

change in coverage is effective the first day of the calendar month following the month in which the election is made, unless otherwise noted.

(e) *Special election period for individual age 65.* For an election of coverage under original Medicare made during a special election period for an individual age 65 as described in § 422.62(c), coverage is effective as of the first day of the first calendar month following the month in which the election is made.

(f) *Annual 45-day period for disenrollment from MA plans to Original Medicare.* Through 2018, an election made from January 1 through February 14 to disenroll from an MA plan to Original Medicare, as described in § 422.62(a)(5), is effective the first day of the first month following the month in which the election is made.

[63 FR 35071, June 26, 1998, as amended at 65 FR 40317, June 29, 2000; 67 FR 13288, Mar. 22, 2002; 70 FR 4718, Jan. 28, 2005; 76 FR 21562, Apr. 15, 2011; 83 FR 16724, Apr. 16, 2018; 85 FR 33903, June 2, 2020]

#### § 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).

(v) The individual is not lawfully present in the United States.

(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 supplementary 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 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 had monthly premiums withheld per § 422.262(f)(1)

and (g) of this part, or who is in premium withhold status, as defined by CMS.

(v) *Extension of grace period for good cause and reinstatement.* When an individual is disenrolled for failure to pay the plan premium, CMS (or a third party to which CMS has assigned this responsibility, such as an MA organization) may reinstate enrollment in the MA plan, without interruption of coverage, if the individual—

(A) Shows good cause for failure to pay within the initial grace period; and

(B) Pays all overdue premiums within 3 calendar months after the disenrollment date; and

(C) Establishes by a credible statement that failure to pay premiums within the initial grace period was due to circumstances for which the individual had no control, or which the individual could not reasonably have been expected 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 circumstances subsequent to the involuntary disenrollment for non-payment of premiums.

(2) *Disruptive behavior*—(i) *Definition of disruptive behavior.* An MA plan enrollee is disruptive if his or her behavior substantially impairs the plan's ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered 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 presented by the individual, including providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities. In addition, the

MA organization must inform the individual of the right to use the organization's grievance procedures. The beneficiary has a right to submit any information or explanation that he or she may wish to the MA organization.

(iv) *Documentation.* The MA organization must document the enrollee's behavior, its own efforts to resolve any problems, as described in paragraph (iii), and any extenuating circumstances. The MA organization may request from CMS the ability to decline future enrollment by the individual. The MA organization must submit this information and any documentation received by the beneficiary to CMS.

(v) *CMS review of the proposed disenrollment.* CMS will review the information submitted by the MA organization and any information submitted by the beneficiary (which the MA organization must forward to CMS) to determine if the MA organization has fulfilled the requirements to request disenrollment for disruptive behavior. If the organization has fulfilled the necessary requirements, CMS will review the information and make a decision to approve or deny the request for disenrollment, including conditions on future enrollment, within 20 working days. During the review, CMS will ensure that staff with appropriate clinical or medical expertise review the case before making the final decision. The MA organization will be required to provide a reasonable accommodation, as determined by CMS, for the individual in such exceptional circumstances 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 organization gives the individual notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section, unless otherwise determined by CMS.

(3) *Individual commits fraud or permits abuse of enrollment card—(i) 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 is incarcerated as specified in paragraph (d)(4)(v) of this section.

(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)(iii)(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.

(v) *Incarceration.* (A) The MA organization must disenroll an individual if the MA organization establishes, on the basis of evidence acceptable to CMS, that the individual is incarcerated and does not reside in the service area of the MA plan as specified at § 422.2 or when notified of the incarceration by CMS as specified in paragraph (d)(4)(v)(B) of this section.

(B) *Notification by CMS of incarceration.* When CMS notifies the MA organization of the disenrollment due to the individual being incarcerated and not residing in the service area of the MA plan as per § 422.2, disenrollment is effective the first of the month following the start of incarceration, unless otherwise specified by CMS.

(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 date of the plan termination or area reduction and a description of alternatives for obtaining benefits under the MA program.

(ii) The notice must be sent before the effective date of the plan termination or area reduction, and in the timeframes specified in § 422.506(a)(2).

(8) *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) of this chapter.

(e) *Consequences of disenrollment—*(1) *Disenrollment for non-payment of premiums, disruptive behavior, fraud or abuse, loss of Part A or Part B.* An individual who is disenrolled under paragraph (b)(1)(i), (b)(1)(ii), (b)(1)(iii), or paragraph (b)(2)(ii) of this section is deemed to have elected original Medicare.

(2) *Disenrollment based on plan termination, area reduction, or individual moves out of area.* (i) An individual who is disenrolled under paragraph (b)(2)(i) or (b)(3) of this section has a special election period in which to make a new election as provided in § 422.62(b)(1) and (b)(2).

(ii) An individual who fails to make an election during the special election

period is deemed to have elected original Medicare.

[63 FR 35071, June 26, 1998; 63 FR 52612, Oct. 1, 1998, as amended at 65 FR 40318, June 29, 2000; 68 FR 50855, Aug. 22, 2003; 70 FR 4718, Jan. 28, 2005; 74 FR 1541, Jan. 12, 2009; 75 FR 19804, Apr. 15, 2010; 76 FR 21562, Apr. 15, 2011; 79 FR 29955, May 23, 2014; 80 FR 7959, Feb. 12, 2015]

### Subpart C—Benefits and Beneficiary Protections

SOURCE: 63 FR 35077, June 26, 1998, unless otherwise noted.

#### § 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)(1) of this section (except that additional telehealth benefits may be, but are not required to be, offered by the MA plan) and, to the extent applicable, supplemental benefits as described in paragraph (c)(2) of this section, by furnishing the benefits directly or through arrangements, or by paying for the benefits. CMS reviews these benefits subject to the requirements of this section 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 en-

rollee 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 items and services (other than hospice care or, beginning in 2021, coverage for organ acquisitions for kidney transplants) for which benefits are available under Parts A and B of Medicare, including additional telehealth benefits offered consistent with the requirements at § 422.135.

(2) Supplemental benefits are benefits offered under § 422.102.

(i) Supplemental benefits consist of—

(A) 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.

(B) 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.

(ii) Supplemental benefits must meet the following requirements:

(A) Except in the case of special supplemental benefit for the chronically ill (SSBCI) offered in accordance with § 422.102(f) that are not primarily health related, the benefits diagnose, prevent, or treat an illness or injury; compensate for physical impairments; act to ameliorate the functional/psychological impact of injuries or health conditions; or reduce avoidable emergency and health care utilization;