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(2) An enrollee who moves out of the service area and into the geographic area designated as the continuation area has the choice of continuing enrollment or disenrolling from the MA local plan. The enrollee must make the choice of continuing enrollment in a manner specified by CMS. If no choice is made, the enrollee must be disenrolled from the plan.

(d) *Specific requirements*—(1) *Continuation of enrollment benefits.* The MA organization must, at a minimum, provide or arrange for the Medicare-covered benefits as described in § 422.101(a).

(2) *Reasonable access.* The MA organization must ensure reasonable access in the continuation area—

(i) Through contracts with providers, or through direct payment of claims that satisfy the requirements in § 422.100(b)(2), to other providers who meet the requirement in subpart E of this part; and

(ii) By ensuring that the access requirements of § 422.112 are met.

(3) *Reasonable cost sharing.* For services furnished in the continuation area, an enrollee's cost-sharing liability is limited to the cost-sharing amounts required in the MA local plan's service area (in which the enrollee no longer resides).

(4) *Protection of enrollee rights.* An MA organization that offers a continuation of enrollment option must convey all enrollee rights conferred under this rule, with the understanding that—

(i) The ultimate responsibility for all appeals and grievance requirements remain with the organization that is receiving payment from CMS; and

(ii) Organizations that require enrollees to give advance notice of intent to use the continuation of enrollment option, must stipulate the notification process in the marketing materials.

(e) *Capitation payments.* CMS's capitation payments to all MA organizations, for all Medicare enrollees, are based on rates established on the basis of the enrollee's permanent residence, regardless of where he or she receives services.

[63 FR 35071, June 26, 1998; 63 FR 52611, Oct. 1, 1998, as amended at 65 FR 40316, June 29, 2000; 70 FR 4716, Jan. 28, 2005]

§ 422.56 Enrollment in an MA MSA plan.

(a) *General.* An individual is not eligible to elect an MA MSA plan unless the individual provides assurances that are satisfactory to CMS that he or she will reside in the United States for at least 183 days during the year for which the election is effective.

(b) *Individuals eligible for or covered under other health benefits program.* Unless otherwise provided by the Secretary, an individual who is enrolled in a Federal Employee Health Benefit plan under 5 U.S.C. chapter 89, or is eligible for health care benefits through the Veteran's Administration under 10 U.S.C. chapter 55 or the Department of Defense under 38 U.S.C. chapter 17, may not enroll in an MA MSA plan.

(c) *Individuals eligible for Medicare cost-sharing under Medicaid State plans.* An individual who is entitled to coverage of Medicare cost-sharing under a State plan under title XIX of the Act is not eligible to enroll in an MA MSA plan.

(d) *Other limitations.* An individual who receives health benefits that cover all or part of the annual deductible under the MA MSA plan may not enroll in an MA MSA plan. Examples of this type of coverage include, but are not limited to, primary health care coverage other than Medicare, current coverage under the Medicare hospice benefit, supplemental insurance policies not specifically permitted under § 422.104, and retirement health benefits.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 70 FR 4716, Jan. 28, 2005]

§ 422.57 Limited enrollment under MA RFB plans.

An RFB society that offers an MA RFB plan may offer that plan only to members of the church, or convention or group of churches with which the society is affiliated.

§ 422.60 Election process.

(a) *Acceptance of enrollees: General rule.* (1) Except for the limitations on enrollment in an MA MSA plan provided by § 422.62(d)(1) and except as

specified in paragraph (a)(2) of this section, each MA organization must accept without restriction (except for an MA RFB plan as provided by § 422.57) individuals who are eligible to elect an MA plan that the MA organization offers and who elect an MA plan during initial coverage election periods under § 422.62(a)(1), annual election periods under § 422.62(a)(2), and under the circumstances described in § 422.62(b)(1) through (b)(4).

(2) MA organizations must accept elections during the open enrollment periods specified in § 422.62(a)(3), (a)(4), and (a)(5) if their MA plans are open to new enrollees.

(b) *Capacity to accept new enrollees.* (1) MA organizations may submit information on enrollment capacity of plans.

(2) If CMS determines that an MA plan offered by an MA organization has a capacity limit, and the number of MA eligible individuals who elect to enroll in that plan exceeds the limit, the MA organization offering the plan may limit enrollment in the plan under this part, but only if it provides priority in acceptance as follows:

(i) First, for individuals who elected the plan prior to the CMS determination that capacity has been exceeded, elections will be processed in chronological order by date of receipt of their election forms.

(ii) Then for other individuals in a manner that does not discriminate on the basis of any factor related to health as described in § 422.110.

(3) CMS considers enrollment limit requests for an MA plan service area, or a portion of the plan service area, only if the health and safety of beneficiaries is at risk, such as if the provider network is not available to serve the enrollees in all or a portion of the service area.

(c) *Election forms and other election mechanisms.* (1) The election must comply with CMS instructions regarding content and format and be approved by CMS as described in § 422.80. The election must be completed by the MA eligible individual (or the individual who will soon become eligible to elect an MA plan) and include authorization for disclosure and exchange of necessary information between the U.S. Department of Health and Human Services and its designees and the MA organization. Persons who assist beneficiaries in completing forms must sign the form, or through other approved mechanisms, indicate their relationship to the beneficiary.

(2) The MA organization must file and retain election forms for the period specified in CMS instructions.

(d) *When an election is considered to have been made.* An election in an MA plan is considered to have been made on the date the completed election is received by the MA organization.

(e) *Handling of elections.* The MA organization must have an effective system for receiving, controlling, and processing elections. The system must meet the following conditions and requirements:

(1) Each election is dated as of the day it is received in a manner acceptable to CMS.

(2) Elections are processed in chronological order, by date of receipt.

(3) The MA organization gives the beneficiary prompt notice of acceptance or denial in a format specified by CMS.

(4) If the MA plan is enrolled to capacity, it explains the procedures that will be followed when vacancies occur.

(5) Upon receipt of the election, or for an individual who was accepted for future enrollment from the date a vacancy occurs, the MA organization transmits, within the timeframes specified by CMS, the information necessary for CMS to add the beneficiary to its records as an enrollee of the MA organization.

(f) *Exception for employer group health plans.* (1) In cases in which an MA organization has both a Medicare contract and a contract with an employer group health plan, and in which the MA organization arranges for the employer to process elections for Medicare-entitled group members who wish to enroll under the Medicare contract, the effective date of the election may be retroactive. Consistent with § 422.308(f)(2), payment adjustments based on a retroactive effective date may be made for up to a 90-day period.

(2) In order to obtain the effective date described in paragraph (f)(1) of this section, the beneficiary must certify that, at the time of enrollment in

the MA organization, he or she received the disclosure statement specified in § 422.111.

(3) Upon receipt of the election from the employer, the MA organization must submit the enrollment within timeframes specified by CMS.

(g) *Passive enrollment by CMS.* In situations involving either immediate terminations as provided in § 422.510(a)(5) or other situations in which CMS determines that remaining enrolled in a plan poses potential harm to the members, CMS may implement passive enrollment procedures.

(1) *Passive enrollment procedures.* Individuals will be considered to have elected the plan selected by CMS unless they—

(i) Decline the plan selected by CMS, in a form and manner determined by CMS, or

(ii) Request enrollment in another plan.

(2) *Beneficiary notification.* The organization that receives the enrollment must provide notification that describes the costs and benefits of the plan and the process for accessing care under the plan and clearly explains the beneficiary's ability to decline the enrollment or choose another plan. Such notification must be provided to all potential enrollees prior to the enrollment effective date (or as soon as possible after the effective date if prior notice is not practical), in a form and manner determined by CMS.

(3) *Special election period.* All individuals will be provided with a special election period, as described in § 422.62(b)(4).

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998; 63 FR 54526, Oct. 9, 1998; 64 FR 7980, Feb. 17, 1999; 65 FR 40316, June 29, 2000; 70 FR 4716, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005; 74 FR 1541, Jan. 12, 2009]

§ 422.62 Election of coverage under an MA plan.

(a) *General: Coverage election periods—*(1) *Initial coverage election period for MA.* The initial coverage election period is the period during which a newly MA-eligible individual may make an initial election. This period begins 3 months before the month the individual is first entitled to both Part A and Part B and ends on the later of—

(i) The last day of the month preceding the month of entitlement; or

(ii) If after May 15, 2006, the last day of the individual's Part B initial enrollment period.

(2) *Annual coordinated election period.* (i) Beginning with 2002, the annual coordinated election period for the following calendar year is November 15th through December 31st, except for 2006.

(ii) For 2006, the annual coordinated election period

begins on November 15, 2005 and ends on May 15, 2006.

(iii) During the annual coordinated election period, an individual eligible to enroll in an MA plan may change his or her election from an MA plan to original Medicare or to a different MA plan, or from original Medicare to an MA plan. If an individual changes his or her election to original Medicare, he or she may also elect a PDP.

(3) *Open enrollment and disenrollment opportunities through 2005.* Through 2005, the number of elections or changes that an MA eligible individual may make is not limited (except as provided for in paragraph (d) of this section for MA MSA plans). Subject to the MA plan being open to enrollees as provided under § 422.60(a)(2), an individual eligible to elect an MA plan may change his or her election from an MA plan to original Medicare or to a different MA plan, or from original Medicare to an MA plan.

(4) *Open enrollment and disenrollment during 2006.* (i) Except as provided in paragraphs (a)(4)(ii), (a)(4)(iii), and (a)(6) of this section, an individual who is not enrolled in an MA plan, but who is eligible to elect an MA plan in 2006, may elect an MA plan only once during the first 6 months of the year.

(A) An individual who is enrolled in an MA-PD plan may elect another MA-PD plan or original Medicare and coverage under a PDP. Such an individual may not elect an MA plan that does not provide qualified prescription drug coverage.

(B) An individual who is enrolled in an MA plan that does not provide qualified prescription drug coverage may elect another MA plan that does not provide that coverage or original Medicare. Such an individual may not