of an individual retirement account (IRA); and

(2) Meets the requirements of § 422.262(b).

National coverage determination (NCD) means a national policy determination regarding the coverage status of a particular service that CMS makes under section 1862(a)(1) of the Act, and publishes as a FEDERAL REGISTER notice or CMS ruling. (The term does not include coverage changes mandated by statute.)

Optional supplemental benefits are health services not covered by Medicare that are purchased at the option of the MA enrollee and paid for in full, directly by (or on behalf of) the Medicare enrollee, in the form of premiums or cost-sharing. These services may be grouped or offered individually.

Original Medicare means health insurance available under Medicare Part A and Part B through the traditional fee-for service payment system.

Parent organization means the legal entity that exercises a controlling interest, through the ownership of shares, the power to appoint voting board members, or other means, in a Part D sponsor or MA organization, directly or through a subsidiary or sub-

sidaries, and which is not itself a subsidiary of any other legal entity.

Point of service (POS) means a benefit option that an MA HMO plan can offer to its Medicare enrollees as a mandatory supplemental, or optional supplemental benefit. Under the POS benefit option, the HMO plan allows members the option of receiving specified services outside of the HMO plan's provider network. In return for this flexibility, members typically have higher cost-sharing requirements for services received and, when offered as a mandatory or optional supplemental benefit, may also be charged a premium for the POS benefit option.

Preclusion list means a CMS compiled list of individuals and entities that—

(1) Meet all of the following requirements:

(i) The individual or entity is currently revoked from Medicare for a reason other than that stated in § 424.535(a)(3) of this chapter.

(ii) The individual or entity is currently under a reenrollment bar under § 424.535(c).

(iii) CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program. In making this determination under this paragraph (1)(iii), CMS considers the following factors:

(A) The seriousness of the conduct underlying the individual's or entity's revocation.

(B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program.

(C) Any other evidence that CMS deems relevant to its determination; or

(2) Meet both of the following requirements:

(i) The individual or entity has engaged in behavior, other than that described in § 424.535(a)(3) of this chapter, for which CMS could have revoked the individual or entity to the extent applicable had they been enrolled in Medicare.

(ii) CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. In making this determination under this paragraph (2)(ii), CMS considers the following factors:

(A) The seriousness of the conduct involved.

(B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program; and

(C) Any other evidence that CMS deems relevant to its determination; or

(3) The individual or entity, regardless of whether they are or were enrolled in Medicare, has been convicted of a felony under Federal or State law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program. Factors that CMS considers in making such a determination under this paragraph (3) are—

(i) The severity of the offense;

(ii) When the offense occurred; and

(iii) Any other information that CMS deems relevant to its determination.

Prescription drug plan (PDP). PDP has the definition set forth in § 423.4 of this chapter.

Prescription drug plan (PDP) sponsor. A prescription drug plan sponsor has the definition set forth in § 423.4 of this chapter.

Provider means—

(1) Any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and

(2) Any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Provider network means the providers with which an MA organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an MA coordinated care plan or network PFFS plan.

RADV appeal process means an administrative process that enables MA organizations that have undergone RADV audit to appeal the Secretary's medical record review determinations and the Secretary's calculation of an MA organization's RADV payment error.

Related entity means any entity that is related to the MA organization by common ownership or control and

(1) Performs some of the MA organization's management functions under contract or delegation;

(2) Furnishes services to Medicare enrollees under an oral or written agreement; or

(3) Leases real property or sells materials to the MA organization at a cost of more than \$2,500 during a contract period.

Religious Fraternal benefit (RFB) society means an organization that—

(1) Is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of that Act; and

(2) Is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches.

RFB plan means an MA plan that is offered by an RFB society.

Risk adjustment data validation (RADV) audit means a payment audit of a MA organization administered by the Secretary that ensures the integrity and accuracy of risk adjustment payment data.

Senior housing facility plan means an MA coordinated care plan that—

(1) Restricts enrollment to individuals who reside in a continuing care retirement community as defined in § 422.133(b)(2);

(2) Provides primary care services on-site and has a ratio of accessible physicians to beneficiaries that CMS determines is adequate consistent with prevailing patterns of community health care referenced at § 422.112(a)(10);

(3) Provides transportation services for beneficiaries to specialty providers outside of the facility; and

(4) Was participating as of December 31, 2009 in a demonstration established by CMS for not less than 1 year.

Service area means a geographic area that for local MA plans is a county or multiple counties, and for MA regional plans is a region approved by CMS within which an MA-eligible individual may enroll in a particular MA plan offered by an MA organization. Facilities in which individuals are incarcerated are not included in the service area of an MA plan. Each MA plan must be available to all MA-eligible individuals

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within the plan's service area. In deciding whether to approve an MA plan's proposed service area, CMS considers the following criteria:

(1) For local MA plans:

(i) Whether the area meets the "county integrity rule" that a service area generally consists of a full county or counties.

(ii) However, CMS may approve a service area that includes only a portion of a county if it determines that the "partial county" area is necessary, nondiscriminatory, and in the best interests of the beneficiaries. CMS may also consider the extent to which the proposed service area mirrors service areas of existing commercial health care plans or MA plans offered by the organization.

(2) For all MA coordinated care plans, whether the contracting provider network meets the access and availability standards set forth in § 422.112. Although not all contracting providers must be located within the plan's service area, CMS must determine that all services covered under the plan are accessible from the service area.

(3) For MA regional plans, whether the service area consists of the entire region.

Severe or disabling chronic condition means for the purpose of defining a special needs individual, an MA eligible individual who has one or more co-morbid and medically complex chronic conditions that are substantially disabling or life-threatening, has a high risk of hospitalization or other significant adverse health outcomes, and requires specialized delivery systems across domains of care.

Special needs individual means an MA eligible individual who is institutionalized or institutionalized-equivalent, as those terms are defined in this section, is entitled to medical assistance under a State plan under title XIX, or has a severe or disabling chronic condition(s) and would benefit from enrollment in a specialized MA plan.

Specialized MA Plans for Special Needs Individuals means an MA coordinated care plan that exclusively enrolls special needs individuals as set forth in § 422.4(a)(1)(iv) and that provides Part D benefits under part 423 of this chapter

to all enrollees; and which has been designated by CMS as meeting the requirements of an MA SNP as determined on a case-by-case basis using criteria 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.

Step therapy means a utilization management policy for coverage of drugs that begins medication for a medical condition with the most preferred or cost effective drug therapy and progresses to other drug therapies if medically necessary.

[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; 72 FR 68722, Dec. 5, 2007; 74 FR 1540, Jan. 12, 2009; 75 FR 19803, Apr. 15, 2010; 76 FR 21561, Apr. 15, 2011; 79 FR 29955, May 23, 2014; 83 FR 16722, Apr. 16, 2018; 84 FR 15827, Apr. 16, 2019; 84 FR 23879, May 23, 2019; 86 FR 6094, Jan. 19, 2021; 87 FR 27893, May 9, 2022]

§ 422.3 MA organizations' use of reinsurance.

(a) An MA organization may obtain insurance or make other arrangements for the cost of providing basic benefits to an individual enrollee in either of the following ways—

(1) The MA organization must retain risk for at least the first \$10,000 in costs per individual enrollee for providing basic benefits during a contract year; or

(2) If the MA organization uses insurance or makes other arrangements for sharing such costs proportionately on a per member per year first dollar basis, the MA organization must retain risk based on the following:

(i) The actuarially equivalent value of the retained risk is greater than or equal to the value of risk retained in paragraph (a)(1) of this section.

(ii) The MA organization makes a determination of actuarial equivalence based on reasonable actuarial methods. For example, a reasonable method for determining actuarial equivalence would be to equate the percentage of net claim costs that the MA organization would retain under paragraphs (a)(1) and (a)(2)(i) of this section.

(b) In evaluating compliance with section 1855(b) of the Act and with paragraph (a) of this section, CMS will consider a parent organization and any of its subsidiaries to be part of the MA organization.

(c) The type of payment arrangement used between an MA organization and contracting physicians, other health professionals or institutions for the financial risk specified in section 1855(b)(4) of the Act (that is, the financial risk on a prospective basis for the provision of basic benefit by those physicians or other health professionals or through those institutions) is not limited by paragraph (a) of this section.

[85 FR 33901, June 2, 2020]

§ 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 any of the following:

(A) Health maintenance organizations (HMOs);

(B) Provider-sponsored organizations (PSOs), subject to paragraph (a)(1)(vi) of this section.

(C) Regional or local preferred provider organizations (PPOs) as specified in paragraph (a)(1)(v) of this section.

(D) 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's SNP requirements and exclusively enrolls special needs individuals as defined by § 422.2 of this subpart. All MA plans wishing to offer a SNP will be required to be approved by the National Commission on Quality Assurance (NCQA) effective January 1, 2012. This approval process applies to existing SNPs as well as new SNPs joining the program. All SNPs must submit their model of care (MOC) to CMS for NCQA evaluation and approval as per CMS guidance.

(v) A PPO plan is a plan that—

(A) Has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(B) Provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers;

(C) 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; and

(D) Does not permit prior notification for out-of-network services—that is, a reduction in the plan's standard cost-sharing levels when the out-of-network provider from whom an enrollee is receiving plan-covered services voluntarily notifies the plan prior to furnishing those services, or the enrollee voluntarily notifies the PPO plan prior to receiving plan-covered services from an out-of-network provider.

(vi) In accordance with § 422.370, CMS does not waive the State licensure requirement for organizations seeking to offer a PSO.

(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);

(B) Does not permit prior notification—that is, a reduction in the plan's standard cost-sharing levels when the

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provider from whom an enrollee is receiving plan-covered services voluntarily notifies the plan prior to furnishing those services, or the enrollee voluntarily notifies the MSA plan prior to receiving plan-covered services from a provider; and

(C) 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) Subject to paragraphs (a)(3)(ii)(A) and (B) of this section, does not vary the rates for a provider based on the utilization of that provider's services; and

(A) May vary the rates for a provider based on the specialty of the provider, the location of the provider, or other factors related to the provider that are not related to utilization and do not violate § 422.205 of this part.

(B) May increase the rates for a provider based on increased utilization of specified preventive or screening services.

(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.

(iv) Does not permit prior notification—that is, a reduction in the plan's standard cost-sharing levels when the provider from whom an enrollee is receiving plan-covered services voluntarily notifies the plan prior to furnishing those services, or the enrollee voluntarily notifies the PFFS plan

prior to receiving plan-covered services from a provider.

(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; 73 FR 54248, Sept. 18, 2008; 74 FR 1541, Jan. 12, 2009; 75 FR 19804, Apr. 15, 2010; 76 FR 21561, Apr. 15, 2011]

§ 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 amount determined in accordance with paragraph (d)(2) of this section.

(2) CMS determines each MA organization’s and PDP sponsor’s pro rata share of the annual fee on the basis of the organization’s calculated monthly payment amount during the 9 consecutive months beginning with January. CMS calculates each organization’s monthly pro rata share by multiplying the established percentage rate by the total monthly calculated Medicare payment amount to the organization as recorded in CMS’s payment system on the first day of the month.

(3) CMS deducts the organization’s fee from the amount of Federal funds otherwise payable to the MA organization or PDP sponsor for that month.

(4) If assessments reach the amount authorized for the year before the end of September, CMS discontinues assessment.

(5) If there are delays in determining the amount of the annual aggregate fees specified in paragraph (d)(2) of this section, or the fee percentage rate specified in paragraph (f)(2), CMS may adjust the assessment time period and the fee percentage amount.

[65 FR 40315, June 29, 2000. Redesignated and amended at 70 FR 4715, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

Subpart B—Eligibility, Election, and Enrollment

SOURCE: 63 FR 35071, June 26, 1998, unless otherwise noted.

§ 422.50 Eligibility to elect an MA plan.

For this subpart, all references to an MA plan include MA-PD and both MA local and MA regional plans, as defined in § 422.2 unless specifically noted otherwise.