

who meets the qualifications specified in § 410.74(c) of this chapter, or a nurse practitioner as defined in section 1861(aa)(5)(A) of the Act and who meets the qualifications specified in § 410.75(b)(1)(i) and (ii) of this chapter to confirm that the applicant has the qualifying condition(s). The organization must obtain this information in one of the following two ways described in paragraph (f)(1)(i) or (ii) of this section:

(i) Contact the current health care provider or current health care provider's office and obtain verification of the applicant's condition(s) prior to enrollment in a form and manner authorized by CMS.

(ii) Through an assessment with the enrollee using a pre-enrollment qualification assessment tool (PQAT) where the assessment and the information gathered are verified (as described in paragraph (f)(1)(iii) of this section) before the end of the first month of enrollment in the C-SNP. Use of a PQAT requires the following:

(A) The PQAT must do all of the following:

(1) Include clinically appropriate questions relevant to the chronic condition(s) on which the C-SNP focuses.

(2) Gather sufficient reliable evidence of having the applicable condition using the applicant's past medical history, current signs or symptoms, and current medications.

(3) Include the date and time of the assessment completion if done face-to-face with the applicant, or the receipt date if the C-SNP receives the completed PQAT by mail or by electronic means (if available).

(4) Include a signature line for and, once completed, be signed by the current health care provider specified in paragraph (f)(1) of this section to confirm the individual's eligibility for C-SNP enrollment.

(B) The C-SNP conducts a post-enrollment confirmation of each enrollee's information and eligibility by having the completed PQAT reviewed and signed by the enrollee's current health care provider as specified in paragraph (f)(1) of this section.

(C) The C-SNP must include the information gathered in the PQAT and used in this verification process in its

records related to or about the enrollee that are subject to the confidentiality requirements in § 422.118.

(D)(1) The C-SNP tracks the total number of enrollees and the number and percent by condition whose post-enrollment verification matches the pre-enrollment assessment.

(2) Data and supporting documentation are made available upon request by CMS.

(E) If the organization does not obtain verification of the enrollees' required chronic condition(s) by the end of the first month of enrollment in the C-SNP, the organization must—

(1) Disenroll the enrollee as of the end of the second month of enrollment; and

(2) Send the enrollee notice of the disenrollment within the first 7 calendar days of the second month of enrollment.

(F) The organization must maintain the enrollment of the individual if verification of the required condition(s) is obtained at any point before the end of the second month of enrollment.

(iii) Prior to enrollment, the PQAT must be completed by the enrollee, completed by the enrollee's current health care provider, or administered with the enrollee by a provider employed or contracted by the plan. The PQAT must be signed by the enrollee's current health care provider as verification and confirmation that the enrollee has the severe or disabling chronic condition required to be eligible for the C-SNP, which may be done post-enrollment.

(2) [Reserved]

(g) *Special eligibility rule for certain C-SNPs.* For C-SNPs that use a group of multiple severe or disabling chronic conditions as described in § 422.4(a)(1)(iv) of this chapter, special needs individuals need only have one of the qualifying severe or disabling chronic conditions in order to be eligible to enroll.

[70 FR 4716, Jan. 28, 2005, as amended at 74 FR 1541, Jan. 12, 2009; 85 FR 33901, June 2, 2020; 89 FR 30814, Apr. 23, 2024]

§ 422.53 Eligibility to elect an MA plan for senior housing facility residents.

(a) *Basic eligibility requirements.* To be eligible to elect an MA senior housing facility plan, the individual must meet both of the following:

(1) Be a resident of an MA senior housing facility defined in § 422.2.

(2) Be eligible to elect an MA plan under § 422.50.

(b) *Restricting enrollment.* An MA senior housing facility plan must restrict enrollment to only those individuals who reside in a continuing care retirement community as defined at § 422.133(b)(2).

(c) *Establishing eligibility for enrollment.* An MA senior housing facility plan must verify the eligibility of each individual enrolling in its plan using a CMS approved process.

[76 FR 21561, Apr. 15, 2011]

§ 422.54 Continuation of enrollment for MA local plans.

(a) *Definition.* *Continuation area* means an additional area (outside the service area) within which the MA organization offering a local plan furnishes or arranges to furnish services to its continuation-of-enrollment enrollees. Enrollees must reside in a continuation area on a permanent basis. A continuation area does not expand the service area of any MA local plan.

(b) *Basic rule.* An MA organization may offer a continuation of enrollment option to MA local plan enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the MA organization as a continuation area. The intent to no longer reside in an area and permanently live in another area is verified through documentation that establishes residency, such as a driver's license or voter registration card.

(c) *General requirements.* (1) An MA organization that wishes to offer a continuation of enrollment option must meet the following requirements:

(i) Obtain CMS's approval of the continuation area, the communication materials that describe the option, and the MA organization's assurances of access to services.

(ii) Describe the option(s) in the member materials it offers and make the option available to all MA local plan enrollees residing in the continuation area.

(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 communication materials.

(e) *Capitation payments.* CMS's capitation payments to all MA organizations, for all Medicare enrollees, are based on