(2) Approved waivers or modifications under this paragraph granted to any MA organization may be used by any other similarly situated MA organization in developing its bid.

(d) Employer sponsored MA plans for plan years beginning on or after January 1, 2006.

(1) CMS may waive or modify any requirement in this part or Part D that hinders the design of, the offering of, or the enrollment in, an MA plan (including an MA-PD plan) offered by one or more employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof), or that is offered, sponsored or administered by an entity on behalf of one or more employers or labor organizations, to furnish benefits to the employers’ employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations. Any entity seeking to offer, sponsor, or administer such an MA plan described in this paragraph may request, in writing, from CMS, a waiver or modification of requirements in this part that hinder the design of, the offering of, or the enrollment in, such MA plan.

(2) An MA plan described in this paragraph may restrict the enrollment of individuals in that plan to individuals who are beneficiaries and participants in that plan.

(3) Approved waivers or modifications under this paragraph granted to any MA plan may be used by any other similarly situated MA plan in developing its bid.


§ 422.107 Special needs plans and dual-eligibles: Contract with State Medicaid Agency.

(a) Definition. For the purpose of this section, a contract with a State Medicaid agency means a formal written agreement between an MA organization and the State Medicaid agency documenting each entity’s roles and responsibilities with regard to dual-eligible individuals.

(b) General rule. MA organizations seeking to offer a special needs plan serving beneficiaries eligible for both Medicare and Medicaid (dual-eligible) must have a contract with the State Medicaid agency. The MA organization retains responsibility under the contract for providing benefits, or arranging for benefits to be provided, for individuals entitled to receive medical assistance under title XIX. Such benefits may include long-term care services consistent with State policy.

(c) Minimum contract requirements. At a minimum, the contract must document—

(1) The MA organization’s responsibility, including financial obligations, to provide or arrange for Medicaid benefits.

(2) The category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the SNP, as described under the Statute at sections 1902(a), 1902(f), 1902(p), and 1905.

(3) The Medicaid benefits covered under the SNP.

(4) The cost-sharing protections covered under the SNP.

(5) The identification and sharing of information on Medicaid provider participation.

(6) The verification of enrollee’s eligibility for both Medicare and Medicaid.

(7) The service area covered by the SNP.

(8) The contract period for the SNP.

(d) Date of Compliance.

(1) Effective January 1, 2010—

(i) MA organizations offering a new dual-eligible SNP must have a State Medicaid agency contract.

(ii) MA organizations with an existing dual-eligible SNP without a State Medicaid agency contract may continue to operate through 2010 provided they meet all other statutory requirements, that is, care management and quality improvement program requirements. However, they cannot expand their service areas during 2010.

(2) [Reserved]

(73 FR 54248, Sept. 18, 2008)

§ 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
§ 422.109 Effect of national coverage determinations (NCDs) and legislative changes in benefits.

(a) Definitions. The term significant cost, as it relates to a particular NCD or legislative change in benefits, 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; and
   (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 § 422.308(a).

(2) The estimated cost of Medicare services furnished as a result of a particular NCD or legislative change in benefits represents at least 0.1 percent of the national average per capita costs.

(b) General rule. If CMS determines and announces that an individual NCD or legislative change in benefits meets the criteria for significant cost described in paragraph (a) of this section, a MA organization is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the cost of the NCD service or legislative change in benefits. If CMS determines that an NCD or legislative change in benefits does not meet the “significant cost” threshold described in § 422.109(a), the MA organization is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date stated in the NCD or specified in the legislation.