

(b) *Specific preemption.* As they might otherwise apply to the M+C plans of an M+C organization in a State, State laws and regulations pertaining to the following areas are specifically preempted by this part:

(1) Benefit requirements, such as mandating the inclusion in an M+C plan of a particular service, or specifying the scope or duration of a service (for example, length of hospital stay, number of home health visits). State cost-sharing standards with respect to any benefits are preempted only if they are inconsistent with this part, as provided for in paragraph (a) of this section.

(2) Requirements relating to inclusion or treatment of providers and suppliers.

(3) Coverage determinations (including related appeal and grievance processes for all benefits included under an M+C contract). Determinations on issues other than whether a service is covered under an M+C contract, and the extent of enrollee liability under the M+C plan for such a service, are not considered coverage determinations for purposes of this paragraph.

(c) Except as provided in paragraphs (a) and (b) of this section, nothing in this section may be construed to affect or modify the provisions of any other law or regulation that imposes or preempts a specific State authority.

§ 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 subdivision or other governmental authorities with respect to any payment HCFA makes on behalf of M+C enrollees under subpart F of this part.

(b) *Construction.* Nothing in this section shall be construed to exempt any M+C 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.

Subpart J [Reserved]

Subpart K—Contracts With Medicare+Choice Organizations

SOURCE: 63 FR 35099, June 26, 1998, unless otherwise noted.

§ 422.500 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

(ii) Health services furnished to the M+C organization's enrollees by hospitals and other providers, and by M+C 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 § 422.257(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 M+C 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 M+C organization or contract applicant to provide administrative services or health care services for a Medicare eligible individual.

Party in interest includes the following: