period is deemed to have elected original Medicare.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 65 FR 40318, June 29, 2000; 68 FR 50855, Aug. 22, 2003; 70 FR 4718, Jan. 28, 2005; 74 FR 1541, Jan. 12, 2009; 75 FR 19804, Apr. 15, 2010; 76 FR 21562, Apr. 15, 2011; 79 FR 29955, May 23, 2014; 80 FR 7959, Feb. 12, 2015]

Subpart C—Benefits and Beneficiary Protections

SOURCE: 63 FR 35077, June 26, 1998, unless otherwise noted.

§422.100 General requirements.

(a) *Basic rule.* Subject to the conditions and limitations set forth in this subpart, an MA organization offering an MA plan must provide enrollees in that plan with coverage of the basic benefits described in paragraph (c)(1) of this section (except that additional telehealth benefits may be, but are not required to be, offered by the MA plan) and, to the extent applicable, supplemental benefits as described in paragraph (c)(2) of this section, by furnishing the benefits directly or through arrangements, or by paying for the benefits. CMS reviews these benefits subject to the requirements of this section and the requirements in subpart G of this part.

(b) *Services of noncontracting providers and suppliers.* (1) An MA organization must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier that does not contract with the MA organization to provide services covered by the MA plan:

(i) Ambulance services dispatched through 911 or its local equivalent as provided in §422.113.

(ii) Emergency and urgently needed services as provided in §422.113.

(iii) Maintenance and post-stabilization care services as provided in §422.113.

(iv) Renal dialysis services provided while the enrollee was temporarily outside the plan's service area.

(v) Services for which coverage has been denied by the MA organization and found (upon appeal under subpart M of this part) to be services the enrollee was entitled to have furnished, or paid for, by the MA organization.

(2) An MA plan (and an MA MSA plan, after the annual deductible in §422.103(d) has been met) offered by an MA organization satisfies paragraph (a) of this section with respect to benefits for services furnished by a noncontracting provider if that MA plan provides payment in an amount the provider would have received under original Medicare (including balance billing permitted under Medicare Part A and Part B).

(c) *Types of benefits.* An MA plan includes at a minimum basic benefits, and also may include mandatory and optional supplemental benefits.

(1) Basic benefits are all items and services (other than hospice care or, beginning in 2021, coverage for organ acquisitions for kidney transplants) for which benefits are available under Parts A and B of Medicare, including additional telehealth benefits offered consistent with the requirements at §422.135.

(2) Supplemental benefits are benefits offered under §422.102.

(i) Supplemental benefits consist of—

(A) Mandatory supplemental benefits are services not covered by Medicare that an MA enrollee must purchase as part of an MA plan that are paid for in full, directly by (or on behalf of) Medicare enrollees, in the form of premiums or cost sharing.

(B) Optional supplemental benefits are health services not covered by Medicare that are purchased at the option of the MA enrollee and paid for in full, directly by (or on behalf of) the Medicare enrollee, in the form of premiums or cost sharing. These services may be grouped or offered individually.

(ii) Supplemental benefits must meet the following requirements:

(A) Except in the case of special supplemental benefit for the chronically ill (SSBCI) offered in accordance with §422.102(f) that are not primarily health related, the benefits diagnose, prevent, or treat an illness or injury; compensate for physical impairments; act to ameliorate the functional/psychological impact of injuries or health conditions; or reduce avoidable emergency and health care utilization;

(B) The MA organization incurs a non-zero direct medical cost, except that in the case of a SSBCI that is not primarily health related that is offered in accordance with § 422.102, the MA organization may instead incur a non-zero direct non-administrative cost; and

(C) The benefits are not covered by Medicare (This specifically includes Medicare Parts A, B, and D).

(d) *Availability and structure of plans.* An MA organization offering an MA plan must offer it—

(1) To all Medicare beneficiaries residing in the service area of the MA plan;

(2)(i) At a uniform premium, with uniform benefits and level of cost-sharing throughout the plan's service area, or segment of service area as provided in § 422.262(c)(2).

(ii) MA plans may provide supplemental benefits (such as specific reductions in cost sharing or additional services or items) that are tied to disease state or health status in a manner that ensures that similarly situated individuals are treated uniformly; there must be some nexus between the health status or disease state and the specific benefit package designed for enrollees meeting that health status or disease state.

(e) *Multiple plans in one service area.* An MA organization may offer more than one MA plan in the same service area subject to the conditions and limitations set forth in this subpart for each MA plan.

(f) *CMS review and approval of MA benefits and associated cost sharing.* CMS 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) *Guidelines.* Medicare-covered services meet CMS fee-for-service guidelines.

(2) *Discrimination.* 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.

(3) *Other requirements.* Benefit design meets other MA program requirements.

(4) *In-network MOOP limit.* Except as provided in paragraph (f)(5) of this section, MA local plans (as defined in § 422.2) must have an enrollee in-network maximum out-of-pocket (MOOP) amount for basic benefits that is no greater than the annual limit calculated by CMS using Medicare Fee-for-Service (FFS) data projections. With respect to a private fee-for-service (PFFS) plan, the in-network MOOP limits specified in this paragraph (f)(4) apply. MA organizations are responsible for tracking out-of-pocket spending accrued by the enrollee, and must alert enrollees and contracted providers when the plan's in-network MOOP amount is reached.

(i) *Medicare FFS data projections in CMS MOOP limit calculations.* For each year beginning on or after January 1, 2023, CMS calculates three MOOP limits using Medicare FFS data projections. For purposes of this paragraph (f)(4) and calculating actuarially equivalent copayments as described in paragraph (f)(7) of this section, the term *Medicare FFS data projections* means the projections of beneficiary out-of-pocket costs for the applicable contract year, based on recent Medicare FFS data, including data for beneficiaries with and without diagnoses of ESRD, that are consistent with generally accepted actuarial principles and practices as outlined in paragraph (f)(7)(i) of this section. The dollar ranges for the three MOOP limits are as follows:

(A) *Mandatory MOOP limit.* One dollar above the intermediate MOOP limit and up to and including the mandatory MOOP limit.

(B) *Intermediate MOOP limit.* One dollar above the lower MOOP limit and up to and including the intermediate MOOP limit.

(C) *Lower MOOP limit.* Between $0.00 and up to and including the lower MOOP limit.

(ii) *MOOP type.* An MA organization that establishes a plan's MOOP amount within the dollar range specified in paragraphs (f)(4)(i)(A) through (C) of this section has the corresponding mandatory, intermediate, or lower MOOP type for purposes of paragraphs (f) and (j) of this section and §§ 422.101(d) and 422.113(b)(2)(v).

(iii) *CMS rounding of MOOP limits.* Each MOOP limit CMS calculates is rounded to the nearest $50 increment and in cases where the MOOP limit is projected to be exactly in between two $50 increments, CMS rounds to the lower $50 increment.

(iv) *MOOP limits for 2023.* For 2023, CMS calculates the MOOP limits as follows, applying paragraph (f)(4)(vi)(A) of this section:

(A) *Mandatory MOOP limit.* $7,175 (the 95th percentile of projected contract year 2021 Medicare FFS beneficiary out-of-pocket spending for beneficiaries without diagnoses of ESRD) plus 70 percent of the ESRD cost differential unless: The resulting MOOP limit (after application of the rounding rules in paragraph (f)(4)(iii) of this section) reflects an increase greater than 10 percent compared to the mandatory MOOP limit from the prior year, in which case CMS caps the increase to the mandatory MOOP limit by 10 percent of the prior year's MOOP limit.

(B) *Intermediate MOOP limit.* The numeric midpoint between the mandatory and lower MOOP limits (calculated before application of the rounding rules in paragraph (f)(4)(iii) of this section and after application of the 10 percent cap on increases to the mandatory and lower MOOP limits from the prior year in paragraphs (f)(4)(iv)(A) and (C) of this section).

(C) *Lower MOOP limit.* $3,360 (the 85th percentile of projected contract year 2021 Medicare FFS beneficiary out-of-pocket spending for beneficiaries without diagnoses of ESRD) plus 70 percent of the ESRD cost differential unless: The resulting MOOP limit (after application of the rounding rules in paragraph (f)(4)(iii) of this section) reflects an increase greater than 10 percent compared to the voluntary MOOP limit from the prior year, in which case CMS caps the increase to the lower MOOP limit by 10 percent of the prior year's MOOP limit.

(v) *MOOP limits for 2024 and subsequent years.* For 2024 and subsequent years, CMS annually calculates the MOOP limits as follows, applying paragraph (f)(4)(vi)(B) of this section:

(A) *Mandatory and lower MOOP limits.* The prior year's MOOP limits are increased or decreased for the upcoming contract year to reflect the applicable percentiles (95th for the mandatory MOOP and 85th for the lower MOOP) of the Medicare FFS data projections unless: Either of the resulting MOOP limits reflect an increase greater than 10 percent compared to the same type of MOOP limit from the prior year, in which case CMS caps the increase to the applicable MOOP limit(s) by 10 percent of the prior year's MOOP limit annually until the MOOP limit(s) reflects the applicable percentile(s).

(B) *Intermediate MOOP limit.* Is either maintained at the prior year's limit or if either the mandatory or lower MOOP limit changes from the prior year, updated to the new numeric midpoint between the mandatory and lower MOOP limits (calculated before application of the rounding rules in paragraph (f)(4)(iii) of this section and after application of the 10-percent cap on increases to the mandatory and lower MOOP limits from the prior year in paragraph (f)(4)(v)(A) of this section).

(vi) *CMS calculation of the ESRD cost differential.* For purposes of the ESRD cost transition methodology to calculate annual MOOP limits contained in this section, the *ESRD cost differential* is the difference between, first, for the mandatory MOOP limit, $7,175 and for the lower MOOP limit, $3,360 and second, for the mandatory MOOP limit, the 95th percentile and, for the lower MOOP limit, the 85th percentile of the Medicare FFS data projections for each year between 2023 and 2024. CMS transitions to using the Medicare FFS data projections by factoring in a percentage of the ESRD cost differential on the following schedule:

(A) For 2023, CMS uses projected Medicare FFS beneficiary out-of-pocket spending for beneficiaries without diagnoses of ESRD plus 70 percent of the ESRD cost differential.

(B) For 2024 and subsequent years, CMS uses the Medicare FFS data projections.

(5) *Combined MOOP limit.* With respect to a local PPO plan, the MOOP limits specified under paragraph (f)(4) of this section apply only to use of in-network providers.

(i) *Combined and total catastrophic MOOP limits.* MA local PPO plans must establish a combined enrollee MOOP

amount for basic benefits that are provided in-network and out-of-network that is no greater than the total catastrophic limit applicable to regional plans in § 422.101(d)(3).

(ii) *In-network and combined MOOP type.* The type of in-network MOOP limit dictates the type of combined MOOP limit the MA plan may use. MA PPO plans must have the same MOOP type (lower, intermediate, or mandatory) for the in-network MOOP limit and combined limit on in-network and out-of-network out-of-pocket expenditures.

(iii) *MOOP limit attainment.* MA organizations are responsible for tracking out-of-pocket spending accrued by the enrollee and must alert enrollees and contracted providers when the combined MOOP amount is reached.

(6) *General cost sharing limits.* Cost sharing for basic benefits specified by CMS does not exceed levels annually determined by CMS to be discriminatory for such services. For each year beginning on or after January 1, 2023, a MA organization must establish cost sharing for basic benefits that complies with the cost sharing limits in this paragraph (f)(6), paragraph (j) of this section, and § 422.113(b)(2), which are in addition to any other limits and rules applicable to MA cost sharing, including the requirement in § 422.254(b)(4) that overall MA cost sharing for basic benefits be actuarially equivalent to Medicare FFS cost sharing. Cost sharing may be a coinsurance or copayment; a cost sharing limit is calculated for a plan benefit package service category or for a reasonable group of benefits covered under the plan. For purposes of cost sharing evaluation, the analysis is completed at the plan (or segment) level. An MA plan must not charge an enrollee a copayment for a basic benefit that is greater than the cost of the covered service(s).

(i) *The 50 percent cap on original Medicare benefits.* For in-network basic benefits that are not specifically addressed in this paragraph (f)(6), paragraph (j)(1) of this section, or § 422.113(b)(2), and for out-of-network basic benefits, MA plans must not establish a cost sharing amount that exceeds 50 percent coinsurance or an actuarially equivalent copayment value (calculated by CMS following the requirements in paragraph (f)(7) of this section or, if CMS does not calculate a copayment limit, based on the average Medicare FFS allowable amount for the plan service area or the estimated total MA plan financial liability for the service category or for a reasonable group of benefits in the PBP for that contract year). The rules in this paragraph (f)(6)(i) apply regardless of the type of MOOP limit established by the plan.

(ii) *Copayment rounding rules.* The following rounding rules apply in calculating copayment limits and in evaluating compliance with this paragraph (f)(6) and paragraphs (f)(7), (f)(8), and (j)(1) of this section:

(A) For service categories subject to paragraph (f)(6)(i) of this section, professional services subject to paragraph (f)(6)(iii) of this section, and benefits listed in paragraph (j)(1)(i) of this section, the final actuarially equivalent copayment value is rounded to the nearest whole $5.

(B) For inpatient hospital acute and psychiatric and skilled nursing facility cost sharing limits subject to paragraphs (f)(6)(iv) and (j)(1)(i)(C) of this section, the final actuarially equivalent copayment value is rounded to the nearest whole $1.

(C) When the actuarially equivalent copayment value is projected to be exactly between two increments, the final figure is rounded to the lower dollar amount.

(iii) *Cost sharing limits for professional services.* (A) For in-network basic benefits that are professional services, including primary care services, physician specialist services, partial hospitalization, and rehabilitation services, an MA plan must not establish cost sharing that exceeds the limits in this paragraph (f)(6)(iii) for the MOOP limit established by the MA plan.

(B) When calculating copayment limits for purposes of this paragraph, CMS calculates an actuarially equivalent value to the coinsurance limits in this paragraph (f)(6)(iii), subject to the requirements in paragraph (f)(7) of this section and the restrictions on increases to copayment limits in paragraph (f)(8) of this section. If CMS does not calculate a copayment limit for a professional service category, the MA

plan must not establish a copayment that exceeds the actuarially equivalent value to the coinsurance limits in this paragraph (f)(6)(iii) based on the estimated total MA plan financial liability for that benefit for that contract year.

(C) For 2023, MA plans must not exceed the cost sharing limits for professional service categories, as follows:

(*1*) *Mandatory MOOP limit.* 45 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 55 percent of the estimated total MA plan financial liability for the benefit.

(*2*) *Intermediate MOOP limit.* 47 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 53 percent of the estimated total MA plan financial liability for the benefit.

(*3*) *Lower MOOP limit.* 50 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 50 percent of the estimated total MA plan financial liability.

(D) For 2024, MA plans must not exceed the cost sharing limits for professional service categories, as follows:

(*1*) *Mandatory MOOP limit.* 40 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 60 percent of the estimated total MA plan financial liability for the benefit.

(*2*) *Intermediate MOOP limit.* 45 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 55 percent of the estimated total MA plan financial liability for the benefit.

(*3*) *Lower MOOP limit.* 50 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 50 percent of the estimated total MA plan financial liability.

(E) For 2025, MA plans must not exceed the cost sharing limits for professional service categories, as follows:

(*1*) *Mandatory MOOP limit.* 35 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 65 percent of the estimated total MA plan financial liability for the benefit.

(*2*) *Intermediate MOOP limit.* 42 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 58 percent of the estimated total MA plan financial liability for the benefit.

(*3*) *Lower MOOP limit.* 50 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 50 percent of the estimated total MA plan financial liability.

(F) For 2026 and subsequent years, MA plans must not exceed the cost sharing limits for professional service categories, as follows:

(*1*) *Mandatory MOOP limit.* 30 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 70 percent of the estimated total MA plan financial liability for the benefit.

(*2*) *Intermediate MOOP limit.* 40 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 60 percent of the estimated total MA plan financial liability for the benefit.

(*3*) *Lower MOOP limit.* 50 percent coinsurance or an actuarially equivalent copayment value and the MA plan must not pay less than 50 percent of the estimated total MA plan financial liability.

(iv) *Inpatient hospital acute and psychiatric service category cost sharing limits.* (A) For in-network basic benefits that are inpatient hospital acute and psychiatric service categories, an MA plan must not establish cost sharing that exceeds the limits calculated by CMS under paragraph (f)(6)(iv) of this section and subject to paragraph (f)(7) of this section for the MOOP limit established by the MA plan.

(B) Cost sharing limits for inpatient hospital acute and psychiatric service categories are calculated for the following seven length-of-stay scenarios for a period for which cost sharing would apply under original Medicare: Inpatient hospital acute stay scenarios of 3 days, 6 days, 10 days, and 60 days and inpatient hospital psychiatric stay scenarios of 8 days, 15 days, and 60 days.

(C) CMS calculates the inpatient hospital acute and psychiatric service category cost sharing limits annually using projections of Medicare FFS out-of-pocket costs and utilization for the

applicable year and length of stay scenario and factors in out-of-pocket costs incurred by beneficiaries with diagnoses of ESRD on the transition schedule described in paragraphs (f)(4)(vi)(A) through (B) of this section and may also use patient utilization information from MA encounter data.

(D) Provided that the total cost sharing for the inpatient benefit does not exceed the MA plan's MOOP limit or overall cost sharing for inpatient benefits in original Medicare on a per member per month actuarially equivalent basis, cost sharing applicable to inpatient hospital acute and psychiatric service categories is permitted up to the following limits (based on original Medicare cost sharing for a new benefit period):

(*1*) *Mandatory MOOP limit.* Cost sharing must not exceed 100 percent of estimated Medicare FFS cost sharing, including the projected Part A deductible and related Part B costs, for each length-of-stay scenario.

(*2*) *Intermediate MOOP limit.* Cost sharing must not exceed the numeric midpoint between the cost sharing limits established in paragraphs (f)(6)(iv)(D)(*1*) and (*3*) of this section for the same inpatient hospital length of stay scenario, before application of the rounding rules in paragraph (f)(6)(ii) of this section.

(*3*) *Lower MOOP limit.* Cost sharing must not exceed 125 percent of estimated Medicare FFS cost sharing, including the projected Part A deductible and related Part B costs, for each length of stay scenario other than the inpatient hospital acute 60-day length-of-stay for MA plans that establish a lower MOOP limit. For inpatient hospital acute 60-day length of stays, MA plans that establish a lower MOOP limit have the flexibility to establish cost sharing above 125 percent of estimated Medicare FFS cost sharing.

(7) *Using generally accepted actuarial principles and practices.* (i) *Application of generally accepted actuarial principles and practices.* The projections and calculations used in the methodologies described in paragraphs (f)(4), (f)(5), (f)(6), (f)(7)(ii), (f)(8), and (j) of this section and in § 422.101(d)(2) and (3) must be made using generally accepted actuarial principles and practices.

(A) In applying generally accepted actuarial principles and practices, actuarial judgment and discretion may be used, including taking into account information such as changes in legislation (such as changes in Medicare benefits), Medicare payment policy, trends over several years of data, and external variables (such as public health emergencies); selecting among different approaches (such as weighting for utilization and using average or median values); and in selecting data or data samples.

(B) MA organizations must use generally accepted actuarial principles and practices in complying with the regulations in paragraphs (f)(6) and (j) of this section.

(C) CMS applies generally accepted actuarial principles and practices in evaluating MA plan compliance with paragraphs (f)(6) and (j) of this section.

(ii) *CMS calculation of actuarially equivalent copayment limits.* As feasible and appropriate to carry out program purposes, CMS calculates copayment limits for basic benefits in accordance with paragraphs (f)(6)(i) and (iii) and (j)(1) of this section. Beginning January 1, 2023, unless specified otherwise in paragraphs (f)(6) and (j)(1) of this section, CMS calculates these copayment limits at an actuarially equivalent value to the cost sharing standard as follows:

(A) Using Medicare FFS data projections, as defined in paragraph (f)(4)(i) of this section, for the applicable year and service category.

(B) Using patient utilization information from MA encounter data, in addition to the Medicare FFS data projections (including cost and utilization data), if available and where appropriate to consider utilization differences between Medicare FFS beneficiaries and MA enrollees to reach a value that most closely reflects an actuarially equivalent copayment for the benefit and beneficiary population.

(C) Selecting a particular approach to calculate an actuarially equivalent copayment value in situations where there may be multiple or a range of actuarially equivalent copayment values for a service category in order to carry

out program purposes, including: Setting copayment limits that most closely reflect an actuarially equivalent copayment for the benefit and beneficiary population, protecting against discriminatory cost sharing, and avoiding unnecessary fluctuations in cost sharing that may confuse beneficiaries.

(D) Applying the actuarially equivalent copayment transition in paragraph (f)(8) of this section.

(E) Applying rounding rules in paragraph (f)(6)(ii) of this section.

(iii) *CMS issuance of annual guidance.* CMS issues guidance that specifies the MOOP limits and cost sharing standards for the upcoming contract year (beginning with contract year 2024) that are set and calculated using the methodology and standards in paragraphs (f) and (j) of this section and §§ 422.101(d) and 422.113. This guidance is released prior to bid submission to allow sufficient time for MA organizations to prepare and submit plan bids. Unless a public comment period is impracticable, unnecessary, or contrary to the public interest, CMS provides a public notice and comment period on the projected MOOP limits and cost sharing standards for the upcoming contract year.

(8) *Annual cap on CMS increasing copayment limits during the actuarially equivalent copayment transition.* For 2023 through 2025, CMS sets a copayment limit for a service category subject to paragraph (f)(6)(iii) or (j)(1) of this section at an amount that is the lesser of an actuarially equivalent value to the applicable cost sharing standard (from paragraph (f)(6)(iii) or (j)(1) of this section) or the value resulting from the actuarially equivalent copayment transition in paragraph (f)(8)(ii) of this section for that service category.

(i) CMS *calculation of the actuarially equivalent copayment differential.* For purposes of this section, the actuarially equivalent copayment differential is as follows:

(A) For cost sharing at the mandatory and lower MOOP limits, the difference between, first, the copayment limit set for a plan benefit package service category based on the MOOP type for 2022 and second, the copayment value for the same service category that is actuarially equivalent to the coinsurance limits in paragraphs (f)(6)(iii) and (j)(1) of this section that apply in 2026 based on the MOOP type, using the Medicare FFS data projections that are updated each year to reflect the costs of the contract year for which the copayment limit will apply.

(B) For cost sharing at the intermediate MOOP limit, the difference between, first, the copayment limit set for a plan benefit package service category based on the mandatory MOOP type for 2022 and second, the copayment value for the same service category that is actuarially equivalent to the coinsurance limits in paragraphs (f)(6)(iii) and (j)(1) of this section that apply in 2026 for the intermediate MOOP type, using the Medicare FFS data projections that are updated each year to reflect the costs of the contract year for which the copayment limit will apply.

(ii) *CMS's actuarially equivalent copayment transition.* For service categories subject to the cost sharing standards in paragraphs (f)(6)(iii) and (j)(1) of this section, copayment limits calculated by CMS for 2023 through 2025 are capped at the amounts calculated under this paragraph, unless specified otherwise in paragraph (f)(8) of this section, rounded as provided in paragraph (f)(6)(ii) of this section:

(A) For 2023, CMS uses the copayment limits set for 2022 plus 25 percent of the actuarially equivalent copayment differential.

(B) For 2024, CMS uses the copayment limits set for 2022 plus 50 percent of the actuarially equivalent copayment differential.

(C) For 2025, CMS uses the copayment limits set for 2022 plus 75 percent of the actuarially equivalent copayment differential.

(D) For 2026 and subsequent years, CMS calculates service category copayment limits at the projected actuarially equivalent value to the cost sharing standards in paragraphs (f)(6)(iii)(F) and (j)(1) of this section and subject to paragraph (f)(7) of this section.

(9) *Bundled cost sharing.* Cost sharing (copayments and coinsurance) for basic

benefits must reflect the enrollee's entire cost sharing responsibility, inclusive of professional, facility, or provider setting charges, by combining (or bundling) all applicable fees into the cost sharing amount for that particular service(s) and setting(s) and be clearly reflected as a single, total cost sharing in appropriate materials distributed to beneficiaries for basic benefits.

(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) *Cost sharing and actuarial equivalence standards for basic benefits*—(1) *Specific benefits for which cost sharing may not exceed cost sharing under original Medicare.* (i) *General rule.* For each year beginning on or after January 1, 2023, in-network cost sharing established by an MA plan for the basic benefits listed in this paragraph may not exceed the cost sharing required under original Medicare. When an MA plan uses coinsurance, the coinsurance must not exceed the coinsurance charged in original Medicare. When an MA plan uses copayments, the copayment must not exceed the actuarially equivalent value calculated using the rules in paragraph (j)(1)(ii) of this section. The benefits listed in this paragraph are as follows:

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

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

(C) 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, when the MA plan establishes the mandatory MOOP type; when the MA plan establishes the lower MOOP type, the cost sharing must not be greater than $20 per day for the first 20 days of a SNF stay; when the MA plan establishes the intermediate MOOP type, the cost sharing must not be greater than $10 per day for the first 20 days of a SNF stay.

(1) Regardless of the MOOP amount established by the MA plan, the per-day cost sharing for days 21 through 100 must not be greater than one eighth of the projected (or actual) Part A deductible amount.

(2) Total cost sharing for the overall SNF benefit must not be greater than the per member per month actuarially equivalent cost sharing for the SNF benefit in original Medicare.

(D) Home health services (as defined in section 1861(m) of the Act), when the MA plan establishes a mandatory or intermediate MOOP type; when the MA plan establishes the lower MOOP type, the cost sharing must not be greater than 20 percent coinsurance or an actuarially equivalent copayment.

(E) The following specific service categories of durable medical equipment (DME): Equipment, prosthetics, medical supplies, diabetes monitoring supplies, diabetic shoes or inserts when the MA plan establishes the mandatory MOOP limit. For all MOOP limits, total cost sharing for the overall DME benefit must not be greater than the per member per month actuarially equivalent cost sharing for the DME benefit in original Medicare.

(F) Other drugs covered under Part B of original Medicare (that is, Part B drugs not included in paragraph (j)(1)(i)(A) of this section).

(ii) *Rules for calculating copayment limits.* For 2023 and subsequent years, CMS calculates copayment limits for the basic benefits listed in paragraph (j)(1)(i) of this section subject to the requirements in paragraph (f)(7) of this section and the restrictions on increases to copayment limits in paragraph (f)(8) of this section. If CMS does

not calculate a copayment limit for a benefit listed in paragraph (j)(1)(i) of this section, an MA plan must establish a copayment that does not exceed an actuarially equivalent value to the coinsurance required under original Medicare; such actuarially equivalent value must be established in accordance with paragraph (f)(7)(i) of this section and based on the average Medicare FFS allowed amount in the plan's service area or the estimated total MA plan financial liability for that benefit for that contract year.

(2) *Actuarially equivalent cost sharing evaluation for all basic benefits and specific categories of basic benefits in the aggregate.* For each year beginning on or after January 1, 2023, an MA plan's total cost sharing for all basic benefits, excluding out of network benefits covered by a regional MA plan, must not exceed cost sharing for those benefits in original Medicare on a per member per month actuarially equivalent basis.

(i) MA plans must have cost sharing for the following specific benefit categories that does not exceed the cost sharing for those benefit categories in original Medicare on a per member per month actuarially equivalent basis:

(A) Inpatient hospital acute and psychiatric services, defined as services provided during a covered inpatient stay during the period for which cost sharing would apply under original Medicare.

(B) Durable medical equipment (DME).

(C) Drugs and biologics covered under Part B of original Medicare.

(D) 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.

(ii) CMS may extend flexibility for MA plans when evaluating compliance with the requirements in paragraph (j)(2)(i) of this section regarding actuarial equivalent cost sharing for all basic benefits and specific categories of basic benefits to the extent that it is actuarially justifiable provided that the MA plan's cost sharing is based on generally accepted actuarial principles and practices (consistent with paragraph (f)(7) of this section), supporting documentation included in the bid, and the MA plan's cost sharing for specific service categories otherwise satisfies applicable cost sharing standards.

(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)).

(l) Coverage of DME. MA organizations—

(1) Must cover and ensure enrollees have access to all categories of DME covered under Part B; and

(2) May, within specific categories of DME, limit coverage to certain DME brands, items, and supplies of preferred manufacturers provided the MA organization ensures all of the following:

(i) Its contracts with DME suppliers ensure that enrollees have access to all DME brands, items, and supplies of preferred manufacturers.

(ii) Its enrollees have access to all medically-necessary DME brands, items, and supplies of non-preferred manufacturers.

(iii) At the enrollees' request, it provides for an appropriate transition process for new enrollees during the first 90 days of their coverage under its MA plan, during which time the MA organization will do the following:

(A) Ensure the provision of a transition supply of DME brands, items, and supplies of non-preferred manufacturers.

(B) Provide for the repair of DME brands, items, and supplies of non-preferred manufacturers.

(iv) It makes no negative changes to its DME brands, items, and supplies of preferred manufacturers during the plan year.

(v) It treats denials of DME brands, items, and supplies of non-preferred manufacturers as organization determinations subject to § 422.566.

(vi) It discloses DME coverage limitations and beneficiary appeal rights in the case of a denial of a DME brand, item, or supply of a non-preferred manufacturer as part of the description of benefits required under § 422.111(b)(2) and § 422.111(h).

(vii) It provides full coverage, without limitation on brand and manufacturer, to all DME categories or subcategories annually determined by CMS to require full coverage.

(m) *Special requirements during a disaster or emergency.* (1) When a disaster or emergency is declared as described in paragraph (m)(2) of this section and there is disruption of access to health care as described in paragraph (m)(6) of this section, an MA organization offering an MA plan must, until the end date specified in paragraph (m)(3) of this section occurs, ensure access to covered benefits in the following manner:

(i) Cover Medicare Parts A and B services and supplemental Part C plan benefits furnished at non-contracted facilities subject to § 422.204(b)(3).

(ii) Waive, in full, requirements for gatekeeper referrals where applicable.

(iii) Provide the same cost-sharing for the enrollee as if the service or benefit had been furnished at a plan-contracted facility.

(iv) Make changes that benefit the enrollee effective immediately without the 30-day notification requirement at § 422.111(d)(3).

(2) *Declarations of disasters.* A declaration of a disaster or emergency will identify the geographic area affected by the event and may be made as one of the following:

(i) Presidential declaration of a disaster or emergency under the either of the following:

(A) Stafford Act.

(B) National Emergencies Act.

(ii) Secretarial declaration of a public health emergency under section 319 of the Public Health Service Act.

(iii) Declaration by the Governor of a State or Protectorate.

(3) *End of the special requirements for the disaster or emergency.* An MA organization must continue furnishing access to benefits as specified in paragraphs (m)(1)(i) through (iv) of this section for 30 days after the conditions described in paragraph (m)(3)(i) or (ii) of this section occur with respect to all applicable emergencies or after the condition described in paragraph (m)(3)(iii) of this section occurs, whichever is earlier:

(i) All sources that declared a disaster or emergency that include the service area declare an end.

(ii) No end date was identified as described in paragraph (m)(3)(i) of this section, and all applicable emergencies or disasters declared for the area have ended, including through expiration of the declaration or any renewal of such declaration.

(iii) There is no longer a disruption of access to health care as defined in paragraph (m)(6) of this section.

(4) *MA plans unable to operate.* An MA plan that cannot resume normal operations by the end of the disaster or emergency as described in paragraph (m)(3)(i) or (ii) of this section must notify CMS.

(5) *Disclosure.* In addition to other requirements of annual disclosure under § 422.111, an organization must do all of the following:

(i) Indicate the terms and conditions of payment during the disaster or emergency for non-contracted providers furnishing benefits to plan enrollees residing in the affected service area(s).

(ii) Annually notify enrollees of the information listed in paragraphs (m)(1) through (3) and (m)(5) of this section.

(iii) Provide the information described in paragraphs (m)(1), (2), and (3) and (m)(5)(i) of this section on its website.

(6) *Disruption of access to health care.* A disruption of access to health care for the purpose of paragraph (m) of this section is an interruption or interference in the service area (as defined at § 422.2) such that enrollees do not have the ability to access contracted providers or contracted providers do not have the ability to provide needed services to enrollees, resulting in MA plans failing to meet the normal prevailing patterns of community health care delivery in the service area under § 422.112(a).

(n) *Digital health education program.* MA organizations must establish procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing any medically necessary covered benefits that are furnished when the enrollee and the provider are not in

the same location using electronic exchange, as defined in § 422.135.

(1) The MA organization must make information about its digital health literacy screening and digital health education programs available to CMS upon request. Requested information may include, but is not limited to, statistics on the number of enrollees identified with low digital health literacy and receiving digital health education, manner(s) or method of digital health literacy screening and digital health education, financial impact of the programs on the MA organization, evaluations of effectiveness of digital health literacy interventions, and demonstration of compliance with the requirements of this section.

(2) [Reserved]

[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; 77 FR 22166, Apr. 12, 2012; 80 FR 7959, Feb. 12, 2015; 83 FR 16724, Apr. 16, 2018; 84 FR 15828, Apr. 16, 2019; 86 FR 6094, Jan. 19, 2021; 87 FR 22423, Apr. 14, 2022; 87 FR 27893, May 9, 2022; 88 FR 22328, Apr. 12, 2023]

§ 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 and benefit conditions included in Traditional Medicare laws, unless superseded by laws applicable to MA plans. This includes criteria for determining whether an item or service is a benefit available under Traditional Medicare. For example, this includes payment criteria for inpatient admissions at 42 CFR 412.3, services and procedures that the Secretary designates as requiring inpatient care under 42 CFR 419.22(n), and requirements for payment of Skilled Nursing Facility (SNF) Care, Home Health Services under 42 CFR part 409, and Inpatient Rehabilitation Facilities (IRF) at 42 CFR 412.622(a)(3).

(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