

paid for under part 412 of this chapter, the HMO or CMP—

(1) Is not responsible for the provision of any of the inpatient hospital services under Part A during the stay and is not required to pay for those services;

(2) Must assume responsibility for payment for or provision of inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay; and

(3) Is responsible for the full scope of services under paragraph (b) of this section, other than inpatient hospital services under Part A, beginning on the effective date of enrollment.

(e) *Extension of provision of inpatient hospital services.* If an enrollee's effective date of disenrollment, as defined by § 417.460, occurs during an inpatient stay in a hospital paid for under part 412 of this chapter and the stay is provided or arranged for by the HMO or CMP, or the HMO or CMP is financially responsible for the hospitalization under paragraph (a)(2) of this section, the HMO or CMP—

(1) Is financially responsible for payment of the inpatient services under Part A through the date the beneficiary is discharged from the inpatient stay; and

(2) Is not responsible for the provision of services, furnished on or after the effective date of disenrollment, other than inpatient hospital services under Part A.

(f) *Notice of noncoverage of inpatient hospital care.* (1) If an enrollee is an inpatient of a hospital, entitlement to inpatient hospital care continues until he or she receives notice of noncoverage of that care.

(2) Before giving notice of noncoverage, the HMO or CMP must obtain the concurrence of its affiliated physician responsible for the hospital care of the enrollee, or other physician as authorized by the HMO or CMP.

(3) The HMO or CMP must give the enrollee written notice that includes the following:

(i) The reason why inpatient hospital care is no longer needed.

(ii) The effective date of the enrollee's liability for continued inpatient care.

(iii) The enrollee's appeal rights.

(4) If the HMO or CMP delegates to the hospital the determination of non-coverage of inpatient care, the hospital obtains the concurrence of the HMO- or CMP-affiliated physician responsible for the hospital care of the enrollee, or other physician as authorized by the HMO or CMP, and sends notice, following the procedures set forth in § 412.42(c)(3) of this chapter.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 52 FR 8901, Mar. 20, 1987; 58 FR 38079, July 15, 1993; 59 FR 59941, Nov. 21, 1994; 60 FR 45678, Sept. 1, 1995; 70 FR 4525, Jan. 28, 2005]

§ 417.442 Risk HMO's and CMP's: Conditions for provision of additional benefits.

(a) *General rule.* Except as provided in paragraph (b) of this section, a risk HMO or CMP must, during any contract period, provide to its Medicare enrollees the additional benefits described in § 417.440(b)(4) if its ACRs (calculated in accordance with § 417.594) are less than the average per capita rates that CMS pays for the Medicare enrollees during the contract period.

(b) *Exceptions—(1) Reduced payment election.* An HMO or CMP is not obligated to furnish additional services under paragraph (a) of this section if it has requested a reduction in its monthly payment from CMS under § 417.592(e), and it—

(i) Elects to receive reduced payment so that there is no difference between the average of its per capita rates of payment and its ACR; or

(ii) Elects to receive partially reduced payment and furnish Medicare enrollees with additional benefits described in § 417.440 (b)(4) so that the combined value of benefits and reduced payment is equivalent to the difference between the average of its per capita rates of payment and its ACR.

(2) *Benefit stabilization fund.* An HMO or CMP may elect to have a part of the value of the additional benefits it must provide under paragraph (a) of this section withheld in a benefit stabilization fund as described in § 417.596.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985; 58 FR 38082, July 15, 1993; 60 FR 45678, Sept. 1, 1995]