

requirement for any other type of MA plan.

(c) *Rule for MA Plans' Part D coverage.*

(1) Coordinated care plans. In order to offer an MA coordinated care plan in an area, the MA organization offering the coordinated care plan must offer qualified Part D coverage meeting the requirements in § 423.104 of this chapter in that plan or in another MA plan in the same area.

(2) *MSAs.* MA organizations offering MSA plans are not permitted to offer prescription drug coverage, other than that required under Parts A and B of Title XVIII of the Act.

(3) *Private Fee-For-Service.* MA organizations offering private fee-for-service plans can choose to offer qualified Part D coverage meeting the requirements in § 423.104 in that plan.

[63 FR 35068, June 26, 1998, as amended at 65 FR 40315, June 29, 2000; 70 FR 4714, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

§ 422.6 Cost-sharing in enrollment-related costs.

(a) *Basis and scope.* This section implements that portion of section 1857 of the Act that pertains to cost-sharing in enrollment-related costs. It sets forth the procedures that CMS follows to determine the aggregate annual "user fee" to be contributed by MA organizations and PDP sponsors under Medicare Part D and to assess the required user fees for each MA plan offered by MA organizations and PDP sponsors.

(b) *Purpose of assessment.* Section 1857(e)(2) of the Act authorizes CMS to charge and collect from each MA plan offered by an MA organization its pro rata share of fees for administering section 1851 of the Act (relating to dissemination of enrollment information), and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program) and section 1860D-1(c) of the Act (relating to dissemination of enrollment information for the drug benefit).

(c) *Applicability.* The fee assessment also applies to those demonstrations for which enrollment is effected or coordinated under section 1851 of the Act.

(d) *Collection of fees—(1) Timing of collection.* CMS collects the fees over 9

consecutive months beginning with January of each fiscal year.

(2) *Amount to be collected.* The aggregate amount of fees for a fiscal year is the lesser of—

(i) The estimated costs to be incurred by CMS in that fiscal year to carry out the activities described in paragraph (b) of this section; or

(ii) For fiscal year 2006 and each succeeding year, the applicable portion (as defined in paragraph (e) of this section) of \$200 million."

(e) *Applicable portion.* In this section, the term "applicable portion" with respect to an MA plan means, for a fiscal year, CMS's estimate of Medicare Part C and D expenditures for those MA organizations as a percentage of all expenditures under title XVIII and with respect to PDP sponsors, the applicable portion is CMS's estimate of Medicare Part D prescription drug expenditures for those PDP sponsors as a percentage of all expenditures under title XVIII.

(f) *Assessment methodology.* (1) The amount of the applicable portion of the user fee each MA organization and PDP sponsor must pay is assessed as a percentage of the total Medicare payments to each organization. CMS determines the annual assessment percentage rate separately for MA organizations and for PDPs using the following formula:

(i) The assessment formula for MA organizations (including MA-PD plans): C divided by A times B where—

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

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

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

(ii) The assessment formula for PDPs: C divided by A times B where— A is the total estimated January payments to all PDP sponsors subject to the assessment; B is the 9-month (January through September) assessment period; and C is the total fiscal year PDP sponsor's user fee assessment amount determined in accordance with paragraph (d)(2) of this section.

(2) CMS determines each MA organization's and PDP sponsor'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 MA organization or PDP sponsor for that month.

(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. Redesignated and amended at 70 FR 4715, Jan. 28, 2005; 70 FR 52026, Sept. 1, 2005]

Subpart B—Eligibility, Election, and Enrollment

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

§ 422.50 Eligibility to elect an MA plan.

For this subpart, all references to an MA plan include MA-PD and both MA local and MA regional plans, as defined in § 422.2 unless specifically noted otherwise.

(a) An individual is eligible to elect an MA 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 MA organization as an MA plan enrollee);

(2) Has not been medically determined to have end-stage renal disease, except that—

(i) An individual who develops end-stage renal disease while enrolled in an MA plan or in a health plan offered by

the MA organization is eligible to elect an MA plan offered by that organization;

(ii) An individual with end-stage renal disease whose enrollment in an MA plan was terminated or discontinued after December 31, 1998, because CMS or the MA organization terminated the MA organization's contract for the plan or discontinued the plan in the area in which the individual resides, is eligible to elect another MA plan. If the plan so elected is later terminated or discontinued in the area in which the individual resides, he or she may elect another MA plan; and

(iii) An individual with end-stage renal disease may elect an MA special needs plan as defined in § 422.2, as long as that plan has opted to enroll ESRD individuals.

(3) Meets either of the following residency requirements:

(i) Resides in the service area of the MA plan.

(ii) Resides outside of the service area of the MA plan and is enrolled in a health plan offered by the MA 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 MA organization chooses to offer this option and that CMS determines that all applicable MA access requirements of § 422.112 are met for that individual through the MA plan's established provider network. The MA 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 MA plan, even if the individual lives outside of the MA plan service area, provided that an MA organization chooses to offer this option and that CMS determines that all applicable MA access requirements at § 422.112 are met for that individual through the MA plan's established provider network. The MA 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 or completes another CMS-approved election method offered by the