

## Centers for Medicare & Medicaid Services, HHS

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AUTHORITY: 42 U.S.C. 1302, 1306, 1395w–21 through 1395w–28, and 1395hh.

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### 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

## § 422.2

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

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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 Part A and Part B benefits except—

- (1) Hospice services; and
- (2) Beginning in 2021, organ acquisitions for kidney transplants, including costs covered under section 1881(d) of the Act.

*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.

*Chronic condition special needs plan (C-SNPs)* means an SNP that restricts enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under this section, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in § 422.4(a)(1)(iv).

*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.

*Facility-based Institutional special needs plan (FI-SNP)* means a type of I-SNP that—

(1) Restricts enrollment to MA eligible individuals who meet the definition of institutionalized;

(2) Must own or contract with at least one institution, specified in the definition of institutionalized in this section, for each county in the plan's service area; and

(3) Must own or have a contractual arrangement with each institutionalized facility serving enrollees in the 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.

*Hybrid Institutional special needs plan (HI-SNP)* means a type of I-SNP that—

- (1) Restricts enrollment to both MA eligible individuals who meet the definition of institutionalized and MA eligible individuals who meet the definition of institutionalized-equivalent in this section; and
- (2) Meet the standards specified in the definitions of FI-SNP and IE-SNP.

*Institutional-equivalent special needs plan (IE-SNP)* means a type of I-SNP that restricts enrollment to MA eligible individuals who meet the definition of institutionalized-equivalent in this section.

*Institutional special needs plan (I-SNP)* means a SNP that restricts enrollment to MA eligible individuals who meet the definition of institutionalized and institutionalized-equivalent in this section. I-SNPs include the following subtypes:

- (1) IE-SNP.
- (2) HI-SNP.
- (3) FI-SNP.

*Institutionalized* means, for the purposes of defining a special needs individual and for the open enrollment pe-

riod 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.)

*Network-based plan*—

(1) Means—

(i) A coordinated care plan as specified in § 422.4(a)(1)(iii);

(ii) A network-based MSA plan; or

(iii) A section 1876 reasonable cost plan; and

(2) Excludes an MA regional plan that meets access requirements substantially through the authority of § 422.112(a)(1)(ii) instead of written contracts.

*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

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Part D sponsor or MA organization, directly or through a subsidiary or subsidiaries, 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 within the plan's service area. In decid-

ing 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, the following co-morbid and medically complex chronic conditions that are life-threatening or significantly limit overall health or function, has a high risk of hospitalization or other significant adverse health outcomes, and requires intensive care coordination, and that which is designated by the Secretary under sections 1859(b)(6)(B)(iii)(II) and 1859(f)(9)(A) of the Act:

(1) Chronic alcohol use disorder and other substance use disorders (SUDs).

(2) Autoimmune disorders:

(i) Polyarteritis nodosa.

(ii) Polymyalgia rheumatica.

(iii) Polymyositis.

(iv) Dermatomyositis.

(v) Rheumatoid arthritis.

(vi) Systemic lupus erythematosus.

(vii) Psoriatic arthritis.

(viii) Scleroderma.

(3) Cancer.

(4) Cardiovascular disorders:

(i) Cardiac arrhythmias.

- (ii) Coronary artery disease.
- (iii) Peripheral vascular disease.
- (iv) Valvular heart disease.
- (5) Chronic heart failure.
- (6) Dementia.
- (7) Diabetes mellitus.
- (8) Overweight, obesity, and metabolic syndrome.
- (9) Chronic gastrointestinal disease:
  - (i) Chronic liver disease.
  - (ii) Non-alcoholic fatty liver disease (NAFLD).
  - (iii) Hepatitis B.
  - (iv) Hepatitis C.
  - (v) Pancreatitis.
  - (vi) Irritable bowel syndrome.
  - (vii) Inflammatory bowel disease.
  - (10) Chronic kidney disease (CKD):
    - (i) CKD requiring dialysis/End-stage renal disease (ESRD).
    - (ii) CKD not requiring dialysis.
    - (11) Severe hematologic disorders:
      - (i) Aplastic anemia.
      - (ii) Hemophilia.
      - (iii) Immune thrombocytopenic purpura.
      - (iv) Myelodysplastic syndrome.
      - (v) Sickle-cell disease (excluding sickle-cell trait).
      - (vi) Chronic venous thromboembolic disorder.
    - (12) HIV/AIDS.
    - (13) Chronic lung disorders:
      - (i) Asthma, Chronic bronchitis.
      - (ii) Cystic Fibrosis.
      - (iii) Emphysema.
      - (iv) Pulmonary fibrosis.
      - (v) Pulmonary hypertension.
      - (vi) Chronic Obstructive Pulmonary Disease (COPD).
    - (14) Chronic and disabling mental health conditions:
      - (i) Bipolar disorders.
      - (ii) Major depressive disorders.
      - (iii) Paranoid disorder.
      - (iv) Schizophrenia.
      - (v) Schizoaffective disorder.
      - (vi) Post-traumatic stress disorder (PTSD).
      - (vii) Eating Disorders.
      - (viii) Anxiety disorders.
    - (15) Neurologic disorders:
      - (i) Amyotrophic lateral sclerosis (ALS).
      - (ii) Epilepsy.
      - (iii) Extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia).
      - (iv) Huntington's disease.

- (v) Multiple sclerosis.
- (vi) Parkinson's disease.
- (vii) Polyneuropathy.
- (viii) Fibromyalgia.
- (ix) Chronic fatigue syndrome.
- (x) Spinal cord injuries.
- (xi) Spinal stenosis.
- (xii) Stroke-related neurologic deficit.
- (16) Stroke.
- (17) Post-organ transplantation care.
- (18) Immunodeficiency and Immunosuppressive disorders.
- (19) Conditions associated with cognitive impairment:
  - (i) Alzheimer's disease.
  - (ii) Intellectual disabilities and developmental disabilities.
  - (iii) Traumatic brain injuries.
  - (iv) Disabling mental illness associated with cognitive impairment.
  - (v) Mild cognitive impairment.
- (20) Conditions with functional challenges and require similar services including the following:
  - (i) Spinal cord injuries.
  - (ii) Paralysis.
  - (iii) Limb loss.
  - (iv) Stroke.
  - (v) Arthritis.
- (21) Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell.
- (22) Conditions that require continued therapy services in order for individuals to maintain or retain functioning.

*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