

those specified in § 417.452. It includes amounts collected when the enrollee was believed not entitled to Medicare benefits if the enrollee is later determined to have been entitled to Medicare benefits and CMS is liable for payments as specified in § 417.450.

Other amounts due means amounts due a Medicare enrollee for services obtained outside the HMO or CMP if they were—

- (1) Emergency services;
- (2) Urgently needed services for which the HMO or CMP has assumed financial responsibility; or
- (3) On appeal under subpart Q of this part, found to be services the enrollee was entitled to have furnished by the HMO or CMP.

(b) *Basic commitment.* An HMO or CMP must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and any other amounts due the enrollees or others on their behalf.

(c) *Refund by lump sum payment.* An HMO or CMP must make refunds to its current and former Medicare enrollees, or to others who have made payments on behalf of enrollees, by lump sum payment for the following:

- (1) Incorrectly collected amounts that were not collected as premiums.
- (2) Other amounts due.
- (3) All amounts due, if the HMO or CMP is going out of business.

(d) *Refund by premium adjustment or lump sum payment or both.* An HMO or CMP may make refund by adjustment of future premiums, by lump sum payment, or by a combination of both methods, for amounts that were incorrectly collected in the form of premiums or through a combination of premium payments and other charges.

(e) *Refund when enrollee has died or cannot be located.* If an enrollee has died or cannot be located after reasonable effort by the HMO or CMP, the HMO or CMP must make the refund in accordance with State law.

(f) *Reduction by CMS.* If the HMO or CMP does not make refund in accordance with paragraphs (b) through (d) of this section by the end of the contract period following the contract period during which an amount was determined to be due an enrollee, CMS re-

duces its payment to the HMO or CMP by the amounts incorrectly collected or otherwise due, and arranges for those amounts to be paid to the Medicare enrollee.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

§ 417.458 Recoupment of uncollected deductible and coinsurance amounts.

An HMO or CMP agrees not to recoup deductible and coinsurance amounts for which Medicare enrollees were liable in a previous contract period except in the following circumstances:

(a) The HMO or CMP failed to collect the deductible and coinsurance amounts during the contract period in which they were due because of—

- (1) Underestimation of the actuarial value of the deductible and coinsurance amounts; or
- (2) A billing error.

(b) The HMO or CMP has identified the amounts and obtained advance CMS approval of the recoupment and the method and timing of recoupment.

(c) The HMO or CMP collects these amounts no later than the end of the contract period following the contract period during which they were found to be due.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 45678, Sept. 1, 1995]

§ 417.460 Disenrollment of beneficiaries by an HMO or CMP.

(a) *General rule.* Except as provided in paragraphs (b) through (i) of this section, an HMO or CMP may not—

(1) Disenroll a Medicare beneficiary; or

(2) Orally or in writing, or by any action or inaction, request or encourage a Medicare enrollee to disenroll.

(b) *Bases for disenrollment: Overview—*

(1) *Optional disenrollment.* Generally, an HMO or CMP may disenroll a Medicare enrollee if he or she—

- (i) Fails to pay the required premiums or other charges;
- (ii) Commits fraud or permits abuse of his or her enrollment card; or
- (iii) Behaves in a manner that seriously impairs the HMO's or CMP's ability to furnish health care services to

the particular enrollee or to other enrollees.

(2) *Required disenrollment.* Generally, an HMO or CMP must disenroll a Medicare enrollee if he or she—

(i) Moves out of the HMO's or CMP's geographic service area or is incarcerated;

(ii) Fails to convert to the risk provisions of the HMO's or CMP's Medicare contract;

(iii) Loses entitlement to Medicare Part B benefits;

(iv) Is not lawfully present in the United States; or

(v) Dies.

(3) *Related provisions.* Specific requirements, limitations, and exceptions are set forth in paragraphs (c) through (j) of this section.

(c) *Failure to pay premiums or other charges—*(1) *Basic rule.* Except as specified in paragraph (c)(2) of this section, an HMO or CMP may disenroll a Medicare enrollee who fails to pay premiums or other charges imposed by the HMO or CMP for deductible and coinsurance amounts for which the enrollee is liable, if the HMO or CMP—

(i) Can demonstrate to CMS that it made reasonable efforts to collect the unpaid amount;

(ii) Gives the enrollee written notice of disenrollment, including an explanation of the enrollee's right to a hearing under the HMO's or CMP's grievance procedures; and

(iii) Sends the notice of disenrollment to the enrollee before it notifies CMS.

(2) *Exception.* If the enrollee fails to pay the premium for optional supplemental benefits (that is, a package of benefits that an enrollee is not required to accept), but pays the basic premium and other charges, the HMO or CMP may discontinue the optional benefits but may not disenroll the beneficiary.

(3) *Good cause and reinstatement.* When an individual is disenrolled for failure to pay premiums or other charges imposed by the HMO or CMP for deductible and coinsurance amounts for which the enrollee is liable, CMS (or a third party to which CMS has assigned this responsibility, such as an HMO or CMP) may reinstate enrollment in the plan, without inter-

ruption of coverage, if the individual shows good cause for failure to pay and pays all overdue premiums or other charges within 3 calendar months after the disenrollment date. The individual must establish by a credible statement that failure to pay premiums or other charges was due to circumstances for which the individual had no control, or which the individual could not reasonably have been expected to foresee.

(4) *Exception for reinstatement.* A beneficiary's enrollment in the plan will not be reinstated if the only basis for such reinstatement is a change in the individual's circumstances subsequent to the involuntary disenrollment for non-payment of premiums or other charges.

(d) *Enrollee commits fraud or permits abuse of the enrollment card—*(1) *Basis for disenrollment.* An HMO or CMP may disenroll a Medicare beneficiary if the beneficiary—

(i) Knowingly provides, on the application form, fraudulent information that materially affects the beneficiary's eligibility to enroll in the HMO or CMP; or

(ii) Intentionally permits others to use his or her enrollment card to obtain services from the HMO or CMP.

(2) *Notice requirement.* If disenrollment is for either of the reasons specified in paragraph (d)(1) of this section, the HMO or CMP must give the beneficiary a written notice of termination of enrollment.

(i) The notice must be mailed to the enrollee before submission of the disenrollment notice to CMS.

(ii) The notice must include an explanation of the enrollee's right to have the disenrollment heard under the grievance procedures established in accordance with § 417.436.

(3) *Report to the Inspector General.* The HMO or CMP must report to the Office of the Inspector General of the Department any disenrollment based on fraud or abuse by the enrollee.

(e) *Disenrollment for cause—*(1) *Basis for disenrollment.* An HMO or CMP may disenroll a Medicare enrollee for cause if the enrollee's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continuing

enrollment in the HMO or CMP seriously impairs the HMO's or CMP's ability to furnish services to either the particular enrollee or other enrollees.

(2) *Effort to resolve the problem.* The HMO or CMP must make a serious effort to resolve the problem presented by the enrollee, including the use (or attempted use) of internal grievance procedures.

(3) *Consideration of extenuating circumstances.* The HMO or CMP must ascertain that the enrollee's behavior is not related to the use of medical services or to mental illness.

(4) *Documentation.* The HMO or CMP must document the problems, efforts, and medical conditions as described in paragraphs (e)(1) through (e)(3) of this section.

(5) *CMS review of an HMO's or CMP's proposed disenrollment for cause.* (i) CMS decides on the basis of review of the documentation submitted by the HMO or CMP, whether disenrollment requirements have been met.

(ii) CMS makes this decision within 20 working days after receipt of the documentation material, and notifies the HMO or CMP within 5 working days after making its decision.

(6) *Effective date of disenrollment.* If CMS permits an HMO or CMP to disenroll an enrollee for cause, the disenrollment takes effect on the first day of the calendar month after the month in which the HMO or CMP gives the enrollee a written notice of disenrollment that meets the requirements set forth in paragraphs (d)(2)(i) and (d)(2)(ii) of this section.

(f) *Enrollee moves out of the HMO's or CMP's geographic area—(1) Basic rules—*

(i) *Disenrollment.* Except as provided in paragraph (f)(2) of this section, an HMO or CMP must disenroll a Medicare enrollee who moves out of its geographic area if the HMO or CMP establishes, on the basis of a written statement from the enrollee, or other evidence acceptable to CMS, that the enrollee has permanently moved out of its geographic area.

(A) *Incarceration.* The HMO or CMP must disenroll an individual if the HMO or CMP establishes, on the basis of evidence acceptable to CMS, that the individual is incarcerated and does

not reside in the geographic service area of the HMO or CMP per §417.1.

(B) *Notification by CMS of incarceration.* When CMS notifies an HMO or CMP of disenrollment due to the individual being incarcerated and not residing in the geographic service area of the HMO or CMP, as per §417.1, the disenrollment is effective the first of the month following the start of incarceration, unless otherwise specified by CMS.

(C) *Exception.* The exception in paragraph (f)(2) of this section does not apply to individuals who are incarcerated.

(ii) *Notice requirement.* The HMO or CMP must comply with the notice requirements set forth in paragraph (d)(2) of this section.

(iii) *Effect on geographic area.* Failure to disenroll an enrollee who has moved out of the HMO's or CMP's geographic area does not expand that area to encompass the location of the enrollee's new residence.

(2) *Exception.* An HMO or CMP may retain a Medicare enrollee who is absent from its geographic area for an extended period, but who remains within the United States as defined in §400.200 of this chapter if the enrollee agrees. For purposes of this exception, the following provisions apply:

(i) An absence for an extended period means an uninterrupted absence from the HMO's or CMP's geographic area for more than 90 days but less than 1 year.

(ii) The HMO or CMP and the enrollee may mutually agree upon restrictions for obtaining services while the enrollee is absent for an extended period from the HMO's or CMP's geographic area. However, restrictions may not be imposed on the scope of services described in §417.440.

(iii) HMOs and CMPs that choose to exercise this exception must make the option available to all Medicare enrollees who are absent for an extended period from their geographic areas. However, HMOs and CMPs may limit this option to enrollees who go to a geographic area served by an affiliated HMO or CMP.

(iv) As used in this paragraph, "affiliated HMO or CMP" means an HMO or CMP that—

(A) Is under common ownership or control of the HMO or CMP that seeks to retain the absent enrollees; or

(B) Has in effect an agreement to furnish services to enrollees who are on an extended absence from the geographic area of the HMO or CMP that seeks to retain them.

(v) When the enrollee returns to the HMO's or CMP's geographic area (even temporarily), the restrictions of § 417.448(a) (which limit payment for services not provided or arranged for by the HMO or CMP) apply again immediately.

(vi) If the enrollee fails to return to the HMO's or CMP's geographic area within 1 year from the date he or she left that area, the HMO or CMP must disenroll the beneficiary on the first day of the month following the anniversary of the date the enrollee left that area in accordance with paragraph (f)(1) of this section.

(g) *Failure to convert to risk provisions of Medicare contract*—(1) *Basis for disenrollment.* A risk HMO or CMP must disenroll a nonrisk Medicare enrollee who refuses to convert to the risk provisions of the Medicare contract after CMS determines that all of the HMO's or CMP's nonrisk Medicare enrollees must convert.

(2) *Advance notice requirement.* At least 30 days before it gives CMS notice of disenrollment, the HMO or CMP must give the enrollee written notice of the fact that failure to convert will result in disenrollment.

(h) *Loss of entitlement to Medicare benefits*—(1) *Loss of entitlement to Part A benefits.* If an enrollee loses entitlement to benefits under Part A of Medicare but remains entitled to benefits under Part B, the enrollee automatically continues as a Medicare enrollee of the HMO or CMP and is entitled to receive and have payment made for Part B services, beginning with the month immediately following the last month of his or her entitlement to Part A benefits.

(2) *Loss of entitlement to Part B benefits.* If a Medicare enrollee loses entitlement to Part B benefits, the HMO or CMP must disenroll him or her as a Medicare enrollee effective with the month following the last month of entitlement to Part B benefits. However,

the HMO or CMP may continue to enroll the individual under its regular plan if the individual so chooses.

(i) *Death of the enrollee.* Disenrollment is effective with the month following the month of death.

(j) *Enrollee is not lawfully present in the United States.* Disenrollment is effective the first day of the month following notice by CMS that the individual is ineligible in accordance with § 417.422(h).

[60 FR 45678, Sept. 1, 1995, as amended at 77 FR 22166, Apr. 12, 2012; 79 FR 29955, May 23, 2014; 80 FR 7958, Feb. 12, 2015]

§ 417.461 Disenrollment by the enrollee.

(a) *Request for disenrollment.* (1) A Medicare enrollee who wishes to disenroll may at any time give the HMO or CMP a signed, dated request in the form and manner prescribed by CMS.

(2) The enrollee may request a certain disenrollment date but it may be no earlier than the first day of the month following the month in which the HMO or CMP receives the request.

(b) *Responsibilities of the HMO or CMP.* The HMO or CMP must—

(1) Submit a disenrollment notice to CMS promptly;

(2) Provide the enrollee with a copy of the request for disenrollment; and

(3) In the case of a risk HMO or CMP, also provide the enrollee with a statement explaining that he or she—

(i) Remains enrolled until the effective date of disenrollment; and

(ii) Until that date, is subject to the restrictions of § 417.448(a) under which neither the HMO or CMP nor CMS pays for services not provided or arranged for by the HMO or CMP.

(c) *Effect of failure to submit disenrollment notice to CMS promptly.* If the HMO or CMP fails to submit timely the correct and complete notice required in paragraph (b)(1) of this section, the HMO or CMP must reimburse CMS for any capitation payments received after the month in which payments would have ceased if the requirement had been met timely.

[60 FR 45679, Sept. 1, 1995]