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 the HMO’s or CMP’s application form or another CMS-approved election mechanism 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).

§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.

§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 general population in the HMO’s or CMP’s geographic area.

(b) Selection policies. (1) Denial under paragraph (a)(4) of this section must be in accordance with written selection policies approved by CMS. (2) Enrollment of individuals will not be considered to make the enrollment of the HMO or CMP substantially nonrepresentative of the general population in the HMO’s or CMP’s geographic area unless, as a result of the enrollment, the proportion of the subgroup of enrollees to which the enrollee belongs as compared to the HMO’s or CMP’s total enrollment exceeds by at least ten percent the subgroup’s proportion of the general population in the geographic area of the HMO or CMP. (A subgroup is a class of Medicare enrollees of an HMO or CMP that CMS constructs on the basis of actuarial factors.)

§417.426 Open enrollment requirements.

(a) Basic requirements. (1) HMOs or CMPs must provide open enrollment for Medicare beneficiaries for at least 30 consecutive days during each contract year.

(2) During open enrollment, the HMO or CMP must enroll eligible Medicare beneficiaries in the order in which their applications are received and until its enrollment capacity is reached.

(3) The HMO or CMP may accept applications from Medicare beneficiaries after it has reached capacity if it places those individuals on a waiting list and enrolls them in chronological order as vacancies occur.
(4) An HMO or CMP with a risk contract must accept applications from eligible Medicare beneficiaries during the month of November 1998.

(b) Capacity to accept new enrollees. (1) If an HMO or CMP chooses to limit enrollments because of its capacity, it must notify CMS at least 90 days before the beginning of its open enrollment period and, at that time, provide CMS with its reasons for limiting enrollment.

(2) CMS evaluates the HMO’s or CMP’s submittal under paragraph (b)(1) of this section.

(3) The HMO or CMP must promptly notify CMS if there is any change in its enrollment capacity.

(c) Reserved vacancies. (1) Subject to CMS’s approval, an HMO or CMP may set aside a reasonable number of vacancies for an anticipated new group contract or for anticipated new enrollees under an existing group contract that will have its enrollment period after the Medicare open enrollment period during the contract year.

(2) Any set aside vacancies that are not filled within a reasonable time after the beginning of the group contract enrollment period must be made available to Medicare beneficiaries and other nongroup applicants under the requirements of this subpart.

§ 417.427 Extending MA and Part D program disclosure requirements to section 1876 cost contract plans.

(a) The procedures and requirements relating to disclosure in § 422.111 and § 423.128 apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(b) In applying the provisions of §§ 422.111 and 423.128, references to part 422 and part 423 of this chapter must be read as references to this part, and references to MA organizations and Part D sponsors as references to HMOs and CMPs.

§ 417.428 Marketing activities.

(a) With the exception of § 422.2276 of this chapter, the procedures and requirements relating to marketing requirements set forth in subpart V of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(b) In applying those provisions, references to part 422 of this chapter must be read as references to this part, and references to MA organizations as references to HMOs and CMPs.

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