

on a fee-for-service basis (subject to the usual Medicare rules of payment) but only for the following covered Medicare services:

(1) Services of the enrollee's attending physician if the physician is an employee or contractor of the HMO or CMP and is not employed by or under contract to the enrollee's hospice.

(2) Services not related to the treatment of the terminal condition for which the enrollee elected hospice care or a condition related to the terminal condition.

(3) Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again.

(c) Payment for hospice care services furnished to Medicare enrollees of an HMO or CMP is made to the Medicare-participating hospice elected by the enrollee.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 46232, Sept. 6, 1995]

**§ 417.588 Computation of adjusted average per capita cost (AAPCC).**

(a) *Basic data.* In computing the AAPCC, CMS uses the U.S. per capita incurred cost and adjusts it by the factors specified in paragraph (c) of this section to establish an AAPCC for each class of Medicare enrollees.

(b) *Advance notice to the HMO or CMP.* Before the beginning of a contract period, CMS informs the HMO or CMP of the specific adjustment factors it will use in computing the AAPCC.

(c) *Adjustment factors*—(1) *Geographic.* CMS makes an adjustment to reflect the relative level of Medicare expenditures for beneficiaries who reside in the HMO's or CMP's geographic area (or a similar area). This adjustment is based on reimbursement for Medicare covered services and uses the most accurate and timely data that pertain to the HMO's or CMP's geographic area and that is available to CMS when it makes the determination.

(2) *Enrollment.* CMS makes a further adjustment to remove the cost effect of all area Medicare beneficiaries who are enrolled in the HMO or CMP or another HMO or CMP.

(3) *Age, sex, and disability status.* CMS makes adjustments to reflect the age

and sex distribution and the disability status of the HMO's or CMP's enrollees based on Medicare program experience and available data that indicate cost differences that result from those factors.

(4) *Other relevant factors.* If accurate data are available and appropriate, CMS makes adjustments to reflect welfare and institutional status and other relevant factors.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38083, July 15, 1993; 60 FR 46232, Sept. 6, 1995]

**§ 417.590 Computation of the average of the per capita rates of payment.**

(a) *Computation by the HMO or CMP.* As indicated in § 417.584(b), before an HMO's or CMP's contract period begins, CMS determines a per capita rate of payment for each class of the HMO's or CMP's Medicare enrollees. In order to determine the additional benefits required under § 417.592, weighted averages of those per capita rates must be computed separately for enrollees entitled to Part A and Part B, and for enrollees entitled only to Part B. Except as provided in paragraph (b) of this section, the HMO or CMP must make the computations.

(b) *Computation by CMS.* If the HMO or CMP claims to have insufficient enrollment experience to make the computations required by paragraph (a) of this section, and CMS agrees with the claim, CMS makes the computations, using the best available information, which may include the enrollment experience of other risk HMOs and CMPs.

[58 FR 38075, July 15, 1993]

**§ 417.592 Additional benefits requirement.**

(a) *General rules.* (1) An HMO or CMP that has an APCRP (as determined under § 417.590) greater than its ACR (as determined under § 417.594) must elect one of the options specified in paragraph (b) of this section.

(2) The dollar value of the elected option must, over the course of a contract period, be at least equal to the difference between the APCRP and the proposed ACR.