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(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 M+C coordinated care plan or M+C private fee-for-service plan must accept as payment in full the amounts (less any payments under §§ 412.105(g) and 413.86(d)) 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 413.86(d) concerns calculating payment for direct graduate medical education costs.)

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000]

§ 422.216 Special rules for M+C private fee-for-service plans.

(a) *Payment to providers—(1) Payment rate.* (i) The M+C 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 M+C organization must make information on its payment rates available to providers that furnish services that may be covered under the M+C private fee-for-service plan.

(2) *Payment to contract providers.* For each service, the M+C 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 M+C private fee-for-service plan must accept as payment in full the amounts (less any payments under

§§ 412.105(g) and 413.86(d) 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.

(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 M+C 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.

(iv) The M+C 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 M+C private fee-for-service plan as specified in § 422.308(b), 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 M+C organization that offers an M+C fee-for-service plan must enforce the limit specified in paragraph (b)(1) of this section.

(2) *Noncontract providers.* An M+C organization that offers an M+C 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 M+C 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 M+C organization that offers an M+C 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 M+C 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 M+C organization must make coverage determinations 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 M+C 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 M+C 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 M+C 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 M+C 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 M+C 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 M+C organization has in effect a procedure under which—

(i) Any provider furnishing services to an enrollee in an M+C 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.

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(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 credentialing 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(a)(1) and (a)(1)(iii).

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000]

§ 422.220 Exclusion of services furnished under a private contract.

An M+C 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 M+C 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—Payments to Medicare+Choice Organizations

SOURCE: 63 FR 35090, June 26, 1998, unless otherwise noted.

§ 422.249 Terminology.

In this subpart—

(a) The terms “per capita rate” and “capitation rate” (see § 422.252) are used interchangeably; and

(b) In the term “area-specific,” “area” refers to any of the payment areas described in § 422.250(c).

§ 422.250 General provisions.

(a) *Monthly payments—(1) General rule.* Except as provided in paragraphs

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(a)(2) or (f) of this section, CMS makes advance monthly payments equal to $\frac{1}{12}$ th of the annual M+C capitation rate for the payment area described in paragraph (c) of this section adjusted for such demographic risk factors as an individual’s age, disability status, sex, institutional status, and other such factors as it determines to be appropriate to ensure actuarial equivalence. Effective January 1, 2000, CMS adjusts for health status as provided in § 422.256(c). When the new risk adjustment is implemented, $\frac{1}{12}$ th of the annual capitation rate for the payment area described in paragraph (c) of this section will be adjusted by the risk adjustment methodology under § 422.256(d).

(2) *Special rules—(i) Enrollees with end-stage renal disease.* (A) For enrollees determined to have end-stage renal disease (ESRD), CMS establishes special rates that are determined under an actuarially equivalent approach to that used in establishing the rates under original Medicare.

(B) CMS reduces the payment rate for each renal dialysis treatment by the same amount that the Secretary 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 pay for the ESRD network program in the same manner as similar reductions are used in original Medicare.

(ii) *MSA enrollees.* For MSA enrollees, CMS makes advanced monthly payments as described in paragraph (a)(1) less the amount (if any) identified in § 422.262(c)(1)(ii) to be deposited in the M+C MSA. In addition, CMS deposits in the M+C MSA the lump sum amounts (if any) determined in accordance with § 422.262(c).

(iii) *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. Such adjustment can be made on an individual or organization basis.

(b) *Adjustment of payments to reflect number of Medicare enrollees—(1) General*