A. Purpose and Function of the Health Maintenance Organization/ Competitive Medical Plan (HMO/CMP) Manual.--This manual is for use by health maintenance organizations (HMOs) and competitive medical plans (CMPs) that contract with the Health Care Financing Administration (HCFA) to provide health care services to Medicare beneficiaries. It includes information that HMOs and CMPs need to meet contract requirements and to answer questions from Medicare enrollees about their benefits.

The manual is designed primarily for organizations that have Medicare cost or risk contracts under §1876 of the Social Security Act (Act) as amended by §114 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). However, some sections also apply to organizations that have a demonstration contract, and organizations with agreements that cover only Part B services under §1833 of the Act known as health care prepayment plans (HCPPs).

This manual can also assist HMOs and CMPs that do not currently have a Medicare contract in making a decision on whether to enter into a contract. It likewise provides information to assist in developing a contract application.

B. Contents and Organization.--

1. Contents.--The manual provides instructions on how an HMO and CMP can meet the requirements in the law and regulations governing Medicare contracts. It also describes procedures and documentation necessary to meet the administrative requirements established by HCFA. Examples and sample forms are provided where appropriate.

2. Organization.--The material is organized into six parts: introduction, contracting conditions, contract provisions, payment to cost contractors, payment to risk contractors, and information exchange requirements. Each part is divided into chapters and sections. A table of contents for each chapter lists the section titles and page numbers.

C. HMO/CMP Revisions.--HMOs/CMPs are responsible for keeping this manual updated and for using the manual as a resource to answer questions about your responsibilities as a Medicare contractor.

1. Frequency and Format.--The manual is designed to accommodate new pages as changes in the implementing instructions are made. Accordingly, interim instructions and revised or new pages or chapters are issued as needed. Any new or revised material includes a transmittal sheet and number and identifies new page numbers or the pages to be replaced. The transmittal sheet also summarizes the principal changes in the material being issued and the effective date. The new or revised manual pages are attached to the transmittal sheet. The transmittal number is included at the bottom of each page. Changed material is identified by a line on the left margin of a page in the following manner:

   Line on which change begins.
   Line on which change ends.

2. Filing Suggestions.--Immediately after the title page of this manual, a check sheet is provided where you may record receipt of manual revisions. File manual transmittals in order of the transmittal number. Transmittals are not always distributed in strict numerical sequence. Allow 10-working days after receipt of a higher number transmittal before contacting the following office for a transmittal you have not received:
Insert the new material or replace revised pages, discarding the outdated pages. You may wish to file the transmittal sheets separately so that you can refer to the background explanation at a later date.

3. Effective Dates.--Generally, new or revised instructions include prospective effective dates, while corrective instructions are usually retroactive. Revisions which clarify instructions already in effect do not specify an effective date.

D. HCFA Information Sources.--Each HMO/CMP has a number of contacts in HCFA's Central Office (CO) and a contact in the HCFA Regional Office (RO). Part 1, Chapter 2, describes the role of each contact person. In general, direct questions concerning the administration of your Medicare contract, including payment, to your CO contact person. Direct operational questions, such as those regarding enrollment or disenrollment problems, to your RO contact person.
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1000. OVERVIEW OF MANUAL

This manual describes the operating requirements and procedures for health maintenance organizations (HMOs) and competitive medical plans (CMPs) which contract with the Health Care Financing Administration (HCFA) to provide medical services to Medicare beneficiaries. In general, these procedures concern the process of entering into a contract, contracting requirements, the scope of medical benefits under the contract, enrollment and disenrollment procedures, appeals, and payments to the organizations. These contracts operate under the authority of title XVIII, §1876 of the Act (42 U.S.C. 1395mm), and its implementing regulations (42 CFR Part 417).

1000.1 Purpose.--This chapter summarizes the general requirements of the Medicare program. It does not describe all of the legal requirements of the Medicare program. Refer to the Medicare statute, regulations and the Medicare Intermediary Manual (MIM) and the Medicare Carrier Manual (MCM) for full details.

In most cases, an HMO/CMP is held to the same requirements as apply in fee-for-service Medicare. For example, you must provide or arrange for all covered Medicare services and use providers that meet Medicare standards. In other cases, requirements are different, such as the method of payment or system of quality review.

This chapter describes the basic Medicare policy or requirement in the fee-for-service system, provides cross references to the Medicare Intermediary or Carrier Manuals where you may find additional information on the specific requirement, and briefly describes the requirement as it applies to prepaid health care organizations (or references the section in this manual where the requirement is described).

Administration of the Medicare Program

1010. INTRODUCTION

The Health Insurance for the Aged and Disabled (title XVIII of the Act), also known as Medicare, makes available to nearly every American who is 65 years of age or older, plus certain disabled persons and most persons with end stage renal disease, a broad program of health insurance designed to assist in meeting hospital, medical, and other health costs. The program includes two related health insurance programs--hospital insurance (Part A of the Act) and supplementary medical insurance (Part B of the Act).

The administration of the Medicare program has been delegated by the Secretary of Health and Human Services to HCFA. The Act provides roles for the States, for insurance organizations and for peer review organizations (PROs) in the operation of the program. The Medicare law does not permit the Federal government to control the practice of medicine or dictate the manner in which medical services are provided. The responsibility for treatment and the control of patient care remains with the physician and the provider or other facility or agency furnishing services. The patient is free to choose any participating institution, agency, or person offering services, including the choice to enroll in an HMO or a CMP.

1012. FINANCING THE PROGRAM

Part A (Hospital Insurance) is essentially financed through separate payroll contributions paid by employees, employers, and self-employed persons. The
proceeds are deposited in the account of the Federal Hospital Insurance Trust Fund, which may be
used for hospital insurance benefits and administrative expenses for persons who meet Medicare
eligibility requirements.

Part B (Supplementary Medical Insurance) is financed by the monthly premiums of those who
voluntarily enroll in Part B and by the Federal government which makes contributions from general
revenues. All premiums and government contributions are deposited in a separate account known
as the Federal Supplementary Medical Insurance Trust Fund. This fund may be used only to pay for
Part B benefits and administrative expenses.

In addition to Part B premiums, Medicare beneficiaries are responsible for paying:

- An inpatient hospital deductible for each spell of illness (defined as the period of time
  beginning when a beneficiary first receives inpatient hospital or skilled nursing facility (SNF)
  services and ending when the beneficiary has not received inpatient hospital or SNF care for 60
  consecutive days);

- Coinsurance equal to one-quarter of the inpatient hospital deductible for days 61 - 90 in
  a spell of illness. Coinsurance for 60 lifetime reserve days is equal to one-half of the inpatient
  hospital deductible;

- The costs of the first three pints of blood provided in a calendar year,

- Coinsurance equal to one-eighth of the inpatient hospital deductible for days 21 - 100 of
  SNF care in a spell of illness, and

- Coinsurance equal to 20 percent of the Medicare determined reasonable charge for
  physician and other covered medical services after an annual Part B deductible has been met.

Beneficiaries are also liable for the difference between the Medicare determined reasonable charge
and a physician's actual charge on unassigned claims.

Enrollee liability in HMOs and CMPs is discussed in §§2101ff.

1012.1 State Buy-In.--Medicaid is the State/Federal program for health care for the poor. It pays
Medicare premiums, coinsurance and deductibles for low income elderly and disabled whose
incomes are at or below a specified percentage of the Federal poverty level and whose resources are
at or below twice the Supplemental Security Income (SSI) level. By 1993, all States must cover all
enrollees at or below the poverty level. The Commonwealths and Territories have the option to
provide this coverage.

1014. DISCRIMINATION PROHIBITED

The providers of services, under the hospital insurance program, i.e., hospitals, SNFs, hospices, and
home health agencies, as well as HMOs/CMPs and the providers they use, must comply with the
requirements of title VI of the Civil Rights Act of 1964. Under the provisions of the Civil Rights
Act, a
participating provider or HMO/CMP is prohibited from making a distinction on the grounds of race, color, or national origin in the treatment of patients; in the use of equipment and other facilities; or in the assignment of personnel to provide services.

The Department of Health and Human Services (DHHS) is responsible for investigating complaints of noncompliance.

1016. FRAUD AND ABUSE

Certain actions of a Medicare provider, physician or supplier (or an HMO/CMP and its contractors and affiliated entities) are subject to penalty under Medicare's fraud and abuse provisions. The penalties include civil money penalties; criminal penalties; or exclusion from Medicare, Medicaid, and other Federal or State health care programs.

Fraud involves an intentional misrepresentation or deception for the purpose of obtaining Medicare payment or other benefits not otherwise due. Most fraudulent acts involving the Medicare program are considered felonies and are subject to a fine of up to $25,000 and/or imprisonment of up to 5 years. Abuse includes those practices that are inconsistent with accepted sound fiscal, business, or medical practices. Kickbacks, bribes or rebates are strictly prohibited. The following acts have a potential for penalty:

- Misrepresentation of services rendered,
- Deliberate application for duplicate reimbursement,
- Falsely obtaining certification for participation in Medicare,
- Mail fraud,
- Controlled substance violations,
- Loss or suspension of license,
- Improper billing practices,
- Failure to maintain adequate records to substantiate costs, and
- Failure to provide services that meet professionally recognized standards of health care.

The following areas have been specifically identified (in addition to the general areas of fraud and abuse) where action may be taken against prepaid plans:

- HMOs that fail to provide medically necessary services may be excluded from Medicare and other Federal and State health care programs if the failure has adversely affected covered individuals or may adversely affect them.
- Entities that are owned or controlled by persons against whom a civil money penalty or exclusion has been assessed may be excluded. In addition, HCFA may deny payment for services provided by an HMO employee who has been excluded from the program. A semi-annual report and monthly update are sent to each HMO to identify any excluded persons. (See Medicare/Medicaid Sanction Reinstatement Reports.)
Up to $25,000 in civil money penalties may be imposed for each time an organization:

- Fails substantially to provide medically necessary items and services required by law or by contract to Medicare beneficiaries if such failure does have, or is likely to have, an adverse impact on the patient;
- Charges enrollees for premiums in excess of premiums allowed;
- Expels or refuses to re-enroll an individual in violation of the statute;
- Misrepresents or provides false information to the Secretary or to an individual or entity;
- Fails to pay promptly for services or supplies furnished by non-contracting providers or suppliers or fails to comply with the rules governing physician incentive plans; or
- Employs or contracts with or through any individual or entity that has been excluded from participation in Medicare or Medicaid for the provision of health care, utilization review, medical social work or administrative services. (This provision only applies to risk contracts.)

If there is a civil money penalty assessed against an organization for charging excess premiums, the penalty is double the excess premium amount. The amount of the excess premiums is deducted from the civil money penalty paid by the organization and paid to the beneficiary.

Up to $100,000 in civil money penalties may be imposed for each instance an organization:

- Denies or discourages enrollment based on health status (the Secretary may also impose an additional penalty of $15,000 for each individual not enrolled), or
- Misrepresents or falsifies information to the Secretary.

For violations that are subject to civil money penalties, HCFA also has the authority to impose intermediate sanctions that include:

- Suspension of new applications for enrollment after a date specified by HCFA; or
- Suspension of payments for any individuals who apply for enrollment after a date specified by HCFA.

Up to $5,000 in civil money penalties may be imposed on organizations that use the emblem or name of Social Security or Medicare in a manner that conveys a false impression of official authorization. Penalties of up to $25,000 may be assessed for broadcast or television violations.

The Office of the Inspector General in the DHHS is responsible for conducting investigations of suspected instances of fraud and abuse and for determining whether a civil or criminal penalty is applied. Direct questions to the regional offices of the Inspector General. (See §1103.)
HCFA also has the authority to terminate a contract with an HMO. (See Part 3 of this manual.)

1020. FEDERAL GOVERNMENT ROLE

HCFA is responsible for policy formulation as well as for the general management and operational aspects of the Medicare program. Briefly, these include determination of amounts to be paid to providers, physicians, and suppliers; determination of the nature and duration of services which may be covered; establishment, maintenance, and administration of agreements with State agencies, providers of services, and intermediaries and carriers; establishment of major policies regarding conditions of participation for providers and policies to assure quality of care; development and maintenance of statistical research and actuarial programs; and general financial management of the program. HCFA uses contractors, such as intermediaries, carriers, or peer review organizations to accomplish some of these responsibilities.

HCFA is also responsible for determining Federal qualification of HMOs and eligibility of CMPs and for establishing and administering Medicare contracts with HMOs/CMPs.

Responsibility within HCFA for the management of HMO/CMP contract is discussed in §§1100ff.

The Social Security Administration (SSA) is responsible for determining an individual's entitlement to Medicare benefits, verifying a Social Security number, and answering general inquiries about the Medicare program. Also, a Medicare beneficiary who is enrolled in an HMO or CMP may disenroll at a local SSA office.

1022. STATE AGENCIES

State agencies certify to the DHHS whether hospices, hospitals, SNFs, home health agencies, independent laboratories, portable x-ray facilities, and other types of providers and suppliers satisfy, and continue to satisfy, health care quality requirements for participation in the Medicare program.

In the case of HMOs and CMPs, HCFA performs these functions through the Federal HMO qualification process, the CMP eligibility process and the contract application process described in §§1200ff. as well as through regular monitoring of contracts.

1024. MEDICARE CONTRACTORS

HCFA contracts with intermediaries and carriers to process and pay claims for services provided to Medicare beneficiaries in the fee-for-service system. HMOs and CMPs are responsible for processing claims or otherwise paying for services provided to their enrollees, except in certain circumstances which are discussed in §§1100ff. HMOs and CMPs also often coordinate with Medicare contractors on payment for emergency and out-of-area urgently needed services and on issues concerning eligibility of Medicare beneficiaries or Medicare coverage requirements. HMOs and CMPs with cost contracts may choose to have the intermediaries either pay claims on their behalf or transfer claims for HMO/CMP processing.
1024.1 **Role of Part A Intermediaries.**--The Part A intermediary is an organization that has entered into a contract with HCFA to process Medicare claims for hospitals, home health agencies, hospices, SNFs, outpatient physical therapy and speech pathology providers, end-stage renal disease facilities, comprehensive outpatient rehabilitation facilities, and rural health clinics.

Intermediaries pay providers in accordance with provisions of the Medicare law, pertinent regulations, the Provider Reimbursement Manual and the Medicare Intermediary Manual. They also assist providers in the development and application of safeguards against unnecessary use of covered services, furnish consultative services to providers to enable them to establish and maintain the requisite fiscal data, communicate to providers information or instructions furnished by HCFA, conduct audits of provider records, assist in the appeals process, and provide information and advice to any institution, facility, or agency that wishes to qualify as a provider of services.

1024.2 **Role of Part B Carriers.**--The Act also authorizes HCFA to enter into contracts with organizations to serve as carriers in the operation and administration of most of the Part B program. Carriers determine the amount of payment made to physicians and suppliers. Other major functions include controlling overutilization of covered services, communicating with the health care community and beneficiaries on matters pertaining to the Part B program, encouraging physicians and suppliers to participate in Medicare, and establishing and maintaining procedures for the beneficiary appeals process.

1026. **PEER REVIEW ORGANIZATIONS**

Peer Review Organizations (PROs) are groups of practicing doctors and other health care professionals who contract with HCFA to provide an independent review of health services delivered to Medicare patients. PROs review a statistical random sample of Medicare cases to determine whether:

- Care was reasonable and necessary;
- Services were provided in the appropriate setting;
- Services met the standards of quality accepted by the medical profession; and
- A hospital's discharge decision was appropriate.

They have the authority to deny fee-for-service payment if the appropriate standards are not met.

PROs also investigate individual patient complaints, conduct intensified reviews focused on problem areas, and review cases using specified generic screens developed by HCFA.

PROs also review services provided by HMOs and CMPs to Medicare enrollees to ensure that services provided are of adequate quality. (See §§2500ff.)
1028. **APPEALS**

Medicare beneficiaries (and in some cases providers, physicians and suppliers,) have four levels of appeal if payment is denied for a service that they think should have been covered or they are dissatisfied with the payment amount for a covered service. The first level of appeal is a reconsideration request to the Medicare intermediary, the carrier, or the HMO/CMP that made the initial determination on a claim, or to the PRO that made the initial determination on appropriateness or quality of a service. If the reconsideration is unfavorable and the claim is at least $100, an administrative appeal is available to an Administrative Law Judge (ALJ). ALJ decisions may be appealed to the SSA Appeals Council. The final level of appeal, again based on the amount in controversy, is to a Federal court.

Medicare beneficiaries enrolled in an HMO or CMP have similar rights as described in §§2700ff.

1030. **PROVISION OF SERVICE - GENERAL**

Providers of services, physicians, and certain suppliers must meet all licensing requirements of State or local health authorities. They must also meet additional Medicare requirements before payments can be made for their services. HMOs/CMPs are required to use Medicare certified providers, practitioners and suppliers. Physicians used must be licensed, but do not have to agree to accept assignment under Medicare. You may not employ or contract with physicians for the provision of health care, utilization review, medical social work, or administrative services if they have been excluded from the Medicare, Medicaid or another federal health program. See §§2101ff. for specific health service delivery requirements.

1032. **DEFINITION OF PROVIDER**

A Medicare provider is a hospital, SNFs, home health agency (HHA), hospice, comprehensive outpatient rehabilitation facility (CORF), and for the limited purpose of furnishing outpatient physical therapy, occupational therapy, or speech pathology services, a clinic, rehabilitation agency, or public health agency.

Medicare does not pay for services of providers that are not certified to participate in the program, except in the case of certain emergencies. Participating providers must agree that their total charges, including applicable deductible and coinsurance amounts, do not exceed the Medicare allowable amount. A provider may voluntarily terminate its agreement to participate in the Medicare program, or Medicare may terminate the agreement for cause.

1034. **PHYSICIANS**

Physicians under Medicare are doctors of medicine or osteopathy who are legally authorized to practice medicine or surgery by the State where the service is performed. Podiatrists, optometrists, dentists and chiropractors are included for certain procedures.

Under fee-for-service Medicare, physicians have a choice of accepting assignment (that is, the Medicare payment and applicable beneficiary coinsurance and deductibles as payment in full) on an individual claim basis or on all Medicare claims. In the latter case, the physician signs an agreement to become a Medicare participating physician. Medicare offers incentives to physicians to participate, such as higher payment than is usually available under Medicare charge screens. Physicians who do not participate
must limit their charges to beneficiaries. A physician's decision to participate in the Medicare program limits the amount he or she may bill the HMO/CMP as described in §§2101ff.

1036. SUPPLIERS

The term suppliers includes therapists, practitioners and certain others who furnish health services. The following suppliers must meet the conditions for coverage in order to receive Medicare payment: ambulatory surgical centers, independent physical therapists, independent occupational therapists, clinical laboratories, portable X-ray suppliers, dialysis facilities, and rural health clinics.

Suppliers have the same choice as physicians to accept assignment on an individual claim basis or to become a participating supplier.

1038. PRACTITIONERS

Practitioners are health professionals who may deliver covered Medicare services if the services are incident to a physician's service or if there is specific authorization in the law. The following practitioners may deliver services without direct physician supervision: nurse practitioners and physician assistants in rural health clinics, designated manpower shortage areas or HMOs; qualified clinical psychologists, clinical social workers, certified nurse midwives and certified registered nurse anesthetists. (See MCM §§2050.3 and 2260.11.)

While HMOs and CMPs have flexibility in the use of different types of practitioners, those used must meet Medicare requirements. Sections 2101ff. describe the qualifications and other conditions that these practitioners must meet.

Medicare Covered Benefits

The following sections briefly describe the benefits covered under the Medicare Part A and Part B programs. Refer to the Intermediary and Carrier Manuals for a more complete description of definitions and limitations. Appropriate references are provided for your information. HMOs and CMPs are required to provide or arrange for the provision of all these Medicare covered Part A and Part B benefits. In some cases, special rules apply. (See §§2101ff.)

1040. HOSPITAL INSURANCE (PART A) - A BRIEF DESCRIPTION

Hospital insurance (or Part A) is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, Part A provides coverage for skilled nursing or rehabilitative care in SNFs, care furnished by a home health agency in the patient's home, or hospice care for terminally ill patients. Payments to hospitals for inpatient services rendered to beneficiaries are generally made under the prospective payment system (PPS), according to the diagnosis related group (DRG) classification of the Medicare patient's hospital stay. Payments to other providers are generally based on the reasonable costs of the covered services. Hospices are paid on the basis of prospectively determined rates limited by an annual cap.

1040.1 Inpatient Hospital Services.--After payment of a deductible for each spell of illness, Medicare covers up to 90 days of medically necessary inpatient hospital care if:
A doctor prescribes inpatient care for the treatment of an illness or injury;

- The hospital participates in Medicare; and

- The hospital's utilization review committee or the PRO does not disapprove the stay.

A spell of illness begins when a Medicare beneficiary enters a hospital and ends when the beneficiary has been out of the hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row. The number of spell of illness periods is not limited. Medicare also covers an extra lifetime reserve of 60 days which can be used if the beneficiary requires a hospital stay that is longer than 90 days in a benefit period.

The deductible is $628 in 1991. The deductible is published in the Federal Register by September 15 for the following calendar year.

The items and services covered include bed and board (semi-private room); nursing and other related services; use of hospital facilities such as the intensive care unit and services such as anesthesia ordinarily furnished by the hospital for the care and treatment of inpatients; drugs, biologicals, supplies, appliances, and equipment for use in the hospital which are ordinarily furnished by the hospital; and diagnostic lab tests or other therapeutic items or services furnished by the hospital or by others under arrangements made by the hospital.

Inpatient psychiatric hospital services are covered for up to 190 days during the patient's lifetime if furnished in a psychiatric hospital. (The limit for psychiatric care in a general acute care hospital is the same as it is for medical care in a general acute care hospital.)

Payment may be made for emergency inpatient hospital services furnished by nonparticipating U.S. hospitals when a threat to the life or health of the individual necessitates the use of the most accessible hospital. Payment may also be made for emergency inpatient hospital and certain related Part B services in Canada and Mexico if the emergency occurs in the U.S. or in transit to or from Alaska, and the foreign hospital is more accessible from the site of the emergency than the nearest participating U.S. hospital.

Inpatient hospital services and related Part B services provided to a United States resident in a hospital in Canada or Mexico which is closer or more accessible to his or her U.S. residence than the nearest participating U.S. hospital are covered whether or not an emergency existed. (See MIM §§3101ff.)

NOTE: The definition of emergency for purposes of an HMO/CMP is distinct and is included in §§2101ff.

1040.2 Extended Care Services.--After a qualifying 3 day hospital stay, Medicare Part A hospital insurance may help pay for inpatient care in a participating SNF if the beneficiary's condition requires daily skilled nursing (i.e., performed by or under the supervision of licensed nursing personnel) or daily skilled rehabilitation services (i.e., performed by or under the supervision of a physical therapist, occupational therapist, or speech pathologist) and if:
A doctor certifies that the patient needs, and the patient actually receives, skilled nursing or skilled rehabilitation services on a daily basis; and

The facility's Utilization Review Committee or the Fiscal Intermediary does not disapprove the stay.

Items and services covered include:

- Bed and board;
- Nursing services;
- Physical therapy, occupational therapy and speech therapy;
- Drugs and biologicals;
- Medical supplies; and
- Use of appliances.

Part A does not pay for a stay if the patient needs skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if the rehabilitation services are no longer improving the patient’s condition and may be carried out by someone other than a skilled therapist. Also, hospital insurance does not pay for a stay in a SNF if a patient only needs custodial care.

When a stay in a SNF is covered by Medicare, Part A may help pay for up to 100 days in a spell of illness, but only if the patient needs daily skilled nursing care or daily rehabilitation services for that period.

Medicare Part A pays for all covered services for the first 20 days and the beneficiary pays coinsurance for days 21 - 100 in each benefit period. In 1991 the coinsurance is $78.50 each day. (See MIM §3130ff.)

NOTE: Most nursing homes in the United States are not SNFs and many SNFs are not certified by Medicare. In some facilities, only certain distinct portions participate in Medicare.

Additional information on SNF benefits provided by an HMO/CMP is located in §§2101ff.

1040.3 Home Health Services.--Home health services are services provided by a home health agency (HHA) that participates in Medicare or by others under arrangements with such an agency. A HHA is a public agency or private organization, such as a visiting nurse association, official health agency, or a hospital-based home care program, which is primarily engaged in providing skilled nursing and therapeutic services.
To qualify for home health benefits under either Part A or Part B of the program, a beneficiary must be (1) home-bound, (2) under a plan of treatment reviewed and approved by a physician, and (3) in need of intermittent skilled nursing services, physical therapy, or speech therapy. If a person initially qualifies for home health services because of the need for intermittent skilled nursing care, physical therapy or speech therapy, the patient's eligibility for home health services may be extended solely on the basis of the continuing need for occupational therapy.

Covered items and services include:

- Part-time or intermittent skilled nursing;
- Physical or speech therapy;
- Occupational therapy;
- Medical social services;
- Medical supplies (except for drugs and biologicals) and medical appliances; and
- Part-time or intermittent services of home health aides.

Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

Home health services are usually furnished on a visiting basis in a place of residence used as the individual's home. The home may not be a facility that primarily provides skilled care. However, home health services may be covered when furnished on an outpatient basis under arrangements with a hospital, SNF or rehabilitation facility if equipment is required that cannot be made available in the patient's home. The services of an intern or resident- in-training are covered if the agency has an affiliation with or is under common control of a hospital that provides such medical services and the agency bills for such services. See Part 2 and MIM §3116ff.

1040.4 Hospice Care.--A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

Medicare helps pay for hospice care if:

- A doctor certifies that the patient is terminally ill and is expected to live 6 months or less;
- A patient chooses to receive palliative care only from a Medicare certified hospice instead of therapeutic care under Medicare for the terminal illness; and
- Care is provided by a Medicare-certified hospice program.

Special requirements apply to hospice care. Medicare Part A may pay for two 90-day periods, a subsequent 30-day period, and a subsequent extension period upon re-certification of the patient's medical condition as terminally ill. Even though HCFA's payments are limited, a hospice may not discontinue care because of the beneficiary's inability to pay.
The Medicare hospice benefit includes:

- Nursing services;
- Doctors' services;
- Drugs, including outpatient drugs for pain relief and symptom management;
- Physical therapy, occupational therapy, and speech therapy;
- Home health aide and homemaker services;
- Medical social services;
- Short term inpatient care, including respite care which is a short stay intended to give temporary relief (up to 5 days in a row) to the person who regularly assists with home care; and
- Counseling.

Medicare pays the full cost of all covered services for the terminal illness, except for coinsurance amounts for outpatient drugs (the lesser of $5 or 5 percent of the cost of each prescription) and inpatient respite care (5 percent of the Medicare allowed rate), not to exceed the inpatient hospital deductible amount.

HMOs/CMPs do not furnish hospice care. See §§2101ff. and MIM §§3140ff.

1050. SUPPLEMENTARY MEDICAL INSURANCE (PART B) - A BRIEF DESCRIPTION

The supplementary medical insurance program (Part B) provides coverage for a variety of medical services and supplies furnished by physicians or others in connection with physicians' services, outpatient hospital services, and a number of other specific items and services. Individuals participate voluntarily in the Part B program and pay a monthly premium to participate. This monthly premium must be made whether the beneficiary receives services in the fee-for-service system or through a prepaid plan.

Medicare payment for Part B services is generally made on the basis of Medicare's determination of the reasonable charge for the service or according to fee schedules. Beneficiaries generally pay coinsurance of 20 percent of the Medicare payment amount for Part B services.

1050.1 Physicians' Services.--After a yearly $100 Part B deductible, Medicare pays 80 percent of the approved amount for medically necessary physicians' services provided in the physician's office, in a hospital, in a SNF, the patient's home, or other U.S. location.

Major physician services include:

- Medical and surgical services, including anesthesia;
Diagnostic tests and procedures that are part of treatment;

Radiology and pathology services in the hospital (inpatient and outpatient departments);

Related physician services provided in the physician's office such as X-rays, nursing services, drugs and biologicals that may not be self-administered, blood transfusions, medical supplies; and

Second surgical opinions.

The only chiropractic service covered by Medicare is manual manipulation of the spine to correct a subluxation demonstrated by a physician read X-ray.

Medicare covers foot care provided by a licensed podiatrist including removal of plantar warts and treatment of mycotic toenails (generally no more than once every 60 days). Routine foot care services, e.g., hygienic care, are generally not covered unless the patient has a medical condition affecting the lower limbs.

Medicare covers vision care services provided by a licensed optometrist, but not routine eye exams, eyeglasses or corrective lenses unless they are prosthetic lenses that replace the natural lens of the eye, usually following cataract surgery. (See MIM §§3145ff. and MCM §§2020ff.)

**Dental Services.**--Items and services in connection with the care, treatment, filling, removal, or replacement of teeth are not covered. However, there are some normally defined exceptions when a dental procedure may be covered under the Medicare program. They are:

- If a dental procedure that is not covered is performed as an integral part of a covered procedure or service performed by the dentist, the total procedure or service is covered;
- The extraction of teeth to prepare the jaw for radiation treatment for neoplastic disease is covered;
- A dental examination for patients requiring certain complex surgical procedures is covered to rule out infection that contraindicates surgery (see MIM §3162 and MCM §§2020.3 and 2336),
- Surgery of the jaw or related structures;
- Setting fractures of the jaw or facial bones;
- Services that would be covered when provided by a physician; and
- Hospitalizations for severe dental problems.

**Outpatient Hospital Services.**--Medicare covers services provided by a hospital to outpatients that are provided to diagnose or treat an illness or an injury. (See MIM §3112.) Examples of services covered include:

- Services in an emergency room or outpatient clinic;
- Laboratory tests;
Medical supplies;
X-rays and other radiology services;
Drugs and biologicals that may not be self-administered and blood transfusions; and
Outpatient surgery.

1050.4 Outpatient Mental Health Services.--Medicare covers mental health care in a hospital outpatient program if a physician certifies that the treatment is a substitute for hospitalization. This benefit is not subject to the 190 day lifetime limit in a psychiatric hospital for inpatient hospitalization for treatment of mental illness or to the outpatient psychiatric limit. Medicare also covers outpatient mental health services in a comprehensive outpatient rehabilitation facility (CORF) or a clinic. Beginning in 1990, Medicare does not limit payment for physician services and CORF services for outpatient treatment of mental illness to a specific dollar amount in a year. In addition, Medicare covers the services of psychologists and clinical social workers if they are legally authorized to perform the service in the State in which it is furnished. See §§2101ff. for a description of how these services limitations apply in an HMO or CMP setting. (See MIM §3112.7 and MCM §§2470ff.)

1050.5 Ambulatory Surgical Services.--Medicare covers surgical services (and pre- and post-operative care) for procedures that Medicare specifies can be safely performed in an ambulatory surgical center (ASC). The ASC must be certified by Medicare and may be freestanding or affiliated with a hospital. (See MCM §§2265ff.)

1050.6 Outpatient Physical, Occupational Therapy and Speech Pathology Services.--Medically necessary outpatient physical and occupational therapy or speech pathology services are covered if:

A physician prescribes the services;
The physician or therapist establishes a plan of treatment; and
The physician periodically reviews the treatment plan.

These services can be provided by a participating hospital, HHA or SNF, or a clinic, rehabilitation agency, or public health agency approved by Medicare. In addition, services may be provided directly by an independently practicing, Medicare certified physical or occupational therapist in his or her office or in the patient's home up to a limit of $600 per year (80 percent of $750 in reasonable charges). (See MIM §3147ff. and MCM §§2215ff.)

1050.7 Comprehensive Outpatient Rehabilitation Facility (CORF) Services.--Services covered in a CORF include physicians' services; physical, speech, occupational and respiratory therapies; counseling; and other related services if these services are approved by a physician who certifies the need for skilled rehabilitation services. (See MIM §§3180ff. and MCM §2220.)

1050.8 Durable Medical Equipment.--Medicare covers durable medical equipment such as oxygen equipment, wheelchairs, and medically necessary equipment prescribed by a physician for use in the patient's home. (See MIM §§3113ff. and MCM §§2100ff.)
1050.9 **Prosthetic Devices.**--Medicare pays for prosthetic devices which replace all or part of an internal body organ, including one pair of conventional eyeglasses or contact lens after each cataract operation involving insertion of a intraocular lens. Colostomy (and other) bags, and necessary accoutrements required for attachment are covered as prosthetic devices. (See MIM §3110.4 and MCM §2130.)

1050.10 **Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms and Eyes.**--These appliances are covered when furnished incident to physicians' services or on a physician's order. In most cases, orthopedic shoes are covered only when they are a non-integral part of a leg brace. (See MIM §§3110.5, 2133, and 2323.)

1050.11 **Medical Supplies.**--Part B covers medical supplies such as surgical dressings, splints, casts, and other supplies (but not first aid supplies) ordered by a physician in connection with medical treatment. (See MIM §§3110; 2079, and 2050.)

1050.12 **Other Covered Services and Supplies.**--Part B covers the additional items and services including the following:

- Diagnostic x-ray tests, lab tests provided by certified laboratories and other diagnostic tests (see MCM §2070);
- Portable diagnostic X-ray services ordered by a physician to be provided in the home (see MCM §2070.4);
- X-ray, radium, and radioactive isotope therapy (see MCM §2075);
- Immunosuppressive drugs for one year following a Medicare covered transplant and injectable drugs for the treatment of post-menopausal osteoporosis if the patient is confined to the home (see MCM §2050.5G);
- Antigens (see MCM §2050.5E) and blood clotting factors (see MCM §2050.5B) and effective 7/1/91, self administered erythropoieten (EPO) for certain home dialysis patients (see MCM §2050.5H for coverage of EPO when not self-administered);
- Medically necessary ambulance transportation if the service meets Medicare requirements and transportation in another vehicle could endanger the patient's health (see MCM §2120);
- Pneumococcal vaccine (100 percent of allowable charges) and hepatitis B vaccine (if administered to beneficiaries who are at high or intermediate risk) (see MCM §2050.5C);
- Rural health clinic services, physician assistant, certified registered nurse anesthetist, nurse-midwife, and clinical psychologist and clinical social worker services;
- ESRD services (see MCM §2230ff.);
- Pap smears and a biennial screening mammography benefit for women over 64 (more frequent for high risk patients) (see MCM §2000); and
Surgical dressings, splints, casts, and other devices used for the reduction of fracture and dislocation. (See MIM §3110 and MCM §2079.)

1060. ENTITLEMENT TO PART A - GENERAL

The aged, disabled and persons with end-stage renal disease (ESRD) are entitled to Medicare Part A benefits as described below. Part A entitlement decisions are made by the SSA.

1060.1 Persons Age 65 or Over.--An individual is entitled to coverage under Part A beginning with the first day of the month of attainment of age 65 if he or she files a timely application for such entitlement and is determined to be eligible for monthly social security benefits, whether or not he or she is actually receiving the monthly benefit payments. Such entitlement also extends to qualified railroad retirement beneficiaries and to those insured on the basis of qualified Medicare government employment. Part A coverage established under this provision continues through the date of death.

1060.2 Premium Part A for Persons Age 65 or Over.--Aged individuals who want hospital insurance coverage but who are not eligible under the above provision may elect such coverage and pay a Part A monthly premium. To qualify, the person must be age 65 and a resident of the United States. In addition, the individual must be either a U.S. citizen or an alien who is lawfully admitted for permanent residence, with 5 years continuous residence in this country. He or she must also enroll in the supplementary medical insurance program under Part B of Medicare.

Coverage under this provision continues through the date of death unless terminated earlier based on a voluntary request or because of non-payment of premiums.

1060.3 Disabled.--A disabled person who is entitled to social security or railroad retirement benefits on the basis of disability is, after 24 months of entitlement to such benefits, automatically entitled to Part A coverage. Since there is a 5-month disability benefit waiting period, the person actually becomes entitled to Part A coverage after being disabled for 29 months. In addition, disabled persons who are not eligible for monthly social security disability benefits but are insured on the basis of qualified Medicare government employment are deemed to be entitled to disability benefits and are automatically entitled to Part A after being disabled for 29 months. Part A entitlement on the basis of disability is available, not only to the worker, but to the widow, widower, or child of a deceased, disabled or retired worker if any of them becomes disabled within the meaning of the Social Security or Railroad Retirement Acts.

If an individual recovers from his or her disability, Part A entitlement ends with the month after the month he or she is notified of the disability benefit termination. However, if the individual's disability benefit entitlement has ended because he or she was working while still disabled, premium free Part A entitlement may continue for up to 48 months following the month he or she returns to work. Individuals who return to work but whose impairment continues may purchase Part A when premium-free Part A entitlement ends.

Individuals who re-establish entitlement to disability benefits may be covered by Medicare without again having to meet the 2-year waiting period requirement.
1060.4 Persons Needing Kidney Transplant or Dialysis.--People with irreversible kidney disease (ESRD) are also eligible for premium-free Part A coverage. To qualify, the individual must require a regular hemodialysis or peritoneal dialysis or a kidney transplant.

If an individual is a social security beneficiary or is otherwise insured on the basis of covered employment, he or she, his or her spouse, and dependent children are eligible for Part A under the ESRD provisions. If any one of them contracts ESRD, only the person with ESRD receives Part A coverage.

If a timely application is filed, Part A entitlement begins with the third month after the month in which a regular course of dialysis began. However, this 3-month waiting period is waived if the individual participates in a course of self-dialysis training during the waiting period. Entitlement for an individual who receives a kidney transplant begins with the month of transplant or with either of the 2 previous months, if he or she was hospitalized in an approved renal transplant center or an approved renal dialysis center during those or earlier months in preparation for the transplant.

Entitlement ends 12 months after the person's course of dialysis ends or 36 months after transplant.

1060.5 Special Part A Enrollment Period for HMO Enrollees.--Effective February 1, 1991, an individual aged 65 or older, who meets the requirements for Premium-HI for the aged may enroll in Part A:

- During any month he or she is enrolled in an HMO or CMP, or
- During any of the 8 consecutive months following the last month during any part of which the individual was enrolled in an HMO/CMP.

The effective date of Part A enrollment begins with the first day of the month of Part A enrollment (or at the individual's option the first day of any of the three following months) if the individual enrolls in Part A while:

- He or she is enrolled in an HMO/CMP, or
- During the first full month when he or she is not enrolled in an HMO/CMP.

The effective date of Part A begins with the first day of the month after the month of enrollment in Part A if the HMO/CMP enrollee signs up for Part A during any of the seven months following the month after disenrollment from an HMO.

In determining the premium penalty for late enrollment in Part A, months of coverage under the HMO are not counted as late months. Enrolling early in the special Part A enrollment period may eliminate or further reduce a premium penalty.

1062. ENTITLEMENT TO PART B

An individual is eligible to enroll for supplementary medical insurance (Part B) if he or she either: (1) is entitled to Part A, or (2) has attained age 65, is a resident of the United States and is either a U.S. citizen or an alien, lawfully admitted for permanent residence, who has 5 years of continuous
residence in the U.S. The date coverage begins is dependent on when the individual files a request for enrollment.

Once an individual is enrolled in Part B, coverage continues until it is terminated because of non-payment of premiums, a voluntary request for termination, or, in the case of individuals under age 65, loss of Part A entitlement.

1063. BENEFICIARY ELIGIBILITY TO ENROLL IN HMOs/CMPs

To be eligible to enroll in an HMO or CMP with a Medicare contract, a beneficiary must:

- Be entitled to Medicare Parts A and B, or only Part B, and continue to pay the Part B premium to Medicare;
- Live in the geographic area served by the organization; and
- Agree to abide by the organization's membership rules.

A beneficiary who receives hospice care may not initially enroll in an HMO or CMP until the hospice option is terminated. If a beneficiary becomes terminally ill after enrollment in an HMO or CMP, the organization is required to refer the person to a hospice if the person elects hospice care. (See §§2101ff.)

A beneficiary who has ESRD may not enroll in an HMO or CMP. However, if ESRD develops after enrollment in the organization (including enrollment in the organization before Medicare entitlement), then the beneficiary may not be involuntarily disenrolled. (See §§2001ff.)

1070. DISCLOSURE OF HEALTH INSURANCE INFORMATION

Records and information acquired by HCFA in the administration of the Medicare program may be disclosed only under the conditions prescribed in applicable Federal rules and regulations. As described in §§2101ff., as part of the enrollment process, HMOs/CMPs are required to secure a statement from each Medicare enrollee authorizing HCFA to furnish to the organization information maintained in HCFA records. This authorization allows HCFA to furnish the organization information about Part A health insurance entitlement and Part B enrollment and benefit usage under Parts A and B, as well as other information necessary to administer the Medicare contract.

1072. HMO/CMP DISCLOSURE OF BENEFICIARY INFORMATION

You must ensure the confidentiality of your medical records and other information on beneficiaries that is contained in your records or obtained from HCFA or others. Release only to authorized individuals information from, or copies of, patient records. Your procedures must ensure that unauthorized individuals cannot gain access to or alter patient records.

In addition, the procedures on confidentiality must ensure that release of original medical records is in accordance with Federal or State laws, court orders, or subpoenas.
These limitations apply whether the individual to whom the information pertains authorizes further disclosure to third parties (e.g., to a private medical plan.)

1074. DISCLOSURE OF INFORMATION ABOUT HMOs/CMPs BY HCFA

The following information about HMOs/CMPs and the providers they use that participate in the Medicare program may be disclosed by HCFA under the Freedom of Information Act in response to requests from the public.

1074.1 Medicare Reports.--

A. Provider Survey Reports and Related Information.--Information concerning survey reports of providers which are used by HMOs/CMPs, as well as statements of deficiencies based on survey reports, are available at the local Social Security offices where the providers are located.

B. Program Validation Review Reports and Other Formal Evaluations.--Upon written request, official reports and other formal evaluations of the performance of providers are made available to the public. Provider comments are incorporated in the report if pertinent.

C. Medicare Audit Reports.--HHS audit reports issued to you are made available, if requested, to members of the press and general public. These reports are released, in response to a request, after a period of fourteen (14) calendar days have elapsed from the date of issuance of the final audit report to you.

1074.2 Disclosure of Medicare Statistics.--Numerous statistics on HMOs/CMPs and providers are available to the public. They include, but are not limited to, the following:

- Information as to whether an HMO/CMP or provider participates in the Medicare program;
- Amount of Medicare payment;
- Overpayment data;
- Name of the HMO/CMP which is authorized to disclose information;
- Benefits and premiums; and
- Information collected by a Peer Review Organization.

Information on individual physicians or beneficiaries is not released. Information on individual hospitals or HMOs/CMPs may be released only after a 30 day notice is provided to a hospital or HMO/CMP.

Information that an organization has applied for a Medicare contract and data to support an individual HMO/CMP's adjusted community rate is considered confidential and may not be released.

1074.3 HMO/CMP Qualification and Compliance Reports.--HHS makes available, upon request, certain information about federally qualified HMOs and eligible CMPs, as well as information on organizations that we determine are out of
compliance, but only after the compliance review is complete. Privileged information, such as financial or marketing information on an individual organization, is protected to the extent authorized by law.

1076. COST TO AN HMO/CMP WHICH REQUESTS INFORMATION AVAILABLE TO THE PUBLIC

You are required to pay appropriate fees for information pertaining to other providers, Medicare contractors, or State agencies. HMOs/CMPs with a cost contract report such fees as allowable costs only if it is clear that the information is necessary in developing and maintaining patient care services.
### PART 1

### CHAPTER 2

**PROGRAM ADMINISTRATION**

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1100. ROLE OF HCFA

In order to contract with Medicare, you must be approved as an eligible organization--either a federally qualified HMO or an eligible CMP (see §§2200ff.) and meet Medicare contracting requirements described in Parts 1-3. The Health Care Financing Administration (HCFA) in the Department of Health and Human Services (DHHS) is responsible for awarding and administering Medicare contracts and determining as a prerequisite for a Medicare contract whether your organization meets requirements to become a federally qualified HMO or an eligible CMP. These responsibilities are divided between the Central Office (CO) and the Regional Offices (ROs).

1101. ROLE OF HCFA CENTRAL OFFICE

There are two offices that manage aspects of the Medicare prepaid health care program. The Office of Prepaid Health Care Operations and Oversight (OPHCOO) is your primary contact in HCFA. The Health Standards and Quality Bureau (HSQB) is involved in quality review of prepaid plans that contract with Medicare.

OPHCOO in HCFA CO is responsible for determining your status as an eligible organization, approving Medicare contracts, monitoring your continued compliance with all requirements and carrying out financial activities related to the contract. OPHCOO has three separate operating offices. You need to work with each operating office to enter into a Medicare contract.

OPHCOO's Office of Qualification is responsible for determining your status as an eligible organization, and reviewing and approving your Medicare contract application. It is also responsible for contract renewals, contract modifications, nonrenewals, and terminations. Other responsibilities include review of novation agreements, national marketing materials, and capacity waiver requests.

During the process to determine your status as a federally qualified HMO or an eligible CMP, the Office of Qualification assigns a qualification or eligibility officer to work with you. During the Medicare contracting process, a contract officer is assigned to review your application. If you are applying as an HMO/CMP and for a Medicare contract, eligibility review and review of your Medicare contract application are performed concurrently. Once your Medicare contract is signed, the contract officer is assigned for the duration of the contract.

Use the following address and phone number for information, as well as to request an application for a Medicare contract and/or to become a federally qualified HMO.

Health Care Financing Administration
Office of Prepaid Health Care Operations and Oversight (OPHCOO)
Room 4360, Wilbur J. Cohen Bldg.
330 Independence Ave., SW
Washington, DC  20201
(202) 619-0780

OPHCOO's Office of Compliance is responsible for monitoring to ensure that contracting and eligibility requirements continue to be met after you sign a Medicare contract and/or after you are approved as a federally qualified HMO. Monitoring involves both on-site visits and desk reviews of reports and data.
The Office of Compliance directs corrective action if a deficiency is found and recommends any sanctions, if applicable. It also monitors the Federal HMO loan program.

A compliance officer is assigned to each plan. This officer works closely with the RO HMO coordinator described in §1102. The address and phone number are:

Health Care Financing Administration  
Office of Compliance, OPHCOO  
Room 4360, Wilbur J. Cohen Bldg.  
330 Independence Ave., SW  
Washington, DC  20201  
(202) 619-2844

OPHCOO's Office of Financial Management is responsible for the systems and financial activities related to your Medicare contract, including processing your monthly payments, enrolling and disenrolling beneficiaries, and approving your proposed benefits and premiums.

After the Medicare contract is signed, a systems analyst is assigned to process enrollment and disenrollment of Medicare beneficiaries and to coordinate the applicable data exchange between your organization and HCFA. An accountant is also assigned to each organization. For risk contracts, the accountant reviews and approves the adjusted community rate (ACR) proposal, including benefit packages and premiums. For organizations reimbursed on a cost basis, the accountant reviews and approves budget and enrollment forecasts prior to each year's contract and reviews interim cost reports and final cost reports at the end of each contract period. The address is:

Health Care Financing Administration  
Office of Financial Management, OPHCOO  
1-G-2 Oak Meadows Bldg.  
6340 Security Blvd.  
Baltimore, MD 21207  
(301) 966-7626

HSQB is responsible for developing the scope of work for and approving and monitoring HCFA contracts with Peer Review Organizations (PROs) to conduct independent external review of the quality of care provided to Medicare enrollees by HMOs and CMPs. HSQB's mailing address is:

Health Care Financing Administration  
Director, Health Standards and Quality Bureau  
2-D-2 Meadows East Bldg.  
6325 Security Bvld.  
Baltimore, MD  21207  
(301) 966-6842

1102. ROLE OF HCFA REGIONAL OFFICES

The primary responsibilities of the ROs are to serve as your contact point for any questions about Medicare procedures after a Medicare contract is signed and to work with the Office of Compliance to assure that Medicare contracting and HMO/CMP eligibility requirements continue to be met.

In addition, the ROs are responsible for:
Review and approval of marketing material used subsequent to the CO contract review approval (unless arrangements are made by a national organization for CO review of these materials);

- Coordination of information exchange between your organization and Medicare carriers and intermediaries or SSA;
- Responding to inquiries from Medicare enrollees and the public regarding enrollment/disenrollment issues, Medicare requirements, and beneficiary problems;
- On-site monitoring reviews;
- Collection and reporting of information for the Beneficiary Inquiry Tracking System (see §1206);
- Resolving enrollment and disenrollment problems;
- Providing technical assistance to plans; and
- Monitoring of PRO contracts.

Section 1103 lists the address and phone number for each RO.

1103. ROLE OF OFFICE OF INSPECTOR GENERAL (OIG)

Under Public Law 94-505, the OIG was given a broad mandate to carry out a wide variety of activities to test the efficiency and economy of DHHS programs. This includes conducting investigations into suspected fraud or abuse, performing audits and inspections of DHHS programs as well as data collection and analysis, special studies and other functions designed to meet its overall mission. As an independent office, the OIG has access to HCFA’s files, records, and data, as well as those of its contractors. Through evaluations of HCFA's self-assessment techniques and/or by conducting independent reviews of HCFA's activities, OIG exercises an oversight role to assure HCFA is prudently and efficiently managing the Medicare program. OIG is responsible for case development and for initiating punitive action against individual health care providers through criminal or civil case referrals to the Department of Justice, civil money penalty (CMP) action, or by initiating administrative sanctions. In carrying out these responsibilities, the OIG may request information or assistance from HCFA's contractors.

The OIG is empowered to:

- Direct and coordinate the development and investigation of potential Medicare fraud and certain abuse allegations;
- Conduct investigations of suspected criminal fraud, retain independent authority for civil fraud and civil money penalties, and participate in negotiating settlements to avoid court proceedings;
- In certain instances, establish overpayments and recommend collection of same to HCFA;
- Conduct special analyses and reviews to identify and document policy and procedural weaknesses;
Collect and analyze contractor produced information on resources and results, and conduct reviews and special projects (inspections) to determine level of effort and performance in health provider fraud and abuse controls; and

Implement administrative sanctions which include exclusion of convicted providers from program participation and of providers found to have engaged in fraudulent and/or abusive practices as they relate to Medicare patients and/or the Medicare program.

The following list contains the OIG RO Coordinators addresses and phone numbers.

HCFA HMO AND INSPECTOR GENERAL REGIONAL COORDINATORS

REGION I
CT, ME, MA, NH, RI, VT

HMO Coordinator
Health Care Financing Admin.
John F. Kennedy Federal Bldg.
Room 1301
Boston, MA 02203

TELEPHONE: (617) 565-1264

Regional Coordinator
Office of Inspector General
Department of Health and Human Services
Room 1405
John F. Kennedy Federal Bldg.
Boston, MA 02203

TELEPHONE: (617) 565-1050

REGION II
NY, NJ, PR, VI

HMO Coordinator
Health Care Financing Admin.
26 Federal Plaza
Room 3800B, Federal Bldg.
New York, NY 10278

TELEPHONE: (215) 264-3124

Regional Coordinator
Office of Inspector General
Department of Health and Human Services
Room 43900B, Federal Bldg.
26 Federal Plaza
New York, NY 10278

TELEPHONE: (212) 264-4620

REGION III
DE, DC, MD, PA, VA, WV

HMO Coordinator
Health Care Financing Admin.
Room 3100, Mail Stop 13
3535 Market Street, Suite 702
Philadelphia, PA 19101

TELEPHONE: (215) 596-6831

Regional Coordinator
Office of Inspector General
Department of Health and Human Services
Room 4430
3535 Market Street, 101 Marietta Tower
Philadelphia, PA 19101

TELEPHONE: (215) 596-6796

REGION IV
AL, NC, SC, FL, GA, KY, MI, TN

HMO Coordinator
Health Care Financing Admin.
101 Marietta Tower
Atlanta, GA 30323

TELEPHONE: (404) 331-2054

Regional Coordinator
Office of Inspector General
Department of Health and Human Services
Suite 1404
Atlanta, GA 30323

TELEPHONE: (404) 331-2131
REGION V
IL, IN, MI, MN, OH, WI

HMO Coordinator
Health Care Financing Admin.
105 West Adams Street
15th Floor
Chicago, IL  60603

TELEPHONE: (312) 353-5737

REGION VI
AR, LA, NM, OK, TX

HMO Coordinator
Health Care Financing Admin.
1200 Main Tower
Room 2000
Dallas, TX  75202

TELEPHONE: (214) 767-6401

REGION VII
IA, KS, MO, NE

HMO Coordinator
Health Care Financing Admin.
601 East 12th Street
Room 220
Kansas City, MO  64106

TELEPHONE: (816) 426-3682

REGION VIII
CO, MO, ND, SD, UT, WY

HMO Coordinator
Health Care Financing Admin.
1961 Stout Street
Room 1185
Denver, CO  80294-3538

TELEPHONE: (303) 844-4024

REGION IX
AS, AZ, CA, GU, HA, NV

HMO Coordinator
Health Care Financing Admin.
75 Hawthorne Street
4th Floor
San Francisco, CA  94105

TELEPHONE: (415) 744-3617

REGION X
AK, ID, OR, WA

HMO Coordinator
Health Care Financing Admin.
2201 Sixth Avenue
Mail Stop RX44
Seattle, WA  98121

TELEPHONE: (206) 553-8189
PART 1
CHAPTER 3
CONTRACT ELIGIBILITY

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1200. GENERAL REQUIREMENTS

In order to enter into a Medicare contract, you must demonstrate that you are able to enroll members and to deliver a comprehensive range of high quality services efficiently, effectively, and economically. Your organization must meet two general requirements:

Be approved by HCFA as an eligible organization - either a federally qualified health maintenance organization (HMO) or a competitive medical plan (CMP) as defined in §1201, and

- Meet Medicare's contracting requirements described in §1202.

1201. ELIGIBLE ORGANIZATIONS

An eligible organization is an entity organized under State law that is either:

- A federally qualified HMO as defined in §1301 of the Public Health Service Act or
- A CMP as defined in §1876 of the Act.

HMOs and CMPs are compensated for health care services on a prepaid, capitated basis. There are specific requirements relating to organization and contractual arrangements, minimum benefits and health services delivery, financial arrangements, and marketing and enrollment that must be met.

An HMO is deemed to be an eligible organization if it has received Federal qualification under the Public Health Service Act and such status has not been revoked.

1201.1 Criteria for CMP Eligibility.--

A. Requirements.--You must

- Provide your enrolled commercial members at least the following services:
  - Physician services performed by physicians who are doctors of medicine or osteopathy;
  - Laboratory and X-ray services;
  - Emergency services;
  - Inpatient hospital services;
  - Coverage of services while enrollees are out of the area served by the entity; and
  - Preventive services.

- Provide physician services primarily through physicians who are employees or partners of the entity or physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity. HCFA defines the word primarily as at least 51 percent of physician
services, as measured either by total physician costs or by physician encounters. HCFA considers alternative methods of demonstrating that 51 percent of physician services are provided through the organization.

- Assume full financial risk on a prospective basis for the health services described, although certain reinsurance and risk-sharing arrangements with providers are permitted. Reinsurance is permitted for: costs exceeding $5,000 per member in a single year; costs of emergency or urgently needed care; or 90 percent of the amount by which costs exceed 115 percent of the organization's income in a single year.

- Demonstrate financial viability by establishing:
  - Total assets of the organization are greater than total unsubordinated liabilities;
  - The organization has sufficient cash flow and adequate liquidity to meet obligations as they become due; and
  - The organization has a net operating surplus.

- Maintain a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which payment is made (including inpatient care until the patient is discharged) and protection of members against bills which are the liability of the organization.

B. Exception.—If you had a Medicaid prepayment risk contract before 1970 that did not include provision of inpatient hospital services, you do not have to provide that service in order to qualify as an eligible CMP.

1201.2 Differing Scope of HMO and CMP Services.—There are differences between being qualified as an HMO and meeting the definition of a CMP. Federal qualification as an HMO may be received separately for purposes of commercial enrollment unrelated to Medicare, but CMP status is provided only in conjunction with a Medicare contract. Much of the review process is the same. However, there are differences:

- Federal qualification requires payment of an application fee of $18,400 ($3,100 if you have previously contracted with Medicare as a CMP).

- HMOs must provide a more comprehensive benefit package to their commercial enrollees, such as home health care, mental health services, and substance abuse services.

- Federally qualified HMOs can mandate an employer. This means that if an employer offers health insurance to employees and meets certain requirements, such as having 25 employees, the HMO may require the employer to include an HMO in the company's health benefits offering. CMPs cannot mandate employers.

- HMOs must arrange or provide at least 90 percent of physician services through the HMO. CMPs need provide only 51 percent of physician services through physicians under contract with the CMP.

- HMOs may not health screen (i.e., refuse enrollment based on health status) when they enroll employer group members or when they allow members leaving the group to convert to individual memberships. CMPs may health screen commercial enrollees if permitted under State law.
Once your organization is determined to be a qualified HMO or a CMP, there is no difference between the two types of organizations for purposes of the Medicare contract.

**1202. MEDICARE CONTRACTING REQUIREMENTS**

In addition to meeting the requirements to become a federally qualified HMO or a CMP, your organization must also meet all of the applicable requirements of the Medicare statute and regulations governing Medicare contracts. These requirements include the following:

- Do not enroll more than 50 percent of your members from a Medicare and Medicaid population. (See §§2001.ff.)

- Conduct at least one annual open enrollment period of at least 30 consecutive days. See §§2001ff.)

- Market your Medicare plan throughout the entire service area specified in your contract and use only marketing materials approved by HCFA. Certain marketing practices are prohibited. (See §§2200ff.)

  Have the capability, e.g., sufficient administrative support, reporting and recordkeeping capacity, to meet Medicare requirements effectively and efficiently. (See §§3000ff.)

- Provide (or arrange for) at least the Medicare covered benefit package to Medicare enrollees. These services must be available, accessible, and provide for continuity of care. You must also assure availability of 24-hour emergency services and have provisions to pay for out-of-area unforeseen urgently needed services and emergency services not obtained through your organization. (See §§2101ff.)

- Use only licensed physicians or providers that are certified by Medicare and suppliers that are listed with the Medicare program. (See §§2101ff.)

- Have an acceptable quality assurance program. (See §§2500ff.)

- If you want a risk contract, assure HCFA that you can bear the potential financial loss.

- None of your agents, management staff or persons who contract with you or have a management interest in your organization can be (or have been) convicted of a criminal offense related to his or her involvement in the Medicare, Medicaid, or other Federal health or social service programs.

**1203. TYPES OF MEDICARE CONTRACTS**

There are two types of Medicare contracts with HMOs and CMPs.

A. Risk contract.--A contract for the full Medicare benefit package with payment made on a prospective per capita basis, with the organization required to absorb any losses and permitted to retain any savings, is known as a risk contract. Sometimes it is referred to as a TEFRA risk contract. TEFRA stands for the Tax Equity and Fiscal Responsibility Act of 1982 which made a full risk contracting option available under Medicare.
A risk contract has the following unique features:

- Payment is made on a prepaid capitation basis with no retroactive adjustment. There is a specific payment formula based on 95 percent of the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is an actuarial measure of the costs that would have been incurred by Medicare on behalf of enrollees of the HMO if they received their covered services in fee-for-service Medicare. (See Part 5.)

- Beneficiaries are locked-in to the HMO or CMP. All Medicare services, except for emergency services in or out of the organization's service area or unforeseen, urgently needed care outside the service area must be provided or arranged through the HMO or CMP. Unauthorized services need not be paid by the organization and are not paid by Medicare. (See §§2101ff.)

- If the estimated revenue requirements for providing Medicare covered services are less than the expected Medicare payment rate, the HMO/CMP must provide additional benefits (i.e. services not covered by Medicare), reduce beneficiary cost sharing, and/or refund the difference to the government. (See Part 5.)

- You must demonstrate an ability to bear the potential of financial losses under a risk contract. You also may not have terminated or failed to renew a risk contract within the preceding 5 years. HCFA may waive this requirement if there are special circumstances.

**B. Cost contract.** A contract for the full Medicare benefit package with payment made on a reasonable cost basis is known as a cost contract. Beneficiaries are not restricted to the HMO or CMP to receive covered Medicare services, i.e., services may be received through non-HMO/CMP sources and are reimbursed by Medicare intermediaries and carriers. Medicare payment to the HMO or CMP is based on the reasonable costs of providing services to Medicare beneficiaries.

1203.1 Other Arrangements. --There are several other arrangements an HMO or CMP may use to receive payment for services provided to Medicare beneficiaries:

- An HMO or CMP may provide services to Medicare beneficiaries who are not enrolled under a Medicare contract and bill Medicare intermediaries and carriers on a fee-for-service basis using an indirect billing method. (See Part 4.)

- An HMO, CMP or other entity which provides or arranges for services on a prepaid basis may enter into an agreement to provide some or all of Part B Medicare benefits only and receive payment on a reasonable cost basis. This is known as a health care prepayment plan (HCPP) agreement.

- Several prepaid plans have entered into contracts with HCFA to demonstrate a payment or organizational arrangement that differs from the models currently permitted by the Medicare statute. These are demonstration contracts. HCFA interest in demonstration projects is announced in the Federal Register or Commerce Business Daily.
HCFA encourages organizations to apply for a risk contract. A risk contract is similar to the type of contracts that you negotiate with employers. It covers a comprehensive benefit package for a price that is agreed upon in advance. It offers the Medicare beneficiary all of their covered benefits through one organization and permits them to know their out-of-pocket costs in advance. A risk contract is easier for your plan and the Medicare program to administer because actual costs do not have to be determined at the end of the contract period.

If you are a new organization with a small enrollment and/or cannot meet HCFA risk requirements, consider a cost contract with the goal of converting to a risk contract at a later date.

1204. APPLICATIONS

The purpose of an application is to allow HCFA to determine whether you meet all of the requirements for granting a Medicare contract. HCFA also want to determine whether you have a sufficient understanding of how serving a Medicare enrolled population may differ from your other groups.

The application includes information in five areas: general; organizational and contractual; health services delivery; financial; and marketing.

An authorized official must sign and date the contract application.

1204.1 Types of Applications.--If your organization is already approved as a federally qualified HMO, you need only complete an application to become a Medicare contractor.

If your organization is not a federally qualified HMO, you have a choice of:

- Applying to become a federally qualified HMO (or expanding your service area if you are already a federally qualified HMO) at the same time you apply for a Medicare contract (a single application is available to do this,) or

- Applying to become a CMP at the same time you apply for a Medicare contract. There is also a single application for this since CMP status is not awarded without concurrent award of a Medicare contract.

The fee for Federal qualification as an HMO or a regional component of an HMO is $18,400 per application. The fee for a service area expansion of a previously qualified HMO is $6,900. The fee for a competitive medical plan with a Medicare contract seeking HMO qualification is $3,100. There is no fee if you are a prepaid health care organization seeking certification as a CMP with a Medicare risk contract or if you are already a federally qualified HMO and now seek a Medicare risk contract.

To receive these applications or to learn more about the specific requirements and application process, contact:
1204.2 Application/Contract Process.--Once HCFA receives your completed application(s), HCFA visits your organization for approximately two days to verify the information in your application. This is done through interviews and review of documents.

HCFA also reviews your proposed Medicare rates, benefit packages and premiums (see Part 5) and your proposed marketing materials. (See §§2201ff.)

A final decision on your eligibility/contract application usually is made within 120 days of receipt of your completed application.

Based on the findings, HCFA either signs a contract with you or explains which requirements you do not meet. If the reason for the denial is that you do not meet HMO qualification or CMP eligibility requirements, HCFA provides a 60-day notice that HCFA intends to deny your application. If HCFA denies your application, you may request a reconsideration. (See §§3200ff.)

The contract is not effective until it is signed by HCFA. Sections 3000ff. describe the specific contract requirements.

1205. MONITORING OF ELIGIBILITY

Once you are approved as an eligible organization and as a Medicare contractor, HCFA monitors your organization to assure that you continue to meet the HMO or CMP requirements as well as the specific Medicare contracting requirements. HCFA usually visits your plan within the first 6 months of award and at least every other year thereafter. Desk reviews (where HCFA reviews your reports and other data that HCFA collects) are conducted during the intervening year. If HCFA determines that you no longer meet these requirements, HCFA begins an evaluation process which could result in termination or nonrenewal of your Medicare contract. (See §§3000ff.)

1206. BENEFICIARY INQUIRY TRACKING SYSTEM

The Beneficiary Inquiry Tracking System (BITS) is an automated system used primarily by HCFA's ROs for tracking and monitoring inquiries and complaints from Medicare beneficiaries and others involving Medicare approved HMOs and CMPs.

BITS includes inquiries or complaints in the following areas:

- Quality of care;
- Enrollment or disenrollment problems;
- Bill payment problems; or
- Other inquiries.
The purpose of the tracking system is to assure that individual beneficiary inquiries are followed up. In addition, HCFA plans to use the information captured by BITS to target potential problems in HMOs/CMPs and to focus HCFA monitoring efforts.
# CHAPTER 4

THE MEDICARE CATASTROPHIC COVERAGE REPEAL ACT

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1300. OVERVIEW

1300.1 Background.--On December 13, 1989, the President signed P.L. 101-234, the Medicare Catastrophic Coverage Repeal Act of 1989. In general, other than for Medicare beneficiaries who are enrolled in a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) with a risk contract, P.L. 101-234 repeals the Part A and Part B benefit expansions enacted by the Medicare Catastrophic Coverage Act (MCCA) of 1988. Medicare benefits are restored to those available prior to January 1, 1989. In addition, the Repeal Act cancels the financing for Medicare catastrophic benefits, including the catastrophic surtax and increase in the Part B flat monthly premium. Any funds already collected will be returned to beneficiaries.

1300.2 Exception for HMOs and CMPs with Risk Contract.--For contract year 1990, certain prepaid health plans must provide Part A and Part B catastrophic benefits as if the Catastrophic Repeal Act was not enacted. Prepaid health plans that are required to provide catastrophic benefits in 1990 are defined as risk contracts with:

- Eligible organizations under section 1876 of the Social Security Act (Act); or
- Health maintenance organizations under section 1876 (i)(2)(A) of the Act (as in effect before February 1, 1985), under section 402(a) of the Social Security Act Amendments of 1967, or under section 222(a) of the Social Security Act Amendments of 1972.

Contract year 1990 covers the period beginning January 1, 1990 and ending December 31, 1990 or any period within these dates if the contract does not coincide with the full twelve month period.

1300.3 HMOs, CMPs, and HCPPs with Cost Contract or Agreement.--Prepaid health plans with a cost contract under section 1876 of the Act and Health Care Prepayment Plans (HCPPs) with agreements under section 1833 are not required to provide catastrophic Part A and Part B benefits during 1990.

1301. PAYMENT FOR CATASTROPHIC BENEFITS IN 1990

1301.1 Payment to Risk Plans.--HCFA's monthly payments to prepaid plans with a risk contract during calendar year 1990 include an actuarial equivalent amount for provision of Part A and Part B catastrophic benefits. These amounts were announced on September 7, 1989. Monthly payment amounts for 1991 do not include any amounts for catastrophic benefits.
1301.2 Payment to Cost Plans.--Beginning January 1, 1990, Medicare pays cost plans only for Medicare benefits that were covered prior to January 1, 1989 (or are newly covered Medicare benefits not included in catastrophic, such as coverage of pap smears). HCFA does not approve any costs for either Part A or Part B catastrophic benefits that are included on a cost report for months after December 31, 1989.

1301.3 Beneficiary Costs.--Plan premiums or other charges to Medicare beneficiaries who are enrolled in a risk plan during calendar year 1990 may not include charges that are covered by the Medicare monthly payment for catastrophic benefits. This includes reduced deductible and coinsurance amounts for Part A and limits on Part B out-of-pocket expenses. However, premiums or other charges may reflect increased amounts for new benefits added by the MCCA, such as coinsurance for the new mammogram benefit, respite care or outpatient drug benefit.

Plan premiums for beneficiaries enrolled in cost contracts during 1990 must be adjusted to reflect repeal of catastrophic benefits unless catastrophic benefits are offered at no charge or as part of a high option package.

1302. EXPANDED SCOPE OF BENEFITS UNDER PART A

Part A benefit expansions included in the MCCA (other than home health benefits described in section 1303) were effective January 1, 1989. All plans were required to provide broadened Part A benefits in 1989. Only risk plans are required to provide expanded Part A benefits in 1990.

1302.1 Benefits to be Provided by Risk Plans in 1990.--Risk plans must provide the same catastrophic benefits in 1990 that were provided in 1989. These include:

- Expanded Inpatient Hospital Services.--Medicare beneficiaries may receive an unlimited number of medically necessary hospital days and may not pay more than one annual deductible. The deductible in 1990 is $592 or the customary charges for the hospital stay if less than $592. If a beneficiary incurs a deductible during December of the previous year, the beneficiary is not required to pay a deductible for a hospitalization beginning in January.

- Expanded Skilled Nursing Facility (SNF) Services. Medicare beneficiaries may receive up to 150 days in a Medicare-certified nursing home without a prior hospital stay if
they need a skilled level of care. Beneficiaries must pay coinsurance for the first 8 days. In 1990, this amount is $26.50 per day (or its actuarial equivalent)

- **Blood Deductible.** Medicare does not cover the first three pints of unreplaced blood provided as a Part A or Part B service in a calendar year. The Part A blood deductible may be reduced by any blood deductible under Part B.

- **Hospice.** When a Medicare beneficiary who is enrolled in a risk HMO or CMP elects hospice care, he or she may elect to suspend their enrollment in the plan and receive hospice care in the regular Medicare system. Beneficiaries receive the pre-catastrophic benefit described in section 1302.2.

1302.2 **Benefits to be Provided by Cost Plans In 1990 (Including Transition Rules).**--With the exception of the blood deductible, Medicare benefits return to the definitions that were covered prior to January 1, 1989. In addition, the Repeal Act provided for transition benefits that must be provided to Medicare beneficiaries who meet the definitions.

- **Inpatient Hospital Services.** Medicare covers 90 days of inpatient care in each benefit period, plus reserve days up to a lifetime total of 60 days for each beneficiary. A benefit period begins on the first day of a hospital stay and ends when the beneficiary is out of a hospital or SNF for 60 consecutive days. The beneficiary is responsible for the following cost-sharing:
  - a hospital deductible for each benefit period;
  - coinsurance for days 60 through 90 and for lifetime reserve days;
  - and the full charge for days after inpatient Part A benefits are exhausted.

**NOTE:** Beneficiaries must be given the option of not using lifetime reserve days. In 1990, the hospital deductible is $592. Coinsurance is $148 a day for days 60 - 90 and $296 a day for each lifetime reserve day.

**Transition:** The following rules apply during the transition from catastrophic to no catastrophic coverage:

- **No day of inpatient hospital care or SNF care received before January 1, 1990 is counted in determining a spell of illness.** Effectively, all beneficiaries who are inpatients in a hospital or SNF on January 1, 1990 begin a new spell of illness on January 1, 1990.
Day of inpatient hospital care which was counted as a lifetime reserve day and received before January 1, 1989 is counted towards the lifetime reserve limit. (That is, any days used prior to January 1, 1989 carry over.)

A beneficiary does not have to pay a deductible in 1990 if:

- the beneficiary received hospital services during a continuous period which began before January 1, 1990 and continues into 1990 or beyond and he or she was liable for an inpatient deductible at any time during 1989;

- a beneficiary was admitted to a hospital during January 1990 and was liable for an inpatient deductible in December 1989; or


Skilled Nursing Facility Services. Medicare covers 100 days of SNF services in a benefit period if the beneficiary has a prior hospital stay of at least 3 days. In addition, the beneficiary must be admitted to the SNF within 30 days after hospital discharge and require care for the same condition.

Coinsurance is required for days 21 through 100. In 1990, the coinsurance is $74 a day.

Transition: A beneficiary whose stay in a SNF (or at the SNF level of care in a swing-bed hospital) continues from 1989 to 1990 is initially exempt from the post-hospital requirement that is reinstated in 1990 if all other requirements for Medicare payment for extended care services are met for a continuous period that includes at least 12/31/89 and 1/1/90. If Medicare payment cannot be made for extended care services furnished on both 12/31/89 and 1/1/90, this transition exemption does not apply. This exemption from the post-hospital requirement ceases at the end of a period of 30 consecutive days for which no Medicare payment is made for either inpatient hospital or extended care services.

NOTE: In fee-for-service, Medicare has determined that a new spell of illness begins on January 1, 1990 and thus a beneficiary who is already in a nursing home and has paid coinsurance under the 1989 rules may also be charged coinsurance under the 1990 rules.

Blood Deductible. The blood deductible remains at 3 units per year of unreplaced blood and may be met by any blood credited toward the Part A drug deductible.
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- **Hospice.** The hospice benefit returns to a lifetime limit of 210 days per beneficiary.

**NOTE:** A hospice may not discontinue care after the 210 day limit is reached because of the individual's inability to pay.

**Transition.** If the beneficiary makes a final hospice election prior to January 1, 1990, then there is no limit on the benefit.

### 1303. HOME HEALTH SERVICES

Home health services may be provided as either a Part A or Part B benefit. The original Medicare catastrophic law provided that Medicare expand its coverage of home health services beginning January 1, 1990. **Only risk plans** are required to offer the expanded home health benefit and **only during 1990.** Cost plans continue to provide the same home health benefit that was offered in 1989.

**1303.1 Pre-Catastrophic Definitions.**—To qualify for Medicare home health services in 1989 (and in 1990 for a cost plan), a Medicare beneficiary must meet the following three eligibility conditions:

- Be confined to the home (but need not be bedridden),
- Be under the care of a physician, and
- Require skilled nursing care on an intermittent basis, or physical therapy, or speech therapy. If a beneficiary otherwise qualifies for home health services, eligibility may continue solely based on the continuing need for occupational therapy services.

Once a beneficiary is eligible, Medicare covers either "part-time or intermittent" medically necessary home health services.

"Part-time" means any number of days per week:

- Up to and including 28 hours per week of skilled nursing and home health aide services combined, provided less than 8 hours per day; or
- Up to 35 hours per week of skilled nursing and home health aide services combined, provided less than 8 hours per day if need and reasonableness of the additional 7 hours of care can be documented.
"Intermittent" means:

- Up to and including 28 hours per week of skilled nursing and home health aide services combined, provided less than daily; or

- Up to 35 hours per week of skilled nursing and home health aide services combined, provided on less than a daily basis if need or reasonableness of the additional 7 hours of care can be documented; or

- Up to and including full-time (i.e., 8 hours per day) skilled nursing and home health aide services combined, which are provided and needed 7 days per week for temporary, but not indefinite, periods of time of up to 21 days. Extensions are allowed on a case by case basis in exceptional circumstances where the need for care in excess of 21 days is finite and predictable.

1303.2 Expanded Definitions for Risk Plans in 1990.--The Catastrophic law expanded the home health benefit by broadening the definitions of "intermittent".

Effective January 1, 1990 through December 31, 1990, "intermittent" home health services are:

- Up to 48 hours per week (six full time days) of skilled nursing and home health aide services combined; or

- Up to and including seven full-time days per week (i.e., 8 hours per day) of skilled nursing and home health aide services combined which are provided and needed for temporary, but not indefinite, periods of time of up to 38 consecutive days. Allowances may be made for care in excess of 38 days if there is an exceptional circumstance and the need for care is finite and predictable.

In order to be eligible for home health services, beneficiaries must still meet the three basic eligibility criteria that they be homebound, under a physician's care, and in need of intermittent skilled nursing care, physical therapy, or speech therapy.

1304. EXPANDED SCOPE OF BENEFITS UNDER PART B -- SUMMARY

Beginning January 1, 1990, catastrophic protection was scheduled to extend to beneficiary Part B out-of-pocket costs and new benefits were scheduled to be added to Part B. Under the Repeal Act, only risk plans are required to provide these Part B catastrophic benefits and only in 1990. These benefits include: a reduction in Part B out-of-pocket expenses as described in section 1305; coverage of outpatient prescription drugs described
in section 1306; coverage of home intravenous (IV) therapy services described in section 1307; coverage of in-home respite care as described in section 1308; and coverage of screening mammograms as described in section 1309.

1305. LIMIT ON BENEFICIARY PART B COST-SHARING

The original catastrophic law provided that in 1990, a fee-for-service Medicare beneficiary's out-of-pocket liability for Part B services is limited to $1,370. This same limit applied to Medicare enrollees of HMOs/CMPs and HCPPs that did not qualify as "buy-out plans" based upon their premium structure. The limit counts Part B deductible and coinsurance amounts for Part B services, or in the case of non-buy-out plans, any enrollee expenses representing these deductible and coinsurance amounts. It does not apply to the Part B premium or to expenses for Part B services that are not approved by Medicare, such as non-covered services or balance bill amounts. The benefits of the limit were extended to enrollees of buy-out plans by virtue of the lower limit on enrollee charges that resulted from the lower actuarial value of Part B deductibles and coinsurance.

The Repeal Act eliminated this limit on cost-sharing for all beneficiaries except for enrollees in risk plans who are to receive the benefits they would have received if the catastrophic law had not been repealed. In addition, the Repeal Act eliminated the special "buy-out" structure which made distinctions between prepaid plans.

There are no special instructions for implementing the Part B limit in 1990. However, risk plans must identify beneficiaries who are eligible for respite care benefits on the basis of having met or been deemed to meet the Part B Cap. Therefore, consider the requirements in section 1308 before making a decision not to track any Part B out-of-pocket expenses.

1306. COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS

In 1990, Medicare covers two additional outpatient prescription drugs for Medicare enrollees in risk plans:

- Expanded coverage of immunosuppressive drugs; and
- Home intravenous (IV) therapy drugs.

1306.1 Beneficiary Cost Sharing and Tracking of Expenses.--The original MCCA specified cost sharing amounts for covered drugs in 1990. The drug deductible was set at $550. That is, a beneficiary pays $550 in out-of-pocket expenses for drugs used...
in immunosuppressive therapy and home IV therapy before Medicare would cover these drugs for the balance of the year. Coinsurance was set at 20 percent for home IV drugs and previously covered immunosuppressive drugs (50 percent for immunosuppressive drugs that were not previously covered by Medicare).

In 1990 HCFA is not imposing specific requirements on risk plans related to special beneficiary cost-sharing amounts for drugs. As with any other Medicare benefit, plans can set premium, deductible, coinsurance or copayment amounts at any level they choose, provided the total charges do not exceed the actuarial amount that would have been charged in the fee-for-service system if the catastrophic law had not been repealed, as determined in the Adjusted Community Rating (ACR) process. However, consider other drug benefits that you offer and your general premium structure to determine how to implement the two new Medicare drugs.

Any drug deductible you set for the two categories of drugs covered under catastrophic may not apply to the drugs that were previously covered by Medicare prior to catastrophic and were not previously subject to a deductible:

- Drugs used in immunosuppressive therapy furnished to an individual who receives an organ transplant for 365 days after the date of discharge from a hospital for an organ transplant paid for by Medicare. (Medicare covered transplants include heart, kidney and bone marrow transplants, and liver transplants for certain children under 18.); or

- Home IV drugs dispensed in conjunction with home IV drug therapy services which are part of a continuous course of therapy initiated while the individual was an inpatient in a hospital.

In addition, HCFA is not imposing a requirement that risk plans track individual beneficiary utilization of the new outpatient prescription drugs since the Repeal Act eliminated the drug-related "buy-out" structure for prepaid plans. This structure would have utilized the plan's drug deductible as the basis for requiring a plan to track drug expenses that could be credited towards the Medicare catastrophic drug deductible if a beneficiary left the HMO. Since the drug deductible is not applicable in the fee-for-service system, it is not necessary for us to establish a system to transfer credits. Thus, as with other service utilization, HCFA leaves this process to the plan's discretion.

Since risk plans must identify beneficiaries who are eligible for respite care benefits on the basis of having met the drug deductible, consider the requirements in section 1308 when considering a process to track drug expenses.
1306.3 Definition of Immunosuppressive Drugs.--Immunosuppressive drugs and drugs used in immunosuppressive therapy prevent the body from rejecting a transplanted organ.

Medicare covered immunosuppressive drugs must be:

- Dispensed only upon a prescription; and
- Approved for safety and effectiveness by the Food and Drug Administration.

Catastrophic expanded coverage to include drugs used in immunosuppressive therapy that are furnished in:

- The second and subsequent years following an organ transplant paid by Medicare; and
- Any year following an organ transplant that was not paid by Medicare (e.g. a heart transplant that was performed by a hospital not approved by Medicare as a heart transplant facility).

In 1990, risk plans must provide both the pre-catastrophic and the expanded coverage of outpatient drugs used in immunosuppressive therapy to Medicare enrollees.

1306.3 Definition of Home IV Drugs.--Home IV drugs are medically necessary outpatient drugs that are furnished by a qualified home IV drug therapy provider to individuals and that are intravenously administered to an individual in their home. IV drugs may be required because a medication is not available in oral form, is not therapeutically recommended for the patient in oral form, or the drug is more effective if administered intravenously. IV drugs may be provided in the home after a person has been discharged from the hospital or has an alternative to treatment in a hospital.

A Medicare covered home IV drug must be:

- Dispensed with a prescription from a physician who has determined that an IV drug administered in the home is the most appropriate method of treatment;
- Approved as a prescription drug or biological product by the Food and Drug Administration;
- Intravenously administered in a place of residence used as the individual's home;
- Provided as part of a home IV drug therapy service described in section 1307; and
Approved for use in the home in the case of non-antibiotic drugs and not on the list of antibiotic drugs determined not to be safe and effective in the home setting. In addition, HCFA has determined that antineoplastic drugs used for chemotherapy are considered safe and effective for home use. Therefore, home IV drugs are covered in 1990 where it is accepted medical practice to administer the drugs in the home and you currently provide these drugs to your enrollees in their homes.

Appendix I lists the antibiotic and non-antibiotic drugs and/or indications that the Secretary has determined can generally be administered safely and effectively in a home setting. If the other conditions are met, plans must cover these drugs. Note that the list of antibiotic drugs that are covered is not exhaustive. The only legal requirement is that you may not cover the antibiotic drugs listed in Appendix II.

Appendix II lists the antibiotic drugs and/or indications that the Secretary has determined may not be administered safely and effectively in a home setting. Medicare does not cover these drugs as home IV drugs.

1306.4 Prohibition on Use of Formularies.-- HMOs and CMPs are required to provide all Medicare covered immunosuppressive and IV drugs subject to a determination that the drug is medically necessary for a particular patient. Thus, a formulary that prospectively bars a physician from making a judgement about the medical needs of a particular patient could not be adopted.

1307. HOME IV DRUG THERAPY SERVICES

During 1990, risk HMOs and CMPs are required to provide home IV therapy services to Medicare beneficiaries who are approved for home IV drugs.

1307.1 Definition.--Home IV drug therapy services are items and services necessary to provide an intravenously administered drug regimen safely and effectively in the home. They may include:

- Nursing;
- Pharmacy;
- Medical supplies;
- Intravenous fluids other than those included in the definition of a covered drug, e.g. diluent for the home IV drug (however, fluids for hydration are considered a covered home IV drug rather than a therapy service);
o Equipment, such as IV poles and infusion pumps;

o Training of the patient or his or her caregiver in the technique of IV drug therapy. If administration of the IV drug begins in the hospital, then the hospital conducts preliminary training;

o Delivery of medical items and supplies; and

o Other related services.

Home IV drug therapy services do not include home IV drugs described in section 1306 which are a separate covered benefit. They do not include services to administer drugs by means other than through the veins, e.g., arterial, subcutaneous, intramuscular, or intrathecal modes of administration.

Home IV drug therapy services are also distinct from the Medicare home health benefit which may be similar in many areas.

1307.2 Provision of Services.--The catastrophic law sets forth requirements applicable to home IV providers. Home IV therapy services are only covered if they are provided by a home IV therapy provider that the Secretary determines meets these requirements. The purpose of these requirements is to assure that IV drugs and drug therapy administered in the home setting are provided by properly trained personnel and to assure that there is appropriate monitoring of the use and administration of the drugs including the quality of the preparation of the drugs, delivery to the beneficiary's home, proper maintenance and storage.

HCFA consider a home IV therapy provider to meet statutory requirements based upon your assurances that the provider satisfies the following conditions:

o All services necessary to administer a drug safely and effectively in the home must be available through a single entity. If multiple suppliers are used, either the provider or the plan must assume responsibility for coordination.

o A clinical record must be maintained for all patients. This may be part of the plan record or a separate record.

o There must be written protocols and policies directing the provision of home IV therapy services.
For example, you may wish to consider policies for patient assessment; establishment of medical criteria that allow IV drugs to be safely administered at home; guidelines on administration of the first dosage; criteria for pharmacist service management; standards for storage of drugs and drug labeling criteria; written instructions for patients; and standards for catheter care and air filter care.

- Services must be available (as needed) 24 hours a day, seven days a week.
- Services must be coordinated with the patient's physician, as evidenced by a physician developed plan of care and periodic physician reviews.
- A quality assessment and assurance program which includes a review of the drug regimen and coordination of patient care must be conducted.
- Only trained personnel may provide covered home IV drugs and related items and services. You may conduct the training directly or have another provider or entity do so on your behalf. Training programs must be specifically designed for administration of IV drugs in the home and must include principles and practices of infusion therapy and cardio-pulmonary (CPR).
- The provider, including any personnel, must be licensed under State law or approved by the State or locality responsible for licensure as meeting the licensure standards.

To assure the quality and appropriateness of a home IV drug regimen, you may limit the provision of home IV therapy drugs and services based on medical and non-medical criteria, such as:

- Presence of venous access devices;
- Patient or caretaker's ability to administer drugs and care after education; and
- Presence of a home environment that is conducive to provision of home IV drug services, such as a clean environment with adequate electricity, water, refrigeration and space.

1308. IN-HOME CARE FOR CHRONICALLY DEPENDENT INDIVIDUALS (RESPITE CARE)

During 1990, risk HMOs and CMPs are required to provide in-home care to eligible Medicare enrollees. This is a new benefit that has not previously been covered by Medicare. It is commonly know as "respite care". Respite care is intended to provide
occasional relief to a primary caregiver who is necessary to maintain and support a chronically dependent individual in their home. Without the constant help of a caregiver, usually a spouse or child, chronically dependent individuals require care in a higher cost nursing home or require the "intermittent" or "part-time" help of a home health aide.

For a Medicare beneficiary enrolled in a risk HMO, Part B covers up to 80 hours of in-home respite care in a twelve month period.

For purposes of eligibility, a risk plan must determine that the beneficiary meets the financial eligibility requirements described in section 1308.2 and a physician must determine that the beneficiary has been chronically dependent for the prior three months according to the definitions in section 1308.1. You may do this in either order. However, it is your responsibility to notify physicians in your plan about the new respite care benefits as well as these guidelines relating to the criteria for determining whether a beneficiary is chronically dependent. Send a copy of your physician notification letter to the HCFA RO.

1308.1 Definitions--80 hours: If respite care is provided for 3 hours or less in a day, it is counted as three hours toward the 80-hour limit.

In-home: Respite care must be provided in the individual's place of residence that is used as a home. Beneficiaries who reside in a hospital or nursing home (skilled or intermediate level of care) may not receive respite care services.

Twelve month period: Benefits must be provided during calendar year 1990. Benefits do not extend beyond the calendar year if eligibility is met too late in the year to receive the full 80 hours.

Chronically Dependent Individual: A Medicare beneficiary is chronically dependent if he or she:

- Is confined to the home, but need not be bedridden;
- Is dependent on a daily basis (that is, requires 24 hour supervision, seven days a week) on a primary caregiver who lives with the individual and assists the individual in performing at least two activities of daily living;
- Provides no monetary compensation to the caregiver for assistance;
- Without assistance, could not safely perform those activities of daily living; and
Is certified by a physician as having a chronic medical condition which results in the need for assistance during the three-month period immediately preceding the date the individual is deemed to be financially eligible to receive in-home respite care.

Activities of Daily Living: Activities of daily living are:

- Eating;
- Bathing;
- Dressing;
- Toileting; and
- Transferring in and out of bed or in and out of a chair.

Financial Eligibility.--The original MCCA required a Medicare beneficiary to meet a financial test in 1990 before he or she could be considered to be eligible for in-home respite care. The chronically dependent individual was required under this test to either:

- Incur out-of-pocket Part B cost sharing equal to the Part B catastrophic limit amount of $1,370 (the Part B cap); or
- Be entitled to have Medicare pay for home IV drugs and immunosuppressive drugs.

The law also required the Secretary to "establish such procedures as may be appropriate to identify individuals "who should be "deemed" to meet the above financial test because they likely would have met it if they had not been enrolled in a "buy-out plan" that was not required to track expenses. Because all risk plans are now treated like buy-out plans for purposes of tracking expenses, this section sets forth the methodology that is used to determine who can be "deemed" to satisfy the financial test for respite care eligibility.

Part B Limit: For purposes of the respite care benefit, beneficiaries are deemed to meet the limit on Part B out-of-pocket expenses of $1,370 if the plan:

- records indicate that Part B services worth $6,850 have been provided; or
- determines that the beneficiary has received services included in Tables 1, 2, or 3 in Appendix III.
Appendix III summarizes data collected by HCFA which reflects Part B service use sufficient to meet the Part B catastrophic limit amount of $1,370 in 1990. Thus, we are permitting risk prepaid plans to use the 20 Diagnostic Related Group (DRG) codes, 20 ICD-9-CM surgical codes, and 20 ICD-9-CM diagnostic codes included in Appendix III as a proxy for meeting the Part B cap. Any beneficiary who receives any one service in these codes is automatically considered to have met the financial test for respite care.

Each plan is expected to provide to HCFA upon request a monthly listing of all enrollees who qualify for respite care on the basis of Part B service use or these proxies.

See additional beneficiary notice requirement in section 1308.5.

**Drug Deductible:** For purposes of the respite care benefit, beneficiaries qualify for respite care if they receive immunosuppressive drugs during the first year following a Medicare covered organ transplant or are deemed to meet the Medicare drug deductible of $550 in 1990. Beneficiaries may be deemed to meet the drug deductible if the plan determines that the beneficiary receives:

- At least one home IV drug or immunosuppressive drug (following an organ transplant not covered by Medicare or during a second or subsequent year following a Medicare covered transplant) in 1990 after having met the plan drug deductible; or
- Medicare drugs as measured by the following proxies derived from information available from the HCFA Actuary:
  - one month of immunosuppressive drug therapy (following organ transplants not covered by Medicare or during the second and subsequent year following a Medicare covered transplant);
  - 8 home IV therapy visits involving antibiotic drugs; or
  - 14 home IV therapy visits involving pain therapy.

Since these proxies are based on imprecise data, there may be some beneficiaries who meet the drug deductible without meeting the amounts specified in the proxies. The regular appeals process is used to permit beneficiaries to present information demonstrating that they are eligible for respite care services.

Each plan is expected to provide to HCFA, upon request, a monthly listing of all enrollees who qualify for respite care on the basis
of drug utilization.

See additional beneficiary notice requirement in section 1308.5.

1308.3 Provision of Services.--Respite care services must be reasonable and necessary to assure that the health and condition of the individual is maintained in the home and prevents institutionalization.

Respite care includes the following items and services which are furnished to a chronically dependent individual:

- Services of a homemaker/home health aide who has successfully completed an orientation program conducted by the plan or an agency or entity on the plan's behalf;
- Personal care services; and
- Nursing care provided by a licensed professional nurse (or a licensed practical nurse).

These services may be provided directly by the HMO or CMP or through arrangements. At a minimum, these services must be:

- Provided or arranged by the HMO's or another Medicare certified home health agency;

NOTE: The home health agency does not need to be separately certified as an in-home respite care provider.

- Based on a plan of care established and reviewed by a physician;
- Under the supervision of a licensed registered professional nurse; and
- Provided in the Medicare beneficiary's home which is the primary residence and is not an institution such as a nursing facility. (See exception in section 1308.6.)

1308.4 Beneficiary Cost-Sharing.--The initial MCCA specifies coinsurance of 20 percent for respite care benefits. HMOs and CMPs may impose cost-sharing requirements for this benefit that are reasonable and do not result in total charges to beneficiaries that exceed the actuarial amount that would have been paid in fee-for-service Medicare if the catastrophic law had not been repealed, as determined by the ACR process.
1308.5 Mid-Year Enrollments and Beneficiary Notice Requirement.--The respite care benefit is limited to 80 hours for each beneficiary during 1990. Thus, if a beneficiary enrolls in a risk plan mid-year and has previously been enrolled in another risk plan in 1990, any respite care hours are transferred to the new HMO.

Because this is a one year benefit, HCFA is not responsible for reporting any mid-year balances to the new HMO. Plans must provide each beneficiary at the time of their disenrollment a written notice that specifies if the beneficiary was eligible for respite care services and how many hours of respite care were provided. Risk plans which enroll a Medicare beneficiary mid-year are responsible for requesting a copy of this beneficiary notice directly from the new enrollee.

1309. COVERAGE OF SCREENING MAMMOGRAPHY

Effective January 1, 1990 through December 31, 1990, risk HMOs and CMPs are required to provide screening mammograms for the purpose of early detection of breast cancer as a covered Medicare benefit. Cost plans may choose to provide screening mammograms as an optional supplemental benefit. Both cost and risk plans are required to continue to provide diagnostic mammography for Medicare women who exhibit symptoms of breast cancer, such as a lump, if ordered by a physician to diagnose breast cancer since this benefit was covered prior to enactment of the MCCA.

The following rules apply to screening mammograms provided by risk HMOs in 1990.

1309.1 Definition.-- Screening mammography means:

- Radiological procedure performed by a provider that meets the quality standards described in section 1309.4 which is provided to a symptom-free woman for the purpose of early detection of breast cancer; and
- Physician's interpretation of the results of the procedure.

1309.2 Frequency.--A risk plan must cover one screening mammogram procedure in 1990 for each asymptomatic enrolled woman who is 35 years of age or older.

1309.3 Beneficiary Costs.--The MCCA permitted coinsurance of 20 percent and a maximum of $50 for each covered screen in 1990. Plans may include the actuarial equivalent of this amount as part of their overall premium and charging structure approved by HCFA as part of the ACR process.
1309.4 Quality.--Risk plans are responsible for assuring that quality standards are established and met for mammogram procedures. Mammograms can be performed in an inpatient or outpatient setting. However, the quality standards must be the same regardless of the setting or whether the services are performed directly by the plan or arranged through other providers.

These standards, at a minimum, include:

- Equipment used to perform the mammography must be specifically designed for mammography and may not be general purpose units with special attachments;
- Procedure must include a bilateral four-view procedure that includes a cranio-caudal and a medial lateral oblique view of each breast;
- Individual who performs the mammography must be licensed by the State or certified by an appropriate professional organization. If performed by a non-physician, the program must be supervised by a licensed physician who is qualified to interpret screening mammography procedures;
- Radiological personnel must receive training in procedures to protect from unnecessary radiation; and
- Results of the mammograms must be placed in the patient's permanent medical record.

1310. MAINTENANCE OF EFFORT

The MCCA included a maintenance of effort provision to provide equitable treatment for some beneficiaries who received duplicative benefits through their employers' health plans. The maintenance of effort provision required that if an employer provided to employees or retirees as of July 1, 1988 benefits that are available through the MCCA, the employer must provide additional benefits, a refund, or a combination, if the duplicative benefits had an actuarial value of at least 50 percent of the national average actuarial value of the benefits added or increased in 1989 and in 1990. Employers providing health benefits to Medicare eligible employees and retirees under collective bargaining agreements that were in effect on July 1, 1988, were required to comply with the maintenance of effort provisions for each year the agreements were in effect.

The Catastrophic Repeal Act repealed the maintenance of effort provision. Because this provision is entirely independent of the risk contracts under which catastrophic benefits are retained for
1990, it is HCFA's interpretation that employers will not be required to maintain efforts for retirees who are enrolled in such plans in 1990. Thus, employers are not to use the maintenance of effort requirements as a basis to negotiate payment to risk HMOs in 1990 for Medicare covered enrollees or retirees who enroll in the plan.
I. Amdinocillin
   Urinary tract infections, bacterial

Amikacin Sulfate
   Bone and joint infections
   Endocarditis, bacterial
   Genitourinary tract infections
   Skin and soft-tissue infections
   Urinary tract infections, bacterial

Ampicillin Sodium
   Arthritis, gonococcal
   Bone and joint infections
   Endocarditis, bacterial
   Enterocolitis, "Shigella"
   Genitourinary tract infections
   Gonorrhea
   "Hemophilus" infections
   Listeriosis
   Paratyphoid fever
   Skin and soft-tissue infections
   Urethritis, gonococcal

Ampicillin Sodium and Sulbactam Sodium
   Bone and joint infections
   Endocarditis, bacterial
   Genitourinary tract infections
   Skin and skin structure infections

Azlocillin Sodium
   Bone and joint infections
   Endocarditis, bacterial
   Skin and skin structure infections
   Urinary tract infections, bacterial

Aztreonam
   Bone and joint infections
   Endocarditis, bacterial
   Genitourinary tract infections
   Skin and skin structure infections
   Urinary tract infections, bacterial

Carbenicillin Disodium
   Genitourinary tract infections
   Skin and soft-tissue infections
   Urinary tract infections, bacterial
Cefamandole Nafate
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial

Cefazolin Sodium
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial

Cefonicid Sodium
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial

Cefoperazone Sodium
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial

Ceforanide
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial

Cefotaxime Sodium
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial

Cefotetan Disodium
  Bone and joint infections
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial

Cefoxitin Sodium
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial
Ceftazidime
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial
Ceftizoxime Sodium
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial
Ceftriaxone Sodium
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Lyme Disease, joint and CNS
  Skin and skin structure infections
  Urinary tract infections, bacterial
Cefuroxime Sodium
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Gonorrhea
  Skin and skin structure infections
  Urinary tract infections, bacterial
Cephalothin Sodium
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial
Cepapirin Sodium
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial
Cephradine
  Bone and joint infections
  Endocarditis, bacterial
  Genitourinary tract infections
  Skin and skin structure infections
  Urinary tract infections, bacterial
Clindamycin Phosphate
  Bone and joint infections
  Genitourinary tract infections
  Skin and soft-tissue infections
Appendix I (Cont.)

Gentamicin Sulfate
- Bone and joint infections
- Endocarditis, bacterial
- Genitourinary tract infections
- Listeriosis
- Skin and soft-tissue infections
- Urinary tract infections, bacterial

Imipenem and Cilastatin Sodium
- Bone and joint infections
- Genitourinary tract infections
- Skin and skin structure infections
- Urinary tract infections, bacterial

Methicillin Sodium
- Endocarditis, bacterial
- Skin and soft-tissue infections

Mezlocillin Sodium
- Bone and joint infections
- Endocarditis, bacterial
- Genitourinary tract infections
- Skin and skin structure infections
- Urinary tract infections, bacterial

Miconazole
- Candidiasis, disseminated
- Candidiasis, mucocutaneous chronic
- Petriellidiosis
- Urinary bladder infections, fungal

Nafcillin Sodium
- Bone and joint infections
- Endocarditis, bacterial

Netilmicin Sulfate
- Bone and joint infections
- Endocarditis, bacterial
- Genitourinary tract infections
- Skin and skin structure infections
- Urinary tract infections, bacterial

Oxacillin Sodium
- Endocarditis, bacterial
- Skin and soft-tissue infections

Penicillin G Potassium
- Arthritis, gonococcal
- Diphtheria, prophylaxis
- Endocarditis, bacterial
- Genitourinary tract infections
- Gingivostomatitis, necrotizing ulcerative
- Listeriosis
- Lyme Disease, joint and CNS
- Syphilis
Penicillin G Sodium
- Arthritis, gonococcal
- Diphteria, prophylaxis
- Endocarditis, bacterial
- Genitourinary tract infections
- Gingivostomatitis, necrotizing ulcerative
- Listeriosis
- Lyme Disease, joint and CNS
- Syphilis

Piperacillin Sodium
- Bone and joint infections
- Endocarditis, bacterial
- Genitourinary tract infections
- Skin and skin structure infections
- Urethritis, gonococcal
- Urinary tract infections, bacterial

Ticarcillin Disodium
- Bone and joint infections
- Endocarditis, bacterial
- Genitourinary tract infections
- Skin and soft-tissue infections
- Urinary tract infections, bacterial

Ticarcillin Disodium and Clavulanate Potassium
- Bone and joint infections
- Endocarditis, bacterial
- Genitourinary tract infections
- Skin and skin structure infections
- Urinary tract infections, bacterial

Tobramycin Sulfate
- Bone and joint infections
- Endocarditis, bacterial
- Genitourinary tract infections
- Listeriosis
- Skin and skin structure infections
- Urinary tract infections

Vancomycin Hydrochloride
- Bone and joint infections
- Endocarditis, bacterial

II. Non-Antibiotic Drugs

A. Anti-infectives (other than antibiotics)

Acyclovir Sodium
- Herpes zoster
- Herpes simplex

Pentamidine Isethionate
- Pneumonia, "Pneumocystis carinii"
- Leishmaniasis, visceral
- Trypanosomiasis, African
Sulfamethoxazole and Trimethoprim

Bone and joint infections
Chancroid
Chlamydial infections
Enterocolitis "Shigella"
Genitourinary tract infections
Gonorrhea
"Hemophilus" infections
Lymphogranuloma venereum
Paratyphoid fever
Pneumonia, "Pneumocystis carinii"
Rheumatic fever
Urinary tract infections, bacterial

B. Hydration Therapy

Intravenous Solutions

1. dextrose in water solutions
2. sodium chloride solutions
3. dextrose/sodium chloride solutions
4. premixed potassium chloride solution up to concentrations of 40mEq/L

The following limitations apply for all of the above solutions:

a. Concentration of dextrose in any solution is not to exceed 10%.
b. Concentration of sodium chloride in any solution is not to exceed 0.9%.

5. Premixed electrolyte solutions, containing any combination of the following electrolytes in their various salt forms, which are not intended for parenteral nutrition:

sodium
potassium
calcium
magnesium
chloride
phosphate

The caloric content of these solutions is limited to 340 calories.

Electrolytes

calcium chloride
calcium gluconate
calcium glucepte
magnesium chloride
magnesium sulfate
potassium acetate
potassium chloride
potassium phosphate
sodium acetate
sodium bicarbonate
sodium chloride
sodium phosphate

The indications for drugs in this category are less specific than for other drugs. After referring to various clinical texts, we have determined that water depletion, and combined water and electrolyte depletion, can be the result of many disease and non-disease states, including but not limited to the following:

Extrarenal Losses

1. Gastrointestinal (vomiting, diarrhea, ostomy drainage)
2. Skin losses (sweating, burns)
3. Lung losses (bronchorrhea)

Renal losses

1. Renal disease (chronic renal failure, diuretic phase of acute renal failure)
2. Diuretic excess
3. Osmotic diuresis (diabetic glycosuria)
4. Mineral corticoid deficiency (Addison's disease, hypoaldosteronism)

There may be other instances when a patient needs hydration therapy. Patients taking antineoplastic drugs must often be hydrated to increase urine output to insure the timely excretion of the drug because of its toxic side effects.

C. Pain Management Drugs

Indication: For treatment of chronic intractable pain.

Butorphanol Tartate
Hydromorphone Hydrochloride
Meperidine Hydrochloride
Morphine sulfate

D. Other

Aminophylline
   Asthma, bronchial
Bumetanide
   Edema
Appendix I (Cont.)

Cimetidine Hydrochloride
   Adenoma, multiple endocrine
   Bleeding, upper gastrointestinal
   Hypersecretory conditions, gastric
   Mastocytosis, systemic
   Pancreatic insufficiency
   Reflux, gastroesophageal
   Stress-related mucosal damage
   Ulcer, duodenal
   Ulcer, gastric
   Zollinger-Ellison syndrome

Deferoxamine Mesylate
   Toxicity, iron chronic
   Toxicity, aluminum

Dexamethasone Sodium Phosphate
   Adrenocortical insufficiency, chronic primary
      (Addison's)
   Adrenocostical insufficiency, secondary
   Adrenocortical syndrome (adrenal hyperplasia, congenital)
   Anemia, hemolytic, acquired (autoimmune)
   Anemia, hypoplastic, congenital (erythroid)
   Anemia, red blood cell (erythroblastopenia)
   Arthritis, psoriatic
   Bowel disease, inflammatory, including colitis, ulcerative
   Bronchitis, asthmatic, acute or chronic
   Calcium pyrophosphate deposition disease, acute
      (pseudogout, chondrocalcinosis articularis, synovitis, crystal-induced)
   Carcinoma, breast
   Carcinoma, prostatic
   Connective tissue disease, mixed
   Dermatitis, exfoliative
   Dermatitis herpetiformus bullus
   Dermatitis, seborrheic, severe
   Dermatomyositis systemic
   Dermatoses, inflammatory, severe Enteritis, regional
      (Crohn's disease)
   Erythema multiforme, severe (Stevens-Johnson syndrome)
   Fever, due to malignancy
   Gouty arthritis, acute
   Hemolysis
   Hypercalcemia associated with neoplasms (or sarcoidosis)
   Increased cranial pressure due to malignancy
   Leukemia, acute or chronic
   Lupus erythematosus, systemic
   Lymphomas, Hodgkins, or non-Hodgkins
   Multiple myeloma
   Mycosis fungoides
Appendix I (Cont.)

Nausea and vomiting, cancer-chemotherapy induced
Pemphigoid
Pemphigus
Polychondritis, relapsing
Polymyalgia, rheumatica
Polyps, nasal
Pulmonary disease, chronic obstructive (not controlled with theophylline and beta-adrenergic agonists)
Reiter's disease
Rheumatic fever
Rhinitis, allergic, perennial, or seasonal, severe
Thrombocytopenia, secondary, in adults
Thrombocytopenia purpura, idiopathic, in adults
Trichinosis

Diphenhydramine Hydrochloride
Nausea and vomiting

Famotidine
Adenoma, multiple endocrine
Bleeding, upper gastrointestinal
Hypersecretory conditions, gastric
Mastocytosis, systemic
Pancreatic insufficiency
Reflux, gastroesophageal
Stress-related mucosal damage
Ulcer, duodenal
Ulcer, gastric
Zollinger-Ellison syndrome

Furosemide
Edema

Heparin Calcium
Herparin Sodium
Thromboembolism

Hydrocortisone Sodium Phosphate
Hydrocortisone Sodium Succinate
Adrenocortical insufficiency, chronic primary (Addison's)
Adrenocortical insufficiency, secondary
Adrenogenital syndrome (adrenal hyperplasia, congenital)
Anemia, hemolytic, acquired (autoimmune)
Anemia, hypoplastic, congenital (erythroid)
Anemia, red blood cell (erythroblastopenia)
Arthritis, psoriatic
Arthritis, rheumatoid
Bowel disease, inflammatory, including colitis, ulcerative
Bronchitis, asthmatic, acute or chronic
Calcium pyrophosphate deposition disease, acute (pseudogout, chondrocalcinosis articulares, synovitis, crystal-induced)
Appendix I (Cont.)

Carcinoma, breast
Carcinoma, prostatic
Connective tissue disease, mixed
Dermatitis, exfoliative
Dermatitis herpetiformus, bullous
Dermatitis, seborrheic, severe
Dematomyositis, systemic
Dermatoses, inflammatory, severe
Enteritis, regional (Crohn's disease)
Erythema multiforme, severe
Fever, due to malignancy
Gouty arthritis, acute
Hemolysis
Hypercalcemia associated with neoplasms (or sarcoidsis)
Increased cranial pressure, due to malignancy
Leukemia, acute or chronic
Lupus erythematosus, systemic
Lymphomas, Hodgkin's or non-Hodgkin's
Multiple myeloma
Mycosis fungoides
Nausea and vomiting, cancer-chemotherapy induced
Pemphigoid
Pemphigus
Polychondritis, relapsing
Polymyalgia, rheumatica
Polyps, nasal
Pulmonary disease, chronic obstructive (not controlled with Theophylline and beta-adrenergic agonists)
Reiter's disease
Rhinitis, allergic, perennial or seasonal, severe
Thrombocytopenia, secondary, in adults
Thrombocytopenia purpura, idiopathic, in adults
Trichinosis
Iron Dextran
Iron deficiency anemia
Leucovorin Calcium
Methotrexate toxicity (antidote to folic acid antagonist)
Mannitol
Premedication, cancer chemotherapy
Methylprednisolone Sodium Succinate
Adrenocortical insufficiency, chronic primary (Addison's)
Adrenocortical insufficiency, secondary
Adrenogenital syndrome (adrenal hyperplasia, congenital)
Anemia, hemolytic, acquired (autoimmune)
Anemia, hypoplastic, congenital (erythroid)
Appendix I (Cont.)

Anemia, red blood cell (erythroblastopenia)
Arthritis, psoriatic
Arthritis, rheumatoid
Bowel disease, inflammatory, including colitis, ulcerative
Bronchitis, asthmatic, acute or chronic
Calcium pyrophosphate deposition disease, acute (pseudogout; chondrocalcinosis articularis; synovitis, crystal-induced)
Carcinoma, breast
Carcinoma, prostatic
Dermatitis, exfoliative
Dermatitis, herpetiformis, bullous
Dermatitis, seborrheic, severe
Dermatomyositis, systemic
Dermatoses, inflammatory, severe
Enteritis, regional (Crohn's disease)
Erythema multiforme, severe (Stevens-Johnson syndrome)
Fever, due to malignancy
Gouty arthritis, acute
Hemolysis
Hepatitis, chronic active
Hepatitis, nonalcoholic, in women
Hypercalcemia associated with neoplasms (or sarcoidosis)
Increased cranial pressure, due to malignancy
Leukemia, acute or chronic
Lupus erythmatosus, systemic
Lymphomas, Hodgkins or non-Hodgkins
Multiple myeloma
Mycosis fungoides
Necrosis, hepatic, subacute
Pemphigoid
Pemphigus
Polychondritis, relapsing
Polymyalgia, rheumatica
Polyps, nasal
Pulmonary disease, chronic obstructive (not controlled with Theophylline and beta-adrenergic agonists)
Reiter's disease
Rheumatic fever
Rhinitis, allergic, perennial or seasonal severe
Thrombocytopenia, secondary, in adults
Thrombocytopenic purpura, idiopathic, in adults
Trichinosis
Metoclopramide
Gastroparesis
Nausea and vomiting, cancer chemotherapy induced
Appendix I (Cont.)

Phenytoin Sodium  
Epilepsy  

Prochlorperazine Edisylate  
Nausea and vomiting

Ranitidine Hydrochloride  
Adenoma, multiple endocrine  
Bleeding, upper gastrointestinal  
Hypersecretory conditions, gastric  
Mastocytosis, systemic  
Pancreatic insufficiency  
Reflux, gastroesophageal  
Stress-related mucosal damage  
Ulcer, duodenal  
Ulcer, gastric  
Zollinger-Ellison syndrome

III. IV Biologicals and Indications

A. Anti-Infectives  
NONE

B. Fluid Replacement  
NONE

C. Anti-Cancer Chemotherapeutic  
NONE

D. Other  
Immune Globulin

Immunodeficiency Syndrome  
Thrombocytopenic purpose, idiopathic  
Alpha-proteinase Inhibitor, Human  
Emphysema, panacinar, due to alpha-antitrypsin deficiency
Appendix II

LIST OF NON-COVERED HOME IV ANTIBIOTIC DRUGS AND INDICATIONS

I. Antibiotic Drugs not Proposed for Coverage

- Chloramphenicol Sodium Succinate
- Colistimethate Sodium
- Doxycycline Hyclate
- Erythromycin Glucopate
- Erythromycin Lactobionate
- Kanamycin Sulfate
- Lincomycin Hydrochloride
- Minocycline Hydrochloride
- Moxalactum Disodium
- Oxytetracycline Hydrochloride
- Polymyxin B Sulfate
- Tetracycline Hydrochloride

II. Indications for Antibiotic Drugs not Proposed for Coverage

- Biliary Tract infections
- Central nervous system infections
- Intra-abdominal infections
- Respiratory tract infections
- Septicemia
### The 20 Leading Diagnosis-Related Groups (DRGs) for Persons Who Met the Part B Simulated Cost-Sharing Cap 1/

<table>
<thead>
<tr>
<th>Leading DRG's Code Number and Description</th>
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<tr>
<td>014</td>
</tr>
<tr>
<td>082</td>
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<tr>
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<td>296</td>
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<tr>
<td>336</td>
</tr>
<tr>
<td>468</td>
</tr>
</tbody>
</table>

1/ The Part B beneficiary simulated cost cap for 1987 was based on 7 percent of beneficiaries exceeding an estimated Part B deductible and coinsurance liability amount of $921. (Sum of $846 coinsurance and $75 deductible).
TABLE 2

The 20 Leading Surgical Procedures for Persons Who Met the Part B Simulated Cost-Sharing Cap 1/

<table>
<thead>
<tr>
<th>ICD-9-CM Surgical Code 2/</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03.09</td>
<td>Other exploration and compression of spinal canal</td>
</tr>
<tr>
<td>36.01</td>
<td>Single vessel percutaneous transluminal coronary angioplasty without mention of thrombolytic agent</td>
</tr>
<tr>
<td>36.13</td>
<td>Aortocoronary bypass of three coronary arteries</td>
</tr>
<tr>
<td>36.14</td>
<td>Aortocoronary bypass of four or more coronary arteries</td>
</tr>
<tr>
<td>37.74</td>
<td>Insertion of replacement of epicardial lead (electrode) into epicardium</td>
</tr>
<tr>
<td>38.12</td>
<td>Endarterectomy - other vessels of head and neck</td>
</tr>
<tr>
<td>38.44</td>
<td>Resection of vessel with replacement, aorta, abdominal</td>
</tr>
<tr>
<td>39.29</td>
<td>Other (peripheral) vascular shunt or bypass</td>
</tr>
<tr>
<td>45.73</td>
<td>Right hemicolecotomy</td>
</tr>
<tr>
<td>45.76</td>
<td>Sigmoidectomy</td>
</tr>
<tr>
<td>51.22</td>
<td>Total cholecystectomy</td>
</tr>
<tr>
<td>57.49</td>
<td>Other transurethral excision or destruction of lesion or tissue</td>
</tr>
<tr>
<td>60.2</td>
<td>Transurethral prostatectomy</td>
</tr>
<tr>
<td>79.35</td>
<td>Open reduction of fracture with internal fixation -femur</td>
</tr>
<tr>
<td>81.41</td>
<td>Total knee replacement</td>
</tr>
<tr>
<td>81.51</td>
<td>Total hip replacement with use of methyl methacrylate</td>
</tr>
<tr>
<td>81.59</td>
<td>Other total hip replacement</td>
</tr>
<tr>
<td>81.62</td>
<td>Other replacement of head of femur</td>
</tr>
<tr>
<td>85.43</td>
<td>Unilateral extended simple mastectomy</td>
</tr>
<tr>
<td>85.22</td>
<td>Excisional debridement of wound, infection, or burn</td>
</tr>
</tbody>
</table>

2/ The codes were derived from the International Classification of Diseases 9th Revision, Clinical Modification. Only those codes Designated as operating room procedures by HCFA were included in the leading procedures.
### TABLE 3

The 20 Leading Diagnostic Codes for Persons Who Met Part B Simulated Cost-Sharing Cap 1/

<table>
<thead>
<tr>
<th>Leading diagnoses (ICD-9-CM)</th>
<th>code number and description 3/</th>
</tr>
</thead>
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<tr>
<td>162.3 Malignant neoplasm of upper lobe, bronchus or lung</td>
<td></td>
</tr>
<tr>
<td>185 Malignant neoplasm of prostate</td>
<td></td>
</tr>
<tr>
<td>410.0 Acute myocardial infarction of other anterior wall</td>
<td></td>
</tr>
<tr>
<td>411.1 Intermediate coronary syndrome</td>
<td></td>
</tr>
<tr>
<td>413.9 Other and unspecified angina pectoris</td>
<td></td>
</tr>
<tr>
<td>414.0 Coronary atherosclerosis</td>
<td></td>
</tr>
<tr>
<td>428.0 Congestive heart failure</td>
<td></td>
</tr>
<tr>
<td>433.1 Occlusion and stenosis of carotid artery</td>
<td></td>
</tr>
<tr>
<td>434.9 Cerebral artery occlusion, unspecified</td>
<td></td>
</tr>
<tr>
<td>435.9 Unspecified transient cerebral ischemia</td>
<td></td>
</tr>
<tr>
<td>441.4 Abdominal aneurysm without mention of rupture</td>
<td></td>
</tr>
<tr>
<td>444.22 Arterial embolism and thrombosis of arteries of the lower extremity</td>
<td></td>
</tr>
<tr>
<td>466.0 Acute bronchitis</td>
<td></td>
</tr>
<tr>
<td>486 Pneumonia, organism unspecified</td>
<td></td>
</tr>
<tr>
<td>496 Chronic airway obstruction, not elsewhere classified</td>
<td></td>
</tr>
<tr>
<td>562.1 Diverticula of colon</td>
<td></td>
</tr>
<tr>
<td>600 Hyperplasia of prostate</td>
<td></td>
</tr>
<tr>
<td>715.96 Osteoarthrosis, unspecified whether generalized or localized, lower leg</td>
<td></td>
</tr>
<tr>
<td>820.0 Fracture of neck of femur transcervical fracture, closed</td>
<td></td>
</tr>
<tr>
<td>820.2 Pertrochanteric fracture, closed</td>
<td></td>
</tr>
</tbody>
</table>

3/ Codes and description are derived from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Based on frequency of occurrence during 1987 for beneficiaries who met the Part B simulated cap.
## PART 2
### CHAPTER 1
### ENROLLMENT

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<td>2003.4 2-1-15</td>
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<td>2003.5 2-1-15</td>
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<tr>
<td>Disenrollment</td>
<td>2004 2-1-16</td>
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<tr>
<td>General Requirements</td>
<td>2004.1 2-1-16</td>
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<tr>
<td>Failure to Pay Premium</td>
<td>2004.2 2-1-16</td>
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<tr>
<td>Permanent Move Out of Geographic Area</td>
<td>2004.3 2-1-16</td>
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<tr>
<td>Retention of Enrollees Who Temporarily Leave Geographic Area</td>
<td>2004.4 2-1-17</td>
</tr>
<tr>
<td>Death</td>
<td>2004.5 2-1-18</td>
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<tr>
<td>Enrollee's Entitlement to Benefits Under Part B</td>
<td>2004.6 2-1-18</td>
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<tr>
<td>End</td>
<td>2004.7 2-1-18</td>
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<tr>
<td>Fraud in Enrollment or Abuse of Membership Cards</td>
<td>2004.8 2-1-18</td>
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<td>Beneficiary Chooses to Disenroll</td>
<td>2004.9 2-1-19</td>
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<td>Disenrollment for Cause</td>
<td>2004.10 2-1-20</td>
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<td>2004.10 2-1-20</td>
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Rev. 11 2-1-1
2001. GENERAL REQUIREMENTS

In order to contract with HCFA, you must meet certain qualifying conditions as outlined in §§1200ff. One of these qualifying conditions requires you to demonstrate an ability to enroll members and to sustain a membership that ensures effective, efficient and economical care to your Medicare enrollees.

In order to maintain your contract with HCFA, you must comply with standards in three areas:

- Operating experience and enrollment;
- Composition of enrollment; and
- Open enrollment.

2001.1 Plan Operating Experience and Enrollment Requirements.--Plan operating experience and enrollment requirements are minimum standards. In addition to demonstrating your ability to enroll members, these enrollment levels are necessary to provide a reasonable basis for HCFA to establish payment rates for your plan.

Enrollment requirements vary depending on whether you are seeking a risk contract as an urban or a rural HMO/CMP, or a cost contract.

A. Requirements for Urban Risk Organizations.--You are considered an urban HMO/CMP if more than 50 percent of the population of your proposed geographic area resides in areas designated as Metropolitan Statistical Areas, or your geographic area contains a city with a population of more than 50,000.

As an urban HMO/CMP seeking a risk contract, you are required to:

- Have established a commercial membership of at least 5,000 enrollees and;
- Include in your contract application a marketing plan for achieving a minimum Medicare enrollment of 75 members within two years of the proposed initial contract date.

B. Requirements for Rural Risk Organizations.--You are considered a rural HMO/CMP if at least 50 percent of the population of your proposed geographic area reside in areas outside Metropolitan Statistical Areas, and your geographic area contains no city with a population of more than 50,000.

If you are a rural HMO/CMP seeking a risk contract, you are required to:

- Have established a commercial membership of at least 1500 enrollees; and
- Include in your contract application a marketing plan for achieving a Medicare enrollment of 75 members within two years of the proposed initial contract date.

C. Requirements for Cost Organizations.--If you are seeking a cost contract, you are required to:

- Have established a commercial membership of at least 1500 enrollees,
Include in your contract application a marketing plan for achieving a Medicare enrollment of 75 members within two years of the proposed initial contract date, and

Have a Medicare enrollment of 250 members by the beginning of your fourth contract period.

If you fail to enroll 250 Medicare beneficiaries by the beginning of the fourth contract period, you cannot renew on a cost basis, but you may apply for a risk contract.

**2001.2 Composition of Enrollment.--**The second standard that you must comply with establishes a limit on the number of Medicare and Medicaid enrollees your organization may have.

**A. 50/50 Requirement.--**Your Medicare and/or Medicaid enrollees cannot make up more than 50 percent of your organization's enrollment. This rule helps to assure that Medicare and Medicaid members have access to health care of the same standard as care provided to non-Medicare or non-Medicaid members. The computation includes only non-Medicare/Medicaid enrollees in the geographic area specified in your Medicare contract. Commercial enrollment in other areas is not counted towards meeting the 50/50 requirement. This rule also helps to assure that the adjusted community rate (ACR) calculation (see §5303), which is based on private premiums, is valid.

**B. Waivers.--**You have the option of applying to HCFA for a waiver of the composition of enrollment (50/50) rule in either of the following two situations:

1. According to census data or other data acceptable to HCFA, Medicare and Medicaid beneficiaries constitute more than 50 percent of the population of your service area (in which case, HCFA may grant a waiver which permits the percentage of Medicare and Medicaid enrollees in the organization to be at or below the percentage of Medicare and Medicaid enrollees in the general population), or

2. You are an organization owned and operated by a government entity (a public HMO/CMP).

Waivers generally are granted for a one-year period except for those given to public HMOs/CMPs. Waivers to public HMOs/CMPs may be granted for up to 3 years from the initial contract date if the conditions described in subsection C are met, but may not be extended beyond three years.

**C. Efforts to Meet the Composition of Enrollment Rule.--**A waiver can be granted to a public HMO/CMP only if the organization is making reasonable efforts to enroll commercial members. If you apply for a waiver of the 50/50 requirement, HCFA evaluates your activities and ongoing plan to enroll persons not entitled to Medicare and/or Medicaid. The evaluation includes an assessment of:

1. Your financial commitment and marketing efforts to attract enrollees not entitled to Medicare and Medicaid;

2. Whether the HMO/CMP has closed or will close enrollment to Medicare and/or Medicaid beneficiaries in an effort to balance private enrollment with Medicare/Medicaid enrollment; and
Your good faith efforts to secure contracts with private employers in the geographic area to serve the health needs of their employees.

The above listed factors are not all-inclusive. Because the responsibility for enrollment is on the HMO/CMP, you may use other strategies to meet the composition of enrollment standard. Your means of achieving the composition of enrollment requirement is evaluated by HCFA to determine whether it will be effective in increasing non-Medicare/Medicaid enrollment.

2001.3 Open Enrollment.--The third standard that you must comply with involves your enrollment process for Medicare beneficiaries.

A. General Enrollment Requirements.--The requirements are:

- Hold an open enrollment for Medicare beneficiaries annually;
- Publicize your upcoming enrollment period in appropriate media throughout the enrollment area (see §2204);
- Maintain the required open enrollment period for 30 or more consecutive days; and
- Enroll Medicare beneficiaries on a first come, first served basis. If you have met the 30-day requirement through a longer enrollment period or through continuous open enrollment and you decide to change this process, notify HCFA and the general public 30 days in advance of the new limitations on your open enrollment process.

Process applications from Medicare beneficiaries as they are received to assure that applicants are enrolled on a first come, first served basis.

B. Waivers.--You may obtain a waiver of the open enrollment requirement under one of the following two conditions:

1. Nonrepresentative Enrollment.-- An open enrollment will result in an enrollment that is substantially nonrepresentative of the population in the geographic area. In such a case, request a selection restriction in writing at least 90 days before the proposed open enrollment period. Prove to HCFA's satisfaction, by means of statistical data, that a specific subgroup of enrollees will exceed, by at least 10 percent, its proportion in the general population in the geographic area. A subgroup is defined as the group to which a particular adjusted average per capita cost (AAPCC) payment rate cell applies. (See §5204 for an explanation of these rate cells.) HCFA will make every effort to notify you 60 days prior to the beginning of the enrollment period whether your selection policy is approved. You may not limit enrollment unless and until HCFA approves the selection policy. If you submit insufficient data to make a decision, HCFA will deny the request.

2. Limited Capacity.--You do not have capacity for additional enrollees, or you must limit enrollment to a certain number of enrollees. As your enrollment grows, estimate whether you may reach capacity during your next open enrollment and therefore would need a HCFA approved capacity waiver.

The following subsections describe criteria and procedures for capacity waiver applications. You must submit all required information to your Regional Office at least (and preferably more than) 90 days prior to the open enrollment period for Medicare beneficiaries. HCFA will make every attempt to notify you of its
decision at least 60 days in advance of the enrollment period. If the waiver is granted, it remains in effect only for one year.

C. Determining Enrollment Availability for Medicare Beneficiaries.--Verify to HCFA the number of vacancies open to Medicare beneficiaries during the open enrollment period. If there are conditions or factors that you believe are pertinent to determining your enrollment availability for Medicare beneficiaries, submit this information to HCFA. Utilizing a worksheet (see §2099, Exhibit 3), determine your enrollment availability as follows:

1. Establish your present capacity.

2. Obtain current Medicare, Medicaid and commercial enrollment numbers.

3. Adjust these enrollment numbers by the following numbers:

   a. Your reserved vacancies--add to your commercial enrollment the number of members you expect to enroll from your existing group contracts and from anticipated new group contracts. (See subsection E.)

   b. Subtract expected age-ins (commercial members of your plan who will convert to Medicare status on becoming eligible for Medicare) from the commercial enrollment total and add to the Medicare enrollment numbers for a new Medicare enrollment total.

   c. Multiply the new Medicare enrollment total by your Medicare utilization factor (see subsection D) to obtain an adjusted Medicare enrollment total.

4. Subtract the adjusted commercial enrollment total and the adjusted Medicare enrollment total from your capacity. The remainder determines the number of vacancies available for open enrollment.

These vacancies must be filled with Medicare beneficiaries up to the point where Medicare and Medicaid enrollees make up 50 percent of your enrollment or further enrollment would be substantially non-representative of the population in the geographic area (see §2001.2).

D. Utilization Adjustment Factor.--HCFA recognizes the greater intensity of services and frequency of health care utilization among Medicare beneficiaries. Because there is not a one-to-one equivalence between Medicare and commercial members in this respect, a utilization adjustment factor is incorporated in calculating enrollment capacity. The utilization adjustment factor represents the number of commercial members you could serve to every one Medicare member served over the course of the contract year. To adjust your Medicare enrollment, use the utilization adjustment factor calculated in developing your ACR. (See §5305.) Also provide backup documentation and discussion of the methodology employed in the calculations. For example, if your data show that Medicare utilization is three times that of commercial members, your capacity for new commercial members is three times what it would be for new Medicare members. Therefore, if you have capacity for 3,000 additional commercial members in your next contract period, and you anticipate filling 1,500 of those slots with commercial members, the remaining 1,500 slots must be divided by three. That is, full capacity is reached if you enroll 500 Medicare members in addition to the 1,500 commercial members, based on a ratio of one Medicare vacancy being equal to three commercial vacancies.

E. Reserved Vacancies.--Reserved vacancies are those set aside for members of anticipated new group contracts or for anticipated new members of an already
existing group contract when these group enrollment periods are held after the Medicare open enrollment period.

If open enrollment(s) for one or more of your group contracts is scheduled after your Medicare open enrollment period, set aside a reasonable number of slots or vacancies for anticipated new members from these groups. Then factor these reserved vacancies into the determination of your enrollment availability for Medicare beneficiaries as described in subsections C and D.

Because these reserved vacancies limit your available slots for Medicare members, HCFA must approve your use and number of reserved vacancies. Therefore, reserved vacancies are included in the calculations outlined in subsection C and on the worksheet shown in §2099, Exhibit 3. Reserved vacancies not used within a reasonable period must be released to Medicare enrollment.

F. Special Requirements When Reaching Capacity.--If you reach capacity during open enrollment and you have a HCFA approved waiver, you have two options: refuse further enrollments or continue to accept applications to be placed on a waiting list. If you continue to accept applications, place all prospective members who wish to wait for an opening on the waiting list in chronological order and enroll them in that order as vacancies occur.

2001.4 Additional Open Enrollment Periods.--If you are a risk-based contractor, you must hold an additional open enrollment period if any other risk-based organizations serving any part of your service area:

- Do not renew their Medicare contract,
- Have their Medicare contract terminated, or
- Reduce their service area to exclude any area which you serve.

If any Medicare beneficiaries residing in your service area lose their enrollment in other HMOs/CMPs as a result of one of these actions, you must offer open enrollment to these individuals. Since service area reductions and non-renewals are effective at the end of the contract year, HCFA intends to meet the following schedule in order to ensure that new enrollments for these beneficiaries be effective in January.

- August 5--Requests for capacity waivers must be submitted to HCFA if you anticipate capacity problems for an enrollment period beginning November 3.
- October 2--All risk-based HMOs/CMPs that do not intend to renew their contracts notify HCFA by this date, and HCFA notifies each organization whose contract HCFA declines to renew.
- October 4--HCFA notifies you if you are required to hold an open enrollment period under this provision.
- November 1--Risk-based organizations which are non-renewing their contracts send beneficiary notification letters. This letter lists your name, address, and phone number.
- November 3 - December 2--The additional open enrollment period (for beneficiaries losing enrollment in another risk-based HMO/CMP) is held.
- January 1--Enrollment in your organization becomes effective.
If another risk-based HMO/CMP in your service area terminates its contract with HCFA mid-year, you are required to hold an additional open enrollment period, unless you have been granted a capacity waiver. In the event this occurs, HCFA will notify you of the schedule to follow to hold the open enrollment period. If you are already at capacity, contact HCFA as soon as possible to discuss a possible waiver.

2001.5 Enrollment Application Procedures.--The enrollment application form is a portion of your contract with the enrollee. There are several requirements regarding the exchange of information between you and the applicant during the application process. There are also certain requirements regarding who may complete the application form.

A. Information Obtained from the Applicant.--Whether you enroll Medicare beneficiaries in a face-to-face interview or by mail, verify all information. If the enrollment application is being completed in person, use the applicant's Medicare card to verify the spelling of the name and to confirm the correct recording of sex, date of birth, Health Insurance Claim Number (HICN), and the beneficiary's type of entitlement, i.e., whether entitled to both Parts A and B, or Part B only. Obtain the enrollee's address and verify that he/she resides within your Medicare contract area. If enrollment assistance is given by telephone, establish a back-up system for verifying this information. For example, some HMOs/CMPs direct staff responsible for recording enrollment information to call the applicant and double check the information.

Obtain information on whether the prospective enrollee has end stage renal disease (ESRD) or has made an election of hospice coverage through Medicare. These are not considered health screening questions because in either case the prospective enrollee must be denied enrollment. (There is an exception for individuals who are current members of your health plan and have ESRD. These individuals may elect to enroll in your Medicare plan.)

In addition, ask whether a person is a Medicaid recipient or is institutionalized. (See §6009.) This information affects the rate HCFA pays you for providing services to the individual.

B. Information Provided to the Applicant.--During the enrollment application process, make sure that the applicant has received a member handbook and all the necessary information about being a Medicare member of your HMO/CMP, such as member rights and rules. (See §2204.) During the interview process:

- Describe the charges for which the enrollee is liable, e.g., any premiums, coinsurances, fees or other amounts; and, for a high option, identify separately from other charges any amount attributable to the Medicare deductible and coinsurance.

- Explain the enrollee's authorization for the disclosure and exchange of necessary information between you and HCFA. (See §1070 for a discussion of disclosure of health insurance information.)

- Provide the enrollee a copy of the signed, dated application.

- If you are contracting with HCFA on a risk basis, explain the lock-in requirement and obtain the enrollee's acknowledgement that he/she understands that care is received through designated providers except for emergency services and urgently needed out-of-area care.
C. Application Forms.--Use an application form that complies with the following guidelines on structure and content. A model Health Care Plan Enrollment Application Form is included as Exhibit 1 in §2099. On your application form, include statements that attest to the enrollee's understanding of the provisions outlined in subsection B. For example, include a statement acknowledging that premium and copayment amounts were stated to the member and may be found in the subscriber agreement or other document. Also include statements that the member:

- Agrees to abide by your HMO/CMP membership rules as outlined in the material provided to the member, including the lock-in provisions for risk HMOs/CMPs;
- Authorizes you to disclose and exchange necessary information with HCFA;
- Understands that enrollment in your plan automatically disenrolls him/her from any other Medicare contracting HMO/CMP in which he or she is enrolled; and
- Knows the proposed date(s) he/she must begin receiving care through the plan, i.e., the effective date.

Obtain the enrollee's signature and the date. Retain the application form while the enrollee is a member of the organization and for one year after disenrollment.

D. Who May Complete an Application.--An individual beneficiary is generally the only person who may execute a valid application for membership. However, another individual would be the appropriate party to execute an enrollment application if a court has designated such other individual as the proper party to take such actions on behalf of the beneficiary, including a case in which the beneficiary has been judged legally incompetent and the court has appointed a legal guardian.

If the individual's Social Security benefits are received by a representative payee, there has been a determination by SSA that the person is unable to manage his or her finances. In many cases the beneficiary's Medicare card will show the name of the payee. The SSA determination is evidence that the individual may be unable to understand lock-in and other rules of enrollment in your plan, and consequently would be unable to execute a valid application for enrollment. Contact the representative payee who receives the beneficiary's Social Security payments to determine his or her legal relationship to the beneficiary, and to ascertain whether he or she is the appropriate person, under State law, to complete the individual's application for membership.

When someone other than the beneficiary completes the application, be sure to keep documentation showing how you made the determination that another entity or person was legally authorized to enroll the Medicare beneficiary.

2001.6 Processing Applications.--You must maintain a system for receiving, controlling and processing applications for membership in which you:

- Date each application as of the date it is received;
Assure that each beneficiary who enrolls (whether previously a member of the organization or not) receives a signed and dated copy of the application form;

Process applications from beneficiaries in chronological order by date of receipt, subject to the provisions of §2001.3F;

Transmit enrollment information to HCFA within 30 days of the date of application or the date a vacancy occurs (if prospective enrollees were put on a waiting list), or within a time period approved by HCFA;

Notify the beneficiary in writing of the acceptance or denial of his/her application no later than 30 days following the date the application was signed:

- If the application is accepted, inform the beneficiary of the proposed effective date of coverage; or

- If the application is denied, provide the applicant with a written explanation of the reason for denial;

If you place the application on a waiting list as described in §2001.3F, provide the enrollee with an explanation of procedures to follow as vacancies occur; and

Fill vacancies which occur during a capacity period in chronological order by date of application.

2001.7 Submission of Enrollment Information to HCFA.--Within 30 days of the date of application, transmit to HCFA the information necessary to add the enrollee to HCFA's records. In the case of applications which are accepted when the HMO/CMP is enrolled to capacity, transmit the information within 30 days after a vacancy has become available. However, if a current HMO/CMP enrollee is converting to Medicare enrollment status, submit the enrollment information no earlier than 90 days, but at least 30 days, prior to the individual becoming eligible for Medicare. (See §6000ff.)

2002. EFFECTIVE DATE OF ENROLLMENT AND DISENROLLMENT

A Medicare beneficiary's enrollment begins with the first day of the month in which his/her membership in the HMO/CMP is effective, as shown on HCFA records. In no case may the plan enroll a beneficiary effective earlier than the month after, or later than the third month after, the month in which the enrollment information is correctly submitted and received by HCFA.

You are responsible for submitting to HCFA correct and timely records for new enrollments. In general, HCFA does not accept records:

- Received after the monthly cut-off date for submission of records, as announced by HCFA periodically, or

- That are incomplete or incorrect.

If you have informed a beneficiary that his/her enrollment in your organization is effective as of a certain date, but you then submit an incorrect enrollment record to HCFA, you must honor your contract with the enrollee and begin providing coverage on the stated date. If you provide services to the enrollee before you can submit the correct enrollment information, you may still receive Medicare fee-for-service payment for any services you render. In order for you to receive direct payments for physician and supplier services from a Medicare

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carrier, you must have a third party billing number. (See Medicare Carriers Manual (MCM) §7065.) However, if you collect, or have waived collection of, a premium from the beneficiary which covers the deductible and coinsurance for Medicare covered services for the originally designated month of enrollment, you are financially responsible for Medicare deductibles and coinsurance amounts not paid by carriers and intermediaries on pre-enrollment claims for services obtained in plan or for emergency or urgently needed care. The Medicare enrollee is liable for any copayments you impose for services, and is liable for deductible and coinsurance amounts for any services for which you have no financial responsibility under the terms of your Medicare contract.

A. Retroactive Enrollment for Employer Group Members.—In some cases an HMO/CMP that has both a risk contract and a contract with an employer group health plan arranges for the employer to process applications by Medicare-entitled group members who wish to enroll under the risk contract. However, there is often a delay between the time the beneficiary enrolls through the employer plan, and becomes entitled to receive services from the HMO under the risk contract, and the time the application is received by the HMO/CMP and transmitted to HCFA. The statute now allows HCFA to retroactively adjust Medicare payments to the HMO/CMP to cover this period of time, not to exceed 90 days. Adjustments may only be made for enrollment dates on or after January 1, 1991. No adjustment may be made unless the individual certifies that the organization provided him or her with the explanation of enrollee rights (including an explanation of the lock-in requirement) required by §1876(c)(3)(E) of the statute. Submit such enrollments electronically as code 60 accretions.

B. Retroactive Enrollment to Date of Initial Medicare Entitlement.—The effective date of membership as a Medicare enrollee is the month in which the individual becomes entitled to benefits under Medicare Part B if:

- The individual enrolls in the supplementary medical insurance program (Part B of Medicare) and applies to the HMO/CMP prior to the month in which he/she is entitled to Part B of Medicare, or
- The individual is a member of your organization prior to his/her entitlement to Medicare benefits.

However, for some beneficiaries, there may not be a record of entitlement to Part B established in HCFA's data system until after the actual date of first entitlement. In such cases, the HCFA Regional Office (RO) takes action to correct the effective date retroactively. (See §2002.1B.)

2002.1 Other Retroactive Enrollments.—In some instances, problems may occur that are related to SSA and/or HCFA systems. Examples of possible problems are given below.

A. Termination of Medicare Entitlement Due to Disability Cessation by SSA.—When a beneficiary's disability ends, two time frames affect the continuation of Medicare.

1. Cessation When a Person Is Able to Resume Work.—Entitlement to Medicare continues for at least 39 months after the individual completes a successful 9 month trial work period.

2. Cessation Upon Medical Recovery.—Entitlement to Medicare ends two months after the month the beneficiary is medically determined not to be disabled. The beneficiary may appeal the termination of his/her eligibility for SSA disability payments and Medicare benefits within ten days after receiving the notice of medical cessation. He/she may request continuation
of SSA payments and/or Medicare coverage during the appeals period. When this occurs, Medicare eligibility does not end until the last day of the month following the month the notice of affirmation of disability cessation is sent. Because of internal SSA time lags in notification and/or the possibility of a retroactive SSA disability cessation, the Medicare system may show termination of coverage even if the beneficiary has filed a timely request for continuation of Medicare coverage.

In these cases, the member must provide you with evidence that continuation of coverage has been requested from SSA. Continue the beneficiary's enrollment with the plan and continue to provide services. You must submit the request for the retroactive adjustment to the RO, which will make the adjustment as soon as SSA corrects its records to reflect continued Medicare eligibility.

B. **Errors in SSA Records/Medicare Entitlement Data.**—Request a retroactive enrollment for any SSA/HCFA systems problems which delay processing of applications. These include: 1) if a beneficiary's enrollment application was rejected because Part B entitlement is not reflected on Medicare records prior to the first month of entitlement (because there is often a lag period when an individual enrolls during a special enrollment period at the time of retirement instead of the initial enrollment period at age 65), 2) HIC number changes, 3) erroneous death notifications, 4) problems with posting of premiums, or 5) any other SSA/HCFA systems issue which may cause Medicare entitlement data to be incorrect or missing.

2002.2 **Disenrollment.**—When a Medicare beneficiary voluntarily disenrolls from your plan, the disenrollment must be effective on the first day of the month immediately following the month in which you or SSA (or the Railroad Retirement Board) receive a written request. At the request of the beneficiary, you may report a later effective date of disenrollment to HCFA. This delay may only be for one or two months, i.e., the disenrollment cannot take place later than the third month after which you submit the disenrollment request for HCFA processing. (See §2004.) You are responsible for submitting timely and correct disenrollment records to HCFA. Keep your enrollment records reconciled with HCFA on an ongoing basis.

2002.3 **Retroactive Disenrollment.**—In general, HCFA does not accept retroactive disenrollments for records received after the monthly cut-off date for processing current disenrollments.

However, HCFA will approve retroactive disenrollments for certain situations. Submit retroactive disenrollment requests, including supporting evidence justifying the late disenrollment, to the RO. Only in cases of computer system errors on the part of HCFA is the error submitted to HCFA central office for correction. If HCFA approves your request for retroactive disenrollment, you must return any premium paid by the member for any month for which HCFA processes a retroactive disenrollment.

The following are examples of situations where retroactive disenrollments are permissible. This list contains examples; it is not meant to be all-inclusive.

A. **Systems Problems.**—By statute, disenrollments are effective with the month following the date on which the beneficiary makes the request to disenroll. If the beneficiary submits a proper request, but as a result of systems problems the disenrollment is not shown on a timely basis in HMO and HCFA records, you may submit a retroactive disenrollment request to (a) HCFA central office, for a HCFA or SSA computer system problem involving multiple beneficiaries, or (b) HCFA regional office, for individual beneficiary cases or if you are experiencing internal systems problems. If you are uncertain which HCFA office should process your request, contact the HCFA RO.
B. **SSA District Office Errors.**--Submit a retroactive disenrollment request to the RO for errors made by the SSA district offices in submitting HMO/CMP disenrollments. The RO makes either a retroactive or prospective adjustment of deletion dates, depending upon the nature of the error.

C. **Lack of Intent to Enroll.**--Submit a retroactive disenrollment request to the RO if there is evidence that the beneficiary did not intend to enroll in your organization (e.g., the beneficiary did not realize he/she ever enrolled in an HMO/CMP).

Evidence of lack of intent to enroll by the beneficiary may include:

- Continuing supplemental (Medigap) insurance coverage after the effective date of HMO/CMP enrollment;
- Enrolling in a supplemental insurance program immediately after enrolling in your organization;
- Receiving non-emergency or non-urgent services out-of-plan immediately after the effective date of enrollment; or
- Making an inquiry to HCFA, after receipt of the HCFA lock-in notice, questioning HMO/CMP enrollment.

Payment of your premium does not necessarily indicate an informed decision to enroll. The beneficiary may believe that he/she was purchasing a supplemental health insurance policy. In addition, use of a plan doctor does not necessarily indicate an understanding of the lock-in requirement if the doctor also treats non-HMO/CMP members.

Depending upon the facts of each of these types of cases, a partial disenrollment may be appropriate, i.e., the beneficiary is disenrolled for the initial period of membership and enrolled beginning with the date he/she clearly intended to be enrolled in your organization. In other cases, disenrollment for the entire membership period is warranted.

D. **Failure of Employer to Notify Plan.**--Submit a retroactive disenrollment request to the RO if an employer fails to provide you with timely notification of a Medicare retiree's requested disenrollment. Up to 90 days' retroactivity is possible in such a case. The employer notification is untimely if it does not result in a disenrollment effective for the month following the request, or for the requested effective date (if later).

Evidence must demonstrate that the beneficiary acted to disenroll in a timely fashion (i.e., prospectively) but the employer was late in providing the information to you. Such evidence may include an election or application form signed by the beneficiary and given to the employer during an open enrollment season. (Note that the application form could be the employer's generic form used during its open enrollment season for all employees and retirees. Do not confuse it with the HCFA approved application form used by HMOs/CMPs.)

**2003 WHO MAY ENROLL AND WHO MAY BE DENIED ENROLLMENT**

**2003.1 General Requirements.**--There are several guidelines you must follow for enrolling or denying enrollment to Medicare beneficiaries.

You must enroll any Medicare beneficiary or any individual who is a Medicare beneficiary and a Medicaid recipient who:
2003.1 (Cont.) ENROLLMENT

You may not deny enrollment to a Medicare beneficiary who continues to work and to be enrolled in his/her employer's health benefits plan (or that of a spouse).

You are permitted to deny enrollment if:

- Enrollment of the individual causes the organization to exceed 50 percent Medicare/Medicaid enrollment;
- HCFA has granted a waiver or limitation of the open enrollment requirement;
- The enrollee has been medically determined to have end stage renal disease (ESRD) prior to applying for enrollment; or
- The enrollee has elected Medicare hospice benefits, and the election is in force at the time of application.

2003.2 How to Process Applicants With ESRD.--End stage renal disease is defined as that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life (MCM §2230.1). A general definition of ESRD is that 5 percent or less of normal kidney function remains. You are permitted to ask at the time of application whether the applicant requires a regular course of maintenance dialysis for treatment of kidney failure, or whether the person has had a kidney transplant. These questions are not considered health screening since the law does not permit persons with ESRD to enroll in HMOs/CMPs and you are obligated to determine the existence of ESRD. If the applicant answers "yes" to the question of whether (s)he requires maintenance dialysis, deny enrollment.

If the applicant answers "yes" to the question of whether (s)he has had a kidney transplant, determine the date of the transplant. If it was less than 36 months before the date of the applicant's proposed enrollment in your health plan, deny enrollment. If 36 or more months have elapsed since the transplant, the individual is no longer considered to have ESRD, and you must enroll the beneficiary.

If there is some doubt about the date of transplant or whether a regular course of dialysis has begun, process the application as usual. HCFA rejects the enrollment if Medicare records indicate the applicant has ESRD.

An individual may not be denied enrollment if the medical determination of ESRD occurred between the date of application and the effective date of enrollment. Also, you may not deny enrollment to an individual with ESRD who is enrolled in your organization and is converting to Medicare enrollment status.

2003.3 Hospice Patients.--When it is determined that a current Medicare enrollee of your health plan has a terminal illness and life expectancy is 6
months or less, the enrollee may elect to receive care through a Medicare certified hospice. If the current enrollee elects hospice care, he/she must waive the right to receive treatment for the terminal condition and related conditions from any provider other than the hospice and the attending physician. **Do not disenroll the individual merely because the person has made a hospice election.** During the hospice election, the enrollee's membership is partially suspended and the Medicare program will make fee-for-service payments to you or other providers for any services unrelated to the terminal condition. The beneficiary remains enrolled in your plan as long as he/she continues payment of the plan premium. This means that you are to provide those services which have not been waived, e.g., services unrelated to the terminal condition that you provide, authorize, or for which you assume financial responsibility (including coinsurance or deductibles not paid by fee-for-service Medicare), or services which do not require the attending physician, as well as any supplemental benefits for which the enrollee has paid. In addition, if you are a risk organization, continue to provide any additional benefits you are required to provide under your Medicare contract. (See §2103.)

Upon revocation or exhaustion of the hospice benefit, immediately reinstate the beneficiary's full enrollment. In the interim, i.e., before resumption of full monthly capitation, you may bill HCFA on a fee-for-service basis for any services you provide. (See 42 CFR 417.585(b)(3).)

**2003.4 Reenrollment.** Some members may disenroll, then wish to reenroll at a later time. Enroll these members following standard enrollment procedures, i.e., the member must meet the requirements of §2003.1 and reapply during an open enrollment period. If there is a waiting list, place the former enrollee on a waiting list with other applicants. Applications of former enrollees must be processed in chronological order with new applications. The former member cannot be enrolled ahead of other applicants.

**2003.5 Conversion Enrollments.** You must accept as a Medicare enrollee any individual who was an enrolled member of your plan for the month immediately before the month in which he/she is entitled to both Medicare Parts A and B, or Part B only.

**A. Enrollees Newly Eligible for Medicare.** When enrolling a beneficiary in accordance with this section, forward the enrollment information required in §6002 at least 30 days but no earlier than 90 days before the enrollee becomes eligible for Medicare, e.g., attainment of age 65 or entitlement based on disability or ESRD.

For some beneficiaries, there may not be a record established in HCFA's data system until after the actual date of first entitlement. In such cases, you must request assistance from the Regional Office as described in §2002(B).

**B. Conversion from Cost-Based Status to Risk-Based Status.** If you are a cost-based HMO/CMP or health care prepayment plan (HCPP) converting to a risk-based contract, and your contract (or HCPP agreement) was in effect on February 1, 1985, your current Medicare members have the option of converting to the risk plan or retaining their cost-reimbursed status. The cost-reimbursed members who choose not to convert to risk status may retain their status indefinitely unless:

- There are 75 or fewer of these members remaining; or
- HCFA determines that the conversions must be made for administrative reasons.

When either of these criteria is met, HCFA will follow procedures described in 42 C.F.R. §417.444.
C. Conversion from Risk-Based Status to Cost-Based Status.--If you are a risk-based HMO/CMP converting to a cost-based contract, you may offer all current Medicare members the option of joining as new cost contract members or returning to fee-for-service Medicare. These beneficiaries are not automatically enrolled under the new contract; they must complete a new application form.

2004 DISENROLLMENT

2004.1 General Requirements.--You are responsible for submitting disenrollment notices to HCFA in a timely, accurate fashion. The liability of HCFA to make monthly capitation payments to you on behalf of a beneficiary ends as of the first day of the month following the month in which membership in the organization terminates, as shown on the records of HCFA. There are some exceptions, described in the following sections. In no case is the effective date of disenrollment earlier than the month immediately following, or later than the third month following, the month in which the beneficiary submits a written request for disenrollment to the HMO (or SSA), or, in the case of involuntary disenrollments, the month in which HCFA receives the disenrollment notice in acceptable form. (See §2002.2.)

Do not request or encourage, by written or oral communication or by any action or inaction, a Medicare enrollee to disenroll, other than under the conditions defined in this section. Apply disenrollment policies in a consistent manner for similar beneficiaries in similar circumstances. For example, if you elect to disenroll beneficiaries who move out of the Medicare contract area, disenroll all beneficiaries who move out of the Medicare contract area.

2004.2 Failure to Pay Premium.--You may disenroll a Medicare enrollee who fails to pay your premiums, other charges imposed for Medicare deductible and coinsurance amounts, or charges for mandatory supplemental benefits for which he/she is liable. However, you must demonstrate to HCFA that a reasonable effort was made to collect the unpaid amount and that you gave the beneficiary written notice of disenrollment before you notified HCFA. Since it is possible that the beneficiary believes that nonpayment of premiums is a way to disenroll, you may wish to include in your payment reminder notices an explanation of the proper way to disenroll. HCFA will consider you to have demonstrated reasonable effort in collecting unpaid premiums if you mail a notice of disenrollment for nonpayment of premium to the beneficiary at least 20 days before the effective date of disenrollment. This allows 5 days for mailing time and 15 days for the beneficiary to act on the notice. Include an explanation of the enrollee's rights to a hearing under your grievance procedures. You may not notify HCFA until after you have sent the notice to the beneficiary.

There is one exception to this general rule:

- You may not disenroll a Medicare beneficiary for failure to pay the premium or other charges attributable to optional supplemental benefits (high option package). You may cease to provide only the supplemental coverage. Do not disenroll the beneficiary.

2004.3 Permanent Move Out of Geographic Area.--A beneficiary must be disenrolled if he/she moves permanently out of the geographic area and does not voluntarily disenroll. Initiate a disenrollment as soon as you become aware that the beneficiary has moved permanently outside the service area. An uninterrupted absence of more than 90 days is deemed to be a permanent move. A written statement from the beneficiary or other reasonable evidence establishes that the beneficiary has moved out of the geographic area. Even if the beneficiary has not informed you of her/his new address, attempt to
provide written notice of termination of enrollment to the beneficiary. Enrollees who permanently leave the area, or who leave for an extended absence, without informing the HMO/CMP, remain subject to the lock-in restriction until disenrollment is effective.

2004.4 Retention of Enrollees Who Temporarily Leave Geographic Area.--You are allowed to retain a Medicare member under either of the two options described below if the individual leaves your geographic area for an extended absence (an absence of over 90 days, but not more than a year, where the member intends to return to your geographic area within the one year period). The extended absence option is available only to members remaining in the United States.

A. General Retention Option.--You may choose to cover all out-of-area routine services for anyone who leaves the service area for an extended absence. Such an option must be made available to all members of your plan, if you decide to offer it. (If an individual to whom this policy applies returns to your service area, the lock-in restriction applies again while the person is in your service area.)

You may place restrictions on receiving out-of-area services for individuals to whom this extended absence option applies, as long as the Medicare enrollee agrees to the restrictions and as long as the full scope of contracted benefits is available to the enrollee in the new area. Possible restrictions on services include obtaining medical care through designated providers or requiring prior authorization. This option must be available to all members who leave your geographic area, and all members to whom this option applies must be advised of its availability.

B. Retention of Enrollment With Services Provided Through Affiliated Organization.--If you are affiliated with another organization (by common ownership or control, or if there is a written agreement) and the other organization is also a Medicare §1876 contractor, you may provide that the extended absence option is only available to enrollees who move to the geographic area of the affiliate during an extended absence. They must agree to obtain services exclusively through the affiliated organization. You may retain such individuals as Medicare enrollees of your plan for up to one year. The option must be made available to anyone moving to the affiliated organization's geographic area during an extended absence, and all members to whom this option applies must be advised of its availability.

All covered Medicare services and supplies plus any additional benefits and mandatory supplemental benefits offered by a risk-based HMO must be available from the affiliated organization. Also, you are financially responsible for emergency and out-of-area urgently needed services. For this extended absence option, urgently needed services are those services obtained while temporarily absent from the geographic area of the affiliate organization responsible for providing services to the enrollee during the extended absence. (See §2105.)
HCFA approves extended absence options as part of your initial Medicare application, or as you develop such options. HCFA also reviews your marketing materials and membership rules to assure that the options are clearly explained and beneficiaries are advised of the distinction between authorized and unauthorized out-of-plan service use.

If you wish to offer an extended absence option, we suggest that you have the member sign an agreement which states any restrictions on services imposed, where and how to obtain services, and how billing is accomplished. It would also be advisable for the agreement to state that the member understands that
all prior lock-in restrictions apply whenever the member returns to the service area of the original
HMO/CMP.

Supplemental benefits for which the member is paying a premium may be discontinued on leaving
the service area as long as the member is not required to continue paying the premium or portion of
a premium that corresponds to these services.

Your HCFA payment for members who leave the service area and continue their membership during
an extended absence is at the county rate of their residence of record as shown on SSA files.

If a beneficiary whom you have retained as a member under an extended absence option fails to
return to your service area within one year, you must disenroll the individual as of the first day of
the month following the one-year anniversary date of their original departure from your service area.

2004.5 Death.--Disenroll the enrollee effective the month immediately following the month of
death. Monthly per capita payments end with that month.

2004.6 Enrollee's Entitlement to Benefits Under Part B Ends.--The beneficiary is disenrolled by
HCFA for the month immediately following the month that enrollment in Part B ends. Monthly
capitation payments on behalf of the beneficiary terminate effective with the month immediately
following the last month of entitlement to benefits under Part B. The beneficiary may be continued
as an enrollee under an individual (non-Medicare) plan if you have such an option available.

If an enrollee loses entitlement to benefits under Part A, but remains entitled to benefits under Part
B, he/she continues as an enrollee of your HMO/CMP. The enrollee is entitled to receive and have
payment made for Part B services only, beginning with the month immediately following the last
month of his/her entitlement to Part A. With HCFA's approval, you may offer all or some of the
equivalent of Medicare Part A benefits as a mandatory supplemental benefit and charge a premium
for such coverage. (See §5301C regarding mandatory supplemental benefits plans for enrollees with
Part B only.)

2004.7 Fraud in Enrollment or Abuse of Membership Cards.--A Medicare beneficiary may be
disenrolled if he/she commits fraud in connection with his or her enrollment or permits abuse of the
membership card, e.g. the beneficiary knowingly provides on the application form fraudulent
information which materially affects eligibility for enrollment. An example of abuse includes a
Medicare beneficiary who permits others to use his/her membership card to receive services. This
category includes any abuse relating to HMO/CMP membership or the Medicare program.

In the case of fraud or abuse, give the beneficiary written notice of termination prior to submission
of the disenrollment notice to HCFA. Include an explanation of the enrollee's rights to a hearing
under grievance procedures established by the organization. Also notify the RO so that the Office
of the Inspector General may initiate its own investigation of the alleged fraud or abuse. For
addresses of the Regional HHS Inspector General, see §1103.

2004.8 Beneficiary Chooses to Disenroll.--A Medicare beneficiary may disenroll at any time by
giving the organization, or any Social Security or Railroad Retirement Board Office (if the enrollee
is an annuitant), a signed and dated written request. The liability of HCFA to make monthly
payments on the beneficiary's behalf ends with the close of the last month of membership specified
by the beneficiary except that the last month of payment may not be earlier than the month in which
the beneficiary requested disenrollment.
Submit disenrollment requests to HCFA immediately. The disenrollment must be effective no later than the first day of the month following submittal of the member's written request for disenrollment, unless the member requests a later date.

Provide the enrollee with a copy of his/her request for termination of enrollment and, if you are a risk-based HMO/CMP, a written explanation of the lock-in restrictions for the period during which the enrollee remains enrolled in the organization. Also, provide the beneficiary with a final letter once the disenrollment has been confirmed by HCFA.

If you are a risk HMO/CMP, advise disenrolling beneficiaries to hold Medicare fee-for-service claims for up to one month so that Medicare computer records can be updated to show that the person is no longer enrolled in the HMO/CMP.

2004.9 Disenrollment for Cause.--You have the right to initiate procedures to disenroll a Medicare enrollee if the enrollee's behavior is disruptive, unruly, abusive, or uncooperative to the point that his/her continuing membership seriously impairs the ability to furnish services to either the enrollee or other members. You may not propose to terminate an enrollee based upon his/her utilization of services or mental illness unless it has a direct effect upon your ability to deliver services. You may not initiate disenrollment because the beneficiary exercises his/her option to make treatment decisions with which you disagree, e.g. refuses aggressive treatment for cancer.

Before beginning the disenrollment for cause process, make a serious effort to resolve the problem presented by the enrollee. Inform the enrollee that his/her continued behavior may result in termination of membership in the organization. If the problem cannot be resolved, give the member written notice of your intent to request disenrollment for cause. In this notice, include an explanation of the enrollee's right to a hearing under the organization's grievance procedures.

A. Proposed Disenrollment Notice.--Once the grievance process has been completed or the member has chosen not to use this process, submit a proposed disenrollment notice to the RO stating reasons for the termination of enrollment and the proposed effective date. Also, summarize the case and submit documentation to the RO, including:

- The reason that the plan is requesting disenrollment for cause;
- A summary of plan efforts to explain these issues to the enrollee and the other types of options presented before disenrollment was considered;
- A description of the enrollee's age, diagnosis, mental status, functional status, and social support system; and
- Separate statements from primary providers describing their experience with the enrollee.

B. Regional Office Review.--The RO reviews your request based on the documentation submitted and makes a decision within 20 working days of receipt of complete documentation. The RO notifies you within five working days after the decision is made.

When you have received the decision, inform the enrollee of the determination. If membership is being terminated, send a notice that contains the reason for disenrollment, the effective date of termination, and a statement that this action was approved by HCFA.
C. Effective Date of Disenrollment.--If HCFA permits an HMO/CMP to disenroll an enrollee for cause, the disenrollment takes effect on the first day of the calendar month after the month in which the HMO/CMP serves written notice of termination on the enrollee and the grievance period has expired. HCFA's liability for payment ends on that date. Retain a copy of your documentation, the proposed disenrollment notice, HCFA's approval letter, and the notice to the beneficiary in your files for purposes of verification.

2004.10 Disenrollment in Cases of Nonrenewal, Reduction of Service Area, Termination or Default of Contract.--The termination, nonrenewal, or partial nonrenewal of a contract between you and HCFA, whether by mutual consent or by unilateral action of either party, ends the liability of HCFA to make monthly capitation payment on behalf of Medicare enrollees.

If you default on your contract with HCFA prior to the close of the contract year, HCFA establishes the month in which capitation payments end for all enrolled Medicare beneficiaries, and notifies you and your Medicare enrollees in writing as soon as practical.
(Please Print in ink)

NAME (exactly as appears on Medicare Card):

First  Middle  Last

Signature

Also, please attach a copy of your Medicare Card to this enrollment form.

ADDRESS:

Street  City

County  State  Zip

TELEPHONE NUMBER: (___)___________

Required, if you have a phone.

MALE  FEMALE  DATE OF BIRTH

MEDICARE NO:   (Take NUMBER from your Medicare Card.)

Optional: Person to call in emergency (relative or friend)

Name __________________________________________ (___)________________________

Phone Number

Address ______________________________________________________________________

_____________________________________________________________________________
PLEASE CHECK THE APPROPRIATE BOXES BELOW:

1. I am enrolled in Medicare Part A (Hospital Insurance). (Provide the date of your entitlement to Part A ____.)
   Yes No
   O O

2. I am enrolled in Medicare Part B (Medical Insurance). (Provide the date of your entitlement to Part B ____.)
   Yes No
   O O

3. I am currently enrolled in another HMO which offers a Medicare Plan. I understand that by enrolling in (HEALTH PLAN), I will be canceling my membership in my current HMO.
   Yes No
   O O

4. I have health insurance through my or my spouse's employer
   Yes No
   O O
   If yes, Employer Name:
   Address______________________________
   City __________________________ State _____________ Zip __________
   Policy Holder Name: __________________________
   Policy Number: __________________________

5. I am currently receiving hospice benefits in a Medicare certified hospice.
   Yes No
   O O
   (Note: You cannot enroll in (HMO) if you are receiving hospice benefits in Medicare certified hospice.)

6. I have end stage renal disease (ESRD).
   Yes No
   O O
   (Note: You cannot enroll in the (HMO) if you have ESRD, unless you are already enrolled in the HMO as a non-Medicare member.)

7. Are you currently eligible for Medicaid?
   Yes No
   O O

8. Are you currently a resident in a nursing home, sanatorium, rest home, convalescent home, long-term care hospital or domiciliary home?
   Yes No
   O O

Please provide the name and address of the home if different from the address on the first page:

(Note: The information of 7 and 8 cannot be used to deny your application for membership in (HEALTH PLAN).)
9. Under this arrangement, you as a member of (HEALTH PLAN) are "locked-in" to the use of (HEALTH PLAN) providers. All health care (other than emergencies anywhere in the United States and in certain Mexican or Canadian hospitals or urgently needed services when you are temporarily outside the (HEALTH PLAN) service area must be provided or authorized by (HEALTH PLAN). The use of non-plan providers, except in the emergency or urgent situations mentioned above, will result in your obligation to pay for routine care. NEITHER (HEALTH PLAN) NOR MEDICARE WILL PAY FOR THESE SERVICES. *

10. By enrolling in (HEALTH PLAN), I authorize:

   a. The Health Care Financing Administration to furnish information to (HEALTH PLAN) confirming my entitlement to Medicare Hospital Insurance Benefits (Part A) and/or Supplementary Medical Insurance Benefits (Part B) under Title XVIII (the Medicare Program) of Social Security Act; and

   b. (HEALTH PLAN's) providers or any other holder of medical or other relevant information about me to release to the Health Care Financing Administration or its medical claims agencies any information needed to administer Title XVIII (the Medicare Program) of the Social Security Act.

11. I understand that it is my responsibility to inform (HEALTH PLAN) prior to moving or leaving the service area for more than 90 consecutive days, and that my absence means the (HEALTH PLAN) may take action to disenroll me from the (HEALTH PLAN) and return me to traditional Medical coverage.

12. I understand that (HEALTH PLAN) will send me written notification of the effective date of my enrollment in (HEALTH PLAN).

   I understand that, beginning with my effective date, I must receive all of my health care from (HEALTH PLAN) with the exception of emergency care anywhere in the United States including certain hospitals in Mexico and Canada, urgently needed out-of-area care, and referrals authorized by (HEALTH PLAN).

   I understand that my proposed effective date is . Unless notified otherwise, I should begin receiving all my medical care from (HEALTH PLAN) as of that date.

   Signature

   Date

*Cost Contract Enrollment Form: Omit this language from the Cost Enrollment Form, and provide an in-plan, out-of-plan, explanation of beneficiary liabilities for cost members.
 HEALTH CARE PLAN
MODEL REQUEST FOR DISENROLLMENT FORM

DATE __________________________

(Please Print In Ink)

MEMBER'S NAME ____________________________

First                   Middle                   Last

ADDRESS ____________________________

City                  State       Zip Code       County

TELEPHONE (___) ____________________________

MALE ___________ FEMALE ___________ DATE OF BIRTH ___________

MEDICARE # ________________

DISENROLLMENT RESPONSIBILITIES:

Please carefully read and complete the information below before signing and dating the
disenrollment form.

HAVE YOU RECENTLY ENROLLED IN ANOTHER HMO AS A MEDICARE MEMBER?

Yes      No

O       O

NOTE: (a) If you want to return to the Medicare fee-for-service program, then you have to
complete this disenrollment form.  (b) If you want to join another HMO immediately
following termination from (HEALTH PLAN), then you do not need to complete this
form.  Once you enroll in another HMO, your current membership in (HEALTH PLAN)
will automatically be cancelled.

Disenrollment from the (HEALTH PLAN) will be effective on the first day of the month after the
month (HEALTH PLAN) receives the written request (unless you request a later date of
disenrollment).  FOR EXAMPLE, if you complete this form and give it to (HEALTH PLAN) on
April 30th, the last day of the month, your disenrollment will be effective the next day, May 1st.

Members who have requested disenrollment must continue to receive all medical care from
(HEALTH PLAN) until the effective date of disenrollment.

Requested disenrollment date: _____________________________________

Signature: ___________________________________

Date: ___________________________________
MODEL CAPACITY WAIVER CALCULATION WORKSHEET

STEP

1. Start with total capacity for the year that the waiver is requested (i.e., how many slots are available for both commercial and Medicare).

2. Current total (Medicare/Medicaid and commercial) membership, excluding estimated number of "age-ins" (i.e., non-Medicare enrollees of your plan who will convert to Medicare status during the period for which you are seeking a capacity waiver).

3. Projected new Medicaid-only and commercial individual or group members.

4. Add steps (2) and (3) and subtract result from step (1) above to determine remaining slots available.

5. Divide step (4) above by the utilization factor or factors from the most recent ACR to determine available slots for Medicare enrollees. Use an inpatient factor, and ambulatory factor, or both. However, if both are used, the data must be shown separately for each one, or show an acceptable methodology for combining the factors.

6. The resultant figure is the initial number of available Medicare slots.

7. Enter estimated Medicare enrollment from "age-ins." (Current members excluded from (2) above.)

8. Subtract step (7) from step (6). The result is the total number of slots available to individual Medicare members.
## PART 2
### CHAPTER 2
### BENEFITS

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2101. ENTITLEMENT TO SERVICES

All Medicare beneficiaries enrolled in your HMO/CMP (whether risk-based or cost-reimbursed) are entitled to receive at least the services that are covered by fee-for-service Medicare in your geographic area. You must provide, or arrange to provide, all services covered by Part A and Part B of Medicare. In the case of an enrollee who is only entitled to Part B, you must provide, or arrange to provide, all services covered by Part B. If you have a risk-based contract, you may require a Part B only Medicare beneficiary to purchase, as a mandatory supplemental benefit (see §2109), a package of benefits that includes some or all Part A services covered under Medicare. Medicare-covered services are described in §§1040 and 1050. Do not rely on this general description. For detailed descriptions of coverage under fee-for-service Medicare, refer to the Medicare Carriers Manual (MCM), Medicare Intermediary Manual (MIM), and Coverage Issues Manual (CIM), which are provided to you when you sign your contract with Medicare.

Risk-based organizations also may be required to provide additional benefits not covered by Medicare. (See §2108.)

Risk-based and cost-reimbursed organizations are responsible for emergency services both in and out of the geographic area served under your Medicare contract and for urgently needed services outside the geographic area served under your contract. (See §2107.)

If you have a health care prepayment plan (HCPP) agreement with HCFA, you may offer a limited scope of Part B services.

You must provide or arrange for services that meet Medicare standards and are available and accessible. (See §2160.)

2102. BENEFITS WHICH ALL CONTRACTING HMOS/CMPS MUST FURNISH

A. Medicare Covered Services.--Provide or arrange for, at a minimum, all medically necessary services (except hospice services (see §2103)) that are covered under Parts A and B. These services include, but are not limited to:

- Inpatient hospital care for up to 90 days in each benefit period (see §1040.1), plus any lifetime reserve days available out of 60 total lifetime reserve days. (There is a 190 day lifetime limit for care in a Medicare certified psychiatric hospital.);

- Inpatient care in a skilled nursing facility (SNF) for up to 100 days of post-hospital care for each benefit period;

- Physician services and services incident to their services, including first and second surgical opinion in the plan, manual manipulation of the spine to correct subluxation demonstrated by physician-read x-ray, and non-routine podiatric services (e.g., plantar warts and mycotic toenails);

- Outpatient physical therapy, occupational therapy, and speech pathology services;

- Ambulatory surgical center (ASC) services;

- Outpatient hospital services;

- Comprehensive outpatient rehabilitation facility (CORF) services;
Home health services;
Diagnostic laboratory, x-ray and other diagnostic tests, including portable x-rays used in the home;
The following drugs and biologicals (see MCM §2050.5):
- Blood (see §2115A for limit on coverage);
- Hemophilia clotting factors;
- Antigens;
- Pneumococcal vaccine;
- Hepatitis B vaccine for persons at high or intermediate risk of contracting the disease;
- Drugs used in immunosuppressive therapy for one year beginning with the date of discharge from the inpatient hospital stay during which a Medicare covered organ transplant is performed;
- Effective June 1989, erythropoietin (EPO) for dialysis patients who meet the medical criteria, administered either in the dialysis facility, or incident to the professional services of a physician, or, effective July 1991, self-administered by home dialysis patients; and
- Injectable drugs for treatment of osteoporosis if the patient is homebound and cannot self-administer the drug (as certified by a physician);
Surgical dressings, splints, casts (see MCM §2079);
Braces, and artificial limbs and eyes (see MCM §2133);
Prosthetic devices (see MCM §2130);
Durable medical equipment (see MCM §2100);
X-ray, radium and radioactive isotope therapy (see MCM §2075);
Ambulance services when transportation by other means is contraindicated by the individual's condition (see MCM §2120);
Treatment of end stage renal disease (see MCM §2230);
Outpatient treatment of mental illness (see MCM §§2470ff. and §2115E for limitation on recognized charges and coverage of partial hospitalization);
Outpatient physical therapy and speech pathology services (see MCM §§2200ff.); and
Screening mammography and pap smears according to a schedule based on age and risk of developing breast or cervical cancer (see CIM §§50-20.1 and 50-21).
Medicare also covers services in the following settings:
Rural health clinics (see MCM §2260);
Normal Medicare coverage and/or payment rules may not apply in these special settings.

Medicare covers the services of the following non-physician practitioners (refer to the manual sections cited for conditions that apply):

- Clinical psychologists (see MCM §2150);
- Clinical social workers (see MCM §2152);
- Physician assistants (see MCM §5259);
- Nurse practitioners (see MCM §1M 2156)*;
- Clinical nurse specialists*;
- Nurse midwives (see MCM §2138); and
- Certified registered nurse anesthetists (see MCM §5261).

See §2153.4 for a discussion of the coverage of auxiliary personnel when furnished without physician supervision.

* Section 4155 of the Omnibus Budget Reconciliation Act of 1990 amended coverage of nurse practitioners in rural areas and added coverage of clinical nurse specialists effective January 1, 1991.

B. Transplants.--You are required to cover organ and tissue transplants that the Secretary determines are not experimental. Required transplants include:

- Kidney (see CIM §§35-35, 35-58, 45-22, and 50-26);
- Heart (see CIM §35-87);
- Liver (see CIM §35-53);
- Bone marrow (see CIM §35-30); and
- Cornea.

You are required to provide or arrange for certain transplants in out-of-area hospitals. Heart and liver transplants may only be performed in Medicare approved transplant centers. Not all hospitals performing transplants are Medicare approved transplant centers, even if they are participating hospitals for other services.
If one of your Medicare enrollees is a candidate for heart or liver transplant surgery, give him/her written notification that the procedure is a covered Medicare service and that it is performed in facilities specially approved by Medicare. The transplant facility makes the determination as to whether the enrollee meets the patient selection criteria. Refer your enrollees who are appropriate candidates only to Medicare approved heart or liver transplant facilities for evaluation. HCFA notifies you of each new Medicare approved transplant facility. The Regional Office (RO) has a complete list of these facilities. The facility determines whether to perform the transplant. Failure to refer appropriate candidates to, or to provide or arrange for the service in, a Medicare approved heart or liver transplant center is subject to a civil money penalty of up to $25,000 for each violation.

C. Midyear Coverage Changes.--As benefits become covered, they must be made available to Medicare enrollees on the effective date of Medicare coverage. The cost of providing new or expanded benefits which are mandated by Congress midyear must be borne in its entirety by contracting risk HMOs and CMPs. However, when the Secretary expands benefits which the Secretary identifies as involving significant costs, and these benefits were not included in the adjusted average per capita cost (AAPCC) calculation, risk-based HMOs and CMPs are not responsible for providing or paying for these benefits. When HMO/CMP enrollees receive such services, Medicare pays the benefits under fee-for-service until the next contract year, when the benefits are included in the AAPCC.

2103. EXCEPTION FOR HOSPICE SERVICES

You are not required to furnish hospice care. If an enrollee elects Medicare hospice coverage, the care may only be furnished through a Medicare certified hospice that is paid directly by Medicare. Medicare capitation payments made to the HMO/CMP on behalf of the enrollee for Medicare covered services are suspended on the effective date of his or her election of Medicare hospice benefits. If you have a risk-based contract, a reduced Medicare payment may continue to the extent it reflects savings used to provide additional benefits. (See §2103.2.) Hospice elections can be effective any day of the month.

The beneficiary's election means that only the hospice may be paid for care related to the terminal condition. (See §2103.2.) However, suspension of payment does not mean that the beneficiary is disenrolled. You may not involuntarily disenroll the beneficiary if he or she chooses to remain enrolled and continues to pay any applicable premiums. If the beneficiary remains enrolled, you are responsible for providing any Medicare covered services not related to the terminal condition, and you are paid by HCFA on a fee-for-service basis. If you have a risk contract, the beneficiary is not locked in while the hospice election is in effect.

2103.1 Definition.--In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and certified terminally ill by an attending physician.

2103.2 Service to Hospice Patients.--Continue to provide services for conditions that are unrelated to the enrollee's terminal illness and attending physician services if the beneficiary selects an HMO/CMP physician as his/her attending physician.

If you have a risk-based contract, continue to provide approved additional benefits (see §2108), and both risk-based and cost-reimbursed contractors must continue to provide any supplemental benefits the individual is entitled to receive.
The hospice is responsible for providing or arranging for any care related to the terminal condition.

2103.3 Continuation and Revocation of Hospice Election.--Hospice care may continue for four election periods. The fourth period, which is of unlimited duration, cannot be elected independently. It must immediately follow the third period. If the beneficiary revokes hospice care in the third or fourth period, or if the third period expires and the fourth period is not elected, the beneficiary is no longer eligible for Medicare hospice benefits. (See 42 CFR 418.28.)

The enrollee may revoke election of hospice benefits at any time and resume full membership in your HMO/CMP effective on the date of revocation.

2103.4 HMO/CMP Responsibility to Refer Patients for Hospice Care.--Inform terminally ill Medicare enrollees about the availability of hospice care if a Medicare participating hospice is located in your geographic area, or it is common medical practice to refer patients to hospices out of the area. The RO has a list of Medicare certified hospices. Medicare does not pay for care in non-certified hospices.

The hospice obtains a copy of the attending physician's certification and the beneficiary election documents. Request a copy of the patient's election of hospice benefits for your records. The document identifies the effective date and the beneficiary's acknowledgement that certain services are waived (e.g., the beneficiary has waived his/her right to therapeutic services in favor of palliative care only).

2103.5 Medicare Payment for Services to Hospice Patients.--If you have a risk-based contract and your Medicare average payment rate (APR) exceeds your adjusted community rate (ACR), HCFA reduces the Medicare monthly payment to your plan to the amount of the difference between the APR and the ACR. If you provide any non-hospice services to the enrollee that are not related to the terminal illness, you are paid by intermediaries and carriers under the fee-for-service system. If the enrollee specifies a physician at your HMO/CMP as his/her attending physician, the physician continues furnishing hospice services related to the terminal illness. These services may be billed directly to Medicare on a fee-for-service basis provided the physician is not employed by, or under contract to, the enrollee's hospice. When the enrollee revokes his/her hospice election mid-month, bill fee-for-service for all covered services furnished from the date of revocation until the full monthly capitation payment begins again on the first day of the following month.

If you have a cost-reimbursed contract, HCFA continues to pay you for the reasonable cost of Medicare covered services that are not related to the terminal illness, and for services provided by the beneficiary's attending physician if he or she is employed by, or under contract to, your plan and is not being paid by the hospice.

Reimbursement arrangements for HMO/CMP services to enrollees who have elected hospice care are discussed further in §§4100ff. and 5000ff.

2104. EMERGENCY SERVICES

Assure that medically necessary emergency care is available 24 hours a day, 7 days a week. Beneficiaries are not required to receive emergency services at your plan facilities nor are they required to secure prior approval for emergency services provided inside or outside your geographic area. Provide
a system to pay claims for emergency services provided out-of-plan and pay for all emergency services provided out-of-plan. (See §2107 for the permissible limits on the amount you must pay.)

2104.1 Definition.--Use the definition provided in 42 CFR 417.401. Specifically, "emergency services" mean covered inpatient and outpatient services that are:

- Furnished by an appropriate source other than the organization;
- Needed immediately because of an injury or sudden illness; and
- Needed because the time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health. Such services must be, or appear to be, needed immediately.

EXAMPLE: While visiting her son, a 70 year old woman with a history of cardiac arrhythmias experiences a rapid onset of chest pain, nonproductive hacking cough, and generalized tired feeling. The son calls his own physician, who recommends he bring his mother in to see him right away. After the physician evaluates the patient, the physician diagnosis is a common cold, and he prescribes two over-the-counter medications for treatment.

In this case, the HMO/CMP is required to pay for the physician's services because the enrollee's medical condition appeared to require immediate medical services.

There does not need to be a threat to a patient's life. An emergency is determined at the time a service is delivered. Do not require prior authorization. You may request notification within 48 hours of an emergency admission or as soon thereafter as medically reasonable. However, payment may not be denied if notification is not received.

If it is clearly a case of routine illness where the patient's medical condition never was, or never appeared to be, an emergency as defined above, then you are not responsible for payment of claims for the services. Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature.

All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. An example is a member who is treated in an emergency room for chest pain and the attending physician orders diagnostic pulmonary angiography as part of the evaluation. Upon retrospective review, you cannot decide that the angiography was unnecessary and refuse to cover this service.

If during treatment for an emergency situation, the enrollee receives care for an unrelated problem, you are not responsible for the care provided for this unrelated non-emergency problem. An example is a member who is treated for a fracture and the attending physician also treats a skin lesion. You are not responsible for any costs, such as a biopsy, associated with treatment of this unrelated non-emergency care.

After the emergency, pay the cost of medically necessary follow-up care. (See §2105.)

2104.2 Transfers.--If one of your Medicare enrollees receives emergency medical care in a non-plan hospital, you may wish to transfer the patient to
your facility (or a facility that you designate) as soon as possible. Pay the transfer costs, such as an ambulance charge, if it is necessary.

Be aware that the transferring hospital is subject to statutory limitations on when, and how, the transfer may be made. Under §1867 of the Act, the hospital must first determine whether the patient's condition has stabilized within the meaning of the statute. In general, this means that within reasonable medical probability, no material deterioration of the condition is likely to result from, or occur during, the transfer.

If the patient's condition has not stabilized, the patient may only be transferred if the patient makes an informed, written request for transfer, or the attending physician or appropriate medical authority signs a certification that the risks of the transfer are outweighed by the medical benefits expected from transfer to another medical facility. If these conditions are met, then the transfer may be made, but only if it also meets the definition of an appropriate transfer. (See §1867(c)(2) of the Act.)

In general terms, an appropriate transfer is one in which:

- The transferring hospital:
  - Provides medical treatment to minimize the risks to the individual,
  - Forwards all relevant medical records, and
  - Uses qualified personnel and transportation equipment for the transfer;

- The receiving facility:
  - Has available space and qualified personnel, and
  - Except for specialized facilities that under §1867(g) of the Act cannot refuse a transfer, agrees to accept the transfer and provide appropriate medical treatment; and

- The transfer meets any other requirements the Secretary may find necessary in the interest of health and safety of individuals.

If the transferring hospital fails to meet these requirements, it may lose its Medicare provider agreement or be subject to civil money penalties or a civil action for damages. Physicians involved in an improper transfer may also be subject to civil money penalties and may be excluded from participation in Medicare.

Provide assistance with the above requirements to facilitate an appropriate transfer to one of your facilities or a facility that you designate.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the HMO/CMP.

2105. URGENTLY NEEDED SERVICES

Urgently needed services are Medicare covered services required in order to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or an injury. Cover these services if:

- The enrollee is temporarily absent from your geographic area, and
The receipt of health care services cannot be delayed until the enrollee returns to your organization's geographic area. The enrollee is not required to return to the service area because of the urgently needed services.

Urgently needed care pertains only to out-of-area care to treat an unforeseen condition. Prior authorization is not needed in seeking urgently needed services. Your marketing materials must clearly describe the concept of urgently needed services as well as include an explanation of the enrollee’s rights in these situations.

EXAMPLE: A 72 year old man had a left femoral bypass graft 6 weeks ago. He goes on his previously scheduled vacation to his sister's house who lives out of the service area. While there, he begins to notice left leg numbness that is occurring with greater frequency and intensity and is not totally relieved by his medications. His sister takes him to see her physician.

Pay for the physician's services because the enrollee's medical condition appeared to be such that the provision of medical services could not be delayed until the enrollee returned to your service area.

Services that can be foreseen are not considered urgently needed services, and you are not required to pay for these services without prior authorization.

For example, you are not required to pay without prior authorization when a member who needs routine dialysis or oxygen therapy travels outside your service area for a personal emergency or a vacation. Develop a clear policy on your responsibility and the beneficiary's financial responsibility in these situations. Consider making special arrangements with providers outside your service area or clearly discussing any restrictions on out-of-area coverage with Medicare beneficiaries at the time of application. Marketing materials must clearly describe the limits of your out-of-area coverage.

Assume responsibility for urgently needed services without regard to the length of absence from the geographic area, as long as the enrollee maintains membership in your plan. However, if the enrollee is absent for an extended period (beyond 90 consecutive days) and you have not been notified and have not arranged for membership to continue, you may assume that the move is a permanent move and begin procedures to disenroll the beneficiary. If you do not disenroll the beneficiary and you know that he/she is absent for more than 90 consecutive days, then you are liable for all services rendered, including routine care. (See §§2001ff.)

Cover medically necessary follow-up care to emergency and urgent care situations if that care cannot be delayed without adverse medical effects.

2106. SERVICES IMPROPERLY DENIED

You are financially responsible for services that you deny or fail to furnish that are found, upon appeal, to be services which should have been furnished. (See §§2400ff.)

2107. PAYMENT FOR SERVICES FURNISHED BY NON-PLAN PROVIDERS

If you have a Medicare HMO/CMP contract, assume financial liability and pay for emergency services, urgently needed services, and services found on appeal to have been your responsibility. You must also pay for referral services when furnished by providers with whom you have made no formal arrangements for payment.
For inpatient care, hospitals and SNFs that do not have an agreement with you, or that have an agreement that does not specify payment arrangements, must accept as payment in full the amount that Medicare pays in the fee-for-service system, or, if less, billed charges.

For hospitals under the prospective payment system (PPS), this amount is the amount Medicare pays to the hospital under PPS for the particular discharge, based on diagnosis-related groups (DRGs), plus a hospital specific add-on for capital and direct medical education expenses. HCFA provides you with the software necessary to calculate this amount, or you may obtain this information from the intermediary in your area. Hospitals and hospital units exempt from PPS are paid a per patient or per diem amount using the interim payment rates obtained from the intermediaries. (The interim payment rates are used here because they reflect the cost limits applied to all operating costs as well as additional payments for capital and direct medical education expenses.)

For HMO Medicare enrollees served by a non-contracting SNF, the nursing facility is paid the sum of a per diem rate for routine care (not to exceed the SNF limit) multiplied by the number of days of care, plus a per diem rate for capital costs, plus the reasonable cost of all ancillary services calculated using the Medicare principles of payment.

In order for you to use these formulas, obtain data from the SNF’s fiscal intermediary (FI) and ensure the data is in a useable form for calculating per patient payment amounts. Make your requests for data from the FI as unburdensome as possible. For example, only request the specific information needed to establish a particular payment. Information which remains unchanged for a period of time, such as the per diem rates for routine care and capital costs, is not requested again until the period is over and new rates are available. If the FI cannot provide you with the necessary data or cannot respond within your timeframe, you must work from a cost report. Request that the SNF voluntarily share the necessary sections of the report with you.

For both hospitals and SNFs that do not have an agreement with you, you must pay the hospital deductible and the SNF coinsurance amounts. These amounts are included in the monthly premium that you are permitted to collect (or waive) from Medicare beneficiaries.

In paying for physician services or renal dialysis services furnished by a physician, provider of services or a renal dialysis facility that does not have a contract with you, use Medicare fee-for-service payment amounts, which must be accepted as payment in full. These payment amounts may be applied to all physician services (including emergency or urgently needed out-of-area situations) and renal dialysis services received by your enrollees from a non-contracting physician, provider of services or renal dialysis facility. You may use these payment amounts for services that a Medicare enrollee obtains on the basis of a referral made by your HMO/CMP to a physician not under contract to your HMO/CMP. Unlike the computation of prospective payment amounts for Medicare hospital payments, there are no software programs which HCFA can provide which allow you to calculate Medicare physician payments.

With regard to provider and supplier services, other than those described above, you are expected to pay the amount billed unless you negotiate a different payment amount. If you negotiate a lower amount than billed, the Medicare beneficiary may not be held liable for the difference between billed charges and your actual payment. (See §2107.1.)

In addition, for physician and supplier services and hospital outpatient services, you are responsible for the Part B deductible and the twenty percent
beneficiary coinsurance amount.

2107.1 Beneficiary Cost Sharing Responsibilities for Services.--If you are a risk HMO/CMP, the sum of your charges for copayments, coinsurance, or deductibles may not exceed, on the average, the national actuarial value of the coinsurance and deductible amounts the beneficiary would have paid had he/she not been enrolled in a Medicare contracting plan.

While you may negotiate lower payment amounts with providers and suppliers as described in §2107, it is ultimately your responsibility to assume full financial responsibility for the services. Assure that the beneficiary has no liability beyond any approved copayments (i.e., the beneficiary is not balance billed).

Similarly, if you are determined, upon appeal (see §2400), to be liable for services that a beneficiary obtained without authorization because you improperly denied coverage, the beneficiary does not have liability for any balance billing from the provider of such services. In this instance also, you are liable for paying the full charges or paying whatever amount you can negotiate with the provider as payment in full. The beneficiary is only liable to you for copayments or other beneficiary liability amounts approved as part of your Medicare contract.

2108. ADDITIONAL BENEFITS

If you have a risk-based contract under which the Medicare APR exceeds your ACR, provide your Medicare enrollees with additional benefits beyond the scope of Medicare coverage, and/or reduce premiums or other charges to Medicare enrollees. You may, as an alternative or in addition, return all or part of the excess payment to the government, or ask the government to keep a portion of the excess amount in a benefit stabilization fund (BSF).

Describe any additional benefits, including reduced premiums, in the annual ACR submission to HCFA. HCFA reviews and approves these additional benefits to ensure that their value is equal to the difference between the APR and ACR (and any requested reduction in monthly payment and amounts withheld in a BSF).

Make approved additional benefits available to all Medicare enrollees. Any adjustment of the premium charged for the Part A/B enrollee package must be reflected equally in the package of benefits offered a Part B only beneficiary. Approved additional benefits must remain in effect through the term of the contract. If you use the difference between the ACR and APR to reduce premiums, you may not raise them during the remainder of the contract period. If you provide additional benefits, you may not discontinue the additional benefits during the contract year. The only change that HCFA considers is one that is more advantageous for the enrollee, such as enhanced benefits or reduced premiums. See §§5300ff. for further explanation of how to determine the value of these benefits.

2109. SUPPLEMENTAL BENEFITS (SUBJECT TO PREMIUM)

You may also offer supplemental benefits that are beyond the scope of Medicare coverage. (For risk-based contractors, supplemental benefits are in addition to the additional benefits described in §2108.) Enrollees may be charged an additional premium over and above the amounts which may be charged to cover Medicare deductible and coinsurance amounts. The amounts charged to cover supplemental services must be separately identified and may not exceed the ACR for those services.
If you are a cost-reimbursed contractor, you may offer an optional supplemental benefit package. However, you must offer a basic Medicare package that covers only Part A and B covered services.

If you are a risk-based contractor, your supplemental benefit package may be mandatory or optional or a combination of both. Submit your proposal to HCFA as part of the ACR proposal. You may not discriminate on the basis of health status with respect to these benefits. HCFA must also approve any mandatory supplemental benefits. HCFA approves the proposal if it determines that the design does not discourage some beneficiaries from enrolling in the organization.

If a beneficiary chooses to drop an optional supplemental plan (either by providing notice or by stopping premium payments), you must continue the basic Medicare plan (i.e., Part A and B services for cost-reimbursed contractors and Part A and B services, additional benefits, plus mandatory supplemental benefits for risk-based contractors). Do not disenroll enrollees for failure to pay the optional supplemental premium. (See §2170.5.)

Make any supplemental benefits package available to any Medicare enrollee who wishes to purchase it. Do not set health status standards for enrollees you accept for optional or mandatory supplemental benefit packages.

2109.1 Employer Group Retirees.--You may offer extra benefits to beneficiaries who are eligible (based upon their past employment) for employer group benefits beyond those you offer to other Medicare members. Such benefits are offered pursuant to HMO/CMP agreements with unions or employers, and are not additional benefits or supplemental benefits as these terms are used for Medicare purposes. Because these benefits are not offered pursuant to the Social Security Act, it is up to you to negotiate such agreements, including the amount of the premium to be charged, directly with employers and unions. Offer employer group members at least what is offered to other Medicare enrollees. This is necessary in order to ensure that any additional and supplemental benefits that are offered pursuant to the Act are made available to all Medicare enrollees.

2110. FLEXIBLE BENEFIT PACKAGES

You have flexibility to structure your Medicare benefit package according to your market needs under certain circumstances:

- Benefits/premiums may vary by county within the service area. For example, you may wish to waive part of the premium in some counties, while charging the full ACR approved premium in others.

- Benefits/premiums may vary by delivery system. For example, the ACR approved premium is charged to those members who select an individual practice association (IPA) type delivery system, and some of the premium is waived for those individuals who choose a staff model system.

If you are interested in submitting a proposal to HCFA for an alternative benefit structure, submit it in writing at least 60 days before the ACR is due. Clearly designate any benefit/premium variations in your marketing materials. Reductions in, or waivers of, premiums that do not apply to all Medicare enrollees may not be financed by funds representing the difference between your ACR and your APR.
2111. PROHIBITION ON HEALTH SCREENING

Except as provided below, do not require a Medicare enrollee, as part of enrollment, reenrollment or receipt of any services, to submit to or pass a health examination. This prohibition on health screening applies to any service or set of services offered to Medicare enrollees, whether they are required services under Medicare, additional services, or mandatory or optional supplemental services. This prohibition applies to HMOs/CMPs which contract with HCFA on a risk or cost basis.

There are penalties specified in law for violations of the health screening prohibitions. (See §1016.)

2111.1 Exceptions.--Do not enroll persons who have been medically determined to have end stage renal disease (ESRD) or who have elected the Medicare hospice benefit (unless they are already enrolled in the organization and convert to the Medicare contract when they become Medicare eligible, in which case you may not disenroll them). Question the applicant to determine whether he/she has ESRD or has made a Medicare hospice election. You may also question Medicare beneficiaries about whether they reside in an institution for purposes of determining proper payment under a risk contract.

2112. SNF COVERAGE

Medicare covers care in a SNF if all of the following three factors are met:

- The patient requires and receives skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel;
- The patient requires and receives these skilled services on a daily basis; and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.

If any of these three factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care is not made if a patient needs an intermittent rather than daily skilled service. If the need for a skilled service does not exist, then the daily and practical matter requirements are not addressed.

In addition, the services must be furnished pursuant to a physician's order and must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, his or her particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Inpatient stays solely to provide custodial care, i.e., assisting individuals in the activities of daily living, are excluded from coverage.

Review your SNF coverage criteria to assure that your policies and practices meet the Medicare guidelines. For example, an intermediary processing a claim is bound by the practical matter assumption which means that absent evidence to the contrary, the intermediary assumes that alternatives to SNF care are not practical and, therefore, are not covered. Use the criteria based on the actual alternatives available to meet an individual enrollee's needs; for example, you
could use home health services to meet the person's need for skilled care if you are choosing to provide home care in place of skilled nursing facility care.

2112.1 Level of Care Determination.--If your physician admits an enrollee to a SNF and certifies that the enrollee requires a skilled level of care, you are responsible for that care. Do not retroactively determine that the enrollee did not require a skilled level of care and deny coverage. Do not retroactively require a beneficiary to be liable for services that have been previously authorized. (See §2116.)

If you deny admission to a SNF or determine that coverage is no longer required because the enrollee no longer meets skilled care guidelines, notify the enrollee in writing at or before the time of denial. When a copy of the notice is given to a beneficiary (or person acting on his or her behalf), the HMO/CMP's copy should contain the signature of the beneficiary (or person acting on his or her behalf) acknowledging the date he or she received the notice. Where personal delivery is not possible, the HMO/CMP's copy reflects the date the notice was mailed to the beneficiary and evidence of receipt by the beneficiary (e.g., date the beneficiary was telephoned to confirm receipt or use of return-receipt mail).

The notice must specify:

- The reasons why the patient does not meet SNF coverage guidelines;
- Any financial liability that is shifted to the beneficiary or another party, and the effective date;
- Alternative services that are covered, e.g., home health services; and
- Procedures for the beneficiary to appeal the determination.

If you fail to give the beneficiary proper notice, the beneficiary is protected from liability until he/she receives the notice. A sample notice is included in Appendix A.

A notice giving authorization for a prescribed number of days of service is not considered a notice of non-coverage. Continue to monitor the member's progress to determine if the initial prescribed estimate was appropriate, and either authorize continued coverage or give a written notice of non-coverage.

You may delegate the determination of continued eligibility for coverage and discharge planning to the SNF. However, the actual written notification to the patient, or the patient's representative, regarding any change in coverage or financial liability remains your responsibility. As a condition of participation, the SNF must devise and monitor a plan of care.

2113 HOME HEALTH COVERAGE

Medicare covers medically necessary home health services under Part A or Part B of the program. The eligibility criteria for Medicare coverage of home health services require the beneficiary to be:
o Confined to the home;

o Under a plan of treatment established and periodically reviewed by a physician; and

o In need of intermittent skilled nursing care, physical therapy, speech therapy, or, in certain situations, occupational therapy.

A beneficiary must meet all three eligibility criteria before Medicare pays for home health services.

Occupational therapy is not a basis for initial eligibility for home health services. However, if a beneficiary otherwise qualifies for home health services and is also in need of occupational therapy, the patient's eligibility for home health services may be continued solely on the basis of the continuing need for occupational therapy, even after he or she no longer needs intermittent skilled nursing care or speech or physical therapy.

2113.1 Definitions for Part-Time or Intermittent Skilled Nursing Care and Home Health Aide Services.--Once a beneficiary is determined eligible for home health services, Medicare covers either part-time or intermittent reasonable and necessary home health aide services and skilled nursing services as defined below.

Part-time means up to 35 hours per week, any number of days per week, of skilled nursing and home health aide services combined, provided less than 8 hours per day. The additional hours per week are subject to review by the HMO/CMP based on documentation justifying the need and reasonableness of such additional care.

Intermittent means:

o Up to 35 hours per week of skilled nursing and home health aide services combined, provided on less than a daily basis. The additional hours per week are subject to review by the HMO/CMP based on documentation justifying the need for and reasonableness of such additional care; or

o Up to and including full-time (i.e., 8 hours per day) skilled nursing and home health aide services combined, which are provided and needed 7 days per week. They are for temporary, but not indefinite, periods of time of up to 21 days with allowances for extensions in exceptional circumstances where the need for care in excess of 21 days is finite and predictable.

2113.2 Care Provided in Excess of Part-Time or Intermittent Care.--Under certain circumstances, Medicare permits exceptions to the part-time or intermittent coverage rules. These extenuating circumstances are based on medical necessity and are considered on a case by case basis.

Example: A beneficiary needs skilled nursing care monthly for a catheter change, and the home health agency also renders needed daily home health aide services 24 hours per day which are needed for a long and indefinite period of time. The home health agency bills you for the skilled nursing and home health aide services which were provided before the 35th hour of service each week and bills the beneficiary for the remainder of care. If you (or an intermediary on your behalf) determine that the 35 hours of skilled nursing services and home health aide services are medically reasonable and necessary, then cover the 35 hours of services.
Insulin shots for beneficiaries who are incapable of administering the drugs themselves are covered under the home health benefit.

Example: A blind beneficiary requires daily insulin injections, and there is no other caretaker to assume this responsibility. Medicare covers a daily visit by a nurse.

Note: The above definition only pertains to part-time or intermittent services. It does not affect the intermittent eligibility requirement under §§1814(a)(2)(c) and 1835(a)(2)(a) of the Act.

2114. ESRD TREATMENT SETTING

Patients may be treated at a facility or at home. Since it is not likely that all enrollees with ESRD are good candidates for home dialysis, be prepared to make the service available in either setting. It is not appropriate for you to have an across-the-board policy that all of your patients dialyze at home.

Your physician must develop, in consultation with the ESRD patient, a personalized patient care plan reflecting the psychological, social and functional needs of the patient as well as medical considerations. Patients must also be consulted when changes are made in a treatment plan.

If you wish to transfer a patient from facility to home dialysis, you must give the patient advance notice to ensure orderly transfer. A patient may be transferred only for medical reasons, for the patient's welfare or that of other patients, or for non-payment of fees. An ESRD patient may not be forced into home dialysis solely for economic reasons.

HMO enrollees may appeal the ESRD treatment that you provide through the HMO and Medicare appeals procedures. Enrollees may also appeal through the ESRD network patient grievance procedure. Information on the latter appeals process is provided to the beneficiary directly by the ESRD treatment facility.

2115. LIMITATIONS ON MEDICAL COVERAGE

Certain Medicare benefits are limited in coverage, e.g., an annual payment maximum or a lifetime coverage limit. You may offer benefits beyond the Medicare limits as part of a supplemental benefit package or, if you are a risk contractor, as part of your additional benefits. You may also offer benefits beyond the Medicare limits if they are provided at no cost to Medicare beneficiaries.

Establish a system to track utilization of these Medicare limited services. If you are a risk-based contractor, you need to account for the utilization of limited services for each Medicare beneficiary who disenrolls to assure that Medicare fee-for-service does not pay for services after a limit has been exceeded.

A. Blood.--Medicare does not pay for the first three pints of whole blood or equivalent units of packed red cells furnished to a Medicare beneficiary on an inpatient or outpatient basis in a calendar year. The beneficiary may replace the blood or packed red cells in lieu of payment. If the provider obtained the blood or red cells at no charge other than a processing or service charge, the blood is deemed to have been replaced.

B. Outpatient Mental Health Care/Payment Reduction (See MCM §§2470-2476).--Outpatient mental health services are not subject to a dollar or visit limit. However, Medicare recognizes only 62.5 percent of reasonable charges
(or customary charges in the case of a CORF) for services to treat a mental, psychoneurotic, or personality disorder for a Medicare beneficiary who is not an inpatient of a hospital. The charge is adjusted to 62.5 percent of the reasonable charge before payment. Payment is made at 80 percent of the reduced charge.

Services subject to the reduction include:

- Physician services to treat a mental disorder;
- Clinical psychologist (see MCM §2150) and clinical social worker services (see MCM §2152);
- Nonphysician mental health services furnished in a CORF; and
- Physician assistant and nurse practitioner mental health services whose services are being provided in accordance with §2153.2.

The 62.5 percent reduction only applies to treatment of the specified disorders. It, therefore, does not apply to the following services (i.e., these services are paid at 80 percent):

- Services to diagnose and test a condition rather than treat it (e.g., initial psychiatric visit, psychiatrist's consultation for attending physician);
- Treatment provided a patient with a diagnosis of Alzheimer's disease or a related disorder which represents medical management of the patient's condition rather than psychiatric treatment (see MCM §2476.2);
- Brief office visits solely to prescribe or monitor medications used in the treatment of mental, psychoneurotic or personality disorders; or
- Services of non-physician health care professionals which are incident to those of a physician or incident to those of a clinical psychologist, including services through the outpatient department of a hospital and partial hospitalization services (less than 24 hours of care).

Medicare uses the definition of mental, psychoneurotic and personality disorders as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Medicare coverage criteria do not draw any distinction between the treatment of the psychiatric aspects of alcoholism and drug addiction and any other types of mental health care.

There are special considerations for entities with agreements under §1833 of the Act (i.e., health care prepayment plans):

- Unlike risk-based and cost-reimbursed HMOs/CMPs contracting under §1876 of the Act, HCPPs must assure that services of physician assistants and nurse practitioners are supervised by a physician or performed through a physician-directed clinic, except when provided in rural health clinics (see MCM §§2260 and 5259); and
- Services other than those of a physician, clinical psychologist or clinical social worker are covered only as incident to those of a physician,
there is no 62.5 percent reduction, and such services may be billed through the cost report as long as the physician supervision requirement is met.

C. Inpatient Psychiatric Care.--Medicare covers a lifetime total of 190 days of inpatient psychiatric care in a psychiatric hospital for each beneficiary. If a Medicare beneficiary has used part of his or her 190 day lifetime benefit in a psychiatric hospital prior to enrolling in an HMO/CMP, he or she is only entitled to receive the difference between the number of days already used and the HMO/CMP benefit (190 days if the HMO/CMP has limited this coverage to the Medicare requirement). Partial hospitalizations (i.e., less than 24 hour daily care furnished by a hospital to its outpatients) are exempted from counting against the benefit limitation. Psychiatric confinements to general hospitals do not come under this limit; the regular benefit periods apply.

D. Independent Physical Therapist.--Medicare covers up to $500 each year for services performed by a licensed, independently practicing physical therapist who is certified by Medicare. (See MCM §§2210 and 2215.)

E. Independent Occupational Therapist.--Medicare covers up to $500 each year for the services of a licensed, independently practicing occupational therapist who is certified by Medicare for services rendered in the therapist's office or beneficiary's home. (See MCM §§2215 and 2217.)

F. Alcoholism/Drug Treatment.--Medicare does not provide benefits on a disease-specific basis. Thus, services for alcohol or drug treatment are those services that are otherwise covered by Medicare. Some guidelines to determine reasonable and necessary services are:

- Inpatient hospital stays for alcohol detoxification are generally 2-3 days, occasionally up to 5 days.

- Inpatient hospital stays for alcohol rehabilitation programs, comprised primarily of coordinated educational and psychotherapeutic services provided on a group basis under the supervision or direction of a physician, are available to the chronic alcoholic. Individual psychotherapy or family counseling may be provided in selected cases. Generally, 16-19 days of rehabilitation services are sufficient before care is provided on an outpatient basis.

- Coverage is available for both diagnostic and therapeutic services (but not meals, transportation, recreational or social activities) furnished for the treatment of alcoholism by a hospital to outpatients, subject to the same rules that apply to outpatient services.

- Detoxification and/or rehabilitation for drug substance abuse as a hospital inpatient or outpatient are covered if medically necessary and reasonable for the patient's condition.

- Alcoholism or drug abuse treatment services may be provided incident to a physician's professional services in a freestanding clinic according to the same rules that generally apply to coverage of clinic services.

- Chemical aversion therapy is covered if a physician certifies the need and the specific drugs have been approved by the Food and Drug Administration.
G. Covered Services for Part B Only Enrollees.—For risk-based HMOs/CMPs, beneficiaries must receive all covered Part B services either from or through the organization. (See also MCM §2255 for coverage of services to enrollees who have exhausted Part A benefits.) For cost-based HMOs/CMPs, beneficiaries are not locked-in and thus may receive services outside of the HMO/CMP. If the Part B enrollee is an inpatient in a hospital, pay for any service that is covered under Part B including physician services. For example, since Medicare Part B covers nutritional therapy as part of the prosthetic device benefit, you are responsible for providing enteral and parenteral nutritional therapy. The Part B only eligible beneficiary is also entitled to Medicare covered home health benefits, because they are covered under Part B for individuals who do not have Part A.

2116. POST-SERVICE COVERAGE DENIAL

Assure that physicians or providers know whether services are covered by Medicare or by your plan as an additional or supplemental benefit, and that they properly use the authorization system that you establish. If a Medicare beneficiary receives services under the direction or authorization of a plan physician, who is any physician who contracts with an HMO/CMP or is otherwise associated with the HMO/CMP, and the beneficiary has not been informed that he or she is liable for the costs of such services, then you must pay for such services. Do not, after the service is received, overturn a plan physician's decision that a service is medically reasonable and necessary. Do not deny coverage retroactively for a service ordered by a plan physician based upon a determination that the service exceeds Medicare limits, e.g., that it was a custodial rather than a skilled nursing service.

The only exceptions to the above instruction are (1) the presence of written evidence (including clear specification of non-coverage in marketing material) that the HMO physician advises the beneficiary before each and every service is received that the service is not covered unless further action is taken by the member and (2) cases where the beneficiary should be expected to know the services were not covered by Medicare, e.g., for acupuncture. You may require the Medicare enrollee to receive prior authorization from a primary care physician or a gatekeeper before specialty care is received.

If one of your physicians provides or directs a beneficiary to receive a covered Medicare service without following your internal procedures, then pay for the service. Do not penalize a beneficiary who has already received a service if the authorizing physician's referral was improper or the specialist delivered the service without the necessary authorization.

Furnishing of Services

2150. GENERAL

Subject to the rules described below, organize your service delivery system in the most efficient manner possible. If more than one type of practitioner or provider is qualified to perform a service, you have the option of choosing which practitioner or provider (as allowed by State law) you use to furnish a specific service as long as all Medicare covered services are available and accessible and services are of high quality. The providers and practitioners you use must meet minimum requirements to participate in the Medicare program as well as applicable State licensure requirements (i.e., be certified). The Medicare minimum standards may be less stringent than your own requirements. However, in certain cases, Medicare sets standards which specify the type of care that is appropriate and the setting for such care, e.g., in the case of heart transplants, Medicare specifies the coverage criteria and approves the specific facilities. (See §2102B.) You can use non-Medicare certified providers for services you offer to supplement the required Medicare benefits, including additional benefits for risk-based plans.
2151. CONDITIONS FOR PROVIDERS

Providers must meet minimum standards of health and safety identified as Medicare conditions of participation. HCFA defines the minimum standards, and States survey facilities and certify that facilities meet these standards. These providers are then known as participating Medicare providers. Conditions are defined for hospitals, SNFs, HHAs, hospices, CORFs, rural health clinics (RHCs), and providers of outpatient physical therapy and speech pathology services.

2151.1 Exception for HHAs Operated by HMO/CMP.--If you operate an HHA as an integral part of your HMO/CMP and it serves only your enrollees, do not sign a separate Medicare provider agreement for your HHA. However, your HHA must be reviewed by the State survey and certification team to assure that your HHA meets Medicare's conditions of participation.

2151.2 Submission of No-Pay Bills.--Hospitals that provide services to HMO/CMP patients are required to complete a Medicare bill and submit this bill for informational purposes to the fiscal intermediary. These bills are known as no-pay bills and data from them is sent to the utilization and quality control peer review organization (PRO) for sample selection purposes. The PROs use these bills to conduct their independent review of the quality of care provided to Medicare beneficiaries who are enrolled in risk-based HMOs or CMPs. (See §2300ff.) HCFA also uses no-pay bills for other data purposes.

2152. CONDITIONS FOR SUPPLIERS

Suppliers must meet minimum standards that are specified as conditions of coverage. Suppliers include ambulatory surgical centers (ASCs), independent laboratories, independent physical therapists and occupational therapists, portable x-ray suppliers, RHCs and suppliers of ESRD services.

2153. PHYSICIANS AND OTHER PRACTITIONERS

2153.1 Physician Services.--A physician must be licensed by the State in which he/she practices. For Medicare purposes, the term includes doctors of medicine or osteopathy or dentists. It also includes optometrists, chiropractors, and podiatrists, but only for certain services as defined under Medicare law and as permitted by State law. For example, a chiropractor is a physician under the Medicare definition only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist. Your marketing materials must clearly state which physician specialties you authorize to provide manual manipulation of the spine.

You have the flexibility to choose the appropriate physician specialty or non-physician practitioner to furnish a specific service. For example, you may choose the appropriate physician specialist to perform manual manipulation of the spine: chiropractor, orthopedic specialist, or osteopath.

You may not use physicians who have been excluded from participation in Medicare, Medicaid or other Federal health programs (i.e., those funded by title V or title XX). This restriction also includes physicians who have been sanctioned for failure to provide care of adequate quality or medically necessary care. (See §§2300ff.)

2153.2 Physician Direction and Supervision.--A licensed physician who is your employee, partner or contractor directs the overall furnishing of services to

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Each Medicare enrollee. Except as provided in §2153.4, a licensed physician must directly and personally supervise nonphysicians when those personnel are directly involved in the provision of health care services in your clinic or in the offices of a physician with whom you have an agreement. The nature of the service generally governs the type of physician who supervises the services. For instance, a podiatrist might supervise the provision of covered foot care services.

2153.3 Presence of Physician.--A licensed doctor of medicine or osteopathy should be present and available to administer medical services at each location where inpatient or outpatient services are furnished. Medicare does not require that a physician be present for the provision of home health, clinical laboratory, CORF rehabilitation, outpatient physical therapy or speech pathology, diagnostic audiological, diagnostic portable x-ray, or diagnostic physiological laboratory services.

2153.4 Exceptions to Physician Supervision.--You may permit the following personnel to furnish care, and services and supplies incident to such care, without the direct, personal supervision of a physician.

A. Nurse Practitioners.--A nurse practitioner is a registered professional nurse who is currently licensed to practice in the State, meets the State's requirements governing the qualifications of nurse practitioners, and meets one of the following conditions:

- Is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or

- Has satisfactorily completed a formal educational program of one academic year that:
  - Prepares registered nurses to perform an expanded role in the delivery of primary care;
  - Includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and
  - Awards a degree, diploma, or certificate to persons who successfully complete the program; or

- Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the above requirements but performed an expanded role in the delivery of primary care for a total of 12 months during the 18-month period preceding March 1, 1978.

B. Physician Assistants.--A physician assistant is a person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians, and who meets at least one of the following conditions:

- Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or

- Has satisfactorily completed a program for preparing physician's assistants that:
- Was at least 1 academic year in length;
- Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and
- Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or
  - Has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the above requirements but assisted primary care physicians for a total of 12 months during the 18-month period immediately preceding March 1, 1978.

C. Clinical Psychologists.--Clinical psychologists are exempt from the physician supervision requirements of §2153.2.

A clinical psychologist is a person who counsels patients and who:

  - Holds a doctoral degree in psychology from a program in clinical psychology of an educational institution that is accredited by an organization recognized by the Council on Post-Secondary Accreditation;
  - Is licensed or certified at the independent practice level of psychology in the State in which he or she practices; and
  - Possesses 2 years of supervised clinical experience, at least one of which is post-degree.

D. Certified Nurse Midwife.--A certified nurse midwife is a registered nurse who performs services in managing the care of mothers and babies throughout the maternity cycle. A certified nurse midwife must successfully complete a program of study and clinical experience approved by the Secretary or be certified by an organization recognized by the Secretary. Services incident to the services of certified nurse midwives may be covered.

E. Clinical Social Worker (CSW).--A CSW may provide services if the services would be covered if provided by a physician. An exception is that CSW services are not separately covered for inpatients of hospitals and SNFs under the fee-for-service system. Their services are provided or arranged by the hospital. CSWs are exempt from the physician supervision requirements of §2153.2. Services incident to the services of a CSW are covered in risk-based HMOs/CMPs but are not covered in cost-reimbursed HMOs/CMPs or health care prepayment plans.

A CSW must:

  - Have a master's or doctoral degree in social work;
  - Have at least 2 years of subsequent supervised clinical social work; and
  - Be licensed or certified by the State. If the State does not provide licensure or certification, the individual must have completed 2 years or 3,000 hours of post master's degree supervised clinical social work in an appropriate setting.

F. Certified Registered Nurse Anesthetists (CRNAs).--A CRNA may provide anesthesia services and related care, subject to State licensure requirements. A CRNA must meet the education, training and other requirements relating to
anesthesia services as the Secretary may prescribe. Services incident to the services of CRNAs are not covered.

G. Clinical Nurse Specialist (CNS).--Certain services of CNSs working in collaboration with a physician in a rural area in which the CNS is authorized to perform services may be covered, as well as services incident to the services of a CNS. (See §1861(s)(2)(K)(iii) of the Act.)

2160. AVAILABILITY, ACCESSIBILITY AND CONTINUITY OF SERVICES

All medically necessary Medicare covered services, supplemental services, and additional benefits must be available and accessible with reasonable promptness to Medicare members.

2160.1 Availability of Services.--The provider networks for Medicare enrollees must be sufficient to deliver inpatient and outpatient primary and specialty services to current and expected Medicare members in your plan or to make appropriate referrals. If you lose providers in a portion of the service area during the contract year, you must still assure the provision of covered services. Consider the practical ability of your provider networks to accommodate new enrollees.

The provider networks for Medicare enrollees must be from the same networks that you use for commercial members. However, the Medicare network may be a subset of a larger commercial network as long as there are no Medicare only providers. (Some providers might, in fact, treat only Medicare enrollees, but it must be as the result of non-Medicare enrollees not choosing the particular provider, or the nature of the provider's practice, e.g., gerontologists.)

Marketing materials must clearly state providers or physicians currently available to Medicare members and those accepting new patients.

An availability issue arises if Medicare certified facilities are not available in your geographic area, e.g., if there is no SNF. Generally, you may not deny a Medicare covered service because it is not available in your area. Seek prior approval for denial of coverage from HCFA if services are unavailable. If HCFA determines that Medicare beneficiaries in the fee-for-service system commonly seek services in another town or that it is common practice for a beneficiary to be referred to services outside the geographic area, then provide or arrange for these unavailable services for your Medicare enrollees. You are financially responsible for referral services as if they had been provided at your own facility. HCFA's decision as to whether coverage may be denied for a service not offered in your area applies to all Medicare enrollees who require that service. (See §2102B.)

2160.2 Accessibility of Services.--All Medicare covered services, any additional benefits which a risk-based organization is required to furnish, and any supplemental services for which the enrollee has contracted must be made accessible to the enrollee. Consider geographic location, hours of operation, promptness of services and provision of after hours service.

Services are generally considered accessible if they reflect usual practice and travel arrangements in the local area. Generally, this is within 30 minutes travel time from the Medicare beneficiary's residence. Exceptions may be made if the usual travel patterns for medical care exceed 30 minutes.

Medically necessary emergency care must be available and accessible 24 hours a day, 7 days a week.

2160.3 Continuity of Care.--Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes linkages between primary and specialty care, coordination among specialists, appropriate
combinations of prescribed medications, coordinated use of ancillary services, appropriate discharge planning, and timely placement at different levels of care including hospital, skilled nursing and home health care. HCFA recommends that you develop a comprehensive treatment plan for the overall health maintenance and management of each Medicare beneficiary. Include any treatment modalities which are employed to offset any illness and related medical conditions. Also include treatment at the proper level of care and assure adequate follow-up for the health maintenance of each beneficiary.

Provide a basic system for continuity of care and case management. This may be established through reliance on a primary physician who serves as an enrollee's case coordinator. Establish and maintain a record keeping system that includes health and medical information on each Medicare enrollee. Assure that the system is readily available to appropriate professionals.

**Scope of Benefits**

2162. **RESTRICTIONS ON OBTAINING SERVICES; LOCK-IN; OTHER OUT-OF-PLAN SERVICES**

If you have a risk-based contract, only your organization is authorized to receive Medicare payment for services provided to your Medicare enrollees. This provision is known as the beneficiary lock-in. (See §2162.1.)

Members of cost-reimbursed plans are not subject to the lock-in. Such members may present bills to the plan for payment if the services are covered under the plan, or may have claims submitted in their behalf with the Medicare intermediary or carrier. See §2170.2 for lock-in when Medicare is the secondary payer.

2162.1 **Risk-Based Contract Lock-In.--**Beneficiaries must receive all covered health care services directly from or through your organization, or from sources that you authorize. You are not liable for the costs of unauthorized services obtained from sources outside your organization, except for emergency services, urgently needed services furnished while a beneficiary is temporarily outside your geographic area, or services determined on appeal to be services which you should have furnished. (See §2107.)

Medicare enrollees are liable for the costs of unauthorized services obtained from sources outside your plan (except for emergency services furnished anywhere, urgently needed services furnished outside your geographic area, or services determined on appeal to be services which you should have furnished). Assure that marketing materials and presentations clearly explain beneficiary liability. (See §2200ff.) Enrollment forms and rules must also be very explicit in describing your rules. HCFA recommends comprehensive educational campaigns, including face-to-face sessions to inform beneficiaries about lock-in and limited coverage for out-of-plan services.

Make clear to beneficiaries the difference between lock-in and restrictions that you might establish to manage care, e.g., requiring services to be approved by a primary care gatekeeper. These restrictions must also be explained in appropriate marketing materials. Do not subject emergency or urgently needed services to prior approval requirements.

2162.2 **Authorized Out-of-Plan Services.--**You may or may not specifically require prior authorization on an individual service basis. These actions include:

- You may decide to cover or pay for out-of-area routine services that are neither emergency or out-of-area urgent claims.
- You may choose to refer patients out-of-plan for unusual or infrequently used services.
You may permit the referral of beneficiaries to Medicare certified unaffiliated hospitals for certain services.

All of the bills for these out-of-plan services must be processed through your claims processing system. Medicare carriers and intermediaries do not process such claims.

Special provisions allowing you to retain members apply for your members who leave your service area for an extended absence (an absence of over 90 days, but only if the absence lasts a year or less):

- You may choose to cover all out-of-area routine services for anyone who leaves the service area for an absence of over 90 days. Such an option must be made available to all members of your plan, if you decide to offer it. (If an individual to whom this policy applies returns to your service area, all routine services must be received through your organization.)

- If you are affiliated with another organization (by common ownership or control, or if there is a written agreement), and the other organization is also a Medicare §1876 contractor, you may establish a policy for beneficiaries moving to the service area of the affiliated organization to obtain services through the affiliated organization. All covered Medicare services and supplies plus additional and supplemental benefits approved through the adjusted community rate computation for risk-based HMOs must be available. You may retain such individuals as Medicare enrollees of your plan for up to one year. The option must be made available to anyone moving to the affiliated organization's service area who intends to return to your service area within one year.

HCFA approves these options as part of your initial application to become a Medicare contractor or through our compliance monitoring activities. HCFA also reviews your marketing materials to assure that beneficiaries are advised of the distinction between authorized and unauthorized out-of-plan service use.

2170. ENROLLEE LIABILITY

You may require a Medicare beneficiary who enrolls in your plan (or someone who acts on his or her behalf) to pay premiums, coinsurance, copayments, deductibles, or other amounts to cover the following items:

- The actuarial value of deductibles and coinsurance amounts that a Medicare beneficiary otherwise pays in the fee-for-service system. (See §2170.1.)

- Supplemental benefits (services not covered by Medicare) that you offer which are not additional benefits as defined in §2108. Charges for these services must be separately identified. (See §1876(e)(2) of the Act and 42 CFR 417.452(d)(2).)

- Services not covered under Part B if the beneficiary is entitled only to Medicare Part B benefits. These services are considered supplemental services. Only risk-based organizations can have mandatory supplemental benefits. Risk-based contractors may not charge a Part B only beneficiary more than the ACR-approved amount for a supplemental benefit package that includes benefits included in Medicare Part A.

This liability begins on the first day of the month in which the enrollee is enrolled in your organization. (See §2001.) Beneficiaries enrolled in risk-based contracts are also responsible for the full costs of covered
services that are obtained out-of-plan other than those you authorize unless they are emergency or unforeseen urgently needed out-of-area services, or are services determined to be your liability as a result of an appeal. (See §2162.2.)

If you are a risk-based contractor, you may reduce or eliminate beneficiary cost-sharing amounts as part of your additional benefits.

You may offer more than one set of optional supplemental benefits. If one of your options includes charges for services that are not covered by Medicare, then disclose the charge attributable to the Medicare deductible and coinsurance separately prior to beneficiary election of an option. Charges for noncovered services may not exceed the ACR for those services.

Do not increase enrollee premiums or charges during the contract year. HCFA considers proposals to reduce enrollee liability at any time. Once you have decreased enrollee charges, they cannot be increased in the same contract year.

2170.1 National Actuarial Value of Deductibles and Coinsurance.--HCFA calculates this amount and makes it available each year for risk contractors to use in their ACR computation.

Beneficiaries in traditional fee-for-service Medicare are required to pay the following cost-sharing amounts for Part A benefits:

- An inpatient hospital deductible for each spell of illness and hospital coinsurance after the 60th day;
- An annual blood deductible; and
- SNF coinsurance equal to one eighth of the Medicare hospital deductible for days 21-100.

In addition to the monthly Part B premium, beneficiaries are required to pay the following amounts for Part B benefits:

- $100 annual deductible;
- 20 percent coinsurance for physician and other covered medical services; and
- Blood deductible equal to the first three pints of blood that are not replaced.

2170.2 Medicare Not Primary Payer.--Medicare beneficiaries are liable for payments received from certain third party payers for covered services when Medicare is not the primary payer. Within certain limitations, you may charge the Medicare enrollee for any amounts which the individual has been reimbursed by a primary payer for Medicare covered services. You may also charge the insurance carrier, employer or other entity liable for these charges directly. (See §§4300ff.)

Medicare is secondary payer for:

- Services payable under a workers' compensation policy or plan;
- Services payable under automobile medical, no-fault, or any liability insurance;
A Medicare beneficiary age 65 or older who has employer group health plan (EGHP) coverage through his/her own current employment or the current employment of a spouse of any age. This applies only to group health plans of employers with 20 or more employees;

A beneficiary who is entitled to Medicare solely on the basis of end stage renal disease (ESRD) and is covered by an EGHP. Medicare is secondary for a period of up to 18 months after the individual has been determined eligible for ESRD benefits. This applies to all employer group health plans regardless of the number of employees; and

Certain disabled beneficiaries (except for ESRD beneficiaries) who have coverage under an EGHP or a family member's EGHP. This applies to plans that cover employees of at least one employer with 100 or more employees.

Similarly, Medicare does not pay for services that a beneficiary elects to receive through, or have paid for, by the Department of Veterans Affairs or under the Federal Black Lung program of the U.S. Department of Labor. However, you may not require a beneficiary to use Veterans Affairs providers.

In almost all cases, an employer health plan's contract with an HMO/CMP provides that employees are locked-in to receiving services only through the HMO/CMP. If a Medicare beneficiary is covered by such a plan through current employment (including a spouse's employment), the employer plan is the primary payer, and services available under the plan remain primary to Medicare even if the employee fails to comply with the HMO's/CMP's lock-in requirements. If the employee goes outside the HMO/CMP for covered services which could have been obtained through the HMO/CMP pursuant to the employer contract, and the HMO/CMP legitimately refuses payment, then the Medicare carrier or intermediary does not make primary payments for those services. This applies even if the beneficiary is enrolled under a Medicare cost contract and would not otherwise be locked-in for Medicare purposes. Explain this clearly in your marketing materials. (See §6105.1 on coordination of benefits.)

2170.3 Refunds.--Refund all amounts incorrectly collected from Medicare enrollees or others on their behalf. Make refunds by lump sum payment, premium adjustment, or a combination of both methods. If the enrollee dies or cannot be located, make refunds in accordance with State law. HCFA reduces payment to your organization if you do not make necessary refunds to beneficiaries by the end of the contract period following the contract period when the error was made. HCFA will use the amounts withheld to make direct refunds to your enrollees.

2170.4 Nonpayment of Premiums.--A Medicare beneficiary who does not pay your premium(s), or other cost-sharing amounts, may be disenrolled only after you have taken the following steps:

Demonstrate to HCFA that you made a reasonable effort to collect the unpaid amount. HCFA considers it to be a reasonable effort if you mail a notice of disenrollment for nonpayment of premium to the beneficiary at least 20 calendar days before the proposed effective date of disenrollment. This allows 5 days for mailing time and gives the beneficiary 15 days in which to act on your notice. This is a minimum time frame. Beneficiaries may be given more than 20 days to pay premiums before they are involuntarily disenrolled. Below are several examples illustrating this policy.
Example: If a premium is due on June 10 for July and is not received, you may send a notice to the beneficiary on June 10 informing him/her that if the premium is not received by June 30 (i.e., at least 20 days later), he/she will be disenrolled as of August 1.

Example: If a premium is due on June 15 and is not received, then, in order to fulfill the requirement of at least 20 days notice, you are not able to disenroll the beneficiary until August 1 even though a notice is mailed June 15. Your plan is not able to disenroll the beneficiary July 1 because the minimum required 20 days notice would not have been given. The 20th day is July 5.

Example: There are no current month disenrollments for nonpayment of premiums. For example, for any disenrollments you submit with an effective date of August 1, the minimum 20 days prior notice must be satisfied by August 1, even though you submit the disenrollments on August 10 to HCFA. (This situation is similar to when members request disenrollment on July 31 for an August 1 effective date. You then submit this action in the August operating month since the deadline for an August 1 disenrollment of about July 10 has already passed.) You are responsible for providing full benefits to the beneficiary until the effective date of disenrollment even though you have not received a premium payment from the member for the month.

Example: If a beneficiary has not paid your premium for July and August and you do not notify the beneficiary until September 10 that he/she will be disenrolled, disenrollment cannot be effective before October 1 in order to give at least 20 days notice.

- State in all information provided to members (e.g., in member contracts) that nonpayment of premiums does not result in automatic disenrollment.

- Give the beneficiary a written notice of disenrollment including the proposed effective date of disenrollment and information on the right to a hearing under your grievance procedures. Indicate that the beneficiary needs to act on this right before the effective date of disenrollment or he/she will be disenrolled. If you have a risk-based contract, emphasize that the beneficiary must receive all services through your plan until the effective date of disenrollment. This avoids a situation where members think that not paying premiums automatically causes them to be disenrolled from your plan. It also makes clear that the proposed disenrollment date is subject to change and that the beneficiary should verify the actual disenrollment date before obtaining services other than through the organization.

- Send the notice to the beneficiary before you notify HCFA of the disenrollment.

2170.5 Failure to Pay Portion of Premium Attributable to Optional Supplemental Benefits.--The only situation where you may stop providing services for nonpayment of premium without meeting the above requirements is a situation where a beneficiary fails to pay that portion of your premium or charges that covers optional supplemental benefits. In this case, when you receive a payment which is equal to the amount of your basic premium only, notify the beneficiary that the optional benefits were not paid for and are, therefore, discontinued. However, the individual remains enrolled in your organization.
and is entitled to receive all services covered under the Medicare contract basic option as long as he/she is enrolled.

2170.6 Recoupment of Uncollected Deductible and Coinsurance Amounts.--If you are a cost contractor, you can recoup deductible and coinsurance amounts owed by a beneficiary during a prior contract period only if:

You underestimate the actual values of the deductible and coinsurance amounts, or

o There is a billing error.

HCFA must approve your plan to recoup these amounts. Collections must be made no later than the end of the contract period following the contract period during which the amounts were due.
Appendix A

Sample Notification of Non-SNF Level of Care

Dear [Name],

This is to inform you that [Name of HMO/CMP] has determined that you are not eligible for continued care in a skilled nursing facility. Based upon our review of your medical condition, it does not appear that you meet Medicare guidelines for skilled nursing care. Skilled care must be furnished by or under the supervision of skilled personnel to assure the safety of the patient and to achieve the medically appropriate result. However, when an individual does not require skilled services on a daily basis, the services they do receive while in a skilled nursing facility are not covered. Thus your admission to [continued stay in] ______ will not be covered as of _______ because you will not need skilled nursing care or skilled rehabilitation services on a daily basis. If you choose to be admitted to [continue your stay in] ______, you will be responsible for the cost of all services except services covered under Part B of Medicare.

Instead of care in a skilled nursing facility, we can provide the following covered services for you:

If you have any questions about this decision, or would like to discuss your case further, please contact [Name] at [Phone Number].

If you believe the determination is not correct, you have the right to request a reconsideration. You must file the request in writing with our plan (at the following address: [Address]), with a Social Security office (SSO), or with an office of the Railroad Retirement Board if you are a railroad annuitant. You must file your request within 60 days of the date of this notice. You may mail your request or file it in person. You may also provide additional evidence to support your claim in person or writing. Even though you may file your request with a Social Security office or Railroad Retirement Board office, that office will transfer your request to us for processing. We are initially responsible for processing your request for reconsideration. However, if we do not rule fully in your favor, your reconsideration request is forwarded to a HCFA contractor for processing.

If you want help with your appeal, you may have a friend, lawyer or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal.

Sincerely yours,

[Name of HMO]

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of non-coverage of services from [Name of HMO/CMP]. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

[Signature of Beneficiary] (or Person Acting on His/Her Behalf) [Date]

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2200. MARKETING - GENERAL

Marketing includes activities undertaken by an HMO/CMP to generate good will, encourage individuals to enroll in or remain in a prepaid health plan, or to provide information on plan benefits or costs and membership rules.

Only a federally qualified HMO or eligible CMP may enter into a Medicare risk or cost contract. HCFA assesses your overall ability to market and to enroll members in your plan based on the following information you submit in your contract application:

- Market analysis;
- Enrollment projections;
- Marketing strategy;
- Description of marketing staff;
- Marketing budget;
- Marketing and enrollment materials;
- Subscriber contracts and agreements; and
- Description of your management information system.

HCFA reviews and determines your overall capacity to market your plan to commercial individuals or groups, as well as your ability to meet the requirements in the law and regulations for enrolling Medicare beneficiaries in a prepaid plan. Your Medicare marketing activity may be a subset of your overall marketing system for commercial enrollment, or it may be a separate activity. Medicare requirements regarding marketing are outlined in §2201.

All marketing material for Medicare beneficiaries must be reviewed and approved by HCFA prior to its use as described in §2209.

Instructions in this chapter apply to both risk and cost HMOs and CMPs unless specifically designated below.

2201. MEDICARE REQUIRED MARKETING ACTIVITIES

As a contracting HMO/CMP, you must:

- Offer your plan to all Medicare beneficiaries eligible to enroll;
- Have at least one 30 day continuous open enrollment period annually (see §2001ff.);
- Publicize the annual open season and all enrollment periods, whether of limited duration or continuous, through appropriate media, throughout your entire Medicare enrollment area;
- Provide to those Medicare beneficiaries interested in enrolling adequate written description of the organization's rules and other information necessary to make an informed decision about enrollment (see §2203);
- Use only marketing materials that have been approved by HCFA (see §2209);
Accept enrollees on a first come, first accepted basis. If your plan's open enrollment has been restricted under a capacity waiver (see §2001ff.), you may maintain a waiting list of applicants, but the waiting list must be designed to assure that vacancies are filled in chronological order by the date you receive each application; and

Provide a written copy of membership rules to each Medicare enrollee at the time of enrollment and at least annually thereafter. Notify members of changes in the rules 30 days before the effective date of the changes. (See §2210.)

Your HMO/CMP member rules cannot conflict with Medicare rules. You also must meet all State (and local) requirements for marketing activities (e.g., State licensure and in some States, review of marketing material).

2202. DEFINITION OF MARKETING MATERIALS

Marketing materials include informational materials targeted to Medicare beneficiaries which:

- Promote the HMO/CMP;
- Inform Medicare beneficiaries that they may enroll or remain in the HMO/CMP; or
- Explain how the HMO/CMP membership works, including conditions of membership and disenrollment procedures.

Any material that mentions the Medicare plan or beneficiaries must be submitted to HCFA for review prior to use.

Specific marketing materials include:

- General audience materials such as general circulation brochures and newspaper, magazine, television, radio, billboard, or yellow pages advertisements;
- Enrollment and disenrollment forms;
- Marketing representative materials such as scripts or outlines for telemarketing or other presentations;
- Presentation materials such as slides and charts;
- Promotional material such as brochures or leaflets, including materials for circulation by third parties, e.g., physicians;
- Membership communication materials such as membership rules, subscriber agreements (also called member contracts, enrollment agreements or evidence of coverage), member handbooks, and newsletters; and
- Letters to members about:
  -- Changes in your contractual arrangement with HCFA (e.g., the nonrenewal of the Medicare contract);
  -- Changes in providers, physicians, premiums, benefits, or plan procedures; and
-- Membership/claims processing activities (e.g., non-payment of premiums and confirmation of enrollment).

2203. CONTENT OF MARKETING MATERIALS

The content of the marketing materials which you develop for use with Medicare beneficiaries varies depending on its purpose. Marketing material provided to the Medicare beneficiary interested in enrolling in your organization must contain an explanation of its rules and other information sufficient for the beneficiary to make an informed decision about enrollment. Marketing material provided to beneficiaries at the time of their enrollment in the plan, and at least annually thereafter, informs them of the rules governing their rights and responsibilities as enrollees. Other marketing material sent to enrollees during the contract year, such as letters and newsletters, encourages them to remain enrolled in the plan and provides information and procedural updates.

A. Pre-Enrollment Marketing Materials.--Include at least the following information in the written material which you provide to Medicare beneficiaries who are interested in enrolling in your plan:

o Eligibility requirements. Materials must convey that a beneficiary's eligibility for plan membership is based on that individual's eligibility for Medicare, not on his/her age, despite the fact that the term senior may be used;

o A written statement that the plan may neither refuse enrollment based on an individual's health status, or prior use or anticipated use of health services, nor impose restrictions for preexisting conditions;

o Description of benefits provided under the contract, including additional benefits approved through the adjusted community rate (ACR) process for risk contractors (see §2108) and supplemental benefits for both risk and cost contractors. (See §2109.) State that enrollees are entitled to all Medicare covered services at a minimum;

o Information on application and enrollment procedures;

o How and where to obtain services from or through the organization, including an explanation of the gatekeeper system and prior authorization procedures, i.e., lock-in, and instructions for accessing emergency and urgently needed care (see §§2205 and 2206 for more information on what to include in your materials on these subjects);

o Notice that the organization is authorized by law to terminate or refuse to renew its contract with HCFA, that HCFA may also choose not to renew its contract with the organization and that termination or nonrenewal may result in termination of the individual Medicare beneficiary's enrollment in the organization;

o A statement that enrollment in your plan results in automatic disenrollment from any other Medicare prepaid health plan of which the beneficiary is a member;

o Discussion of premiums, copayments and deductibles, if any, and the requirement for beneficiaries to continue to pay Medicare Part B premiums. Include the statement that the premium and benefit package may change at the beginning of each contract period, but may not change during the contract period unless the change is to the advantage of the enrollee. Advise them of the contract renewal date for your plan;
o Voluntary disenrollment rights and procedures, including the fact that disenrollment at a Social Security Administration (SSA) office or a Railroad Retirement Board (RRB) office is permitted; and

o Other information necessary to enable the beneficiary to make an informed decision about enrollment (e.g., a telephone number through which the beneficiary may obtain a list of contracting providers and data on their location and availability, such as operation and availability of public transportation, if known).

B. Membership Rules for Enrollees.--Include at least the following information in the copy of the membership rules you provide Medicare beneficiaries at the time of enrollment and annually thereafter:

o Description of all benefits provided under the contract, including additional benefits approved through the adjusted community rate (ACR) process for risk contractors (see §2108) and supplemental benefits for both risk and cost contractors. (See §2109.) State that enrollees are entitled to all Medicare covered services available in the geographic area at a minimum.

o How and where to obtain services from or through the organization, including a list of contracting providers, an explanation of the gatekeeper system and prior authorization procedures, a discussion of the use of the HMO/CMP identification card, and instructions for accessing emergency and urgently needed care;

o The restrictions on coverage for services furnished from sources outside an organization contracting on a risk basis, other than emergency services and out-of-area urgently needed services, including lock-in and other restrictions discussed in §2205;

o Your organization's obligation to assume financial responsibility and provide reimbursement for emergency services and urgently needed services, including procedures and time limits for filing claims for these and other out-of-plan services (see §2207);

o Any services you choose to provide from outside sources, other than emergency services and out-of-area urgently needed services, including a discussion of beneficiary liability and responsibility in each case. A cost contracting organization must disclose that the enrollee may receive service through any Medicare provider or supplier and must also explain beneficiary liability and responsibility in these circumstances (see §2205.1);

o Premium information, including the amount (or, if the amount cannot be included, the telephone number of the source from which this information may be obtained) and the procedures for paying premiums and other charges for which enrollees may be liable. Include a statement that each Medicare beneficiary must continue to pay the Medicare Part B premium while enrolled in the HMO/CMP. Additionally, state that the premium and benefit package may change at the beginning of each contract period, but may not change during the contract period unless the change is to the advantage of the enrollee;

o Internal grievance and Medicare appeals procedures. Be certain that these two procedures are described separately (see §§2400ff.);

o Disenrollment rights and procedures for both voluntary and involuntary disenrollment, including the option to disenroll at a local SSA or RRB office. Include a statement that the disenrollment can be effective as early as the first day of the month following a written disenrollment request, and that the enrollee must be given a copy of the disenrollment form;
o A statement regarding the obligation of an enrollee who is leaving your Medicare geographic area for more than 90 days to notify you of the move or extended absence, as well as a description of your policies concerning retention of enrollees who leave the geographic area for more than 90 days;

o The expiration date of your contract with HCFA, and notice that you are authorized by law to terminate or refuse to renew the contract, that HCFA may also terminate or refuse to renew the contract and that termination or nonrenewal of the contract may result in termination of the individual's enrollment in your organization;

o Policies regarding coordination of benefits;

o A statement that Part B only enrollees may enroll in Medicare's premium Part A without a waiting period if they request enrollment while still enrolled in the HMO or CMP. If the beneficiary disenrolls from the HMO or CMP, or if the contract is terminated or not renewed, he or she may also enroll during any of the 7 months following the first full month of non-coverage by the HMO or CMP and have premium Part A begin with the month following the month of enrollment. A premium surcharge of 10 percent may apply if the individual was not enrolled in either an HMO/CMP or Part A for 12 or more months. (An HMO/CMP cannot require that a beneficiary purchase Part A coverage from the Federal government; however, a risk contractor may require that a Part B only enrollee purchase mandatory supplemental benefits that include all or some of the benefits of Medicare Part A that the plan would cover); and

o Language stating that beneficiaries who fail to pay a premium for an optional supplemental benefit package, or the portion of a premium that includes optional supplemental benefits, will have the optional supplement discontinued but will not be disenrolled from the organization. (See §2109.)

You are encouraged to give enrollees a copy of the membership rules as early as possible after the application for enrollment is received. However, in every case, give the enrollee a copy of the membership rules prior to the effective date of the enrollment. If there are changes in the rules, provide the enrollee with notice of the changes at least 30 days prior to the effective date.

2204. INFORMED CHOICE

Your marketing materials must provide to Medicare beneficiaries interested in enrolling in your plan adequate written descriptions of your rules and other information necessary for them to make an informed decision about enrollment. One important element of an informed decision for a Medicare beneficiary is an understanding of the difference between fee-for-service Medicare and membership in an HMO/CMP.

Over the years, a majority of Medicare beneficiaries have developed a certain understanding of how benefits are provided and financed in fee-for-service Medicare. Your HMO/CMP plan is a significant departure from traditional Medicare. To assist the beneficiary in making an informed choice, give him/her clear, complete, and accurate information regarding the nature of membership in an HMO/CMP as compared to fee-for-service, such as the lock-in requirement for a risk HMO/CMP and prior authorization requirements for obtaining specialist services. Pre-enrollment material must be sufficiently informative to permit a potential enrollee to distinguish the HMO/CMP plan from the traditional fee-for-service provider arrangement, as well as to choose among competing HMO/CMPs if other organizations contract with Medicare in your area.
MARKETING

2205. LOCK-IN; RESTRICTIONS ON SERVICES

Marketing material must describe all restrictions on out-of-plan and in-plan service use. Since Medicare enrollees may be fully and personally liable for the costs of unauthorized service, assure that the following restrictions are fully explained in all marketing material.

2205.1 Lock-In.--

A. Lock-In Restrictions under Risk-Based Contracts.--Risk organizations usually have a lock-in restriction on all services, i.e., Medicare beneficiaries are locked into the plan. All needed health care (other than emergency or out-of-area urgently needed services) must be provided, or authorized, by the plan. Accentuate the lock-in concept in your marketing materials, since the lock-in concept is new to beneficiaries who have been accustomed to receiving care through fee-for-service providers. State lock-in information prominently on the enrollment form, preferably directly over the enrollee's signature. In describing lock-in, avoid terms such as closed panel or exclusive providers. Consider using bold or colored print to attract the beneficiary's attention. Your marketing materials must also emphasize that emergency and urgently needed services are exempt from the lock-in requirement. Clearly describe beneficiary liability for unauthorized out-of-plan service use.

B. Lock-In Restrictions under Cost-Based Contracts.--Cost organizations may have a lock-in restriction on supplemental services, but must make clear to Medicare beneficiaries that they are not locked-in for Medicare covered services. If you have a cost-based contract with HCFA, inform beneficiaries that they may receive Medicare covered services outside the plan, i.e., from Medicare approved providers and suppliers, through the Medicare fee-for-service system. Also inform beneficiaries of their responsibility for Medicare coinsurance and deductibles under these circumstances.

C. Areas of Interest to Beneficiaries Regarding Lock-In.--Give special consideration to including information in the following areas as you develop your marketing materials on lock-in, as these are the ways in which this restriction most affects Medicare beneficiaries:

1. Availability of Benefits.--Describe any restrictions on use of providers of services (such as specific clinics, facilities, hospitals, or groups of hospitals to which members are limited) or limitations on physician services (such as restrictions on use of chiropractors as discussed in §2153.1). Provide an explanation of how the gatekeeper primary care physician functions and how referrals to specialists are made.

2. Prior Authorization.--Describe beneficiary responsibility for securing prior authorization, e.g., for specialty or elective services, including the procedures and timeframes to be followed by the beneficiary during this process. Stress everywhere possible the requirement for obtaining referrals from the member's primary care physician.

3. Costs to the Beneficiary.--Describe member liability for noncovered services and unauthorized out-of-plan care.

2205.2 Restrictions on Medicare Covered Services.--Each Medicare enrollee of the plan is entitled at a minimum to receive all Medicare covered services available in the geographic area. In fee-for-service Medicare, some services are subject to certain limitations on coverage. Highlight any of the restrictions on Medicare covered services which the plan chooses to retain, e.g., one-year limitation on coverage of immunosuppressive therapy (covered only after a
Medicare covered transplant) or services of independently-practicing physical therapists limited to a certain dollar amount each year.

2205.3 Non-Covered Services.--If you wish to highlight services excluded from Medicare coverage which the plan has chosen not to offer to the Medicare enrollee, assure that the list in your marketing materials is accurate by consulting the Medicare Coverage Issues Manual, the coverage chapter of the Medicare Carriers Manual or Intermediary Manual, and/or the Medicare Handbook.

2205.4 Communicating Restrictions to Medicare Beneficiaries.--Include prominent statements about lock-in and about any benefit/service restrictions in the:

- Marketing material which may be the basis of a person's decision to enroll;
- Enrollment form (lock-in);
- Letters confirming a person's date of enrollment; and
- Subscriber agreement and member handbook.

HCFA strongly recommends that your enrollment department make a verification call to each Medicare beneficiary who has applied for enrollment, before his/her enrollment form is finally processed, to confirm that he/she understands all restrictions. Also, consider developing comprehensive educational campaigns, including face-to-face sessions, to inform beneficiaries of the HMO/CMP system of health care delivery and to assure that there is a full understanding on the part of enrollees of their financial and procedural responsibilities.

2206 EMERGENCY AND URGENTLY NEEDED SERVICES; OTHER OUT-OF-PLAN SERVICES

Marketing materials must clearly state when the plan does or does not have financial responsibility, as well as spell out those instances when the beneficiary has liability for out-of-plan services. Define all terms and conditions in your marketing materials carefully, because this is a major area of disputed claims.

2206.1 Emergency and Urgently Needed Services.--Marketing materials must clearly state that the plan is required to pay for emergency and out-of-area urgently needed services. When defining these terms in your materials, use the language provided in 42 CFR 417.401. Specifically:

- "Emergency services" means covered inpatient or outpatient services that are furnished by an appropriate source other than the organization and--
  
  (a) Are needed immediately because of an injury or sudden illness, and
  
  (b) The time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health."

Such services must be, or appear to be, needed immediately.

- "Urgently needed services" means covered services required in order to prevent serious deterioration of an enrollee's health that results from an unforesseen illness or injury if--
(a) The enrollee is temporarily absent from the organization's geographic area; and

(b) Receipt of the health services cannot be delayed until the enrollee's return to the organization's geographic area."

You may find it helpful to provide examples of conditions that are considered emergencies or urgent.

You may not:

- Require prior authorization for the receipt of emergency or out-of-area urgent services or indicate that emergencies are not covered unless care is secured within a certain period of time, e.g., within 24 hours after the onset of the condition. In your instructions about what to do in an emergency, tell members to first call the paramedics or go to the nearest emergency room for treatment;

- Use words such as life-threatening or bona fide to qualify the kind of emergency that is covered; and/or

- Deny payment based on the beneficiary's failure to notify your plan in advance or within a certain period of time after the care is given.

You may encourage the beneficiary to notify your plan or the primary care physician within a certain reasonable time period, e.g., 48 hours or as soon as possible after an emergency or the provision of urgently needed services; however, you may not require this notification. In regard to an emergency, your marketing material should clearly explain that emergency care is covered only as long as it continues to be an emergency and that the beneficiary should notify the plan so that it can arrange for the member's continued care. In regard to urgently needed services, emphasize the need for the beneficiary to notify the plan when services are obtained so that the plan can authorize follow up care when necessary or be involved in any necessary transfers in the case of hospitalization.

For further discussion of emergency and urgently needed services, see §§2104.1 and 2105.

2206.2 Other Out-of-Plan Services.--There are other situations where the plan may choose to pay for services that beneficiaries receive out-of-plan when there is no emergency or urgent need (e.g., when the plan offers a delivery option that permits out-of-plan use for a specified package of services).

In these instances, the plan must still provide or arrange for the full scope of Medicare services. Describe these options, if offered, in your marketing material, including the beneficiary's responsibilities with respect to such services.

2207. FILING

Inform beneficiaries of procedures for filing claims for emergency, urgently needed or other out-of-plan services in marketing materials. Consider the following information when you prepare your material advising Medicare enrollees of the time limits for submitting claims for covered benefits.

- These time frames are established by HCFA and are the same for beneficiaries enrolled in an HMO/CMP as for those individuals in fee-for-service Medicare.
Medicare permits beneficiaries from 15 to 27 months to submit claims for physician and supplier services depending on when the service or item is received. If the service or item is received between October 1 of Year 1 and September 30 of Year 2, claims can be filed as late as December 31 of Year 3 (the maximum 27 months period).

While you may encourage Medicare enrollees to submit claims for covered benefits as soon as possible, you may not impose time frames for submitting claims that are shorter than the Medicare fee-for-service time frame.

If a claim is filed within the period allowed under Medicare and the service is the plan's liability, the claim must be paid by the plan even if the contract between HCFA and the plan is no longer in effect or if the beneficiary has ceased membership in the plan, provided that the beneficiary was an enrollee at the time of the incident and the service was a covered benefit.

2208. FORMAT AND STYLE OF MARKETING MATERIALS

HCFA does not mandate a format or style for your Medicare marketing materials, other than requiring that the member rules be written and that marketing materials, including the subscriber agreement, be understandable to the average beneficiary. Many plans satisfy these requirements by incorporating written member rules into a Medicare member handbook.

HCFA strongly recommends the use of larger-than-normal type (required in some States), to make material easier to read for the elderly population.

HCFA further recommends that plans conduct face-to-face interviews with a potential member and with the beneficiary's family, if appropriate, prior to the plan's submission of the individual's enrollment to HCFA. (This is not to be confused with door-to-door solicitation which is prohibited. (See §2211.)) Personal discussion helps prevent some of the problems that have resulted when beneficiaries have not understood the lock-in provision, such as costly billings to a beneficiary by an out-of-plan provider.

2208.1 Special Language Requirements.--Provide marketing materials understood by the Medicare beneficiaries in your Medicare contract service area. Make printed material available in all language(s) in which verbal marketing activities are conducted.

2208.2 HCFA Model Marketing Materials.--HCFA has developed a model format and standard language which you may wish to incorporate into your written marketing materials. Specifically, HCFA has developed a model Evidence of Coverage document, as well as model enrollment and disenrollment forms. These materials are updated annually and are sent automatically to each organization which requests an application to contract with HCFA. You may request a copy by writing to:

Health Care Financing Administration
Office of Prepaid Health Care Operations and Oversight
Room 4406, Cohen Building
330 Independence Ave., S.W.
Washington, DC 20201

2209. HCFA REVIEW OF MARKETING MATERIALS

All marketing materials, including any revised or updated material, must be approved by HCFA before use. Submit material to HCFA for review at least 45 days prior to planned distribution.
HCFA notifies you of the acceptability of your marketing materials and/or returns all unacceptable materials, stating specific reasons for non-acceptance, within 45 days. Any materials which HCFA has not disapproved after 45 days are deemed approved.

HCFA recognizes that it may be preferable in some cases for you to receive approval of marketing material sooner than 45 days after submission and makes an effort to respond to you as soon as possible. Verify that HCFA has received the materials that you have submitted and that your deadlines are clearly marked.

You are cautioned against mass producing marketing materials that have not been approved. Medicare marketing materials that have not been approved may not be distributed.

2209.1 Who Reviews Marketing Materials.--Initial review is accomplished by the HCFA Central Office (CO) staff assigned to the Medicare contract application. Once the contract has been executed, marketing material review takes place in the HCFA Regional Office (RO) responsible for monitoring.

2209.2 Employer Group Retiree Marketing Materials.--You may develop marketing materials targeted specifically to retired employees who are members of your employer group accounts. Individuals to whom these materials are applicable are Medicare beneficiaries who join a risk or cost organization through their former employer. Although these individuals no longer work, their former employer pays some or all of their HMO/CMP premium and/or provides payment for additional benefits.

Since you are responsible for providing all Medicare beneficiaries who are prospective enrollees with the information they need to make an informed decision with regard to enrollment in your plan (see §2204), assure that marketing material you develop for use with these groups provides all of the information that is normally distributed to individual Medicare enrollees. (See §2203.) In addition, there may be some special group requirements or considerations for these group-related beneficiaries which you need to put into the material. For example, include a statement that members enrolled through their former employer may have additional enrollment and disenrollment rules imposed by the employer, e.g., an employer group member who disenrolls from your HMO/CMP may lose employer coverage if the individual disenrolls directly through you and not during the employer's open season.

Submit your employer group Medicare marketing materials to HCFA for review in the same manner as you submit marketing materials produced for individual Medicare enrollees. (See §2209.)

An employer group may wish to develop marketing materials, in addition to those which you have developed, and disseminate them directly to its former employees. These materials are not subject to pre-approval by HCFA; however, you may wish to assist the group in assuring that the information it provides to Medicare beneficiaries is accurate and in keeping with Medicare requirements by providing it with model materials.

2209.3 Medicare Secondary Payer Provisions in Marketing Materials.--You may wish to develop special marketing materials for employer group health plan (EGHP) accounts which include members who are also eligible to enroll in the Medicare contract. While information in those materials pertaining to the EGHP is not subject to review by HCFA, any information pertaining to Medicare must be submitted to HCFA for review and approval as specified in §2209.
There are several Medicare secondary payer provisions to consider in marketing to individuals who are eligible for both EGHPs and Medicare.

- In the following cases, Medicare is secondary payer unless the individual chooses not to enroll in the employer plan:
  - Members who are age 65 or over and still working;
  - Members who are spouses (age 65 or over) of individuals who are still working (regardless of the age of the working spouse); and
  - Certain disabled members who are under 65 and eligible for Medicare based on disability (including dependents of employees covered under the EGHP).

- The EGHP may not discriminate against aged workers, aged spouses of workers of any age, or certain disabled beneficiaries in regard to the employee health benefits they offer, or the conditions under which they are offered. When Medicare is secondary payer, the EGHP may not offer benefits that supplement Medicare covered benefits. The EGHP may offer benefits that are not covered at all by Medicare, such as eyeglasses.

- EGHPs with fewer than 20 employees (for working aged beneficiaries) or 100 employees (for certain disabled beneficiaries) are exempt from Medicare secondary payer provisions. This means that the employer of fewer than 20 or 100 employees, as applicable, may offer a plan that supplements Medicare, rather than one that offers these individuals full benefits.

- You may inform Medicare eligible enrollees of EGHPs that the Medicare risk program is one of their available options. However, §4204(g) of OBRA of 1990 provides that, if the beneficiary is still currently employed, any entity which provides financial or other incentives to switch to the Medicare contract, thus making Medicare the primary payer, may be subject to civil money penalties.

If an eligible individual enrolls in both the EGHP and the Medicare plan, your plan collects both the employer's premium and the capitation payment. However, enrolling in both programs may not be financially advantageous to the beneficiary, who must be enrolled in and pay the premium for Part B of Medicare, and may also pay any premiums that the Medicare HMO/CMP and/or the EGHP require. In some cases, it may be to the enrollee's advantage to choose between the EGHP and the HMO/CMP. As part of your responsibility to give a prospective enrollee the information necessary to make an informed choice about enrollment in your plan, provide complete, clear, and objective information in the areas described above so as to assist the individual to make the choice which best suits him/her.

2210. NOTICE AND FREQUENCY OF CHANGES

Generally, update your materials at least annually. If changes in coverage, rules, providers, or procedures occur which render portions of previously developed membership rules obsolete, notify enrolled Medicare beneficiaries of the new information at least 30 days before the effective date. Include changes that are required because the overall Medicare program has changed.

To reduce printing costs, HCFA allows the use of errata sheets for updating marketing materials with the expectation that the new information is incorporated into a revised product within a reasonable time period.
Notice of changes to membership rules, revised marketing materials, and errata sheets must be submitted to HCFA for review and approval at least 45 days prior to planned distribution.

2211. PROHIBITED MARKETING ACTIVITIES

The following activities are prohibited.

A. Discriminatory Activities.--These include attempts to discourage participation on the basis of actual or perceived health status, such as:

   o Attempts to enroll beneficiaries from a high income area if you are not making a comparable effort to enroll beneficiaries from lower income areas in your service area; or

   o Attempts to give enrollment priority to those in your service area who are newly eligible for Medicare over other beneficiaries, unless those newly eligible are "age-ins", i.e., members of your plan prior to Medicare entitlement.

B. Activities Which Mislead, Confuse, or Misrepresent.--Activities that could mislead or confuse beneficiaries, or activities that misrepresent the organization, its marketing representatives, or HCFA are prohibited. The following are examples of activities considered to fall within these categories:

   o Claiming recommendation or endorsement by HCFA of the plan or claiming that HCFA recommends that beneficiaries enroll in the plan;

   o Using terms such as "official U.S. Government" or "Medicare" on envelopes or in other marketing materials in ways likely to result in beneficiary confusion;

   o Using terms such as "Medicare substitute" or "instead of Medicare" which imply that Medicare entitlement does not continue once a beneficiary is enrolled in the plan;

   o Using coupons or cards seemingly intended for requesting additional information for enrollment and/or enrollment screening;

   o Identifying your representative as an agent of Medicare or the Federal government. You may, however, explain that your organization has a contract with HCFA or the Medicare program;

   o Omitting information necessary for the beneficiary to make an informed choice, whether or not the beneficiary specifically requests the information;

   o Making inaccurate statements about fee-for-service Medicare;

   o Making overstatements about your plan's coverage;

   o Giving implications of perpetual coverage;

   o Using enrollment forms which are not accompanied by sufficient other information to allow for an informed choice;

   o Incorrectly describing Medicare covered services; and

   o Not offering benefits approved by HCFA as part of the ACR.
C. Gifts or Payments to Induce Enrollment.--Offers of gifts or payments as an inducement to enroll in your organization are prohibited. However, HCFA does allow plans to give Medicare beneficiaries nominal value gifts, provided that the plan offers these gifts whether or not the beneficiary enrolls in the plan. For example, HMOs may give nominal value gifts to all beneficiaries who attend a marketing presentation. We define nominal value as an item having little or no resale value and which cannot be readily converted to cash. Generally, nominal value gifts are worth less than $10.00.

Although you may describe legitimate benefits the beneficiary might obtain as an HMO/CMP enrollee, you are prohibited from offering or giving rebates, dividends or any other incentives, especially those that in any way compensate for lowered utilization of health services by beneficiaries. You may not tie lowered or reduced premium costs for the beneficiary to the beneficiary's decreased utilization of health services.

D. Door-to-Door Solicitation.--Door-to-door solicitation of beneficiaries who have not contacted the HMO or who have not invited an HMO presentation in their residence is prohibited. This applies to any personal residence, including non-common areas of nursing or rest homes.

E. Distribution of Disapproved Marketing Materials.--You are prohibited from distributing marketing materials which have not been submitted to HCFA for approval. Similarly, you are prohibited from distributing marketing materials which HCFA has disapproved in writing within 45 days after your submission of them.

2211.1 Penalties.--Medicare's broad authority to penalize fraud and abuse includes specific penalties for deceptive marketing practices. HCFA may suspend new enrollment and/or payment for new enrollees if an HMO/CMP misrepresents or falsifies information provided to an individual or an entity. In addition, up to $25,000 in civil money penalties may be imposed for each time an HMO/CMP misrepresents or falsifies information provided to an individual or an entity, and up to $100,000 may be imposed for each time an HMO/CMP misrepresents or falsifies information provided to HCFA.

2212. USE OF MARKETING AGENTS

Sales or marketing agents play a critical role in representing your plan to Medicare beneficiaries. Exercise direct management control over the activities of these individuals to assure that they are presenting clear, complete, and accurate information necessary for potential enrollees to make informed decisions to enroll. (See §§2202 and 2203.)

HCFA strongly discourages the use of Medicare marketing representatives who are not employees of your health plan. If you decide to use such agents, establish monitoring and training systems to assure that the agents clearly understand and operate within the limits permitted for their activities, specifically in regard to the prohibited marketing activities described in §2211.

HCFA suggests the following practices be followed with regard to marketing agents:

- Use the same professional standards for Medicare marketing staff as you use for commercial marketing staff. For example, if you require your commercial sales staff to be licensed by the State, extend this requirement to Medicare sales representatives. If you use company employees as commercial sales representatives, use company employees as Medicare sales representatives;
o Establish an enrollment verification system which requires that a different individual from
the sales agent call or meet with a Medicare beneficiary who has applied for enrollment to assure that
he/she understands such restrictions as the lock-in provision before the enrollment form is finally
processed;

o Analyze disenrollment data to identify marketing agents with high and low percentages
of member disenrollments within 90 days of enrollment. Use this data for problem identification and
resolution; and

o Establish a compensation program that encourages a marketing agent to engage in full and
clear discussion with a potential enrollee during the enrollment process about benefits, restrictions
(including lock-in), and other organization rules. For example, when commissions or bonuses are
used as part of the compensation system, base them on sustained retention of enrollees.

2213. PHYSICIAN MARKETING

Some plans use their physicians as marketing agents. HCFA strongly discourages this practice
because:

o Physicians are usually not fully aware of membership plan benefits and costs;

o Physicians may not be the best source of membership information for their patients;

o A physician acting outside the role of providing medical services may confuse the
beneficiary as to when the physician is acting as an agent of the plan; and

o Physicians' knowledge of their patients' health status increases the potential for their
discriminating in favor of Medicare beneficiaries with positive health status when acting as a
marketing agent. Such activity is potentially a prohibited marketing activity. (See §2211 A.)
# HMO Arrangements for Health Services

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## Availability, Accessibility and Continuity of Care

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2300. NATURE OF ARRANGEMENTS

To participate in a Medicare contract under §1876 of the Social Security Act (the Act), you must be an eligible organization. An eligible organization is defined as either a health maintenance organization (HMO) or a competitive medical plan (CMP). An HMO must be federally qualified as defined in §1301 of the Public Health Service Act. A CMP is a public or private entity as defined in §1876(b) of the Act. As a federally qualified HMO or eligible CMP, you are required to provide or arrange for all Medicare benefits and those supplemental services for which your members have contracted. A detailed description of required benefits is included in §§2101ff.

To discuss the nature of arrangements, you must understand the term provider. The Medicare definition of provider includes a hospital, a skilled nursing facility (SNF), a comprehensive outpatient rehabilitation facility, or a home health agency that meets Medicare conditions of participation. Providers also include a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has a Medicare agreement to furnish only outpatient physical therapy or speech pathology services. A community mental health center furnishing partial hospitalization services is also a provider. The Medicare definition of supplier is a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare. The health industry's definition of provider encompasses both the Medicare definition of provider and supplier. This chapter uses provider or supplier as those terms are defined by Medicare.

For a Medicare contract, you must provide all Medicare services to all your Medicare eligible enrollees. The services furnished directly by you, or through arrangements with others, must include the same services available to other Medicare beneficiaries who live in the same geographic area but are not enrolled in your plan. If a Medicare covered service is not procurable in your geographic area because a facility or a specialist is not available, you are still required to arrange for these services outside the plan's service area. (See §2101.)

Arrangements with providers are to be in writing whenever possible. A written agreement is evidence that a health delivery network is operational and able to provide health services to enrollees. These arrangements include service contracts, employment contracts, letters of agreement, and memoranda of understanding. Your operational structure and size determine the most appropriate provider/supplier arrangements for your HMO/CMP. Sometimes due to the geographic and demographic conditions of the area, it may not be possible to secure a contract or written agreement with a particular provider/supplier. For example, an HMO/CMP may not be able to secure a contract or written agreement with a physician sub-specialist such as a thoracic surgeon. The surgeon may not contract with any HMO/CMP in the service area because the physician's ability to maintain a patient panel is not contingent upon participation, possibly due to the fact that he/she is the only thoracic surgeon in the service area. Oral arrangements in such situations are permissible. However, the absence of a written agreement does not obviate the requirement that you provide all Medicare services. Continue your efforts, therefore, to secure a contract or other written agreement with the provider. Guidelines for making payments to non-contracting providers and physicians are discussed in §2107. Where possible, your informal arrangements with a non-contracting provider should provide for continuity of care and external peer review as required by §2304.
Your health care providers/suppliers must meet applicable Medicare regulations and be certified for participation in the Medicare program. Your arrangements with providers/suppliers must assure that health services are available and accessible to all of your members and must promote continuity of health care. Also, you must assure that participating providers/suppliers follow your programs and procedures. Typical contracts include provisions for:

- Participation by providers/suppliers in the HMO/CMP's quality assurance and utilization review programs,
- Medical coverage after office hours and during absences,
- Cooperation with peer review organizations for purposes of medical record review,
- Incentive or risk sharing arrangements,
- Types of services to be provided,
- Treatment for Medicare enrollees, and
- Adherence to your medical policies.

See §§2101ff. for additional information.

2301. HOSPITAL and NURSING FACILITY SERVICES

You or your affiliated providers/suppliers must arrange or provide all hospital services except when:

- Emergencies occur outside the service area,
- Emergencies occur within the area that result in treatment at a non-affiliated hospital, or
- Urgently needed services occur out of the area.

You are responsible for paying for services in these three situations.

You must furnish the required hospital services to Medicare enrollees through hospitals that meet conditions of Medicare participation found in 42 CFR 482. Criteria for hospital participation are:

- Compliance with Federal laws and regulations relating to the health and safety of patients,
- State licensure, and
- Assurance that hospital personnel have credentials required by Federal, state or local laws.

An HMO or CMP must also have arrangements for skilled nursing services. These services are provided through SNFs that must meet conditions of Medicare participation noted in 42 CFR 483 (subpart B). Information relating to the current certification status of Medicare hospitals and SNFs, including deficiencies cited during onsite evaluations, may be obtained from the HCFA regional office serving your area.
2301.1 **Hospital Admitting Privileges**.--Your primary care physicians and specialists must have hospital admitting privileges to at least one of the hospitals with which you have arrangements. Also, the hospitals in which the physicians are privileged must serve the area from which the physicians draw your enrollees.

2302. **PROFESSIONAL SERVICES**

Medicare benefits provided by licensed health professionals, including physicians, must be provided or arranged through:

- Physicians or health professionals who are on your staff,
- A medical group or groups,
- One or more individual practice associations (IPAs),
- Physicians or health professionals under direct service contracts with you, or
- Any combination of the above.

2302.1 **Other Health Professionals**.--In order to provide services at the most efficient and cost effective level, you may enter into arrangements with other health professionals who are licensed, certified, or practice under an institutional license, or other authority consistent with State law. For example, if a health service provided by a physician may also be provided under applicable State law by a dentist, optometrist, chiropractor or other health care personnel, you may have these professionals provide this service. However, all providers/suppliers rendering services to Medicare enrollees must be Medicare certified.

2302.2 **Direct Physician Supervision**.--For services performed by non-physicians, direct physician supervision of such services is required. (See Medicare Carriers Manual §§2050ff.) The supervising physician or physicians must be available during office hours to perform medical rather than administrative services. In an HMO/CMP setting, the following practitioners are excepted from the physician supervision requirement under certain circumstances (see §2153.4):

- Physician assistants,
- Nurse practitioners,
- Clinical psychologists,
- Certified nurse midwives,
- Clinical social workers, and
- Certified registered nurse anesthetists.

2302.3 **Services for Which Arrangements Are Not Necessary**.--You do not need arrangements for services your members obtain out of plan and for which you assume financial responsibility because they are emergency services (out-of-area and in-area) or urgently-needed services (out-of-area).

2302.4 **Supplemental Services**.--The provisions of this chapter do not apply with respect to additional or supplemental services. (See §§2101ff.)
2303. **AVAILABILITY AND ACCESSIBILITY OF SERVICES**

Assure that all Medicare covered services, supplemental services, and additional benefits that members have contracted for in your geographic area are available and accessible. Your geographic area is the contract area, approved by HCFA, in which you provide or arrange for the provision of health services and in which you enroll Medicare members.

Construct provider/supplier networks or make arrangements for referrals for Medicare enrollees sufficient to deliver inpatient and outpatient primary and specialty services to current and expected Medicare members in your plan. Marketing materials and other member information must include a description of your participating providers/suppliers as well as your contract area.

Services must be available and accessible with reasonable promptness with respect to geographic location, hours of operation, and provision for after hours care.

2303.1 **Geographic Location**.--Providers/suppliers must be located throughout the geographic area.

A. **Travel Time**.--Services are generally considered accessible if they reflect usual practice and travel arrangements in the local area. Generally hospital and primary care physician services must be within 30 minutes travel time for members. This guideline does not apply if usual travel patterns in a service area for hospital and primary care physician services exceed 30 minutes. For example, travel time might be greater than 30 minutes in a rural area.

B. **Provider/Supplier Networks**.--The provider/supplier networks for Medicare enrollees must be the same that you use for commercial members. However, the Medicare network may be a subset of a larger commercial network as long as there are no Medicare only providers/suppliers. This does not restrict some providers/suppliers from treating only Medicare enrollees as the result of non-Medicare enrollees not choosing certain providers/suppliers, location in a senior center, or the nature of a supplier's practice (e.g., gerontologists).

C. **Physician Withdrawals**.--If you lose physicians in a portion of the service area during the contract year, you are still responsible for assuring the provision of covered services. You must inform members, in writing, 30 days before a physician/supplier terminates affiliation.

D. **Providers/Suppliers at Capacity**.--Some physicians and other providers in your network may go through periods of time when they are not accepting new patients. State in your marketing materials which physicians and providers are not accepting new patients. Update these materials annually or more frequently as changes in your provider/supplier network take place.

E. **Unavailability of a Provider/Supplier**.--Generally, if a Medicare certified facility such as an SNF is not available in your area, you are still responsible for providing Medicare-covered services. Arrange to refer Medicare enrollees to providers/suppliers outside the geographic area.

If a Medicare benefit is not available to any Medicare beneficiary residing in your geographic area, see §2160.1.
F. Admission Policy.--If a provider (i.e. hospital, SNF or other entity having a Medicare provider agreement under §1866 of the Act) chooses not to admit your Medicare enrollees, then the HMO may not refer its commercial enrollees to this provider. Providers may apply any restriction on admission that is not otherwise prohibited by State or Federal law, but only if the restriction is applied the same way to non-Medicare beneficiaries as it is to Medicare beneficiaries. A hospital or SNF can refuse to admit a Medicare HMO/CMP enrollee (except in emergencies) if the same criteria for denying admission are applied equally to all enrollees (of the HMO/CMP) seeking admission, regardless of their Medicare entitlement.

2303.2 Hours of Operation.--Hours of operation for health services for membership must be convenient to the population served and must reflect patterns of care in your geographic area.

2303.3 After Hours Care.--Make provision for after hours care, including emergency care.

Medically necessary emergency care must be available and accessible 24 hours a day, 7 days a week. (See §2104 for further discussion of these services.) Member information must include a clear definition of a medical emergency and the procedures for obtaining care in such a situation. Specifically, these materials must address how to obtain care or authorization:

- During office hours in the service area,
- After office hours in the service area, and
- Outside of the service area.

2303.4 Monitoring.--Have systems in place to collect data to evaluate the availability and accessibility of services you provide or arrange. Specifically, these systems monitor factors such as the following:

- Waiting times to obtain appointments for routine scheduled and urgent care,
- Waiting times to receive services at physician offices and clinical and diagnostic facilities,
- Procedures for receiving and analyzing member complaints,
- Telephone access to the plan and primary care physician for routine and urgent care, as well as in emergencies, both during and after office hours,
- Inappropriate use of emergency services as an indication of lack of availability and accessibility of plan services,
- Number of requests as well as reason for requests to change primary care physicians,
- Number of physician requests to close their practice to new patients,
- Physician back-up and on-call arrangements for primary care physicians, and
- Volume of out-of-plan referrals by specialty and service.
2303.5 Methods of Monitoring.--Monitoring availability and accessibility of care can be done through:

- Surveying physician offices and other plan facilities initially and on a continued routine basis,
- Surveying promptness of services at physician offices and other plan facilities with feedback to the offices and facilities surveyed,
- Tracking physician turnover and the stability of the provider/supplier network,
- Surveying waiting times for an appointment at physician offices and other plan facilities with feedback to these offices and facilities,
- Reviewing appointment scheduling procedures,
- Reviewing member complaints on availability, accessibility and other quality of care issues, and
- Analyzing the system used to determine the need for additional providers/suppliers and the system for recruiting.

2304. CONTINUITY OF CARE

Continuity of care is the degree to which the care needed by a patient is coordinated effectively among practitioners across provider organizations over time. This concept emphasizes:

- Coordination of health care services among primary and specialty care physicians,
- Coordination among specialists,
- Appropriate combinations of prescribed medications,
- Coordinated use of ancillary services, including social services and other community resources,
- Appropriate discharge planning, and
- Timely placement at different levels of care, including hospital, SNF and home health care.

Services provided to members must be structured in a manner which assures continuity. This can be achieved by having a primary physician responsible for coordinating a member's overall health care and by maintaining recordkeeping systems through which pertinent information relating to the health care of the member is accumulated and readily available and shared among appropriate professionals and available for external peer review. Make arrangements for the physician or other health professional coordinating the member's overall health care to be kept informed about referral services provided to members.

2304.1 Systems for Assuring Continuity of Care.--Employ systems to promote continuity of care and case management. This could include development of a plan for the overall treatment of each patient. This plan could cover the full course of illness and related medical conditions. It should also address issues related to treatment at the proper level of care and ensure adequate follow-up.
### PART 2
### CHAPTER 5
### BENEFICIARY APPEALS AND GRIEVANCES

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**Grievances**

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2400. DISTINGUISHING BETWEEN GRIEVANCES AND APPEALS

There are two types of procedures for resolving enrollee complaints, the Medicare appeals procedures and the plan-internal grievance procedures. Resolve all enrollee complaints through one of these procedures. Use the procedure appropriate to the complaint. Disputes about initial determinations, are resolved only through the Medicare appeals procedure. These are primarily complaints concerning payment for services or denial of services. Use the grievance procedures for all complaints which do not involve an initial determination. Transfer complaints between the two procedures when appropriate.

2400.1 Complaints Which Apply Both to Appeals and Grievances--The appeals and grievance procedures are mutually exclusive. Process complaints under the appeals procedures or grievance procedures. If an enrollee addresses two issues in one complaint, process each issue separately and simultaneously under the proper procedure. Do not process these complaints first through the grievance procedures, and then through the appeals procedures.

2400.2 Appeals.--All initial determinations are subject to the appeals procedures. Complaints sometimes do not appear to involve an initial determination and are mis-classified as grievances. This may occur because the plan did not issue the written notice of an adverse determination. (See §2403.5.) Common mis-classifications include:

A. Service Denials.--Service denials are often mis-identified in cases in which:
   o The provider of services made a coverage denial;
   o A notice of adverse initial determination was not issued within sixty days; and
   o The beneficiary appeals pursuant to §2403.1.

Inform providers that they must ensure timely issuance of a written notice of adverse initial determination as described in §2403.5 when coverage is denied. The provider may issue the initial determination notice or he/she may ensure that the medical group or organization issues the notice.

B. Quality of Care.--Complaints concerning the quality of a service a member received are treated as a grievance. However, quality of care complaints are occasionally complaints of a denial of services. For example, a member complains of poor medical care because his doctor did not authorize a surgery or other medical service. This complaint involves a denial of service. Process it through the appeals procedures. Peer Review Organizations (PROs) also review beneficiary quality of care complaints. (See §2305.1F.)

C. Accessibility.--Complaints concerning timely receipt for services already provided are treated as grievances. If the member complains that he has not been able to obtain a service, treat it as an appeal. If the member complains that he had to wait so long for a service that he went out-of-plan, treat it as an appeal for payment for the out-of-plan services.

D. Non-Medicare Covered Services.--The Medicare appeals procedures apply to all benefits offered under a risk-based contractor's basic benefit package. They also apply to Part A benefits which "Part B only" members buy from the plan. Benefits offered under an optional supplemental plan are
subject only to the grievance procedures. (See § 2403.2E.) Non-Medicare benefits in a cost-
reimbursed contractor's basic benefit package are not subject to the appeals procedures.

2400.3 Claims Processed by Carriers and Intermediaries--Carriers or intermediaries receiving 
claims for members of risk-based plans transfer the claims to the plan for processing. Carriers and 
intermediaries sometimes correctly process claims for members of cost-reimbursed plans (i.e., when 
enrollees see a non-plan physician). Enrollees file for appeal with the entity that made the 
determination. For example:

A. Claims Denied by the Carrier or Intermediary.--The enrollee files an appeal with that 
carrier or intermediary.

B. Claims Paid by the Carrier or Intermediary, but the Enrollee Disagrees with Payment 
Amount.--The enrollee files the claim with the carrier or intermediary. For example, a member 
submits a claim for a motorized wheelchair. The carrier decides the motorized wheelchair was not 
medically necessary and reimburses the member at the rate approved for a non-motorized 
wheelchair. If the enrollee believes the motorized wheelchair was medically necessary, he/she 
appeals through the carrier.

C. Claims Paid by the Carrier or Intermediary and the Enrollee Wants Reimbursement for 
Coinsurance or Deductibles.--Enrollees file appeals with the HMO/CMP if they agree with the 
carrier's or intermediary's decision, but disagree with the plan's reimbursement for the Medicare 
deductible and coinsurance. For example, the carrier processes a claim for a motorized wheelchair 
and pays 80% of the allowable charge. However, the plan issues an initial determination denying 
the deductible and coinsurance because the member purchased the wheelchair from a non-plan 
provider. The enrollee appeals to the HMO/CMP for reimbursement. Process appeals on carrier or 
intermediary claims only in this situation.

2400.4 Grievances.--The following items are not subject to the appeals procedures. Process them 
under the grievance procedures outlined in §2410:

o Disputes that do not meet the definition of an initial determination. Examples of 
grievances include:

- Determinations of items or services included in an optional supplemental plan;
- Complaints about waiting times, physician demeanor and behavior, adequacy of 
facilities; or
- Involuntary disenrollment issues.

o Disputes about items or services that you have furnished, either directly or under 
arrangement, for which the enrollee has no further liability for payment (i.e. services rendered 
without charge or for which the responsibility for payment does not rest with the Medicare 
beneficiary). However, services for which Medicaid has paid or could pay are subject to appeal.

Enrollee Appeals

2401. SCOPE

All HMOs, CMPs and demonstrations with Medicare contracts requiring compliance with 
§1876(c)(5)(B) of the Act must provide the appeals procedures. This
requirement includes both risk and cost contractors. Appeal procedures do not apply to beneficiaries who receive Part B services under a health care prepayment plan (HCPP) agreement. (See § 1833 of the Act.) HCPP enrollees only have access to whatever internal grievance process the health plan may have.

2401.1 Representation of Parties.--The provisions of 20 CFR 404.1700ff dealing with representation of parties, apply to appeals under this chapter, with two exceptions:

- Representative fees; (See §2406.2.) and
- Plan providers, suppliers or employees may not represent an enrollee in an appeal.

2401.2 Steps in the Appeals Process.--There are five levels of determination available to Medicare beneficiaries enrolled in entities required to provide appeals procedures. These levels are:

- Initial determination by the plan;
- Reconsideration determination;
- Plan reviews its initial determination;
- HCFA reviews case if plan decision is partially or fully against the beneficiary;
- Hearing by an Administrative Law Judge, if at least $100 is at issue;
- Appeals Council Review; and
- Judicial Review, if at least $1000 is at issue.

2402. WRITTEN EXPLANATION OF APPEALS PROCEDURES

Inform all enrollees in writing of the appeals procedures. Provide members with written descriptions in the following situations:

- At initial enrollment as part of the membership materials;
- Each year in the annual rights notice; and
- Upon request by the enrollee or his/her representative.

Clearly distinguish between grievance issues and appeals issues in all written explanations. Describe all steps of the Medicare appeals procedure, from the initial determination by the health plan to the judicial review rights after exhaustion of administrative appeal rights. Include time limits, amount in controversy requirements and procedures for filing appeals.

In all adverse initial determination notices, include the member's right to a reconsideration. (See §2403.5A.)

2403. INITIAL DETERMINATIONS

An initial determination is defined at 42 CFR 417.606(a) as (1) a determination concerning the rights of an enrollee with regard to services covered by
Medicare that are furnished by the organization, and (2) any determination made concerning the following items:

- Reimbursement for emergency or urgently needed services;
- Any other health services furnished by a provider or supplier other than the organization that the enrollee believes are Medicare covered and should have been furnished, arranged for, or reimbursed by the organization; or
- The organization's refusal to provide services the enrollee believes the organization is obligated to cover, and the enrollee has not obtained them elsewhere.

Issue a written notice for all initial determinations. Resolve all disputes involving initial determinations through the appeals procedures.

2403.1 Time Limit for Issuing an Initial Determination Notice--Issue initial determination notices for all "clean" claims within 24 calendar days of receiving the claim. A "clean" claim has no defect, impropriety or particular circumstance requiring special treatment preventing timely payment. Claims that lack any required documentation or authorization numbers are not considered clean.

For non-"clean" claims, issue an initial determination notice to the member within 60 calendar days of receiving the request for payment or services. Send initial determination notices for transferred claims to the member within 60 calendar days of the receipt of the claim from the carrier or intermediary. Do not delay the determination past 60 days, even to wait for medical records or additional information. Failure to issue a written notice within 60 days of your claim constitutes an adverse initial determination, which the member may appeal.

2403.2 Required Initial Determination Notices--Issue an initial determination notice when a member requests payment or services as described below:

A. Reimbursement for Emergency or Urgently Needed Services.--Issue an initial determination notice whenever a member requests reimbursement for emergency services or urgently needed out-of-area services.

B. Reimbursement for Services Denied by the Plan that the Member Received Out-of-Plan.--Issue an initial determination notice for health services received out-of-plan that the enrollee believes:

- Are covered under Medicare; and
- You should have furnished, arranged for, or reimbursed.

C. Transferred Claims.--Issue an initial determination notice on all claims transferred by carriers or intermediaries.

D. Service Denials.--Issue an initial determination notice if you refuse to provide services for which the enrollee believes you are responsible and the enrollee has not received the services out-of-plan. Make this written determination whenever any plan representative denies a service, whether it is a plan-contracted provider or a plan employee or official.

Advise physicians and other plan representatives that if they refuse to provide a service for a member, the member may appeal the decision. Educate plan...
physicians and representatives on beneficiary appeals rights, including how and when a member may file an appeal. If a physician denies an enrollee's request for a service, he/she should ask the enrollee if he/she would like to appeal. The plan must issue a written determination to the member whenever the member disagrees with the physician's decision or wants to appeal a service denial.

E. Initial Determinations for Supplemental Benefits--The Medicare appeals procedures do not apply to services included in an optional supplemental benefit package. However, they do apply to all benefits offered in risk-based plans' basic Medicare package, whether these benefits are funded through Medicare payments or through member premiums. The appeals procedures also apply to Part A benefits (inpatient hospital and skilled nursing facility services) for which "Part B only" Medicare beneficiaries pay a premium.

F. Initial Determination Concerning Enrollee Rights Regarding Medicare Covered Services You Have Furnished.--Issue an initial determination notice when you deny rights claimed by an enrollee regarding Medicare covered services you furnished, if the denial produces a dispute with an identifiable dollar value.

2403.3 Processing Guidelines for Initial Determinations with Incomplete Documentation.--If documentation of a request for payment or service is incomplete, try to obtain all relevant documentation within the 60 calendar day deadline. If you cannot obtain relevant documentation before the deadline, make the best decision possible based on the available information. Do not automatically deny the claim due to lack of medical documentation. If the only information available is the beneficiary's description of the situation, base the decision on that description. If you receive further information after making your decision, you may reopen it as described in §2409.

2403.4 Notice of Initial Determination--Send timely notices of initial determination. (See §2403.1.) If the beneficiary has a representative, send the representative a copy of the notice. Notices for decisions unfavorable to the member must:

A. Inform Member of Appeals Rights.--Inform the enrollee of his or her right to a reconsideration and right to be represented by an attorney in the reconsideration. Include instructions on filing a request for reconsideration. Also, inform beneficiaries that free legal services are available for qualified individuals. The following sample language provides the required information about appeal rights.

If you have any questions about this notice, you may wish to contact our Member Relations Department at ____________.

If you believe the determination is not correct, you have the right to request a reconsideration. You must file the request in writing with our plan (at the following address: ____________), with a Social Security office (SSO), or with an office of the Railroad Retirement Board if you are a railroad annuitant. You must file your request within 60 days of the date of this notice. You may mail your request or file it in person. You may also provide additional evidence to support your claim in person or writing. Even though you may file your request with a Social Security office or Railroad Retirement Board office, that office will transfer your request to us for processing. Your health plan is initially responsible for processing your request for reconsideration. However, if your health plan does not rule fully in your favor, your reconsideration request is forwarded to a HCFA contractor for processing.
If you want help with your appeal, you may have a friend, lawyer or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal.

B. State the Specific Reasons for the Determination.--The notice must state in clear language, the basis of your denial. One generalized statement which covers all possible reasons for denial is not appropriate.

EXAMPLES:

USE- We denied your request of payment for dialysis services you received out-of-plan. As stated in your membership materials, out-of-plan services are not covered when you are in the service area except in an emergency or when a plan representative authorizes the service before you receive it. Our records show that the services you received were not emergency services, and were not authorized.

DO NOT USE- We have denied your out-of-plan service because it was not emergency care, out-of-area urgently needed care, or authorized by a plan representative.

2403.5 Effect of the Initial Determination.--The initial determination is final and binding on all parties unless it is reconsidered or revised under §2409.

2404. RECONSIDERATION RIGHTS

Parties to the initial determination have the right to reconsideration. Those parties are:

- The enrollee;
- The legal representative on behalf of a deceased enrollee's estate; or
- Any other entity determined to have an appealable interest in the proceeding. Entities with an appealable interest include out-of-plan physicians and suppliers who (1) are seeking reimbursement from you for an item or service, and (2) have formally agreed to waive any right to payment from the beneficiary for the item or service in question.

2404.1 Enrollee Representation by a Non-Plan Physician, Provider, or Supplier--An institutional provider may represent a beneficiary if the beneficiary appoints the provider. For issues involving medically unnecessary services or custodial care, the provider must waive in writing any right to payment from the beneficiary for the item or service in question. The beneficiary may appoint a provider by:

- Signing a statement that clearly says that the provider will act as a representative; or
- Completing a Form SSA-1696, U4, Appointment of Representative (available at SSOs).

Any physician or supplier may act as the representative of the beneficiary in a reconsideration case if there is a written appointment of representative signed by both the beneficiary and the physician/supplier.

Physicians and suppliers do not complete this form if they are a party to the appeal (i.e. they have formally waived any right to payment from the beneficiary to whom they furnished the items or services). In this case, the physician or supplier is not representing the beneficiary. Therefore, the
A provider, physician or supplier does not need a written appointment or representative.

A provider, physician or supplier may not charge a beneficiary for representation in an appeal. Costs associated with the appeal are not reasonable costs for Medicare reimbursement purposes.

2404.2 Prohibition Against Appeals by In-Plan Suppliers and Providers.--Institutional providers, physicians, and suppliers who furnish items or services under an arrangement with you may not file an appeal. The enrollee must file the appeal if it concerns an in-plan service.

2405. RECONSIDERATION DETERMINATIONS

2405.1 Filing Requests for Reconsideration.--Enrollees must request reconsiderations in writing. They may file the request with you or a SSO. Qualified railroad retirement beneficiaries may file at a Railroad Retirement Board (RRB) office. The SSOs and RRB offices will forward all reconsideration requests to you.

A. Time Limits for Filing for Reconsideration.--The enrollee has 60 days from the date of the initial determination notice to file the request. If the enrollee appeals because you did not issue an adverse initial determination notice, the 60 day time limit does not apply.

B. Extensions for Filing.--Consider a time extension for good cause, if the enrollee makes the request in writing.

C. Determination of Good Cause.--Consider the circumstances which kept the enrollee from making the request on time and whether any of your actions may have misled the enrollee. Examples of circumstances where good cause may exist include (but are not limited to) the following situations:

- The enrollee did not personally receive the adverse initial determination notice, or he/she received it late;
- The member was seriously ill, which prevented a timely appeal;
- There was a death or serious illness in the member's immediate family;
- An accidental cause destroyed important records;
- Documentation was difficult to locate within the time limits; or
- The member had incorrect or incomplete information the reconsideration process.

D. Withdrawal of Reconsideration Request.--The party who filed a request for reconsideration may withdraw that request. The party must file the withdrawal in writing with one of the entities specified in §2405.1.

2405.2 Opportunity to Submit Evidence.--Provide the parties to the reconsideration reasonable opportunity to present evidence and allegations of fact or law related to the issues in dispute. Allow parties to present such evidence in person or in writing and take the evidence into account.
2405.3 Processing the Reconsideration Determination.--Review the initial determination and all other evidence submitted to make a reconsidered decision. Use a person not involved in making the initial determination to review the reconsideration. Individuals responsible for Medicare appeals must be thoroughly familiar with the procedures and know when to process a complaint through the appeals procedures.

The reconsideration is a two part process. If you make a determination completely favorable to the beneficiary, the reconsideration process ends. If you decide against the beneficiary in whole or in part, HCFA reviews the case through its reconsideration contractor, Network Design Group (NDG) and makes the final determination. You may not make a reconsideration determination which is unfavorable to the beneficiary. Only HCFA has this authority.

A. Time Limit for Processing Reconsideration.--You have 60 calendar days in which to make the reconsideration recommendation. Notify the beneficiary of a favorable decision or forward the case to HCFA's reconsideration contractor within this 60 days. You may not extend the 60 calendar days, even to obtain necessary medical records. Days counted toward processing times begin the day you receive the request.

B. Incomplete Documentation.--Occasionally, you may incomplete documentation for a reconsideration request. Try to obtain all necessary medical records within the time limit. If you cannot obtain all relevant documentation, make the decision based on the material in file.

C. Reconsideration Determination Fully Favorable to the Enrollee.--If you completely reverse the initial determination, the reconsideration is completed. Send a written notice and pay or provide for the disputed services within 60 days of the request for reconsideration.

D. Review of Reconsideration Not Fully Favorable to the Enrollee.--If you recommend partial or complete affirmation of the adverse initial determination, forward the case file to HCFA's reconsideration contractor, NDG. Send the prepared file to:

   Network Design Group
   1000 Pittsford-Victor Road
   Pittsford, N.Y. 14534

   1. Preparing the File for the Reconsideration Contractor.--Fully document the case within the 60 calendar day time limit. However, do not delay sending the file to the reconsideration contractor to obtain information. Give each file a separate folder, labeled with the member's name and Health Insurance Claim Number (HIC #).

   a. Cover Sheet.--Complete the cover sheet and attach to the case file. (See Appendix 1.)

   b. Case Summary.--Provide a case summary presenting all the facts of the case and explaining the rationale for your decision. Document the case file to support your recommendation. Prepare the case summary as follows:

      o Refer to providers by name (not initials or "center #"). Specify whether or not they are HMO-associated;

      o Explain how and when you first became aware of out-of-plan services;
o If the member received routine medically necessary services (care that is neither emergency nor out-of-area urgent) out-of-plan, explain why you did not provide or cover the services;

o Submit copies of all documents referred to in the file. Make certain that copies are legible and complete; and

o If another individual or entity represents the beneficiary, include a copy of authorization or explanation.

c. Chronology of Events.--Give a date-by-date chronology of events. Include member's enrollment date, disenrollment date, dates he/she went out-of-plan and history of use or non-use of plan's services.

d. Documents.--All reconsideration cases must contain the initial determination notice, unless you did not issue a notice and the beneficiary seeks reconsideration. (See 2403.1). Include:

o The member's written request for reconsideration. If the request for reconsideration was late, address issue of good cause for late filing;

o All contested claims, bills or requests for services, marked with date of receipt;

o All pertinent medical records, including, but not limited to, physician notes, nursing notes, progress reports, therapist notes, and discharge summaries. Include medical records if the issue involves emergency or urgently needed care, level of care, medical necessity, etc.;

o Beneficiary statements (e.g., why the enrollee used out-of-plan services);

o Responses to beneficiary statements (or address the issue in the case summary);

o Copies of relevant portions of the evidence of coverage or other description of benefits;

o Internal authorization/referral approvals and denials; and

o Records of relevant phone conversations and phone logs. State if you have no record of alleged phone calls.

e. Reconsideration Case Checklist.--Use the reconsideration case checklist to be sure you have properly organized and documented the case file. (See Appendix 2.) You do not need to submit this checklist.

2405.4 Notice of Reconsideration Determination.--The entity that makes the reconsideration determination is responsible for notifying the parties of the determination.

A. Notice from HMO/CMP.--Issue a notice of reconsideration determination only if you decide completely in favor of the beneficiary. Otherwise, the reconsideration contractor issues the notice when it makes its determination. Never issue more than one denial notice (i.e., the initial determination notice) for a request for a service or item or payment for an out-of-plan claim. Do not send another denial notice when you forward the member's file.
to the reconsideration contractor. You may, however, send a courtesy notice to beneficiaries to inform them that you have sent the reconsideration to HCFA's contractor for determination.

If you overturn your adverse initial determination, send a notice to the member. Pay, authorize or provide the services under dispute within 60 days of the request for reconsideration.

B. Notice from Reconsideration Contractor.--The contractor sends a reconsideration determination notice to the beneficiary, with a copy to the plan. If your decision is overturned, you have 60 calendar days from the date you receive the notice to pay, authorize or provide the services under dispute and inform the contractor that you have done so. You do not have the right to appeal the contractor's decision. However, you may request a reopening. (See §2409.)

2405.5 Effect of Reconsideration Determination.--The reconsideration determination is final and binding on all parties unless (1) an appropriate party requests a hearing or (2) the case is reopened under §2409. The filing of a request for reopening does not relieve you from your obligation to make payment or provide services within 60 days.

2406. HEARINGS

42 CFR 417.600 through 417.638 and 20 CFR 404.929 through 404.961 deal with the conduct of hearings and are applicable to hearings under this chapter.

2406.1 Right to a Hearing.--Any party to the reconsideration dissatisfied with the reconsideration determination has a right to a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration (SSA). The dispute must involve at least $100. The HMO/CMP is not a party to the reconsideration and does not have a right to a hearing.

2406.2 Request for a Hearing.--A request for a hearing must be in writing and filed with one of the entities specified in §2405.1. Forward all hearing requests to NDG; it compiles the reconsideration file and forwards it to the hearings office.

Although you do not have a right to request a hearing, you must be made a party to the hearing. Fees for services provided by your representative are not subject to 20 CFR 404.1700ff which govern appointment of representatives and payment of fees to representatives.

A. Time Limit for Filing for Hearing.--Eligible parties must file a request for a hearing within 60 calendar days from the date of the reconsideration notice unless the ALJ grants a good cause extension.

B. Extension for Time Limit for Filing.--The request for an extension must be in writing and state the reasons why the request was late. If the party shows good cause for missing the deadline, the ALJ grants an extension. (See 20 CFR 404.911 for the ALJ standards for good cause.)

2406.3 Determination of Amount in Controversy.--The ALJ determines whether the amount remaining in controversy (for both Part A and Part B services) is $100 or more. For cases involving denied services, the projected value of the services is used to determine whether the amount in controversy is $100 or more. The hearing may be conducted on more than one claim at a time; i.e., the enrollee may have several claims involving several issues. The enrollee may combine claims to meet the $100 limitation, if the following requirements are met:
The claims must belong to the same beneficiary;

- The claims must have been through the reconsideration process;

- The 60 day filing time limit must be met for all claims involved; and

- The hearing request must identify all claims.

The ALJ dismisses cases involving less than $100. Parties may request review of the dismissal of a hearing through the Appeals Council (AC).

2406.4 Storage of Hearing Files.--The reconsideration contractor stores the hearing files.

2407. APPEALS COUNCIL REVIEW

Any party dissatisfied with the hearing decision (including the HMO/CMP) may request the AC of SSA to review the ALJ's decision or dismissal. The AC may grant or deny the request for review. If it grants the request, it may either issue a final decision or dismissal or remand the case to the ALJ with instructions.

2407.1 Filing a Request for Review.--To file a request for review, sign a Form HA-520 or write a letter. Submit the request for appeal to any local SSO, hearing office or directly to the AC.

Appeals Council
Office of Hearings and Appeals
P.O. Box 3200
Arlington, VA 22203

2407.2 Time Limit for Filing Request.--File the request for review within 60 days from the date you receive the hearing decision or dismissal. The AC assumes you received the decision five days after it sends the notice, unless you can show otherwise. The AC may grant an extension to request a review if the party can show good cause for missing the deadline. (See 20 CFR 404.911 for the AC standards for good cause.)

2407.3 Appeals Council Initiation of Review.--The AC may initiate a review on its own motion within 60 days after the hearing decision or dismissal. If the AC initiates a review, it mails notice of this action to all parties at their last known address.

2407.4 Appeals Council Review Procedure.--The AC reviews the entire record in the case. It reviews the disputed and non-disputed parts of the case. It makes a new determination, which may be less favorable to the party requesting review.

2408. JUDICIAL REVIEW

2408.1 Right to Judicial Review.--No party may obtain a court review unless the AC has acted on the case, either in response to a request for review or on its own motion. A party to the hearing (including the HMO/CMP) may request judicial review of an ALJ's decision if:
The AC denies the party's request for review; and
The amount in remaining in controversy is at least $1,000.

A party to the hearing (including the HMO/CMP) may request judicial review of the AC decision if:

- It is the final decision of the Secretary; and
- The amount remaining in controversy is at least $1,000.

The beneficiary may combine claims to meet the $1,000 amount in controversy requirement. To meet the requirement:

- All claims must belong to the same beneficiary;
- The AC must have acted on all the claims;
- The beneficiary must meet the 60 day filing time limit for all claims; and
- The request must identify the claims.

2408.2 Filing for Judicial Review.--File the civil action in a Federal district court in accordance with §205(g) of the Act. Institute the action in the judicial district in which the member lives or where you have your principal place of business. If neither you nor the member are in such judicial district, file the action in the United States district court for the District of Columbia.

2408.3 Time Limits for Filing.--File within 60 days after you receive the AC's decision or notice of denial of review.

2408.4 Effectuation of Decisions.--If you have not already provided or paid for the services on appeal and you have filed a valid request for AC review, you may await the outcome of the review before you provide or pay for the services.

2409. REOPENING DETERMINATIONS AND DECISIONS

The entity which makes an initial, reconsidered, or revised determination may reopen the determination.

Reopenings occur after a decision has been made, generally, to correct an error, in response to suspected fraud, or in response to the receipt of information not available or known to exist at the time the claim was initially processed. A reopening is not an appeal right. It is an administrative procedure under which the entity that made a determination re-examines that decision for a specific reason. The decision to reopen a case is at the discretion of the party who made the determination and is not appealable. Any party subject to a determination may request a reopening. The filing of a request for reopening does not relieve you from your obligation to make payment or provide services within 60 days.

Typically, reopenings are only requested after the exhaustion of appeal rights. A party may request a reopening even if it still has appeal rights, as long as the guidelines for reopenings are met. For example, if a beneficiary receives an adverse reconsideration determination, but later obtains relevant medical
records, he or she may request a reopening rather than a hearing before an ALJ. However, if the beneficiary did not have additional information and just disagreed with the reasoning of the decision, he or she must file for the appeal.

If a party requests a reopening while it still has appeal rights, it also files for the appeal and asks for a continuance until the reopening is decided. If the reopening is denied or the original determination is not revised, the party retains its appeal rights.

2409.1 Guidelines for Reopenings.--Do not reopen a decision unless the request follows these guidelines. Also, follow these guidelines when you are requesting the reopening:

- Make the request in writing;
- State the purpose for the reopening. Make clear that you are requesting a reopening. Do not request a reconsideration. HMOs/CMPs do not have a right to reconsideration;
- Do not submit a statement of dissatisfaction. It is not grounds to grant a reopening; and
- Make the request within the time frames permitted by § 2409.2.

2409.2 Time Limits for Reopenings.--Reopenings must be filed:

- Within 12 months from the date of the notice of the initial or reconsideration determination, at the discretion of the party who made the determination;
- After such 12-month period, but within 4 years after the date of the notice of the initial determination, if there is good cause for reopening the determination or decision; or
- At any time:
  - To correct a clerical error or an error on the face of the evidence which affects the determination or decision; or
  - When fraud or similar fault affected the determination or decision.

2409.3 Good Cause for Reopening.--Good cause exists where:

- There is new and material evidence, not readily available at the time of the determination, and consideration of this material may result in a different conclusion;
- There is an error on the face of the evidence which affects the determination or decision; or,
- There is a clerical error in the claim file.

2409.4 Definitions--

A. Meaning of New and Material Evidence.--New and Material Evidence is evidence not considered when making the previous decision. This evidence must show facts not available previously and possibly result in a different decision. The submittal of any additional evidence is not a basis for
reopening. New information also includes an interpretation of existing information (e.g., a different interpretation of a benefit).

B. Meaning of Clerical Error.--A clerical error includes such human and mechanical errors as mathematics or computational mistakes, inaccurate coding, or computer errors.

C. Meaning of Error on Face of the Evidence.--An error on the face of evidence exists if the determination or decision is clearly incorrect based on all the evidence present in the appeal file, the SSA files, or HCFA files at the time of determination.

Grievances

2410. SCOPE

Process all member complaints which are not initial determinations through the grievance procedures. This includes complaints about coverage under an optional benefit package, waiting times, physician behavior and involuntary disenrollment concerns. Handle all disputes about initial determinations under the appeals procedures. See §2401 for distinguishing grievances and appeals.

2411. PROCEDURES

Maintain internal grievance procedures. Provide the following procedures:

- Transmit timely grievances and complaints to appropriate decision making levels in the plan;
- Take prompt, appropriate action, including a full investigation if necessary; and
- Notify concerned parties of investigation results.

2412. WRITTEN EXPLANATION OF GRIEVANCE PROCEDURES

Provide all members with written grievance procedures upon enrollment, involuntary disenrollment, and on request. Clearly explain the procedures in the Evidence of Coverage and Annual Rights Notice. Notify enrollees about any changes to the rules 30 days in advance. Include at least the following information:

- How to file a grievance;
- Differences between the appeals and grievances procedures;
- Time limits for filing a grievance; and
- Time limits for each step in the procedures.
RECONSIDERATION CASE COVER SHEET

1. Beneficiary name: _________________________________
   (If deceased, so indicate and give date):
   Address and phone #:

2. Health insurance claim (HIC) number: ______________

3. Beneficiary representative:
   Relationship:
   Address and phone #:

   If reconsideration being pursued by provider, name of provider:

4. HMO information
   Name:
   Name of Medicare product line (if different):
   Address:

   HCFA contract number: H________
   Contact person and phone number:

5. Beneficiary Membership Data
   Indicate risk or cost:
   Date of enrollment:

   Date of disenrollment (if applicable):

6. Issue
   Give brief explanation of issue (such as "out-of-plan care--not emergency" or "self-referral--not authorized"):

   Date(s) of service(s):

   Amount in Controversy:

   Date of initial denial:

   Date of beneficiary's request for reconsideration:

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RECONSIDERATION CASE CHECKLIST

__ Each file has a separate folder, labeled with name and HIC#

__ File begins with cover sheet, summary of plan's justification for denial, and chronology of events

File Documents for Reconsideration Request Included

__ Dated notice of initial determination (or reconsideration requested because there was no determination within 60 days of claim receipt)

__ Member's written request for reconsideration, dated by member or dated on receipt

__ Issue of good cause for late filing addressed

__ If relevant, member's additional written statements or summary of oral statements

__ All contested claims or request for coverage, dated by receipt at plan

__ All medical records sufficient to render a medical decision

__ Authorization of legal representative, if appeal not being pursued by member, or provider information if provider is pursuing the reconsideration.

File Review

__ Photocopies legible and complete?

Note: This document is only for your convenience; the health plan is not required to submit this with the request and case file.
## PART 3
### CHAPTER 1

**CONTRACT REQUIREMENTS**

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3000. TERM LENGTH AND EFFECTIVE DATE

3000.1 Initial Term Length.--The term of an HMO/CMP Medicare contract with HCFA is at least 12 months. Upon your request, HCFA may grant a contract term for your initial contract of up to 23 months. HCFA determines the length of the initial term of the agreement for health care prepayment plans (HCPPs).

3000.2 Additional Periods.--Each additional term is for 12 months with automatic renewal unless either party terminates, or chooses not to renew, the contract.

3000.3 Effective Date.--The effective date of an HMO/CMP contract may not be earlier than the date both HCFA and you sign the contract.

3000.4 Waivers.--An HMO/CMP contract contains the specific terms and conditions, and the expiration date, of any waiver of the composition of enrollment rule or the open enrollment requirement. (See §§2001.1 and 2001.2.)

3001. ONGOING CONTRACT REQUIREMENTS

3001.1 Basic Contract Requirements for HMOs/CMPs.--By signing the contract, you agree to comply with all regulations and other HCFA requirements. Regulations pertaining to HMOs and CMPs constitute a part of the HMO/CMP contract. Additional requirements are specified in the contract document itself.

A. External Quality Review.--For services furnished to Medicare enrollees, you agree to allow review of your medical operations by utilization and quality control peer review organizations (PROs) authorized under title XI of the Social Security Act (the Act) as set forth in 42 CFR 466.72.

Upon request, you agree to provide to the PRO on-site access to, or, at the PROs request, copies of, patient care records and other pertinent data, and permit the PRO or its subcontractor to examine your operations and records as necessary for the PRO to carry out its functions under the Act.

If you are a risk-based HMO/CMP, you agree to:

- Maintain a written agreement with the PRO that has a HCFA contract under Part B of title XI of the Act for the area served under your Medicare contract. In accordance with §§1154(a)(4)(B) and (a)(14) of the Act, the agreement must provide for the review of services (including both inpatient and outpatient services) provided to your Medicare enrollees to:

  - Determine whether such services meet professionally recognized standards of health care, including whether appropriate services have not been provided or have been provided in inappropriate settings (§1154(a)(4)(B));

  - Determine whether individuals enrolled with an eligible organization have adequate access to health care services provided by or through such organization (as determined, in part, by a survey of individuals enrolled with the organization who have yet used the organization to receive such services); and

  - Maintain a beneficiary outreach program designed to apprise individuals of the role of the peer review system, of the rights of the individual under such system, and of the method and purposes for contacting the organization.
The agreement must also provide for review by the PRO of all written complaints filed by Medicare beneficiaries or their representatives about the quality of services you provide. HCFA pays the PRO its costs under the agreement on your behalf; and

- Provide hospitals with any information necessary for the completion of the UB-82 forms which the hospital must submit to the intermediary for any discharges after July 31, 1988.

B. Liability Arrangements, Financial Records, and Reports to HCFA.--HMOs/CMPs agree to:

- Comply with §§1318(a) and (c) of the Public Health Service Act, that require the reporting of specified financial and other information; and to make the information available to its enrollees upon reasonable request;

- Comply with §1301(c)(8) of the Public Health Service Act, which requires the provision of an effective procedure for developing, compiling, evaluating, and reporting statistics and other information relating to operation costs; service utilization, availability, accessibility and acceptability; members' health status developments; and such other required matters;

- For reasonable cost organizations, maintain financial records sufficient to ensure an audit trail and to properly reflect all direct and indirect costs claimed to have been incurred under the contract, including at least records of the following:
  - Ownership, organization, and operation of the organization's financial, medical and other recordkeeping systems;
  - Financial statements for the current contract period and three prior periods;
  - Federal income tax or informational returns for the current contract period and three prior periods;
  - Assets acquisition, lease, sale, or other action;
  - Agreements, contracts, and subcontracts;
  - Franchise, marketing, and management agreements;
  - Schedules of charges for the organization's fee-for-service patients;
  - Matters pertaining to costs of operations;
  - Amounts of income received by source and payment;
  - Cash flow statements; and
  - Any financial reports filed with other Federal programs or State authorities; and

- For risk organizations, maintain records sufficient to:
  - Establish component rates of the adjusted community rate (ACR);
- Determine additional and supplemental benefits; and
- Determine the rates utilized in setting premiums for State insurance agency purposes. Maintain any other records or financial reports filed with other Federal agencies or State authorities.

By entering into a contract with HCFA, you agree to furnish information required to determine continued eligibility to contract, in the manner prescribed in 42 CFR 417.107(j) (the national data reporting requirements). You report information relating to:

- The cost of operations;
- The patterns of utilization of services;
- The availability, accessibility, and acceptability of services;
- To the extent practical, developments in members' health status; and
- Information demonstrating that you are fiscally sound.

You also agree to submit quarterly reports of commercial, Medicaid and Medicare enrollment in the geographic area of your Medicare contract.

C. Excluded Providers and Practitioners.--You agree not to employ any agents or management staff or persons with ownership or control interests who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social service programs under title XX of the Act. (See 42 CFR 417.412(b)(2).)

D. Prompt Payment of Claims.--You agree to provide prompt payment (consistent with the provisions of §§1816(c)(2) and 1842(c)(2) of the Act) of claims submitted for services and items furnished to your Medicare enrollees, if the services or items are not furnished under a contract you have with the provider or supplier.

E. Advance Directives.--You agree to:

Provide written information to all adult enrollees (both Medicare and non-Medicare) at the time of enrollment concerning their rights under State law (whether statutory or as recognized by the courts of the State) to accept or refuse medical or surgical treatment and to execute and formulate advance directives, such as living wills or durable powers of attorney for health care;

- Inform all enrollees of your written policies on implementation of that right;
- Document in the individual's medical records whether he or she has executed an advance directive;
- Not condition the provision of care, or otherwise discriminate, on the basis of whether an individual has executed an advance directive;
- Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) respecting advance directives at your facilities; and
- Provide (individually or with others) for education of your staff and the community on issues concerning advance directives.
F. Compliance with Other Laws.--You agree to comply with title VI of the Civil Rights Act of 1964 (and pertinent regulations in 45 CFR 80), §504 of the Rehabilitation Act of 1973 (and pertinent regulations in 45 CFR 84), and the Age Discrimination Act of 1975 (and pertinent regulations in 45 CFR 91).

3001.2 Basic Requirements Under HCPP Agreement.--(See 42 CFR 417.801(b).) HCPPs agree to:

- Furnish physician services through employees or under a formal arrangement with a medical group, individual practice association or individual physicians;
- Furnish covered Part B services to Medicare enrollees through institutions, entities, and persons that have qualified under the applicable requirements of the Act;
- Maintain compliance with the requirements for payment from HCFA outlined in 42 CFR 417.800;
- Not charge Medicare beneficiaries or other persons for items or services for which the HCPP is paid by HCFA, except for deductible and coinsurance amounts that are the individual's responsibility;
- Refund, as promptly as possible, any monies incorrectly collected as charges or premiums, or in any other way, from Medicare enrollees, in accordance with the provisions of 42 CFR 417.456; and
- Not impose any limitations on the acceptance of Medicare enrollees or beneficiaries for care and treatment that you do not impose on all other individuals.

The requirements of §3001.1E regarding advance directives also apply to HCPPs. In addition, HCPPs agree to consider any other requirements that HCFA may find necessary for the effective and efficient administration of the Medicare program.

3001.3 Definition of Related Entity.--A related entity is an entity related to you by common ownership or control which:

- Performs some of your management functions under contract or delegation;
- Furnishes services to Medicare enrollees under an oral or a written agreement; or
- Leases real property or sells materials to you at a cost of more than $2500 during a contract period.

3001.4 Right to Inspect, Evaluate and Audit.--HCFA has the right to inspect, evaluate and audit all organizations with Medicare contracts or agreements and their related entities. Different requirements apply depending on the type of contract or agreement you have with HCFA.

HMOs and CMPs must submit, upon request, any information HCFA needs to administer or evaluate the Medicare program. You must provide HCFA and other Federal agencies with access to facilities and records of your plan and related entities to:
o Evaluate the quality, appropriateness and timeliness of services to Medicare enrollees;
o Inspect facilities;
o Audit or inspect records about the amount payable under your Medicare contract; and
o Audit the enrollment and disenrollment of Medicare beneficiaries.

HCPPs must permit HCFA and the Comptroller General to audit or inspect any books and records of the HCPP and of any related organization that pertain to the determination of amounts payable for covered part B services provided to its Medicare enrollees (42 CFR 417.806(c)).

3001.5 Access to Records and Records Maintenance.--(See 42 CFR 417.482.) HCFA’s right to inspect, evaluate, and audit HMO/CMP records extends for a reasonable duration from the date of the final settlement for any contract period. (See §1833(e).) Therefore, retain records for a reasonable period, in case any questions are raised at a later date. Maintain records longer in the following situations:

- HCFA determines that there is a special need for you to retain and make the records available for a longer period, and HCFA notifies you at least 30 days before the normal disposition date; or
- There has been a termination, dispute, fraud, or fault by your organization. HCFA may require you to maintain records for three years after HCFA makes its final determination.

HCFA may reopen a final settlement at any time if it determines that there is a reasonable possibility of fraud.

3001.6 Disclosure of Information and Confidentiality.--HMOs/CMPs agree to:

- Submit to HCFA all financial information required under 42 CFR 417.530 through 42 CFR 417.576 and for final settlement (see 42 CFR 417.486(a)(1));

- Submit to HCFA any other information requested because it is necessary for the administration or evaluation of the Medicare program;

- Disclose, prior to signing the initial and each succeeding contract, the name and address of each person with an ownership or control interest in the HMO/CMP, or of any subcontractor in which the HMO/CMP has a direct or indirect ownership interest totaling five percent or more, and:
  - Specify whether any of the persons named are related as spouse, child, parent or sibling to another person on the list; and
  - Comply with the requirement under 42 CFR 417.486(b), which states the need to apply guidelines in 42 CFR 420.206(a)(3) concerning the disclosure of ownership and control information. Request all persons named to supply this information. Retain all such inquiries and their replies and, upon request, make them available to HCFA;

- Comply with the requirements of the Privacy Act with respect to any system of records developed in performing Part A intermediary and Part B carrier responsibilities under §§42 CFR 417.532 and 533; and
o Maintain confidentiality of all medical records and other information which is not otherwise protected under the requirements of the Privacy Act, which pertains to enrollees and which is received from HCFA, the enrollee, or any other source. The HMO/CMP must ensure that:

- A medical record is maintained for every enrollee;
- Only authorized personnel have access to the record; and
- Medical records generally are not removed from the organization's facilities except in accordance with Federal or State laws, and court orders under subpoenas.

3002. RENEWALS

Prior to the end of each contract or agreement period, HCFA reviews your past year's performance and generally renews your contract or agreement if your performance has been satisfactory. (See §3004.2B.)

Because the law provides that the contract continues in force from year to year unless there is a nonrenewal or termination, you may not have to sign a new contract document or agreement each year. The terms of the contract or agreement that you initially sign obligate you to implement any new applicable Medicare regulations, policy issuances, and instructions upon their effective date without a change to the contract. However, if substantial policy or operational changes have occurred, HCFA may issue a contract or agreement amendment, or a new contract or agreement, for your signature.

3003. CONTRACT MODIFICATIONS

Generally, service area expansions are the only type of mid-year contract modifications HCFA permits at your request. You may request a service area expansion at any time by submitting an application for an expansion to HCFA.

If you contract as an HMO or CMP under §1876 of the Act, you may request a change to cost or risk status at the end of a contract year. Conversions from one type of §1876 contract to another type of §1876 contract at the end of a contract year are considered contract modifications rather than terminations. (See 3004.1D.)

If HCFA wants to modify a contract, it notifies the official who signed the contract. For any type of contract modification, HCFA determines whether any contract changes affect your Medicare enrollees. If so, you must send a written notice to your enrollees regarding the contract changes.

3004. CONTRACT AND AGREEMENT NONRENEWALS AND TERMINATIONS

3004.1 Types of Contract and Agreement Cessations.--

A. Nonrenewal.--A nonrenewal is the cessation of your contract or agreement with HCFA when the term ends. You or HCFA may initiate a nonrenewal to be effective at the end of any contract period. You or HCFA may decide to nonrenew a contract, with at least 90 days notice. (See 42 CFR §417.492.)

B. Termination.--A termination is the cessation of your contract or agreement with HCFA before the term ends.

C. Service Area Reductions.--HCFA views service area reductions as partial contract terminations or nonrenewals. All requirements for nonrenewals and terminations also apply to service area reductions.
D. Conversions.--A conversion is a change from one type of §1876 contract with HCFA to another. An organization may change from a cost-reimbursed HMO/CMP contract under §1876(h) of the Act to an HMO/CMP risk-based contract under §1876(g), or the reverse. Conversions do not apply to HCPP agreements.

1. Conversion from Cost to Risk.--If you convert from a §1876 cost contract to a §1876 risk contract, you must retain all enrollees who make a written election of continued membership, specifying their understanding of the lock-in provision under a risk contract. Enrollees must be given at least a 30-day (but preferably 60-day) notice prior to the end of the contract period, stating:
   - That they will be disenrolled as Medicare members if they do not make a written election of risk membership;
   - That they will be locked in to the HMO/CMP (see §2205.1); and
   - The premium amount and coverage under the basic option in which they will be enrolled unless they elect to enroll in any high option you may offer (which also needs to be described in the notification).

The general public must also be informed of the change in the nature of your HCFA contract.

2. Conversion from Risk to Cost.--If you convert from a §1876 risk contract to a §1876 cost contract, all Medicare enrollees who remain enrolled will be covered under the reasonable cost provisions of the contract. Enrollees must be given at least a 30-day (but preferably a 60-day) notice prior to the end of the contract period, stating:
   - That their status will change unless they choose to disenroll;
   - That they will no longer be locked in to the HMO/CMP; and
   - The premium amount and coverage under the basic option (i.e., Medicare Parts A and B coverage; or Part B only for individuals without Part A) in which they will be enrolled unless they elect to enroll in any high option you may offer (which also needs to be described in the notification).

3. Changes To or From HCPP Status.--Changing from either a risk or cost contract under §1876 to an HCPP agreement requires both a new application by your organization and a new, written request for enrollment by any Medicare enrollee who wishes to remain enrolled in your organization.

Except for certain HCPPs with agreements dating from prior to February 1, 1985 (see §3004.1D4), an organization that changes from an HCPP agreement to a section 1876 contract must have a general Medicare open enrollment if it wishes to enroll any HCPP enrollees under the new section 1876 contract.

4. Rights of Enrollees of Cost HMOs and HCPPs from Prior to February 1, 1985.--If you are a cost HMO/CMP that has continuously maintained a §1876 cost contract with HCFA since prior to February 1, 1985, and you have not previously entered into a risk contract; or you have continuously had an HCPP agreement with HCFA since before February 1, 1985, and have not previously entered into a risk contract, special rules apply to your Medicare enrollees if you enter into a risk-based contract. A cost enrollee of your organization may generally retain his or her cost membership indefinitely if the HMO had a cost contract, or had an HCPP agreement under §1833 of the Act, as of the initial effective date of the amendments to the Act made
by the Tax Equity and Fiscal Responsibility Act of 1982. (This was established to be the effective
date of the implementing regulations, February 1, 1985.) For members retaining their cost status
under this provision, HCFA will require conversion to risk status (or the members may be
involuntarily disenrolled) if you have 75 or fewer remaining cost members, or if HCFA determines
that discontinuing the cost members is necessary for administrative reasons. Your cost enrollees may
also convert to risk status at any time by completing an application form, regardless of whether you
have an open enrollment for new Medicare members.

3004.2  Nonrenewal and Termination Process.--HCFA processes all nonrenewals and terminations.

A. Notifying Contracting Parties.--The first step in ending a contract is to notify the other
contracting party. This must be done 90 days before the intended or desired effective date. (See
§3004.3B.)

1. HMO/CMP and HCPP Requirements.--If you are requesting a termination, include
your reasons and the requested effective date in your notification to HCFA. (See §3004.3.)

2. HCFA Requirements.--HCFA's notification to contractors includes the reason for the
nonrenewal or termination and any applicable appeal rights. (See §§3201.2 and 3201.3.)

B. Reasons for Nonrenewal or Termination.--HMOs/CMPs may nonrenew a contract with
HCFA at the end of the contract period for any reason. They may terminate the contract only if
HCFA substantially fails to carry out the terms of the contract. HCPPs may nonrenew or terminate
for any reason.

HCFA and an HMO/CMP may modify or terminate a contract at any time if it is done by mutual
consent. Terminations by mutual consent are usually done to change a contract from a non-calendar
year to a calendar year basis.

HCFA may terminate or refuse to renew your HMO/CMP contract for any of the following reasons:

- You have failed substantially to carry out the terms of the contract;
- You are carrying out the contract in a manner that is inconsistent with the effective
  and efficient implementation of the law; or
- You are no longer eligible to contract with HCFA because you are not a federally
  qualified HMO or you no longer meet the requirements to be eligible to contract as a CMP.

HCFA terminates or nonrenews an HCPP agreement for any of the following reasons:

- You no longer meet the requirements for participation and payment as an HCPP;
- You are not in substantial compliance with the provisions of the agreement,
  applicable HCFA regulations, or applicable provisions of the Medicare law; or
- You undergo a change in ownership. (See §§3101ff.)
C. Termination When HCFA and/or the HMO/CMP Fail to Agree on ACR.--At least 45 days prior to the start of the contract period, you must furnish to HCFA a report for your contract period which describes your proposed ACR, your projected average payment rate (APR), and a description of any additional and/or supplemental benefits you propose to provide to your Medicare enrollees in accordance with requirements in §§5300ff. In the event that HCFA fails to approve this report, you fail to make the modifications requested by HCFA, or you fail to meet the requirements for timely and complete submittal of the report, HCFA may choose not to renew your contract. If HCFA decides not to renew the contract, HCFA must:

- Determine the month in which its liability for payment ends;
- Notify you that the contract will not be renewed because of your failure to submit a complete, approvable ACR report;
- Notify you of the month in which the contract is terminated; and
- Notify affected Medicare enrollees as soon as practicable.

3004.3 Effective Dates.--

A. Nonrenewals.--Nonrenewals are effective the day after the contract period ends.

B. Terminations.--

1. HMOs/CMPs.--When you terminate a contract, the termination is effective the later of (a) 90 days after the termination request to HCFA, or (b) 60 days after you mail a termination notice to Medicare enrollees. (See §3004.4.)

2. HCFA.--When HCFA terminates a contract, it determines the termination date. HCFA notifies you at least 90 days before the termination date. HCFA must also notify your enrollees and the general public at least 30 days before the effective date of termination. Risk-based contractors must send the notice of HCFA termination to their enrollees. (See §3004.4A1)

3. HCPP.--HCFA determines the effective date of any termination that either you or HCFA initiates. If you initiate the termination, HCFA may approve the termination date you request or set a different date. If HCFA initiates the termination, you are notified at least 90 days in advance of the termination date. HCFA makes its determination based upon whether termination on a specific date:

- Unduly disrupts the furnishing of services to the community you serve; or
- Otherwise interferes with the efficient administration of the Medicare program.

3004.4 Notification Requirements.--

A. Beneficiary Notification (HMOs and CMPs Only).--In most cases, the party terminating or refusing to renew the contract must send a written notice to all Medicare members enrolled in the organization at least 60 days before the effective date. However, if HCFA initiates a termination, it notifies members 30 days before the effective date. If HCFA terminates a risk contract, the risk-based organization must send (and pay for) the notice. (See 1876(i)(3)(B).) The notice must be reviewed by HCFA prior to issuance.
1. **Termination of Risk-Based Organizations.**--Risk-based organizations send a member notice meeting the above requirements for all contract terminations, even if HCFA initiated the termination.

2. **Model Letter.**--Appendix 1 is a model letter for you to use to notify beneficiaries about a nonrenewal or termination. The letter contains appropriate language for plans that meet the requirements for supplemental coverage by arranging supplemental (Medigap) insurance. (See §3004.5A1.) If you make other arrangements for supplemental coverage, adapt the language for your particular circumstances.

   B. **Public Notice (HMOs and CMPs Only).**--The party initiating the nonrenewal or termination process must publish a public notice in a local newspaper of general circulation. Publish the notice at least 30 days before the end of the contract period. HCFA notifies the public when contracts are terminated by mutual consent. HCFA recommends that the notice:

   o Specify the date the contract ends;

   o Specify the date the party sent a notice to enrollees; and

   o Identify a contact at the plan.

Appendix 2 contains a model public notice for plans which propose to meet the requirements for supplemental coverage by arranging for supplemental (Medigap) insurance. (See §3004.5A1.) If you make other arrangements for supplemental coverage, adapt the language for your particular circumstances.

   C. **Review of Notices.**--HCFA must review and approve beneficiary and public notices before you send or publish them. Submit the proposed notices for review in sufficient time for you to meet all deadlines. Provide your HCFA contract officer with final copies of notices sent to beneficiaries and published in the press within five days after the required publication date.

   D. **HCFA Notifications.**-- HCFA sends the following organizations notice of contract terminations or nonrenewals:

   o National and local Congressional offices;

   o National and local beneficiary advocacy groups; and

   o Local Social Security Offices.

The notice includes members' options for obtaining alternative coverage.

   E. **Press Notification.**--HCFA does not send the press a notice when contracts end. HCFA recommends that you inform the press. Include any actions you take to provide Medicare enrollees with other options.

   F. **Financial Liability for Notices.**--The entity responsible for sending the notices bears the cost.

3004.5 **Supplemental Policy Coverage (HMOs and CMPs Only).**--Upon termination or nonrenewal of a contract, or for members being disenrolled as a result of a reduction of a contract service area, you are required to provide or arrange for supplemental coverage to be made available to members who choose to return to fee-for-service Medicare.

   A. **Supplemental Policy Options.**--The following are acceptable ways to satisfy this requirement:
1. **Arrange Supplemental Insurance.**--Arrange for Medicare beneficiaries to obtain a State-certified Medicare supplemental (Medigap) policy that covers Medicare deductible and coinsurance amounts for Medicare covered services and that waives any exclusion period for coverage of pre-existing conditions for the lesser of six months or the duration of the waiting period. The policy must:
   
   o Provide beneficiaries a reasonable period to enroll (30 days is acceptable);
   
   o Be effective the day following the last day of the contract;
   
   o Not health screen for coverage; and
   
   o Be offered at terms and rates approved by the State insurance commissioner.

   If there are no Medigap policies available that cover Medicare beneficiaries under age 65 (i.e., the disabled and individuals entitled to Medicare on the basis of end-stage renal disease), the policy that you arrange to have offered may exclude the under-65.

2. **Provide Services Directly.**--You may directly provide or arrange for the provision of services related to pre-existing conditions with no charge to the beneficiary.

3. **Allow the Beneficiary to Choose a Policy.**--You may allow the beneficiary to secure a State-certified Medicare supplemental policy of his or her choice which does have a waiting period for pre-existing conditions. Cover, for six months or the duration of the waiting period (if shorter), Medicare coinsurance and deductible amounts for services related to pre-existing conditions. (Note that your State's laws might not permit you to use this option.)

3004.6 **Systems Issues.**--Since HMO/CMP enrollees need to be notified 60 days before a contract ends, you must stop enrolling new Medicare beneficiaries no later than the date of that notice. HCFA recommends that you stop enrolling additional Medicare beneficiaries after you send HCFA notice or HCFA sends you notice of a contract termination or nonrenewal. (See §§6000ff. for more information on accretions, deletions and exchange of information.)

A. **HCFA's Mass Disenrollment.**--Do not submit deletions for members who will remain enrolled through the end of the Medicare contract period. HCFA disenrolls these members through a mass disenrollment during the last month of your contract. HCFA conducts the mass disenrollment after it processes all other transactions for all Medicare plans. This allows members to enroll in other plans and does not interfere with any final month deletions you submit. It also assures that all members who do not enroll in another plan return to fee-for-service Medicare.

B. **Members who Request Disenrollment.**--Submit deletions for members who request disenrollment effective before the end of the contract period. Medicare law entitles members to disenroll effective the first day of the month following the month they make the request. If some members request disenrollment for the first day of the last month of your contract, submit these deletions before the last contract month or prior to the HCFA cut-off date for submission of disenrollments in the last month of the contract.

C. **Reports.**--You do not receive a reply listing report for members deleted through the HCFA mass disenrollment. However, you do receive one for any
transactions you submit during the last operating month or any prior month. You continue to receive bill itemizations and bill summaries as long as HCFA receives payment data. You also receive a final history listing.

D. Service Area Reductions.--If you reduce your service area, delete all members who live in the affected area. HCFA does not conduct mass disenrollments for service area reductions. Submit deletion records for all affected members no later than the last month of the contract term. You receive a reply listing showing all submitted transactions. Review this report when you receive it to verify the deletions. If you find deletion rejections, correct the information and submit the deletions again.

E. Conversions.--If you are converting from a §1876 risk contract to a §1876 cost contract, HCFA will convert all your members to cost status unless they request disenrollment. Any deletions that you submit in the last month of your risk contract will be treated as requests for disenrollment of members of your new cost plan.

If you are converting from §1876 cost to section 1876 risk status, you must submit individual requests for enrollment in the new plan for all your enrollees who have elected risk status. (See §3004.1D.)

F. Termination to Enter into HCPP Agreement.--If you are terminating a risk or cost contract under §1876 in order to enter into an HCPP agreement under §1833, each beneficiary must complete a new enrollment form, and you must submit an individual request for enrollment to HCFA.
APPENDIX 1-MODEL BENEFICIARY NOTICE

THIS IS AN IMPORTANT NOTICE REGARDING YOUR MEDICARE BENEFITS

Dear Medicare Beneficiary:

This letter is to inform you that after (end date), the (name of nonrenewing plan) Health Plan will no longer continue its contract with the Medicare program to provide health care to Medicare beneficiaries. The benefits you now receive from (name of nonrenewing plan) Health Plan will not be available after this date.

The following alternatives are available to you as a Medicare beneficiary:

1. You may remain enrolled in (name of nonrenewing plan) Health Plan until the end of the contract period. If you choose this option, you need take no further action; you will automatically be disenrolled from the plan and returned to regular fee-for-service Medicare as of ___(date)___; OR

2. You may disenroll from the (name of nonrenewing plan) Health Plan and return to regular fee-for-service Medicare before the end of the contract period. If you choose this option, you may disenroll by completing the enclosed form and returning it to the (name of nonrenewing plan) Health Plan. You may also disenroll by contacting your local Social Security Office or, if appropriate, your local Railroad Retirement Board Office. You will be disenrolled effective the first day of the month following the month during which you requested disenrollment. For example, if you request disenrollment on November 20th, you will be returned to regular fee-for-service Medicare effective December 1.

   [THIS PARAGRAPH FOR RISK PLANS ONLY:] Remember, the lock-in provision is effective until the date that your disenrollment from (name of nonrenewing plan) Health Plan is effective. In other words, until your disenrollment from (name of nonrenewing plan) Health Plan is effective, you must continue to use (name of nonrenewing plan) Health Plan providers.

If you return to fee-for-service Medicare, you may wish to purchase a supplemental ("Medigap") health insurance policy. Such a policy requires an additional monthly premium; it will pay for some of the charges which are not covered under regular Medicare. (name of supplemental insurer) has been identified by (name of nonrenewing plan) Health Plan as a carrier which offers supplemental coverage and will waive the waiting period for coverage of pre-existing conditions. You may enroll under this policy between ___(date)___ and ___(date)___ for an effective date of ___(effective date)_. For further information, please call (phone number of insurer); OR

3. You may join another health maintenance organization (HMO) or competitive medical plan (CMP) in your area which contracts with the Medicare program. If you choose this alternative before the (ending date of your contract), you will automatically be disenrolled from the (name of nonrenewing plan) Health Plan when you enroll in the new HMO.

   [FOR RISK PLANS ONLY:] The following Health Plan(s) in your area have contracts with Medicare and are required to accept your enrollment.

   [FOR COST PLANS ONLY:] The following Health Plan(s) in your area have contracts with Medicare and may be accepting new enrollees.

   (Name, address, and phone number of plan(s))
You should contact these plans concerning benefits and premiums in order to make the best selection for your personal needs. You should contact the plan(s) at the phone number(s) listed above concerning the enrollment process. These plans are holding an enrollment period from (date of open enrollment period) for all Medicare beneficiaries, such as yourself, who are affected by the discontinuation of the (name of nonrenewing plan) Health Plan Medicare contract.

[FOR RISK PLANS ONLY:] If you wish to remain in a Medicare coordinated care health plan (HMO or CMP) in your area, you must enroll during the (date of open enrollment period) period. The health plan(s) listed above is (are) not obligated to take members from (name of nonrenewing plan) Health Plan after (ending date of special open enrollment period).

We regret the need for this action and apologize for any inconvenience it may cause you. If you wish more information, please feel free to contact the (name of nonrenewing plan) Health Plan Member Services Department at (phone number of nonrenewing plan).

Sincerely,

(Name of nonrenewing plan)

Add to MODEL BENEFICIARY NOTICE for Part B members:

PART B MEMBERS ONLY

You must have both Part A and Part B of Medicare to buy supplemental insurance through (name of supplemental insurer). If you only have Part B of Medicare, you may enroll in Part A of Medicare at your local Social Security Office or through the Railroad Retirement Board, if you are a railroad annuitant. To be eligible for this special supplemental insurance policy offered by (name of supplemental insurer), your effective date for Part A enrollment must be no later than (date contract nonrenews).

To be enrolled in Part A of Medicare by this date, you must enroll in Part A while you are a member of (name of health plan) or during the first month after the contract ends. You could be subject to an increased Part A premium if you enroll in HMO/CMP after initial Part A Medicare eligibility.

You may also enroll in Part A up to 8 months after your enrollment in (name of health plan) ends. Your enrollment would be effective the first day of the next month. However, you could be subject to an increased Part A premium if you enroll in HMO/CMP after initial Part A Medicare eligibility. Also, you will not be eligible for the waiver of pre-existing condition waiting periods for Medigap coverage that (name of supplemental insurer) is offering members of (name of HMO).
APPENDIX 2-MODEL PUBLIC NOTICE

Effective January 1, (name of nonrenewing plan) Health Plan will no longer have a Medicare contract with the Health Care Financing Administration. Members affected by this decision were notified on (date) of their options to enroll in another Medicare health maintenance organization or competitive medical plan in the area or to disenroll from (name of nonrenewing plan) Health Plan and return to regular fee-for-service Medicare. The following health plan(s) is (are) located in the (name of nonrenewing plan) service area and offer a HMO/CMP contract:

(Name, address, and phone number of plan(s))

Under Federal law, some of these plans are required to accept those Medicare beneficiaries who are affected by the nonrenewal of (nonrenewing plan name)'s Medicare contract. Other plans listed may also be accepting new members.

Members choosing to remain in (name of nonrenewing plan) until December 31 will be automatically transferred back to regular Medicare effective January 1, (the following year). [THIS SENTENCE FOR RISK PLANS ONLY:] Members were advised that until their disenrollment from (name of nonrenewing plan) Health Plan is effective, they must continue to use their (name of nonrenewing plan) Health Plan providers.

(name of supplemental insurer), a supplemental (Medigap) insurer, has agreed to waive waiting periods for coverage of pre-existing conditions for any interested (name of nonrenewing plan) Health Plan members choosing to purchase Medigap coverage. Inquiries about the nonrenewal of the contract should be directed to the (name of nonrenewing plan) Member Services Department at (phone number of nonrenewing plan). Inquiries about the supplemental insurance policy should be directed to (name of insurer) at (phone number).
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Rev. 13 3-2-1
3101. DEFINITION OF TERMS

A. **Lessee.**--The entity to which an HMO/CMP leases all or part of its facilities is a lessee.
B. **Lessor.**--The HMO/CMP that leases all or part of its facilities to another entity is a lessor.
C. **Novation Agreement.**--A novation agreement is a document executed and signed by the current owner of the HMO/CMP, the proposed new owner, and HCFA under which HCFA recognizes the new owner as the successor in interest to the current owner's Medicare contract.

3103. BASIC RULE ON CHANGE OF OWNERSHIP

A change of ownership invalidates a Medicare contract for the period following the change of ownership, unless HCFA and the present and prospective owners execute a novation agreement.

3103.1 **Effect of Change Without Novation Agreement.**--If the new owner wishes to participate in a Medicare contract, notify HCFA of the change of owners and request a contract application.

3103.2 **Notice of Anticipated Change.**--When considering or negotiating a change of ownership, notify HCFA at least 60 days before the anticipated change.

3103.3 **Effect of Failure to Notify.**--Failure to notify HCFA timely of an anticipated change in ownership results in the former owner's continued liability for capitation payments HCFA makes on behalf of Medicare enrollees after the date ownership changes.

3105. ACTIONS THAT ARE CHANGES OF OWNERSHIP

The following actions are changes in ownership:

A. The removal, addition, or substitution of a partner (unless the partners expressly agree otherwise, and State law permits such an agreement);
B. The transfer of title and property to another party; and
C. The merger of a corporation into another corporation or the consolidation of the organization with one or more other corporations, resulting in a new corporate body. Transfer of corporate stock or the merger of another corporation into the HMO/CMP's corporation, when the HMO/CMP survives, does not ordinarily constitute change of ownership.

3107. PROCEDURES FOR APPROVAL OF NOVATION AGREEMENT

3107.1 **Advance Notification.**--Notify HCFA at least 60 days before the date of the proposed change of ownership.

3107.2 **Submittal of Novation Agreement.**--At least 30 days before the proposed date for change in ownership, submit 3 copies of the novation agreement containing the following information:
A. The prospective owner's agreement to assume all contract obligations;

B. The current owner's waiver of rights to reimbursement for covered services furnished during the remainder of the contract period;

C. The current owner's guarantee that the prospective owner will carry out the terms of the contract or a performance bond guaranteeing the prospective owner's performance of contract responsibilities; and

D. The current owner's agreement to make its books and records and any other necessary information available to the prospective owner and to HCFA in order to permit an accurate determination of costs for the final settlement of the contract period.

Exhibit 1 contains a model novation agreement that satisfies HCFA's requirements.

3109. CONDITIONS FOR HCFA APPROVAL OF NOVATION AGREEMENT

HCFA approves a proposed novation agreement if:

- The material specified in §3107 is received timely;
- The proposed new owner is determined to be the successor in interest to the contractor;
- Any performance bond posted is found acceptable (see §3107.2C);
- Recognition of the new owner as successor in interest is in the best interests of the Medicare program; and
- The successor in interest qualifies as an eligible organization. (See §§1200ff.)

3111. LEASING OF HMO/CMP FACILITIES

If an organization leases all or part of its facilities to another entity, the lessee does not acquire the status of an eligible organization. (See §§1201ff.) In addition, if an organization leases all of its facilities to another entity, HCFA terminates the contract because the organization ceases to be an eligible organization. (See §3004.2B.)

If the lessee wishes to participate in a Medicare contract, the lessee must establish that it is an eligible organization by applying to HCFA for a contract.

If an HMO/CMP leases part of its facilities to another entity, HCFA surveys the HMO/CMP to determine whether it continues to comply with all requirements. HCFA terminates the contract if the requirements are no longer met.
EXHIBIT 1

MODEL NOVATION AGREEMENT

(Name of HMO/CMP being sold/merged) (Transferor), dba (where applicable, the dba name), a corporation duly organized and existing under the laws of the state of (indicate the state that has jurisdiction over the sale/merger) with its principal office in (city and state of HMO/CMP being sold/merged); (Name of new organization taking over) (Transferee), a corporation duly organized and existing under the laws of the state of (indicate the state that has jurisdiction) with its principal office in (city and state of purchaser) and the Health Care Financing Administration (HCFA) enter into this Agreement:

(a) THE PARTIES AGREE TO THE FOLLOWING FACTS:

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

(indicate Medicare contract type i.e. risk/cost)
(indicate Medicare contract number)

The term "the contract(s)" as used in this Agreement, means the above contract(s) including all modifications, made between HCFA and the Transferor before the effective date of this Agreement (whether or not performance and payment have been completed) and releases executed if HCFA 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 HCFA and the Transferee, on or after the effective date of this Agreement.

(2) As of (date transfer 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 obligations and liabilities of the Transferor under the contract(s) by virtue of the above transfer.

(5) The Transferee is in a position to fully perform all obligations that may exist under the contract(s).

(6) All payments and reimbursements previously made by HCFA to the Transferor, and all other previous actions taken by HCFA under the contract(s), shall be considered to have discharged those parts of HCFA's obligations under the contract(s). All payments and reimbursements made by HCFA 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 HCFA's obligations under the contract(s) to the extent of the amounts paid or reimbursed.
(7) The Transferor and the Transferee agree that HCFA 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 the transfer or this Agreement other than those that HCFA in the absence of this transfer or 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 contract(s) be modified under their terms and conditions. The Transferor waives notice of, and consents to, any such future modifications.

NOTE: If the Transferor has no assets after the change in ownership, this clause can be deleted.

(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 Office of Managed Care in the Health Care Financing Administration.

(b) IN CONSIDERATION OF THESE FACTS THE PARTIES AGREE THAT BY THIS AGREEMENT:

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

(2) The Transferee agrees to be bound by and to perform 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) as if the Transferee were the original party to the contract(s).

(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) HCFA recognizes the Transferee as the Transferor's successor in interest in and to the contracts. The Transferee by this Agreement becomes entitled to all rights, titles and interests of the Transferor in and to the contract(s) as if the Transferee were the original party 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 HCFA against the Transferor.
(6) All payments and reimbursements previously made by HCFA to the Transferor, and all other previous actions taken by HCFA under the contract(s), shall be considered to have discharged those parts of HCFA's obligations under the contract(s). All payments and reimbursements made by HCFA 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 HCFA's obligations under the contract(s) to the extent of the amounts paid or reimbursed.

(7) The Transferor and the Transferee agree that HCFA 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 the transfer of this Agreement other than those that HCFA in the absence of this transfer or this Agreement would have been obligated to 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 contract(s) 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 Health Care Financing Administration.

HEALTH CARE FINANCING ADMINISTRATION

By _________________________________             Date
DIRECTOR, OFFICE OF OPERATIONS AND OVERSIGHT
OFFICE OF MANAGED CARE
HEALTH CARE FINANCING ADMINISTRATION

(name of Transferee)__________________________

By _________________________________             Date
Title ________________________________

(name of Transferor)________________________

By _________________________________             Date
Title ________________________________
CERTIFICATE

I, ________________________________, certify that I am the __________________ of ________________________________; that ________________________________, who signed this Agreement for this corporation was then ________________________________ of this corporation; and that this Agreement was duly signed for and on behalf of this corporation by authority of its governing body and within the scope of its corporate powers.

By ________________________________ Date __________________________

CERTIFICATE

I, ________________________________, certify that I am the __________________ of ________________________________; that ________________________________, who signed this Agreement for this corporation was then ________________________________ of this corporation; and that this Agreement was duly signed for and on behalf of this corporation by authority of its governing body and within the scope of its corporate powers.

By ________________________________ Date __________________________
PART 3
CHAPTER 3
CONTRACT APPEALS

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Contract Appeals

3200. **SCOPE**

HCFA provides special appeals procedures for organizations which have contracts or have applied for contracts under §1876 of the Act. Organizations may appeal contract denials, certain nonrenewals, and terminations. Contract appeal procedures do not apply to denied applications for Federal qualification or denials of contracts because the applicant is not an eligible organization (federally qualified HMO or competitive medical plan (CMP)). You must receive an initial determination notice (see §3201) to use contract appeals procedures. Contract appeals procedures do not apply to administrative actions which are not initial determinations.

3200.1 **Steps in the Appeals Process.**--There are three steps in the contract appeals process. These steps are:

- Initial determination;
- Reconsideration; and
- Hearing.

HCFA uses the reconsideration step only for appeals from a denial of an application for a contract. To appeal a termination or nonrenewal, request a hearing.

3201. **INITIAL DETERMINATIONS**

HCFA issues initial determination notices in the following situations. You may appeal any of these initial determinations.

3201.1 **Contract Denials.**--HCFA issues an initial determination notice when it denies an eligible organization a contract under §1876 of the Act. There are two types of contract denials:

- A risk contract, a cost contract or both types of contracts; or
- A risk contract, but HCFA grants a cost contract.

3201.2 **Contract Terminations or Nonrenewals.**--Determination notices of termination or nonrenewal are issued for one the following reasons:

- The organization has failed substantially to carry out the terms of the contract;
- The organization is not carrying out the contract consistently with the efficient and effective administration of §1876 of the Act; or
- The organization no longer meets the requirements of an eligible organization under §1876 of the Act.

If a contract is nonrenewed for reasons other than one of those set forth above, the decision is not an initial determination that is subject to appeal.

3201.3 **Initial Determination Notice.**--HCFA sends a written notice for every initial determination. The notice includes:

- The reasons for the determination;
o Appeal rights; and
o Instructions on filing for an appeal.

HCFA mails the notice at least 90 days before the end of the contract period or the effective termination date.

3201.4 Effect of the Initial Determination.--The initial determination is final and binding on all parties unless:

- HCFA reopens and revises the determination under §3205; or
- You file a valid request for a reconsideration under §3202; or
- You file a valid request for a hearing under §3203.

3201.5 Postponement of the Initial Determination's Effective Date.--If you file a timely request for a hearing, the initial determination’s effective date is affected as follows:

A. Contract Terminations.--The termination date stated in the initial determination notice is postponed until issuance of a hearing decision.

B. Contract Nonrenewals.--HCFA may extend the current contract period only:

- If HCFA finds that a contract extension is consistent with the purpose of §1876 of the Act; and
- For as long as HCFA and the organization agree with the extension.

3202. RECONSIDERATIONS

You have the right to a reconsideration of an initial determination denying a risk or a cost contract. (See §3201.1.) This reconsideration process must be completed before you have a right to a hearing under §3203. However, initial determinations involving contract terminations or nonrenewals are appealed by requesting a hearing directly.

3202.1 Filing for Reconsideration.--File a written request for reconsideration with the Office of Prepaid Health Care. An authorized official of the organization must make the request.

Health Care Financing Administration
Office of Prepaid Health Care
Rm. 4360, Cohen Building
330 Independence Ave. S.W.
Washington D.C. 20201

A. Time Frames.--File the request within 60 days from the date of the initial determination notice. HCFA may grant a time extension for good cause.

B. Determination of Good Cause.--HCFA considers why you filed late and whether any of our actions may have misled you. Examples of good cause include:

- You did not receive HCFA's notice of the determination you seek to appeal; or
A fire or other accident destroyed important records.

C. Withdrawal of Reconsideration Request.--The party who filed the request may withdraw it at any time before HCFA mails the notice of its reconsidered decision. Request withdrawal in writing with HCFA. If HCFA agrees, it approves the withdrawal.

3202.2 Opportunity to Submit Evidence.--Submit evidence pertinent to the dispute before HCFA issues the reconsideration determination notice. We will provide reasonable opportunity (at least 30 days) to introduce applicable documents or written statements.

3202.3 Reconsideration Determination.--A reconsideration determination is a new determination that affirms, reverses, or modifies the initial determination. HCFA bases the determination on the evidence and findings used to make the initial determination, additional facts about the organization received after the initial determination and any other written evidence you submit.

3202.4 Notice of Reconsideration Determination.--HCFA issues a reconsideration determination notice to the organization. The notice includes:

- Findings concerning the organization's qualifications to enter into a contract under §1876 of the Act;
- The specific reasons for the determination;
- Notice of hearing rights; and
- Hearing filing procedures.

3202.5 Effect of Reconsideration Determination--The reconsideration determination is final and binding on all parties unless:

- HCFA reopens and revises the determination under §3205; or
- You file a request for a hearing under §3203.

3203. HEARINGS

You may request a hearing after receiving one of the following determinations:

- A reconsideration determination to deny a risk or cost contract (See §3201.1);
- An initial determination to terminate or nonrenew your contract for one of the reasons set forth in §3201.2; or
- A revised determination made after reopening a reconsideration determination or an initial determination.

3203.1 Filing for a Hearing.--Write to the Office of Prepaid Health Care to request a hearing. An authorized official must make the request. HCFA acknowledges all requests for a hearing, including those not filed timely. File the request within 60 days from the date you receive the initial determination or reconsideration notice, whichever is applicable. HCFA may grant a time extension for good cause. (See §3202.1B.)
3203.2 Parties to the Hearing.--The parties to a hearing are:

- The organization that was the subject of the determination;
- HCFA; and
- Other interested individuals or entities who show that the decision may prejudice their rights. The hearing officer determines this matter.

3203.3 Hearing Officers.--HCFA appoints a hearing officer to conduct the hearing. The hearing officer does not need to be an administrative law judge (ALJ).

A. Authority of Hearing Officers.--Hearing officers follow all the provisions of Title XVIII and related provisions of the Act, as well as regulations and general instructions HCFA has issued to implement these provisions.

B. Disqualification of Hearing Officers.--Hearing officers may not conduct a hearing in any case in which:

- They are prejudiced;
- They are partial about any party; or
- They have any interest in the matter before them.

If you object to the hearing officer conducting the case, write that officer concerning your objections. The hearing officer considers the objections and decides whether to proceed or withdraw.

If a hearing officer withdraws, HCFA appoints a different hearing officer. If a hearing officer proceeds, you may present post-hearing objections to HCFA. You may request revision of the decision or a new hearing before a different hearing officer.

3203.4 Time and Place of Hearing.--The hearing officer fixes a time and place for the hearing and notifies the parties in writing. The notice informs the parties of the issues to be resolved, their 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. Hearing officers may also adjourn or postpone a hearing. They must give reasonable notice to the parties of any change in time of place or adjournment.

3203.5 Prehearing Discovery.--Request discovery (formal methods of obtaining documents and information in the possession of another party to the hearing, e.g., interrogatories, depositions, and requests for the production of documents) before the hearing begins. Hearing officers rule on the discovery request. If discovery is permitted, the hearing officer provides reasonable time for inspection and reproduction of any requested documents. Rulings by hearing officers on all discovery matters are final.

3203.6 Prehearing Conference.--Hearing officers may schedule a prehearing conference if they believe it clearly delineates the issues involved.

3203.7 Conduct of the Hearing.--The hearing is open to the parties and the public. Hearing officers inquire into all pertinent matters and receive in evidence relevant and material testimony of witnesses and applicable documents. The hearing officer hears your objections to documents offered as evidence.
The hearing officer decides the presentation order of the evidence and allegations of the parties.

A. Evidence.--Hearing officers decide whether evidence is admissible. They may admit evidence which is inadmissible under rules of evidence applicable to court procedures.

B. Witnesses.--Hearing officers may examine witnesses. You have the right to examine your witnesses and cross-examine witnesses of other parties.

3203.8 Record of Hearing.--A complete record of the proceedings at the hearing will be transcribed and reproduced at the request of any of the parties. The party requesting the copy must pay for its transcription and reproduction. The record remains open until the hearing officer issues a decision.

3203.9 Hearing Officer's Decision

The hearing officer issues a decision notice as soon as possible and provides a copy of the notice to each party. In producing the decision notice, the hearing officer must:

- Base the decision upon the evidence presented at the hearing or otherwise included in the hearing record; and
- Include separately numbered findings of fact and conclusions of law.

3203.10 Effect of Hearing Officer's Decision.--The hearing decision is final and binding on the HMO/CMP and HCFA. There is no further appeal. However, the decision is subject to reopening under §3205.

3204. APPOINTMENT OF A REPRESENTATIVE

You may appoint a representative for the hearing. Notify HCFA in writing of the appointed representative's name and address. You may not appoint individuals disqualified or suspended from acting as a representative in dealings before the Secretary or who are otherwise prohibited by law.

3204.1 Appointment of an Organization.--An organization cannot qualify as your representative. You may appoint an individual or individuals within an organization as your representative.

3204.2 Authority of the Representative.--An appointed representative has the right to:

- Accept, make, or give for you any request or notice about the hearing and related proceedings;
- Present evidence and allegations as to facts and law;
- Examine or cross-examine witnesses in the proceeding; and
- Obtain information about the request for hearing.

The hearing officer sends notices of action, determination, or decision and requests for the production of evidence to the representative. Notices sent
to a representative have the same force and effect as notices sent to the party.

If you appoint a representative, contacts about the request for hearing are through or with the representative's permission. This includes all requests, whether written, by telephone, or in person. However, the hearing officer sends the original of any decision to the party with a copy to the representative.

3205. REOPENINGS

The individual or entity responsible for a determination (HCFA or the hearing officer) may reopen it under the provisions in this section. HCFA or the hearing officer may reopen a decision on HCFA's or the hearing officer's own motion or by request.

A reopening is not an appeal right. It is an administrative procedure which permits re-examination of a decision for a specific reason. If the hearing officer who made a determination is unavailable, HCFA may appoint another hearing officer to reopen the determination.

3205.1 Requesting a Reopening.--Only parties subject to a determination may request a reopening. Follow these guidelines to request a reopening:

- Request (or have your authorized representative request) the reopening in writing;
- Clearly state the purpose for the reopening. Make clear that you are requesting a reopening, not further appeal; and
- Request the reopening within one year of the date of the determination notice or the hearing decision.

The individual or entity which made the determination decides whether to reopen it. You cannot appeal this decision.

3205.2 Notice of Reopening.--When an individual or entity reopens a determination or decision, a notice of reopening is sent to the parties.

3205.3 Conditions for Reopening.--Cases in which reopening would be appropriate include, but are not limited to, the following:

- Fraud affected the determination;
- There is new and material evidence not readily available or known to exist at the time of the determination. Consideration of this material may result in a different conclusion;
- There is an error on the face of the evidence which affects the determination; or
- There is a clerical error in the file which affects the determination.

3205.4 Definitions.--

A. Meaning of New and Material Evidence.--New and material evidence is evidence not considered when making the previous determination or decision. New information also includes a new interpretation of existing information. The new evidence must show facts not available before and possibly result in a conclusion different from that reached in the determination or decision.
Thus, the mere existence of additional evidence is not a basis for reopening, if it is immaterial.

B. Meaning of Clerical Error.--The term clerical error includes such human and mechanical errors as mathematics or computational mistakes, inaccurate coding, or computer errors.

C. Meaning of Error on the Face of the Evidence.--An error on the face of the evidence exists if the determination or decision is clearly incorrect based on all the evidence present in the appeal file, the SSA files, or HCFA files at the time of determination.

3205.5 Determination Notice.--The entity or individual reopening the determination mails a notice to the parties after making a decision. If the previous decision is revised, the notice states the reasons for the revised decision.

3205.6 Effect of Revised Determination.--The revision of an initial or reconsideration determination is final and binding unless a party files a written request for a hearing under §3203.
CHAPTER 1
HCFA PAYMENT PROCESS

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4000. GENERAL

Both health maintenance organizations (HMOs) and competitive medical plans (CMPs) are public or private entities which are organized under the laws of a state to provide health services on a prepayment basis to enrolled members, and which are eligible to enter into contracts with the Secretary of DHHS under §1876 of the Act to furnish services to Medicare beneficiaries. Section 1876 of the Act provides two methods of payment for services furnished to Medicare enrollees of HMOs/CMPs: reasonable cost reimbursement and risk based payment. This part sets forth the rules HCFA follows in determining the amount HCFA will pay to an HMO/CMP for services furnished on a reasonable cost basis.

HMOs paid on a cost basis are paid the reasonable cost actually incurred in providing covered services to Medicare enrollees.

Cost basis HMOs/CMPs are paid each month, in advance, an interim per capita rate for each Medicare enrollee. The total monthly payment is determined by multiplying the interim per capita rate by the number of your Medicare enrollees. Retroactive adjustments are made at the end of the contract period to bring the interim payments made to you during the period into agreement with the reimbursement amount determined payable to you for service rendered to Medicare enrollees during that period. Total payment is calculated based on your final certified cost report.

In addition, you may furnish services to Medicare beneficiaries who are not enrolled in your prepayment plan. Since payment to you under §1876 of the Act is limited to your Medicare enrollees, services furnished to nonenrolled Medicare beneficiaries are outside the scope of your agreement with the Secretary. Medicare payment for services furnished to nonenrolled beneficiaries may be made through a Part A intermediary or Part B carrier in accordance with the usual Medicare payment process.

4001. REASONABLE COST PAYMENT

An HMO/CMP that elects to be paid on a reasonable cost basis is paid the reasonable cost of the covered services it furnishes to its Medicare enrollees. The determination of reasonable costs is based on the Medicare reimbursement principles which are used to calculate the reasonable cost of hospitals, skilled nursing facilities (SNF), home health agencies and other entities paid by the Medicare program on a cost basis. In addition to the costs directly related to the provision of health services, the costs incurred by you that are unique to the prepayment setting such as marketing, enrollment, and membership expenses are also taken into account in determining reasonable costs.

The cost payment principles for HMOs/CMPs are discussed in detail in chapter 2.

4002. BILL PROCESSING OPTIONS

Your contract with HCFA must state on an individual provider basis whether you elect:

   A. To have HCFA pay, on your behalf, hospitals and SNFs for covered items and services furnished to your Medicare enrollees (Option 1); and
B. To assume responsibility for paying some or all of these providers directly for covered items and services furnished to your Medicare enrollees (Option 2). Under this option, you must specify each hospital and/or SNF for which you will assume the responsibility of paying for the services rendered by that hospital or SNF.

The HMO/CMP must modify its contract with HCFA for any changes in its election prior to the beginning of the contract period for which the change would be effective.

4003. DIRECT PAYMENT BY HMO/CMP TO HOSPITAL AND SKILLED NURSING FACILITIES

If you elect to pay some or all hospital and SNF providers directly for covered items and services, you must:

A. Determine the eligibility of your Medicare enrollees to receive covered items and services through your HMO/CMP;

B. Make proper coverage decisions and appropriate payments for covered items and services for which your Medicare enrollees are eligible;

C. Assure that these providers maintain and furnish appropriate documentation of physician certification and recertification, as required under Subpart B; 42 CFR, Part 424; and

D. Carry out any other procedures which HCFA may from time to time require.

HCFA will determine whether you have the experience and capability to efficiently and effectively carry out the responsibilities specified above.

4004. DIRECT PAYMENT BY HCFA (HOSPITAL AND SNF SERVICES)

If HCFA determines that you are not carrying out your bill processing operations properly (or do not have the experience or capability to do so in the future), HCFA may require you to elect to have HCFA pay your hospital and SNF providers directly. If you refuse this election, HCFA may decline to enter into or may terminate your contract.

4005. SERVICES FURNISHED DIRECTLY OR THROUGH ARRANGEMENT

Your contract with HCFA must provide that in paying for services furnished to your Medicare enrollees, you are responsible for:

A. Determining the eligibility of individuals to receive such items and services through your HMO/CMP;

B. Making proper coverage decisions and appropriate payment for items and services for which your Medicare enrollees are eligible; and

C. Carrying out any other procedures which HCFA may from time to time require.

All health care services furnished by you may be provided through facilities directly (facilities that are owned or related through common control) or under an arrangement. An arrangement is defined as a written agreement executed between you and another entity in which the other entity agrees to furnish specified services to your Medicare enrollees. However, you must retain responsibility for those services.
4006. PRINCIPLES OF PAYMENTS

Cost basis HMOs/CMPs are paid each month, in advance, an interim rate for each Medicare enrollee. Retroactive adjustments are made at the end of the contract period to reconcile the interim payments made to you with the reimbursement amount determined payable to you for services rendered to Medicare enrollees during that period. Total reimbursement is calculated on your final certified cost report.

4007. BUDGET AND ENROLLMENT FORECAST

You must submit an annual operating budget and enrollment forecast at least 90 days before the start of each contract year. Estimated costs used in completing the operating budget are determined under the rules in chapter 2. The enrollment forecast must reflect your past experience, your anticipated enrollment for the coming year, and describe your plans for providing the services anticipated. The reports are then used to compute the interim per capita rate.

If the annual budget and enrollment forecast is not submitted on a timely basis, HCFA may:

A. Establish an interim per capita rate of payment on the basis of the best available data and adjust payments based on such a rate until such time as the required reports are submitted and the new interim per capita rate can be established, or

B. If there is not enough data on which to base an interim rate, HCFA will advise you that interim payments will not be made until the required reports are submitted.

HCFA reserves the right to examine all records and statistical data used by you in completing these reports. To the extent the annual operating budget and enrollment forecast is accurate, interim payments will approximate the total HCFA obligation.

4008. INTERIM PER CAPITA RATE

The interim per capita rate for a cost basis HMO/CMP is determined by dividing estimated allowable costs of providing covered services to your Medicare enrollees by projected Medicare enrollee months for the contract period. Estimated allowable costs and the projected number of Medicare enrollee months are derived from your annual operating budget and enrollment forecast. The number of Medicare enrollees is compared to HCFA's latest updated records of enrollment for reasonableness. These records will identify the number of Medicare beneficiaries HCFA has identified as enrollees of your HMO/CMP.

4009. INTERIM PAYMENT FOR COST REIMBURSED PLANS

At the beginning of each month, HCFA will send you an interim payment. This payment is established by multiplying the interim per capita rate (see §4008) by the number of your Medicare members enrolled for that month. Each month HCFA will determine the total number of Medicare beneficiaries enrolled in your plan to date. This number is increased or decreased by any changes in enrollment submitted by you or generated by HCFA. In addition, certain retroactive adjustments will be made on an as needed basis.
4010. ELECTRONIC TRANSFER OF FUNDS

HCFA, in conjunction with the Department of Treasury, may utilize electronic funds transfers. Interim and other types of payments are electronically sent to plans through the automated clearing house (ACH). This process improves the efficiency of Federal financial management and also benefits the plans.

The ACH provides on-line access to the Federal Reserve Communications System (FRCS) allowing payments to financial institutions with access to the FRCS. For financial institutions that do not have access to the FRCS, plan payments can be paid through correspondent financial institutions or Federal Reserve Banks.

The ACH payment method will eliminate mail and processing time associated with payment by check. You will receive a payment through your financial institution on the payment due date. This is a more secure and reliable method of making and receiving payment. Plans electing the electronic transfer of funds must indicate this on the system setup sheet which is included in the contract application. To initiate this process, plans should contact their HCFA plan manager.

4011. PLAN PAYMENT REPORT

Each month HCFA will mail to the cost based HMOs/CMPs a plan payment report which will explain how the interim payment was computed. See Part 6 of this manual for a detailed description of the plan payment report.

4012. INTERIM COST AND ENROLLMENT REPORTS

In addition to the annual budget and enrollment forecast, you are required to submit interim reports and enrollment data on a cumulative quarterly basis. HCFA, in accordance with 42 CFR 417.572(c)(2), may reduce the frequency of your interim reporting requirements if it is determined that you have an adequate ongoing accounting and enrollment data system that will furnish the records needed to verify the interim per capita rate. Generally, HCFA would require, at a minimum, 1 year of operating experience under a Medicare contract before waiving any quarterly interim cost reporting requirements. The interim cost and enrollment reports, unless waived, must be submitted to HCFA within 60 days of the end of each HMO/CMP fiscal quarter. If the report is not submitted timely, HCFA may adjust the interim rate based on the best available information. An adjustment to the interim rate will remain in effect until such time as the required reports are submitted. If there is not enough data available, interim payments will not be made.

4013. INTERIM COST REPORT FOR EXPERIENCED HMOs/CMPs

If HCFA has reduced the frequency for you to submit interim reports, you will, nevertheless, be required to submit an interim cost report within 60 days of the end of your fiscal year detailing cost, utilization, and enrollment data for the entire fiscal year. This report, unless it contains obvious errors or inconsistencies, will be the basis for interim settlement with you. (See §4015.)

4014. ADJUSTMENT OF PAYMENTS

In order to maintain the interim payments at the level of current reasonable costs, HCFA will adjust the interim per capita rate. Adjustments are based on
data supplied by you in your interim estimated cost and enrollment reports or such other evidence that HCFA may have which indicates that the rate based on actual costs is more or less than the current rate. Adjustments may also be made when there is:

- A material variation from the costs estimated when the annual operating budget was prepared;
- A significant change in the use of covered services by your Medicare enrollees; or
- A change in the number of Medicare enrollees in the HMO/CMP, and the per capita cost rate is affected.

The interim per capita rate is flexible and may be adjusted if you submit a revised budget or enrollment forecast indicating that an adjustment is needed to maintain payments at the level of current costs.

Settlement Procedures For Cost HMOs/CMPs

4015. INTERIM SETTLEMENT - COST BASIS HMOs/CMPs

Within 30 days of receipt of your final interim cost report and enrollment data or, in the case in which you are not submitting quarterly reports, within 30 days of receipt of the interim cost report (see §4013), HCFA will make a determination of your estimated allowable costs. This interim determination will be made either on the basis of the four quarterly interim cost reports and enrollment data submitted by you throughout the contract period or on the basis of the interim cost report for HMO/CMP referred to in §4013. For this purpose, costs are accepted as reported except for obvious errors or inconsistencies, subject to later audit.

An interim settlement payment will be made amounting to the total difference between the amount found payable in the interim settlement determination and the total capitation payments made to you throughout the contract period. If you have been underpaid, HCFA will pay you the difference within 30 days of the determination. If you have been overpaid, a refund is due HCFA within 30 days of the determination, or you must negotiate a repayment schedule with HCFA.

4016. FINAL CERTIFIED COST REPORT

All HMO/CMPs must submit an independently certified cost report and supporting documents to HCFA no later than 180 days following the close of each contract period detailing cost, utilization, and enrollment data for the entire contract period. (See 42 CFR 417.576(b)(1).) An extension of time to submit the report may be granted provided you request such extension before the due date of the cost report and show good cause for the extension. The report shall be in the form and detail required by HCFA. This information will be used to make final settlement for the period. The statement should include:

- The per capita costs incurred for the provision of covered services to your Medicare enrollees during the contract period, including costs incurred by another organization related to you through common ownership or control;
- HCFA’s payments for health care services incurred on behalf of your Medicare enrollees;
NOTE: This would include payments by HCFA to providers, on your behalf, pursuant to your election under 42 CFR 417.532(c), your referral services that were billed and paid directly by HCFA, and emergency and urgently needed services that were billed and paid directly by HCFA. Payment information for these services are supplied by HCFA's intermediaries and carriers.)

- Your methods of apportioning costs among Medicare enrollees, other enrollees, and nonenrollees receiving health care services on a fee-for-service or other basis; and

- Such information on enrollment and other data as HCFA may require.

The total reasonable costs which you incur and which are related to the certification of the cost report are paid in full by HCFA. However, other administrative costs incurred by you in preparing the cost reports and other data required by the program (other than costs related to reporting enrollment information) are included in general and administrative costs. HCFA has the right to reject the independently certified cost report if HCFA has the reason to believe the certifying firm was not independent of the HMO/CMP or if HCFA believes there are significant deficiencies in the report which have not been properly addressed by the auditors. In addition, HCFA may deny payment for those additional costs incurred by you for a deficient certification.

Unless you request and receive an extension of time for submitting the certified cost report, HCFA may consider the failure to report timely as evidence of a likely overpayment (see §4019) and may initiate recovery of amounts previously paid, reduction of current interim payments, or both.

4017. FINAL SETTLEMENT PROCESS - COST BASIS HMOs/CMPS

Final settlement with a cost basis HMO/CMP is based on information in the independently certified cost report and payments previously made under interim settlement procedures, subject to the Medicare program's standard audit and retroactive adjustment procedures. In addition, HCFA retains the right to conduct an independent audit of the information contained in the final certified cost report.

A final settlement may be made with you even though a provider of services has not had a final settlement with HCFA for services furnished to Medicare beneficiaries not enrolled in the HMO/CMP. This exception does not apply if the provider is owned or operated by the HMO/CMP or related to the HMO/CMP by common ownership or control. HCFA will only permit this exception if HCFA is satisfied that prompt settlement would be in the best interests of the Medicare program, as shown by factors such as the following:

- The provider's costs represent an insignificant amount of your total payment; or

- HCFA is satisfied that the provider's costs for serving your enrollees will not be modified significantly by the final settlement with the provider under 42 CFR Parts 412 and 413.
Final settlement for cost basis HMOs/CMPs will equal the total allowable costs you incurred throughout the contract period for rendering covered care to your Medicare enrollees (less applicable deductible and coinsurance). Once the final determination of reasonable costs is made, HCFA will promptly notify you by sending a notice of program reimbursement (NPR). This notice will:

- Explain HCFA's determination regarding total reimbursement, including an explanation of the computation of overpayments or underpayments;
- Relate this determination to your claimed total reimbursement;
- Explain differences between your and our determination; and
- Inform you of your right to have the determination reviewed at a hearing.

4018. FINAL SETTLEMENT PAYMENT - COST BASIS HMOs/CMPs

If the final settlement determination is less than reimbursement already made to you through monthly capitation payments and interim settlement, an underpayment will be declared, and HCFA will make a lump-sum payment to you. Conversely, if total reimbursement due is less than the total payment made, you have been overpaid and HCFA must recover the overpayment.

4019. RECOVERY OF OVERPAYMENT

When a cost report has been filed by an HMO/CMP indicating an amount is due HCFA, or when the HMO/CMP is notified by an NPR or otherwise that an overpayment has been made, the amount involved is a debt owed the United States Government. Under the Federal Claims Collection Act of 1966, HCFA must take timely collection action. Recovery will be undertaken even though the HMO/CMP disputes in whole or in part HCFA's findings. As a matter of policy, HCFA will attempt recoupment as quickly as possible.

If you have been overpaid, a refund is due HCFA. Generally, if payment is made by you within 30 days of notification by HCFA of the overpayment, no interest will be charged. However, in order to avoid the imposition of interest if the overpayment arises out of the filing of a cost report:

- Full payment must be made by the due date of the cost report (including an extension); or
- The HMO/CMP and HCFA must agree in advance to reduce interim payments over the next 30 day period to liquidate the overpayment.

When you choose to repay the debt in installments, you must document the need for such installment payments and must submit a written proposal, outlining repayment dates and amounts, including any interest. (See §4019.1.) In no case may a repayment schedule be approved for a time period exceeding one year. HCFA has the authority to approve or disapprove such repayment schedule and will notify you of its decision in writing. In addition, the proposed repayment schedule must be submitted:

- Within 30 days of the due date of the cost report; or
- Within 30 days of notification by HCFA (by NPR or otherwise) of the overpayment.
If subsequent information (e.g., the results of an audit) indicates an additional overpayment was made and you choose to repay this additional debt in installments, you must again document your need and submit a written proposal within 30 days of the subsequent determination outlining repayment dates and amounts (including interest) for the additional amount owed.

HCFA has the authority to reduce or suspend interim payments to your HMO/CMP if you do not make timely repayment of the debt and you:

- Fail to submit a repayment schedule;
- Fail to receive HCFA approval of a repayment schedule; or
- Fail to meet your obligations under an approved repayment schedule.

In addition, HCFA will send a letter to you demanding immediate repayment of the entire amount owed or the immediate submission of a repayment schedule which assures recoupment of the entire amount of the overpayment within the original one year time frame previously established. (If HCFA determines that recovery through a repayment program would be unsuccessful, HCFA will simply demand immediate repayment of the entire amount.) Unless a satisfactory arrangement is worked out, the case will be referred to the General Accounting Office for collection.

4019.1 Interest Charges for Medicare Overpayments/Underpayments.--Section 117 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) requires interest payments for Medicare overpayments and underpayments. 42 CFR 405.376 sets forth the rules for the charging and payment of interest. The following sets forth the rules governing interest on overpayments/underpayments for HMOs/CMPs.

A. Basic Rules.--HCFA will charge interest on overpayments, and pay interest on underpayments, to HMOs/CMPs, except as specified in subsections E and G.

Interest will accrue from the date of the final determination as defined in subsection B and either will be charged on the overpayment balance or paid on the underpayment balance for each 30-day period that payment is delayed. (Periods of less than 30 days will be treated as a full 30-day period, and the 30-day interest charge will be applied to any balance outstanding.) For example, if there is an outstanding balance due HCFA or you for 45 days beginning on the day after the date of the final determination, two full months of interest will be accrued.

B. Definition of Final Determination.--For purposes of this section, a final determination is deemed to occur:

- Upon the issuance of both a notice of program reimbursement (NPR) and either (1) a written demand for payment, or (2) a written determination of an underpayment by HCFA after the cost report is filed;
When an NPR is not utilized as a notice of determination, upon the issuance of either (1) a written determination that an overpayment exists and a written demand for payment, or (2) a written determination of an underpayment. (An example of when an NPR is not utilized is an interim settlement determination (see §4015) made after the final cost report is filed by the HMO/CMP. In this case, a final determination is deemed to have been made if the HMO/CMP does not dispute the interim settlement determination within 15 days of the notice of the determination. If the HMO/CMP does dispute portions of the determination, a final determination is deemed to have been made on those portions when HCFA issues a new determination in response to the dispute);

Upon the due date of a timely filed cost report that (1) indicates an amount is due HCFA, and (2) is not accompanied by payment in full. (If an additional overpayment or underpayment is determined by HCFA, a final determination on the additional amount will be made in accordance with subsection B.); or

For a cost report that is not filed on time, the day following the date the cost report was due (plus a single extension of time not to exceed 30 days if granted for good cause), until such time as a cost report is filed. (When such cost report is subsequently filed, there will be an additional determination as specified in subsection B.)

Except as required to any subsequent administrative or judicial reversal, interest will accrue from the date of final determination as specified in this section.

C. Rate of Interest.--The interest rate on overpayments and underpayments will be the prevailing rate(s) specified in bulletins issued under §8020.20 of the Treasury Fiscal Requirements Manual.

If an HMO/CMP signs a repayment agreement with HCFA for the overpayment:

1. The rate of interest specified in the agreement will continue unchanged if there is no default; and

2. Interest on the balance of the debt may be changed to the prevailing rate if:

   a. The HMO/CMP defaults on an installment; and

   b. The prevailing rate in effect on the date the installment becomes overdue is higher than the rate specified in the agreement.

D. Accrual of Interest.--If a cost report is filed that does not indicate an amount is due HCFA but HCFA makes a final determination that an overpayment exists, interest will accrue beginning with the date of such final determination. Interest will continue to accrue during periods of administrative and judicial appeal and until final disposition of the claim.

If a cost report is filed and indicates that an amount is due HCFA, interest on the amount due will accrue from the due date of the cost report unless:
Full payment on the amount due accompanies the cost report; or

HCFA and the HMO/CMP agree in advance to liquidate the overpayment through a reduction in interim payments over the next 30 day period.

If HCFA determines an additional overpayment during the cost settlement process, interest will accrue from the date of each determination.

The interest rate on each of the final determinations of an overpayment will be the rate of interest in effect on the date the determination is made.

In the case of a cost report that is not filed on time, interest also will accrue on a determined overpayment from the day following the due date of the report (plus a single extension of time not to exceed 30 days if granted for good cause) to the time the cost report is filed.

If HCFA makes a final determination that an underpayment exists, interest to the HMO/CMP will accrue from the date of notification of the underpayment.

E. Waiver of Interest Charges.--When HCFA makes a final determination that an overpayment or underpayment exists, as specified in subsection D:

- Interest charges will be waived if the overpayment or underpayment is completely liquidated within 30 days from the date of the final determination.

- HCFA may waive interest charges if it determines that the administrative cost of collecting them exceeds the interest charges.

Interest will not be waived for that period of time during which the cost report was due but remained unfiled for more than 30 days, as specified in subsection D.

F. Rules Applicable to Partial Payments.--If an overpayment is repaid in installments or recouped by withholding from other payments due you:

- Each payment or recoupment will be applied first to accrued interest and then to the principal; and

- After each payment or recoupment, interest will accrue on the remaining unpaid balance.

G. Exception to Applicability.--If an overpayment or an underpayment determination is reversed administratively or judicially and the reversal is no longer subject to appeal, appropriate adjustments will be made for the overpayment or underpayment and the amount of interest charged.

H. Nonallowable Cost.--Interest accrued on overpayments and interest on funds borrowed specifically to repay overpayments are not considered allowable costs to the HMO/CMP, up to the amount of the overpayment, unless the HMO/CMP had made a prior commitment to borrow funds for other purposes (e.g., capital improvements). However, when an overpayment determination is ultimately reversed in favor of the HMO/CMP, interest paid on funds borrowed to repay the overpayment and interest paid on funds borrowed to pay required interest on the overpayment will be considered an allowable cost.
## CHAPTER 2

**HMO/CMP PAYMENT PRINCIPLES**

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4100. GENERAL

Medicare's payment to cost HMOs/CMPs is based on the reasonable cost of providing covered services to Medicare enrollees.

All necessary and proper expenses of the HMO/CMP in providing covered services are recognized. The share of the total HMO/CMP cost that is borne by HCFA is related to the covered care furnished Medicare beneficiaries so that no part of their cost would need to be borne by other enrollees or nonenrolled patients. Conversely, costs attributable to other HMO/CMP enrollees and nonenrolled patients are not to be borne by Medicare.

The HMO/CMP payment principles take into account the special nature of HMOs/CMPs by recognizing costs of marketing, enrollment, and certain other costs unique to the HMO/CMP form of health delivery.

Under these principles, there may be more than one method of handling a particular cost item (including apportionment and allocation methods). The method elected by you must be consistently followed in subsequent periods. A change of method must have advance approval from HCFA. Any request for a change in method of handling a particular cost item, including the apportionment or allocation of such items, should be made 90 days prior to the beginning of the accounting year in which the new method is proposed for use.

This chapter discusses general HMO/CMP payment principles. Chapter 3 summarizes provider payment principles that are applicable to HMOs/CMPs. Chapter 4 discusses payment principles unique to HMOs/CMPs.

4101. PAYMENT FOR PROVIDER SERVICES

You may furnish hospital and other provider services through facilities which are owned and operated by you or through arrangements with other providers. In either case, the calculation of Medicare's payment for services furnished to your Medicare enrollees is based on the reasonable cost incurred by the provider, or Medicare's prospective payment, if applicable. In calculating the reasonable cost of provider services, the principles and procedures set forth in the Provider Reimbursement Manual, Part I are to be used.

For provider services furnished through facilities owned or operated by you or related to you through common ownership or control and also for provider services furnished through arrangements with other providers, the calculation of Medicare's payment for such providers is identical to that which would be used if the provider had no HMO/CMP involvement. The allowable cost of the HMO/CMP in purchasing provider services through arrangements is described in §§4300, 4301 and 4302. The allowable cost of the HMO/CMP in furnishing provider services through facilities owned or operated by you or related to you through common ownership or control is described in the following chapter.

4102. PRUDENT BUYER PRINCIPLE

You are expected to minimize costs incurred in furnishing physicians' and other Part B supplier services to your Medicare enrollees, so that actual costs do not exceed what a prudent and cost conscious buyer would incur in the same or similar geographic area. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not paid under the Medicare program.
4103. ALLOWABLE COSTS

Allowable costs are those direct and indirect costs, including normal standby costs, which you incur and are proper and necessary to efficient delivery of needed health care. Such costs include those costs related to the care of beneficiaries that are normally paid by Medicare, and, in addition, enrollment, membership, and similar costs unique to HMO/CMPs and necessary to your operations.

The types of items of cost generally incurred by providers of services under Medicare that are allowable under the principles of reimbursement for provider costs are allowable when incurred by you or by providers of services and other facilities owned or operated by you through which covered care is furnished to your Medicare enrollees.

Your allowable costs are determined in accordance with the principles set forth in this manual, the Medicare principles of reimbursement as described in the Provider Reimbursement Manual, and generally accepted accounting principles, in that order.

4104. COST NOT REIMBURSABLE DIRECTLY TO HMO/CMP

In determining amounts due you, certain costs are excluded from the payments made directly to you by HCFA through your contract with HCFA. The following subsections, while not necessarily all-inclusive, detail some of these costs.

4104.1 Deductibles and Coinsurance.--In determining amounts due you, an amount equal to the actuarial value of the deductible and coinsurance for which the Medicare enrollee would otherwise be liable, if not enrolled in the HMO/CMP, is deducted. Procedures for determining this amount are contained in §4313.

4104.2 Certain Provider Costs.--An HMO/CMP has the option to have hospitals and SNFs that furnish covered services to your Medicare enrollees obtain reimbursement directly from Medicare on your behalf. (See §4003.) When you opt for this alternative, these providers are each paid the reasonable cost of covered services furnished Medicare enrollees as determined under Medicare payment principles, or Medicare's prospective payment, as applicable, and the amounts reimbursed are deducted from payments to the HMO/CMP.

4104.3 Costs in Excess of Adjusted Average Per Capita Costs.--In evaluating the reasonableness of costs, for a cost basis HMO/CMP, HCFA takes into account the HMO/CMP's per capita incurred costs for providing covered services to Medicare enrollees, in relation to the adjusted average per capita cost (AAPCC), (see Part 5) for the geographic areas served by the HMO/CMP or a similar area. The AAPCC is used as a general guideline to evaluate the reasonableness of HMO/CMP costs rather than a strict payment limitation.

4104.4 Hospice Care Costs.--If a Medicare enrollee of an HMO/CMP with a reasonable cost contract makes an election to receive hospice care services under §1812(d) of the Act, payment for these hospice care services is made to the Medicare participating hospice that furnishes the services, in accordance with 42 CFR Part 418 and the Hospice Manual. While the HMO/CMP enrollee's hospice election is in effect, the cost basis HMO/CMP may only be paid for the following covered Medicare services furnished to such enrollee:
Services of the enrollee's attending physician, if the physician is an employee or contractor of the HMO/CMP and is not employed or under contract to the enrollee's hospice; and

Services not related to the treatment of the terminal condition for which hospice care was elected, or a condition related to the terminal condition.

A Medicare beneficiary's hospice election may continue as long as the individual continues to desire to receive hospice services while terminally ill. Upon revocation of the election, the individual resumes normal Medicare coverage and any services provided by the HMO/CMP will be reimbursed in the usual manner.

Medicare as Secondary Payer.--Medicare does not pay you for covered services for which Medicare is the secondary payer. For more information on Medicare as secondary payer (MSP), see §4321.

FINANCIAL RECORDS, STATISTICAL DATA, AND COST FINDING

You must maintain sufficient and adequate financial and statistical records for HCFA to make a proper determination of the costs incurred by you in furnishing services either directly or through arrangements to your Medicare enrollees.

ACCOUNTING STANDARDS

Your records must be capable of verification by qualified auditors and properly reflect all direct and indirect costs claimed by you under the contract. This means that your cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, if an HMO/CMP is owned and operated by a Federal, State or local government agency and operates on a cash basis of accounting, HCFA will accept cost data on this basis, subject to appropriate treatment of capital expenditures.

Accrual Basis of Accounting.--This means that revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

Cash Basis of Accounting.--This means that revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

SUFFICIENT AND ADEQUATE RECORDS

As used here, adequate records means that the cost data developed by an HMO/CMP must be current, accurate, and in sufficient detail for HCFA to make a proper determination of the HMO/CMP's costs. Records must be maintained in a consistent manner from one contract period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures provided that the HMO/CMP makes a full disclosure to HCFA of the significant changes in advance and secures approval for the change.

As used here, sufficient records means, at the minimum, the following financial records:

Matters of ownership, organization, and operation of the HMO/CMP's financial, medical, and other recordkeeping systems;
B. Financial statements for the current contract period and three prior periods;
C. Federal income tax or information returns for the current contract period and three prior periods;
D. Asset acquisition documents and leases;
E. Agreements, contracts, and subcontracts;
F. Franchise, marketing, and management agreements;
G. Schedules of charges for the HMO/CMP's fee-for-service patients;
H. Records pertaining to costs of operations;
I. Amounts of income received by source and payment;
J. Cash flow statements; and
K. Any financial reports filed with other Federal programs or State authorities.
## CHAPTER 3
PROVIDER PRINCIPLES APPLICABLE TO HMO/CMPs

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4200. GENERAL

Unless otherwise specified in this part of the cost HMO/CMP manual, the types and items of cost generally incurred by providers of service (e.g., hospitals, SNFs, home health agencies) that are allowable under the principles of payment for providers (see 42 CFR Parts 405, 412 and 413) are allowable when incurred by HMOs/CMPs or by providers of services and other facilities owned and operated by HMOs/CMPs or related to the HMO/CMP by common ownership or control. An exception to the application of provider payment principles is available for the cost incurred by an HMO/CMP for covered services furnished by a provider under an arrangement with the HMO/CMP. In order to qualify for payment in excess of the amount authorized under 42 CFR Parts 405, Subpart D, 412, and 413, you must demonstrate to HCFA’s satisfaction that the excess payment is justified on the basis of advantages gained by you. (See §§4300 and 4302.)

Under these principles, allowable costs are determined according to the Medicare principles of reimbursement as set out in the Provider Reimbursement Manual and generally accepted accounting principles, in that order. Contracting HMOs/CMPs will be furnished a copy of the Provider Reimbursement Manual for reference to the principles of provider reimbursement.

4201. PAYMENT PROCEDURES FOR PROVIDER SERVICES PAID FOR DIRECTLY BY HMO/CMP

Unless you elect to have HCFA pay certain providers (hospitals and SNFs) directly for provider services, you are responsible for making payment directly to these providers. The payment to you will be equivalent to what HCFA’s intermediary or carrier would have paid for the service unless you demonstrate that additional payments are justified. (See §§4300 and 4302.) Since certain additional work will be required by the provider in some cases, you must secure an agreement with the provider to accomplish all the things necessary to establish proper payment. Regardless of the billing option selected, all Medicare covered services for which you have financial liability are included in the settlement process. (See §4104.2.)

4202. DATA COLLECTION REQUIREMENTS

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

4203. FILING REQUIREMENTS FOR PROVIDERS USING FORM HCFA-2552

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

For those hospitals and SNFs furnishing services to an HMO/CMP's Medicare enrollees for an HMO/CMP that has elected to have HCFA process the bills of that provider on behalf of the HMO/CMP, these providers will prepare their cost reports and submit them to their intermediary just as the do now. The cost of
the HMO/CMP's Medicare enrollees should be included with the provider's other Medicare patients, apportioned, and submitted to the intermediary for payment.

In addition, the provider will prepare a separate set of apportionment and settlement worksheets apportioning the costs to your Medicare enrollees. A separate set of worksheets will be needed for each HMO/CMP with whom the provider has an agreement to have payment made directly by the HMO/CMP. Each set of worksheets will apportion each cost center between the applicable group of Medicare beneficiaries and all other provider patients.

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

\[
\frac{\text{Total Costs}}{\text{Total Charges}} \times \text{Charges for the HMO's Medicare enrollees}
\]

Similarly, the apportionment ratios by cost centers on the worksheets for non-HMO Medicare patients would be:

\[
\frac{\text{Total Costs}}{\text{Total Charges}} \times \text{Charges for Medicare patients that are not members of the HMO}
\]

All other schedules currently required will be completed under existing instructions. Copies of all schedules will be sent to the provider's intermediary for processing and settlement.

4204. FILING REQUIREMENTS FOR PROVIDERS USING OTHER COST REPORT FORMS

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

4205. INTERMEDIARY FINAL SETTLEMENT WITH PROVIDER

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

4206. PROVIDERS RECEIVING PAYMENT UNDER PROSPECTIVE PAYMENT SYSTEM (PPS)

Payment to an HMO/CMP for provider services provided either directly or under arrangements shall be determined in accordance with 42 CFR, Parts 405, 412, or 413, as appropriate, unless the HMO or CMP can demonstrate in accordance with 42 CFR 417.548 that payment in excess of the amount authorized is justified on the basis of advantages gained by the HMO or CMP.
For example, for inpatient hospital services provided by a hospital participating under Medicare's PPS, the hospital is paid a predetermined amount for each inpatient stay by a Medicare patient based on the principal diagnosis for the inpatient stay. Additional payments are made for certain pass through costs, cost outliers, etc.

Each hospital stay is grouped by principal diagnosis into one of the many diagnosis related groups (DRGs). The DRG determines the amount the hospital receives for the inpatient stay, with some exceptions (e.g., cost outliers, day outliers). Payment is made with no retrospective adjustments.

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

Similarly, some SNFs have elected to be paid on a prospective basis under §1888 of the Act. Payment to the HMO or CMP will be determined in accordance with the provider's election.

This rule applies to inpatient hospital and SNF services provided by facilities owned or operated by the HMO/CMP, inpatient hospital, and SNF services provided by facilities related to the HMO/CMP by common ownership or control, and inpatient hospital and SNF services provided by facilities with which the HMO/CMP has an arrangement.

4207. SUMMARY OF PROVIDER REIMBURSEMENT PRINCIPLE TOPICS

The following list summarizes the general topics covered in the Provider Reimbursement Manual. These principles will be used in determining the allowability and reasonableness of costs incurred by HMOs/CMPs and by providers of services and other facilities owned or operated by the HMO/CMP. Principles relating to cost apportionment and the payment process are contained in chapters 5 and 1 of this manual, respectively. Absent specific instructions in this manual, an HMO/CMP should apply those principles of reimbursement of provider costs contained in the Provider Reimbursement Manual.
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PROVIDER AND PHYSICIAN COSTS

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4300. PROVIDER SERVICES THROUGH ARRANGEMENTS

At the option of the contracting cost HMO/CMP, HCFA will pay (through the provider's intermediary) hospitals and skilled nursing facilities (SNFs) for covered services furnished the HMO/CMP's Medicare enrollees in accordance with §1861(v) or §1886 of the Act, as applicable. In these circumstances, HCFA will pay these providers for covered services furnished to your enrollees, and these payments will be deducted from your payments.

Section 1876 offers you the option of making direct payments to SNFs through an arrangement (as defined in §4005) for covered services furnished your Medicare enrollees. The cost incurred by you through this arrangement is allowable to the extent that it does not exceed (1) the reasonable cost of furnishing such covered services (as determined under §1861(v) of the Act) for those providers currently paid on a reasonable cost basis, or (2) the payment amount determined under §1886 of the Act for those providers currently paid under Medicare's prospective payment system or under an approved State reimbursement cost control system. (See §4301.) An exception is permitted if you can demonstrate that payments in excess of reasonable costs or Medicare's prospective payment, as applicable, are justified on the basis of advantages gained by you. (See §4302.) Should you elect to pay your providers, you must adhere to the reporting requirements imposed on providers and intermediaries.

4301. PAYMENTS TO PROVIDERS PARTICIPATING UNDER §1886(c) OF THE ACT

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

4302. INFREQUENTLY PURCHASED PROVIDER SERVICES

If a provider infrequently furnishes services to your Medicare enrollees, you may be paid more than reasonable cost or the amount determined under §1886 of the Act for that provider service, if you can prove that a real and tangible benefit was received.

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

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

The advantages gained in this example include a more timely final settlement with you and the elimination of administrative costs necessary to determine the provider's reasonable costs for these services.
4303. PHYSICIAN SERVICES - GENERAL

Amounts paid by an HMO/CMP for physicians' services are allowable to the extent they are reasonable. Different tests of reasonableness apply, depending upon whether you employ the physicians directly or obtain physician services from outside sources such as:

- Individual practice physicians;
- Physician groups organized on a group practice basis; or
- Physician groups organized as an individual practice association (IPA).

The manner in which an individual physician is compensated (e.g., salary, fee-for-service, capitation, fixed sum, or other basis) also determines which test of reasonableness applies.

The allowability of physician and other Part B supplier services furnished directly is determined in accordance with the provisions of §4304.

For HMOs/CMPs with existing cost contracts, the allowability of physician and other Part B supplier services furnished under arrangements is determined in accordance with the provisions of §4305 for contract periods beginning before January 1, 1986.

For any contract period beginning on or after January 1, 1986, the allowability of physician and other Part B supplier services furnished under arrangements is determined in accordance with the provisions of §4306.

4304. PHYSICIAN AND OTHER PART B SERVICES FURNISHED DIRECTLY BY HMO/CMP

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

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

- Are commensurate with amounts paid for similar items and services furnished by similar personnel and suppliers in the same or similar locality; and
- Do not exceed those that a prudent and cost conscious buyer would incur to purchase those services.
4305. PHYSICIAN AND OTHER PART B SUPPLIER SERVICES FURNISHED UNDER ARRANGEMENTS - HMOs/CMPs WITH EXISTING COST CONTRACTS, CONTRACT PERIODS BEGINNING BEFORE JANUARY 1, 1986

The amount paid by you for physician services and other Part B supplier services furnished under arrangements is an allowable cost to the extent it is reasonable. The method used to determine the reasonableness of such costs depends upon your financial arrangements with the physician, physician group, or supplier which furnishes the services.

4305.1 Payment on Other Than Fee-for-Service Basis.--If you pay for physician services and other Part B supplier services on other than a fee-for-service basis (e.g., capitation, fixed sum, incentive payments), the costs incurred by you may be considered reasonable if they:

o Do not exceed those that a prudent and cost conscious buyer would incur to purchase those services; and

o Are comparable to costs incurred for similar services furnished by similar physicians or other suppliers in the same or similar locality.

EXCEPTION: If the physician group to whom you make non fee-for-service payments compensates its physicians or suppliers on a fee-for-service basis, your payments to the physician group will be considered reasonable provided they do not exceed what the area carrier would pay for the services rendered, in accordance with 42 CFR, Part 405, Subpart E or 42 CFR, Part 414. (See §4305.2 for application principles for this limitation.)

However, payment in excess of these limits is allowable if the group has procedures under which members of the group accept effective incentives, such as risk sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount paid by you is considered reasonable in accordance with the first paragraph of this section.

4305.2 Payment on Fee-for-Service Basis.--If you pay for physicians services and other Part B supplier services on a fee-for-service basis, the costs incurred by you will be considered reasonable provided they do not exceed:

o The reasonable charges for those services, as defined in 42 CFR, Part 405, Subpart E or the fee schedule amount specified in 42 CFR Part 414; and

o The amount that HCFA would pay for those services if they were provided to beneficiaries who are not enrolled in your HMO/CMP and who receive the services from sources other than providers of services or other entities that are paid on a reasonable cost basis.

In determining what Medicare would pay, you should use the prevailing charge profiles of the carrier and the Medicare fee schedules. The local Medicare carrier will furnish you with schedules of these fees for the area so that you will be aware of the allowable levels in the area and can use these schedules in negotiating payment rates with physicians and developing apportionment ratios. HCFA may sample the apportionment ratios developed by you which are subject to this limitation and compare them to the Medicare carrier's prevailing charge schedules or the Medicare fee schedules (as appropriate) in order to verify that you are applying the limits properly. If the sample indicates that you are claiming, in the aggregate, an amount greater than the carrier's prevailing charge or fee schedules, the cost of all such services will be reduced by the proportion indicated in the test sample.
EXCEPTION 1: Payment on a fee-for-service basis to a physician group organized on an individual practice basis is not subject to the limits contained in 42 CFR, Part 405, Subpart E or 42 CFR, Part 414 if the group pays its physicians on a fee-for-service basis and has procedures under which the members of the group accept effective incentives, such as risk sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount you pay is considered reasonable in accordance with §4305.1.

EXCEPTION 2: Payment of the charges of a physician or other Part B supplier on other than a reasonable charge or fee schedule basis (as defined in 42 CFR, Part 405, Subpart E or 42 CFR, Part 414) is allowable if you demonstrate to HCFA's satisfaction that (a) the physician or other Part B supplier furnishes services to your enrollees on an infrequent basis; (b) these charges represent an insignificant portion of total Medicare payments to the HMO/CMP; and (c) these charges do not exceed the amounts the physician or supplier charges other patients for the same or similar services.

Situations where payment in excess of the allowable charge could occur include fee-for-service compensation paid by you to nonplan physicians for purchased services, such as emergency or urgently needed care outside the plan and unusual specialty services not available within the plan.

4306. PHYSICIAN AND OTHER PART B SUPPLIER SERVICES FURNISHED UNDER ARRANGEMENTS - CONTRACT PERIODS BEGINNING ON OR AFTER JANUARY 1, 1986

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

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

Section 1876(j) of the Act places a limit on the charges of noncontracted physicians and suppliers of end stage renal disease services for enrollees of plans with §1876 contracts. You are allowed to use the Medicare fee-for-service payment limits for these services rendered on or after April 1, 1990. This provision does not preclude you from negotiating charges less than the Medicare limits.

4306.1 Payment for Services Rendered On or After April 1, 1994, by Noncontracted Medicare Participating Physicians.--The limit of your liability for services rendered by a physician with whom you do not contract depends on whether the physician is a Medicare participating physician (i.e., has agreed to accept assignment on all Medicare claims submitted to Medicare). The Medicare participation agreement is deemed to apply to such a physician's services in the sense that the physician may not bill you, the beneficiary, or any other party for any amount in excess of the Medicare allowed amount (the fee schedule amount or the actual charge, if lower). However, you have financial responsibility for the amount that would have been the beneficiary's liability in fee-for-service Medicare (the 20% coinsurance and any unmet deductible).
4306.2 Payment for Services Rendered On or After April 1, 1994, by Noncontracted, Nonparticipating Physicians.--If a noncontracted physician provides a service to one of your enrollees and the physician is not a Medicare participating physician, the limit of your liability is the lower of the actual charge or the limiting charge permitted under the statute for fee-for-service Medicare. You are responsible for beneficiary coinsurance and deductible payments.

Enrollment, Marketing, and Membership Costs

4307. ENROLLMENT AND MARKETING COSTS

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

These costs do not include membership costs (see §4309) or special costs. (See §4311.)

4308. INITIAL ENROLLMENT

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

4309. MEMBERSHIP COSTS

Your cost of maintaining and servicing subscriber contracts for prepayment enrollees, including but not limited to the reasonable cost of maintaining statistical, financial, and other data on members, are allowable to the extent they are reasonable. Membership expenses should not be included with allowable enrollment and marketing expenses.

4310. REINSURANCE

Reinsurance is the transfer of all or part of the risk you assume in agreeing to deliver health care to your enrollees. Reinsurance costs are not allowable.

4310.1 Self Insurance.--If you self insure for the cost of services by maintaining independently, or as part of a group or pool, a self insurance fund, the costs of payments into such a fund are not allowable. Other types of self insurance funds are subject to the rules contained in chapter 21 of the Provider Reimbursement Manual, Part I.

Special Costs and Deductible/Coinsurance Computation

4311. COSTS PAID IN FULL

HCFA will pay in full the total reasonable cost incurred by you for services that are solely for the purposes of the Medicare program and unique to the
HMO/CMP provisions in Medicare. These special costs will be taken into account in your monthly per capita rate. They must be shown separately in your operating budget and approved by HCFA in advance of the contract period for which they are claimed subject to retrospective adjustment at the end of the contract period. These special costs do not include management service costs and the normal administrative costs incurred by you in obtaining payment from the Medicare program (such as the cost of maintaining and reporting statistical and actuarial data needed to determine the amount of payment due you and the cost of preparing cost reports). Such costs are apportioned to the Medicare program in accordance with §§4416 or 4417, as applicable, so that the Medicare program pays its proportionate share of these costs.

The following types of costs incurred by you will be paid in full by HCFA:

A. Medicare Enrollment Data.--This is the reasonable cost of reporting individual Medicare beneficiary enrollment accretion and deletion data as described in Part 6.

B. Special Program Evaluation and Planning Data.--This is the reasonable cost of special data required by HCFA solely for Medicare program evaluation and planning purposes. However, unless specifically provided for, this data does not include the data the HMO/CMP is required to maintain and furnish under other sections of this manual.

C. Certification of Cost Report.--This is the reasonable costs of certifying the HMO/CMP's cost report as required in §4016. However, as indicated above, the reasonable cost of preparing this cost report is apportioned in accordance with §§4416 or 4417, as applicable. HCFA will pay in full under this section only those additional costs incurred by you that are related to the certification of that report.

4312. BENEFICIARY LIABILITY

HCFA will pay you for the reasonable cost of providing covered services to Medicare enrollees less an amount representing the actuarial value of the deductible and coinsurance the Medicare enrollee otherwise would have been liable for had they not enrolled in your HMO/CMP or in another HMO/CMP as determined in §4313. You may charge Medicare enrollees up to this aggregate amount in the form of premiums, membership fees, copayments, charge per unit of service, or similar charges. Premiums may be paid on behalf of the Medicare enrollee by another individual, organization, or entity. In addition, a Medicare beneficiary's private health insurance may be the primary payer under certain circumstances. (See §4321.)

You may offer your Medicare enrollees a supplemental benefit plan to cover deductibles and coinsurance amounts, services not covered under Medicare, or both. If a supplemental benefit plan premium (or other payment method) includes charges for both noncovered services and the deductible and coinsurance amounts applicable to covered services, the portion of the premium representing deductibles and coinsurance must be computed separately and disclosed to the beneficiary prior to his/her election of such coverage options during the enrollment process.
The Medicare beneficiary may, at his/her option, choose coverage under such a plan. If so, he/she is liable for payment for the supplemental benefit plan. In addition, the sum of the amounts you charge your Medicare enrollees for such supplemental benefit plan services that are not covered under Part A or Part B of Medicare may not exceed the adjusted community rate (ACR) for these services. (See Part 5 chapter 3 of this manual for a discussion of the ACR.) For Medicare enrollees entitled to Part B only, your premium (or other payment method) for Medicare Part A services offered under a supplemental benefit plan to such individual may not exceed the ACR for these services.

4313. Determining Deductibles and Coinsurance

In determining the amount due you, HCFA will deduct from the reasonable cost actually incurred by you in furnishing covered services to your Medicare enrollees an amount equal to the value of the Medicare deductible and coinsurance amounts which would have been payable if your Medicare enrollees had not been enrolled in your HMO/CMP. However, this amount which becomes the Medicare enrollees' liability for covered services, can not exceed, on the average, the actuarial value of the deductible and coinsurance the Medicare enrollees otherwise would have been liable for had they not enrolled in your HMO/CMP or in another HMO/CMP. (See §4312.) This actuarial value is provided by HCFA on a calendar year basis.

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

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

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

Your use of the actuarial method will involve three major computations. First, list the actual Part A deductible and coinsurance and Part B coinsurance for each provider furnishing services to your Medicare enrollees. Next, calculate the Part B deductible amount by multiplying the Medicare Part B monthly standard deductible amount (determined by HCFA) by the HMO's/CMP's Part B Medicare enrollee months. The actuarial value of the Medicare Part B monthly deductible for the years 1985 through 1993 as determined by HCFA are:

<table>
<thead>
<tr>
<th>Year</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>$5.03</td>
</tr>
<tr>
<td>1986</td>
<td>$5.05</td>
</tr>
<tr>
<td>1987</td>
<td>$5.00</td>
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<tr>
<td>1988</td>
<td>$5.28</td>
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<tr>
<td>1989</td>
<td>$5.41</td>
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<td>1990</td>
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<td>1991</td>
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<tr>
<td>1992</td>
<td>$6.92</td>
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<tr>
<td>1993</td>
<td>$7.08</td>
</tr>
<tr>
<td>1994</td>
<td>$7.23</td>
</tr>
</tbody>
</table>

In the third major computation, you will compute the Part B blood deductible amount and the Part B coinsurance applicable to nonprovider services. The sum of these three computations gives the Medicare Part A and Part B deductible and coinsurance amounts.
To compute your Medicare enrollees' premiums, add the total Part A and Part B deductible and coinsurance for your incurred costs and the Part A and Part B deductible and coinsurance for costs paid by intermediaries or carriers on your behalf. From this total, subtract your Medicare enrollees' copayments, if any. The resulting figure is then divided by your Medicare enrollee months to produce a monthly premium.

EXAMPLE OF FORMULA:

1. Factors
   
   \[
   a = \text{Total Part A and Part B deductible and coinsurance on HMO/CMP incurred costs.}
   \]
   
   \[
   b = \text{Total Part A and Part B deductible and coinsurance on intermediary or carrier incurred costs.}
   \]
   
   \[
   c = \text{Total HMO/CMP Medicare enrollee copayments.}
   \]
   
   \[
   d = \text{HMO/CMP Medicare enrollee months.}
   \]
   
   \[
   e = \text{Monthly deductible and coinsurance amount to be recovered through Medicare beneficiary premiums.}
   \]

2. Computation
   
   \[
   \frac{a + b - c}{d} = e
   \]

4313.1 Payment for Bad Debts.--Bad debts are deductions from revenue and may be included in allowable costs only if:

   o They are attributable to Medicare deductible and coinsurance amounts for which the Medicare enrollee is liable; and
   
   o You have made a reasonable, but unsuccessful, effort to collect these amounts.

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

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

Payment Limitations

4314. LIMITATION ON PAYMENT

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

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

The payment limitations applicable to cost basis HMO/CMPs include (but are not limited to) those described in §§4315-4320.

4315. END STAGE RENAL DISEASE

Individuals who have been medically determined to have end stage renal disease (ESRD) are not eligible to enroll in your cost basis HMOs/CMPs. However, individuals already enrolled in your HMO/CMP who subsequently become eligible for Medicare because of ESRD, and aged Medicare enrollees who subsequently develop ESRD, cannot be disenrolled from your HMO/CMP as a result of the development of ESRD. Special limitations apply to Medicare program payment for ESRD services.

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

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

4316. LIMITATIONS ON COSTS

The limitation on costs provisions contain special rules for evaluating allowable provider costs that apply in addition to certain Medicare reimbursement principles. Specifically, these rules deal with the cost limits that apply to most SNF services and to home health agency costs, as well as to the rate of increase ceilings applicable to hospitals exempt from the prospective payment system (PPS). The rules do not apply to hospitals paid under PPS.

For a detailed discussion of the limitation on costs provision, see chapter 25 of the Provider Reimbursement Manual, Part I.

4317. PHYSICAL AND OTHER THERAPY SERVICES FURNISHED UNDER ARRANGEMENTS

The reasonable cost of the services of physical, occupational, speech, and other therapists, or services of other health-related specialists (except
physicians) performed by outside suppliers for a provider of services, a clinic, a rehabilitation agency, a public health agency, or an HMO/CMP may not exceed (1) amounts equivalent to the salary and other costs that would have been incurred by the provider or other entity if the services had been performed in an employment relationship, plus (2) an allowance to compensate for other costs an individual not working as an employee might incur in furnishing services under arrangements. However, this reasonable cost may be determined on the basis of a reasonable rate per unit of service (1) when the services of a therapist or other health-related specialist are required only on a limited part-time basis or only intermittently, and (2) when aggregate reimbursement on this per unit of service basis is less than what the provider would have paid a salaried employee therapist or other health-related specialist on a full-time or regular part-time basis. (See 42 CFR 413.106.) In no case, though, may reasonable cost exceed the amount actually paid the outside supplier for services rendered.

For a detailed discussion of reasonable cost, see chapter 14 of the Provider Reimbursement Manual, Part I.

4318. ALLOWABLE COST FOR DRUGS IN PROVIDER

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

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

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

4319. LOWER OF COSTS OR CHARGES

Payment to providers (including HMO/CMP providers) for services provided to Medicare beneficiaries will be based upon the lower of the reasonable cost of providing those services or the customary charges for the same services. However, in the case of hospital Part A services, this provision will not apply to cost reporting periods beginning on or after October 1, 1982, for any hospital that is subject to the rate of increase ceiling under §1886(b) of the Act. The lower of cost or charges provision also will not apply with respect to hospital Part A services furnished by a hospital that is subject to the PPS pursuant to §1886(d) of the Act for cost reporting periods beginning on or after October 1, 1983. Providers entitled to recapture previously disallowed costs will continue to be able to do so during this time.
Payments to providers will be based on the interim rate which approximates reasonable cost as nearly as practicable, but cannot exceed 100 percent of the customary charges for the same services.

Care should be exercised in the application of the lower of costs or charges provisions due to its limited applicability.

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

Lower of costs or charges rules apply to services obtained by you from outside providers and to services furnished to your Medicare enrollees by providers owned and operated by you or related to you by common ownership and control. Rules applicable to related organizations are discussed in chapter 10 of the Provider Reimbursement Manual, Part I.

For a more detailed discussion of the lower of costs or charges provision, see Chapter 26 of the Provider Reimbursement Manual, Part I.

4320. PROSPECTIVE PAYMENT SYSTEM (PPS)

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

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

- Hospitals located outside the 50 States and the District of Columbia;
- Psychiatric hospitals;
- Rehabilitation hospitals;
- Long term hospitals;
- Children's hospitals;
- Psychiatric and rehabilitation units of general hospitals which meet the separate entity requirement of the Provider Reimbursement Manual, Part I, §2336; and
- Hospitals subject to State rate setting authority operated under §§1814 or 1886(c) of the Act.

These hospitals will continue to be paid on the basis of reasonable costs, subject to applicable target rate ceilings contained in §1886(b) of the Act.
NOTE: The exemption is not optional on the part of the provider but is required as long as the hospital or hospital unit meets the definition for exemption.

In addition, certain SNF may elect to be paid on a prospective basis under §1888(d) of the Act. Payments made for services will be governed by the same rules that are used for Medicare beneficiaries not enrolled in an HMO/CMP.

For a detailed discussion of the PPS provision, see chapter 28 the Provider Reimbursement Manual, Part I.

Coordination of Benefits

4321. GENERAL

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

- Services covered by a State or Federal workers' compensation law (WC);
- Services covered by no fault insurance;
- Services covered by any liability insurance;
- Services covered by EGHPs in the case of end stage renal disease beneficiaries during a period of generally 18 months;
- Services covered by EGHPs in the case of employed beneficiaries age 65 and over and the spouses age 65 and over of employed individuals; and
- Services covered by LGHPs in the case of certain disabled Medicare beneficiaries who are covered by reason of their employment or the employment of a family member.

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

If a Medicare enrollee receives otherwise covered services from you for which the enrollee is entitled to benefits under one of the above categories, you may charge or authorize a provider that furnished the service to charge:

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

4321.1 Definitions.--

A. HCFA's Claim.--The amount that is determined to be owed to the Medicare program. This is the amount that was paid out by Medicare, less any prorated procurement costs (see 42 CFR 411.37) if the claim is in dispute.
B. **Employer.**--The term "employer" as used in these instructions means not only individuals and organizations engaged in a trade or business, but also includes organizations exempt from income tax, such as religious, charitable, and educational institutions, as well as the governments of the United States, the States, Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Mariana Islands, and the District of Columbia, including their agencies, instrumentalities, and political subdivisions.

C. **Secondary.**--For purposes of this instruction, the term "secondary," when used with respect to Medicare payment, means that Medicare incurs a legal obligation to pay only after other primary third party payers satisfy their payment responsibilities. If the primary payer covers all expenses, Medicare has no payment obligation. If the primary payer covers part of the expenses, Medicare may pay for the residual, uncovered amounts. In certain instances when the primary payer does not pay promptly, HCFA pays conditional primary benefits and later recovers them from the responsible party.

D. **Subrogation.**--The term "subrogation" means the substitution of one person or entity for another.

4321.2 **HMO/CMPs' Obligations.**--When the Medicare program is not the primary payer for covered Medicare services provided to Medicare members of the HMO/CMP, the HMO/CMP must:

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

In addition, in situations when you may charge another plan or the Medicare beneficiary for services when Medicare is not primary payer, you may also require the enrollee to sign a subrogation under which you are given the rights the beneficiary has against the third party.

4321.3 **General Fee-for-Service Rules.**--All Medicare payments are contingent upon payment on reimbursement to the appropriate trust fund when notice or other information is received that payment for the same items or services has also been made, or could be made, by a primary payer. Section 1862(b) of the Act now expressly provides that:

- HCFA may bring an action against any entity which is required or responsible to pay primary in order to recover Medicare payments directly from that entity;
- The government is subrogated to the right of any individual or entity to receive payment from a responsible third party. Under the Medicare subrogation provision, the government is given whatever rights the beneficiary or any other entity had against the responsible third party to the extent that Medicare has made payments to or on behalf of the beneficiary; and
- The government may join or intervene in any action related to the events which gave rise to the need for the items or services for which Medicare paid.
4321.4 Other Provisions.--Any claimant, including an individual who received services and the provider or supplier, has the right to take legal action against an EGHP or LGHP that fails to pay primary benefits for services covered by both the EGHP or LGHP and Medicare and to collect double damages. (See §4327.2.)

An excise tax is imposed by §5000 of the Internal Revenue Code on any employer or employee organization that contributes to the nonconforming EGHP or LGHP during a calendar year. The amount of tax is 25 percent of the total amount that the employer or employee organization contributed to the EGHP or LGHP during that year. This tax penalty does not apply to Federal and other governmental entities.

4321.5 Conflicting Claims by Medicare and Other Third Parties.--Situations may arise in which both Medicare and another insurer or a State Medicaid agency have conditionally or erroneously paid for services, and the amount payable by the third party payer is insufficient to reimburse both programs. Under §1862(b)(2)(B)) of the Act, Medicare has the right to recover its benefits from the responsible third party before any other entity, including a State Medicaid agency. Also, Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that has been paid by the responsible third party. In other words, Medicare's recovery rights when another third party is primary payer take precedence over the rights of any other entity.

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

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

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

Moreover, the right of Medicaid agencies to recover their benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party payment. Since the beneficiary can assign to the State a right no higher than his/her own, and since Medicare's statutory right is higher than the beneficiary's, Medicare's right is higher than that assigned to the State.
4322. COORDINATION WITH WORKERS' COMPENSATION (WC)

See §4322.1 for additional definitions applicable to this section.

Medicare may not pay for services that are payable under WC laws. Where you coordinate your own health plan with WC coverage, use the procedures developed by your own plan to identify and recover costs for services furnished to Medicare members. When you do not coordinate benefits for your own plan, you must establish reasonable screening procedures to identify potential WC liability situations. If it is determined that Medicare has paid for items or services which can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

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

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

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

4322.1 Definitions.--

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

The limitation stated in §4322 also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program). These Federal programs provide WC protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs (e.g., coal miners totally disabled due to pneumoconiosis; maritime workers, with the exception of seamen; employees of companies performing overseas contracts with the United States government; employees of American companies who are injured in an armed conflict; employees paid from nonappropriated fund accounts).
Federal funds, such as employees of post exchanges; and offshore oil field workers). The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this provision. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this provision.

B. Workers' Compensation Agency.--The term "workers' compensation agency" means any governmental entity that administers a Federal or State WC law. This term includes WC commissions, industrial commissions, industrial boards, WC insurance funds, WC courts and, in the case of Federal workers' compensation programs, the U.S. Department of Labor.

C. Workers' Compensation Carrier.--The term "workers' compensation carrier" means any insurance carrier authorized to write WC insurance under the State or Federal law, the State compensation fund in which the State administers the WC program, and the beneficiary's employer in which the employer is self-insured.

D. Lump Sum Compromise Settlement.--This is a settlement which provides less in total compensation than the individual would have received if the claim had not been compromised. This may occur when compensability is contested.

4322.2 Additional Processing Instructions.--For further information on how to implement this Medicare secondary payer provision, refer to §§3407.2-3417.2 of the Intermediary Manual. These sections include information regarding the method of calculating Medicare secondary payments, contested WC claims, lump sum commutations of future benefits, and the effect of a lump sum compromise settlement.

4323. COORDINATION FOR END STAGE RENAL DISEASE BENEFICIARIES

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

The 18-month period begins with the earlier of the first month of Part A eligibility or entitlement based solely or partly on ESRD.

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

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

4323.1 Definition of Employer Group Health Plan (EGHP) or Employer Plan.--When used in context of entitlement to Medicare based solely on ESRD, these terms mean any health plan that (1) is paid for by, or contributed to by,
an employer, and (2) provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, or to current or former employees and their families. It includes the Federal Employees Health Benefits program. Employees pay all plans, i.e., group health plans under the auspices of an employer which do not receive any contributions from the employer, also meet the definition of EGHP.

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

4323.2 Additional Processing Instructions.--For further information on how to implement this Medicare secondary payer provision, refer to §§3490.3-3490.16 of the Intermediary Manual. These sections include, among other things, information regarding the implementation of this provision retroactively, the processing of current claims, the determination of the 18-month period in which Medicare may be secondary, and the method of calculating the Medicare secondary payment.

4324. COORDINATION WITH NO FAULT INSURANCE

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

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

Expenses for services for which Medicare payment may not be made because payment has been made or can reasonably be expected to be made promptly under any no fault insurance are credited toward Part A or Part B deductible amounts. Inpatient care that is paid for by a third party payer is not counted against the number of days available to the beneficiary under Medicare Part A.

4324.1 Definitions.--

A. Automobile.--This is any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

B. No Fault Insurance.--This is insurance coverage (including a self-insured plan) that pays for all or part of the medical expenses for injuries regardless of who may have been responsible for causing the accident. (This insurance is sometimes called personal injury protection, medical payments coverage, or medical expense coverage.)
Additional Processing Instructions.--For further information on how to implement this Medicare secondary provision, refer to §§3489.3-3489.9 of the Intermediary Manual. These sections include, but are not limited to, information regarding the processing of claims, the necessary action to take if there is the possibility of payments under no fault insurance, and the method of calculating the secondary Medicare payment.

BENEFIT COORDINATION FOR SERVICES REIMBURSABLE UNDER LIABILITY INSURANCE

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

Under this Medicare secondary payer provision, the program is a claimant against the responsible party and the liability insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary. Medicare can be a party to any claim by a beneficiary or other entity against a liability insurer, can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare, and may seek recovery of conditional payments directly from the liability insurer. Section 1862(b) of the Act provides that any claimant has the right to take legal action against a liability insurer that fails to pay primary benefits for services covered by the insurer and to collect double damages.

Definitions.--

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

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

B. Self-Insured Plan.--This is a plan under which an individual or other entity is authorized by State law to carry its own risk instead of taking out insurance with a carrier. Authorized by State law means not prohibited by State law. The plan established for the Federal government under the Federal Tort Claims Act is also a self-insured plan.
C. **Uninsured Motorist Insurance.**—This means liability insurance under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law.

D. **Underinsured Motorist Insurance.**—This is optional liability insurance available in some jurisdictions under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.

E. **Accident.**—This is any occurrence or activity that the individual believes resulted in injury or illness for which he or she holds another party liable.

4325.2 Additional Processing Instructions.--For further information on how to implement this Medicare secondary payer provision, refer to §§3419.3-3419.10 of the Intermediary Manual. These sections include, among other things, information regarding billing rights and responsibilities, identification of liability situations, and action to be taken when a liability claim has been filed.

4326. **BENEFIT COORDINATION FOR WORKING AGED INDIVIDUALS ENTITLED TO MEDICARE**

Under §1872(b)(1)(A) of the Act, if an employer has 20 or more employees (calculated as described below) and offers a group health plan (referred to here as an EGHP), the EGHP is the primary payer for individuals who are 65 or over, and who are covered under the plan based on current employment of the individual or the individual's spouse. (Medicare remains the primary payer for retirees.)

Medicare is secondary only if the individual is entitled to Medicare Part A. Generally, Medicare is not secondary for persons over age 65 who have ESRD. (See §4323.)

The law also prohibits EGHPs from taking into account, in furnishing services, that an individual is entitled to Medicare benefits, and requires that employees or their spouses, who are 65 or over, be entitled to the same benefits under the same conditions as individuals under age 65. If the EGHP violates either of these provisions, Medicare is entitled to collect primary payments from the plan as if the violations had not occurred. The nonconforming plan is also subject to an excise tax imposed under the Internal Revenue Code. (See §4329.)

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

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

Assume for purposes of developing claims that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. An employer's allegation that the 20-employee requirement is not met, or a multi-employer plan's statement identifying specific members as employees of employers of fewer than 20 employees (see definition of EGHP in §4326.l), can be accepted as a basis for making Medicare primary payments. Refer questionable cases to the RO.

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

1. Determine if the member (or spouse) is eligible for consideration:
   - Determine if the member or spouse is age 65 or over and entitled to Part A, this is shown on the reply listing. (See Part 6 of this manual.);
   - Determine if the individual who is age 65 or over is covered under the employer's health plan by reason of current employment;
   - Determine if the member or spouse has ESRD;

2. If the Medicare member age 65 or over is not covered due to current employment (including self-employment), determine if the spouse is covered by reason of current employment and, if so, whether the Medicare member is covered under the spouse's EGHP; and

3. Determine if the services are covered under the employer plan.

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

4326.1 Definitions.--

A. Employed.--For purposes of this discussion, the term "employed" encompasses not only employees, but also, subject to the special rules in §4326.2, self-employed persons such as consultants, owners of businesses, and directors of corporations, and members of the clergy and religious orders who are paid for their services by a religious body or other entity.
B. **Employer.**--This term means, in addition to individuals and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.

C. **EGHP.**--For the working aged, this term means any health plan that is paid for by or contributed to by an employer of 20 or more employees and which provides medical care, directly or through other methods, such as insurance or reimbursement, to current or former employees or to current or former employees and their families. This includes a multi-employer plan (i.e., a plan sponsored jointly by employers and unions) and a multiple employer plan (i.e., a plan sponsored by more than one employer) which is sponsored by or contributed to by at least one employer that has 20 or more employees. Under §1862(b)(1)(A)(iii) of the Act, if a multi-employer plan or multiple EGHP plan can identify particular enrollees as employees of employers that do not meet the 20-employee threshold, the MSP rules do not apply to these enrollees and their spouses. However, the plan must elect this treatment for the exception to apply.

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

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

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

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

4326.2 **Special Rules.**--Additional special rules applicable to EGHPs follow.

A. **Self-Employed Individuals.**--The term "current employment" includes not only employees, but also self-employed persons such as directors of corporations and owners of businesses. If a self-employed individual enrolls in an EGHP which meets the definition in §4326.1.C, the employer plan is primary for that individual and the individual's spouse.

B. **Members of Clergy and Religious Orders.**--

1. **General.**--The following general guidelines apply in determining the employment or retirement status of members of the clergy and members of religious orders when an EGHP alleges that such an individual is retired.

2. **Members of Clergy or Members of Religious Order Who Have Not Taken Vow of Poverty.**--Such members are:
3. Members of Religious Order Who Have Taken Vow of Poverty.--Medicare is not secondary for individuals who perform services as members of a religious order whose members are required to take a vow of poverty if those activities are considered employment only because of an election of Social Security coverage by the order under §3121(r) of the Internal Revenue Code (IRC). This means Medicare is primary to the group health coverage provided as a result of those activities. Those activities may not be considered in determining whether a member of the order is considered an employed individual for purposes of the working aged provision.

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

C. Individuals Who Receive Disability Payments.--A person receiving disability payments from an employer is considered employed if such payments are subject to taxes under the Federal Insurance Contributions Act (FICA).

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

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

4326.3 Additional Processing Instructions.--For further information on how to implement this Medicare secondary provision, refer to §§3491.3-3491.17 of the Intermediary Manual. These sections include, among other things, information regarding the individuals covered by this provision, the coordination of benefits with other insurers, the method of calculating the Medicare secondary payment, and special rules for services furnished by a source outside the prepaid EGHP.
4327. **BENEFIT COORDINATION WITH LARGE GROUP HEALTH PLANS (LGHPs)**

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

4327.1 **Definitions.--**

A. **LGHP.**--A large group health plan means any health plan which meets the following criteria:

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

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

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

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

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

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

4327.2 Special Rules.--In general, an individual who is not actively working is considered to have employee status if the relationship is such that:

- The individual is receiving payments from an employer which are subject to taxes under the Federal Insurance Contributions Act (FICA) or would be subject to such taxes except that the employer is one that is not required to pay such taxes under the Internal Revenue Code;
- The individual is termed an employee under State or Federal law or in accordance with a court decision;
- The employer pays the same taxes for the individual as he/she pays for actively working employees;
- The individual continues to accrue vacation time or receives vacation pay;
- The individual participates in an employer's benefit plan in which only employees may participate;
- The individual has rights to return to duty if his/her condition improves; and
- The individual continues to accrue sick leave.

A. Individuals Not Subject to This Limitation on Payment.--Medicare is not secondary for:

- Individuals entitled, or who would upon application be entitled, to Medicare under the ESRD provision that are not in the coordination period (see §4323), i.e., individuals who have ESRD even though their current Medicare entitlement is on the basis of disability;
- Individuals who are covered by an EGHP of employers of less than 100 employees, unless the EGHP is a multi-employer plan in which there is at least one employer of 100 or more employees; and
- Individuals whose coverage by an LGHP is not based on either employment or a relationship to an employee, employer, or an individual associated with an employer in a business relationship. For example, Medicare is primary for a disabled individual who is covered under an LGHP as a retired former employee and who does not meet any of the criteria in §4327.1.D or who is the spouse of a retired former employee.
B. Failure to Pay Primary Benefits.--Any claimant, including an individual who received services and the provider or supplier, has the right to take legal action against an LGHP that fails to pay primary benefits for services covered by both the LGHP and Medicare and to collect double damages.

4327.3 Additional Processing Instructions.--For further information on how to implement this Medicare secondary provision, refer to §§3492.E-3492.K of the Intermediary Manual. These sections include, among other things, information regarding individuals subject to this provision, the legal action that may be brought against a LGHP, and the tax penalty for noncompliance by a LGHP.

4328. FEDERAL GOVERNMENT'S RIGHT TO SUE AND COLLECT DOUBLE DAMAGES

Separate from its subrogation rights, the Federal Government has an independent right to take legal action to recover payments from entities that are required or responsible to pay benefits primary to Medicare but which fail to do so. The Federal Government may recover double damages in this type of lawsuit pursuant to §1862(b)(2)(B)(ii) of the Act. Entities that are required or responsible to pay primary to Medicare include:

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

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

The government's right to sue and collect double damages is effective for items and services furnished on or after December 20, 1989, under all MSP provisions except the MSP for the disabled provision. The government's right to sue and collect double damages under the MSP for the disabled provision is effective for items and services furnished on or after January 1, 1987.
Section 5000 of the Internal Revenue Code of 1986 imposes an excise tax penalty on employers and employee organizations which contribute to nonconforming group health plans. They are taxed 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each group health plan (conforming as well as nonconforming) to which they contribute. This tax penalty does not apply to Federal and other governmental employers.

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

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

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

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

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

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

- Failure to make primary payment on behalf of an individual for whom Medicare is secondary;
- Providing secondary or complementary coverage to such an individual;
- Refusal to allow such an individual to enroll or re-enroll in the group health plan or large group health plan because of Medicare entitlement;
- Providing a different level of benefits for individuals for whom Medicare is secondary than it provides for other persons enrolled in the plan;
- Imposing limitations on benefits, exclusions of benefits, reductions in benefits, higher premiums, higher deductibles or coinsurance, longer waiting periods, lower annual or lifetime benefit limits, or more restrictive pre-existing illness limitations, for persons for whom Medicare is secondary payer that are not applicable to others enrolled in the plan;
Refer any case of a nonconforming group health plan to the RO servicing your area. Include, in addition to the beneficiary's name, address, and SSN or HICN, the formal name and address of the nonconforming group health plan; the name and address of the entity required or responsible for making payment on behalf of the plan (e.g., the employer, an insurer, or a third party administrator (TPA)); a copy of the employer's agreement with the TPA; the name of the sponsoring or contributing employer or employee organization; the employer or employee organization taxpayer identification number; year(s) of violation; the provider's name, address and identification number; the specific amount of Medicare payments associated with the nonconformance; the specific date(s) of service; the specific procedure or diagnosis code(s); the MSP type (e.g., ESRD or working aged); and a full explanation of the reasons for the referral. The RO reviews the case file for completeness and obtains any needed additional information. When the file is complete, the RO refers the case to HCFA CO. HCFA CO reviews the case and refers it to the Internal Revenue Service to impose the excise tax on employers and employee organizations that have contributed to the plan.

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

4330. APPLYING RECOVERIES TO COST REPORT

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

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

The bases for offsets are:

- The amount recoverable; or
- A member month ratio, as described in §4331.

4331. ALTERNATIVE METHOD FOR COST REPORT TREATMENT OF EMPLOYER HEALTH PLANS

In the case of benefits covered by an employer plan for a Medicare member who is also a group member under employer's plan, you may elect to identify the cost or charge for the service covered under that plan. However, instead of specifically identifying those services for which an employer health plan is primarily liable for payment (ESRD - §4323, working aged - §4326, and disabled Medicare beneficiaries - §4327), you may elect to utilize a member month ratio to establish Medicare's liability. This election must be made in writing at the time of a timely submitted budget. In addition, this election must be made for the following groups of Medicare enrollees:

- Terminating coverage because a person has become entitled to Medicare; or
- Failure to cover routine maintenance dialysis services or kidney transplants.
- Members that meet the conditions of §4323;
- Members that meet the conditions of §4326; or
- Members that meet the conditions of §4327.

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

The member month ratio is developed by dividing the Medicare member months (exclusive of the three groups identified in §§4323, 4326, and 4327) by total Medicare member months. This ratio would then be applied to covered Medicare service costs resulting in those costs for which Medicare is the primary payer.

**4332. DETERMINING TOTAL COSTS FOR COMPARISON WITH AAPCC LIMITS**

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

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

Costs will consist of those costs incurred directly by the plan (normally reimbursed through the cost report mechanism). The bill summary report will be used to report the total cost for services finished in a provider setting (e.g., hospital, SNF, and HHA).

**4333. TAXES**

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

Whenever exemptions to taxes are legally available, you are expected to take advantage of them. If you do not take advantage of available exemptions, the expenses incurred for such taxes are not recognized as allowable under the program.

More detail can be found in the Provider Reimbursement Manual, Part I, §§2122ff.

**4333.1 Premium Taxes.--**Some State and local governments are assessing organizations a tax based on premium revenue. If there are no exemptions that could be used to legally avoid the assessment of this tax, HCFA will recognize the expense as an allowable cost.
However, the amount HCFA should pay would be the amount of the assessment that is applicable to premiums charged to Medicare enrollees for covered services. Payments by HCFA to a cost contractor for covered services rendered to Medicare enrollees do not constitute premiums. Rather, HCFA is buying each covered service at cost less applicable Medicare deductible and coinsurance. The only premium for covered services paid to you is paid by the Medicare enrollee for Medicare's deductibles and coinsurance. Therefore, the amount of the assessment to be paid by HCFA should be limited to that amount applicable to Medicare's deductible and coinsurance charged as a premium.
CHAPTER 5
COST APPORTIONMENT FOR HMOs/CMPs

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4400. GENERAL

The term apportionment, as used here, refers to the process of distributing allowable cost among various groups of HMO/CMP patients. This chapter sets forth instructions for apportionment of the total allowable direct and indirect cost of the HMO/CMP among Medicare beneficiaries enrolled in the HMO/CMP, other enrollees, and any nonenrolled patients. Certain costs incurred by HMO/CMPs for the purpose of meeting special Medicare program requirements are separately identified, and paid in full by Medicare. These are discussed in §§4311ff.

4401. OBJECTIVES OF APPORTIONMENT

The objectives of the apportionment process are to assure that:

- Costs of covered care to Medicare enrollees will not be borne by non-Medicare enrollees and nonenrolled patients of the HMO/CMP; and
- Costs of services to non-Medicare enrollees and nonenrolled patients will not be borne by Medicare enrollees.

4402. HMO/CMP SERVICES FURNISHED NONENROLLED MEDICARE PATIENTS

You may furnish services to Medicare beneficiaries who are not enrolled in your HMO/CMP's prepayment plan. Since your contract with HCFA is limited to Medicare beneficiaries actually enrolled in the HMO/CMP, the cost apportionment process distinguishes between Medicare enrollees of the HMO/CMP and nonenrolled Medicare patients. For services furnished Medicare patients not enrolled in the HMO/CMP, Medicare payment is made through your Part A intermediary or Part B carrier, outside the scope of your contract with HCFA.

4403. APPORTIONMENT OF PROVIDER SERVICES

A provider of services (e.g., a hospital, skilled nursing facility (SNF), home health agency, comprehensive outpatient rehabilitation center, etc.) which furnishes services to your enrollees is subject to the same principles of reimbursement under Medicare as are providers which do not have HMO/CMP involvement. Consequently, except for specific instructions in this chapter regarding apportionment of provider costs, the rules in the Provider Reimbursement Manual apply.

4404. PROVIDER SERVICES FURNISHED DIRECTLY BY HMOs/CMPs

When a provider owned or operated by you, or related to you by common ownership or control (referred to here as an "HMO/CMP provider"), furnishes services directly to your enrollees, it is subject to the same cost finding and apportionment requirements or the prospective payment system applicable to other providers under Medicare. These are set forth in chapters 23 and 28 of the Provider Reimbursement Manual, Part I. An approved method of cost finding described in that manual must be used to determine the actual cost of covered services furnished directly by you during the reporting period.

The essential difference between HMO/CMP and non-HMO/CMP (i.e., unrelated) providers is that an HMO/CMP provider will, in effect, have two separate reimbursement settlements with the Medicare program, one for Medicare patients who are not enrolled in the HMO/CMP and one for Medicare beneficiaries who are HMO/CMP enrollees.
4405. PROVIDER SERVICES FURNISHED BY HMOs/CMPs THROUGH ARRANGEMENTS

Costs of covered services you furnish to Medicare enrollees through arrangements with non-HMO/CMP providers will, in most cases, be the amount you pay the provider under your financial arrangement, to the extent it is found reasonable subject to the rules in chapters 2 and 3. The apportionment process used to determine the reasonable cost of, or prospective payment for provider services furnished to your Medicare enrollees must be on the same basis that is used by the provider in determining the reasonable cost of or prospective payment for, provider services furnished to Medicare beneficiaries who are not HMO/CMP enrollees, subject to the rules set forth in §§4300, 4301, and 4302. However, if the special nature or terms of your financial arrangement with the provider would result in the Medicare program bearing the costs of delivering care to individuals other than Medicare enrollees of the HMO/CMP, the apportionment must be on some other appropriate basis approved by HCFA intended to assure that the share allocated to the Medicare program does not include costs of delivering care to non-Medicare enrollees.

When you elect to have hospital or SNF providers seek reimbursement directly from their Part A intermediary for covered services furnished your Medicare enrollees, the share to be borne by HCFA is the amount that the intermediary pays the provider. This will be determined on the same approved basis otherwise used by the hospital or SNF provider in apportioning Medicare's share of allowable costs or the Medicare prospective payment for covered services furnished Medicare beneficiaries who are not your enrollees.

4406. APPORTIONMENT OF PHYSICIAN AND OTHER PART B SERVICES

The following sections set forth the requirements for apportionment of the allowable costs of physician services and other Part B services. For HMOs/CMPs with existing cost contracts, the apportionment rules contained in §§4407, 4408, 4408.1, and 4408.2 shall apply only for contract periods beginning before January 1, 1986. For contract periods beginning on or after January 1, 1986, for existing cost contract HMOs/CMPs, and for all other HMOs/CMPs entering into new cost contracts, the apportionment rules in §4409 shall apply. In general, such medical services are furnished through the HMO/CMP's medical services facility or through arrangements with a medical group or individual practice association (IPA).

4407. APPORTIONMENT OF MEDICAL SERVICES FURNISHED DIRECTLY BY HMOs/CMPs WITH EXISTING COST CONTRACTS, CONTRACT PERIODS BEGINNING BEFORE 1/1/86

Medical services furnished directly by you are those covered physician services and other Part B nonprovider services which you furnished through physicians and other health care personnel who are your employees or partners or by a physician group, health center, or other facility which is related to you by common ownership or control. The allowable direct and indirect costs of such medical services are apportioned to Medicare using a service ratio that is commensurate with the costs being apportioned. The cost of services furnished to your Medicare enrollees is determined by the ratio of covered services furnished to your Medicare enrollees to the total services furnished all patients. The statistics used to apportion costs between your Medicare enrollees and your other patients must be based on the services furnished. You may use billable procedures, relative value units, charges or other methods.
HCFA will base its approval of an alternate method on a finding that:

- The method will result in an accurate and equitable allocation of allowable costs; and
- The method is justifiable by the HMO/CMP from an administrative and cost efficiency standpoint.

Any method chosen must be used consistently and result in an equitable apportionment of costs.

4408. APPORTIONMENT OF MEDICAL SERVICES FURNISHED UNDER ARRANGEMENTS - HMOs/CMPs WITH EXISTING COST CONTRACTS, CONTRACT PERIODS BEGINNING BEFORE 1/1/86

The cost of covered physicians' services and other Part B services furnished under arrangements is an allowable cost. The method of apportionment of such costs between Medicare enrollees and other patients depends upon your financial arrangements with the physician, physician group, or supplier which furnishes the services.

4408.1 Payment On Non Fee-for-Service Basis - HMOs/CMPs With Existing Cost Contracts, Contract Periods Beginning Before 1/1/86.--If you pay a physician, physician group, or supplier for services on a capitation, fixed-sum, or some basis other than fee-for-service, the share of the allowable cost applicable to your Medicare enrollees is determined on the basis of the ratio of the covered services furnished to your Medicare enrollees to the total services furnished all enrollees and other patients covered by the payment, to the extent it is reasonable. (See §4407 for acceptable methods to accumulate service statistics.) An acceptable relative value system, operating as intended by the author of the system, may be used in the apportionment process. However, if you wish to weight the apportionment of services to reflect the time differential (see §4412), you will be required to submit cost and statistical information in the same detail required for services furnished directly by the HMO/CMP. In situations in which this method of apportionment results in the Medicare program bearing the cost of care to individuals who are not beneficiaries, apportionment must be on some other basis approved by HCFA. (See §§4407 and 4418 concerning approval of alternative apportionment methodologies.) (See §4305.1 for special rules that could limit the amount of apportioned costs allowed for payment.)

4408.2 Payment On Fee-for-Service Basis - HMOs/CMPs With Existing Cost Contracts, Contract Periods Beginning Before 1/1/86.--If you pay a physician, physician group, or supplier for services on a fee-for-service basis, the Medicare share of the allowable cost is determined by multiplying the total amount of payment for all such services by the ratio of charges for covered services furnished to your Medicare enrollees to the total charges for all such services. See §4305.2 for rules that could limit the amount of apportioned costs allowed for payment.
4409. APPORTIONMENT OF MEDICAL SERVICES FURNISHED DIRECTLY AND UNDER ARRANGEMENTS - CONTRACT PERIODS BEGINNING ON OR AFTER 1/1/86 FOR HMOs/CMPs WITH EXISTING COST CONTRACTS; NEW HMOs/CMPs

The apportionment rules contained in this section shall apply to HMO/CMPs with existing cost contracts for contract periods beginning on or after January 1, 1986, and to all other HMO/CMPs entering into new cost contracts.

4409.1 Services Furnished Directly.--The total allowable cost of Part B physician and supplier services (see §4304) furnished directly shall be apportioned to Medicare on the basis of the ratio of covered Part B services furnished to Medicare enrollees to total services furnished to all the organizations' enrollees and nonenrolled patients.

The organization must use a method for reporting costs and statistics that is approved by HCFA. HCFA will base its approval on a finding that the method:

- Results in an accurate and equitable allocation of allowable costs; and
- Is justifiable from an administrative and cost efficiency standpoint.

For example, if you elect to use a relative value system to apportion costs, you must use the entire system as described by the designer of the system and obtain our approval before implementation.

4409.2 Services Furnished Under Arrangements.--The Part B physician and supplier services you furnish under an arrangement are grouped into two categories for apportionment purposes. The basis you use to pay for a service determines which category the service is grouped. The two categories are:

- Services furnished under an arrangement that provides for you to pay for the service on a fee-for-service basis; and
- Services furnished under an arrangement that provides for you to pay for the service on some basis other than fee-for-service.

If the arrangement provides for the HMO/CMP to pay for these services on a fee-for-service basis, the total cost for the services furnished under such arrangement shall be apportioned between Medicare enrollees and others based on the ratio of charges for covered services furnished to Medicare enrollees to total charges for services furnished to all enrollees and nonenrolled patients. (See payment limitations contained in §§4306.1 and 4306.2.) If apportionment on this basis would result in Medicare bearing the cost of furnishing services to individuals who are not Medicare enrollees, the Medicare share must be determined on another basis (approved by HCFA) to insure that Medicare pays only for services furnished to Medicare enrollees.

If the arrangement provides for the HMO/CMP to pay for these services on some basis other than fee-for-service, the reasonable cost you pay, under the financial arrangement for the services furnished, shall be apportioned between Medicare enrollees and others based on the ratio of covered services furnished to Medicare enrollees to total services furnished to all enrollees and
nonenrolled patients. (See §4409.1.) If apportionment on this basis would result in Medicare bearing the cost of furnishing services to individuals who are not Medicare enrollees, the Medicare share must be determined on another basis (approved by HCFA) to insure that Medicare pays only for services furnished to Medicare enrollees.

4410. EMERGENCY AND URGENTLY NEEDED PROVIDER SERVICES, AND OUT OF AREA PROVIDER SERVICES FOR WHICH HMO/CMP ASSUMES FINANCIAL RESPONSIBILITY

A Medicare intermediary may pay its providers for the reasonable cost of covered emergency or urgently needed services and other covered out of area services for which you assume financial responsibility and which are furnished to your Medicare enrollees.

Alternatively, you may reimburse a provider for these services, in which case payment will be made to you through the cost reporting mechanism. However, payment to you for such services is allowable only to the extent that it does not exceed the reasonable cost for the service or Medicare's prospective payment for the service, as defined in 42 CFR, Parts 405, 412, and 413.

EXCEPTION: Payment in excess of the amount allowed under 42 CFR, Parts 405, 412, and 413 may be made if you demonstrate to HCFA's satisfaction that the excess payment is justified on the basis of advantages gained by you. (See §§4300-4302.)

4411. EMERGENCY AND URGENTLY NEEDED MEDICAL SERVICES AND OTHER COVERED MEDICAL SERVICES FOR WHICH HMO/CMP ASSUMES FINANCIAL RESPONSIBILITY

Payments for services to nonplan physicians and suppliers for purchased services, such as emergency or urgently needed care outside the plan or unusual specialty services not available within the plan, are apportioned to Medicare enrollees in accordance with the principles set forth in §4409. In most cases, this will limit HCFA's payment to you to what the area carrier would have paid for the service.

For contract periods beginning prior to January 1, 1986, costs are apportioned between Medicare enrollees and other patients on the basis described in §§4408.1 and 4408.2. However, if you pay for such services on a fee-for-service basis, payment of an amount greater than the reasonable charge is permissible with the approval of HCFA under the following circumstances:

- The physician or other supplier furnishes services to your enrollees on an infrequent basis;
- The charges for such services represent less than 5 percent of your total cost of medical services; and
- Such charges do not exceed the amounts charged by such physicians or other suppliers to other patients for similar services.

In such cases, the amount apportioned to Medicare would equal the amount paid by you for covered services rendered to your Medicare enrollees, to the extent this amount is reasonable.
4412. WEIGHTING PHYSICIAN AND OTHER SERVICES

For contract periods beginning before January 1, 1986, an existing cost basis HMO/CMP may adjust (weight) the statistics it uses to compute the apportionment of the costs of the direct professional covered Part B services of physicians and other health care personnel.

As used here, the term "weighting" refers to a process of adjustment of the statistics used to apportion the cost of compensation of physicians and other health care personnel for direct professional services. The adjustment may be made to account for variations in time and complexity of services which are not otherwise reflected in the apportionment statistics. For example, if aged patients require more time consuming or more complex services than nonaged patients, and the costs of compensation of physicians and other health care personnel are apportioned on the basis of an unweighted count of services, the apportionment of these costs will not reflect the higher cost of services of physicians and other health care personnel applicable to aged patients.

4413. CONDITIONS FOR WEIGHTING OF SERVICES

The HMO/CMP may weight the statistics used to apportion the costs of the direct professional services of physicians and other health care personnel. The weighting system used by the HMO/CMP must be approved by HCFA in advance. HCFA will approve weighting if:

- The weighting is based on statistics or adequate data acceptable to HCFA;
- The services furnished Medicare enrollees of the HMO/CMP are weighted on the same basis as services furnished other enrollees and nonmember patients in computing apportionment ratios;
- The HMO/CMP uses only one weighting method at a time;
- The weighting is applied only to services furnished to Medicare enrollees in which there is a face-to-face contact between the enrollee and the health care personnel, and services are furnished in an ambulatory health care setting that is not a provider (e.g., a medical center or clinic);
- Apportionment is on the basis of services, as described in §§4407 and 4408 of this chapter; and
- The limitation set forth in chapter 4 concerning the allowable cost of physician services under arrangements applies.

4414. WEIGHTING PROCEDURE

The only cost subject to weighting is the allowable compensation paid physicians and other health care personnel (including salaries, wages, incentive payments, fringe benefits and payroll taxes) for direct patient care services. Direct patient care services mean services that involve face-to-face contact between patients and health care personnel.

To assure that no other costs are weighted, the HMO/CMP must, after distribution of allowable expenses, apportion the costs on the basis of unweighted statistics. It may then calculate the difference in the
apportionment of the costs of compensation of physicians and other health care personnel between weighted and unweighted statistics. This difference is then added to the apportionment cost of furnishing covered medical and other health services to Medicare enrollees. The HMO/CMP may not weight the apportionment of costs related to equipment, medical records, supplies, and other costs not related to the compensation for the direct professional services of physicians and other health care personnel. In addition, costs already apportioned by relative value units or some other apportionment method in which time or complexity is reflected in the apportionment statistics may not be weighted.

4415. LIMITATION ON WEIGHTING FACTOR PAYMENT FOR SERVICES FURNISHED UNDER ARRANGEMENT

If payment is on a fee-for-service basis, time and complexity will be recognized subject to applicable Medicare reasonable charge payment limitations, but only to the extent that they are specific and reasonable elements of the amount that the HMO/CMP has agreed to pay for the services.

4416. APPORTIONMENT OF ADMINISTRATIVE AND GENERAL COSTS NOT DIRECTLY ASSOCIATED WITH PROVIDING MEDICAL CARE

Enrollment and marketing costs (as defined in §4307), membership costs (as defined in §4309), as well as other administrative and general costs of the HMO/CMP plan that benefit the total enrolled population of the HMO/CMP which are not directly associated with providing medical care are apportioned on the basis of a ratio of Medicare enrollment to total HMO/CMP enrollment. Examples of such costs are:

- Directors' salaries and fees;
- Executive and staff administrative salaries;
- Organizational costs; and
- Other costs of plan administration.

4417. ALLOCATION AND DISTRIBUTION OF OTHER ADMINISTRATIVE AND GENERAL COSTS

Administrative and general costs other than those described in §4416 which bear a significant relationship to the services rendered are not apportioned to Medicare directly. Instead, these costs are allocated or distributed to the components of the HMO/CMP which, in turn, are then apportioned to Medicare in accordance with the rules contained in this chapter. The allocation or distribution process occurs in two steps:

- The total allowable costs of a separate entity or department that performs administrative services (e.g., centralized purchasing, accounting, data processing) that can be quantitatively measured, should be allocated or distributed to each component of the HMO/CMP in reasonable proportion to the benefits received by that component.

- Those remaining service related administrative costs that cannot otherwise be distributed or allocated in reasonable proportion to the benefits received by the components must be allocated to the components on the basis of a ratio of total incurred and distributed cost of the component to total incurred and distributed cost to all components.
4418. ALTERNATE ALLOCATION AND APPORTIONMENT METHODS

A method of apportionment or basis for allocation of costs other than the methods prescribed in this chapter may be used provided the desired change results in a more accurate and equitable apportionment or allocation of costs and is justifiable from an administrative cost standpoint. An HMO/CMP that desires to use an alternative method of apportionment or basis for allocation of costs must submit its request to HCFA in writing at least 90 days prior to the beginning of the period in which the different method or basis of allocation is to be used. The HMO/CMP's request would state the specific change it desires and explain how this will result in a more accurate and equitable apportionment or allocation.

HCFA's approval of a request to change methods will be given the HMO/CMP in writing and is binding as of the date approved. Once approval is given, the HMO/CMP is bound to this method for the cost reporting period to which the request applies and all subsequent periods, unless HCFA approves a subsequent request to change methods.
PART 5
CHAPTER 1

HCFA PAYMENT PROCESS

Section

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5000. GENERAL

Both health maintenance organizations (HMOs) and competitive medical plans (CMPs) are public or private entities which enter into agreements with the Secretary of DHHS under §1876 of the Act to provide health services on a prepayment basis to enrolled members. Section 1876, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, provides two methods of payment for services furnished to Medicare enrollees of HMO/CMPs: cost reimbursement and payment on a risk basis. This part sets forth the rules HCFA follows in determining the amount you will receive for Medicare enrollees who are enrolled on a risk basis.

In general, you are paid each month, in advance, a per capita rate for each enrolled Medicare beneficiary. The total amount of advance monthly payment is determined by totaling the individual payment amounts for all Medicare enrollees, with some adjustments. (See §5002.) There are no retroactive adjustments other than adjustments due to errors in enrollment estimates. (See §5004.)

In addition to providing covered services to enrolled beneficiaries under a risk contract with HCFA, you may furnish services to Medicare beneficiaries who are not enrolled in your prepayment plan. Since payment to an HMO/CMP under §1876 of the Act is limited to Medicare enrollees of the HMO/CMP, services furnished to nonenrolled Medicare patients are outside the scope of the HMO/CMP's contract with the Secretary. Medicare payment for services furnished to nonenrolled beneficiaries may be made through a fee-for-service intermediary or carrier in accordance with the usual Medicare payment process.

5002. RISK PAYMENT

Your payments are based on the adjusted average per capita cost (AAPCC). (See §5100.) In general, you receive a monthly per capita payment, in advance, for each beneficiary who is registered in HCFA's records as a Medicare enrollee of your organization. (See Part 6, Chapter 1.) In order to determine the appropriate payment amount, enrolled beneficiaries are first grouped into various demographic classes by actuarial factors such as age, sex, Medicare entitlement status, Medicaid status, disability status, institutional status, and other relevant factors that HCFA determines have a significant effect on the use and cost of health services. The annual rate of payment for each enrollee is equal to 95% of the AAPCC for the demographic class to which that enrollee is assigned.

The AAPCC applicable to a demographic class is a prospective estimate of the average per capita amount that would be payable by Medicare in the contract year for a group of similarly classified Medicare eligibles in a geographic area if services were to be furnished by other than an HMO/CMP in the same or a similar geographic area. Thus, the AAPCC is a prospective estimate of Medicare cost levels by demographic category in the fee-for-service (i.e., nonprepayment) sector of the geographic area.

The AAPCC is computed by HCFA only on a calendar year basis. Therefore, new per capita rates of payment for each class of Medicare enrollees will be effective on January 1 of each year and will be printed and available to you by September 7th of the preceding year. Your initial contract with HCFA must be for at least a 12-month period and may be for a period of up to 23 months. Subsequent contract periods must be 12 months. The initial contract, i.e. one
starting on a day other than January 1, or any noncalendar year contract, can be terminated by mutual consent on December 31st to put the contract on a calendar year basis. If so, you will be required to renew your risk contract at the beginning of the next calendar year when the new AAPCC rates go into effect. Payment will be made by HCFA to HMO/CMPs with various contract terms as follows:

A. Calendar Year Contracts.--If you have a calendar year contract, you will be paid based on the per capita rates of payment in effect on January 1 of the calendar year. These payment rates will remain in effect for all months in the contract period.

B. Noncalendar Year Contracts.--If you have a noncalendar year contract, you will be paid based on the rates in effect each month. The ACR should reflect any expected changes in the AAPCCs that will take effect each January of your contract period.

5003. ADDITIONS OR REDUCTIONS TO PAYMENT

The actual monthly payment made by HCFA to a risk basis HMO/CMP on behalf of enrolled Medicare members is also affected by other additions or reductions to payments due to:

A. Errors in estimating the number of Medicare enrollees in each class for purposes of determining the amount of advance payment;

B. Your election to return to HCFA any excess amount between the adjusted community rate (ACR) and the average payment rate (APR) (see §5005);

C. An election by an individual Medicare enrollee to receive Medicare hospice services from a Medicare participating hospice (see §5006); and

D. Your electing to have monies withheld in or withdrawn from a benefit stabilization fund. (See §5007.)

5004. ANNUAL RECONCILIATION

HCFA's payments to an HMO/CMP are subject to an enrollment reconciliation at least annually. HCFA will conduct this reconciliation in conjunction with the benefit stabilization fund reconciliation (see §5007) as necessary to assure that the payments made do not exceed or amount to less than the appropriate per capita rate of payment for each Medicare enrollee during the contract period. You must submit any information or reports required by HCFA to conduct the reconciliation.

5005. REQUESTED REDUCTION OF PAYMENTS

If you request a reduction in your monthly payment in lieu of providing certain additional benefits (see Part 5, Chapter 3), HCFA will reduce the amount of payment by the amount to be returned as determined by the adjusted community rate-setting process. (See Part 5, Chapter 3.) If HCFA approves the request, the election to receive reduced payments shall be binding for the entire contract period. Such adjustment in payments will be made equally to each monthly per capita payment made during the contract period.
5006. EXCEPTION FOR HOSPICE CARE SERVICES

An enrollee may make an election to receive Medicare hospice services from a Medicare participating hospice. No payment is made to the HMO/CMP on behalf of a Medicare enrollee who has elected hospice care under 42 CFR 418.24 except for the portion of the payment applicable to the additional benefits described in §5201. The payment suspension is effective the first day of the month following the month of the enrollee’s election to receive hospice care. If the hospice care benefit is revoked or exhausted and the enrollee has not disenrolled, payment to you will resume the first day of the following month.

During the time the enrollee's hospice election is in effect, you may bill HCFA on a fee-for-service basis (subject to the usual Medicare rules of payment) only for the following covered services:

A. Services of the enrollee's attending physician if the physician is your employee or contractor and is not employed by, or under contract to, the enrollee's hospice;

B. Services not related to the treatment of the terminal condition for which hospice care was elected or a condition related to the terminal condition; and

C. Any covered Medicare services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again.

Medicare payment for hospice care services furnished to your Medicare enrollees through a Medicare participating hospice is made directly to the hospice in accordance with the payment procedures set forth in 42 CFR 418ff.

5007. BENEFIT STABILIZATION FUND WITHHOLDS/WITHDRAWALS

If you are required to provide your Medicare enrollees with additional benefits as described in §5200, you may request that HCFA withhold a part of your monthly per capita payment in a benefit stabilization fund (BSF). The BSF is used to prevent fluctuation in the provision of those additional benefits in subsequent contract periods. In addition, if the conditions outlined in §5209.4 are met, you may make withdrawals from the BSF.

Your monthly per capita payment will be reduced/increased by the amount of BSF withholding/withdrawal in equal amounts for all such per capita payments made during the contract period.

5009. ELECTRONIC TRANSFER OF FUNDS

HCFA, in conjunction with the Department of Treasury, has increased the use of electronic funds transfers. Payments are electronically sent to the plan through the automatic clearinghouse (ACH).

The ACH provides on-line access to the Federal Reserve Communications System (FRCS) enabling payments to be made to financial institutions that have access to the FRCS. Payments can also be made to financial institutions that do not have access to the FRCS through correspondent financial institutions or Federal Reserve Banks.
The ACH payment method will eliminate mail and processing time associated with payment by check. Instead of waiting for a large check payment to arrive in the mail, the plan will receive a payment, through its financial institution, on the actual payment due date. This is a more secure and reliable method of making and receiving payment. In addition, the plan can still receive information about the invoice(s) being paid, as each ACH payment message will contain invoice information and the account number at the financial institution.

If you desire to have payment made by ACH, you must provide certain payment information. If this method of payment is chosen, HCFA will not forward any payment without using ACH. Therefore, it is imperative that you provide accurate payment information at the time a contract is signed, and that you update the information as necessary.

The information needed in order to effect an electronic transfer of funds should be available through your company's treasurer or financial institution. The following is a sample of the types of information that may be needed.

- Name of the HMO/CMP.
- Address of the HMO/CMP.
- Contact person.
- Phone number.
- Name of financial institution.
- Address of financial institution.
- Financial institution's 9-digit ABA identifying number for routing transfer of funds if your financial institution has access to the Federal Reserve Communications System.
- Telegraphic abbreviation of financial institution.
- Account number at your financial institution to be credited with the funds.
- Name of the correspondent financial institution your financial institution receives electronic funds transfer messages through if it does not have access to the Federal Reserve Communications System.
- Address of correspondent financial institution.
- Correspondent financial institution's 9-digit ABA identifying number for routing transfer of funds.
- Telegraphic abbreviation of correspondent financial institution.

5010. PLAN PAYMENT REPORT

Each month HCFA mails a plan payment report which explains how the monthly interim payment is computed. See Part 6 for a detailed description of the plan payment report.
PART 5
CHAPTER 2
PAYMENT RATES UNDER RISK CONTRACTS

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The Medicare program will pay monthly per capita payments in advance to an eligible organization with a risk contract for each Medicare eligible individual enrolled with the organization under the risk contract. In order to determine the appropriate payments, each enrollee will be assigned to a demographic class based on age, sex, Medicare entitlement status, institutionalization, and Medicaid status. The annual rate of the payment for each enrollee will then be set at 95 percent of the adjusted average per capita cost (AAPCC) for the demographic class to which that enrollee is assigned. This chapter discusses the methodology HCFA uses to determine the AAPCCs.

The AAPCC applicable to a demographic class is a prospective estimate of the average per capita amount that would be payable by Medicare in the contract year for a group of similarly classified Medicare eligibles in a geographic area if services were furnished by other than an eligible organization in the same or a similar geographic area. Thus, the AAPCC is a prospective estimate of Medicare cost levels, by demographic category, in the fee-for-service (i.e., other than through organizations with contracts under §1876 of the Act) sector of the geographic area.

A set of AAPCC values is calculated at the county level for all Medicare insured except those having end stage renal disease (ESRD), in which case the calculation is performed at the State level because of the relatively small size of this segment of the population. The calculation of AAPCC values that are applicable to a future calendar year is developed in four basic steps:

A. Medicare national average calendar year per capita costs are projected for the future year under consideration;

B. Geographic adjustment factors that reflect the historical relationships between the county's and the nation's per capita costs are used to convert the national average per capita costs to the county level;

C. Expected Medicare per capita costs for the county are adjusted (by removing both reimbursement and enrollment attributable to Medicare beneficiaries in eligible organizations under contract with HCFA) to a fee-for-service basis; and

D. The fee-for-service Medicare cost per capita is disaggregated into its demographically defined component parts to produce a set of county AAPCC values.

These steps are discussed in greater detail below.

The national average per capita costs to the Medicare program are projected for the future calendar year under consideration. These numbers are known as the United States per capita costs (USPCCs) and are estimated average incurred benefit costs per Medicare enrollee, loaded for carrier and intermediary expenses.

For each of Part A (hospital insurance) and Part B (supplementary medical insurance), the USPCCs are developed separately for the aged, the disabled, and those beneficiaries having end stage renal disease (ESRD). The estimates that
are used as the basis for the USPCCs are the most recent Medicare cost estimates prepared for the President's budget submission cycle by actuaries of HCFA. These estimates are adjusted, if necessary, for the effects of any legislation passed or regulations implemented between the time of the budget submission and the announcement of the AAPCC rates.

Carrier and intermediary expense loadings are calculated separately for Part A and Part B as the ratio of cash administrative expenses to cash benefits. The administrative expense amounts are obtained from HCFA reports. The cash benefit amounts are obtained from reports of the U.S. Treasury's Division of Financial Management.

Monthly USPCCs are calculated for the future calendar year as:

\[
\frac{1}{12} \times \left( \frac{\text{annual incurred benefit outlays}}{\text{projected enrollment}} \right) \times (1.0 + \text{loading factor})
\]

when

\[
\text{loading factor} = \frac{\text{(cash administrative expenses)}}{\text{(cash benefit outlays)}}
\]

5102. STEP 2: ADJUSTMENTS TO COUNTY LEVEL

After the USPCCs have been determined, national costs to the Medicare program are adjusted to a county level. For each of Parts A and B, the historical relationship between the county per capita cost and the national per capita cost is established separately for the aged, the disabled, and the ESRD beneficiaries and is used to make the adjustment. These per capita costs are developed from the entire Medicare enrollment and the aggregate amount of claims paid for each of five years. No sample population is involved.

In addition to the adjustment for historical cost relationship between each county and the nation as a whole, the USPCCs can also be adjusted to account for differences between the actual historical relationship and the expected future relationship (in the contract year) between county and national costs. For example, since the implementation of the prospective payment system (PPS) in fiscal year 1984, the payment provisions for hospitals have been changing. Before fiscal year 1984, hospitals were paid the cost of providing care, but under PPS, hospitals are paid a pre-determined rate. Thus, the payment provisions differ between the five-year historical period and the contract year for which AAPCC rates are being determined.

Consequently, an adjustment based solely on a historical cost relationship is not sufficient to estimate the contract year cost relationship between the county and the nation. Since the AAPCC should be the best estimate of fee-for-service reimbursements in any particular county in the contract year, another adjustment is made for changes in the hospital payment provisions. PPS provisions are applied only under Part A, so the Part B USPCC is not affected by this additional adjustment.

Calculations of county and national per capita costs are based on payment and enrollment data tabulated in Medicare's statistical system along with payment data provided by HCFA. The payment data provided by HCFA represents payments excluded from Medicare's statistical system that were made to health care prepayment plans (HCPPs) and HMOs/CMPs dealing directly with HCFA.
Claims data is extrapolated and tabulated by the county of the beneficiary's residence as well as by coverage (Part A or Part B) and Medicare eligibility status (aged, disabled, or ESRD). A vast majority of the HCFA payment data is aggregated as well. However, because some prepaid health plans are unable to provide detailed data (i.e. county of residence), some HCFA payment data is available only by coverage and by the prepaid plan to which it was paid. Consequently, an approximation method is used to allocate these payments in the same manner in which the statistical system claims data is aggregated. Allocations are performed separately for each plan. The allocation is based on the number of enrollees residing in each county and the relative cost of providing services in each county. Once all the payments made by HCFA are determined for each county, they are added to the statistical system's payment amount. This results in the total payment for the county.

Next, the PPS adjustment is calculated by modeling hospital payments in the contract year and in each of the five historical years using the same hospital admissions. The next step requires that the modeled payments are aggregated for each county. The PPS adjustment factor for each county and each historical year is computed by dividing the modeled contract year payments by the modeled historical year payments. The adjustment factors are applied to the portion of the Part A payment attributable to hospital payments under PPS.

When the Part A payment has been adjusted for PPS, county per capita costs for each of the five most recent available years are then calculated as follows:

\[
\text{statistical system payment + HFCA payment} \\
\text{statistical system enrollment}
\]

National per capita costs for each of the five years involved are similarly calculated using payment and enrollment data applicable to the entire nation.

If CPCC\_i and NPCC\_i respectively represent the county and national per capita costs in year i, then the geographic index for year i is:

\[
GA_i = \frac{\text{CPCC}_i}{\text{NPCC}_i}
\]

The adjustment factor to be applied to the prospective USPCC is the average of the geographic adjustments for the five years. This factor is known as the average geographic adjustment (AGA), and is derived as follows:

\[
\text{AGA} = \frac{(GA_1 + GA_2 + GA_3 + GA_4 + GA_5)}{5}
\]

Application of this factor to the contract year USPCC is used to adjust the projected national per capita cost, derived in Step 1, to the county level:

\[
\text{Projected County Per Capita Cost} = \text{AGA} \times \text{USPCC}
\]

For that portion of the population having end stage renal disease, the relationship between the State per capita cost and the national per capita cost is used to make the geographic adjustment. State data rather than county data are used because of the relatively small size of this segment of the population.
5103. STEP 3: ADJUSTMENTS FOR PREPAYMENT PLAN COSTS

At this point, six per capita cost figures have been calculated for the county. For each of Parts A and B, there is a separate cost for each of the aged, disabled, and renal disease populations. These costs are averages for the entire county (or State for the renal disease beneficiaries) and therefore include the payment and enrollment totals of prepaid health plans. The third step is to remove, from the county (or State) per capita cost, the incurred cost and enrollment of any eligible organization that serves the county and is under contract with HCFA. This is accomplished by subtracting the combined total of the organization's incurred costs and enrollments from the entire county's (or State's) Medicare cost and enrollment. The per capita cost is then recalculated.

5104. STEP 4: DEMOGRAPHIC ADJUSTMENTS

In the final step, the recalculated county per capita cost is converted into rates that vary according to certain demographic variables: age, sex, Medicaid status, and institutional status. For purposes of this methodology, an institutionalized individual is a Medicare beneficiary who has been a resident for at least 30 days of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital, or domiciliary home. A Medicaid individual is a Medicare beneficiary who has been determined by the Medicaid agency of the State in which he or she resides to be eligible for Medicaid. For each of the aged and disabled, there are thirty cells for each of Parts A and B, corresponding to different combinations of these variables. (See Tables 1 and 2.)

The factor shown in each cell is the ratio of the cost for a Medicare beneficiary having that particular demographic cell characteristic to the average per capita cost. These relative cost factors are referred to as demographic factors. The relative effects of age and sex on the demographic factors are updated annually based on the same Medicare cost experience used to develop base year costs. An adjustment for the institutional and Medicaid populations is made using the last three years (1974-1976) of the current Medicare survey, incorporating approximately 20,000 Medicare beneficiary years of observations.

Through the use of these demographic factors, the county per capita cost is converted into rates. (A methodology for this step is shown in §5105.) However, no demographic adjustment is made to the State per capita cost for those beneficiaries having end stage renal disease.

For the county, there will be thirty rates for each of Parts A and B, for the aged and disabled populations separately. For each Medicare eligible enrolled under the risk contract, Medicare will pay the organization 95 percent of the rate corresponding to the demographic class to which the beneficiary is assigned.
5105. CONVERSION OF COUNTY PER CAPITA COSTS INTO RATES

The AAPCC methodology adjusts for age, sex, Medicaid status, and institutional status of the Medicare beneficiaries in a given county. It does not apply to those beneficiaries suffering from end stage renal disease. Tables 1 and 2 show the demographic cells used in this adjustment. The adjustment process hinges on the demographic factors (DFi for each demographic cell i) developed from the current Medicare survey. Each factor relates the Medicare cost for a person in that demographic cell to the cost for the average Medicare beneficiary. Because of rounding and shifts in the demographic distribution of the Medicare population, it is possible that the average demographic factor for the entire Medicare population would not be exactly 1.00, although it should be close to that value. Demographic distributions for a given county could lead to an average demographic factor other than 1.00. This problem of county demographic variations is addressed by adjusting the county fee-for-service per capita costs (PCCfs) to the theoretical level, K, that would result if the county demographic distribution were such as to give an average demographic factor of 1.00.

\[
K = \frac{\left( f_{s1}P_{s1} + f_{s2}P_{s2} + \ldots + f_{s30}P_{s30} \right)}{\left( f_{s1}P_{s1}^{\ast DF_{s1}} + f_{s2}P_{s2}^{\ast DF_{s2}} + \ldots + f_{s30}P_{s30}^{\ast DF_{s30}} \right)}
\]

This calculation (and, in fact, the entire AAPCC calculation) must be done separately for each of aged Part A, aged Part B, disabled Part A, and disabled Part B beneficiaries. Demographic adjustments are not made for Medicare beneficiaries with end stage renal disease (ESRD) because demographics do not have a significant effect on the cost for people having this condition. After the county fee-for-service per capita cost has been standardized for demographic variables, yielding a value for K as defined above, it is possible to estimate the amount that those in a given demographic cell would have cost Medicare had they not been enrolled in a prepaid health plan, simply by multiplying K by DFi for each cell i. This procedure allows 95 percent of the AAPCC to be presented as a set of rates, \( R_i = .95 \times K \times DFi \), varying according to the demographic cells shown in Tables 1 and 2. These tables are examples and do not contain the actual figures used in a real contract. HCFA provides the actual tables used at least once a year.
5106. EXAMPLE OF AAPCC METHODOLOGY

The following example illustrates how an HMO's rate cell is calculated once the AAPCC is aggregated to the county level. The example is for Part A - aged group only, but the procedure for other groups follows accordingly. The county data provided below is illustrative and does not represent actual data.

**Step 1 - Calculation of Non-HMO Per Capita Costa (PCC)**

For county X:

1. Non-HMO enrollment: $9,500
2. HMO enrollment: $500
3. Aggregate enrollment: $10,000
4. Aggregate county PCC: $161.36
5. Total projected HMO reimbursement in the county: $25,264
6. Aggregate county reimbursement: $1,613,600
7. Non-HMO reimbursement [(6)-(5)]: $1,588,336
8. Non-HMO PCC [(7)/(1)]: $167.19

**Step 2 - Normalization of Non-HMO PCC (Adjusting for Average County Demographic Factor)**

10. Normalization factor*: .9837
11. Normalized Non-HMO PCC: $164.47

*The normalization factor is the weighted average demographic factor for the county.

The rates for any cell can now be calculated.

**EXAMPLE:**

Institutionalized Male Age 70
Demographic factor = 2.40
Rate = 2.40 x $164.47 = $394.72

Noninstitutionalized Non-Medicaid Female Age 72
Demographic factor = .70
Rate = .70 x 164.47 = $115.13

The above AAPCC rates would then be multiplied by .95 in order to get the final rates since the Medicare program will reimburse 95% of the AAPCC.
5107. TABLES OF DEMOGRAPHIC COST FACTORS

**Table 1 - Demographic Cost Factors for the Aged.**

<table>
<thead>
<tr>
<th>SEX AND NONINSTITUTIONALIZED</th>
<th>INSTITUTIONALIZED</th>
<th>MEDICAID</th>
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</thead>
<tbody>
<tr>
<td>AGE GROUP</td>
<td>PART A - HOSPITAL INSURANCE</td>
<td>MEDICAID</td>
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<tr>
<td>NON-MEDICAID</td>
<td></td>
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</table>

| | Male: | Female: |
| | MEDICAID | NON-MEDICAID | MEDICAID | NON-MEDICAID | MEDICAID | NON-MEDICAID |
| | 65-69 | 70-74 | 75-79 | 80-84 | 85 & Over | 65-69 | 70-74 | 75-79 | 80-84 | 85 & Over |
| | 1.90 | 2.40 | 2.40 | 2.40 | 2.40 | 1.55 | 2.00 | 2.00 | 2.00 | 2.00 |
| | | | | | | | | | | |
| | 1.25 | 1.70 | 2.05 | 2.35 | 2.50 | .85 | 1.40 | 1.65 | 2.00 | 2.00 |
| | | | | | | | | | | |
| | .70 | .90 | 1.10 | 1.20 | 1.30 | .55 | .80 | .90 | 1.15 | 1.15 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

**PART B - SUPPLEMENTARY MEDICAL INSURANCE**

| | Male: | Female: |
| | MEDICAID | NON-MEDICAID | MEDICAID | NON-MEDICAID | MEDICAID | NON-MEDICAID |
| | 65-69 | 70-74 | 75-79 | 80-84 | 85 & Over | 65-69 | 70-74 | 75-79 | 80-84 | 85 & Over |
| | 1.60 | 1.85 | 1.90 | 1.90 | 1.90 | 1.50 | 1.65 | 1.70 | 1.70 | 1.70 |
| | | | | | | | | | | |
| | 1.10 | 1.40 | 1.65 | 1.65 | 1.65 | 1.05 | 1.25 | 1.25 | 1.25 | 1.25 |
| | | | | | | | | | | |
| | .75 | 1.00 | 1.15 | 1.15 | 1.15 | .70 | 1.00 | 1.00 | 1.00 | 1.00 |
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5200. VALUE OF ADDITIONAL AND SUPPLEMENTAL BENEFITS DETERMINATION, BASIS, AND SCOPE

This chapter describes the rate setting process by which you and HCFA determine the value of basic benefits covered by Medicare, additional benefits, and supplemental benefits to be provided if you contract with Medicare on a risk basis. For payments made by HCFA, this process determines whether you will retain the full amount of payments based on the AAPCC, take a reduced payment, or be required to provide additional benefits. The value of additional benefits that you may have to furnish your Medicare enrollees depends on the amount by which your adjusted community rate (ACR) is less than the average payment rate (APR) you estimate you will receive from Medicare. In addition, the Act and 42 CFR 417.452 limit the amount you can charge Medicare beneficiaries for supplemental benefits to your ACR for these services. The chapter is based on 42 CFR 417.590-417.597.

As described earlier in §2101ff., if, prior to the start of your contract period, it is determined that your ACR for furnishing Medicare covered services to your Medicare enrollees is less than your APR for the contract period, you must:

- Provide non-Medicare covered benefits to your Medicare enrollees;
- Reduce the enrollee's membership premium or other charges for Medicare covered services;
- Contribute to a benefit stabilization fund;
- Accept reduced per capita payments from Medicare; or
- Use a combination of any of these options.

This determination is made through an ACR rate setting process under which you calculate your premiums for your Medicare enrollees for Medicare covered services and supplemental benefits. Medicare enrollees who are covered under Part A and Part B are separately identified from those who are covered under Part B only. The additional benefits (including any reduced member premiums or reduced cost sharing) or payment reductions (or combination of both) must be equal in value to the difference between the ACR and the APR (hereafter referred to as savings). However, HCFA may, at your request, withhold a part of the savings in a benefit stabilization fund to be used for stabilizing additional benefits in future contract periods. The major calculations in this process involve your APR, which is calculated on a per capita basis, and your ACR. Subsequent sections of this chapter:

- Define the ACR and describe how ACR calculations are made;
- Explain your obligation to furnish information and supporting documentation;
- Explain the benefit stabilization fund; and
- Outline HCFA's rate setting review authority.
5200.1 Definitions.--

A. APCC (Adjusted Average Per Capita Cost).--This is an actuarial estimate made by HCFA in advance of your contract period that represents what the average per capita cost to the Medicare program would be for each class of Medicare enrollees, if they had received covered services other than through you or another eligible organization in the same geographic area.

B. APR (Average Payment Rate).--This is the per capita weighted average of Medicare payment rates projected by a risk organization. It is based on rates obtained from the payment ratebook (i.e. 95 percent of AAPCC) multiplied by your anticipated enrollment distribution and divided by total Medicare member months to obtain a per capita monthly average payment rate.

C. ACR (Adjusted Community Rate).--This is the equivalent of the premium that you would have charged to Medicare enrollees independently of Medicare payments for Medicare covered services using as a basis the same rates you charge to your non-Medicare enrollees and adjusting for Medicare enrollees' utilization.

D. Base Rate.--This is the first step in calculating the ACR. It is the premium derived from either the community rating system (projected budget) or from the weighted average of aggregate premiums to non-Medicare enrollees (using an aggregate premium method approved by HCFA). It must be broken down into the respective components of the ACR. All benefits offered to non-Medicare members are included in the base rate. The base rate is a gross amount, equal to the member's monthly premium, plus all copayments.

E. Initial Rate.--This is the premium that you would charge to your commercial (non-Medicare enrollees), if commercial plans were limited to Medicare coverage. It is obtained from the sum of the base rate and the adjustments for coverage and third party liability.

F. Additional Benefits.--These are Health care benefits not covered by Medicare, or premium reductions for Medicare covered services, funded entirely out of savings.

NOTE: Medicare beneficiaries are not charged for services constituting additional benefits. No copayments are permitted, except to the extent that HCFA permits you to impose a charge for mandatory supplemental benefits. For example, the entire savings amount may be used to finance a noncovered service for which your required revenue exceeds the value of savings. The remaining cost of the noncovered service may be financed through a mandatory premium amount, copayment or other beneficiary charge(s).

G. Optional Supplemental Benefits.--These are noncovered services provided to Medicare enrollees which are paid for directly by Medicare enrollees (usually in the form of premiums). These services and premiums apply at the option of the Medicare enrollee.

H. Mandatory Supplemental Benefits.--These are noncovered services provided to Medicare enrollees which are paid for directly by Medicare enrollees (usually in the form of premiums). These services are imposed on all Medicare beneficiaries enrolled under your risk contract without regard to health status.
I. BSF (Benefit Stabilization Fund).--This is a fund established by HCFA at your request to withhold a portion of the per capita payments available to you for payment in subsequent contract periods for the purpose of stabilizing fluctuations in the availability of additional benefits you provide to your Medicare enrollees.

J. Savings.--This is the difference between your APR and your ACR if the APR is larger than the ACR.

K. Loss.--For Medicare ACR purposes, this is the amount by which the ACR exceeds the APR. Losses are not passed through to the Medicare enrollees. A loss does not necessarily represent a financial statement loss, since the ACR may not represent the actual cost of providing Medicare benefits during the course of the contract year.

L. Basic Benefit Package.--This is the minimum benefit package a Medicare beneficiary must purchase in order to enroll in your organization. At a minimum, the package must incorporate all benefits covered by Medicare. (Note that unlike cost contracting HMOs/CMPs, if you are a risk HMO/CMP, you are not required to have a benefit package that includes only Medicare covered services.)

5200.2 ACRP Submission Deadlines.--Adjusted community rate proposals (ACRP) are required by regulations to be submitted 45 days prior to the beginning of your contract period. However, it is in your interest to submit your ACRP as soon as possible, preferably by November 1 for a calendar year contract. For example, in order to implement new benefits by January 1, 1992, beneficiaries must be notified of the new package by December 1, 1991, in order to comply with the 30 day notification rule. (See 42 CFR 417.436(c).) In the event there is a delay and the ACRP is not approved by December 1, you must notify members in writing by December 1 of the proposed benefits and premiums and inform your members that the proposed charges and benefits are subject to HCFA's approval. HCFA must approve the letter in advance. If the proposed premiums and/or benefits change, members must be notified of those changes.

Each new contract requires a separate ACRP. No contract can be renewed without an approved ACRP. However, service area expansions made during a contract period do not require the submission of a new ACRP. The ACRP for the next contract period will include the expansion area.

5200.3 Basis for ACRP.--You are required to submit an ACRP on an annual basis prior to the beginning of the contract period. The demographic factors and published AAPCC payment rates applicable to the ACR year are used to calculate the average payment rate in the ACRP and are based on a calendar year (CY). The same payment rates and demographic factors will be used in the ACRP for risk contracts that are not on a calendar year basis.

5200.4 Need for Coordination With States.--Some organizations operate in States which also require prior approval of benefit packages. HCFA gives priority to the review of these ACR proposals. Highlight in your cover letter to HCFA that the State requires prior approval. Work with the State early in the process to avoid unnecessary delays in having a package approved.

5200.5 Automated ACRP Process.--In order to expedite the preparation and review of the ACRP, HCFA uses an automated ACRP package. You should contact the auditor in HCFA charged with reviewing your ACRP for further details. The use of the automated package is highly recommended. This automated version of the ACRP does not negate the need for submission of hard copy support documentation.
**5200.6 Coinsurance and Deductible.**—When you are furnished the
AAPCC rate tables on September 7 of each year, you will also be
notified of the HCFA actuaries’ projection of coinsurance and
deductible equivalents for the upcoming calendar year.

**5200.7 Mid-Contract Service Area Expansions.**—Certification of
service area expansions made during a contract period do not
require the submission of a new ACRP. The ACRP for the next
contract period will include the expansion area.

**5200.8 Benefit Stabilization Fund (BSF).**—As an organization with
a risk-based contract, you may elect to have a portion of the value
of required additional benefits withheld by HCFA and reserved in
the Medicare trust funds (see §5209) to prevent future fluctuations
in additional benefits and premiums. Requests for contributions to
and withdrawals from a BSF in subsequent contract years must be
made by you at least 45 days prior to the start of the contract
period and included as part of the ACR proposal. After HCFA has
approved the establishment of a BSF, contributions to it consist of
withholdings from your monthly Medicare per capita payment. These
withholdings come from the savings that you would otherwise have to
use to finance additional benefits when your APR exceeds your ACR.
Requests for withdrawals from a BSF are made at the same time that
you submit your ACRP. If HCFA approves the request, the money is
withdrawn from the BSF for use during the subsequent contract
period. (See §5209.)

**5200.9 Group Retiree Benefit and Premium Packages.**—Group retirees
are Medicare beneficiaries who are enrolled under your risk
contract as individuals, but whose former employer (or union or
other association) pays for all or some premiums and benefits.
Many of these group retirees receive coverage of extra (non-
Medicare covered) benefits through their former employer or union.

You are required to offer to all individual and group members
enrolled under your Medicare risk plan at least the minimum benefit
package which is set forth in the approved ACRP. For example, if
the ACR benefit package contains all Medicare covered services plus
yearly eye exams, eye glasses, and physicals, then the package sold
to the employer group accounts must include at least all of these
benefits.

The contractual relationship you have with an employer or union is
separate from the relationship with HCFA. It is this contract
which allows you to negotiate to offer benefits to group retirees
which are beyond the minimum package approved in the ACRP.

The premium charged to group retirees (for the same benefits
package offered to individual Medicare beneficiaries) cannot be
higher than the premium individual Medicare enrollees are charged.
However the following apply to group retirees:

- A group retiree may pay less than an individual enrollee of
  the plan if his/her group pays a portion of the premium. However,
  the sum of both premiums can not exceed the premium individual
  Medicare enrollees are charged; and

- A group retiree may have a higher or different premium if
  his/her group contracts with you to provide additional services
  which are not part of the ACRP.
For example, a group retiree's premium may be higher to cover the cost of prescription drugs, which are not part of the ACRP, but are offered under contract between you and the group.

Special rules apply to group members who are Medicare beneficiaries and are still working and their spouses. (See §§4326 and 4327.)

5200.10 Flexible Benefit Packages.--Under certain circumstances, HCFA permits you to offer flexible benefit packages consisting of different premiums and/or additional benefits offered only to Medicare enrollees in certain categories. The basic rule is that all members must receive at least the level of benefits described in the ACRP. You may choose to reduce the ACRP approved premiums or offer additional benefits not included in the ACRP to some enrollees of your plan.

The only type of flexible benefit package permitted involves charging a lower premium or offering benefits in addition to the benefits approved in the ACR proposal in one or more counties. In the example in the next paragraph, all members receive the ACRP approved benefits as required. The extra or flexible benefits are limited to members who live in a certain county. This allows you to be more competitive in that county. For further discussion of this concept, see §2110.

The difference between a flexible benefit package and a high option package is that flexible benefits are offered to a subset of your membership, and high option packages include optional supplemental benefits for which you charge a premium and which must be made available to any enrollee. For example, flexible benefit packages may be offered only to members in a certain county, but high option packages must be offered to all members of a plan. You charge a premium to the member for a high option package, but you may not charge members for flexible benefit packages.

HCFA must approve the specific flexible benefit proposals before the ACRP submission. You must submit your proposal to your plan manager, in writing, no later than September 20. HCFA will not be able to process your ACRP without this approval. Therefore, all ACR proposals with a flexible benefit package must contain a copy of this approval. Your plan manager will approve any flexible benefit proposal in concept (for purposes of proceeding with the ACR review).

5200.11 Coordination of Benefits.--Coordination of Benefits (COB) is the method of determining the order in which two or more payers will cover medical services provided to an enrolled member. Section 1862(b) of the Act makes Medicare the secondary payer for the following services:

- Services covered by workers' compensation (see §4322);
- Services covered by group health plans in the case of end stage renal disease (ESRD) beneficiaries during a period of up to 18 months (see §4323);
- Services covered by automobile, no-fault or any liability insurance (see §§4324 and 4325);
- Services covered by group health plans of employers with 20 or more employees (see §4326); and
Services to disabled Medicare beneficiaries who are active individuals and are covered by large group health plans of employers of 100 or more. (See §4327.) The term active individual means a self-employed person such as the employer, an individual associated with the employer in a business relationship, or a member of the family or any of these persons such as a spouse, parent, or child.

See §§4321 - 4327ff for more complete instructions regarding the circumstances in which Medicare is the secondary payer.

Prepaid health plans that contract with HCFA to provide covered services to Medicare beneficiaries must adhere to these COB provisions to determine what amount, if any, may be collected from the Medicare enrollee and the primary payer. Regardless of whether you are billing the primary payer, HCFA will treat these services as though Medicare is secondary.

Under 42 CFR 417.528, you may collect primary payments from other insurers and responsible entities or from a beneficiary that has been reimbursed by such an entity. When Medicare is the secondary payer, you should coordinate payments from another payer with the benefits provided under the Medicare contract. The ACRP must be adjusted to remove these services in the ACR regardless of your coordination efforts.

5200.12 Computation of Potential Losses.--During its review of the ACRP, HCFA determines if you will incur a potential loss. A potential loss occurs if the plan either waives all or part of its Medicare monthly premium (in addition to reductions representing additional benefits as described in §5200) and/or computes an ACR which is higher than the APR shown on the ACRP worksheet. If you incur a potential loss using the above criteria, submit a written explanation in your ACRP package indicating how you plan to remain solvent during the contract period without endangering either your Medicare enrollees, HCFA, or your plan. Use your prior year's actual experience, current financial status, and all financial projections for the current year to support your position. Have an officer of your organization sign and date the statement.

5200.13 Support Data Requirements.--In order for the ACRP to be approved by HCFA in a timely manner, it is not only necessary that an ACRP be filed as early as possible, but the submitted package must be in a format acceptable to HCFA and contain backup data to support all figures and computations. It is not unusual for the reviewer of an ACRP to request additional information or clarification of submitted data. The approval of an ACRP is delayed each time HCFA requests additional documentation. In an attempt to avoid unnecessary delays and speed up the review process, follow the guidelines listed below when preparing the ACRP.

All adjustments you make must be accompanied by adequate supporting data. If you do not have sufficient enrollment experience to develop data, you may, during the initial contract period, use documented statistics from a nationally recognized statistical source.

Each renewing health organization uses its own cost and utilization data as a basis for preparing the ACRP. In those cases in which you have either a small Medicare enrollment or limited Medicare experience, HCFA has created a data base based on the experience of other risk contractors. It is in your best interest to use your own data. However, if you do not have your own data, HCFA's data base can be used. Any requests to use the data base must be made in writing to HCFA prior to the submission of the ACRP.
In order to use any data other than actual experience, you must demonstrate why your data is inadequate. Approval of your request is not automatic. Risk organizations renewing their contracts are not allowed to use published data and studies to compute their ACRPs.

Use both volume and complexity factors in the computation of the ACR. Provide explanations and documentation showing the source of the figures used and how they were computed for each Medicare service category, even when the factor is one. Provide supporting data. Also, compare the volume and complexity factors shown in last year's ACRP and those shown in the most recently submitted package. Explain any factor that increases or decreases by one half (.5) of a factor point.

Support each adjustment to a base rate premium with statistics. Provide supporting documentation for all adjustments made to the commercial rate.

5200.14 General Information.--Observe the following guidelines to assure timely review:

- Clearly show and fully explain in the ACRP all copayments listed in a Medicare benefit package;
- List reinsurance under the category Administrative and General;
- In the ACRP, use service categories similar to those set forth in the regulations (see 42 CFR 417.594(b)(3));
- From year to year, consistently group medical services included in specific categories;
- Provide the number of projected hospital inpatient days per 1,000 enrollees for both Medicare and non-Medicare enrollees;
- Your identification number (Medicare contract number) must be noted in the cover letter and all subsequent correspondence sent to HCFA; and
- Submit ACRPs containing changes in benefit packages and premium rates to HCFA for approval in sufficient time to allow you to provide your enrollees with at least 30 days notice of the changes. Because of tight time constraints, you are allowed to market packages prior to approval, provided you indicate in the marketing material that the stated benefits and premiums are subject to HCFA approval.

5200.15 Specific Information.--HCFA will provide you with a format on a PC disk to assist you in submitting your ACRP. Each HMO/CMP completes the two data forms appearing on the one PC disk. These forms specify exactly what benefit package(s) are offered under the Medicare contract. This allows HCFA to determine more accurately and efficiently whether marketing materials include all required benefits from the approved ACR. Instructions for completing these forms can be found in Exhibit II.

The premiums approved in the ACRP for Medicare members apply for the entire contract period and cannot be increased for any reason. Any reduction in premiums offered as an incentive to retain or increase Medicare enrollment or resulting from reduced operating expenses must be offered without any change in the benefit package(s). If a reduced premium is offered to new members, it
must also be provided to existing Medicare enrollees in the form of a comparable reduction in premium. Once the premium is reduced at any point in the contract year, it must remain at that level (or a lower level) for the remainder of the contract year.

Your ACRP submission to HCFA must include a certification by your chief executive officer. An example is shown in Exhibit I.

5201. REPORT ON VALUE OF ADDITIONAL AND SUPPLEMENTAL BENEFITS

A. General.--At least 45 days prior to the start of your contract period, you must furnish HCFA with a report which describes, for your contract period, the following:

- Your proposed ACR;
- Your APR;
- Your proposed premium and other beneficiary liability amounts for Medicare covered services; and
- Any supplemental benefits you propose to provide your Medicare enrollees as described in §2101ff, under which the enrollees must pay premiums or copayments.

If your proposed ACR is less than your APR, the report must show that you will:

1. Provide additional benefits (reduce premiums or other charges for Medicare covered services or provide noncovered benefits) to your Medicare enrollees who are entitled to such benefits under §2105 or §2106 (hereafter referred to as Medicare enrollees) which are equal in value to your savings;

2. Accept a reduction in your monthly per capita payment rates which is equal in value to the savings;

3. Accept a combination of both items 1 and 2 which is equal in value to the savings;

4. Request HCFA to withhold a portion of the value of additional benefits in a benefit stabilization fund. (See §5209.)

B. Additional Benefits: Content.--If you choose either option 1 or 3 above (see §5201A), you must provide HCFA with the following:

1. A description of the additional benefits (see §5300.2) you have elected to provide your Medicare enrollees and include, if you have an approved benefit stabilization fund, any contributions to the fund (see §5209); and

2. Supporting evidence to demonstrate that the selected additional benefits are at least equal in value to the savings (taking into account reductions in payment, if appropriate).

C. Supplemental Benefits.--Sections 2101ff describe various ways in which a Medicare enrollee may receive supplemental benefits. If you offer supplemental benefits, the charges you make for the services may not exceed your ACR for the services. Therefore, if you plan to provide supplemental
services during the contract year, you must so indicate to HCFA in
the report described in this section. You must also provide the
appropriate calculations and supporting documentation to show that
your charges will not exceed the ACR for the services.

You may add coverage of non-Medicare covered benefits during the
course of the contract year if you do not charge for the benefits
or if you provide such services with a copayment or coinsurance. If
there is a charge associated with the services, you must
demonstrate to HCFA that the charge does not exceed the adjusted
community rate (or HCFA approved aggregate premium rate) for the
services. You may not increase your premium mid-year to charge for
added benefits.

D. Supporting Documentation.--The report must include adequate
supporting data, including copies of premium reports submitted to
other Federal and State agencies, such as State rate review
offices, and the Office of Personnel Management (OPM). As part of
HCFA's review of the assumptions and calculations in the report,
HCFA may require you to furnish additional information if the
information you supplied initially is inadequate in scope or
content. (See §5203.1.)

E. Part A and B Enrollees and Part B Only Enrollees.--There are
some differences in the ACR for Medicare enrollees who have
different Medicare entitlement benefits, as follows:

1. Since Medicare enrollees who are entitled to both Part A
   and Part B services have a different Medicare benefit package (and
   payment rate from HCFA) than Medicare enrollees who are entitled to
   Part B services only, an organization's APR, ACR, additional
   benefits, and supplemental benefits must be identified separately
   for each of these two groups of enrollees. This does not preclude
   you from using the same Part B data for each group.

2. Your savings for Medicare enrollees who are entitled to
   Part A and Part B benefits is the net sum of the differences
   between your APR and ACR for Part A services and your APR and ACR
   for Part B services. (See line 25 of Page 2 in the example in
   §5207.) For example, if the savings for Part A services is $20 and
   the loss for Part B services is $5, your savings is $15 ($20 less
   $5 equals $15). In this example, there are no savings for Part B
   only enrollees.

3. If you choose, you can waive some or all of the premiums
developed through the ACRP. Each waiver is treated as a waiver of
   a specific benefit premium. Therefore, waivers must be
   consistently applied to all Medicare enrollees receiving the
   benefit. Waived premiums can not be reinstated at any time during
   a contract period. In addition, if you choose to waive premiums
during a contract period, the waiver must remain in effect for the
   rest of the contract period.

F. Limitation of Part B Only Premiums for Part A.--42 CFR
417.452(e) provides that, if you furnish coverage of Medicare Part
A services to a Medicare enrollee entitled to Part B only, your
premium (or other payment method) for these services may not exceed
the ACR for these services. In addition, Medicare regulations
place a limit on the premium a risk organization is allowed to
charge if it furnishes these services, plus supplemental services
which are the same as the additional benefits furnished Medicare
enrollees entitled to both Parts A and B. The combined premium for
both of these groups
of services that the Part B enrollees must pay may not exceed 95 percent of the weighted AAPCC for Part A services (or the Medicare premium for Part A services, if it is less) for your Medicare enrollees. In the example in §5207, page 3, line 35C, the adjustment to the B only premium consists of converting the following mandatory supplemental benefits and reduction of premium to an additional benefit.

The computation of the adjustment to B only premium is illustrated below.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive - Immunizations</td>
<td>$ 0.20</td>
</tr>
<tr>
<td>Preventive - Health Education</td>
<td>$ 0.25</td>
</tr>
<tr>
<td>Eye Care</td>
<td>$ 4.62</td>
</tr>
<tr>
<td>Administration</td>
<td>$ 0.90</td>
</tr>
<tr>
<td>Reduction in Premium</td>
<td>$12.42</td>
</tr>
</tbody>
</table>

**TOTAL (Sums of Items 1-5): Adjustment to B Only Premium $18.39**

G. HCFA Review and Approval.--HCFA will review your report and determine whether to approve it. HCFA may:

1. Approve the report, as proposed;
2. Approve the report, subject to your making specified modifications, or providing HCFA with specified additional information;
3. Determine, based on the information supplied by, you that the proposed figures in the report (e.g., ACR, APR) are incorrect and accept the report after correcting your errors; or
4. Return the report for resubmittal.

If you are dissatisfied with HCFA's determination on the report and it results in either less Medicare payment to you or a decrease in Medicare enrollees' premiums, you may appeal the decision, as specified in Chapter 5, Part 2.

H. Confidentiality of Report.--HCFA takes the position that information in an HMO's/CMP’s report is exempted from mandatory disclosure to the public under the Freedom of Information Act by 5 U.S.C. 552 (b)(4). However, you should separate the report from other submissions to HCFA and clearly identify it as confidential. Within HCFA, access to this information will be limited to those who have a responsibility for review and evaluation of the data.

5202. ESTIMATED AVERAGE OF PER CAPITA PAYMENT RATES

As indicated in §5002, by September 7, HCFA furnishes you monthly per capita rates of payment in a rate table format. Using your anticipated enrollment, distributed by ratebook class, and the payment rates in the ratebook, you must compute a weighted average of the monthly per capita rates of payment you expect to receive from Medicare during the contract period (average payment rate or APR).
5202.1 Example of Computation of APR.--The following is an example of an APR calculation for an organization with a Medicare contract covering only one county.

### Calculation of Average Payment Rate
(Part A and Part B Enrollees)

<table>
<thead>
<tr>
<th>Anticipated Enrollment</th>
<th>Monthly Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratebook Class</td>
<td>(Per Member Per Month)</td>
</tr>
<tr>
<td>(Column 1)</td>
<td>(Column 2)</td>
</tr>
<tr>
<td>(Col. 2 x Col.3)</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>50</td>
</tr>
<tr>
<td>B</td>
<td>73</td>
</tr>
<tr>
<td>C</td>
<td>60</td>
</tr>
<tr>
<td>D</td>
<td>85</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

Per Capita APR: $50,888 = $189.88

5202.2 Computation of APR for Noncalendar Year Contract Periods.--You may elect to have an initial contract period which is not on a calendar year basis. However, since HCFA's payment to you is based on a calendar year ratebook, you must estimate any changes in this ratebook that will take effect in each January of your contract period in computing your APR.

5203. ADJUSTED COMMUNITY RATE (ACR) - METHODOLOGY AND OVERVIEW

This section is based on 42 CFR 417.592 and 417.594, which require you to submit to HCFA, prior to the start of your contract period, your adjusted community rate (ACR) for the contract period. The purpose of the ACR is to estimate your revenue requirements on a per capita basis for furnishing Medicare covered services to your Medicare enrollees (less their deductible and coinsurance liabilities) during the contract period. In general, the computation of your ACR consists of four major steps that are described in detail in §§5204 through 5208. They occur in a sequential order as follows:

A. Constructing a base rate from your revenue requirements that is consistent with the premiums you charge your non-Medicare enrollees and allocating it into approved capitation rate components;

B. Constructing an initial rate by adjusting the base rate to reflect Medicare covered services;

C. Factoring the initial rate for differences in utilization between non-Medicare enrollees' and Medicare enrollees' utilization, using approved and documented factors; and

D. Subtracting applicable Medicare deductibles and coinsurance and recoveries from coordination of benefits when Medicare is the secondary payer.
The calculation of your ACR must begin by using data and assumptions of revenue requirements that are internally consistent with the premium calculations you use in your non-Medicare business. For example, this would mean you could include in your ACR a revenue requirement for a contingency reserve fund that protects you against the risk of adverse selection or overutilization on the part of all your enrollees if you demonstrate that the premiums for your non-Medicare enrollees included this element. However, this element could not be included in the ACR if the fund applied only to Medicare enrollees.

5203.1 Burden of Proof.--The burden of identifying and proving the basis of the community rate and the adjustments for the ACR fall to each organization and will depend upon a fact finding process that is based on the individual organization's circumstances, utilization experience, private business, and expenses. No standardized formula applies and, thus, proof of the validity of an ACR depends upon you using reliable, consistent, accurate, and authentic records and furnishing HCFA with adequate supporting documentation. The order of priority in accepting proof on adjustments for the volume and intensity of services will first require data from your experience (i.e., utilization data from the hospitals, physicians, and other health service entities that you use). If, in your first contract year, you are unable, after a good faith effort, to obtain such data, you may use published cost and utilization data from other sources pertaining to the following areas:

A. Your service area;

B. Your State or, if the rest of the State is not typical of the area you serve, another area which you document as having similar Medicare service utilization and costs experience; and

C. The United States as a whole.

5204. ACR METHODOLOGY - INITIAL RATE CALCULATION

The initial rate (actually shown as a set of initial rates for each component) is what your per member per month (PM/PM) revenue requirements would be for providing medical services to your general enrolled membership (i.e., non-Medicare enrollees) if their benefit package was the same as the Medicare covered services benefit package. Although the actual premium rates you charge your non-Medicare enrollee subscribers may vary from the initial rate (because of differences in such things as benefit packages, family composition, and enrollment periods), the assumptions, cost data, revenue requirements, and any other elements you use in your calculations must be consistent with the calculations you use for the premiums you charge your non-Medicare enrollees.

The process of constructing the initial rate consists of a series of steps in which an organization's total budgeted expenses for non-Medicare enrollees for the contract period are converted by capitation rate components into base rates representing projected revenue requirements per component on a PM/PM basis. These base rates are then subject to certain adjustments, as necessary, to make them consistent with the benefit package for which Medicare is making capitation payments to the organization. They now represent PM/PM revenue requirements upon which utilization differences between your non-Medicare enrollment and your Medicare enrollment are applied, as appropriate. In the aggregate, the rates for these components represent the premium you would charge a non-Medicare enrollee for the Medicare covered service benefit package for the Medicare contract period.
5204.1 Base Rate Calculation.--The base rate is the average premium rate that you charge to your non-Medicare enrollees. This rate must be shown in terms of the components of the ACR, but may be calculated either by:

- A community rating process; or
- The weighted average of aggregate premiums charged to non-Medicare enrollees.

A. Community Rating Method.--Community rating is a method of establishing premiums for health insurance based on the average cost of actual or anticipated health care used by all subscribers and does not vary for different groups or subgroups of subscribers. Medicare requires that rates are to be established on a per person basis, since eligibility in Medicare is individually determined and Medicare payment is based on individual enrollment. Accordingly, the per member per month (PM/PM) rates must be uniform for all groups, excluding Medicare enrollees, and must reflect the revenue requirements (future budget) of your organization (exclusive of revenues needed to pay for Medicare enrollees) divided by the total number of non-Medicare member months for the budget year. Below is a formula which shows how the community rating process works:

1. Calculate the total actual budget for your organization and deduct expenses and items attributable to Medicare enrollees.

2. Adjust the total actual budget by any rate changes pending with the State insurance commission or OPM which reflect adjustments to premiums to create the projected budget (which may include inflation adjustments only).

3. Divide the (adjusted) projected budget by the total number of member months projected for enrollment during the contract period (excluding Medicare enrollment).

These steps must be followed for each component of the base rate. You must justify the use of components that differ from the requirements in this section.

When the components of the base rate are completed, the base rate calculation must still be determined reasonable. First, the components must be determined to be in proportion to the actual cost experience of your organization. (For example, if hospital services made up 17 percent of the total costs of the previous year, it may not exceed 17 percent in the base rate unless adequate supporting documentation is provided.)

Second, if you charge premiums to your non-Medicare population, you must multiply the premium rate charged to non-Medicare enrollees for each premium and each group you enroll by the enrollee months for each group. Add all the non-Medicare premiums received and divide by the total number of non-Medicare member months to show the corresponding weighted aggregate average premium. If the weighted aggregate average premium is less than the aggregate base rate premium calculated by the community rating system, then you must provide adequate supporting documentation for the difference. Otherwise, the weighted aggregate average premium will act as a test of reasonableness for the base rate.
B. Weighted Average Aggregate Premium.--An alternative to the community rating system for calculating the base rate is to calculate the weighted average of the aggregate premiums to be charged to the public. This methodology requires you to add the premiums to be charged to each individual non-Medicare enrollee using each of the premiums you use for non-Medicare enrollees and divide by the total number of the member months of the plans in which premiums are charged. The resulting total average premium is the total base rate premium to be used in the ACR computation. The average aggregate premium may be adjusted for inflation only if the most recently approved premiums reflect an increase for inflation not reflected in all premiums charged to the non-Medicare enrollees.

Once the total average aggregate premium per member month is obtained, it must be allocated to the components of the ACR. The allocation must be based upon the actual cost experience in charging premiums to the public. Thus, if your cost experience allocates 17% to inpatient hospital services, then 17% of the base rate premium must be set aside for inpatient hospital services. You must document your prior fiscal experience in justifying the allocation of the base rate to the components of the ACR.

C. Base Rate Calculation.--Below are the minimum steps and supporting documents that must be used to construct your base rates.

<table>
<thead>
<tr>
<th>Step</th>
<th>Minimum Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. After deducting revenue expected from nonenrollee and from sources unrelated to revenue collected for medical care, show your total revenue requirements on a per member per month (PM/PM) basis for providing medical services to non-Medicare enrollees. Care must be taken to eliminate all revenue required to service Medicare members. Allocate this figure into the accounting categories you use in maintaining your business records and submitting financial reports to State and Federal authorities.</td>
<td>Include a copy of most recent certified financial statement required to be filed with State and Federal authorities. Provide worksheets to support allocation.</td>
</tr>
<tr>
<td>2. Show a composite premium by calculating the average of non-Medicare premiums to be collected, including all non-Medicare copayments, weighted by the enrollment in each group. Give the reasons if this figure is not the same as the PM/PM revenue requirement in step 1.</td>
<td></td>
</tr>
</tbody>
</table>
3. Reduce composite premium by the revenue you require to be set aside for the general and administrative component. Compute this amount using the same methodology that was used to develop the composite premium in step 2.

4. Allocate the composite premium in step 3 into capitation rate components which include, at a minimum, the following:

   (1) Inpatient hospital
   (2) Skilled nursing
   (3) Home health
   (4) Physicians
   (5) Outpatient (o.p.) hospital
   (6) O.p. x-ray
   (7) O.p. lab
   (8) Out-of-plan emergency services
   (9) Ambulance
   (10) Other Medicare (e.g. physical therapy)
   (11) Non-Medicare
   (12) Working aged
   (13) Other coordinated benefits

5204.2 Initial Rate Calculation.--The initial rate is what your PM/PM revenue requirements would be for providing medical services to your general enrolled membership (i.e., non-Medicare enrollees) if their benefit package was the same as the Medicare covered services benefit package. It is calculated by adding to, or subtracting from, the base rate, as appropriate, to take account of differences in your revenue requirements between the benefit package you offer your non-Medicare enrollees and the covered services that Medicare normally pays. In doing so, you must explain how the value of these benefits were calculated. Examples include services you furnish your non-Medicare enrollees which are not covered by Medicare and collections for covered Medicare services where Medicare is not the primary payer.

A. Initial Rate Calculation Steps.--Below is a summary of the types of adjustments that you must make to the base rate in order to calculate the initial rate. Adjust the base rates calculated under §5204.1, as appropriate, to take into account the following:
1. Subtract, if included in the base rate, revenue to make up losses experienced by your organization under Medicare contracts prior to the one this ACR is being calculated for.

2. Subtract Medicare non-covered type services using a percentage of the base rate.

3. Add Medicare covered services you do not cover (e.g., durable medical equipment).

4. Anticipated revenue from health insurance payers for covered Medicare services where Medicare is not the primary payer, as described in §1862(b) of the Act which include the following:
   a. Working aged, working disabled, and employer end stage renal disease coverage;
   b. Workers' compensation;
   c. Automobile or liability insurance; and
   d. No fault insurance.

B. Example of Adjustment for Inpatient Hospital Services in Initial Rate Calculation.—If you cover 365 days of inpatient hospital services for non-Medicare enrollees, an adjustment will need to be made between the base rate and the initial rate to reduce the inpatient hospital base rate component. Below is a hypothetical example of how to calculate this adjustment:

1. Identify non-Medicare inpatient days in excess of Medicare coverage limits on the basis of days per 1,000 non-Medicare enrollees. 16

2. Identify the total number of non-Medicare inpatient days per 1000 non-Medicare enrollees. 454

3. Compute ratio of line 1 to line 2. \[ \frac{16}{454} = 0.0352 \]


5. Adjustment: Multiply line 3 by line 4. \[ 26.92 \times 0.0352 = 0.95 \]
5204.3 Coordinated Benefits.--Since Medicare may not pay for Medicare covered services where Medicare is not the primary payer (see 42 CFR 417.528), the base and initial rates must be adjusted to remove the rates for these services, as specified below.

A. All rates for service, except those for the working aged, including disabled individuals for whom Medicare is not the primary payer (see 42 CFR 405.340-405.344), must be shown in the base rate. After this amount is carried over to the initial rate, subject to appropriate adjustments, you must make a utilization adjustment by the amount you could have collected per average non-Medicare enrollee if it is different from the amount you expect to collect per average Medicare enrollee. This adjustment may result in an increase or a decrease in the initial rate, as appropriate.

B. Amounts that you could collect for the working aged must be shown as an adjustment to the base rate on a separate line from the amounts in subsection A. After this amount is carried to the initial rate, there is no utilization adjustment since this revenue requirement is unique to Medicare.

5204.4 Example of Adjustment for Working Aged.--Using actual statistics from your records, follow the example provided to compute the adjustment for working Medicare:

1. Projected enrolled working Medicare member months: 75
2. Projected enrolled Medicare member months eligible for Part A: 7500
3. Ratio of step 1 to step 2: 75/7500 = 0.0100
4. ACR from line 14 of the example in §5207: $354.86
5. Adjustment = Ratio X ACR (.010 X $354.86) = 3.55

5204.5 Alternate Method of Calculating Base and Initial Rates.--You may use a different method of calculating your base and initial rates, including using variations of the methods shown above in §§5204 through §5204.2. However, you must demonstrate to HCFA's satisfaction that the method (or variations) results in a set of components of the initial rate that accurately reflect your revenue requirements for furnishing the Medicare covered services benefit package to your non-Medicare enrollees and is consistent with the calculations you use for the premiums you charge your non-Medicare enrollees.

5205. ACR METHODOLOGY - UTILIZATION FACTOR

A. General.--The third major step that you must perform in calculating your ACR consists of factoring components of your initial rates in order to reflect the utilization characteristics of your Medicare enrollees. The purpose of this factoring is to arrive at a figure that as accurately as possible and to the extent permitted under the law, reflects your revenue requirements for furnishing Medicare covered services to your Medicare enrollees. The types of allowable factors are described below. Since these factors reflect the relative difference between Medicare and non-Medicare enrollee utilization, the resulting calculation is multiplied by the initial rate in order to obtain the final components of the ACR.
B. Utilization Factoring Criteria.--Each utilization factor to the initial rate of a service must be accompanied by adequate supporting documentation. In addition, the following rules apply:

1. The factor must not duplicate another utilization factor of the same initial rate components;

2. The factor must be described clearly and be justified. For instance, you must show the source of the data and describe the factor in detail, including the assumptions underlying the calculation, show the period for which the data was determined, and give the size of the Medicare and non-Medicare enrollee population. It must also state why the factor is the most appropriate factor available to you;

3. The factor must have, as its basis, your own experience in furnishing services to Medicare beneficiaries, except as permitted under §5205.4; and

4. The adjustment may not use Medicare's prospective payment system for inpatient hospital services as a basis for factoring unless you use this system to pay for inpatient hospital services for your non-Medicare enrollees and it is shown in the base rates for inpatient hospital services. Otherwise, such an adjustment would artificially elevate your ACR in a manner that is not related to your own purchasing arrangements for hospital services.

C. Allowable Utilization Factors.--The final utilization factor consists of a volume factor and an intensity/complexity factor. Once each factor is calculated, it must be multiplied by the other to obtain the final utilization factor for a component in the ACR, (i.e., utilization factor = volume factor x complexity/intensity factor). Sections 5205.1 through 5205.4 describe these factors in greater detail.

5205.1 ACR Utilization Factors - Volume of Services.--You may adjust a component of the initial rate for the relative difference in the volume of services you expect your Medicare enrollees to use compared to that which your non-Medicare enrollees are expected to use if you purchase or identify the service on a unit of service basis and the unit of service is defined the same for all enrollees. Examples of units of services include the following:

A. Inpatient hospital services on a per day or per admission basis;

B. Physician office visits;

C. Physician house calls; and

D. Radiologist visits.

5205.2 Calculation of Volume Factor for Inpatient Hospital Services.--The volume factor for inpatient hospital services may be calculated by determining the relative difference in inpatient days per thousand enrollees between your Medicare and non-Medicare enrollees. For instance, if you have 454 non-Medicare days per thousand non-Medicare enrollees, but have 1916 Medicare days per thousand Medicare enrollees, the relative difference, after adjusting for coverage limits, is the average number of Medicare inpatient days divided by the average number of non-Medicare inpatient days. The adjustment to total inpatient days per thousand is necessary in order to limit factors by Medicare
coverage. Thus, if your inpatient hospital statistics show that 16 days of care used for inpatient hospital stays was in excess of Medicare coverage for non-Medicare persons and 78 days was for excess days beyond Medicare inpatient coverage for Medicare beneficiaries, the differences would have to be reflected in the factoring process. (See §5205.3.)

5205.3 ACR Utilization Factors - Complexity or Intensity of Services.--You may multiply an initial rate service component to reflect the relative differences in the complexity and intensity of services furnished to your Medicare enrollees if the supporting data for the calculation of your initial rate includes the elements of this factor. This adjustment represents variations in expenses and resources necessary to provide a given volume of services to different enrollee groups.

An example of a complexity/intensity factor is a hospital intensity and complexity factor based on relative costs per patient day. If you make a volume change for inpatient hospital services in which the units of services are described in terms of number of days Medicare enrollees use, you must also compute a complexity/intensity factor for each day.

For practitioner services, another way to calculate this factor is by applying a recognized relative value scale of physicians' services for such elements as time and skill. If an organization shows the number of relative value units your Medicare enrollees are expected to use for a given service, the Medicare utilization would, by definition, be included in these figures.

**Computation of Inpatient Hospital Utilization Factor**

<table>
<thead>
<tr>
<th>Commercial</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inpatient Days/1000</td>
<td>316</td>
</tr>
<tr>
<td>2. Average Cost Per Day</td>
<td>$350.00</td>
</tr>
<tr>
<td>3. Medicare Inpatient Days</td>
<td>1909 = 6.0411</td>
</tr>
<tr>
<td>Commercial Inpatient Days</td>
<td>316</td>
</tr>
<tr>
<td>4. Average Cost/Day - Medicare</td>
<td>$322.28</td>
</tr>
<tr>
<td>Average Cost/Day - Commercial</td>
<td>$350.00</td>
</tr>
<tr>
<td>5. Utilization Factor (Product of lines 3 and 4)</td>
<td>5.5627</td>
</tr>
</tbody>
</table>

5205.4 ACR Utilization Factors - Adjustments by HCFA.--If you do not have adequate data from your own experience to reflect the expected utilization characteristics of your Medicare enrollees, HCFA will, at your request, adjust the initial rate, if you provide sufficient data on the utilization characteristics of your non-Medicare enrollees. HCFA will make utilization adjustments based on:

A. Data from your providers and practitioners which currently provide services to Medicare beneficiaries if such data are available;

B. The utilization experience of enrollees in other HMOs/CMPs;

C. Data and studies from nationally recognized statistical sources on the utilization of medical services (only for first-year plans); or

D. A combination of the above.
5206. ACR CALCULATION - ADJUSTMENTS FOR DEDUCTIBLES AND COINSURANCE

After completing the initial rate and making utilization adjustments, as described above, the final step you must complete to calculate your proposed ACR is to make a reduction for the actuarial value of applicable Medicare coinsurance and deductibles. These values must be separately determined for Medicare enrollees who are entitled under Parts A and B from those entitled under Part B only. The figures will be furnished to you by HCFA. After this reduction the resulting figure is your proposed ACR for a given contract period.

5207. EXAMPLE OF SUMMARY DISPLAY OF ACR CALCULATION

The following pages illustrate a hypothetical ACR and premium calculation. The figures used in the example are fictitious. Part I shows, through the calculation of an ACR, how savings are determined. Part II illustrates how, using the savings as a starting point, premiums are determined.
### ADJUSTED COMMUNITY RATE PROPOSAL

<table>
<thead>
<tr>
<th>Period: 1/1-12/31/92</th>
<th>Rate</th>
<th>Adj. Util.</th>
<th>Total ACR</th>
<th>ACR Factor</th>
<th>ACR</th>
<th>Part A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Inpatient Hospital</td>
<td>26.92</td>
<td>(0.95)</td>
<td>25.97</td>
<td>5.56</td>
<td>144.46</td>
<td>11.01</td>
</tr>
<tr>
<td>2 Skilled Nursing</td>
<td>0.23</td>
<td>0.01</td>
<td>0.2445</td>
<td>0.8750</td>
<td>11.01</td>
<td>11.01</td>
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<tr>
<td>3 Home Health</td>
<td>0.34</td>
<td>0.00</td>
<td>0.3426</td>
<td>0.8235</td>
<td>9.12</td>
<td>9.12</td>
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<tr>
<td>4 Physician Services</td>
<td>31.65</td>
<td></td>
<td>1631.81</td>
<td>2.9047</td>
<td>92.40</td>
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</tr>
<tr>
<td>5 Outpatient Lab</td>
<td>2.81</td>
<td>0.00</td>
<td>2.81</td>
<td>2.5359</td>
<td>7.13</td>
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<tr>
<td>6 Outpatient Radiology</td>
<td>3.29</td>
<td>0.00</td>
<td>3.29</td>
<td>2.7735</td>
<td>9.13</td>
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<tr>
<td>7 Hospital Outpatient</td>
<td>5.15</td>
<td>0.00</td>
<td>5.15</td>
<td>2.8319</td>
<td>14.58</td>
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<tr>
<td>8 Prescriptions Drugs</td>
<td>6.83</td>
<td>(6.79)</td>
<td>0.04</td>
<td>1.9232</td>
<td>0.08</td>
<td>0.08</td>
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<tr>
<td>9 Emergency Ser.</td>
<td>2.32</td>
<td>0.00</td>
<td>2.32</td>
<td>2.4690</td>
<td>5.73</td>
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</tr>
<tr>
<td>10 Misc. Services</td>
<td>1.54</td>
<td>0.22</td>
<td>1.76</td>
<td>4.5406</td>
<td>7.99</td>
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<tr>
<td><strong>11 Non-Medicare Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Prevent.-Physicals</td>
<td>1.53</td>
<td>(1.53)</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Prevent.-Immun.</td>
<td>0.10</td>
<td>(0.10)</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Prevent.-Hth. Ed.</td>
<td>0.25</td>
<td>(0.25)</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Prevent.-Other</td>
<td>0.00</td>
<td>(0.00)</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Dental</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F Eye Care</td>
<td>1.44</td>
<td>(1.44)</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G Ear Care</td>
<td>0.22</td>
<td>(0.22)</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H Podiatry</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Misc. Add. Serv.</td>
<td>2.14</td>
<td>(2.14)</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>12 Subtotal</strong></td>
<td>86.7</td>
<td>(13.03)</td>
<td>73.73</td>
<td>301.63</td>
<td>164.59</td>
<td></td>
</tr>
<tr>
<td>13 Administration</td>
<td>15.31</td>
<td>(2.30)</td>
<td>13.01</td>
<td>53.23</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>14 Subtotal</strong></td>
<td>102.07</td>
<td>(15.33)</td>
<td>86.74</td>
<td>354.86</td>
<td>193.64</td>
<td></td>
</tr>
<tr>
<td><strong>15 Coordination of Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Working Medicare</td>
<td>0.00</td>
<td>(3.55)</td>
<td>3.55</td>
<td>1.0000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Other</td>
<td>(1.94)</td>
<td>(1.61)</td>
<td>(0.60)</td>
<td>(0.33)</td>
<td>(0.27)</td>
<td>.4172</td>
</tr>
<tr>
<td><strong>16 Rev. 15 Requirement</strong></td>
<td>100.63</td>
<td>(18.88)</td>
<td>81.75</td>
<td>350.71</td>
<td>191.37</td>
<td></td>
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<tr>
<td>17 Commercial Copays</td>
<td>(2.08)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Commercial Prem.</td>
<td>98.55</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>19 Actuarial Value of Ded. and Coins.</strong></td>
<td>(55.77)</td>
<td></td>
<td>(17.73)</td>
<td>(38.04)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Adj. For Outpatient Psych. Copay</td>
<td>(0.90)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>21 Adjusted Community Rate</strong></td>
<td>294.04</td>
<td></td>
<td>173.64</td>
<td>120.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>22 Average Payment Rate</strong></td>
<td>315.67</td>
<td></td>
<td>196.22</td>
<td>119.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>23 Less Adjusted Community Rate</strong></td>
<td>294.04</td>
<td></td>
<td>173.64</td>
<td>120.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>24 Savings</strong></td>
<td>21.63</td>
<td>22.58</td>
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## ADJUSTED COMMUNITY RATE PROPOSAL

**PERIOD: 1/1-12/31/92**

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Your proposed ACR is part of the report submitted to HCFA for review and approval that is described in §5201A. HCFA will review both the methodology and calculations of the proposed ACR and make a determination as described in §5201G. HCFA's determination is your ACR for purposes of determining the savings, if any, or payment reductions, as appropriate (unless the determination is later reversed as a result of an appeal you file). If you are dissatisfied with HCFA's determination on the report and it results in either less Medicare payment to you or a decrease in Medicare enrollees' premiums, you may appeal the decision, as specified in Chapter 5, Part 2. Amounts of monies which are due you from HCFA because of such a reversal of HCFA's determination shall be made to you as part of the payment reconciliation process, as described in Chapter 1. At no time will HCFA pay an organization amounts in excess of the payment rates described in Chapter 1 plus approved withdrawals from your BSF.

5208.1 Example of Situations Resulting From ACR Appeal.--

A. Background.--Your average monthly per capita payment is $180 for enrollees entitled to Part A and B, and you propose an ACR of $160. You intend to provide $20 worth of additional benefits and you do not have a benefit stabilization fund. HCFA determines your ACR to be $150. You appeal HCFA's determination, but the contract period starts prior to the final decision by the hearing officer.

B. Action Taken.--Thirty dollars is the amount to be used for additional benefits or a payment reduction (or a combination of both) because it is the difference between $180 and $150. You may allocate the $30 any way you wish between additional benefits and payment reductions. Assuming you still want to provide $20 worth of additional benefits and payment reductions (the difference between $180 and your proposed ACR of $160), you may do so and take a payment reduction of $10. However, if you elect to alter your package to provide additional benefits for the added $10, you must drop your appeal of the ACR calculation.

If the hearing officer affirms HCFA's determination, there is no change in the above. If the officer accepts your proposed ACR (or an amount between this figure and HCFA's determination), the amount of money HCFA owes you because of the hearing officer's decision shall be paid to you as part of the payment reconciliation process. (See §5004.)

5209. BENEFIT STABILIZATION FUND

This section describes (1) how HCFA may establish, at your request, a benefit stabilization fund (BSF) and (2) the operation of such a fund.

The purpose of a BSF is to stabilize and prevent excessive fluctuations in the additional benefits you provide your Medicare enrollees in contract periods subsequent to those in which monies are put into the fund. Therefore, the fund may not be used in the contract period in which the monies were withheld in order to cover your reserve requirements or to prevent you from losing money. Similarly, you may not withdraw monies from your fund to refinance prior contract period losses. In the absence of a BSF, you might have to charge your enrollees' premiums for benefits in a future contract period which, during prior contract periods, were provided at no charge.
Contributions to BSF.--After HCFA has approved the establishment of a BSF, contributions to the fund consist of withholdings from HCFA’s monthly per capita payment to the HMO/CMP. These withholdings come from the amounts that you would otherwise have to use to finance additional benefits when your ACR is lower than the average of your payment rates. (See §5200.) They consist of a per capita monthly amount for the Medicare enrollees covered by the fund (e.g., enrollees entitled to Parts A and B of Medicare), and they may not exceed the limits described below.

A. Limit Per Contract Period.--HCFA may not approve a request for contributions to a BSF if they total more than 15 per cent of the difference between your ACR and your APR for a contract period. (See 42 CFR 417.596(c).)

B. Cumulative Limit.--HCFA will not approve a request for contributions to a BSF for a contract period if the requested amount would cause the aggregate dollar value of the BSF to exceed 25 percent of the difference between your ACR and your APR for that contract period.

Example of Limits on Contributions.--For determining your ACR for the second year of a risk contract, an HMO/CMP with no Part B only members has the following data elements:

A. 5,500 actual Medicare enrollee-months;
B. $1,500 withheld from the first year contract in its BSF;
C. 7,564 projected Medicare enrollee-months for the second year contract;
D. $22.58 PM/PM excess of APR over its ACR for Part A (see line 24 of the example in §5207); and
E. $0.95 PM/PM loss of ACR over its APR for Part B benefits. (See line 24 of the example in §5207.)

The cumulative maximum allowable withholding for year 2 of the contract is calculated as follows.

Aggregate BSF withholding amount:
1. Part A: 25% of $22.58 x 7564 Medicare enrollees-months = $42,699
2. Part B: 25% of $0.95 x 7564 Medicare enrollee-months = ($1,796)
3. Combined aggregate BSF withholding amount (gross) = $40,903
4. Less BSF withholding from first year = $1,500
5. Total aggregate allowance withholding for year 2 = $39,403
6. Total allowable BSF contribution PM/PM = $5.21
   \[ \frac{39,403}{7,564} \]
7. Actual limit for the current period would be = $3.24
   \[ 15\% \times 21.63 = 3.24 \]
5209.3 Financial Management of BSF.--HCFA maintains your BSF in accounts under the custody of the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. These accounts do not earn interest for your organization.

5209.4 Withdrawals From BSF.--

A. Requests for Withdrawals From BSF.--Your request for a withdrawal from your BSF is made at the same time that you submit your report on additional benefits. (See §5201.) If HCFA approves the request, the money will be withdrawn from the BSF for use during the subsequent contract period. In making a withdrawal request, you must:

1. Indicate how you intend to use the withdrawn amounts;
2. Justify the need for the withdrawal in terms of stabilizing the additional benefits you provide to Medicare enrollees;
3. Document your experience with fluctuations between your ACRs and APRs for different contract periods;
4. Document your experience during the contract period previous to the one for which the withdrawal is requested to ensure that you will not be using the withdrawn amounts to refinance losses suffered during that previous contract period;
5. Demonstrate to HCFA's satisfaction that the proposed withdrawal will not result in your offering without charge the supplemental services you provide to your Medicare enrollees, as described in §§2101ff; and
6. Demonstrate to HCFA's satisfaction that the proposed withdrawal will not be used to refinance prior contract period losses or avoid losses in the upcoming contract period.

B. Criteria for HCFA Approval.--In order for HCFA to approve your request for a withdrawal from your BSF, HCFA must be satisfied that your request meets the requirements above and that one of the following conditions exists:

1. Your APR for the next contract period is less than that of the previous contract period;
2. Your ACR for the next contract period is significantly higher than that of the previous contract period; or
3. Your revenue requirements for the next contract period for providing the additional benefits you provided during the previous contract period are significantly higher than your requirements for the previous period, and your ACR for the next contract period results in an additional benefits package that is less in total value than that for the previous contract period.

5209.5 Form of Payment for Withdrawals From BSF.--If HCFA approves your request for withdrawals from your BSF, HCFA will make the payment by calculating an amount which will be paid as an additional amount to the monthly advance payment made to you during the contract period.
5210. EXHIBITS

EXHIBIT I
CERTIFICATION BY ORGANIZATION'S CHIEF EXECUTIVE OFFICER

I hereby certify that the information contained in the Adjusted Community Rate Proposal submitted to the Health Care Financing Administration by ________ for the contract year beginning ________ is current, complete, accurate and, to the best of my knowledge, in accordance with provisions governing the computation of Medicare beneficiary premiums and the adjusted community rate contained in Federal regulations published in 42 CFR 417.580 through 417.598.

________________________________________________________________________

Signature (Chief Executive Officer of Organization)       Title

________________________________________________________________________

Date
EXHIBIT II
BENEFICIARY INFORMATION FORM (BIF)

The first part is the MEDICARE PREMIUM form. This form provides premium information associated with the various options you plan to offer your Medicare members.

**MEDICARE PREMIUM**

**Line A. - PLAN BASIC BENEFIT OPTIONS:**

In the first column, labeled "Maximum Monthly Premium ACR/Part A and B Enrollees," enter the premium proposed in the ACRP for members who are entitled to Medicare Part A and Part B.

In the second column, labeled "Monthly Premium Actual/Part A and B Enrollees," if an organization proposes a premium waiver in the ACRP, enter the premium that will actually be charged to members who are entitled to Medicare Part A and Part B.

In the third column, labeled "Maximum Monthly Premium ACR/Part B Only Enrollees," enter the premium proposed in the ACRP for members who are entitled to Medicare Part B only. Indicate if members are required to purchase Part A benefits through the plan.

In the fourth column, labeled "Monthly Premium Actual/Part B Only Enrollees," if a premium waiver is requested in your ACRP, enter the premium that will actually be charged to members who are entitled to Medicare Part B only.

**Line B. - PLAN BENEFIT HIGH OPTION 1:**

Complete this line only if there is a high option package. In the first column, labeled "Maximum Monthly Premium ACR/Part A and B Enrollees," enter the premium proposed in the ACR for members who are entitled to Medicare Part A and Part B. Enter the total premium (basic plus the additional for this high option package).

In the second column, labeled "Monthly Premium Actual/Part A and B Enrollees," if a premium waiver is requested in the ACR proposal, enter the premium actually charged members. Enter the total premium (basic plus the additional for this high option package) for members who are entitled to Medicare Part A and Part B.

In the third column, labeled "Maximum Monthly Premium ACR/Part B Only Enrollees," enter the premium proposed in the ACR for members who are entitled to Medicare Part B only. Enter the total premium (basic plus the additional for this high option package).

In the fourth column, labeled "Monthly Premium Actual/Part B Only Enrollees," enter the premium actually charged Medicare Part B only members after any waiver. Enter the total premium (basic plus the additional for this high option package).

**Line C. - PLAN BENEFIT HIGH OPTION 2.**

**Line D. - PLAN BENEFIT HIGH OPTION 3.**

**Line E. - PLAN BENEFIT HIGH OPTION 4.**
Complete these lines in the same way as line B, but only if there is more than one high option benefit plan.

MEDICARE COVERED BENEFITS

The second part is the Medicare Covered Benefits Form. Lines one and two in each column have been completed to demonstrate Medicare covered benefits, coinsurance, deductibles, and limitations. This is not a complete list of fee-for-service (FFS) Medicare coverage. However, it does cover the general categories of Medicare services. The coinsurance and deductible amounts listed for FFS Medicare are included in the national actuarial equivalent figure used in calculating the ACR. Therefore, if you wish to charge your members all or some of these amounts, you must make a commensurate reduction in the premium. For example, if you charge a hospital deductible, reduce the premium by an actuarial equivalent amount, since the FFS Medicare deductible has already been included in the figure used as the base premium in the ACR calculation.

When review of the ACR proposal is complete, HCFA returns the form with any revisions made to it as a result of the review. HCFA also uses this form to review your marketing materials.

Instructions for Completion of Medicare Covered Benefits Form.--
Each column refers to a specific category of services. Under the column headings, lines 1 and 2 describe Medicare coverage for those services. Complete lines 3 through 10, which describe your benefit package(s). The instructions for completing each column are shown below.

Line 1.--HCFA has completed this space in each column.

Line 2.--HCFA has completed this space in each column.

Line 3.--Describe your basic benefit option offered to all of the members. This includes all additional benefits and their limits for each category of service as submitted in the ACRP. For example, if you offer unlimited hospital days, note it under inpatient hospital. If benefits and limits are identical to fee-for-service Medicare coverage, enter "Same as FFS Medicare coverage".

Line 4.--Describe copayments and deductibles for the services described in line 3. If copayments and/or deductibles are identical to fee-for-service Medicare coverage, enter "Same as FFS Medicare coverage."

Line 5.--If a high option benefit package is offered, describe the benefit package and the limits offered for each category of service. Only show supplemental benefits not available under the basic option. List any copayments or deductibles associated with the high option package.

Line 6.--If a second high option benefit package is offered, describe the benefits and limits offered for each category of service. Only show supplemental benefits not available under the basic option. List any copayments or deductible associated with this high option package.

Line 7.--If a third high option benefit package is offered, describe the benefits and limits offered for each category of service. Only show supplemental benefits not available under the basic option.
List any copayments or deductibles associated with this high option package.

Line 8.--If a fourth high option benefit package is offered, describe the benefits and limits offered for each category of service. Only show supplemental benefits not available under the basic option.

List any copayments or deductibles associated with this high option package.

Line 9.--Complete this item only if you are offering a flexible benefit package. This option must be approved by HCFA prior to submission of your ACRP. Describe the extra benefits, limits, and any associated copayments or deductibles. Use a footnote to show how members qualify for this package (if they live in a certain county or if they choose a certain delivery system).

Line 10.--Complete this item if you have more than one flexible benefit plan.
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ACCRETION AND DELETION

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HCFA reimbursement to an HMO/CMP is based upon the number of Medicare (Part A and B or Part B only) beneficiaries enrolled in the plan. This requires the HMO/CMP and HCFA to exchange information and maintain records on Medicare enrollees.

This chapter describes the data exchange requirements between HCFA and the HMO/CMP. It also provides information of data flow between HCFA, HMO/CMPs, intermediaries and carriers.

HCFA maintains a separate recordkeeping system, known as the Group Health Plan Master Records System (GHP Master), for all Medicare beneficiaries who are members of an HMO/CMP. The system is used to process all HMO/CMP membership records sent to HCFA by the plan, and to produce the verification and reply records and other reports for the plan.

When a Medicare beneficiary joins an HMO/CMP, or a current HMO/CMP enrollee becomes eligible for Medicare, send a membership record to HCFA to identify the beneficiary.

Additionally, whenever a previously enrolled Medicare member leaves the plan send a record to HCFA identifying the beneficiary.

These records are known as accretions and deletions.

-Accretion Records - These are records which identify a Medicare beneficiary who has joined an HMO/CMP.

-Deletion Records - These are records which identify a Medicare beneficiary who disenrolled or was dropped from HMO/CMP membership.

Schedule for Submitting and Processing of Membership Records.--Submit accretion and deletion records to HCFA at any time. However, HCFA processes the records using a monthly schedule known as the HCFA Operating Month. The schedule begins with the 26th day of the month and ends with the 25th day of the succeeding month. For example, the operating month of March begins on February 26th and ends on March 25th. Records received after the 25th of a month will be processed in the next operating month. You will receive a response from HCFA about the 10th of each month for each submitted accretion and deletion. It consists of acceptance and rejection records.
6002.2. Restrictions on Membership Records Sent to HCFA.—HCFA will accrete beneficiaries to the GHP Master File with an effective date of 1 to 3 months after the operating month. HCFA will delete beneficiaries from the GHP Master file with an effective date of the current month to 3 months after the operating month.

**EXAMPLE**

A plan submits accretions which are received in the HCFA June operating month. Assuming all beneficiaries are identified and are entitled to Part A and B or Part B only, HCFA will accept accretions with a July, August, or September effective date.

If the effective date of the accretion is the same as, or earlier than, the operating month of receipt, HCFA will adjust the effective date of the accretion to the month following the operating month of receipt. Thus, any accretions submitted with an effective date of June or earlier will be adjusted to an effective date of July.

Any accretions submitted which show an effective date four or more months later than the operating month of receipt will be rejected as invalid. Using the example cited above, if an accretion has an effective date of October or later it will be rejected.

In addition, an accretion will not be effective until the submitted data can be verified against HCFA's master records of Medicare beneficiaries. Investigate and resolve accretions rejected by HCFA. Once the discrepancy has been resolved, submit a new accretion. Until the rejected accretion record is effectively accreted to HCFA's records, the beneficiary will be covered for Medicare services and have payment made to him or on his behalf under the regular provisions of the Medicare law. Seek reimbursement through the Medicare processes for only those services which were rendered prior to the effective date of the accretion.

HCFA will process deletion records with effective dates no earlier than the operating month of receipt and no later than the third month after the operating month of receipt.

**EXAMPLE**

An HMO/CMP submits deletion records which are received by HCFA in the April operating month. HCFA will process any deletions having an effective date of April, May, June, or July.

HCFA will adjust deletion records which are dated earlier than the operating month to be equal to the operating month. In the example above, any deletions with an effective date of March or earlier would be adjusted to be effective in April.

HCFA will reject deletions which show an effective date of four or more months later than the operating month. Using the example cited above, if you submit a deletion with a date of August or later, the deletion would be rejected.
When HCFA initiates a deletion action, i.e., because the enrollee joined another Plan, died, or Part B entitlement has ended, the effective date will be no earlier than the month preceding the current operating month. For example, HCFA initiated deletions processed during the first week of May (the May operating month) will show an effective date of deletion no earlier than April even if the event occurred earlier.

The restrictions outlined above make it imperative that you follow the HCFA operating month schedule closely and submit accretions and deletions promptly. Plans wishing to meet a particular operating month cut-off, should time the submission of the items to provide enough lead time for mailing and input preparation. A good "rule of thumb" is to mail transactions by the 15th day of the month.

**6002.3 Mode of Submitting Membership Records to HCFA.**—Accretion and deletion records can be submitted to HCFA on paper listing, punchcards, or magnetic tape. However, submission of cards or magnetic tape is strongly encouraged.

A. **Paper Listing and Punchcards.**—When submitting a paper listing of the membership records use Form HCFA-1929, Group Health Plan Data Card Coding Worksheet. (See Exhibit 1-1 and 1-2.) Clearly write or type the entries in capital (BLOCK) letters, i.e., ABCDEFGHIJKLMNOPQRSTUVWXYZ. Note that the letter O is slashed to distinguish it from the number 0. See §6002.4 for the information to place on the form. Supplies of Form HCFA-1929 can be obtained from HCFA.

When using punchcards to submit accretion and deletion records complete them in accordance with the input requirements in §6002.4.

Send completed HCFA-1929s and punchcards to:

```
HCFA - GHPOS
Attn: Medicare Department
320 Meadows East Building
6300 Security Boulevard
Baltimore, MD 21207
```

B. **Magnetic Tape.**—When using magnetic tape to send membership records to HCFA use the following standards.

1. **Tape Data Records** - Tape records must be a block of ten 80-position items. If the last tape block is not full, do not include padding records. Record data in extended binary coded decimal, odd parity. Recording is on 9-track at a density of 1600 characters per inch.

2. **Labeling** - The HCFA system is an IBM OS (Operating System) with a standard header and trailer label requirement. The label must include the data set name "GHP" plus your plan number. For example, the data set name for an organization which has plan number H9999 is "GHP9999."
When using other than the IBM OS system, contact GHPOS for necessary information. Include the membership data requirements in §6002.4.

Mail completed magnetic tapes to the address in A above.

NOTE:

If you elect to exchange records with HCFA via magnetic tape, contact HCFA for prior approval. While the taping standard noted is preferred by HCFA, it does not rule out other formats. Therefore, if you desire to use magnetic tape but cannot meet these standards, contact the GHPO to determine if you can submit other formats. Send requests and information to the address in A above.

6002.4 Data Requirements on Membership Records Submitted to HCFA.--Regardless of the input media used, data requirements for membership records are the same.

The input record is a 12-field, 80-position, fixed format. Exhibit 1-3 displays the record format for punchcards and magnetic tape. Exhibit 1-1 and 1-2 are facsimiles of Form HCFA-1929, Group Health Plan Data Card Coding Worksheet.

The following is a description of data entry requirements.

Field 1 - Positions 1-12: HICN

Each individual who becomes entitled to health insurance benefits receives a health insurance card bearing his/her name, sex, health insurance claim number (HICN), and the effective dates of entitlement to hospital insurance and/or medical insurance. The local social security office may furnish a temporary health insurance eligibility notice when immediate medical service is needed before the health insurance card is issued. Since HCFA records are maintained by the individual's HICN, it is essential that you use that number in all communications with HCFA.

Both HCFA and the Railroad Retirement Board (RRB) issue health insurance cards. Most HICNs are social security numbers with letter suffixes. The claim number may also be an RRB number or social security number with letter prefixes.

A. HICNs Assigned by HCFA.--The HI number always consists of nine digits divided into three parts and a letter suffix. The first three digits are referred to as the area, the second two as the group, and the last four as the serial number. The area numbers range from 001 through 588 and from 700 through 728. Any combination of two digits, except "00," make up the group number. The last four digits of the social security number, the serial portion, run from 0001 through 9999. The addition of the letter suffix makes the Social Security Number a HICN. A complete list of valid HICNs can be found in HCFA Pub. 14.3 §3200.
B. HICNs Assigned by the Railroad Retirement Board.--The RRB did not begin using the social security number in its numbering system until 1964. The numbers assigned prior to that time were 6-digit numbers and were assigned in numerical sequence; they have no special characteristics. However, the 6-digit numbers and the 9-digit social security numbers, when used as claim numbers by the RRB always have letter prefixes. (In rare cases, a qualified railroad retirement beneficiary may have a claim number with fewer than 6 digits; add sufficient zeros between the prefix and other digits to make a 6-digit number; e.g., WD-001234.) A complete list of valid RRBs can be found in HCFA Pub. 14.3 § 3200.

C. Explanation of HCFA Sequence for Transmitting Data.--The HCFA files are sequenced so that all RRB HICNs are listed first, followed by all the HCFA HICNs. Additionally, the RRB HI claim symbols (letter prefixes) are listed in high order (leftmost) position followed by the RRB claim number. The HI claim numbers are listed in numeric sequence in high order position followed by the letter suffix.

D. Special Precautions for Entering HICNs.--Enter all HICNs left justified, i.e., the number must begin in column 1 and continue until it is fully entered. In the case of numbers requiring fewer than 12 spaces, leave the spaces to the right of the number blank. No claim number is complete without at least one letter prefix or suffix. No number can have both a prefix and a suffix.

Field 2 - Positions 13-24: Surname

Although twelve positions are provided in the surname field, if fewer than 12 positions are needed, use blanks to complete the field. In cases of a compound surname, show the name as it appears on the beneficiary's health insurance card (including hyphenation). If the surname consists of more than 12 characters, show only the first 12 characters; insert a blank between the surname and a designation of "JR" or "SR." Left justify this field.

Field 3 - Positions 25-31: First Name

The same considerations that apply to field 2 above apply to field 3. However, only seven positions are available for the first name. Left justify this field.

Field 4 - Position 32: Middle Initial

If the enrollee has a middle initial, provide it in this field; otherwise, leave it blank.

Field 5 - Position 33: Sex

Always complete this field. It helps HCFA identify the beneficiary. Complete this field by showing 1 if the enrollee is male, 2 if the enrollee is female.
Field 6 - Positions 34-39: Date of Birth
Leave this field blank.

Field 7 - Positions 40-46: Reserved
Leave this field blank.

Field 8 - Positions 47-51: Plan Number
Always enter the HMO/CMP alpha/numeric identification number as assigned by HCFA.

Field 9 - Positions 52-59: Reserved
Leave this field blank.

Field 10 - Positions 60-67: Exchange of Information
This field defines the type of record you are submitting and the effective date

Positions 60-61 - Must contain one of the two-digit numeric codes shown below.

--Code 51 - Voluntary Withdrawal, Beneficiary Being Deleted
Use this code when deleting the enrollee because he no longer wishes to be enrolled.

--Code 52 - Involuntary Withdrawal, Beneficiary Being Deleted
Use this code when deleting the enrollee because he has failed to pay the plan's premiums or has moved from the plan's enrollment area.

--Code 61 - Accretion
Use this code when accreting (enrolling) the beneficiary into the plan based upon Medicare entitlement.

--Code 62 - Accretion, Cost to Risk Enrollment
Use this code when accreting a member from your cost to risk contract. Do not submit a deletion record for the cost contract, this will occur automatically in the HCFA system.

Positions 62-63 - Leave these fields blank.
Postions 64-67 - Provide the month and year that the accretion or deletion should be effective. This must be a 2-digit month and 2-digit year. For example, a proposed effective date of January 1985 should be shown as 0185. Conform the proposed effective date to the restrictions in §6002.2.

EXAMPLE

An HMO/CMP sends HCFA data indicating that an individual is enrolled in the plan effective August 1, 1984.

This information should read as "61bb0884"("b" means blank space) in positions 60-67.

Field 11 - Positions 68-79: Reserved

Same as field 7.

Field 12 - Position 80:

Blank or a tape item record mark.

6002.5 Transmittal and Certification Form - HCFA-3361 (Exhibit 1-4).--Use this form as the covering transmittal for all accretions and deletion records sent to HCFA. Besides being a transmittal, it provides HCFA with the required certification that the plan has the Medicare beneficiary's authorization for disclosure of health insurance information, and accretion/deletion data for determining HCFA's capitation payments. Failure to submit or complete this form will delay the processing of your monthly capitation payment. Complete the form as follows:

Item 1 - Mailing Address

Mail all records to HCFA at the address listed.

Item 2 - Health Plan Number

Provide your identification number.

Item 3 - Plan Name and Address

Provide the complete name and address of your organization.

Item 4 - Shipping Information

Blocks A, B and C: Provide the total number of records and a separate count of the accretions and deletions shipped.
Block D: Complete this block when shipping Forms HCFA-1929 (Coding Sheets).

Block E: Complete this block only when shipping punchcards.

Block F: Breakdown the total accretions and deletions by month and the number effective each month.

Item 5 - Additional Comments

Use this space to provide additional information about the items.

Item 6 - Certification for Disclosure of Information

Whenever accretions are included in the shipment, complete this portion of the form. An official of the plan signs the form, giving his/her complete title, and the date.

Blocks G and H: If shipping magnetic tape, complete these blocks. Include the number of reels being mailed and the reel numbers which have been assigned and displayed.

6003 HCFA REPORTS TO HMO/CMPS ON MEMBERSHIP RECORDS

One of the main factors in the determination of reimbursement to an HMO/CMP is the HMO/CMP membership records maintained by HCFA. It is imperative that your records be accurate and agree with HCFA’s. To help assure agreement, HCFA provides several membership record reports.

6003.1 Accretions, Deletions, and Maintenance Records Reply Listing.--A monthly report is supplied. It lists the status of the accretion and deletion records submitted to HCFA and any changes in the group health plan records established on HCFA's GHP Master Record File.

Records which supply the status of accretions and deletions are "reply" records. Records which inform of changes in the established master file are "maintenance" records.

Reply records are supplied each time you submit an accretion or deletion. Maintenance records, however, are supplied only when a change has been made to a substantive piece of information about a beneficiary in HCFA's files. For example, a maintenance record is generated by HCFA if a change occurs in the beneficiary's name or HICN. The generation of a reply record may require action by you to update your records. On the other hand, maintenance records always require action by you.

Reply and maintenance records are identified on the report by numeric codes. The reply record codes are: 11, 17, 21, 22, 23, 24, 25, 26, 27, 28, 29, 31 and 83. They indicate the status of the accretion or deletion record submitted.

The maintenance record codes are 40, 41, 42, 43, 44, 45, 46, 47, 48 and 49.

The reply and maintenance record codes appear in field 10 (Positions 47-48) of the record. A description of field 10 under the "Remarks" column explains the codes and indicates the required action.
Following is a complete description of the HCFA output record:

6003.2 Format of the HCFA Reply Listing (Exhibit 1-5).--The HCFA reply listing is an 18-field, 80-position record supplied in listing form for all plans. It can be prepared in punchcard or magnetic tape format for plans requesting that format. Exhibit 1-5 illustrates the format. The information on the output record is the same for all three. However, on paper listing, a "remark" column is provided at the end of each record. The display of this information does not alter the data recording positions but explains further the code displayed in field 10 of the output record.

Field 1 - Positions 1-12: The HICN

This field is always completed. Section 6102.4 contains a description of possible claim numbers which can appear. For reply records, the claim number is the number which you supplied on the accretion or deletion record. On maintenance records, with the exception of code 41, the number is the number HCFA has on the GHP Master Record File as the active HICN. When code 41 appears in field 10, the number shown in field 1 is the inactive HICN. The active claim number is shown in field 17. A further explanation can be found below in the description of field 10, code 41.

Field 2 - Positions 13-24: Beneficiary's Surname

The surname you submitted is shown on the reply record. The name on HCFA's GHP Master Record File is shown on maintenance records.

Field 3 - Positions 25-31: Beneficiary's Given Name

The name you submitted is shown on the reply record. The name on HCFA's GHP Master Record File is shown on maintenance records.

Field 4 - Position 32: Beneficiary's Middle Initial

The middle initial you supplied is shown on reply records. The middle initial on HCFA's GHP Master Record File is shown on maintenance records. If a middle initial is not supplied or on record, this field is blank.

Field 5 - Position 33: Beneficiary's Sex

This field is always completed. Following are the codes which can appear in this field:

1 = male, 2 = female, 3 = unknown, or M = Male, F = Female

Field 6 - Positions 34-39: Beneficiary's Date of Birth

Accepted accretions or deletions records reflect the date of birth from HCFA's records on reply records. On rejected accretions or deletions, the field is blank except for a zero in the last position. If you submitted a record which rejected, the date of birth you submitted appears on the rejected reply record.

On maintenance records, the date of birth from HCFA's records is supplied with all codes except code 43. For code 43, it is always blank.
Field 7 - Position 40
This field is always blank.

Field 8 - Positions 41-45: Plan Number
This field contains the alpha/numeric identification code assigned to you by HCFA.

Field 9 - Position 46
This field is always blank.

Field 10 - Positions 47-48: HCFA Reply and Maintenance Codes
This field contains the 2-digit numeric code which identifies the type of record. The codes which can appear in this field and an explanation of their meaning are:

Reply Codes
Reply codes supply information about the status of an accretion or deletion sent to HCFA. There are three categories.

1. Acceptance Records
These are generated when an accretion or deletion you submitted is completely processable. The GHP Master Record File is updated with the action. There are two codes:

Code 11 - Accretion Accepted
The accretion is accepted and the GHP Master Record File updated. The effective date of the accretion is shown in field 14 of the reply record. Field 15 contains the date you proposed as the effective date. If there is a difference, update your records with the date shown in field 14.

Code 17 - Deletion Accepted
The deletion is accepted and the GHP Master Record file updated. The effective date of the deletion appears in field 17 (positions 67-70) of the reply record. The proposed effective date appears in field 15. If there is a difference, update your records with the date show in field 17.

A Code 17 is automatically generated by the GHP System when a beneficiary enrolls in a different HMO/CMP. The plan from which the beneficiary is deleted receives the following message in the Remarks column, BENEFICIARY ENROLLED IN PLAN (new plan ID number).

2. Rejection Records
Rejection record codes are generated when your submitted accretion or deletion is unacceptable. The GHP Master File is not updated. Usually, there is an action required by you.
Code 21 - Accretion Rejected
This code is generated when the GHP Master Record indicates enrollee has elected hospice coverage prior to HMO/CMP enrollment. When the code is provided in listing form, field 15 shows requested accretion date, field 17 shows the MMYY of hospice coverage, and the Remarks "REJECTED - BENEFICIARY ELECTED HOSPICE CARE."

Code 22 - Accretion Rejected
This code is generated because the beneficiary is shown as deceased on the HI Master Record File and the date of death is earlier than the effective date you submitted. The month and year of death contained in the GHP Master Record File is shown in positions 67-70 of field 17. When provided in listing form, the remark "BENEFICIARY DECEASED" is displayed following field 17.

Code 23 - Deletion Rejected
The GHP Master Record File does not have a record for the beneficiary. There was no prior accretion to the GHP Master Record File. When the record is provided in listing form, the remark "NO RECORD OF PRIOR ACCRETION UNDER THIS NUMBER" is shown after field 17.

Code 24 - Accretion/Deletion Rejected
The accretion or deletion received by HCFA contains invalid data which prevented an update of the GHP Master Record File. This can occur for reasons such as the proposed effective date contained alpha characters rather than numeric or the proposed effective date was more than 3 months later than the HCFA Operating Month. When this code is generated, field 17, positions 67-79, will contain an appropriate remark such as, "INVALID NAME", "INVALID DATE", "INVALID NUMBER". When provided in listing form the record includes the remark "INVALID DATA" after field 17.

Code 25 - Accretion/Deletion Rejected
This code is generated when HCFA's records shows that the beneficiary is already accreted or deleted by you. For an accretion, field 14 shows the previously recorded effective date. For a deletion, positions 67-70 of field 17 includes the previously recorded deletion date. The record in listing form, includes the remark "DUPLICATE TRANSACTION" after field 17.

Code 26 - Accretion/Deletion Rejected
This code is generated when an accretion and deletion record for an enrollee is submitted in the same GHP operating run by either one or two different HMO/CMPs. It also occurs when an HMO/CMP submits a deletion record for an enrollee in a subsequent GHP operating run after receiving an automatic disenrollment (Code 17). When provided in listing form, the remarks column shows "BENEFICIARY ENROLLED IN PLAN (plan ID number) and field 17 shows the other plan's ID number.
Code 27 - Accretion/Deletion Rejected

This code is generated by HCFA when the HI Master Record System is unable to match (for reasons other than code 28) the record against the information provided. When the record is provided in listing form, the remark "FINAL REJECT" appears after field 17. Verify the information submitted and resubmit a corrected record.

Code 28 - Accretion/Deletion Rejected

This code is generated when an accretion or deletion contained an HICN and surname which match HCFA's records, but did not match HCFA's records on the first initial, or sex. When the record is provided in listing form, the remarks "PERSONAL CHARACTERISTICS DIFFER" appears after field 17. See §6004 for corrective action.

Code 29 - Accretion Rejected

This code is generated when the GHP Master Record indicates an enrollee does not have current coverage under supplementary medical insurance (Part B). When this code is provided in listing form, the remark "NOT ENROLLED IN PART B" appears after field 17. See §6004.4 for corrective action.

Code 31 - Accretion/Deletion Rejected

This code is generated by HCFA when the HI Master System is temporarily unable to process the record. When a code 31 record is displayed in listing form, the remark "REJECT" appears in field 17 followed by "MASTER RECORD FROZEN RESUBMIT RECORD" in the Remarks column. Verify the information submitted. If information is correct, resubmit the record. Otherwise, submit a corrected record.

Code 83 - Accretion Rejected

This code is generated when the GHP Master Record indicates the enrollee has ESRD and the enrollment code is a 61. When the code is provided in listing form, the remark "REJECTED DUE TO CRD STATUS" appears after field 17.

3. Maintenance Records

Maintenance records are produced by the GHP Master Records System. Generally, they are not initiated by the receipt of a record from you as are reply records. Maintenance records can be generated at any time based on changes made in a substantive piece of information in HCFA's records.

When you receive a maintenance record, some action is usually required to update your record for the enrollee. While there can be a change in more than one piece of pertinent information for an enrollee in a HCFA operating month, multiple changes are not reported on one record. Rather, each change is reported in a separate record.
Following are the maintenance record codes and their meaning.

**Code 40 - Beneficiary Has Elected Hospice Coverage**

This code is generated when an enrolled HMO/CMP member elects hospice coverage. The member is not deleted from the GHP master records. When the code is provided in listing form, the remark "HOSPICE CARE ELECTED EFFECTIVE MMYY" appears after field 17.

**Code 41 - a Change Has Been Made in the Beneficiary's Claim Number**

This code is generated when a change occurs in the Medicare number under which the beneficiary's record is maintained at HCFA. The Medicare number change could be a completely different number or a change in the alpha character which precedes or follows the number (prefix or suffix). Such a change requires you to adjust your records and to use the new number on future submittals.

When this code is generated, the "old" or inactive number is shown in field 1. This enables you to find the record in your current file. The new HICN is shown in field 17, positions 67-79. When provided in listing form, the remark "NOTE CORRECT CLAIM NUMBER" appears after field 17.

**Code 42 - A Change in the Beneficiary's Name**

This code is generated when any part of the enrollee's name is changed in HCFA's records. The corrected name is reflected in fields 2, 3, and 4. Update your records for the enrollee and use it for future submittals. When the record is provided in listing form, the remark "NOTE CORRECT NAME" appears after field 17.

**Code 43 - Beneficiary Deceased**

When HCFA receives a notice that an enrollee has died, this code is generated to notify you. The GHP system will post the month following the month of death. The record generated includes the effective date of the deletion for death. This date appears in field 17, positions 67-70. When the record is provided in listing form, the remark "BENEFICIARY DECEASED" appears after field 17.

See §6004.5 for action upon receipt of a code 43. Since HCFA records have been annotated, it is not necessary to submit a deletion record.

**Code 44 - Beneficiary's Part A Coverage Terminated**

This code indicates that a beneficiary's entitlement to Part A has terminated. A code 44 is sometimes accompanied by a code 45, which indicates loss of eligibility to Part B coverage. (See description of code 45 below.) When this occurs, follow the procedures given for receipt of a code 45; i.e., update your files and disenroll the beneficiary from membership. It is not necessary to submit a deletion record as HCFA records have been updated.
If a code 44 is received and is not accompanied by a code 45, contact the enrollee to determine whether the enrollee desires to remain a member of the plan with Part B coverage only. If so, adjust the premium accordingly.

Field 17 reflects the effective date (month and year) of the Part A termination.

See §6004.5 for action upon receipt of code 44.

**Code 45 - Beneficiary's Plan Membership Terminated**

On occasion, a beneficiary's plan membership is terminated because he loses entitlement under Part B. When this occurs, the GHP Master Record System generates a termination record for you. Disenroll the beneficiary from your records based upon the Part B termination.

The effective date of the deletion is shown in positions 67-70 of field 17 of the record. This is the date HCFA made the deletion effective on its records and is not necessarily the month and year in which the enrollee's Part B coverage ended. When provided in listing form, the remark "ENTITLEMENT TERMINATED" appears following field 17. A deletion need not be submitted. HCFA's records have been updated. See §6004.5 for your action following receipt of code 45.

**Code 46 - Beneficiary's Plan Membership Reinstated**

Occasionally an enrollee's Part B entitlement is reinstated, thus reversing a previous deletion. When this occurs, the HCFA system generates a code 46 so you can reinstate coverage. You must submit an enrollment record to reestablish the beneficiary on HCFA files.

Field 14 reflects the effective date of the reinstated coverage. Usually, it is the month and year of first coverage as recorded before the code 45 was received. In addition to the date in field 14, field 13 reflects the enrollment date of Part A coverage if it exists. When the code 46 is provided in listing form, the remark "PART B REINSTATED" appears following field 17.

**Code 47 - State Buy-in Indicator**

This code indicates State buy-in of the Part B premium on behalf of the beneficiary. The remarks column indicates "INTO WELFARE" and field 17 reflects the date (year and month) HCFA annotated its record.

**Code 48 - Termination of the State Buy-in Indicator**

This code indicates termination of State buy-in of the Part B premium on behalf of the beneficiary. The remarks column indicates "OUT OF WELFARE" and field 17 reflects the date (year and month) HCFA annotated its records.
Code 49 - Clerical Correction Record

There are instances in which a plan erroneously deletes an enrollee's membership, provides HCFA with an incorrect deletion date, or an internal change must be made to an enrollee's record.

When a correction is to be made, contact HCFA with an explanation of the situation and receive agreement to the change. HCFA takes action centrally to remove or change the date. The result is a code 49 to you. Send any such requests to the address in §6002.3.

When a code 49 is generated, the record shows the following information:

1. When an accretion date is changed, fields 13, 14 and 17 display updated Part A, Part B and the date (if any). The corrected date requested is displayed in field 15. Following field 17, the message "Clerical Correction - Accretion Date" is displayed.

2. When a deletion date is changed, fields 13, 14, and 17 display updated Part A, Part B and the date (if any). The correction date requested is displayed in field 15. Following field 17, the message "Clerical Correction - Deletion Date" is displayed.

3. Where a deletion date is removed, fields 13 and 14 display updated Part A and Part B dates. Field 15 shows "XXXX". Following field 17 the message "Clerical Correction - Deletion Date" is displayed.

Field 11 - Positions 49-50: Plan Transaction Code

This field is completed only for reply records. For maintenance records, this field is blank.

These are the 2-digit numeric codes used on the input record to indicate the type of record. See §6002.4, field 10 for an explanation of the codes.

Field 12 - Position 51

This field contains a letter code which indicates the basis for the enrollee's eligibility to medical insurance benefits and the status of the enrollee's use of HMO/CMP services. The codes are:

A - Disabled - Restricted
B - Renal Disease - Restricted
C - Disabled plus Current or Prior Renal Disease - Restricted
D - Aged plus Current or Prior Renal Disease - Restricted
E - Aged - Restricted
J - Disabled - Unrestricted
K - Renal Disease - Unrestricted
L - Disabled plus Current or Prior Renal Disease - Unrestricted
M - Aged plus Current or Prior Renal Disease - Unrestricted
N - Aged - Unrestricted
Field 13 - Positions 52-56: Hospital Insurance Data

This field is completed with a 2-position month and 2-position year in the following situations:

- Hospital Insurance (Part A) coverage exists and the reply record is:
  a. An accepted accretion (code 11); or
  b. An accretion rejected as a duplicate transaction (code 25).

In all other cases, the field is blank.

Field 14 - Positions 57-61: Effective Date of Accretion

This field is completed when the reply record shown in field 10 is:

1. An accepted accretion (code 11); or
2. An accretion rejected as a duplicate transaction (code 25).

In all other situations, this field is blank.

When a date appears in this field, it is the month and year HCFA made the accretion effective on its records. Occasionally, the effective date of the submitted accretion is different than the date HCFA allowed the record to be effective. When this occurs, an "X" immediately follows the date shown. Accordingly, correct your records.

Field 15 - Positions 62-65: Proposed Transaction Date

This field is completed on all reply records. On maintenance records it is blank. When a date is shown, it is the month and year you proposed to make the accretion or deletion effective.

Field 16 - Position 66

This field is always blank.

Field 17 - Positions 67-79: Miscellaneous Data

This field can contain a variety of information, or it may be blank. Content is dictated by the type of code in field 10. The description of the various reply and maintenance codes, provided in field 10, outline the information. The codes in which this field will always be blank are codes 23, 28, 29, 42, and 46.
Monthly Capitation Report

Monthly, HCFA sends each HMO/CMP a computer-printed Monthly Capitation Report. (See Exhibit 1-6) This report is designed to keep you informed of the number of HMO/CMP members and the member months HCFA has on record. It reflects totals and changes resulting from processed accretions and deletions during the month. The capitation report is broken down as follows:

1. HMO/CMP Identification Data
   a. HMO/CMP Number - the alpha/numeric HMO/CMP number assigned by HCFA
   b. HMO/CMP Name
   c. Current Month - The month for which the report is prepared.

2. Monthly Update Data - Monthly update data is broken out by aged-members-Part A and aged-members-Part B, non-aged-members-Part/A and non-aged-members-Part B. Figures are shown for six months on each report: the current month, the 2 months prior to it, and the 3 prospective months.
   a. Previous Membership - This is the updated membership as shown on the preceding month's report. Occasionally, the total is adjusted for changes made in HCFA's records and shown on this month's reply (codes 46 and 49 replies to the HMO/CMP) listings. There will be clerical adjustments from time to time based on a need to make a master record correction.
   b. Accretions - For the current month, this field contains a cumulative total for all accepted accretions which have the current month as an effective date.
      For the prior and prospective months, only those accretions processed during this monthly update are counted. (Code 11 replies to the HMO/CMP.)
   c. Updated Membership - Total updated membership including accretions and deletions for the current month.

3. Six Month Summaries - Provide the total number of member months to date (capitation figures) for two 6-month periods, i.e., January - June and July -December. The figures are cumulative and change monthly.
   During the first 6 months of the year, the totals for the last 6 months of the prior year are displayed in the "prior" six month column. In July of each year, the totals for the prior six months, i.e., January -June, are displayed in the "prior" column, and the totals for July are displayed in the "current" column.
   a. Previous Capitation - The total number of member months credited to you before the accretions and deletions for the current month were processed.
b. Current Capitation - Net change in the capitation total to date based on the accretions and deletions received in the HCFA operating month of report. This figure is directly related to the totals for accretions and deletions in the membership column of the report.

c. Capitation to Date - The total member months credited to you including the previous capitation and the current (net/change) capitation.

6003.4 Report on Plan's Membership Master Record at HCFA - History Listing --HCFA sends you a history listing every 6 months (during July and January) showing you the status of your members. This listing is informational and may be used to identify members who have not been accreted, deleted, re-accreted, etc. The history list is not a tool to use routinely for correcting problems. Identify problems from the reports described in §6003.1, and handle in accordance with the procedures in §6004.

You will receive one copy of the history listing on either magnetic tape or computer "hard copy" as requested. Reports on computer "hard copy" have the following format:

Field 1. Health Insurance Claim Number
Field 2. Surname
Field 3. First Name
Field 4. Middle Initial
Field 5. Sex. The following codes are applicable in this field:

1-Male  
2-Female  
3-Unknown

Field 6. HMO/CMP Identification No.

Field 7. Status. Shows the current or latest status of the beneficiary.

Codes are:

A-Active member  
D-HCFA or SSA death deletion  
M-Plan Deletion  
N-HCFA termination
HCFA produces a reply record for every accretion and deletion record received. As pointed out in §6003, some of these accretions and deletions are accepted and updated to the HCFA GHP Master Record File while others are rejected. Usually, you will have to take some kind of corrective action on the rejected records. Occasionally, there is a need to correct an accepted record.

This section describes the instances in which corrective action is required.

6004.1 Adjustment of Deletion Date to an Earlier Date.--HCFA will adjust a previously recorded deletion date to an earlier date if the initial or subsequent attempt to delete the beneficiary was a code 27 or 28 reject (See §6004.3 for reconciling code 27 and code 28 rejects) and if written authorization to make the adjustment is received by HCFA not later than the last day of the month following the effective month of the deletion transaction. (See §6004.7.)

EXAMPLE: You submit a deletion in the July operating month which has an effective date in July. The deletion transaction does not match HCFA's records and is rejected with a code 27. Correct the data and resubmit a deletion in the August operating month, which in accordance with the rules for deletion, contains an effective date of August. The new deletion is accepted and processed by HCFA. The effective deletion date will be adjusted to July if notification to make such a change is received by HCFA before October 1.

6004.2 Adjustment of a Deletion Date to a Later Date or Removal of the Deletion Date.--HCFA will adjust a previously recorded deletion date to a later date or will remove the deletion date completely if authorization to make such a change is received no later than the last day of the month following the effective month of the deletion shown on HCFA's records. (See §6004.7.)

NOTE: When you erroneously delete a beneficiary, follow the above procedure rather than submit a new accretion. There may be a break in coverage since accretions are processed only on a prospective basis.

6004.3 Rejection Codes 27 and 28.--Codes 27 and 28 occur when plan data does not match a beneficiary record in the system. In order to reduce the number of reject items:

- Contact the local social security office for assistance in obtaining the correct HICNs (including suffix) and the correct spelling of the beneficiary's name according to SSA records. If the HI number or name is in doubt, contact HCFA before submitting a code 61 (accretion); and

- Perform electronic or clerical edit of HICNs and other data prior to submittal. Criteria for the edits can be established by reviewing §6002.4.
Code 27 - FINAL REJECT - Code 28 - Deletion Transaction

Do not submit a deletion transaction until you have received notice that the accretion transaction has been accepted. Therefore, the incidence of code 27 and code 28 rejects on deletion transactions should be rare. However, if a code 27 or code 28 reject is received, check your records:

1. To determine if the claim number and name were furnished correctly;
2. For the processed accretion transaction to determine if HCFA furnished a corrected claim number, surname or corrected first name, or sex on the accretion reply; and
3. To determine if HCFA furnished a maintenance record which included a change in the beneficiary's claim number and/or name (codes 41 and 43, respectively).

If, after following these procedures, corrected identifying data is found, submit a new deletion using the corrected data. If following these procedures does not resolve the problems, follow the procedures for resolving code 27 and 28 rejections on accretion transactions.

Code 27 - FINAL REJECT - Code 28 - Accretion Transaction

Receipt of these reject codes on an accretion transaction (as well as a code 28 on a deletion transaction) provides a clue as to which information on the accretion did not match HCFA's records. However, note that the information which did not match HCFA's records may not be the only incorrect information on the transaction. For example, a code 27 FINAL REJECT may mean more than only the surname is incorrect. The HICN could be the incorrect element but just happened to match a HCFA record only to be rejected because that HICN belonged to another beneficiary. Accordingly, verify all identifying data when reconciling code 27 and code 28 accretion rejects. The following procedures should help to resolve them:

1. Recheck your records to determine if the HICN and name were furnished correctly. If either the number or name (or both) was incorrect, resubmit a new accretion with the correct information.
2. When you cannot reconcile the item from your records, contact the member to determine if the data originally furnished was correct. If either the number or name (or both) was incorrect, resubmit a new accretion with the correct information.
3. The local social security office can also provide assistance in reconciling code 27 and code 28 reject items.
4. Once it has been verified that the information was submitted correctly, submit the problem to HCFA for investigation in accordance with the procedures in §6004.7.

6004.4 Other Rejection Codes (for description See §6003.1).--When investigating these records, first recheck your records to determine if correct HICN and name data were furnished to HCFA. For example, a husband and wife were accreted to your membership rolls by HCFA. The wife was subsequently deleted because of her death. You now wish to delete the husband but incorrectly furnish HCFA with the identifying information for the wife. HCFA rejects the deletion as a code 25 because the record shows a previously processed deletion.

Code 22 - If your investigation confirms that the beneficiary is alive, submit the problem to HCFA for investigation pursuant to §6004.7.

Code 23 - If your records verify that an accretion has been processed and the data is correct (HCFA has not given you a corrected HICN or name data), submit the problem to HCFA for investigation pursuant to §6004.7.

Code 24 - Correct the invalid data and resubmit the transaction to HCFA.

Code 25 - Since the action requested already has been processed, no problem exists unless you submitted identifying information for a different beneficiary or the wrong transaction code was used. If so, resubmit the transaction using the corrected data.

Code 29 - Do not investigate these rejects unless there is strong evidence indicating a beneficiary is currently entitled to Part B. If there is such evidence, verify entitlement with the local social security office. Submit the verified information and problem to HCFA for investigation pursuant to §6004.7.

6004.5 Maintenance Record Replies (See §6002.5 for description).--Code 43 - When HCFA notifies you that a beneficiary has died but you confirm that the beneficiary is alive, submit the problem to HCFA pursuant to §6004.7. It is not necessary to submit a deletion record for the enrollee since HCFA records have already been annotated.

Code 45 - Follow the same procedure described for code 29 replies. (There is no need to submit a deletion record to HCFA as it has been done within the HCFA system.)

6004.6 Reply Record Not Received for an Accretion or Deletion Submitted to HCFA.--For every accretion and deletion sent to HCFA, the GHP Master Records system produces a reply record as outlined in §6003. The one exception to this is if an incorrect plan number was used on the accretion or deletion record. In this case, you will not receive a reply record.
Reply records to all accretions and deletions will be received within one operating month (see §6002.1) after the month in which you transmit the record to HCFA. If a review of all the reply listings received up to six weeks after release of the records to HCFA failed to provide the reply record for the accretion or deletion in question, notify HCFA following the instructions in §6004.7.

6004.7 Submission of Problem Cases.--Submit all problem cases to:

HCFA - GHPOS
Attn: Medicare Department
320 Meadows East Building
6300 Security Boulevard
Baltimore, MD 21207

Problem cases must contain the following information:

1. The full name of the beneficiary;
2. The HICN of the beneficiary;
3. The sex of the beneficiary;
4. The dates of all accretion and deletion transactions processed by HCFA (whether accepted or rejected) as shown on the reply listing (see § 6003.1);
5. The dates of all maintenance records furnished for the beneficiary (again using the date on the reply listing);
6. If requesting a change in the deletion date (see §§6004.1 and 6004.2), the nature of the desired changes:
   a. change deletion effective date to _________;
   b. remove previously recorded deletion date;
7. A detailed explanation of the problem, the steps taken to resolve it, and the results of the investigation.
8. All available documentation, e.g., reports from the local social security office, evidence that the beneficiary is alive.
6005   HCFA ACTIONS ON PROBLEM CASES

If a submitted request cannot be processed because it was not submitted timely or contains inaccurate
or insufficient information, it will be returned.

If you submit a request to adjust or remove a deletion date, or remove a date of death following a
code 22 or 43 notification from HCFA, you will be notified as soon as the adjustment has been
submitted for processing. Final verification that the adjustment has been processed is a code 49
maintenance record sent to you.

For any other type of problem submitted, HCFA notifies you when the beneficiary's record is
corrected, so you can resubmit an accretion or deletion. Likewise, HCFA notifies you if no
correction action is required because the investigation has demonstrated your request to be incorrect
and HCFA's records to be correct.

6006   BRIEF EXPLANATION OF HCFA SYSTEM FOR MAINTAINING PART B
DEDUCTIBLE AND REIMBURSEMENT AMOUNTS

6006.1 Carrier and Intermediary Query.--To understand the information in HCFA records, it is
necessary to know how HCFA makes Part B payments through its carriers and fiscal intermediaries.
The process follows:

   A. The area carrier receives claims from beneficiaries, physicians, laboratories, and others
      who furnish medical services or supplies. The fiscal intermediary receives Part B billing forms from
      providers of services for outpatient services, Part B medical and other health services, and home
      health agency services.

   B. The area carrier or fiscal intermediary queries HCFA to see what portion of the Part B
deductible has been satisfied for the year in which the expenses were incurred. The "query" includes
      the amount of the expense incurred and updates the beneficiary's deductible amount. Once the area
      carrier or fiscal intermediary knows that the Part B deductible, as reflected on HCFA records, is
      satisfied, it can make payment on subsequent claims for the year in question without querying again.

   C. The area carrier sends a payment record to HCFA after it pays the claim. The fiscal
      intermediary sends a copy of the billing form to HCFA after it makes payment. The payment record
      (or billing form) updates the Part B reimbursement amount recorded for the beneficiary. Since the
      deductible record is updated on the basis of queries submitted before the payment is made, it is
      generally current. However, it reflects only Part B expenses credited toward the deductible.

Since the reimbursement is updated after payment is made and the maintenance of this record is not
critical to the payment of benefits, there may be a lag of several months between the time payment
is made and the time that the amount appears in HCFA's records.
6006.2 Pro-rata Deductible.--Beneficiaries enrolled in a HMO/CMP will have their records credited by a national actuarial equivalent Part B deductible. This amount is referred to as the pro-rata deductible. The pro-rata deductible is posted monthly to beneficiaries records until the current year's Part B deductible is satisfied. Part B pro-rata deductible follows:

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Pro-Rata</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>$22.63</td>
</tr>
</tbody>
</table>

6007 DEMOGRAPHIC REPORT

HMO/CMPs with a risk contract have their reimbursement determined based on a demographic report "rate book" of the enrolled Medicare population of the HMO/CMP. The demographic report is prepared each month to determine actual reimbursement. Direct any questions involving the demographic report to:

HCFA - GHPOS  
Attn: Medicare Department  
320 Meadows East Building  
6300 Security Boulevard  
Baltimore, MD 21207

6007.1 Factors Concerning Preparation.--

A. Preparation of the demographic report is the final step in the monthly update of the GHP system. The report is scheduled for release to each HMO/CMP around the 20th of the month after the month of the update. For example, the final step in the update of the GHP update for September 1984 is the preparation of the demographic report for September. The report is released to each HMO/CMP around October 20th.

B. The demographic report displays an HMO/CMP's enrolled Medicare population for 124 separate rate cells (62 for beneficiaries with Part A entitlement and 62 for beneficiaries with Part B entitlement) for each county of the HMO/CMP's service area. Rates for each cell are determined by the HCFA Actuary. The actual rates for each cell are based on your contract with HCFA. For example, the HCFA Actuary establishes a rate for cell "A" at $100. The HMO/CMP has a contract with HCFA which limits reimbursement to 95 percent of the established rate. Ninety-five dollars is the rate used for cell "A" on the demographic report.

C. In addition to the demographic breakdown of Medicare beneficiaries, the demographic report calculates total reimbursement each month based on the established rates and the beneficiaries placed in each rate cell. Exhibit 1-8 is an example. Use this exhibit as a reference guide for all procedures in this section.
6007.2 Data Elements Include.--

A. State and County Code of Residence for Beneficiary (ST/CTY CODE XXXXX) from HCFA records. If HCFA records show a State and County code other than one of the identifiable State and County codes of the HMO/CMP's service area, the beneficiary will be placed in the appropriate rate cell under ST/CTY code 99999.

B. Chronic Renal Disease (TOTAL CRD-A and TOTAL CRD-B) from HCFA records. The beneficiary will be placed in an ESRD rate cell.

C. Hospice from HCFA records. The beneficiary will be placed in a Hospice rate cell.

D. Sex (MALE AND FEMALE) from HCFA records.

E. Age (AGE GROUP) from HCFA records. Used to place a beneficiary in one of the ten age group categories.

F. Institutionalized status (INST) from your records. Used to place a beneficiary in one of the institutionalized rate cells.

G. Medicaid status (BUY-IN). Used to place a beneficiary in one of the Medicaid rate cells.

H. All other beneficiaries (NON BUY-IN). In the absence of evidence that a beneficiary has ESRD, is institutionalized, elected hospice coverage, or a Medicaid recipient, the beneficiary is placed in this rate cell.

I. Other data displayed. The demographic report displays the total number of beneficiaries in each rate cell and the total reimbursement amount in each. For example, there are ten beneficiaries with Part A entitlement in ST/CTY Code 99999, MALE, AGE GROUP 85+, INST and the reimbursement rate for that cell is $95, the demographic report displays the following:

<table>
<thead>
<tr>
<th>ST/CTY CODE 99999</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART A ENTITLEMENT</td>
</tr>
<tr>
<td>AGE</td>
</tr>
<tr>
<td>MALE</td>
</tr>
<tr>
<td>GROUP</td>
</tr>
<tr>
<td>INST</td>
</tr>
<tr>
<td>85+</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>950.00</td>
</tr>
</tbody>
</table>

The final line of the demographic report displays the total reimbursement and total number of beneficiaries included in the calculation.
HCFA will use the State buy-in indicator on the HI master record to annotate the GHP record for accretions and deletions to the Medicaid rate cell. Some States do not buy-in for all Medicaid eligible beneficiaries. These States are: Connecticut, Delaware, Illinois, Kentucky, Louisiana, Massachusetts, Minnesota, Missouri, New Hampshire, New York, North Dakota, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Vermont, West Virginia and Wyoming. Therefore, it is necessary to submit accretion and deletion Medicaid records for beneficiaries where the State does not buy-in but has determined Medicaid eligibility.

Each month submit the following beneficiary data to assure the accuracy of the demographic report:

- Accretions to institutionalized rate cell.
- Accretions to Medicaid rate cell for non-buy-in States, and
- Deletions from Medicaid rate cell for non-buy-in States.

The following rules apply to the above categories.

A. Beneficiary current health status must meet the definitions of either institutionalized or Medicaid status.

1. **Institutionalized**—A Medicare beneficiary who has been a resident for 30 days or longer of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital or domiciliary home.

2. **Medicaid**—A Medicare beneficiary who has been determined by the Medicaid Agency of the State in which he or she resided to be eligible for Medicaid.

B. To be used in a particular month's update of the demographic report, all data must be submitted (post-marked) no later than the 15th of the month and included with the accretions and deletions in accordance with §6002.

C. Do not submit data on Medicaid and institutionalized beneficiaries if information is not to be used in that month's update of the demographic report.

D. If a beneficiary is both institutionalized and on Medicaid (or a Medicaid deletion), submit data for both categories. Data for Medicaid is not needed if State is buy-in for Medicare. HCFA places the beneficiary in the appropriate rate cell as explained in §6009.

**EXAMPLES:** Using September 1984 as the month of the demographic report and September 15th as the cut-off date to submit data for preparation of the demographic report.
1. Beneficiary A, who enrolled in the plan July 1, 1984, is identified as meeting the definition of institutionalized. Submit data on September 15th, using the procedures in §6008.1.

2. Beneficiary B, who was enrolled in the plan July 1, 1984, now meets the definition of Medicaid status. Submit data on September 15th, using the procedures in §6008.2. Similarly, if the beneficiary no longer meets the Medicaid definition, submit data using the procedures in §6008.3.

3. Beneficiary C, who was enrolled in the plan July 1, 1984, is identified as meeting both the institutional and Medicaid definitions. Submit data on September 15th, using the procedures in both §§6008.2 and 6008.3. Similarly, if the beneficiary no longer meets the Medicaid definition, submit data using the procedures in 6008.3.

4. Beneficiary D is enrolled in the HMO/CMP with an effective date of coverage of October 1, 1984. Beneficiary D meets the Medicaid definition. Do not submit data for beneficiary D on September 15th. If beneficiary D still meets the definition for Medicaid, submit data on October 15th, using the procedures in §6008.2, used for the October 1984 demographic report.

6008.1 Beneficiary Accretion to Institutionalized Rate Cell.--The institutional factor is dropped from the GHP master record after preparation of the demographic report. Therefore, identify all beneficiaries each month who meet the institutional definition and submit the coding work sheet "Beneficiary Accretion to Institutionalized Rate Cell." (See Exhibit 1-9.) Complete the following items on the coding work sheet:

A. Health Insurance Claim Number (positions 1-12)--Specifications for the HICN are in §6002.4. To insure the HICN matches an existing GHP Master record, review all reply listings to determine if HCFA has given you a correction or a change in the beneficiary's HICN.

B. Surname (positions 13-24)--Specifications for completion of the surname field are in §6002.4.

C. FI (First Initial) (position 25))--Show the beneficiary's first initial in position 25.

D. Plan HMO/CMP Number (positions 47-51)--Show the HMO/CMP number assigned in positions 47-51. This is the same number used on your accretion and deletion transactions.

6008.2 Beneficiary Accretion to Medicaid Rate Cell for non-buy-in States.--Once accreted to the Medicaid rate cell, HCFA maintains that designation in the GHP and uses that factor in the preparation of the demographic report until such time as the beneficiary is deleted in accordance with §6007.4. To add a beneficiary to a Medicaid rate cell, complete the coding work sheet titled "Beneficiary Accretion to the Medicaid Rate Cell" (see Exhibit 1-10). The requirements for completion of this work sheet are in §6007.2.
6008.3 Beneficiary Deletion From Medicaid Rate Cell for non-buy-in States.--To delete a beneficiary from the Medicaid rate cell, complete the coding work sheet titled "Beneficiary Deletion from Medicaid Rate Cell." The requirements for completion of this work sheet are the same as found in §6008.2.

6009 PREPARATION OF THE DEMOGRAPHIC REPORT

The following points should be understood about the demographic report:

A. Because of the nature of the data going into the update, the demographic report can be prepared neither retroactively nor prospectively. It only can be prepared for the current GHP system update month.

B. You will not receive the demographic report for the current GHP update month until about the 20th of the following month. For example, the output from the September 1984 update would not be available for distribution until about October 20, 1984.

C. A beneficiary is placed in one, and only one, rate cell using the following priorities, from highest to lowest:

1. Hospice
2. ESRD
3. Institutionalized
4. Medicaid
5. Other
### HMO/CMP INPUT RECORD FORMAT

<table>
<thead>
<tr>
<th>Field</th>
<th>Positions</th>
<th>Descriptions</th>
</tr>
</thead>
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| 9     | 46        | Blank |
| 10    | 47-48     | HCFA Reply Code |
| 11    | 49-50     | Transaction Code (Blanks if Maintenance Record Reply) |
| 12    | 51        | Basis for Medicare Eligibility and Status of HMO/CMP Service Usage |
| 13    | 52-56     | Part A Entitlement Status (MM/YY)  
  Blanks if Beneficiary not Entitled to Part A. Position 56 is Always Blank. |
| 14    | 57-61     | Effective Date of Accretion (MM/YY)  
  Pos. 61-"X" if Accretion Date Adjusted by HCFA, Otherwise Blank |
| 15    | 62-65     | Proposed Effective Date of Accretion Deletion Submitted by the HMO/CMP (MM/YY) |
| 16    | 66        | Blank |
| 17    | 67-79     | Miscellaneous Data as Required for the Various Reply Records |
| 18    | 80        | Blank or Tape Item Record Mark |

Rev. 1 6-1-35
EXHIBIT 1-6  MONTHLY CAPITATION REPORT
EXHIBIT 1-7  DEMOGRAPHIC REPORT FOR HMO
EXHIBIT 1-8  BENEFICIARY ACCREATION TO INSTITUTIONALIZED RATE CELL
EXHIBIT 1-9  BENEFICIARY ACCREATION TO MEDICAID RATE CELL
EXHIBIT 1-10 BENEFICIARY DELETION FROM MEDICAID RATE CELL
# CHAPTER II

## BILL PROCESSING CONTROLS AND PROCEDURES

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Bill Processing Controls and Procedures

6100. GENERAL

In addition to the interchange between HCFA and HMO/CMPs of accretion and deletion records, capitation reports and summaries, there is an exchange of claims and billing information between HMO/CMPs, HCFA, and intermediaries and carriers (collectively "contractors").

HCFA and contractors have a query system. Based on information in the query response from HCFA, the contractors make several decisions. For the purposes of these instructions, their first question is: Is the beneficiary a member of an HMO/CMP? If the person is not, the contractor processes the claim. If the beneficiary is an HMO/CMP member, the contractor makes several more determinations:

1. Did the service fall within a period of HMO/CMP entitlement?
2. Is the beneficiary a restricted or unrestricted member?
3. Was the service in-plan or out-of-plan, in-area or out-of-area?
4. Was the service emergency or urgently needed?
5. What is the HMO/CMP payment option?

These questions lead to the decision whether or not the contractor has jurisdiction. If the contractor has jurisdiction, they process the claim. Otherwise, the contractor transfers the claim to you and notify the provider or physician who submitted the claim.

Beyond the interchange of claims as outlined above, there is some interchange between you and contractors when the beneficiary's record in each organization does not agree on a pertinent point, e.g., date of entitlement. In this event, it is necessary to resolve the problems by an exchange of information. Section 6004 provides instructions for resolving these problems.

In some instances, both you and a contractor will have jurisdiction of a claim. This occurs when some (but not all) of the expenses of the claim were incurred outside the period of HMO/CMP enrollment.

If this occurs, the contractor processes the non-HMO/CMP portion of the claim and forwards a copy to you for processing.

This chapter discusses Medicare bill processing options available to you, forms, procedures, and controls required to process Medicare bills and relates HMO/CMP systems to the health insurance master system.
6100.1 **Definitions.**--

**In-Plan Services** - Services directly provided or ordered and arranged for by you.

**Out-of-Plan Services** - Services furnished by an organization or individual not ordered or arranged for by you.

**Providers** - Institutions providing covered Medicare services; i.e., hospitals, skilled nursing facilities (SNF), and home health agencies (HHA).

**Medical and Other Health Services** - Covered Part B services and supplies such as physician services, X-ray, diagnostic, ambulance, and durable medical equipment.

**Bill Processing** - The act of receiving and reviewing bills or claims from providers prescribing medical and other health services. This includes reviewing whether services are medically necessary, and covered under Medicare. It further entails the payment (or denial) and appropriate notification of the determination to the parties involved. Bill processing also involves establishing and maintaining special controls as specified in §§6203, 6204, and 6205.

6100.2 **Description of Forms.**--Billing forms most frequently encountered:

1. **HCFA-1450 - Uniform (Institutional Provider) Bill (UB-82)** (For Inpatient and/or Outpatient Services)
2. **HCFA-1483 - Provider Billing for Medical and Other Health Services**
3. **HCFA-1487 - Home Health Agency Report and Billing**
4. **HCFA-1500 - Health Insurance Claim Form**
5. **HCFA-1491 - Request for Medicare Payment - Non-arranged claim**

6100.3 **HCFA-1450 - Uniform (Institutional Provider) Bill (UB-82) (For Inpatient and/or Outpatient Services)**--The HCFA-1450 is a multi-part billing form. When a Medicare beneficiary is admitted to a hospital or SNF, the provider sends an admission notice to the intermediary which in turn queries HCFA for eligibility status. The response is sent to the provider via the intermediary. Upon the patient's discharge, the remainder of the billing form is completed and sent to the intermediary which makes a number of reimbursement and medical determinations and payment. Payment, deductible, coinsurance, and utilization data is forwarded to HCFA where the data is posted to several files including the beneficiary's HI master record.

6100.4 **HCFA-1483 - Provider Billing for Medical and Other Health Services.**--The HCFA-1483 form is used by providers (not independent practitioners or suppliers) to bill intermediaries for covered supplemental medical services (Part B) provided to Medicare beneficiaries on either an outpatient or inpatient basis. When the intermediary receives the bill, it is reviewed, paid or denied, and forwarded to HCFA for posting of payment and deductible data to the HI Master files.

Where no reimbursement is claimed but Part B cash deductible or outpatient blood deductibles have not been met, the provider submits a HCFA-1483 to update the HCFA HI Master File. (See §6103.)
6100.5 HCFA-1487 - Home Health Agency Report and Billing.--The Form HCFA-1487 is used for covered home health services furnished to a Medicare beneficiary and may be submitted on a periodic basis, e.g., monthly or quarterly.

NOTE: For more detailed information on the use and processing of the forms, refer to HCFA-Pub 13, Part A Intermediary Manual.

6100.6 HCFA-1500 - Health Insurance Claim Form.--The HCFA-1500 is the basic Part B claim form used by Medicare beneficiaries to submit itemized bills. Also, the physicians and suppliers use the HCFA-1500 for filing claims (for ambulance services a HCFA-1491 is used).

6101. BILL PROCESSING OPTIONS

Section 1876 of the Social Security Act provides that you may elect to have the Secretary reimburse hospitals and SNFs through the existing Medicare reimbursement process. Therefore, several options are available to you for reimbursement of services you "purchased" (arranged for). The options available depend upon the contract you have with the Secretary. These options are:

6101.1 Risk HMO/CMP.--

A. Non-Provider Part B Services (Form HCFA-1500, 1491, and 1490S).--Regardless of the bill processing option selected, a risk HMO/CMP will process all non-provider Part B bills, except for the following services provided to an enrollee electing hospice coverage:

- Services of the enrollee's attending physician if the physician is an employee or contractor of the HMO/CMP and is not employed by or under contract to the enrollee's hospice.
- Services not related to the treatment of the terminal condition for which hospice care was elected or a condition related to the terminal condition.
- Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payment begins again.

Therefore, carriers transfer claims for HMO/CMP enrollees to you, except as noted above.

B. Provider Services (Part A or Part B) Forms HCFA-1450, HCFA-1483, and HCFA-1487.--

1. Option A

   a. HCFA intermediaries process all hospital and SNF bills. You will not process any hospital or SNF bills.
b. You process all HHA bills, except for enrollees electing hospice coverage. You will not process HHA bills for hospice enrollees during hospice coverage and after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payment begins again.

c. HCFA intermediaries reimburse all Medicare participating hospices. You will not reimburse Medicare participating hospices.

2. Option B

a. You process bills from hospitals and SNFs you elect to pay directly except for enrollees electing hospice coverage. You will not process hospital and SNF bills for hospice enrollees during hospice coverage and after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payment begins again. HCFA intermediaries process all other hospital and SNF bills.

b. You process all HHA bills, except for enrollees electing hospice coverage. You will not process HHA bills for hospice enrollees during hospice coverage and after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payment begins again.

c. HCFA intermediaries reimburse all Medicare participating hospices. You do not reimburse Medicare participating hospices.

3. Option C

a. You process all hospital, HHA, and SNF bills, except for enrollees electing hospice coverage. You will not process hospital, HHA, and SNF bills for hospice enrollees during hospice coverage and after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payment begins again.

b. HCFA intermediaries reimburse all Medicare participating hospices. You will not reimburse Medicare participating hospices.

6101.2 Cost HMO/CMP

A. Bills for Non-Provider Part B Services.--

1. Regardless of the option selected, process all non-provider Part B bills for services which you provided or arranged except as noted below. These exceptions are processed by the carrier. A copy of the EOMB is sent to you for carrier processed claims.

   a. Claims involving outpatient psychiatric services;
   b. Claims for services by an independent physical therapist;
   c. Claims for outpatient blood transfusions;
   d. Claims from physicians for dialysis and related services provided through an approved dialysis facility; and
e. Hospice care by Medicare participating hospices except: services of the enrollee's attending physician if the physician is an employee or contractor of the organization and is not employed by or under contract to the member's hospice; and services not related to the treatment of, or a condition related to the terminal condition.

2. Since an enrollee of a cost HMO/CMP is free to obtain Medicare services wherever available, carriers process claims received as if they were non-arranged services. A copy of the EOMB is sent to you for all claims processed by the carrier for your enrollees.

B. Provider Services (Part A or Part B) Forms HCFA-1450, HCFA-1483, and HCFA-1487.-

1. Option 1

a. HCFA intermediaries process all hospital and SNF bills. You will not process any hospital or SNF bills.

b. You process all in-plan HHA bills, except for HHA services to an enrollee electing hospice coverage relating to the treatment of or a condition related to the terminal condition. HCFA intermediaries will process all out-of-plan HHA bills.

c. HCFA intermediaries process all bills from approved dialysis facilities for dialysis and related services. You will not process any bills from dialysis facilities for dialysis and related services.

d. HCFA intermediaries reimburse all Medicare participating hospices. You will not reimburse Medicare participating hospices.

2. Option 2

a. You process bills only from hospitals and SNFs you have elected to pay directly, except for services to an enrollee electing hospice coverage relating to the treatment of, or a condition related to, the terminal condition. HCFA intermediaries will process all other hospital and SNF bills.

b. You process all in-plan HHA bills, except for HHA services to an enrollee electing hospice coverage relating to the treatment of, or a condition related to, the terminal condition. HCFA intermediaries will process all out-of-plan HHA bills.

c. HCFA intermediaries process all bills from approved dialysis facilities for dialysis and related services. You will not process any bills from dialysis facilities for dialysis and related services.

d. HCFA intermediaries reimburse all Medicare participating hospices. You will not reimburse Medicare participating hospices.
6102. BILL PROCESSING PROCEDURES (FORMS HCFA-1450, HCFA-1483, and HCFA-1487)

Depending upon the bill processing option selected (see §6201) and the type of contract you have with HCFA (cost or risk), procedures for processing inpatient and outpatient bills vary. However, the basic bill process for an inpatient service begins with an admission notice.

6102.1 Inpatient Bill Processing.--When a Medicare beneficiary is admitted to a hospital, including one owned and operated by you, the provider fills out the admission notice (HCFA-1450) and sends it to the intermediary.

Upon receipt of the admission notice, the intermediary queries HCFA for eligibility and deductible status. When a reply is received, the intermediary forwards a report of eligibility to the provider.

When you have jurisdiction over the payment of a bill (Option codes 2, B, or C) the hospital sends a copy of the reply data to you as soon as it is received from the intermediary. Whether the reply is given by telephone, mail, or wire to the hospital, it contains eligibility information.

The intermediary uses the remarks section to advise the hospital whether the bill should be sent to you or itself for processing. Additionally, the appropriate period of HMO/CMP entitlement necessary to process the bill is shown. If the billing falls in a prior period of HMO/CMP enrollment, the start and termination dates of such enrollment are shown.

When the Medicare beneficiary is discharged from the hospital, the remainder of the HCFA-1450 is completed and sent to you or the intermediary for processing and payment. If you have jurisdiction over the payment (Option codes, 2, B, or C), the final disposition of the HCFA-1450 is to be completed and forwarded to the proper intermediary. The bill is to be clearly marked "HMO Paid Bill." The intermediary forwards the information to HCFA for posting utilization data to the enrollee's record.

Regardless of whether your enrollee's provider bill is paid by an intermediary or you, bills are completed in the same manner. Providers should fully complete bills for your enrollees.

However, special instructions applicable to all-inclusive rate or no-charge structure hospitals and bills for emergency services furnished by non-participating hospitals apply. Existing instructions for determining covered level of care, and medical necessity apply to your enrollee's bills, whether paid by you or an intermediary.

In cases where the eligibility response or other information supplied by the beneficiary and verified by the hospital indicate that an intermediary has jurisdiction for your enrollee's bill, the hospital sends that bill directly to the intermediary. Conversely, if it is confirmed that you have contractual responsibility for a particular bill, the bill is sent to you.
The hospital always sends the admission notice copies of the HCFA-1450, in specially annotated envelopes, directly to its intermediary for it to query HCFA even if the patient is an HMO/CMP enrollee, since querying HCFA is an intermediary function.

When required by the intermediary, the hospital sends supporting medical information with the admission notice to the intermediary (i.e., when the intermediary has jurisdiction for bill processing). If the hospital has knowledge that the bill will be paid and processed by you, it does not send medical information with the admission notice. Immediately upon receipt of the ROE from the intermediary confirming your jurisdiction, the hospital sends medical information with a copy of the ROE to you. If the hospital does not know whether you or the intermediary has jurisdiction, it follows the usual procedures of sending medical information with the admission notice.

6102.2 Outpatient Bill Processing.--The HCFA-1483 is completed in the same manner as any hospital bill for outpatient services except an indication of HMO/CMP involvement in the Remarks section.

If the beneficiary is an enrollee of an HMO/CMP, "HMO/CMP ENROLLEE" is entered in the Remarks section by the hospital. The name and address of the HMO/CMP is entered in block 10. If the enrollee has an enrollment number associated with you, the number is entered in block 11. When the hospital knows the bill will be paid and processed by the intermediary, it sends it to the intermediary.

However, when the hospital knows the bill will be paid and processed by you, it sends the HCFA-1483 directly to you for coverage determination, and payment and/or denial action. With one exception, there will be no query submitted to HCFA via the intermediary for HMO/CMP-paid HCFA-1483s. The exception occurs when the bill contains entries in Item 17, "Blood Information." In this situation, you must request the intermediary to submit a Part B query to HCFA for determining the blood deductible status. (See §6203.)

If the hospital does not know whether the intermediary or you has jurisdiction, it sends the bill to the intermediary.

6102.3 Home Health Care Bill Processing.--Regardless of the selected billing option, risk contracting HMO/CMPs process all home health care bills. Cost contracting HMO/CMPs process all in-plan home health care bills, and out-of-plan HHA bills are processed by HCFA's intermediaries.

The HCFA-1487 is used for covered home health services furnished to a Medicare enrollee and may be submitted on a periodic basis, e.g., monthly or quarterly. The HCFA-1487 is a multi-part form containing a start-of-care notice and billing form and is processed in the same manner as the HCFA-1450. The bill is to be clearly marked "HMO Paid Bill." The intermediary forwards the information to HCFA for posting utilization data to the enrollee's record.
6103. SERVICES REQUIRING SPECIAL PROCEDURES BY COST HMO/CMPs

Special procedures apply to processing bills for the following services by cost HMO/CMPs:

1. **Outpatient Blood.**--The first three pints of blood furnished under Part B benefits in a year are not reimbursable by Medicare. The first three pints constitute a Part B blood deductible.

2. **Outpatient Psychiatric Care.**--Total expenses covered under Medicare are limited each year to the lesser of $312.50 or 62.5 percent of the reasonable charge. (Under this formula, the maximum payable by Medicare is $250.)

3. **Independent Physical Therapist.**--Service performed by a licensed, independently practicing physical therapist are covered only for $400 each year.

4. **Services Related to End Stage Renal Disease ESRD.**--While no special deductibles or limitations apply to these services, special reimbursement rules apply.

Regardless of the claims processing option selected by you, submit a claim to the area carrier or intermediary for ESRD services, outpatient psychiatric care, services from an independent physical therapist, and for recording the first three pints of blood as a deductible.

If you provide these services directly, use form HCFA-1500.

If you purchase the services, you may use form HCFA-1490 U (Request for Payment by Qualified Organizations) provided you have been approved by the HCFA to use it and the following conditions are met:

1. You pay the member's bill in full;

2. You relieve the member of any liability (other than premium liability) for payment of the bill; and

3. You have the member's written authorization to receive the Part B payment.

You must pay any applicable deductible, coinsurance and any amount in excess of the "reasonable charge" as determined by the carrier. This does not prevent you from receiving premiums. You cannot claim or receive from the enrollee (or a person responsible for the enrollee's care) any payment toward a bill for which you claim and receive Part B benefits. You are permitted to recover expenditures (total charge minus Part B benefit), under a subrogation or nonduplication clause in your contract with the enrollee, in the event the enrollee recovers medical care costs through litigation in a personal injury action or through an insurance policy.

"Payment in full" does not mean that you must pay the bill as originally presented. If you can obtain the agreement of the physician or supplier to accept a lower amount as full discharge of the patient's obligation on the bill, payment of such lower amount would
represent payment in full. Obtain written evidence of the physician's or supplier's agreement to the reduction of the bill, e.g., a new bill or an annotation on the original bill showing acceptance of a specific lesser amount. The claim as submitted to the carrier must show clearly the amount the plan actually paid.

6103.1 Determining Blood Deductible Status.--When you submit a Form HCFA-1500, HCFA-1483 or HCFA-1490 U to the carrier for blood furnished to a Medicare beneficiary, the carrier queries HCFA to determine the blood deductible status. The carrier sends you an "Explanation of Medicare Benefits" (EOMB), which reports the blood deductible status. Pints in excess of three are reimbursable under Medicare, subject to the Part B coinsurance and deductible requirements.

6103.2 Rules for Completing HCFA-1500 or HCFA-1490 U for Blood Reimbursement.--

A. Blood Replaced.--When the blood or packed red cells furnished to an enrollee is replaced, enter the number of pints of replaced blood, along with the date and place of service, in item 7 of the HCFA-1490 U or item 24 of the HCFA-1500. Do not enter charges in the charge column (E). Treat costs incurred in furnishing the blood as care costs and do not enter them on the HCFA-1500 or HCFA-1490 U. However, you may include in costs, the charges paid to a blood bank organization or provider for replaced deductible blood.

B. Blood Not Replaced.--When the blood or packed red cells furnished to an enrollee is not replaced and the blood deductible has not been met, the purchase price (if any) is not a reimbursable cost. Such costs are excluded from the care costs applicable to Medicare. Submit a Form HCFA-1500, HCFA-1483 or HCFA-1490 U to the carrier to record the deductible. Treat costs incurred for furnishing the blood, including processing, storing, transportation, etc., as covered care costs. If the deductible has been met at the time blood is administered, the purchase price is a covered cost whether or not the blood is replaced.

6103.3 Outpatient Psychiatric Services.--Regardless of the expense for physician's services incurred for outpatient psychiatric services in a calendar year, total Medicare allowable charges are limited to the lesser of $312.50 or 62.5 percent of the reasonable charges. The computation of psychiatric expenses for deductible purposes is also subject to the 62.5 percent rule. Since $312.50 represents 62.5 percent of $500, any amount of non-inpatient psychiatric service expense in excess of $500 is not considered in computing incurred expenses. Since Medicare's share of covered incurred expenses (after the deductible) is 80 percent of the reasonable charges, the maximum possible payment for services is 80 percent of $312.50, or $250. This maximum could be reached only if the individual has met the deductible through other than non-inpatient psychiatric service expenses. Charges for initial diagnostic services (i.e., psychiatric testing and evaluation used to diagnose the patient's illness) are not subject to this limitation. The limitation applies only to therapeutic services (e.g., psychotherapy) and to follow-up diagnostic services performed to evaluate the treatment.

If you furnish outpatient psychiatric services directly, you will be reimbursed by the carrier for the physician's component. Other costs connected with the rendering of such care will be included in your care costs subject to cost reimbursement.
Following is a suggested method to determine an average cost per psychiatric visit in reporting these services. The method outlined for determining an average cost per visit may not be applicable to all plans. You may propose other methods for the carrier's approval, provided it yields comparable results. Submit to your carrier for approval, the cost per visit and the method used to determine that amount. Base the cost per visit on costs for the accounting year in which the visit took place, i.e., when using a calendar year for accounting purposes, determine a cost per visit for 1981 and 1982 and subsequent years based on the costs for each year.

The carrier is the carrier servicing the location of your headquarters.

A. Estimated Average Cost Per Visit for Psychiatric Services.--An estimated average cost per visit may be determined by dividing the estimated physician cost of providing outpatient psychiatric visits by the estimated total number of such visits which will be rendered by the plan, adjusted to reflect the additional time required to treat Medicare patients. This becomes the estimated average cost per visit applied to all outpatient psychiatric visits rendered to enrollees.

The term "visit" refers to a face-to-face visit with a plan physician either informally or on an appointment basis for examination and/or treatment.

EXAMPLE: A plan's cost for the year 1984 for providing outpatient psychiatric services to all of its enrollees was $9,000, of which $5,400 represented physician salaries. During the same period there were 950 outpatient psychiatric visits of which 95 (10 percent) were for individuals who were Medicare beneficiaries. The plan estimates that in 1985 its costs will increase to $12,000 with physician salaries representing $7,200 of this amount. The plan also estimates that the number of outpatient psychiatric visits will increase to 1,000 with 10 percent being used by persons who are Medicare beneficiaries.

The estimated average cost per outpatient psychiatric visit is determined by the following computation:

| Estimated number of outpatient psychiatric visits provided to plan members and nonmembers who are Medicare beneficiaries | 100 |
| Estimated number of outpatient psychiatric visits provided to other individuals | 900 |
| Total number of estimated outpatient psychiatric visits | 1,000 |
| Total estimated physicians costs for outpatient psychiatric visits | $7,200 |
| Divided by the total estimated number of outpatient psychiatric visits | 1,000 |
| Average charge per outpatient psychiatric visit | $ 7.20 |
Since the limitation applies to any physician who treats a mental, psychoneurotic, or personality disorder, whether or not the physician is a psychiatrist, it may be necessary to allocate a portion of such physician's salaries to the costs used to compute the average cost per visit. This is done by allocating an appropriate part of salaries based on the percentage of time the physicians devote to psychiatric visits.

Where a plan's psychiatrist, or other physician providing psychiatric services, spends a portion of his time in administrative duties or consultation with other plan physicians not seeing the patient, his entire salary need not be included in the calculation. You may allocate the salary on the basis of the percentage of time spent in face-to-face contact with patients and administrative consultative functions. Include that portion applicable to face-to-face contacts in your total care costs. However, where the consultation results in another physician treating the patient for a mental, psychoneurotic, or personality disorder, allocate a portion of the physician's salary to the cost which the average cost for such visits is based.

B. Request for Payment.--Prepare a Request for Payment Form HCFA-1500 and send it to the carrier. The enrolled beneficiary's signature is required. In Column E, under Charges, enter a charge for each outpatient psychiatric visit. Enter for each visit, the full amount determined to be the physician's component per visit.

Do not include fee-for-service payments made to psychiatrists on an "arranged for" basis in the estimated cost of providing outpatient psychiatric services. Submit receipted bills to the carrier with a Form HCFA-1490 U showing the organization requesting the reimbursement. (See §6103B.)

When an enrollee has reached the maximum Medicare reimbursement limit ($250) for outpatient psychiatric services, it is not necessary to bill the carrier for additional visits. However, allocate the noncovered costs for such visits to the appropriate outpatient psychiatric accounts.

6103.4 Independent Physical Therapy.--In any calendar year, a maximum of $500, less deductible and coinsurance, is reimbursable for such services.

Submit a Form HCFA-1500 or HCFA-1490 U for reimbursement to the carrier. When the reimbursement limit ($400) is met, further billings are not required. (See §6103B.)

6103.5 Reimbursement for ESRD.--The costs of ESRD treatment are covered Medicare costs. However, there are limits on the reimbursement levels which are based on the charge screens maintained by the intermediaries and carriers. Therefore, all bills for treatment of ESRD must be sent to the intermediary and carrier. Costs for these services are not claimed on the cost report.

6104. EXCHANGE OF HOSPITAL AND MEDICAL INSURANCE DEDUCTIBLE AND COINSURANCE INFORMATION

While the reimbursement to you for Medicare members is unique, it does not obviate the need to record care and services information on HCFA's records. For Part B, the information recorded is an actuarial standard pro-rata deductible. Monthly, HCFA posts the pro-rata to the enrollee's record until the Part B yearly deductible has been met.
Part A utilization information is entered into the HCFA master record based on service data submitted by the provider. This is true whether the service is provided by you or by an outside provider. Unlike the Part B deductible and coinsurance provisions, the Part A data is applied to HCFA's records only when service data is provided.

Bills paid by you for inpatient hospitals and SNFs are forwarded to the provider's intermediary. The intermediary forwards the bills to the HCFA for posting deductible, coinsurances and utilization data to beneficiaries' records.

6105. DUPLICATE PAYMENT DETECTION FOR COST CONTRACTING HMO/CMP

Several entities may have jurisdiction over the processing and payment of Part B bills for your members. This could result in duplicate payments to either the physician, supplier, or to the enrollee. It is incumbent upon you to establish a system to preclude or detect duplicate payments.

Regardless of the claims option selected, process all non-provider Part B bills, with some exceptions (See §§6101 and 6103.) If a physician/supplier submits a HCFA-1500 for payment, be sure:

1. The bill was not previously paid; and
2. The bill was not for services restricted as defined in §§6101 and 6103.

After you receive paid claim information (denial or an EOMB from the carrier), perform several duplicate check functions. If you have not previously paid the claim, file a copy of claims information in the beneficiary's history file. If your duplicate check reveals you have already paid for the service(s):

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

6105.1 Coordination of Benefits.--The Medicare program is usually the primary payer for covered Medicare services provided to your members. However, there are four situations where Medicare is not the primary payer and benefits are coordinated with other health insurance payers. These are services covered by:

1. Worker's compensation;
2. Employer group health plans in the case of ESRD beneficiaries during a period of up to 12 months;
3. Auto medical, no fault, or any liability insurance; or
4. Employer group health plans in the case of employed beneficiaries age 65-69 and spouses age 65-69 of employed individuals of any age under 70.
You need not coordinate benefits in situations where the probability of recovery is highly unlikely, or the cost to pursue a claim is in excess of the amount recoverable.

A. Coordination With Worker's Compensation.--Medicare may not pay for services reimbursable under workers' compensation laws. Where you coordinate your own health plan with worker's compensation coverage, use the procedures to identify and recover costs for services furnished to Medicare members. Where you do not coordinate benefits for your own plan, establish reasonable screening procedures to identify potential workers' compensation liability situations. Recovered costs are excluded from Medicare reimbursement for cost contracts.

B. Coordination for ESRD Beneficiaries.--Medicare is secondary to benefits payable under an employer group health plan in the case of individuals who are entitled to benefits solely on the basis of ESRD, during a period of up to 12 months. During this period, Medicare is secondary for all Medicare covered services, not just ESRD-related services.

The 12-month period begins with the earlier of: (1) the month in which a regular course of dialysis is initiated; or (2) in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.

Since Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis, Medicare will usually be the secondary payer for the first 9 months of an individual's entitlement. However, for those individuals who undertake a course in self-dialysis training or who receive a kidney transplant during the 3-month waiting period, Medicare may be the secondary payer for up to the first 12 months of the individual's Medicare entitlement. Refer to HCFA Pub. 14 for specific information.

If the basis for an individual's entitlement to Medicare changes from ESRD to age 65 or disability, the coordination period terminates with the month before the month in which the change is effective.

The following examples illustrate how to determine the number of months in which Medicare pays secondary benefits for various situations in which benefits are payable by employer group health plan:

1. Individual became entitled to Medicare after a waiting period

   a. Janice started a regular course of dialysis in October 1983. The 12-month period begins in October 1983 (the month in which Janice started a regular course of dialysis) and the waiting period consists of October, November and December 1983. Medicare is secondary payer from January through September 1984.

   b. Peter started a regular course of dialysis in January 1983 and was hospitalized and received a kidney transplant in March 1983. The 12-month period begins with January 1983. The kidney transplant cuts short the dialysis waiting period so that Peter becomes entitled in March 1983. Medicare is secondary payer from March through December 1983.
2. Individual became entitled to Medicare without a waiting period

In October 1983 John began a regular course of dialysis. In December 1983 John began a course of self-dialysis training. Since the self-dialysis training course was initiated during the first 3 months of dialysis, he is exempt from the waiting period and becomes entitled as of October 1983 the first month of dialysis. In this situation the first month of entitlement coincides with the beginning of the 12-month period. Thus, the coordination period extends from October 1983 through September 1984. Medicare is secondary payer during this period.

The following steps are involved in determining Medicare responsibility as the secondary or primary payer:

1. Identify Medicare members entitled solely because of ESRD;
2. Determine the period within which benefits must be coordinated; and
3. Determine if services rendered can be paid by an employer group health plan.

C. Coordination With Liability Insurance.--Medicare is the secondary payer for services payable under automobile, auto medical or no-fault insurance or any liability insurance. Where you coordinate your own plan in these situations, use procedures for identifying and recovering costs for services furnished Medicare members. If you do not coordinate benefits in these situations for your own plan, establish reasonable procedures to identify and recover costs in these situations. Costs recovered are excluded from Medicare reimbursement for cost contracts.

D. Coordination With Employer Group Health Plans.--Effective January 1, 1983, Medicare is secondary payer to employer group health plans of employers with 20 or more employees, for employed Medicare members (age 65-69) and their spouses (age 65-69). Effective January 1, 1985, Medicare is secondary payer for the spouses (age 65-69) of employed individuals of any age under 70. Medicare is secondary payer only if the individual is entitled to Medicare Part A. Medicare is not secondary for persons (age 65-69) who have ESRD.

The following steps are involved in determining Medicare's responsibilities as secondary or primary payer.

1. Determine if the member or spouse is age 65 through 69 and entitled to Part A;
2. Determine if the employee or spouse is entitled to Part A and does not have ESRD;
3. Determine if the member is employed;
4. Determine if the employee or spouse is covered under the employer's health plan; and
5. Determine if the services are covered under the employer plan.

Identify those individuals affected as part of the enrollment process. Medicare reimbursement to cost HMO/CMPs is reduced to the extent that the expenses are reimbursed under an employer plan.
MONTHLY SUMMARY OF BILLS PAID BY CONTRACTORS FOR HMO/CMP ENROLLEES

When contractors make Medicare payments, detailed information about the benefits and payments are recorded in the HI master record maintained by the HCFA. Although there may be a 45-60 day lag time between the payment date and the posted date, all payments are ultimately recorded.

When the contractor makes a payment for an HMO/CMP enrollee, the information is recorded on a separate file. Once each month, reports are made from this file for each HMO/CMP. They show all payments by contractors which have been posted to the HI master record and which involve HMO/CMP enrollees. Only payments made while the enrollee is a member of an HMO/CMP are shown.

Potential Uses of Summary Reports.--The reports allow an analysis for both operational and reimbursement aspects of the HMO/CMP program. Examples of potential uses of the reports include:

A. An analysis of whether contractors are sending informational notices to the HMO/CMP when payments are made for their enrollees.

B. A determination of the amount of out-of-plan usage by HMO/CMP enrollees.

C. An analysis of total cost of furnishing services to an HMO/CMP's enrollees.

D. A tool to determine an HMO/CMP's total costs in comparison to the adjusted average per capita (AAPCC) for determining whether to convert from a cost-basis to a risk-basis HMO/CMP.

E. A supplement to the duplicate detection process required by §6105.

Distribution of Reports.--Reports are sent once a month. The reports are included with the capitation reports and should be received about the 15th of each month.

Description of Monthly Summary of Bills Paid by Intermediaries for HMO/CMP Enrollees.--Shows a sample of the monthly summary prepared for intermediary payments.

A. Identification Data.--The first line of each report identifies the HMO/CMP for which the report is prepared.

HMO/CMP No. - The HMO/CMP identification number. This is the same number used to submit accretion/deletion data to HCFA. However, the letter H prefix is omitted.

HMO/CMP Name - The name of the HMO/CMP.

HMO/CMP FY Ending - The HMO/CMP fiscal year ending date. Separate reports are prepared for each HMO/CMP fiscal year.

Current Month - The month and year of the report.

Bills Through - The report reflects all bills posted to the HI master record through this date (month and day).
B. Detailed Information.--HCFA selects up to three intermediaries servicing providers in the HMO/CMP's area. For these, detailed information is broken out for each provider for which a payment has been posted. For providers serviced by other intermediaries, all payments are accumulated under the "INTER NO. - OTHER" category. In this latter case, there is no breakout of payments to individual providers.

The items which appear on the report on the left hand side, reading from top to bottom include:

- **Inter No. -** The five position number for the intermediary servicing the providers listed under it.
- **Prov. No. -** The six position provider number showing reimbursement made by the intermediary listed above.
- **Monthly Tot. -** Total of all payments made by the intermediary which were posted during the month of report.
- **Fiscal Yr. -** Running total of all posted intermediary payments through the month of report for the HMO/CMP fiscal year.

Note: If you make Medicare payments to a provider, the information for that provider reflects payments made by you, not the intermediary.

- **Inter No. -** Data under this heading is a cumulative total of payments made by all other intermediaries to providers. As above, this information includes a monthly total (Monthly Tot.) and a fiscal year total (Fiscal Yr.).

The detailed information from posted bills is taken from HCFA-1450s, HCFA-1483s and HCFA-1487s. The report shows summary information for each provider.

6106.4 **Description of Monthly Summary of Bills Paid by Carriers for HMO/CMP Enrollees.--**

A. **Identification Data.--** The identification data for the carrier report is the same as for the intermediary report. Section 6106.3A contains a description of these data elements.

B. **Detailed Information.--** Information for the carrier reports is not taken directly from bills but extracted from payment records which the carrier submits to HCFA each time program reimbursement is made.

HCFA selects up to three carriers processing bills for an HMO/CMP's enrollees. Detailed information showing monthly and fiscal year totals is displayed for them. Payments made by all other carriers are lumped together in an "OTHER" category.
Detailed information appearing on the report includes:

**Carrier Number** - The five position number identifying the selected carrier(s) which made program reimbursement for HMO/CMP's enrollees.

**Medical Charges** - Reasonable medical charges and outpatient psychiatric expenses from carrier payment records.

**Amount Reimbursed** - Medicare payments made by the carrier shown on carrier payment records.

**Number of Services** - Number of services for which Medicare reimbursement was made as shown on carrier payment records.

**Total Bills** - Systems-generated cumulative total.

6107. **HMO/CMP BILL ITEMIZATION**

The HMO/CMP Bill Itemization is a detailed listing of all bills used to prepare the Monthly Summary of Bills Paid by Intermediaries for HMO/CMP Enrollees. The bill itemization shows additional information not available on a monthly summary and helps HMO/CMPs to determine beneficiary and/or HMO/CMP liability for deductibles and coinsurance for specific bills. Since the bill itemization includes denied bills, risk HMO/CMPs are able to determine the appropriate action to take on bills for physician services provided in a hospital (for example, if an intermediary denies payment of a bill because services were not an emergency or urgently needed, the physician services would be noncovered Medicare services).

A. **Distribution of Reports**.--Reports are sent once a month.

B. **Description of HMO/CMP Bill Itemization**.--The itemization reports are broken out in four parts. There are reports for Inpatient Hospital and Extended Care Admission and Billings; Provider Billing for Medical and Other Health Services, Home Health Agency Report and Billing, and Non-Payment Records.

**Note 1:** HCFA receives a wide variety of bills from intermediaries. Because of this, bills for which payment has been denied could be shown under either non-payment records or under HCFA-1450s.

**Note 2:** Bill itemizations are generated only for those categories of bills processed through the HCFA system for a given month. For example, if an intermediary-paid HCFA-1450 for HMO/CMP HOOOO is the only bill processed through the HCFA system from January 1, 1984 through January 31, 1984, the bill itemization is in one part only and shows the payment for the HCFA-1450. If no bills are processed for HMO/CMP HOOOO, no bill itemization is sent.
Identification Data

Date - The date which appears in the upper left hand corner is the same as the Bills Through date shown on the Monthly Summary of Bills Paid by Intermediaries for the HMO/CMP Enrollees.

Bill Type - Inpatient Hospital and Extended Care Admission and Billings, Provider Billing for Medical and Other Health Services, Home Health Agency Report Billings or Non-Payment Records. One bill itemization is prepared for each of four types of bills posted to the HI master record through the date shown above.

HMO/CMP Number - The HMO/CMP identification number. This is the same number used to submit accretion/deletion data to HCFA. However, the letter H prefix is omitted.

C. Detailed Information - General - There is one line item for each bill posted to the HI master record. Information identifying the beneficiary, provider, and intermediary for a particular bill are common to each bill itemization and are in the same position on each. Reading from left to right, they are:

1. CLAIM NUM - The beneficiary's HICN. Each bill itemization is listed in HICN sequence.

Note: Railroad numbers appear at the beginning of the report. However, because of programming limitations the railroad claim numbers are in the same format as they are maintained in the HI master record. For example, an actual railroad claim number of MA700000000 is maintained in the HI master record as G000000014. Should you experience difficulty in identifying railroad beneficiaries, refer to HCFA Pub. 14.3, §3200.

2. NAME - Up to six positions of the beneficiary's surname.

3. INIT - The beneficiary's first and middle initial.

4. PROV - The six position number for the provider furnishing the service and submitting a bill for reimbursement.

5. INTER - The five position number for the intermediary which processed the bill.

Detailed information for each bill itemization is taken from HCFA-1450s and is listed below.

D. Detailed Information - Inpatient Hospital and Extended Care Admission and Billings --

1. ADM DATE - Date of admission for inpatient stay.

2. TOTAL CHARGES - Charges for all accommodations and services.
3. NON-COV CHARGES - Noncovered charges for all accommodations and services.
4. INP DED - Deductible to be paid by beneficiary.
5. NC BLD DEDUCT - Deductible to be paid by beneficiary for blood.
6. COINSURANCE
   a. DAYS - Number of beneficiary coinsurance days.
   b. CHGS - Charge for each day of coinsurance.
   c. AMOUNT - Total to be paid by beneficiary for coinsurance.
7. TOTAL DEDUC - Total to be paid by beneficiary for deductible and coinsurance.
8. FROM DATE AND THRU DATE - The inclusive dates reported on the bill. In the case of a final billing, the THRU DATE shows the date of discharge or death (Item 20).
9. COV DAYS - Total covered days for the bill.
10. REIM AMT - Estimated covered costs less deductions shown under TOTAL DEDUCT.
11. NP CODE - Reason for nonpayment of bill. Applicable codes are:
   W - Workers' Compensation
   B - Benefits Exhausted, including situations where the regular spell of illness days have been exhausted and the patient elects not to use lifetime reserve days.
   R - Spell of Illness Benefits Refused, Failure to Submit Evidence, Provider Responsible for Not Filing Timely, or Waiver of Liability - the provider is at fault.
   E - Cases which are denied because HMO/CMP out-of-plan services were determined to be neither emergency nor urgently needed while temporarily absent from the service area.
   C - Noncovered care.
   N - All other reasons for nonpayment.

Note 1: All dates are Julian and contain five positions. The first two reading left to right show the year, the last three positions show the Julian date. For example: 78024 is January 24, 1978; 78263 is September 20, 1978; 78321 is November 17, 1978.
Note 2: All money positions represent dollars and cents. There is no decimal point to separate the cents. The last two positions on the right show cents. For example, 50 reads $.50; 150 reads $1.50; 2150 reads $21.50; 32150 reads $321.50.

Note 3: If a CR appears on the right side of any line item after all other items, the bill shown is an adjustment bill. The amounts shown have been subtracted from the Monthly Summary of Bills Paid by Intermediaries for HMO/CMP enrollees.

E. Detailed Information - Provider Billing for Medical and Other Health Services.--Review and keep in mind Notes 1, 2, and 3 which assist in interpreting the information listed below:

1. **TYPE SER** - An O represents outpatient service, and an I represents inpatient service (Item 9).
2. **DATE OF 1ST SER** - Date of first service.
3. **DATE OF LAST SER** - Date of last service.
4. **BLOOD DEDUCT** - Amount beneficiary is to pay for blood deductible.
5. **CASH DEDUCT** - Amount beneficiary is to pay for Part B deductible.
6. **COIN AMT** - Amount beneficiary is to pay for coinsurance.
7. **TOT CHARGES** - Total charges for all services.
8. **PMT DIST PROVIDER** - Amount to be paid to the provider.
9. **PMT DIST PATIENT** - Amount to be paid to the beneficiary.

F. Detailed Information - Home Health Agency Report and Billings.--

1. **DATE CARE STARTED**
2. **BEG DATE OF SERV AND END DTE OF SERV** - Beginning and ending dates of services for the bill submitted.
4. **TOTAL VISITS** - Total number of visits for all services.
5. **TOTAL CHARGES**
6. **REIMB AMOUNT** - Reimbursable amount.
7. **VERIF DEDUCT** - Patient's liability for Part B deductible.
G. Detailed Information - Non-Payment Record
   1. ADMIS/START DATE - Admission or start of service date.
   2. TOT CHARGES - Total Charges.
   3. FROM DATE AND THRU DATE - Beginning and ending dates of stay or service for the bill.
   4. NON-PAY CODE - See §6107.D.11 for a listing of all nonpayment codes.

6107.1 HMO/CMP Payment Record Report.--Carriers submit to HCFA a payment record for every bill reimbursed under Part B. The HMO/CMP Payment Record report is a detailed listing of all payment records used to prepare the Monthly Summary of Bills Paid by Carriers for your enrollees. This report shows additional information not available on the monthly summary and serves the same general purposes. Use the payment record report as the basis to perform duplicate payment checks required by §6105.

   A. Distribution of Reports.--Reports are sent monthly.

   B. Description of Payment Record Report.--Payment record reports are prepared only if payment records were processed for an HMO/CMP's enrollee(s) during the month. Thus, if no payment records are processed for HMO/CMP HOOOO, no payment record report is sent. Confirmation that no payment records were processed can be made by reviewing the Monthly Summary of Bills Paid by Carriers for HMO/CMP Enrollees. This report should show no entries in the "Total This Month" fields.

   C. Detailed Information - General.--There is one line item for each payment record processed by HCFA. Payment records on the report are sequenced first by the physician/supplier identification number and then by HICN for each grouping of physician/supplier identification numbers. The first two lines of each page show the month and year of the report and the HMO/CMP identification number. The H prefix is omitted. The page number in the upper right hand corner has no significance for an HMO/CMP.

   D. Detailed Information.--
      1. CLAIM NUM - The beneficiary's HICN. The note regarding railroad claim numbers (see §6107.C.1) applies to the payment record report.
      2. NAME - Up to six positions of the beneficiary's surname plus the first initial.
3. **EXPENSE DATES.--**
   
a. **FIRST** - The month and year of the earliest covered incurred expense included on the payment record.

b. **LAST** - The month and year of the most recent incurred covered expense included on the payment record.

Note: Although month, day, and year are shown on the report, the day is always "01". Current payment record processing requirements require only the month and year.

4. **REIM AMT** - The amount of payment made to, or on behalf of, the beneficiary. This field is right justified with both dollars and cents shown. No decimal point separates cents. Thus, 50 reads $.50; 150 reads $1.50; and 2150 reads $21.50, etc.

5. **TOT CHARGES** - Total reasonable charges for non-psychiatric items. This field is right justified with both dollars and cents shown.

6. **DED APP** - The total amount of incurred expenses on this payment record which were applied to meet the deductible. This field is right justified with both dollars and cents shown. "9999" in this field means that services were reimbursed at 100 percent of reasonable charges. If there is no entry in this field, the beneficiary previously has satisfied the deductible.

7. **PHY/SUPP ID** - The physician or supplier identification number. The payment record report is listed in the physician/supplier identification number sequence. This field may contain Social Security account numbers, employer identification numbers, or other identification numbers assigned by carriers until Social Security or employer identification numbers are available. Determine the numbers your physician or supplier use to bill Medicare in order to make the most effective use of the payment record report.

8. **POS** - Place of Service Code
   
   1 = Office
   2 = Home
   3 = Inpatient Hospital
   4 = SNF and Nursing Home
   5 = Outpatient Hospital
   6 = Independent Laboratory
   7 = Other
   8 = Independent Kidney Disease Treatment Center
9. **TYP** - Type of Service Code

1 = Medical Care  
2 = Surgery  
3 = Consultation  
4 = Diagnostic X-Ray  
5 = Diagnostic Laboratory  
6 = Radiation Therapy  
7 = Anesthesia  
8 = Assistance at Surgery  
9 = Other Medical Assistance  
O = Charges for Whole Blood or Packed Red Blood Cells  
M = Alternate Payment Method of Maintenance Dialysis  
N = Kidney Donor  
Y = Second Opinions on Elective Surgery  
V = Flu immunization reimbursed 100%  
Z = Third Opinions on Elective Surgery

10. **PMT** - Payment Code

1 = For Payment to Physician or Surgeon  
2 = For Payment to Beneficiary  
3 = For Partial Payment to Both  
4 = For Payment to Hospital (Hospital-Based Physicians)  
5 = For Partial Payment to Both Hospital and Beneficiary  
6 = For Payment to Health Care Prepayment Plan  
7 = For Payment to Other Entities (e.g., Employer, Union)  
8 = For Payment to Federally-Funded Entities

11. **CARRIER INFORMATION**

   a. **NUMBER** - The five position number for the carrier which processed the bill.

   b. **RCPT DTE** - Month, day, and year the bill was received by the carrier.

   c. **PAID DTE** - Month, day and year carrier shows on the benefit check.

12. **HMO/CMP DATES - EFFEC - TERM** - These are control dates used to select records for the monthly summary and for the payment record report. They are used to insure selection of all applicable records.