

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—

(1) To each enrollee electing an M+C plan it offers;

(2) In clear, accurate, and standardized form; and

(3) At the time of enrollment and at least annually thereafter.

(b) *Content of plan description.* The description must include the following information:

(1) *Service area.* The M+C plan's service area and any enrollment continuation area.

(2) *Benefits.* The benefits offered under the plan, including applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with receipt or use of benefits; and for purposes of comparison—

(i) The benefits offered under original Medicare, including the content specified in paragraph (f)(1) of this section;

(ii) For an M+C MSA plan, the benefits under other types of M+C plans; and

(iii) The availability of the Medicare hospice option and any approved hospices in the service area, including those the M+C organization owns, controls, or has a financial interest in.

(3) *Access.* The number, mix, and distribution (addresses) of providers from whom enrollees may obtain services; any out-of-network coverage; any point-of-service option, including the supplemental premium for that option; and how the M+C organization meets the requirements of §§ 422.112 and 422.114 for access to services offered under the plan.

(4) Out-of-area coverage provided under the plan, including coverage provided to individuals eligible to enroll in the plan under § 422.50(a)(3)(ii).

(5) *Emergency coverage.* Coverage of emergency services, including—

(i) Explanation of what constitutes an emergency, referencing the definitions of emergency services and emergency medical condition at § 422.113;

(ii) The appropriate use of emergency services, stating that prior authorization cannot be required;

(iii) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent; and

(iv) The locations where emergency care can be obtained and other locations at which contracting physicians and hospitals provide emergency services and post-stabilization care included in the M+C plan.

(6) *Supplemental benefits.* Any mandatory or optional supplemental benefits and the premium for those benefits.

(7) *Prior authorization and review rules.* Prior authorization rules and other review requirements that must be met in order to ensure payment for the services. The M+C organization must instruct enrollees that, in cases where noncontracting providers submit a bill directly to the enrollee, the enrollee should not pay the bill, but submit it to the M+C organization for processing and determination of enrollee liability, if any.

(8) *Grievance and appeals procedures.* All grievance and appeals rights and procedures.

(9) *Quality assurance program.* A description of the quality assurance program required under § 422.152.

(10) *Disenrollment rights and responsibilities.*

(c) *Disclosure upon request.* Upon request of an individual eligible to elect an M+C plan, an M+C organization must provide to the individual the following information:

(1) The information required paragraph (f) of this section.

(2) The procedures the organization uses to control utilization of services and expenditures.

(3) The number of disputes, and the disposition in the aggregate, in a manner and form described by the Secretary. Such disputes shall be categorized as

(i) Grievances according to § 422.564; and

(ii) Appeals according to § 422.578 et. seq.

(4) A summary description of the method of compensation for physicians.

(5) Financial condition of the M+C organization, including the most recently audited information regarding, at least, a description of the financial condition of the M+C organization offering the plan.

(d) *Changes in rules.* If an M+C organization intends to change its rules for an M+C plan, it must:

(1) Submit the changes for HCFA review under the procedures of § 422.80.

(2) For changes that take effect on January 1, notify all enrollees by the previous October 15.

(3) For all other changes, notify all enrollees at least 30 days before the intended effective date of the changes.

(e) *Changes to provider network.* The M+C organization must make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified.

(f) *Disclosable information*—(1) *Benefits under original Medicare.* (i) Covered services.

(ii) Beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts.

(iii) Any beneficiary liability for balance billing.

(2) *Enrollment procedures.* Information and instructions on how to exercise election options under this subpart.

(3) *Rights.* A general description of procedural rights (including grievance and appeals procedures) under original Medicare and the M+C program and the right to be protected against discrimination based on factors related to health status in accordance with § 422.110.

(4) *Medigap and Medicare Select.* A general description of the benefits, enrollment rights, and requirements applicable to Medicare supplemental policies under section 1882 of the Act, and provisions relating to Medicare Select policies under section 1882(t) of the Act.

(5) *Potential for contract termination.* The fact that an M+C organization may terminate or refuse to renew its contract, or reduce the service area included in its contract, and the effect that any of those actions may have on

individuals enrolled in that organization's M+C plan.

(6) *Comparative information.* A list of M+C plans that are or will be available to residents of the service area in the following calendar year, and, for each available plan, information on the aspects described in paragraphs (c)(7) through (c)(11) of this section, presented in a manner that facilitates comparison among the plans.

(7) *Benefits.* (i) Covered services beyond those provided under original Medicare.

(ii) Any beneficiary cost-sharing.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an M+C MSA plan, the amount of the annual MSA deposit and the differences in cost-sharing, enrollee premiums, and balance billing, as compared to M+C plans.

(v) In the case of an M+C private fee-for-service plan, differences in cost-sharing, enrollee premiums, and balance billing, as compared to M+C plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The types of providers that participate in the plan's network and the extent to which an enrollee may select among those providers.

(viii) The coverage of emergency and urgently needed services.

(8) *Premiums.* (i) The M+C monthly basic beneficiary premiums.

(ii) The M+C monthly supplemental beneficiary premium.

(9) *The plan's service area.*

(10) *Quality and performance indicators* for benefits under a plan to the extent they are available as follows (and how they compare with indicators under original Medicare):

(i) Disenrollment rates for Medicare enrollees for the 2 previous years, excluding disenrollment due to death or moving outside the plan's service area, calculated according to HCFA guidelines.

(ii) Medicare enrollee satisfaction.

(iii) Health outcomes.

(iv) Plan-level appeal data.

(v) The recent record of plan compliance with the requirements of this part, as determined by the Secretary.

(vi) Other performance indicators.

(11) *Supplemental benefits.* Whether the plan offers mandatory supplemental benefits or offers optional supplemental benefits and the premiums and other terms and conditions for those benefits.

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

§ 422.112 Access to services.

(a) *Rules for coordinated care plans and network M+C MSA plans.* An M+C organization that offers an M+C coordinated care plan or network M+C MSA plan may specify the networks of providers from whom enrollees may obtain services if the M+C organization ensures that all covered services, including additional or supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the M+C organization must meet the following requirements:

(1) *Provider network.* Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically utilized in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.

(2) *PCP panel.* Establish a panel of PCPs from which the enrollee may select a PCP. If an M+C organization requires its enrollees to obtain a referral in most situations before receiving services from a specialist, the M+C organization must either assign a PCP for purposes of making the needed referral or make other arrangements to ensure access to medically necessary specialty care.

(3) *Specialty care.* Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits (as defined in § 422.2). The M+C organization arranges for specialty care outside of the plan provider network when network providers are un-

available or inadequate to meet an enrollee's medical needs.

(4) *Serious medical conditions.* Ensure that for each plan, the M+C organization has in effect HCFA-approved procedures that enable the M+C organization, through appropriate health care professionals, to—

(i) Identify individuals with complex or serious medical conditions;

(ii) Assess those conditions, and use medical procedures to diagnose and monitor them on an ongoing basis; and

(iii) Establish and implement a treatment plan that—

(A) Is appropriate to those conditions;

(B) Includes an adequate number of direct access visits to specialists consistent with the treatment plan;

(C) Is time-specific and updated periodically; and

(D) Ensures adequate coordination of care among providers.

(5) *Service area expansion.* If seeking a service area expansion for an M+C plan, demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served.

(6) *Credentialed providers.* Demonstrate to HCFA that its providers in an M+C plan are credentialed through the process set forth at § 422.204(a).

(7) *Written standards.* Establish written standards for the following:

(i) Timeliness of access to care and member services that meet or exceed standards established by HCFA. Timely access to care and member services within a plan's provider network must be continuously monitored to ensure compliance with these standards, and the M+C organization must take corrective action as necessary.

(ii) Policies and procedures (coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations.

(iii) Provider consideration of beneficiary input into the provider's proposed treatment plan.

(8) *Hours of operation.* Ensure that—

(i) The hours of operation of its M+C plan providers are convenient to the population served under the plan and do not discriminate against Medicare enrollees; and