30.1 – General Open Enrollment Requirements

(Rev. 38, 10-31-03)

The general requirements for open enrollment are that the cost plan:

- Hold an annual open enrollment period of at least 30 or more consecutive days for Medicare beneficiaries;

- Publicize its upcoming enrollment period in appropriate media throughout the service area (this requirement does not apply for Cost Plans that are continuously open for enrollment); and

- Enroll Medicare beneficiaries on a first come, first serve basis.

If the organization has met the 30-day requirement through a longer enrollment period or through continuous open enrollment and it decides to close enrollment, the plan must notify CMS and the general public 30 days in advance of the new limitations on its open enrollment process (refer to Exhibit 12).

If the organization has both a cost contract and a Medicare+Choice contract in the same service area, it may not enroll new individuals in the cost plan (42 CFR 422.501(b)(4)). In this case, the cost plan would not be able to retain its Medicare+Choice contract if it were to accept new enrollments in the cost plan at any time of the year. In this instance only, CMS will not enforce the cost plan's obligation to open enrollment. The cost plan must always accept requests for disenrollment.

If a cost plan is closed for enrollment, then it is closed to all individuals in the entire plan service area for enrollment. When a cost plan re-opens after being closed, there is no requirement for the cost plan to notify the general public. However, the cost plan should notify CMS when this occurs. If this occurs, the plan would no longer be able to offer a Medicare+Choice contract in the area.

30.1.1 – Waivers for Open Enrollment

(Rev. 38, 10-31-03)

The organization may obtain a waiver of the open enrollment requirements under one of the following two conditions – (1) Non-representative enrollment, and (2) Limited capacity.

Non-Representative Enrollment

An open enrollment period will result in a membership substantially non-representative of the population in the geographic area. In this case, the organization may request a selection restriction in writing at least 90 days before the proposed open enrollment period. The organization must provide statistical data that an open enrollment period would cause a particular membership subgroup to exceed its proportion of the geographic area by at least 10 percent. A subgroup is defined as a class of Medicare beneficiaries based on factors such as age, sex, or other factors that CMS determines significantly affects health care utilization. The organization may not limit enrollment unless and until CMS approves the selection policy. If the organization submits insufficient data to make a decision, CMS will deny the request.

Limited Capacity

The organization does not have capacity for additional members, or the organization must limit enrollment to a certain number of members. The organization must estimate whether it would reach capacity during its next open enrollment period, and would therefore need a CMS-approved capacity waiver.

The following sections describe criteria and procedures for capacity waiver applications. An organization must submit all required information to its Regional Office at least (and preferably more than) 90 days prior to the open enrollment period for Medicare beneficiaries. The CMS will make every attempt to notify the organization of its decision at least 60 days in advance of the enrollment period. If the waiver is granted, it remains in effect for one year only.

30.1.2 – Determining Enrollment Availability for Medicare Beneficiaries

(Rev. 38, 10-31-03)

The cost plan must verify to CMS the number of vacancies open to Medicare beneficiaries during the open enrollment period. If there are conditions or factors that the organization believes are pertinent to determining its enrollment availability for Medicare beneficiaries, it should submit this information to CMS. Utilizing a worksheet (Exhibit 11), the plan will determine enrollment availability by:

1. Establishing present capacity;

2. Obtaining current Medicare, Medicaid, and commercial enrollment numbers;

3. Adjusting these enrollment numbers by the following figures:

    i. Reserved vacancies – add to commercial enrollment the number of members the plan expects to enroll from its existing group contracts and from anticipated new group contracts (see §30.1.5);

    ii. Subtract expected age-ins (commercial members of the plan who will convert to Medicare status upon becoming eligible for Medicare) from the commercial enrollment total and add to the Medicare enrollment numbers for a new Medicare enrollment total; and

    iii. Multiply the new Medicare enrollment total by the organization's Medicare utilization factor (see §30.1.4) to obtain an adjusted Medicare enrollment total.

4. Subtracting the adjusted commercial enrollment total and the adjusted Medicare enrollment total from the organization's capacity. The remainder determines the number of vacancies available for open enrollment

These vacancies must be filled with Medicare beneficiaries up to the point where further enrollment would be substantially non-representative of the population in the geographic area.

30.1.3 – Utilization Adjustment Factor

(Rev. 38, 10-31-03)

The CMS recognizes the greater intensity of services and frequency of health care utilization among Medicare beneficiaries than among commercial membership. Since there is no one-to-one equivalence between Medicare and commercial members in this respect, a utilization adjustment factor is incorporated in calculating enrollment capacity. The utilization adjustment factor represents the number of commercial members the organization could serve for every one Medicare member served over the course of the contract year. The organization also provides backup documentation and discussion of the methodology employed in the calculations. For example, if the data show that Medicare utilization is three times that of commercial members, the capacity for new commercial members is three times what it would be for new Medicare members. Therefore, if the available capacity is for 3,000 additional commercial members in the next contract period, and the organization anticipates filling 1,500 of those slots with commercial members, the remaining 1,500 slots must be divided by three. That is, full capacity is reached if the organization enrolls 500 Medicare members in addition to the 1,500 commercial members, based on a ratio of one Medicare vacancy to every three commercial vacancies.

30.1.4 – Reserved Vacancies

(Rev. 38, 10-31-03)

Reserved vacancies are those set aside for members of anticipated new group contracts or for anticipated new members of an existing group contract when these group enrollment periods are held after the cost plan open enrollment period.

If open enrollment(s) for one or more of the organization's group contracts is scheduled after the organization's cost plan open enrollment period, the plan should set aside a reasonable number of slots or vacancies for anticipated new members from these groups. These reserved vacancies should also be used to determine the enrollment availability for Medicare beneficiaries as described in §20.1.

Because these reserved vacancies limit the available spaces for Medicare members, CMS must approve the organization's use and number of reserved vacancies. Therefore, reserved vacancies are included in the calculations outlined in §30.1.5 and on the worksheet shown in Exhibit 12. Reserved vacancies not used within a reasonable time after the group contract enrollment period has begun must be released and made available to Medicare beneficiaries.

30.1.5 – Special Requirements When Reaching Capacity

(Rev. 38, 10-31-03)

If an organization reaches capacity during open enrollment and it has a CMS approved waiver, it has two options: It can refuse further enrollments or continue accepting applications and place them on a waiting list. For example, if the organization opts to continue accepting applications, it must place all prospective members who wish to wait for an opening on the waiting list in chronological order. As vacancies occur, the plan should contact the beneficiary, and enroll him or her after ensuring he or she still wants the plan to honor the application.