

§ 417.428 Marketing activities.

(a) With the exception of § 422.2276 of this chapter, the procedures and requirements relating to marketing requirements set forth in subpart V of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(b) In applying those provisions, references to part 422 of this chapter must be read as references to this part, and references to MA organizations as references to HMOs and CMPs.

[75 FR 19802, Apr. 15, 2010]

§ 417.430 Application procedures.

(a) *Application forms and other enrollment mechanisms.* (1) The application form must comply with CMS instructions regarding content and format and be approved by CMS as described in § 422.2262 of this chapter. The application must be completed by an HMO or CMP eligible (or soon to become eligible) individual and include authorization for disclosure between HHS and its designees and the HMO or CMP.

(2) The HMO or CMP must file and retain application forms for the period specified in CMS instructions.

(b) *Handling of applications.* An HMO or CMP must have an effective system for receiving, controlling, and processing applications from Medicare beneficiaries. The system must meet the following conditions and requirements:

(1) Each application is dated as of the day it is received.

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

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

(4) The notice of acceptance. If the HMO or CMP is currently enrolled to capacity, explains the procedures that will be followed when vacancies occur.

(5) The notice of denial explains the reason for denial.

(6) The HMO or CMP transmits the information necessary for CMS to add the beneficiary to its records of the HMO's or CMP's Medicare enrollees—

(i) Within 30 days from the date of application or from the date a vacancy occurs for an applicant who was ac-

cepted (for future enrollment) while there were no vacancies; or

(ii) Within an additional period of time approved by CMS on a showing by the HMO or CMP that it needs more time.

(7) The HMO or CMP promptly notifies the beneficiary of the effective month of his or her enrollment as a Medicare enrollee, when it receives that information from CMS.

(8) If the HMO or CMP accepts applications while it is enrolled to capacity, its procedures ensure that vacancies are filled in chronological order by date of application of beneficiaries who are still eligible to enroll, unless that would result in failure to comply with any of the qualifying conditions set forth in § 417.413.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 76 FR 21560, Apr. 15, 2011; 83 FR 16721, Apr. 16, 2018]

§ 417.432 Conversion of enrollment.

(a) *Basic rule.* An HMO or CMP must accept as a Medicare enrollee any individual who is enrolled in the HMO or CMP for the month immediately before the month in which he or she is entitled to both Medicare Parts A and B or Part B only.

(b) *Effective date of conversion.* Unless the individual chooses to disenroll from the HMO or CMP the individual's conversion to a Medicare enrollee is effective the month in which he or she is entitled to both Medicare Parts A and B or Part B only.

(c) *Prohibition against disenrollment.* An HMO or CMP may not disenroll an individual who is converting under the provisions of paragraph (a) of this section unless one of the conditions specified in § 417.460 is met.

(d) *Application form.* The individual who is converting must complete an application form or another CMS-approved election mechanism as described in § 417.430(a).

(e) *Expedited submittal of information to CMS.* The HMO or CMP must notify CMS, within the following time frames, of the enrollee's authorization for disclosure and exchange of information and the information necessary for CMS to include the enrollee in its records as

§ 417.434

42 CFR Ch. IV (10–1–23 Edition)

a Medicare enrollee of the HMO or CMP:

(1) At least 30, but no earlier than 90, days before the enrollee—

(i) Attains age 65; or

(ii) Reaches his or her 25th month of entitlement to social security disability benefits under title II of the Act or railroad retirement disability benefits under section 7(d) of the Railroad Retirement Act of 1974.

(2) Within 30 days after the enrollee initiates a course of renal dialysis, or on or before the day he or she enters a hospital in anticipation of a kidney transplant.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 46570, Sept. 13, 1991; 58 FR 38082, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 77 FR 22166, Apr. 12, 2012]

§ 417.434 Reenrollment.

If an HMO or CMP requires periodic reenrollment, it must reenroll Medicare enrollees unless there is a basis for disenrollment as set forth in § 417.460.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

§ 417.436 Rules for enrollees.

(a) *Maintaining rules.* An HMO or CMP must maintain written rules that deal with, but need not be limited to the following:

(1) All benefits provided under the contract, as described in § 417.440.

(2) How and where to obtain services from or through the HMO or CMP.

(3) The restrictions on coverage for services furnished from sources outside a risk HMO or CMP, other than emergency services and urgently needed services (as defined in § 417.401).

(4) The obligation of the HMO or CMP to assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services as required by § 417.414(c).

(5) Any services other than the emergency or urgently needed services that the HMO or CMP chooses to provide as permitted by this part, from sources outside the HMO or CMP. A cost HMO or CMP must disclose that the enrollee may receive services through any Medicare providers and suppliers.

(6) Premium information, including the amount (or if the amount cannot be included, the telephone number of the source from which this information may be obtained) and the procedures for paying premiums and other charges for which enrollees may be liable.

(7) Grievance and appeal procedures.

(8) Disenrollment rights.

(9) The obligation of an enrollee who is leaving the HMO's or CMP's geographic area for more than 90 days to notify the HMO or CMP of the move or extended absence and the HMO's or CMP's policies concerning retention of enrollees who leave the geographic area for more than 90 days, as described in § 417.460(a)(2).

(10) The expiration date of the Medicare contract with CMS and notice that both CMS and the HMO or CMP are authorized by law to terminate or refuse to renew the contract, and that termination or nonrenewal of the contract may result in termination of the individual's enrollment in the HMO or CMP.

(11) Advance directives as specified in paragraph (d) of this section.

(12) Any other matters that CMS may prescribe.

(b) *Availability of rules.* The HMO or CMP must furnish a copy of the rules to each Medicare enrollee at the time of enrollment and at least annually thereafter.

(c) *Changes in rules.* If an HMO or CMP changes its rules, it must submit the changes to CMS in accordance with § 417.428(a)(3), and notify its Medicare enrollees of the changes at least 30 days before the effective date of the changes.

(d) *Advance directives.* (1) An HMO or CMP must maintain written policies and procedures concerning advance directives, as defined in § 489.100 of this chapter, with respect to all adult individuals receiving medical care by or through the HMO or CMP and are required to:

(i) Provide written information to those individuals concerning—

(A) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning such