

### § 422.3

### 42 CFR Ch. IV (10–1–23 Edition)

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