

Subpart K—Enrollment, Entitlement, and Disenrollment under Medicare Contract

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

§ 417.420 Basic rules on enrollment and entitlement.

(a) *Enrollment.* Individuals who are entitled to benefits under both Part A and Part B of Medicare or only Part B may elect to receive those benefits through an HMO or CMP that has in effect a contract with CMS under subpart L of this part.

(b) *Entitlement.* If a Medicare beneficiary enrolls with an HMO or CMP, CMS pays the HMO or CMP on his or her behalf for the services to which he or she is entitled.

(c) *Beneficiary liability.* (1) The HMO or CMP may require payment, in the form of premiums or otherwise, from individuals for services not covered under Medicare, as well as deductible and coinsurance amounts attributable to Medicare covered services.

(2) As described in § 417.448, Medicare enrollees of risk HMOs or CMPs are liable for services that they obtain from sources other than the HMO or CMP, unless the services are—

- (i) Emergency or urgently needed; or
- (ii) Determined, on appeal under subpart Q of this part, to be services that should have been furnished by the HMO or CMP.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38078, July 15, 1993; 60 FR 45677, Sept. 1, 1995]

§ 417.422 Eligibility to enroll in an HMO or CMP.

Except as specified in §§ 417.423 and 417.424, an HMO or CMP must enroll, either for an indefinite period or for a specified period of at least 12 months, any individual who—

- (a) Is entitled to Medicare benefits under Parts A and B or under Part B only;
- (b) Lives within the geographic area served by the HMO or CMP;
- (c) Is not enrolled in any other HMO or CMP that has entered into a contract under subpart L of this part;
- (d) During an enrollment period of the HMO or CMP, completes and signs

the HMO's or CMP's application form and gives whatever information is required for enrollment;

(e) Agrees to abide by the HMO's or CMP's rules after they are disclosed to him or her in connection with the enrollment process;

(f) Is not denied enrollment by the HMO or CMP under a selection policy, if any, that has been approved by CMS under § 417.424(b); and

(g) Is not denied enrollment by the HMO or CMP on the basis of any of the administrative criteria concerning denial of enrollment in § 417.424(a).

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38078, July 15, 1993; 60 FR 45677, Sept. 1, 1995]

§ 417.423 Special rules: ESRD and hospice patients.

(a) *ESRD patients.* (1) A Medicare beneficiary who has been medically determined to have end-stage renal disease is not eligible to enroll in an HMO or CMP.

(2) However, if a beneficiary is already enrolled in an HMO or CMP when he or she is determined to have end-stage renal disease, the HMO or CMP—

- (i) Must reenroll the beneficiary as required by § 417.434; and
- (ii) May not disenroll the beneficiary except as provided in § 417.460.

(b) *Hospice patients.* A Medicare beneficiary who elects hospice care under § 418.24 of this chapter is not eligible to enroll in an HMO or CMP as long as the hospice election remains in effect.

[60 FR 45677, Sept. 1, 1995]

§ 417.424 Denial of enrollment.

(a) *Basis for denial.* An HMO or CMP may deny enrollment to an individual who meets the criteria of § 417.422 if acceptance would—

- (1) Cause the number of enrollees who are Medicare or Medicaid beneficiaries to exceed 50 percent of the HMO's or CMP's total enrollment;
- (2) Prevent the HMO or CMP from complying with any of the other contract qualifying conditions set forth in subpart J of this part;
- (3) Require the HMO or CMP to exceed its enrollment capacity; or
- (4) Cause the enrollment to become substantially nonrepresentative of the