

§ 422.220

(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*