

(3) *Payments under the State hospital reimbursement system.* To the extent that HCFA estimates that a 1997 per capita rate reflects payments to hospitals under section 1814(b)(3) of the Act, HCFA makes a payment adjustment that is comparable to the adjustment that would have been made under paragraph (e)(2) of this section if the hospitals had not been reimbursed under section 1814(b)(3) of the Act.

(4) *Areas with highly variable per capita rates.* With respect to a payment area for which the per capita rate for 1997 varies by more than 20 percent from the per capita rate for 1996, HCFA may substitute for the 1997 rate a rate that is more representative of the costs of the enrollees in the area.

(f) *National standardized annual capitation rate.* The national standardized annual capitation rate is equal to—

(1) The sum, for all payment areas, of the products of—

(i) The annual area-specific capitation rate and

(ii) The average number of Medicare beneficiaries residing in the area multiplied by the average of the risk-factor weights used to adjust payments under § 422.256(c);

(2) Divided by the sum, for all payment areas, of the products specified in paragraph (f)(1)(ii) of this section for all payment areas.

(g) *The input-price-adjusted annual national capitation rate—(1) General rule.* The input-price-adjusted annual national capitation rate for a M+C payment area for a year is equal to the sum, for all the types of Medicare services (as classified by HCFA), of the product (for each service) of—

(i) The national standardized annual M+C capitation rate (determined under paragraph (f) of this section) for the year;

(ii) The proportion of such rates for the year which is attributable to such type of services; and

(iii) An index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price for such services.

(2) HCFA may, subject to the special rules for 1988, use indices that are used in applying or updating national pay-

ment rates for particular areas and localities.

(3) *Special rules for 1988.* In applying this paragraph for 1998—

(i) Medicare services are classified as Part A and Part B services;

(ii) The proportion attributable to Part A services is the ratio (expressed as a percentage) of the national average per capita rate of payment for Part A services for 1997 to the national average per capita rate of payment for Part A and Part B services for that year;

(iii) The proportion attributed to part B services is 100 percent minus the ratio described in paragraph (g)(3)(ii) of this section;

(iv) For Part A services, 70 percent of the payments attributable to those services are adjusted by the index used under section 1886(d)(3)(E) of the Act to adjust payment rates for relative hospital wage levels for hospitals located in the particular payment area; and

(v) For part B services—

(A) 66 percent of payments attributable to those services are adjusted by the index of the geographic area factors under section 1848(e) of the Act used to adjust payment rates for physician services in the particular payment area; and

(B) Of the remaining 34 percent, 40 percent is adjusted by the index specified in paragraph (g)(3)(iv) of this section.

§ 422.256 Adjustments to capitation rates and aggregate payments.

(a) *Adjustment for over or under projection of national per capita growth percentages.* (1) Beginning with rates for 1999, HCFA adjusts all area-specific and national capitation rates for the previous year to reflect any differences between the projected national per capita growth percentages for that year and previous years, and the current estimates of those percentages for such years.

(2) Beginning with rates for 2000, HCFA also adjusts the minimum amount rate (calculated under § 422.252(b)) in the same manner.

(b) *Adjustment for national coverage determination (NCD) services.* If HCFA determines that the cost of furnishing an NCD service is “significant,” HCFA adjusts capitation rates for the next

calendar year to take account of the cost of that service. Until the new capitation rates are in effect, the M+C organization is paid for the "significant cost" service on a fee-for-service basis as provided under section 422.105(b).

(c) *Risk adjustment: General rule.* Capitation payments are adjusted for age, gender, institutional status, and other appropriate factors, including health status.

(d) *Risk adjustment: Health status—(1) Data collection.* To adjust for health status, HCFA applies a risk factor based on data obtained in accordance with § 422.257.

(2) *Initial implementation.* HCFA applies this adjustment factor to payments beginning January 1, 2000.

(3) *Uniform application.* Except as provided for M+C RFB plans under § 422.250(a)(2)(iii), HCFA applies this adjustment factor to all types of plans.

§ 422.257 Encounter data.

(a) *Data collection: Basic rule.* Each M+C organization must submit to HCFA (in accordance with HCFA instructions) all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

(b) *Types of service and timing of submission.* M+C organizations must submit data as follows:

(1) Beginning on a date determined by HCFA, inpatient hospital care data for all discharges that occur on or after July 1, 1997.

(2) HCFA will provide advance notice to M+C organizations to collect and submit data for services that occur on or after July 1, 1998, as follow:

(i) Physician, outpatient hospital, SNF, and HHA data beginning no earlier than October 1, 1999; and

(ii) All other data HCFA deems necessary beginning no earlier than October 1, 2000.

(c) *Sources and extent of data.* (1) To the extent required by HCFA, the data must account for services covered under the original Medicare program, for Medicare covered services for which Medicare is not the primary payor, or for other additional or supplemental

benefits that the M+C organization may provide.

(2) The data must account separately for each provider, supplier, physician, or other practitioner that would be permitted to bill separately under the Medicare fee-for-service program, even if they participate jointly in the same encounter.

(d) *Other data requirements.* The data must—

(1) Conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards; and

(2) Be submitted electronically to the appropriate HCFA contractor.

(e) *Validation of data.* M+C organizations and their providers and practitioners will be required to submit medical records for the validation of encounter data, as prescribed by HCFA.

(f) *Use of data.* HCFA uses the data obtained under this section to determine the risk adjustment factor that it applies to annual capitation rates under § 422.256(c). HCFA may also use the data for other purposes.

§ 422.258 Announcement of annual capitation rates and methodology changes.

(a) *Capitation rates.* (1) No later than March 1 of each year, HCFA announces to M+C organizations and other interested parties the capitation rates for the following calendar year.

(2) HCFA includes in the announcement a description of the risk and other factors and explains the methodology in sufficient detail to enable M+C organizations to compute monthly adjusted capitation rates for individuals in each of its payment areas.

(b) *Advance notice of changes in methodology.* (1) No later than January 15 of each year, HCFA notifies M+C organizations of changes it proposes to make in the factors and the methodology it used in the previous determination of capitation rates.

(2) The M+C organizations have 15 days to comment on the proposed changes.