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. 

§ 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 in addition to Medicare-covered services described in § 422.101. 

(2) If the MA organization imposes mandatory supplemental benefits, it must impose them on all Medicare beneficiaries enrolled in the MA plan. 

(3) CMS approves mandatory supplemental benefits if the benefits are designed in accordance with CMS' guidelines and requirements as stated in this part and other written instructions. 

(4) Beginning in 2006, an MA plan may reduce cost sharing below the actuarial value specified in section 1854(e)(4)(A) of the Act only as a mandatory supplemental benefit. 

(b) Optional supplemental benefits. Except as provided in §422.104 in the case of MSA plans, each MA organization may offer (for election by the enrollee and without regard to health status) services that are not included in the basic benefits as described in §422.100(c) and any mandatory supplemental benefits described in paragraph (a) of this section. Optional supplemental benefits are purchased at the discretion of the enrollee and must be offered to all Medicare beneficiaries enrolled in the MA plan. 

(c) Payment for supplemental services. All supplemental benefits are paid for in full, directly by (or on behalf of) the enrollee of the MA plan. 

(d) Marketing of supplemental benefits. MA organizations may offer enrollees a group of services as one optional supplemental benefit, offer services individually, or offer a combination of groups and individual services. 

(e) Supplemental benefits for certain dual eligible special needs plans. Subject to CMS approval, dual eligible special needs plans that meet a high standard of integration and minimum performance and quality-based standards may offer additional supplemental benefits, consistent with the requirements of this part, where CMS finds that the offering of such benefits would better integrate care for the dual eligible population provided that the special needs plan— 

(1) Operated in the MA contract year prior to the MA contract year for which it is submitting its bid; and 

(2) Offers its enrollees such benefits without cost-sharing or additional premium charges.

§ 422.103 Benefits under an MA MSA plan. 

(a) General rule. An MA organization offering an MA MSA plan must make available to an enrollee, or provide reimbursement for, at least the services described in §422.101 after the enrollee incurs countable expenses equal to the amount of the plan’s annual deductible. 

(b) Countable expenses. An MA organization offering an MA MSA plan must count toward the annual deductible at least all amounts that would be paid for the particular service under original Medicare, including amounts that would be paid by the enrollee as deductibles or coinsurance. 

(c) Services after the deductible. For services received by the enrollee after the annual deductible is satisfied, an MA organization offering an MA MSA plan must pay, at a minimum, the lesser of the following amounts: 

(1) 100 percent of the expense of the services. 

(2) 100 percent of the amounts that would have been paid for the services under original Medicare, including amounts that would be paid by the enrollee as deductibles and coinsurance.
§ 422.104 Special rules on supplemental benefits for MA MSA plans.

(a) An MA organization offering an MA MSA plan may not provide supplemental benefits that cover expenses that count towards the deductible specified in §422.103(d).

(b) In applying the limitation of paragraph (a) of this section, the following kinds of policies are not considered as covering the deductible:

(1) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(2) A policy of insurance in which substantially all of the coverage relates to liabilities incurred under workers’ compensation laws, tort liabilities, liabilities relating to use or ownership of property, and any other similar liabilities that CMS may specify by regulation.

(3) A policy of insurance that provides coverage for a specified disease or illness or pays a fixed amount per day (or other period) of hospitalization.

§ 422.105 Special rules for self-referral and point of service option.

(a) Self-referral. When an MA plan member receives an item or service of the plan that is covered upon referral or pre-authorization from a contracted provider of that plan, the member cannot be financially liable for more than the normal in-plan cost sharing, if the member correctly identified himself or herself as a member of that plan to the contracted provider before receiving the covered item or service, unless the contracted provider can show that the enrollee was notified prior to receiving the item or service that the item or service is covered only if further action is taken by the enrollee.

(b) Point of service option. As a general rule, a POS benefit is an option that an MA organization may offer in an HMO plan to provide enrollees with additional choice in obtaining specified health care services. The organization may offer a POS option—

(1) Before January 1, 2006, under a coordinated care plan as an additional benefit as described in section 1854(f)(1)(A) of the Act;

(2) Under an HMO plan as a mandatory supplemental benefit as described in §422.102(a); or

(3) Under an HMO plan as an optional supplemental benefit as described in §422.102(b).

(c) Ensuring availability and continuity of care. An MA HMO plan that includes a POS benefit must continue to provide all benefits and ensure access as required under this subpart.

(d) Enrollee information and disclosure. The disclosure requirements specified in §422.111 apply in addition to the following requirements:

(1) Written rules. MA organizations must maintain written rules on how to obtain health benefits through the POS benefit.

(2) Evidence of coverage document. The MA organization must provide to beneficiaries enrolling in a plan with a POS benefit an “evidence of coverage” document, or otherwise provide written documentation, that specifies all costs and possible financial risks to the enrollee, including—

(i) Any premiums and cost-sharing for which the enrollee is responsible;

(ii) Annual limits on benefits and on out-of-pocket expenditures;

(iii) Potential financial responsibility for services for which the plan denies payment because they were not