

§ 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 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.)

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 58 FR 38078, July 15, 1993; 60 FR 45677, Sept. 1, 1995]

§ 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