

A times B divided by C where—

A is the total estimated January payments to all organizations subject to the assessment;

B is the 9-month (January through September) assessment period; and

C is the total fiscal year M+C user fee assessment amount determined in accordance with paragraph (d)(2) of this section.

(2) CMS determines each organization's pro rata share of the annual fee on the basis of the organization's calculated monthly payment amount during the 9 consecutive months beginning with January. CMS calculates each organization's monthly pro rata share by multiplying the established percentage rate by the total monthly calculated Medicare payment amount to the organization as recorded in CMS's payment system on the first day of the month.

(3) CMS deducts the organization's fee from the amount of Federal funds otherwise payable to the organization for that month under the M+C program.

(4) If assessments reach the amount authorized for the year before the end of September, CMS discontinues assessment.

(5) If there are delays in determining the amount of the annual aggregate fees specified in paragraph (d)(2) of this section, or the fee percentage rate specified in paragraph (f)(2), CMS may adjust the assessment time period and the fee percentage amount.

[65 FR 40315, June 29, 2000]

Subpart B—Eligibility, Election, and Enrollment

SOURCE: 63 FR 35071, June 26, 1998, unless otherwise noted.

§ 422.50 Eligibility to elect an M+C plan.

(a) An individual is eligible to elect an M+C plan if he or she—

(1) Is entitled to Medicare under Part A and enrolled in Part B (except that an individual entitled only to Part B and who was enrolled in an HMO or CMP with a risk contract under part 417 of this chapter on December 31, 1998 may continue to be enrolled in the M+C organization as an M+C plan enrollee);

(2) Has not been medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in an M+C plan or in a health plan offered by the M+C organization is eligible to elect an M+C plan offered by that organization;

(3) Meets either of the following residency requirements:

(i) Resides in the service area of the M+C plan.

(ii) Resides outside of the service area of the M+C plan and is enrolled in a health plan offered by the M+C organization during the month immediately preceding the month in which the individual is entitled to both Medicare Part A and Part B, provided that an M+C organization chooses to offer this option and that CMS determines that all applicable M+C access requirements of § 422.112 are met for that individual through the M+C plan's established provider network. The M+C organization must furnish the same benefits to these enrollees as to enrollees who reside in the service area;

(4) Has been a member of an Employer Group Health Plan (EGHP) that includes the elected M+C plan, even if the individual lives outside of the M+C plan service area, provided that an M+C organization chooses to offer this option and that CMS determines that all applicable M+C access requirements at § 422.12 are met for that individual through the M+C plan's established provider network. The M+C organization must furnish the same benefits to all enrollees, regardless of whether they reside in the service area;

(5) Completes and signs an election form and gives information required for enrollment; and

(6) Agrees to abide by the rules of the M+C organization after they are disclosed to him or her in connection with the election process.

(b) An M+C eligible individual may not be enrolled in more than one M+C plan at any given time.

[63 FR 35071, June 26, 1998; 63 FR 52611, Oct. 1, 1998, as amended at 65 FR 40316, June 29, 2000]

§ 422.54 Continuation of enrollment.

(a) *Definition.* Continuation area means an additional area (outside the

service area) within which the M+C organization furnishes or arranges for furnishing 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 plan.

(b) *Basic rule.* An M+C organization may offer a continuation of enrollment option to enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the M+C organization as a continuation of enrollment 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, driver's license, voter registration.

(c) *General requirements.* (1) An M+C 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 marketing materials that describe the option, and the M+C 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 enrollees residing in the continuation area.

(2) An enrollee who moves out of the service area into the geographic area designated as the continuation area has the choice of continuing enrollment or disenrolling from the 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 M+C organization must, at a minimum, provide or arrange for the Medicare-covered benefits as described in § 422.101(a).

(2) *Reasonable access.* The M+C 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 M+C plan's service area (in which the enrollee no longer resides).

(4) *Protection of enrollee rights.* An M+C 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 marketing materials.

(e) *Capitation payments.* CMS's capitation payments to all M+C organizations, for all Medicare enrollees, are based on rates established on the basis of the enrollee's permanent residence, regardless of where he or she receives services.

[63 FR 35071, June 26, 1998; 63 FR 52611, Oct. 1, 1998, as amended at 65 FR 40316, June 29, 2000]

§ 422.56 Limitations on enrollment in an M+C MSA plan.

(a) *General.* An individual is not eligible to elect an M+C MSA plan—

(1) If the number of individuals enrolled in M+C MSA plans has reached 390,000;

(2) Unless the individual provides assurances that are satisfactory to CMS that he or she will reside in the United States for at least 183 days during the year for which the election is effective; or

(3) On or after January 1, 2003, unless the enrollment is the continuation of an enrollment in effect as of that date.

(b) *Individuals eligible for or covered under other health benefits program.* An individual who is enrolled in a Federal Employee Health Benefit plan under 5 U.S.C. chapter 89, or is eligible for health care benefits through the Veteran's Administration under 10 U.S.C.