

(iii) In the management of care, use an interdisciplinary team that includes a team of providers with demonstrated expertise and training, and, as applicable, training in a defined role appropriate to their licensure in treating individuals similar to the targeted population of the plan.

(iv) Provide, on at least an annual basis, beginning within the first 12 months of enrollment, as feasible and with the individual's consent, for face-to-face encounters for the delivery of health care or care management or care coordination services and be between each enrollee and a member of the enrollee's interdisciplinary team or the plan's case management and coordination staff, or contracted plan healthcare providers. A face-for-face encounter must be either in person or through a visual, real-time, interactive telehealth encounter.

(2) MA organizations offering SNPs must also develop and implement the following model of care components to assure an effective care 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) For I-SNPs, ensure that contracts with long-term care institutions (listed in the definition of the term institutionalized in §422.2) contain requirements allowing I-SNP clinical and care coordination staff access to enrollees of the I-SNP who are institutionalized.

(3)(i) All MA organizations 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.

(ii) As part of the evaluation and approval of the SNP model of care, NCQA must evaluate whether goals were fulfilled from the previous model of care.

(A) Plans must provide relevant information pertaining to the MOC's goals as well as appropriate data pertaining to the fulfillment the previous MOC's goals.

(B) Plans submitting an initial model of care must provide relevant information pertaining to the MOC's goals for review and approval.

(C) If the SNP model of care did not fulfill the previous MOC's goals, the plan must indicate in the MOC submission how it will achieve or revise the goals for the plan's next MOC.

(iii) Each element of the model of care of a plan must meet a minimum benchmark score of 50 percent and each MOC must meet an aggregate minimum benchmark of 70 percent, and a plan's model of care is only approved if each element of the model of care meets the minimum benchmark and the model of care meets the aggregate minimum benchmark.

(A) An MOC for a C-SNP that receives a passing score is approved for 1 year.

(B)(1) An MOC for an I-SNP or D-SNP that receives an aggregate minimum benchmark score of 85 percent or greater is approved for 3 years.

(2) An MOC for an I-SNP or D-SNP that receives a score of 75 percent to 84 percent is approved for 2 years.

(3) An MOC for an I-SNP or DSNP that receives a score of 70 percent to 74 percent is approved for 1 year.

(C) For an MOC that fails to meet a minimum element benchmark score of 50 percent or an MOC that fails to meet the aggregate minimum benchmark of 70 percent, the MA organization is permitted a one-time opportunity to re-submit the corrected MOC for reevaluation; and an MOC that is corrected

and resubmitted using this cure period is approved for only 1 year.

(iv) An MA organization sponsoring a SNP that seeks to revise the MOC before the end of the MOC approval period may submit changes to the MOC as off-cycle MOC submissions for review by NCQA as follows:

(A) C-SNPs, D-SNPs and I-SNPs must submit updates and corrections to their NCQA-approved MOC when CMS requires an off-cycle submission to ensure compliance with applicable law.

(B) D-SNPs and I-SNPs must submit updates and corrections to their NCQA approved MOC between June 1st and November 30th of each calendar year if the I-SNP or D-SNP wishes to make any of the following revisions:

(1) Substantial changes in policies or procedures pertinent to any of the following:

(i) The health risk assessment (HRA) process.

(ii) Revising processes to develop and update the Individualized Care Plan (ICP).

(iii) The integrated care team process.

(iv) Risk stratification methodology.

(v) Care transition protocols.

(2) Target population changes that warrant modifications to care management approaches.

(3) Changes in a SNP's plan benefit package between consecutive contract years that can considerably impact critical functions necessary to maintain member well-being and are related to SNP operations.

(4) Changes in level of authority or oversight for personnel conducting care coordination activities (for example, medical provider to non-medical provider, clinical vs. non-clinical personnel).

(5) Changes to quality metrics used to measure performance.

(C) NCQA only reviews off-cycle submissions after the start of the effective date of the current MOC unless CMS deems it necessary to ensure compliance with the applicable regulations.

(D) SNPs may not implement any changes to a MOC until NCQA has reviewed and approved the off-cycle MOC changes. NCQA does not rescure the MOC during the off-cycle review of

changes to the MOC, but changes are reviewed and determined by NCQA to be either "Acceptable" or "Non-acceptable." "Acceptable" means that the changes have been approved by NCQA and the MOC has been updated; "Non-acceptable" means the changes have been rejected by NCQA and the MOC has not been changed. If NCQA determines that off-cycle changes are unacceptable, the SNP must continue to implement the MOC as originally approved.

(E) Successful revision of the MOC under paragraph (f)(3)(iv)(B) of this section does not change the MOC's original period of approval.

(F) C-SNPs are only permitted to submit an off-cycle MOC submission when CMS requires an off-cycle submission to ensure compliance with applicable law.

(G) When a deficiency is identified in the off-cycle MOC revision(s) submitted by a SNP, the SNP has one opportunity to submit a corrected off-cycle revision between June 1st and November 30th of each calendar year.

[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; 76 FR 54634, Sept. 1, 2011; 77 FR 22167, Apr. 12, 2012; 83 FR 16724, Apr. 16, 2018; 86 FR 6094, Jan. 19, 2021; 86 FR 29528, June 2, 2021; 87 FR 22427, Apr. 14, 2022; 87 FR 27894, May 9, 2022; 88 FR 22328, Apr. 12, 2023; 89 FR 30817, Apr. 23, 2024; 89 FR 79451, Sept. 30, 2024]

#### § 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 for Part A and B benefits only as a mandatory supplemental benefit.

(5) An MA plan may reduce the cost sharing for items and services that are not basic benefits only as a mandatory supplemental benefit (reductions or payment of cost sharing for Part D drugs is not permissible as a Part C supplemental benefit).

(6) An MA plan may offer mandatory supplemental benefits in the following forms:

(i) Reductions in cost sharing through the use of reimbursement, through a debit card or other means, for cost sharing paid for covered benefits. Reimbursements must be limited to the specific plan year.

(ii) Use of a uniform dollar amount as a maximum plan allowance for a package of supplemental benefits, including reductions in cost sharing or coverage of specific items and services, available to enrollees on a uniform basis for enrollee use for any supplemental benefit in the package. Allowance must be limited to the specific plan year.

(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) *Supplemental benefits packaging.* 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, fully integrated dual eligible special needs plans and highly integrated dual eligible special needs plans that meet 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 could 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.

(f) *Special supplemental benefits for the chronically ill (SSBCI)*—(1) *Requirements*—(i) *Chronically-ill enrollee.* (A) A chronically ill enrollee is an individual enrolled in the MA plan who has one or more comorbid and medically complex chronic conditions that meet all of the following:

(1) Is life threatening or significantly limits the overall health or function of the enrollee;

(2) Has a high risk of hospitalization or other adverse health outcomes; and

(3) Requires intensive care coordination.

(B) CMS may publish a non-exhaustive list of conditions that are medically complex chronic conditions that are life threatening or significantly limit the overall health or function of an individual.

(ii) *SSBCI definition.* A special supplemental benefit for the chronically ill (SSBCI) is a supplemental benefit that has, with respect to a chronically ill enrollee, a reasonable expectation of improving or maintaining the health or overall function of the enrollee; an SSBCI that meets the standard in this paragraph (f)(1)(ii) may also include a benefit that is not primarily health related.

(2) *Offering SSBCI.* (i) An MA plan may offer SSBCI to a chronically ill enrollee only as a mandatory supplemental benefit.

(ii) Upon approval by CMS, an MA plan may offer SSBCI that are not uniform for all chronically ill enrollees in the plan.

(iii) An MA plan may consider social determinants of health as a factor to help identify chronically ill enrollees whose health or overall function could be improved or maintained with SSBCI. An MA plan may not use social determinants of health as the sole

basis for determining eligibility for SSBCI.

(3) *MA organization responsibilities.* An MA organization that includes an item or service as SSBCI in its bid must be able to demonstrate through relevant acceptable evidence that the item or service has a reasonable expectation of improving or maintaining the health or overall function of a chronically ill enrollee. By the date on which an MA organization submits its bid, the MA organization must establish a written bibliography of relevant acceptable evidence concerning the impact that the item or service has on the health or overall function of its recipient. For each citation in the written bibliography, the MA organization must include a working hyperlink to or a document containing the entire source cited.

(i) Relevant acceptable evidence includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to investigate whether the item or service impacts the health or overall function of a population, or large systematic reviews or meta-analyses summarizing the literature of the same.

(ii) An MA organization must include in its bibliography a comprehensive list of relevant acceptable evidence published within the 10 years prior to the June immediately preceding the coverage year during which the SSBCI will be offered, including any available negative evidence and literature.

(iii) If no evidence of the type described in paragraphs (f)(3)(i) and (ii) of this section exists for a given item or service, then MA organization may cite case studies, federal policies or reports, internal analyses, or any other investigation of the impact that the item or service has on the health or overall function of its recipient as relevant acceptable evidence in the MA organization's bibliography.

(iv) The MA organization must make its bibliography of relevant acceptable evidence available to CMS upon request.

(4) *Plan responsibilities.* An MA plan offering SSBCI must do all of the following:

(i) Have written policies for determining enrollee eligibility and must document its determination that an enrollee is a chronically ill enrollee based on the definition in paragraph (f)(1)(i) of this section.

(ii) Make information and documentation related to determining enrollee eligibility available to CMS upon request.

(iii)(A) Have and apply written policies based on objective criteria for determining a chronically ill enrollee's eligibility to receive a particular SSBCI; and

(B) Document the written policies specified in paragraph (f)(4)(iii)(A) of this section and the objective criteria on which the written policies are based.

(iv) Document each eligibility determination for an enrollee, whether eligible or ineligible, to receive a specific SSBCI and make this information available to CMS upon request.

(v) Maintain without modification, as it relates to an SSBCI, evidentiary standards for a specific enrollee to be determined eligible for a particular SSBCI, or the specific objective criteria used by a plan as part of SSBCI eligibility determinations for the full coverage year.

(5) *CMS review of SSBCI offerings in bids.* (i) CMS may decline to approve an MA organization's bid if CMS determines that the MA organization has not demonstrated, through relevant acceptable evidence, that an SSBCI has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollees that the MA organization is targeting.

(ii) CMS may annually review the items or services that an MA organization includes as SSBCI in its bid for compliance with all applicable requirements, taking into account updates to the relevant acceptable evidence applicable to each item or service.

(iii) This provision does not limit CMS's authority to review and negotiate bids or to reject bids under section 1854(a) of the Act and 42 CFR part 422 subpart F nor does it limit CMS's authority to review plan benefits and