

HCFA adjusts the rate on the basis of differences in the utilization characteristics of—

- (i) Medicare and non-Medicare enrollees in other M+C plans; or
- (ii) Medicare beneficiaries in the M+C organization's area, State, or the United States who are eligible to elect an M+C plan and other individuals in that same area, State, or the United States.

(d) *Special rules for certain organizations.* An M+C organization that does not have non-Medicare enrollees or sufficient Medicare enrollment experience to adequately calculate ACR values may calculate its ACR using estimates described in paragraphs (d)(1) and (d)(2) of this section as an additional adjustment described in paragraph (c)(4) of this section.

(1) The M+C organization may use an estimate of the ACR value for the direct medical and administrative components of a service or services offered using generally-accepted accounting principles.

(2) The M+C organization may use an estimate of the ACR value for the additional revenue component of a service or services offered based on the lesser of (if the information is available)—

- (i) The average of additional revenues received through risk payments for health services contracted to be furnished to an enrolled population of other organizations;
- (ii) The average of additional revenues received for health services furnished; or
- (iii) A reasonable estimate of additional revenues of other M+C organizations in the general marketplace.

(e) *Adjustment by HCFA.* If HCFA finds that there is insufficient enrollment experience to determine the APR or ACR for a M+C plan at the beginning of a contract period, HCFA may—

- (1) Determine the APR based on the enrollment experience of other M+C organizations;
- (2) Determine ACR using data in the general commercial marketplace; or
- (3) Determine either or both rates using the best available information, which may include enrollment experience of other M+C organizations and section 1876 risk contractors.

(f) *HCFA review.* (1) The M+C organization's methodology and computation of its ACR are subject to review and approval by HCFA. When the M+C organization submits the ACR computation, it must include adequate supporting data. Except as provided in § 422.306(e)(2), HCFA authorizes the M+C organization to collect premiums and other cost sharing amounts described in § 422.306 that are equal to the amounts calculated in the ACR.

(2) If the M+C organization is dissatisfied with an HCFA determination that the M+C organization's computation is not acceptable, the M+C organization may within 2 weeks after the date of receipt of notification of this determination, file a request for a hearing with HCFA. The request must state why the M+C organization believes the determination is incorrect and must be accompanied by any supporting evidence the M+C organization wishes to submit. The hearing is conducted by a hearing officer designated by HCFA under the hearing procedures described in subpart N.

[63 FR 35093, June 26, 1998; 63 FR 52614, Oct. 1, 1998, as amended at 65 FR 40326, June 29, 2000]

§ 422.312 Requirement for additional benefits.

(a) *Definitions.* As used in this section—

(1) *Excess amount* is the amount by which the APR exceeds the actuarial value of the Medicare covered services required under § 422.101(a), as determined on the basis of the ACR determined under § 422.310, as reduced for the actuarial value of the cost-sharing under Medicare Parts A and B. A separate excess amount must be determined for Part B-only enrollees.

(2) *Adjusted excess amount* is the excess amount minus any amount withheld and reserved for the organization in a stabilization fund, as provided in paragraph (c) of this section.

(b) *Requirement for additional benefits.* If there is an adjusted excess amount for the plan it offers, the M+C organization must—

- (1) Provide additional benefits with an actuarial value (less the actuarial value of any cost-sharing associated

with the benefit) which HCFA determines is at least equal to the adjusted excess amount; and

(2) Provide those benefits uniformly for all Medicare enrollees electing the plan.

(c) *Stabilization fund.* (1) An M+C organization may request for part of an excess amount to be withheld and reserved, for a specified number of contract periods, in the Federal Hospital Insurance Trust Fund, or the Federal Supplementary Insurance Trust Fund in the proportions that HCFA determines to be appropriate.

(2) The reserved funds are to be used to stabilize and prevent undue fluctuations in the additional benefits that are required under this section and are provided during subsequent contract periods.

(3) Any amounts not provided as additional benefits during the period specified by the M+C organization for which the stabilization fund is established, reverts for the use of the trust funds.

(4) *Establishment of a stabilization fund.* An M+C organization's request to have monies withheld in a stabilization fund for a specific M+C plan must be made when the M+C organization notifies HCFA under § 422.306 of its proposed premiums, other cost-sharing amounts, and related information in preparation for its next contract period.

(i) *Limit per contract period.* Except as provided in paragraph (c)(4)(iii) of this section, HCFA does not withhold in a stabilization fund more than 15 percent of the excess amount for a given contract period.

(ii) *Cumulative limit.* If HCFA has established a stabilization fund for an M+C plan, it does not approve a request for withholding made by that M+C organization for a subsequent contract period that would cause the total value of the stabilization fund to exceed 25 percent of the excess amount applicable to the M+C plan for that subsequent contract period.

(iii) *Exception.* HCFA may grant an exception to the limit described in paragraph (c)(3)(i) of this section if the M+C organization can demonstrate to HCFA's satisfaction that the value of the additional benefits it provides to

its Medicare enrollees electing this M+C plan fluctuates substantially in excess of 15 percent from one contract period to another.

(iv) *Interest.* The amounts withheld in a stabilization fund are accounted for by HCFA in accounts for which interest does not accrue to the M+C organization.

(5) *Withdrawal from a stabilization fund.* An M+C organization's request to make a withdrawal from the stabilization fund established for an M+C plan to be used during a contract period must be made when the M+C organization notifies HCFA under § 422.306 of its proposed premiums, cost-sharing amounts, and related information in preparation for its next contract period.

(i) *Notification requirements.* An M+C organization must—

(A) Indicate how it intends to use the withdrawn amounts;

(B) Justify the need for the withdrawal in terms of stabilizing the additional benefits it provides to Medicare enrollees;

(C) Document the M+C plan's experience with fluctuations of revenue requirements relative to the additional benefits it provides to Medicare enrollees; and

(D) Document its experience during the contract period previous to the one for which it requests withdrawal to ensure that the M+C organization will not be using the withdrawn amounts to refinance losses suffered during that previous contract period.

(ii) *Criteria for HCFA approval.* HCFA approves a request for a withdrawal from a benefit stabilization fund for use during the next contract period only if—

(A) The average of the APR for the M+C plan's next contract period of the M+C plan is less than that of the previous contract period;

(B) The M+C plan's ACR for the next contract period is significantly higher than that of the previous contract period;

(C) The M+C plan's revenue requirements for the next contract period for providing the additional benefits it provided during the previous contract period is significantly higher than the

requirements for that previous period; or

(D) The ACR for the next contract period results in additional benefits that are significantly less in total value than that of the previous contract period.

(iii) *Basis for denial.* HCFA does not approve a request for a withdrawal from a stabilization fund if the withdrawal would allow the M+C organization to refinance prior contract period losses or to avoid losses in the upcoming contract period.

(iv) *Form of payment.* Payment of monies withdrawn from a stabilization fund is made, in equal parts, as an additional amount to the monthly advance payment made to the M+C organization for Medicare beneficiaries electing the M+C plan during the period of the contract.

(d) *Construction.* Nothing in this section may be construed as preventing an M+C organization from providing supplemental benefits in addition to those required under this section and from imposing a premium for those supplemental benefits.

[63 FR 35093, June 26, 1998, as amended at 65 FR 40326, June 29, 2000]

Subpart H—Provider-Sponsored Organizations

EDITORIAL NOTE: Nomenclature changes to subpart H appear at 63 FR 35098, 35099, June 26, 1998.

§ 422.350 Basis, scope, and definitions.

(a) *Basis and scope.* This subpart is based on sections 1851 and 1855 of the Act which, in part,—

(1) Authorize provider sponsored organizations, (PSOs), to contract as a M+C plan;

(2) Require that a PSO meet certain qualifying requirements; and

(3) Provide for waiver of State licensure for PSOs under specified conditions.

(b) *Definitions.* As used in this subpart (unless otherwise specified)—

Capitation payment means a fixed per enrollee per month amount paid for contracted services without regard to the type, cost, or frequency of services furnished.

Cash equivalent means those assets excluding accounts receivable that can be exchanged on an equivalent basis as cash, or converted into cash within 90 days from their presentation for exchange.

Control means that an individual, group of individuals, or entity has the power, directly or indirectly, to direct or influence significantly the actions or policies of an organization or institution.

Current ratio means total current assets divided by total current liabilities.

Deferred acquisition costs are those costs incurred in starting or purchasing a business. These costs are capitalized as intangible assets and carried on the balance sheet as deferred charges since they benefit the business for periods after the period in which the costs were incurred.

Engaged in the delivery of health care services means—

(1) For an individual, that the individual directly furnishes health care services, or

(2) For an entity, that the entity is organized and operated primarily for the purpose of furnishing health care services directly or through its provider members or entities.

Generally accepted accounting principles (GAAP) means broad rules adopted by the accounting profession as guides in measuring, recording, and reporting the financial affairs and activities of a business to its owners, creditors and other interested parties.

Guarantor means an entity that—

(1) Has been approved by HCFA as meeting the requirements to be a guarantor; and

(2) Obligates its resources to a PSO to enable the PSO to meet the solvency requirements required to contract with HCFA as an M+C organization.

Health care delivery assets (HCDAs) means any tangible assets that are part of a PSO's operation, including hospitals and other medical facilities and their ancillary equipment, and such property as may be reasonably required for the PSO's principal office or for such other purposes as the PSO may need for transacting its business.

Insolvency means a condition in which the liabilities of the debtor exceed the fair valuation of its assets.