§ 422.68 Effective dates of coverage and change of coverage.

(a) Initial coverage election period. An election made during an initial coverage election period as described in §422.62(a)(1) is effective as of the first day of the month of entitlement to both Part A and Part B.

(b) Annual coordinated election periods. For an election or change of election made during the annual coordinated election period as described in §422.62(a)(2)(i), coverage is effective as of the first day of the following calendar year except that for the annual coordinated election period described in §422.62(a)(2)(ii), elections made after December 31, 2005 through May 15, 2006 are effective as of the first day of the first calendar month following the month in which the election is made.

(c) Open enrollment periods. For an election, or change in election, made during an open enrollment period, as described in §422.62(a)(3) through (a)(6), coverage is effective as of the first day of the first calendar month following the month in which the election is made.

(d) Special election periods. For an election or change of election made during a special election period as described in §422.62(b), the effective date of coverage shall be determined by CMS, to the extent practicable, in a manner consistent with protecting the continuity of health benefits coverage.

(e) Exception for employer group health plans. (1) In cases when 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 election forms for Medicare-entitled group members who wish to disenroll from 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) Upon receipt of the election from the employer, the MA organization must submit a disenrollment notice to CMS within timeframes specified by CMS.

§ 422.74 Disenrollment by the MA organization.

(a) General rule. Except as provided in paragraphs (b) through (d) of this section, an MA organization may not—

(1) Disenroll an individual from any MA plan it offers; or

(2) Orally or in writing, or by any action or inaction, request or encourage an individual to disenroll.

(b) Basis for disenrollment—(1) Optional disenrollment. An MA organization may disenroll an individual from an MA plan it offers in any of the following circumstances:

(i) Any monthly basic and supplementary beneficiary premiums are not paid on a timely basis, subject to the grace period for late payment established under paragraph (d)(1) of this section.

(ii) The individual has engaged in disruptive behavior specified at paragraph (d)(2) of this section.

(iii) The individual provides fraudulent information on his or her election form or permits abuse of his or her enrollment card as specified in paragraph (d)(3) of this section.

(2) Required disenrollment. An MA organization must disenroll an individual
from an MA plan it offers in any of the following circumstances:

(i) The individual no longer resides in the MA plan’s service area as specified under paragraph (d)(4) of this section, is no longer eligible under §422.50(a)(3)(ii), and optional continued enrollment has not been offered or elected under §422.54.

(ii) The individual loses entitlement to Part A or Part B benefits as described in paragraph (d)(5) of this section.

(iii) Death of the individual as described in paragraph (d)(6) of this section.

(iv) Individuals enrolled in a specialized MA plan for special needs individuals that exclusively serves and enrolls special needs individuals who no longer meet the special needs status of that plan (or deemed continued eligibility, if applicable).

(3) Plan termination or reduction of area where plan is available—(i) General rule. An MA organization that has its contract for an MA plan terminated, that terminates an MA plan, or that discontinues offering the plan in any portion of the area where the plan had previously been available, must disenroll affected enrollees in accordance with the procedures for disenrollment set forth at paragraph (d)(7) of this section, unless the exception in paragraph (b)(3)(ii) of this section applies.

(ii) Exception. When an MA organization discontinues offering an MA plan in a portion of its service area, the MA organization may elect to offer enrollees residing in all or portions of the affected area the option to continue enrollment in an MA plan offered by the organization, provided that there is no other MA plan offered in the affected area at the time of the organization’s election. The organization may require an enrollee who chooses to continue enrollment to agree to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively through facilities designated by the organization within the plan service area.

(c) Notice requirement. If the disenrollment is for any of the reasons specified in paragraphs (b)(1), (b)(2)(i), or (b)(3) of this section (that is, other than death or loss of entitlement to Part A or Part B) the MA organization must give the individual a written notice of the disenrollment with an explanation of why the MA organization is planning to disenroll the individual. Notices for reasons specified in paragraphs (b)(1) through (b)(2)(i) must—

(1) Be provided to the individual before submission of the disenrollment to CMS; and

(2) Include an explanation of the individual’s right to a hearing under the MA organization’s grievance procedures.

(d) Process for disenrollment. (1) Except as specified in paragraph (d)(1)(iv) of this section, an MA organization may disenroll an individual from the MA plan for failure to pay basic and supplemental premiums under the following circumstances:

(i) The MA organization can demonstrate to CMS that it made reasonable efforts to collect the unpaid premium amount, including:

(A) Alerting the individual that the premiums are delinquent;

(B) Providing the individual with a grace period, that is, an opportunity to pay past due premiums in full. The length of the grace period must—

(1) Be at least 2 months; and

(2) Begin on the first day of the month for which the premium is unpaid or the first day of the month following the date on which premium payment is requested, whichever is later.

(C) Advising the individual that failure to pay the premiums by the end of the grace period must—

(1) Be at least 2 months; and

(2) Begin on the first day of the month for which the premium is unpaid or the first day of the month following the date on which premium payment is requested, whichever is later.

(C) Advising the individual that failure to pay the premiums by the end of the grace period will result in termination of MA coverage.

(ii) The MA organization provides the enrollee with notice of disenrollment that meets the requirements set forth in paragraph (c) of this section.

(iii) If the enrollee fails to pay the premium for optional supplemental benefits but pays the basic premium and any mandatory supplemental premium, the MA organization has the option to discontinue the optional supplemental benefits and retain the individual as an MA enrollee.

(iv) An MA organization may not disenroll an individual who has monthly premiums withheld per §422.262(f)(1)
and (g) of this part, or who is in pre-

mium withhold status, as defined by

CMS.

(v) Extension of grace period for good
cause and reinstatement. When an indi-

vidual is disenrolled for failure to pay
the plan premium, CMS may reinstate
enrollment in the MA plan, without

interrupting coverage, if the individ-

ual shows good cause for failure to pay
within the initial grace period, and

pays all overdue premiums within 3

calendar months after the

disenrollment date. The individual

must establish by a credible statement

that failure to pay premiums within

the initial grace period was due to cir-

cumstances for which the individual

had no control, or which the individual

could not reasonably have been ex-

pected to foresee.

(vi) No extension of grace period. A

beneficiary’s enrollment in the MA

plan may not be reinstated if the only

basis for such reinstatement is a

change in the individual’s cir-

cumstances subsequent to the involun-

tary disenrollment for non-payment of

premiums.

(2) Disruptive behavior—(1) Definition

of disruptive behavior. An MA plan en-

rollee is disruptive if his or her behav-

ior substantially impairs the plan’s

ability to arrange for or provide serv-

ices to the individual or other plan

members. An individual cannot be con-

sidered disruptive if such behavior is

related to the use of medical services

or compliance (or noncompliance) with

medical advice or treatment.

(ii) Basis of disenrollment for disruptive

behavior. An organization may

disenroll an individual whose behavior

is disruptive as defined in 422.74(d)(2)(i)

only after it meets the requirements

described in this section and CMS has

reviewed and approved the request.

(iii) Effort to resolve the problem. The

MA organization must make a serious

effort to resolve the problems pre-

sented by the individual, including pro-

viding reasonable accommodations, as

determined by CMS, for individuals

with mental or cognitive conditions,

including mental illness and develop-

mental disabilities. In addition, the

MA organization must inform the indi-

vidual of the right to use the organiza-

tion’s grievance procedures. The bene-

ficiary has a right to submit any infor-

mation or explanation that he or she

may wish to the MA organization.

(iv) Documentation. The MA organiza-

tion must document the enrollee’s be-

havior, its own efforts to resolve any

problems, as described in paragraph

(iii), and any extenuating cir-

cumstances. The MA organization may

request from CMS the ability to de-

cline future enrollment by the indi-

vidual. The MA organization must sub-

mit this information and any docu-

mentation received by the beneficiary
to CMS.

(v) CMS review of the proposed
disenrollment. CMS will review the in-

formation submitted by the MA organi-

zation and any information submitted

by the beneficiary (which the MA orga-

nization must forward to CMS) to de-

termine if the MA organization has ful-

filled the requirements to request
disenrollment for disruptive behavior.

If the organization has fulfilled the

necessary requirements, CMS will re-

view the information and make a deci-

sion to approve or deny the request for
disenrollment, including conditions on
future enrollment, within 20 working
days. During the review, CMS will en-

sure that staff with appropriate clinical

or medical expertise review the case be-

fore making the final decision. The

MA organization will be required to

provide a reasonable accommodation,
as determined by CMS, for the indi-

vidual in such exceptional cir-

cumstances that CMS deems necessary.

CMS will notify the MA organization

within 5 working days after making its

decision.

(vi) Effective date of disenrollment. If

CMS permits an MA organization to
disenroll an individual for disruptive

behavior, the termination is effective

the first day of the calendar month

after the month in which the MA orga-
nization gives the individual notice of

the disenrollment that meets the re-
quirements set forth in paragraph (c) of

this section, unless otherwise deter-

mined by CMS.

(3) Individual commits fraud or permits

abuse of enrollment card—(1) Basis for
disenrollment. An MA organization may
disenroll the individual from an MA

plan if the individual—
(A) Knowingly provides, on the election form, fraudulent information that materially affects the individual’s eligibility to enroll in the MA plan; or

(B) Intentionally permits others to use his or her enrollment card to obtain services under the MA plan.

(ii) Notice of disenrollment. The MA organization must give the individual a written notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section.

(iii) Report to CMS. The MA organization must report to CMS any disenrollment based on fraud or abuse by the individual.

(4) Individual no longer resides in the MA plan’s service area—(i) Basis for disenrollment. Unless continuation of enrollment is elected under §422.54, the MA organization must disenroll an individual if the MA organization establishes, on the basis of a written statement from the individual or other evidence acceptable to CMS, that the individual has permanently moved—

(A) Out of the MA plan’s service area; or

(B) From the residence in which the individual resided at the time of enrollment in the MA plan to an area outside the MA plan’s service area, for those individuals who enrolled in the MA plan under the eligibility requirements at §422.50(a)(3)(ii) or (a)(4).

(ii) Special rule. If the individual has not moved from the MA plan’s service area (or residence, as described in paragraph (d)(4)(i)(B) of this section), but has left the service area (or residence) for more than 6 months, the MA organization must disenroll the individual from the plan, unless the exception in paragraph (d)(4)(iii) of this section applies.

(iii) Exception. If the MA plan offers a visitor/traveler benefit when the individual is out of the service area but within the United States (as defined in §400.200 of this chapter) for a period of consecutive days longer than 6 months but less than 12 months, the MA organization may elect to offer to the individual the option of remaining enrolled in the MA plan if—

(A) The individual is disenrolled on the first day of the 13th month after the individual left the service area (or residence, if paragraph (d)(4)(i)(B) of this section applies);

(B) The individual understands and accepts any restrictions imposed by the MA plan on obtaining these services while absent from the MA plan’s service area for the extended period, consistent with paragraph (d)(4)(i)(C) of the section;

(C) The MA organization makes this visitor/traveler option available to all Medicare enrollees who are absent for an extended period from the MA plan’s service area. MA organizations may limit this visitor/traveler option to enrollees who travel to certain areas, as defined by the MA organization, and who receive services from qualified providers who directly provide, arrange for, or pay for health care; and

(D) The MA organization furnishes all Medicare Parts A and B services and all mandatory and optional supplemental benefits at the same cost sharing levels as apply within the plan’s service area; and

(E) The MA organization furnishes the services in paragraph (d)(4)(ii)(D) of this section consistent with Medicare access and availability requirements at §422.112 of this part.

(iv) Notice of disenrollment. The MA organization must give the individual a written notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section.

(5) Loss of entitlement to Part A or Part B benefits. If an individual is no longer entitled to Part A or Part B benefits, CMS notifies the MA organization that the disenrollment is effective the first day of the calendar month following the last month of entitlement to Part A or Part B benefits.

(6) Death of the individual. If the individual dies, disenrollment is effective the first day of the calendar month following the month of death.

(7) Plan termination or area reduction. (i) When an MA organization has its contract for an MA plan terminated, terminates an MA plan, or discontinues offering the plan in any portion of the area where the plan had previously been available, the MA organization must give each affected MA plan enrollee a written notice of the effective
§ 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) of this section (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. CMS 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 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 Medicare-covered services, except hospice services.

(2) Supplemental benefits, which consist of:

(i) 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.

(ii) 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.