

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.

(b) *Options*—(1) *Additional benefits*. Provide its Medicare enrollees with additional benefits in accordance with paragraph (c) of this section.

(2) *Payment reduction*. Request CMS to reduce its monthly payments.

(3) *Combination of additional benefits and payment reduction*. Provide fewer than the additional benefits required under paragraph (b)(1) of this section and request CMS to reduce the monthly payments by the remaining difference between the APCRP and the ACR.

(4) *Combination of additional benefits and withholding in a stabilization fund*. Provide fewer than the additional benefits required under paragraph (b)(1) of this section, and request CMS to withhold in a stabilization fund (as provided in § 417.596) the remaining difference between the APCRP and the ACR.

(c) *Special rules: Additional benefits option*. (1) The HMO or CMP must determine additional benefits separately for enrollees entitled to both Part A and Part B benefits and those entitled only to Part B.

(2) The HMO or CMP may elect to provide additional benefits in any of the following forms—

(i) A reduction in the HMO's or CMP's premium or in other charges it imposes in the form of deductibles or coinsurance.

(ii) Health benefits in addition to the required Part A and Part B covered services.

(iii) A combination of reduced charges and additional benefits.

(d) *Notification to CMS*. (1) The HMO or CMP must give CMS notice of its ACR and its weighted APCRP at least 45 days before its contract period begins.

(2) An HMO or CMP that elects the option of providing additional benefits must include in its submittal—

(i) A description of the additional benefits it will provide to its Medicare enrollees; and

(ii) Supporting evidence to show that the selected benefits meet the requirements of paragraph (a)(2) of this section with respect to dollar value equivalence.

[60 FR 46232, Sept. 6, 1995]

§ 417.594 Computation of adjusted community rate (ACR).

(a) *Basic rule*. Each HMO or CMP must compute its basic rate as follows:

(1) Compute an initial rate in accordance with paragraph (b) of this section.

(2) Adjust and reduce the initial rate in accordance with paragraphs (c) and (d) of this section.

(b) *Computation of initial rates*. (1) The HMO or CMP must compute its initial rate using either of the following systems:

(i) A community rating system as defined in § 417.104(b); or

(ii) A system, approved by CMS, under which the HMO or CMP develops an aggregate premium for all its enrollees and weights the aggregate by the size of the various enrolled groups that compose its enrollment.

(For purposes of this section, enrolled groups are defined as employee groups or other bodies of subscribers that enroll in the HMO or CMP through payment of premiums.)

(2) Regardless of which method the HMO or CMP uses—

(i) The initial rate must be equal to the premium it would charge its non-Medicare enrollees for the Medicare-covered services;

(ii) The HMO or CMP must compute the rates separately for enrollees entitled to Medicare Part A and Part B and for those entitled only to Part B; and

(iii) The HMO or CMP must identify and take into account anticipated revenue from health insurance payers for those services for which Medicare is not the primary payer as provided in § 417.528.

(3) Except as provided in paragraph (b)(4) of this section, the HMO or CMP must identify in its initial rate calculation, the following components whose rates must be consistent with rates used by the HMO or CMP in calculating premiums for non-Medicare enrollees:

(i) Hospital services (services covered under Medicare Part A and Part B shown separately).

(ii) Physicians' services.

(iii) Other medical services (for example, X-ray and laboratory services).

(iv) Home health services.

(v) Out-of-plan claims for emergency services.