

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 M+C organization offering an M+C plan must provide enrollees in that plan with coverage of the basic benefits described in § 422.101 (and, to the extent applicable, the benefits described in § 422.102) by furnishing the benefits directly or through arrangements, or by paying for the benefits. HCFA reviews these benefits subject to the requirements of § 422.100(g) and the requirements in subpart G of this part.

(b) *Services of noncontracting providers and suppliers.* (1) An M+C 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 M+C organization to provide services covered by the M+C plan:

(i) Emergency services as defined in § 422.2.

(ii) Urgently needed services as defined § 422.2.

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

(iv) Post-stabilization care services that were—

(A) Pre-approved by the organization; or

(B) Were not pre-approved by the organization because the organization did not respond to the provider of post-stabilization care services' request for pre-approval within 1 hour after being requested to approve such care, or could not be contacted for pre-approval.

(v) Services for which coverage has been denied by the M+C 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 M+C organization.

(2) An M+C plan (other than an M+C MSA plan) offered by an M+C organization satisfies paragraph (a) of this section with respect to benefits for services furnished by a noncontracting pro-

vider if that M+C 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 M+C plan may include two types of benefits:

(1) Basic benefits as defined in § 422.2.

(2) Supplemental benefits, which consist of—

(i) Mandatory supplemental benefits as defined in § 422.2; and

(ii) Optional supplemental benefits as defined in § 422.2.

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

(1) To all Medicare beneficiaries residing in the service area of the M+C plan;

(2) At a uniform premium; and

(3) With a uniform level of cost-sharing, as defined in § 422.2.

(e) *Terms of M+C plans.* Terms of M+C plans described in instructions to beneficiaries, as required by § 422.111, will include basic and supplemental benefits and terms of coverage for those benefits.

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

(g) *HCFA review and approval of M+C plans.* HCFA reviews and approves each M+C plan to ensure that the plan does not—

(1) Promote discrimination;

(2) Discourage enrollment;

(3) Steer specific subsets of Medicare beneficiaries to particular M+C plans; or

(4) Inhibit access to services.

(h) *Benefits affecting screening mammography, influenza vaccine, and pneumococcal vaccine.* (1) Enrollees of M+C organizations may directly access (through self-referral) screening mammography and influenza vaccine.

(2) M+C organizations may not impose cost-sharing for influenza vaccine and pneumococcal vaccine.

(i) *Requirements relating to Medicare conditions of participation.* Basic benefits must be provided through providers meeting the requirements in § 422.204(a)(3).

(j) *Choice of practitioners.* Consistent with the requirements of § 422.204 relating to the prohibition of discrimination against providers, if more than one type of practitioner is qualified to furnish a particular service, the M+C organization may select the type of practitioner to be used.

§ 422.101 Requirements relating to basic benefits.

Except as specified in § 422.264 (for entitlement that begins or ends during a hospital stay) and § 422.266 (with respect to hospice care), each M+C organization must—

(a) Provide coverage of, through the provision of or 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 geographic area in which services are covered under the M+C plan (or to Part A and Part B services obtained outside the geographic area if it is common practice to refer patients to sources outside that geographic area); and

(b) Comply with—

(1) HCFA's national coverage decisions; and

(2) Written coverage decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered under the M+C plan.

§ 422.102 Supplemental benefits.

(a) *Mandatory supplemental benefits.*

(1) Subject to HCFA's approval, an M+C organization may require Medicare enrollees of an M+C plan other than an MSA plan to accept and pay for services in addition to those included in the basic benefits described in § 422.101.

(2) If the M+C organization imposes mandatory supplemental benefits, it must impose them on all Medicare beneficiaries enrolled in the M+C plan.

(3) HCFA approves mandatory supplemental benefits if it determines that imposition of the mandatory benefits will not substantially discourage Medicare beneficiaries from enrolling in the M+C plan.

(b) *Optional supplemental benefits.* Except as provided in § 422.104 in the case of MSA plans, each M+C organization may offer (for election by the enrollee and without regard to health status) services that are in addition to those included in the basic benefits described in § 422.101 and any mandatory supplemental benefits described in paragraph (a) of this section. Optional supplemental benefits must be offered to all Medicare beneficiaries enrolled in the M+C plan.

(c) *Payment for supplemental services.* All supplemental benefits are paid for directly by (or on behalf of) the enrollee of the M+C plan.

§ 422.103 Benefits under an M+C MSA plan.

(a) *General rule.* An M+C organization offering an M+C MSA plan must make available to an enrollee, or provide reimbursement for, at least the services described under in § 422.101 after the enrollee incurs countable expenses equal to the amount of the plan's annual deductible.

(b) *Countable expenses.* An M+C organization offering an M+C 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 M+C organization offering an M+C 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 M+C 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 § 422.252(b).