

(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 a plan's model of care will only be approved if each element of the model of care meets the minimum benchmark.

[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]

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

(i) Must 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) Must have written policies based on objective criteria for determining a chronically ill enrollee's eligibility to receive a particular SSBCI and must document these criteria.

(iv) Document each determination that an enrollee is eligible to receive an SSBCI and make this information available to CMS upon request.

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§ 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.

(d) *Annual deductible*. The annual deductible for an MA MSA plan—

(1) For contract year 1999, may not exceed \$6,000; and

(2) For subsequent contract years may not exceed the deductible for the preceding contract year, increased by the national per capita growth percentage determined under § 422.306(a)(2).