

(ii) “Historical data” are defined as a representative 90-day assigned claims payment trend within the most recent 180-day experience before the system malfunction.

(iii) Based on this amount and the number of claims pending for the supplier, the carrier must determine and issue advance payments.

(iv) If historical data are not available or if backlogged claims cannot be identified, the carrier must determine and issue advance payments based on some other methodology approved by CMS.

(v) Advance payments can be made no more frequently than once every 2 weeks to a supplier.

(2) Generally, a supplier will not receive advance payments for more assigned claims than were paid, on a daily average, for the 90-day period before the system malfunction.

(3) A carrier must recover an advance payment by applying it against the amount due on the claim on which the advance was made. If the advance payment exceeds the Medicare payment amount, the carrier must apply the unadjusted balance of the advance payment against future Medicare payments due the supplier.

(4) In accordance with CMS instructions, a carrier must maintain a financial system of data in accordance with the Statement of Federal Financial Accounting Standards for tracking each advance payment and its recoupment.

(g) *Requirements for CMS.* (1) In accordance with the provisions of this section, CMS may determine that circumstances warrant the issuance of advance payments to all affected suppliers furnishing Part B services. CMS may waive the requirement in paragraph (e)(1) of this section as part of that determination.

(2) If adjusting Medicare payments fails to recover an advance payment, CMS may authorize the use of any other recoupment method available (for example, lump sum repayment or an extended repayment schedule) including, upon written notice from the carrier to the supplier, converting any unpaid balances of advance payments to overpayments. Overpayments are recovered in accordance with part 401, subpart F of this chapter concerning

claims collection and compromise and part 405, subpart C of this chapter concerning recovery of overpayments.

(h) *Prompt payment interest.* An advance payment is a “payment” under section 1842(c)(2)(C) of the Act for purposes of meeting the time limit for the payment of clean claims, to the extent of the advance payment.

(i) *Notice, review, and appeal rights.* (1) The decision to advance payments and the determination of the amount of any advance payment are committed to CMS’s discretion and are not subject to review or appeal.

(2) The carrier must notify the supplier receiving an advance payment about the amounts advanced and recouped and how any Medicare payment amounts have been adjusted.

(3) The supplier may request an administrative review from the carrier if it believes the carrier’s reconciliation of the amounts advanced and recouped is incorrectly computed. If a review is requested, the carrier must provide a written explanation of the adjustments.

(4) The review and explanation described in paragraph (i)(3) of this section is separate from a supplier’s right to appeal the amount and computation of benefits paid on the claim, as provided at part 405, subpart H of this chapter. The carrier’s reconciliation of amounts advanced and recouped is not an initial determination as defined at §405.803 of this chapter, and any written explanation of a reconciliation is not subject to further administrative review.

[61 FR 49275, Sept. 19, 1996]

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AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (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 sections of the Act:

- 1851—Eligibility, election, and enrollment.  
 1852—Benefits and beneficiary protections.  
 1853—Payments to Medicare Advantage (MA) organizations.  
 1854—Premiums.  
 1855—Organization, licensure, and solvency of MA organizations.  
 1856—Standards.

- 1857—Contract requirements.  
 1858—Special rules for MA Regional Plans.  
 1859—Definitions; enrollment restriction for certain MA plans.

(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]

##### § 422.2 Definitions.

As used in this part—

*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.

*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.

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*Institutionalized* means for the purpose of defining a special needs individual, an MA eligible individual who continuously resides or is expected to continuously reside for 90 days or longer in a long-term care facility which is a skilled nursing facility (SNF) nursing facility (NF); SNF/NF; an intermediate care facility for the mentally retarded (ICF/MR); or an inpatient psychiatric facility.

*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.

*Point of service (POS)* is a benefit option that an MA coordinated care plan can offer to its Medicare enrollees as an additional, mandatory supplemental, or optional supplemental benefit. Under the POS benefit option, the MA plan allows members the option of receiving specified services outside of

the MA plan's provider network. In return for this flexibility, members typically have higher cost-sharing requirements for services received and, where offered as a mandatory or optional supplemental benefit, may also be charged a premium for the POS benefit option.

*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.

*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.

*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. Each MA plan must be available to all MA-eligible individuals 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.

*Special needs individual* means an MA eligible individual who is institutionalized, as defined above, 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 a MA coordinated care plan that exclusively enrolls or enrolls a disproportionate percentage of special needs individuals as set forth in § 422.4(a)(1)(iv) and that, beginning January 1, 2006, 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 a 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

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against sicker members of the target population.

[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]

### § 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 health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), regional or local preferred provider organizations (PPOs) as specified in paragraph (a)(1)(v) of this section, and 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'SNP requirements and either—

(A) Exclusively enrolls special needs individuals as defined in § 422.2; or

(B) Enrolls a greater proportion of special needs individuals than occur nationally in the Medicare population as defined by CMS.

(v) A PPO plan is a plan that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of pro-

viders; and, 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.

(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); and

(B) 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) Does not vary the rates for a provider based on the utilization of that provider's services; and

(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.

(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]

#### § 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.

(a) An individual is eligible to elect an MA plan if he or she—

(1) Is entitled to Medicare under Part A and enrolled in Part B (except that an individual entitled only to Part B and who was enrolled in an HMO or CMP with a risk contract under part 417 of this chapter on December 31, 1998 may continue to be enrolled in the MA organization as an MA plan enrollee);

(2) Has not been medically determined to have end-stage renal disease, except that—

(i) An individual who develops end-stage renal disease while enrolled in an MA plan or in a health plan offered by

the MA organization is eligible to elect an MA plan offered by that organization;

(ii) An individual with end-stage renal disease whose enrollment in an MA plan was terminated or discontinued after December 31, 1998, because CMS or the MA organization terminated the MA organization's contract for the plan or discontinued the plan in the area in which the individual resides, is eligible to elect another MA plan. If the plan so elected is later terminated or discontinued in the area in which the individual resides, he or she may elect another MA plan; and

(iii) An individual with end-stage renal disease may elect an MA special needs plan as defined in § 422.2, as long as that plan has opted to enroll ESRD individuals.

(3) Meets either of the following residency requirements:

(i) Resides in the service area of the MA plan.

(ii) Resides outside of the service area of the MA plan and is enrolled in a health plan offered by the MA organization during the month immediately preceding the month in which the individual is entitled to both Medicare Part A and Part B, provided that an MA organization chooses to offer this option and that CMS determines that all applicable MA access requirements of § 422.112 are met for that individual through the MA plan's established provider network. The MA organization must furnish the same benefits to these enrollees as to enrollees who reside in the service area;

(4) Has been a member of an Employer Group Health Plan (EGHP) that includes the elected MA plan, even if the individual lives outside of the MA plan service area, provided that an MA organization chooses to offer this option and that CMS determines that all applicable MA access requirements at § 422.112 are met for that individual through the MA plan's established provider network. The MA organization must furnish the same benefits to all enrollees, regardless of whether they reside in the service area;

(5) Completes and signs an election form or completes another CMS-approved election method offered by the

MA organization and provides information required for enrollment; and

(6) Agrees to abide by the rules of the MA organization after they are disclosed to him or her in connection with the election process.

(b) An MA eligible individual may not be enrolled in more than one MA plan at any given time.

[63 FR 35071, June 26, 1998; 63 FR 52611, Oct. 1, 1998, as amended at 65 FR 40316, June 29, 2000; 68 FR 50855, Aug. 22, 2003; 70 FR 4715, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

**§ 422.52 Eligibility to elect an MA plan for special needs individuals.**

(a) *General rule.* In order to elect a specialized MA plan for a special needs individual (Special Needs MA plan, or SNP), the individual must meet the eligibility requirements specified in this section.

(b) *Basic eligibility requirements.* Except as provided in paragraph (c) of this section, to be eligible to elect an SNP, an individual must:

(1) Meet the definition of a special needs individual, as defined at § 422.2;

(2) Meet the eligibility requirements for that specific SNP; and

(3) Be eligible to elect an MA plan under § 422.50.

(c) *Exception to § 422.50.* CMS may waive § 422.50(a)(2) concerning the exclusion of persons with ESRD.

(d) *Deeming continued eligibility.* If an SNP determines that the enrollee no longer meets the eligibility criteria, but can reasonably be expected to again meet that criteria within a 6-month period, the enrollee is deemed to continue to be eligible for the MA plan for a period of not less than 30 days but not to exceed 6 months.

(e) *Restricting Enrollment.* An SNP must restrict future enrollment to only special needs individuals as established under § 422.2.

(f) *Exceptions.* (1) As specified in § 422.4, CMS may designate certain MA plans that disproportionately serve special needs individuals, as defined in § 422.2 as SNPs.

(2) Individuals already enrolled in an MA plan that CMS subsequently designates as an SNP may continue to be enrolled in the plan and may not be involuntarily disenrolled because they do

not meet the definition of special needs individuals in § 422.2.

[70 FR 4716, Jan. 28, 2005]

**§ 422.54 Continuation of enrollment for MA local plans.**

(a) *Definition.* *Continuation area* means an additional area (outside the service area) within which the MA organization offering a local plan furnishes or arranges to furnish services to its continuation-of-enrollment enrollees. Enrollees must reside in a continuation area on a permanent basis. A continuation area does not expand the service area of any MA local plan.

(b) *Basic rule.* An MA organization may offer a continuation of enrollment option to MA local plan enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the MA organization as a continuation area. The intent to no longer reside in an area and permanently live in another area is verified through documentation that establishes residency, such as a driver's license or voter registration card.

(c) *General requirements.* (1) An MA organization that wishes to offer a continuation of enrollment option must meet the following requirements:

(i) Obtain CMS's approval of the continuation area, the marketing materials that describe the option, and the MA organization's assurances of access to services.

(ii) Describe the option(s) in the member materials it offers and make the option available to all MA local plan enrollees residing in the continuation area.

(2) An enrollee who moves out of the service area and into the geographic area designated as the continuation area has the choice of continuing enrollment or disenrolling from the MA local plan. The enrollee must make the choice of continuing enrollment in a manner specified by CMS. If no choice is made, the enrollee must be disenrolled from the plan.

(d) *Specific requirements—*

(1) *Continuation of enrollment benefits.* The MA organization must, at a minimum, provide or arrange for the Medicare-covered benefits as described in § 422.101(a).

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(2) *Reasonable access.* The MA organization must ensure reasonable access in the continuation area—

(i) Through contracts with providers, or through direct payment of claims that satisfy the requirements in § 422.100(b)(2), to other providers who meet the requirement in subpart E of this part; and

(ii) By ensuring that the access requirements of § 422.112 are met.

(3) *Reasonable cost sharing.* For services furnished in the continuation area, an enrollee's cost-sharing liability is limited to the cost-sharing amounts required in the MA local plan's service area (in which the enrollee no longer resides).

(4) *Protection of enrollee rights.* An MA organization that offers a continuation of enrollment option must convey all enrollee rights conferred under this rule, with the understanding that—

(i) The ultimate responsibility for all appeals and grievance requirements remain with the organization that is receiving payment from CMS; and

(ii) Organizations that require enrollees to give advance notice of intent to use the continuation of enrollment option, must stipulate the notification process in the marketing materials.

(e) *Capitation payments.* CMS's capitation payments to all MA organizations, for all Medicare enrollees, are based on rates established on the basis of the enrollee's permanent residence, regardless of where he or she receives services.

[63 FR 35071, June 26, 1998; 63 FR 52611, Oct. 1, 1998, as amended at 65 FR 40316, June 29, 2000; 70 FR 4716, Jan. 28, 2005]

## § 422.56 Enrollment in an MA MSA plan.

(a) *General.* An individual is not eligible to elect an MA MSA plan unless the individual provides assurances that are satisfactory to CMS that he or she will reside in the United States for at least 183 days during the year for which the election is effective.

(b) *Individuals eligible for or covered under other health benefits program.* Unless otherwise provided by the Secretary, an individual who is enrolled in a Federal Employee Health Benefit plan under 5 U.S.C. chapter 89, or is eligible for health care benefits through

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the Veteran's Administration under 10 U.S.C. chapter 55 or the Department of Defense under 38 U.S.C. chapter 17, may not enroll in an MA MSA plan.

(c) *Individuals eligible for Medicare cost-sharing under Medicaid State plans.* An individual who is entitled to coverage of Medicare cost-sharing under a State plan under title XIX of the Act is not eligible to enroll in an MA MSA plan.

(d) *Other limitations.* An individual who receives health benefits that cover all or part of the annual deductible under the MA MSA plan may not enroll in an MA MSA plan. Examples of this type of coverage include, but are not limited to, primary health care coverage other than Medicare, current coverage under the Medicare hospice benefit, supplemental insurance policies not specifically permitted under § 422.104, and retirement health benefits.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 70 FR 4716, Jan. 28, 2005]

## § 422.57 Limited enrollment under MA RFB plans.

An RFB society that offers an MA RFB plan may offer that plan only to members of the church, or convention or group of churches with which the society is affiliated.

## § 422.60 Election process.

(a) *Acceptance of enrollees: General rule.* (1) Except for the limitations on enrollment in an MA MSA plan provided by § 422.62(d)(1) and except as specified in paragraph (a)(2) of this section, each MA organization must accept without restriction (except for an MA RFB plan as provided by § 422.57) individuals who are eligible to elect an MA plan that the MA organization offers and who elect an MA plan during initial coverage election periods under § 422.62(a)(1), annual election periods under § 422.62(a)(2), and under the circumstances described in § 422.62(b)(1) through (b)(4).

(2) MA organizations must accept elections during the open enrollment periods specified in § 422.62(a)(3), (a)(4), and (a)(5) if their MA plans are open to new enrollees.

(b) *Capacity to accept new enrollees.* (1) MA organizations may submit information on enrollment capacity of plans.

(2) If CMS determines that an MA plan offered by an MA organization has a capacity limit, and the number of MA eligible individuals who elect to enroll in that plan exceeds the limit, the MA organization offering the plan may limit enrollment in the plan under this part, but only if it provides priority in acceptance as follows:

(i) First, for individuals who elected the plan prior to the CMS determination that capacity has been exceeded, elections will be processed in chronological order by date of receipt of their election forms.

(ii) Then for other individuals in a manner that does not discriminate on the basis of any factor related to health as described in § 422.110.

(3) CMS considers enrollment limit requests for an MA plan service area, or a portion of the plan service area, only if the health and safety of beneficiaries is at risk, such as if the provider network is not available to serve the enrollees in all or a portion of the service area.

(c) *Election forms and other election mechanisms.* (1) The election must comply with CMS instructions regarding content and format and be approved by CMS as described in § 422.80. The election must be completed by the MA eligible individual (or the individual who will soon become eligible to elect an MA plan) and include authorization for disclosure and exchange of necessary information between the U.S. Department of Health and Human Services and its designees and the MA organization. Persons who assist beneficiaries in completing forms must sign the form, or through other approved mechanisms, indicate their relationship to the beneficiary.

(2) The MA organization must file and retain election forms for the period specified in CMS instructions.

(d) *When an election is considered to have been made.* An election in an MA plan is considered to have been made on the date the completed election is received by the MA organization.

(e) *Handling of elections.* The MA organization must have an effective system for receiving, controlling, and

processing elections. The system must meet the following conditions and requirements:

(1) Each election is dated as of the day it is received in a manner acceptable to CMS.

(2) Elections are processed in chronological order, by date of receipt.

(3) The MA organization gives the beneficiary prompt notice of acceptance or denial in a format specified by CMS.

(4) If the MA plan is enrolled to capacity, it explains the procedures that will be followed when vacancies occur.

(5) Upon receipt of the election, or for an individual who was accepted for future enrollment from the date a vacancy occurs, the MA organization transmits, within the timeframes specified by CMS, the information necessary for CMS to add the beneficiary to its records as an enrollee of the MA organization.

(f) *Exception for employer group health plans.* (1) In cases in which an MA organization has both a Medicare contract and a contract with an employer group health plan, and in which the MA organization arranges for the employer to process elections for Medicare-entitled group members who wish to enroll under the Medicare contract, the effective date of the election may be retroactive. Consistent with § 422.308(f)(2), payment adjustments based on a retroactive effective date may be made for up to a 90-day period.

(2) In order to obtain the effective date described in paragraph (f)(1) of this section, the beneficiary must certify that, at the time of enrollment in the MA organization, he or she received the disclosure statement specified in § 422.111.

(3) Upon receipt of the election from the employer, the MA organization must submit the enrollment within timeframes specified by CMS.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998; 63 FR 54526, Oct. 9, 1998; 64 FR 7980, Feb. 17, 1999; 65 FR 40316, June 29, 2000; 70 FR 4716, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

#### § 422.62 Election of coverage under an MA plan.

(a) *General: Coverage election periods—*  
(1) *Initial coverage election period for*

MA. The initial coverage election period is the period during which a newly MA-eligible individual may make an initial election. This period begins 3 months before the month the individual is first entitled to both Part A and Part B and ends on the later of—

(i) The last day of the month preceding the month of entitlement; or

(ii) If after May 15, 2006, the last day of the individual's Part B initial enrollment period.

(2) *Annual coordinated election period.*

(i) Beginning with 2002, the annual coordinated election period for the following calendar year is November 15th through December 31st, except for 2006.

(ii) For 2006, the annual coordinated election period

begins on November 15, 2005 and ends on May 15, 2006.

(iii) During the annual coordinated election period, an individual eligible to enroll in an MA plan may change his or her election from an MA plan to original Medicare or to a different MA plan, or from original Medicare to an MA plan. If an individual changes his or her election to original Medicare, he or she may also elect a PDP.

(3) *Open enrollment and disenrollment opportunities through 2005.* Through 2005, the number of elections or changes that an MA eligible individual may make is not limited (except as provided for in paragraph (d) of this section for MA MSA plans). Subject to the MA plan being open to enrollees as provided under § 422.60(a)(2), an individual eligible to elect an MA plan may change his or her election from an MA plan to original Medicare or to a different MA plan, or from original Medicare to an MA plan.

(4) *Open enrollment and disenrollment during 2006.* (i) Except as provided in paragraphs (a)(4)(ii), (a)(4)(iii), and (a)(6) of this section, an individual who is not enrolled in an MA plan, but who is eligible to elect an MA plan in 2006, may elect an MA plan only once during the first 6 months of the year.

(A) An individual who is enrolled in an MA-PD plan may elect another MA-PD plan or original Medicare and coverage under a PDP. Such an individual may not elect an MA plan that does not provide qualified prescription drug coverage.

(B) An individual who is enrolled in an MA plan that does not provide qualified prescription drug coverage may elect another MA plan that does not provide that coverage or original Medicare. Such an individual may not elect an MA-PD plan or coverage under a PDP.

(ii) *Newly eligible MA individual.* An individual who becomes MA eligible during 2006 may elect an MA plan or change his or her election once during the period that begins the month the individual is entitled to both Part A and Part B and ends on the last day of the 6th month of the entitlement, or on December 31, whichever is earlier, subject to the limitations in paragraphs (a)(4)(i)(A) and (a)(4)(i)(B) of this section.

(iii) The limitation to one election or change in paragraphs (a)(4)(i) and (a)(4)(ii) of this section does not apply to elections or changes made during the annual coordinated election period specified in paragraph (a)(2) of this section or during a special election period specified in paragraph (b) of this section.

(5) *Open enrollment and disenrollment beginning in 2007.* (i) For 2007 and subsequent years, except as provided in paragraphs (a)(5)(ii), (a)(5)(iii), and (a)(6) of this section, an individual who is not enrolled in an MA plan but is eligible to elect an MA plan may make an election into an MA plan once during the first 3 months of the year.

(A) An individual who is enrolled in an MA-PD plan may elect another MA-PD plan or original Medicare and coverage under a PDP. An individual who is in original Medicare and has coverage under a PDP may elect a MA-PD plan. Such an individual may not elect an MA plan that does not provide qualified prescription drug coverage.

(B) An individual who is enrolled in an MA plan that does not provide qualified prescription drug coverage may elect another MA plan that does not provide that coverage or original Medicare. An individual who is in original Medicare and does not have coverage under a PDP may elect an MA plan that does not provide qualified prescription drug coverage. Such an individual may not elect an MA-PD plan or coverage under a PDP.

(ii) *Newly eligible MA individual.* An individual who becomes MA eligible during 2007 or later may elect an MA plan or change his or her election once during the period that begins the month the individual is entitled to both Part A and Part B and ends on the last day of the 3rd month of the entitlement, or on December 31, whichever is earlier subject to the limitations in paragraphs (a)(5)(i)(A) and (a)(5)(i)(B) of this section.

(iii) The limitation to one election or change in paragraph (a)(5)(i) and (a)(5)(ii) of this section does not apply to elections made or changes made during the annual coordinated election period specified in paragraph (a)(2) of this section or during a special election period specified in paragraph (b) of this section.

(6) *Open enrollment period for institutionalized individuals.* After 2005, an individual who is eligible to elect an MA plan and who is institutionalized, as defined by CMS, is not limited (except as provided for in paragraph (d) of this section for MA MSA plans) in the number of elections or changes he or she may make. Subject to the MA plan being open to enrollees as provided under § 422.60(a)(2), an MA eligible institutionalized individual may at any time elect an MA plan or change his or her election from an MA plan to original Medicare, to a different MA plan, or from original Medicare to an MA plan.

(b) *Special election periods.* An individual may at any time (that is, not limited to the annual coordinated election period) discontinue the election of an MA plan offered by an MA organization and change his or her election, in the form and manner specified by CMS, from an MA plan to original Medicare or to a different MA plan under any of the following circumstances:

(1) CMS or the organization has terminated the organization's contract for the plan, discontinued the plan in the area in which the individual resides, or the organization has notified the individual of the impending termination of the plan, or the impending discontinuation of the plan in the area in which the individual resides.

(2) The individual is not eligible to remain enrolled in the plan because of

a change in his or her place of residence to a location out of the service area or continuation area or other change in circumstances as determined by CMS but not including terminations resulting from a failure to make timely payment of an MA monthly or supplemental beneficiary premium, or from disruptive behavior.

(3) The individual demonstrates to CMS, in accordance with guidelines issued by CMS, that—

(i) The organization offering the plan substantially violated a material provision of its contract under this part in relation to the individual, including, but not limited to the following:

(A) Failure to provide the beneficiary on a timely basis medically necessary services for which benefits are available under the plan.

(B) Failure to provide medical services in accordance with applicable quality standards; or

(ii) The organization (or its agent, representative, or plan provider) materially misrepresented the plan's provisions in marketing the plan to the individual.

(4) The individual meets such other exceptional conditions as CMS may provide.

(c) *Special election period for individual age 65.* Effective January 1, 2002, an MA eligible individual who elects an MA plan during the initial enrollment period, as defined under section 1837(d) of the Act, that surrounds his or her 65th birthday (this period begins 3 months before and ends 3 months after the month of the individual's 65th birthday) may discontinue the election of that plan and elect coverage under original Medicare at any time during the 12-month period that begins on the effective date of enrollment in the MA plan.

(d) *Special rules for MA MSA plans—(1) Enrollment.* An individual may enroll in an MA MSA plan only during an initial coverage election period or annual coordinated election period described in paragraphs (a)(1) and (a)(2) of this section.

(2) *Disenrollment.* (i) Except as provided in paragraph (d)(2)(ii) of this section, an individual may disenroll from an MA MSA plan only during—

(A) An annual election period; or

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(B) The special election period described in paragraph (b) of this section.

(ii) *Exception.* An individual who elects an MA MSA plan during an annual election period and has never before elected an MA MSA plan may revoke that election, no later than December 15 of that same year, by submitting to the organization that offers the MA MSA plan a signed and dated request in the form and manner prescribed by CMS or by filing the appropriate disenrollment form through other mechanisms as determined by CMS.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 65 FR 40317, June 29, 2000; 70 FR 4717, Jan. 28, 2005]

**§ 422.64 Information about the MA program.**

Each MA organization must provide, on an annual basis, and in a format and using standard terminology that may be specified by CMS, the information necessary to enable CMS to provide to current and potential beneficiaries the information they need to make informed decisions with respect to the available choices for Medicare coverage.

[65 FR 40317, June 29, 2000]

**§ 422.66 Coordination of enrollment and disenrollment through MA organizations.**

(a) *Enrollment.* An individual who wishes to elect an MA plan offered by an MA organization may make or change his or her election during the election periods specified in § 422.62 by filing the appropriate election form with the organization or through other mechanisms as determined by CMS.

(b) *Disenrollment*—(1) *Basic rule.* An individual who wishes to disenroll from an MA plan may change his or her election during the election periods specified in § 422.62 in either of the following manners:

(i) Elect a different MA plan by filing the appropriate election with the MA organization.

(ii) Submit a request for disenrollment to the MA organization in the form and manner prescribed by CMS or file the appropriate disenrollment request through other mechanisms as determined by CMS.

(2) *When a disenrollment request is considered to have been made.* A disenrollment request is considered to have been made on the date the disenrollment request is received by the MA organization.

(3) *Responsibilities of the MA organization.* The MA organization must—

(i) Submit a disenrollment notice to CMS within timeframes specified by CMS;

(ii) Provide enrollee with notice of disenrollment in a format specified by CMS; and

(iii) In the case of a plan where lock-in applies, include in the notice a statement explaining that he or she—

(A) Remains enrolled until the effective date of disenrollment; and

(B) Until that date, neither the MA organization nor CMS pays for services not provided or arranged for by the MA plan in which the enrollee is enrolled; and

(iv) File and retain disenrollment requests for the period specified in CMS instructions.

(4) *Effect of failure to submit disenrollment notice to CMS promptly.* If the MA organization fails to submit the correct and complete notice required in paragraph (b)(3)(i) of this section, the MA organization must reimburse CMS for any capitation payments received after the month in which payment would have ceased if the requirement had been met timely.

(5) *Retroactive disenrollment.* CMS may grant retroactive disenrollment in the following cases:

(i) There never was a legally valid enrollment.

(ii) A valid request for disenrollment was properly made but not processed or acted upon.

(c) *Election by default: Initial coverage election period.* An individual who fails to make an election during the initial coverage election period is deemed to have elected original Medicare.

(d) *Conversion of enrollment (seamless continuation of coverage)*—(1) *Basic rule.* An MA plan offered by an MA organization must accept any individual (regardless of whether the individual has end-stage renal disease) who is enrolled in a health plan offered by the MA organization during the month immediately preceding the month in which

he or she is entitled to both Part A and Part B, and who meets the eligibility requirements at § 422.50.

(2) *Reserved vacancies.* Subject to CMS's approval, an MA organization may set aside a reasonable number of vacancies in order to accommodate enrollment of conversions. Any set aside vacancies that are not filled within a reasonable time must be made available to other MA eligible individuals.

(3) *Effective date of conversion.* If an individual chooses to remain enrolled with the MA organization as an MA enrollee, the individual's conversion to an MA enrollee is effective the month in which he or she is entitled to both Part A and Part B in accordance with the requirements in paragraph (d)(5) of this section.

(4) *Prohibition against disenrollment.* The MA organization may disenroll an individual who is converting under the provisions of paragraph (a) of this section only under the conditions specified in § 422.74.

(5) *Election.* The individual who is converting must complete an election as described in § 422.60(c)(1) unless otherwise provided in a form and manner approved by CMS.

(6) *Submission of information to CMS.* The MA organization must transmit the information necessary for CMS to add the individual to its records as specified in § 422.60(e)(6).

(e) *Maintenance of enrollment.* (1) An individual who has made an election under this section is considered to have continued to have made that election until either of the following, which ever occurs first:

(i) The individual changes the election under this section.

(ii) The elected MA plan is discontinued or no longer serves the area in which the individual resides, as provided under § 422.74(b)(3), or the organization does not offer or the individual does not elect the option of continuing enrollment, as provided under § 422.54.

(2) An individual enrolled in an MA plan that becomes an MA-PD plan on January 1, 2006, will be deemed to have elected to enroll in that MA-PD plan.

(3) An individual enrolled in an MA plan that, as of

December 31, 2005, offers any prescription drug coverage will be deemed

to have elected an MA-PD plan offered by the same organization as of January 1, 2006.

(4) An individual who has elected an MA plan that does not provide prescription drug coverage will not be deemed to have elected an MA-PD plan and will remain enrolled in the MA plan as provided in paragraph (e)(1) of this section.

(5) An individual enrolled in an MA-PD plan as of December 31 of a year is deemed to have elected to remain enrolled in that plan on January 1 of the following year.

(f) *Exception for employer group health plans.* (1) In cases when an MA organization has both a Medicare contract and a contract with an employer group health plan, and in which the MA organization arranges for the employer to process election forms for Medicare-entitled group members who wish to disenroll from the Medicare contract, the effective date of the election may be retroactive. Consistent with § 422.308(f)(2), payment adjustments based on a retroactive effective date may be made for up to a 90-day period.

(2) Upon receipt of the election from the employer, the MA organization must submit a disenrollment notice to CMS within timeframes specified by CMS.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 65 FR 40317, June 29, 2000; 70 FR 4718, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

#### § 422.68 Effective dates of coverage and change of coverage.

(a) *Initial coverage election period.* An election made during an initial coverage election period as described in § 422.62(a)(1) is effective as of the first day of the month of entitlement to both Part A and Part B.

(b) *Annual coordinated election periods.* For an election or change of election made during the annual coordinated election period as described in § 422.62(a)(2)(i), coverage is effective as of the first day of the following calendar year except that for the annual coordinated election period described in § 422.62(a)(2)(ii), elections made after December 31, 2005 through May 15, 2006 are effective as of the first day of the

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first calendar month following the month in which the election is made.

(c) *Open enrollment periods.* For an election, or change in election, made during an open enrollment period, as described in § 422.62(a)(3) through (a)(6), coverage is effective as of the first day of the first calendar month following the month in which the election is made.

(d) *Special election periods.* For an election or change of election made during a special election period as described in § 422.62(b), the effective date of coverage shall be determined by CMS, to the extent practicable, in a manner consistent with protecting the continuity of health benefits coverage.

(e) *Special election period for individual age 65.* For an election of coverage under original Medicare made during a special election period for an individual age 65 as described in § 422.62(c), coverage is effective as of the first day of the first calendar month following the month in which the election is made.

[63 FR 35071, June 26, 1998, as amended at 65 FR 40317, June 29, 2000; 67 FR 13288, Mar. 22, 2002; 70 FR 4718, Jan. 28, 2005]

**§ 422.74 Disenrollment by the MA organization.**

(a) *General rule.* Except as provided in paragraphs (b) through (d) of this section, an MA organization may not—

(1) Disenroll an individual from any MA plan it offers; or

(2) Orally or in writing, or by any action or inaction, request or encourage an individual to disenroll.

(b) *Basis for disenrollment—(1) Optional disenrollment.* An MA organization may disenroll an individual from an MA plan it offers in any of the following circumstances:

(i) Any monthly basic and supplementary beneficiary premiums are not paid on a timely basis, subject to the grace period for late payment established under paragraph (d)(1) of this section.

(ii) The individual has engaged in disruptive behavior specified at paragraph (d)(2) of this section.

(iii) The individual provides fraudulent information on his or her election form or permits abuse of his or her en-

rollment card as specified in paragraph (d)(3) of this section.

(2) *Required disenrollment.* An MA organization must disenroll an individual from an MA plan it offers in any of the following circumstances:

(i) The individual no longer resides in the MA plan's service area as specified under paragraph (d)(4) of this section, is no longer eligible under § 422.50(a)(3)(ii), and optional continued enrollment has not been offered or elected under § 422.54.

(ii) The individual loses entitlement to Part A or Part B benefits as described in paragraph (d)(5) of this section.

(iii) Death of the individual as described in paragraph (d)(6) of this section.

(iv) Individuals enrolled in a specialized MA plan for special needs individuals that exclusively serves and enrolls special needs individuals who no longer meet the special needs status of that plan (or deemed continued eligibility, if applicable).

(3) *Plan termination or reduction of area where plan is available—(i) General rule.* An MA organization that has its contract for an MA plan terminated, that terminates an MA plan, or that discontinues offering the plan in any portion of the area where the plan had previously been available, must disenroll affected enrollees in accordance with the procedures for disenrollment set forth at paragraph (d)(7) of this section, unless the exception in paragraph (b)(3)(ii) of this section applies.

(ii) *Exception.* When an MA organization discontinues offering an MA plan in a portion of its service area, the MA organization may elect to offer enrollees residing in all or portions of the affected area the option to continue enrollment in an MA plan offered by the organization, provided that there is no other MA plan offered in the affected area at the time of the organization's election. The organization may require an enrollee who chooses to continue enrollment to agree to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively through facilities designated by the organization within the plan service area.

(c) *Notice requirement.* If the disenrollment is for any of the reasons specified in paragraphs (b)(1), (b)(2)(i), or (b)(3) of this section (that is, other than death or loss of entitlement to Part A or Part B) the MA organization must give the individual a written notice of the disenrollment with an explanation of why the MA organization is planning to disenroll the individual. Notices for reasons specified in paragraphs (b)(1) through (b)(2)(i) must—

(1) Be provided to the individual before submission of the disenrollment to CMS; and

(2) Include an explanation of the individual's right to a hearing under the MA organization's grievance procedures.

(d) *Process for disenrollment—(1) Monthly basic and supplementary premiums are not paid timely.* An MA organization may disenroll an individual from the MA plan for failure to pay basic and supplementary premiums under the following circumstances:

(i) The MA organization can demonstrate to CMS that it made reasonable efforts to collect the unpaid premium amount, including:

(A) Alerting the individual that the premiums are delinquent;

(B) Providing the individual with a grace period, that is, an opportunity to pay past due premiums in full. The length of the grace period will be, at minimum, one month and will begin on the first day of the month for which the premium is unpaid.

(C) Advising the individual that failure to pay the premiums by the end of the grace period will result in termination of MA coverage.

(ii) The MA organization provides the enrollee with notice of disenrollment that meets the requirements set forth in paragraph (c) of this section.

(iii) If the enrollee fails to pay the premium for optional supplemental benefits but pays the basic premium and any mandatory supplemental premium, the MA organization has the option to discontinue the optional supplemental benefits and retain the individual as an MA enrollee.

(2) *Disruptive behavior.* (i) *Definition of disruptive behavior.* An MA plan enrollee is disruptive if his or her behavior substantially impairs the plan's

ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

(ii) *Basis of disenrollment for disruptive behavior.* An organization may disenroll an individual whose behavior is disruptive as defined in 422.74(d)(2)(i) only after it meets the requirements described in this section and CMS has reviewed and approved the request.

(iii) *Effort to resolve the problem.* The MA organization must make a serious effort to resolve the problems presented by the individual, including providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. In addition, the MA organization must inform the individual of the right to use the organization's grievance procedures. The beneficiary has a right to submit any information or explanation that he or she may wish to the MA organization.

(iv) *Documentation.* The MA organization must document the enrollee's behavior, its own efforts to resolve any problems, as described in paragraph (iii), and any extenuating circumstances. The MA organization may request from CMS the ability to decline future enrollment by the individual. The MA organization must submit this information and any documentation received by the beneficiary to CMS.

(v) *CMS review of the proposed disenrollment.* CMS will review the information submitted by the MA organization and any information submitted by the beneficiary (which the MA organization must forward to CMS) to determine if the MA organization has fulfilled the requirements to request disenrollment for disruptive behavior. If the organization has fulfilled the necessary requirements, CMS will review the information and make a decision to approve or deny the request for disenrollment, including conditions on future enrollment, within 20 working days. During the review, CMS will ensure that staff with appropriate clinical or medical expertise review the

case before making the final decision. The MA organization will be required to provide a reasonable accommodation, as determined by CMS, for the individual in such exceptional circumstances that CMS deems necessary. CMS will notify the MA organization within 5 working days after making its decision.

(vi) *Effective date of disenrollment.* If CMS permits an MA organization to disenroll an individual for disruptive behavior, the termination is effective the first day of the calendar month after the month in which the MA organization gives the individual notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section, unless otherwise determined by CMS.

(3) *Individual commits fraud or permits abuse of enrollment card.*—(i) *Basis for disenrollment.* An MA organization may disenroll the individual from an MA plan if the individual—

(A) Knowingly provides, on the election form, fraudulent information that materially affects the individual's eligibility to enroll in the MA plan; or

(B) Intentionally permits others to use his or her enrollment card to obtain services under the MA plan.

(ii) *Notice of disenrollment.* The MA organization must give the individual a written notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section.

(iii) *Report to CMS.* The MA organization must report to CMS any disenrollment based on fraud or abuse by the individual.

(4) *Individual no longer resides in the MA plan's service area.*—(i) *Basis for disenrollment.* Unless continuation of enrollment is elected under § 422.54, the MA organization must disenroll an individual if the MA organization establishes, on the basis of a written statement from the individual or other evidence acceptable to CMS, that the individual has permanently moved—

(A) Out of the MA plan's service area; or

(B) From the residence in which the individual resided at the time of enrollment in the MA plan to an area outside the MA plan's service area, for those individuals who enrolled in the MA

plan under the eligibility requirements at § 422.50(a)(3)(ii) or (a)(4).

(ii) *Special rule.* If the individual has not moved from the MA plan's service area (or residence, as described in paragraph (d)(4)(i)(B) of this section), but has left the service area (or residence) for more than 6 months, the MA organization must disenroll the individual from the plan, unless the exception in paragraph (d)(4)(iii) of this section applies.

(iii) *Exception.* If the MA plan covers services other than emergent, urgent, maintenance and poststabilization, and renal dialysis services (as described in § 422.100(b)(1)(iv) and § 422.113) when the individual is out of the service area for a period of consecutive days longer than 6 months but less than 12 months, but within the United States (as defined in § 400.200 of this chapter), the MA organization may elect to offer to the individual the option of remaining enrolled in the MA plan if—

(A) The individual is disenrolled on the first day of the 13th month after the individual left the service area (or residence, if paragraph (d)(4)(i)(B) of this section applies);

(B) The individual understands and accepts any restrictions imposed by the MA plan on obtaining these services while absent from the MA plan's service area for the extended period; and

(C) The MA organization makes this option available to all Medicare enrollees who are absent for an extended period from the MA plan's service area. However, MA organizations may limit this option to enrollees who travel to certain areas, as defined by the MA organization, and who receive services from qualified providers who directly provide, arrange for, or pay for health care.

(iv) *Notice of disenrollment.* The MA organization must give the individual a written notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section.

(5) *Loss of entitlement to Part A or Part B benefits.* If an individual is no longer entitled to Part A or Part B benefits, CMS notifies the MA organization that the disenrollment is effective the first day of the calendar month following

the last month of entitlement to Part A or Part B benefits.

(6) *Death of the individual.* If the individual dies, disenrollment is effective the first day of the calendar month following the month of death.

(7) *Plan termination or area reduction.*

(i) When an MA organization has its contract for an MA plan terminated, terminates an MA plan, or discontinues offering the plan in any portion of the area where the plan had previously been available, the MA organization must give each affected MA plan enrollee a written notice of the effective date of the plan termination or area reduction and a description of alternatives for obtaining benefits under the MA program.

(ii) The notice must be sent before the effective date of the plan termination or area reduction, and in the timeframes specified in § 422.506(a)(2).

(e) *Consequences of disenrollment—(1) Disenrollment for non-payment of premiums, disruptive behavior, fraud or abuse, loss of Part A or Part B.* An individual who is disenrolled under paragraph (b)(1)(i), (b)(1)(ii), (b)(1)(iii), or paragraph (b)(2)(ii) of this section is deemed to have elected original Medicare.

(2) *Disenrollment based on plan termination, area reduction, or individual moves out of area.* (i) An individual who is disenrolled under paragraph (b)(2)(i) or (b)(3) of this section has a special election period in which to make a new election as provided in § 422.62(b)(1) and (b)(2).

(ii) An individual who fails to make an election during the special election period is deemed to have elected original Medicare.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 65 FR 40318, June 29, 2000; 68 FR 50855, Aug. 22, 2003; 70 FR 4718, Jan. 28, 2005]

**§ 422.80 Approval of marketing materials and election forms.**

(a) *CMS review of marketing materials.*

(1) Except as provided in paragraph (a)(2) of this section, an MA organization may not distribute any marketing materials (as defined in paragraph (b) of this section), or election forms, or make such materials or forms avail-

able to individuals eligible to elect an MA organization unless—

(i) At least 45 days (or 10 days if using marketing materials that use, without modification, proposed model language as specified by CMS) before the date of distribution the MA organization has submitted the material or form to CMS for review under the guidelines in paragraph (c); and

(ii) CMS does not disapprove the distribution of new material or form.

(2) The MA organization may distribute the marketing materials 5 days following their submission to CMS if—

(i) The MA organization is deemed by CMS to meet certain performance requirements established by CMS; or

(ii) The MA organization certifies that in the case of certain marketing materials designated by CMS, it followed all applicable marketing guidelines or used model language specified by CMS without modification.

(b) *Definition of marketing materials.* Marketing materials include any informational materials targeted to Medicare beneficiaries which:

(1) Promote the MA organization, or any MA plan offered by the MA organization;

(2) Inform Medicare beneficiaries that they may enroll, or remain enrolled in, an MA plan offered by the MA organization;

(3) Explain the benefits of enrollment in an MA plan, or rules that apply to enrollees;

(4) Explain how Medicare services are covered under an MA plan, including conditions that apply to such coverage;

(5) Examples of marketing materials include, but are not limited to:

(i) General audience materials such as general circulation brochures, newspapers, magazines, television, radio, billboards, yellow pages, or the internet.

(ii) Marketing representative materials such as scripts or outlines for telemarketing or other presentations.

(iii) Presentation materials such as slides and charts.

(iv) Promotional materials such as brochures or leaflets, including materials for circulation by third parties (e.g., physicians or other providers).

(v) Membership communication materials such as membership rules, subscriber agreements (evidence of coverage), member handbooks and wallet card instructions to enrollees.

(vi) Letters to members about contractual changes; changes in providers, premiums, benefits, plan procedures etc.

(vii) Membership or claims processing activities (*e.g.*, materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or annual notification information).

(c) *Guidelines for CMS review.* In reviewing marketing material or election forms under paragraph (a) of this section, CMS determines that the marketing materials:

(1) Provide, in a format (and, where appropriate, print size), and using standard terminology that may be specified by CMS, the following information to Medicare beneficiaries interested in enrolling:

(i) Adequate written description of rules (including any limitations on the providers from whom services can be obtained), procedures, basic benefits and services, and fees and other charges.

(ii) Adequate written description of any supplemental benefits and services.

(iii) Adequate written explanation of the grievance and appeals process, including differences between the two, and when it is appropriate to use each.

(iv) Any other information necessary to enable beneficiaries to make an informed decision about enrollment.

(2) Notify the general public of its enrollment period (whether time-limited or continuous) in an appropriate manner, through appropriate media, throughout its service and continuation area.

(3) Include in the written materials notice that the MA organization is authorized by law to refuse to renew its contract with CMS, that CMS also may refuse to renew the contract, and that termination or non-renewal may result in termination of the beneficiary's enrollment in the plan.

(4) Are not materially inaccurate or misleading or otherwise make material misrepresentations.

(5) For markets with a significant non-English speaking population, provide materials in the language of these individuals.

(d) *Deemed approval (one-stop shopping).* If CMS has not disapproved the distribution of marketing materials or forms submitted by an MA organization with respect to an MA plan in an area, CMS is deemed not to have disapproved the distribution in all other areas covered by the MA plan and organization except with regard to any portion of the material or form that is specific to the particular area.

(e) *Standards for MA organization marketing.* (1) In conducting marketing activities, MA organizations may not:

(i) Provide for cash or other monetary rebates as an inducement for enrollment or otherwise. This does not prohibit explanation of any legitimate benefits the beneficiary might obtain as an enrollee of the MA plan, such as eligibility to enroll in a supplemental benefit plan that covers deductibles and coinsurance, or preventive services.

(ii) Engage in any discriminatory activity, including targeted marketing to Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas.

(iii) Solicit Medicare beneficiaries door-to-door.

(iv) Engage in activities that could mislead or confuse Medicare beneficiaries, or misrepresent the MA organization. The MA organization may not claim it is recommended or endorsed by CMS or Medicare or the Department of Health and Human Services or that CMS or Medicare or the Department of Health and Human Services recommends that the beneficiary enroll in the MA plan. It may, however, explain that the organization is approved for participation in Medicare.

(v) Distribute marketing materials for which, before expiration of the 45-day period (or 10 days as provided in paragraph (a)(1) of this section), the MA organization receives from CMS written notice of disapproval because it is inaccurate or misleading, or misrepresents the MA organization, its marketing representatives, or CMS.

(vi) Use providers or provider groups to distribute printed information comparing the benefits of different health plans unless the materials have the concurrence of all MA organizations involved and have received prior approval by CMS. Physicians or providers may distribute health plan brochures (exclusive of application forms) at a health fair or in their offices. Physicians may discuss, in response to an individual patient's inquiry, the various benefits in different health plans.

(vii) Accept plan applications in provider offices or other places where health care is delivered.

(viii) Employ MA plan names that suggest that a plan is not available to all Medicare beneficiaries. This prohibition shall not apply to MA plan names in effect on July 31, 2000.

(ix) Engage in any other marketing activity prohibited by CMS in its marketing guidance.

(2) In its marketing, the MA organization must:

(i) Demonstrate to CMS's satisfaction that marketing resources are allocated to marketing to the disabled Medicare population as well as beneficiaries age 65 and over.

(ii) Establish and maintain a system for confirming that enrolled beneficiaries have in fact, enrolled in the MA plan, and understand the rules applicable under the plan.

(f) *Employer group retiree marketing.* MA organizations may develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits through the MA organization, and furnish these materials only to the group members. While the materials must be submitted for approval under paragraph (a) of this section, CMS will not review portions of these materials that relate to employer group benefits.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 65 FR 40318, June 29, 2000; 67 FR 13288, Mar. 22, 2002; 70 FR 4719, Jan. 28, 2005]

### Subpart C—Benefits and Beneficiary Protections

SOURCE: 63 FR 35077, June 26, 1998, unless otherwise noted.

#### § 422.100 General requirements.

(a) *Basic rule.* Subject to the conditions and limitations set forth in this subpart, an MA organization offering an MA plan must provide enrollees in that plan with coverage of the basic benefits described in paragraph (c) of this section (and, to the extent applicable, the benefits described in § 422.102) by furnishing the benefits directly or through arrangements, or by paying for the benefits. CMS reviews these benefits subject to the requirements of § 422.100(g) and the requirements in subpart G of this part.

(b) *Services of noncontracting providers and suppliers.* (1) An MA organization must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier that does not contract with the MA organization to provide services covered by the MA plan:

(i) Ambulance services dispatched through 911 or its local equivalent as provided in § 422.113.

(ii) Emergency and urgently needed services as provided in § 422.113.

(iii) Maintenance and post-stabilization care services as provided in § 422.113.

(iv) Renal dialysis services provided while the enrollee was temporarily outside the plan's service area.

(v) Services for which coverage has been denied by the MA organization and found (upon appeal under subpart M of this part) to be services the enrollee was entitled to have furnished, or paid for, by the MA organization.

(2) An MA plan (and an MA MSA plan, after the annual deductible in § 422.103(d) has been met) offered by an MA organization satisfies paragraph (a) of this section with respect to benefits for services furnished by a noncontracting provider if that MA plan provides payment in an amount the provider would have received under original Medicare (including balance billing permitted under Medicare Part A and Part B).

(c) *Types of benefits.* An MA plan includes at a minimum basic benefits, and also may include mandatory and optional supplemental benefits.

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(1) Basic benefits are all Medicare-covered services, except hospice services.

(2) Supplemental benefits, which consist of—

(i) Mandatory supplemental benefits are services not covered by Medicare that an MA enrollee must purchase as part of an MA plan that are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums or cost-sharing.

(ii) 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.

(d) *Availability and structure of plans.* An MA organization offering an MA plan must offer it—

(1) To all Medicare beneficiaries residing in the service area of the MA plan;

(2) At a uniform premium, with uniform benefits and level of cost-sharing throughout the plan's service area, or segment of service area as provided in § 422.262(c)(2).

(e) *Multiple plans in one service area.* An MA organization may offer more than one MA plan in the same service area subject to the conditions and limitations set forth in this subpart for each MA plan.

(f) *CMS review and approval of MA benefits.* CMS reviews and approves MA benefits using written policy guidelines and requirements in this part and other CMS instructions to ensure that—

(1) Medicare-covered services meet CMS fee-for-service guidelines;

(2) MA organizations are not designing benefits to discriminate against beneficiaries, promote discrimination, discourage enrollment or encourage disenrollment, steer subsets of Medicare beneficiaries to particular MA plans, or inhibit access to services; and

(3) Benefit design meets other MA program requirements.

(g) *Benefits affecting screening mammography, influenza vaccine, and pneumococcal vaccine.* (1) Enrollees of MA organizations may directly access

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(through self-referral) screening mammography and influenza vaccine.

(2) MA organizations may not impose cost-sharing for influenza vaccine and pneumococcal vaccine on their MA plan enrollees.

(h) *Requirements relating to Medicare conditions of participation.* Basic benefits must be furnished through providers meeting the requirements in § 422.204(b)(3).

(i) *Provider networks.* The MA plans offered by an MA organization may share a provider network as long as each MA plan independently meets the access and availability standards described at § 422.112, as determined by CMS.

[65 FR 40319, June 29, 2000, as amended at 67 FR 13288, Mar. 22, 2002; 70 FR 4719, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

### § 422.101 Requirements relating to basic benefits.

Except as specified in § 422.318 (for entitlement that begins or ends during a hospital stay) and § 422.320 (with respect to hospice care), each MA organization must meet the following requirements:

(a) Provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the plan's service area. Services may be provided outside of the service area of the plan if the services are accessible and available to enrollees.

(b) Comply with—

(1) CMS's national coverage determinations;

(2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations in this part or related instructions; and

(3) Written coverage decisions of local Medicare contractors with jurisdiction for claims in the geographic area in which services are covered under the MA plan. If an MA plan covers geographic areas encompassing more than one local coverage policy area, the MA organization offering

such an MA plan may elect to apply to plan enrollees in all areas uniformly the coverage policy that is the most beneficial to MA enrollees. MA organizations that elect this option must notify CMS before selecting the area that has local coverage policies that are most beneficial to enrollees as follows:

(i) An MA organization electing to adopt a uniform local coverage policy for a plan or plans must notify CMS at least 60 days before the date specified in § 422.254(a)(1), which is 60 days before the date bid amounts are due for the subsequent year. Such notice must identify the plan or plans and service area or service areas to which the uniform local coverage policy or policies will apply, the competing local coverage policies involved, and a justification explaining why the selected local coverage policy or policies are most beneficial to MA enrollees.

(ii) CMS will review notices provided under paragraph (b)(3)(i) of this section, evaluate the selected local coverage policy or policies based on such factors as cost, access, geographic distribution of enrollees, and health status of enrollees, and notify the MA organization of its approval or denial of the selected uniform local coverage policy or policies.

(4) Instead of applying rules in paragraph (b)(3)(ii) of this section, and to the extent it exercises this option, an organization offering an MA regional plan in an MA region that covers more than one local coverage policy area must uniformly apply all of the local coverage policy determinations that apply in the selected local coverage policy area in that MA region to all parts of that same MA region. The selection of the single local coverage policy area's local coverage policy determinations to apply throughout the MA region is at the discretion of the MA regional plan and is not subject to CMS pre-approval.

(5) If an MA organization offering an MA local plan elects to exercise the option in paragraph (b)(3) of this section related to a local MA plan, or if an MA organization offering an MA regional plan elects to exercise the option in paragraph (b)(4) of this section related to an MA regional plan, then the MA organization must make information

on the selected local coverage policy readily available, including through the Internet, to enrollees and health care providers.

(c) MA organizations may elect to furnish, as part of their Medicare covered benefits, coverage of posthospital SNF care as described in subparts C and D of this part, in the absence of the prior qualifying hospital stay that would otherwise be required for coverage of this care.

(d) *Special cost-sharing rules for MA regional plans.* In addition to the requirements in paragraph (a) through paragraph (c) of this section, MA regional plans must provide for the following:

(1) *Single deductible.* MA regional plans, to the extent they apply a deductible, are permitted to have only a single deductible related to combined Medicare Part A and Part B services (to the extent they have a deductible). Applicability of the single deductible may be differential for specific in-network services and may also be waived for preventative services or other items and services.

(2) *Catastrophic limit.* MA regional plans are required to provide for a catastrophic limit on beneficiary out-of-pocket expenditures for in-network benefits under the original Medicare fee-for-service program (Part A and Part B benefits).

(3) *Total catastrophic limit.* MA regional plans are required to provide a total catastrophic limit on beneficiary out-of-pocket expenditures for in-network and out-of-network benefits under the original Medicare fee-for-service program. This total out-of-pocket catastrophic limit, which would apply to both in-network and out-of-network benefits under original Medicare, may be higher than the in-network catastrophic limit in paragraph (d)(2) of this section, but may not increase the limit described in paragraph (d)(2) of this section.

(4) *Tracking of deductible and catastrophic limits and notification.* MA regional plans are required to track the deductible (if any) and catastrophic limits in paragraphs (d)(1) through (d)(3) of this section based on incurred out-of-pocket beneficiary costs for original Medicare covered services, and are also required to notify members

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and health care providers when the deductible (if any) or a limit has been reached.

(e) *Other rules for MA regional plans.*

(1) MA regional plans are required to provide reimbursement for all covered benefits, regardless of whether those benefits are provided within or outside of the network of contracted providers.

(2) In applying the actuarially equivalent level of cost-sharing with respect to MA bids related to benefits under the original Medicare program option as set forth at § 422.256(b)(3), only the catastrophic limit on out-of-pocket expenses for in-network benefits in paragraph (d)(2) of this section will be taken into account.

[65 FR 40319, June 29, 2000, as amended at 68 FR 50856, Aug. 22, 2003; 70 FR 4720, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005; 70 FR 76197, Dec. 23, 2005]

### § 422.102 Supplemental benefits.

(a) *Mandatory supplemental benefits.*

(1) Subject to CMS approval, an MA organization may require Medicare enrollees of an MA plan (other than an MSA plan) to accept or pay for services in addition to Medicare-covered services described in § 422.101.

(2) If the MA organization imposes mandatory supplemental benefits, it must impose them on all Medicare beneficiaries enrolled in the MA plan.

(3) CMS approves mandatory supplemental benefits if the benefits are designed in accordance with CMS' guidelines and requirements as stated in this part and other written instructions.

(4) Beginning in 2006, an MA plan may reduce cost sharing below the actuarial value specified in section 1854(e)(4)(A) of the Act only as a mandatory supplemental benefit.

(b) *Optional supplemental benefits.* Except as provided in § 422.104 in the case of MSA plans, each MA organization may offer (for election by the enrollee and without regard to health status) services that are not included in the basic benefits as described in § 422.100(c) and any mandatory supplemental benefits described in paragraph (a) of this section. Optional supplemental benefits are purchased at the discretion of the enrollee and must be offered to all Medicare beneficiaries enrolled in the MA plan.

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(c) *Payment for supplemental services.* All supplemental benefits are paid for in full, directly by (or on behalf of) the enrollee of the MA plan.

(d) *Marketing of supplemental benefits.* MA organizations may offer enrollees a group of services as one optional supplemental benefit, offer services individually, or offer a combination of groups and individual services.

[65 FR 40320, June 29, 2000, as amended at 70 FR 4720, Jan. 28, 2005]

### § 422.103 Benefits under an MA MSA plan.

(a) *General rule.* An MA organization offering an MA MSA plan must make available to an enrollee, or provide reimbursement for, at least the services described in § 422.101 after the enrollee incurs countable expenses equal to the amount of the plan's annual deductible.

(b) *Countable expenses.* An MA organization offering an MA MSA plan must count toward the annual deductible at least all amounts that would be paid for the particular service under original Medicare, including amounts that would be paid by the enrollee as deductibles or coinsurance.

(c) *Services after the deductible.* For services received by the enrollee after the annual deductible is satisfied, an MA organization offering an MA MSA plan must pay, at a minimum, the lesser of the following amounts:

(1) 100 percent of the expense of the services.

(2) 100 percent of the amounts that would have been paid for the services under original Medicare, including amounts that would be paid by the enrollee as deductibles and coinsurance.

(d) *Annual deductible.* The annual deductible for an MA MSA plan—

(1) For contract year 1999, may not exceed \$6,000; and

(2) For subsequent contract years may not exceed the deductible for the preceding contract year, increased by the national per capita growth percentage determined under § 422.306(a)(2).

[63 FR 35077, June 26, 1998, as amended at 70 FR 4720, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

**§ 422.104 Special rules on supplemental benefits for MA MSA plans.**

(a) An MA organization offering an MA MSA plan may not provide supplemental benefits that cover expenses that count towards the deductible specified in § 422.103(d).

(b) In applying the limitation of paragraph (a) of this section, the following kinds of policies are not considered as covering the deductible:

(1) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(2) A policy of insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to use or ownership of property, and any other similar liabilities that CMS may specify by regulation.

(3) A policy of insurance that provides coverage for a specified disease or illness or pays a fixed amount per day (or other period) of hospitalization.

**§ 422.105 Special rules for self-referral and point of service option.**

(a) *Self-referral.* When an MA plan member receives an item or service of the plan that is covered upon referral or pre-authorization from a contracted provider of that plan, the member cannot be financially liable for more than the normal in-plan cost sharing, if the member correctly identified himself or herself as a member of that plan to the contracted provider before receiving the covered item or service, unless the contracted provider can show that the enrollee was notified prior to receiving the item or service that the item or service is covered only if further action is taken by the enrollee.

(b) *Point of service option.* As a general rule, a POS benefit is an option that an MA organization may offer in an MA coordinated care plan to provide enrollees with additional choice in obtaining specified health care services. The organization may offer a POS option—

(1) Before January 1, 2006, under a coordinated care plan as an additional benefit as described in section 1854(f)(1)(A) of the Act;

(2) Under a coordinated care plan as a mandatory supplemental benefit as described in § 422.102(a); or

(3) Under a coordinated care plan as an optional supplemental benefit as described in § 422.102(b).

(4) An MA regional plan or local MA PPO is permitted to offer a POS-LIKE benefit as described in paragraphs (b)(2) or (b)(3) of this section as a supplemental benefit. An MA regional plan or local MA PPO may offer a POS-LIKE option as a supplemental benefit where cost sharing for out-of-network services is reduced, in a limited manner, for services obtained from out-of-network providers. Offering a POS-LIKE supplemental benefit does not affect the MA regional plan's or local MA PPO's responsibility to provide reimbursement for all covered benefits, regardless of whether those benefits are provided within the network of contracted providers.

(c) *Ensuring availability and continuity of care.* An MA network plan that includes a POS benefit must continue to provide all benefits and ensure access as required under this subpart.

(d) *Enrollee information and disclosure.* The disclosure requirements specified in § 422.111 apply in addition to the following requirements:

(1) *Written rules.* MA organizations must maintain written rules on how to obtain health benefits through the POS benefit.

(2) *Evidence of coverage document.* The MA organization must provide to beneficiaries enrolling in a plan with a POS benefit an "evidence of coverage" document, or otherwise provide written documentation, that specifies all costs and possible financial risks to the enrollee, including—

(i) Any premiums and cost-sharing for which the enrollee is responsible;

(ii) Annual limits on benefits and on out-of-pocket expenditures;

(iii) Potential financial responsibility for services for which the plan denies payment because they were not covered under the POS benefit, or exceeded the dollar limit for the benefit; and

(iv) The annual maximum out-of-pocket expense an enrollee could incur.

(e) *Prompt payment.* Health benefits payable under the POS benefit are subject to the prompt payment requirements in § 422.520.

(f) *POS-related data.* An MA organization that offers a POS benefit through an MA plan must report enrollee utilization data at the plan level by both plan contracting providers (in-network) and by non-contracting providers (out-of-network) including enrollee use of the POS benefit, in the form and manner prescribed by CMS.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40320, June 29, 2000; 70 FR 4721, Jan. 28, 2005]

**§ 422.106 Coordination of benefits with employer or union group health plans and Medicaid.**

(a) *General rule.* If an MA organization contracts with an employer, labor organization, or the trustees of a fund established by one or more employers or labor organizations that cover enrollees in an MA plan, or contracts with a State Medicaid agency to provide Medicaid benefits to individuals who are eligible for both Medicare and Medicaid, and who are enrolled in an MA plan, the enrollees must be provided the same benefits as all other enrollees in the MA plan, with the employer, labor organization, fund trustees, or Medicaid benefits supplementing the MA plan benefits. Jurisdiction regulating benefits under these circumstances is as follows:

(1) All requirements of this part that apply to the MA program apply to the MA plan coverage and benefits provided to enrollees eligible for benefits under an employer, labor organization, trustees of a fund established by one or more employers or labor organizations, or Medicaid contract.

(2) Employer benefits that complement an MA plan, which are not part of the MA plan, are not subject to review or approval by CMS.

(3) Medicaid benefits are not reviewed under this part, but are subject to appropriate CMS review under the Medicaid program. MA plan benefits provided to individuals entitled to Medicaid benefits provided by the MA organization under a contract with the State Medicaid agency are subject to MA rules and requirements.

(b) *Examples.* Permissible employer, labor organization, benefit fund trustee, or Medicaid plan benefits include the following:

(1) Payment of a portion or all of the MA basic and supplemental premiums.

(2) Payment of a portion or all of other cost-sharing amounts approved for the MA plan.

(3) Other employer-sponsored benefits that may require additional premium and cost-sharing, or other benefits provided by the organization under a contract with the State Medicaid agency.

(c) *Waiver or modification of contracts with MA organizations.* (1) MA organizations may request, in writing, from CMS, a waiver or modification of those requirements in this part that hinder the design of, the offering of, or the enrollment in, MA plans under contracts between MA organizations and employers, labor organizations, or the trustees of funds established by one or more employers or labor organizations to furnish benefits to the entity's employees, former employees, or members or former members of the labor organizations.

(2) Approved waivers or modifications under this paragraph granted to any MA organization may be used by any other similarly situated MA organization in developing its bid.

(d) *Employer sponsored MA plans for plan years beginning on or after January 1, 2006.* (1) CMS may waive or modify any requirement in this part or Part D that hinders the design of, the offering of, or the enrollment in, an MA plan (including an MA-PD plan) offered by one or more employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof), or that is offered, sponsored or administered by an entity on behalf of one or more employers or labor organizations, to furnish benefits to the employers' employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations. Any entity seeking to offer, sponsor, or administer such an MA plan described in this paragraph may request, in writing, from CMS, a waiver or modification of requirements in this

part that hinder the design of, the offering of, or the enrollment in, such MA plan.

(2) An MA plan described in this paragraph may restrict the enrollment of individuals in that plan to individuals who are beneficiaries and participants in that plan.

(3) Approved waivers or modifications under this paragraph granted to any MA plan may be used by any other similarly situated MA plan in developing its bid.

[65 FR 40320, June 29, 2000, as amended at 68 FR 50856, Aug. 22, 2003; 70 FR 4721, Jan. 28, 2005]

**§ 422.108 Medicare secondary payer (MSP) procedures.**

(a) *Basic rule.* CMS does not pay for services to the extent that Medicare is not the primary payer under section 1862(b) of the Act and part 411 of this chapter.

(b) *Responsibilities of the MA organization.* The MA organization must, for each MA plan—

(1) Identify payers that are primary to Medicare under section 1862(b) of the Act and part 411 of this chapter;

(2) Identify the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers.

(c) *Collecting from other entities.* The MA organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) *Collecting from other insurers or the enrollee.* If a Medicare enrollee receives from an MA organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the MA organization may bill, or authorize a provider to bill any of the following—

(1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.

(2) The Medicare enrollee, to the extent that he or she has been paid by the

carrier, employer, or entity for covered medical expenses.

(e) *Collecting from group health plans (GHPs) and large group health plans (LGHPs).* An MA organization may bill a GHP or LGHP for services it furnishes to a Medicare enrollee who is also covered under the GHP or LGHP and may bill the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP.

(f) *MSP rules and State laws.* Consistent with § 422.402 concerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans. A State cannot take away an MA organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40320, June 29, 2000; 70 FR 4721, Jan. 28, 2005]

**§ 422.109 Effect of national coverage determinations (NCDs) and legislative changes in benefits.**

(a) *Definitions.* The term *significant cost*, as it relates to a particular NCD or legislative change in benefits, means either of the following:

(1) The average cost of furnishing a single service exceeds a cost threshold that—

(i) For calendar years 1998 and 1999, is \$100,000; and

(ii) For calendar year 2000 and subsequent calendar years, is the preceding year's dollar threshold adjusted to reflect the national per capita growth percentage described in § 422.308(a).

(2) The estimated cost of Medicare services furnished as a result of a particular NCD or legislative change in benefits represents at least 0.1 percent of the national average per capita costs.

(b) *General rule.* If CMS determines and announces that an individual NCD or legislative change in benefits meets

the criteria for significant cost described in paragraph (a) of this section, a MA organization is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the cost of the NCD service or legislative change in benefits. If CMS determines that an NCD or legislative change in benefits does not meet the “significant cost” threshold described in § 422.109(a), the MA organization is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date stated in the NCD or specified in the legislation.

(c) *Before payment adjustments become effective.* Before the contract year that payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits become effective, the service or benefit is not included in the MA organization’s contract with CMS, and is not a covered benefit under the contract. The following rules apply to these services or benefits:

(1) Medicare payment for the service or benefit is made directly by the fiscal intermediary and carrier to the provider furnishing the service or benefit in accordance with original Medicare payment rules, methods, and requirements.

(2) Costs for NCD services or legislative changes in benefits for which CMS intermediaries and carriers will not make payment and are the responsibility of the MA organization are—

(i) Services necessary to diagnose a condition covered by the NCD or legislative changes in benefits;

(ii) Most services furnished as follow-up care to the NCD service or legislative change in benefits;

(iii) Any service that is already a Medicare-covered service and included in the annual MA capitation rate or previously adjusted payments; and

(iv) Any services, including the costs of the NCD service or legislative change in benefits, to the extent the MA organization is already obligated to cover it as a supplemental benefit under § 422.102.

(3) Costs for significant cost NCD services or legislative changes in bene-

fits for which CMS fiscal intermediaries and carriers will make payment are those Medicare costs not listed in paragraphs (c)(2)(i) through (c)(2)(iv) of this section.

(4) Beneficiaries are liable for any applicable coinsurance amounts.

(d) *After payment adjustments become effective.* For the contract year in which payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits are in effect, the service or benefit is included in the MA organization’s contract with CMS, and is a covered benefit under the contract. Subject to all applicable rules under this part, the MA organization must furnish, arrange, or pay for the NCD service or legislative change in benefits. MA organizations may establish separate plan rules for these services and benefits, subject to CMS review and approval. CMS may, at its discretion, issue overriding instructions limiting or revising the MA plan rules, depending on the specific NCD or legislative change in benefits. For these services or benefits, the Medicare enrollee will be responsible for MA plan cost sharing, as approved by CMS or unless otherwise instructed by CMS.

[68 FR 50856, Aug. 22, 2003, as amended at 70 FR 4721, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

**§ 422.110 Discrimination against beneficiaries prohibited.**

(a) *General prohibition.* Except as provided in paragraph (b) of this section, an MA organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

(1) Medical condition, including mental as well as physical illness.

(2) Claims experience.

(3) Receipt of health care.

(4) Medical history.

(5) Genetic information.

(6) Evidence of insurability, including conditions arising out of acts of domestic violence.

(7) Disability.

(b) *Exception.* An MA organization may not enroll an individual who has been medically determined to have end-stage renal disease. However, an enrollee who develops end-stage renal disease while enrolled in a particular MA organization may not be disenrolled for that reason. An individual who is an enrollee of a particular MA organization, and who resides in the MA plan service area at the time he or she first becomes MA eligible, or, an individual enrolled by an MA organization that allows those who reside outside its MA service area to enroll in an MA plan as set forth at § 422.50(a)(3)(ii), then that individual is considered to be “enrolled” in the MA organization for purposes of the preceding sentence.

[63 FR 35077, June 26, 1998; 63 FR 52612, Oct. 1, 1998; 64 FR 7980, Feb. 17, 1999, as amended at 65 FR 40321, June 29, 2000; 70 FR 4721, Jan. 28, 2005]

#### § 422.111 Disclosure requirements.

(a) *Detailed description.* An MA organization must disclose the information specified in paragraph (b) of this section—

- (1) To each enrollee electing an MA plan it offers;
- (2) In clear, accurate, and standardized form; and
- (3) At the time of enrollment and at least annually thereafter.

(b) *Content of plan description.* The description must include the following information:

(1) *Service area.* The MA plan’s service area and any enrollment continuation area.

(2) *Benefits.* The benefits offered under a plan, including applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with receipt or use of benefits; and to the extent it offers Part D as an MA-PD plan, the information in § 423.128 of this chapter; and for purposes of comparison—

- (i) The benefits offered under original Medicare, including the content specified in paragraph (f)(1) of this section;
- (ii) For an MA MSA plan, the benefits under other types of MA plans; and

(iii) The availability of the Medicare hospice option and any approved hospices in the service area, including those the MA organization owns, controls, or has a financial interest in.

(3) *Access.* (i) The number, mix, and distribution (addresses) of providers from whom enrollees may reasonably be expected to obtain services; any out-of-network coverage; any point-of-service option, including the supplemental premium for that option; and how the MA organization meets the requirements of § 422.112 and § 422.114 for access to services offered under the plan.

(ii) The process MA regional plan enrollees should follow to secure in-network cost sharing when covered services are not readily available from contracted network providers.

(4) Out-of-area coverage provided under the plan, including coverage provided to individuals eligible to enroll in the plan under § 422.50(a)(3)(ii).

(5) *Emergency coverage.* Coverage of emergency services, including—

(i) Explanation of what constitutes an emergency, referencing the definitions of emergency services and emergency medical condition at § 422.113;

(ii) The appropriate use of emergency services, stating that prior authorization cannot be required;

(iii) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent; and

(iv) The locations where emergency care can be obtained and other locations at which contracting physicians and hospitals provide emergency services and post-stabilization care included in the MA plan.

(6) *Supplemental benefits.* Any mandatory or optional supplemental benefits and the premium for those benefits.

(7) *Prior authorization and review rules.* Prior authorization rules and other review requirements that must be met in order to ensure payment for the services. The MA organization must instruct enrollees that, in cases where noncontracting providers submit a bill directly to the enrollee, the enrollee should not pay the bill, but submit it to the MA organization for processing and determination of enrollee liability, if any.

(8) *Grievance and appeals procedures.* All grievance and appeals rights and procedures.

(9) *Quality improvement program.* A description of the quality improvement program required under § 422.152.

(10) *Disenrollment rights and responsibilities.*

(11) *Catastrophic caps and single deductible.* MA organizations sponsoring MA regional plans are required to provide enrollees a description of the catastrophic stop-loss coverage and single deductible (if any) applicable under the plan.

(c) *Disclosure upon request.* Upon request of an individual eligible to elect an MA plan, an MA organization must provide to the individual the following information:

(1) The information required in paragraph (f) of this section.

(2) The procedures the organization uses to control utilization of services and expenditures.

(3) The number of disputes, and the disposition in the aggregate, in a manner and form described by the Secretary. Such disputes shall be categorized as

(i) Grievances according to § 422.564; and

(ii) Appeals according to § 422.578 et. seq.

(4) A summary description of the method of compensation for physicians.

(5) Financial condition of the MA organization, including the most recently audited information regarding, at least, a description of the financial condition of the MA organization offering the plan.

(d) *Changes in rules.* If an MA organization intends to change its rules for an MA plan, it must:

(1) Submit the changes for CMS review under the procedures of § 422.80.

(2) For changes that take effect on January 1, notify all enrollees at least 15 days before the beginning of the Annual Coordinated Election Period defined in section 1851(e)(3)(B) of the Act.

(3) For all other changes, notify all enrollees at least 30 days before the intended effective date of the changes.

(e) *Changes to provider network.* The MA organization must make a good faith effort to provide written notice of

a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified.

(f) *Disclosable information—(1) Benefits under original Medicare.* (i) Covered services.

(ii) Beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts.

(iii) Any beneficiary liability for balance billing.

(2) *Enrollment procedures.* Information and instructions on how to exercise election options under this subpart.

(3) *Rights.* A general description of procedural rights (including grievance and appeals procedures) under original Medicare and the MA program and the right to be protected against discrimination based on factors related to health status in accordance with § 422.110.

(4) *Potential for contract termination.* The fact that an MA organization may terminate or refuse to renew its contract, or reduce the service area included in its contract, and the effect that any of those actions may have on individuals enrolled in that organization's MA plan.

(5) *Benefits.* (i) Covered services beyond those provided under original Medicare.

(ii) Any beneficiary cost-sharing.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MA MSA plan, the amount of the annual MSA deposit.

(v) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vi) The types of providers that participate in the plan's network and the extent to which an enrollee may select among those providers.

(vii) The coverage of emergency and urgently needed services.

(6) *Premiums.* (i) The MA monthly basic beneficiary premiums.

(ii) The MA monthly supplemental beneficiary premium.

(iii) The reduction in Part B premiums, if any.

(7) *The plan's service area.*

(8) *Quality and performance indicators* for benefits under a plan to the extent they are available as follows (and how they compare with indicators under original Medicare):

(i) Disenrollment rates for Medicare enrollees for the 2 previous years, excluding disenrollment due to death or moving outside the plan's service area, calculated according to CMS guidelines.

(ii) Medicare enrollee satisfaction.

(iii) Health outcomes.

(iv) Plan-level appeal data.

(v) The recent record of plan compliance with the requirements of this part, as determined by the Secretary.

(vi) Other performance indicators.

(9) *Supplemental benefits.* Whether the plan offers mandatory and optional supplemental benefits, including any reductions in cost sharing offered as a mandatory supplemental benefit as permitted under section 1852(a)(3) of the Act (and implementing regulations at § 422.102) and the terms, conditions, and premiums for those benefits.

(10) The names, addresses, and phone numbers of contracted providers from whom the enrollee may obtain in-network coverage in other parts of the service area.

(11) If an MA organization exercises the option in § 422.101(b)(3) or (b)(4) related to an MA plan, then it must make the local coverage determination that applies to members of that plan readily available to providers, including through a web site on the Internet.

(12) To the extent an MA organization has a web site or provides MA plan information through the Internet, then it must also post copies of its Evidence of Coverage, Summary of Benefits and information (names, addresses, phone numbers, specialty) on the network of contracted providers on an Internet web site. Such posting does not relieve the MA organization of its responsi-

bility under § 422.111(a) to provide hard copies to enrollees.

[63 FR 35077, June 26, 1998, as amended at 64 FR 7980, Feb. 17, 1999; 65 FR 40321, June 29, 2000; 68 FR 50857, Aug. 22, 2003; 70 FR 4722, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

#### § 422.112 Access to services.

(a) *Rules for coordinated care plans.* An MA organization that offers an MA coordinated care plan may specify the networks of providers from whom enrollees may obtain services if the MA organization ensures that all covered services, including supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the MA organization must meet the following requirements:

(1) *Provider network.* (i) Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.

(ii) *Exception:* MA regional plans, upon CMS pre-approval, can use methods other than written agreements to establish that access requirements are met.

(2) *PCP panel.* Establish a panel of PCPs from which the enrollee may select a PCP. If an MA organization requires its enrollees to obtain a referral in most situations before receiving services from a specialist, the MA organization must either assign a PCP for purposes of making the needed referral or make other arrangements to ensure access to medically necessary specialty care.

(3) *Specialty care.* Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits (as defined in § 422.2). The MA organization arranges for specialty

care outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs.

(4) *Service area expansion.* If seeking a service area expansion for an MA plan, demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served.

(5) *Credentialed providers.* Demonstrate to CMS that its providers in an MA plan are credentialed through the process set forth at § 422.204(a).

(6) *Written standards.* Establish written standards for the following:

(i) Timeliness of access to care and member services that meet or exceed standards established by CMS. Timely access to care and member services within a plan's provider network must be continuously monitored to ensure compliance with these standards, and the MA organization must take corrective action as necessary.

(ii) Policies and procedures (coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations.

(iii) Provider consideration of beneficiary input into the provider's proposed treatment plan.

(7) *Hours of operation.* Ensure that—

(i) The hours of operation of its MA plan providers are convenient to the population served under the plan and do not discriminate against Medicare enrollees; and

(ii) Plan services are available 24 hours a day, 7 days a week, when medically necessary.

(8) *Cultural considerations.* Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

(9) *Ambulance services, emergency and urgently needed services, and post-stabilization care services coverage.* Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services in accordance with § 422.113.

(b) *Continuity of care.* MA organizations offering coordinated care plans must ensure continuity of care and in-

tegration of services through arrangements with contracted providers that include—

(1) Policies that specify under what circumstances services are coordinated and the methods for coordination;

(2) Offering to provide each enrollee with an ongoing source of primary care and providing a primary care source to each enrollee who accepts the offer;

(3) Programs for coordination of plan services with community and social services generally available through contracting or noncontracting providers in the area served by the MA plan, including nursing home and community-based services; and

(4) Procedures to ensure that the MA organization and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that—

(i) The MA organization makes a "best-effort" attempt to conduct an initial assessment of each enrollee's health care needs, including following up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment;

(ii) Each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the MA organization, taking into account professional standards; and

(iii) There is appropriate and confidential exchange of information among provider network components.

(5) Procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and

(6) Systems to address barriers to enrollee compliance with prescribed treatments or regimens.

(c) *Essential hospital.* An MA regional plan may seek, upon application to CMS, to designate a noncontracting hospital as an essential hospital as defined in section 1858(h) of the Act under the following conditions:

(1) The hospital that the MA regional plan seeks to designate as essential is a general acute care hospital identified

as a “subsection(d)” hospital as defined in section 1886(d)(1)(B) of the Act.

(2) The MA regional plan provides convincing evidence to CMS that the MA regional plan needs to contract with the hospital as a condition of meeting access requirements under this section.

(3) The MA regional plan must establish that it made a “good faith” effort to contract with the hospital to be designated as an essential hospital and that the hospital refused to contract with it despite its “good faith” effort. A “good faith” effort to contract will be established to the extent that the MA regional plan can show it has offered the hospital a contract providing for the payment of rates in an amount no less than the amount the hospital would have received had payment been made under section 1886(d) of the Act.

(4) The MA regional plan must establish that there are no competing Medicare participating hospitals in the area to which MA regional plan enrollees could reasonably be referred for inpatient hospital services.

(5) The hospital that is an essential hospital under this paragraph provides convincing evidence to CMS that the amounts normally payable under section 1886 of the Act (and which the MA regional plan has agreed to pay) will be less than the hospital’s actual costs of providing care to the MA regional plan’s enrollee.

(6) If CMS determines the requirements in paragraphs (c)(1) through (c)(5) of this section have been met, it will make payment to the essential hospital in accordance with section 1858(h)(2) of the Act based on the order in which claims are received, as limited by the amounts specified in section 1858(h)(3) of the Act.

(7) If CMS determines the requirements in paragraphs (c)(1) through (c)(4) of this section have been met, (and if they continue to be met upon annual renewal of the CMS contract with the MA organization offering the MA regional plan), then the hospital designated by the MA regional plan in paragraph (c)(1) of this section shall be “deemed” to be a network hospital to that MA regional plan based on the exception in paragraph (a)(1)(ii) of this section and normal in-network inpa-

tient hospital cost sharing levels (including the catastrophic limit described in § 422.101(d)(2)) shall apply to all plan members accessing covered inpatient hospital services in that hospital.

[64 FR 7980, Feb. 17, 1999, as amended at 65 FR 40321, June 29, 2000; 70 FR 4722, Jan. 28, 2005; 70 FR 76197, Dec. 23, 2005]

**§ 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services.**

(a) *Ambulance services.* The MA organization is financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary’s health.

(b) *Emergency and urgently needed services—(1) Definitions.* (i) *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(ii) *Emergency services* means covered inpatient and outpatient services that are—

(A) Furnished by a provider qualified to furnish emergency services; and

(B) Needed to evaluate or stabilize an emergency medical condition.

(iii) *Urgently needed services* means covered services that are not emergency services as defined in this section, provided when an enrollee is temporarily absent from the MA plan’s service (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization’s provider network is temporarily unavailable or inaccessible) when the

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services are medically necessary and immediately required—

(A) As a result of an unforeseen illness, injury, or condition; and

(B) It was not reasonable given the circumstances to obtain the services through the organization offering the MA plan.

(2) *MA organization financial responsibility.* The MA organization is financially responsible for emergency and urgently needed services—

(i) Regardless of whether the services are obtained within or outside the MA organization;

(ii) Regardless of whether there is prior authorization for the services.

(A) Instructions to seek prior authorization for emergency or urgently needed services may not be included in any materials furnished to enrollees (including wallet card instructions), and enrollees must be informed of their right to call 911.

(B) Instruction to seek prior authorization before the enrollee has been stabilized may not be included in any materials furnished to providers (including contracts with providers);

(iii) In accordance with the prudent layperson definition of *emergency medical condition* regardless of final diagnosis;

(iv) For which a plan provider or other MA organization representative instructs an enrollee to seek emergency services within or outside the plan; and

(v) With a limit on charges to enrollees for emergency department services of \$50 or what it would charge the enrollee if he or she obtained the services through the MA organization, whichever is less.

(3) *Stabilized condition.* The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MA organization.

(c) *Maintenance care and post-stabilization care services* (hereafter together referred to as “post-stabilization care services”).

(1) *Definition.* *Post-stabilization care services* means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the sta-

bilized condition, or, under the circumstances described in paragraph (c)(2)(iii) of this section, to improve or resolve the enrollee’s condition.

(2) *MA organization financial responsibility.* The MA organization—

(i) Is financially responsible (consistent with § 422.214) for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative;

(ii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain the enrollee’s stabilized condition within 1 hour of a request to the MA organization for pre-approval of further post-stabilization care services;

(iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee’s stabilized condition if—

(A) The MA organization does not respond to a request for pre-approval within 1 hour;

(B) The MA organization cannot be contacted; or

(C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee’s care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in § 422.113(c)(3) is met; and

(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

(3) *End of MA organization's financial responsibility.* The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—

(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(ii) A plan physician assumes responsibility for the enrollee's care through transfer;

(iii) An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or

(iv) The enrollee is discharged.

[65 FR 40322, June 29, 2000, as amended at 70 FR 4723, Jan. 28, 2005]

**§ 422.114 Access to services under an MA private fee-for-service plan.**

(a) *Sufficient access.* (1) An MA organization that offers an MA private fee-for-service plan must demonstrate to CMS that it has sufficient number and range of providers willing to furnish services under the plan.

(2) CMS finds that an MA organization meets the requirement in paragraph (a)(1) of this section if, with respect to a particular category of health care providers, the MA organization has—

(i) Payment rates that are not less than the rates that apply under original Medicare for the provider in question;

(ii) Contracts or agreements with a sufficient number and range of providers to furnish the services covered under the MA private fee-for-service plan; or

(iii) A combination of paragraphs (a)(2)(i) and (a)(2)(ii) of this section.

(b) *Freedom of choice.* MA fee-for-service plans must permit enrollees to obtain services from any entity that is authorized to provide services under Medicare Part A and Part B and agrees to provide services under the terms of the plan.

(c) *Contracted network.* Private fee-for-service plans that meet network adequacy requirements for a category of health care professional or provider by meeting the requirements in paragraph (a)(2)(ii) of this section may provide for a higher beneficiary copayment in the case of health care profes-

sionals or providers of that same category who do not have contracts or agreements to provide covered services under the terms of the plan.

[63 FR 35077, June 26, 1998, as amended at 70 FR 4723, Jan. 28, 2005]

**§ 422.118 Confidentiality and accuracy of enrollee records.**

For any medical records or other health and enrollment information it maintains with respect to enrollees, an MA organization must establish procedures to do the following:

(a) Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. The MA organization must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify—

(1) For what purposes the information will be used within the organization; and

(2) To whom and for what purposes it will disclose the information outside the organization.

(b) Ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

(c) Maintain the records and information in an accurate and timely manner.

(d) Ensure timely access by enrollees to the records and information that pertain to them.

[65 FR 40323, June 29, 2000]

**§ 422.128 Information on advance directives.**

(a) Each MA organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in subpart I of part 489 of this chapter. For purposes of this part, *advance directive* has the meaning given the term in § 489.100 of this chapter.

(b) An MA organization must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MA organization.

(1) An MA organization must provide written information to those individuals with respect to the following:

(i) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that the requirements of this section are met. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law.

(ii) The MA organization's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the MA organization cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

(A) Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians.

(B) Identify the state legal authority permitting such objection.

(C) Describe the range of medical conditions or procedures affected by the conscience objection.

(D) Provide the information specified in paragraph (a)(1) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the MA organization may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The MA organization is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given

to the individual directly at the appropriate time.

(E) Document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.

(F) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

(G) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives.

(H) Provide for education of staff concerning its policies and procedures on advance directives.

(I) Provide for community education regarding advance directives that may include material required in paragraph (a)(1)(i) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the MA organization. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An MA organization must be able to document its community education efforts.

(2) The MA organization—

(i) Is not required to provide care that conflicts with an advance directive; and

(ii) Is not required to implement an advance directive if, as a matter of conscience, the MA organization cannot implement an advance directive and State law allows any health care provider or any agent of the provider to conscientiously object.

(3) The MA organization must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.

**§ 422.132 Protection against liability and loss of benefits.**

Enrollees of MA organizations are entitled to the protections specified in § 422.504(g).

[63 FR 35077, June 26, 1998, as amended at 70 FR 52026, Sept. 1, 2005]

**§ 422.133 Return to home skilled nursing facility.**

(a) *General rule.* MA plans must provide coverage of posthospital extended care services to Medicare enrollees through a home skilled nursing facility if the enrollee elects to receive the coverage through the home skilled nursing facility, and if the home skilled nursing facility either has a contract with the MA organization or agrees to accept substantially similar payment under the same terms and conditions that apply to similar skilled nursing facilities that contract with the MA organization.

(b) *Definitions.* In this subpart, *home skilled nursing facility* means—

(1) The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of posthospital extended care services;

(2) A skilled nursing facility that is providing posthospital extended care services through a continuing care retirement community in which the MA plan enrollee was a resident at the time of admission to the hospital. A continuing care retirement community is an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period; or

(3) The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from the hospital.

(4) If an MA organization elects to furnish SNF care in the absence of a prior qualifying hospital stay under § 422.101(c), then that SNF care is also subject to the home skilled nursing facility rules in this section. In applying the provisions of this section to coverage under this paragraph, references to a hospitalization, or discharge from a hospital, are deemed to refer to wherever the enrollee resides immediately

before admission for extended care services.

(c) *Coverage no less favorable.* The posthospital extended care scope of services, cost-sharing, and access to coverage provided by the home skilled nursing facility must be no less favorable to the enrollee than posthospital extended care services coverage that would be provided to the enrollee by a skilled nursing facility that would be otherwise covered under the MA plan.

(d) *Exceptions.* The requirement to allow an MA plan enrollee to elect to return to the home skilled nursing facility for posthospital extended care services after discharge from the hospital does not do the following:

(1) Require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under Part A for Medicare beneficiaries not enrolled in the MA plan.

(2) Prevent a skilled nursing facility from refusing to accept, or imposing conditions on the acceptance of, an enrollee for the receipt of posthospital extended care services.

[68 FR 50857, Aug. 22, 2003, as amended at 70 FR 4723, Jan. 28, 2005]

**Subpart D—Quality Improvement**

SOURCE: 63 FR 35082, June 26, 1998, unless otherwise noted.

**§ 422.152 Quality improvement program.**

(a) *General rule.* Each MA organization (other than MA private-fee-for-service and MSA plans) that offers one or more MA plans must have, for each of those plans, an ongoing quality improvement program that meets the applicable requirements of this section for the services it furnishes to its MA enrollees. As part of its ongoing quality improvement program, a plan must—

(1) Have a chronic care improvement program that meets the requirements of paragraph (c) of this section concerning elements of a chronic care program;

(2) Conduct quality improvement projects that can be expected to have a favorable effect on health outcomes and enrollee satisfaction, and meet the

requirements of paragraph (d) of this section; and

(3) Encourage its providers to participate in CMS and HHS quality improvement initiatives.

(b) *Requirements for MA coordinated care plans (except for regional MA plans) and including local PPO plans that are offered by organizations that are licensed or organized under State law as HMOs.* An MA coordinated care plan's (except for regional PPO plans and local PPO plans as defined in paragraph (e) of this section) quality improvement program must—

(1) In processing requests for initial or continued authorization of services, follow written policies and procedures that reflect current standards of medical practice.

(2) Have in effect mechanisms to detect both underutilization and overutilization of services.

(3) Measure and report performance. The organization offering the plan must do the following:

(i) Measure performance under the plan, using the measurement tools required by CMS, and report its performance to CMS. The standard measures may be specified in uniform data collection and reporting instruments required by CMS.

(ii) Make available to CMS information on quality and outcomes measures that will enable beneficiaries to compare health coverage options and select among them, as provided in § 422.64.

(4) Special rule for MA local PPO-type plans that are offered by an organization that is licensed or organized under State law as a health maintenance organization must meet the requirements specified in paragraphs (b)(1) through (b)(3) of this section.

(c) *Chronic care improvement program requirements.* Develop criteria for a chronic care improvement program. These criteria must include—

(1) Methods for identifying MA enrollees with multiple or sufficiently severe chronic conditions that would benefit from participating in a chronic care improvement program; and

(2) Mechanisms for monitoring MA enrollees that are participating in the chronic care improvement program.

(d) *Quality improvement projects.* (1) Quality improvement projects are an

organization's initiatives that focus on specified clinical and nonclinical areas and that involve the following:

(i) Measurement of performance.

(ii) System interventions, including the establishment or alteration of practice guidelines.

(iii) Improving performance.

(iv) Systematic and periodic follow-up on the effect of the interventions.

(2) For each project, the organization must assess performance under the plan using quality indicators that are—

(i) Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research; and

(ii) Capable of measuring outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies of those outcomes.

(3) Performance assessment on the selected indicators must be based on systematic ongoing collection and analysis of valid and reliable data.

(4) Interventions must achieve demonstrable improvement.

(5) The organization must report the status and results of each project to CMS as requested.

(e) *Requirements for MA regional plans and MA local plans that are PPO plans as defined in this section—*(1) *Definition of local preferred provider organization plan.* For purposes of this section, the term local preferred provider organization (PPO) plan means an MA plan that—

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

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

(iii) Is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(2) MA organizations offering an MA regional plan or local PPO plan as defined in this section must:

(i) Measure performance under the plan using standard measures required by CMS and report its performance to CMS. The standard measures may be specified in uniform data collection

and reporting instruments required by CMS.

(ii) Evaluate the continuity and coordination of care furnished to enrollees.

(iii) If the organization uses written protocols for utilization review, the organization must—

(A) Base those protocols on current standards of medical practice; and

(B) Have mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation.

(f) *Requirements for all types of plans—*  
(1) *Health information.* For all types of plans that it offers, an organization must—

(i) Maintain a health information system that collects, analyzes, and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information it receives from providers of services is reliable and complete; and

(iii) Make all collected information available to CMS.

(2) *Program review.* For each plan, there must be in effect a process for formal evaluation, at least annually, of the impact and effectiveness of its quality improvement program.

(3) *Remedial action.* For each plan, the organization must correct all problems that come to its attention through internal surveillance, complaints, or other mechanisms.

[70 FR 4723, Jan. 28, 2005, as amended at 70 FR 52026, Sept. 1, 2005]

**§ 422.156 Compliance deemed on the basis of accreditation.**

(a) *General rule.* An MA organization is deemed to meet all of the requirements of any of the areas described in paragraph (b) of this section if—

(1) The MA organization is fully accredited (and periodically reaccredited) for the standards related to the applicable area under paragraph (b) of this section by a private, national accreditation organization approved by CMS; and

(2) The accreditation organization used the standards approved by CMS for the purposes of assessing the MA organization's compliance with Medicare requirements.

(b) *Deemable requirements.* The requirements relating to the following areas are deemable:

(1) Quality improvement.

(2) Antidiscrimination.

(3) Access to services.

(4) Confidentiality and accuracy of enrollee records.

(5) Information on advance directives.

(6) Provider participation rules.

(7) Part D prescription drug benefit programs that are offered by MA programs.

(c) *Effective date of deemed status.* The date on which the organization is deemed to meet the applicable requirements is the later of the following:

(1) The date on which the accreditation organization is approved by CMS.

(2) The date the MA organization is accredited by the accreditation organization.

(d) *Obligations of deemed MA organizations.* An MA organization deemed to meet Medicare requirements must—

(1) Submit to surveys by CMS to validate its accreditation organization's accreditation process; and

(2) Authorize its accreditation organization to release to CMS a copy of its most recent accreditation survey, together with any survey-related information that CMS may require (including corrective action plans and summaries of unmet CMS requirements).

(e) *Removal of deemed status.* CMS removes part or all of an MA organization's deemed status for any of the following reasons:

(1) CMS determines, on the basis of its own investigation, that the MA organization does not meet the Medicare requirements for which deemed status was granted.

(2) CMS withdraws its approval of the accreditation organization that accredited the MA organization.

(3) The MA organization fails to meet the requirements of paragraph (d) of this section.

(f) *Enforcement authority.* CMS retains the authority to initiate enforcement action against any MA organization that it determines, on the basis of its own survey or the results of an accreditation survey, no longer meets the

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Medicare requirements for which deemed status was granted.

[63 FR 35082, June 26, 1998, as amended at 65 FR 40323, June 29, 2000; 65 FR 59749, Oct. 6, 2000; 70 FR 4724, Jan. 28, 2005]

§ 422.157 Accreditation organizations.

(a) *Conditions for approval.* CMS may approve an accreditation organization with respect to a given standard under this part if it meets the following conditions:

(1) In accrediting MA organizations, it applies and enforces standards that are at least as stringent as Medicare requirements with respect to the standard or standards in question.

(2) It complies with the application and reapplication procedures set forth in § 422.158.

(3) It ensures that:

(i) Any individual associated with it, who is also associated with an entity it accredits, does not influence the accreditation decision concerning that entity.

(ii) The majority of the membership of its governing body is not comprised of managed care organizations or their representatives.

(iii) Its governing body has a broad and balanced representation of interests and acts without bias.

(b) *Notice and comment*—(1) *Proposed notice.* CMS publishes a notice in the FEDERAL REGISTER whenever it is considering granting an accreditation organization's application for approval. The notice—

(i) Announces CMS's receipt of the accreditation organization's application for approval;

(ii) Describes the criteria CMS will use in evaluating the application; and

(iii) Provides at least a 30-day comment period.

(2) *Final notice.* (i) After reviewing public comments, CMS publishes a final FEDERAL REGISTER notice indicating whether it has granted the accreditation organization's request for approval.

(ii) If CMS grants the request, the final notice specifies the effective date and the term of the approval, which may not exceed 6 years.

(c) *Ongoing responsibilities of an approved accreditation organization.* An accreditation organization approved by

CMS must undertake the following activities on an ongoing basis:

(1) Provide to CMS in written form and on a monthly basis all of the following:

(i) Copies of all accreditation surveys, together with any survey-related information that CMS may require (including corrective action plans and summaries of unmet CMS requirements).

(ii) Notice of all accreditation decisions.

(iii) Notice of all complaints related to deemed MA organizations.

(iv) Information about any MA organization against which the accrediting organization has taken remedial or adverse action, including revocation, withdrawal or revision of the MA organization's accreditation. (The accreditation organization must provide this information within 30 days of taking the remedial or adverse action.)

(v) Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implements the changes before or without CMS approval, CMS may withdraw its approval of the accreditation organization.

(2) Within 30 days of a change in CMS requirements, submit to CMS—

(i) An acknowledgment of CMS's notification of the change;

(ii) A revised cross-walk reflecting the new requirements; and

(iii) An explanation of how the accreditation organization plans to alter its standards to conform to CMS's new requirements, within the time-frames specified in the notification of change it receives from CMS.

(3) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(4) Within 3 days of identifying, in an accredited MA organization, a deficiency that poses immediate jeopardy to the organization's enrollees or to the general public, give CMS written notice of the deficiency.

(5) Within 10 days of CMS's notice of withdrawal of approval, give written notice of the withdrawal to all accredited MA organizations.

(6) Provide, on an annual basis, summary data specified by CMS that relate

to the past year's accreditation activities and trends.

(d) *Continuing Federal oversight of approved accreditation organizations.* This paragraph establishes specific criteria and procedures for continuing oversight and for withdrawing approval of an accreditation organization.

(1) *Equivalency review.* CMS compares the accreditation organization's standards and its application and enforcement of those standards to the comparable CMS requirements and processes when—

(i) CMS imposes new requirements or changes its survey process;

(ii) An accreditation organization proposes to adopt new standards or changes in its survey process; or

(iii) The term of an accreditation organization's approval expires.

(2) *Validation review.* CMS or its agent may conduct a survey of an accredited organization, examine the results of the accreditation organization's own survey, or attend the accreditation organization's survey, in order to validate the organization's accreditation process. At the conclusion of the review, CMS identifies any accreditation programs for which validation survey results—

(i) Indicate a 20 percent rate of disparity between certification by the accreditation organization and certification by CMS or its agent on standards that do not constitute immediate jeopardy to patient health and safety if unmet;

(ii) Indicate any disparity between certification by the accreditation organization and certification by CMS or its agent on standards that constitute immediate jeopardy to patient health and safety if unmet; or

(iii) Indicate that, irrespective of the rate of disparity, there are widespread or systematic problems in an organization's accreditation process such that accreditation no longer provides assurance that the Medicare requirements are met or exceeded.

(3) *Onsite observation.* CMS may conduct an onsite inspection of the accreditation organization's operations and offices to verify the organization's representations and assess the organization's compliance with its own policies and procedures. The onsite inspection

may include, but is not limited to, reviewing documents, auditing meetings concerning the accreditation process, evaluating survey results or the accreditation status decision making process, and interviewing the organization's staff.

(4) *Notice of intent to withdraw approval.* If an equivalency review, validation review, onsite observation, or CMS's daily experience with the accreditation organization suggests that the accreditation organization is not meeting the requirements of this subpart, CMS gives the organization written notice of its intent to withdraw approval.

(5) *Withdrawal of approval.* CMS may withdraw its approval of an accreditation organization at any time if CMS determines that—

(i) Deeming based on accreditation no longer guarantees that the MA organization meets the MA requirements, and failure to meet those requirements could jeopardize the health or safety of Medicare enrollees and constitute a significant hazard to the public health; or

(ii) The accreditation organization has failed to meet its obligations under this section or under § 422.156 or § 422.158.

(6) *Reconsideration of withdrawal of approval.* An accreditation organization dissatisfied with a determination to withdraw CMS approval may request a reconsideration of that determination in accordance with subpart D of part 488 of this chapter.

[63 FR 35082, June 26, 1998, as amended at 65 FR 40323, June 29, 2000; 65 FR 59749, Oct. 6, 2000]

**§ 422.158 Procedures for approval of accreditation as a basis for deeming compliance.**

(a) *Required information and materials.* A private, national accreditation organization applying for approval must furnish to CMS all of the following information and materials. (When reapplying for approval, the organization need furnish only the particular information and materials requested by CMS.)

(1) The types of MA plans that it would review as part of its accreditation process.

(2) A detailed comparison of the organization's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk).

(3) Detailed information about the organization's survey process, including—

(i) Frequency of surveys and whether surveys are announced or unannounced.

(ii) Copies of survey forms, and guidelines and instructions to surveyors.

(iii) Descriptions of—

(A) The survey review process and the accreditation status decision making process;

(B) The procedures used to notify accredited MA organizations of deficiencies and to monitor the correction of those deficiencies; and

(C) The procedures used to enforce compliance with accreditation requirements.

(4) Detailed information about the individuals who perform surveys for the accreditation organization, including—

(i) The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;

(ii) The education and experience requirements surveyors must meet;

(iii) The content and frequency of the in-service training provided to survey personnel;

(iv) The evaluation systems used to monitor the performance of individual surveyors and survey teams; and

(v) The organization's policies and practice with respect to the participation, in surveys or in the accreditation decision process by an individual who is professionally or financially affiliated with the entity being surveyed.

(5) A description of the organization's data management and analysis system with respect to its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

(6) A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.

(7) A description of the organization's policies and procedures with respect to the withholding or removal of accreditation for failure to meet the accreditation organization's standards or requirements, and other actions the organization takes in response to non-compliance with its standards and requirements.

(8) A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if CMS approves the accreditation organization.

(9) A list of all currently accredited MA organizations and the type, category, and expiration date of the accreditation held by each of them.

(10) A list of all full and partial accreditation surveys scheduled to be performed by the accreditation organization as requested by CMS.

(11) The name and address of each person with an ownership or control interest in the accreditation organization.

(b) *Required supporting documentation.* A private, national accreditation organization applying or reapplying for approval must also submit the following supporting documentation:

(1) A written presentation that demonstrates its ability to furnish CMS with electronic data in CMS compatible format.

(2) A resource analysis that demonstrates that its staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(3) A statement acknowledging that, as a condition for approval, it agrees to comply with the ongoing responsibility requirements of § 422.157(c).

(c) *Additional information.* If CMS determines that it needs additional information for a determination to grant or deny the accreditation organization's request for approval, it notifies the organization and allows time for the organization to provide the additional information.

(d) *Onsite visit.* CMS may visit the accreditation organization's offices to

verify representations made by the organization in its application, including, but not limited to, review of documents, and interviews with the organization's staff.

(e) *Notice of determination.* CMS gives the accreditation organization, within 210 days of receipt of its completed application, a formal notice that—

- (1) States whether the request for approval has been granted or denied;
- (2) Gives the rationale for any denial; and
- (3) Describes the reconsideration and reapplication procedures.

(f) *Withdrawal.* An accreditation organization may withdraw its application for approval at any time before it receives the formal notice specified in paragraph (e) of this section.

(g) *Reconsideration of adverse determination.* An accreditation organization that has received notice of denial of its request for approval may request reconsideration in accordance with subpart D of part 488 of this chapter.

(h) *Request for approval following denial.* (1) Except as provided in paragraph (h)(2) of this section, an accreditation organization that has received notice of denial of its request for approval may submit a new request if it—

- (i) Has revised its accreditation program to correct the deficiencies on which the denial was based;
- (ii) Can demonstrate that the MA organizations that it has accredited meet or exceed applicable Medicare requirements; and
- (iii) Resubmits the application in its entirety.

(2) An accreditation organization that has requested reconsideration of CMS's denial of its request for approval may not submit a new request until the reconsideration is administratively final.

[63 FR 35082, June 26, 1998, as amended at 65 FR 40324, June 29, 2000]

### Subpart E—Relationships With Providers

SOURCE: 63 FR 35085, June 26, 1998, unless otherwise noted.

#### § 422.200 Basis and scope.

This subpart is based on sections 1852(a)(1), (a)(2), (b)(2), (c)(2)(D), (j), and (k) of the Act; section 1859(b)(2)(A) of the Act; and the general authority under 1856(b) of the Act requiring the establishment of standards. It sets forth the requirements and standards for the MA organization's relationships with providers including physicians, other health care professionals, institutional providers and suppliers, under contracts or arrangements or deemed contracts under MA private fee-for-service plans. This subpart also contains some requirements that apply to noncontracting providers.

#### § 422.202 Participation procedures.

(a) *Notice and appeal rights.* An MA organization that operates a coordinated care plan or network MSA plan must provide for the participation of individual physicians, and the management and members of groups of physicians, through reasonable procedures that include the following:

- (1) Written notice of rules of participation including terms of payment, credentialing, and other rules directly related to participation decisions.
- (2) Written notice of material changes in participation rules before the changes are put into effect.
- (3) Written notice of participation decisions that are adverse to physicians.
- (4) A process for appealing adverse participation procedures, including the right of physicians to present information and their views on the decision. In the case of termination or suspension of a provider contract by the MA organization, this process must conform to the rules in § 422.202(d).

(b) *Consultation.* The MA organization must establish a formal mechanism to consult with the physicians who have agreed to provide services under the MA plan offered by the organization, regarding the organization's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met:

- (1) Practice guidelines and utilization management guidelines—
  - (i) Are based on reasonable medical evidence or a consensus of health care professionals in the particular field;

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(ii) Consider the needs of the enrolled population;

(iii) Are developed in consultation with contracting physicians; and

(iv) Are reviewed and updated periodically.

(2) The guidelines are communicated to providers and, as appropriate, to enrollees.

(3) Decisions with respect to utilization management, enrollee education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines.

(c) *Subcontracted groups.* An MA organization that operates an MA plan through subcontracted physician groups must provide that the participation procedures in this section apply equally to physicians within those subcontracted groups.

(d) *Suspension or termination of contract.* An MA organization that operates a coordinated care plan or network MSA plan providing benefits through contracting providers must meet the following requirements:

(1) *Notice to physician.* An MA organization that suspends or terminates an agreement under which the physician provides services to MA plan enrollees must give the affected individual written notice of the following:

(i) The reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the MA organization.

(ii) The affected physician's right to appeal the action and the process and timing for requesting a hearing.

(2) *Composition of hearing panel.* The MA organization must ensure that the majority of the hearing panel members are peers of the affected physician.

(3) *Notice to licensing or disciplinary bodies.* An MA organization that suspends or terminates a contract with a physician because of deficiencies in the quality of care must give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.

(4) *Timeframes.* An MA organization and a contracting provider must provide at least 60 days written notice to

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each other before terminating the contract without cause.

[64 FR 7981, Feb. 17, 1999, as amended at 65 FR 40324, June 29, 2000; 68 FR 50857, Aug. 22, 2003; 70 FR 4724, Jan. 28, 2005]

**§ 422.204 Provider selection and credentialing.**

(a) *General rule.* An MA organization must have written policies and procedures for the selection and evaluation of providers. These policies must conform with the credential and recredentialing requirements set forth in paragraph (b) of this section and with the antidiscrimination provisions set forth in § 422.205.

(b) *Basic requirements.* An MA organization must follow a documented process with respect to providers and suppliers who have signed contracts or participation agreements that—

(1) For providers (other than physicians and other health care professionals) requires determination, and redetermination at specified intervals, that each provider is—

(i) Licensed to operate in the State, and in compliance with any other applicable State or Federal requirements; and

(ii) Reviewed and approved by an accrediting body, or meets the standards established by the organization itself;

(2) For physicians and other health care professionals, including members of physician groups, covers—

(i) Initial credentialing that includes written application, verification of licensure or certification from primary sources, disciplinary status, eligibility for payment under Medicare, and site visits as appropriate. The application must be signed and dated and include an attestation by the applicant of the correctness and completeness of the application and other information submitted in support of the application;

(ii) Recredentialing at least every 3 years that updates information obtained during initial credentialing, considers performance indicators such as those collected through quality improvement programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and

that includes an attestation of the correctness and completeness of the new information; and

(iii) A process for consulting with contracting health care professionals with respect to criteria for credentialing and recredentialing.

(3) Specifies that basic benefits must be provided through, or payments must be made to, providers and suppliers that meet applicable requirements of title XVIII and part A of title XI of the Act. In the case of providers meeting the definition of “provider of services” in section 1861(u) of the Act, basic benefits may only be provided through these providers if they have a provider agreement with CMS permitting them to provide services under original Medicare.

(4) Ensures compliance with the requirements at § 422.752(a)(8) that prohibit employment or contracts with individuals (or with an entity that employs or contracts with such an individual) excluded from participation under Medicare and with the requirements at § 422.220 regarding physicians and practitioners who opt out of Medicare.

[65 FR 40324, June 29, 2000, as amended at 66 FR 47413, Sept. 12, 2001; 70 FR 4724, Jan. 28, 2005]

**§ 422.205 Provider antidiscrimination rules.**

(a) *General rule.* Consistent with the requirements of this section, the policies and procedures concerning provider selection and credentialing established under § 422.204, and with the requirement under § 422.100(c) that all Medicare-covered services be available to MA plan enrollees, an MA organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an MA organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the ef-

fective provider(s) of the reason for the decision.

(b) *Construction.* The prohibition in paragraph (a)(1) of this section does not preclude any of the following by the MA organization:

(1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan’s enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis).

(2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.

(3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

[65 FR 40324, June 29, 2000]

**§ 422.206 Interference with health care professionals’ advice to enrollees prohibited.**

(a) *General rule.* (1) An MA organization may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under an MA plan about—

(i) The patient’s health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;

(ii) The risks, benefits, and consequences of treatment or non-treatment; or

(iii) The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

(2) Health care professionals must provide information regarding treatment options in a culturally-competent manner, including the option of no treatment. Health care professionals must ensure that individuals with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

(b) *Conscience protection.* The general rule in paragraph (a) of this section does not require the MA plan to cover, furnish, or pay for a particular counseling or referral service if the MA organization that offers the plan—

(1) Objects to the provision of that service on moral or religious grounds; and

(2) Through appropriate written means, makes available information on these policies as follows:

(i) To CMS, with its application for a Medicare contract, within 10 days of submitting its bid proposal or, for policy changes, in accordance with § 422.80 (concerning approval of marketing materials and election forms) and with § 422.111.

(ii) To prospective enrollees, before or during enrollment.

(iii) With respect to current enrollees, the organization is eligible for the exception provided in paragraph (b)(1) of this section if it provides notice of such change within 90 days after adopting the policy at issue; however, under § 422.111(d), notice of such a change must be given in advance.

(c) *Construction.* Nothing in paragraph (b) of this section may be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(d) *Sanctions.* An MA organization that violates the prohibition of paragraph (a) of this section or the conditions in paragraph (b) of this section is subject to intermediate sanctions under subpart O of this part.

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000; 70 FR 52026, Sept. 1, 2005]

**§ 422.208 Physician incentive plans: requirements and limitations.**

(a) *Definitions.* In this subpart, the following definitions apply:

*Bonus* means a payment made to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withhold.

*Capitation* means a set dollar payment per patient per unit of time (usually per month) paid to a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of

services provided. The services covered may include the physician's own services, referral services, or all medical services.

*Physician group* means a partnership, association, corporation, individual practice association, or other group of physicians that distributes income from the practice among members. An individual practice association is defined as a physician group for this section only if it is composed of individual physicians and has no subcontracts with physician groups.

*Physician incentive plan* means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.

*Potential payments* means the maximum payments possible to physicians or physician groups including payments for services they furnish directly, and additional payments based on use and costs of referral services, such as withholds, bonuses, capitation, or any other compensation to the physician or physician group. Bonuses and other compensation that are not based on use of referrals, such as quality of care furnished, patient satisfaction or committee participation, are not considered payments in the determination of substantial financial risk.

*Referral services* means any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish directly.

*Risk threshold* means the maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. This is set at 25 percent risk.

*Substantial financial risk*, for purposes of this section, means risk for referral services that exceeds the risk threshold.

*Withhold* means a percentage of payments or set dollar amounts deducted from a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.

(b) *Applicability.* The requirements in this section apply to an MA organization and any of its subcontracting arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Subcontracting arrangements may include an intermediate entity, which includes but is not limited to, an individual practice association that contracts with one or more physician groups or any other organized group such as those specified in § 422.4.

(c) *Basic requirements.* Any physician incentive plan operated by an MA organization must meet the following requirements:

(1) The MA organization makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

(2) If the physician incentive plan places a physician or physician group at substantial financial risk (as determined under paragraph (d) of this section) for services that the physician or physician group does not furnish itself, the MA organization must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with paragraph (f) of this section.

(3) For all physician incentive plans, the MA organization provides to CMS the information specified in § 422.210.

(d) *Determination of substantial financial risk—(1) Basis.* Substantial financial risk occurs when risk is based on the use or costs of referral services, and that risk exceeds the risk threshold. Payments based on other factors, such as quality of care furnished, are not considered in this determination.

(2) *Risk threshold.* The risk threshold is 25 percent of potential payments.

(3) *Arrangements that cause substantial financial risk.* The following incentive arrangements cause substantial financial risk within the meaning of this section, if the physician's or physician group's patient panel size is not great-

er than 25,000 patients, as shown in the table at paragraph (f)(2)(iii) of this section:

(i) Withholds greater than 25 percent of potential payments.

(ii) Withholds less than 25 percent of potential payments if the physician or physician group is potentially liable for amounts exceeding 25 percent of potential payments.

(iii) Bonuses that are greater than 33 percent of potential payments minus the bonus.

(iv) Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula—Withhold % =  $-0.75 (\text{Bonus \%}) + 25\%$ .

(v) Capitation arrangements, if—

(A) The difference between the maximum potential payments and the minimum potential payments is more than 25 percent of the maximum potential payments;

(B) The maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group.

(vi) Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25 percent of potential payments.

(e) *Prohibition for private MA fee-for-service plans.* An MA fee-for-service plan may not operate a physician incentive plan.

(f) *Stop-loss protection requirements—*

(1) *Basic rule.* The MA organization must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

(2) *Specific requirements.* (i) Aggregate stop-loss protection must cover 90 percent of the costs of referral services that exceed 25 percent of potential payments.

(ii) For per-patient stop-loss protection if the stop-loss protection provided is on a per-patient basis, the stop-loss limit (deductible) per patient must be determined based on the size

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of the patient panel and may be a combined policy or consist of separate policies for professional services and institutional services. In determining patient panel size, the patients may be pooled in accordance with paragraph (g) of this section.

(iii) Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per patient deductible limit. The per-patient stop-loss deductible limits are as follows:

Panel size	Single combined deductible	Separate institutional deductible	Separate professional deductible
1–1,000 .....	\$6,000	\$10,000	\$3,000
1,001–5,000 .....	30,000	40,000	10,000
5,001–8,000 .....	40,000	60,000	15,000
8,001–10,000 .....	75,000	100,000	20,000
10,001–25,000 .....	150,000	200,000	25,000
>25,000 .....	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )

<sup>1</sup> None.

(g) *Pooling of patients.* Any entity that meets the pooling conditions of this section may pool commercial, Medicare, and Medicaid enrollees or the enrollees of several MA organizations with which a physician or physician group has contracts. The conditions for pooling are as follows:

(1) It is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group.

(2) The physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled.

(3) The terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled.

(4) The distribution of payments to physicians from the risk pool is not calculated separately by patient category.

(5) The terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled.

(h) *Sanctions.* An MA organization that fails to comply with the requirements of this section is subject to intermediate sanctions under subpart O of this part.

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000; 70 FR 4724, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

**§ 422.210 Assurances to CMS.**

(a) Assurances to CMS. Each organization will provide assurance satisfac-

tory to the Secretary that the requirements of § 422.208 are met.

(b) Disclosure to Medicare Beneficiaries. Each MA organization must provide the following information to any Medicare beneficiary who requests it:

(1) Whether the MA organization uses a physician incentive plan that affects the use of referral services.

(2) The type of incentive arrangement.

(3) Whether stop-loss protection is provided.

[70 FR 52026, Sept. 1, 2005]

**§ 422.212 Limitations on provider indemnification.**

An MA organization may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify the organization against any civil liability for damage caused to an enrollee as a result of the MA organization's denial of medically necessary care:

(a) A physician or health care professional.

(b) Provider of services.

(c) Other entity providing health care services.

(d) Group of such professionals, providers, or entities.

**§ 422.214 Special rules for services furnished by noncontract providers.**

(a) *Services furnished by non-section 1861(u) providers.* (1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that

does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

(2) Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an MA plan also apply to the payment described in paragraph (a)(1) of this section.

(b) Services furnished by section 1861(u) providers of service. Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under § 412.105(g) and § 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direct medical education costs.)

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000; 70 FR 4724, Jan. 28, 2005; 70 FR 47490, Aug. 12, 2005]

**§ 422.216 Special rules for MA private fee-for-service plans.**

(a) *Payment to providers*—(1) *Payment rate.* (i) The MA organization must establish uniform payment rates for items and services that apply to all contracting providers, regardless of whether the contract is signed or deemed under paragraph (f) of this section.

(ii) Contracting providers must be reimbursed on a fee-for-service basis.

(iii) The MA organization must make information on its payment rates available to providers that furnish services that may be covered under the MA private fee-for-service plan.

(2) *Payment to contract providers.* For each service, the MA organization pays a contract provider (including one

deemed to have a contract) an amount that is equal to the payment rate under paragraph (a)(1) of this section minus any applicable cost-sharing.

(3) *Noncontract providers.* The organization pays for services of noncontract providers in accordance with § 422.100(b)(2).

(4) *Service furnished by providers of service.* Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA private fee-for-service plan must accept as payment in full the amounts (less any payments under §§ 412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare.

(b) *Charges to enrollees*—(1) *Contract providers* (i) Contract providers and “deemed” contract providers may charge enrollees no more than the cost-sharing and, subject to the limit in paragraph (b)(1)(ii) of this section, balance billing amounts that are permitted under the plan, and these amounts must be the same for “deemed” contract providers as for those that have signed contracts in effect, unless access requirements with respect to a particular category of health care providers are met solely through § 422.114(a)(2)(ii) and the MA organization imposes higher beneficiary copayments as permitted under § 422.114(c).

(ii) The organization may permit balance billing no greater than 15 percent of the payment rate established under paragraph (a)(1) of this section.

(iii) The MA organization must specify the amount of cost-sharing and balance billing in its contracts with providers and these amounts must be the same for “deemed” contract providers as for those that have signed contracts in effect, unless access requirements with respect to a particular category of health care providers are met solely through § 422.114(a)(2)(ii) and the MA organization imposes higher beneficiary copayments as permitted under § 422.114(c).

(iv) The MA organization is subject to intermediate sanctions under § 422.752(a)(7), under the rules in subpart O of this part, if it fails to enforce

the limit specified in paragraph (b)(1)(i) of this section.

(2) *Noncontract providers.* A noncontract provider may not collect from an enrollee more than the cost-sharing established by the MA private fee-for-service plan as specified in § 422.256(b)(3), unless the provider has opted out of Medicare as described in part 405, subpart D of this chapter.

(c) *Enforcement of limit—(1) Contract providers.* An MA organization that offers an MA fee-for-service plan must enforce the limit specified in paragraph (b)(1) of this section.

(2) *Noncontract providers.* An MA organization that offers an MA private fee-for-service plan must monitor the amount collected by noncontract providers to ensure that those amounts do not exceed the amounts permitted to be collected under paragraph (b)(2) of this section, unless the provider has opted out of Medicare as described in part 405, subpart D of this chapter. The MA organization must develop and document violations specified in instructions and must forward documented cases to CMS.

(d) *Information on enrollee liability—(1) General information.* An MA organization that offers an MA fee-for-service plan must provide to plan enrollees, for each claim filed by the enrollee or the provider that furnished the service, an appropriate explanation of benefits. The explanation must include a clear statement of the enrollee's liability for deductibles, coinsurance, copayment, and balance billing.

(2) *Advance notice for hospital services.* In its terms and conditions of payment to hospitals, the MA organization must require the hospital, if it imposes balance billing, to provide to the enrollee, before furnishing any services for which balance billing could amount to not less than \$500—

(i) Notice that balance billing is permitted for those services;

(ii) A good faith estimate of the likely amount of balance billing, based on the enrollees presenting condition; and

(iii) The amount of any deductible, coinsurance, and copayment that may be due in addition to the balance billing amount.

(e) *Coverage determinations.* The MA organization must make coverage de-

terminations in accordance with subpart M of this part.

(f) *Rules describing deemed contract providers.* Any provider furnishing health services, except for emergency services furnished in a hospital pursuant to § 489.24 of this chapter, 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, is treated as having a contract in effect and is subject to the limitations of this section that apply to contract providers if the following conditions are met:

(1) The services are covered under the plan and are furnished—

(i) To an enrollee of an MA fee-for-service plan; and

(ii) Provided by a provider including a provider of services (as defined in section 1861(u) of the Act) that does not have in effect a signed contract with the MA organization.

(2) Before furnishing the services, the provider—

(i) Was informed of the individual's enrollment in the plan; and

(ii) Was informed (or given a reasonable opportunity to obtain information) about the terms and conditions of 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]

**§ 422.220 Exclusion of services furnished under a private contract.**

An MA organization may not pay, directly or indirectly, on any basis, for services (other than emergency or urgently needed services as defined in § 422.2) furnished to a Medicare enrollee by a physician (as defined in section 1861(r)(1) of the Act) or other practitioner (as defined in section 1842(b)(18)(C) of the Act) who has filed with the Medicare carrier 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. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner who has not signed a private contract with the beneficiary.

**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 section 1853 and section 1858 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, and negotiation and approval of bids by CMS.

**§ 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.

*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 an MA plan (except an MSA plan) charges an enrollee for benefits under the original Medicare fee-for-service program option (if any), and is calculated as described at § 422.262.

*MA monthly MSA premium* means the amount of the plan premium for coverage of benefits under the original Medicare program through an MSA plan, as set forth at § 422.254(e).

*MA monthly prescription drug beneficiary premium* is the MA-PD plan base beneficiary premium, defined at section 1860D-13(a)(2) of the Act, as adjusted to reflect the difference between the plan's bid and the national average

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bid (as described in § 422.256(c)) less the amount of rebate the MA-PD plan elects to apply, as described at § 422.266(b)(2).

*MA monthly supplemental beneficiary premium* is the portion of the plan bid attributable to mandatory and/or optional supplemental health care benefits described under § 422.102, less the amount of beneficiary rebate the plan elects to apply to a mandatory supplemental benefit, as described at § 422.266(b)(1).

*MA-PD plan* means an MA local or regional plan that provides prescription drug coverage under Part D of Title XVIII of the Social Security Act.

*Monthly aggregate bid amount* means the total monthly plan bid amount for coverage of an MA eligible beneficiary with a nationally average risk profile for the factors described in § 422.308(c), and this amount is comprised of the following:

(1) The unadjusted MA statutory non-drug monthly bid amount for coverage of original Medicare benefits;

(2) The amount for coverage of basic prescription drug benefits under Part D (if any); and

(3) The amount for provision of supplemental health care benefits (if any).

Plan basic cost sharing means cost sharing that would be charged by a plan for benefits under the original Medicare FFS program option before any reductions resulting from mandatory supplemental benefits.

*Unadjusted MA area-specific non-drug monthly benchmark amount* means, for local MA plans serving one county, the county capitation rate CMS publishes annually, and for local MA plans serving multiple counties it is the weighted average of county rates in a plan's service area, weighted by the plan's projected enrollment per county.

*Unadjusted MA region-specific non-drug monthly benchmark amount* means, for MA regional plans, the amount described at § 422.258(b).

*Unadjusted MA statutory non-drug monthly bid amount* means a plan's estimate of its average monthly required revenue to provide coverage of original Medicare benefits to an MA eligible beneficiary with a nationally average risk profile for the risk factors CMS

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applies to payment calculations as set forth at § 422.308(c).

63 FR 35085, June 26, 1998, as amended at 70 FR 52026, Sept. 1, 2005]

### § 422.254 Submission of bids.

(a) *General rules.* (1) Not later than the first Monday in June, each MA organization must submit to CMS an aggregate monthly bid amount for each MA plan (other than an MSA plan) the organization intends to offer in the upcoming year in the service area (or segment of such an area if permitted under § 422.262(c)(2)) that meets the requirements in paragraph (b) of this section. With each bid submitted, the MA organization must provide the information required in paragraph (c) of this section and, for plans with rebates as described at § 422.266(a), the MA organization must provide the information required in paragraph (d) of this section.

(2) CMS has the authority to determine whether and when it is appropriate to apply the bidding methodology described in this section to ESRD MA enrollees.

(3) If the bid submission described in paragraphs (a)(1) and (2) of this section is not complete, timely, or accurate, CMS has the authority to impose sanctions under subpart O of this part or may choose not to renew the contract.

(b) *Bid requirements.* (1) The monthly aggregate bid amount submitted by an MA organization for each plan is the organization's estimate of the revenue required for the following categories for providing coverage to an MA eligible beneficiary with a national average risk profile for the factors described in § 422.308(c):

(i) The unadjusted MA statutory non-drug monthly bid amount, which is the MA plan's estimated average monthly required revenue for providing benefits under the original Medicare fee-for-service program option (as defined in § 422.252).

(ii) The amount to provide basic prescription drug coverage, if any (defined at section 1860D–2(a)(3) of the Act).

(iii) The amount to provide supplemental health care benefits, if any.

(2) Each bid is for a uniform benefit package for the service area.

(3) Each bid submission must contain all estimated revenue required by the plan, including administrative costs and return on investment.

(4) The bid amount is for plan payments only but must be based on plan assumptions about the amount of revenue required from enrollee cost-sharing. The estimate of plan cost-sharing for the unadjusted MA statutory non-drug monthly bid amount for coverage of original Medicare benefits must reflect the requirement that the level of cost sharing MA plans charge to enrollees must be actuarially equivalent to the level of cost sharing (deductible, copayments, or coinsurance) charged to beneficiaries under the original Medicare program option. The actuarially equivalent level of cost sharing reflected in a regional plan's unadjusted MA statutory non-drug monthly bid amount does not include cost sharing for out-of-network Medicare benefits, as described at § 422.101(d).

(c) *Information required for coordinated care plans and MA private fee-for-service plans.* MA organizations' submission of bids for coordinated care plans, including regional MA plans and specialized MA plans for special needs beneficiaries (described at § 422.4(a)(1)(iv)), and for MA private fee-for-service plans must include the following information:

(1) The plan type for each plan.

(2) The monthly aggregate bid amount for the provision of all items and services under the plan, as defined in § 422.252 and discussed in paragraph (a) of this section.

(3) The proportions of the bid amount attributable to—

(i) The provision of benefits under the original Medicare fee-for-service program option (as defined at § 422.100(c));

(ii) The provision of basic prescription drug coverage (as defined at section 1860D-2(a)(3) of the Act; and

(iii) The provision of supplemental health care benefits (as defined § 422.102).

(4) The projected number of enrollees in each MA local area used in calculation of the bid amount, and the enrollment capacity, if any, for the plan.

(5) The actuarial basis for determining the amount under paragraph

(c)(2) of this section, the proportions under paragraph (c)(3) of this section, the amount under paragraph (b)(4) of this section, and additional information as CMS may require to verify actuarial bases and the projected number of enrollees.

(6) A description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of the deductibles, coinsurance, and copayments.

(7) For qualified prescription drug coverage, the information required under section 1860D-11(b) of the Act with respect to coverage.

(8) For the purposes of calculation of risk corridors under § 422.458, MA organizations offering regional MA plans in 2006 and/or 2007 must submit the following information developed using the appropriate actuarial bases.

(i) Projected allowable costs (defined in § 422.458(a)).

(ii) The portion of projected allowable costs attributable to administrative expenses incurred in providing these benefits.

(iii) The total projected costs for providing rebatable integrated benefits (as defined in § 422.458(a)) and the portion of costs that is attributable to administrative expenses.

(9) For regional plans, as determined by CMS, the relative cost factors for the counties in a plan's service area, for the purposes of adjusting payment under § 422.308(d) for intra-area variations in an MA organization's local payment rates.

(d) *Beneficiary rebate information.* In the case of a plan required to provide a monthly rebate under § 422.266 for a year, the MA organization offering the plan must inform CMS how the plan will distribute the beneficiary rebate among the options described at § 422.266(b).

(e) *Information required for MSA plans.* MA organizations intending to offer MA MSA plans must submit—

(1) The enrollment capacity (if any) for the plan;

(2) The amount of the MSA monthly premium for basic benefits under the original Medicare fee-for-service program option;

(3) The amount of the plan deductible; and

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(4) The amount of the beneficiary supplemental premium, if any.

(f) Separate bids must be submitted for Part A and Part B enrollees and Part B-only enrollees for each MA plan offered.

63 FR 35085, June 26, 1998, as amended at 70 FR 52026, Sept. 1, 2005]

### § 422.256 Review, negotiation, and approval of bids.

(a) *Authority.* Subject to paragraphs (a)(2), (d), and (e) of this section, CMS has the authority to review the aggregate bid amounts submitted under § 422.252 and conduct negotiations with MA organizations regarding these bids (including the supplemental benefits) and the proportions of the aggregate bid attributable to basic benefits, supplemental benefits, and prescription drug benefits.

(1) When negotiating bid amounts and proportions, CMS has authority similar to that provided the Director of the Office of Personnel Management for negotiating health benefits plans under 5 U.S.C. chapter 89.

(2) *Noninterference.* (i) In carrying out Parts C and D under this title, CMS may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services.

(ii) CMS may not require a particular price structure for payment under such a contract, with the exception of payments to Federally qualified health centers as set forth at § 422.316.

(b) *Standards of bid review.* Subject to paragraphs (d) and (e) of this section, CMS can only accept bid amounts or proportions described in paragraph (a) of this section if CMS determines the following standards have been met:

(1) The bid amount and proportions are supported by the actuarial bases provided by MA organizations under § 422.254.

(2) The bid amount and proportions reasonably and equitably reflects the plan's estimated revenue requirements for providing the benefits under that plan, as the term revenue requirements is used for purposes of section 1302(8) of the Public Health Service Act.

(3) *Limitation on enrollee cost sharing.* For coordinated care plans (including

regional MA plans and specialized MA plans) and private fee-for-service plans:

(i) The actuarial value of plan basic cost sharing, reduced by any supplemental benefits, may not exceed—

(ii) The actuarial value of deductibles, coinsurance, and copayments that would be applicable for the benefits to individuals entitled to benefits under Part A and enrolled under Part B in the plan's service area with a national average risk profile for the factors described in § 422.308(c) if they were not members of an MA organization for the year, except that cost sharing for non-network Medicare services in a regional MA plan is not counted under the amount described in paragraph (b)(2)(i) of this section.

(c) *Negotiation process.* The negotiation process may include the resubmission of information to allow MA organizations to modify their initial bid submissions to account for the outcome of CMS' regional benchmark calculations required under § 422.258(c) and the outcome of CMS' calculation of the national average monthly bid amount required under section 1860D–13(a)(4) of the Act.

(d) *Exception for private fee-for-service plans.* For private fee-for-service plans defined at § 422.4(a)(3), CMS will not review, negotiate, or approve the bid amount, proportions of the bid, or the amounts of the basic beneficiary premium and supplemental premium.

(e) *Exception for MSA plans.* CMS does not review, negotiate, or approve amounts submitted with respect to MA MSA plans, except to determine that the deductible does not exceed the statutory maximum, defined at § 422.103(d).

63 FR 35085, June 26, 1998, as amended at 70 FR 52026, Sept. 1, 2005; 70 FR 76198, Dec. 23, 2005]

### § 422.258 Calculation of benchmarks.

(a) The term “MA area-specific non-drug monthly benchmark amount” means, for a month in a year:

(1) *For MA local plans with service areas entirely within a single MA local area,* 1/12th of the annual MA capitation rate (described at § 422.306) for the area, adjusted as appropriate for the purpose of risk adjustment.

(2) *For MA local plans with service areas including more than one MA local*

*area*, an amount equal to the weighted average of annual capitation rates for each local area (county) in the plan's service area, using as weights the projected number of enrollees in each MA local area that the plan used to calculate the bid amount, and adjusted as appropriate for the purpose of risk adjustment.

(b) For MA regional plans, the term "MA region-specific non-drug monthly benchmark amount" is:

(1) The sum of two components: the statutory component (based on a weighted average of local benchmarks in the region, as described in paragraph (c)(3) of this section; and the plan bid component (based on a weighted average of regional plan bids in the region as described in paragraph (c)(4) of this section).

(2) Announced before November 15 of each year, but after CMS has received the plan bids.

(c) *Calculation of MA regional non-drug benchmark amount.* CMS calculates the monthly regional non-drug benchmark amount for each MA region as follows:

(1) *Reference month.* For all calculations that follow, CMS will determine the number of MA eligible individuals in each local area, in each region, and nationally as of the reference month, which is a month in the previous calendar year CMS identifies.

(2) *Statutory market share.* CMS will determine the statutory national market share percentage as the proportion of the MA eligible individuals nationally who were not enrolled in an MA plan.

(3) *Statutory component of the region-specific benchmark.* (i) CMS calculates the unadjusted region-specific non-drug amount by multiplying the county capitation rate by the county's share of the MA eligible individuals residing in the region (the number of MA eligible individuals in the county divided by the number of MA eligible individuals in the region), and then adding all the enrollment-weighted county rates to a sum for the region.

(ii) CMS then multiplies the unadjusted region-specific non-drug amount from paragraph (c)(3)(i) of this section by the statutory market share

to determine the statutory component of the regional benchmark.

(4) *Plan-bid component of the region-specific benchmark.* For each regional plan offered in a region, CMS will multiply the plan's unadjusted region-specific non-drug bid amount by the plan's share of enrollment (as determined under paragraph (c)(5) of this section) and then sum these products across all plans offered in the region. CMS then multiplies this by 1 minus the statutory market share to determine the plan-bid component of the regional benchmark.

(5) *Plan's share of enrollment.* CMS will calculate the plan's share of MA enrollment in the region as follows:

(i) In the first year that any MA regional plan is being offered in an MA region, and more than one MA regional plan is being offered, CMS will determine each regional plan's share of enrollment based on one of two possible approaches. CMS may base this factor on equal division among plans, so that each plan's share will be 1 divided by the number of plans offered. Alternatively, CMS may base this factor on each regional plan's estimate of projected enrollment. Plan enrollment projections are subject to review and adjustment by CMS to assure reasonableness.

(ii) If two or more regional plans are offered in a region and were offered in the reference month: The plan's share of enrollment will be the number of MA eligible individuals enrolled in the plan divided by the number of MA eligible individuals enrolled in all of the plans in the region, as of the reference month.

(iii) If a single regional plan is being offered in the region: The plan's share of enrollment is equal to 1.

#### § 422.262 Beneficiary premiums.

(a) Determination of MA monthly basic beneficiary premium. (1) For an MA plan with an unadjusted statutory non-drug bid amount that is less than the relevant unadjusted non-drug benchmark amount, the basic beneficiary premium is zero.

(2) For an MA plan with an unadjusted statutory non-drug bid amount that is equal to or greater than the relevant unadjusted non-drug

benchmark amount, the basic beneficiary premium is the amount by which (if any) the bid amount exceeds the benchmark amount. All approved basic premiums must be charged; they cannot be waived.

(b) Consolidated monthly premiums. Except as specified in paragraph (b)(2) of this section, MA organizations must charge enrollees a consolidated monthly MA premium.

(1) The consolidated monthly premium for an MA plan (other than a MSA plan) is the sum of the MA monthly basic beneficiary premium (if any), the MA monthly supplementary beneficiary premium (if any), and the MA monthly prescription drug beneficiary premium (if any).

(2) *Special rule for MSA plans.* For an individual enrolled in an MSA plan offered by an MA organization, the monthly beneficiary premium is the supplemental premium (if any).

(c) *Uniformity of premiums*—(1) *General rule.* Except as permitted for supplemental premiums pursuant to § 422.106(d), for MA contracts with employers and labor organizations, the MA monthly bid amount submitted under § 422.254, the MA monthly basic beneficiary premium, the MA monthly supplemental beneficiary premium, the MA monthly prescription drug premium, and the monthly MSA premium of an MA organization may not vary among individuals enrolled in an MA plan (or segment of the plan as provided for local MA plans under paragraph (c)(2) of this section). In addition, the MA organization cannot vary the level of cost-sharing charged for basic benefits or supplemental benefits (if any) among individuals enrolled in an MA plan (or segment of the plan).

(2) *Segmented service area option.* An MA organization may apply the uniformity requirements in paragraph (c)(1) of this section to segments of an MA local plan service area (rather than to the entire service area) as long as such a segment is composed of one or more MA payment areas. The information specified under § 422.254 is submitted separately for each segment. This provision does not apply to MA regional plans.

(d) *Monetary inducement prohibited.* An MA organization may not provide

for cash or other monetary rebates as an inducement for enrollment or for any other reason or purpose.

(e) *Timing of payments.* The MA organization must permit payments of MA monthly basic and supplemental beneficiary premiums and monthly prescription drug beneficiary premiums on a monthly basis and may not terminate coverage for failure to make timely payments except as provided in § 422.74(b).

(f) *Beneficiary payment options.* An MA organization must permit each enrollee, at the enrollee's option, to make payment of premiums (if any) under this part to the organization through—

(1) Withholding from the enrollee's Social Security benefit payments, or benefit payments by the Railroad Retirement Board or the Office of Personnel Management, in the manner that the Part B premium is withheld;

(2) An electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account);

(3) According to other means that CMS may specify, including payment by an employer or under employment-based retiree health coverage on behalf of an employee, former employee (or dependent), or by other third parties such as a State.

(i) Regarding the option in paragraph (f)(1) of this section, MA organizations may not impose a charge on beneficiaries for the election of this option.

(ii) An enrollee may opt to make a direct payment of premium to the plan.

**§ 422.264 Calculation of savings.**

(a) *Computation of risk adjusted bids and benchmarks.* (1) *The risk adjusted MA statutory non-drug monthly bid amount* is the unadjusted plan bid amount for coverage of original Medicare benefits (defined at § 422.254), adjusted using the factors described in paragraph (c) of this section for local plans and paragraph (e) of this section for regional plans.

(2) *The risk adjusted MA area-specific non-drug monthly benchmark amount* is the unadjusted benchmark amount for coverage of original Medicare benefits by a local MA plan (defined at § 422.258),

adjusted using the factors described in paragraph (c) of this section.

(3) The *risk adjusted MA region-specific non-drug monthly benchmark amount* is the unadjusted benchmark for coverage of original Medicare benefits amount by a regional MA plan (defined at § 422.258) adjusted using the factors described in paragraph (e) of this section.

(b) *Computation of savings for MA local plans.* The average per capita monthly savings for an MA local plan is 100 percent of the difference between the plan's risk-adjusted statutory non-drug monthly bid amount (described in paragraph (a)(1) of this section) and the plan's risk-adjusted area-specific non-drug monthly benchmark amount (described in paragraph (a)(2) of this section). Plans with bids equal to or greater than plan benchmarks will have zero savings.

(c) *Risk adjustment factors for determination of savings for local plans.* CMS will publish the first Monday in April before the upcoming calendar year the risk adjustment factors described in paragraph (c)(1) or (c)(2) of this section determined for the purpose of calculating savings amounts for MA local plans.

(1) For the purpose of calculating savings for MA local plans CMS has the authority to apply risk adjustment factors that are plan-specific average risk adjustment factors, Statewide average risk adjustment factors, or factors determined on a basis other than plan-specific factors or Statewide average factors.

(2) In the event that CMS applies Statewide average risk adjustment factors, the statewide factor for each State is the average of the risk factors calculated under § 422.308(c), based on all enrollees in MA local plans in that State in the previous year. In the case of a State in which no local MA plan was offered in the previous year, CMS will estimate an average and may base this average on average risk adjustment factors applied to comparable States or applied on a national basis.

(d) *Computation of savings for MA regional plans.* The average per capita monthly savings for an MA regional plan and year is 100 percent of the difference between the plan's risk-adjusted statutory non-drug monthly bid

amount (described in paragraph (a)(1) of this section) and the plan's risk-adjusted region-specific non-drug monthly benchmark amount (described in paragraph (a)(3) of this section), using the risk adjustment factors described in paragraph (e) of this section. Plans with bids equal to or greater than plan benchmarks will have zero savings.

(e) *Risk adjustment factors for determination of savings for regional plans.* CMS will publish the first Monday in April before the upcoming calendar year the risk adjustment factors described in paragraph (e)(1) and (e)(2) of this section determined for the purpose of calculating savings amounts for MA regional plans.

(1) For the purpose of calculating savings for MA regional plans, CMS has the authority to apply risk adjustment factors that are plan-specific average risk adjustment factors, Region-wide average risk adjustment factors, or factors determined on a basis other than MA regions.

(2) In the event that CMS applies region-wide average risk adjustment factors, the region-wide factor for each MA region is the average of the risk factors calculated under § 422.308(c), based on all enrollees in MA regional plans in that region in the previous year. In the case of a region in which no regional plan was offered in the previous year, CMS will estimate an average and may base this average on average risk adjustment factors applied to comparable regions or applied on a national basis.

#### § 422.266 Beneficiary rebates.

(a) *General rule.* An MA organization must provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in § 422.264(b) for MA local plans and § 422.264(d) for MA regional plans.

(b) *Form of rebate.* The rebate required under this paragraph must be provided by crediting the rebate amount to one or more of the following:

(1) *Supplemental health care benefits.* MA organizations may apply all or some portion of the rebate for a plan toward payment for non-drug supplemental health care benefits for enrollees as described in § 422.102, which may

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include the reduction of cost sharing for benefits under original Medicare and additional health care benefits that are not benefits under original Medicare. MA organizations also may apply all or some portion of the rebate for a plan toward payment for supplemental drug coverage described at § 423.104(f)(1)(ii), which may include reduction in cost sharing and coverage of drugs not covered under Part D. The rebate, or portion of rebate, applied toward supplemental benefits may only be applied to a mandatory supplemental benefit, and cannot be used to fund an optional supplemental benefit.

(2) *Payment of premium for prescription drug coverage.* MA organizations that offer a prescription drug benefit may credit some or all of the rebate toward reduction of the MA monthly prescription drug beneficiary premium.

(3) *Payment toward Part B premium.* MA organizations may credit some or all of the rebate toward reduction of the Medicare Part B premium (determined without regard to the application of subsections (b), (h), and (i) of section 1839 of the Act).

(c) *Disclosure relating to rebates.* MA organizations must disclose to CMS information on the amount of the rebate provided, as required at § 422.254(d). MA organizations must distinguish, for each MA plan, the amount of rebate applied to enhance original Medicare benefits from the amount of rebate applied to enhance Part D benefits.

**§ 422.270 Incorrect collections of premiums and cost-sharing.**

(a) *Definitions.* As used in this section-

(1) Amounts incorrectly collected-

(i) Means amounts that-

(A) Exceed the limits approved under § 422.262;

(B) In the case of an MA private fee-for-service plan, exceed the MA monthly basic beneficiary premium or the MA monthly supplemental premium submitted under § 422.262; and

(C) In the case of an MA MSA plan, exceed the MA monthly beneficiary supplemental premium submitted under § 422.262, or exceed permissible cost sharing amounts after the deductible has been met per § 422.103; and

(ii) Includes amounts collected from an enrollee who was believed to be entitled to Medicare benefits but was later found not to be entitled.

(2) *Other amounts due* are amounts due for services that were—

(i) Emergency, urgently needed services, or other services obtained outside the MA plan; or

(ii) Initially denied but, upon appeal, found to be services the enrollee was entitled to have furnished by the MA organization.

(b) *Basic commitments.* An MA organization must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and to pay any other amounts due the enrollees or others on their behalf.

(c) *Refund methods*—(1) *Lump-sum payment.* The MA organization must use lump-sum payments for the following:

(i) Amounts incorrectly collected that were not collected as premiums.

(ii) Other amounts due.

(iii) All amounts due if the MA organization is going out of business or terminating its MA contract for an MA plan(s).

(2) *Premium adjustment or lump-sum payment, or both.* If the amounts incorrectly collected were in the form of premiums, or included premiums as well as other charges, the MA organization may refund by adjustment of future premiums or by a combination of premium adjustment and lump-sum payments.

(3) *Refund when enrollee has died or cannot be located.* If an enrollee has died or cannot be located after reasonable effort, the MA organization must make the refund in accordance with State law.

(d) *Reduction by CMS.* If the MA organization does not make the refund required under this section by the end of the contract period following the contract period during which an amount was determined to be due to an enrollee, CMS will reduce the premium the MA organization is allowed to charge an MA plan enrollee by the amounts incorrectly collected or otherwise due. In addition, the MA organization would be subject to sanction under

subpart O of this part for failure to refund amounts incorrectly collected from MA plan enrollees.

### Subpart G—Payments to Medicare Advantage Organizations

SOURCE: 70 FR 4729, Jan. 28, 2005, unless otherwise noted.

#### § 422.300 Basis and scope.

This subpart is based on sections 1853, 1854, and 1858 of the Act. It sets forth the rules for making payments to Medicare Advantage (MA) organizations offering local and regional MA plans, including calculation of MA capitation rates and benchmarks, conditions under which payment is based on plan bids, adjustments to capitation rates (including risk adjustment), and other payment rules.

See § 422.458 in subpart J for rules on risk sharing payments to MA regional organizations.

#### § 422.304 Monthly payments.

(a) *General rules.* Except as provided in paragraph (b) of this section, CMS makes advance monthly payments of the amounts determined under paragraphs (a)(1) and (a)(2) of this section for coverage of original fee-for-service benefits for an individual in an MA payment area for a month.

(1) *Payment of bid for plans with bids below benchmark.* For MA plans that have average per capita monthly savings (as described at § 422.264(b) for local plans and § 422.264(d) for regional plans), CMS pays:

(i) The unadjusted MA statutory non-drug monthly bid amount defined in § 422.252, risk-adjusted as described at § 422.308(c) and adjusted (if applicable) for variations in rates within the plan's service area (described at § 422.258(a)(2)) and for the effects of risk adjustment on beneficiary premiums under § 422.262; and

(ii) The amount (if any) of the rebate described in paragraph (a)(3) of this section.

(2) *Payment of benchmark for plans with bids at or above benchmark.* For MA plans that do not have average per capita monthly savings (as described at

§ 422.264(b) for local plans and § 422.264(d) for regional plans), CMS pays the unadjusted MA area-specific non-drug monthly benchmark amount specified at § 422.258, risk-adjusted as described at § 422.308(c) and adjusted (if applicable) for variations in rates within the plan's service area (described at § 422.258(a)(2)) and for the effects of risk adjustment on beneficiary premiums under § 422.262.

(3) *Payment of rebate for plans with bids below benchmarks.* The rebate amount under paragraph (a)(1)(ii) of this section is the amount of the monthly rebate computed under § 422.266(a) for that plan, less the amount (if any) applied to reduce the Part B premium, as provided under § 422.266(b)(3).

(b) *Separate payment for Federal drug subsidies.* In the case of an enrollee in an MA-PD plan, defined at § 422.252, the MA organization offering such a plan also receives-

(1) Direct and reinsurance subsidy payments for qualified prescription drug coverage, described at section 1860D-15(a) and (b) of the Act (other than payments for fallback prescription drug plans described at section 1860D-11(g)(5) of the Act); and

(2) Reimbursement for premium and cost sharing reductions for low-income individuals, described at section 1860D-14 of the Act.

(c) *Special rules—(1) Enrollees with end-stage renal disease.* (i) For enrollees determined to have end-stage renal disease (ESRD), CMS establishes special rates that are actuarially equivalent to rates in effect before the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(ii) CMS publishes annual changes in these capitation rates no later than the first Monday in April each year, as provided in § 422.312.

(iii) CMS applies appropriate adjustments when establishing the rates, including risk adjustment factors.

(iv) CMS reduces the payment rate for each renal dialysis treatment by the same amount that CMS is authorized to reduce the amount of each composite rate payment for each treatment as set forth in section 1881(b)(7) of the Act. These funds are to be used to help

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pay for the ESRD network program in the same manner as similar reductions are used in original Medicare.

(2) *MSA enrollees.* In the case of an MSA plan, CMS pays the unadjusted MA area-specific non-drug monthly benchmark amount for the service area, determined in accordance with § 422.314(c) and subject to risk adjustment as set forth at § 422.308(c), less 1/12 of the annual lump sum amount (if any) CMS deposits to the enrollee's MA MSA.

(3) *RFB plan enrollees.* For RFB plan enrollees, CMS adjusts the capitation payments otherwise determined under this subpart to ensure that the payment level is appropriate for the actuarial characteristics and experience of these enrollees. That adjustment can be made on an individual or organization basis.

(d) *Payment areas—(1) General rule.* Except as provided in paragraph (e) of this section—

(i) An MA payment area for an MA local plan is an MA local area defined at § 422.252.

(ii) An MA payment area for an MA regional plan is an MA region, defined at § 422.455(b)(1).

(2) *Special rule for ESRD enrollees.* For ESRD enrollees, the MA payment area is a State or other geographic area specified by CMS.

(e) *Geographic adjustment of payment areas for MA local plans—(1) Terminology.* “Metropolitan Statistical Area” and “Metropolitan Division” mean any areas so designated by the Office of Management and Budget in the Executive Office of the President.

(2) *State request.* A State's chief executive may request, no later than February 1 of any year, a geographic adjustment of the State's payment areas for MA local plans for the following calendar year. The chief executive may request any of the following adjustments to the payment area specified in paragraph (c)(1)(i) of this section:

(i) A single statewide MA payment area.

(ii) A metropolitan-based system in which all non-metropolitan areas within the State constitute a single payment area and any of the following constitutes a separate MA payment area:

(A) All portions of each single Metropolitan Statistical Area within the State.

(B) All portions of each Metropolitan Statistical Area within each Metropolitan Division within the State.

(iii) A consolidation of noncontiguous counties.

(3) *CMS response.* In response to the request, CMS makes the payment adjustment requested by the chief executive. This adjustment cannot be requested or made for payments to regional MA plans.

(4) *Budget neutrality adjustment for geographically adjusted payment areas.* If CMS adjusts a State's payment areas in accordance with paragraph (d)(2) of this section, CMS at that time, and each year thereafter, adjusts the capitation rates so that the aggregate Medicare payments do not exceed the aggregate Medicare payments that would have been made to all the State's payments areas, absent the geographic adjustment.

§ 422.306 Annual MA capitation rates.

Subject to adjustments at § 422.308(b) and § 422.308(g), the annual capitation rate for each MA local area is determined under paragraph (a) of this section for 2005 and each succeeding year, except for years when CMS announces under § 422.312(b) that the annual capitation rates will be determined under paragraph (b) of this section.

(a) *Minimum percentage increase rate.* The annual capitation rate for each MA local area is equal to the minimum percentage increase rate, which is the greater of—

(1) 102 percent of the annual capitation rate for the preceding year; or

(2) The annual capitation rate for the area for the preceding year increased by the national per capita MA growth percentage (defined at § 422.308(a)) for the year, but not taking into account any adjustment under § 422.308(b) for a year before 2004.

(b) *Greater of the minimum percentage increase rate or local area fee-for-service costs.* The annual capitation rate for each MA local area is the greater of—

(1) The minimum percentage increase rate under paragraph (a) of this section; or

(2) The amount determined, no less frequently than every 3 years, to be the adjusted average per capita cost for the MA local area, as determined under section 1876(a)(4) of the Act, based on 100 percent of fee-for-service costs for individuals who are not enrolled in an MA plan for the year, with the following adjustments:

(i) Adjusted as appropriate for the purpose of risk adjustment;

(ii) Adjusted to exclude costs attributable to payments under section 1886(h) of the Act for the costs of direct graduate medical education; and

(iii) Adjusted to include CMS' estimate of the amount of additional per capita payments that would have been made in the MA local area if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

**§ 422.308 Adjustments to capitation rates, benchmarks, bids, and payments.**

CMS performs the following calculations and adjustments to determine rates and payments:

(a) *National per capita growth percentage.* The national per capita growth percentage for a year, applied under § 422.306, is CMS' estimate of the rate of growth in per capita expenditures under this title for an individual entitled to benefits under Part A and enrolled under Part B. CMS may make separate estimates for aged enrollees, disabled enrollees, and enrollees who have ESRD.

(b) *Adjustment for over or under projection of national per capita growth percentages.* CMS will adjust the minimum percentage increase rate at § 422.306(a)(2) and the adjusted average per capita cost rate at § 422.306(b)(2) for the previous year to reflect any differences between the projected national per capita growth percentages for that year and previous years, and the current estimates of those percentages for those years. CMS will not make this adjustment for years before 2004.

(c) *Risk adjustment—(1) General rule.* CMS will adjust the payment amounts under § 422.304(a)(1), (a)(2), and (a)(3) for age, gender, disability status, institu-

tional status, and other factors CMS determines to be appropriate, including health status, in order to ensure actuarial equivalence. CMS may add to, modify, or substitute for risk adjustment factors if those changes will improve the determination of actuarial equivalence.

(2) *Risk adjustment: Health status—(i) Data collection.* To adjust for health status, CMS applies a risk factor based on data obtained in accordance with § 422.310.

(ii) *Implementation.* CMS applies a risk factor that incorporates inpatient hospital and ambulatory risk adjustment data. This factor is phased as follows:

(A) 100 percent of payments for ESRD MA enrollees in 2005 and succeeding years.

(B) 75 percent of payments for aged and disabled enrollees in 2006.

(C) 100 percent of payments for aged and disabled enrollees in 2007 and succeeding years.

(3) *Uniform application.* Except as provided for MA RFB plans under § 422.304(c)(3), CMS applies this adjustment factor to all types of plans.

(d) *Adjustment for intra-area variations.* CMS makes the following adjustments to payments.

(1) *Intra-regional variations.* For payments for an MA regional plan for an MA region, CMS will adjust the payment amount specified at § 422.304(a)(1) and (a)(2) to take into account variations in local payment rates among the different MA local areas included in the region.

(2) *Intra-service area variations.* For payments to an MA local plan with a service area covering more than one MA local area (county), CMS will adjust the payment amount specified in § 422.304(a)(1) and (a)(2) to take into account variations in local payment rates among the different MA local areas included in the plan's service area.

(e) *Adjustment relating to risk adjustment: the government premium adjustment.* CMS will adjust payments to an MA plan as necessary to ensure that the sum of CMS' monthly payment made under § 422.304(a) and the plan's monthly basic beneficiary premium equals the unadjusted MA statutory

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non-drug bid amount, adjusted for risk and for intra-area or intra-regional payment variation.

(f) *Adjustment of payments to reflect number of Medicare enrollees—(1) General rule.* CMS adjusts payments retroactively to take into account any difference between the actual number of Medicare enrollees and the number on which it based an advance monthly payment.

(2) *Special rules for certain enrollees.* (i) Subject to paragraph (f)(2)(ii) of this section, CMS may make adjustments, for a period (not to exceed 90 days) that begins when a beneficiary elects a group health plan (as defined in § 411.1010) offered by an MA organization, and ends when the beneficiary is enrolled in an MA plan offered by the MA organization.

(ii) CMS does not make an adjustment unless the beneficiary certifies that, at the time of enrollment under the MA plan, he or she received from the organization the disclosure statement specified in § 422.111.

(g) *Adjustment for national coverage determination (NCD) services and legislative changes in benefits.* If CMS determines that the cost of furnishing an NCD service or legislative change in benefits is significant, as defined in § 422.109, CMS will adjust capitation rates, or make other payment adjustments, to account for the cost of the service or legislative change in benefits. Until the new capitation rates are in effect, the MA organization will be paid for the significant cost NCD service or legislative change in benefits on a fee-for-service basis as provided under § 422.109(b).

(h) *Adjustments to payments to regional MA plans for purposes of risk corridor payments.* For the purpose of calculation of risk corridors under § 422.458, MA organizations offering regional MA plans in 2006 and/or 2007 must submit, after the end of a contract year and before a date CMS specifies, the following information:

(1) Actual allowable costs (defined in § 422.458(a)) for the previous contract year.

(2) The portion of the costs attributable to administrative expenses incurred in providing these benefits.

(3) The total costs for providing rebatable integrated benefits (as defined in § 422.458(a)) and the portion of the costs that is attributable to administrative expenses in addition to the administrative expenses described in paragraph (h)(2) of this section.

### § 422.310 Risk adjustment data.

(a) *Definition of risk adjustment data.* Risk adjustment data are all data that are used in the application of a risk adjustment payment model.

(b) *Data collection: Basic rule.* Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization.

(c) *Sources and extent of data.* (1) To the extent required by CMS, risk adjustment data must account for the following:

(i) Services covered under the original Medicare program.

(ii) Medicare covered services for which Medicare is not the primary payer.

(iii) Other additional or supplemental benefits that the MA organization may provide.

(2) The data must account separately for each provider, supplier, physician, or other practitioner that would be permitted to bill separately under the original Medicare program, even if they participate jointly in the same service.

(d) *Other data requirements.* (1) MA organizations must submit data that conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards. Alternatively, MA organizations may submit data according to an abbreviated format, as specified by CMS.

(2) The data must be submitted electronically to the appropriate CMS contractor.

(3) MA organizations must obtain the risk adjustment data required by CMS from the provider, supplier, physician,

or other practitioner that furnished the services.

(4) MA organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data.

(e) *Validation of risk adjustment data.* MA organizations and their providers and practitioners will be required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data.

(f) *Use of data.* CMS uses the data obtained under this section to determine the risk adjustment factor used to adjust payments, as required under § 422.304(a)(1), (a)(2), and (a)(3). CMS may also use the data for other purposes except for medical records data.

(g) *Deadlines for submission of risk adjustment data.* Risk adjustment factors for each payment year are based on risk adjustment data submitted for services furnished during the 12-month period before the payment year that is specified by CMS. As determined by CMS, this 12-month period may include a 6-month data lag that may be changed or eliminated as appropriate.

(1) The annual deadline for risk adjustment data submission is the first Friday in September for risk adjustment data reflecting services furnished during the 12-month period ending the prior June 30, and the first Friday in March for data reflecting services furnished during the 12-month period ending the prior December 31.

(2) CMS allows a reconciliation process to account for late data submissions. CMS continues to accept risk adjustment data submitted after the March deadline until December 31 of the payment year. After the payment year is completed, CMS recalculates the risk factors for affected individuals to determine if adjustments to payments are necessary. Risk adjustment data that are received after the annual December 31 late data submission deadline will not be accepted for the purposes of reconciliation.

**§ 422.312 Announcement of annual capitation rate, benchmarks, and methodology changes.**

(a) *Capitation rates*—(1) *Initial announcement.* Not later than the first Monday in April each year, CMS announces to MA organizations and other interested parties the following information for each MA payment area for the following calendar year:

(i) The annual MA capitation rate.

(ii) The risk and other factors to be used in adjusting those rates under § 422.308 for payments for months in that year.

(2) CMS includes in the announcement an explanation of assumptions used and a description of the risk and other factors.

(3) *Regional benchmark announcement.* Before the beginning of each annual, coordinated election period under § 422.62(a)(2), CMS will announce to MA organizations and other interested parties the MA region-specific non-drug monthly benchmark amount for the year involved for each MA region and each MA regional plan for which a bid was submitted under § 422.256.

(b) *Advance notice of changes in methodology.* (1) No later than 45 days before making the announcement under paragraph (a)(1) of this section, CMS notifies MA organizations of changes it proposes to make in the factors and the methodology it used in the previous determination of capitation rates.

(2) The MA organizations have 15 days to comment on the proposed changes.

**§ 422.314 Special rules for beneficiaries enrolled in MA MSA plans.**

(a) *Establishment and designation of medical savings account (MSA).* A beneficiary who elects coverage under an MA MSA plan—

(1) Must establish an MA MSA with a trustee that meets the requirements of paragraph (b) of this section; and

(2) If he or she has more than one MA MSA, designate the particular account to which payments under the MA MSA plan are to be made.

(b) *Requirements for MSA trustees.* An entity that acts as a trustee for an MA MSA must—

(1) Register with CMS;

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(2) Certify that it is a licensed bank, insurance company, or other entity qualified, under sections 408(a)(2) or 408(h) of the Internal Revenue Code of 1986, to act as a trustee of individual retirement accounts;

(3) Agree to comply with the MA MSA provisions of section 138 of the Internal Revenue Code of 1986; and

(4) Provide any other information that CMS may require.

(c) *Deposit in the MA MSA.* (1) The payment is calculated as follows:

(i) The monthly MA MSA premium is compared with 1/12 of the annual capitation rate applied under this section for the.

(ii) If the monthly MA MSA premium is less than 1/12 of the annual capitation rate applied under this section for the area, the difference is the amount to be deposited in the MA MSA for each month for which the beneficiary is enrolled in the MSA plan.

(2) CMS deposits the full amount to which a beneficiary is entitled under paragraph (c)(1)(ii) of this section for the calendar year, beginning with the month in which MA MSA coverage begins.

(3) If the beneficiary's coverage under the MA MSA plan ends before the end of the calendar year, CMS recovers the amount that corresponds to the remaining months of that year.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 52027, Sept. 1, 2005]

**§ 422.316 Special rules for payments to Federally qualified health centers.**

If an enrollee in an MA plan receives a service from a Federally qualified health center (FQHC) that has a written agreement with the MA organization offering the plan concerning the provision of this service (including the agreement required under section 1857(e)(3) of the Act and as codified in § 422.527)—

(a) CMS will pay the amount determined under section 1833(a)(3)(B) of the Act directly to the FQHC at a minimum on a quarterly basis, less the amount the FQHC would receive for the MA enrollee from the MA organization (which includes the cost sharing amount the FQHC may charge an enrollee, as established in the contract

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between the FQHC and the MA organization); and

(b) CMS will not reduce the amount of the monthly payments under this section as a result of the application of paragraph (a) of this section.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 76198, Dec. 23, 2005]

**§ 422.318 Special rules for coverage that begins or ends during an inpatient hospital stay.**

(a) *Applicability.* This section applies to inpatient services in a “subsection (d) hospital” as defined in section 1886(d)(1)(B) of the Act, a psychiatric hospital described in section 1886(d)(1)(B)(i) of the act, a rehabilitation hospital described in section 1886(d)(1)(B)(ii) of the Act, a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B) of the Act, or a long-term care hospital (described in section 1886(d)(1)(B)(iv)).

(b) *Coverage that begins during an inpatient stay.* If coverage under an MA plan offered by an MA organization begins while the beneficiary is an inpatient in one of the facilities described in paragraph (a) of this section—

(1) Payment for inpatient services until the date of the beneficiary's discharge is made by the previous MA organization or original Medicare, as appropriate;

(2) The MA organization offering the newly-elected MA plan is not responsible for the inpatient services until the date after the beneficiary's discharge; and

(3) The MA organization offering the newly-elected MA plan is paid the full amount otherwise payable under this subpart.

(c) *Coverage that ends during an inpatient stay.* If coverage under an MA plan offered by an MA organization ends while the beneficiary is an inpatient in one of the facilities described in paragraph (a) of this section—

(1) The MA organization is responsible for the inpatient services until the date of the beneficiary's discharge;

(2) Payment for those services during the remainder of the stay is not made by original Medicare or by any succeeding MA organization offering a newly-elected MA plan; and

(3) The MA organization that no longer provides coverage receives no payment for the beneficiary for the period after coverage ends.

**§ 422.320 Special rules for hospice care.**

(a) *Information.* An MA organization that has a contract under subpart K of this part must inform each Medicare enrollee eligible to select hospice care under § 418.24 of this chapter about the availability of hospice care (in a manner that objectively presents all available hospice providers, including a statement of any ownership interest in a hospice held by the MA organization or a related entity) if—

(1) A Medicare hospice program is located within the plan's service area; or

(2) It is common practice to refer patients to hospice programs outside that area.

(b) *Enrollment status.* Unless the enrollee disenrolls from the MA plan, a beneficiary electing hospice continues his or her enrollment in the MA plan and is entitled to receive, through the MA plan, any benefits other than those that are the responsibility of the Medicare hospice.

(c) *Payment.* (1) No payment is made to an MA organization on behalf of a Medicare enrollee who has elected hospice care under § 418.24 of this chapter, except for the portion of the payment attributable to the beneficiary rebate for the MA plan, described in § 422.266(b)(1) plus the amount of the monthly prescription drug payment described in § 423.315 (if any). This no-payment rule is effective from the first day of the month following the month of election to receive hospice care, until the first day of the month following the month in which the election is terminated.

(2) During the time the hospice election is in effect, CMS' monthly capitation payment to the MA organization is reduced to the sum of—

(i) An amount equal to the beneficiary rebate for the MA plan, as described in § 422.304(a)(3) or to zero for plans with no beneficiary rebate, described at § 422.304(a)(2); and

(ii) The amount of the monthly prescription drug payment described in § 423.315 (if any).

(3) In addition, CMS pays through the original Medicare program (subject to the usual rules of payment)—

(i) The hospice program for hospice care furnished to the Medicare enrollee; and

(ii) The MA organization, provider, or supplier for other Medicare-covered services to the enrollee.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 52027, Sept. 1, 2005]

**§ 422.322 Source of payment and effect of MA plan election on payment.**

(a) *Source of payments.* (1) Payments under this subpart for original fee-for-service benefits to MA organizations or MA MSAs are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund. CMS determines the proportions to reflect the relative weight that benefits under Part A, and benefits under Part B represents of the actuarial value of the total benefits under title XVIII of the Act.

(2) Payments to MA-PD organizations for statutory drug benefits provided under this title are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

(b) *Payments to the MA organization.* Subject to § 412.105(g) and § 413.86(d) of this chapter and § 422.109, § 422.316, and § 422.320, CMS' payments under a contract with an MA organization (described in § 422.304) with respect to an individual electing an MA plan offered by the organization are instead of the amounts which (in the absence of the contract) would otherwise be payable under original Medicare for items and services furnished to the individual.

(c) *Only the MA organization entitled to payment.* Subject to § 422.314, § 422.316, § 422.318, § 422.320, and § 422.520 and sections 1886(d)(11) and 1886(h)(3)(D) of the Act, only the MA organization is entitled to receive payment from CMS under title XVIII of the Act for items and services furnished to the individual.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 52027, Sept. 1, 2005]

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§ 422.324 **Payments to MA organizations for graduate medical education costs.**

(a) MA organizations may receive direct graduate medical education payments for the time that residents spend in non-hospital provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs.

(b) MA organizations may receive direct graduate medical education payments if all of the following conditions are met:

(1) The resident spends his or her time assigned to patient care activities.

(2) The MA organization incurs "all or substantially all" of the costs for the training program in the non-hospital setting as defined in § 413.86(b) of this chapter.

(3) There is a written agreement between the MA organization and the non-hospital site that indicates the MA organization will incur the costs of the resident's salary and fringe benefits and provide reasonable compensation to the non-hospital site for teaching activities.

(c) An MA organization's allowable direct graduate medical education costs, subject to the redistribution and community support principles specified in § 413.85(c) of this chapter, consist of—

(1) Residents' salaries and fringe benefits (including travel and lodging where applicable); and

(2) Reasonable compensation to the non-hospital site for teaching activities related to the training of medical residents.

(d) The direct graduate medical education payment is equal to the product of—

(1) The lower of—

(i) The MA organization's allowable costs per resident as defined in paragraph (c) of this section; or

(ii) The national average per resident amount; and

(2) Medicare's share, which is equal to the ratio of the number of Medicare beneficiaries enrolled to the total number of individuals enrolled in the MA organization.

(e) Direct graduate medical education payments made to MA organiza-

tions under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

**Subpart H—Provider-Sponsored Organizations**

EDITORIAL NOTE: Nomenclature changes to subpart H appear at 63 FR 35098, 35099, June 26, 1998.

§ 422.350 **Basis, scope, and definitions.**

(a) *Basis and scope.* This subpart is based on sections 1851 and 1855 of the Act which, in part,—

(1) Authorize provider sponsored organizations, (PSOs), to contract as a MA plan;

(2) Require that a PSO meet certain qualifying requirements; and

(3) Provide for waiver of State licensure for PSOs under specified conditions.

(b) *Definitions.* As used in this subpart (unless otherwise specified)—

*Capitation payment* means a fixed per enrollee per month amount paid for contracted services without regard to the type, cost, or frequency of services furnished.

*Cash equivalent* means those assets excluding accounts receivable that can be exchanged on an equivalent basis as cash, or converted into cash within 90 days from their presentation for exchange.

*Control* means that an individual, group of individuals, or entity has the power, directly or indirectly, to direct or influence significantly the actions or policies of an organization or institution.

*Current ratio* means total current assets divided by total current liabilities.

*Deferred acquisition costs* are those costs incurred in starting or purchasing a business. These costs are capitalized as intangible assets and carried on the balance sheet as deferred charges since they benefit the business for periods after the period in which the costs were incurred.

*Engaged in the delivery of health care services* means—

(1) For an individual, that the individual directly furnishes health care services, or

(2) For an entity, that the entity is organized and operated primarily for

the purpose of furnishing health care services directly or through its provider members or entities.

*Generally accepted accounting principles (GAAP)* means broad rules adopted by the accounting profession as guides in measuring, recording, and reporting the financial affairs and activities of a business to its owners, creditors and other interested parties.

*Guarantor* means an entity that—

(1) Has been approved by CMS as meeting the requirements to be a guarantor; and

(2) Obligates its resources to a PSO to enable the PSO to meet the solvency requirements required to contract with CMS as an MA organization.

*Health care delivery assets (HCDAs)* means any tangible assets that are part of a PSO's operation, including hospitals and other medical facilities and their ancillary equipment, and such property as may be reasonably required for the PSO's principal office or for such other purposes as the PSO may need for transacting its business.

*Insolvency* means a condition in which the liabilities of the debtor exceed the fair valuation of its assets.

*Net worth* means the excess of total assets over total liabilities, excluding fully subordinated debt or subordinated liabilities.

*Provider-sponsored organization (PSO)* means a public or private entity that—

(1) Is established or organized, and operated, by a provider or group of affiliated providers;

(2) Provides a substantial proportion (as defined in § 422.352) of the health care services under the MA contract directly through the provider or affiliated group of providers; and

(3) When it is a group, is composed of affiliated providers who—

(i) Share, directly or indirectly, substantial financial risk, as determined under § 422.356, for the provision of services that are the obligation of the PSO under the MA contract; and

(ii) Have at least a majority financial interest in the PSO.

*Qualified actuary* means a member in good standing of the American Academy of Actuaries or a person recognized by the Academy as qualified for membership, or a person who has otherwise demonstrated competency in

the field of actuarial determination and is satisfactory to CMS.

*Statutory accounting practices* means those accounting principles or practices prescribed or permitted by the domiciliary State insurance department in the State that PSO operates.

*Subordinated debt* means an obligation that is owed by an organization, that the creditor of the obligation, by law, agreement, or otherwise, has a lower repayment rank in the hierarchy of creditors than another creditor. The creditor would be entitled to repayment only after all higher ranking creditors' claims have been satisfied. A debt is fully subordinated if it has a lower repayment rank than all other classes of creditors.

*Subordinated liability* means claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all other creditors.

*Uncovered expenditures* means those expenditures for health care services that are the obligation of an organization, for which an enrollee may also be liable in the event of the organization's insolvency and for which no alternative arrangements have been made that are acceptable to CMS. They include expenditures for health care services for which the organization is at risk, such as out-of-area services, referral services and hospital services. However, they do not include expenditures for services when a provider has agreed not to bill the enrollee.

[63 FR 18134, Apr. 14, 1998, as amended at 63 FR 25376, May 7, 1998; 63 FR 35098, June 26, 1998]

#### § 422.352 Basic requirements.

(a) *General rule.* An organization is considered a PSO for purposes of a MA contract if the organization—

(1) Has obtained a waiver of State licensure as provided for under § 422.370;

(2) Meets the definition of a PSO set forth in § 422.350 and other applicable requirements of this subpart; and

(3) Is effectively controlled by the provider or, in the case of a group, by one or more of the affiliated providers that established and operate the PSO.

(b) *Provision of services.* A PSO must demonstrate to CMS's satisfaction that it is capable of delivering to Medicare

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enrollees the range of services required under a contract with CMS. Each PSO must deliver a substantial proportion of those services directly through the provider or the affiliated providers responsible for operating the PSO. Substantial proportion means—

(1) For a non-rural PSO, not less than 70% of Medicare services covered under the contract.

(2) For a rural PSO, not less than 60% of Medicare services covered under the contract.

(c) *Rural PSO*. To qualify as a rural PSO, a PSO must—

(1) Demonstrate to CMS that—

(i) It has available in the rural area, as defined in § 412.62(f) of this chapter, routine services including but not limited to primary care, routine specialty care, and emergency services; and

(ii) The level of use of providers outside the rural area is consistent with general referral patterns for the area; and

(2) Enroll Medicare beneficiaries, the majority of which reside in the rural area the PSO serves.

[63 FR 18134, Apr. 14, 1998, as amended at 63 FR 35098, June 26, 1998; 65 FR 40327, June 29, 2000]

**§ 422.354 Requirements for affiliated providers.**

A PSO that consists of two or more providers must demonstrate to CMS'S satisfaction that it meets the following requirements:

(a) The providers are affiliated. For purposes of this subpart, providers are affiliated if, through contract, ownership, or otherwise—

(1) One provider, directly or indirectly, controls, is controlled by, or is under common control with another;

(2) Each provider is part of a lawful combination under which each shares substantial financial risk in connection with the PSO's operations;

(3) Both, or all, providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986; or

(4) Both, or all, providers are part of an affiliated service group under section 414 of that Code.

(b) Each affiliated provider of the PSO shares, directly or indirectly, substantial financial risk for the fur-

nishing of services the PSO is obligated to provide under the contract.

(c) Affiliated providers, as a whole or in part, have at least a majority financial interest in the PSO.

(d) For purposes of paragraph(a)(1) of this section, control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance right of another.

[63 FR 18134, Apr. 14, 1998, as amended at 63 FR 35098, June 26, 1998]

**§ 422.356 Determining substantial financial risk and majority financial interest.**

(a) *Determining substantial financial risk*. The PSO must demonstrate to CMS's satisfaction that it apportions a significant part of the financial risk of the PSO enterprise under the MA contract to each affiliated provider. The PSO must demonstrate that the financial arrangements among its affiliated providers constitute "substantial" risk in the PSO for each affiliated provider. The following mechanisms may constitute risk-sharing arrangements, and may have to be used in combination to demonstrate substantial financial risk in the PSO enterprise.

(1) Agreement by a provider to accept capitation payment for each Medicare enrollee.

(2) Agreement by a provider to accept as payment a predetermined percentage of the PSO premium or the PSO's revenue.

(3) The PSO's use of significant financial incentives for its affiliated providers, with the aim of achieving utilization management and cost containment goals. Permissible methods include the following:

(i) Affiliated providers agree to a withholding of a significant amount of the compensation due them, to be used for any of the following:

(A) To cover losses of the PSO.

(B) To cover losses of other affiliated providers.

(C) To be returned to the affiliated provider if the PSO meets its utilization management or cost containment goals for the specified time period.

(D) To be distributed among affiliated providers if the PSO meets its utilization management or cost-containment goals for the specified time period.

(ii) Affiliated providers agree to preestablished cost or utilization targets for the PSO and to subsequent significant financial rewards and penalties (which may include a reduction in payments to the provider) based on the PSO's performance in meeting the targets.

(4) Other mechanisms that demonstrate significant shared financial risk.

(b) *Determining majority financial interest.* Majority financial interest means maintaining effective control of the PSO.

[63 FR 18134, Apr. 14, 1998, as amended at 63 FR 35098, June 26, 1998]

#### § 422.370 Waiver of State licensure.

For an organization that seeks to contract to offer an MA plan under this subpart, CMS may waive the State licensure requirement of section 1855(a)(1) of the Act if—

(a) The organization requests a waiver no later than November 1, 2002; and

(b) CMS determines there is a basis for a waiver under § 422.372.

[63 FR 25376, May 7, 1998, as amended at 63 FR 35098, June 26, 1998]

#### § 422.372 Basis for waiver of State licensure.

(a) *General rule.* Subject to this section and to paragraphs (a) and (e) of § 422.374, CMS may waive the State licensure requirement if the organization has applied (except as provided in paragraph (b)(4) of this section) for the most closely appropriate State license or authority to conduct business as an MA plan.

(b) *Basis for waiver of State licensure.* Any of the following may constitute a basis for CMS's waiver of State licensure.

(1) *Failure to act timely on application.* The State failed to complete action on the licensing application within 90 days of the date the State received a substantially complete application.

(2) *Denial of application based on discriminatory treatment.* The State has—

(i) Denied the license application on the basis of material requirements, procedures, or standards (other than solvency requirements) not generally applied by the State to other entities engaged in a substantially similar business; or

(ii) Required, as a condition of licensure that the organization offer any product or plan other than an MA plan.

(3) *Denial of application based on different solvency requirements.* (i) The State has denied the application, in whole or in part, on the basis of the organization's failure to meet solvency requirements that are different from those set forth in §§ 422.380 through 422.390; or

(ii) CMS determines that the State has imposed, as a condition of licensure, any documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, or standards set forth by CMS to implement, monitor, and enforce §§ 422.380 through 422.390.

(4) *State declines to accept licensure application.* The appropriate State licensing authority has given the organization written notice that it will not accept its licensure application.

[63 FR 35098, June 26, 1998]

#### § 422.374 Waiver request and approval process.

(a) *Substantially complete waiver request.* The organization must submit a substantially complete waiver request that clearly demonstrates and documents its eligibility for a waiver under § 422.372.

(b) CMS gives the organization written notice of granting or denial of waiver within 60 days of receipt of a substantially complete waiver request.

(c) *Subsequent waiver requests.* An organization that has had a waiver request denied, may submit subsequent waiver requests until November 1, 2002.

(d) *Effective date.* A waiver granted under § 422.370 will be effective on the effective date of the organization's MA contract.

(e) *Consistency in application.* CMS reserves the right to revoke waiver eligibility if it subsequently determines

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that the organization's MA application is significantly different from the application submitted by the organization to the State licensing authority.

[63 FR 25377, May 7, 1998, as amended at 63 FR 35098, June 26, 1998]

### § 422.376 Conditions of the waiver.

A waiver granted under this section is subject to the following conditions:

(a) *Limitation to State.* The waiver is effective only for the particular State for which it is granted and does not apply to any other State. For each State in which the organization wishes to operate without a State license, it must submit a waiver request and receive a waiver.

(b) *Limitation to 36-month period.* The waiver is effective for 36 months or through the end of the calendar year in which the 36 month period ends unless it is revoked based on paragraph (c) of this section.

(c) *Mid-period revocation.* During the waiver period (set forth in paragraph (b) of this section), the waiver is automatically revoked upon—

- (1) Termination of the MA contract;
- (2) The organization's compliance with the State licensure requirement of section 1855(a)(1) of the Act; or
- (3) The organization's failure to comply with § 422.378.

[63 FR 25377, May 7, 1998]

### § 422.378 Relationship to State law.

(a) *Preemption of State law.* Any provisions of State law that relate to the licensing of the organization and that prohibit the organization from providing coverage under a contract as specified in this subpart, are superseded.

(b) *Consumer protection and quality standards.* (1) A waiver of State licensure granted under this subpart is conditioned upon the organization's compliance with all State consumer protection and quality standards that—

- (i) Would apply to the organization if it were licensed under State law;
- (ii) Generally apply to other MA organizations and plans in the State; and
- (iii) Are consistent with the standards established under this part.

(2) The standards specified in paragraph (b)(1) of this section do not in-

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clude any standard preempted under section 1856(b)(3)(B) of the Act.

(c) *Incorporation into contract.* In contracting with an organization that has a waiver of State licensure, CMS incorporates into the contract the requirements specified in paragraph (b) of this section.

(d) *Enforcement.* CMS may enter into an agreement with a State for the State to monitor and enforce compliance with the requirements specified in paragraph (b) of this section by an organization that has obtained a waiver under this subpart.

[63 FR 25377, May 7, 1998]

### § 422.380 Solvency standards.

*General rule.* A PSO or the legal entity of which the PSO is a component that has been granted a waiver under § 422.370 must have a fiscally sound operation that meets the requirements of §§ 422.382 through 422.390.

[63 FR 25377, May 7, 1998]

### § 422.382 Minimum net worth amount.

(a) At the time an organization applies to contract with CMS as a PSO under this part, the organization must have a minimum net worth amount, as determined under paragraph (c) of this section, of:

(1) At least \$1,500,000, except as provided in paragraph (a)(2) of this section.

(2) No less than \$1,000,000 based on evidence from the organization's financial plan (under § 422.384) demonstrating to CMS's satisfaction that the organization has available to it an administrative infrastructure that CMS considers appropriate to reduce, control or eliminate start-up administrative costs.

(b) After the effective date of a PSO's MA contract, a PSO must maintain a minimum net worth amount equal to the greater of—

- (1) One million dollars;
- (2) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with CMS for up to and including the first \$150,000,000 of annual premiums and 1 percent of annual premium revenues on premiums in excess of \$150,000,000;

(3) An amount equal to the sum of three months of uncovered health care expenditures as reported on the most recent financial statement filed with CMS; or

(4) Using the most recent financial statement filed with CMS, an amount equal to the sum of—

(i) Eight percent of annual health care expenditures paid on a non-capitated basis to non-affiliated providers; and

(ii) Four percent of annual health care expenditures paid on a capitated basis to non-affiliated providers plus annual health care expenditures paid on a non-capitated basis to affiliated providers.

(iii) Annual health care expenditures that are paid on a capitated basis to affiliated providers are not included in the calculation of the net worth requirement (regardless of downstream arrangements from the affiliated provider) under paragraphs (a) and (b)(4) of this section.

(c) *Calculation of the minimum net worth amount*—(1) *Cash requirement.* (i) At the time of application, the organization must maintain at least \$750,000 of the minimum net worth amount in cash or cash equivalents.

(ii) After the effective date of a PSO's MA contract, a PSO must maintain the greater of \$750,000 or 40 percent of the minimum net worth amount in cash or cash equivalents.

(2) *Intangible assets.* An organization may include intangible assets, the value of which is based on Generally Accepted Accounting Principles (GAAP), in the minimum net worth amount calculation subject to the following limitations—

(i) *At the time of application.* (A) Up to 20 percent of the minimum net worth amount, provided at least \$1,000,000 of the minimum net worth amount is met through cash or cash equivalents; or

(B) Up to 10 percent of the minimum net worth amount, if less than \$1,000,000 of the minimum net worth amount is met through cash or cash equivalents, or if CMS has used its discretion under paragraph (a)(2) of this section.

(ii) *From the effective date of the contract.* (A) Up to 20 percent of the minimum net worth amount if the greater

of \$1,000,000 or 67 percent of the minimum net worth amount is met by cash or cash equivalents; or

(B) Up to ten percent of the minimum net worth amount if the greater of \$1,000,000 or 67 percent of the minimum net worth amount is not met by cash or cash equivalents.

(3) *Health care delivery assets.* Subject to the other provisions of this section, a PSO may apply 100 percent of the GAAP depreciated value of health care delivery assets (HCDAs) to satisfy the minimum net worth amount.

(4) *Other assets.* A PSO may apply other assets not used in the delivery of health care provided that those assets are valued according to statutory accounting practices (SAP) as defined by the State.

(5) *Subordinated debts and subordinated liabilities.* Fully subordinated debt and subordinated liabilities are excluded from the minimum net worth amount calculation.

(6) *Deferred acquisition costs.* Deferred acquisition costs are excluded from the calculation of the minimum net worth amount.

[63 FR 25377, May 7, 1998, as amended at 64 FR 71678, Dec. 22, 1999]

#### § 422.384 Financial plan requirement.

(a) *General rule.* At the time of application, an organization must submit a financial plan acceptable to CMS.

(b) *Content of plan.* A financial plan must include—

- (1) A detailed marketing plan;
- (2) Statements of revenue and expense on an accrual basis;
- (3) Cash-flow statements;
- (4) Balance sheets;
- (5) Detailed justifications and assumptions in support of the financial plan including, where appropriate, certification of reserves and actuarial liabilities by a qualified actuary; and

(6) If applicable, statements of the availability of financial resources to meet projected losses.

(c) *Period covered by the plan.* A financial plan must—

(1) Cover the first 12 months after the estimated effective date of a PSO's MA contract; or

(2) If the PSO is projecting losses, cover 12 months beyond the end of the period for which losses are projected.

(d) *Funding for projected losses.* Except for the use of guarantees, LOC, and other means as provided in § 422.384(e), (f) and (g), an organization must have the resources for meeting projected losses on its balance sheet in cash or a form that is convertible to cash in a timely manner, in accordance with the PSO's financial plan.

(e) *Guarantees and projected losses.* Guarantees will be an acceptable resource to fund projected losses, provided that a PSO—

(1) Meets CMS's requirements for guarantors and guarantee documents as specified in § 422.390; and

(2) Obtains from the guarantor cash or cash equivalents to fund the projected losses timely, as follows—

(i) Prior to the effective date of a PSO's MA contract, the amount of the projected losses for the first two quarters;

(ii) During the first quarter and prior to the beginning of the second quarter of a PSO's MA contract, the amount of projected losses through the end of the third quarter; and

(iii) During the second quarter and prior to the beginning of the third quarter of a PSO's MA contract, the amount of projected losses through the end of the fourth quarter.

(3) If the guarantor complies with the requirements in paragraph (e)(2) of this section, the PSO, in the third quarter, may notify CMS of its intent to reduce the period of advance funding of projected losses. CMS will notify the PSO within 60 days of receiving the PSO's request if the requested reduction in the period of advance funding will not be accepted.

(4) If the guarantee requirements in paragraph (e)(2) of this section are not met, CMS may take appropriate action, such as requiring funding of projected losses through means other than a guarantee. CMS retains discretion to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

(f) *Letters of credit.* Letters of credit are an acceptable resource to fund projected losses, provided they are irrevocable, unconditional, and satisfactory to CMS. They must be capable of being

promptly paid upon presentation of a sight draft under the letters of credit without further reference to any other agreement, document, or entity.

(g) *Other means.* If satisfactory to CMS, and for periods beginning one year after the effective date of a PSO's MA contract, a PSO may use the following to fund projected losses—

(1) Lines of credit from regulated financial institutions;

(2) Legally binding agreements for capital contributions; or

(3) Legally binding agreements of a similar quality and reliability as permitted in paragraphs (g)(1) and (2) of this section.

(h) *Application of guarantees, Letters of credit or other means of funding projected losses.* Notwithstanding any other provision of this section, a PSO may use guarantees, letters of credit and, beginning one year after the effective date of a PSO's MA contract, other means of funding projected losses, but only in a combination or sequence that CMS considers appropriate.

[63 FR 25378, May 7, 1998, as amended at 63 FR 35098, June 26, 1998; 64 FR 71678, Dec. 22, 1999]

**§ 422.386 Liquidity.**

(a) A PSO must have sufficient cash flow to meet its financial obligations as they become due and payable.

(b) To determine whether the PSO meets the requirement in paragraph (a) of this section, CMS will examine the following—

(1) The PSO's timeliness in meeting current obligations;

(2) The extent to which the PSO's current ratio of assets to liabilities is maintained at 1:1 including whether there is a declining trend in the current ratio over time; and

(3) The availability of outside financial resources to the PSO.

(c) If CMS determines that a PSO fails to meet the requirement in paragraph (b)(1) of this section, CMS will require the PSO to initiate corrective action and pay all overdue obligations.

(d) If CMS determines that a PSO fails to meet the requirement of paragraph (b)(2) of this section, CMS may require the PSO to initiate corrective action to—

(1) Change the distribution of its assets;

(2) Reduce its liabilities; or

(3) Make alternative arrangements to secure additional funding to restore the PSO's current ratio to 1:1.

(e) If CMS determines that there has been a change in the availability of outside financial resources as required by paragraph (b)(3) of this section, CMS requires the PSO to obtain funding from alternative financial resources.

[63 FR 25378, May 7, 1998, as amended at 64 FR 71678, Dec. 22, 1999]

#### § 422.388 Deposits.

(a) *Insolvency deposit.* (1) At the time of application, an organization must deposit \$100,000 in cash or securities (or any combination thereof) into an account in a manner that is acceptable to CMS.

(2) The deposit must be restricted to use in the event of insolvency to help assure continuation of services or pay costs associated with receivership or liquidation.

(3) At the time of the PSO's application for an MA contract and, thereafter, upon CMS's request, a PSO must provide CMS with proof of the insolvency deposit, such proof to be in a form that CMS considers appropriate.

(b) *Uncovered expenditures deposit.* (1) If at any time uncovered expenditures exceed 10 percent of a PSO's total health care expenditures, then the PSO must place an uncovered expenditures deposit into an account with any organization or trustee that is acceptable to CMS.

(2) The deposit must at all times have a fair market value of an amount that is 120 percent of the PSO's outstanding liability for uncovered expenditures for enrollees, including incurred, but not reported claims.

(3) The deposit must be calculated as of the first day of each month required and maintained for the remainder of each month required.

(4) If a PSO is not otherwise required to file a quarterly report, it must file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(5) The deposit required under this section is restricted and in trust for

CMS's use to protect the interests of the PSO's Medicare enrollees and to pay the costs associated with administering the insolvency. It may be used only as provided under this section.

(c) A PSO may use the deposits required under paragraphs (a) and (b) of this section to satisfy the PSO's minimum net worth amount required under § 422.382(a) and (b).

(d) All income from the deposits or trust accounts required under paragraphs (a) and (b) of this section, are considered assets of the PSO. Upon CMS's approval, the income from the deposits may be withdrawn.

(e) On prior written approval from CMS, a PSO that has made a deposit under paragraphs (a) or (b) of this section, may withdraw that deposit or any part thereof if—

(1) A substitute deposit of cash or securities of equal amount and value is made;

(2) The fair market value exceeds the amount of the required deposit; or

(3) The required deposit under paragraphs (a) or (b) of this section is reduced or eliminated.

[63 FR 25379, May 7, 1998]

#### § 422.390 Guarantees.

(a) *General policy.* A PSO, or the legal entity of which the PSO is a component, may apply to CMS to use the financial resources of a guarantor for the purpose of meeting the requirements in § 422.384. CMS has the discretion to approve or deny approval of the use of a guarantor.

(b) *Request to use a guarantor.* To apply to use the financial resources of a guarantor, a PSO must submit to CMS—

(1) Documentation that the guarantor meets the requirements for a guarantor under paragraph (c) of this section; and

(2) The guarantor's independently audited financial statements for the current year-to-date and for the two most recent fiscal years. The financial statements must include the guarantor's balance sheets, profit and loss statements, and cash flow statements.

(c) *Requirements for guarantor.* To serve as a guarantor, an organization must meet the following requirements:

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(1) Be a legal entity authorized to conduct business within a State of the United States.

(2) Not be under Federal or State bankruptcy or rehabilitation proceedings.

(3) Have a net worth (not including other guarantees, intangibles and restricted reserves) equal to three times the amount of the PSO guarantee.

(4) If the guarantor is regulated by a State insurance commissioner, or other State official with authority for risk-bearing entities, it must meet the net worth requirement in § 422.390(c)(3) with all guarantees and all investments in and loans to organizations covered by guarantees excluded from its assets.

(5) If the guarantor is not regulated by a State insurance commissioner, or other similar State official it must meet the net worth requirement in § 422.390(c)(3) with all guarantees and all investments in and loans to organizations covered by a guarantee and to related parties (subsidiaries and affiliates) excluded from its assets.

(d) *Guarantee document.* If the guarantee request is approved, a PSO must submit to CMS a written guarantee document signed by an appropriate authority of the guarantor. The guarantee document must—

(1) State the financial obligation covered by the guarantee;

(2) Agree to—

(i) Unconditionally fulfill the financial obligation covered by the guarantee; and

(ii) Not subordinate the guarantee to any other claim on the resources of the guarantor;

(3) Declare that the guarantor must act on a timely basis, in any case not more than 5 business days, to satisfy the financial obligation covered by the guarantee; and

(4) Meet other conditions as CMS may establish from time to time.

(e) *Reporting requirement.* A PSO must submit to CMS the current internal financial statements and annual audited financial statements of the guarantor according to the schedule, manner, and form that CMS requests.

(f) *Modification, substitution, and termination of a guarantee.* A PSO cannot

modify, substitute or terminate a guarantee unless the PSO—

(1) Requests CMS's approval at least 90 days before the proposed effective date of the modification, substitution, or termination;

(2) Demonstrates to CMS's satisfaction that the modification, substitution, or termination will not result in insolvency of the PSO; and

(3) Demonstrates how the PSO will meet the requirements of this section.

(g) *Nullification.* If at any time the guarantor or the guarantee ceases to meet the requirements of this section, CMS will notify the PSO that it ceases to recognize the guarantee document. In the event of this nullification, a PSO must—

(1) Meet the applicable requirements of this section within 15 business days; and

(2) If required by CMS, meet a portion of the applicable requirements in less than the time period granted in paragraph (g)(1) of this section.

[63 FR 25379, May 7, 1998]

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

SOURCE: 63 FR 35099, June 26, 1998, unless otherwise noted.

**§ 422.400 State licensure requirement.**

Except in the case of a PSO granted a waiver under subpart H of this part, each MA organization must—

(a) Be licensed under State law, or otherwise authorized to operate under State law, as a risk-bearing entity (as defined in § 422.2) eligible to offer health insurance or health benefits coverage in each State in which it offers one or more MA plans;

(b) If not commercially licensed, obtain certification from the State that the organization meets a level of financial solvency and such other standards as the State may require for it to operate as an MA organization; and

(c) Demonstrate to CMS that—

(1) The scope of its license or authority allows the organization to offer the type of MA plan or plans that it intends to offer in the State; and

(2) If applicable, it has obtained the State certification required under paragraph (b) of this section.

**§ 422.402 Federal preemption of State law.**

The standards established under this part supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to the MA plans that are offered by MA organizations.

[70 FR 4733, Jan. 28, 2005]

**§ 422.404 State premium taxes prohibited.**

(a) *Basic rule.* No premium tax, fee, or other similar assessment may be imposed by any State, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa, or any of their political subdivisions or other governmental authorities with respect to any payment CMS makes on behalf of MA enrollees under subpart G of this part, or with respect to any payment made to MA plans by beneficiaries, or payment to MA plans by a third party on a beneficiary's behalf.

(b) *Construction.* Nothing in this section shall be construed to exempt any MA organization from taxes, fees, or other monetary assessments related to the net income or profit that accrues to, or is realized by, the organization from business conducted under this part, if that tax, fee, or payment is applicable to a broad range of business activity.

[63 FR 35099, June 26, 1998, as amended at 70 FR 4733, Jan. 28, 2005]

**Subpart J—Special Rules for MA Regional Plans**

SOURCE: 70 FR 4733, Jan. 28, 2005, unless otherwise noted.

**§ 422.451 Moratorium on new local preferred provider organization plans.**

CMS will not approve the offering of a local preferred provider organization plan during 2006 or 2007 in a service area unless the MA organization seeking to offer the plan was offering a local preferred provider organization

plan in the service area before December 31, 2005.

**§ 422.455 Special rules for MA Regional Plans.**

(a) *Coverage of entire MA region.* The service area for an MA regional plan will consist of an entire MA region established under paragraph (b) of this section, and an MA region may not be segmented as described in § 422.262(c)(2).

(b) *Establishment of MA regions—(1) MA region.* The term “MA region” means a region within the 50 States and the District of Columbia as established by CMS under this section.

(2) *Establishment—(i) Initial establishment.* By January 1, 2005, CMS will establish and publish the MA regions.

(ii) *Periodic review and revision of service areas.* CMS may periodically review MA regions and may revise the regions if it determines the revision to be appropriate.

(3) *Requirements for MA regions.* CMS will establish, and may revise, MA regions in a manner consistent with the following:

(i) *Number of regions.* There will be no fewer than 10 regions, and no more than 50 regions.

(ii) *Maximizing availability of plans.* The main purpose of the regions is to maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, or geographic location, especially those residing in rural areas.

(4) *Market survey and analysis.* Before establishing MA regions, CMS will conduct a market survey and analysis, including an examination of current insurance markets, to assist CMS in determining how the regions should be established.

(c) *National plan.* An MA regional plan can be offered in more than one MA region (including all regions).

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

(a) *Terminology.* For purposes of this section—

*Allowable costs* means, with respect to an MA regional plan offered by an organization for a year, the total amount of costs that the organization incurred in providing benefits covered under the

original Medicare fee-for-service program option for all enrollees under the plan in the region in the year and in providing rebatable integrated benefits, as defined in this paragraph, reduced by the portion of those costs attributable to administrative expenses incurred in providing these benefits.

*Rebatable integrated benefits* means those non-drug supplemental benefits that are funded through beneficiary rebates (described at § 422.266(b)(1)) and that CMS determines are additional health benefits not covered under the original Medicare program option and that require expenditures by the plan. For purposes of the calculation of risk corridors, these are the only supplemental benefits that count toward allowable costs.

*Target amount* means, with respect to an MA regional plan offered by an organization in a year, the total amount of payments made to the organization for enrollees in the plan for the year (which includes payments attributable to benefits under the original Medicare fee-for-service program option as defined in § 422.100(c)(1), the total of the MA monthly basic beneficiary premium collectable for those enrollees for the year, and the total amount of rebatable integrated benefits), reduced by the amount of administrative expenses assumed in the portion of the bid attributable to benefits under original Medicare fee-for-service program option or to rebatable integrated benefits.

(b) *Application of risk corridors for benefits covered under original fee-for-service Medicare—(1) General rule.* This section will only apply to MA regional plans offered during 2006 or 2007.

(2) *Notification of allowable costs under the plan.* In the case of an MA organization that offers an MA regional plan in an MA region in 2006 or 2007, the organization must notify CMS, before that date in the succeeding year as CMS specifies, of—

(i) Its total amount of costs that the organization

incurred in providing benefits covered under the original Medicare fee-for-service program option for all enrollees under the plan (as described in paragraph (a) of this section).

(ii) Its total amount of costs that the organization incurred in providing rebatable integrated benefits for all enrollees under the plan (as described in paragraph (a) of this section), and, with respect to those benefits, the portion of those costs that is attributable to administrative expenses that is in addition to the administrative expense incurred in provision of benefits under the original Medicare fee-for-service program option.

(c) *Adjustment of payment—(1) No adjustment if allowable costs within 3 percent of target amount.* If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there will be no payment adjustment under this section for the plan and year.

(2) *Increase in payment if allowable costs above 103 percent of target amount—*

(i) *Costs between 103 and 108 percent of target amount.* If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, CMS will increase the total of the monthly payments made to the organization offering the plan for the year under § 422.302(a) (section 1853(a) of the Act) by an amount equal to 50 percent of the difference between those allowable costs and 103 percent of that target amount.

(ii) *Costs above 108 percent of target amount.* If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, CMS will increase the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) of the Act by an amount equal to the sum of—

(A) 2.5 percent of that target amount; and

(B) 80 percent of the difference between those allowable costs and 108 percent of that target amount.

(3) *Reduction in payment if allowable costs below 97 percent of target amount—*

(i) *Costs between 92 and 97 percent of target amount.* If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, CMS will reduce the

total of the monthly payments made to the organization offering the plan for the year under § 422.302(a) (section 1853(a) of the Act) by an amount (or otherwise recover from the plan an amount) equal to 50 percent of the difference between 97 percent of the target amount and those allowable costs.

(ii) *Costs below 92 percent of target amount.* If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, CMS will reduce the total of the monthly payments made to the organization offering the plan for the year under § 422.302(a) (section 1853(a) of the Act) by an amount (or otherwise recover from the plan an amount) equal to the sum of-

(A) 2.5 percent of that target amount; and

(B) 80 percent of the difference between 92 percent of that target amount and those allowable costs.

(d) *Disclosure of information*—(1) *General rule.* Each MA organization offering an MA regional plan must provide CMS with information as CMS determines is necessary to implement this section; and

(2) According to § 422.504(d)(1)(iii), CMS has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to CMS under paragraph (b)(2) of this section.

(3) *Restriction on use of information.* Information disclosed or obtained for the purposes of this section may be used by officers, employees, and contractors of DHHS only for the purposes of, and to the extent necessary in, implementing this section.

(e) *Organizational and financial requirements*—(1) *General rule.* Regional MA plans offered by MA organizations must be licensed under State law, or otherwise authorized under State law, as a risk-bearing entity (as defined in § 422.2) eligible to offer health insurance or health benefits coverage in each State in which it offers one or more plans. However, as provided for under this section, MA organizations offering MA regional plans may obtain a temporary waiver of State licensure. In the case of an MA organization that is offering an MA regional plan in an MA region, and is not licensed in each

State in which it offers such an MA regional plan, the following rules apply:

(i) The MA organization must be licensed to bear risk in at least one State of the region.

(ii) For the other States in a region in which the organization is not licensed to bear risk, if it demonstrates to CMS that it has filed the necessary application to meet those requirements, CMS may temporarily waive the licensing requirement with respect to each State for a period of time as CMS determines appropriate for the timely processing of the application by the State or States.

(iii) If the State licensing application or applications are denied, CMS may extend the licensing waiver through the end of the plan year or as CMS determines appropriate to provide for a transition.

(2) *Selection of appropriate State.* In the case of an MA organization to which CMS grants a waiver and that is licensed in more than one State in a region, the MA organization will select one of the States, the rules of which shall apply in States where the organization is not licensed for the period of the waiver.

(f) *Regional stabilization fund*—(1) *Establishment.* The MA Regional Plan Stabilization Fund (referred to in this paragraph (f) as the “Fund”) is available beginning in 2007 for two purposes:

(i) *Plan entry.* To provide incentives to have MA regional plans offered in each MA region under paragraph (f)(4) of this section.

(ii) *Plan retention.* To provide incentives to retain MA regional plans in certain MA regions with below-national-average MA market penetration under paragraph (f)(5) of this section.

(2) *Availability of funding from savings.* Funds made available under section 1853(f) of the Act are transferred into a special account in the Treasury from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f) of the Act, “payments From Trust Funds,” on a monthly basis.

(3) *Funding limitation*—(i) *General rule.* The total amount expended from the Fund as a result of the application of

this section through the end of a calendar year may not exceed the amount available to the Fund as of the first day of that year. For purposes of this section, amounts that are expended under this title insofar as those amounts would not have been expended but for the application of this section will be counted as amounts expended as a result of that application.

(ii) *Application of limitation.* CMS will obligate funds from the Fund for a year only if the Chief Actuary of CMS and the appropriate budget officer certify that there are available in the Fund at the beginning of the year sufficient amounts to cover all of those obligations incurred during the year consistent with paragraph (f)(3)(i) of this section. CMS will take those steps, in connection with computing additional payment amounts under paragraphs (f)(4) and (f)(5) of this section and including limitations on enrollment in MA regional plans receiving those payments or computing lower payment amounts, to ensure that sufficient funds are available to make those payments for the entire year.

(4) *Plan entry funding—(i) General rule.* Funding is available under this paragraph for a year in the following situations:

(A) *National plan.* For a national bonus payment described in paragraph (f)(4)(ii) of this section, when a single MA organization offers an MA regional plan in each MA region in the year, but only if there was not a national plan offered in each region in the previous year. Funding under this paragraph is only available with respect to any individual MA organization for a single year, but may be made available to more than one such organization in the same year.

(B) *MA Regional Plans.* Subject to paragraph (f)(4)(i)(C) of this section, for an increased amount under paragraph (f)(4)(iv) of this section for an MA regional plan offered in an MA region that did not have any MA regional plan offered in the prior year.

(C) *Limitation on MA regional plan funding in case of national plan.* There will be no payment adjustment under paragraph (f)(4)(iii) of this section for a year for which a national bonus pay-

ment is made under paragraph (f)(4)(ii) of this section.

(ii) *National bonus payment.* The national bonus payment under this paragraph will—

(A) Be available to an MA organization only if the organization offers MA regional plans in every MA region;

(B) Be available for all MA regional plans of the organization regardless of whether any other MA regional plan is offered in any region; and

(C) Be subject to amounts available under paragraph (f)(3) of this section for a year and be equal to 3 percent of the benchmark amount otherwise applicable for each MA regional plan offered by the organization.

(iii) *Regional payment adjustment—(A) General rule.* The increased amount under this paragraph for an MA regional plan in an MA region for a year must be an amount, determined by CMS, based on the bid submitted for that plan (or plans) and will be available to all MA regional plans offered in that region and year. That amount may be based on the mean, mode, or median or other measure of those bids and may vary from region to region. CMS will not limit the number of plans or bids in a region.

(B) *Multi-year funding.* Subject to amounts available under paragraph (f)(3) of this section, funding will be available for a period determined by CMS.

(C) *Application to all plans in a region.* Funding under this paragraph for an MA region will be made available for all MA regional plans offered in the region.

(D) *Limitation on availability of plan retention funding in next year.* If plans receive plan entry funding in a year, plans in that region are prohibited from receiving plan retention funding in the following year.

(iv) *Application.* Any additional payment under this section provided for an MA regional plan for a year will be treated as if it were an addition to the benchmark amount otherwise applicable to that plan and year, but will not be taken into account in the computation of any benchmark amount for any subsequent year.

(5) *Plan retention funding—(i) General rule.* Funding is available under this

paragraph for a year with respect to MA regional plans offered in an MA region for the increased amount specified in paragraph (f)(5)(ii) of this section but only if the region meets the requirements of paragraphs (f)(5)(iii)(A), (f)(5)(iii)(B), (f)(5)(iii)(C) and (f)(5)(iii)(E) of this section.

(ii) *Payment increase.* The increased amount under this paragraph for an MA regional plan in an MA region for a year will be an amount, determined by CMS, that does not exceed the greater of—

(A) 3 percent of the benchmark amount applicable in the region; or

(B) The amount as (when added to the benchmark amount applicable to the region) will result in the ratio of—

(I) That additional amount plus the benchmark amount computed under section 1854(b)(4)(B)(i) of the Act, “the risk-adjusted benchmark amount” for the region and year, to the adjusted average per capita cost for the region and year, as estimated by CMS under section 1876(a)(4) of the Act and adjusted as appropriate for the purpose of risk adjustment; being equal to—

(2) The weighted average of those benchmark amounts for all the regions and that year, to the average per capita cost for the United States and that year, as estimated by CMS under section 1876(a)(4) of the Act and adjusted as appropriate for the purpose of risk adjustment.

(iii) *Regional requirements.* The requirements of this paragraph for an MA region for a year are as follows:

(A) *Notification of plan exit.* CMS has received notice (as specified by CMS), before a new contract year, that one or more MA regional plans that were offered in the region in the previous year will not be offered in the succeeding year.

(B) *Regional plans available from fewer than two MA organizations in the region.* CMS determines that if the plans referred to in paragraph (f)(5)(iii)(A) of this section are not offered in the year, fewer than two MA organizations will be offering MA regional plans in the region in the year involved.

(C) *Percentage enrollment in MA regional plans below national average.* For the previous year, CMS determines that the average percentage of MA eli-

gible individuals residing in the region who are enrolled in MA regional plans is less than the average percentage of those individuals in the United States enrolled in those plans.

(D) *Application.* Any additional payment under this paragraph provided for an MA regional plan for a year will be treated as if it were an addition to the benchmark amount otherwise applicable to that plan and year, but will not be taken into account in the computation of any benchmark amount for any subsequent year.

(E) *2-consecutive-year limitation.* In no case will plan retention funding be available under this paragraph in an MA region for more than 2 consecutive years.

[70 FR 4732, Jan. 28, 2005, as amended at 70 FR 52027, Sept. 1, 2005]

### Subpart K—Contracts With Medicare Advantage Organizations

SOURCE: 63 FR 35099, June 26, 1998, unless otherwise noted.

#### § 422.500 Scope and definitions.

(a) *Scope.* This subpart sets forth application requirements for entities seeking a contract as a Medicare organization offering an MA plan. MA organizations offering prescription drug plans must, in addition to the requirements of this part, follow the requirements of part 423 of this chapter specifically related to the prescription drug benefit.

(b) *Definitions.* For purposes of this subpart, the following definitions apply:

*Business transaction* means any of the following kinds of transactions:

(1) Sale, exchange, or lease of property.

(2) Loan of money or extension of credit.

(3) Goods, services, or facilities furnished for a monetary consideration, including management services, but not including—

(i) Salaries paid to employees for services performed in the normal course of their employment; or

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(ii) Health services furnished to the MA organization's enrollees by hospitals and other providers, and by MA organization staff, medical groups, or independent practice associations, or by any combination of those entities.

*Clean claim* means—

(1) A claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with § 422.310(d)) or particular circumstance requiring special treatment that prevents timely payment; and

(2) A claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

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

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

*Party in interest* includes the following:

(1) Any director, officer, partner, or employee responsible for management or administration of an MA organization.

(2) Any person who is directly or indirectly the beneficial owner of more than 5 percent of the organization's equity; or the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than 5 percent of the organization.

(3) In the case of an MA organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law.

(4) Any entity in which a person described in paragraph (1), (2), or (3) of this definition:

(i) Is an officer, director, or partner; or

(ii) Has the kind of interest described in paragraphs (1), (2), or (3) of this definition.

(5) Any person that directly or indirectly controls, is controlled by, or is under common control with, the MA organization.

(6) Any spouse, child, or parent of an individual described in paragraph (1), (2), or (3) of this definition.

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

(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.

*Significant business transaction* means any business transaction or series of transactions of the kind specified in the above definition of "business transaction" that, during any fiscal year of the MA organization, have a total value that exceeds \$25,000 or 5 percent of the MA organization's total operating expenses, whichever is less.

[65 FR 35099, June 26, 1998, as amended at 65 FR 40327, June 29, 2000; 70 FR 4736, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005]

**§ 422.501 Application requirements.**

(a) *Scope.* This section sets forth application requirements for entities that seek a contract as an MA organization offering an MA plan.

(b) *Completion of an application.* (1) In order to obtain a determination on whether it meets the requirements to become an MA organization and is qualified to provide a particular type of MA plan, an entity, or an individual authorized to act for the entity (the applicant) must complete a certified application, in the form and manner required by CMS, including the following:

(i) Documentation of appropriate State licensure or State certification that the entity is able to offer health insurance or health benefits coverage that meets State-specified standards applicable to MA plans, and is authorized by the State to accept prepaid capitation for providing, arranging, or paying for the comprehensive health

care services to be offered under the MA contract; or

(ii) For regional plans, documentation of application for State licensure in any State in the region that the organization is not already licensed.

(2) The authorized individual must thoroughly describe how the entity and MA plan meet, or will meet, the requirements described in this part.

(c) *Responsibility for making determinations.* (1) CMS is responsible for determining whether an entity qualifies as an MA organization and whether proposed MA plans meet the requirements of this part.

(2) A CMS determination that an entity is qualified to act as an MA organization is distinct from the bid negotiation that occurs under subpart F of this part and such negotiation is not subject to the appeals provisions included in subpart N of this part.

(d) *Resubmittal of application.* An application that has been denied by CMS may not be resubmitted for 4 months after the date of the notice from CMS denying the application.

(e) *Disclosure of application information under the Freedom of Information Act.* An applicant submitting material that he or she believes is protected from disclosure under 5 U.S.C. 552, the Freedom of Information Act, or because of exemptions provided in 45 CFR part 5 (the Department's regulations providing exceptions to disclosure), must label the material "privileged" and include an explanation of the applicability of an exception described in 45 CFR part 5. Any final decisions as to whether material is privileged is the final decision of the Secretary.

[70 FR 4736, Jan. 28, 2005]

**§ 422.502 Evaluation and determination procedures.**

(a) *Basis for evaluation and determination.* (1) CMS evaluates an application for an MA contract on the basis of information contained in the application itself and any additional information that CMS obtains through other means such as on-site visits, public hearings, and any other appropriate procedures.

(2) After evaluating all relevant information, CMS determines whether the applicant's application meets the applicable requirements of § 422.501.

(b) *Use of information from a prior contracting period.* If an MA organization has failed to comply with the terms of a previous contract with CMS under title XVIII of the Act, or has failed to complete a corrective action plan during the term of the contract, CMS may deny an application based on the applicant's failure to comply with that prior contract with CMS even if the contract applicant meets all of the current requirements.

(c) *Notice of determination.* Within timeframes determined by CMS, it notifies each applicant that applies for an MA contract under this part of its determination and the basis for the determination. The determination is one of the following:

(1) *Approval of application.* If CMS approves the application, it gives written notice to the applicant, indicating that it qualifies to contract as an MA organization.

(2) *Intent to deny.* (i) If CMS finds that the applicant does not appear to be able to meet the requirements for an MA organization and/or has not provided enough information to evaluate the application, CMS gives the contract applicant notice of intent to deny the application for an MA contract and a summary of the basis for this preliminary finding.

(ii) Within 10 days from the date of the intent to deny notice, the contract applicant must respond in writing to the issues or other matters that were the basis for CMS' preliminary finding and must revise its application to remedy any defects CMS identified.

(3) *Denial of application.* If CMS denies the application, it gives written notice to the contract applicant indicating—

(i) That the applicant is not qualified to contract as an MA organization under Part C of title XVIII of the Act;

(ii) The reasons why the applicant is not qualified; and

(iii) The applicant's right to request reconsideration in accordance with the procedures specified in subpart N of this part.

(d) *Oversight of continuing compliance.* (1) CMS oversees an MA organization's continued compliance with the requirements for an MA organization.

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(2) If an MA organization no longer meets those requirements, CMS terminates the contract in accordance with § 422.510.

[70 FR 4736, Jan. 28, 2005]

**§ 422.503 General provisions.**

(a) *Basic rule.* In order to qualify as an MA organization, enroll beneficiaries in any MA plans it offers, and be paid on behalf of Medicare beneficiaries enrolled in those plans, an MA organization must enter into a contract with CMS.

(b) *Conditions necessary to contract as an MA organization.* Any entity seeking to contract as an MA organization must:

(1) Complete an application as described in § 422.501.

(2) Be licensed by the State as a risk bearing entity in each State in which it seeks to offer an MA plan as defined in § 422.2.

(3) Meet the minimum enrollment requirements of § 422.514, unless waived under § 422.514(b).

(4) Have administrative and management arrangements satisfactory to CMS, as demonstrated by at least the following:

(i) A policy making body that exercises oversight and control over the MA organization's policies and personnel to ensure that management actions are in the best interest of the organization and its enrollees.

(ii) Personnel and systems sufficient for the MA organization to organize, implement, control, and evaluate financial and marketing activities, the furnishing of services, the quality improvement program, and the administrative and management aspects of the organization.

(iii) At a minimum, an executive manager whose appointment and removal are under the control of the policy making body.

(iv) A fidelity bond or bonds, procured and maintained by the MA organization, in an amount fixed by its policymaking body but not less than \$100,000 per individual, covering each officer and employee entrusted with the handling of its funds. The bond may have reasonable deductibles, based upon the financial strength of the MA organization.

(v) Insurance policies or other arrangements, secured and maintained by the MA organization and approved by CMS to insure the MA organization against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks.

(vi) A compliance plan that consists of the following:

(A) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.

(B) The designation of a compliance officer and compliance committee that are accountable to senior management.

(C) Effective training and education between the compliance officer and organization employees.

(D) Effective lines of communication between the compliance officer and the organization's employees.

(E) Enforcement of standards through well-publicized disciplinary guidelines.

(F) Procedures for internal monitoring and auditing.

(G) Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives relating to the organization's MA contract.

(1) If the MA organization discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct.

(2) The MA organization must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph (b)(4)(vi)(G)(1) of this section.

(H) For MA-PDs, A comprehensive fraud and abuse plan to detect and prevent fraud, waste, and abuse as specified at § 423.504(b)(4)(vi)(H) of this chapter.

(5) Not accept new enrollees under a section 1876 reasonable cost contract in any area in which it seeks to offer an MA plan.

(6) The MA organization's contract must not have been non-renewed under § 422.506 within the past 2 years unless—

(i) During the 6-month period beginning on the date the organization notified CMS of the intention to non-renew the most recent previous contract, there was a change in the statute or regulations that had the effect of increasing MA payments in the payment area or areas at issue; or

(ii) CMS has otherwise determined that circumstances warrant special consideration.

(c) *Contracting authority.* Under the authority of section 1857(c)(5) of the Act, CMS may enter into contracts under this part without regard to Federal and Departmental acquisition regulations set forth in title 48 of the CFR and provisions of law or other regulations relating to the making, performance, amendment, or modification of contracts of the United States if CMS determines that those provisions are inconsistent with the efficient and effective administration of the Medicare program.

(d) *Protection against fraud and beneficiary protections.* (1) CMS annually audits the financial records (including data relating to Medicare utilization, costs, and computation of the bid) of at least one-third of the MA organizations offering MA plans. These auditing activities are subject to monitoring by the Comptroller General.

(2) Each contract under this section must provide that CMS, or any person or organization designated by CMS has the right to:

(i) Inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the MA contract;

(ii) Inspect or otherwise evaluate the facilities of the organization when there is reasonable evidence of some need for such inspection; and

(iii) Audit and inspect any books, contracts, and records of the MA organization that pertain to—

(A) The ability of the organization or its first tier or downstream providers to bear the risk of potential financial losses; or

(B) Services performed or determinations of amounts payable under the contract.

(e) *Severability of contracts.* The contract must provide that, upon CMS's request—

(1) The contract will be amended to exclude any MA plan or State-licensed entity specified by CMS; and

(2) A separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made.

[63 FR 35099, June 26, 1998, as amended at 65 FR 40327, June 29, 2000. Redesignated at 70 FR 4736, Jan. 28, 2005, and amended at 70 FR 4737, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005; 70 FR 76198, Dec. 23, 2005]

#### § 422.504 Contract provisions.

The contract between the MA organization and CMS must contain the following provisions:

(a) *Agreement to comply with regulations and instructions.* The MA organization agrees to comply with all the applicable requirements and conditions set forth in this part and in general instructions. An MA organization's compliance with paragraphs (a)(1) through (a)(13) of this section is material to performance of the contract. The MA organization agrees—

(1) To accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in subpart B of this part.

(2) That it will comply with the prohibition in § 422.110 on discrimination in beneficiary enrollment.

(3) To provide—

(i) The basic benefits as required under § 422.101 and, to the extent applicable, supplemental benefits under § 422.102; and

(ii) Access to benefits as required under subpart C of this part;

(iii) In a manner consistent with professionally recognized standards of health care, all benefits covered by Medicare.

(4) To disclose information to beneficiaries in the manner and the form prescribed by CMS as required under § 422.111;

(5) To operate a quality assurance and performance improvement program and have an agreement for external quality review as required under subpart D of this part;

(6) To comply with all applicable provider requirements in subpart E of this part, including provider certification

requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans;

(7) To comply with all requirements in subpart M of this part governing coverage determinations, grievances, and appeals;

(8) To comply with the reporting requirements in § 422.516 and the requirements in § 422.310 for submitting data to CMS;

(9) That it will be paid under the contract in accordance with the payment rules in subpart G of this part;

(10) To develop its annual bid, and submit all required information on premiums, benefits, and cost-sharing by not later than the first Monday in June, as provided in subpart F of this part;

(11) That its contract may not be renewed or may be terminated in accordance with this subpart and subpart N of this part.

(12) To comply with all requirements that are specific to a particular type of MA plan, such as the special rules for private fee-for-service plans in §§ 422.114 and 422.216 and the MSA requirements in §§ 422.56, 422.103, and 422.262; and

(13) To comply with the confidentiality and enrollee record accuracy requirements in § 422.118.

(14) An MA organization's compliance with paragraphs (a)(1) through (a)(13) and (c) of this section is material to performance of the contract.

(b) *Communication with CMS.* The MA organization must have the capacity to communicate with CMS electronically.

(c) *Prompt payment.* The MA organization must comply with the prompt payment provisions of § 422.520 and with instructions issued by CMS, as they apply to each type of plan included in the contract.

(d) *Maintenance of records.* The MA organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that—

(1) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data

related to Medicare utilization, costs, and computation of the bid) of MA organizations.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the organization.

(iii) Enable CMS to audit and inspect any books and records of the MA organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the bid proposal.

(v) Establish component rates of the bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(2) Include at least records of the following:

(i) Ownership and operation of the MA organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and 10 prior periods.

(iii) Federal income tax or informational returns for the current contract period and 10 prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts, and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities.

(e) *Access to facilities and records.* The MA organization agrees to the following:

(1) HHS, the Comptroller General, or their designee may evaluate, through inspection or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the MA organization; and

(iii) The enrollment and disenrollment records for the current contract period and 10 prior periods.

(2) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the MA organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(3) The MA organization agrees to make available, for the purposes specified in paragraph (d) of this section, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require.

(4) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the end of the final contract period or completion of audit, whichever is later unless—

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or allegation of fraud or similar fault by the MA organization, in which case the retention may be extended to 6 years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or

(iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit the MA organization at any time.

(f) *Disclosure of information.* The MA organization agrees to submit—

(1) To CMS, certified financial information that must include the following:

(i) Such information as CMS may require demonstrating that the organization has a fiscally sound operation.

(ii) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA organization.

(2) To CMS, all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(i) The benefits covered under an MA plan;

(ii) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan or in the case of an MSA plan, the MA monthly MSA premium.

(iii) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(iv) Plan quality and performance indicators for the benefits under the plan including—

(A) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(B) Information on Medicare enrollee satisfaction;

(C) Information on health outcomes;

(D) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(E) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(v) Information about beneficiary appeals and their disposition;

(vi) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(vii) To CMS, any other information deemed necessary by CMS for the administration or evaluation of the Medicare program.

(3) To its enrollees all informational requirements under § 422.64 and, upon

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an enrollee's, request the financial disclosure information required under § 422.516.

(g) *Beneficiary financial protections.* The MA organization agrees to comply with the following requirements:

(1) Each MA organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability (for example, as a result of an organization's insolvency or other financial difficulties) for payment of any fees that are the legal obligation of the MA organization. To meet this requirement, the MA organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the organization's providers from holding any beneficiary enrollee liable for payment of any such fees; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA organization, to provide services to the organization's beneficiary enrollees.

(2) The MA organization must provide for continuation of enrollee health care benefits—

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of an insolvency, through discharge.

(3) In meeting the requirements of this paragraph, other than the provider contract requirements specified in paragraph (g)(1)(i) of this section, the MA organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS.

(h) *Requirements of other laws and regulations.* The MA organization agrees to comply with—

(1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of

Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Act); and

(2) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

(i) *MA organization relationship with related entities, contractors, and subcontractors.* (1) Notwithstanding any relationship(s) that the MA organization may have with related entities, contractors, or subcontractors, the MA organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS.

(2) The MA organization agrees to require all related entities, contractors, or subcontractors to agree that—

(i) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to the MA contract; and

(ii) HHS', the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

(3) All contracts or written arrangements between MA organizations and providers, related entities, contractors, subcontractors, first tier and downstream entities must contain the following:

(i) Enrollee protection provisions that provide, consistent with paragraph (g)(1) of this section, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the obligation of the MA organization.

(ii) Accountability provisions that indicate that the MA organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with the requirements set forth at paragraph (i)(4) of this section.

(iii) A provision requiring that any services or other activity performed by

a related entity, contractor, subcontractor, or first-tier or downstream entity in accordance with a contract or written agreement are consistent and comply with the MA organization's contractual obligations.

(4) If any of the MA organizations' activities or responsibilities under its contract with CMS are delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

(i) Written arrangements must specify delegated activities and reporting responsibilities.

(ii) Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) Written arrangements must specify that the performance of the parties is monitored by the MA organization on an ongoing basis.

(iv) Written arrangements must specify that either—

(A) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization; or

(B) The credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

(v) All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions.

(5) If the MA organization delegates selection of the providers, contractors, or subcontractor to another organization, the MA organization's written arrangements with that organization must state that the CMS-contracting MA organization retains the right to approve, suspend, or terminate any such arrangement.

(j) *Additional contract terms.* The MA organization agrees to include in the contract such other terms and conditions as CMS may find necessary and appropriate in order to implement requirements in this part.

(k) *Severability of contracts.* The contract must provide that, upon CMS's request—

(1) The contract will be amended to exclude any MA plan or State-licensed entity specified by CMS; and

(2) A separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made.

(1) *Certification of data that determine payment.* As a condition for receiving a monthly payment under subpart G of this part, the MA organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on a document that certifies (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of relevant data that CMS requests. Such data include specified enrollment information, encounter data, and other information that CMS may specify.

(1) The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify that each enrollee for whom the organization is requesting payment is validly enrolled in an MA plan offered by the organization and the information relied upon by CMS in determining payment (based on best knowledge, information, and belief) is accurate, complete, and truthful.

(2) The CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the data it submits under § 422.310 are accurate, complete, and truthful.

(3) If such data are generated by a related entity, contractor, or subcontractor of an MA organization, such entity, contractor, or subcontractor must similarly certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

(4) The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who

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reports directly to such officer, must certify (based on best knowledge, information, and belief) that the information in its bid submission is accurate, complete, and truthful and fully conforms to the requirements in § 422.254.

[63 FR 35099, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 64 FR 7980, Feb. 17, 1999; 65 FR 40327, June 29, 2000. Redesignated at 70 FR 4736, Jan. 28, 2005 and amended at 70 FR 4737, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005]

### § 422.505 Effective date and term of contract.

(a) *Effective date.* The contract is effective on the date specified in the contract between the MA organization and CMS and, for a contract that provides for coverage under an MSA plan, not earlier than January 1999.

(b) *Term of contract.* Each contract is for a period of at least 12 months.

(c) *Renewal of contract.* In accordance with § 422.506, contracts are renewed annually only if—

(1) CMS informs the MA organization that it authorizes a renewal; and

(2) The MA organization has not provided CMS with a notice of intention not to renew.

(d) *Renewal of contract contingent on reaching agreement on the bid.* Although an MA organization may be determined qualified to renew its contract under this section, if the organization and CMS cannot reach agreement on the bid under subpart F of this part, no renewal will take place, and the failure to reach an agreement is not subject to the appeals provisions in subpart N of this part.

[63 FR 35099, June 26, 1998, as amended at 65 FR 40328, June 29, 2000. Redesignated at 70 FR 4736, Jan. 28, 2005 and amended at 70 FR 4737, Jan. 28, 2005]

### § 422.506 Nonrenewal of contract.

(a) *Nonrenewal by an MA organization.* (1) An MA organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason provided it meets the timeframes for doing so set forth in paragraphs (a)(2) and (a)(3) of this section.

(2) If an MA organization does not intend to renew its contract, it must notify—

(i) CMS in writing, by the first Monday in June of the year in which the contract would end;

(ii) Each Medicare enrollee, at least 90 days before the date on which the nonrenewal is effective. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA plans, Medigap options, and original Medicare and must receive CMS approval prior to issuance.

(iii) The general public, at least 90 days before the end of the current calendar year, by publishing a notice in one or more newspapers of general circulation in each community located in the MA organization's service area.

(3) CMS may accept a nonrenewal notice submitted after the first Monday in June if—

(i) The MA organization notifies its Medicare enrollees and the public in accordance with paragraph (a)(2)(ii) and (a)(2)(iii) of this section; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(4) If an MA organization does not renew a contract under this paragraph (a), CMS will not enter into a contract with the organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS.

(b) *CMS decision not to renew.* (1) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) The MA organization has not fully implemented or shown discernable progress in implementing quality improvement projects as defined in § 422.152(d).

(ii) For any of the reasons listed in § 422.510(a), which would also permit CMS to terminate the contract.

(iii) The MA organization has committed any of the acts in § 422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under subpart O of this part.

(2) *Notice.* CMS provides notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA organization by May 1 of the contract year.

(ii) If CMS decides not to authorize a renewal of the contract, to the MA organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(iii) If CMS decides not to authorize a renewal of the contract, to the general public at least 90 days before the end of the current calendar year, by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA organization's service area.

(3) *Notice of appeal rights.* CMS gives the MA organization written notice of its right to appeal the decision not to renew in accordance with § 422.644.

[63 FR 35099, June 26, 1998, as amended at 65 FR 40328, June 29, 2000; 67 FR 13289, Mar. 22, 2002; 70 FR 4737, Jan. 28, 2005]

**§ 422.508 Modification or termination of contract by mutual consent.**

(a) A contract may be modified or terminated at any time by written mutual consent.

(1) If the contract is terminated by mutual consent, except as provided in paragraph (b) of this section, the MA organization must provide notice to its Medicare enrollees and the general public as provided in § 422.512(b)(2) and (b)(3).

(2) If the contract is modified by mutual consent, the MA organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within timeframes specified by CMS.

(b) If the contract terminated by mutual consent is replaced the day following such termination by a new MA contract, the MA organization is not required to provide the notice specified in paragraph (a)(1) of this section.

**§ 422.510 Termination of contract by CMS.**

(a) *Termination by CMS.* CMS may terminate a contract for any of the following reasons:

(1) The MA organization has failed substantially to carry out the terms of its contract with CMS.

(2) The MA organization is carrying out its contract with CMS in a manner that is inconsistent with the effective and efficient implementation of this part.

(3) CMS determines that the MA organization no longer meets the requirements of this part for being a contracting organization.

(4) There is credible evidence that the MA organization committed or participated in false, fraudulent, or abusive activities affecting the Medicare program, including submission of false or fraudulent data.

(5) The MA organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(6) The MA organization substantially fails to comply with the requirements in subpart M of this part relating to grievances and appeals.

(7) The MA organization fails to provide CMS with valid data as required under § 422.310.

(8) The MA organization fails to implement an acceptable quality assessment and performance improvement program as required under subpart D of this part.

(9) The MA organization substantially fails to comply with the prompt payment requirements in § 422.520.

(10) The MA organization substantially fails to comply with the service access requirements in § 422.112 or § 422.114.

(11) The MA organization fails to comply with the requirements of § 422.208 regarding physician incentive plans.

(12) The MA organization substantially fails to comply with the marketing requirements in § 422.80.

(b) *Notice.* If CMS decides to terminate a contract for reasons other than the grounds specified in § 422.510(a)(5), it gives notice of the termination as follows:

(1) *Termination of contract by CMS.* (i) CMS notifies the MA organization in writing 90 days before the intended date of the termination.

(ii) The MA organization notifies its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

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(iii) The MA organization notifies the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA organization's service area.

(2) *Immediate termination of contract by CMS.* (i) For terminations based on violations prescribed in § 422.510(a)(5), CMS notifies the MA organization in writing that its contract has been terminated effective the date of the termination decision by CMS. If termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA organization covering the period of the month following the contract termination.

(ii) CMS notifies the MA organization's Medicare enrollees in writing of CMS's decision to terminate the MA organization's contract. This notice occurs no later than 30 days after CMS notifies the plan of its decision to terminate the MA contract. CMS simultaneously informs the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA organizations in a similar geographic area and original Medicare.

(iii) CMS notifies the general public of the termination no later than 30 days after notifying the plan of CMS's decision to terminate the MA contract. This notice is published in one or more newspapers of general circulation in each community or county located in the MA organization's service area.

(c) *Corrective action plan*—(1) *General.* Before terminating a contract for reasons other than the grounds specified in paragraph (a)(5) of this section, CMS provides the MA organization with reasonable opportunity to develop and receive CMS approval of a corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(2) *Exception.* If a contract is terminated under § 422.510(a)(5), the MA organization will not have the opportunity to submit a corrective action plan.

(d) *Appeal rights.* If CMS decides to terminate a contract, it sends written notice to the MA organization informing it of its termination appeal rights

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in accordance with subpart N of this part.

[63 FR 35099, June 26, 1998, as amended at 65 FR 40328, June 29, 2000; 70 FR 52027, Sept. 1, 2005]

### § 422.512 Termination of contract by the MA organization.

(a) *Cause for termination.* The MA organization may terminate the MA contract if CMS fails to substantially carry out the terms of the contract.

(b) *Notice.* The MA organization must give advance notice as follows:

(1) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA organization is requesting contract termination.

(2) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the services area, including alternative MA plans, Medigap options, original Medicare and must receive CMS approval.

(3) To the general public at least 60 days before the termination effective date by publishing an CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA organization's geographic area.

(c) *Effective date of termination.* The effective date of the termination is determined by CMS and is at least 90 days after the date CMS receives the MA organization's notice of intent to terminate.

(d) *CMS's liability.* CMS's liability for payment to the MA organization ends as of the first day of the month after the last month for which the contract is in effect.

(e) *Effect of termination by the organization.* CMS does not enter into an agreement with an organization that has terminated its contract within the preceding 2 years unless there are circumstances that warrant special consideration, as determined by CMS.

[63 FR 35099, June 26, 1998, as amended at 67 FR 13288, Mar. 22, 2002]

**§ 422.514 Minimum enrollment requirements.**

(a) *Basic rule.* Except as provided in paragraph (b) of this section, CMS does not enter into a contract under this subpart unless the organization meets the following minimum enrollment requirement—

(1) At least 5,000 individuals (or 1,500 individuals if the organization is a PSO) are enrolled for the purpose of receiving health benefits from the organization; or

(2) At least 1,500 individuals (or 500 individuals if the organization is a PSO) are enrolled for purposes of receiving health benefits from the organization and the organization primarily serves individuals residing outside of urbanized areas as defined in § 412.62(f) (or, in the case of a PSO, the PSO meets the requirements in § 422.352(c)).

(3) Except as provided for in paragraph (b) of this section, an MA organization must maintain a minimum enrollment as defined in paragraphs (a)(1) and (a)(2) of this section for the duration of its contract.

(b) *Minimum enrollment waiver.* (1) For a contract applicant or MA organization that does not meet the applicable requirement of paragraph (a) of this section at application for an MA contract or during the first 3 years of the contract, CMS may waive the minimum enrollment requirement as provided for below. To receive a waiver, a contract applicant or MA organization must demonstrate to CMS's satisfaction that it is capable of administering and managing an MA contract and is able to manage the level of risk required under the contract. Factors that CMS takes into consideration in making this evaluation include the extent to which—

(i) The contract applicant or MA organization's management and providers have previous experience in managing and providing health care services under a risk-based payment arrangement to at least as many individuals as the applicable minimum enrollment for the entity as described in paragraph (a) of this section, or

(ii) The contract applicant or MA organization has the financial ability to bear financial risk under an MA con-

tract. In determining whether an organization is capable of bearing risk, CMS considers factors such as the organization's management experience as described in paragraph (b)(1)(i) of this section and stop-loss insurance that is adequate and acceptable to CMS; and

(iii) The contract applicant or MA organization is able to establish a marketing and enrollment process that allows it to meet the applicable enrollment requirement specified in paragraph (a) of this section before completion of the third contract year.

(2) If an MA organization fails to meet the enrollment requirement in the first year, CMS may waive the minimum requirements for another year provided that the organization—

(i) Requests an additional minimum enrollment waiver no later than 120 days before the end of the first year;

(ii) Continues to demonstrate it is capable of administering and managing an MA contract and is able to manage the level of risk; and,

(iii) Demonstrates an acceptable marketing and enrollment process. Enrollment projections for the second year of the waiver will become the organization's transitional enrollment standard.

(3) If an MA organization fails to meet the enrollment requirement in the second year, CMS may waive the minimum requirements for the third year only if the organization has attained the transitional enrollment standard as described in paragraph (b)(2)(iii) of this section.

(c) Failure to meet enrollment requirements. CMS may elect not to renew its contract with an MA organization that fails to meet the applicable enrollment requirement in paragraph (a) of this section

[63 FR 35099, June 26, 1998, as amended at 65 FR 40328, June 29, 2000]

**§ 422.516 Reporting requirements.**

(a) *Required information.* Each MA organization must have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality

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of the doctor-patient relationship, statistics and other information with respect to the following:

- (1) The cost of its operations.
- (2) The patterns of utilization of its services.
- (3) The availability, accessibility, and acceptability of its services.
- (4) To the extent practical, developments in the health status of its enrollees.
- (5) Information demonstrating that the MA organization has a fiscally sound operation.
- (6) Other matters that CMS may require.

(b) *Significant business transactions.* Each MA organization must report to CMS annually, within 120 days of the end of its fiscal year (unless for good cause shown, CMS authorizes an extension of time), the following:

- (1) A description of significant business transactions (as defined in § 422.500) between the MA organization and a party in interest.
- (2) With respect to those transactions—
  - (i) A showing that the costs of the transactions listed in paragraph (c) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or
  - (ii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.
- (3) A combined financial statement for the MA organization and a party in interest if either of the following conditions is met:
  - (i) Thirty-five percent or more of the costs of operation of the MA organization go to a party in interest.
  - (ii) Thirty-five percent or more of the revenue of a party in interest is from the MA organization.

(c) *Requirements for combined financial statements.* (1) The combined financial statements required by paragraph (b)(3) of this section must display in separate columns the financial information for the MA organization and each of the parties in interest.

(2) Inter-entity transactions must be eliminated in the consolidated column.

(3) The statements must have been examined by an independent auditor in

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accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(4) Upon written request from an MA organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this paragraph (c) with respect to a particular entity.

(d) *Reporting and disclosure under ERISA.* (1) For any employees' health benefits plan that includes an MA organization in its offerings, the MA organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the particular MA organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(2) The MA organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA.

(e) *Loan information.* Each organization must notify CMS of any loans or other special financial arrangements it makes with contractors, subcontractors and related entities.

(f) *Enrollee access to information.* Each MA organization must make the information reported to CMS under § 422.502(f)(1) available to its enrollees upon reasonable request.

**§ 422.520 Prompt payment by MA organization.**

(a) *Contract between CMS and the MA organization.* (1) The contract between CMS and the MA organization must provide that the MA organization will pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an MA private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.

(2) The MA organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B).

(3) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request.

(b)(1) *Contracts between MA organizations and providers and suppliers.* Contracts or other written agreements between MA organizations and providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA organization and the relevant provider.

(2) The MA organization is obligated to pay contracted providers under the terms of the contract between the MA organization and the provider.

(c) *Failure to comply.* If CMS determines, after giving notice and opportunity for hearing, that an MA organization has failed to make payments in accordance with paragraph (a) of this section, CMS may provide—

(1) For direct payment of the sums owed to providers, or MA private fee-for-service plan enrollees; and

(2) For appropriate reduction in the amounts that would otherwise be paid to the organization, to reflect the amounts of the direct payments and the cost of making those payments.

(d) A CMS decision to not conduct a hearing under paragraph (c) of this section does not disturb any potential remedy under State law for 1866(a)(1)(O) of the Act.

[63 FR 35099, June 26, 1998, as amended at 65 FR 40328, June 29, 2000; 70 FR 4738, Jan. 28, 2005]

**§ 422.521 Effective date of new significant regulatory requirements.**

CMS will not implement, other than at the beginning of a calendar year, requirements under this part that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute.

[68 FR 50858, Aug. 22, 2003]

**§ 422.524 Special rules for RFB societies.**

In order to participate as an MA organization, an RFB society—

(a) May not impose any limitation on membership based on any factor related to health status; and

(b) Must offer, in addition to the MA RFB plan, health coverage to individuals who are members of the church or convention or group of churches with which the society is affiliated, but who

are not entitled to receive benefits from the Medicare program.

**§ 422.527 Agreements with Federally qualified health centers.**

The contract between the MA organization and CMS must specify that—

(a) The MA organization must pay a Federally qualified health center (FQHC) a similar amount to what it pays other providers for similar services.

(b) Under such a contract, the FQHC must accept this payment as payment in full, except for allowable cost sharing which it may collect.

(c) Financial incentives, such as risk pool payments or bonuses, and financial withholdings are not considered in determining the payments made by CMS under § 422.316(a).

[70 FR 4738, Jan. 28, 2005]

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

SOURCE: 63 FR 35067, June 26, 1998, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to subpart L appear at 63 FR 35106, June 26, 1998.

**§ 422.550 General provisions.**

(a) *What constitutes change of ownership—*(1) *Partnership.* The removal, addition, or substitution of a partner, unless the partners expressly agree otherwise as permitted by applicable State law, constitutes a change of ownership.

(2) *Asset transfer.* Transfer of title and property to another party constitutes change of ownership.

(3) *Corporation.* (i) The merger of the MA organization's corporation into another corporation or the consolidation of the MA organization with one or more other corporations, resulting in a new corporate body, constitutes a change of ownership.

(ii) Transfer of corporate stock or the merger of another corporation into the MA organization's corporation, with the MA organization surviving, does not ordinarily constitute change of ownership.

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(b) *Advance notice requirement.* (1) An MA organization that has a Medicare contract in effect and is considering or negotiating a change in ownership must notify CMS at least 60 days before the anticipated effective date of the change. The MA organization must also provide updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization.

(2) If the MA organization fails to give CMS the required notice timely, it continues to be liable for capitation payments that CMS makes to it on behalf of Medicare enrollees after the date of change of ownership.

(c) *Novation agreement defined.* A novation agreement is an agreement among the current owner of the MA organization, the prospective new owner, and CMS—

(1) That is embodied in a document executed and signed by all three parties;

(2) That meets the requirements of § 422.552; and

(3) Under which CMS recognizes the new owner as the successor in interest to the current owner's Medicare contract.

(d) *Effect of change of ownership without novation agreement.* Except to the extent provided in paragraph (b)(2) of this section, the effect of a change of ownership without a novation agreement is that—

(1) The existing contract becomes invalid; and

(2) If the new owner wishes to participate in the Medicare program, it must apply for, and enter into, a contract in accordance with subpart K of this part.

(e) *Effect of change of ownership with novation agreement.* If the MA organization submits a novation agreement that meets the requirements of § 422.552, and CMS signs it, the new owner becomes the successor in interest to the current owner's Medicare contract.

[60 FR 45681, Sept. 1, 1995. Redesignated and amended at 63 FR 35067, 35106, June 26, 1998; 63 FR 52614, Oct. 1, 1998; 65 FR 40328, June 29, 2000; 70 FR 4738, Jan. 28, 2005]

§ 422.552 Novation agreement requirements.

(a) *Conditions for CMS approval of a novation agreement.* CMS approves a novation agreement if the following conditions are met:

(1) *Advance notification.* The MA organization notifies CMS at least 60 days before the date of the proposed change of ownership. The MA organization also provides CMS with updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization.

(2) *Advance submittal of agreement.* The MA organization submits to CMS, at least 30 days before the proposed change of ownership date, three signed copies of the novation agreement containing the provisions specified in paragraph (b) of this section, and one copy of other relevant documents required by CMS.

(3) *CMS's determination.* CMS determines that—

(i) The proposed new owner is in fact a successor in interest to the contract;

(ii) Recognition of the new owner as a successor in interest to the contract is in the best interest of the Medicare program; and

(iii) The successor organization meets the requirements to qualify as an MA organization under subpart K of this part.

(b) *Provisions of a novation agreement—*(1) *Assumption of contract obligations.* The new owner must assume all obligations under the contract.

(2) *Waiver of right to reimbursement.* The previous owner must waive its rights to reimbursement for covered services furnished during the rest of the current contract period.

(3) *Guarantee of performance.* (i) The previous owner must guarantee performance of the contract by the new owner during the contract period; or

(ii) The new owner must post a performance bond that is satisfactory to CMS.

(4) *Records access.* The previous owner must agree to make its books and records and other necessary information available to the new owner and to

CMS to permit an accurate determination of costs for the final settlement of the contract period.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38079, July 15, 1993; 60 FR 45681, Sept. 1, 1995. Redesignated and amended at 63 FR 35067, 35106, June 26, 1998; 70 FR 52027, Sept. 1, 2005]

**§ 422.553 Effect of leasing of an MA organization's facilities.**

(a) *General effect of leasing.* If an MA organization leases all or part of its facilities to another entity, the other entity does not acquire MA organization status under section 1876 of the Act.

(b) *Effect of lease of all facilities.* (1) If an MA organization leases all of its facilities to another entity, the contract terminates.

(2) If the other entity wishes to participate in Medicare as an MA organization, it must apply for and enter into a contract in accordance with subpart K of this part.

(c) *Effect of partial lease of facilities.* If the MA organization leases part of its facilities to another entity, its contract with CMS remains in effect while CMS surveys the MA organization to determine whether it continues to be in compliance with the applicable requirements and qualifying conditions specified in subpart K of this part.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45681, Sept. 1, 1995. Redesignated and amended at 63 FR 35067, 35106, June 26, 1998; 70 FR 52027, Sept. 1, 2005]

**Subpart M—Grievances, Organization Determinations and Appeals**

SOURCE: 63 FR 35107, June 26, 1998, unless otherwise noted.

**§ 422.560 Basis and scope.**

(a) *Statutory basis.* (1) Section 1852(f) of the Act provides that an MA organization must establish meaningful grievance procedures.

(2) Section 1852(g) of the Act establishes requirements that an MA organization must meet concerning organization determinations and appeals.

(3) Section 1869 of the Act specifies the amount in controversy needed to pursue a hearing and judicial review

and authorizes representatives to act on behalf of individuals that seek appeals. These provisions are incorporated for MA appeals by section 1852(g)(5) of the Act and part 405 of this chapter.

(b) *Scope.* This subpart sets forth—

(1) Requirements for MA organizations with respect to grievance procedures, organization determinations, and appeal procedures.

(2) The rights of MA enrollees with respect to organization determinations, and grievance and appeal procedures.

(3) The rules concerning notice of noncoverage of inpatient hospital care.

(4) The rules that apply when an MA enrollee requests immediate QIO review of a determination that he or she no longer needs inpatient hospital care.

(c) *Relation to ERISA requirements.* Consistent with section 1857(i)(2) of the Act, provisions of this subpart may, to the extent applicable under regulations adopted by the Secretary of Labor, apply to claims for benefits under group health plans subject to the Employee Retirement Income Security Act.

[63 FR 35107, June 26, 1998, as amended at 70 FR 4738, Jan. 28, 2005]

**§ 422.561 Definitions.**

As used in this subpart, unless the context indicates otherwise—

*Appeal* means any of the procedures that deal with the review of adverse organization determinations on the health care services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service, as defined under § 422.566(b). These procedures include reconsiderations by the MA organization, and if necessary, an independent review entity, hearings before ALJs, review by the Medicare Appeals Council (MAC), and judicial review.

*Enrollee* means an MA eligible individual who has elected an MA plan offered by an MA organization.

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*Grievance* means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of an MA organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested.

*Physician* has the meaning given the term in section 1861(r) of the Act.

*Representative* means an individual appointed by an enrollee or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in the appeal. Unless otherwise stated in this subpart, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination or in dealing with any of the levels of the appeals process, subject to the applicable rules described in part 405 of this chapter.

[63 FR 35067, June 26, 1998, as amended at 65 FR 40328, June 29, 2000; 68 FR 16667, Apr. 4, 2003; 70 FR 4738, Jan. 28, 2005]

**§ 422.562 General provisions.**

(a) *Responsibilities of the MA organization.* (1) An MA organization, with respect to each MA plan that it offers, must establish and maintain—

(i) A grievance procedure as described in § 422.564 for addressing issues that do not involve organization determinations;

(ii) A procedure for making timely organization determinations;

(iii) Appeal procedures that meet the requirements of this subpart for issues that involve organization determinations; and

(2) An MA organization must ensure that all enrollees receive written information about the—

(i) Grievance and appeal procedures that are available to them through the MA organization; and

(ii) Complaint process available to the enrollee under the QIO process as set forth under section 1154(a)(14) of the Act.

(3) In accordance with subpart K of this part, if the MA organization delegates any of its responsibilities under this subpart to another entity or individual through which the organization provides health care services, the MA

organization is ultimately responsible for ensuring that the entity or individual satisfies the relevant requirements of this subpart.

(b) *Rights of MA enrollees.* In accordance with the provisions of this subpart, enrollees have the following rights:

(1) The right to have grievances between the enrollee and the MA organization heard and resolved, as described in § 422.564.

(2) The right to a timely organization determination, as provided under § 422.566.

(3) The right to request an expedited organization determination, as provided under § 422.570.

(4) If dissatisfied with any part of an organization determination, the following appeal rights:

(i) The right to a reconsideration of the adverse organization determination by the MA organization, as provided under § 422.578.

(ii) The right to request an expedited reconsideration, as provided under § 422.584.

(iii) If, as a result of a reconsideration, an MA organization affirms, in whole or in part, its adverse organization determination, the right to an automatic reconsidered determination made by an independent, outside entity contracted by CMS, as provided in § 422.592.

(iv) The right to an ALJ hearing if the amount in controversy is met, as provided in § 422.600.

(v) The right to request MAC review of the ALJ hearing decision, as provided in § 422.608.

(vi) The right to judicial review of the hearing decision if the amount in controversy is met, as provided in § 422.612.

(c) *Limits on when this subpart applies.*

(1) If an enrollee receives immediate QIO review (as provided in § 422.622) of a determination of noncoverage of inpatient hospital care—

(i) The enrollee is not entitled to review of that issue by the MA organization; and

(ii) The QIO review decision is subject only to the appeal procedures set forth in parts 476 and 478 of this chapter.

(2) If an enrollee has no further liability to pay for services that were furnished by an MA organization, a determination regarding these services is not subject to appeal.

(d) *When other regulations apply.* Unless this subpart provides otherwise, the regulations in part 405 of this chapter (concerning the administrative review and hearing processes and representation of parties under titles II and XVIII of the Act), apply under this subpart to the extent they are appropriate.

[63 FR 35067, June 26, 1998, as amended at 65 FR 40329, June 29, 2000; 70 FR 4738, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005]

**§ 422.564 Grievance procedures.**

(a) *General rule.* Each MA organization must provide meaningful procedures for timely hearing and resolving grievances between enrollees and the organization or any other entity or individual through which the organization provides health care services under any MA plan it offers.

(b) *Distinguished from appeals.* Grievance procedures are separate and distinct from appeal procedures, which address organization determinations as defined in § 422.566(b). Upon receiving a complaint, an MA organization must promptly determine and inform the enrollee whether the complaint is subject to its grievance procedures or its appeal procedures.

(c) *Distinguished from the quality improvement organization (QIO) complaint process.* Under section 1154(a)(14) of the Act, the QIO must review beneficiaries' written complaints about the quality of services they have received under the Medicare program. This process is separate and distinct from the grievance procedures of the MA organization. For quality of care issues, an enrollee may file a grievance with the MA organization; file a written complaint with the QIO, or both. For any complaint submitted to a QIO, the MA organization must cooperate with the QIO in resolving the complaint.

(d) *Method for filing a grievance.* (1) An enrollee may file a grievance with the MA organization either orally or in writing.

(2) An enrollee must file a grievance no later than 60 days after the event or

incident that precipitates the grievance.

(e) *Grievance disposition and notification.* (1) The MA organization must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee's health status, but no later than 30 days after the date the organization receives the oral or written grievance.

(2) The MA organization may extend the 30-day timeframe by up to 14 days if the enrollee requests the extension or if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. When the MA organization extends the deadline, it must immediately notify the enrollee in writing of the reasons for the delay.

(3) The MA organization must inform the enrollee of the disposition of the grievance in accordance with the following procedures:

(i) All grievances submitted in writing must be responded to in writing.

(ii) Grievances submitted orally may be responded to either orally or in writing, unless the enrollee requests a written response.

(iii) All grievances related to quality of care, regardless of how the grievance is filed, must be responded to in writing. The response must include a description of the enrollee's right to file a written complaint with the QIO. For any complaint submitted to a QIO, the MA organization must cooperate with the QIO in resolving the complaint.

(f) *Expedited grievances.* An MA organization must respond to an enrollee's grievance within 24 hours if:

(1) The complaint involves an MA organization's decision to invoke an extension relating to an organization determination or reconsideration.

(2) The complaint involves an MA organization's refusal to grant an enrollee's request for an expedited organization determination under § 422.570 or reconsideration under § 422.584.

(g) *Recordkeeping.* The MA organization must have an established process to track and maintain records on all grievances received both orally and in writing, including, at a minimum, the date of receipt, final disposition of the grievance, and the date that the MA

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organization notified the enrollee of the disposition.

[68 FR 16667, Apr. 4, 2003, as amended at 70 FR 4738, Jan. 28, 2005]

**§ 422.566 Organization determinations.**

(a) *Responsibilities of the MA organization.* Each MA organization must have a procedure for making timely organization determinations (in accordance with the requirements of this subpart) regarding the benefits an enrollee is entitled to receive under an MA plan, including basic benefits as described under § 422.100(c)(1) and mandatory and optional supplemental benefits as described under § 422.102, and the amount, if any, that the enrollee is required to pay for a health service. The MA organization must have a standard procedure for making determinations, in accordance with § 422.568, and an expedited procedure for situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, in accordance with §§ 422.570 and 422.572.

(b) *Actions that are organization determinations.* An organization determination is any determination made by an MA organization with respect to any of the following:

(1) Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.

(2) Payment for any other health services furnished by a provider other than the MA organization that the enrollee believes—

(i) Are covered under Medicare; or

(ii) If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the MA organization.

(3) The MA organization's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the MA organization.

(4) Discontinuation or reduction of a service if the enrollee believes that continuation of the services is medically necessary.

(5) Failure of the MA organization to approve, furnish, arrange for, or provide payment for health care services

in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

(c) *Who can request an organization determination.* (1) Those individuals or entities who can request an organization determination are—

(i) The enrollee (including his or her authorized representative);

(ii) Any provider that furnishes, or intends to furnish, services to the enrollee; or

(iii) The legal representative of a deceased enrollee's estate.

(2) Those who can request an expedited determination are—

(i) An enrollee (including his or her authorized representative); or

(ii) A physician (regardless of whether the physician is affiliated with the MA organization).

[63 FR 35067, June 26, 1998, as amended at 65 FR 40329, June 29, 2000; 68 FR 50858, Aug. 22, 2003; 70 FR 4739, Jan. 28, 2005]

**§ 422.568 Standard timeframes and notice requirements for organization determinations.**

(a) *Timeframe for requests for service.* When a party has made a request for a service, the MA organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination. The MA organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an MA organization's decision to deny). When the MA organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension.

(b) *Timeframe for requests for payment.* The MA organization must process requests for payment according to the

“prompt payment” provisions set forth in § 422.520.

(c) *Written notice for MA organization denials.* If an MA organization decides to deny service or payment in whole or in part, or if an enrollee disagrees with an MA organization’s decision to discontinue or reduce the level of care for an ongoing course of treatment, the organization must give the enrollee written notice of the determination.

(d) *Written notice for MA Organization denials.* If an enrollee requests an MA organization to provide an explanation of a practitioner’s denial of an item or service, in whole or in part, the MA organization must give the enrollee a written notice.

(e) *Form and content of the MA organization notice.* The notice of any denial under paragraph (d) of this section must—

(1) Use approved notice language in a readable and understandable form;

(2) State the specific reasons for the denial;

(3) Inform the enrollee of his or her right to a reconsideration;

(4)(i) For service denials, describe both the standard and expedited reconsideration processes, including the enrollee’s right to, and conditions for, obtaining an expedited reconsideration and the rest of the appeal process; and

(ii) For payment denials, describe the standard reconsideration process and the rest of the appeal process; and

(5) Comply with any other notice requirements specified by CMS.

(f) *Effect of failure to provide timely notice.* If the MA organization fails to provide the enrollee with timely notice of an organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.

[65 FR 40329, June 29, 2000, as amended at 70 FR 4739, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005]

**§ 422.570 Expediting certain organization determinations.**

(a) *Request for expedited determination.* An enrollee or a physician (regardless of whether the physician is affiliated with the MA organization) may request that an MA organization expedite an organization determination involving

the issues described in § 422.566(b)(3) and (b)(4). (This does not include requests for payment of services already furnished.)

(b) *How to make a request.* (1) To ask for an expedited determination, an enrollee or a physician must submit an oral or written request directly to the MA organization or, if applicable, to the entity responsible for making the determination, as directed by the MA organization.

(2) A physician may provide oral or written support for a request for an expedited determination.

(c) *How the MA organization must process requests.* The MA organization must establish and maintain the following procedures for processing requests for expedited determinations:

(1) Establish an efficient and convenient means for individuals to submit oral or written requests. The MA organization must document all oral requests in writing and maintain the documentation in the case file.

(2) Promptly decide whether to expedite a determination, based on the following requirements:

(i) For a request made by an enrollee the MA organization must provide an expedited determination if it determines that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

(ii) For a request made or supported by a physician, the MA organization must provide an expedited determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

(d) *Actions following denial.* If an MA organization denies a request for expedited determination, it must take the following actions:

(1) Automatically transfer a request to the standard timeframe and make the determination within the 14-day timeframe established in § 422.568 for a standard determination. The 14-day period begins with the day the MA organization receives the request for expedited determination.

(2) Give the enrollee prompt oral notice of the denial and subsequently deliver, within 3 calendar days, a written letter that—

(i) Explains that the MA organization will process the request using the 14-day timeframe for standard determinations;

(ii) Informs the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision not to expedite; and

(iii) Informs the enrollee of the right to resubmit a request for an expedited determination with any physician's support; and

(iv) Provides instructions about the grievance process and its timeframes.

(e) *Action on accepted request for expedited determination.* If an MA organization grants a request for expedited determination, it must make the determination and give notice in accordance with § 422.572.

(f) *Prohibition of punitive action.* An MA organization may not take or threaten to take any punitive action against a physician acting on behalf or in support of an enrollee in requesting an expedited determination.

[63 FR 35107, June 26, 1998, as amended at 65 FR 40329, June 29, 2000; 70 FR 4739, Jan. 28, 2005]

**§ 422.572 Timeframes and notice requirements for expedited organization determinations.**

(a) *Timeframe.* Except as provided in paragraph (b) of this section, an MA organization that approves a request for expedited determination must make its determination and notify the enrollee (and the physician involved, as appropriate) of its decision, whether adverse or favorable, as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

(b) *Extensions.* The MA organization may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an MA organization's decision to deny). When the MA organization

extends the deadline, it must notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension. The MA organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(c) *Confirmation of oral notice.* If the MA organization first notifies an enrollee of an adverse expedited determination orally, it must mail written confirmation to the enrollee within 3 calendar days of the oral notification.

(d) *How the MA organization must request information from noncontract providers.* If the MA organization must receive medical information from noncontract providers, the MA organization must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited organization determination. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the MA organization in meeting the required timeframe. Regardless of whether the MA organization must request information from noncontract providers, the MA organization is responsible for meeting the timeframe and notice requirements of this section.

(e) *Content of the notice of expedited determination.* (1) The notice of any expedited determination must state the specific reasons for the determination in understandable language.

(2) If the determination is not completely favorable to the enrollee, the notice must—

(i) Inform the enrollee of his or her right to a reconsideration;

(ii) Describe both the standard and expedited reconsideration processes, including the enrollee's right to request, and conditions for obtaining, an expedited reconsideration, and the rest of the appeal process; and

(iii) Comply with any other requirements specified by CMS.

(f) *Effect of failure to provide a timely notice.* If the MA organization fails to provide the enrollee with timely notice

of an expedited organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.

[63 FR 35107, June 26, 1998, as amended at 65 FR 40329, June 29, 2000; 70 FR 4739, Jan. 28, 2005]

**§ 422.574 Parties to the organization determination.**

The parties to the organization determination are—

(a) The enrollee (including his or her authorized representative);

(b) An assignee of the enrollee (that is, a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);

(c) The legal representative of a deceased enrollee's estate; or

(d) Any other provider or entity (other than the MA organization) determined to have an appealable interest in the proceeding.

**§ 422.576 Effect of an organization determination.**

The organization determination is binding on all parties unless it is reconsidered under §§ 422.578 through 422.596 or is reopened and revised under § 422.616.

**§ 422.578 Right to a reconsideration.**

Any party to an organization determination (including one that has been reopened and revised as described in § 422.616) may request that the determination be reconsidered under the procedures described in § 422.582, which address requests for a standard reconsideration. An enrollee or physician (acting on behalf of an enrollee) may request an expedited reconsideration as described in § 422.584.

**§ 422.580 Reconsideration defined.**

A reconsideration consists of a review of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit or the MA organization or CMS obtains.

**§ 422.582 Request for a standard reconsideration.**

(a) *Method and place for filing a request.* A party to an organization determination must ask for a reconsideration of the determination by making a written request to the MA organization that made the organization determination. The MA organization may adopt a policy for accepting oral requests.

(b) *Timeframe for filing a request.* Except as provided in paragraph (c) of this section, a party must file a request for reconsideration within 60 calendar days from the date of the notice of the organization determination.

(c) *Extending the time for filing a request—*(1) *General rule.* If a party shows good cause, the MA organization may extend the timeframe for filing a request for reconsideration.

(2) *How to request an extension of timeframe.* If the 60-day period in which to file a request for reconsideration has expired, a party to the organization determination may file a request for reconsideration with the MA organization. The request for reconsideration and to extend the timeframe must—

(i) Be in writing; and

(ii) State why the request for reconsideration was not filed on time.

(d) *Parties to the reconsideration.* The parties to the reconsideration are the parties to the organization determination, as described in § 422.574, and any other provider or entity (other than the MA organization) whose rights with respect to the organization determination may be affected by the reconsideration, as determined by the entity that conducts the reconsideration.

(e) *Withdrawing a request.* The party who files a request for reconsideration may withdraw it by filing a written request for withdrawal at one of the places listed in paragraph (a) of this section.

[63 FR 35107, June 26, 1998, as amended at 70 FR 4739, Jan. 28, 2005]

**§ 422.584 Expediting certain reconsiderations.**

(a) *Who may request an expedited reconsideration.* An enrollee or a physician (regardless of whether he or she is affiliated with the MA organization) may request that an MA organization

expedite a reconsideration of a determination that involves the issues described in § 422.566(b)(3) and (b)(4). (This does not include requests for payment of services already furnished.)

(b) *How to make a request.* (1) To ask for an expedited reconsideration, an enrollee or a physician acting on behalf of an enrollee must submit an oral or written request directly to the MA organization or, if applicable, to the entity responsible for making the reconsideration, as directed by the MA organization.

(2) A physician may provide oral or written support for a request for an expedited reconsideration.

(c) *How the MA organization must process requests.* The MA organization must establish and maintain the following procedures for processing requests for expedited reconsiderations:

(1) *Handling of requests.* The MA organization must establish an efficient and convenient means for individuals to submit oral or written requests, document all oral requests in writing, and maintain the documentation in the case file.

(2) *Prompt decision.* Promptly decide on whether to expedite the reconsideration or follow the timeframe for standard reconsideration based on the following requirements:

(i) For a request made by an enrollee, the MA organization must provide an expedited reconsideration if it determines that applying the standard timeframe for reconsidering a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) For a request made or supported by a physician, the MA organization must provide an expedited reconsideration if the physician indicates that applying the standard timeframe for conducting a reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(d) *Actions following denial.* If an MA organization denies a request for expedited reconsideration, it must take the following actions:

(1) Automatically transfer a request to the standard timeframe and make the determination within the 30-day

timeframe established in § 422.590(a). The 30-day period begins the day the MA organization receives the request for expedited reconsideration.

(2) Give the enrollee prompt oral notice, and subsequently deliver, within 3 calendar days, a written letter that—

(i) Explains that the MA organization will process the enrollee's request using the 30-day timeframe for standard reconsiderations;

(ii) Informs the enrollee of the right to file a grievance if he or she disagrees with the organization's decision not to expedite;

(iii) Informs the enrollee of the right to resubmit a request for an expedited reconsideration with any physician's support; and

(iv) Provides instructions about the grievance process and its timeframes.

(e) *Action following acceptance of a request.* If an MA organization grants a request for expedited reconsideration, it must conduct the reconsideration and give notice in accordance with § 422.590.

(f) *Prohibition of punitive action.* An MA organization may not take or threaten to take any punitive action against a physician acting on behalf or in support of an enrollee in requesting an expedited reconsideration.

[63 FR 35107, June 26, 1998, as amended at 65 FR 40330, June 29, 2000; 70 FR 4739, Jan. 28, 2005]

**§ 422.586 Opportunity to submit evidence.**

The MA organization must provide the parties to the reconsideration with a reasonable opportunity to present evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing. In the case of an expedited reconsideration, the opportunity to present evidence is limited by the short timeframe for making a decision. Therefore, the MA organization must inform the parties of the conditions for submitting the evidence.

**§ 422.590 Timeframes and responsibility for reconsiderations.**

(a) *Standard reconsideration: Request for services.* (1) If the MA organization makes a reconsidered determination that is completely favorable to the enrollee, the MA organization must issue

the determination (and effectuate it in accordance with § 422.618(a)) as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date it receives the request for a standard reconsideration. The MA organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an MA organization's decision to deny). When the MA organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension. For extensions, the MA organization must issue and effectuate its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(2) If the MA organization makes a reconsidered determination that affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the case file to the independent entity contracted by CMS as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date it receives the request for a standard reconsideration (or no later than the expiration of an extension described in paragraph (a)(1) of this section). The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.

(b) *Standard reconsideration: Request for payment.* (1) If the MA organization makes a reconsidered determination that is completely favorable to the enrollee, the MA organization must issue its reconsidered determination to the enrollee (and effectuate it in accordance with § 422.618(a)) no later than 60 calendar days from the date it receives the request for a standard reconsideration.

(2) If the MA organization affirms, in whole or in part, its adverse organization determination, it must prepare a

written explanation and send the case file to the independent entity contracted by CMS no later than 60 calendar days from the date it receives the request for a standard reconsideration. The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.

(c) *Effect of failure to meet timeframe for standard reconsideration.* If the MA organization fails to provide the enrollee with a reconsidered determination within the timeframes specified in paragraph (a) or paragraph (b) of this section, this failure constitutes an affirmation of its adverse organization determination, and the MA organization must submit the file to the independent entity in the same manner as described under paragraphs (a)(2) and (b)(2) of this section.

(d) *Expedited reconsideration—(1) Timeframe.* Except as provided in paragraph (d)(2) of this section, an MA organization that approves a request for expedited reconsideration must complete its reconsideration and give the enrollee (and the physician involved, as appropriate) notice of its decision as expeditiously as the enrollee's health condition requires but no later than 72 hours after receiving the request.

(2) *Extensions.* The MA organization may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an MA organization's decision to deny). When the MA organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension. The MA organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires but no later than upon expiration of the extension.

(3) *Confirmation of oral notice.* If the MA organization first notifies an enrollee of a completely favorable expedited reconsideration, it must mail

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written confirmation to the enrollee within 3 calendar days.

(4) *How the MA organization must request information from noncontract providers.* If the MA organization must receive medical information from noncontract providers, the MA organization must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited reconsideration. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the MA organization in meeting the required timeframe. Regardless of whether the MA organization must request information from noncontract providers, the MA organization is responsible for meeting the timeframe and notice requirements.

(5) *Affirmation of an adverse expedited organization determination.* If, as a result of its reconsideration, the MA organization affirms, in whole or in part, its adverse expedited organization determination, the MA organization must submit a written explanation and the case file to the independent entity contracted by CMS as expeditiously as the enrollee's health condition requires, but not later than within 24 hours of its affirmation. The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.

(e) *Notification of enrollee.* If the MA organization refers the matter to the independent entity as described under this section, it must concurrently notify the enrollee of that action.

(f) *Failure to meet timeframe for expedited reconsideration.* If the MA organization fails to provide the enrollee with the results of its reconsideration within the timeframe described in paragraph (d) of this section, this failure constitutes an adverse reconsidered determination, and the MA organization must submit the file to the independent entity within 24 hours of expiration of the timeframe set forth in paragraph (d) of this section.

(g) *Who must reconsider an adverse organization determination.* (1) A person or persons who were not involved in mak-

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ing the organization determination must conduct the reconsideration.

(2) When the issue is the MA organization's denial of coverage based on a lack of medical necessity (or any substantively equivalent term used to describe the concept of medical necessity), the reconsidered determination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician.

[63 FR 35107, June 26, 1998, as amended at 65 FR 40330, June 29, 2000; 70 FR 4739, Jan. 28, 2005]

**§ 422.592 Reconsideration by an independent entity.**

(a) When the MA organization affirms, in whole or in part, its adverse organization determination, the issues that remain in dispute must be reviewed and resolved by an independent, outside entity that contracts with CMS.

(b) The independent outside entity must conduct the review as expeditiously as the enrollee's health condition requires but must not exceed the deadlines specified in the contract.

(c) When the independent entity conducts a reconsideration, the parties to the reconsideration are the same parties listed in § 422.582(d) who qualified during the MA organization's reconsideration, with the addition of the MA organization.

**§ 422.594 Notice of reconsidered determination by the independent entity.**

(a) *Responsibility for the notice.* When the independent entity makes the reconsidered determination, it is responsible for mailing a notice of its reconsidered determination to the parties and for sending a copy to CMS.

(b) *Content of the notice.* The notice must—

(1) State the specific reasons for the entity's decisions in understandable language;

(2) If the reconsidered determination is adverse (that is, does not completely reverse the MA organization's adverse organization determination), inform the parties of their right to an ALJ

hearing if the amount in controversy is \$100 or more;

(3) Describe the procedures that a party must follow to obtain an ALJ hearing; and

(4) Comply with any other requirements specified by CMS.

[63 FR 35107, June 26, 1998, as amended at 65 FR 40330, June 29, 2000]

**§ 422.596 Effect of a reconsidered determination.**

A reconsidered determination is final and binding on all parties unless a party other than the MA organization files a request for a hearing under the provisions of § 422.602, or unless the reconsidered determination is revised under § 422.616.

[65 FR 40331, June 29, 2000]

**§ 422.600 Right to a hearing.**

(a) If the amount remaining in controversy after reconsideration meets the threshold requirement established annually by the Secretary, any party to the reconsideration (except the MA organization) who is dissatisfied with the reconsidered determination has a right to a hearing before an ALJ.

(b) The amount remaining in controversy, which can include any combination of Part A and Part B services, is computed in accordance with part 405 of this chapter.

(c) If the basis for the appeal is the MA organization's refusal to provide services, CMS uses the projected value of those services to compute the amount remaining in controversy.

[63 FR 35107, June 26, 1998, as amended at 70 FR 4740, Jan. 28, 2005]

**§ 422.602 Request for an ALJ hearing.**

(a) *How and where to file a request.* A party must file a written request for a hearing with the entity specified in the IRE's reconsideration notice.

(b) *When to file a request.* Except when an ALJ extends the time frame as provided in part 405 of this chapter, a party must file a request for a hearing within 60 days of the date of the notice of a reconsidered determination. The time and place for a hearing before an ALJ will be set in accordance with § 405.1020.

(c) *Parties to a hearing.* The parties to a hearing are the parties to the reconsideration, the MA organization, and any other person or entity whose rights with respect to the reconsideration may be affected by the hearing, as determined by the ALJ.

(d) *Insufficient amount in controversy.* (1) If a request for a hearing clearly shows that the amount in controversy is less than that required under § 422.600, the ALJ dismisses the request.

(2) If, after a hearing is initiated, the ALJ finds that the amount in controversy is less than the amount required under § 422.600, the ALJ discontinues the hearing and does not rule on the substantive issues raised in the appeal.

[63 FR 35107, June 26, 1998, as amended at 70 FR 4740, Jan. 28, 2005]

**§ 422.608 Medicare Appeals Council (MAC) review.**

Any party to the hearing, including the MA organization, who is dissatisfied with the ALJ hearing decision, may request that the MAC review the ALJ's decision or dismissal. The regulations under part 405 of this chapter regarding MAC review apply to matters addressed by this subpart to the extent that they are appropriate.

[70 FR 4740, Jan. 28, 2005]

**§ 422.612 Judicial review.**

(a) *Review of ALJ's decision.* Any party, including the MA organization, may request judicial review (upon notifying the other parties) of an ALJ's decision if—

(1) The Board denied the party's request for review; and

(2) The amount in controversy meets the threshold requirement established annually by the Secretary.

(b) *Review of MAC decision.* Any party, including the MA organization, may request judicial review (upon notifying the other parties) of the MAC decision if it is the final decision of CMS and the amount in controversy meets the threshold established in paragraph (a)(2) of this section.

(c) *How to request judicial review.* In order to request judicial review, a

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party must file a civil action in a district court of the United States in accordance with section 205(g) of the Act. See part 405 of this chapter for a description of the procedures to follow in requesting judicial review.

[63 FR 35107, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 65 FR 40331, June 29, 2000; 70 FR 4740, Jan. 28, 2005]

### § 422.616 Reopening and revising determinations and decisions.

(a) An organization or reconsidered determination made by an MA organization, a reconsidered determination made by the independent entity described in § 422.592, or the decision of an ALJ or the MAC that is otherwise final and binding may be reopened and revised by the entity that made the determination or decision, under the rules in part 405 of this chapter.

(b) Reopening may be at the instigation of any party.

(c) The filing of a request for reopening does not relieve the MA organization of its obligation to make payment or provide services as specified in § 422.618.

(d) Once an entity issues a revised determination or decision, any party may file an appeal.

[63 FR 35107, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 70 FR 4740, Jan. 28, 2005]

### § 422.618 How an MA organization must effectuate standard reconsidered determinations or decisions.

(a) *Reversals by the MA organization—*(1) *Requests for service.* If, on reconsideration of a request for service, the MA organization completely reverses its organization determination, the organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days after the date the MA organization receives the request for reconsideration (or no later than upon expiration of an extension described in § 422.590(a)(1)).

(2) *Requests for payment.* If, on reconsideration of a request for payment, the MA organization completely reverses its organization determination, the organization must pay for the service no later than 60 calendar days after

the date the MA organization receives the request for reconsideration.

(b) *Reversals by the independent outside entity—*(1) *Requests for service.* If, on reconsideration of a request for service, the MA organization's determination is reversed in whole or in part by the independent outside entity, the MA organization must authorize the service under dispute within 72 hours from the date it receives notice reversing the determination, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from that date. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(2) *Requests for payment.* If, on reconsideration of a request for payment, the MA organization's determination is reversed in whole or in part by the independent outside entity, the MA organization must pay for the service no later than 30 calendar days from the date it receives notice reversing the organization determination. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(c) *Reversals other than by the MA organization or the independent outside entity—*(1) *General rule.* If the independent outside entity's determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, the MA organization must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the determination. The MA organization must inform the independent outside entity that the organization has effectuated the decision or that it has appealed the decision.

(2) *Effectuation exception when the MA organization files an appeal with the Medicare Appeals Council.* If the MA organization requests Medicare Appeals Council (the Board) review consistent with § 422.608, the MA organization may await the outcome of the review before it pays for, authorizes, or provides the service under dispute. A MA organization that files an appeal with the Board must concurrently send a copy of its

appeal request and any accompanying documents to the enrollee and must notify the independent outside entity that it has requested an appeal.

[63 FR 35107, June 26, 1998, as amended at 65 FR 40331, June 29, 2000; 68 FR 50858, Aug. 22, 2003]

**§ 422.619 How an MA organization must effectuate expedited reconsidered determinations.**

(a) *Reversals by the MA organization.* If on reconsideration of an expedited request for service, the MA organization completely reverses its organization determination, the MA organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 72 hours after the date the MA organization receives the request for reconsideration (or no later than upon expiration of an extension described in § 422.590(d)(2)).

(b) *Reversals by the independent outside entity.* If the MA organization's determination is reversed in whole or in part by the independent outside entity, the MA organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(c) *Reversals other than by the MA organization or the independent outside entity—(1) General rule.* If the independent outside entity's expedited determination is reversed in whole or in part by the ALJ, or at a higher level of appeal, the MA organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 days from the date it receives notice reversing the determination. The MA organization must inform the independent outside entity that the organization has effectuated the decision.

(2) *Effectuation exception when the MA organization files an appeal with the Medicare Appeals Council.* If the MA organization requests Medicare Appeals Council (the Board) review consistent with § 422.608, the MA organization may await the outcome of the review before

it authorizes or provides the service under dispute. A MA organization that files an appeal with the Board must concurrently send a copy of its appeal request and any accompanying documents to the enrollee and must notify the independent outside entity that it has requested an appeal.

[65 FR 40331, June 29, 2000, as amended at 68 FR 50859, Aug. 22, 2003]

**§ 422.620 How enrollees of MA organizations must be notified of non-covered inpatient hospital care.**

(a) *Enrollee's entitlement.* (1) Where an MA organization has authorized coverage of the inpatient admission of an enrollee, either directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.113), the MA organization (or hospital that has been delegated the authority to make the discharge decision) must provide a written notice of noncoverage when—

(i) The beneficiary disagrees with the discharge decision; or

(ii) The MA organization (or the hospital that has been delegated the authority to make the discharge decision) is not discharging the individual but no longer intends to continue coverage of the inpatient stay.

(2) An enrollee is entitled to coverage until at least noon of the day after such notice is provided. If QIO review is requested under § 422.622, coverage is extended as provided in that section.

(b) *Physician concurrence required.* Before discharging an individual or changing the level of care in an inpatient hospital setting, the MA organization must obtain the concurrence of the physician who is responsible for the enrollee's inpatient care.

(c) *Notice to the enrollee.* When applicable, the written notice of non-coverage must be issued no later than the day before hospital coverage ends. The written notice must include the following elements:

(1) The reason why inpatient hospital care is no longer needed or covered;

(2) The effective date and time of the enrollee's liability for continued inpatient care;

(3) The enrollee's appeal rights;

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(4) If applicable, the new lower level of care being covered in the hospital setting; and

(5) Any additional information specified by CMS.

[68 FR 16667, Apr. 4, 2003, as amended at 70 FR 4740, Jan. 28, 2005]

EFFECTIVE DATE NOTE: At 68 FR 20349, Apr. 4, 2003, § 422.620 was revised. This section contains information collection and record-keeping requirements and will not become effective until approval has been given by the Office of Management and Budget

**§ 422.622 Requesting immediate QIO review of noncoverage of inpatient hospital care.**

(a) *Enrollee's right to review or reconsideration.* (1) An enrollee who wishes to appeal a determination by an MA organization or hospital that inpatient care is no longer necessary must request immediate QIO review of the determination in accordance with paragraph (b) of this section. An enrollee who requests immediate QIO review may remain in the hospital with no additional financial liability as specified in paragraph (c) of this section.

(2) An enrollee who fails to request immediate QIO review in accordance with the procedures in paragraph (b) of this section may request expedited reconsideration by the MA organization as described in § 422.584, but the financial liability rules of paragraph (c) of this section do not apply.

(b) *Procedures enrollee must follow.* For the immediate QIO review process, the following rules apply:

(1) The enrollee must submit the request for immediate review—

(i) To the QIO that has an agreement with the hospital under parts 476 and 478 of this chapter.

(ii) In writing or by telephone; and

(iii) By noon of the first working day after he or she receives written notice that the MA organization or hospital has determined that the hospital stay is no longer necessary.

(2) On the date it receives the enrollee's request, the QIO must notify the MA organization that the enrollee has filed a request for immediate review.

(3) The MA organization must supply any information that the QIO requires to conduct its review and must make it available, by phone or in writing, by

the close of business of the first full working day immediately following the day the enrollee submits the request for review.

(4) In response to a request from the MA organization, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day the organization makes its request.

(5) The QIO must solicit the views of the enrollee who requested the immediate QIO review.

(6) The QIO must make a determination and notify the enrollee, the hospital, and the MA organization by close of business of the first working day after it receives all necessary information from the hospital, or the organization, or both.

(c) *Liability for hospital costs*—(1) *When the MA organization determines that hospital services are not, or are no longer, covered.* (i) Except as provided in paragraph (c)(1)(ii) of this section, if the MA organization authorized coverage of the inpatient admission directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.112(c)), the organization continues to be financially responsible for the costs of the hospital stay when a timely appeal is filed under paragraph (a)(1) of this section until noon of the calendar day following the day the QIO notifies the enrollee of its review determination. If coverage of the hospital admission was never approved by the MA organization (or the admission does not constitute emergency or urgently needed care, as described in §§ 422.2 and 422.112(c)), the MA organization is liable for the hospital costs only if it is determined on appeal that the hospital stay should have been covered under the MA plan.

(ii) The hospital may not charge the MA organization (or the enrollee) if—

(A) It was the hospital (acting on behalf of the enrollee) that filed the request for immediate QIO review; and

(B) The QIO upholds the noncoverage determination made by the MA organization.

(2) *When the hospital determines that hospital services are no longer required.* If the hospital determines that inpatient

hospital services are no longer necessary, and the enrollee could not reasonably be expected to know that the services would not be covered, the hospital may not charge the enrollee for inpatient services received before noon of the calendar day following the day the QIO notifies the enrollee of its review determination.

[63 FR 35107, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 70 FR 4740, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005]

**§ 422.624 Notifying enrollees of termination of provider services.**

(a) *Applicability.* (1) For purposes of §§ 422.624 and 422.626, the term provider includes home health agencies (HHAs), skilled nursing facilities (SNFs), and comprehensive outpatient rehabilitation facilities (CORFs).

(2) *Termination of service defined.* For purposes of this section and § 422.626, a termination of service is the discharge of an enrollee from covered provider services, or discontinuation of covered provider services, when the enrollee has been authorized by the MA organization, either directly or by delegation, to receive an ongoing course of treatment from that provider. Termination includes cessation of coverage at the end of a course of treatment preauthorized in a discrete increment, regardless of whether the enrollee agrees that such services should end.

(b) *Advance written notification of termination.* Prior to any termination of service, the provider of the service must deliver valid written notice to the enrollee of the MA organization's decision to terminate services. The provider must use a standardized notice, required by the Secretary, in accordance with the following procedures—

(1) *Timing of notice.* The provider must notify the enrollee of the MA organization's decision to terminate covered services no later than two days before the proposed end of the services. If the enrollee's services are expected to be fewer than two days in duration, the provider should notify the enrollee at the time of admission to the provider. If, in a non-institutional setting, the span of time between services exceeds two days, the notice should be given no

later than the next to last time services are furnished.

(2) *Content of the notice.* The standardized termination notice must include the following information:

(i) The date that coverage of services ends.

(ii) The date that the enrollee's financial liability for continued services begins.

(iii) A description of the enrollee's right to a fast-track appeal under § 422.626, including information about how to contact an independent review entity (IRE), an enrollee's right (but not obligation) to submit evidence showing that services should continue, and the availability of other MA appeal procedures if the enrollee fails to meet the deadline for a fast-track IRE appeal.

(iv) The enrollee's right to receive detailed information in accordance with § 422.626 (e)(1) and (2).

(v) Any other information required by the Secretary.

(c) *When delivery of notice is valid.* Delivery of the termination notice is not valid unless—

(1) The enrollee (or the enrollee's authorized representative) has signed and dated the notice to indicate that he or she has received the notice and can comprehend its contents; and

(2) The notice is delivered in accordance with paragraph (b)(1) of this section and contains all the elements described in paragraph (b)(2) of this section.

(d) *Financial liability for failure to deliver valid notice.* An MA organization is financially liable for continued services until 2 days after the enrollee receives valid notice as specified under paragraph (c) of this section. An enrollee may waive continuation of services if he or she agrees with being discharged sooner than 2 days after receiving the notice.

EFFECTIVE DATE NOTE: At 68 FR 20349, Apr. 4, 2003, § 422.624 was added. This section contains information collection and record-keeping requirements and will not become effective until approval has been given by the Office of Management and Budget

**§ 422.626 Fast-track appeals of service terminations to independent review entities (IREs).**

(a) *Enrollee's right to a fast-track appeal of an MA organization's termination decision.* An enrollee of an MA organization has a right to a fast-track appeal of an MA organization's decision to terminate provider services.

(1) An enrollee who desires a fast-track appeal must submit a request for an appeal to an IRE under contract with CMS, in writing or by telephone, by noon of the first day after the day of delivery of the termination notice. If, due to an emergency, the IRE is closed and unable to accept the enrollee's request for a fast-track appeal, the enrollee must file a request by noon of the next day that the IRE is open for business.

(2) When an enrollee fails to make a timely request to an IRE, he or she may request an expedited reconsideration by the MA organization as described in § 422.584.

(3) If, after delivery of the termination notice, an enrollee chooses to leave a provider or discontinue receipt of covered services on or before the proposed termination date, the enrollee may not later assert fast-track IRE appeal rights under this section relative to the services or expect the services to resume, even if the enrollee requests an appeal before the discontinuation date in the termination notice.

(b) *Coverage of provider services.* Coverage of provider services continues until the date and time designated on the termination notice, unless the enrollee appeals and the IRE reverses the MA organization's decision. If the IRE's decision is delayed because the MA organization did not timely supply necessary information or records, the MA organization is liable for the costs of any additional coverage required by the delayed IRE decision. If the IRE finds that the enrollee did not receive valid notice, coverage of provider services by the MA organization continues until at least two days after valid notice has been received. Continuation of coverage is not required if the IRE determines that coverage could pose a threat to the enrollee's health or safety.

(c) *Burden of proof.* When an enrollee appeals an MA organization's decision to terminate services to an IRE, the burden of proof rests with the MA organization to demonstrate that termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage policies.

(1) To meet this burden, the MA organization must supply any and all information that an IRE requires to sustain the MA organization's termination decision, consistent with paragraph (e) of this section.

(2) The enrollee may submit evidence to be considered by an IRE in making its decision.

(3) The MA organization or an IRE may require an enrollee to authorize release to the IRE of his or her medical records, to the extent that the records are necessary for the MA organization to demonstrate the correctness of its decision or for an IRE to determine the appeal.

(d) *Procedures an IRE must follow.* (1) On the date an IRE receives the enrollee's request for an appeal, the IRE must immediately notify the MA organization and the provider that the enrollee has filed a request for a fast-track appeal, and of the MA organization's responsibility to submit documentation consistent with paragraph (e)(3) of this section.

(2) When an enrollee requests a fast-track appeal, the IRE must determine whether the provider delivered a valid notice of the termination decision, and whether a detailed notice has been provided, consistent with paragraph (e)(1) of this section.

(3) The IRE must notify CMS about each case in which it determines that improper notification occurs.

(4) Before making its decision, the IRE must solicit the enrollee's views regarding the reason(s) for termination of services as specified in the detailed written notice provided by the MA organization, or regarding any other reason that the IRE uses as the basis of its review determination.

(5) An IRE must make a decision on an appeal and notify the enrollee, the MA organization, and the provider of services, by close of business of the day

after it receives the information necessary to make the decision. If the IRE does not receive the information needed to sustain an MA organization's decision to terminate services, it may make a decision on the case based on the information at hand, or it may defer its decision until it receives the necessary information. If the IRE defers its decision, coverage of the services by the MA organization would continue until the decision is made, consistent with paragraph (b) of this section, but no additional termination notice would be required.

(e) *Responsibilities of the MA organization.* (1) When an IRE notifies an MA organization that an enrollee has requested a fast-track appeal, the MA organization must send a detailed notice to the enrollee by close of business of the day of the IRE's notification. The detailed termination notice must include the following information:

(i) A specific and detailed explanation why services are either no longer reasonable and necessary or are no longer covered.

(ii) A description of any applicable Medicare coverage rule, instruction or other Medicare policy including citations, to the applicable Medicare policy rules, or the information about how the enrollee may obtain a copy of the Medicare policy from the MA organization.

(iii) Any applicable MA organization policy, contract provision, or rationale upon which the termination decision was based.

(iv) Facts specific to the enrollee and relevant to the coverage determination that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case.

(v) Any other information required by CMS.

(2) Upon an enrollee's request, the MA organization must provide the enrollee a copy of, or access to, any documentation sent to the IRE by the MA organization, including records of any information provided by telephone. The MA organization may charge the enrollee a reasonable amount to cover the costs of duplicating the information for the enrollee and/or delivering the documentation to the enrollee. The

MA organization must accommodate such a request by no later than close of business of the first day after the day the material is requested.

(3) Upon notification by the IRE of a fast-track appeal, the MA organization must supply any and all information, including a copy of the notice sent to the enrollee, that the IRE needs to decide on the appeal. The MA organization must supply this information as soon as possible, but no later than by close of business of the day that the IRE notifies the MA organization that an appeal has been received from the enrollee. The MA organization must make the information available by phone (with a written record made of what is transmitted in this manner) and/or in writing, as determined by the IRE.

(4) An MA organization is financially responsible for coverage of services as provided in paragraph (b) of this section, regardless of whether it has delegated responsibility for authorizing coverage or termination decisions to its providers.

(5) If an IRE reverses an MA organization's termination decision, the MA organization must provide the enrollee with a new notice consistent with § 422.624(b).

(f) *Reconsiderations of IRE decisions.*

(1) If the IRE upholds an MA organization's termination decision in whole or in part, the enrollee may request, no later than 60 days after notification that the IRE has upheld the decision that the IRE reconsider its original decision.

(2) The IRE must issue its reconsidered determination as expeditiously as the enrollee's health condition requires but no later than within 14 days of receipt of the enrollee's request for a reconsideration.

(3) If the IRE reaffirms its decision, in whole or in part, the enrollee may to appeal the IRE's reconsidered determination to an ALJ, the MAC, or a federal court, as provided for under this subpart.

(4) If on reconsideration the IRE determines that coverage of provider services should terminate on a given date, the enrollee is liable for the costs of continued services after that date unless the IRE's decision is reversed on

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appeal. If the IRE's decision is reversed on appeal, the MA organization must reimburse the enrollee, consistent with the appealed decision, for the costs of any covered services for which the enrollee has already paid the MA organization or provider.

EFFECTIVE DATE NOTE: At 68 FR 20349, Apr. 4, 2003, § 422.626 was added. This section contains information collection and record-keeping requirements and will not become effective until approval has been given by the Office of Management and Budget

### Subpart N—Medicare Contract Determinations and Appeals

SOURCE: 63 FR 35113, June 26, 1998, unless otherwise noted.

#### § 422.641 Contract determinations.

This subpart establishes the procedures for making and reviewing the following contract determinations:

(a) A determination that an entity is not qualified to enter into a contract with CMS under Part C of title XVIII of the Act.

(b) A determination to terminate a contract with an MA organization in accordance with § 422.510(a).

(c) A determination not to authorize a renewal of a contract with an MA organization in accordance with § 422.506(b).

#### § 422.644 Notice of contract determination.

(a) When CMS makes a contract determination, it gives the MA organization written notice.

(b) The notice specifies—

(1) The reasons for the determination; and

(2) The MA organization's right to request reconsideration.

(c) For CMS-initiated terminations, CMS mails notice 90 days before the anticipated effective date of the termination. For terminations based on initial determinations described at § 422.510(a)(5), CMS immediately notifies the MA organization of its decision to terminate the organization's MA contract.

(d) When CMS determines that it will not authorize a contract renewal, CMS mails the notice to the MA organiza-

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tion by May 1 of the current contract year.

#### § 422.646 Effect of contract determination.

The contract determination is final and binding unless—

(a) The determination is reconsidered in accordance with §§ 422.648 through 422.658;

(b) A timely request for a hearing is filed under § 422.662; or

(c) The reconsideration decision is revised as a result of a reopening under § 422.696.

#### § 422.648 Reconsideration: Applicability.

(a) Reconsideration is the first step for appealing a contract determination specified in § 422.641.

(b) CMS reconsiders the specified determinations if the contract applicant or the MA organization files a written request in accordance with § 422.650.

(c) Notice of any redetermination favorable to the MA organization applicant, including those resulting from a hearing or Administrator review conducted under this subpart, must be issued by July 15 for the contract in question to be effective on January 1 of the following year.

[63 FR 35113, June 26, 1998, as amended at 65 FR 40331, June 29, 2000; 70 FR 4741, Jan. 28, 2005]

#### § 422.650 Request for reconsideration.

(a) *Method and place for filing a request.* A request for reconsideration must be made in writing and filed with any CMS office.

(b) *Time for filing a request.* The request for reconsideration must be filed within 15 days from the date of the notice of the initial determination.

(c) *Proper party to file a request.* Only an authorized official of the contract applicant or MA organization that was the subject of a contract determination may file the request for reconsideration.

(d) *Withdrawal of a request.* The MA organization or contract applicant who filed the request for a reconsideration may withdraw it at any time before the

notice of the reconsidered determination is mailed. The request for withdrawal must be in writing and filed with CMS.

[63 FR 35113, June 26, 1998, as amended at 65 FR 40331, June 29, 2000]

**§ 422.652 Opportunity to submit evidence.**

CMS provides the MA organization or contract applicant and the CMS official or officials who made the contract determination reasonable opportunity, not to exceed the timeframe in which an MA organization could choose to request a hearing as described at § 422.662, to present as evidence any documents or written statements that are relevant and material to the matters at issue.

[65 FR 40332, June 29, 2000]

**§ 422.654 Reconsidered determination.**

A reconsidered determination is a new determination that—

(a) Is based on a review of the contract determination, the evidence and findings upon which that was based, and any other written evidence submitted before notice of the reconsidered determination is mailed, including facts relating to the status of the MA organization subsequent to the contract determination; and

(b) Affirms, reverses, or modifies the initial determination.

**§ 422.656 Notice of reconsidered determination.**

(a) CMS gives the MA organization or contract applicant written notice of the reconsidered determination.

(b) The notice—

(1) Contains findings with respect to the contract applicant's qualifications to enter into, or the MA organization's qualifications to remain under, a contract with CMS under Part C of title XVIII of the Act;

(2) States the specific reasons for the reconsidered determination; and

(3) Informs the MA organization or contract applicant of its right to a hearing if it is dissatisfied with the determination.

[63 FR 35113, June 26, 1998, as amended at 65 FR 40332, June 29, 2000]

**§ 422.658 Effect of reconsidered determination.**

A reconsidered determination is final and binding unless a request for a hearing is filed in accordance with § 422.662 or it is revised in accordance with § 422.696.

**§ 422.660 Right to a hearing.**

The following parties are entitled to a hearing:

(a) A contract applicant that has been determined in a reconsidered determination to be unqualified to enter into a contract with CMS under Part C of title XVIII of the Act.

(b) An MA organization whose contract with CMS has been terminated or has not been renewed as a result of a contract determination as provided in § 422.641.

[63 FR 35113, June 26, 1998, as amended at 65 FR 40332, June 29, 2000]

**§ 422.662 Request for hearing.**

(a) *Method and place for filing a request.* A request for a hearing must be made in writing and filed by an authorized official of the contract applicant or MA organization that was the party to the determination under appeal. The request for a hearing must be filed with any CMS office.

(b) *Time for filing a request.* A request for a hearing must be filed within 15 days after the date of the reconsidered determination.

(c) *Parties to a hearing.* The parties to a hearing must be—

(1) The parties described in § 422.660;

(2) At the discretion of the hearing officer, any interested parties who make a showing that their rights may be prejudiced by the decision to be rendered at the hearing; and

(3) CMS.

[63 FR 35113, June 26, 1998, as amended at 65 FR 40332, June 29, 2000]

**§ 422.664 Postponement of effective date of a contract determination when a request for a hearing with respect to a contract determination is filed timely.**

(a) CMS postpones the proposed effective date of the contract determination to terminate a contract with an MA organization until a hearing decision is

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reached and affirmed by the Administrator following review under § 422.692 in instances where an MA organization requests review by the Administrator; and

(b) CMS extends the current contract at the end of the contract period (in the case of a determination not to renew) only—

(1) If CMS finds that an extension of the contract will be consistent with the purpose of this part; and

(2) For such period as CMS and the MA organization agree.

(c) Exception: A contract terminated in accordance with § 422.510(a)(5) will be immediately terminated and will not be postponed if a hearing is requested.

**§ 422.666 Designation of hearing officer.**

CMS designates a hearing officer to conduct the hearing. The hearing officer need not be an ALJ.

**§ 422.668 Disqualification of hearing officer.**

(a) A hearing officer may not conduct a hearing in a case in which he or she is prejudiced or partial to any party or has any interest in the matter pending for decision.

(b) A party to the hearing who objects to the designated hearing officer must notify that officer in writing at the earliest opportunity.

(c) The hearing officer must consider the objections, and may, at his or her discretion, either proceed with the hearing or withdraw.

(1) If the hearing officer withdraws, CMS designates another hearing officer to conduct the hearing.

(2) If the hearing officer does not withdraw, the objecting party may, after the hearing, present objections and request that the officer's decision be revised or a new hearing be held before another hearing officer. The objections must be submitted in writing to CMS.

**§ 422.670 Time and place of hearing.**

(a) The hearing officer fixes a time and place for the hearing, which is not to exceed 30 days from the receipt of the request for the hearing, and sends written notice to the parties. The notice also informs the parties of the gen-

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eral and specific issues to be resolved and information about the hearing procedure.

(b) The hearing officer may, on his or her own motion, or at the request of a party, change the time and place for the hearing. The hearing officer may adjourn or postpone the hearing.

(c) The hearing officer will give the parties reasonable notice of any change in time or place of hearing, or of adjournment or postponement.

**§ 422.672 Appointment of representatives.**

A party may appoint as its representative at the hearing anyone not disqualified or suspended from acting as a representative before the Secretary or otherwise prohibited by law.

**§ 422.674 Authority of representatives.**

(a) A representative appointed and qualified in accordance with § 422.672 may, on behalf of the represented party—

(1) Gives or accepts any notice or request pertinent to the proceedings set forth in this subpart;

(2) Presents evidence and allegations as to facts and law in any proceedings affecting that party; and

(3) Obtains information to the same extent as the party.

(b) A notice or request sent to the representative has the same force and effect as if it had been sent to the party.

**§ 422.676 Conduct of hearing.**

(a) The hearing is open to the parties and to the public.

(b) The hearing officer inquires fully into all the matters at issue and receives in evidence the testimony of witnesses and any documents that are relevant and material.

(c) The hearing officer provides the parties an opportunity to enter any objection to the inclusion of any document.

(d) The hearing officer decides the order in which the evidence and the arguments of the parties are presented and the conduct of the hearing.

**§ 422.678 Evidence.**

The hearing officer rules on the admissibility of evidence and may admit

evidence that would be inadmissible under rules applicable to court procedures.

**§ 422.680 Witnesses.**

(a) The hearing officer may examine the witnesses.

(b) The parties or their representatives are permitted to examine their witnesses and cross-examine witnesses of other parties.

**§ 422.682 Discovery.**

(a) Prehearing discovery is permitted upon timely request of a party.

(b) A request is timely if it is made before the beginning of the hearing.

(c) A reasonable time for inspection and reproduction of documents is provided by order of the hearing officer.

(d) The hearing officer's order on all discovery matters is final.

**§ 422.684 Prehearing.**

The hearing officer may schedule a prehearing conference if he or she believes that a conference would more clearly define the issues.

**§ 422.686 Record of hearing.**

(a) A complete record of the proceedings at the hearing is made and transcribed and made available to all parties upon request.

(b) The record may not be closed until a hearing decision has been issued.

**§ 422.688 Authority of hearing officer.**

In exercising his or her authority, the hearing officer must comply with the provisions of title XVIII and related provisions of the Act, the regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act.

**§ 422.690 Notice and effect of hearing decision.**

(a) As soon as practical after the close of the hearing, the hearing officer issues a written decision that—

(1) Is based upon the evidence of record; and

(2) Contains separately numbered findings of fact and conclusions of law.

(b) The hearing officer provides a copy of the hearing decision to each party.

(c) The hearing decision is final and binding unless it is reversed or modified by the Administrator following review under § 422.692, or reopened and revised in accordance with § 422.696.

**§ 422.692 Review by the Administrator.**

(a) *Request for review by Administrator.* An MA organization that has received a hearing decision upholding a contract termination determination may request review by the Administrator within 15 days of receiving the hearing decision as provided under § 422.690(b).

(b) *Review by the Administrator.* The Administrator shall review the hearing officer's decision, and determine, based upon this decision, the hearing record, and any written arguments submitted by the MA organization, whether the termination decision should be upheld, reversed, or modified.

(c) *Decision by the Administrator.* The Administrator issues a written decision, and furnishes the decision to the MA organization requesting review.

**§ 422.694 Effect of Administrator's decision.**

A decision by the Administrator under section 422.692 is final and binding unless it is reopened and revised in accordance with § 422.696.

**§ 422.696 Reopening of contract or reconsidered determination or decision of a hearing officer or the Administrator.**

(a) *Initial or reconsidered determination.* CMS may reopen and revise an initial or reconsidered determination upon its own motion within one year of the date of the notice of determination.

(b) *Decision of hearing officer.* A decision of a hearing officer that is unfavorable to any party and is otherwise final may be reopened and revised by the hearing officer upon the officer's own motion within one year of the notice of the hearing decision. Another hearing officer designated by CMS may reopen and revise the decision if the hearing officer who issued the decision is unavailable.

(c) *Decision of Administrator.* A decision by the Administrator that is otherwise final may be reopened and revised by the Administrator upon the Administrator's own motion within

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one year of the notice of the Administrator’s decision.

(d) *Notices.* (1) The notice of reopening and of any revisions following the reopening is mailed to the parties.

(2) The notice of revision specifies the reasons for revisions.

**§ 422.698 Effect of revised determination.**

The revision of a contract or reconsidered determination is binding unless a party files a written request for hearing of the revised determination in accordance with § 422.662.

**Subpart O—Intermediate Sanctions**

SOURCE: 63 FR 35115, June 26, 1998, unless otherwise noted.

**§ 422.750 Kinds of sanctions.**

(a) The following intermediate sanctions and civil money penalties may be imposed:

(1) Civil money penalties ranging from \$10,000 to \$100,000 depending upon the violation.

(2) Suspension of enrollment of Medicare beneficiaries.

(3) Suspension of payment to the MA organization for Medicare beneficiaries who enroll.

(4) Require the MA organization to suspend all marketing activities to Medicare beneficiaries for the MA plan subject to the intermediate sanctions.

(b) The enrollment, payment, and marketing sanctions continue in effect until CMS is satisfied that the deficiency on which the determination was based has been corrected and is not likely to recur.

**§ 422.752 Basis for imposing sanctions.**

(a) *All intermediate sanctions.* For the violations listed in this paragraph (a), we may impose one, or more, of the sanctions specified in § 422.750(a)(2), (a)(3), or (a)(4) on any MA organization that has a contract in effect. The MA organization may also be subject to other applicable remedies available under law.

(1) Fails substantially to provide, to an MA enrollee, medically necessary services that the organization is required to provide (under law or under

the contract) to an MA enrollee, and that failure adversely affects (or is substantially likely to adversely affect) the enrollee.

(2) Imposes on MA enrollees premiums in excess of the monthly basic and supplemental beneficiary premiums permitted under section 1854 of the Act and subpart F of this part.

(3) Expels or refuses to reenroll a beneficiary in violation of the provisions of this part.

(4) Engages in any practice that could reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose medical condition or history indicates a need for substantial future medical services.

(5) Misrepresents or falsifies information that it furnishes—

(i) To CMS; or

(ii) To an individual or to any other entity.

(6) Fails to comply with the requirements of § 422.206, which prohibits interference with practitioners’ advice to enrollees.

(7) Fails to comply with § 422.216, which requires the organization to enforce the limit on balance billing under a private fee-for service plan.

(8) Employs or contracts with an individual or entity who is excluded from participation in Medicare under section 1128 or 1128A of the Act (or with an entity that employs or contracts with such an excluded individual or entity) for the provision of any of the following:

(i) Health care.

(ii) Utilization review.

(iii) Medical social work.

(iv) Administrative services.

(b) *Suspension of enrollment and marketing.* If CMS makes a determination under § 422.510(a), CMS may impose the intermediate sanctions in § 422.750(a)(2) and (a)(4).

[63 FR 35115, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 69 FR 78338, Dec. 30, 2004; 70 FR 4741, Jan. 28, 2005; 70 FR 52027, Sept. 1, 2005]

**§ 422.756 Procedures for imposing sanctions.**

(a) *Notice of Sanction and opportunity to respond—*(1) *Notice of sanction.* Before imposing the intermediate sanctions

specified in paragraph (c) of this section CMS—

(i) Sends a written notice to the MA organization stating the nature and basis of the proposed sanction; and

(ii) Sends the OIG a copy of the notice.

(2) *Opportunity to respond.* CMS allows the MA organization 15 days from receipt of the notice to provide evidence that it has not committed an act or failed to comply with the requirements described in § 422.752, as applicable. CMS may allow a 15-day addition to the original 15 days upon receipt of a written request from the MA organization. To be approved, the request must provide a credible explanation of why additional time is necessary and be received by CMS before the end of the 15-day period following the date of receipt of the sanction notice. CMS does not grant an extension if it determines that the MA organization's conduct poses a threat to an enrollee's health and safety.

(b) *Informal reconsideration.* If, consistent with paragraph (a)(2) of this section the MA organization submits a timely response to CMS's notice of sanction, CMS conducts an informal reconsideration that:

(1) Consists of a review of the evidence by an CMS official who did not participate in the initial decision to impose a sanction; and

(2) Gives the MA organization a concise written decision setting forth the factual and legal basis for the decision that affirms or rescinds the original determination.

(c) *Specific sanctions.* If CMS determines that an MA organization has acted or failed to act as specified in § 422.752 and affirms this determination in accordance with paragraph (b) of this section, CMS may—

(1) Require the MA organization to suspend acceptance of applications made by Medicare beneficiaries for enrollment in the sanctioned MA plan during the sanction period;

(2) In the case of a violation under § 422.752(a), suspend payments to the MA organization for Medicare beneficiaries enrolled in the sanctioned MA plan during the sanction period; and

(3) Require the MA organization to suspend all marketing activities for

the sanctioned MA plan to Medicare enrollees.

(d) *Effective date and duration of sanctions—*(1) *Effective date.* Except as provided in paragraph (d)(2) of this section, a sanction is effective 15 days after the date that the organization is notified of the decision to impose the sanction or, if the MA organization timely seeks reconsideration under paragraph (b) of this section, on the date specified in the notice of CMS's reconsidered determination.

(2) *Exception.* If CMS determines that the MA organization's conduct poses a serious threat to an enrollee's health and safety, CMS may make the sanction effective on a date before issuance of CMS's reconsidered determination.

(3) *Duration of sanction.* The sanction remains in effect until CMS notifies the MA organization that CMS is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

(e) *Termination by CMS.* In addition to or as an alternative to the sanctions described in paragraph (c) of this section, CMS may decline to authorize the renewal of an organization's contract in accordance with § 422.506(b)(2) and (b)(3), or terminate the contract in accordance with § 422.510.

(f) *Civil money penalties.* (1) If CMS determines that an MA organization has committed an act or failed to comply with a requirement described in § 422.752, CMS notifies the OIG of this determination, and also notifies OIG when CMS reverses or terminates a sanction imposed under this part.

(2) In the case of a violation described in paragraph (a) of § 422.752, or a determination under paragraph (b) of § 422.752 based upon a violation under § 422.510(a)(4) (involving fraudulent or abusive activities), in accordance with the provisions of part 1003 of this chapter, the OIG may impose civil money penalties on the MA organization in accordance with part 1003 of this chapter in addition to, or in place of, the sanctions that CMS may impose under paragraph (c) of this section.

(3) In the case of a determination under § 422.752(b) other than a determination based upon a violation under § 422.510(a)(4), CMS may impose civil

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money penalties on the MA organization in the amounts specified in § 422.758 in addition to, or in place of, the sanctions that CMS may impose under paragraph (c) of this section.

[63 FR 35113, June 26, 1998, as amended at 68 FR 50859, Aug. 22, 2003; 70 FR 4741, Jan. 28, 2005]

### § 422.758 Maximum amount of civil money penalties imposed by CMS.

If CMS makes a determination under § 422.510(a), as described in § 422.752(b) excepting those determinations under § 422.510(a)(4), CMS may impose civil money penalties in addition to, or in place of, the sanctions that CMS may impose under § 422.756(c) in the following amounts:

(a) If the deficiency on which the determination is based has directly adversely affected (or has the substantial likelihood of adversely affecting) one or more Medicare Advantage enrollees—up to \$25,000 for each determination.

(b) For each week that a deficiency remains uncorrected after the week in which the Medicare Advantage organization receives CMS' notice of the determination—up to \$10,000.

(c) If CMS makes a determination that a MA organization has terminated its contract other than in a manner described under § 422.512 and that the MA organization has therefore failed to substantially carry out the terms of the contract—\$250 per Medicare enrollee from the terminated MA plan or plans at the time the MA organization terminated its contract, or \$100, 000, whichever is greater.

[69 FR 78338, Dec. 30, 2004, as amended at 70 FR 4741, Jan. 28, 2005]

### § 422.760 Other applicable provisions.

The provisions of section 1128A of the Act (except subsections (a) and (b)) apply to civil money penalties under this subpart to the same extent that they apply to a civil money penalty or procedure under section 1128A of the Act.

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