

(b) *Enrollment status.* Unless the enrollee disenrolls from the M+C plan, a beneficiary electing hospice continues his or her enrollment in the M+C plan and is entitled to receive, through the M+C plan, any benefits other than those that are the responsibility of the Medicare hospice.

(c) *Payment.* During the time the hospice election is in effect, HCFA's monthly capitation payment to the M+C organization is reduced to an amount equal to the adjusted excess amount determined under § 422.312. In addition, HCFA pays through the original Medicare program (subject to the usual rules of payment)—

(1) The hospice program for hospice care furnished to the Medicare enrollee; and

(2) The M+C organization, provider or supplier for other Medicare-covered services furnished to the enrollee.

§ 422.268 Source of payment and effect of election of the M+C plan election on payment.

(a) *Source of payments.* Payments under this subpart, to M+C organizations or M+C MSAs, are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund. HCFA determines the proportions to reflect the relative weight that benefits under Part A, and benefits under Part B represents of the actuarial value of the total benefits under title XVIII of the Act.

(b) *Payments to the M+C organization.* Subject to §§ 412.105(g) and 413.86(d) of this chapter and §§ 422.109, 422.264, and 422.266, HCFA's payments under a contract with an M+C organization (described in § 422.250) with respect to an individual electing an M+C plan offered by the organization are instead of the amounts which (in the absence of the contract) would otherwise be payable under original Medicare for items and services furnished to the individual.

(c) *Only the M+C organization entitled to payment.* Subject to § 422.262, 422.264, 422.266, and 422.520 of this part and sections 1886(d)(11) and 1886(h)(3)(D) of the Act, only the M+C organization is entitled to receive payment from HCFA under title XVIII of the Act for items

and services furnished to the individual.

[63 FR 35090, June 26, 1998; 63 FR 52613, Oct. 1, 1998]

Subpart G—Premiums and Cost-Sharing

SOURCE: 63 FR 35093, June 26, 1998, unless otherwise noted.

§ 422.300 Basis and scope.

(a) *General.* This subpart is based on section 1854 of the Act. It sets forth the requirements and limitations for payments by and on behalf of Medicare beneficiaries who elect an M+C plan.

(b) *Transition period.* For contract periods beginning before January 1, 2002, HCFA applies the following special rules.

(1) M+C organizations may, with HCFA's agreement, modify an M+C plan offered prior to January 1, 2002 by—

(i) Adding benefits at no additional cost to the M+C plan enrollee; and

(ii) Lowering the premiums approved through the ACR process;

(iii) Lowering other cost-sharing amounts approved through the ACR process.

(2) For contracts beginning on a date other than January 1 (according to § 422.504(d)), M+C organizations may submit ACRs on a date other than May 1 approved by HCFA.

§ 422.302 Terminology.

As used in this subpart, unless specified otherwise—

Additional revenues are revenues collected or expected to be collected from charges for M+C plans offered by an M+C organization in excess of costs actually incurred or expected to be incurred. Additional revenues would include such things as revenues in excess of expenses of an M+C plan, profits, contribution to surplus, risk margins, contributions to risk reserves, assessments by a related entity that do not represent a direct medical or related administrative cost, and any other premium component not reflected in direct medical care costs and administrative costs.

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APR stands for the M+C plan's average per capita rates of payment. The *APR* is the average amount the M+C organization estimates HCFA will pay (without any needed offsets or reductions, such as, those required by § 422.250(a)(2)(ii) for M+C MSA plan enrollees) for the period covered by the *ACR* for all of the Medicare beneficiaries electing the M+C plan.

M+C monthly basic beneficiary premium means, with respect to an M+C coordinated care plan, the amount authorized to be charged under § 422.308(a)(1) for the plan, or, with respect to a M+C private fee-for-service plan, the amount filed under § 422.306(d)(1).

M+C monthly supplemental beneficiary premium means, with respect to an M+C coordinated care plan, the amount authorized to be charged under § 422.308(a)(2) for the M+C plan, or, with respect to an MSA or an M+C private fee-for-service plan, the amount filed under § 422.306(c)(2) or § 422.306(d)(2).

M+C monthly MSA premium means, with respect to an M+C plan, the amount of such premium filed under § 422.306(c)(1).

§ 422.304 Rules governing premiums and cost-sharing.

(a) *Monthly premiums.* The monthly premium charged to the beneficiary is—

(1) For an individual enrolled in an M+C plan (other than an M+C MSA plan) offered by an M+C organization, the sum of the M+C monthly basic beneficiary premium plus the M+C monthly supplemental beneficiary premium (if any); or

(2) For an individual enrolled in an M+C MSA plan offered by an M+C organization, the M+C monthly supplemental beneficiary premium (if any).

(b) *Uniformity.* The M+C monthly basic beneficiary premium, the M+C monthly supplemental beneficiary premiums, and the M+C monthly MSA premium of an M+C organization may not vary among individuals enrolled in the M+C plan. In addition, the M+C organization may not vary the level of copayments, coinsurance, or deductibles charged for basic benefits or supplemental benefits (if any), among individuals enrolled in the M+C plan.

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(c) *Timing of payments.* The M+C organization must permit payments of M+C monthly basic and supplemental beneficiary premium on a monthly basis and may not terminate coverage for failure to make timely payments except as provided in § 422.74(b)(1).

(d) *Monetary inducements prohibited.* An M+C organization may not provide for cash or other monetary rebates as an inducement for enrollment or for any other reason or purpose.

§ 422.306 Submission of proposed premiums and related information.

(a) *General rule.* (1) Not later than May 1 of each year, each M+C organization and any organization intending to contract as an M+C organization in the subsequent year must submit to HCFA, in the manner and form prescribed by HCFA, for each M+C plan it intends to offer in the following year—

(i) The information specified in paragraph (b), (c), or paragraph (d) of this section for the type of M+C plan involved; and

(ii) The service area and enrollment capacity (if any).

(2) If the submission is not complete, timely, or accurate, HCFA has the authority to impose sanctions under subpart O of this part or may choose not to renew the contract.

(b) *Information required for coordinated care plans—*(1) *Basic benefits.* For basic benefits, the following information is required:

(i) The *ACR* as specified in § 422.310.

(ii) The M+C monthly basic beneficiary premium.

(iii) A description of cost-sharing to be imposed under the plan, and its actuarial value.

(iv) A description of any additional benefits to be provided pursuant to § 422.312 and the actuarial value determined for those benefits.

(v) Amounts collected in the previous contract period for basic benefits.

(2) *Supplemental benefits.* For supplemental benefits, the following information is required:

(i) The *ACR*.

(ii) The M+C monthly supplemental beneficiary premium.

(iii) A description of supplemental benefits being offered, the cost sharing