
42 C.F.R. § 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(2) General coverage and benefit conditions included in Traditional Medicare laws, unless superseded by laws applicable to MA plans.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 coverage policy determinations that apply in the selected local coverage policy area in that MA region to all parts of that same MA region. The selection of the single local coverage policy area's local coverage policy determinations to apply throughout the MA region is at the discretion of the MA regional plan and is not subject to CMS pre-approval.

(5) If an MA organization offering an MA local plan elects to exercise the option in paragraph (b)(3) of this section related to a local MA plan, or if an MA organization offering an MA regional plan elects to exercise the option in paragraph (b)(4) of this section related to an MA regional plan, then the MA organization must make information on the selected local coverage policy readily available, including through the Internet, to enrollees and health care providers.

(6) MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs. Current, widely-used treatment guidelines are those developed by organizations representing clinical medical specialties, and refers to guidelines for the treatment of specific diseases or conditions. Acceptable clinical literature includes large, randomized controlled trials or prospective cohort studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question, or large systematic reviews or meta-analyses summarizing the literature of the specific clinical question.

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