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42 C.F.R. § 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).