reviews and approves MA benefits and associated cost sharing using written policy guidelines and requirements in this part and other CMS instructions to ensure all of the following:

(1) Medicare-covered services meet CMS fee-for-service guidelines.

(2) MA organizations are not designing benefits to discriminate against beneficiaries, promote discrimination, discourage enrollment or encourage disenrollment, steer subsets of Medicare beneficiaries to particular MA plans, or inhibit access to services. and

(3) Benefit design meets other MA program requirements.

(4) Except as provided in paragraph (f)(5), MA local plans (as defined in §422.2) must have an out-of pocket maximum for Medicare Parts A and B services that is no greater than the annual limit set by CMS.

(5) With respect to a local PPO plan, the limit specified under paragraph (f)(4) applies only to use of network providers. Such local PPO plans must include a total catastrophic limit on beneficiary out-of-pocket expenditures for both in-network and out-of-network Parts A and B services that is—

(i) Consistent with the requirements applicable to MA regional plans at §422.101(d)(3) of this part; and

(ii) Not greater than the annual limit set by CMS.

(6) Cost sharing for Medicare Part A and B services specified by CMS does not exceed levels annually determined by CMS to be discriminatory for such services.

(g) *Benefits affecting screening mammography, influenza vaccine, and pneumoccal vaccine.* (1) Enrollees of MA organizations may directly access (through self-referral) screening mammography and influenza vaccine.

(2) MA organizations may not impose cost-sharing for influenza vaccine and pneumococcal vaccine on their MA plan enrollees.

(h) *Requirements relating to Medicare conditions of participation.* Basic benefits must be furnished through providers meeting the requirements in §422.204(b)(3).

(i) *Provider networks.* The MA plans offered by an MA organization may share a provider network as long as each MA plan independently meets the access and availability standards described at §422.112, as determined by CMS.

(j) *Services for which cost sharing may not exceed cost sharing under Original Medicare.* On an annual basis, CMS will evaluate whether there are service categories for which MA plans' in-network cost sharing may not exceed that required under Original Medicare and specify in regulation which services are subject to that cost sharing limit. The following services are subject to this limit on cost sharing:

(1) Chemotherapy administration services to include chemotherapy drugs and radiation therapy integral to the treatment regimen.

(2) Renal dialysis services as defined at section 1881(b)(14)(B) of the Act.

(3) Skilled nursing care defined as services provided during a covered stay in a skilled nursing facility during the period for which cost sharing would apply under Original Medicare.

(k) *Cost sharing for in-network preventive services.* MA organizations may not charge deductibles, copayments, or coinsurance for in-network Medicare-covered preventive services (as defined in §410.152(l)).

[65 FR 40319, June 29, 2000, as amended at 67 FR 13288, Mar. 22, 2002; 70 FR 4719, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005; 75 FR 19804, Apr. 15, 2010; 76 FR 21562, Apr. 15, 2011]

§422.101 Requirements relating to basic benefits.

Except as specified in §422.318 (for entitlement that begins or ends during a hospital stay) and §422.320 (with respect to hospice care), each MA organization must meet the following requirements:

(a) Provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the plan's service area. Services may be provided outside of the service area of the plan if the services are accessible and available to enrollees.

(b) Comply with—

(1) CMS's national coverage determinations;

(2) General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations in this part or related instructions; and

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

(i) An MA 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 § 422.254(a)(1), which is 60 days before the date bid amounts 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 MA 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 MA organization of its approval or denial of the selected uniform local coverage policy or policies.

(4) Instead of applying rules in paragraph (b)(3)(ii) of this section, and to the extent it exercises this option, an organization offering an MA regional plan in an MA region that covers more than one local coverage policy area must uniformly apply all of the local coverage policy determinations that apply in the selected local coverage policy area in that MA region to all parts of that same MA region. The selection of the single local coverage policy area's local coverage policy determinations to apply throughout the MA region is at the discretion of the MA regional plan and is not subject to CMS pre-approval.

(5) If an MA organization offering an MA local plan elects to exercise the option in paragraph (b)(3) of this section related to a local MA plan, or if an MA organization offering an MA regional plan elects to exercise the option in paragraph (b)(4) of this section related to an MA regional plan, then the MA organization must make information on the selected local coverage policy readily available, including through the Internet, to enrollees and health care providers.

(c) MA 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.

(d) *Special cost-sharing rules for MA regional plans.* In addition to the requirements in paragraph (a) through paragraph (c) of this section, MA regional plans must provide for the following:

(1) *Single deductible.* MA regional plans, to the extent they apply a deductible, are permitted to have only a single deductible related to combined Medicare Part A and Part B services (to the extent they have a deductible). Applicability of the single deductible may be differential for specific in-network services and may also be waived for preventative services or other items and services.

(2) *Catastrophic limit.* MA regional plans are required to establish a catastrophic limit on beneficiary out-of-pocket expenditures for in-network benefits under the Original Medicare fee-for-service program (Part A and Part B benefits) that is no greater than the annual limit set by CMS.

(3) *Total catastrophic limit.* MA regional plans are required to establish a total catastrophic limit on beneficiary out-of-pocket expenditures for in-network and out-of-network benefits under the Original Medicare fee-for-service program. This total out-of-pocket catastrophic limit, which would

apply to both in-network and out-of-network benefits under Original Medicare, may be higher than the in-network catastrophic limit in paragraph (d)(2) of this section, but may not increase the limit described in paragraph (d)(2) of this section and may be no greater than the annual limit set by CMS.

(4) *Tracking of deductible and catastrophic limits and notification.* MA regional plans are required to track the deductible (if any) and catastrophic limits in paragraphs (d)(1) through (d)(3) of this section based on incurred out-of-pocket beneficiary costs for original Medicare covered services, and are also required to notify members and health care providers when the deductible (if any) or a limit has been reached.

(e) *Other rules for MA regional plans.* (1) MA regional plans are required to provide reimbursement for all covered benefits, regardless of whether those benefits are provided within or outside of the network of contracted providers.

(2) In applying the actuarially equivalent level of cost-sharing with respect to MA bids related to benefits under the original Medicare program option as set forth at §422.256(b)(3), only the catastrophic limit on out-of-pocket expenses for in-network benefits in paragraph (d)(2) of this section will be taken into account.

(f) *Special needs plan model of care.* (1) MA organizations offering special needs plans (SNP) must implement an evidence-based model of care with appropriate networks of providers and specialists designed to meet the specialized needs of the plan's targeted enrollees. The MA organization must, with respect to each individual enrolled—

(i) Conduct a comprehensive initial health risk assessment of the individual's physical, psychosocial, and functional needs as well as annual health risk reassessment, using a comprehensive risk assessment tool that CMS will review during oversight activities.

(ii) Develop and implement a comprehensive individualized plan of care through an interdisciplinary care team in consultation with the beneficiary, as feasible, indentifying goals and objectives including measurable outcomes as well as specific services and benefits to be provided.

(iii) Use an interdisciplinary team in the management of care.

(2) MA organizations offering SNPs must also develop and implement the following model of care components to assure an effective management structure:

(i) Target one of the three SNP populations defined in §422.2 of this part.

(ii) Have appropriate staff (employed, contracted, or non-contracted) trained on the SNP plan model of care to coordinate and/or deliver all services and benefits.

(iii) Coordinate the delivery of care across healthcare settings, providers, and services to assure continuity of care.

(iv) Coordinate the delivery of specialized benefits and services that meet the needs of the most vulnerable beneficiaries among the three target special needs populations as defined in §422.2 of this part, including frail/disabled beneficiaries and beneficiaries near the end of life.

(v) Coordinate communication among plan personnel, providers, and beneficiaries.

(vi) All MAOs wishing to offer or continue to offer a SNP will be required to be approved by the National Committee for Quality Assurance (NCQA) effective January 1, 2012 and subsequent years. All SNPs must submit their model of care (MOC) to CMS for NCQA evaluation and approval in accordance with CMS guidance.

[65 FR 40319, June 29, 2000, as amended at 68 FR 50856, Aug. 22, 2003; 70 FR 4720, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005; 70 FR 76197, Dec. 23, 2005; 73 FR 54248, Sept. 18, 2008; 74 FR 1541, Jan. 12, 2009; 76 FR 21562, Apr. 15, 2011]

EFFECTIVE DATE NOTE: At 76 FR 54634, Sept. 1, 2011, §422.101 was amended by removing the phrase ''indentifying goals'' and adding the phrase ''identifying goals'' in its place in paragraph (f)(1)(ii), effective October 31, 2011.

§ 422.102 Supplemental benefits.

(a) *Mandatory supplemental benefits.* (1) Subject to CMS approval, an MA organization may require Medicare enrollees of an MA plan (other than an MSA plan) to accept or pay for services