10.2 – Basic Rule

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

An *MAO* offering an MA plan must provide enrollees in that plan with all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts, and Part B services if the enrollee is a grandfathered "Part B only" enrollee. The MAO fulfills its obligation of providing original Medicare benefits by furnishing the benefits directly, through arrangements, or by paying *for the benefits* on behalf of enrollees.

Basic benefits must be furnished through providers meeting requirements that are specified *at* 42 CFR §422.204(b)(3) and discussed more fully in *chapter* 6 of this manual, "Relationships with Providers," which may be found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c06.pdf.

Administration of the Medicare program is governed by *title* XVIII of the Social Security Act (the Act). Under the Medicare program, the scope of benefits available to eligible beneficiaries is prescribed by law and divided into several main parts. Part A is the hospital insurance program and Part B is the voluntary supplementary medical insurance program.

The scope of the benefits under Part A and Part B is defined in the Act. Part A and Part B benefits are discussed in *sections* 1812 and 1832 of the Act, respectively, while *section* 1861 of the Act lays out the definition of medical and other health services. Specific health care services must fit into one of these benefit categories, and not be otherwise excluded from coverage under the Medicare program (see §1862 for exclusions).

In general, the Act lists categories of items and services covered by Medicare, although Congress occasionally adds specific services to be covered by Medicare. Some categories are defined more broadly than others; for example, the Act includes hospital outpatient services furnished incident to physicians' services (§1861(s)(2)(B)) but also specifically includes diabetes screening tests (§1861(s)(2)(Y)). The Secretary *has* the authority to make determinations about which specific items and services, within categories, may be covered under the Medicare program. Further interpretation is provided in the Code of Federal Regulations and CMS guidance.

In general, Medicare coverage and payment is contingent upon a determination that:

- A service is in a covered benefit category;
- A service is not specifically excluded from Medicare coverage by the Act; and
- The item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury, to improve functioning of a malformed body member, or is a covered preventive service.

These criteria are codified through rulemaking in the Code of Federal Regulations and/or applied in manual guidance, or are applied through coverage determinations (see *section* 90 *of this chapter*). In addition, beneficiaries under part B are entitled to receive an "annual wellness visit," certain preventive services for which no cost-sharing may be charged, and additional preventive services.

Several original Medicare covered benefits and services are covered only for specific benefit periods, e.g., inpatient hospital services, skilled nursing facility services, and inpatient psychiatric hospital services. While an MA plan may offer additional coverage as a supplemental benefit, it may not limit the original Medicare coverage.

MA plans must provide their enrollees with all basic benefits covered under original Medicare. Consequently, plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare.

The following requirements apply with respect to the rule that MAOs must cover the costs of original Medicare benefits:

- Benefits: MA plans must provide or pay for medically necessary Part A (for those entitled) and Part B covered items and services.

- Access: MA enrollees must have access to all medically necessary Part A and Part B services**.** However, MA plans are not required to provide MA enrollees the same access to providers that is provided under original Medicare (see accessibility rules for MA plans *under section* 110 of this chapter).

- Cost-*Sharing*: With the exception of the services listed at 42 CFR 422.100(j) *and certain preventive services graded A or B by the United States Preventive Services Task Force and covered by original Medicare without cost-sharing (co-insurance)*, MA plans may impose cost-sharing for a particular item or service that is above or below the original Medicare cost-sharing for that service, provided the overall cost-sharing under the plan is actuarially equivalent to that under original Medicare and the plan cost-sharing structure does not discriminate against sicker beneficiaries, as *discussed* in *sections* 10.5.2 and 10.5.3 of this chapter. MA plans may require enrollees to pay higher cost-sharing amounts for services furnished out-of-network.

- Billing and *Payment*: MA plans need not follow original Medicare claims processing procedures. MA plans may create their own billing and payment procedures as long as providers – whether contracted or not – are paid accurately, timely and with an audit trail. MA plans may not require enrollees to pay providers – whether contracted or not – for original Medicare services and then be reimbursed by the plan. See *section* 110.1.3 of this chapter for rules governing payment to non-contracted providers for original Medicare non-emergent services.

10.2.1 – Inpatient Stay During Which Enrollment Ends

(Rev. 120, Issued: 01-16-15, Effective: 01-01-15, Implementation: 01-01-15)

MAOs must continue to cover, through discharge, inpatient services of a non-plan enrollee if the individual was an enrollee at the beginning of the inpatient stay. Note that incurred non-inpatient services are paid by original Medicare or the new MAO the enrollee joined as of the effective date of the new coverage.

Enrollee cost-sharing for the inpatient hospital stay is based on the cost-sharing amounts as of the entry date into the hospital.

If the enrollee is in a SNF in December and in an MAO that does not require a prior qualifying 3-day hospital stay and then joins original Medicare on January 1, the stay continues to be considered a covered stay (if medically required).

10.2.2 – Exceptions to Requirement for MA plans to Cover FFS Benefits

(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)

The following circumstances are exceptions to the rule that MAOs must cover the costs of original Medicare benefits:

- Hospice: Original Medicare (rather than the MAO) will pay the hospice for the services received by an enrollee who has elected hospice while enrolled in the plan. For detailed information about services furnished to an enrollee who has elected hospice care, see *section* 10.4 below.

- Clinical trials: Original Medicare pays for the costs of routine services provided to an MA enrollee who joins a qualifying clinical trial. MA plans pay the enrollee the difference between original Medicare cost-sharing incurred for qualifying clinical trial items and services and the MA plan's in-network cost-sharing for the same category of items and services. For further information on coverage and payment of clinical trials in MA plans, see *section* 10.7 *below*.

- Inpatient stay during which MA enrollment begins: (42 CFR § 422.318) If a Medicare beneficiary is in an inpatient stay and his enrollment in an MA plan takes effect after the stay begins, but prior to discharge from that stay:

    - Original Medicare is responsible for the costs of that inpatient stay; and

    - The beneficiary is responsible for payment of cost-sharing as required under original Medicare.

In addition to providing original Medicare benefits, the MAO also must furnish, arrange, or pay for supplemental benefits and prescription drug benefits covered under the plan.

CMS reviews and approves an MAO's coverage of benefits by ensuring compliance with requirements described in this manual, including those outlined in this chapter, *chapter* 8, "Payments to Medicare Advantage Organizations," and other applicable CMS guidance, such as that contained in the annual Call Letter.