COST PLAN POLICY ISSUE
03-006

QUESTION:

Are 1876 cost contractors responsible for processing claims in the same manner as Medicare fee-for-service, i.e. bundling?

DRAFT FINAL RESPONSE:

The allowable costs of an HMO/CMP are first determined in accordance with the principles set forth in 42 CFR 417 subpart O and with Chapter 17 of the Medicare Managed Care Manual. After those requirements are met, the Medicare principles of reimbursement as described in the Provider Reimbursement Manual (Pub. 15) are applicable - if those principles are not otherwise in contradiction with the Cost HMO/CMP regulation and the Medicare Managed Care Manual.

The costs incurred by an HMO or CMP for covered services furnished under arrangement with a provider is allowable to the extent that it would be allowable and payable under part 413 (Principles of Reasonable Cost Reimbursement) of the 42 CFR. The HMO or CMP can petition CMS and seek payment in excess of the amounts otherwise payable under part 413, if it can demonstrate to CMS's satisfaction that payment in excess of that amount is justified on the basis of advantages gained by the HMO or CMP.

Generally, a cost HMO/CMP is not required to follow FFS Medicare payment rules when processing claims for its enrolled Medicare members. What a cost HMO/CMP is required to do is apportion appropriate costs between Medicare enrollees and other enrollees (and non-enrollees to whom the HMO/CMP provides services) in such a way that Medicare only bears the cost of furnishing services to Medicare enrollees.