

individual left the service area (or residence, if paragraph (d)(4)(i)(B) of this section applies);

(B) The individual understands and accepts any restrictions imposed by the M+C plan on obtaining these services while absent from the M+C plan's service area for the extended period; and

(C) The M+C organization makes this option available to all Medicare enrollees who are absent for an extended period from the M+C plan's service area. However, M+C organizations may limit this option to enrollees who travel to certain areas, as defined by the M+C organization, and who receive services from qualified providers who directly provide, arrange for, or pay for health care.

(iv) *Notice of disenrollment.* The M+C organization must give the individual a written notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section.

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### Subpart C—Benefits and Beneficiary Protections

■ 11. In § 422.101, the following amendments are made as follows:

- a. Paragraph (b)(3) is revised.
- b. Paragraph (c) is added.

#### § 422.101 Requirements relating to basic benefits.

\* \* \* \* \*

(b) \* \* \*

(3) Written coverage decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered under the M+C organization. If an M+C organization covers geographic areas encompassing more than one local coverage policy area, the M+C organization may elect to uniformly apply to plan enrollees in all areas the coverage policy that is the most beneficial to M+C enrollees. M+C organizations that elect this option must notify CMS before selecting the area that has local coverage policies that are most beneficial to M+C enrollees as follows:

(i) An M+C organization electing to adopt a uniform local coverage policy for a plan or plans must notify CMS at least 60 days before the date specified in § 422.306(a), which is 60 days before the date adjusted community rate proposals are due for the subsequent year. Such notice must identify the plan or plans and service area or services areas to which the uniform local coverage policy or policies will apply, the competing local coverage policies involved, and a justification explaining why the selected local coverage policy

or policies are most beneficial to M+C enrollees.

(ii) CMS will review notices provided under paragraph (b)(3)(i) of this section, evaluate the selected local coverage policy or policies based on such factors as cost, access, geographic distribution of enrollees, and health status of enrollees, and notify the M+C organization of its approval or denial of the selected uniform local coverage policy or policies.

(c) M+C organizations may elect to furnish, as part of their Medicare covered benefits, coverage of posthospital SNF care as described in subparts C and D of this part, in the absence of the prior qualifying hospital stay that would otherwise be required for coverage of this care.

■ 12. In § 422.106, the following amendments are made as follows:

- a. The section heading is revised.
- b. Paragraphs (a) introductory text, (a)(1), and (a)(2) are revised.
- c. Paragraph (b) introductory text is revised.
- d. A new paragraph (c) is added.

#### § 422.106 Coordination of benefits with employer or union group health plans and Medicaid.

(a) *General rule.* If an M+C organization contracts with an employer, labor organization, or the trustees of a fund established by one or more employers or labor organizations that cover enrollees in an M+C plan, or contracts with a State Medicaid agency to provide Medicaid benefits to individuals who are eligible for both Medicare and Medicaid, and who are enrolled in an M+C plan, the enrollees must be provided the same benefits as all other enrollees in the M+C plan, with the employer, labor organization, fund trustees, or Medicaid benefits supplementing the M+C plan benefits. Jurisdiction regulating benefits under these circumstances is as follows:

(1) All requirements of this part that apply to the M+C program apply to the M+C plan coverage and benefits provided to enrollees eligible for benefits under an employer, labor organization, trustees of a fund established by one or more employers or labor organizations, or Medicaid contract.

(2) Employer benefits that complement an M+C plan, which are not part of the M+C plan, are not subject to review or approval by CMS.

\* \* \* \* \*

(b) *Examples.* Permissible employer, labor organization, benefit fund trustee, or Medicaid plan benefits include the following:

\* \* \* \* \*

(c) *Waiver or modification.* (1) M+C organizations may request, in writing, from CMS, a waiver or modification of those requirements in this part that hinder the design of, the offering of, or the enrollment in, M+C plans under contracts between M+C organizations and employers, labor organizations, or the trustees of funds established by one or more employers or labor organizations to furnish benefits to the entity's employees, former employees, or members or former members of the labor organizations.

(2) Approved waivers or modifications under this paragraph may be used by any M+C organization in developing its Adjusted Community Rate (ACR) proposal. Any M+C organization using a waiver or modification must include that information in the cover letter of its ACR proposal submission.

■ 13. Section 422.109 is revised to read as follows:

#### § 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 § 422.254(b).

(2) The estimated cost of all Medicare services furnished as a result of a particular NCD or legislative change in benefits represents at least 0.1 percent of the national standardized annual capitation rate, as described in § 422.254(f), multiplied by the total number of Medicare beneficiaries for the applicable calendar year. For purposes of § 422.256 only, this test is applied to all NCDs or legislative changes in benefits, in the aggregate, for a given year. If the sum of the average cost of each NCD or legislative change in benefits exceeds the amount in paragraph (a)(1) of this section, or the aggregate costs of all NCDs and legislative changes for a year exceeds the percentage in paragraph (a)(2) of this section, the costs are considered "significant."

(b) *General rule.* If CMS determines and announces that an individual NCD or legislative change in benefits meets the criteria for significant cost described