payment under the plan, including the information described in § 422.202(a)(1).

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

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

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

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

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

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

(i) The provider.

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

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

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

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

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

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

(iii) The information the organization provides includes the following:

(A) Billing procedures.

(B) The amount the organization will pay towards the service.

(C) The amount the provider is permitted to collect from the enrollee.

(D) The information described in § 422.202(a)(1).

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

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

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000; 70 FR 52056, Sept. 1, 2005; 70 FR 47490, Aug. 12, 2005; 70 FR 76197, Dec. 23, 2005; 73 FR 54250, Sept. 18, 2008; 77 FR 22167, Apr. 12, 2012]

§ 422.220 Exclusion of payment for basic benefits furnished under a private contract.

(a) Unless otherwise authorized in paragraph (b) or (c) of this section, an MA organization may not pay, directly or indirectly, on any basis, for basic benefits furnished to a Medicare enrollee by a physician (as defined in paragraphs (1), (2), (3), and (4) of section 1861(r) of the Act) or other practitioner (as defined in section 1842(b)(18)(C) of the Act) who has filed with the Medicare contractor an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts under section 1802(b) of the Act with the beneficiaries.

(b) An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner described in paragraph (a) of this section who has not signed a private contract with the beneficiary.

(c) An MA organization may make payment to a physician or practitioner described in paragraph (a) of this section for services that are not basic benefits but are provided to a beneficiary as a supplemental benefit consistent with § 422.102.

[86 FR 6098, Jan. 19, 2021]

§ 422.222 Preclusion list for contracted and non-contracted individuals and entities.

(a)(1)(i) Except as provided in paragraph (a)(1)(ii) of this section, an MA organization must not make payment for a health care item, service, or drug that is furnished, ordered, or prescribed by an individual or entity that is included on the preclusion list, defined in § 422.2.

(ii) With respect to MA providers that have been added to an updated preclusion list but are not currently excluded by the OIG, the MA organization must do all of the following:

(A) No later than 30 days after the posting of this updated preclusion list, must provide an advance written notice to any beneficiary who has received or been prescribed an MA service, item, or drug from or by the individual or entity added to the preclusion list in this update.

(B)(*1*) Subject to paragraph (a)(1)(ii)(B)(*2*) of this section, must ensure that reasonable efforts are made to notify the individual or entity described in paragraph (a)(1)(ii) of this section of a beneficiary who was sent a notice under paragraph (a)(1)(ii)(A) of this section.

(*2*) Paragraph (a)(1)(ii)(B)(*1*) of this section applies only upon receipt of a claim from a precluded provider in Medicare Part C when—

(*i*) The MA organization has enough information on file to either copy the provider on the notification previously sent to the beneficiary or send a new notice informing the provider that they may not see plan beneficiaries due to their preclusion status; and

(*ii*) The claim is received after the claim denial or reject date in the preclusion file.

(C) Must not deny payment for a service, item, or drug furnished, ordered, or prescribed by the newly added individual or entity, solely on the ground that they have been included in the updated preclusion list, in the 60-day period after the date it sent the notice described in paragraph (a)(1)(ii)(A) of this section.

(2)(i) CMS sends written notice to the individual or entity via letter of their inclusion on the preclusion list. The notice must contain the reason for the inclusion and inform the individual or entity of their appeal rights. An individual or entity may appeal their inclusion on the preclusion list, defined in § 422.2, in accordance with part 498 of this chapter.

(ii) If the individual's or entity's inclusion on the preclusion list is based on a contemporaneous Medicare revocation under § 424.535 of this chapter:

(A) The notice described in paragraph (a)(2)(i) of this section must also include notice of the revocation, the reason(s) for the revocation, and a description of the individual's or entity's appeal rights concerning the revocation.

(B) The appeals of the individual's or entity's inclusion on the preclusion list and the individual's or entity's revocation must be filed jointly by the individual or entity and, as applicable, considered jointly under part 498 of this chapter.

(3)(i) Except as provided in paragraph (a)(3)(ii) of this section, an individual or entity will only be included on the preclusion list after the expiration of either of the following:

(A) If the individual or entity does not file a reconsideration request under § 498.5(n)(1) of this chapter, the individual or entity will be added to the preclusion list upon the expiration of the 60-day period in which the individual or entity may request a reconsideration; or

(B) If the individual or entity files a reconsideration request under § 498.5(n)(1) of this chapter, the individual or entity will be added to the preclusion list effective on the date on which CMS, if applicable, denies the individual's or entity's reconsideration.

(ii) An OIG excluded individual or entity is added to the preclusion list effective on the date of the exclusion.

(4) Payment denials based upon an individual's or entity's inclusion on the preclusion list are not appealable by beneficiaries.

(5)(i) Except as provided in paragraphs (a)(5)(iii) and (iv) of this section, an individual or entity that is revoked under § 424.535 of this chapter will be included on the preclusion list for the same length of time as the individual's or entity's reenrollment bar.

(ii) Except as provided in paragraphs (a)(5)(iii) and (iv) of this section, an individual or entity that is not enrolled in Medicare will be included on the preclusion list for the same length of time as the reenrollment bar that CMS could have imposed on the individual or entity had they been enrolled and then revoked.

(iii) Except as provided in paragraph (a)(5)(iv) of this section, an individual or entity, regardless of whether they

are or were enrolled in Medicare, that is included on the preclusion list because of a felony conviction will remain on the preclusion list for a 10-year period, beginning on the date of the felony conviction, unless CMS determines that a shorter length of time is warranted. Factors that CMS considers in making such a determination are as follows:—

(A) The severity of the offense.

(B) When the offense occurred.

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

(iv) In cases where an individual or entity is excluded by the OIG, the individual or entity must remain on the preclusion list until the expiration of the CMS-imposed preclusion list period or reinstatement by the OIG, whichever occurs later.

(6) CMS has the discretion not to include a particular individual or entity on (or if warranted, remove the individual or entity from) the preclusion list should it determine that exceptional circumstances exist regarding beneficiary access to MA items, services, or drugs. In making a determination as to whether such circumstances exist, CMS takes into account:

(i) The degree to which beneficiary access to MA items, services, or drugs would be impaired; and

(ii) Any other evidence that CMS deems relevant to its determination.

(b) An MA organization that does not comply with paragraph (a) of this section may be subject to sanctions under § 422.750 and termination under § 422.510.

[83 FR 16733, Apr. 16, 2018, as amended at 84 FR 15831, Apr. 16, 2019]

§ 422.224 Payment to individuals and entities excluded by the OIG or included on the preclusion list.

(a) An MA organization may not pay, directly or indirectly, on any basis, for items or services furnished to a Medicare enrollee by any individual or entity that is excluded by the Office of the Inspector General (OIG) or is included on the preclusion list, defined in § 422.2.

(b) If an MA organization receives a request for payment by, or on behalf of, an individual or entity that is excluded by the OIG or an individual or entity that is included on the preclusion list, defined in § 422.2, the MA organization must notify the enrollee and the excluded individual or entity or the individual or entity included on the preclusion list in writing, as directed by contract or other direction provided by CMS, that payments will not be made. Payment may not be made to, or on behalf of, an individual or entity that is excluded by the OIG or is included on the preclusion list.

[83 FR 16733, Apr. 16, 2018]

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

SOURCE: 70 FR 4725, Jan. 28, 2005, unless otherwise noted.

§ 422.250 Basis and scope.

This subpart is based largely on section 1854 of the Act, but also includes provisions from sections 1853 and 1858 of the Act, and is also based on section 1106 of the Act. It sets forth the requirements for the Medicare Advantage bidding payment methodology, including CMS' calculation of benchmarks, submission of plan bids by Medicare Advantage (MA) organizations, establishment of beneficiary premiums and rebates through comparison of plan bids and benchmarks, negotiation and approval of bids by CMS, and the release of MA bid submission data.

[81 FR 80556, Nov. 15, 2016]

§ 422.252 Terminology.

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

Low enrollment contract means a contract that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because of a lack of a sufficient number of enrollees to reliably measure the performance of the health plan.

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

MA monthly basic beneficiary premium means the premium amount (if any) an MA plan (except an MSA plan) charges