

## § 422.106

(e) *Prompt payment.* Health benefits payable under the POS benefit are subject to the prompt payment requirements in § 422.520.

(f) *POS-related data.* An M+C organization that offers a POS benefit through an M+C plan must report enrollee utilization data at the plan level by both plan contracting providers (in-network) and by non-contracting providers (out-of-network) including enrollee use of the POS benefit, in the form and manner prescribed by CMS.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40320, June 29, 2000]

## § 422.106 Coordination of benefits with employer group health plans and Medicaid.

(a) *General rule.* If an M+C organization contracts with an employer group health plan (EGHP) that covers enrollees in an M+C plan, or contracts with a State Medicaid agency to provide Medicaid benefits to individuals who are eligible for both Medicare and Medicaid, and who are enrolled in an M+C plan, the enrollees must be provided the same benefits as all other enrollees in the M+C plan, with the EGHP or Medicaid benefits supplementing the M+C plan benefits. Jurisdiction regulating benefits under these circumstances is as follows:

(1) All requirements of this part that apply to the M+C program apply to the M+C plan coverage provided to enrollees eligible for benefits under an EGHP or Medicaid contract.

(2) Employer benefits that complement an M+C plan, and the marketing materials associated with the benefits, are not subject to review or approval by CMS. M+C plan benefits provided to members of the EGHP, and the associated marketing materials, are subject to CMS review and approval.

(3) Medicaid benefits are not reviewed under this part, but are subject to appropriate CMS review under the Medicaid program. M+C plan benefits provided to individuals entitled to Medicaid benefits provided by the M+C organization under a contract with the State Medicaid agency are subject to M+C rules and requirements.

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(b) *Examples.* Employer/Medicaid benefits, permissible EGHP or Medicaid plan benefits include the following:

(1) Payment of a portion or all of the M+C basic and supplemental premiums.

(2) Payment of a portion or all of other cost-sharing amounts approved for the M+C plan.

(3) Other employer-sponsored benefits that may require additional premium and cost-sharing, or other benefits provided by the organization under a contract with the State Medicaid agency.

[65 FR 40320, June 29, 2000]

## § 422.108 Medicare secondary payer (MSP) procedures.

(a) *Basic rule.* CMS does not pay for services to the extent that Medicare is not the primary payer under section 1862(b) of the Act and part 411 of this chapter.

(b) *Responsibilities of the M+C organization.* The M+C organization must, for each M+C plan—

(1) Identify payers that are primary to Medicare under section 1862(b) of the Act and part 411 of this chapter;

(2) Identify the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers.

(c) *Collecting from other entities.* The M+C organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) *Collecting from other insurers or the enrollee.* If a Medicare enrollee receives from an M+C organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the M+C organization may bill, or authorize a provider to bill any of the following—

(1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.

(2) The Medicare enrollee, to the extent that he or she has been paid by the

carrier, employer, or entity for covered medical expenses.

(e) *Collecting from group health plans (GHPs) and large group health plans (LGHPs).* An M+C organization may bill a GHP or LGHP for services it furnishes to a Medicare enrollee who is also covered under the GHP or LGHP and may bill the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP.

(f) *MSP rules and State laws.* Consistent with § 422.402 concerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to M+C plans only to the extent that those State laws are inconsistent with the standards established under this part. A State cannot take away an M+C organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. Section 1852(a)(4) of the Social Security Act does not prohibit a State from limiting the amount of the recovery; thus, State law could modify, but not negate, an M+C organization's rights in this regard.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40320, June 29, 2000]

**§ 422.109 Effect of national coverage determinations (NCDs).**

(a) If CMS determines and announces that an NCD meets the criteria for "significant cost" described in paragraph (c) of this section, an M+C organization is not required to assume risk for the costs of that service until the contract year for which the annual M+C capitation rate is determined on a basis that includes the cost of the NCD service.

(b) The M+C organization must furnish, arrange or pay for an NCD "significant cost" service before the adjustment of the annual M+C capitation rate. The following rules apply to these services:

(1) Medicare payment for the service is:

(i) In addition to the capitation payment to the M+C organization; and

(ii) Made directly by the fiscal intermediary and carrier to the M+C organization in accordance with original Medicare payment rules, methods, and requirements.

(2) NCD costs for which CMS intermediaries and carriers will not make payment and are the responsibility of the M+C organization are—

(i) Services necessary to diagnose a condition covered by the NCD;

(ii) Most services furnished as follow-up care to the NCD service;

(iii) Any service that is already a Medicare-covered service and included in the annual M+C capitation rate; and

(iv) Any service, including the costs of the NCD service itself, to the extent the M+C organization is already obligated to cover it as an additional benefit under § 422.312 or supplemental benefit under § 422.102.

(3) NCD costs for which CMS intermediaries and carriers make payment are—

(i) Costs relating directly to the provision of services related to the NCD that were noncovered services prior to the issuance of the NCD; and

(ii) A service that is not included in the M+C per capita payment rate.

(4) If the M+C organization does not provide or arrange for the service consistent with CMS's NCD, enrollees may obtain the services through qualified providers not under contract to the M+C organization, and the organization will pay for the services consistent with § 422.109(c).

(5) Beneficiaries are liable for any applicable coinsurance amounts, but are not responsible for the Part A deductible.

(c) The term "significant cost" as it relates to a particular NCD means either of the following:

(1) The average cost of furnishing a single service exceeds a cost threshold that—

(i) For calendar years 1998 and 1999, is \$100,000;

(ii) For calendar year 2000 and subsequent calendar years, is the preceding year's dollar threshold adjusted to reflect the national per capita growth percentage described in § 422.254(b).

(2) The estimated cost of all of Medicare services furnished nationwide as a result of a particular NCD represents