

post-hospital extended care services, and physicians' services).

Provider has the same meaning as specified under § 400.202 of this chapter.

Qualified chain provider means a chain provider comprised of—

(1) 10 or more eligible providers collectively totaling 500 or more certified beds; or

(2) 5 or more eligible providers collectively totaling 300 or more certified beds, with eligible providers in 3 or more contiguous States.

Supplier has the same meaning as specified in § 400.202 of this chapter.

(b) *Assignment of providers to MACs.*

(1) Providers enroll with and receive Medicare payment and other Medicare services from the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider's covered services for the geographic locale in which the provider is physically located.

(2) Qualified chain providers may request and receive an exception from the requirement of paragraph (b)(1) of this section from CMS. Upon CMS' approval, a qualified chain provider may enroll with and bill on behalf of the eligible providers under its common ownership or common control to the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the eligible providers' covered services for the geographic locale in which the qualified chain provider's home office is physically located.

(3) As MAC contractors become available, qualified chain providers, granted approval by CMS to enroll with and bill a single intermediary on behalf of their eligible member providers prior to October 1, 2005, will be assigned at an appropriate time to the MAC contracted by CMS to administer claims for the applicable Medicare benefit category for the geographic locale in which the chain provider's home office is physically located. The qualified chain provider will not need to request an exception to the requirement of paragraph (b)(1) of this section in order for this assignment to take effect.

(4) CMS may grant an exception to the requirement of paragraph (b)(1) of this section to eligible providers that are not under the common ownership

or common control of a qualified chain provider, as well as ineligible providers, only if CMS finds the exception will support the implementation of MACs or will serve some other compelling interest of the Medicare program.

(c) *Assignment of suppliers to MACs.* (1) Suppliers, including physicians and other practitioners, but excluding suppliers of DMEPOS, enroll with and receive Medicare payment and other Medicare services from the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the supplier's covered services for the geographic locale in which the supplier furnished such services.

(2) Suppliers of DMEPOS receive Medicare payment and other Medicare services from the MAC assigned to administer claims for DMEPOS for the regional area in which the beneficiary receiving the DMEPOS resides. The terms of §§ 421.210 and 421.212 continue to apply to suppliers of DMEPOS.

(3) CMS may allow a group of ESRD suppliers under common ownership and common control to enroll with the MAC contracted by CMS to administer ESRD claims for the geographic locale in which the group's home office is located only if—

(i) The group of ESRD suppliers requests such privileges; and

(ii) CMS finds the exception will support the implementation of MACs or will serve some other compelling interest of the Medicare program.

Subpart F [Reserved]

PART 422—MEDICARE ADVANTAGE PROGRAM

Subpart A—General Provisions

Sec.

422.1 Basis and scope.

422.2 Definitions.

422.3 MA organizations' use of reinsurance.

422.4 Types of MA plans.

422.6 Cost-sharing in enrollment-related costs.

Subpart B—Eligibility, Election, and Enrollment

422.50 Eligibility to elect an MA plan.

Centers for Medicare & Medicaid Services, HHS

Pt. 422

- 422.52 Eligibility to elect an MA plan for special needs individuals.
- 422.53 Eligibility to elect an MA plan for senior housing facility residents.
- 422.54 Continuation of enrollment for MA local plans.
- 422.56 Limitations on enrollment in an MA MSA plan.
- 422.57 Limited enrollment under MA RFB plans.
- 422.60 Election process
- 422.62 Election of coverage under an MA plan.
- 422.64 Information about the MA program.
- 422.66 Coordination of enrollment and disenrollment through MA organizations.
- 422.68 Effective dates of coverage and change of coverage.
- 422.74 Disenrollment by the MA organization.

Subpart C—Benefits and Beneficiary Protections

- 422.100 General requirements.
- 422.101 Requirements relating to basic benefits.
- 422.102 Supplemental benefits.
- 422.103 Benefits under an MA MSA plan.
- 422.104 Special rules on supplemental benefits for MA MSA plans.
- 422.105 Special rules for self-referral and point of service option.
- 422.106 Coordination of benefits with employer or union group health plans and Medicaid.
- 422.107 Requirements for dual eligible special needs plans.
- 422.108 Medicare secondary payer (MSP) procedures.
- 422.109 Effect of national coverage determinations (NCDs) and legislative changes in benefits; coverage of clinical trials and A and B device trials.
- 422.110 Discrimination against beneficiaries prohibited.
- 422.111 Disclosure requirements.
- 422.112 Access to services.
- 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services.
- 422.114 Access to services under an MA private fee-for-service plan.
- 422.116 Network adequacy.
- 422.118 Confidentiality and accuracy of enrollee records.
- 422.119 Access to and exchange of health data and plan information.
- 422.120 Access to published provider directory information.
- 422.128 Information on advance directives.
- 422.132 Protection against liability and loss of benefits.
- 422.133 Return to home skilled nursing facility.
- 422.134 Reward and incentive programs.

- 422.135 Additional telehealth benefits.
- 422.136 Medicare Advantage (MA) and step therapy for Part B drugs.
- 422.137 Medicare Advantage Utilization Management Committee.
- 422.138 Prior authorization.

Subpart D—Quality Improvement

- 422.152 Quality improvement program.
- 422.153 Use of quality improvement organization review information.
- 422.156 Compliance deemed on the basis of accreditation.
- 422.157 Accreditation organizations.
- 422.158 Procedures for approval of accreditation as a basis for deeming compliance.
- 422.160 Basis and scope of the Medicare Advantage Quality Rating System.
- 422.162 Medicare Advantage Quality Rating System.
- 422.164 Adding, updating, and removing measures.
- 422.166 Calculation of Star Ratings.

Subpart E—Relationships With Providers

- 422.200 Basis and scope.
- 422.202 Participation procedures.
- 422.204 Provider selection and credentialing.
- 422.205 Provider antidiscrimination rules.
- 422.206 Interference with health care professionals' advice to enrollees prohibited.
- 422.208 Physician incentive plans: requirements and limitations.
- 422.210 Assurances to CMS.
- 422.212 Limitations on provider indemnification.
- 422.214 Special rules for services furnished by noncontract providers.
- 422.216 Special rules for MA private fee-for-service plans.
- 422.220 Exclusion of payment for basic benefits furnished under a private contract.
- 422.222 Preclusion list for contracted and non-contracted individuals and entities.
- 422.224 Payment to individuals and entities excluded by the OIG or included on the preclusion list.

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

- 422.250 Basis and scope.
- 422.252 Terminology.
- 422.254 Submission of bids.
- 422.256 Review, negotiation, and approval of bids.
- 422.258 Calculation of benchmarks.
- 422.260 Appeals of quality bonus payment determinations.
- 422.262 Beneficiary premiums.
- 422.264 Calculation of savings.
- 422.266 Beneficiary rebates.
- 422.270 Incorrect collections of premiums and cost sharing.

Pt. 422

42 CFR Ch. IV (10–1–23 Edition)

422.272 Release of MA bid pricing data.

Subpart G—Payments to Medicare Advantage Organizations

422.300 Basis and scope.
422.304 Monthly payments.
422.306 Annual MA capitation rates.
422.308 Adjustments to capitation rates, benchmarks, bids, and payments.
422.310 Risk adjustment data.
422.311 RADV audit dispute and appeal processes.
422.314 Special rules for beneficiaries enrolled in MA MSA plans.
422.316 Special rules for payments to Federally qualified health centers.
422.318 Special rules for coverage that begins or ends during an inpatient hospital stay.
422.320 Special rules for hospice care.
422.322 Source of payment and effect of MA plan election on payment.
422.324 Payments to MA organizations for graduate medical education costs.
422.326 Reporting and returning of overpayments.
422.330 CMS-identified overpayments associated with payment data submitted by MA organizations.

Subpart H—Provider-Sponsored Organizations

422.350 Basis, scope, and definitions.
422.352 Basic requirements.
422.354 Requirements for affiliated providers.
422.356 Determining substantial financial risk and majority financial interest.
422.370 Waiver of State licensure.
422.372 Basis for waiver of State licensure.
422.374 Waiver request and approval process.
422.376 Conditions of the waiver.
422.378 Relationship to State law.
422.380 Solvency standards.
422.382 Minimum net worth amount.
422.384 Financial plan requirement.
422.386 Liquidity.
422.388 Deposits.
422.390 Guarantees.

Subpart I—Organization Compliance With State Law and Preemption by Federal Law

422.400 State licensure requirement.
422.402 Federal preemption of State law.
422.404 State premium taxes prohibited.

Subpart J—Special Rules for MA Regional Plans

422.451 Moratorium on new local preferred provider organization plans.
422.455 Special rules for MA Regional plans.

422.458 Risk sharing with regional MA organizations for 2006 and 2007.

Subpart K—Application Procedures and Contracts for Medicare Advantage Organizations

422.500 Scope and definitions.
422.501 Application requirements.
422.502 Evaluation and determination procedures.
422.503 General provisions.
422.504 Contract provisions.
422.505 Effective date and term of contract.
422.506 Nonrenewal of contract.
422.508 Modification or termination of contract by mutual consent.
422.510 Termination of contract by CMS.
422.512 Termination of contract by the MA organization.
422.514 Enrollment requirements.
422.516 Validation of Part C reporting requirements.
422.520 Prompt payment by MA organization.
422.521 Effective date of new significant regulatory requirements.
422.524 Special rules for RFB societies.
422.527 Agreements with Federally qualified health centers.
422.530 Plan crosswalks.

Subpart L—Effect of Change of Ownership or Leasing of Facilities During Term of Contract

422.550 General provisions.
422.552 Novation agreement requirements.
422.553 Effect of leasing of an MA organization's facilities.

Subpart M—Grievances, Organization Determinations and Appeals

422.560 Basis and scope.
422.561 Definitions.
422.562 General provisions.
422.564 Grievance procedures.
422.566 Organization determinations.
422.568 Standard timeframes and notice requirements for organization determinations.
422.570 Expediting certain organization determinations.
422.572 Timeframes and notice requirements for expedited organization determinations.
422.574 Parties to the organization determination.
422.576 Effect of an organization determination.
422.578 Right to a reconsideration.
422.580 Reconsideration defined.
422.582 Request for a standard reconsideration.
422.584 Expediting certain reconsiderations.
422.586 Opportunity to submit evidence.

Centers for Medicare & Medicaid Services, HHS

Pt. 422

- 422.590 Timeframes and responsibility for reconsiderations.
- 422.592 Reconsideration by an independent entity.
- 422.594 Notice of reconsidered determination by the independent entity.
- 422.596 Effect of a reconsidered determination.
- 422.600 Right to a hearing.
- 422.602 Request for an ALJ hearing.
- 422.608 Medicare Appeals Council (Council) review.
- 422.612 Judicial review.
- 422.616 Reopening and revising determinations and decisions.
- 422.618 How an MA organization must effectuate standard reconsidered determinations or decisions.
- 422.619 How an MA organization must effectuate expedited reconsidered determinations.
- 422.620 Notifying enrollees of hospital discharge appeal rights.
- 422.622 Requesting immediate QIO review of the decision to discharge from the inpatient hospital.
- 422.624 Notifying enrollees of termination of provider services.
- 422.626 Fast-track appeals of service terminations to independent review entities (IREs).

REQUIREMENTS APPLICABLE TO CERTAIN INTEGRATED DUAL ELIGIBLE SPECIAL NEEDS PLANS

- 422.629 General requirements for applicable integrated plans.
- 422.630 Integrated grievances.
- 422.631 Integrated organization determinations.
- 422.632 Continuation of benefits while the applicable integrated plan reconsideration is pending.
- 422.633 Integrated reconsiderations.
- 422.634 Effect.

Subpart N—Medicare Contract Determinations and Appeals

- 422.641 Contract determinations.
- 422.644 Notice of contract determination.
- 422.646 Effect of contract determination.
- 422.660 Right to a hearing, burden of proof, standard of proof, and standards of review.
- 422.662 Request for hearing.
- 422.664 Postponement of effective date of a contract determination when a request for a hearing is filed timely.
- 422.666 Designation of hearing officer.
- 422.668 Disqualification of hearing officer.
- 422.670 Time and place of hearing.
- 422.672 Appointment of representatives.
- 422.674 Authority of representatives.
- 422.676 Conduct of hearing.
- 422.678 Evidence.
- 422.680 Witnesses.

- 422.682 Witness lists and documents.
- 422.684 Prehearing and summary judgment.
- 422.686 Record of hearing.
- 422.688 Authority of hearing officer.
- 422.690 Notice and effect of hearing decision.
- 422.692 Review by the Administrator.
- 422.694 Effect of Administrator's decision.
- 422.696 Reopening of a contract determination or decision of a hearing officer or the Administrator.

Subpart O—Intermediate Sanctions

- 422.750 Types of intermediate sanctions and civil money penalties.
- 422.752 Basis for imposing intermediate sanctions and civil money penalties.
- 422.756 Procedures for imposing intermediate sanctions and civil money penalties.
- 422.758 Collection of civil money penalties imposed by CMS.
- 422.760 Determinations regarding the amount of civil money penalties and assessment imposed by CMS.
- 422.762 Settlement of penalties.
- 422.764 Other applicable provisions.

Subparts P–S [Reserved]

Subpart T—Appeal Procedures for Civil Money Penalties

- 422.1000 Basis and scope.
- 422.1002 Definitions.
- 422.1004 Scope and applicability.
- 422.1006 Appeal rights.
- 422.1008 Appointment of representatives.
- 422.1010 Authority of representatives.
- 422.1012 Fees for services of representatives.
- 422.1014 Charge for transcripts.
- 422.1016 Filing of briefs with the Administrative Law Judge or Departmental Appeals Board, and opportunity for rebuttal.
- 422.1018 Notice and effect of initial determinations.
- 422.1020 Request for hearing.
- 422.1022 Parties to the hearing.
- 422.1024 Designation of hearing official.
- 422.1026 Disqualification of Administrative Law Judge.
- 422.1028 Prehearing conference.
- 422.1030 Notice of prehearing conference.
- 422.1032 Conduct of prehearing conference.
- 422.1034 Record, order, and effect of prehearing conference.
- 422.1036 Time and place of hearing.
- 422.1038 Change in time and place of hearing.
- 422.1040 Joint hearings.
- 422.1042 Hearing on new issues.
- 422.1044 Subpoenas.
- 422.1046 Conduct of hearing.
- 422.1048 Evidence.
- 422.1050 Witnesses.
- 422.1052 Oral and written summation.

§ 422.1

- 422.1054 Record of hearing.
- 422.1056 Waiver of right to appear and present evidence.
- 422.1058 Dismissal of request for hearing.
- 422.1060 Dismissal for abandonment.
- 422.1062 Dismissal for cause.
- 422.1064 Notice and effect of dismissal and right to request review.
- 422.1066 Vacating a dismissal of request for hearing.
- 422.1068 Administrative Law Judge's decision.
- 422.1070 Removal of hearing to Departmental Appeals Board.
- 422.1072 Remand by the Administrative Law Judge.
- 422.1074 Right to request Departmental Appeals Board review of Administrative Law Judge's decision or dismissal.
- 422.1076 Request for Departmental Appeals Board review.
- 422.1078 Departmental Appeals Board action on request for review.
- 422.1080 Procedures before the Departmental Appeals Board on review.
- 422.1082 Evidence admissible on review.
- 422.1084 Decision or remand by the Departmental Appeals Board.
- 422.1086 Effect of Departmental Appeals Board Decision.
- 422.1088 Extension of time for seeking judicial review.
- 422.1090 Basis, timing, and authority for reopening an Administrative Law Judge or Board decision.
- 422.1092 Revision of reopened decision.
- 422.1094 Notice and effect of revised decision.

Subpart U [Reserved]

Subpart V—Medicare Advantage Communication Requirements

- 422.2260 Definitions.
- 422.2261 Submission, review, and distribution of materials.
- 423.2262 General communications materials and activity requirements.
- 422.2263 General marketing requirements.
- 422.2264 Beneficiary contact.
- 422.2265 Websites.
- 422.2266 Activities with healthcare providers or in the healthcare setting.
- 422.2267 Required materials and content.
- 422.2272 Licensing of marketing representatives and confirmation of marketing resources.
- 422.2274 Agent, broker, and other third-party requirements.
- 422.2276 Employer group retiree marketing.

Subpart W [Reserved]

42 CFR Ch. IV (10–1–23 Edition)

Subpart X—Requirement for a Minimum Medical Loss Ratio

- 422.2400 Basis and scope.
- 422.2401 Definitions.
- 422.2410 General requirements.
- 422.2420 Calculation of the medical loss ratio.
- 422.2430 Activities that improve health care quality.
- 422.2440 Credibility adjustment.
- 422.2450 [Reserved]
- 422.2460 Reporting requirements.
- 422.2470 Remittance to CMS if the applicable MLR requirement is not met.
- 422.2480 MLR review and non-compliance.
- 422.2490 Release of Part C MLR data.

Subpart Y [Reserved]

Subpart Z—Part C Recovery Audit Contractor Appeals Process

- 422.2600 Payment appeals.
- 422.2605 Request for reconsideration.
- 422.2610 Hearing official review.
- 422.2615 Review by the Administrator.

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.