

§ 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

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other nongroup applicants under the requirements of this subpart.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38079, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 63 FR 35066, June 26, 1998]

§ 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.

[77 FR 22166, Apr. 12, 2012]

§ 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.

[75 FR 19802, Apr. 15, 2010]

§ 417.430 Application procedures.

(a) *Application forms and other enrollment mechanisms.* (1) The application form must comply with CMS instructions regarding content and format and be approved by CMS as described in § 422.2262 of this chapter. The application must be completed by an HMO or CMP eligible (or soon to become eligible) individual and include authorization for disclosure between HHS and its designees and the HMO or CMP.

(2) The HMO or CMP must file and retain application forms for the period specified in CMS instructions.

(b) *Handling of applications.* An HMO or CMP must have an effective system for receiving, controlling, and processing applications from Medicare beneficiaries. The system must meet

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the following conditions and requirements:

(1) Each application is dated as of the day it is received.

(2) Applications are processed in chronological order by date of receipt.

(3) The HMO or CMP gives the beneficiary prompt notice of acceptance or denial in a format specified by CMS.

(4) The notice of acceptance. If the HMO or CMP is currently enrolled to capacity, explains the procedures that will be followed when vacancies occur.

(5) The notice of denial explains the reason for denial.

(6) The HMO or CMP transmits the information necessary for CMS to add the beneficiary to its records of the HMO's or CMP's Medicare enrollees—

(i) Within 30 days from the date of application or from the date a vacancy occurs for an applicant who was accepted (for future enrollment) while there were no vacancies; or

(ii) Within an additional period of time approved by CMS on a showing by the HMO or CMP that it needs more time.

(7) The HMO or CMP promptly notifies the beneficiary of the effective month of his or her enrollment as a Medicare enrollee, when it receives that information from CMS.

(8) If the HMO or CMP accepts applications while it is enrolled to capacity, its procedures ensure that vacancies are filled in chronological order by date of application of beneficiaries who are still eligible to enroll, unless that would result in failure to comply with any of the qualifying conditions set forth in § 417.413.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 45677, Sept. 1, 1995; 76 FR 21560, Apr. 15, 2011; 83 FR 16721, Apr. 16, 2018]

§ 417.432 Conversion of enrollment.

(a) *Basic rule.* An HMO or CMP must accept as a Medicare enrollee any individual who is enrolled in the HMO or CMP for the month immediately before the month in which he or she is entitled to both Medicare Parts A and B or Part B only.

(b) *Effective date of conversion.* Unless the individual chooses to disenroll from the HMO or CMP the individual's