

7. Permitting End-Stage Renal Disease Beneficiaries To Enroll in Another Medicare+Choice Plan if the Plan in Which They Are Enrolled Is Terminated

Section 620 of the BIPA amended section 1851(a)(3)(B) of the Act to permit beneficiaries with end-stage renal disease (ESRD) to enroll in any other available M+C plan if the plan in which they are enrolled is terminated or the M+C organization discontinues the plan in the area in which the beneficiary lives. Before the BIPA, beneficiaries with ESRD who were affected by an M+C plan termination were only able to elect another plan offered by the same M+C organization or return to the original Medicare fee-for-service program.

Under this provision, if the beneficiary enrolls in another M+C plan, and that plan is subsequently terminated, he or she is able to elect another M+C plan (offered by the same M+C organization or a different organization) based upon that termination. This would be true for any subsequent M+C plan terminations or discontinuations that result in the enrollee's disenrollment. Thus, if the enrollee's plan is subsequently terminated or discontinued, the individual would have another opportunity to elect another M+C plan. The individual may use this election immediately, or may do so during a subsequent election period. Once the individual has made such an election, he or she may not join another M+C plan offered by another M+C organization unless his or her plan is terminated or discontinued. Thus, if the beneficiary exhausts his or her one election, and then later seeks to disenroll from the plan for reasons other than its termination, he or she may only enroll in another M+C plan offered by the same M+C organization, or return to original fee-for-service Medicare. If the beneficiary returns to original Medicare, he or she will not be able to later enroll in an M+C plan.

Comment: One commenter expressed concern that the preamble to the proposed rule could be misconstrued to mean that a beneficiary who is enrolled in an M+C plan and subsequently disenrolls from the plan for reasons other than the plan's termination or discontinuation can return to the original fee-for-service Medicare program and at some future date reenroll in a different plan offered by the same M+C organization.

Response: As explained above, we are clarifying that a beneficiary who elects another M+C plan as provided for under section 620 of the BIPA and later

decides to disenroll from the plan for reasons other than its termination or discontinuation, may only elect another M+C plan offered by the same M+C organization at the time he or she is enrolled with that organization under some health plan it offers. In the commenters example, the beneficiary has spent time in original fee-for-service Medicare while not an enrollee with the organizations under any option. Under this circumstance, the enrollee would not be eligible to enroll in any M+C plan, including one offered by the M+C organization with which he or she was formerly enrolled.

Comment: Several commenters requested clarification as to whether or not the beneficiary had to elect a new M+C plan within a certain time frame. One commenter supported the establishment of a time limit, while others opposed any such time limit.

Response: In the preamble to the proposed rule, we indicated that we do not interpret section 1851(a)(3)(B) of the Act to require an enrollee to elect a new M+C plan immediately upon the termination or discontinuation of the M+C plan in which he or she is enrolled. This is based on section 620(b)(2) of the BIPA, which specifically extends this provision to individuals who had been enrolled in terminating or discontinued plans any time after December 31, 1998. In accordance with this section, and section 620(a) of the BIPA, these individuals are treated as M+C eligible individuals for purposes of electing to continue enrollment in another M+C plan. Because the statute clearly contemplates enrollment by individuals not currently enrolled in an M+C plan, we believe that the phrase "continue enrollment" in section 620(a) of the BIPA does not necessarily mean "continue without interruption" and, therefore, should not be time-limited. As stated above, the beneficiary may use his or her election immediately upon the plan's termination, or may use this election during a subsequent election period.

8. Providing Choice for Skilled Nursing Facility Services Under the Medicare+Choice Program

Section 621 of the BIPA amended section 1852 of the Act by adding a new subsection (l). This new subsection ensures that an M+C organization will give a Medicare beneficiary who is a resident of a skilled nursing facility (SNF) the option of returning to his or her "home SNF" for post-hospital extended care services upon discharge from a hospital when certain conditions are met.

The term "home skilled nursing facility" is defined as—

- The SNF in which the beneficiary resided at the time of admission to the hospital;
- A SNF providing post-hospital extended care services through a continuing care retirement community that provided residence to the beneficiary at the time of admission to the hospital; or
- The SNF in which the spouse of the beneficiary is residing at the time of discharge from the hospital.

In order for a home SNF to be offered under this section, the SNF to which the beneficiary will be returned must either have a contract with the M+C organization to provide post-hospital services or must agree to accept substantially similar payment under the same terms and conditions that apply to SNFs under contract with the M+C organization. The coverage provided must be no less favorable to the beneficiary than coverage of post-hospital services that are otherwise covered under the M+C plan.

The requirement to return the beneficiary to his or her home SNF would not apply if the applicable SNF is not qualified to provide benefits under Medicare Part A to beneficiaries not enrolled in an M+C plan. A SNF that is not contractually bound to do so could refuse to accept an M+C beneficiary or impose conditions on the acceptance of the beneficiary for post-hospital extended care services.

The requirements of this new subsection (l) first became applicable under contracts entered into or renewed on or after December 20, 2000.

We received one comment relating to this provision.

Comment: The commenter expressed concern regarding potential quality issues when a plan member uses the "return home" benefit to enter a non-plan SNF. In addition, the commenter believes that this provision "binds" the internal operations of an M+C organization and could set a precedent for other areas of care in the future.

Response: We agree that an M+C organization does not have the same ability to verify the quality of non-contract SNFs as it does contract SNFs. For this reason, we will allow an M+C organization to advise members who are obtaining services in a non-contract SNF under the "return home" benefit that the M+C plan cannot guarantee the quality of care that members will receive in the non-contract SNF. However, we also note that an M+C organization can only refer members to Medicare certified SNFs. The "return home" SNF benefit was established