

Medicare Managed Care Manual

Chapter 17, Subchapter B

Payment Principles for Cost-Based HMO/CMPs

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10 - Provider Principles Applicable to Cost-Based Medicare Health Maintenance Organizations and Competitive Medical Plans (HMO/CMPs) - General

(Rev. 4, 10-01-01)

Unless otherwise specified in this manual, costs generally incurred by providers of service (e.g., hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs)) that are allowable under the principles of payment for providers (see 42 CFR Parts 405, 412, and 413) are allowable when incurred by Health Maintenance Organizations and Competitive Medical Plans (HMO/CMPs). This also applies to costs incurred by providers of services and other facilities owned and operated by HMO/CMPs or related to the HMO/CMP by common ownership or control. An exception to the application of provider payment principles is available for the cost incurred by a HMO/CMP for covered services furnished by a provider under an arrangement with the cost-based HMO/CMP. In order to qualify for payment in excess of the amount authorized under 42 CFR Part 405, Subpart D, §§412 and 413, the HMO/CMP must demonstrate to CMS' satisfaction that the excess payment is justified on the basis of advantages gained by the HMO/CMP. (See §§90 and 110 of this subchapter.)

Under these principles, allowable costs are determined according to the Medicare principles of reimbursement as set out in the Provider Reimbursement Manual (Pub. 15)

and Generally Accepted Accounting Principles (GAAP), in that order. Contracting organizations will be furnished a copy of the Provider Reimbursement Manual, Pub. 15, for reference to the principles of provider reimbursement.

20 - Payment Procedures for Provider Services Paid for Directly by the HMO/CMP

(Rev. 4, 10-01-01)

Unless the HMO/CMP elects to have CMS pay certain providers (hospitals and SNFs) directly for provider services, it is responsible for making payment directly to these providers. The payment to the HMO/CMP will be equivalent to what CMS's Fee-For-Service (FFS) system would have paid for the service unless the organization demonstrates that additional payments are justified. (See Chapter 17.)

Since certain additional work will be required by the provider in some cases, the organization must secure an agreement with the provider to accomplish all the things necessary to establish proper payment. Regardless of the billing option selected, all Medicare-covered services for which the HMO/CMP has financial liability are reviewed in the settlement process. (See §80.2 of Chapter 17, Subchapter A.)

30 - Data Collection Requirements

(Rev. 4, 10-01-01)

A provider paid by Medicare on a reasonable cost basis which furnishes services to the Medicare HMO/CMP enrollees under an arrangement whereby the HMO/CMP pays the provider directly is required to maintain separate statistics for the HMO/CMP's Medicare enrollees. These statistics will be maintained in such type, detail, and form as required for the provider's other Medicare patients. Separate statistics must be accumulated for each HMO/CMP with which the provider has an agreement to have payment made directly by the organization.

40 - Filing Requirements for Providers Using Form CMS-2552

(Rev. 4, 10-01-01)

Providers using Form CMS-2552 will prepare their cost reports and submit them to the FFS system just as they now do, except that the cost of only Medicare patients who are not members of the HMO/CMP will be apportioned and submitted to the FFS system for payment.

When an HMO/CMP has elected to have CMS process the bills for some hospitals and SNFs furnishing services to the organization's Medicare enrollees, the affected providers will prepare their cost reports and submit them to the FFS system just as they do now. The cost of the organization's enrollees should be included with the provider's other Medicare patients, apportioned, and submitted to the intermediary for payment.

In addition, the provider will prepare a separate set of apportionment and settlement worksheets apportioning the costs to the organization's Medicare enrollees. A separate set of worksheets will be needed for each organization with which the provider has an agreement to have payment made directly by the HMO/CMP. Each set of worksheets will

apportion each cost center between the applicable group of Medicare beneficiaries and all other provider patients.

For example, HMO A has a bill processing contract with the provider. The provider will submit to the HMO the set of worksheets which will reflect the cost of providing covered services to the HMO's Medicare enrollees. The apportionment ratios by cost center would be:

$$\begin{aligned} & (\text{Total Costs}) \text{ times } (\text{Charges for the HMO's Medicare enrollees}) \\ & = \text{Total Charges} \end{aligned}$$

Ratios by cost centers on the worksheets for non-HMO/CMP Medicare patients would be:

$$\begin{aligned} & (\text{Total Costs}) \text{ times } (\text{Charges for Medicare patients that are not members of the HMO/CMP}) \\ & = \text{Total Charges} \end{aligned}$$

All other schedules currently required will be completed under existing instructions. Copies of all schedules will be sent to the FFS system for processing and settlement.

50 - Filing Requirements for Providers Using Other Cost Report Forms

(Rev. 4, 10-01-01)

Providers using cost reports other than Form CMS-2552 will utilize the principles outlined for Form CMS-2552. That is, separate apportionment and settlement schedules will be prepared by the provider for each Medicare HMO/CMP processing the provider's bills and for non-HMO/CMP beneficiaries. Each set of schedules will apportion the appropriate cost centers between the applicable groups of Medicare patients and all other provider patients.

60 - Fee-For-Service (FFS) System Final Settlement With the Provider

(Rev. 4, 10-01-01)

In making final settlement with the provider, the FFS system will treat services furnished to Medicare HMO/CMP enrollees under arrangement as if the services were furnished to non-Medicare patients. The provider will be paid for such services under the terms of its arrangement with the organization, and payment to the provider might not be limited to cost. However, payment to the HMO/CMP for such services will be limited to the amount the FFS system would have paid the provider for furnishing the services. (See 42 CFR 417.548(a) for an exception to this rule.)

70 - Provider Receiving Payment Under the Prospective Payment System PPS

(Rev. 4, 10-01-01)

Payment to an HMO/CMP for provider services provided either directly or under arrangements shall be determined in accordance with 42 CFR Parts 405, 412, or 413, as appropriate, unless the organization can demonstrate in accordance with 42 CFR 417.548

that payment in excess of the amount authorized is justified on the basis of advantages gained by the organization.

For example, for inpatient hospital services provided by a hospital participating under Medicare's Prospective Payment System (PPS), the hospital is paid a predetermined amount for each inpatient stay by a Medicare patient based on the principal diagnosis or the inpatient stay. Additional payments are made for certain pass through costs, cost outliers, etc.

Each hospital stay is grouped by principal diagnosis into one of the many Diagnosis Related Groups (DRGs). Based on the DRG, CMS's PPS determines the amount the hospital receives for the inpatient stay, with some exceptions (e.g., cost outliers and day outliers). Payment is made with no retrospective adjustments to the DRG payment. However, an adjustment to a particular prospective payment would be needed, for example, where, upon medical review, the payment made was found to be improper or inaccurate.

The Medicare HMO/CMP will be paid the same amount that Medicare would otherwise pay that hospital under PPS. This would include all amounts paid by the intermediary to the hospital for services rendered to the organization's Medicare enrollees, including a proportionate share of pass through costs, payments for cost outliers, etc.

Effective July 1, 1999, all Skilled Nursing Facilities (SNFs) are paid using the PPS. Prior to this date, some SNFs had the option to be paid on a prospective basis under §1888 of the Act. Payment to the HMO/CMP will be determined in accordance with the provider's election.

This rule applies to:

- Inpatient hospital and SNF services provided by facilities owned or operated by the HMO/CMP;
- Inpatient hospital and SNF services provided by facilities related to the HMO/CMP by common ownership or control; and
- Inpatient hospital and SNF services provided by facilities with which the HMO/CMP has an arrangement.

80 - Summary of Provider Reimbursement Principle Topics

(Rev. 4, 10-01-01)

The following list summarizes the general topics covered in the "Provider Reimbursement Manual" (Pub. 15). These principles will be used in determining the reasonableness of costs incurred by HMO/CMPs by providers of services and other facilities owned or operated by the cost-based HMO/CMP, and whether or not they are allowable costs. Principles relating to cost apportionment and the payment process are contained in Chapter 17 of this manual. Absent specific instructions in this manual, an HMO/CMP should apply those principles of reimbursement of provider costs contained in the "Provider Reimbursement Manual" (Pub. 15).

Topic	Chapter Reference in “Provider Reimbursement Manual,” Part I
Depreciation	1
Interest Expense	2
Bad Debts, Charity, and Courtesy Allowances	3
Cost of Educational Activities	4
Research Costs	5
Value of Services of Non-paid Workers	7
Purchase Discounts and Allowances, and Refunds of Expense	8
Compensation of Owners	9
Cost to Related Organizations	10
Return on Equity Capital of Proprietary Providers	12
Reasonable Cost of Therapy and Other Services Furnished by Outside Suppliers	14
Costs Related to Patient Care	21
Determination of Cost of Services to Beneficiaries (Cost Apportionment Chapter)	22
Adequate Cost Data and Cost Finding	23
Payment to Providers (Payment Process Chapter)	24
Limitations on Coverage of Costs Under Medicare and Notice of Schedule of Limits on Provider Costs	25
Lower of Cost or Charges	26
ESRD Services and Supplies (Outpatient	27

Topic**Chapter Reference in
“Provider
Reimbursement
Manual,” Part I**

Maintenance Dialysis Services)

Prospective Payments

28

90 - Provider Service Through Arrangements**(Rev. 4, 10-01-01)**

At the option of the contracting cost-based HMO/CMP, CMS will pay (through the FFS system) hospitals and SNFs for covered services furnished the organization’s Medicare enrollees in accordance with §1861(v) or 1886 of the Act, as applicable. In these circumstances, CMS will pay these providers for covered services furnished to the HMO/CMP’s enrollees.

Section 1876 of the Act offers the cost-based HMO/CMP the option of making direct payments to hospitals and SNFs through an arrangement (as defined in Chapter 17 Subchapter C) for covered services furnished to the organization’s Medicare enrollees.

The cost incurred by the HMO/CMP through this arrangement is allowable to the extent that it does not exceed:

1. The reasonable cost of furnishing such covered services (as determined under §1861(v) of the Act) for those providers currently paid on a reasonable cost basis, or
2. The payment amount determined under §1886 of the Act for those providers currently paid under Medicare’s PPS or under an approved State reimbursement cost control system.

An exception is permitted if the cost-based HMO/CMP can demonstrate that payments in excess of reasonable costs or Medicare’s prospective payment, as applicable, are justified on the basis of advantages gained by the organization. Should the organization elect to pay its providers, it must adhere to the reporting requirements imposed on providers and the FFS system.

100 - Payments to Providers Participating Under §1886 of the Act**(Rev. 4, 10-01-01)**

An exception is available to a cost-based HMO/CMP with respect to the payment rates set by a State under an approved State reimbursement cost control system. Generally, under such a system, all third party payers must adhere to the inpatient hospital rates set by the State. Section 1886(c)(1)(D) of the Act allows an HMO/CMP to negotiate directly with such hospitals for the rate of payment for purchased inpatient hospital services.

110 - Infrequently Purchased Provider Services

(Rev. 4, 10-01-01)

If a provider infrequently furnishes services to cost-based HMO/CMP enrollees, it may be paid more than reasonable cost or the amount determined under §1886 of the Act for that provider service, if the organization can prove that a real and tangible benefit was received.

For example, if the HMO/CMP has an arrangement with a provider (who is not related to the organization by common ownership and control) located outside the organization's service area, payment for the provider's charges to the organization for covered services (rather than the provider's reasonable costs or the amount determined payable under §1886 of the Act) could be justified if:

- The provider furnished services to the Medicare HMO/CMP enrollees on an infrequent basis;
- The charges represent an insignificant amount of payment to the HMO/CMP by Medicare; and
- The charges do not exceed the customary charges by the provider to other patients for similar services.

The advantages gained in this example include a more timely final settlement with the HMO/CMP and the elimination of administrative costs necessary to determine the provider's reasonable cost for these services.

120 - Physician Services- General

(Rev. 4, 10-01-01)

Amounts paid by a cost-based HMO/CMP for physicians' services are allowable to the extent they are reasonable. Different tests of reasonableness apply, depending upon whether the organization employs the physicians directly or pays for physicians' services on a fee-for-service basis or some other basis.

The allowability of physician and other Part B supplier services furnished directly is determined in accordance with §130 of this subchapter.

The allowability of physician and other Part B supplier services furnished under arrangements is determined in accordance with the provisions of §140 of this subchapter.

130 - Physician and Other Part B Services Furnished Directly by the HMO/CMP

(Rev. 4, 10-01-01)

Amounts paid by HMO/CMPs to physicians who are employees of the HMO/CMP or a related facility by common ownership or control will be found reasonable to the extent they commensurate with amounts paid for similar services performed by similar physicians in the same or similar locality.

The amount paid (e.g., salaries, capitation, fixed sum, incentive payments) as well as fringe benefits will be compared in the aggregate to that received by physicians generally

in the community and amounts received by physicians in similar organizations. Compensation paid by the HMO/CMP for personal services of physicians (e.g., salaries, wages, incentive payments, fringe benefits) must be distinguished from payments to physicians for nonpersonal services (e.g., expenses attributable to facilities, equipment, support personnel, supplies), in determining whether compensation is allowable. Physician compensation may take various forms, but the aggregate compensation must be reasonable in relation to the services personally furnished. If aggregate physician compensation costs exceed what is normally incurred, the excess is not considered reasonable. Costs incurred for other Part B items and services, including payments to physicians for nonpersonal services, will be found to be reasonable to the extent they:

- Are commensurate with amounts paid for similar items and services furnished by similar personnel and suppliers in the same or similar locality;
- Do not exceed those that a prudent and cost conscious buyer would incur to purchase those services.

140 - Physician and Other Part B Supplier Services Furnished Under Arrangements

(Rev. 4, 10-01-01)

The amount the HMO/CMP pays to a physician, physician group, or supplier for physician and other Part B supplier services furnished under arrangements is an allowable cost to the extent it is reasonable. Costs are considered reasonable if they:

- Do not exceed those that a prudent and cost conscious buyer would incur to purchase those services; and
- Are comparable to costs incurred for similar services furnished by similar physicians or other suppliers in the same or similar geographic area.

150 - Physician and Other Part B Supplier Services Not Furnished Under Arrangements

(Rev. 4, 10-01-01)

Section 1876(j) of the Act places a limit on the charges of noncontracted physicians and suppliers of End Stage Renal Disease (ESRD) services for enrollees of HMO/CMPs with §1876 of the Act contracts. The HMO/CMP is allowed to use the Medicare FFS payment limits for these services rendered on or after April 1, 1990. This provision does not preclude the HMO/CMP from negotiating charges less than the Medicare limits.

150.1 - Payment for Services Rendered On or After April 1, 1994, by Noncontracted Medicare Participating Physicians

(Rev. 4, 10-01-01)

The limit of the HMO/CMP's liability for services rendered by a physician with whom it does not contract depends on whether the physician is a Medicare participating physician (i.e., has agreed to accept assignment on all Medicare claims submitted to Medicare). The Medicare participation agreement is deemed to apply to such a physician's services in the sense that the physician may not bill the HMO/CMP, the beneficiary, or any other party

for any amount in excess of the Medicare allowed amount (the fee schedule amount or the actual charge, if lower).

However, the HMO/CMP has financial responsibility for the amount that would have been the beneficiary's liability in FFS Medicare (the 20 percent coinsurance and any unmet deductible).

NOTE: The financial responsibility of the HMO/CMP applies only when the services are covered by the HMO/CMP, i.e., for emergency or urgently needed services or when the HMO/CMP refers the enrollee to the non-network physician.

150.2 - Payment for Services Rendered On or After April 1, 1994, by Noncontracted, Nonparticipating Physicians

(Rev. 4, 10-01-01)

If a noncontracted physician provides a service to one of the cost-based HMO/CMP's enrollees, and the physician is not a Medicare participating physician, the limit of the HMO/CMP's liability is the lower of the actual charge or the limiting charge permitted under the statute for FFS Medicare. The HMO/CMP is responsible for beneficiary coinsurance and deductible payments.

160 - Enrollment and Marketing Costs

(Rev. 4, 10-01-01)

Enrollment and marketing costs are those necessary and proper costs incurred in offering the cost-based HMO/CMP to potential enrollees. These costs include selling, advertising, and promotional activities incurred directly by the organization or under contract with outside specialists. Enrollment and marketing costs are allowable to the extent they are reasonable and do not exceed an amount that would be incurred by prudent and cost conscious management.

These costs do not include membership costs (see §180) or special costs (see §200).

170 - Initial Enrollment

(Rev. 4, 10-01-01)

Cost-based HMO/CMPs, which offer Medicare benefits for the first time, are likely to incur relatively higher marketing and enrollment costs in offering their HMO/CMPs to Medicare beneficiaries. In determining whether these higher costs are reasonable, CMS may allow them if they do not exceed what prudent and cost conscious management would incur.

180 - Membership Costs

(Rev. 4, 10-01-01)

The cost-based HMO/CMP's cost of maintaining and servicing subscriber contracts for prepayment enrollees, including but not limited to the reasonable cost of maintaining statistical, financial, and other data on members, are allowable to the extent they are

reasonable. Membership expenses should not be included with allowable enrollment and marketing expenses.

190 - Reinsurance

(Rev. 4, 10-01-01)

Reinsurance is the transfer of all or part of the risk a cost-based HMO/CMP assumes in agreeing to deliver health care to its enrollees. Reinsurance costs are not allowable.

190.1 - Self Insurance

(Rev. 4, 10-01-01)

If the cost-based HMO/CMP self-insures for the cost of services by maintaining independently, or as part of a group or pool, a self insurance fund, the costs of payments into such a fund are not allowable. Other types of self-insurance funds are subject to the rules contained in Chapter 21 of the “Provider Reimbursement Manual” (Pub. 15), Part I.

200 - Special Costs Paid In Full

(Rev. 4, 10-01-01)

CMS will pay in full the total reasonable cost incurred by the HMO/CMP for services that are solely for the purposes of the Medicare program and unique to cost-based organization Medicare provisions. These special costs will be taken into account in the HMO/CMP’s monthly per capita rate. Special costs must be shown separately in the organization’s operating budget and approved by CMS in advance of the contract period for which they are claimed subject to retrospective adjustment at the end of the contract period. These special costs do not include management service costs or the normal administrative costs incurred by the organization in obtaining payment from the Medicare program for example, such as the cost of maintaining and reporting statistical and actuarial data needed to determine the amount of payment due the organization, costs of accumulating accretion and deletion data, marketing, enrollment, and the cost of preparing cost reports. Such costs are apportioned to the Medicare program in accordance with Chapter 17, Subchapter C as applicable, so that the Medicare program pays its proportionate share of these costs.

The following types of costs incurred by the HMO/CMP will be paid in full by CMS:

- Medicare Enrollment Data - This is the reasonable cost of reporting individual Medicare beneficiary enrollment accretion and deletion data;
- Special Program Evaluation and Planning Data - This is the reasonable cost of special data required by CMS solely for Medicare program evaluation and planning purposes. However, unless specifically provided for, this data does not include the data the organization is required to maintain and furnish under other sections of this manual;
- Certification of Cost Report - This is the reasonable costs of certifying the organization’s cost report. However, as indicated above, the reasonable cost of preparing this cost report is apportioned in accordance with Chapter 17, Subchapter C as applicable. CMS will pay in full under this section only those

additional costs incurred by the organization that are related to the certification of that report.

210 - Beneficiary Liability

(Rev. 4, 10-01-01)

CMS will pay the HMO/CMP for the reasonable cost of providing covered services to Medicare enrollees less an amount representing the actuarial value of the deductible and coinsurance the Medicare enrollee otherwise would have been liable for had they not enrolled in the current HMO/CMP or in another Medicare HMO/CMP. The organization may charge Medicare enrollees up to this aggregate amount in the form of premiums, membership fees, copayments, charge per unit of service, or similar charges. Another individual, organization, or entity may pay premiums on behalf of the Medicare enrollee. In addition, a Medicare beneficiary's private health insurance may be the primary payer under certain circumstances.

The HMO/CMP may offer the Medicare beneficiaries supplemental benefit plans to cover deductibles and coinsurance amounts, services not covered under Medicare, or both. If a supplemental benefit plan premium (or other payment method) includes charges for both noncovered services and the deductible and coinsurance amounts applicable to covered services, the portion of the premium representing deductibles and coinsurance must be computed separately, and disclosed to the beneficiary prior to his/her election of such coverage options during the enrollment process.

The Medicare beneficiary may, at his/her option, choose coverage under such a plan. If so, he/she is liable for payment for the supplemental benefit plan. In addition, the sum of the amounts the HMO/CMP charges its Medicare enrollees for such supplemental benefit plan services that are not covered under Part A or Part B of Medicare may not exceed the Adjusted Community Rate (ACR) for these services. (See [Chapter 8](#) of this manual for a discussion of the ACR.) For Medicare enrollees entitled to Part B services only, the HMO/CMP premium (or other payment structure) for Medicare Part A type services offered under a supplemental benefit plan to such individual may not exceed the ACR for these services.

210.1 - Under and Over Collection of Premiums

(Rev. 4, 10-01-01)

The HMO/CMP is responsible for computing any over or under collection of premiums. All over collections of premiums must be returned to the Medicare enrollee. The HMO/CMP may select, with prior approval, one of the following three methods to refund over collections:

- Adjust future years' premiums;
- Provide a lump sum payment to the enrollee; or
- A combination of premium adjustment and lump sum payment.

Unintentional (or involuntary) under collections of premiums may be collected from the HMO/CMP's Medicare enrollees by an adjustment to its Medicare enrollees' future premiums. However, the HMO/CMP must collect the under collections through premium

adjustments no later than the end of the contract period following the contract period during which they were found to be due. Intentional (or voluntary) under collections of premiums cannot be recouped by the HMO/CMP from the Medicare enrollee.

220 - Determining Deductibles and Coinsurance

(Rev. 86; Issued: 04-27-07; Effective/Implementation Dates: 04-27-07)

In determining the amount due the cost-based HMO/CMP, CMS will deduct from the reasonable cost actually incurred by the organization in furnishing Medicare covered services to Medicare enrollees, an amount equal to the value of the Medicare deductible and coinsurance amounts which would have been payable if the Medicare beneficiary had not elected the HMO/CMP. However, this amount which becomes the Medicare enrollees' liability for covered services, cannot exceed, on the average, the actuarial value of the deductible and coinsurance the Medicare enrollees otherwise would have been liable for had they not elected the HMO/CMP or another Medicare HMO/CMP. This actuarial value is provided by CMS's actuaries on a calendar year basis and is the same amount used for M+C organizations.

The monetary amounts for the Medicare deductible and coinsurance for Part A, which are applied to each benefit period, change each calendar year. In addition, Part A does not pay any non-replacement fees for the first three pints of unreplaced blood in each benefit period.

During each calendar year, Part B pays 80 percent of the reasonable charges after the deductible has been met per beneficiary. However, Part B cannot pay for the first three pints of blood a beneficiary receives on an outpatient basis in a calendar year. Starting with the fourth pint per beneficiary, Part B pays 80 percent of the reasonable charge after the deductible has been met.

At the time the HMO/CMP prepares its budget and enrollment forecast (90 days prior to each contract period), the HMO/CMP must calculate the Medicare enrollees' estimated deductible and coinsurance amounts for the upcoming contract period. The following method, known as the actuarial method, is used for premium determination, budget forecasting, and final settlement purposes.

The HMO/CMP's use of this method will involve three major computations. The organization will first list the actual Part A deductible and coinsurance and Part B coinsurance for each provider furnishing services to its Medicare enrollees. Next, the organization will calculate the Part B deductible amount by multiplying the Medicare Part B monthly standard deductible amount (determined by CMS) by the organization's Part B Medicare enrollee months. The actuarial values of the Medicare Part B monthly deductible for the years 1985 through 2007, as determined by CMS, are:

Year	Actuarial Value
1985	\$5.03
1986	\$5.05

Year	Actuarial Value
1987	\$5.00
1988	\$5.28
1989	\$5.41
1990	\$5.29
1991	\$6.65
1992	\$6.92
1993	\$7.08
1994	\$7.23
1995	\$7.22
1996	\$7.46
1997	\$7.48
1998	\$7.51
1999	\$7.71
2000	\$7.58
2001	\$7.56
2002	\$7.64
2003	\$7.54
<i>2004</i>	<i>\$7.54</i>
<i>2005</i>	<i>\$8.85</i>
<i>2006</i>	<i>\$9.88</i>
<i>2007</i>	<i>\$10.69</i>

In the third major computation, the cost-based HMO/CMP will compute the Part B blood deductible amount, the Mental Health Copayment, and all Part B coinsurances applicable to carrier and intermediary paid bills. The sum of these three computations gives the Medicare Part A and Part B deductible and coinsurance amounts

To compute the HMO/CMP Medicare enrollees' premiums, add the total Part A and Part B deductible and coinsurance for the organization's incurred costs, and the Part A and Part B deductible and coinsurance for costs paid by the fee-for-service system on the organization's behalf.

From this total, subtract the HMO/CMP's Medicare enrollees' copayments, if any. The resulting figure is then divided by the organization's Medicare enrollee months to produce a monthly premium. The following is an example of the formula:

1. Factors

a = Total Part A and Part B deductible and coinsurance on the organization's incurred costs;

b = Total Part A and Part B deductible and coinsurance on fee-for-service system incurred costs;

c = Total HMO/CMP Medicare enrollee copayments;

d = HMO/CMP Medicare enrollee months

e = Monthly deductible and coinsurance amount to be recovered through Medicare beneficiary premiums and cost sharing'

2. Computation

$(a + b - c) \text{ divided by } d = e$

220.1 - Payment for Bad Debts

(Rev. 4, 10-01-01)

Bad debts are deductions from revenue and may be included in allowable costs only if:

- They are attributable to Medicare deductible and coinsurance amounts for which the Medicare enrollee is liable; and
- The cost-based HMO/CMP has made a reasonable, but unsuccessful, effort to collect these amounts based on Chapter 3 of the "Provider Reimbursement Manual" (Pub. 15), §300.

The amount included in allowable cost for bad debt expense is limited. If the beneficiary deductible and coinsurance amounts payable to the cost-based organization are made on a monthly premium or other periodic basis, the amount allowed as a bad debt may not exceed three times the monthly rate for the actuarial value of the deductible and coinsurance amounts. If the beneficiary deductible and coinsurance amounts payable to the organization are made on other than a monthly basis, the amount allowed as a bad debt may not exceed the amount equivalent to that indicated above.

Any bad debt related to a service furnished to a Medicare enrollee of the cost-based HMO/CMP, and claimed on a cost report submitted for payment by a provider or other facility paid on a cost basis, may not be claimed as a bad debt by the HMO/CMP.

230 - Limitation on Payment

(Rev. 4, 10-01-01)

Unless otherwise specified, the payment limitations imposed on the amounts payable to providers of services (and other health care facilities) under Medicare reimbursement principles apply to amounts payable for covered services furnished by:

- Providers of services owned and operated by a cost-based HMO/CMP;
- Providers related to a cost-based HMO/CMP by common ownership or control; or
- Providers or other health care facilities which furnish services that are paid on a reasonable cost basis.

The payment limitations applicable to cost-based HMO/CMPs include (but are not limited to) those described in §§250 through 300.

240 - End Stage Renal Disease (ESRD)

(Rev. 74, Issued: 10-14-05, Effective Date: 10-14-05)

Individuals who have been medically determined to have ESRD are not eligible to elect to enroll in a cost-based HMO/CMP. However, individuals already enrolled in the organization who subsequently become eligible for Medicare because of ESRD, and aged Medicare enrollees who subsequently develop ESRD, cannot be disenrolled from the organization as a result of the development of ESRD. Special limitations apply to Medicare program payment for ESRD services. For dialysis and related services, CMS carriers process physician claims and CMS intermediaries process facility claims.

The amount CMS pays to a cost-based HMO/CMP for services rendered to individuals with ESRD will be limited to the amount CMS would otherwise pay for services rendered to these individuals if they were not enrollees of the organization. Generally, effective on or after August 1, 1983, Medicare payment for ESRD services is made to the dialysis facility on the basis of one of two prospective composite rates: one rate for hospital-based ESRD facilities and one rate for independent dialysis facilities. Patients dialyzing at home have the option of having these services paid for under the composite rate system or dealing directly with the Medicare program to receive payment on a FFS basis for items and services provided.

For a full discussion of ESRD reimbursement under Medicare, see Chapter 27 of the "Provider Reimbursement Manual" (Pub. 15), Part I. In addition, general information on coverage, entitlement, and billing for ESRD services under Medicare can be obtained from either the Renal Dialysis Facility Manual or the Hospital Manual.

250 - Limitations on Costs

(Rev. 4, 10-01-01)

The limitations on cost provisions contain special rules for evaluating allowable provider costs that apply in addition to certain Medicare reimbursement principles. Specifically, these rules deal with the cost limits that apply to hospitals exempt from PPS. The rules do not apply to hospitals, SNFs, and HHAs paid under PPS.

For a detailed discussion of the limitation on costs provision, see Chapter 25 of the “Provider Reimbursement Manual” (Pub. 15), Part I.

260 - Physical and Other Therapy Services Furnished Under Arrangements

(Rev. 4, 10-01-01)

The reasonable cost of physical, occupational, speech, and other therapeutic services, or services of other health-related specialists (except physicians) performed by outside suppliers for providers of services, clinics, rehabilitation agencies, public health agencies, or Medicare HMO/CMPs may not exceed the sum of:

- Amounts equivalent to the salary and other costs that would have been incurred by the provider or other entity if the services had been performed in an employment relationship and
- An allowance to compensate for other costs an individual not working as an employee might incur in furnishing services under arrangements.

However, this reasonable cost may be determined on the basis of a reasonable rate per unit of service:

- When the services of a therapist or other health-related specialist are required only on a limited part-time basis or only intermittently and
- When aggregate reimbursement on this per unit of service basis is less than what the provider would have paid a salaried employee therapist or other health-related specialist on a full-time or regular part-time basis. (See 42 CFR 413.106.)

In no case, though, may reasonable cost exceed the amount actually paid the outside supplier for services rendered.

For a detailed discussion of reasonable cost, see Chapter 14 of the “Provider Reimbursement Manual” (Pub. 15), Part I.

270 - Allowable Cost for Drugs in Provider Setting

(Rev. 4, 10-01-01)

The allowable cost to the cost-based HMO/CMP for any multiple source drug may not exceed the lesser of:

- The actual cost;

- The amount which would be paid by a prudent and cost conscious buyer for the drug if obtained from the lowest priced source that is widely and consistently available; or
- The maximum allowable cost limit.

The Department of Health and Human Services (DHHS) publishes in the Federal Register a list of specific multiple source drugs and their maximum allowable costs limitations. For these drugs, the allowable cost to the Medicare program may not exceed the drug ingredient cost incurred in purchasing the drugs that would be paid by a prudent and cost conscious buyer if obtained from the lowest priced source that is widely and consistently available (whether sold by generic or trade name). Moreover, the drug ingredient cost cannot exceed the maximum allowable costs published in the Federal Register. For a more detailed discussion of this provision, see the “Provider Reimbursement Manual” Part I.

280 - Lower of Costs or Charges

(Rev. 4, 10-01-01)

Payment to providers (including Medicare cost-based HMO/CMP Providers) for services provided to Medicare beneficiaries will be based upon the lower of the reasonable cost of providing those services or the customary charges for the same services. However, in the case of Hospital Part A services, this provision will not apply to cost reporting periods beginning on or after October 1, 1982, for any hospital that is subject to the rate of increase ceiling under §1886(b) of the Act. The lower of cost or charges provision also will not apply with respect to Hospital Part A services furnished by a hospital that is subject to the PPS pursuant to §1886(d) of the Act for cost reporting periods beginning on or after October 1, 1983. Providers entitled to recapture previously disallowed costs will continue to be able to do so during this time.

Payments to providers will be based on the interim rate that approximates reasonable cost as nearly as practicable, but cannot exceed 100 percent of the customary charges for the same services.

HMO/CMPs should exercise care in the application of the lower of costs or charges provisions due to its limited applicability.

The principle will be applicable to services rendered by providers other than those public providers that render services free of charge or at a nominal charge. When such public providers render services to beneficiaries, they will be paid full reasonable cost for those services.

Lower of costs or charges rules apply to services obtained by the cost-based HMO/CMP from outside providers, and to services furnished to the HMO/CMP’s Medicare enrollees by providers owned and operated by the HMO/CMP or related to the HMO/CMP by common ownership and control. Rules applicable to related organizations are discussed in Chapter 10 of the “Provider Reimbursement Manual” (Pub. 15), Part I.

For a more detailed discussion of the lower of costs or charges provision, see Chapter 26 of the “Provider Reimbursement Manual” (Pub. 15), Part I.

290 - The Prospective Payment System (PPS)

(Rev. 4, 10-01-01)

The Social Security Amendments of 1983 (P.L. 98-21) provided that, effective with cost reporting periods beginning on or after October 1, 1983, most Medicare payments for Part A hospital inpatient operating costs are to be made prospectively on a per discharge basis. Part A Inpatient Hospital operating costs include costs (including malpractice insurance cost) for general routine services, ancillary services, and intensive care type unit services. However, they exclude capital-related costs incurred prior to October 1, 1991, when capital-related costs began to be paid based on a separate prospective payment rate and direct medical education costs (which are paid using a different method). Part B inpatient ancillary and outpatient service will continue to be paid retrospectively on a reasonable cost basis.

The following hospitals and hospital units are exempt from the PPS:

- Hospitals located outside the 50 States and the District of Columbia;
- Psychiatric hospitals;
- Rehabilitation hospitals
- Long term hospitals;
- Children's hospitals;
- Psychiatric and rehabilitation units of general hospitals which meet the separate entity requirement of the Provider Reimbursement Manual, Part I, or §§1814 or 1886(c); of the Act; and
- Hospitals subject to State rate setting authority operated under §§1814 or 1886(c) of the Act.

These hospitals will continue to be paid on the basis of reasonable costs, subject to applicable target rate ceilings contained in §1886(b) of the Act.

NOTE: The exemption is not optional on the part of the provider but is required as long as the hospital or hospital unit meets the definition for exemption.

In addition, other entities are paid on a prospective basis (including SNFs, Outpatient Hospitals, etc.) under §1888(d) of the Act. Payments made for services will be governed by the same rules that are used for Medicare beneficiaries not enrolled in a HMO/CMP.

For a detailed discussion of the PPS provision, see the Provider Reimbursement Manual and the Intermediary Manual.

300 - Duplicate Payment Detection for Cost Contracting HCPPs and HMOs/CMPs

(Rev. 63, 11-12-04)

Several entities may have jurisdiction over the processing and payment of Part B bills for an HMO's/CMP's members. This could result in duplicate payments to either the

physician, supplier, or to the enrollee. It is incumbent that HCPPs and HMOs/CMPs establish a system to preclude or detect duplicate payments.

Regardless of the claims option selected, HMOs/CMPs are required to process all non-provider Part B bills, with some exceptions. These exceptions, as noted below, are processed by the carrier or intermediary:

- Claims for services by an independent physical therapist;
- Claims for outpatient blood transfusions;
- Claims from physicians for dialysis and related services provided through an approved dialysis facility;
- Claims for home health services received under cost reports beginning on or after January 1, 2005; and
- Hospice care by Medicare participating hospices, except:
 - a. Services of the enrollee's attending physician if the physician is an employee or contractor of the organization and is not employed by or under contract to the member's hospice; and
 - b. Services not related to the treatment of, or a condition related to, the terminal condition.

Duplicate payment detection is the responsibility of the HCPP or HMO/CMP, not the carrier. The HCPP or HMO/CMP should perform several duplicate check functions after it receives paid claims information. If the HCPP or HMO/CMP has not previously paid the claim, a copy of the claims information is filed in the beneficiary's history file. If the duplicate payment check reveals that the HCPP or HMO/CMP has already paid for the services:

- Contact the physician/supplier or enrollee to retrieve the overpayment;
- Record any collections as credits on the cost report;
- Notify CMS of unresolved overpayment situations; and
- Do not return payment to the carrier.

300.1 - Coordination of Benefits

(Rev. 4, 10-01-01)

The Medicare program is usually the primary payer for covered Medicare services provided to Medicare members of a Medicare cost-based HMO/CMP; however, there are six categories of services for which Medicare is the secondary payer if a timely filed claim was submitted to the primary payer. These are:

- Services covered by a State or Federal Workers' Compensation law (WC);

- Services covered by no fault insurance;
- Services covered by any liability insurance;
- Services covered by Employer Group Health Plans (EGHPs) in the case of ESRD beneficiaries during a period of generally 30 months;
- Services covered by EGHPs in the case of employed beneficiaries age 65 and over and the spouses age 65 and over, of employed individuals; and
- Services covered by Large Group Health Plans (LGHPs) in the case of certain disabled Medicare beneficiaries who are covered by reason of their employment or the employment of a family member.

No payment will be made to a cost-based HMO/CMP for services to the extent that Medicare is not the primary payer under the provisions of §1862(b) of the Act.

If a Medicare enrollee receives covered services from the cost-based HMO/CMP for which the enrollee is entitled to benefits under one of the preceding categories, the HMO/CMP may charge or authorize a provider that furnished the service to charge:

- An insurance carrier, employer, or other entity that is the primary payer for these services; or
- The Medicare enrollee, to the extent that he/she has been paid by such a primary payer.

300.1.1 - Definition of Certain Terms Used in Coordination of Benefits

(Rev. 4, 10-01-01)

- CMS's claim is the amount that is determined to be owed to the Medicare program. This is the amount that was paid out by Medicare, less any prorated procurement costs (see 42 CFR 411.37) if the claim is in dispute.
- An Employer, as used in these instructions, means not only individuals and organizations engaged in a trade or business, but also includes organizations exempt from income tax, such as religious, charitable, and educational institutions, as well as the governments of the United States, the States, Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Mariana Islands, and the District of Columbia, including their agencies, instrumentalities, and political subdivisions.
- A secondary payer for purposes of this instruction, when used with respect to Medicare payment, means that Medicare incurs a legal obligation to pay only after other primary third party payers satisfy their payment responsibilities. If the primary payer covers all expenses, Medicare has no payment obligation. If the primary payer covers part of the expenses, Medicare may pay for the residual, uncovered amounts. In certain instances when the primary payer does not pay promptly, CMS pays conditional primary benefits and later recovers them from the responsible party.
- Subrogation means the substitution of one person or entity for another.

300.2 - The Medicare HMO/CMPs' Obligations

(Rev. 4, 10-01-01)

When the Medicare program is not the primary payer for covered Medicare services provided to Medicare members of an HMO/CMP, the organization must:

- Identify payers that are primary to Medicare under §1862(b) of the Act;
- Determine the amounts payable by these payers; and
- Take steps in accordance with these instructions and the instructions in §§3407-3419 and §§3489-3492 of the Medicare Intermediary Manual to assure that Medicare pays only secondary benefits when another insurer is primary payer.

In addition, in situations when the cost-based HMO/CMP may charge another HMO/CMP or the Medicare beneficiary for services when Medicare is not primary payer, it may also require the enrollee to sign a subrogation agreement under which the HMO/CMP is given the rights the beneficiary has against the third party.

300.3 - General Fee-For Service (FFS) Coordination of Benefits Rules

(Rev. 4, 10-01-01)

All Medicare payments are contingent upon payment or reimbursement to the appropriate Trust Fund when notice or other information is received that payment for the same items or services has also been made, or could be made, by a primary payer.

Section 1862(b) of the Act now expressly provides that:

- CMS may bring an action against any entity which is required or responsible to pay primary in order to recover Medicare payments directly from that entity;
- The government is subrogated to the right of any individual or entity to receive payment from a responsible third party. Under the Medicare subrogation provision, the government is given whatever rights the beneficiary or any other entity had against the responsible third party to the extent that Medicare has made payments to or on behalf of the beneficiary; and
- The government may join or intervene in any action related to the events that gave rise to the need for the items or services for which Medicare paid.

300.4 - Other Provisions

(Rev. 4, 10-01-01)

Any claimant, including an individual who received services and the provider or supplier, has the right to take legal action against an Employer Group Health Plan (EGHP) or Large Group Health Plan (LGHP) that fails to pay primary benefits for services covered by both the EGHP or LGHP, Medicare, and to collect double damages. (See §36.5.)

According to §2000 of the Internal Revenue Code (IRC), an excise tax may be imposed on any employer or employee organization that contributes to the nonconforming EGHP or LGHP during a calendar year. The amount of tax is 25 percent of the total amount that

the employer or employee organization contributed to the EGHP or LGHP during that year. This tax penalty does not apply to Federal and other governmental entities.

300.5 - Conflicting Claims by Medicare and Other Third Parties

(Rev. 4, 10-01-01)

Situations may arise in which both Medicare and another insurer or State Medicaid agency have conditionally or erroneously paid for services, and the amount payable by the third party payer is insufficient to reimburse both programs. Under §1862(b)(2)(B) of the Act, Medicare has the right to recover its benefits from the responsible third party before any other entity, including a State Medicaid Agency. Also, Medicare has the right to recover its benefits from any entity, including a State Medicaid Agency that has been paid by the responsible third party. In other words, Medicare's recovery rights when another third party is primary payer take precedence over the rights of any other entity.

The superiority of Medicare's recovery right over those of other entities, including Medicaid, derives from the preceding cited statute.

If Medicare and Medicaid both have claims against the responsible third party, Medicare's right to recover its benefits from another insurer or from a beneficiary that has been paid by another third party is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort, and therefore, does not pay its benefits until after Medicare has been paid.

Medicare's priority right of recovery from insurance plans that are primary to Medicare does not violate the concept of Medicaid being payer of last resort. Under §1862(b) of the Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) when payment can reasonably be expected by a third party which is primary to Medicare. If a third party that is primary payer pays promptly, Medicare makes no payment to the extent of the third party payment. Delay of the other payment does not change Medicare's ultimate obligation to pay the correct amount, if any, regardless of any Medicare payments conditionally made. Thus, when a responsible third party pays the charges, or if it pays less and the provider is obligated to accept that amount as payment in full, Medicare may not pay at all. Pro rata or other sharing of recoveries with third parties would have the effect of creating a Medicare payment when none is authorized under the law, or improperly increasing the amount of any Medicare secondary payment.

Moreover, the right of Medicaid agencies to recover their benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party payment. Since the beneficiary can assign to the State a right no higher than his/her own, and since Medicare's statutory right is higher than the beneficiary's, Medicare's right is higher than that assigned to the State.

300.6 - Coordination with Worker's Compensation

(Rev. 4, 10-01-01)

Medicare may not pay for services that are payable under Workers' Compensation (WC) laws. Where the Medicare cost-based HMO/CMP coordinates its own health organization with WC coverage, it will use the procedures developed by its own organization to

identify and recover costs for services furnished to Medicare members. When the Medicare cost-based HMO/CMP does not coordinate benefits for its own organization, it must establish reasonable screening procedures to identify potential WC liability situations. If it is determined that Medicare has paid for items or services which can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. For specific information regarding the WC plan of a particular governmental entity, contact the appropriate agency of the governmental entity.

If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, the services can be paid for by Medicare.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing of a claim, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

NOTE: When failure to file a proper claim is due to mental or physical incapacity of the beneficiary, and the provider could not have known that WC was involved, this rule does not apply.

300.6.1 - Definitions Under WC

(Rev. 4, 10-01-01)

- A WC law or plan is a government supervised and employer supported system for compensating employees for injury or disease suffered in connection with their employment, regardless of whether the injury was the fault of the employer. WC does not usually cover agricultural employees, interstate railroad employees, employees of small businesses, employees whose work is not in the course of the employer's business (e.g., domestic employees), casual employees, and self-employed people. All States provide compensation for at least some occupational diseases.

The definition also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program). These Federal programs provide WC protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs (e.g., coal miners totally disabled due to pneumoconiosis; maritime workers, with the exception of seamen; employees of companies performing overseas contracts with the United States government; employees of American companies who are injured in an armed conflict; employees paid from non-appropriated Federal funds, such as

employees of post exchanges; and offshore oil field workers). The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this provision. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this provision.

- Workers' Compensation Agency means any governmental entity that administers a Federal or State WC law. This term includes WC commissions, industrial commissions, industrial boards, WC insurance funds, WC courts and, in the case of Federal workers' compensation programs, the U.S. Department of Labor.
- Workers' Compensation Carrier means any insurance carrier authorized to write WC insurance under the State or Federal law, the State compensation fund in which the State administers the WC program, and the beneficiary's employer in which the employer is self-insured.
- Lump Sum Compromise Settlement is a settlement that provides less in total compensation than the individual would have received if the claim had not been compromised. This may occur when compensability is contested.

300.7 - Additional Processing Instructions

(Rev. 4, 10-01-01)

For further information on how to implement this Medicare secondary payer provision, refer to §§3407.2 - 3417.2 of the Intermediary Manual. These sections include information regarding the method of calculating Medicare secondary payments, contested WC claims, lump sum commutations of future benefits, and the effect of a lump sum compromise settlement.

310 - Coordination for ESRD Patients

(Rev. 4, 10-01-01)

Medicare is secondary to benefits payable under an EGHP in the case of individuals who are entitled to benefits solely or partly on the basis of ESRD during a period of 18 months. During a period of 30 months, Medicare is secondary for all Medicare services, not just ESRD-related services. At the end of the coordination period, Medicare becomes the primary payer for these Medicare enrollees.

The 30-month period begins with the earlier of the first month of Part A eligibility or entitlement based solely or partly on ESRD.

If the basis for an individual's entitlement to Medicare changes from ESRD to age 65 or disability, the coordination period will continue. In like respects, if the individual is entitled to Medicare benefits for other reasons, the coordination period will apply once the individual is determined to have ESRD. The following steps are involved in determining Medicare responsibility as the secondary or primary payer:

- Identify Medicare members entitled solely or partly because of ESRD;
- Determine the period within which benefits must be coordinated; and
- Determine if services rendered can be paid for by an EGHP.

310.1 - Definition of Employer Group Health Plan (EGHP) or Employer Plan

(Rev. 4, 10-01-01)

When used in context of entitlement to Medicare based solely on ESRD, these terms mean any health organization that:

- Is paid for by, or contributed to by, an employer, and
- Provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, or to current or former employees and their families.

It includes the Federal Employees Health Benefits (FEHB) program. Employees pay all plans, i.e., group health plans under the auspices of an employer which do not receive any contributions from the employer, also meet the definition of EGHP.

NOTE: Under this provision, Medicare is secondary to EGHPs, regardless of the number of employees who work for the employer.

310.2 - Additional Processing Instructions

(Rev. 4, 10-01-01)

For further information on how to implement this Medicare secondary payer provision, refer to §§3490.3 - 3490.16 of the Intermediary Manual. These sections include, among other things, information regarding the implementation of this provision retroactively, the processing of current claims, the determination of the 18-month period in which Medicare may be secondary, and the method of calculating the Medicare secondary payment.

320 - Coordination With No-Fault Insurance

(Rev. 4, 10-01-01)

Medicare may not pay for any items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services, under any no fault insurance (including a self-insured organization). Medicare is secondary to no fault insurance even if State law or a private contract of insurance stipulates that Medicare is primary. If Medicare payments have been made, but should not have been because they are excluded under this provision, or if the payments were made on a conditional basis, they are subject to recovery.

The issue in cases involving accident related medical expenses is whether no fault benefits can be paid for these particular services. If so, the no fault insurance is primary. If not, Medicare may be primary. Primary Medicare benefits cannot be paid merely because the beneficiary wants to save his/her no fault insurance benefits to pay for future services. Since no fault insurance benefits would be currently available in that situation, they must be used before Medicare.

Expenses for services for which Medicare payment may not be made because payment has been made or can reasonably be expected to be made promptly under any no fault

insurance, are credited toward Part A or Part B deductible amounts. Inpatient care that is paid for by a third party payer is not counted against the number of days available to the beneficiary under Medicare Part A.

320.1 - Definition of Automobile and No-Fault Insurance

(Rev. 4, 10-01-01)

- An automobile is defined for the purposes of this instruction, as any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.
- No-Fault Insurance is insurance coverage (including a self-insured plan) that pays for all or part of the medical expenses for injuries regardless of who may have been responsible for causing the accident. (This insurance is sometimes called personal injury protection (PIP), medical payments coverage, or medical expense coverage.)

320.2 - Additional Processing Instructions

(Rev. 4, 10-01-01)

For further information on how to implement this Medicare secondary provision, refer to §§3489.3 - 3489.9 of the Medicare Intermediary Manual. These sections include, but are not limited to, information regarding the processing of claims, the necessary action to take if there is the possibility of payments under no fault insurance, and the method of calculating the secondary Medicare payment.

330 - Benefit Coordination for Services Reimbursable Under Liability Insurance

(Rev. 4, 10-01-01)

Under §1862(b)(2)(A) of the Act (42 U.S.C. 1395y(b)(2)(A)), payment may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan (including a self-insured plan). All Medicare payments are contingent upon payment to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under a liability insurance policy or plan (including a self-insured plan). Medicare is subrogated to the rights of the beneficiary and may also recover its benefits directly from liability insurance companies and self-insured plans, and from any entity, including the beneficiary, that has been paid by a liability insurer. Medicare's right to recover its benefits from liability insurers, and from those who have been paid by liability insurers takes precedence over the claims of any other party, including Medicaid.

Under this Medicare Secondary Payer (MSP) provision, the program is a claimant against the responsible party and the liability insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary. Medicare can be a party to any claim by a beneficiary or other entity against a liability insurer, can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare, and may seek recovery of conditional payments directly from the liability insurer. Section

1862(b) of the Act provides that any claimant has the right to take legal action against a liability insurer that fails to pay primary benefits for services covered by the insurer, and to collect double damages.

330.1 - Definition Under Liability Insurance

(Rev. 4, 10-01-01)

- Liability Insurance is insurance (including a self-insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured and under-insured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability, insurance and general casualty insurance. It also includes payments under State wrongful death statutes that provide payment for medical damages.

NOTE: This provision does not apply when the homeowner receives payment under his/her own homeowners' insurance policy, since such a payment does not constitute a liability insurance payment.

- A Self-Insured Plan is a plan under which an individual or other entity is authorized by State law to carry its own risk instead of taking out insurance with a carrier. Authorized by State law means not prohibited by State law. The plan established for the Federal government under the Federal Tort Claims Act is also a self-insured plan.
- Uninsured Motorist Insurance is a liability insurance plan under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law.
- Under-Insured Motorist Insurance is optional liability insurance available in some jurisdictions under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.
- An accident is any occurrence or activity that the individual believes resulted in injury or illness for which he/she holds another party liable.

330.2 - Additional Processing Instructions

(Rev. 4, 10-01-01)

For further information on how to implement this MSP provision, refer to §§3419.3 - 3419.10 of the Intermediary Manual. These sections include, among other things, information regarding billing rights and responsibilities, identification of liability situations, and actions to be taken when a liability claim has been filed.

340 - Benefit Coordination for Working Aged Individuals Entitled to Medicare

(Rev. 4, 10-01-01)

Under §1862(b)(1)(A) of the Act, if an employer has 20 or more employees (calculated as described below) and offers a group health plan (referred to here as an EGHP), the EGHP is the primary payer for individuals who are 65 or over, and who are covered under the plan based on current employment of the individual or the individual's spouse. (Medicare remains the primary payer for retirees.)

Medicare is secondary only if the individual is entitled to Medicare Part A. Generally, Medicare is not secondary for persons over age 65 who have ESRD. The law also prohibits EGHPs from taking into account, in furnishing services, that an individual is entitled to Medicare benefits, and requires that employees or their spouses, who are 65 or over, be entitled to the same benefits under the same conditions as individuals under age 65. If the EGHP violates either of these provisions, Medicare is entitled to collect primary payments from the organization as if the violations had not occurred. The nonconforming plan is also subject to an excise tax imposed under the Internal Revenue Code (IRC).

340.1 - Application of 20 Employee Threshold

(Rev. 4, 10-01-01)

This requirement applies if an employer has 20 or more full-time or part-time employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year. An employer who does not have 20 or more employees in the preceding year is required to offer employees and spouses age 65 or over, primary coverage beginning with the point in time at which the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year, even if the number of employees later drops below 20 after the employer has met the threshold. If the individual receives the services for which Medicare benefits are claimed after the employer has met the 20 or more employees threshold in the current year or in the preceding calendar year, the EGHP is the primary payer. An employer that meets this threshold must provide primary coverage even if less than 20 employees participate in the employer plan.

Self-employed individuals who participate in the plan are not counted as employees for the purpose of determining if the 20 or more employees requirement is met. There is no requirement that an employer provide coverage to self-employed individuals. However, any coverage provided to self-employed persons by an employer of 20 or more employees must be primary to Medicare.

Assume for purposes of developing claims that, in the absence of evidence to the contrary, an employer in whose health organization a beneficiary is enrolled because of employment, meets the definition of employer and employs at least 20 people. An employer's allegation that the 20-employee requirement is not met, or a multi-employer organization's statement identifying specific members as employees of employers of

fewer than 20 employees, can be accepted as a basis for making Medicare primary payments. Refer questionable cases to the CMS (RO).

The following steps are involved in determining if Medicare is the secondary or primary payer:

- Determine if the member (or spouse) is eligible for consideration;
- Determine if the member or spouse is age 65 or over and entitled to Part A (this is shown on the reply listing);
- Determine if the individual who is age 65 or over is covered under the employer's health organization by reason of current employment;
- Determine if the member or spouse has ESRD;
- If the Medicare member age 65 or over is not covered due to current employment (including self-employment), determine if the spouse is covered by reason of current employment and, if so, whether the Medicare member is covered under the spouse's EGHP; and
- Determine if the services are covered under the employer plan.

The HMO/CMP is responsible for identifying affected individuals as part of the enrollment process. Medicare payment is reduced to the extent that the expenses are payable under an employer plan.

340.2 - Definition Under EGHP

(Rev. 4, 10-01-01)

A Medicare cost-based HMO/CMP, in making a decision as to whether Medicare is primary or secondary, must be aware of the definition of these terms:

- **Employed**, for purposes of this discussion, encompasses not only employees. It also includes, subject to the special rules in this chapter, self-employed persons such as consultants, owners of businesses, directors of corporations, and members of the clergy and religious orders who are paid for their services by a religious body or other entity.
- **Employer** means, in addition to individuals and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.
- **EGHP for the working aged** means any health organization that is paid for by or contributed to by an employer of 20 or more employees and which provides medical care, directly or through other methods, such as insurance or reimbursement, to current or former employees or to current or former employees and their families. This includes a multi-employer plan (i.e., a plan sponsored jointly by employers and unions) and a multiple employer plan (i.e., a plan sponsored by more than one employer) which is sponsored by or contributed to by

at least one employer that has 20 or more employees. Under §1862(b)(1)(A)(iii) of the Act, if a multi-employer plan or multiple EGHP can identify particular enrollees as employees of employers that do not meet the 20-employee threshold, the MSP rules do not apply to these enrollees and their spouses. However, the organization must elect this treatment for the exception to apply.

The Federal Employees Health Benefits (FEHB) program meets the definition of an EGHP. Employees that pay all plans, i.e., group health plans under the auspices of an employer which do not receive any contribution from the employer, also meet the definition of an EGHP.

Assume, in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the beneficiary's or the beneficiary's spouse's employment meets this definition.

NOTE: Medicare is secondary to EGHP coverage only if the EGHP coverage is by reason of the employee's current employment. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare.

Multi-Employer Group Health Plan and Multi-Employer Plan are terms that refer to a multiple employer plan, which is a plan sponsored by more than one employer, or a multi-employer plan, which is sponsored jointly by employers and unions.

340.3 - Additional Special Rules Applicable to EGHPs

(Rev. 4, 10-01-01)

There are additional rules that the Medicare cost-based HMO/CMP must follow in making EGHP coverage decisions. These rules are outlined in the following sections.

340.3.1 - Self-Employed Individuals

(Rev. 4, 10-01-01)

These are currently employed persons. It includes not only employees, but also self-employed persons such as directors of corporations and owners of businesses. If a self-employed individual enrolls in an EGHP that meets the definition in this chapter, the employer plan is primary for that individual and the individual's spouse.

340.3.2 - Members of Clergy and Religious Orders Who Have Not Taken a Vow of Poverty

(Rev. 4, 10-01-01)

The following general guidelines apply in determining the employment or retirement status of members of the clergy and members of religious orders when an EGHP alleges that such an individual is retired (members of clergy or members of religious order who have not taken vow of poverty). Such members are:

- Considered employed if they are receiving from a church, religious order or other employing entity cash remuneration for services rendered regardless of whether their earnings are exempt from Social Security coverage; and
- Considered retired if the church, religious order, or other employing entity states that the members are retired, and that they receive only retirement pay from the entity rather than remuneration for services rendered.

340.3.3 - Members of Religious Order Who Have Taken Vow of Poverty (Rev. 4, 10-01-01)

Medicare is not secondary for individuals who perform services as members of a religious order whose members are required to take a vow of poverty if those activities are considered employment only because of an election of Social Security coverage by the order under §3121(r) of the Internal Revenue Code. This means Medicare is primary to the group health coverage provided as a result of those activities. Those activities may not be considered in determining whether a member of the order is considered an employed individual for purposes of the working aged provision.

This exception applies only to religious functionaries who are members of religious orders and who have taken a vow of poverty. It does not apply to Protestant and Jewish clergy, who do not take the vow of poverty. It does not usually apply to Catholic parish priests, most of who do not take vows of poverty, nor does it apply to any member of a religious order who has not taken a vow of poverty. Furthermore, the exception does not apply to group health coverage based on work performed by members of religious orders for employers outside of their orders. Also, the MSP definition of “employed” remains applicable to employees of religious orders who provide service and are reimbursed by the orders, but who are not themselves members of the orders. The usual MSP rules apply to such individuals.

340.4 - Individuals Who Receive Disability Payments

(Rev. 4, 10-01-01)

A person receiving disability payments from an employer is considered employed if such payments are subject to taxes under the Federal Insurance Contributions Act (FICA).

Employer disability payments are subject to FICA tax for the first 6 months of disability after the last calendar month in which the employee worked for that employer.

EXAMPLE:

Adam Green stopped working because of disability in December 1987 at age 66. His employer began paying him disability payments as of January 1988. Since sick pay is taxed under FICA for 6 months after the last month in which the employee worked, Medicare is the secondary payer through June 1988. Beginning with July 1988, Medicare becomes the primary payer as the sick payments are no longer considered wages under FICA.

350 - Additional Processing Instructions

(Rev. 4, 10-01-01)

For further information on how to implement this Medicare secondary provision, refer to §§3491.3 - 3491.17 of the Medicare Intermediary Manual. These sections include, among other things, information regarding the individuals covered by this provision, the coordination of benefits with other insurers, the method of calculating the Medicare secondary payment, and special rules for services furnished by a source outside the prepaid EGHP.

350.1 - Benefit Coordination with a Large Group Health Plan

(Rev. 4, 10-01-01)

Under §1862(b)(1)(B) of the Act, Medicare is secondary payer to LGHPs for active individuals under age 65 entitled to Medicare on the basis of disability. Under the law, an LGHP may not take into account that an active individual is eligible for or receives benefits based on disability. The individual's coverage under the LGHP must be based on the individual's employment or the employment of a family member. Refer to §3492 of the Medicare Intermediary Manual for processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to an EGHP of 20 or more employees, substitute the term "large group health plan" for purposes of applying them to disabled individuals. This provision is effective for items and services furnished on or after January 1, 1987, and before October 1, 1995.

A large group health plan means any health plan that meets the following criteria:

- Is paid for by or contributed to by an employer or by an employee organization, including a self-insured plan;
- Provides health care directly or through other methods such as insurance or reimbursement to employees, the employer, other associated or formerly associated with the employer in a business relationship or their families; and
- Covers employees of at least one employer that normally employed at least 100 full or part-time employees on a typical business day during the previous calendar year. The term "employer," for the purpose of this provision, includes the Federal government and other governmental entities.

A group health plan that covers employees of at least one employer that had 100 or more employees on 50 percent or more of its business days during the preceding calendar year, is considered to meet the above definition of an LGHP.

350.2 - A Nonconforming LGHP

(Rev. 4, 10-01-01)

A nonconforming LGHP means that at any time during the calendar year, it is taken into account that an active individual is eligible for or receives benefits based on disability, for example, an LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer.

NOTE: Although the term “large group health plan” includes a plan for former employees or persons formerly associated with the employer in a business relationship or their families, these individuals are not included in the definition of active individual, i.e., Medicare is not secondary for them. These individuals are included within the definition of LGHP for tax purposes.

350.3 - Definition of an Active Individual

(Rev. 4, 10-01-01)

An active individual is an employee, an employer, a self-employed individual (such as the employer), an individual associated with the employer in a business relationship (e.g., suppliers and contractors who do business with the employer and their employees), or a member of the family of any of these persons such as the spouse, parent or child of such an individual.

The disabled individual may be the employee, a self-employed individual such as the employer or individual associated with the employer in a business relationship. Also, the disabled person may be the family member of the employee, a self-employed individual such as the employer, or an individual associated with the employer in a business relationship.

350.4 - Definition of an Employee

(Rev. 4, 10-01-01)

An employee is an individual who is actively working for an employer or, since disabled persons are not usually working, a person whose relationship to an employer is indicative of employee status. Whether or not such a person is an employee is established by the facts applicable to the person’s relationship to the employer. The question to be decided is whether the employer treats a disabled individual who is not working as an employee, in light of commonly accepted indicators of employee status rather than whether the person is categorized in any particular way by the employer.

350.5 - Special Rules for Individual Employee Status

(Rev. 4, 10-01-01)

In general, an individual who is not actively working is considered to have employee status if the relationship is such that:

- The individual is receiving payments from an employer which are subject to taxes under the Federal Insurance Contributions Act (FICA), or would be subject to such taxes except that the employer is one that is not required to pay such taxes under the IRC;
- The individual is termed an employee under State or Federal law or in accordance with a court decision;
- The employer pays the same taxes for the individual as he/she pays for actively working employees;
- The individual continues to accrue vacation time or receives vacation pay;

- The individual participates in an employer's benefit plan in which only employees may participate;
- The individual has rights to return to duty if his/her condition improves; and
- The individual continues to accrue sick leave.

350.5.1 - Individuals Not Subject to This Limitation Payment

(Rev. 4, 10-01-01)

Medicare is not secondary for:

- Individuals entitled, or who would upon application be entitled, to Medicare under the ESRD provision that are not in the coordination period, i.e., individuals who have ESRD even though their current Medicare entitlement is on the basis of disability;
- Individuals who are covered by an EGHP of employers of less than 100 employees, unless the EGHP is a multi-employer plan in which there is at least one employer of 100 or more employees; and
- Individuals whose coverage by an LGHP is not based on either employment or a relationship to an employee, employer, or an individual associated with an employer in a business relationship. For example, Medicare is primary for a disabled individual who is covered under an LGHP as a retired former employee, and who does not meet any of the criteria in §30.1 or who is the spouse of a retired former employee.

350.6 - Failure to Pay Primary Benefits

(Rev. 4, 10-01-01)

Any claimant, including an individual who received services and the provider or supplier, has the right to take legal action against an LGHP that fails to pay primary benefits for services covered by both the LGHP and Medicare, and to collect double damages.

360 - Additional Processing Instructions

(Rev. 4, 10-01-01)

For further information on how to implement this Medicare secondary provision, refer to §§3492.E - 3492.K of the Medicare Intermediary Manual. The following sections include, among other things, information regarding individuals subject to this provision, the legal action that may be brought against an LGHP, and the tax penalty for noncompliance by a LGHP.

360.1 - Federal Government's Right to Sue and Collect Double Damages

(Rev. 4, 10-01-01)

Separate from its subrogation rights, the Federal Government has an independent right to take legal action to recover payments from entities that are required or responsible to pay benefits primary to Medicare, but fail to do so. The Federal Government may recover

double damages in this type of lawsuit pursuant to §1862(b)(2)(B)(ii) of the Act. Entities that are required or responsible to pay primary to Medicare include:

- A group health plan, including insurers, employers, and third party administrators of such plans;
- A LGHP, including insurers, employers, and third party administrators of such plans;
- Any liability insurance policy or plan, including a self-insured plan;
- A WC plan; and
- An automobile or non-automobile no fault insurance plan.

The Medicare cost-based HMO/CMP should refer any case in which an entity is required or responsible to make primary payment, but refuses to do so, to the CMS RO servicing the HMO/CMP's area. The HMO/CMP should include, in addition to the beneficiary's name, address, and SSN or HICN, the formal name and address of the insurer or HMO/CMP; the employee brochure that describes health benefits and coverage; the name and address of the entity required or responsible for making payment on behalf of the plan (e.g., the employer, an insurer or a third party administrator (TPA)); a copy of the employer's agreement with the TPA; the name of the sponsoring or contributing employer or employee organization; the provider's name, address, and identification number; the specific amount of mistaken primary benefits Medicare paid; the specific date(s) of service; the specific procedure or diagnosis code(s) the MSP type (e.g., ESRD or working aged); and a full explanation of the reasons for the referral. The CMS RO reviews the case file for completeness and obtains any needed additional information. When the file is complete, the CMS RO refers the case to CMS CO. CMS CO considers possible legal action to collect double damages from that entity.

The government's right to sue and collect double damages is effective for items and services furnished on or after December 20, 1989, under all MSP provisions except the MSP for the disabled provision. The government's right to sue and collect double damages under the MSP for the disabled provision, is effective for items and services furnished on or after January 1, 1987.

370 - Excise Tax Penalties for Contributors to Nonconforming Group Health Plans

(Rev. 4, 10-01-01)

Section 5000 of the IRC of 1986, imposes an excise tax penalty on employers and employee organizations that contribute to nonconforming group health plans. They are taxed 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each group health plan (conforming as well as nonconforming) to which they contribute. This tax penalty does not apply to Federal and other governmental employers.

The term "nonconforming group health plan" means a group health plan or LGHP that at any time during a calendar year, fails to comply with any of the following provisions of the working aged, disability, or ESRD Medicare secondary laws.

370.1 - Working Aged

(Rev. 4, 10-01-01)

Section 1862(b)(1)(A)(i)(I) of the Act provides that a group health plan may not take into account that a currently employed individual age 65 or over (or a spouse age 65 or over of an employed individual of any age) is entitled to Medicare. Further, §1862(b)(1)(A)(i)(II) of the Act states that a group health plan must provide the same benefits under the same conditions to employees and employees' spouses age 65 or over as it provides to employees and employees' spouses under age 65.

370.2 - Disability

(Rev. 4, 10-01-01)

Section 1862(b)(1)(B)(i) of the Act provides that a LGHP may not take into account that a disabled active individual is entitled to Medicare based on disability. The term "active individual" means an employee, the employer, self-employed individual (such as the employer), an individual associated with the employer in a business relationship, or a member of the family of any such persons.

370.3 - End Stage Renal Disease (ESRD)

(Rev. 4, 10-01-01)

Section 1862(b)(1)(C) of the Act provides that a group health plan may not take into account that an individual is entitled to Medicare solely on the basis of ESRD during the period when Medicare is secondary payer.

Further, a group health plan may not differentiate on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner in the benefits it provides between individuals having ESRD, and other individuals covered by such plan.

Examples of discriminatory actions by a group health plan or LGHP that constitute noncompliance with these provisions include:

- Failure to make primary payment on behalf of an individual for whom Medicare is secondary;
- Providing secondary or complementary coverage to such an individual;
- Refusal to allow such an individual to enroll or re-enroll in the group health plan or large group health plan because of Medicare entitlement;
- Providing a different level of benefits for individuals for whom Medicare is secondary than it provides for other persons enrolled in the plan;
- Imposing limitations on benefits, exclusions of benefits, reductions in benefits, higher premiums, higher deductibles or coinsurance, longer waiting periods, lower annual or lifetime benefit limits, or more restrictive pre-existing illness limitations for persons for whom Medicare is secondary payer that are not applicable to others enrolled in the plan;
- Terminating coverage because a person has become entitled to Medicare; or
- Failure to cover routine maintenance dialysis services or kidney transplants.

The Medicare cost-based HMO/CMP should refer any case of a nonconforming group health plan to the RO servicing its area. The HMO/CMP should include, in addition to the beneficiary's name, address, and SSN or HICN, the formal name and address of the nonconforming group health plan; the name and address of the entity required or responsible for making payment on behalf of the plan (e.g., the employer, an insurer, or a third party administrator (TPA)); a copy of the employer's agreement with the TPA; the name of the sponsoring or contributing employer or employee organization; the employer or employee organization taxpayer identification number; year(s) of violation; the provider's name, address and identification number; the specific amount of Medicare payments associated with the nonconformance; the specific date(s) of service; the specific procedure or diagnosis code(s); the MSP type (e.g., ESRD or working aged); and a full explanation of the reasons for the referral. The CMS RO reviews the case file for completeness and obtains any needed additional information. When the file is complete, the RO refers the case to CMS CO. CMS CO reviews the case and refers it to the Internal Revenue Service (IRS) to impose the excise tax on employers and employee organizations that have contributed to the plan.

The excise tax penalty for nonconformance with the working aged and ESRD MSP provisions can be imposed for acts of discrimination occurring on or after December 20, 1989. The excise tax penalty for nonconformance with the disability MSP provision can be imposed for acts of discrimination occurring on or after January 1, 1987.

380 - Applying Recoveries to the Cost Report

(Rev. 4, 10-01-01)

Total reimbursable Medicare enrollee costs must be reduced by the value of services for which Medicare is not the primary insurer.

In addition, the Part A and Part B deductible should be computed based only upon amounts for which Medicare is the primary insurer. When the primary payer is a WC plan, a no fault insurer, or an EGHP, the amounts paid by the primary payer are credited to the deductibles. Therefore, the entire charge should be considered in computing the deductibles. The bases for offsets are:

- The amount recoverable; or
- A member month ratio

390 - Alternative Method for Cost Report Treatment of Employer Health Plans

(Rev. 4, 10-01-01)

In the case of benefits covered by an employer plan for a Medicare member who is also a group member under the employer's plan, the Medicare cost-based HMO/CMP may elect to identify the cost or charge for the service covered under that plan. However, instead of specifically identifying those services for which an employer health plan is primarily liable for payment, the HMO/CMP may elect to utilize a member month ratio to establish Medicare's liability. This election must be made in writing at the time of a timely submitted budget. In addition, this election must be made for the groups of Medicare beneficiaries subject to the MSP provisions as described in this chapter.

Once the election is made, the election will remain in effect until it is revoked by the Medicare cost-based HMO/CMP in writing on a timely submitted budget.

The member month ratio is developed by dividing the Medicare member months by the total Medicare member months. This ratio would then be applied to covered Medicare service costs resulting in those costs for which Medicare is the primary payer.

400 - Determining Total Costs for Comparison with Capitation Limits

(Rev. 4, 10-01-01)

The total cost of services provided directly or arranged by the Medicare cost-based HMO/CMP, as well as emergency and urgently needed services, will be compared to 100 percent of the weighted average of the capitation amounts, for the Medicare cost-based HMO/CMP's membership. This comparison will be used as a reasonable cost guideline. For comparison purposes, non-emergency or non-urgently needed out-of-plan care arranged independently by the Medicare enrollee would not be considered unless the HMO/CMP accepts financial responsibility for the service.

CMS will use these comparisons to determine if further investigation of claimed costs is necessary. For example, CMS could require the Medicare cost-based HMO/CMP to supply additional information to verify the costs claimed on the cost report. In addition, CMS could use this information to establish the criteria used to select a cost report for audit potential.

Costs will consist of those costs incurred directly by the HMO/CMP plus the costs incurred by CMS on behalf of the HMO/CMP. The bill summary report and the carrier payment report will be used to report the total cost for services furnished on behalf of the HMO/CMP.

NOTE: 42 CFR 417.532(a)(3) applies the weighted average of the AAPCCs of each class of the HMOs or CMPs Medicare enrollees for that plan's geographic area as an absolute limitation on the total amount payable. In October of 1989, Ruling HCFAR-89-2 directed CMS not to use the AAPCC as an absolute limit; however, the AAPCC can be used as a reasonable cost guideline.

410 - Taxes Assessed Against the Medicare Cost-Based HMO/CMP

(Rev. 4, 10-01-01)

The general rule is that taxes assessed against the Medicare cost-based HMO/CMP, in accordance with the levying enactments of the several States and lower levels of government, and for which the organization is liable for payment, are allowable costs. Tax expense should not include fines and penalties.

Whenever exemptions to taxes are legally available, the Medicare cost-based HMO/CMP is expected to take advantage of them. If the HMO/CMP does not take advantage of available exemptions, the expenses incurred for such taxes are not recognized as allowable under the program.

More detail can be found in the Medicare “Provider Reimbursement Manual,” (Pub. 15), Part I, §§2122ff.

410.1 - Premium Taxes Assessed Against the Medicare Cost-Based HMO/CMP

(Rev. 4, 10-01-01)

Some State and local governments are assessing organizations a tax based on premium revenue. If there are no exemptions that could be used to legally avoid the assessment of this tax, CMS will recognize the expense as an allowable cost.

However, the amount CMS should pay would be the amount of the assessment that is applicable to premiums charged to Medicare enrollees for covered services. This is accomplished by including total premium assessments in Plan Administration costs and using the Medicare to Total Member Month ratio to apportion cost. Payments by CMS to a cost contractor for covered services rendered to Medicare enrollees do not constitute premiums. Rather, CMS is buying each covered service at cost less applicable Medicare deductible and coinsurance. The only premium for covered services paid to the Medicare cost-based HMO/CMP is paid by the Medicare enrollee for Medicare’s deductibles and coinsurance. Therefore, the amount of the assessment to be paid by CMS should be limited to that amount applicable to Medicare’s deductible and coinsurance charged as a premium.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R86MCM	04/27/2007	Revisions to Chapter 17, Subpart B, Section 220, Determining Deductibles and Coinsurance	04/27/2007	N/A
R74MCM	10/04/2005	Changes in Manual Instructions for Payment Principles for Cost Based HMO/CMPs	N/A	N/A
R67MCM	08/12/2005	Changes in Requirements for Periodic Surveys of Current and Former Enrollees, and in the CMS Method for Calculating Interest on Overpayments and Underpayments to HMOs, CMPs and HCPPS.	N/A	N/A
R63MCM	11/12/2004	Home Health Services	N/A	N/A
R52MCM	05/07/2004	Payment Principles for Cost-Based HMO/CMPs	N/A	N/A
R17MCM	01/01/2003	Determining Deductible and Coinsurance; and Duplicate Payment Detection	N/A	N/A
R04MCM	10/01/2001	Initial Issuance of Chapter	N/A	N/A