Medicare Managed Care Manual

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
7		10 - 230	---
12		10 - 30	---
14		10 - 20	---

NEW/REVISED MATERIAL --EFFECTIVE DATE: Not Applicable
IMPLEMENTATION DATE: Not Applicable

The Medicare Managed Care Manual (MMCM) is a new vehicle for instructions for Medicare managed care organizations.

This transmittal includes the following:

- An overall Table of Contents which includes the chapters being issued by this transmittal, and anticipates future chapters that will be added to this manual.
- Additional chapters will be published as updated information is available. It is anticipated that eventually most or all material in the Operation Policy Letters that become permanent will be included.
- This initial issuance consists of three chapters. They are:

Chapter 7, Payments to Medicare+Choice (M+C) Organizations, this chapter provides the policies and the methods the Center for Medicare and Medicaid Services follows to determine the amount of payment a Medicare+Choice organization will receive for Medicare beneficiaries enrolled in an M+C plan offered by the organization.

Chapter 12, Effect of Change of Ownership and Leasing, this chapter outlines the effect of a change in ownership on a M+C contract when the contract can be transferred to a new entity, the type of documentation, required, and a Model Novation Agreement than can be used by a contracting entity undergoing a change in ownership.

Chapter 14, Contract Determinations and Appeals, this chapter provides procedures for making and reviewing contract determinations and the appeals process.

The MMCM is an Internet document and may be accessed from the CMS Web site: http://www.hcfa.gov/pubforms/progman.htm.

These instructions should be implemented within your current operating budget.

NOTE*:* **Normally red italicized font identifies new material. However, because this release is a new manual, normal text font is used for the initial release.**

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Manual Transmittals through Transmittal Number 1 are included in this update. As new transmittals are included they will be identified on this page. To review individual transmittal cover pages click here.

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Chapter 7 - Payments To Medicare+Choice (M+C) Organizations

NOTE 1 The following provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) have been incorporated into this release

Section 601 - Increase in minimum payment amount
Section 602 - Increase in minimum percentage increase
Section 603 - Phase-in of risk adjustment
Section 604 - Transition to revised M+C payment rates
Section 607 - Full implementation of risk adjustment for congestive heart failure enrollees for 2001
Section 608 - Expansion of application of M+C new entry bonus

NOTE 2 Section 605 (New payment methodology and rates for M+C ESRD enrollees) will be incorporated in the next release. The proposed ESRD risk adjustment factors and draft payment rates can be found at http://www.hcfa.gov/stats/hmorates/aapccpg.htm.

NOTE 3 On May 25, 2001, the Secretary announced that CMS has suspended through July 1, 2002, any filing by M+C organizations of physician and hospital outpatient encounter data. For this reason, discussions of CMS policy related to these types of encounter data have been deleted from this release.

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Tables

Exhibits

This chapter sets forth the policies and methods CMS follows in determining the amount of payment a Medicare+Choice (M+C) organization will receive for Medicare beneficiaries who are enrolled in an M+C plan offered by the organization. The regulations that govern these policies and methods are set forth in Part 422 Subpart F of the Code of Federal Regulations, and are based primarily on §1853 of the Social Security Act (The Act).

10 - Terminology

(Rev. 1, 07-02-01)

10.1 - Capitation Rate and Per Capita Rate

"Capitation Rate" and "Per Capita Rate" Are Used Interchangeably.

(Rev. 1, 07-02-01)

10.2 - Payment Area

(Rev. 1, 07-02-01)

The general rule is that the payment area is a county or an equivalent geographic area specified by CMS (for example, an island or parish). For ESRD enrollees, there is a special rule that the M+C payment area is a State or other geographic area specified by CMS.

10.3 - "Area" In the Term "Area-Specific Rate"

(Rev. 1, 07-02-01)

"Area" in the term "area-specific rate**"** refers to a payment area (see §10.2).

NOTE: Area-specific rate is also referred to in the statute and in §30.3.2 as the "annual area-specific capitation rate."

10.4 - Metropolitan Statistical Area, Primary Metropolitan Statistical Area, and Consolidated Metropolitan Statistical Area

(Rev. 1, 07-02-01)

These terms mean any areas so designated by the Secretary of Commerce. (See www.census.gov/population/www/estimates/metrodef.html). In tabulating M+C rates for March through December 2001 (published January 4, 2001) and for CY 2002 (published March 1, 2001), CMS used the latest Census Bureau's Metropolitan Area Population Estimates, which were July 1, 1999.

20 - General Rules for M+C Payments

(Rev. 1, 07-02-01)

All payment rates are annual rates, determined and promulgated no later than March 1st for the following calendar year. With the exception of payments to M+C Medical Savings Account (MSA) plans (§130) and payments for ESRD enrollees in all other plans (§20.1.1), CMS pays

M+C organizations, for each enrollee in an M+C plan they offer, an advance monthly payment equal to 1/12th of the annual M+C capitation rates for the payment areas they serve.

These capitation rates are adjusted for demographic factors applicable to each enrollee, such as age, sex, disability status, institutional status, Medicaid status, and other factors determined to be appropriate to ensure actuarial equivalence. Beginning January 1, 2000, CMS implemented a risk adjustment method that accounts for variation in per capita cost that is based on health status and demographic factors, as discussed in §90.

20.1 - Special Rules for M+C Payments for Certain Types of Enrollees

(Rev. 1, 07-02-01)

Exceptions to the general rule for payments are as explained in the section below. See the following sections for explanations of additional special rules:

Section 50.2, Rules for coverage and payment of National Coverage Determinations (NCDs);

Section 50.3, NCD policy on clinical trials;

Section 130, Special rules for beneficiaries enrolled in M+C Medical Savings Account (MSA) plans;

Section 140, Special rules for coverage that begins or ends during an inpatient hospital stay;

Section 150, Special rules for payments to M+C organizations for their beneficiaries enrolled in Hospice;

Section 160, Special rules for M+C payments for beneficiaries enrolled as Qualifying Individuals; and

Section 180, Special rules for new entry bonus payments to M+C organizations.

20.1.1 - Enrollees With End-Stage Renal Disease (ESRD)

(Rev. 1, 07-02-01)

For enrollees diagnosed with ESRD, CMS establishes special rates at the State level. The per capita Part A and Part B rates for each State are based on all fee-for-service ESRD expenditures in that State. Thus, costs related to dialysis, transplantation, and post-transplant drug therapy are included in the M+C rates. Services and supplies that are billable outside of the composite rate under fee-for-service Medicare are included in the M+C capitation rate. In short, all claims for ESRD beneficiaries under original Medicare are included in this tabulation, including claims for treatments not related to ESRD (such as a broken arm).

In addition, CMS subtracts from the State capitation rate the actuarial value of the amount that the Secretary is authorized to subtract from each composite rate payment for each renal dialysis treatment under original Medicare, as set forth in §1881 (b) (7) of the Act. These funds are to be used to help pay for the ESRD network program in the same manner as similar reductions are used in original Medicare.

20.1.2 - Enrollees in MSA Plans

(Rev. 1, 07-02-01)

The MSA design is intended to save a portion of the annual capitation rate in a savings account that an enrollee can use to pay medical expenses, until the large deductible specified by their plan is met, and the plan begins to cover the enrollee's medical expenses. For enrollees in MSA plans, CMS subtracts $1/12^{th}$ of the amount CMS deposits in the enrollee's MSA from the monthly payment that would otherwise be made to the M+C organization. The MSA deposit is calculated using methods discussed in §130. Note that capitation rates for M+C MSA plans are adjusted for enrollee demographic and health status factors.

20.1.3 - Enrollees in Religious and Fraternal Benefit Societies' Plans

(Rev. 1, 07-02-01)

For payments for M+C plans offered by Religious and Fraternal Benefit Societies (RFB plans), CMS adjusts capitation payments to ensure that the payment level is appropriate for the actuarial characteristics and experience of these enrollees. Adjustments to capitation payments can be made on an individual or organizational basis.

20.2 - Adjustment of Payments to Reflect the Number of Medicare Enrollees

(Rev. 1, 07-02-01)

CMS applies payment rates and adjustment factors applicable to the month of enrollment. Monthly payments to M+C organizations reflect existing enrollees, enrollees whose enrollment will be effective before the month for which the payment is made, and enrollees whose enrollment will be effective in the month for which payment is made. For example, the payment for January 1, 2000 reflected members enrolled prior to December 1999, members with enrollments effective on December 1, 1999, and members with enrollments effective January 1, 2000.

CMS makes retroactive adjustments to the aggregate monthly payments to take into account any difference between the actual number of Medicare enrollees in a plan and the number on which CMS had based the organization's advance monthly payment.

If the beneficiary certifies that, at the time of enrollment under the M+C plan, he or she received from the M+C organization the disclosure statement specified at 42 CFR 422.111, CMS may make retroactive enrollment adjustments for a period (not to exceed 90 days) that begins when a beneficiary elects a group health plan (as defined at 42 CFR 422.101) offered by an M+C organization and ends when the beneficiary is enrolled in an M+C plan offered by an M+C organization. See Chapter 4 of this manual for information on disclosure requirements.

20.3 - Geographic Adjustment of Payment Areas

(Rev. 1, 07-02-01)

For contract years beginning after 1999, a State's chief executive may request a geographic adjustment of the State's payment areas for the following calendar year. The State must notify CMS by February 1 of its request to change from the single-county methodology to a

geographically adjusted methodology for the following year. The statute specifies the following alternatives for geographical adjustments of payment areas:

1. One statewide M+C payment area, i.e., .the same rate for every county in the state.

2. A metropolitan-based system with one rate for all non-metropolitan statistical area (MSA) counties and separate rates for all portions of each MSA in the State; or in the case of a consolidated MSA, separate rates for all portions of each primary MSA within each consolidated MSA.

3. A separate rate for a grouping of noncontiguous counties selected by the State (i.e., grouping counties that do not share a border).

20.4 - Budget Neutrality Adjustment for Geographically Adjusted Payment Areas

(Rev. 1, 07-02-01)

If CMS adjusts a State's payment areas in accordance with §20.3, at that time and each year afterwards, CMS adjusts the capitation rates so that the aggregate Medicare payments do not exceed the aggregate Medicare payments that would have been made to all the State's payment areas without the geographic adjustment. As long as the governor's request for new payment areas remains in effect, this budget neutral adjustment is made annually.

20.5 - Adjustment of Payment Rates for County Mergers

(Rev. 1, 07-02-01)

If a county merges with another county, future M+C payment rates will be calculated only for the county whose Social Security Administration State and county code survives the merger.

30 - M+C Payment Methodology

(Rev. 1, 07-02-01)

Prior to the 1997 BBA, Medicare's capitated payments to risk-contracting managed care organizations for aged and disabled beneficiaries were determined using the Adjusted Average Per Capita Cost (AAPCC) methodology, as defined in §1876 of the Act. (See **Exhibit 1** for a description of the AAPCC methodology.)

When Congress created the M+C program in 1997, it mandated a new payment methodology for organizations that enter into M+C contracts (§1853 of the Act). M+C rate calculations begin with the 1997 standardized county rates as a base. The 1997 county rates are standardized by demographic factors to account for differences among counties in the overall demographic profile of their Medicare beneficiaries, the demographic adjustments are carried forward into the M+C payment methodology. The BBA does not stipulate any adjustments to these 1997 base rates, other than to "carve out" a specified portion of the medical education costs implicit in the 1997 base rates (explained in §30.3.3).

Note that the statute permits exceptions to using the 1997 standardized county rates as a base for payment areas where the 1997 rate varied by more than 20 percent from the 1996 rate. For these areas, CMS could have substituted a rate more representative of the costs of enrollees in those areas, but determined that all rates were representative.

The most significant changes in the new methodology are:

- Gradually separating capitated Medicare payments from area-specific fee-for-service rates through the "greatest of three amounts" approach (see §30.1).

- Mandating the use of a risk adjustment method to better account for variation in beneficiary health status (see §90).

30.1 - Greatest of Three Amounts Methodology for Calculating Capitation Rates

(Rev. 1, 07-02-01)

Under the M+C program, the annual capitation rate for a particular payment area is the greatest of three amounts:

- A minimum percentage increase of 2 percent over the rate for the previous year;

- A minimum specified amount or "floor" rate; and

- A blended payment rate.

30.1.1 - A Minimum Percentage Increase Over the Rate for the Previous Year

(Rev. 1, 07-02-01)

For 1998, the minimum percentage increase is 102 percent of the 1997 standardized county payment rates. (The BBA establishes the 1997 rates as the base rates for the M+C payment methodology.) The rates for 1999 and 2000 were increased 102 percent of the preceding year's rate.

BIPA §602 amends §1853(c)(1)(C) of the Act by specifying that for March through December 2001, the minimum percentage increase rate is changed to 103 percent of the annual M+C capitation rate for a payment area for 2000. For January and February of 2001, for 2002, and for each succeeding year, the minimum percentage increase rate will be 102 percent of the prior year's annual M+C capitation rate.

30.1.2 - A Minimum Specified Amount or "Floor" Rate

(Rev. 1, 07-02-01)

The BBA set the floor rate for 1998 at $367 per month. For areas outside of the 50 States and the District of Columbia, for 1998 the minimum amount is the lesser of $367 or 150 percent of the 1997 standardized rate. For each succeeding year, the minimum amount rate equals the rate for the preceding year increased by the national per capita M+C growth percentage for the year (defined in §30.3.1).

BIPA §601 amends §1853(c)(1)(B) of the Act by establishing new minimum payment amount rates (floor rates) in CY 2001 for months after February. The new monthly minimum rates are as follows:

- $525 for any payment area in a Metropolitan Statistical Area (MSA) within the 50 States and the District of Columbia with a population of more than 250,000;

- $475 for any other area within the 50 State s; or

- For any area outside the 50 States and the District of Columbia, $525 or $475 (depending on population size), only to the extent that this is not more than 120 percent of the minimum amount rate determined for CY 2000, which is the maximum established for these areas.

For January and February of 2001, the minimum amount rate is the minimum amount rate for the previous year increased by the national per capita M+C growth percentage, as described in §30.3.1 and 42 CFR 422.254(b), for the year. Minimum amount rates for January and February 2001 are based on the M+C rate book published in the March 1, 2000 "Announcement of Calendar Year (CY) 2001 Medicare+Choice Payment Rates". This document is published on the Health Care Financing Administration (CMS) website at http://www.hcfa.gov/stats/hmorates/cover01. Minimum amount rates established by the BIPA for March through December 2001, are published in the January 4, 2001 "Revised Medicare+Choice (M+C) Payment Rates for Calendar Year (CY) 2001." This document is published on the CMS website at html://www.hcfa.gov/stats/hmorates/cover/01b.

The BIPA mandated that a single floor rate is now assigned to all counties within MSAs of a certain size, and another floor rate is assigned to all other counties. If a county is located in an MSA with a population greater than 250,000, the BIPA changed the floor rate for that county, effective March 1, 2001. As a result, pre-BIPA revisions to prior years' growth estimates for that county cannot be linked to post-BIPA revisions for that county. Thus, revisions to prior years' growth estimates for area-specific rates will differ from revisions to prior years' growth estimates for floor rates.

30.1.3 - A Blended Payment Rate

(Rev. 1, 07-02-01)

The blended rate is based on a composite of area-specific and national rates in proportions defined by law and summarized in Table 1 below. The national rate gradually makes up a larger share of the blended rate until 2003, when the composite remains at 50 percent area-specific rate and 50 percent national rate. The blended rate is subject to budget neutrality (see below).

30.2 - Budget Neutrality Adjustment for the Blended Capitation Rates

(Rev. 1, 07-02-01)

Under budget neutrality, the aggregate national payments that would be made under the BBA's "greatest-of-three-amounts" methodology must equal the aggregate national payments that would have been made if payments were based entirely on area-specific rates. Note that the budget neutrality adjustment applies only to the blended capitation rate.

Once the three rates (minimum percentage increase, floor, and blend) are determined for each payment area, a budget neutrality adjustment must be applied to the blended rate. CMS modifies rates in those counties whose greatest rate is the blended rate. If it is necessary to reduce the blended rates, these reductions can result in the greatest rate for a county changing from the blended rate to the minimum percent increase rate or the floor rate. Depending on factors such as the size of original Medicare's annual growth rate (which determines the M+C growth rate), counties whose blended rates are relatively higher than their floor or minimum percent rates -- compared to other counties -- could retain the blended rate as their greatest rate following the

budget neutrality adjustment. The final payment rate is based on the highest of the minimum percentage increase rate, the minimum amount rate (floor), and blended rate after budget neutrality adjustment.

30.3 - Calculation Of Factors Used To Adjust Capitation Rates

(Rev. 1, 07-02-01)

The following are the factors used in calculating M+C per capita payment rates.

30.3.1 - The National Per Capita M+C Growth Percentage

(Rev. 1, 07-02-01)

This annual national growth percentage is CMS's projection of the national average rate of growth in per capita expenditures for Medicare, reduced by an amount specified in law. (The statutorily required reductions are summarized in Table 1 below.) Note that what makes this national growth rate unique to the M+C program is the reductions summarized in Table 1, which are reflected or "carried forward" in all future rates. (Also note that the growth percentage includes revisions to prior years' estimates of the growth rate; see §40.)

30.3.2 - The Annual Area-Specific Component of the Blended Capitation Rate

(Rev. 1, 07-02-01)

For 1998, the base for the area-specific rate is the 1997 county per capita payment rate (which is 95 percent of the AAPCC). To calculate the area-specific rate, the base rate is adjusted by the national per capita M+C growth percentage (see §30.3.1) for 1998, and also adjusted by the exclusion of a percentage of medical education costs (see §30.3.3)**.** For subsequent years, the area-specific rate determined for the previous year is adjusted by the national per capita M+C growth percentage for the year, and also adjusted by the medical education "carve out" percentage for that year, according to the schedule summarized in Table 1 below.

The annual increases in the area-specific rates and the floor amounts are indexed in future years to the national per capita M+C growth percentage. CMS began this adjustment in 1999 for the area-specific rates. (See §4 for further detail.)

30.3.3 - Medical Education Payment Adjustments

(Rev. 1, 07-02-01)

For the purposes of calculating the annual area-specific capitation rate, the statute directs CMS to adjust the 1997 rates by "carving out" the amounts included in those rates for the indirect costs of medical education, and the direct costs of graduate medical education. This adjustment is phased in over five years, and the amounts "carved out" are paid directly to teaching hospitals. For example, for 1998, 20 percent of medical education payments were removed from the 1997 rates (which are the M+C base rates). Table 1 below presents the schedule of adjustments.

To the extent that CMS estimates that the 1997 per capita base rate reflects payments to State hospitals (under §1814(b)(3) of the Act), CMS makes an appropriate payment adjustment to the M+C payment rate, so that it is comparable to the medical education adjustment that would have

been made if the hospitals were not reimbursed under §1848(b)(3). Under this provision, payments are made to hospitals located in Maryland, until the waiver is rescinded.

Table 1 - Schedule for Phasing In of the Statutory Reduction to the M+C Growth Rate, Exclusion of Medical Education Expenses, and Blending of Area-Specific and National Capitation Rates

Calendar Year	Statutory reduction in national per capita M+C growth %	% Exclusion of graduate medical education expenses from area-specific capitation rate	Blending % for blended rate: Area-specific capitation rate/ national capitation rate
1998	0.8%	20%	90% / 10%
1999	0.5%	40%	82% / 18%
2000	0.5%	60%	74% / 26%
2001	0.5%	80%	66% / 34%
2002	0.3%	100%	58% / 42%
2003 and later	none	100%	50% / 50%

30.3.4 - The National Component Of The Blended Capitation Rate

(Rev. 1, 07-02-01)

The national component of the blended capitation rate is calculated in two steps: (1) The national standardized annual capitation rate; and (2) The national input-price adjusted capitation rate. The calculations are described below.

Step 1. The national standardized annual capitation rate is a weighted average of all area-specific capitation rates. The national standardized rate is calculated separately for Part A and Part B.

1. The weight used to standardize the area-specific capitation rate for each payment area is calculated as follows: The number of all Medicare beneficiaries residing in the payment area is multiplied by the average demographic factor or average risk factor for the payment area (generally a county). This weight represents the total adjusted enrollment for each payment area.

2. Sum the weights described above in (1) across all payment areas to generate the total national adjusted enrollment, which is used in (4) below.

3. Multiply the annual area-specific capitation rate for a payment area by the weight described in (1) for that payment area. Sum these dollar amounts across all payment areas to generate the total national adjusted reimbursement amount, which is used in (4) below.

4. The national standardized annual capitation rate is the total national adjusted reimbursement amount divided by the total national adjusted enrollment.

Step 2. The national standardized annual capitation rates (for Parts A and B) are input-price adjusted for each payment area to produce the input-price adjusted annual national capitation rates. Input-prices adjustments account for geographic variation in the prices of goods and services used to produce medical services. CMS applies two indices from original Medicare: the area hospital wage index, and the geographic practice cost index for physicians.

For each payment area, the annual input-price adjusted rate (calculated separately for Parts A and B) is equal to the product of three amounts:

(1) The national standardized annual capitation rate;

(2) The proportion of the annual rate attributable to Part A services (or Part B services for the Part B calculation); and

(3) An index that reflects (for that year and that type of service) the relative input price of services in the area, as compared to the national average input price for these services.

The two input-price adjusted rates for Part A and B services are then added together to get a combined input-price adjusted national average for the payment area.

The statute specifies the following method for calculating input-price adjustments for 1998:

- The proportion of Medicare services attributable to Part A is the ratio (expressed as a percentage) of the national average per capita rate of payment for Part A services for 1997, to the national average per capita rate of payment for Part A and Part B services for that year. The proportion attributable to Part B services is 100 percent minus the ratio for Part A.

- Input-price indices - For Part A, 70 percent of the payments attributable to those services is adjusted by the area hospital wage index used under §1886(d)(3)(E) of the Act. For Part B, 66 percent of the payments attributable to those services is adjusted by the geographic practice cost index for physicians (under §1848(e) of the Act) and of the remaining 34 percent, 40 percent is adjusted by the hospital wage index.

Therefore, the national input-price adjusted rate is the national capitation rate adjusted for local input prices. For years after 1998, the statute does not mandate a specific method for calculating input-price adjustment. Instead, CMS is given the authority to apply indices used in updating national payment rates for particular areas and localities. Currently, CMS will apply this method in future years.

CMS uses original Medicare's most recent updates to the inpatient hospital Prospective Payment System (PPS) wage index, and to the geographic adjustment factors used for physician payments. For information on the PPS area wage index, see http://www.hcfa.gov/medicare/ippswage.htm. For information on geographic practice cost prices, see pages 160 to 166 of the document found at http://www.hcfa.gov/regs/pfs/1120fc.htm.

The input-price adjusted national average for each payment area is used with the area-specific rate to calculate the blended payment rate, in proportions listed in **Table 1** above. Payment rates are developed separately for aged, disabled, and ESRD beneficiaries. See

http://www.hcfa.gov/stats/hmorates/aapccpg.htm to review payment files used to calculate the annual capitation rates.

40 - Adjustment of Capitation Rates for Over or Under Projection of National Per Capita M+C Growth Percentages

(Rev. 1, 07-02-01)

Section 1853(c)(6)(C) of the Act provided for adjustments to M+C capitation rates to reflect revisions to prior years' projections of growth rates. Beginning with the 1999 payment rates, CMS annually adjusts all area-specific capitation rates (and as a result, the national input-price adjusted rates) to reflect any differences between the projected and current estimates of the national per capita M+C growth percentages. Beginning in 2000, CMS also adjusts the minimum amount rate in the same manner.

Congress mandated a new floor rate for CY 1998 (§1853(c)(1)(B)(i) of the Act), which established CY 1998 as the statutory base year for the floor rate. For this reason, when calculating the ratebook for CY 1999, CMS assumed that the floor rates set by Congress as appropriate for CY 1998 were deemed to include any appropriate revisions to prior years' estimates of the M+C Growth Percentage. CMS corrects only estimates in the rates of increase after the base year, and the 1998 base year was specified by Congress.

When calculating the ratebook for CY 2000, the rate of increase for the floor included, for the first time, an adjustment for the fact that the current estimate of the prior year's M+C Growth Percentage was different than the estimate actually used in calculating the 1999 ratebook. Note that in CY 2000 the total change in estimates of the M+C Growth Percentage differed for area-specific and the floor rates, because adjustments to the area-specific rates due to revisions in prior years' estimates of growth did include a revised estimate for CY 1998, while adjustments to the floors did not include revised estimates for CY 1998.

Under the BIPA, Congress again took the approach of specifying appropriate floor rates in the statute for CY 2001, rather than building on prior year rates, estimates, or expenditure data. The revised CY 2001 rates implementing BIPA (published January 4, 2001) are effective March through December 2001. Again, we believe Congress should be deemed to have included in the new base rates any appropriate adjustments due to revisions of prior years' estimates of growth. As in the case of the year following the year after the BBA-specified floor rate, in the CY 2003 ratebook, CMS will adjust the new BIPA-based floor rates with revised estimates of prior years' growth projections for the first time, using revised estimates for CY 2002.

Information on corrections to prior estimates can be found each year in Enclosure I of the March 1 Announcement of M+C payment rates. See http://www.hcfa.gov/stats/hmorates/aapccpg.htm for all March 1 Announcements.

50 - Adjustment of Capitation Rates for National Coverage Determination (NCD) Services

(Rev. 1, 07-02-01)

A National Coverage Determination (NCD) is a national policy determination regarding the coverage status of a particular service, which CMS makes and publishes as a Federal Register notice or CMS ruling. The term does not include coverage changes mandated by statute.

If CMS determines and announces that an NCD meets the criteria for "significant cost," an M+C organization is not required to assume risk for the costs of that service until the contract year for which the annual M+C capitation rate is determined on a basis that includes the cost of the NCD service.

50.1 - Criteria For Meeting "Significant Cost"

(Rev. 1, 07-02-01)

The NCD must meet either of the following two conditions:

- The average cost of furnishing a single service exceeds a cost threshold that for calendar years 1998 and 1999 is $100,000, and for calendar year 2000 and subsequent calendar years is the preceding year's dollar threshold adjusted to reflect the national per capita M+C growth percentage (defined in §30.3.1), or

- The estimated cost of all of Medicare services furnished nationwide as a result of a particular NCD represents at least 0.1 percent of the national standardized annual capitation rate (defined in §30.3.4), multiplied by the total number of Medicare beneficiaries nationwide for the applicable calendar year.

50.2 - Rules for Coverage and Payment of NCDs

(Rev. 1, 07-02-01)

The M+C organization must furnish, arrange, or pay for an NCD "significant cost" service prior to the adjustment of the annual M+C capitation rate. The following rules apply to such services:

- In affected coverage areas, Medicare payment for the service is:

    - In addition to the capitation payment to the M+C organization; and

    - Made directly by the fiscal intermediary and carrier to the M+C organization (or its designee, which may be the provider) in accordance with original Medicare payment rules, methods, and requirements.

- NCD costs for which CMS intermediaries and carriers will not make payment and are the responsibility of the M+C organization are:

    - Services necessary to diagnose a condition covered by the NCD;

    - Most services furnished as follow-up care to the NCD service;

    - Any service that is already a Medicare-covered service and included in the annual M+C capitation rate; and

    - Any service, including the costs of the NCD service itself, to the extent the M+C organization is already obligated to cover it as an additional or supplemental benefit.

NCD costs for which CMS intermediaries and carriers make payment are:

- Costs relating directly to the provision of services related to the NCD that were non-covered by original Medicare prior to the issuance of the NCD; and

- A service that is not included in the M+C per capita payment rate.

If the M+C organization does not provide or arrange for the service consistent with CMS's NCD, enrollees may obtain the services through qualified providers not under contract to the M+C organization, and the M+C organization must pay for the services. Beneficiaries are liable for Part A deductible and any applicable coinsurance amounts.

See Chapter 4 of the M+C Manual for additional information on NCDs. See Exhibit 2 for details on CMS's NCD policy on clinical trials.

60 - Adjustment of Capitation Rates for Working Aged Status

(Rev. 1, 07-02-01)

Beneficiaries are "working aged" if they are aged 65 or older, currently working for an employer with 20 or more employees, and have health insurance coverage through the employer's group health plan. Medicare-eligible spouses who are aged 65 or older, with health insurance coverage under a currently-employed spouse's employer group health plan (if that employer has 20 or more employees) are also assigned working aged status (even if the currently employed spouse is under 65 years of age and not yet entitled to Medicare).

Medicare spending for working aged beneficiaries is significantly lower than spending for other beneficiaries because other insurers are primary to Medicare. In 1995, working aged status was added as a factor for adjusting payments to managed care organizations with 1876 risk contracts. Payments under the M+C program continue to be adjusted by this factor to take into account that Medicare is the secondary payer for working aged beneficiaries, and that its liability is much smaller than that for non-working aged beneficiaries.

70 - Adjustment of Capitation Rates for Demographic Characteristics and Health Status

(Rev. 1, 07-02-01)

Prior to the BBA, county-wide payment rates were adjusted based on the following factors, which were called "demographic" factors: Age, gender, Medicaid eligibility, and institutional status. (Rates were also adjusted for working aged status; see §60.) Under the BBA (§1853(a)(3) of the Act), the Secretary is required to develop and implement a risk adjustment method to better reflect the expected relative health status of each enrollee.

The purpose of adding health status to demographic factors is to consider the unique cost implications of characteristics related to diagnoses, and to increase the accuracy of the payment estimates for subgroups of the Medicare population. Thus, the goal of the new methodology is to pay M+C organizations based on better estimates of their enrollees' health care utilization, relative to the fee-for-service (FFS) population. Under the new risk adjustment method, capitation payments are adjusted for demographic factors and health status as captured by diagnoses.

NOTE: In this chapter the term **"demographic only method"** is used to indicate the method that does not include diagnostic data, while **"risk adjustment**

method" refers to the new method where encounter data are incorporated.

70.1 - Transition to a Comprehensive Risk Adjustment Method

(Rev. 1, 07-02-01)

The BBA specifically requires implementation of a risk adjustment method no later than January 1, 2000. Under §1853(a)(3)(B), the BBA also requires "Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under §1876) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998."

The timing of this data collection authority indicated that the initial risk adjustment method should be based only on data from inpatient hospital stays, with later implementation of a method based on data from additional sites of care. Thus, CMS selected the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model as the risk adjustment method under which payments are made, beginning January 1, 2000. In this model, diagnoses from hospitalizations are used to identify a particularly ill and high cost subset of beneficiaries for whom higher payments will be made in the next year. The system recognizes admissions for which inpatient care is most frequently appropriate and which are predictive of higher future costs.

BIPA §603 amended §1853(a)(3)(C) of the Act by extending until 2007 the phase-in of risk adjustment. Between 2000 and 2007, the PIP-DCG-based risk adjustment method is used to adjust a portion of payment, and the demographic-only method is used to adjust the other portion. At the conclusion of the transition schedule described below in Table 2, a risk adjustment method centered on health status is scheduled to replace the demographic-only method.

Thus, under the current schedule, there are two methods comprising the M+C payment system until 2007. The demographic-only method is described in §80 and the PIP-DCG risk adjustment method is described in §90.

NOTE: On May 25, 2001, the Secretary announced that CMS has suspended through July 1, 2002 any filing by M+C organizations of physician and hospital outpatient encounter data. For this reason, discussions of policy related to these types of encounter data have been deleted from this release.

70.2 - Transition Schedule for Implementation of the Risk Adjustment Method

(Rev. 1, 07-02-01)

Payment amounts for each enrollee are separately determined using the demographic-only method and the PIP-DCG risk adjustment method. These separate payment amounts are then blended according to the percentages for the transition year, summarized in Table 2.

NOTE: For 2001 only, 100 percent of the payment made for certain enrollees with congestive heart failure (CHF) is risk-adjusted. See §100.4 for information on this special rule.

Table 2 - Transition Schedule for Implementation of the Risk Adjustment Method

YEAR	Demographic-only Method (%)	Risk Adjustment Method (%)
CY 2000	90%	10% PIP-DCG model
CY 2001	90%	10% PIP-DCG model [BBRA amendment]
CY2002	90%	10% PIP-DCG model [BIPA amendment]
CY2003	90%	10 PIP-DCG model [BIPA amendment]
CY2004	70%	30% risk-adjusted model [BIPA amendment]
CY 2005	50%	50% risk-adjusted model [BIPA amendment]
CY 2006	25%	75% risk-adjusted model [BIPA amendment]
CY 2007 & succeeding years	0	100% risk-adjusted model [BIPA amendment]

80 - The Demographic-Only Method for Adjustment of Capitation Rates

(Rev. 1, 07-02-01)

Recall that for 1998, the base for area-specific rates under the new M+C payment system is the 1997 per capita rates. Built into these 1997 rates are the demographic adjustments for sex, age, institutional status, and Medicaid eligibility that were used under the pre-BBA methodology. Thus, the demographic adjustments from the prior system are "carried forward' into the M+C system.

Under this demographic-only method, each combination of demographic characteristics (for example, females aged 70 to 74 who are institutionalized) is assigned a demographic factor. The demographic factor is a relative cost ratio of the national average per capita cost for FFS beneficiaries per cell (i.e., per combination of demographic characteristics) to the national average per capita cost across all cells (all FFS beneficiaries). There are 80 factors (including

working aged status, see §60) for aged beneficiaries, and 60 factors for disabled beneficiaries (excluding working aged status).

Each factor applied under the demographic-only method is defined below. Exhibit 3 lists the factors applied under the demographic-only method.

80.1 - Age and Sex

(Rev. 1, 07-02-01)

There are 24 age/sex categories representing aged and disabled beneficiaries in Parts A and B.

80.2 - Institutional Status

(Rev. 1, 07-02-01)

Institutional status is a concurrent adjustment factor. For each prior month in a certified institution, a beneficiary is assigned the institutional rate cell the following month. (See §170 for a definition of certified institution.)

80.3 - Medicaid Eligibility

(Rev. 1, 07-02-01)

Medicaid status is a concurrent adjustment factor. A Medicare beneficiary is assigned the age-sex-appropriate Medicaid factor based on his or her current Medicaid enrollment status. Payments vary according to month-to-month Medicaid eligibility in the payment year. (See §160 for policy on Qualifying Individuals, QI-1s and QI-2s.)

90 - The Principal Inpatient Diagnostic Cost Group (PIP-DCG) Risk Adjustment Method for Adjustment of Capitation Rates

(Rev. 1, 07-02-01)

The Principal Inpatient Diagnostic Cost Group or PIP-DCG risk adjustment payment method adds diagnostic information to demographic information on beneficiaries. It was implemented for members of M+C organizations effective with the January 1, 2000 payment. CMS applies the PIP-DCG risk adjustment model to payment calculations for all types of M+C plans (except as provided for M+C religious and fraternal benefit plans; see §20.1.3).

CMS uses demographic information and diagnostic information from original Medicare and from all M+C organizations a beneficiary may have joined (taken from encounter data submitted by M+C organizations) to determine the appropriate PIP-DCG-based risk factor for each beneficiary. The risk factor is computed for each beneficiary for a given year and applied prospectively. The factor follows the beneficiary for one calendar year. Since all Medicare beneficiaries have risk factors (including new M+C enrollees as described in §90.2.3 and the second table in Exhibit 3), information is immediately available for payment purposes as beneficiaries join an M+C organization or move among M+C plans. When an M+C organization forwards beneficiary enrollment information to CMS, CMS then sends the organization the appropriate risk factor for the beneficiary, as well as the resultant payment.

CMS adopted a "time shifted" model for payment, where the base year -- also known as the data collection year -- is defined as the 12-month period that ends six months before the payment year begins. For example, data on inpatient discharges from July 1, 1998 through June 30, 1999 were used to assign risk factors for enrollees and calculate payments to M+C organizations for calendar year 2000.

This section provides an overview of the PIP-DCG risk adjustment method. Several sources of information are available for further detail. Located on CMS's external website hcfa.gov/stats/hmorates/aapccpg.htm are: (1) Basic SAS software for the PIP-DCG grouper; (2) A detailed text file of the mapping of ICD-9-CM codes to DxGroups, and finally to PIP-DCGs; and (3) Report to Congress on the development of the PIP-DCG model. No technical support is available from CMS for organizations that utilize the version of the PIP-DCG grouper provided on the web.

This section discusses the demographic factors included in the PIP-DCG risk adjustment method; how PIP-DCG risk scores are calculated; and how PIP-DCG risk adjusted payments are calculated.

90.1 - Demographic Factors Under the PIP-DCC Risk Adjustment Method

(Rev. 1, 07-02-01)

Note that institutional status is not a factor in the risk adjustment method for several reasons, including the fact that the PIP-DCG model accurately predicts average costs for institutionalized beneficiaries.

90.1.1 - Age and Sex

(Rev. 1, 07-02-01)

Twenty-four age/sex categories are included in the risk adjustment method, which mirror the splits used in the demographic-only method. (Compare Exhibits 2 and 3.) Since the risk adjustment method is prospective, however, the value of the age variable is the fraction of the 12 months that person is, for example, 66 before turning 67. Payments for the 12 months are thus set to the weighted average of the two payments for the two different ages, so that no change in payment is necessary during the calendar year to account for birthdays.

90.1.2 - Medicaid Eligibility

(Rev. 1, 07-02-01)

Analysis of expenditure patterns for beneficiaries with Medicaid status in original Medicare revealed that future Medicare expenditures for partial-year Medicaid enrollees are similar to expenditures for full year enrollees. Thus, the measurement of eligibility changed under the risk adjustment method. Beneficiaries who are Medicaid-eligible at any time during the previous data collection year are eligible for the Medicaid payment increment for the entire payment year. (See §80.3 for a discussion of the Medicaid adjustment under the demographic-only method, and §160 for policy on Qualifying Individuals, QI-1s and QI-2s.)

90.1.3 - Originally Disabled

(Rev. 1, 07-02-01)

Originally disabled is not a factor under the demographic-only method. Research confirmed, however, that on average originally disabled beneficiaries aged 65 and older have higher Medicare expenditures than the beneficiaries who "age-in" to Medicare eligibility (i.e., were never entitled by reason of disability). Yet under the demographic-only method, for example, a 64 year old disabled but not institutionalized male who is not on Medicaid and not working aged would be assigned a demographic factor of 1.0 from the disabled table. When he turns 65, he is assigned a factor of 0.65 from the aged table, resulting in a reduction in payment. (See Exhibit 3 for factors under the demographic-only method.)

Hence, under the risk adjustment method, a beneficiary is defined as originally disabled if he or she is currently entitled to Medicare as an aged beneficiary, but was originally entitled by reason of disability. Accordingly, the 64 year old disabled but not institutionalized male who is not on Medicaid and not working aged, would be assigned a base risk score of 0.76. When he turns 65, he is assigned a base score of 0.541 plus a risk score of 0.415 for previously disabled, which sums to 0.956 and triggers an increased payment. (See Exhibit 3 for factors under the risk adjustment method.)

90.2 - Health Status Adjustment Under the PIP-DCG Risk Adjustment Method

(Rev. 1, 07-02-01)

90.2.1 - The PIP-DCG Classification System

(Rev. 1, 07-02-01)

A PIP-DCG is a payment group that represents a range of Medicare costs. Each PIP-DCG category can include heterogeneous diagnoses, as long as they have similar future cost implications. Since the PIP-DCG model depends on data from just one site of service, only a subset of conditions is recognized for increased payments. That is, the model recognizes admissions for which inpatient care is most frequently appropriate and which are predictive of higher future costs.

Under the risk adjustment method, hospitalizations for diseases most commonly treated on an outpatient basis are placed in a base payment category -- for which payment is a function of age and sex. (Note the category called "base" in Exhibit 3.) Inclusion of these admissions in the PIP-DCG classification system would provide inappropriate incentives for hospitalization. Also included in the base payment category are beneficiary diagnoses reported as a result of a short hospital stay (one day or less). This ensures consistent and appropriate payment levels. Since the majority of one-day stays are for diagnoses already assigned to the base payment category, the effect on payment is small. Short stays are often indicative of less serious, and, hence, less costly cases.

Exhibit 5 describes the primary diagnoses making up each PIP-DCG used for payment. In addition to the base payment category (also called PIP-DCG 4), there are a total of 15 PIP-DCGs included in the risk adjustment payment model.

90.2.2 - Diagnostic Exceptions Under The PIP-DCG Risk Adjustment Method

(Rev. 1, 07-02-01)

Under the PIP-DCG payment model, beneficiaries who are hospitalized for chemotherapy (ICD-9 codes V58.1 and V66.2) are treated as exceptions. These codes are indicators of a treatment method, rather than a particular disease. Recognizing, however, that Medicare's current inpatient coding rules require that the diagnoses for beneficiaries who are hospitalized for chemotherapy must be coded using these V-codes as the principal diagnoses, the most appropriate PIP-DCG group for these beneficiaries is assigned based on the type of cancer and using a secondary diagnosis.

In addition, the payment model also treats individuals diagnosed with AIDS as an exception. In this case, individuals with a secondary diagnosis of AIDS are placed in the same PIP-DCG group as individuals with a reported principal diagnosis of AIDS. CMS analysis showed that individuals with a secondary diagnosis of AIDS tended to have expenditures similar to those admitted explicitly for the treatment of AIDS.

90.2.3 - New Enrollees

(Rev. 1, 07-02-01)

The PIP-DCG model is calculated with encounter data submitted in the data collection year that ends six months before the payment year begins. The Medicare program cannot compile diagnosis data on beneficiaries before they enter the M+C program. For purposes of risk adjustment, new enrollees are defined as newly eligible disabled or age-in beneficiaries (including "ever-disabled" age-in beneficiaries) with less than twelve months of Medicare entitlement.

CMS applies separate risk factors for new enrollees, based on the demographic factors used in the risk adjustment method. See the second table in Exhibit 4 for the risk factors used to calculate payments for new enrollees. Note that payments based on Medicaid eligibility will be made retroactively for all new enrollees, once enrollment can be established and verified.

90.3 - Calculation of Beneficiary Risk Factors and Payments to M+C Organizations

(Rev. 1, 07-02-01)

In its basic form, the PIP-DCG model is an algorithm that uses base year inpatient diagnoses, along with demographic factors, to predict total health spending for beneficiaries for a payment year. In applying the PIP-DCG model to risk adjust payments for the M+C program, however, the model is used to determine relative risk factors. Below are two examples of calculating beneficiary risk factors, based on Exhibit 4.

Note that beneficiaries whose risk factors are equal to 1.00 are nationally "average."

Example 1 - Beneficiary A is a male, aged 82, who was originally entitled for Medicare due to disability. He is not eligible for Medicaid (no expenditure increment). He was hospitalized twice during the data collection year (also called the "base year" and distinct from the "base" payment category in Exhibit 4). Encounter data submitted by Beneficiary A's M+C organization reported inpatient diagnoses of Asthma (PIP-DCG 8) and Staphylococcus Pneumonia (PIP-DCG 18).

Beneficiary A is placed in the appropriate sex and age group. "Male, aged 82" carries an incremental risk factor of 1.077. He also is assigned "ever disabled" status, which carries an incremental risk factor of 0.287. Finally, Beneficiary A is assigned PIP-DCG 18, which carries

an incremental risk factor of 2.656. If there is more than one inpatient diagnosis in a data collection year, the risk factor is calculated based on the PIP-DCG category with the highest average expenditures.

Adding the incremental risk factors produces an overall risk factor of 4.02. This risk factor indicates an individual who is likely to incur relatively high costs in the payment year.

Example 2 - Beneficiary B is a female, aged 69, who is not disabled (no expenditure increment), and is eligible for Medicaid. She had no inpatient admissions during the base year. Therefore, no specific PIP-DCG increment is added, because expenditures for non-hospitalized beneficiaries are included in the base payment category.

Beneficiary B is placed in the appropriate sex and age group. "Female, aged 69" carries an incremental risk factor of 0.453. She also is assigned "aged with Medicaid" status, which adds an incremental risk factor of 0.433. Beneficiary B's overall risk factor is 0.89, which indicates someone who is likely to incur relatively low costs in the payment year.

90.4 - Calculation of Monthly Payments to M+C Organizations

(Rev. 1, 07-02-01)

To determine risk adjusted monthly payment amounts for each Medicare+Choice enrollee, individual risk factors are multiplied by the appropriate area-specific (usually county) payment rate.

First, however, an adjustment to the county rate book amounts will be required before multiplying the rate by each individual risk factor. This adjustment, or rescaling factor, is necessary because the risk adjustment method adds disease information to purely demographic information.

90.4.1 - The Rescaling Factor

(Rev. 1, 07-02-01)

The demographic-only rate book calculates county rates by dividing county per capita costs by county average demographic factors. Prior to BBA, these rates were updated annually. However, the BBA requires all M+C county rates to have their basis in the 1997 AAPCC Rate Book. Thus, the factors used to standardize this 1997 Rate Book are "locked in" - including the average county demographic factors.

Although both the demographic-only and risk adjustment methods are attempting to measure the same thing -- relative health status -- the range of factors used in the two methods differs. In order to account for the fact that the factors differ between the two methods, a technical modification is necessary for payments to remain methodologically correct. Without some adjustment, this inconsistency between the demographic-only factors and the risk adjustment factors would result haphazardly in either significant underpayments or overpayments, depending on the county.

By itself, rescaling does not raise or lower payments. Whether aggregate payments to an M+C organization increase or decrease depends upon the risk profile of the beneficiaries enrolled in the plan(s) offered by that M+C organization.

90.4.2 - Method for Calculating County Rescaling Factors

(Rev. 1, 07-02-01)

First, average county risk factors are computed for each county, using the PIP-DCG risk adjustment payment model. The average county risk factors replace the average county demographic factors applied under the demographic-only methodology.

CMS's Office of the Actuary (OACT) calculates combined aged, disabled, Parts A, and Part B per capita costs. These combined county costs then are divided by the average county risk factors, creating new area-specific standardized rates. OACT applies the mandated calculations to these new area-specific rates, e.g., the "greater of three" approach (blends, floors, and two percent increase), budget neutrality, medical education carve outs, etc.

This process generates a risk rate book. To determine the rescaling factor for a county, the per capita risk county rate is divided by the demographic-only county rate. Technically there are two rescaling factors for each county: one to rescale payments for aged enrollees, and the other for disabled enrollees.

In a given county, the rescaling factor used in payments for an aged beneficiary is defined as:

- (Risk County Rate) / (Aged Demographic-only County Rate) = County Aged Rescaling Factor
- For disabled beneficiaries, the rescaling factor is defined as:
- (Risk County Rate) / (Disabled Demographic County Rate) = County Disabled Rescaling Factor

Additional information on average county risk factors is available at CMS website hcfa.gov/stats/hmorates/aapccpg.htm. A file containing estimated county risk factors used to create the risk rate book is posted here.

90.4.3 - Example: Calculating the Payment Amount Per M+C Enrollee

(Rev. 1, 07-02-01)

Risk adjusted payment amounts for each M+C enrollee are calculated as follows:

*Payment = Demographic-only County Rate * rescaling factor * Enrollee Risk Factor*

To determine the risk-adjusted portion of payment for an enrollee, CMS's systems add the appropriate Part A and Part B rates (aged or disabled), multiply by the corresponding rescaling factor (for aged or disabled rates), and then multiply by the enrollee risk factor (calculated from the risk factor tables in Exhibit 4). Finally, we apply the blend percentage in effect for the payment year, e.g., for 2001, the blend is 10 percent rates adjusted by the risk method, and 90 percent demographic-only adjusted rates. (See Table 2 in §70.2.)

90.5 - Treatment of Certain Demonstrations Under the PIP-DCG Risk Adjustment Method

(Rev. 1, 07-02-01)

Certain demonstration projects involve the provision of care to special populations, such as the frail elderly. These projects include Evercare, the Program of All-inclusive Care for the Elderly (PACE), the Social Health Maintenance Organization (SHMO) demonstration, the Minnesota Senior Care Project, and the Wisconsin Partnership Demonstration. These projects currently provide enhanced benefit packages and are paid based on adjustments to M+C capitation rates that are specific to each demonstration model. Given the unique features of these demonstration projects, CMS will delay implementation of the new M+C payment system for these organizations. The risk adjustment method will not be used for payment to these demonstrations in CY 2001.

90.6 - Exclusions from Risk Adjustment Payment

(Rev. 1, 07-02-01)

M+C organizations with Cost or Health Care Pre-payment Plan (HCPP) contracts will be excluded from payment under risk adjustment, but risk adjustment rates will be reported to these organizations as "risk equivalent" rates. This will replace the current reporting of the "risk equivalent" demographic-only rates to the Cost and HCPP plans.

M+C enrollees who are capitated at the ESRD and hospice rates are excluded from payment under risk adjustment. M+C organizations will receive the demographic-only payment for these members. CMS has separate reconciliation processes for ESRD (§230) and hospice (§220).

100 - Adjustment of Capitation Rates Under the Congestive Heart Failure (CHF) Initiative

(Rev. 1, 07-02-01)

This section provides an overview and describes the requirements for extra payment in recognition of the costs of successful outpatient CHF care. M+C organizations desiring extra payment for eligible heart failure patients must meet certain thresholds for two quality indicators for all eligible patients. This initiative is described below. Section 100.4 describes the 100 percent risk-adjusted payments for qualifying Congestive Heart Failure Enrollees in 2001.

100.1 - Extra Payment In Recognition of the Costs of Successful Outpatient CHF Care

(Rev. 1, 07-02-01)

The current M+C organization risk adjustment payment methodology for CHF, the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model, is based upon inpatient hospitalization discharge diagnoses. Recent studies strongly suggest that excellent outpatient management of CHF may decrease hospitalization rates and improve quality of life for CHF patients. In response to industry concerns, and specifically trying to work within current data constraints, CMS has developed a payment mechanism for recognizing and paying for the costs of this successful outpatient CHF care. To qualify for extra payment in 2002, M+C organizations will identify enrollees who have been hospitalized for CHF during a prior two-year period and measure the success in treating these enrollees via two designated quality indicators. M+C organizations achieving threshold levels on both quality indicators will receive extra payment.

100.2 - Requirements for Medicare+Choice Organizations to Qualify for Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care

(Rev. 1, 07-02-01)

Extra payments for CHF will be based on enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of CHF. Currently, the CHF diagnosis codes are the following, although these codes are subject to change: 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.x.

100.2.1 - Two Required Quality Indicators

(Rev. 1, 07-02-01)

Medicare+Choice organizations seeking the extra payment must measure two quality indicators for the entire CHF population (defined below in §100.2.3). No alternative quality indicators may be substituted for the two quality indicators. The required quality indicators are:

- Proportion of M+C organizations enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have evaluation of left ventricular function as of October 1 of the reporting year.

- Proportion of M+C organizations enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have left ventricular systolic dysfunction (LVSD) and, as of October 1 of the reporting year: **(**1) Are prescribed angiotensin converting enzyme inhibitors (ACEI); or (2) Have documented reason for not being on ACEI .

Additional information on the required quality indicators for extra payment may be found in Exhibit 6.

100.2.2 - Designated Measurement Population

(Rev. 1, 07-02-01)

For payment in 2002 - The population for which the required quality indicators will be measured must consist of M+C organizations enrollees who have been continuously enrolled in the plan for a minimum of 180 days prior to October 1, 2001, who were discharged from an acute care hospital between 7/1/99 and 6/30/01, with a greater than one-day stay for a principal inpatient discharge diagnosis of CHF (regardless of whether the enrollee was a member of the M+C organization at the time of the hospitalization).

Where information on an inpatient hospital discharge has been received by CMS, CMS will flag enrollees with CHF diagnoses codes (defined in §100.2.1) on Monthly Membership Reports to M+C organizations to assist them in identifying the designated measurement population.

For payment in 2003 - The population for which the required quality indicators will be measured must consist of M+C organizations enrollees who have been continuously enrolled in the plan for a minimum of 180 days prior to October 1, 2002, who were discharged from an acute care hospital between 7/1/99 and 6/30/02, with greater than a one-day stay for a principal inpatient discharge diagnosis of CHF (regardless of whether the enrollee was a member of the M+C organizations at the time of the hospitalization).

Note that the beginning discharge date for payment in 2003 is the same as the beginning discharge date for payment in 2002 (7/1/99) so that M+C organizations can continue to manage the health care of those hospitalized between 7/1/99 and 6/30/00, as well as those hospitalized between 7/1/00 through 6/30/02. Where information on an inpatient hospital discharge has been

received by CMS, CMS will flag enrollees with CHF diagnoses codes, (defined in §100.2.1) on Monthly Membership Reports to M+C organizations to assist them in identifying the designated measurement population.

100.2.3 - Thresholds Must Be Met

(Rev. 1, 07-02-01)

The M+C organization must meet threshold levels on both quality indicators defined in §100.2.2 and Exhibit 6 in order to qualify for the extra payment. Quality indicator threshold levels will be established by CMS after input from a national clinical expert panel. The practical challenges of measuring the two quality indicators and/or meeting the thresholds will be taken into consideration. The thresholds will be announced by CMS in the "Advance Notice of Methodological Changes in Medicare+Choice Payment Rates for Calendar Year (CY) 2002" to be published on January 15, 2001.

100.2.4 - Reporting

(Rev. 1, 07-02-01)

For payment in 2002 - M+C organizations shall report to CMS on or after October 1, 2001 for payment in 2002. (Exhibit 7 provides a draft format for reporting, pending OMB approval.) Paper copies of the reports should be sent to the attention of Angela Porter, Center for Medicare and Medicaid Services, Mailstop C4-13-01, 7500 Security Blvd, Baltimore, MD 21244. The report must include the following:

- M+C organizations must submit a brief (e.g., two-page) description of their strategies and processes (e.g., disease management program) for managing the care of the designated CHF population.

- M+C organizations who have more than 400 enrollees with the CHF diagnosis (defined in §100.2.1) may sample their population to achieve a sample size of at least 400. The sample must be representative of the population. CMS expects that few M+C organizations will have sufficient CHF enrollees to sample their CHF population for reporting. Medicare+Choice organizations doing sampling must report their sampling methodology on the attached reporting form in Exhibit 7 (pending OMB approval).

- The M+C organizations must report its performance (including numerator, denominator, and proportion) on both of the required quality indicators as of October 1, 2001. The report must be submitted before 1/31/02 to qualify for payment in 2002. For each member of the designated population, M+C organizations must maintain records of the Health Insurance Claim (HIC) numbers, and whether the member appears in the numerator and denominator for each measure. In the event that the M+C organizations is subject to an audit, the M+C organizations must furnish beneficiary-level results for both of the quality indicators in a format to be designated by CMS (see §100.2.7 below).

- Depending upon when M+C organizations report their performance, CMS will make payment in one of two ways: For reports received from M+C organizations between 10/1/01 and 11/30/01, extra payment will be made to qualifying M+C organizations no later than 90 days after 11/30/01. Extra payments will be retroactive to 1/1/02. For reports received from M+C organizations between 12/01/01 and 1/31/02, extra payment will be made no later than

90 days after 1/31/02. Extra payments will be retroactive to 1/1/02. Consistent with the risk adjustment payment system, extra payments will be made on a monthly basis. M+C organizations must not report their performance any later than 1/31/02 for extra payment in 2002.

For payment in 2003 – Medicare+Choice organizations shall report to CMS on or after October 1, 2002 for payment in 2003. (Exhibit 7 provides a draft format for reporting, pending OMB approval). Paper copies of the reports should be sent to the attention of Angela Porter, Center for Medicare and Medicaid Services, Mailstop C4-13-01, 7500 Security Blvd, Baltimore, MD 21244. The report must include the following:

- M+C organizations must submit a brief (e.g., two-page) description of their strategies and processes (e.g., disease management program) for managing the care of the designated CHF population.

- M+C organizations who have more than 400 enrollees with the CHF diagnosis (defined in §100.2.1) may sample their population to achieve a sample size of at least 400. The sample must be representative of the population. CMS expects that few M+C organizations will have sufficient CHF enrollees to sample their CHF population for reporting. M+C organizations doing sampling must report their sampling methodology on the attached reporting form (pending OMB approval).

- The M+C organizations must report its performance (including numerator, denominator, and proportion) for both of the required quality indicators as of October 1, 2002. The report must be submitted before 1/31/03 to qualify for payment in 2003. For each member of the designated population, M+C organizations must maintain records of the HIC number and whether the member appears in the numerator for each measure. In the event that the M+C organizations is subject to an audit, the M+C organizations must furnish these beneficiary-level results for both of the quality indicators (see §100.2.7).

- Depending on when M+C organizations report their performance, CMS will make payment in one of two reporting ways: For reports received from M+C organizations between 10/1/02 and 11/30/02, extra payment will be made to qualifying M+C organizations no later than 90 days after 11/30/02. Extra payments will be retroactive to 1/1/03. For reports received from M+C organizations between 12/01/02 and 1/31/03, extra payment will be made no later than 90 days after 1/31/03. Extra payments will be retroactive to 1/1/03. Consistent with the risk adjustment payment system, extra payments will be made on a monthly basis. Medicare+Choice organizations must not report their performance any later than 1/31/03 for extra payment in 2003.

100.2.5 - Extra Payment

(Rev. 1, 07-02-01)

Assuming the M+C organizations' report on quality indicators shows attainment of the required threshold levels for both quality indicators, extra payments will be made to the M+C organizations in 2002 for each enrollee who was discharged from an acute care hospital between 7/01/99 and 6/30/00, with a greater than one-day stay for a principal inpatient diagnosis of CHF, and who are enrolled in the M+CO at the beginning of each payment month in 2002.

In 2002 – Medicare+Choice organizations with enrollees hospitalized with a greater than one-day stay for a principal diagnosis of CHF between 7/01/00 and 6/30/01, will receive the full PIP-DCG-16 amount under the risk adjustment payment methodology. The extra payment to qualifying M+C organizations for those enrollees discharged between 7/1/99 and 6/30/00, will be based on approximately one-third the full PIP-DCG-16 amount, subject to the risk adjustment transition schedule.

Assuming a payment blend of 80 percent demographic payment and 20 percent risk adjusted payment in 2002, the additional payments to qualifying M+C organizations would be based approximately on the following formula: .33 (one third of PIP-DCG 16 amount) X 2.4 (PIP-DCG-16 risk factor) X .20 (the payment blend in 2002) of the risk adjusted county rate.

In 2003 - Payments will be made to a qualifying M+C organizations for each enrollee who was discharged from an acute care hospital between 7/01/99 and 6/30/02, with a greater than one-day stay for a principal inpatient diagnosis of CHF, and who are enrolled in the M+C organizations at the beginning of each payment month in 2003. M+C organizations with enrollees hospitalized with a principal diagnosis of CHF between 7/01/01 and 6/30/02, will receive the full PIP-DCG-16 amount under the risk adjustment payment methodology. Extra payment to qualifying M+C organizations will be for those enrollees discharged between 7/1/99 and 6/30/01, and will be based on a portion of the full PIP-DCG-16 amount.

The extra payment amount for 2003 will be determined in 2001 and announced in the January 15, 2002 "Advance Notice of Methodological Changes in Medicare+Choice Payment Rates for Calendar Year 2003."

100.2.6 - Auditing

(Rev. 1, 07-02-01)

For payment years 2002 and 2003, a sample of M+C organizations will be selected for auditing of the submitted data. Upon notification, M+C organizations must submit beneficiary level information for the numerator and denominator for each quality indicator, as outlined in 100.2.5 above. For example, M+C organizations must maintain records of the HIC number and whether the member appears in the numerator for each measure. (i.e., for each HIC number: LVF evaluation: yes/no, LVSD, yes/no; ACEI for LVSD: yes/no/not indicated).

Using this information and other administrative data, CMS will identify a sample of medical records. For M+C organizations with more than 400 with the CHF diagnosis (defined in 100.2.1) who use sampling, CMS may choose to review the sampling methodology and/or audit medical records of those who were or were not sampled. CMS will review medical records or other supporting documentation to verify the quality indicator rates. If the review fails to confirm that the M+C organizations met both of the quality indicator thresholds, then CMS will recover all associated payments from the M+C organizations.

100.2.7 - Hospitalization Tracking

(Rev. 1, 07-02-01)

CMS will track re-hospitalization rates for those enrollees for which the M+C organizations is receiving additional payments. The M+C organizations are encouraged to track readmission rates as a means of monitoring their success in preventing re-hospitalization in this population.

100.3 - Questions About the Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care

(Rev. 1, 07-02-01)

Assistance from the Peer Review Organizations (PROs) is not available to M+C organizations for any data collection and abstraction performed solely for extra payment in recognition of the costs of successful outpatient CHF care. For questions regarding the requirements for this extra payment, please contact Jane Andrews at CMS, Center for Health Plans and Providers, Demonstrations and Data Analysis Group, (410) 786-3133.

100.4 - Implementation of 100 Percent Risk-Adjusted Payments for Qualifying Congestive Heart Failure Enrollees in 2001

(Rev. 1, 07-02-01)

BIPA §607 amends §1853(a)(3)(C) of the Act to provide for full implementation of risk adjustment for qualifying congestive heart failure enrollees for 2001. Under the BBRA, the phase-in amount for risk adjustment was 10 percent in 2001. BIPA §607 provides for 100 percent implementation of risk adjustment for each enrollee with a qualifying congestive heart failure inpatient hospital discharge diagnosis that occurred July 1, 1999 through June 30, 2000.

Each of these enrollees must be enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001 in the service area of the enrollee, for CY 2001 only. Full implementation of risk adjustment for congestive heart failure began January 1, 2001, and is excluded from the determination of the budget neutrality factor. Payments will begin in the spring of 2001, retroactive to January 1, 2001, and will end on December 31, 2001.

110 - Encounter Data Collection for the Risk Adjustment Method

(Rev. 1, 07-02-01)

This section provides an overview of encounter data used for risk adjustment of M+C payments, and also includes information on **hospital inpatient** encounter data requirements. Additional information on hospital inpatient encounter data requirements can be found in http://www.hcfa.gov/medicare/opl070.htm, which is Operational Policy Letter 1998.70. In general, information on CMS's M+C encounter data policies, methods, and training materials can be found at http://www.hcfa.gov/medicare/encountr.htm

NOTE: On May 25, 2001, the Secretary announced that CMS has suspended through July 1, 2002, any filing by M+C organizations of physician and hospital outpatient encounter data. For this reason, discussions of CMS policy related to these types of encounter data have been deleted from this release.

110.1 - Overview of Encounter Data

(Rev. 1, 07-02-01)

CMS uses encounter data to: (1) Calculate each beneficiary's risk adjustment factor; and (2) Adjust the area-specific capitation rate assigned to each beneficiary (county of residence) by the beneficiary's risk adjustment factor. This produces the amount paid the M+C organization for

each beneficiary. (See §90.4.3.) CMS may also use the data for other purposes, such as "recalibration" of diagnosis weights in the risk-adjustment payment model to account, for example, for adoption of new technology or for changes in the average use of resources for enrollees in a particular category.

Accordingly, the BBA requires each M+C organization, as well as eligible organizations with risk-sharing contracts under §1876 of the Act, to submit to CMS, in accordance with CMS instructions, all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner. Requirements concerning collection of encounter data apply to M+C organizations with respect to all their M+C plans, including private fee-for-service plans, with the exception of certain demonstration projects discussed in §90.5.

To the extent required by CMS, encounter data must account for services covered under the original Medicare program, for Medicare covered services for which Medicare is not the primary payer, or for other additional or supplemental benefits that the organization must provide.

M+C organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate encounter data that conforms to the format used under original Medicare. These provisions may include financial penalties, including withholding payment, for failure to submit complete and accurate data, or for failure to submit data that conform to the requirements for submission.

Upon enrollment, M+C organizations may obtain permission from the beneficiary to have access to past medical records of their enrollees. However, diagnostic information cannot be passed from CMS to the M+C organizations because of privacy concerns.

NOTE: The policy discussed in §110.2 is current; however, CMS is conducting a review of policy pertaining to certification.

110.2 - Certification of Data Accuracy, Completeness, and Truthfulness

(Rev. 1, 07-02-01)

As a condition for receiving a monthly payment under the M+C program, the M+C organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers and who reports directly to such officer, must make a certification on Attachment B of the M+C contract, based on best knowledge, information, and belief, that the encounter data the M+CO submits to CMS are accurate, complete, and truthful. If such encounter data are generated by a related entity, contractor, or subcontractor of the M+C organization, such entity, contractor, or subcontractor must similarly certify the accuracy, completeness, and truthfulness of the data. (See 42 CFR 422.502(l).)

CMS expects M+C organizations to design and implement effective systems to monitor the accuracy, completeness, and truthfulness of encounter data and to exercise due diligence in reviewing the information provided to CMS. The Department of Justice, the Office of Inspector General, and CMS acknowledge that the volume and variety of data make some inaccuracies inevitable, and they will take into account any legitimate difficulties M+C organizations may have with provider compliance. However, this certification standard does not relieve M+C

organizations of their obligation to comply fully with the M+C program's encounter data requirements.

110.3 - Validation of Data

(Rev. 1, 07-02-01)

M+C organizations and their providers and practitioners are required to submit medical records for validating encounter data, as prescribed by CMS. Medical record reviews of a sample of hospital encounters may be audited to ensure the accuracy of diagnostic information. Independent contractors will conduct the reviews.

110.4 - Hospital Inpatient Encounter Data Requirements

(Rev. 1, 07-02-01)

As discussed in §70, the timing of encounter data collection set forth in the BBA signaled to CMS that the initial risk adjustment method should be based only on data from inpatient hospital stays, with later implementation of a method based on data from additional sites of care. CMS selected the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model as the risk adjustment method under which payments are made, beginning January 1, 2000. In this model, diagnoses from hospitalizations are used to identify a particularly ill and high cost subset of beneficiaries for whom higher payments will be made in the next year.

The hospital inpatient encounter data requirements entail submission of data for discharges from inpatient hospitals, including facilities reimbursed under the prospective payment system (PPS), long stay hospitals, psychiatric and rehabilitation hospitals, and psychiatric/rehabilitation distinct parts of hospitals. Encounter data are not currently required for discharges from skilled nursing facilities (SNFs).

> **NOTE:** In order to participate as a Medicare provider, a hospital must meet certain conditions specified in the Medicare regulations at 42 CFR 482.12. Generally, these conditions pertain to issues such as compliance with applicable Federal, State, and local laws, make-up of the medical staff, and quality assurance plans.

All discharges reflecting inpatient stays should be submitted. If a patient moves from a one-day hospital stay to a swing bed or skilled nursing facility bed, then this is simply a one-day stay (see §90.2.1). If the patient is transferred to a rehabilitation facility, then the diagnoses from the rehabilitation facility stay may be used to determine the risk adjustment payment.

Contracted and Non-contracted Facilities - The M+C organization must ensure that CMS receives a record of each hospital discharge for each managed care enrollee, regardless of whether the hospital is a contracted or non-contracted facility. M+C organizations may need to modify their contracts with hospitals to ensure that all managed care discharges are identified.

Coding Guidance - The records that M+C organizations submit should reflect the original diagnosis that the provider submitted to the M+C organization. M+C organizations should not modify, supplement, or re-sequence diagnosis codes received from hospitals.

Encounter data should be substantiated by the hospital's medical record. If the M+C organization receives a record from a provider that contains an incorrect code in a critical field

(i.e., diagnosis code, procedure code, admission date or discharge date), the organization must make sure that its database matches and supports the provider's database for these fields. Thus, it is recommended that the M+C organization return the record to the provider for correction and resubmission. For other items on the record, the M+C organization may use its own databases to fill in or correct these items.

Secondary Diagnoses - If an M+C organization does not report secondary diagnoses, it may not receive the payment to which it is entitled. Generally, the PIP-DCG model uses only the principal diagnosis to assign a beneficiary to a PIP-DCG category. However, there are two exceptions (see §90.2.2). For beneficiaries with a principal diagnosis related to chemotherapy (ICD-9 codes V58.1 and V66.2), the PIP-DCG category is assigned based on the type of cancer, using a secondary diagnosis. Also, all beneficiaries with a secondary diagnosis of AIDS will be placed in the same PIP-DCG category as those with a principal diagnosis of AIDS. M+C organizations should assure that they obtain all diagnostic information from their providers and submit all diagnoses to their Fiscal Intermediaries (FIs).

110.5 - Data Formats and Processing

(Rev. 1, 07-02-01)

A record of each enrollee discharge should be submitted, from contracted as well as non-contracted hospitals. Encounter data will be priced only for discharges on or after July 1, 1998. M+C organizations may submit to CMS electronic records using either a complete or abbreviated UB-92 format. M+C organizations may also submit using a Medicare Part A ANSI ASC X12 837 format, also called the "ANSI 837.

Abbreviated UB-92 Version 6.0 format - To indicate that the format being submitted is abbreviated, the "Z" code must be included in the third digit of "Type of bill." The abbreviated UB-92 will not be discontinued. Version 6.0 has been approved by CMS for submission of inpatient encounter data. M+C organizations could begin using Version 6.0 effective August 1, 2000 to submit data to their current FI. All M+C organizations are required to transition from Version 5.0 to Version 6.0 for submissions after December 31, 2000.

Teaching Hospitals - M+C organizations should be aware that teaching hospitals submit UB-92/ANSI837 records for the computation and payment of indirect and direct Graduate Medical Education (GME) costs for inpatients who are plan enrollees. Teaching hospitals will submit these records to the hospital's FI. These records will resemble those submitted by the M+C organization or the hospital as encounter data except that the GME transactions will contain the condition code "69" – indicating request by teaching hospital for indirect and direct GME payment. Note that the "69" code cannot be used in M+C encounter data submissions.

110.6 - Deadlines for Submission of Encounter Data

(Rev. 1, 07-02-01)

NOTE: On May 25, 2001, the Secretary announced that CMS has suspended through July 1, 2002, any filing by M+C organizations of physician and hospital outpatient encounter data. For this reason, discussions of policy related to these types of encounter data have been deleted from this release.

The BBA requires that M+C organizations submit data regarding inpatient hospital services for all enrollee discharges that occur on or after July 1, 1997. Below is a list of the first three data collection years for inpatient encounter data. Table 3 presents the current schedule.

Year 1: - Discharges between 7-1-97 and 6-30-98; start-up year (not used for payment)

Year 2: - Discharges between 7-1-98 and 6-30-99; used for CY 2000 payments

Year 3: - Discharges between 7-1-99 and 6-30-00; used for CY 2001 payments

Table 3 - Submission Deadlines for Hospital Inpatient Encounter Data

Data Collection Year (Service Dates)	Payment Year	Deadline
July 1, 2000 - June 30, 2001	2002	Sept. 7, 2001
July 1, 2001 - June 30, 2002	2003	Sept. 6, 2002
July 1, 2002 - June 30, 2003	2004	Sept. 5, 2003
July 1, 2003 - June 30, 2004	2005	Sept. 3, 2004

Risk adjustment factors for each payment year are based on encounter data submitted for services furnished during the 12-month period ending 6 months before to the payment year. (For example, risk adjustment factors for CY 2000 were based on data for services furnished during the period July 1, 1998 through June 30, 1999.)

Reconciliation of Payments - Monthly payments during a payment year are based on the encounter data received by CMS by the annual deadlines for the data collection periods listed in Table 3. CMS conducts a reconciliation process to take into account late encounter data submissions, so that total payment for a year will reflect these late submissions. Under the reconciliation process, the deadline for submission of all data for a payment year will be September 30 of that payment year for the period ending the previous June 30. For example, data for CY 2001 payments consists of encounters that occurred between July 1, 1999 to June 30, 2000. The final deadline for late submission of encounter data used to calculate risk factors for CY 2001 payments is September 30, 2001.

See §210 for further details on reconciliation.

120 - Announcement of Annual Capitation Rates and Methodology Changes

(Rev. 1, 07-02-01)

By January 15 of each year, CMS notifies M+C organizations of any proposed changes to the payment methodology and publishes the preliminary estimates of the national growth rate. M+C organizations have 15 days to comment on the proposed changes. CMS accepts comments through January 31 of the same month.

By March 1 of each year, CMS releases the annual announcements of the payment rates for the following calendar year. This announcement must include the final county rates, a description of

the risk and other factors, and other information necessary to ensure that M+C organizations can calculate the monthly-adjusted capitation rates for individuals in each of their payment areas.

130 - Special Rules for Beneficiaries Enrolled in M+C Medical Savings Account (MSA) Plans

(Rev. 1, 07-02-01)

The statute directs CMS to allocate the per capita amount associated with each M+C MSA enrollee in two portions: the deposit CMS makes to the enrollee's MSA and the premium CMS pays to the M+C organization offering the MSA plan.

CMS allocates the capitated amount associated with each M+C MSA enrollee into a plan premium and an MSA deposit as follows:

- First, CMS compares the monthly M+C MSA premium filed by the organization offering the MSA plan to $1/12^{th}$ of the annual M+C capitation rate for the payment area in which the beneficiary resides.
    - If the monthly M+C MSA premium is less than the monthly capitation rate (see §30.1), then CMS deposits into the individual's M+C MSA account a lump sum equal to the annual difference between these two amounts.
    - This annual difference is calculated as the monthly difference multiplied by 12 or by the number of months remaining in the calendar year when the individual becomes covered under the M+C MSA plan.
- CMS deposits the lump-sum payment to which a beneficiary is entitled for the calendar year, beginning with the month in which M+C MSA coverage begins.
- If the beneficiary's coverage under the M+C MSA plan ends before the end of the calendar year, CMS will recover the amount that corresponds to the remaining months of that year.
- Second, CMS's advance payment of the monthly premium to the M+C MSA plan for an enrollee is equal to the county per capita rate, adjusted by the enrollee's demographic and risk factors, minus $1/12^{th}$ of CMS's lump sum contribution to the enrollee's MSA.

The premium filed by the organization offering the M+C MSA plan is uniform for all enrollees under a single M+C MSA plan. This results in a uniform amount being deposited in enrollees' M+C MSAs in a given payment area, since the uniform premium amount will be subtracted from the uniform capitation rate for every enrollee in that payment area. While monthly premiums are uniform within a plan, the advance monthly payments CMS makes to an M+C organization for each enrollee may differ because the area-specific per capita rate is adjusted for each enrollee's demographic characteristics and health status -- under the blend appropriate for that payment year of demographic-only and risk adjustment methods.

130.1 - Example: Allocating the Per Capita Rate Between the Enrollee's MSA Account and the M+C MSA Plan

(Rev. 1, 07-02-01)

Calculation of payments for two beneficiaries of different ages living in the same county and enrolled in the same M+C MSA plan is performed as follows, assuming a monthly county per capita rate of $500, and a monthly M+C MSA plan premium of $400.

Calculation of CMS annual contribution to the enrollees' M+C MSA plan is equal to the county per capita rate minus monthly plan premium. For this example, ($500-$400) * 12 months = $1,200 for any MSA enrollee in the county.

Calculation of CMS advance monthly payments:

- First, adjust the county per capita rates:
    - $500 * demographic factor for the 65 year old beneficiary = $450
    - $500 * demographic factor for the 85 year old beneficiary = $700
- Second, calculate the advance monthly payment to the plan:
    - Recall that $1/12^{th}$ of CMS lump sum contribution to the enrollee's MSA is $1200 or $100 per month.
    - For the 65 year old beneficiary = $450-$100 = $300
    - For the 85 year old beneficiary =$700-$100 = $600

Thus, each month, CMS pays the organization offering the M+C MSA plan $300 for the 65 year old enrollee and $600 for the 85 year old enrollee.

130.2 - Establishment and Designation of Medical Savings Accounts (MSAs)

(Rev. 1, 07-02-01)

A beneficiary who elects coverage under an M+C MSA plan must establish an account with an entity that acts as a qualified trustee or custodian. A trustee must meet the following requirements:

- Register with CMS;
- Certify that it is a licensed bank, insurance company, or other entity qualified under the IRS Code to act as a trustee of Individual Retirement Accounts;
- Agree to comply with the IRS rules concerning MSAs; and
- Provide any other information that CMS may require.

An enrollee may establish more than one account, but must designate the particular account under the M+C MSA to which CMS makes payments.

140.0 - Special Rules for Coverage that Begins or Ends During an Inpatient Hospital Stay

(Rev. 1, 07-02-01)

If coverage under an M+C plan offered by an M+C organization begins while the beneficiary is receiving inpatient hospital services from a hospital covered under original Medicare's Prospective Payment System (PPS), payment for inpatient services continues to be the responsibility of original Medicare or the previous M+C organization, until the date of the beneficiary's discharge.

- The M+C organization offering the newly elected M+C plan is not responsible for the inpatient services until the date of the beneficiary's discharge.

- Original Medicare or the previous M+C organization pays the full amount for that beneficiary for that inpatient episode, even if it extends beyond the effective date of a beneficiary's M+C election.

- In the case where a beneficiary's M+C plan election ends while he or she is a hospital inpatient, the M+C organization remains responsible for payment for inpatient hospital services furnished by a hospital after expiration of enrollment until the date of discharge. Payment for these services would not be made under Medicare's PPS system, and the responsible M+C organization would not receive any payment from CMS for the hospitalized individual during the period the individual was not enrolled.

150 - Special Rules for Payments to M+C Organizations for Their Beneficiaries Enrolled in Hospice

(Rev. 1, 07-02-01)

M+C organizations must inform each Medicare enrollee who is eligible to elect hospice care under §1812(d)(1) of the Act about the availability of hospice care. M+C enrollees should be informed if there is a Medicare-certified hospice program in the plan's service area. Additionally, if it is common practice to refer patients to Medicare-certified hospice programs outside that area, the M+C organization must inform enrollees about the availability of Medicare-certified hospice care. See Chapter 4 for additional information on hospice benefits.

150.1 - Enrollment Status

(Rev. 1, 07-02-01)

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

150.2 - Payment for Hospice Services

(Rev. 1, 07-02-01)

During the time the hospice election is in effect, CMS monthly capitation payment to the M+C organization is reduced to an amount equal to the adjusted excess amount in the M+C plans' approved ACRP. (See Chapter 8 for information on Adjusted Community Rate Proposals (ACRPs.)

CMS pays the hospice program, through the original Medicare program and subject to the usual rules of payment, for hospice care furnished to the Medicare enrollee.

CMS pays the M+C organization or provider or supplier for other Medicare-covered services furnished to the enrollee. Other services refer to non-hospice services that are not related to the terminal illness.

The M+C organization is responsible for providing to its members who have elected hospice all Medicare-covered non-hospice services , and also any non-hospice services that are not Medicare-covered but are additional benefits provided under the plan. For example, any services provided by an attending physician to an M+C enrollee who has elected hospice are non-hospice services if the physician is not employed or contracted by the enrollee's hospice program.

Since an M+C organization cannot bill a Fiscal Intermediary (FI), nor can an FI make payments to M+C organizations, below are examples of how M+C organizations may choose to handle billing for non-hospice services:

- The M+CO may authorize the provider (e.g., hospital or physician) or supplier to bill the FI or carrier directly. (In this situation, the M+C organization might choose to incorporate rate adjustments in contracts to account for the provision of non-hospice services by providers and suppliers that bill original Medicare directly.)

- In the case of physician and supplier services, the M+C organization may direct them to submit claims for non-hospice services to the M+C organization. The M+C organization would bill the carrier and make payments to the physicians/suppliers.

Under original Medicare (and thus under the M+C program for hospice election), the beneficiary is responsible for the following cost sharing upon electing a hospice:

- Co-pay for drug and biologicals: 5 percent per prescription filled.

- Co-pay for a respite care day: 5 percent of the payment that Medicare makes for a respite care day, not to exceed the hospital inpatient deductible.

160 - Special Rules for M+C Payments for Beneficiaries Re-enrolled as Qualifying Individuals

(Rev. 1, 07-02-01)

The BBA established "Qualified Individuals" (QIs) for CY 1998 through 2002. Qualified Individuals are low-income Medicare beneficiaries for whom State Medicaid programs cover all or a portion of Medicare Part B premiums. Qualified Individuals, by definition, have higher incomes than other groups for whom Medicaid pays Medicare cost sharing and premiums.

160.1 - Terminology

(Rev. 1, 07-02-01)

Qualifying Individuals-1 (QI-1s) - Effective 1/1/1998–12/31/2002. Individuals entitled to Part A of Medicare, with income above 120 percent, but less than 135 percent of the Federal poverty level, resources not exceeding twice the SSI limit, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of a capped allocation.

Qualifying Individuals-2 (QI-2s) - Effective 1/1/1998–12/31/2002. Individuals entitled to Part A of Medicare, with income at least 135 percent, but not exceeding 175 percent of the Federal

poverty level, resources not exceeding twice the SSI limit, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to partial payment of Medicare Part B premiums (an amount attributable to switching some home health coverage from Part A to Part B). The number of eligible individuals is limited by the availability of the capped allocation.

160.2 - Policy

(Rev. 1, 07-02-01)

CMS is changing its systems toward the end of 2000 to discontinue Medicaid adjustments for QI-1s. For 2001 payments, M+C organizations may not present Qualified Individuals (either QI-1s or QI-2s) as eligible for Medicaid payment adjustments. CMS does not believe it is appropriate to penalize M+C organizations for shortcomings in the quality of State data CMS uses as the basis for payments. Furthermore, it is not realistic for M+C organizations to verify the Medicaid eligibility status and categories of each of their enrollees. Therefore:

- CMS will not make retroactive adjustments (and collect overpayments) for payments made for based on the Medicaid adjustment for QIs in the past.

- To the extent that CMS systems incorrectly label Qualified Individuals as other groups of Medicaid eligibles (and therefore qualified for Medicaid payment adjustments), CMS will not hold M+C organizations responsible for correcting this information.

170 - Clarification of the Definition of "Certified Institution" for Adjusting Payments Under the Demographic-Only Method

(Rev. 1, 07-02-01)

One of the categories for which payment adjustments are made under the demographic-only method is institutional status, referring to Medicare beneficiaries who are under care or custody in institutions. To be considered institutionalized, an enrolled member must:

- Be a resident in an institution, or distinct part of an institution, that is one of the seven following types of institutions certified under Title XVIII (Medicare) or Title XIX (Medicaid; and

- Satisfy the qualifying period of residency in a certified institution (or distinct part of an institution) that is Title XVIII or Title XIX certified.

170.1 - Types of Certified Institutions

(Rev. 1, 07-02-01)

Medicare and Medicaid certified institutions are:

- **Skilled Nursing Facility (SNF)**, as defined at §1819(a) of the Act, is an institution, or distinct part of an institution, primarily engaged in providing skilled nursing care or rehabilitative services to residents which has in effect an agreement with a hospital that ensures transfer of patients will be affected between the two whenever such transfer is medically appropriate.

- **Nursing Facility (NF),** as defined at §1919(a) of the Act, is the same as a SNF but also includes institutions that provide health-related care and services to residents who because of

their mental or physical condition require care and services, which can be made available to them only through institutional facilities.

- **Intermediate Care Facility for the Mentally Retarded (ICF/MR**), as defined at §1905(d) of the Act, is an institution that provides health or rehabilitative services for mentally retarded residents receiving active treatment under Medicaid.

- **Psychiatric Hospital or Unit,** as defined at §1886(d)(1)(B) of the Act, is an institution, or distinct part of an institution, primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

- **Rehabilitation Hospital or Unit,** as defined at §1886(d)(1)(B) of the Act, is an institution that serves an inpatient population of whom the vast majority require intensive rehabilitative services for the treatment of certain conditions, e.g., stroke, amputation, brain or spinal cord injuries, and neurological disorders.

- **Long-Term Care Hospital**, as defined at §1886(d)(1)(B) of the Act) is a hospital, which has an average inpatient length of stay of greater than 25 days.

- **Swing-Bed Hospital,** as defined under §1883 of the Act, is a hospital, which has entered into an agreement whereby its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a SNF, would constitute extended care service.

In the case of an enrolled member in a swing-bed hospital, the enrolled member must be receiving post-hospital extended care services or SNF services.

170.2 - Residency Requirements

(Rev. 1, 07-02-01)

A Medicare enrollee must have been a resident of one or more of the above certified institutions for a minimum of 30 consecutive days, which includes, as the 30th day, the last day of the month prior to the month for which the higher institutional rate is paid. This qualifying period of residency must be satisfied each month in order for the M+C organization to be paid at the higher institutional rate.

The term "calendar month" cannot be used. A calendar month can have 28 to 31 days and thus cannot be substituted for 30 days. For example, in a month with 31 days, a beneficiary would have to be institutionalized from the 2nd - 31st day of the month to meet the requirements for reporting institutionalized status.

Temporary Absences - CMS will continue to pay the institutionalized rate while an enrolled member is temporarily absent from the facility for hospitalization or therapeutic leave, if the member returns to a certified institution, or distinct part of an institution. Temporary absences (less than 15 days) for medical necessity will be counted toward the 30-day requirement.

NOTE: "Therapeutic" means requested or supported by a physician; site of service is irrelevant.

The following examples clarify these residency requirements.

1. A member of an M+C organization enters an institution identified above on March 2. On March 20, the individual is hospitalized for a surgical procedure. On April 2, the individual is discharged from the hospital, re-enters the institution, and remains there continuously through April 15. The individual does meet the residence requirement (March 2 through March 31), and the M+C organization is paid the institutional rate for the month of April.

2. Mr. X, whose M+C enrollment is effective April 1, enters one of the institutions identified above on April 15 and remains there continuously until his discharge on May 25. He does not meet the criteria for reporting institutionalized status for May or June. Although he was institutionalized for at least 30 consecutive days, in both April and May his residency was less than 30 days, and in May his residency did not include the last day of the month as the 30th day. His stay would have had to continue through May 31 in order to be reported for an institutional payment adjustment for the month of June.

3. Ms. Y, whose M+C enrollment is effective April 1, enters one of the institutions identified above on February 28 and remains there continuously until her discharge on April 25. She does meet the qualifying period of residency for reporting institutionalized status for April (March 2 through March 31) but not for May. The qualifying period of residency for a payment adjustment for the month of May is April 1 through April 30. Note that Ms. Y was not a member of the M+C organization during the qualifying period of residency (March 2 through March 31). It is not required that Ms. Y be a member of the M+C organization during the qualifying period of residency. Thus, the M+C organization is paid the institutional rate in April for the qualifying period in March. The M+C organization would not be paid the institutional rate for the month of May because the qualifying period of residency (April 1 through April 30) was not satisfied.

180 - Special Rules for New Entry Bonus Payments to M+C Organizations

(Rev. 1, 07-02-01)

The Balanced Budget Refinement Act (BBRA) established bonus payments to encourage M+C organizations to offer plans in payment areas that would otherwise not have a plan participating in the M+C program. The application of the new entry bonus is governed by three factors: The definition of unserved payment area, the date a plan is first offered, and the period of application for the bonus.

180.1 - Previously Unserved Payment Area

(Rev. 1, 07-02-01)

The BBRA defined a previously unserved payment area as:

- A payment area in which an M+C plan had not been offered since 1997; or

- A payment area in which an M+C plan had been offered since 1997, but in which every M+C organization offering an M+C plan in that payment area since then has notified CMS (no later than October 13, 1999) that it would no longer offer M+C plans in that payment area as of January 1, 2000.

BIPA §608 extended by one year the time period during which an area must have had no M+C plan(s) offered in order for that area to be eligible for the bonus. The BIPA mandates that a payment area now will be considered unserved for purposes of bonus payments if:

- An M+C plan (or plans) had been offered since 1997; and
- Every M+C organization offering an M+C plan in that payment area then notified CMS no later than October 3, 2000 that it would no longer offer M+C plans in that payment area as of January 1, 2001.

The effect of this section of the BIPA was to include additional payment areas in the definition of previously unserved payment areas.

M+C organizations entering a payment area that is a county which is partially unserved are not eligible for a New Entry Bonus. CMS does not have that discretion under the law. The statute refers to a payment area, and most payment areas are counties. Therefore, if a plan already is offered in part of a county, any M+C organization offering a plan in that county could not be considered entering a previously unserved payment area since there is already a plan serving that county.

NOTE: A payment area that has §1876 cost plans only, but no M+C plans, would be considered a "previously unserved payment area," justifying the bonus payment.

180.2 - The Date on Which a Plan is Offered

(Rev. 1, 07-02-01)

The date on which a plan is offered is the date on which the M+C organization's contract is effective and an M+C eligible beneficiary is eligible to enroll in the M+C plan, without regard to when an individual enrollment is effective or services are received (see 42 CFR 422.250(g)(3)). Because contract approval dates may vary, two or more M+C organizations with different contract approval dates may be eligible for a bonus in the same area if the M+C plans covered under the contract are first offered in the area on the same date. If an M+C organization first offers two M+C plans simultaneously in a previously unserved payment area, the M+C organization will receive the bonus for enrollees in both plans, since that "organization" is entitled to the bonus. Likewise, if more than two M+C organizations enter at the same time and each has more than one plan, the M+C organizations will receive a bonus for all enrollees in all of the plans offered in a previously unserved payment area. See Operational Policy Letter 2000.117 for additional discussion.

180.3 - Eligibility for Bonus Payment - The Period of Application

(Rev. 1, 07-02-01)

The BBRA specified that the new entry bonus would only apply to M+C plans that are first offered during the period of application, which is the period beginning January 1, 2000 and ending on December 31, 2001. This period of application is a 2-year window during which an M+C organization that enters a previously unserved payment area and offers the first M+C plan in that area, will be eligible for bonus payments.

Note that although the BIPA changed the time period defining a previously unserved payment area, it did not change the time period defining the period of application. The result of this change is that now the time periods defining "previously unserved" payment area and "period of application" are the same: from January 1, 2000 through December 31, 2001. (The BIPA amendment applies as if it were included in the enactment of the BBRA.) Table 1 shows a comparison of the two different time periods in effect for the new entry bonus.

Table 1 - Comparison of BBRA and BIPA Provisions on New Entry Bonus

Provision	BBRA	BIPA
Date a payment area becomes previously unserved	January 1, 2000	January 1, 2000 through December 31, 2001
Period of application (the window for M+C organizations to first offer an M+C plan in an unserved area)	January 1, 2000 through December 31, 2001	January 1, 2000 through December 31, 2001

We discussed the BIPA amendment to the new entry bonus in the January 12, 2001 "Advance Notice of Methodological Changes for Calendar Year 2002 Medicare+Choice Payment Rates", published on our website at Http://www.hcfa.gov/stats/hmorates/cover01, and in the March 1, 2001 "Announcement of Calendar Year 2002 Medicare+Choice Payment Rates". In the March 1 announcement, we indicated that the 1-year extension in the time period defining an unserved area mandated by the BIPA also applied to the 2-year period of application. In effect, this would extend the end of the period of application window from December 31, 2001 to December 31, 2002. As a result, we stated that an M+C organization first offering a plan in a previously unserved payment area on January 1, 2002, would be eligible for the bonus payments.

After further analysis, we have determined that while the BIPA did expand the time period used to define a previously unserved payment area, it did not extend the period of application window during which an M+C organization must first offer a plan in a previously unserved area. The period of application remains January 1, 2000 through December 31, 2001. For example, an M+C organization that first offers a plan in a previously unserved payment area on January 1, 2002 would not be eligible for the new entry bonus payments. However, if the M+C organization first offers a plan in a previously unserved payment area prior to January 1, 2002, then the M+C organization would have first offered an M+C plan within the period of application and the organization would be eligible for new entry bonus payments.

180.4 - Method for Calculating Bonus Payments

(Rev. 1, 07-02-01)

The first M+C plan offered in a previously unserved payment area receives a 5 percent bonus payment during its first 12 months in that payment area and a 3 percent bonus payment during the second 12 months. For example, an M+C organization that enters a previously unserved payment area on March 1, 2000, will receive 5 percent bonus payments until February 2001, and 3 percent bonus payments until February 2002. The BBRA provides for no bonus payments after this second 12-month period. Under the BIPA extension of the time period delineating an "unserved payment area," an M+C organization that enters a previously unserved payment area

on March 1, 2001, will receive 5 percent bonus payments until February 2002, and 3 percent bonus payments until February 2003.

The payment is calculated on a beneficiary level and the 5 percent will be added to the payment calculated for each beneficiary residing in a payment area for which their M+C organization is eligible to receive bonus payments. M+C organizations that qualify for the bonus will be notified by CMS that they will receive these additional payments.

180.5 - Relation of Bonus Payments to the Adjusted Community Rate (ACR) Proposal

(Rev. 1, 07-02-01)

M+C organizations should not include bonus payments in the revenue portion of the ACR proposal.

190 - Source of Payment and Effect of Election of the M+C Plan Election on Payment

(Rev. 1, 07-02-01)

Payments to M+C organizations or M+C MSAs are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund in proportions that reflect the relative weights that benefits under Part A and Part B represent of the actuarial value of total Medicare benefits.

190.1 - Payments to the M+C Organization

(Rev. 1, 07-02-01)

CMS's payments under a contract with an M+C organization with respect to an individual electing an M+C plan offered by the organization are instead of the amounts, which, in the absence of the contract, would otherwise, be payable under original Medicare for items and services furnished to the individual. This statement is subject to provisions set forth in the Act:

- §412.105(g) detailing payments made to a hospital for indirect medical costs for discharges of managed care enrollees;
- §413.86(d) concerning calculations of payments to hospitals for graduate medical education costs;
- 42 CFR 422.109 concerning National Coverage Determinations;
- 42 CFR 422.264 on special rules for coverage that begins or ends during an inpatient hospital stay; and
- 42 CFR 422.266 on special rules for hospice care.

190.2 - Only the M+C Organization is Entitled to Payment

(Rev. 1, 07-02-01)

Only the M+C organization is entitled to receive payment from CMS under title XVIII of the Act for items and services furnished to the individual. This statement is subject to provisions set

forth in the M+C regulations: 42 CFR 422.262 on special rules for beneficiaries enrolled in M+C MSA plans; 42 CFR 422.264 on special rules for coverage that begins or ends during an inpatient hospital stay; 42 CFR 422.266 on special rules for hospice care; and 42 CFR 422.520 detailing the M+C prompt payment provisions specifying conditions under which CMS may make direct payments to providers or M+C private fee-for-service plan enrollees. This statement is also subject to the following provisions of the Act: §1886(d) concerning additional payment amounts to any subsection (d) hospital with an approved medical residency training program for applicable discharges of M+C enrollees; and §1886(h)(3)(D) concerning calculations of payments to hospitals for direct graduate medical education costs.

NOTE: Although the policies discussed below on retroactive payment adjustments are current, CMS is conducting a review of all policies pertaining to retroactive payment adjustments.

200 - Retroactive Payment Adjustments for M+C Organizations

(Rev. 1, 07-02-01)

Retroactive payment adjustments (both increases and decreases) are limited to a 3-year period preceding the month in which CMS receives any data indicating a change is needed to a Medicare enrollee's record. For example, if a payment adjustment is proposed in February 2000 to cover a period of at least 36 months, a payment adjustment will be made beginning in February 1997 (assuming all documentary requirements are met).

This policy applies to retroactive deletions of and changes in the demographic classes and working aged status in which a Medicare enrollee is grouped. In addition, this policy applies to corrections in date of death and administrative errors.

210 - Reconciliation Process for Changes in Risk Adjustment Factors

(Rev. 1, 07-02-01)

Unlike the demographic-only method, the risk adjustment method generates a beneficiary-specific factor that is effective for a calendar year. This annual risk factor is used to adjust county per capita payment rates to determine per enrollee M+C payment amounts, and is based on the following classes of information:

- Age;
- Gender;
- Medicaid Status;
- Disability Status ("previously disabled"); and
- Encounter data consisting of inpatient diagnoses (PIP-DCGs).

Adjustments to beneficiary risk factors due to corrections in the statuses listed above will not occur during the payment year. This includes encounter data submitted for Part B-only members. Making corrections to beneficiaries' statuses and processing the resulting payment adjustments are accomplished through a reconciliation process that occurs after the end of the payment year.

NOTE: There is no adjustment for institutional status under the risk adjustment methodology as it has been accounted for in the development of the risk adjustment factors. Also, Medicaid status is applied prospectively under the risk adjustment method. (See §90.1.)

Changes in beneficiary status that do not impact the risk adjustment factor are processed concurrently during the payment year. They are:

- Enrollment/disenrollment dates;
- Part A/B entitlement;
- State and county codes; and
- Working aged status;

CMS has separate reconciliation processes for hospice (§220) ESRD (§230). (M+C enrollees who are capitated at the ESRD and hospice rates are excluded from payment under the risk adjustment method; they are capitated at the applicable demographic-only rate.)

210.1 - Reconciliation Schedule and Late Submission of Encounter Data

(Rev. 1, 07-02-01)

Each year, M+C organizations have approximately 3 months after the end of the data collection year (June 30) to submit encounter data that is used to develop beneficiary risk factors (see Table 3). If organizations submit encounter data after this annual deadline, it cannot be incorporated into calculations of the beneficiary risk scores for the upcoming payment year. However, M+C organizations should continue submitting encounter data after this deadline because CMS has instituted a reconciliation process that takes into account late encounter data submissions.

Under the reconciliation process for risk adjustment, the deadline for submission of all encounter data for a payment year will be September 30 of that payment year for the encounter data collection period ending the previous June 30. For example, the final deadline for late submission of encounter data for the period July 1, 1999 to June 30, 2000 – which is used for payment in CY 2001 – is September 30, 2001. Encounter data submitted for Part B-only members also will be extracted. After September 30, 2001, data for reconciliation of payments for 2001 will not be accepted.

Reconciliation will occur in the first six months of each year until CMS systems have the capacity to conduct concurrent processing of all updates in beneficiary status that affect the risk adjustment factors. For example, CY 2000 has a September 30, 2000 cut-off date for submission of late encounter data - for discharges between July 1, 1998 and June 30, 1999. Recalculation of CY 2000 risk adjustment factors and processing of the resulting reconciled payment adjustments occurs during the first six months of CY 2001.

210.2 - Organization of Risk-Adjusted Reconciliation

(Rev. 1, 07-02-01)

This reconciliation process consists of the following activities:

- Information related to any Medicare beneficiary who was enrolled or could be retroactively enrolled in an M+C organization during the payment year is extracted from CMS systems, including any updates to the date of birth, gender, Medicaid status, previously disabled status, and health status that have occurred since the previous computation of the beneficiary's annual risk adjustment factor.

- The updated information is processed through the PIP-DCG model program to produce new risk adjustment factors.

- These factors are then sent to CMS managed care system, which compares the newly calculated risk adjustment factors to the factors originally utilized for the payment year. When changes are detected, the risk adjustment information for the affected beneficiaries is updated in the system.

- Payment adjustments are then processed based on the revised risk adjustment factors. Since these factors are annual, the adjustment period(s) for each beneficiary will coincide with the period(s) of enrollment in the M+C organization(s) during the payment year. For example, if a beneficiary were enrolled in an M+C organization for all of CY 2000, the adjustment period for calculating reconciled payments for that beneficiary would be January to December 2000.

  NOTE: The results of this reconciliation process are only applicable to the risk adjusted portion of the M+C payments. See §200 for reconciliation applied to the demographic only portion of the payment.

220 - Reconciliation of Payments for Hospice Enrollees

(Rev. 1, 07-02-01)

When an M+C enrollee elects hospice coverage, the hospice is reimbursed directly for hospice-related care. During the time the hospice election is in effect, CMS's monthly capitation payment to the M+C organization is reduced to an amount equal to the adjusted excess amount in the M+C plans' approved Adjusted Community Rates (ACRs) (see Chapter 8 for information on ACRs). If the plan elected by the member does not provide additional benefits, the hospice capitation rate for that plan will be zero.

M+C organizations can offer multiple plans and hospice capitation rates can differ from plan to plan. Currently, CMS managed care systems do not track enrollees by plan, and thus cannot capitate members at different plan rates under the same contract (H-number). Thus, CMS's systems can only capitate members at the rate associated with only one plan offered by the M+C organization (i.e., one plan rate per H-number). For M+C organizations with more than one plan under the same H-number, there may be differences among the approved ACR hospice rates at the plan level. These differences could cause payment impacts.

Until modifications can be made to handle multiple rates per contract, CMS policy mandates that the lowest Part A/Part B hospice rate be used for payment purposes. As a result, M+C organizations will be underpaid for their hospice members enrolled in plans with higher hospice rates, as was the case in 1999.

To address this situation and beginning with CY 1999, CMS will conduct annual reconciliations to adjust payments made to impacted M+C organizations until the system can be updated to allow capitation of hospice members at the rate applicable to their M+C plan.

The reconciliation process is organized as follows:

- M+C organizations are required to submit to the Health Plan Management System (HPMS) the following aggregate membership information for each of their plans for each month of the payment year:

    - Total number of Medicare beneficiaries enrolled in each plan each month; and

    - Total number of Medicare beneficiaries electing hospice coverage, as identified on the Monthly Membership Report, enrolled in each plan each month.

- This data submission occurs on a retroactive basis after the end of CY 1999 and CY 2000.

- CMS computes an annual payment amount for each plan, based on the data submitted by the M+C organization and the hospice rate information contained in HPMS. Plan payment amounts are aggregated to produce a total member-month per plan payment amount at the contract level. CY payments already made to M+C organizations for their hospice members are then deducted.

- M+C organizations receive a hospice adjustment payment that reflects the additional amount due for hospice members enrolled in plans with hospice capitation rates higher than the rate for which payment was made during the payment year.

230 - Reconciliation of Payments for ESRD Beneficiaries

(Rev. 1, 07-02-01)

See http://www.hcfa.gov/medicare/esrdntwk.htm for guidelines and procedures for reconciling members with ESRD.

EXHIBITS - CHAPTER 7

Exhibit 1 - Previous Adjusted Average Per Capita Cost (AAPCC) Methodology

- First, CMS made actuarial estimates of the per capita costs Medicare incurred paying claims on a fee-for-service (FFS) basis in a beneficiary's county of residence.

- The adjusted average per capita cost (AAPCC) consists of the per capita rates standardized by demographic factors to account for differences among counties in the overall demographic profile of their Medicare beneficiaries. The demographic characteristics used to describe beneficiaries were sex, age, institutional status, Medicaid eligibility, and beginning in 1995, working aged status.

- CMS next reduced the AAPCCs by 5 percent, acknowledging that costs were expected to be lower due to managed care efficiencies.

- CMS next reduced the AAPCCs by 5 percent, acknowledging that costs were expected to be lower due to managed care efficiencies.

- These final capitation rates were published annually in the county rate book, with separate rates for aged and disabled for both Part A (hospital) and Part B (physician and supplies) services. The county rate book also included separate estimates for beneficiaries with end-stage renal disease, which were based on Medicare's costs in paying claims on a statewide basis.

- To calculate the monthly payment amount to a managed care organization for each enrollee, the capitation rate for the county of residence was adjusted by the individual enrollee’s demographic factor. Managed care organizations received prospective monthly payments that were the sum of these calculations for all their enrollees.

Exhibit 2 - National Coverage Determination (NCD) policy on clinical trials for CYs 2000 and 2001.

Effective September 19, 2000, Medicare initiated coverage of certain benefits related to Medicare-covered clinical trials. The cost for covering these benefits is not included in M+C organization capitated payment rates until CY 2002, and CMS has determined that the costs are high enough to meet the NCD threshold for "significant cost." Medicare will, therefore, be paying for these services outside of the M+C capitated payment rate until these costs are reflected in the CY 2002 M+C payment rates. Medicare intermediaries and carriers will be making payments directly to providers of clinical trials services.

Below is additional information CMS (formerly HCFA) provided in November 2000 on coverage of routine costs of clinical trials by M+C organizations and original Medicare. The information, presented in question and answer format, also can be found at http://www.hcfa.gov/medicare/ctqa.htm.

Reminder: The cost for covering these benefits is included in the CY 2002 M+C capitated payment rates.

See Chapter 4 of the manual for general information on NCDs.

Q1 - Do Medicare+Choice organizations need to cover the routine costs of clinical trials described in the National Coverage Determination (NCD)?

A1 - Medicare rules provide that if an NCD meets a threshold for "significant cost," Medicare will pay for these services outside of the capitated payments until the next payment rate announcement after the NCD takes effect. In the case of the clinical trials NCD, the new coverage was determined to meet the significant cost threshold, and Medicare is paying on a fee-for-service basis for these services in 2001.

Q2 - May an M+C enrollee participate in clinical trials even when the providers in the trial are not in the M+C organization's network?

A2 - Yes. Medicare regulations require that NCD services be furnished to M+C enrollees even when these services cannot be furnished though an M+C organization network. The nature of clinical trials is such that many of these services only will be available and accessible to M+C enrollees when furnished by out-of-network providers. For this reason, coverage cannot be limited to trials in which the M+C organization itself may participate or to trials in which M+C organization network providers may participate.

Q3 - Does the fact that Medicare will be paying for the routine costs of clinical trials on a fee-for-service basis mean that all services for M+C enrollees in clinical trials may be billed in this way?

A3 - No. There is no change in M+C organizations' obligation to provide all other benefits that are covered under the contract to beneficiaries who participate in these clinical trials.

Q4 - Medicare+Choice organizations are concerned about losing track of the services and care being provided to members who participate in clinical trials when the organizations do not pay for the services. What can Medicare+Choice organizations do to follow these M+C members?

A4 – CMS's payments for clinical trial services directly to providers in the short term may make it hard for M+C organizations to track and coordinate the care for these beneficiaries. M+C organizations may set up a notification process to collect information about which members are in a clinical trial, and which clinical trial they are in. This notification process may not be used in any way as a pre-authorization mechanism, however.

In addition, the Agency for Health Research and Quality will be developing a registry of approved clinical trials. Once this is developed, M+C organizations and others will be able to use this registry to contact the trial sponsors in the clinical trial to learn more about the nature of the trial, the services that will be furnished, and the providers who are participating.

Q5 - M+C organizations are very concerned about how they are going to cover these services once they are included in capitation payments. How are M+C organizations' questions going to be resolved?

A5 - M+C organizations and their representatives have raised many important questions about how this will work, and HCFA will continue ongoing discussions with industry representatives to resolve operational issues. HCFA will be developing answers to questions of this nature that were submitted as a part of the comment process for the NCD and publishing them on an ongoing basis on the hcfa.gov website.

Q6 - How will payments to providers be calculated?

A6 - Payment for clinical trial services furnished to beneficiaries enrolled in Medicare managed care plans is determined according to the applicable fee-for-service rules, except that M+C enrollees are not responsible for meeting either the Part A or Part B deductible (i.e., the deductible is waived). M+C enrollees are liable for the coinsurance amounts applicable to services paid under Medicare fee-for-service rules.

Q7 - How will intermediaries and carriers recognize bills for the routine costs of clinical trials?

A7 - Please refer to the procedures described in the program memorandum describing implementation of clinical trials coverage. This is available at http://www.hcfa.gov/quality/8d3.htm.

Q8 - What happens if providers forget to put these codes on their bills?

A8 - Bills/services that are not coded accordingly will not be paid; however providers may resubmit the claims with the clinical trials codes if they were inadvertently omitted.

Q9 - What should M+C organizations do if clinical trial providers send them bills?

A9 - if a provider sends a bill with the clinical trial codes on it to an M+C organization, the M+C organization should not pay it. Instead, the organization should inform the provider that the bill should be submitted to the appropriate intermediary or carrier. Of course, M+C organizations

continue to be responsible for all other benefits that are covered under the contract to beneficiaries who participate in the clinical trials.

Q10 - Some of the providers in an M+C organization network are involved in clinical trials but are not enrolled as Medicare providers. What do they need to do to enroll?

A10 - Providers serving managed care enrollees receiving clinical trial services must be enrolled with Medicare in order to bill on a fee-for-service basis for those services. Providers that wish to bill, but that have not yet enrolled with Medicare should contact their local carrier, intermediary, or National Supplier Clearinghouse, as appropriate, to obtain an enrollment application.

Q11 - What should M+C organizations tell beneficiaries about this new coverage?

A11 - In their next regularly scheduled communication with members, M+C organizations must inform that Medicare is now covering certain services related to clinical trials. M+C organizations should also inform their Medicare members that beneficiaries are responsible for paying the coinsurance that applies for fee-for-service benefits when those benefits are provided as part of a clinical trial. In other words, any plan-defined cost sharing would not apply.

M+C organizations are not responsible for making up the difference between the Medicare fee-for-service cost sharing and any plan cost sharing that would apply to that type of service. HCFA will be collaborating with M+C organizations, clinical trial sponsors, and groups that work with beneficiaries to educate beneficiaries about their financial liabilities when they enter a clinical trial.

If M+C members ask their organizations for information on Medicare coverage of these clinical trials services, the organizations may wish to direct them to 1-800-MEDICARE for more information.

Q12 - Do M+C organizations need to furnish non-Medicare benefits as part of the routine costs of clinical trials?

A12 - No. Until the costs of clinical trials' services are factored into M+C capitated payment rates, M+C organizations are not obligated to furnish any additional or supplemental benefits as routine costs of clinical trials.

Q13 - Are M+C organizations responsible for submitting encounter data for these services?

A13 - No. M+C organizations are not responsible for submitting encounter data from clinical trial providers. Because CMS will be making fee-for-service payments directly to providers for clinical trials services, the information needed for risk adjustment (diagnoses and other data elements) will already be present in CMS's systems.

Q14 - Where can M+C organizations go to get more information on clinical trials?

A14 - If M+C organizations or other entities have further questions regarding the coverage of clinical trials and their responsibilities regarding this coverage they may send an e-mail to clinicaltrials@hcfa.gov or contact their plan manager.

Exhibit 3. Demographic Cost Factors - Aged and Disabled Beneficiaries

Demographic Factors for Aged Beneficiaries, CY 2000

Part	Sex	Age	Institutionalized	Non-Institutionalized		
				Medicaid	Non-Medicaid	Working aged
A	Male	65-69	1.75	1.15	0.65	0.4
		70-74	2.25	1.5	0.85	0.45
		75-79	2.25	1.95	1.05	0.7
		80-84	2.25	2.35	1.2	0.8
		85+	2.25	2.6	1.35	0.9
	Female	65-69	1.45	0.8	0.55	0.35
		70-74	1.8	1.05	0.7	0.45
		75-79	2.1	1.45	0.85	0.55
		80-84	2.1	1.7	1.05	0.7
		85+	2.1	2.1	1.2	0.8
B	Male	65-69	1.6	1.1	0.8	0.45
		70-74	1.8	1.35	0.95	0.65
		75-79	1.95	1.55	1.1	0.8
		80-84	1.95	1.7	1.15	0.9
		85+	1.95	1.7	1.15	1
	Female	65-69	1.5	1.05	0.7	0.4
		70-74	1.65	1.15	0.85	0.55
		75-79	1.65	1.25	0.95	0.7
		80-84	1.65	1.25	0.95	0.75
		85+	1.65	1.25	1	0.85

Demographic Factors for Disabled Beneficiaries

Part	Sex	Age	Institutionalized	Non-institutionalized		
				Medicaid	Non-Medicaid	Working aged
A	Male	<35	1.8	1.1	0.6	N/A
		35-44	1.45	1.2	0.7	N/A
		45-54	1.1	1.3	0.65	N/A
		55-59	0.9	1.6	0.85	N/A
		60-64	0.6	1.85	1	N/A
	Female	<35	1.8	1.2	0.55	N/A
		35-44	1.4	1.2	0.6	N/A
		45-54	1.15	1.2	0.75	N/A
		55-59	0.95	1.35	0.95	N/A
		60-64	0.7	1.55	1.3	N/A
B	Male	<35	1.7	1.1	0.45	N/A
		35-44	1.5	1.15	0.55	N/A
		45-54	1.25	1.15	0.6	N/A

	55-59	1.1	1.3	0.75	N/A
	60-64	0.95	1.45	0.95	N/A
Female	<35	1.95	1.05	0.75	N/A
	35-44	1.85	1.15	0.85	N/A
	45-54	1.6	1.25	0.95	N/A
	55-59	1.35	1.35	1.05	N/A
	60-64	1.15	1.55	1.2	N/A

NOTE: Since the BBA stipulated that the base year for the new M+C payment method would be 1997 (the last year of the AAPCC method), and since the BBA did not stipulate any adjustments to these 1997 AAPCC standardized county rates (other than to "carve out" a specified portion of the rates representing medical education expenses), HCFA cannot restandardize the 1997 ratebook with new demographic factors. Thus, the above national demographic factors have been used since 1997.

County average demographic factors (ADFs), however, are calculated every year, using updated information on the number of beneficiaries in each county and the average demographic factor for these beneficiaries. The county ADFs are used to calculate the national average input-price adjusted capitation rate, which is then used in combination with area-specific rates to calculate blended rates.

Exhibit 4: Risk Factors for the PIP-DCG Risk Adjustment Payment Model

TABLE 1: RISK FACTORS FOR MEDICARE BENEFICIARIES ELIGIBLE AT LEAST ONE YEAR

SEX	AGE CATEGORY	BASE	PREVIOUSLY DISABLED ADD-ON	MEDICAID ADD-ON	PIP-DCG SCORES	
Male					**DCG**	**factor**
	0-34	0.367	-	0.125	5	0.375
	35-44	0.38	-	0.283	6	0.458
	45-54	0.487	-	0.37	7	0.697
	55-59	0.615	-	0.397	8	0.822
	60-64	0.76	-	0.418	9	0.915
	65-69	0.541	0.415	0.44	10	1.17
	70-74	0.705	0.398	0.457	11	1.271
	75-79	0.907	0.334	0.461	12	1.662
	80-84	1.077	0.287	0.445	14	2
	85-89	1.258	0.237	0.404	16	2.438
	90-94	1.376	0.189	0.331	18	2.656
	95+	1.357	0.141	0.242	20	3.392
Female	0-34	0.362	-	0.192	23	3.823
	35-44	0.403	-	0.312	26	4.375
	45-54	0.526	-	0.367	29	5.189
	55-59	0.643	-	0.397		
	60-64	0.891	-	0.412		
	65-69	0.453	0.605	0.433		
	70-74	0.588	0.576	0.44		
	75-79	0.747	0.519	0.454		
	80-84	0.918	0.415	0.423		
	85-89	1.096	0.313	0.327		
	90-94	1.162	0.232	0.231		
	95+	1.128	0.152	0.168		

TABLE 2: RISK FACTORS FOR NEW ENROLLEES

SEX	AGE CATEGORY	BASE	MEDICAID ADD-ON
Male	0-34	0.512	0.223
	35-44	0.559	0.386
	45-54	0.649	0.464
	55-59	0.81	0.499
	60-64	0.959	0.506
	65	0.525	0.653
	66	0.573	0.646
	67	0.62	0.64
	68	0.667	0.634
	69	0.715	0.628
	70-74	0.847	0.594
	75-79	1.086	0.616
	80-84	1.307	0.612
	85-89	1.518	0.609
	90-94	1.666	0.386
	95+	1.668	0.354

Female	0-34	0.535	0.261
	34-44	0.579	0.423
	45-54	0.696	0.426
	55-59	0.84	0.542
	60-64	1.11	0.451
	65	0.446	0.603
	66	0.484	0.603
	67	0.522	0.603
	68	0.559	0.602
	69	0.597	0.602
	Female, 70-74	0.703	0.577
	Female, 75-79	0.899	0.594
	Female, 80-84	1.111	0.589
	Female, 85-89	1.328	0.424
	Female, 90-94	1.429	0.328
	Female, 95+	1.381	0.18

Exhibit 5 - Diagnoses (DxGroups) Included In Each PIP-DCG For The Payment Model

PIP-DCG 5

DxGroup	14	Breast Cancer (b)
	131	Ongoing Pregnancy with Complications
	132	Ongoing Pregnancy with No or Minor Complications

PIP-DCG 6

DxGroup	18	Cancer of Prostate/Testis/Male Genital Organs (b)

PIP-DCG 7

DxGroup	1	Central Nervous System Infections
	39	Abdominal Hernia, Complicated
	64	Alcohol/Drug Dependence

PIP-DCG 8

DxGroup	16	Cancer of Uterus/Cervix/Female Genital Organs (b)
	36	Peptic Ulcer
	77	Valvular and Rheumatic Heart Disease
	79	Hypertension, Complicated
	80	Coronary Atherosclerosis
	84	Angina Pectoris
	86	Atrial Arrhythmia
	92	Precerebral Arterial Occlusion
	96	Aortic and Other Arterial Aneurysm
	110	Asthma
	153	Brain Injury
	158	Artificial Opening of Gastrointestinal Tract Status

PIP-DCG 9

DxGroup	21	Other Cancers (b)
	32	Pancreatitis/Other Pancreatic Disorders
	82	Acute Myocardial Infarction
	94	Transient Cerebral Ischemia
	145	Fractures of Skull and Face
	146	Pelvic Fracture
	147	Hip Fracture
	150	Internal Injuries/Traumatic Amputations/Third Degree Burns

PIP-DCG 10

DxGroup	11	Colon Cancer (b)
	59	Schizophrenic Disorders
	81	Post-Myocardial Infarction
	83	Unstable Angina
	97	Thromboembolic Vascular Disease
	116	Kidney Infection
	143	Vertebral Fracture Without Spinal Cord Injury

PIP-DCG 11

DxGroup	42	Gastrointestinal Obstruction/Perforation
	45	Gastrointestinal Hemorrhage
	87	Paroxysmal Ventricular Tachycardia
	109	Bacterial Pneumonia
	133	Cellulitis and Bullous Skin Disorders

PIP-DCG 12

DxGroup	4	Tuberculosis
	10	Stomach, Small Bowel, Other Digestive Cancer
	12	Rectal Cancer
	19	Cancer of Bladder, Kidney, Urinary Organs
	22	Benign Brain/Nervous System Neoplasm
	26	Diabetes with Acute Complications/Hypoglycemic Coma
	41	Inflammatory Bowel Disease
	48	Rheumatoid Arthritis and Connective Tissue Disease
	49	Bone/Joint Infections/Necrosis
	56	Dementia
	57	Drug/Alcohol Psychoses
	60	Major Depression
	73	Epilepsy and Other Seizure Disorders
	91	Cerebral Hemorrhage
	93	Stroke
	98	Peripheral Vascular Disease
	111	Pulmonary Fibrosis and Bronchiectasis
	113	Pleural Effusion/Pneumothorax/Empyema

PIP-DCG 14

DxGroup	2	Septicemia/Shock
	29	Adrenal Gland, Metabolic Disorders
	58	Delirium/Hallucinations
	61	Paranoia and Other Psychoses
	63	Anxiety Disorders
	66	Personality Disorders
	70	Degenerative Neurologic Disorders
	144	Spinal Cord Injury

PIP-DCG 16

DxGroup	8	Mouth/Pharynx/Larynx/Other Respiratory Cancer
	13	Lung Cancer
	34	Cirrhosis, Other Liver Disorders
	89	Congestive Heart Failure
	95	Atherosclerosis of Major Vessel
	105	Chronic Obstructive Pulmonary Disease

PIP-DCG 18

DxGroup	17	Cancer of Placenta/Ovary/Uterine Adnexa
	55	Blood/Immune Disorders
	72	Paralytic and Other Neurologic Disorders
	75	Polyneuropathy
	108	Gram-Negative/Staphylococcus Pneumonia

PIP-DCG 20

DxGroup	27	Diabetes with Chronic Complications
	76	Coma and Encephalopathy
	112	Aspiration Pneumonia
	115	Renal Failure/Nephritis

PIP-DCG 23

DxGroup	9	Liver/Pancreas/Esophagus Cancer (b)
	33	End-stage Liver Disorders
	88	Cardio-Respiratory Failure and Shock
	134	Decubitus and Chronic Skin Ulcers

PIP-DCG 26

DxGroup	7	Metastatic Cancer (b)
	20	Brain/Nervous System Cancers (b)

PIP-DCG 29

DxGroup	3	HIV/AIDS (a)
	15	Blood, Lymphatic Cancers/Neoplasms (b)

Footnotes:

(a) Includes principal and secondary inpatient diagnoses of HIV/AIDs.

(b) Includes principal diagnoses and secondary diagnoses when the principal diagnosis is chemotherapy.

Additional explanation of table.

(c) Each PIP-DCG is identified by a number that originally referred to the lower bound of its expenditure range (based on the cost data used to calibrate the model), e.g., PIP-DCG 12 includes those DxGroups with average costs in the range of $12,000 to $13,999. PIP-DCGs group heterogeneous diagnoses, as long as they have similar future cost implications.

(d) Each person without a base year hospital admission or with (an) admission(s) only for excluded or certain low-cost diagnoses is assigned to the base category, and is risk-adjusted using demographic factors only.

(e) See the section titled Risk Adjustment Information, Data Files, and Programs at http://www.hcfa.gov/stats/hmorates/aapccpg.htm to obtain files containing crosswalks between ICD-9 codes, PIP-DxGs, and PIP-DCGs for 2000, 2001, and 2002.

Exhibit 6 - Quality Indicators For Extra Payment In Recognition Of The Costs Of Successful Outpatient Treatment of CHF.

Quality Indicator EP1	Proportion of M+CO enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have evaluation of left ventricular function as of October 1 of the reporting year:
Population:	M+CO enrollees with a principal inpatient discharge diagnosis of congestive heart failure[1] with a greater than a one-day stay who are continuously enrolled for at least 180 days prior to and including date of reporting (October 1), and: • For reporting on October 1, 2001, were discharged between July 1, 1999 and June 30, 2001 • For reporting on October 1, 2002, were discharged between July 1, 1999 and June 30, 2002
Denominator:	Same as 'Population.' M+CO's with greater than 400 enrollees in this population may perform a random sample of the eligible population, measuring no fewer than 400 enrollees.
Numerator:	Those in denominator who have documented left ventricular function (LVF) evaluation on or before October 1 of reporting year. Documentation of LVF evaluation consists of a billing record indicating that LVF evaluation has been performed, quantitative or qualitative lab report of LVF evaluation results, clinician notation that LVF evaluation has been performed, clinician notation of LVF results, or any other chart of administrative evidence that LVF evaluation has been performed.
Data Sources:	Enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure: Where information on inpatient hospital discharges has been received by CMS, CMS will flag enrollees with CHF diagnosis codes on the Monthly Membership Reports to M+COs; M+COs may have other internal sources of this data, as well.
LVF evaluation:	Billing data, radiology or laboratory reports, medical records, physician or disease management summary, any other reviewable source.
Quality Indicator EP2:	Proportion of M+CO enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have left ventricular systolic dysfunction (LVSD) as of October 2 of reporting year: 1. Are prescribed angiotensin converting enzyme inhibitors (ACEI); or 2. Have documented reason for not being on ACEI.
Population:	Those in numerator of Quality Indicator EPI with left ventricular systolic dysfunction (LVSD). LVSD is defined as an ejection fraction less than 40% or equivalent narrative description. [2]
Denominator:	Same as 'Population.' M+CO's with greater than 400 enrollees in this population may perform a random sample of the eligible population, measuring no fewer than 400 enrollees.

[1] ICD-9-CM codes: 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.x| |

Numerator:	Those in denominator who, as of October 1 of reporting year have 1. Been prescribed ACEI; or 2. Chart documentation of one or more of the following contraindications to ACEI use: ° moderate or severe aortic stenosis, or ° history of angioedema, hives, or severe rash with ACEI use; or ° bilateral renal artery stenosis; or 3. Chart documentation of participation in a clinical trial testing alternatives to ACEIs first-line heart failure therapy
Data Sources:	LVF evaluation results (quantitative or qualitative): Laboratory test reports, medical record, physician summary, and other reviewable source. Prescription of ACEI: Pharmacy data, medical records, physician summary, any other reviewable source. Reason for not prescribing ACEI: Inpatient or outpatient diagnosis codes, medical record, physician summary, any other reviewable source. Participation in a clinical trial testing ACEI alternatives: any reviewable source.

[2] A list of qualitative descriptions from laboratory reports or clinician notes considered consistent with LVSO will be provided prior to Jan 1, 2001.

Exhibit 7. Report of performance on Quality Indicators to qualify for extra payment in recognition of successful outpatient treatment of CHF.

Note: This report is draft pending approval by the Office of Management and Budget.

Instructions:

This report applies only to M+C Organizations that are applying for extra payment in recognition of the costs of successful outpatient CHF care. Definitions to be used in this report are provided in section B of the CHF OPL. Established threshold levels for these quality indicators may be found in the "Advanced Notice of Methodological Changes in the Medicare+Choice Payment Rates for Calendar Year (CY) 2002", published on January 15, 2001.

Contact Name_____ H-Number_____

M+CO Name_____

Telephone Number_____ Fax Number _____

I. Quality Indicator EP1:

A. Number of M+C Organization enrollees with principal inpatient discharge diagnosis of congestive heart failure (CHF) with a greater than a one-day stay during index time frame.

_____

B. Number of M+C Organization enrollees with a greater than one day stay for a principal inpatient discharge diagnosis of CHF during index time frame who had, as of October 1 of reporting year, evaluation of left ventricular function (LVF) _____

C. Proportion (defined as B/A) _____

II. Quality Indicator EP2:

D. Number of M+C Organization enrollees with a greater than one day stay for a principal inpatient discharge diagnosis of CHF during index time frame who had left ventricular systolic dysfunction (LVSD) _____

E. Number of M+C Organization enrollees with a greater than one day stay for a principal inpatient discharge diagnosis of CHF during index time frame and documented LVSD who are either prescribed angiotensin converting enzyme inhibitors (ACEI) or have a documented reason for not being on ACEI as of October 1 of reporting year.

_____

F. Proportion (defined as E/D)_____

Notes: You should review your submission. Note that the number placed in 1.B should be less than the number placed in 1.A. The number in 2.D should also be less than 1.B. The number in 2.E should be less than 2.D.

Sampling

For M+C Organizations with greater than 400 enrollees with a diagnosis of CHF who have sampled their population (your sample size should be no smaller than 400 enrollees), describe your sampling methodology.

Description of CHF Disease Management

Attach a brief description (e.g., two pages) of the strategies and processes (e.g., disease management program) for managing the care of the designated CHF population

Return report no later than January 31, 2002 to:
Angela Porter
Center for Health Plans and Providers
CMS, C4-13-01
7500 Security Boulevard
Baltimore, MD 21244-1850
Or
aporter@hcfa.gov

Medicare Managed Care Manual

Chapter 12 - Effect of Change of Ownership and Leasing

Table of Contents

10 - Change of Ownership

(Rev. 1, 07-02-01)

If the legal entity that contracts with CMS has a change of ownership, the new entity may not necessarily qualify to continue the same Medicare managed care contract with CMS. This chapter outlines the effect of a change of ownership on a Medicare + Choice (M+C) contract when the contract can be transferred to the new entity, the type of documentation required, and a Model Novation Agreement that can be used by a contracting entity undergoing a change in ownership. If you have any questions about whether or not your organization must meet these requirements, please contact your central office (CO) plan manager.

10.1 - What Constitutes a Change of Ownership

(Rev. 1, 07-02-01)

The following situations usually constitute a change of ownership:

- Transfer of title and property to another party;
- Asset sale;
- Partnership - the removal, addition, or substitution of a partner (unless the partners agreed otherwise as permitted by applicable State law); or
- Corporation - the merger of the contracting corporate entity which holds the Medicare contract into another corporate entity; or the consolidation of the corporate entity which holds the Medicare contract with one or more other corporations, resulting in a new corporate body.

NOTE: The transfer of corporate stock or the merger of another corporation into the corporation that holds a contract with CMS does not ordinarily constitute a change of ownership.

10.2 - Examples

(Rev. 1, 07-02-01)

The following situations are some examples of typical ownership transactions:

- If Corporation X maintains a contract with CMS and subsequently purchases the stock of Corporation Y, the ownership of Corporation X has not ordinarily changed.
- If Corporation X maintains a contract with CMS and subsequently acquires Corporation Z, resulting in a merger of Corporation Z into Corporation X, the ownership of Corporation X has not ordinarily changed. However, if the assets and liabilities of Corporation X are merged with Corporation Z and Corporation Z survives, this constitutes a change in ownership in Corporation X.
- If Corporation A, Corporation B, and Corporation C, all subsidiaries of Corporation P (a holding company), consolidate into Corporation ABC (a new legal entity), AND Corporation A, B, and C are fully dissolved, this constitutes a change in ownership in all Corporations A, B, and C.
- If Corporation A sells or transfers portions of its operations, including operations related to its M+C contract to Corporation B, this constitutes a change in ownership of the M+C contract to Corporation B, where Corporation B has been deemed an eligible M+C entity by CMS. Where Corporation B is not already deemed an eligible M+C organization, it must submit an application for eligibility to CMS as stated in Chapter 11, "Contract Requirements."
- If Corporation A, a Medicare managed care contractor, merges with its parent, Corporation B, an eligible M+C organization, and does not survive the merger, this constitutes a change in ownership.

20 - Notification Requirements

(Rev. 1, 07-02-01)

20.1 - Notification Requirements Prior to an Anticipated Change of Ownership

(Rev. 1, 07-02-01)

All Medicare managed care contractors, including Health Care Prepayment Plans, cost-based plans, and Medicare+Choice organizations, which are considering a change of ownership, MUST notify CMS at least 60 days prior to the anticipated effective date of change.

20.2 - Content of Notice for Changes in Ownership

(Rev. 1, 07-02-01)

The organization's notice to CMS regarding a Change of Ownership (as defined in §20.1) must contain the following information:

A - Updated financial information to include the most recent quarterly and annual financial statements; pro forma balance; and income statements following changes in ownership. This must include an explanation of long term loans; and a narrative discussion of the impact of the change of ownership on the financial health and solvency of the surviving legal entity;

B - A detailed listing of the significant steps necessary to complete the transaction including the time frames for submitting required information to CMS;

C - Documentation of any contact with, including evaluations conducted by, the Securities Exchange Commission (SEC) and the Federal Trade Commission (FTC) with respect to the impact of the proposed merger;

D - Acquisition agreement and closing documents;

E - Proposed by-laws and articles of incorporation for the newly formed legal entity;

F - Proposed organization chart for the surviving entity, including the names of its management;

G - Certificate of authority from the State for the new legal entity and State M+C certification form;

H - A brief, written summary of the health care delivery system(s) for each acquired plan;

I - Novation agreements, where necessary, from contracted providers of health care;

J - Financial plan for the new legal entity for a minimum of one year beyond the anticipated date of break even (balance sheets and revenue and expense statements on a quarterly basis),

K - Listing of available financing to support accumulated deficits, if necessary;

L -Evidences of coverage and all marketing literature;

M - Assurances that any outstanding compliance issues such as those discussed in a CMS report or within a Corrective Action Plan will be fully resolved;

N - Assignment of leases for facilities and equipment if the facilities and/or equipment are necessary to provide services under the contract with CMS; and

O - Any other relevant documentation requested by CMS.

NOTE: The above information will be reviewed by CMS in determining whether the new ownership continues to meet legislative and regulatory requirements for operating a M+C contract, cost-based plan, or Health Care Prepayment Plan.

20.3 - Other Notifications When Circumstance Is Not Deemed a Change of Ownership

(Rev. 1, 07-02-01)

CMS requires that all corporate entities which hold a contract with CMS notify CMS whenever the entity either acquires the stock of or obtains the assets and/or liabilities of, another legal entity, even if the transaction is NOT considered a change in ownership as defined in §10.1. This notification should include pro-forma financial statements to reflect the continued financial viability of the Medicare contractor following any legal transactions.

20.4 - Address for Sending Notifications to CMS

(Rev. 1, 07-02-01)

All notifications to CMS required in §20.1, §20.3, and §30.1 (below) should be mailed to:

Centers for Medicare and Medicaid Services
Center for Health Plans and Providers
Health Plan Administration Group
Central Office Plan Manager
C4-21-06
7500 Security Blvd.
Baltimore, MD 21244-1850

20.5 - Effect of Failure to Notify CMS of a Change in Ownership

If the managed care organization fails to notify CMS of a change in ownership within the required time frames, the original contracting entity shall be liable for all capitation payments made by CMS to the organization for services following the legal change of ownership.

30 - Novation Agreement

(Rev. 1, 07-02-01)

30.1 - When a Novation Agreement is Required

(Rev. 1, 07-02-01)

A Novation Agreement is required to transfer the rights and obligations under the Medicare managed care contract. Novation agreements are only required when there has been a change of ownership (as defined in §10.1). In the absence of a Novation Agreement, a change of ownership shall invalidate a Medicare contract except to the extent that the managed care organization receives capitation payments from CMS. In this circumstance, the new entity or organization may be required to file a new application, demonstrate eligibility, and be determined an eligible entity, in order to contract with CMS.

CMS recommends that organizations that anticipate a change in ownership submit a Novation Agreement to CMS at least 60 days prior to the effective date of change of ownership. Organizations should submit three (3) copies of the Novation Agreement with the additional information requested in subpart 20.2. Organizations MUST receive CMS approval of the Novation Agreement prior to the effective date of change in ownership in order to assume an existing contract with CMS. If a Novation Agreement is not completed before the effective date of the change of ownership, the M+C contract will be terminated as of that date. Medicare members enrolled under the terminated contract will be disenrolled and provided notice of their remaining Medicare coverage options in accordance with existing statute, regulations, and policies.

30.2 - Conditions for CMS's Approval of a Novation Agreement

(Rev. 1, 07-02-01)

CMS does not approve or deny a change in ownership. If a change in the ownership of the contracting entity will occur, CMS will review the arrangements in place under new ownership, as necessary, to ensure continued compliance with legal, regulatory, and contractual requirements.

In general, CMS will approve a proposed Novation Agreement if:

- The successor in interest qualifies as an eligible entity;
- The successor in interest maintains arrangements to comply with the legal, regulatory, and other requirements necessary to perform the contract;
- The materials specified in §20.2 are received in accordance with CMS's requirements;
- The proposed new owner is determined to be in fact the successor in interest or title of the contractor;
- Any performance bond posted is found acceptable; and
- Recognition of the new owner as successor in interest is in the best interests of the Medicare program.

30.3 - Acceptable Novation Agreements

(Rev. 1, 07-02-01)

Exhibit 1 contains a Model Novation Agreement. This Agreement is intended to serve only as a guide in preparing a Novation Agreement. Contracting managed care organizations may need to revise the model, as necessary or appropriate, to conform to the circumstances of a particular transaction involving a change of ownership. In order to be accepted, the Novation Agreement must include the following:

- The new owner must assume all obligations under the Medicare managed care contract;
- The new entity must be an eligible organization;
- The entity's previous owner must waive its right to reimbursement for covered services furnished during the rest of the then current contract period;
- The previous owner must guarantee that the new owner will carry out the terms of the contract or the new owner must post a performance bond guaranteeing the new owner's performance of contract responsibilities; and
- The previous owners must agree to make its books and records and any other necessary information available to the new owner and to CMS in order to permit an accurate determination of costs for the final settlement of the contract period.

EXHIBIT 1

MODEL NOVATION AGREEMENT

(Name of Medicare Managed Care Plan or Medicare+Choice Organization being sold/merged) (Transferor), d.b.a. **(Where applicable, the d.b.a. name),** a corporation, partnership, sole proprietorship, etc., duly organized and existing under the laws of the State of **(indicate the State under which the Transferor is formed or organized to operate)** with its principal office in**;** (Name of owner) (Transferee), a corporation, partnership, sole proprietorship, etc. duly organized and existing under the laws of the State of**,** with its principal office in and the Centers for Medicare and Medicaid Services (CMS) enter into this Agreement:

(A) RECITALS:

(1) CMS has entered into certain contract(s) with the Transferor, namely:

(Indicate Medicare Managed Care Plan or Medicare+Choice Organization contract type) (Indicate Medicare contract number/H#s)

The term "the contract(s)" as used in this Agreement, means the above contract(s) including all modifications, made between CMS and the Transferor before the effective date of this Agreement (whether or not performance and payment have been completed) and releases executed if CMS or the Transferor has any remaining rights, duties, or obligations under these contract(s). Included in the term "the contract(s)" are also all modifications made under the terms and conditions of these contract(s) between CMS and the Transferee, on or after the effective date of this Agreement.

(2) As of **(date change of ownership is effective),** the Transferor has transferred to the Transferee all the assets of the Transferor by virtue of a **(indicate the type of transfer, i.e., a merger, corporate reorganization, or an agreement and purchase of the sale of assets)** between the Transferor and the Transferee.

(3) The Transferee has assumed all the assets of the Transferor by virtue of the above transfer.

(4) The Transferee has assumed all the obligations of the Transferor under the contract(s) by virtue of the above transfer.

(5) The Transferee has indicated a desire to assume the obligations of the Transferor under the contract(s) and to fully perform all obligations that may exist under the contract(s).

(B) IN CONSIDERATION OF THESE FACTS THE PARTIES AGREE AS FOLLOWS:

(1) The Transferor confirms the transfer of the contract to the Transferee, and waives any claims and rights against CMS that it now has or may have in the future in connection with the contract(s).

(2) From and after the date of the change of ownership in Section(A)(2), above, the Transferee agrees to be bound by and to perform all the duties and responsibilities of Transferor in each

contract in accordance with the conditions contained in the contract(s). The Transferee also assumes all obligations and liabilities of, and all claims against the Transferor under the contract(s) incurred from and after the effective date of the change of ownership in Section (A)(2), above.

(3) The Transferee ratifies all previous actions taken by the Transferor with respect to the contract(s) with the same force and effect as if the action had been taken by the Transferee.

(4) CMS recognizes the Transferee as the Transferor's successor in interest in and to the contracts. From and after the date of the change of ownership the Transferee by this Agreement becomes entitled to all rights, title, and interests of the Transferor in and to the contract(s). Following the effective date of this Agreement, the terms "Organization" and "Contractor", as used in the contract(s) shall refer to the Transferee.

(5) Except as expressly provided in this Agreement, nothing in it shall be construed as a waiver of any rights of CMS against the Transferor. Notwithstanding any other provision of this Agreement, Transferor remains liable for all acts constituting a breach of the contract(s) occurring or arising before the effective date of the change of ownership, to the fullest extent of applicable laws and regulations.

(6) All payments and reimbursements previously made by CMS to the Transferor shall be considered to have discharged CMS's obligations under the contract(s). All payments and reimbursements made by CMS after the effective date of this Agreement in the name of or to the Transferee, shall have the same force and effect as if made to the Transferor, and shall constitute a complete discharge of CMS's obligations under the contract(s) to the extent of the amounts paid or reimbursed.

(7) The Transferor and the Transferee agree that CMS is not obligated to pay or reimburse either of them for, or otherwise give effect to, any costs, taxes, or other expenses, or any related increases, directly or indirectly arising out of or resulting from this Agreement other than those that CMS in the absence of this Agreement would have been obligated to pay or reimburse under the terms of the contract(s).

(8) The Transferor guarantees payment of all liabilities and the performance of all obligations that the Transferee (i) assumes under this Agreement or (ii) may undertake in the future should these contracts be modified under their terms and conditions. The Transferor waives notice of, and consents to, any such future modifications.

(9) The contract(s) shall remain in full force and effect except as modified by this Agreement. Each party has executed this Agreement which is effective as of the date signed below by the Centers for Medicare and Medicaid Services.

(10) Each party certifies and warrants that it has full power and authority to enter into this Agreement.

(11) Each person executing this Agreement on behalf of a party certifies and warrants that he or she is authorized to enter into this Agreement on behalf of such party.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

By_____Date_____
Director, Medicare Managed Care Group

CENTERS FOR MEDICARE AND MEDICAID SERVICES

(Name of Transferee)

By_____Date_____

Title_____

(Name of Transferor)

By_____Date_____

Title_____

Medicare Managed Care Manual

Chapter 14 - Contract Determinations and Appeals

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10 – Medicare+Choice (M+C) Contract Determinations and Appeals

(Rev. 1, 07-02-01)

There are four steps in the M+C contract appeals process. These steps are:

- A contract determination;
- A reconsideration;
- A hearing; and
- For M+C contract terminations, a review by the CMS Administrator.

10.1 - Contract Determinations

(Rev. 1, 07-02-01)

This section provides procedures for making and reviewing the following M+C contract determinations:

- A determination by CMS that an entity is not qualified to enter into an M+C contract with CMS;
- A determination by CMS to terminate a contract with an M+C organization; and
- A determination by CMS not to authorize a renewal of a contract with an M+C organization.

10.1.1 - Contract Determination Notice

(Rev. 1, 07-02-01)

CMS sends a written notice for every contract determination. The notice includes:

- The reasons for the contract determination;
- The right to request reconsideration of the contract determination; and
- Instructions on how to request a reconsideration.

For CMS-initiated terminations, CMS mails the notice at least 90 days before the anticipated effective date of the termination except in the case of "Immediate Terminations" as described in chapter 11 where notice is sent immediately. When CMS determines that it will not renew its contract with an organization, CMS will notify the organization by May 1 of the current contract year.

10.1.2 - Effect of the Contract Determination

(Rev. 1, 07-02-01)

The contract determination is final and binding on all parties unless:

- The applicant/organization files a valid request for a reconsideration as described in subpart 10.2 of this chapter; or
- The applicant/organization files a timely request for a hearing as described in subpart 10.3; or
- CMS reopens and revises an initial or reconsidered determination as described in subpart 20 of this chapter.

10.1.3 - Postponement of the Contract Determination's Effective Date

(Rev. 1, 07-02-01)

The M+C contract termination date, as stated in the notice to terminate an M+C contract, is postponed if the organization requests a review of the hearing decision by the CMS Administrator. Written notice is issued by the Administrator notifying the organization of the Administrator’s decision. The administrator may uphold, reverse, or modify the hearing officer’s decision.

If the contract determination (termination) is classified as an "Immediate Termination," the effective date cannot be postponed even if the M+C organization requests a review by the Administrator.

The effective date of a contract determination to non-renew an M+C contract may be extended by CMS if CMS finds that a contract extension is consistent with the purpose of Title XVIII of the Social Security Act (the Act) and for as long as CMS and the organization agree with the extension.

10.2 - Reconsiderations

(Rev. 1, 07-02-01)

Reconsideration is the first step for a contract applicant/M+C organization to appeal contract determinations described at subpart 1 of this chapter. A reconsideration determination is a new determination that affirms, reverses, or modifies a contract determination. This reconsideration process must be completed before the contract applicant/M+C organization has a right to a hearing under subpart 10.3 of this chapter.

CMS bases the reconsideration determination on the evidence and findings used to make the contract determination and any other written evidence the applicant/organization submits to CMS before CMS mails its response to the request for reconsideration to the M+C organization.

Only an authorized official of the applicant/organization that was the subject of the contract determination may file a request for reconsideration of a contract determination in writing. The official may send the request to any CMS office.

10.2.1 - Time Frames for Filing a Reconsideration Request

(Rev. 1, 07-02-01)

An organization or M+C contract applicant must file the request for reconsideration in writing within 15 days from the date of the initial M+C contract determination notice. Only an authorized official of the contract applicant or M+C organization that is a subject of a contract determination may file a request for reconsideration.

10.2.2 - Withdrawal of a Reconsideration Request

(Rev. 1, 07-02-01)

An M+C organization or contract applicant may withdraw a request for reconsideration at any time before CMS mails the notice of its reconsideration determination. The request for withdrawal must be in writing and filed with CMS. If CMS agrees, it approves the withdrawal.

10.2.3 - Opportunity to Submit Evidence

(Rev. 1, 07-02-01)

CMS provides the M+C organization or contract applicant and the CMS official or officials who made the contract determination reasonable opportunity, not to exceed 15 days, to present as evidence any documents or written statements that are relevant and material to the matters at issue.

10.2.4 - Notice of a Reconsideration Determination

(Rev. 1, 07-02-01)

After CMS makes a reconsideration determination it sends a written notice to the contract applicant/M+C organization. The notice includes:

- The findings concerning the applicant's qualifications to enter into or remain under an M+C contract;
- The specific reasons for the reconsideration determination; and
- The applicant's/organization's hearing rights if they are dissatisfied with the reconsideration determination.

10.2.5 - Effect of a Reconsideration Determination

(Rev. 1, 07-02-01)

The reconsideration determination is final and binding on all parties unless:

- The applicant/organization files a request for a hearing under §3.3 of this chapter; or
- CMS reopens and revises the reconsideration determination under §4 of this chapter.

10.3 - Hearings

(Rev. 1, 07-02-01)

A hearing is the final appeal available to new applicants that CMS has determined are not qualified to enter into an M+C contract and organizations appealing CMS's decision not to renew an M+C contract. A hearing is the third of four levels of appeals available to organizations whose M+C contracts are being terminated by CMS. Organizations appealing contract terminations must complete a hearing before proceeding to their last level of administrative appeal, which is a review by the CMS Administrator.

A hearing may be requested in writing by:

- A M+C contract applicant that has been found in a reconsidered determination to be unqualified to enter into an M+C contract;
- An M+C organization whose contract with CMS has been terminated or has not been renewed as a result of a contract determination and reconsideration determination; and
- At the discretion of the hearing officer, any interested parties who make a showing that their rights may be prejudiced by the decision to be rendered at the hearing.

10.3.1 - Requesting a Hearing

(Rev. 1, 07-02-01)

A request for a hearing must be made in writing and filed by an authorized official of the contract applicant or M+C organization that was the party to the determination under appeal. The request for a hearing may be filed with any CMS office. CMS will acknowledge all requests for a hearing in writing, including those not filed timely. The request must be filed in writing within 15 days after the notice of the reconsidered determination in order to be considered a valid request for a hearing.

10.3.2 - Hearing Officers

(Rev. 1, 07-02-01)

CMS appoints a hearing officer to conduct the hearing. The hearing officer does not need to be an administrative law judge (ALJ). In exercising his or her authority, the hearing officer must comply with the provisions of Title XVIII and related provisions of the Act, the regulations issued by the Secretary, and general instructions issued by CMS in implementing the Act.

Hearing officers may not conduct a hearing in any case in which they are prejudiced or partial about any of the parties involved, or if they have any interest in the matter before them. If a party objects to the hearing officer conducting the case, they must inform the officer in writing at the earliest opportunity. The hearing officer will consider the objections and decide whether to proceed with the hearing or withdraw. Vesting the hearing officer with the authority to make his or her own determination regarding the ability to be fair and impartial, subject to appeal only after the matter at hand is heard on the merits, is the same approach used with respect to judges in court proceedings.

If the hearing officer withdraws, CMS will appoint a different hearing officer. If the officer does not withdraw when a party has made objections, the objecting party may present post-hearing objections to CMS and request a revision of the decision or a new hearing before a different hearing officer. Any requests by the objecting party must be made in writing to CMS.

10.3.3 - Time and Place of Hearing

(Rev. 1, 07-02-01)

The hearing officer appointed to a particular hearing, will fix the time and place for the hearing and notify the parties in writing. The hearing will be set for no later than 30 days from the date of the receipt of the request for the hearing. The notice includes the following information:

- The time and place for the hearing;
- The issues to be resolved;
- The parties' right to present evidence and witnesses; and
- The hearing procedures.

On their own motion or at the request of a party, hearing officers may change the time and place for the hearing and they may also adjourn or postpone a hearing. The hearing officers are required to give reasonable notice to all the parties of any change in time or place, or of postponement or adjournment of the hearing.

10.3.4 - Parties to the Hearing 42 CFR 422.660

(Rev. 1, 07-02-01)

The parties to a hearing are:

- A contract applicant that has been determined in a reconsidered determination to be unqualified to enter into a contract with CMS under Part C of the Act.
- A M+C organization whose contract with CMS has been terminated or has not been renewed as a result of a contract determination; and

- The Centers for Medicare and Medicaid Services.

10.3.5 - Representatives Appointed by Parties to a Hearing

(Rev. 1, 07-02-01)

A party to the hearing may appoint a representative for the hearing. CMS must be notified in writing of the appointed representative's name and address. The party may not appoint individuals disqualified or suspended from acting as a representative in dealings before the Secretary or who law otherwise prohibits.

Representatives appointed by parties to a hearing may on behalf of the represented party:

- Give or accept any notice or request pertinent to the appeal hearing;
- Present evidence and allegations as to facts and law in the hearing or any administrative actions that take place after the hearing; and
- Obtain information to the same extent as the party.

When a party to a hearing has duly appointed a representative, any notice or request by the representative has the same force and effect as if it had been sent directly by the party.

10.3.6 - Pre-Hearing Discovery and Conference

(Rev. 1, 07-02-01)

Pre-hearing discovery is permitted upon timely request of a party. A request is timely if it is made before the beginning of the hearing. Discovery is a formal method of obtaining documents and information in possession of another party to the hearing, such as interrogatories, depositions, and requests for the production of documents before the hearing begins. Hearing officers will rule on all discovery requests. If discovery is permitted, the hearing officer provides reasonable time for inspection and reproduction of any requested documents. A reasonable time for inspection and reproduction of documents is provided by order of the hearing officer. The hearing officer's order on all discovery matters is final.

Hearing officers may also schedule a pre-hearing conference if they believe a conference would more clearly define the issues involved.

10.3.7 - Conduct of a Hearing

(Rev. 1, 07-02-01)

The hearing is open to the parties and the public. The hearing officer will inquire into all the matters at issue , receives in evidence the testimony of witnesses, and any documents that are relevant and material. If any party objects to the inclusion of any document as evidence, the hearing officer hears the objections. The hearing officer also decides the order in which the evidence and the arguments of the parties are presented and the conduct of the hearing. A complete record of the proceedings at the hearing is made and transcribed, and made available to all parties upon request. A party requesting the transcribed record must pay for its transcription and reproduction.

The record may not be closed until a hearing decision has been issued.

10.3.8 - Admission of Evidence

(Rev. 1, 07-02-01)

The hearing officer rules on the admissibility of evidence and may admit evidence that would be inadmissible under the rules applicable to court procedures.

10.3.9 - Witnesses at the Hearing

(Rev. 1, 07-02-01)

The hearing officer may examine witnesses and the parties or their representatives are permitted to examine their witnesses and cross-examine witnesses of other parties.

10.3.10 - The Hearing Officer's Decision

(Rev. 1, 07-02-01)

The hearing officer issues a written decision notice as soon as practical after the close of a hearing and provides a copy of the written decision to each party. The decision must:

- Be based upon the evidence presented at the hearing or otherwise included in the hearing record; and
- Contain separately numbered findings of fact and conclusions of law.

The hearing decision is final and binding on the contract applicant/M+C organization and on CMS. There is no further appeal unless the matter under appeal is an M+C contract termination. However, the decision may be reopened or revised in accordance with subpart 20 of this chapter.

10.4 - Review by the CMS Administrator

(Rev. 1, 07-02-01)

An M+C organization that has received a hearing decision upholding a contract termination determination may request review by the CMS Administrator within 15 days of receiving the hearing decision. The Administrator will review the hearing officer's decision and determine, based upon this decision, the hearing record, and any written arguments submitted by the M+C organization, if the termination decision should be upheld, reversed, or modified. The Administrator then issues a written decision and furnishes it to the M+C organization requesting the review.

A decision by the CMS Administrator under this subpart is final and binding unless it is reopened and revised under §20 of this chapter.

20 - Reopening of Contract or Reconsidered Determination or Decision of a Hearing Officer or the Administrator

(Rev. 1, 07-02-01)

A reopening is not an appeal right. It is an administrative procedure that permits reexamination of an existing determination for a specific reason. If an applicant or M+C organization believes it has a basis for reopening a decision, it may request that the decision-maker reopen the matter. The decision whether to act on such a request, however, is committed to the decision-maker’s discretion, and is not subject to appeal or further review of any kind. This policy is consistent with our general policies on reopening decisions, as discussed in Federal Regulations at 42 CFR Part 405, Subpart R.

CMS may reopen and revise an initial or reconsidered determination upon its own motion within one year of the date of the notice of determination. A decision of a hearing officer may be reopened and revised by another hearing officer designated by CMS within one year of the notice of the hearing decision if the hearing officer who issued the initial decision is unavailable. A decision by the Administrator that is otherwise final may be reopened and revised by the Administrator upon the Administrator's own motion within one year of the notice of the Administrator's decision.

20.1 - Requesting a Reopening

(Rev. 1, 07-02-01)

The following are the guidelines for requesting a reopening:

- The request for a reopening by a party or its authorized representative must be in writing;
- The purpose for the reopening must be clearly stated. It must be clear that a reopening is being requested, not further appeal; and
- The request for a reopening must be made within one year of the date of the initial or reconsidered determination notice, the hearing officer decision notice, or an Administrator's written determination.

The individual or entity which made the determination decides whether to reopen the determination. When a decision to not reopen a determination is made, the party requesting the reopening may not appeal the decision.

20.2 - Notice of Reopening and Any Revisions to Determinations

(Rev. 1, 07-02-01)

The notice of reopening and of any revisions following the reopening is mailed to the parties. The notice of revision specifies the reasons for revisions.

20.3 - The Effect of a Revised Determination

(Rev. 1, 07-02-01)

The revision of a contract or reconsidered determination is final unless a party files a written request for hearing of the revised determination in accordance with §10.3.1 of this chapter.