

§ 407.47, Nt.

42 CFR Ch. IV (10–1–23 Edition)

(d) *Application of general rule: Other individuals eligible for Medicaid.* For individuals who are not cash assistance beneficiaries, are not treated as cash assistance beneficiaries, and are not QMBs, coverage begins with the later of the following:

(1) The second month after the month in which the individual—

(i) Meets the SMI eligibility requirements specified in § 407.10; and

(ii) Is determined to be eligible for Medicaid.

(2) The month in which the buy-in agreement or agreement modification is effective.

(e) *Coverage based on erroneous report.* If the State erroneously reports to SSA that an individual is a member of its coverage group, the rules of paragraphs (a) through (d) of this section apply, and coverage begins as though the individual were in fact a member of the group. Coverage will end only as provided in § 407.48.

(f) [Reserved]

(g) *Part B enrollment under a buy-in agreement.* Individuals in a buy-in group can enroll in Part B at any time of the year, without regard to Medicare enrollment periods.

[56 FR 38082, Aug. 12, 1991, as amended at 87 FR 66508, Nov. 3, 2022]

EFFECTIVE DATE NOTE: At 87 FR 66508, Nov. 3, 2022, § 407.47 was amended by adding paragraph (f), effective Jan. 1, 2024. For the convenience of the user, the added text is set forth as follows:

§ 407.47 Beginning of coverage under a State buy-in agreement.

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(f) *Exception to the general rule: Limitations on retroactive adjustments in the case of retroactive Medicare Part A entitlement.* (1) In cases in which a Medicaid beneficiary is retroactively entitled to Medicare Part A, beginning with retroactive determinations made on or after January 1, 2024, State liability for retroactive Medicare Part B premiums for Medicaid beneficiaries under a buy-in agreement is limited to a period of no greater than 36 months prior to the date of the Medicare eligibility determination.

(2) The Secretary may grant good cause exceptions for periods of greater or less than 36 months if application of paragraph (f)(1) of the section would result in harm to a beneficiary or if the State cannot benefit from

Medicare and further limiting State liability would not result in harm to the beneficiary.

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§ 407.48 Termination of coverage under a State buy-in agreement.

An individual's coverage under a buy-in agreement terminates with the earliest of the following events:

(a) *Death.* Coverage ends on the last day of the month in which the individual dies.

(b) *Loss of entitlement to hospital insurance benefits before age 65.* If an individual loses entitlement to hospital insurance benefits before attaining age 65, coverage ends on the last day of the last month for which he or she is entitled to hospital insurance.

(c) *Loss of eligibility for the buy-in group.* If an individual loses eligibility for inclusion in the buy-in group, buy-in coverage ends as follows:

(1) On the last day of the last month for which he or she is eligible for inclusion in the buy-in group, if CMS determines ineligibility or receives a State ineligibility notice by a processing cut-off date as described in paragraph (e) of this section, by the second month after the month in which the individual becomes ineligible for inclusion in the buy-in group.

(2) On the last day of the second month before the month in which CMS receives a State ineligibility notice later than the time specified in paragraph (c)(1) of this section. If CMS receives a notice after the processing cut-off date conveyed under paragraph (e) of this section, CMS considers it to have been received the following month.

(d) *Termination or modification of buy-in agreement.* If the State's buy-in agreement is terminated, or modified to substitute a narrower buy-in group, coverage ends on the last day of the last month for which the agreement was in effect, or covered the broader buy-in group.

(e) *Processing cut-off dates for each calendar month.* On a quarterly basis, CMS is to prospectively convey to States a

schedule of processing cut-off dates for each calendar month.

[53 FR 47204, Nov. 22, 1988, as amended at 56 FR 38082, Aug. 12, 1991; 87 FR 66508, Nov. 3, 2022]

§ 407.50 Continuation of coverage: Individual enrollment following end of coverage under a State buy-in agreement.

(a) *Deemed enrollment.* When coverage under a buy-in agreement ends because the agreement terminates, or is modified to substitute a narrower buy-in group, or because the individual is no longer eligible for inclusion in the buy-in group, the individual—

(1) Is considered to have enrolled during his or her initial enrollment period; and

(2) Will be entitled to SMI on this basis and liable for SMI premiums beginning with the first month for which he or she is no longer covered under the buy-in agreement.

(b) *Voluntary termination.* (1) An individual may voluntarily terminate entitlement acquired under paragraph (a) of this section by filing, with SSA or CMS, a request for disenrollment.

(2) Voluntary disenrollment is effective as follows:

(i) If the individual files a request within 30 days after the date of CMS's notice that buy-in coverage has ended, the individual's entitlement ends on the last day of the last month for which the State paid the premium.

(ii) If the individual files the request more than 30 days but not more than 6 months after buy-in coverage ends, entitlement ends on the last day of the month in which the request is filed.

(iii) If the individual files the request later than the 6th month after buy-in coverage ends, entitlement ends at the end of the month after the month in which request is filed.¹

[53 FR 47204, Nov. 22, 1988, as amended at 56 FR 38082, Aug. 12, 1991]

¹For requests filed before July 1987, entitlement ended on the last day of the calendar quarter after the quarter in which the disenrollment request was filed.

**Subpart D—Part B
Immunosuppressive Drug Benefit**

SOURCE: 87 FR 66508, Nov. 3, 2022 unless otherwise noted.

§ 407.55 Eligibility to enroll.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, an individual is eligible to enroll, be deemed enrolled, or reenroll in the Part B-ID benefit if their Part A entitlement ends as described in § 406.13(f)(2) of this subchapter.

(b) *Exception.* An individual is not eligible for the Part B-ID benefit if the individual is enrolled in or for any of the following:

(1) A group health plan or group or individual health insurance coverage, as such terms are defined in section 2791 of the Public Health Service Act.

(2) Coverage under the TRICARE for Life program under section 1086(d) of title 10, United States Code.

(3) A State plan (or waiver of such plan) under title XIX and is eligible to receive benefits for immunosuppressive drugs described in section 1836(b) of the Act under such plan (or such waiver).

(4) A State child health plan (or waiver of such plan) under title XXI and is eligible to receive benefits for such drugs under such plan (or such waiver).

(5) The patient enrollment system of the Department of Veterans Affairs established and operated under section 1705 of title 38, United States Code and is either of the following:

(i) Not required to enroll under section 1705 of title 38 to receive immunosuppressive drugs described in section 1836(b) of the Act.

(ii) Otherwise eligible under a provision of title 38, United States Code, other than section 1710 of such title, to receive immunosuppressive drugs described in section 1836(b) of the Act.

(c) *Appeals.* Denials for enrollment in the Part B-ID benefit will be considered an initial determination that is appealable under § 405.904(a)(1) of this subchapter.