

(b) Reductions in portion of other cost sharing amounts the M+C organization charges to the beneficiary.

(c) The addition of benefits that may require additional premium and cost sharing. The addition of benefits and the charges for those benefits are not subject to HCFA review or approval.

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

(a) *Basic rule.* HCFA 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) Determine the amounts payable by those payers; and

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

(c) *Charges to other entities.* The M+C organization may charge, or authorize a provider to charge, 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) *Charge to 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 charge, or authorize a provider to charge 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) *Charge to group health plans (GHPs) and large group health plans (LGHPs).* An M+C organization may charge a GHP or LGHP for services it furnishes to a Medicare enrollee who is

also covered under the GHP or LGHP and may charge the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP.

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

(a) If HCFA 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 prior to the adjustment of the annual M+C capitation rate. The following rules apply to such 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 HCFA 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 HCFA 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.