

in paragraph (a) of this section, a M+C 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 M+C 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.

(c) *Before payment adjustments become effective.* Before the contract year that payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits become effective, the service or benefit is not included in the M+C organization's contract with CMS, and is not a covered benefit under the contract. The following rules apply to these services or benefits:

(1) Medicare payment for the service or benefit is made directly by the fiscal intermediary and carrier to the provider furnishing the service or benefit in accordance with original Medicare payment rules, methods, and requirements.

(2) Costs for NCD services or legislative changes in benefits for which CMS 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 or legislative changes in benefits;

(ii) Most services furnished as follow-up care to the NCD service or legislative change in benefits;

(iii) Any service that is already a Medicare-covered service and included in the annual M+C capitation rate or previously adjusted payments; and

(iv) Any service, including the costs of the NCD service or legislative change in benefits, 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) Costs for significant cost NCD services or legislative changes in benefits for which CMS fiscal intermediaries and carriers will make payment are—

(i) Costs relating directly to the provision of services related to the NCD or legislative change in benefits that were noncovered services before the issuance of the NCD or legislative change in benefits; and

(ii) A service that is not included in the M+C capitation payment rate.

(4) Beneficiaries are liable for any applicable coinsurance amounts.

(d) *After payment adjustments become effective.* For the contract year in which payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits are in effect, the service or benefit is included in the M+C organization's contract with CMS, and is a covered benefit under the contract. Subject to all applicable rules under this part, the M+C organization must furnish, arrange, or pay for the NCD service or legislative change in benefits. M+C organizations may establish separate plan rules for these services and benefits, subject to CMS review and approval. CMS may, at its discretion, issue overriding instructions limiting or revising the M+C plan rules, depending on the specific NCD or legislative change in benefits. For these services or benefits, the Medicare enrollee will be responsible for M+C plan cost sharing, as approved by CMS or unless otherwise instructed by CMS.

■ 14. In § 422.111, a new paragraph (f)(8)(iii) is added to read as follows:

§ 422.111 Disclosure requirements.

* * * * *

(f) * * *

(8) * * *

(iii) The reduction in Part B premiums, if any.

* * * * *

■ 15. A new § 422.133 is added to subpart C to read as follows:

§ 422.133 Return to home skilled nursing facility.

(a) *General rule.* M+C plans must provide coverage of posthospital extended care services to Medicare enrollees through a home skilled nursing facility if the enrollee elects to receive the coverage through the home skilled nursing facility, and if the home skilled nursing facility either has a contract with the M+C organization or agrees to accept substantially similar payment under the same terms and conditions that apply to similar skilled nursing facilities that contract with the M+C organization.

(b) *Definitions.* In this subpart, *home skilled nursing facility* means—

(1) The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of posthospital extended care services;

(2) A skilled nursing facility that is providing posthospital extended care services through a continuing care retirement community in which the

M+C plan enrollee was a resident at the time of admission to the hospital. A continuing care retirement community is an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period; or

(3) The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from the hospital.

(c) *Coverage no less favorable.* The posthospital extended care scope of services, cost-sharing, and access to coverage provided by the home skilled nursing facility must be no less favorable to the enrollee than posthospital extended care services coverage that would be provided to the enrollee by a skilled nursing facility that would be otherwise covered under the M+C plan.

(d) *Exceptions.* The requirement to allow an M+C plan enrollee to elect to return to the home skilled nursing facility for posthospital extended care services after discharge from the hospital does not do the following:

(1) Require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under Part A for Medicare beneficiaries not enrolled in the M+C plan.

(2) Prevent a skilled nursing facility from refusing to accept, or imposing conditions on the acceptance of, an enrollee for the receipt of posthospital extended care services.

Subpart D—Quality Assurance

■ 16. In § 422.152, a new paragraph (f)(4) is added to read as follows:

§ 422.152 Quality assessment and performance improvement program.

* * * * *

(f) * * *

(4) *Focus on racial and ethnic minorities.* The M+C organization's Quality Assurance program must include a separate focus on racial and ethnic minorities.

Subpart E—Relationships With Providers

■ 17. In § 422.202, paragraph (a)(4) is revised to read as follows:

§ 422.202 Participation procedures.

(a) * * *

(4) A process for appealing adverse participation procedures, including the right of physicians to present information and their views on the decision. In the case of termination or suspension of a provider contract by the