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42 C.F.R. § 422.2

Definitions.

As used in this part—

Aligned enrollment refers to the enrollment in a dual eligible special needs plan of full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and: the dual eligible special needs plan's (D-SNP's) MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization. When State policy limits a D-SNP's membership to individuals with aligned enrollment, this condition is referred to as exclusively aligned enrollment.

Arrangement means a written agreement between an MA organization and a provider or provider network, under which—

(1) The provider or provider network agrees to furnish for a specific MA plan(s) specified services to the organization's MA 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.

Attestation process means a CMS-developed RADV audit-related process that is part of the medical record review process that enables MA organizations undergoing RADV audit to submit CMS-generated attestations for eligible medical records with missing or illegible signatures or credentials. The purpose of the CMS-generated attestations is to cure signature and credential issues. CMS-generated attestations do not provide an opportunity for a provider or supplier to replace a medical record or for a provider or supplier to attest that a beneficiary has the medical condition

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 Part A and Part B benefits except—

(1) Hospice services; and

(2) Beginning in 2021, organ acquisitions for kidney transplants, including costs covered under section 1881(d) of the Act.

Benefits means health care services that are intended to maintain or improve the health status of enrollees, for which the MA organization incurs a cost or liability under an MA plan (not solely an administrative processing cost). Benefits are submitted and approved through the annual bidding process.

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Chronic condition special needs plan (C-SNPs) means an SNP that restricts enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under this section, including restricting enrollment based on the multiple commonly co-morbid and clinically linked condition groupings specified in § 422.4(a)(1)(iv).

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

Copayment is a fixed amount that can be charged to an MA plan enrollee on a per-service basis.

Cost-sharing includes deductibles, coinsurance, and copayments.

Downstream entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Dual eligible special needs plan or D-SNP means a specialized MA plan for special needs individuals who are entitled to medical assistance under a State plan under title XIX of the Act that—

(1) Coordinates the delivery of Medicare and Medicaid services for individuals who are eligible for such services;

(2) May provide coverage of Medicaid services, including long-term services and supports and behavioral health services for individuals eligible for such services;

(3) Has a contract with the State Medicaid agency consistent with § 422.107 that meets the minimum requirements in paragraph (c) of such section; and

(4) Beginning January 1, 2021, satisfies one or more of the following criteria for the integration of Medicare and Medicaid benefits:

(i) Meets the additional requirement specified in § 422.107(d) in its contract with the State Medicaid agency.

(ii) Is a highly integrated dual eligible special needs plan.

(iii) Is a fully integrated dual eligible special needs plan.

Facility-based Institutional special needs plan (FI-SNP) means a type of I-SNP that—

(1) Restricts enrollment to MA eligible individuals who meet the definition of institutionalized;

(2) Must own or contract with at least one institution, specified in the definition of institutionalized in this section, for each county in the plan's service area; and

(3) Must own or have a contractual arrangement with each institutionalized facility serving enrollees in the plan.

First tier entity means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Fiscally sound operation means an operation which at least maintains a positive net worth (total assets exceed

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total liabilities).

Fully integrated dual eligible special needs plan means a dual eligible special needs plan—

(1) That provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Act with the applicable State;

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