(B) A health Flexible Spending Arrangement (FSA) as defined in Internal Revenue Code (Code) section 106(c)(2).

(C) A health savings account (HSA) as defined in Code section 223.

(D) An Archer MSA as defined in Code section 220, to the extent they are subject to ERISA as employee welfare benefit plans providing medical care (or would be subject to ERISA but for the exclusion in ERISA section 4(b), 29 U.S.C.1003(b), for governmental plans or church plans).

[65 FR 40320, June 29, 2000, as amended at 68 FR 50856, Aug. 22, 2003; 70 FR 4721, Jan. 28, 2005; 76 FR 21562, Apr. 15, 2011]

§ 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 dual eligible special needs plan must have a contract consistent with this section with the State Medicaid agency.

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

(1) The MA organization's responsibility to—

(i) Coordinate the delivery of Medicaid benefits for individuals who are eligible for such services; and

(ii) If applicable, provide coverage of Medicaid services, including long-term services and supports and behavioral health services, for individuals eligible for such services.

(2) The category(ies) and criteria for eligibility for dual eligible individuals to be enrolled under the SNP, including as described in sections 1902(a), 1902(f), 1902(p), and 1905 of the Act.

(3) The Medicaid benefits covered under a capitated contract between the State Medicaid agency and the MA organization offering the SNP, the SNP's parent organization, or another entity that is owned and controlled by the SNP's parent organization.

(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) [Reserved]

(e) *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) Existing dual-eligible SNPs that do not have a State Medicaid agency contract—

(A) May continue to operate through the 2012 contract year provided they meet all other statutory and regulatory requirements.

(B) May not expand their service areas during contract years 2010 through 2012.

(2) [Reserved]

[73 FR 54248, Sept. 18, 2008, as amended at 76 FR 21563, Apr. 15, 2011; 84 FR 15828, Apr. 16, 2019]

EFFECTIVE DATE NOTE: At 84 FR 15828, Apr. 16, 2019, § 422.107 was amended by adding paragraphs (c)(9), (d), and (e)(2), effective Jan. 1, 2021. For the convenience of the user, the added text is set forth as follows:

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

(c) * * *

* * * * *

(9) For each dual eligible special needs plan that is an applicable integrated plan as defined in § 422.561, a requirement for the use of the unified appeals and grievance procedures under §§ 422.629 through 422.634, 438.210, 438.400, and 438.402.

* * * * *

(d) *Additional minimum contract requirement.* For any dual eligible special needs plan that is not a fully integrated or highly integrated dual eligible special needs plan, the contract must also stipulate that, for the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the SNP notifies, or arranges for another entity or

entities to notify, the State Medicaid agency, individuals or entities designated by the State Medicaid agency, or both, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the State Medicaid agency. The State Medicaid agency must establish the timeframe(s) and method(s) by which notice is provided. In the event that a SNP authorizes another entity or entities to perform this notification, the SNP must retain responsibility for complying with this requirement.

(e) * * *

(2) MA organizations offering a dual eligible SNP must comply with paragraphs (c)(9) and (d) of this section beginning January 1, 2021.

* * * * *

§ 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 MA organization.* The MA organization must, for each MA 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, including reporting, on an ongoing basis, information obtained related to requirements in paragraphs (b)(1) and (b)(2) of this section in accordance with CMS instructions.

(c) *Collecting from other entities.* The MA 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 MA 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 MA 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 MA 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 MA plans. A State cannot take away an MA 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. The MA organization will exercise the same rights to recover from a primary plan, entity, or individual that the Secretary exercises under the MSP regulations in subparts B through D of part 411 of this chapter.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40320, June 29, 2000; 70 FR 4721, Jan. 28, 2005; 75 FR 19805, Apr. 15, 2010]

§ 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).