

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.

§ 422.262 Special rules for beneficiaries enrolled in M+C MSA plans.

(a) *Establishment and designation of medical savings account (MSA).* A beneficiary who elects coverage under an M+C MSA plan—

(1) Must establish an M+C MSA with a trustee that meets the requirements of paragraph (b) of this section; and

(2) If he or she has more than one M+C MSA, designate the particular account to which payments under the M+C MSA plan are to be made.

(b) *Requirements for MSA trustees.* An entity that acts as a trustee for an M+C MSA must—

(1) Register with HCFA;

(2) Certify that it is a licensed bank, insurance company, or other entity qualified, under sections 408(a)(2) or 408(h) of the IRS Code, to act as a trustee of individual retirement accounts;

(3) Agree to comply with the M+C MSA provisions of section 138 of the IRS Code of 1986; and

(4) Provide any other information that HCFA may require.

(c) *Deposit in the M+C MSA.* (1) The payment is calculated as follows:

(i) The monthly M+C MSA premium is compared with $\frac{1}{12}$ of the annual capitation rate for the area determined under § 422.252.

(ii) If the monthly M+C MSA premium is less than $\frac{1}{12}$ of the annual capitation rate, the difference is the amount to be deposited in the M+C MSA for each month for which the beneficiary is enrolled in the MSA plan.

(2) HCFA deposits the full amount to which a beneficiary is entitled under paragraph (c)(1)(ii) of this section for the calendar year, beginning with the

month in which M+C MSA coverage begins.

(3) If the beneficiary's coverage under the M+C MSA plan ends before the end of the calendar year, HCFA recovers the amount that corresponds to the remaining months of that year.

§ 422.264 Special rules for coverage that begins or ends during an inpatient hospital stay.

(a) *Applicability.* This section applies to inpatient services in a "subsection (d) hospital" as defined in section 1886(d)(1)(B) of the Act.

(b) *Coverage that begins during an inpatient hospital stay.* If coverage under an M+C plan offered by an M+C organization begins while the beneficiary is an inpatient in a subsection (d) hospital—

(1) Payment for inpatient services until the date of the beneficiary's discharge is made by the previous M+C organization or original Medicare, as appropriate.

(2) The M+C organization offering the newly-elected M+C plan is not responsible for the inpatient services until the date after the beneficiary's discharge; and

(3) The M+C organization offering the newly-elected M+C plan is paid the full amount otherwise payable under this subpart.

(c) *Coverage that ends during an inpatient hospital stay.* If coverage under an M+C plan offered by an M+C organization ends while the beneficiary is an inpatient in a subsection (d) hospital—

(1) The M+C organization is responsible for the inpatient services until the date of the beneficiary's discharge;

(2) Payment for those services during the remainder of the stay is not made by original Medicare or by any succeeding M+C organization offering a newly-elected M+C plan; and

(3) The M+C organization that no longer provides coverage receives no payment for the beneficiary for the period after coverage ends.

§ 422.266 Special rules for hospice care.

(a) *Information.* An M+C organization that has a contract under subpart K of this part must inform each Medicare enrollee eligible to elect hospice care