

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.

(4) If the M+C organization does not provide or arrange for the service consistent with HCFA'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 at least 0.1 percent of the national standardized annual capitation rate (see § 422.254(f)), multiplied by the total

number of Medicare beneficiaries nationwide for the applicable calendar year.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40321, June 29, 2000]

§ 422.110 Discrimination against beneficiaries prohibited.

(a) *General prohibition.* Except as provided in paragraph (b) of this section, an M+C organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an M+C plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

(1) Medical condition, including mental as well as physical illness.

(2) Claims experience.

(3) Receipt of health care.

(4) Medical history.

(5) Genetic information.

(6) Evidence of insurability, including conditions arising out of acts of domestic violence.

(7) Disability.

(b) *Exception.* An M+C organization may not enroll an individual who has been medically determined to have end-stage renal disease. However, an enrollee who develops end-stage renal disease while enrolled in a particular M+C organization may not be disenrolled for that reason. An individual who is an enrollee of a particular M+C organization, and resides in the M+C plan service area at the time he or she first becomes M+C eligible, is considered to be "enrolled" in the M+C organization for purposes of the preceding sentence.

(c) *Additional requirements.* An M+C organization is required to observe the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, and Americans with Disabilities Act (see § 422.502(h)).

[63 FR 35077, June 26, 1998; 63 FR 52612, Oct. 1, 1998; 64 FR 7980, Feb. 17, 1999, as amended at 65 FR 40321, June 29, 2000]

§ 422.111 Disclosure requirements.

(a) *Detailed description.* An M+C organization must disclose the information specified in paragraph (b) of this section—