

explanation in these program memoranda.

*Comment:* One commenter requested that we clarify that enrollees in an M+C plan are entitled to receive a new benefit if it is medically necessary, and that the M+C organization is responsible for ensuring access to, but not necessarily payment for, all new benefits.

*Response:* In accordance with section 1852 of the Act and regulations at § 422.101, M+C organizations must provide coverage of all Medicare-covered benefits that are available to beneficiaries residing in the plan's service area by furnishing, arranging for, or making payment for the services.

If an NCD or legislative change in benefits *does not* meet the "significant cost" threshold described in § 422.109(a), the M+C organization is required to provide coverage of the NCD or legislative change in benefits by furnishing, arranging for, or making payment for the services as of the effective date stated in the NCD or specified in the legislation. The M+C organization must also assume risk for the costs of that service or benefit as of the effective date stated in the NCD or specified in the legislation.

If an NCD or legislative change in benefits *does* meet the "significant cost" threshold described in § 422.109(a), the M+C organization must provide coverage of the NCD or legislative change in benefits by furnishing or arranging for the NCD service or legislative change in benefits. However, the M+C organization is not required to pay or assume risk for the costs of that service or benefit until the contract year for which payments are adjusted to take into account the cost of the NCD service or legislative change in benefits. Medicare fee-for-service payment for the service is in addition to the capitation payment to the M+C organization and made directly by the fiscal intermediary and carrier to the M+C organization (or its designee, which may be the provider) in accordance with original Medicare payment rules, methods, and requirements.

*Comment:* One commenter recommended that we include the total costs resulting from all NCDs and legislative changes in benefits when making the "significant cost" determination. The commenter suggested that, if there is insufficient data for us to develop a reasonably reliable cost estimate for any NCD or legislatively mandated coverage, we should conclude that the costs for that new coverage have not been included in current M+C rates and that Medicare

fee-for-service payment should be available for such coverage.

*Response:* We agree with the commenter's first point that several NCDs or legislative changes in benefits that do not individually trigger the existing regulatory definition of "significant" could potentially impose a greater burden than a single change that meets this definition. It would not be practical, however, to attempt to aggregate the costs of NCDs or statutory coverage changes during the "transition" year governed by section 1852(a)(5) of the Act, before capitation payments are "adjust[ed] appropriately" by us in the next payment announcement as required under section 1853(c)(7) of the Act. In part, this is because it would not be clear whether any aggregate test has been met until the last NCD or legislative change in benefits to be aggregated is issued. By that time, it would be too late to make any adjustment with respect to the M+C organization's obligation to cover earlier NCDs.

More importantly, the period prior to an adjustment in capitation rates is by definition "temporary" and limited to a period of less than 12 months. We believe that costs that may not be "significant" when the M+C organization knows they are being incurred for a temporary period of a few months would become "significant" if left unaccounted for in future payments indefinitely. Accordingly, we believe that it is reasonable to adopt a different interpretation of "significant" for purposes of deciding under section 1852(a)(5) of the Act whether to make temporary fee-for-service payments than for purposes of deciding whether, under section 1853(c)(7), to permanently "adjust appropriately" capitation payments. Given the temporary nature of partial year costs, we believe that the existing definition of significant costs in § 422.109(c) is appropriate for purposes of deciding whether to pay for services on a fee-for-service basis until an adjustment can be made to capitation payments. We believe that an M+C organization could bear the cost of any individual NCD or legislative change that does not meet this definition for the limited period of time involved prior to an appropriate adjustment being made to capitation rates.

However we believe that costs of NCDs and legislative changes that may not be significant when only in place for a few months could, when considered in the aggregate, be quite significant if left unaccounted for indefinitely in future capitation payments. Thus, in response to the commenters suggestion that the costs of NCDs and legislative

changes be aggregated, we are providing for a different definition of "significant" costs to be used for purposes of the determination as to whether to make an adjustment under section 1853(c)(7) than applies for purposes of whether to pay on a fee-for-service basis under section 1852(a)(5) of the Act. We have revised the definition of significant cost (which was in § 422.109(c), but is now in § 422.109(a)) to provide that, for purposes of determining whether to make an adjustment under § 422.256, the tests in the definition of "significant cost" are applied to the aggregate costs of all NCDs and legislative changes in benefits made in the contract year. Under this test, the "average cost" of every NCD and legislative change in benefits would be added together. If the sum of all these average amounts exceeds the threshold under § 422.109(a)(1), then an adjustment to payment will be made under § 422.256 to reflect these costs. Alternatively, if the costs of the NCDs and legislative changes in benefits, in the aggregate, exceed the level set forth in § 422.109(a)(2), an adjustment to payment will be made under § 422.256.

We note that even when the "significant cost" threshold has been met under the existing definition, the current methodology for making the adjustment required under section 1853(c)(7) of the Act does not result in any adjustment in counties paid based on the minimum update rate (the so-called "2 percent minimum update" counties). The annual growth rate used to update M+C rates each year includes estimates of expenditures for new mid-year benefits. However, according to section 1853(c) of the Act, our Office of the Actuary uses the annual growth rate to update only the floor and blended rates, so the minimum 2 percent update rate does not reflect the costs of new benefits effective in the middle of the previous payment year. The impact is substantial because 64 percent of the 100 counties with the highest M+C enrollment in 2002 received the minimum update rate in the last three years, 2001 through 2003. The result is that M+C organizations have paid for almost all new benefits out of capitation payments that do not include payment for these new benefits.

We believe the Congress intended, in enacting section 1853(c)(7) of the Act, that payments to M+C organizations be adjusted to reflect the costs of new benefits when they are added through an NCD or legislative change. Since this does not occur under the current approach in the case of 2 percent counties, we are changing our method of making adjustments under section