

§ 422.1

42 CFR Ch. IV (10–1–02 Edition)

- 422.686 Record of hearing.
- 422.688 Authority of hearing officer.
- 422.690 Notice and effect of hearing decision.
- 422.692 Review by the Administrator.
- 422.694 Effect of Administrator's decision.
- 422.696 Reopening of contract or reconsidered determination or decision of a hearing officer or the Administrator.
- 422.698 Effect of revised determination.

Subpart O—Intermediate Sanctions

- 422.750 Kinds of sanctions.
- 422.752 Basis for imposing sanctions.
- 422.756 Procedures for imposing sanctions.
- 422.758 Maximum amount of civil money penalties imposed by CMS.
- 422.760 Other applicable provisions.

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.

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.

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 (not solely an administrative processing cost). Benefits are submitted and approved through the 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, coinsurance, and copayments.

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.