

## Health Care Financing Administration, HHS

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AUTHORITY: Secs. 1851 and 1855 of the Social Security Act.

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### Subpart A—General Provisions

SOURCE: 63 FR 35068, June 26, 1998, unless otherwise noted.

#### § 422.1 Basis and scope.

(a) *Basis*. This part is based on the indicated provisions of the following sections of the Act:

- 1851—Eligibility, election, and enrollment.
- 1852—Benefits and beneficiary protections.
- 1853—Payments to Medicare+Choice (M+C) organizations.
- 1854—Premiums.
- 1855—Organization, licensure, and solvency of M+C organizations.
- 1856—Standards.
- 1857—Contract requirements.
- 1859—Definitions; enrollment restriction for certain M+C plans.

(b) *Scope*. This part establishes standards and sets forth the requirements, limitations, and procedures for Medicare services furnished, or paid for, by Medicare+Choice organizations through Medicare+Choice plans.

#### § 422.2 Definitions.

As used in this part—  
*ACR* stands for adjusted community rate.

*Additional benefits* are health care services not covered by Medicare, and reductions in premiums or cost-sharing for Medicare covered services, funded from adjusted excess amounts as calculated in the ACR.

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*Adjusted community rate (ACR)* is the equivalent of the maximum amount allowed under § 422.310.

*Arrangement* means a written agreement between an M+C organization and a provider or provider network, under which—

(1) The provider or provider network agrees to furnish for a specific M+C plan(s) specified services to the organization's M+C 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, and additional benefits.

*Benefits* are health care services that are intended to maintain or improve the health status of enrollees, for which the M+C organization incurs a cost or liability under an M+C plan, and that are approved in the Benefit/ACR process.

*Coinsurance* is a fixed percentage of the total amount paid for a health care service that can be charged to an M+C enrollee on a per-service basis.

*Copayment* is a fixed amount that can be charged to an M+C plan enrollee on a per-service basis.

*Cost-sharing* includes deductibles, co-insurance, and copayments.

*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—

(1) 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;

(2) Serious impairment to bodily functions; or

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

*Emergency services* means covered inpatient and outpatient services that are—

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

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

*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 M+C contract.

*M+C* stands for Medicare+Choice.

*M+C eligible individual* means an individual who meets the requirements of § 422.50.

*M+C 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 HCFA as meeting the M+C contract requirements.

*M+C plan* means health benefits coverage offered under a policy or contract by an M+C 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 M+C plan.

*M+C plan enrollee* is an M+C eligible individual who has elected an M+C plan offered by an M+C organization.

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

*MSA* stands for medical savings account.

*MSA trustee* means a person or business with which an enrollee establishes an M+C 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).

*Original Medicare* means health insurance available under Medicare Part A and Part B through the traditional fee-for service payment system.

*Optional supplemental benefits* means health benefits normally not covered by Medicare purchased at the option of the M+C enrollee and that are paid for 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.

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

*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 M+C organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an M+C coordinated care or network MSA plan.

*Religious and fraternal (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 a coordinated care plan that is offered by an RFB society.

*Service area* means a geographic area approved by HCFA within which an M+C eligible individual may enroll in a particular M+C plan offered by the organization. For coordinated care plans and network medical savings account (MSA) plans only, the service area also is the area within which a network of providers exists that meets the access standards in § 422.112. The service area also defines the area where a uniform benefit package is offered. In deciding whether to approve a service area proposed by an M+C organization for an M+C plan, HCFA considers the M+C organization's commercial service area for the type of plan in question (if applicable), community practices generally, whether the boundaries of the service area are discriminatory in effect, and, in the case of coordinated care and network MSA plans, the adequacy of the provider network in the proposed service area. HCFA may approve single county M+C non-network MSA plans even if the M+C organization has a different commercial service area.

*Urgently needed services* means covered services provided when an enrollee is temporarily absent from the M+C 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 such services are medically necessary and immediately required—

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

(2) It was not reasonable given the circumstances to obtain the services through the organization offering the M+C plan.

#### § 422.4 Types of M+C plans.

(a) *General rule.* An M+C plan may be a coordinated care plan, a combination of an M+C MSA plan and a contribution into an M+C MSA established in accordance with § 422.262, or an M+C 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