Medicare Managed Care Manual

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

Transmittal No 4 **Date: OCTOBER 1, 2001**

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
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3		10 - 20	---
17A		10 - 110	---
17B		10 - 410	---
17C		10 - 120	---

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

This transmittal includes the following:

- A revised Table of Contents which includes the chapters being issued by this transmittal.
- Additional chapters 3 and 17. Chapter 17 contains three subparts.
- **Chapter 3, Marketing,** this chapter updates and manualizes OPL 120. Some of the manualized changes are:
- The $10 limit on gifts to beneficiaries/members has been increased to $15.
- MCOs may publish separate PCP and specialty provider directories.
- Health fairs may include any active employees. Formerly health fairs were restricted to retirees and those soon to retire.
- M+C organizations may market multiple products.

Chapter 17A, TEFRA Cost-Based Payment Processes and Principles, this chapter provides processes for determining cost for TEFRA cost-based HMO/CMPs.

Chapter 17B, Payment Principles for Cost-Based HMO/CMPs, this chapter provides a description of the payment principles for cost-based HMO/CMPs.

Chapter 17C, Cost Apportionment for Cost-Based HMO/CMPs, this chapter provides procedures for apportioning cost for cost-based HMO/CMPs.

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

These instructions should be implemented within your current operating budget.

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

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Chapter 3 - Marketing

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10 - Introduction

(Rev. 4, 10-01-01)

This chapter explains requirements for marketing. The intent of this chapter is to:

- Expedite the process for CMS's review of marketing materials;
- Conserve resources by avoiding multiple submissions/reviews of a document prior to final approval;
- Ensure consistent marketing review across the nation and,
- Enable managed care organizations to develop accurate, consumer friendly, managed care marketing information that will assist beneficiaries in making informed health care choices.[1]

This chapter will be updated as new issues are identified.

Marketing materials, in general informational materials targeted to Medicare beneficiaries that promotes the M+C organization or any M+C plan offered by M+C organization or communicates or explains an M+C plan.[2] (See 42 CFR 422.80(b).) The definition of marketing materials extends beyond the public's general conception of advertising materials to include notification forms and letters used to enroll, disenroll, and communicate with the member on many different membership scenarios. General guidance regarding the marketing review process, including the process for review of materials submitted by national organizations, is provided in §20. In addition, this chapter contains two separate sections devoted to the discussion of guidelines for marketing materials. Section 30 addresses requirements for advertising or "pre-enrollment" materials, and §40 addresses requirements for beneficiary notification materials that are provided for beneficiary currently enrolled in the plan. Materials relating to promotional activities, including health fairs and sales presentations, are also included in the general definition of marketing materials and are discussed in §50.

20 - Marketing Review Process

Marketing review consists of:

- Pre-approval of marketing materials before they are used by the health plan/M+CO;
- Review of on-site marketing facilities, products, and activities during regularly scheduled contract compliance monitoring visits;
- Random review of actual marketing pieces as they are used in/by the media; and
- "For cause" review of materials and activities when complaints are made by any source.

This chapter deals primarily with the pre-approval of marketing materials. As outlined in regulations at 42 CFR 422.80(a), M+C organizations may not distribute any marketing materials

or election forms or make them available to individuals eligible to elect an M+C plan unless such materials have been submitted to CMS at least 45 days prior to distribution and CMS has not disapproved the materials. An M+C organization may also distribute materials before 45 days have elapsed if prior approval has been granted by CMS. There is a limited exception to this requirement for model beneficiary notices, as outlined in §40 of this Chapter. Guidelines for CMS review are further described at 42 CFR 422.80(c). Marketing materials, once approved, remain approved until either the material is altered by the M+CO or conditions change such that the material is no longer accurate. CMS may, at any time, require an M+C organization to change any previously approved marketing materials if found to be inaccurate, even if the original submission was accurate at the time.

Section 613 of the Benefits Improvement and Protection Act of 2000 limits CMS to a 10 day review period (as opposed to the usual 45 days) for review of any marketing material for which an M+C organization follows CMS model language without modification.

When an M+C organization indicates that it has followed a CMS model without modification, a determination on the marketing material must be made within 10 days, or else the marketing material is deemed approved. "Without modification" means the M+C organization used CMS model language verbatim and only used its own language in areas where we have given them license to include their own information (such as where they are asked to include their plan-specific benefits). It also means that the M+C organization has followed the sequence of information provided in the model in its own marketing material. In these cases, the regional office may only need to review the M+C organization's language in order to make a determination on the marketing material within the 10-day time frame.

NOTE: Some of the CMS models cannot be approved until an M+C organization's ACR is approved. These include the SB, ANOC, and the EOC (if it is submitted early in the year). In these cases, the Regional Office will review and approve all non-ACR-related information within the 10-day review period, and will conduct a cursory review of all ACR-related information based on the M+C organization's ACR submission. However, the Regional Office will need to disapprove the release of ACR-related marketing material within the 10-day window, since there is no basis for approving it, and indicate that the material will be approved upon approval of the ACR. The Regional Office will need to promptly review and approve these marketing materials upon approval of the ACR.

20.1 - Marketing Review Process for Multi-Region Organizations

If you are an organization that operates in more than one of CMS's Regional Offices, your marketing review approach (i.e., lead region, local regions, etc) is determined by the agreement your organization makes with CMS Multi-Region Team management.

The Multi-Region M+C organization must ensure that materials submitted are consistent with the requirements in this chapter.

In addition, the Multi-Region M+CO must distribute final copies of its national marketing materials, within a time frame to be determined by its CMS Multi-Region team, to the lead and local ROs with a dated cover letter, which identifies the recipients.

Note: Although the local ROs may no longer play a part in approval of the national marketing piece, the health plan/M+C organization must send a final copy of the approved material to the local ROs for their records.

30 - Guidelines for Advertising Materials

(Rev. 4, 10-01-01)

30.1 Guidelines for Advertising (Pre-enrollment) Materials

(Rev. 4, 10-01-01)

This section provides guidance to health plans/M+C organizations regarding sales packages and language that may be used in marketing materials. Advertising/pre-enrollment material may be defined as material that is intended primarily to attract or appeal to M+C eligible non-members and to promote membership retention by providing general information to enrollees about the health plan. This includes all ads (print as well as radio TV and Internet ads) and certain other material such as sales scripts, sales presentation flyers, and direct mail pieces that contain information of interest to all potential and current enrollees of the plan. This chapter offers a general guide and a matrix describing marketing language that health plans/M+C organizations "Must Use/Can't Use/Can Use."

These guidelines were created by identifying required language frequently omitted by health plans/M+C organizations or revised by CMS. Acceptable language was created to meet both CMS requirements and the needs of the health plans/M+C organizations. Although use of suggested “Can Use” language is not required, its use will expedite the review process and achieve greater consistency among marketing materials. Please note that the specific language and format used in all standardized marketing materials like the standardized Summary of Benefits (SB) is required. Please also note that the language provided in the "Must Use" column of the "Must Use/Can’t Use/Can Use Chart" (see §30.3 of this Chapter) is required for all the marketing materials as specified in the chart.

Some phrases in this document may not apply to your health plan's/M+C organization's benefit package or marketing strategy. We caution you to apply the information contained in this document with the understanding that it must be evaluated for applicability to your health plan/M+C organization.

Listed below are items that apply to the various pre-enrollment/member retention marketing scenarios experienced by Medicare managed care contracting entities:

Operational Items

1. For M+C coordinated care plans, the concept of "lock-in" must be clearly explained in all materials. For marketing pieces which tend to be of short duration we suggest: "You must receive all routine care from [name of plan/M+C organization] plan providers" or "You must use [name of plan/M+C organization] plan providers except in emergent care situations or for out-of-area urgent care/renal dialysis." However, in all written materials used to make a sale, a more expanded version is suggested: "If you obtain routine care from out-of-plan providers neither Medicare nor the health plan/M+C organization will

be responsible for the costs." Modify materials if the health plan has a Point-of-Service (POS) or Visitors' Program benefit or is a cost contractor or Private Fee-For-Service Plan.

2. All marketing materials must clearly explain the concept of networks and sub-networks and the process for obtaining services including referral requirements.

3. Health plans/M+C organizations must list the hours of operation for customer services and other health plan services anywhere that these phone numbers are provided. This requirement does not apply to any numbers included on advertising materials for persons to call for more information.

4. Definition of Outdoor Advertising (ODA) - ODA is marketing material intended to capture the quick attention of a mobile audience passing the outdoor display (e.g., billboards, signs attached to transportation vehicles, etc.). ODA is designed to catch the attention of a person and influence them to call for detailed information on the product being advertised. Due to the nature of ODA, CMS is willing to waive the disclaimer information required with other forms of marketing media (e.g., lock-in and premium information). [3]

5. Marketing material identification systems - Health plans/M+C organizations must use the system mandated by the reviewing RO for identifying marketing materials submitted to CMS. If the reviewing RO does not have a system, health plans/M+C organizations may use their own system for identifying marketing materials. The health plan identifier should appear on the lower left or right side of the marketing piece. After the RO approves the marketing piece, the approval date (month/year) should always be posted to the marketing piece. The approval date is the date on the CMS approval letter.

6. Where M+C organizations may file separate/distinct Adjusted Community Rate (ACR)s Proposals and the Plan Benefit Package (PBP)s covering the same service area (or portions of the same service area), there is no requirement that all plans be identified in all of the health plan's/M+C organization's marketing materials, although M+C organizations may do so at their discretion. M+C organizations must disclose whether other plans are available in their Annual Notice of Change letter.

7. M+C organizations may market plans directly to beneficiaries of former Medicare plans that have chosen not to renew their contracts as long as the following requirements are met:

   i No such marketing is permitted until after the date the beneficiary has received the plan termination letter; and

   ii In addition to the targeted message, the marketing piece must contain a statement indicating that the plan is open to all Medicare beneficiaries eligible by age or disability in the plan's service area.

8. Sales scripts, both for in-home and telephone sales use, must be reviewed by CMS prior to use. However, health plans/M+C organizations are not required to adhere to a specific format for submission (i.e. verbatim text or bullet points).

9. Health plans/M+C organizations may not use Medicare member lists for non-plan-specific purposes. If a health plan/M+C organization has questions regarding specific material, which it wishes to send to its Medicare members, the material should be submitted to CMS for a decision.

Affiliation Acknowledgements

1. All marketing materials must include a statement that the health plan/M+C organization contracts with the Federal government. One possible statement is "A Federally Qualified HMO with a Medicare contract." Cost-contractors may use "An HMO with a Medicare contract" and/or "An M+C organization with a Medicare contract" if they are State licensed as HMOs. Medicare+Choice organizations may identify Medicare products as "An HMO with an Medicare+Choice contract" if they are Federally Qualified or State licensed as HMOs. M+C organizations may also identify their Medicare plans as "An M+C plan with an Medicare+Choice contract," or "A Coordinated Care Plan with an Medicare+Choice contract," if the health plan/M+C organization meets the requirements of §1851(a)(2)(A) of the Act. In addition, an M+C organization may describe its Medicare product as a "Medicare+Choice plan offered by [name of M+C organization], a Medicare+Choice Organization".

2. A M+C organization may only identify itself as an "M+C PSO" or imply that it is one of the PSO options for Medicare beneficiaries under M+C if it has received a State licensure waiver from CMS in accordance with 42 CFR 422.370-.378. State licensed M+C organizations may identify themselves in marketing materials as a "Provider Sponsored Organization (PSO)," a "State licensed PSO with a M+C contract," or any other term generally applied to managed care organizations that are sponsored by health care providers as long as they do not use the specific term "M+C PSO" or imply that they are one of the specific PSO options for Medicare beneficiaries defined by the Balanced Budget Act of 1997 and implementing regulations at 42 CFR 422.350-.356.

3. M+C organizations are permitted to use ethnic and religious affiliation in their plan names, as long as the legal entity offering the plan has a similar proper name/affiliation. For instance, if a plan were affiliated with the Swedish Hospital of Minnesota, it would be permissible for the plan to use the tag line, "Swedish Plan, offered by Swedish Hospital System of Minnesota."

Special Situations

1. Beneficiaries with disabilities must be considered part of the audience that any marketing strategy is intended to reach. Specifically, and in light of the publication of the final M+C regulation, health plans/M+C organizations may not use plan names that suggest that a plan is available only to Medicare beneficiaries age 65 or over, rather than to all beneficiaries. This prohibition generally bars plan names involving terms such as “seniors,” “65+,” etc. In fairness to M+C organizations with an existing investment in a plan name, CMS will allow the “grandfathering” of existing M+C plan names; that is, plan names established before the final rule took effect.

2. TDD/TTY numbers must appear in conjunction with any other phone numbers in the same font size and style, along with the hours of operation, if these are also provided with the plan phone numbers. This is required for all media. Health plans/M+C organizations can use either their own or State relay services, as long as the number is included.

3. Review of marketing materials in non-English language or Braille: For marketing with non-English or Braille materials the health plan/M+C organization must submit the non-English or Braille version of the marketing piece, an English version (translation) of the piece, and a letter of attestation from the health plan/M+C organization that both pieces convey the same information. Health plans/M+C organizations will be subject to verification monitoring review and associated penalties for violation of this CMS policy. If national health plans/M+C organizations have submitted materials in English to the lead RO and these have been approved, the same materials in other languages or Braille may be used provided that health plans/M+C organizations submit attestation letters vouching that the non-English or Braille version contains the same information as the English language version.

Section 1876 Cost Contracts Only

1. For §1876 of the Social Security Act, the Act, cost-contracting health plans only - In all marketing materials (e.g., brochure narratives and introductions to side-by-side comparisons) the health plan must indicate that it meets Medicare regulatory requirements for providing enrollment opportunity and benefit packages for both Part A and B and Part B-only eligible beneficiaries.[4]

2. Cost-contracting health plans must market a low option or basic benefit package that is identical to the Medicare fee-for-service benefit package (except for any additional benefits the health plan may offer at no charge, for which the health plan claims no reimbursement). Information on the availability of this package must appear in all of the health plan's marketing materials. The health plan/M+C organization may also offer additional optional enriched benefit packages for an additional charge to the extent they wish.

Editorial Items

1. Readability of written materials is crucial to informed choice for Medicare beneficiaries. All member materials that convey the rights and responsibilities of the health plan/M+C organization and the member must be printed with a 12-point font size or larger. Materials subject to this requirement include, but are not limited to, the Evidence of Coverage (EOC) or member brochure and contract, the enrollment and disenrollment applications, letters confirming enrollment and disenrollment, notices of non-coverage (NONC) and notices informing members of their right to an appeals process. CMS is cognizant of the fact that, when actually measured, font size 12 point may vary among different fonts with the result that some font types may be smaller than others. Times New Roman font type is the standard by which font size is measured. Therefore, if M+C organizations choose to use a different font type, it is their responsibility to ensure that the font used is equivalent to or larger than Times New Roman 12 point.

2. The 12-point font size or larger rule also applies to any footnotes or subscript annotations in notices. In all non-notice material (e.g., TV advertisements) the footnote and any text appearing in the material must be the same size font as the commercial message. The term "commercial message" refers to the material, which is designed to capture the reader's attention regarding the health plan/M+C organization. The term does not refer to the commercial membership (i.e., non Medicare/Medicaid members) of the health plan/M+C organization. All non-notice materials must have the same font size for both the commercial message and footnotes. The size is left to the discretion of the health plan/M+C organization and can be smaller than size 12 font, but the commercial message and footnotes must be the same size font.

3. Health plans/M+C organizations must adopt a standard procedure for footnote placement. Footnotes should appear either at the end of the document or the bottom of each page and in the same place throughout the document. In other words, for example, the health plan/M+C organization cannot include a footnote at the bottom of page 2 and then reference this footnote on page 8; the footnote has to also appear at the bottom of page 8.

Other

1. Marketing through the Internet: CMS considers the Internet as simply another vehicle for the distribution of marketing information. Therefore, all regulatory rules and requirements associated with all other marketing conveyances (e.g., newspaper, radio, TV, brochures, etc.) are applicable to health plan/M+C organization marketing activity on the Internet. CMS marketing review authority extends to all marketing activity (both advertising and beneficiary notification activity) the health plan/M+C organization pursues via the Internet.

2. Health education materials are generally not under the purview of CMS marketing review. However, if such materials are used in any way to promote the M+C organization or explain benefits, then they are considered marketing materials and must be approved before use. If there is any "commercial message" (defined previously in this section) or beneficiary notification information in a health education piece, it must be reviewed by CMS.

3. M+C organizations may refer to results of studies or statistical data in relation to customer satisfaction, quality, etc. as long as specific study details are given (at a minimum source, dates, sample size, and number of plans surveyed). M+C organizations may not use study or statistical data to directly compare their plan to another. If M+C organizations use study data that includes information on several other M+C organizations, they will not be required to include data on all organizations. However, study details, such as the number of plans included, must be disclosed. Qualified superlatives (e.g., among the best, one of the highest ranked, etc.) may be used. Superlatives (e.g., ranked number one, etc.) may only be used if they are substantiated with supporting data.

4. CMS recognizes the difference of purpose and intent between company logos/product tag lines and other advertising marketing materials. The guidelines regarding specifically the use of unsubstantiated statements that apply to advertising materials do not apply to

logos/taglines. Contracting health plans may use unsubstantiated statements in their logos and in their product tag lines (e.g., "Your health is our major concern," "Quality care is our pledge to you," "First Care means quality care," etc.). This latitude is allowed only in logo/product tag line language. Such unsubstantiated claims cannot be used in general advertising text regardless of the communication media employed to distribute the message. Not withstanding the ability to use unsubstantiated statements as indicated above, the use of superlatives is not permitted in logos/product tag lines (e.g., "First Care means the first in quality care" or "Senior's Plus means the best in managed care"). Refer to the Must Use/Can't Use/Can Use chart in §30.3 of this Chapter for full information on restrictions associated with the use of superlatives.

30.2 - Sales Package Minimum Information Requirements

(Rev. 4, 10-01-01)

This section contains guidance regarding rules that health plans/M+C organizations are required to provide in writing to beneficiaries prior to enrollment.

30.2.1 - Lock-in Requirements/Selecting a Primary Care Physician - How to Access Care in an HMO

(Rev. 4, 10-01-01)

Health plans/M+C organizations must describe rules for receipt of primary care, specialty care, hospital care, and other medical services in their EOC. These rules may vary by health plan/M+C organization. Health plans/M+C organizations must disclose specific rules for referrals for follow-up specialty care in their EOC. Prior to enrollment, prospective members must be able to obtain information regarding the health plan network coverage and rules in sufficient detail to make an informed choice.

When a beneficiary enrolls in a plan/M+C organization, he/she agrees to use the network of physicians, hospitals, and providers that are affiliated with the plan for all health care services, except emergencies, urgently needed care, or out-of-area renal dialysis services.

Contractors with a POS benefit or Visitors Program benefit should list plan-specific requirements and level of coverage found in your EOC.

For §1876 Cost Contractors - After your enrollment is effective, in order for [name of plan/M+C organization] to fully pay for medical services for you, these services (except for emergency, urgently-needed services, and out-of-area renal dialysis services) must be provided or arranged by [name of plan/M+C organization]. You may receive services that are not provided or arranged by [name of plan/M+C organization], but you will be responsible for payment of all Medicare deductibles and coinsurance as well as any additional charges as prescribed by the Medicare Program. You may be liable for any charges not covered by the Medicare Program.[5]

A plan member selects a primary care physician (PCP) to coordinate all of the member's care. A primary care physician is usually a family practitioner, general practitioner, or internist. The primary care physician knows the plan's network and can guide the member to plan specialists when needed. The member always has the option to change to a different primary care physician.

Changes in PCP will be effective according to the plan guidelines that, in some instances, could be the first or the 15th day of the following month as opposed to immediately.

Neither the health plan/M+C organization nor Medicare will pay for medical services that the member receives outside of the network unless it was authorized, or it is an emergency, urgently needed care, or out-of-area dialysis service. The member may be responsible for paying the bill.

30.2.2 - Emergency Care

(Rev. 4, 10-01-01)

Members are not required to go to health plan-affiliated hospitals and practitioners when they experience an emergency. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

2. Serious impairment to bodily functions;

3. Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are:

1. Furnished by a provider qualified to furnish emergency services; and

2. Needed to evaluate or stabilize an emergency medical condition.

For information on M+C organization responsibility for emergency care stabilization and post-stabilization requirements see 42CFR422.113(b)(3),(c)(2)(i) through (iii).

Describe precisely where emergency coverage will be available under the health plan/M+C organization (e.g., the United States and its Territories, worldwide, etc.).

30.2.3 - Urgent Care

(Rev. 4, 10-01-01)

Urgently needed services means covered services provided when an enrollee is temporarily absent from the M+C plan's service area (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required:

1. As a result of an unforeseen illness, injury, or condition; and

2. It was not reasonable given the circumstances to obtain the services through the organization offering the M+C plan.

Urgently needed care provided by non-plan providers is covered when a member is in the service area or continuation area under the unusual circumstance that the organization's provider network is temporarily unavailable or inaccessible. Normally, if a member needs urgent care and is in the health plan's/M+C organization's service area or continuation area, the member is expected to obtain care from the health plan's/M+C organization's providers.

30.2.4 - Appeal Rights

(Rev. 4, 10-01-01)

Members have a right to appeal any decision the health plan/M+C organization makes regarding, but not limited to, a denial, termination, payment, or reduction of services. This includes denial of service after the service has been rendered (post-service) or denial of service prior to the service being rendered (pre-service).

30.2.5 - Benefits and Plan Premium Information

(Rev. 4, 10-01-01)

Premium information must include the statement: "You must continue to pay your Medicare Part B premium."

When specifying benefits, annual limits (e.g., $1,000 annual maximum for prescription drugs), annual benefit payout (e.g., $700 for eyeglasses every 2 years) and applicable copayments (e.g., $5 copayment for a doctor visit) must be specified. Major exclusions and limitations must be stated clearly. For example, restriction of pharmacy benefits to a specific formulary or a restricted set of pharmacies must be explained. Health plans/M+C organizations must state clearly all monetary limits, as well as any restrictive policies that might impact a beneficiary's access to drugs or services. When annual dollar amounts or limits are provided, the health plan/M+C organization must also mention the applicable quarterly or monthly limits, and whether any unused portion of that benefit can be carried over from one calendar quarter to the next. Include a closing statement such as: "For full information on [plan/M+C organization name] (e.g., drugs, routine physical exam, eyeglasses, dental, etc.) benefits, call our Customer Service Department at [plan/M+C organization phone number]."

Cost contractors must describe required low-option plans as required by regulations.

A statement must be made indicating that (Health Plan/M+C organization Name)'s benefit package, premiums, co-pays and service area are all subject to change annually at the health plan's/M+C organization's contract renewal time with the Medicare Program (usually January 1). Also, a statement must be made that the (Health Plan/M+C organization's Name) contract with CMS is renewed annually, and that the availability of coverage beyond the end of the current contract year is not guaranteed.

30.3 - "Must Use/Can't Use/Can Use" Chart

(Rev. 4, 10-01-01)

The following chart provides guidance on language that M+C organizations must use, can't use, and can use in pre-enrollment advertising. The following items: Lock-in, Eligibility, and Contract with the Government are required items in advertising. The use of any language found in the “Can Use” column is discretionary

Subject	Must Use	Can't Use	Can Use	Reason
Lock-In	- Enrolled members "must use (name of health plan/M+C organization) (contracting, affiliated, or name of health plan/M+C organization participating) providers for routine care" - "Health plan/M+C organization available to all Medicare beneficiaries" MEDIA: All except outdoor advertising *Outdoor advertising has the option of excluding this topic: * See definition of outdoor advertising in §10 of this Chapter. This information may be either in the text of the piece or in a disclosure paragraph at the end/bottom of the piece	- The term "Participating Providers"		CMS requires lock-in for all media to inform beneficiaries of managed care requirement. Because of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising
Descriptions of the M+C organization's Quality[6]		- Superlatives (e.g., highest, best)[7] - Unsubstantiated comparisons with other M+C organizations - Direct negative statements about other M+C organizations including individual statements from members or former members	- Qualified superlatives (e.g., among the best, some of the highest) - Superlatives (e.g., ranked number 1, if they can be substantiated by ratings, studies or statistics(Source must be identified in the advertising piece.) See §30.1 for more information. - "Health plan/M+C organization delivers (adjective) quality of care" - Can use satisfaction survey results. E.g., "The (name of specific study) indicated we rated highest in member satisfaction."	

			(Must disclose year and source.) See §30.3 for more information. - M+C organizations may use CAHPS survey data regarding their own organization but may not use it to make specific comparisons to other M+C organizations. MEDIA: All	
Premium Costs	- If a health plan/M+C organization premium is mentioned, it must be accompanied by a statement that beneficiaries must continue to pay Part B premium or Medicare premium. - If an annual dollar amount/limit is mentioned, quarterly or monthly limits must also be mentioned as well as any ability to carry over any remaining benefit from quarter to quarter. Because of the length of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising. MEDIA: All except outdoor advertising - TV-Part B caveat must be flashed in TV safe range or mentioned in narration.[13]	- "No premium" - "No premium or deductible" - "Free"	The following may be used: - "No health plan/M+C organization premium" - "Health plan/M+C organization premium equals _____" - "$0 health plan/M+C organization premium" - At no extra cost to you" but only if referring to a specific benefit - "No health plan/M+C organization premium or deductibles" - "No premium or deductibles (you must continue to pay the Medicare Part B premium" - "No premium beyond your monthly Medicare payment" - "No premium other than what you currently pay for Medicare" MEDIA: All except outdoor advertising, which has the option of excluding this topic.	Materials must disclose that beneficiaries must continue to pay the Part B premium and continue their Medicare Part B coverage while enrolled in the HMO.
Testimonials	- Content must comply with CMS marketing guidelines, including statements by members	- Cannot have non-members say he/she belongs. (Can use actors, but they cannot say they belong to the health plan/M+C organization.)		

	- Speaker must identify specific health plan/M+C organization membership - Ads must include a verbal statement by member indicating that she/he is a member of a specific plan or a "banner" at the bottom of the screen indicating the same or a voice over identifying the member as an enrollee of the specific plan. MEDIA: All			
Contract with the Government	- Must include one of the phrases from the “Can se” column MEDIA: All except outdoor. Outdoor advertising, which has the option of excluding this topic. This information may be either in the text of the piece or in a disclosure paragraph at the end/bottom of the piece.	- "Recommended or endorsed by Medicare" - Cannot imply that health plan/M+C organization has a unique or custom arrangement with the government, e.g.: -- "Special contract with Medicare" --"Special health plan/M+C organization for Medicare beneficiaries"	- "An HMO with a Medicare contract" - "An M+C organization with a Medicare contract" - "A Federally Qualified HMO with a Medicare contract" - "A Federally Qualified Medicare contracting HMO" - "Medicare approved HMO" - "A Coordinated Care Plan with an Medicare+Choice contract" - "M+C PSO" MEDIA: All	Because of the length of the messages and the nature of outdoor advertising, this topic does not apply to outdoor advertising.
Physicians and Other Health Care Providers	- If the number of physicians and other health care providers is used, it must include only those available to Medicare beneficiaries MEDIA: TV, radio, outdoor - If the number of physicians and other health care providers is used, it must include only providers available to Medicare beneficiaries. If a total number is used it must separately	- Implication that providers are available exclusively through the particular HMO unless such a statement is true - "Participating providers" unless you use health plan/M+C organization name - The M+C organization may not identify itself by the name of a participating provider or provider	- "(Health plan/M+C organization's name) participating providers" - "Network" providers - "Contracting" providers - "Affiliated" providers - Number of providers should be same total number of Medicare providers	Do not use the word "participating" when referring to health plan/M+C organization providers (unless you use health plan/M+C organization name), since it could be confused with a participation agreement with Medicare. Health plan/M+C organizations should either use "contracting" or "health plan/M+C organization name" when referring to health plan/M+C organization

	delineate the number of primary care providers and specialists included. MEDIA: Print and direct mail - If the M+C organization uses the name and/or picture of providers and/or facilities to market itself, the provider information may only be used within the context of informing beneficiaries of providers that are associated with the M+C organization's delivery system. MEDIA: Print and direct mail	group, with the exception of a PSO.	MEDIA: All	providers. It must be clear to the beneficiary with whom the M+C contract with CMS is held.
Eligibility	- Must indicate that beneficiaries must be entitled to Part A and enrolled in B - For M+C plans -- Must indicate that all Medicare beneficiaries with Parts A and B of Medicare may apply -For §1876 cost contracting health plans: -- Must indicate that all Medicare beneficiaries may apply This information may be either in the text of the piece or in a disclosure paragraph at the end/bottom of the piece.	"No health screening" unless specific mention is made of ESRD "Seniors" unless term appears with "and all other Medicare eligibles" "Health plan/M+C organization designed especially for seniors" "Senior health plan/M+C organization" unless part of health plan/M+C organization name "Individuals age 65 and over"	- "Anyone with Medicare may apply" - "Medicare entitled by age or disability" - "Individuals eligible for Medicare by age or disability" - "Individuals on or entitled to Medicare by age or disability" - "Medicare beneficiaries" - "Medicare enrollees" - "People with or on Medicare" - "No physicals requirefd" - "No health screening" if a caveat is included for ESRD - “Grandfathered enrollees” MEDIA: ALL	Since all Medicare beneficiaries may enroll in Medicare-contracting HMOs, you may not refer to your health plan/M+C organization as a "senior health plan/M+C organization" (unless you refer to it as part of the health plan/M+C organization name). The term "senior health plan/M+C organization" implies that disabled beneficiaries may not enroll. Medicare Part A is not a requirement for enrollment in Medicare-cost contracting HMOs. M+C organizations may only enroll individuals with both Parts A and B of Medicare, with the exception of "grandfathered" members.
Claims Forms / Paperwork		"No paperwork" "No claims or paperwork/complicated paperwork"	"Virtually no paperwork" "No paperwork when using health plan/M+C organization providers"	Members may be required to submit bills or claims documentation when using out-of-plan providers.

		No claims forms"	"Hardly any paperwork" MEDIA: All	
Benefits: a) Comparison	- If premiums and benefits vary by geographic area, must clearly state this or must clearly state geographic area in which differing premiums and benefits are applicable. - If only benefits vary, clearly state geographic area in which benefits are applicable. MEDIA: All	- Minimal co-pays may vary by county - Minimal co-pays may apply	- "Premiums and benefits may vary by county" or "These benefits apply to the following counties"* - "Except for ________ county"* MEDIA: All - M+C organizations may compare benefits to Medigap plans as long as information is provided accurately and in detail.	Premiums, benefits, and/or copayment amounts may vary by county within a given service area. This must be clearly conveyed in all marketing materials.
Benefits: b) Limitations		- "At no extra cost to you" or "free" if co-pays apply	- State exact dollar amount limit on any benefit - "Limitations and restrictions may apply" - "Minimal copayments will apply" - "Minimal copayments vary by county"* - State which benefits are subject to limitations MEDIA: All	If benefits are specified within the piece, any applicable copayment should be stated or you may include the general statement as shown.
Benefits: c) Prescription Drugs	- If prescription drugs are mentioned and have limitations, must say: - Limited outpatient drug coverage; or, - Drug coverage benefits subject to limitations; or - Up to xxx annual/quarterly/monthly limit or xxx limit per year/quarter/month and other limits and restrictions may apply. - Copayment amounts and indicate	- "We cover prescription drugs" unless accompanied by reference to limitation - "Prescription drug coverage" unless accompanied by reference to limitation	- Fully disclose dollar amount of copayments and annual/quarterly/monthly limit - If limited, you must say so - Limited outpatient drug coverage with xx copayments for xx number of days supply and xxx annual/quarterly/monthly limit - "Prescriptions must be filled at contracting or health plan/M+C organization affiliated	Prescription drugs are an important benefit that must be adequately described. Any dollar limits must be clearly conveyed.

	for a xx number of days supply - If benefits are restricted to a formulary, this must be clearly stated. - In addition, must state: - that formulary contents are subject to change within a contract year without advance notice - health plan/M+C organization should be contacted for additional details. MEDIA: All		pharmacies." MEDIA: All	
Benefits: d) Multi-Year Benefits	- Whenever multi-year benefits are discussed, M+C organizations are required to make appropriate disclosure that the benefit may not be available in subsequent years. MEDIA: All, where multi-year benefit(s) are mentioned		- "[benefit] may not be available in subsequent years" OR - "[name of M+C organization] contracts with Medicare each year, this benefit may not may not be available next year" MEDIA: All, where multi-year benefit(s) are mentioned	Potential applicants and members must be informed in marketing materials that multi-year benefits in current year benefit packages are not guaranteed in future contract years.
Definitions - Emergency and Urgently Needed Care		- "Life threatening" - "True emergency"	- Emergency - definition as stated in current CMS policy. - Urgent - definition as stated in current CMS policy. MEDIA: All	Emergency and urgent care criteria should be explained per Medicare guidelines rather than in the commercial context.
Drawings / Prizes		- "Eligible for free drawing and prizes" MEDIA: Direct mail, flyers, print advertising	- "Eligible for a free drawing and prizes with no obligation" - "Free drawing without obligation" MEDIA: Direct mail, flyers, print advertising.	It is a prohibited marketing practice to use free gifts and prizes as an inducement to enroll. Any gratuity must be made available to all participants regardless of enrollment. The value of any gift must be less than the nominal amount of $15.
Sales presentations	- "A sales representative will be present with information and applications."	- "A health plan representative will be available to answer questions."		This phrase must be used whenever beneficiaries are invited to attend a group session with the intent of

	MEDIA: Flyers and invitations to sales presentations - "A sales representative may call." MEDIA: Response card where the beneficiary's phone number is requested - "A telecommunications device for the deaf (TDD) is available to get additional information or set up a meeting with a sales representative." MEDIA: All - "For accommodation of persons with special needs at sales meetings, call (Health Plan Phone Number)." MEDIA: Flyers and invitations to sales meetings			enrolling those individuals attending. This phrase must be included on any response card in which the beneficiary is asked to provide a telephone number. All Health plans must indicate in all advertising that a telecommunication device for the deaf (TDD/TTY) is available to get additional information or to set up a meeting with a sales representative.

*NOTE: Flexible benefits are not permitted under the M+C program. Therefore, premiums, co-pays and benefits may not vary by county for the same M+C plan.

40 - Guidelines for Beneficiary Notification Materials

(Rev. 4, 10-01-01)

The definition of marketing materials includes all notification forms and letters used to enroll, disenroll, and communicate with the member on many different membership operational policies and procedures. These materials are also described as beneficiary notification materials and subject to specific CMS requirements. Section 40.1 of this chapter provides general guidance with respect to beneficiary notification materials, including the review process. All beneficiary notification materials are subject to Final Verification Review, a process that is described in §40.2 of this chapter. Section 40.3 provides specific guidance with respect to provider directories. Section 40.4 provides specific guidance about the use of drug formularies.

40.1 - General Guidance for Beneficiary Notification Materials

(Rev. 4, 10-01-01)

40.1.1 - Use of Model Beneficiary Notification Materials

(Rev. 4, 10-01-01)

Beneficiary notification materials are those materials used by health plans/M+C organizations to convey benefit or plan operational information to potential or enrolled beneficiary health plan members.

The passage of the Benefits Improvement and Protection Act of 2000 has changed the review process for model beneficiary notification materials, for specific guidance on these changes and the usage of model beneficiary notification materials, see §20 - Marketing Review Process.

40.1.2 - Use of Standardized Beneficiary Notification Materials

(Rev. 4, 10-01-01)

CMS has initiated a program to develop and implement standardized beneficiary notification marketing materials for health plan participants in Medicare managed care. As part of the first phase of this program, all Medicare+Choice Organizations were required to use a standardized Summary of Benefits (SB) beginning in contract year 2000. (Specific information, including instructions and frequently asked questions and answers are available on the CMS web site at: www.cms.gov/medicare/mgdmktg.htm.) Use of standardized notification materials by health plans/M+C organizations is mandatory**.**

Employer Group Health Plans (EGHPs) were granted an exemption from this requirement to use the standardized Summary of Benefits while CMS conducted a review to determine whether EGHPs should receive a permanent exemption. After discussions with various interested parties, including employer groups, consulting firms, beneficiary advocacy groups, and employer unions, CMS has decided to exempt EGHPs from the requirement to use CMS's standardized Summary of Benefits.

40.2 - Final Verification Review Process

(Rev. 4, 10-01-01)

[8]Beneficiary notification materials described in Category 2 above are subject to CMS's final verification review process, in which the materials are reviewed at the final proof stage. This final proof is usually the printed document or electronic file that is sent to the health plan/M+C organization by the printer prior to printing. When approval is given by the organization based on review of the final proof, the electronic file is transmitted to the printer for execution of the print job. Under special circumstances when final proof copy is not available, blue-line or camera ready copy may be substituted for final proof copy in the final verification review procedure.

When the final text or script version of the beneficiary notification material is satisfactory and the final proof needs to be submitted to CMS for approval, the material is designated by CMS as "acceptable." Approval stamps should not be affixed to documents in this stage of the review process. The RO should indicate that material is not yet the final-proof version by appending the suffix "txt" to the file. Once the final proof is approved by CMS and the marketing material can be published and distributed by the health plan/M+C organization, the material is considered, "approved" and approval stamps (or other methods of indicating approval) should be fixed to the documents at this stage in the process. The RO should indicate that the material is a final proof version by appending the suffix "fv" to the file.

CMS marketing reviewers will stress detection of errors during the initial text review(s) of the material. This effort will, to the extent possible, avoid costly revisions at the "camera ready" or "final proof" review stage. The final verification review is conducted to confirm that the final proof version contains no changes from the initial text version that was approved by CMS.

40.3 - Specific Guidance for Provider Directories

(Rev. 4, 10-01-01)

Regulations at 42 CFR 422.111(b) require that M+C organizations disclose the following information to each enrollee electing an M+C plan offered by the M+C organization:

1. The number, mix, and distribution, including addresses of providers from whom enrollees may obtain services, as well as any out-of-network coverage or point-of-service option;

2. Information regarding out-of-area coverage and emergency coverage, including the process and procedures for obtaining emergency services, and the location where emergency care can be obtained, as well as other locations where contracting physicians and hospitals provide emergency services, and post-stabilization care included in the M+C plan;

3. Prior authorization rules and other review requirements that must be met in order to ensure payment for the services; and

4. Instructions to enrollees that, in cases where noncontracting providers submit a bill directly to the enrollee, the enrollee should not pay the bill, but submit it to the M+C organization for processing and determination of enrollee liability, if any.

Section 422.111(a) requires that this information be disclosed in clear, accurate, and standardized form at the time of enrollment and at least annually thereafter.[9] M+C organizations generally include this information in their provider directory and distribute the directory to new members

upon enrollment and existing members on an annual basis.[10] In addition to the information provided above, provider directories should also contain the following:

1. Names, complete addresses, and phone numbers of the primary care physicians;
2. Names and addresses (city or town) of specialists, skilled nursing facilities, hospitals, outpatient mental health providers, and pharmacies, where outpatient prescription drugs are offered by the M+C plan;
3. General information regarding lock-in, including the role of the primary care physician (PCP) as well as the process for selecting a new PCP and any specific requirements for referrals to specialists and ancillary providers;
4. A description of the plan's service area, including a list of cities and towns;
5. Telephone numbers for customer service or appropriate contact information (including the hours of service) for members who have questions or require assistance in selecting a PCP;[11] and
6. A general disclaimer that indicates that the directory is current as of a particular date and that a provider's listing in the directory does not guarantee that the provider is still in the network or accepting new members.

M+C organizations may publish separate PCP and Specialty directories provided that both directories must be given to enrollees at the time of enrollment and at least annually thereafter.

M+C organizations that use sub-networks of providers must clearly delineate these sub-networks (preferably by listing the providers as a separate sub-network) and describe any restrictions imposed on members that use these sub-networks. This is particularly important since beneficiaries could choose their primary care physician without realizing that this choice restricts them to a specified group of specialists, ancillary providers, and hospitals. M+C organizations must also clearly describe the process for obtaining services in these networks and sub-networks, including any referral requirements, as well as any out-of-network coverage or point-of-service option.

M+C organizations may find it more economical to print a separate directory for each sub-network and disseminate this information to members in a particular sub-network. This practice is permissible, provided that the directory clearly states that a directory that lists providers for other networks is available and provides this information to members upon request.

40.4 - Specific Guidance About Drug Formularies

(Rev. 4, 10-01-01)

In providing a prescription drug benefit, a health plan/M+C organization may rely on a formulary. A formulary is a list of prescription drugs, grouped by therapeutic drug class. There are three categories of formularies: open, preferred, and closed. Open formularies list all drugs and drug products that are covered and do not place restrictions on coverage of drugs within each theregentic class (i.e. the physician can order any one in the class). Preferred formularies are similar to open formularies, but also use incentives and interventions to encourage use of certain

preferred drugs. Closed formularies use limited lists of drugs; enrollees pay penalties (sometimes the entire cost) for drugs not on the formulary.

Many health plans/M+C organizations make periodic changes to formularies or the items on preferred lists, often convening meetings of their pharmacy and therapeutics committees several times a year to add and remove items from the formulary or preferred list. When they enroll in a Medicare+Choice plan, beneficiaries may not be aware that changes to formularies or preferred lists are likely to occur during the contract year.

Every health plan/Medicare+Choice organization that covers outpatient prescription drug benefits (those not covered under the original Medicare fee-for-service program) must provide notice in its Evidence of Coverage (EOC) whether it uses a formulary or preferred list. If it uses formularies or preferred lists, the notice shall include:

- An explanation of what a formulary is;
- A statement that the formulary (or drugs on the preferred list) may change during the contract year;
- An estimate of how often the health plan/M+C organization reviews the contents of the formulary and makes changes based upon that review;
- A description of any process by which a prescribing provider may obtain authorization for a nonformulary or non-preferred list drug to be furnished under the same terms and conditions as drugs on the formulary or preferred list; and
- A statement that members may use health plan/M+C organization grievance and appeals process if they have complaints about the formulary or its administration.

In addition, health plans/M+C organizations that use formularies or preferred lists must disclose whether specific drugs are on the health plan/M+C organizations' formularies or preferred lists when enrollees or potential enrollees make telephone or other inquiries.

With respect to pre-enrollment marketing materials that describe plan benefits, health plans/M+C organizations must disclose whether a formulary or preferred list is used and that the formulary or list may change during the contract year and provide a contact number that the beneficiary can call for more information. This policy will be effective beginning in contract year 2001 and will be incorporated into the Model EOC for 2001.

40.5 - Guidance to Medicare+Choice (M+C organization) Organizations About Outreach to its Dual Eligible Membership

(Rev. 4, 10-01-01)

Medicare+Choice (M+C) Organizations have recently shown an interest in conducting outreach to their current M+C enrollees and screening for whether or not they are potentially eligible for State financial assistance through State Medicaid programs. CMS recognizes the potential financial benefits of such outreach to the M+C enrollees (as illustrated in the following dual eligibility chart) and to the M+C organizations,[12] and encourages organizations to provide this kind of assistance to its members. CMS also recognizes the need to maintain each enrollee's right

to financial privacy and protection from unwelcome solicitation and undue pressure to apply for these additional benefits.

This section provides guidelines that M+C organizations[13] must follow in designing and carrying out State financial assistance outreach, which CMS considers to be marketing according to the definition in 42 CFR 422.80(b)(3), in that such activity explains benefits and rules that apply to dual eligible enrollees. Such activity also can be seen to promote the M+C organization engaging in the outreach, which in such a case would fall under §422.80(b)(3).

NOTE: Only the appropriate state/county agency can make a final determination on eligibility for State financial benefits. In no way can the M+C organization represent itself as being able to adopt that role.

40.5.1 - Dual Eligibility

(Rev. 4, 10-01-01)

There are several categories of dual eligibles, each having specific income requirements and receiving different levels of financial assistance. The categories are outlined in the following chart.

Eligibility Category	Income / Resource Level	Medicaid Assistance
QMB Qualified Medicare Beneficiary without other Medicaid	Income at or below 100 percent Federal poverty level (FPL), resources at or below twice limit under SSI program, not otherwise eligible for Medicaid	Payment of Medicare premiums, deductibles, and coinsurance
QMB+ Qualified Medicare Beneficiary with Full Medicaid	Income at or below 100% FPL, resources at or below twice limit under SSI program	Payment of Medicare premiums, deductibles, and coinsurance plus full Medicaid benefits
SLMB Specified Low-Income Medicare Beneficiary without other Medicaid	Income greater than 100% but less than 120% FPL, resources at or below twice limit under SSI program, not otherwise eligible for Medicaid	Full Payment of Medicare Part B premiums
SLMB+ Specified Low-Income Medicare Beneficiary with Full Medicaid	Income greater than 100% but less than 120% FPL, resources at or below twice limit under SSI program	Full payment of Medicare Part B premiums plus full Medicaid benefits (which may, at State option, include Medicare deductibles and coinsurance)
QDWI Qualified Disabled and Working Individuals	Eligible to purchase Medicare Part A, income less than or equal to 200% FPL, resources not exceeding twice limit under SSI program	Full payment of Medicare Part A premiums
QI-1s Qualifying Individuals - 1	Income greater than or equal to 120% but less than 135% FPL, resources at or below twice limit under SSI program	Full payment of Medicare Part B premiums
QI-1s Qualifying Individuals - 2	Income greater than or equal to 135% but less than 175% FPL, resources at or below twice limit under SSI program	Full payment of Medicare Part B premiums

40.5.2 - Outreach Program Guidance

(Rev. 4, 10-01-01)

An M+C organization conducting a dual eligibility outreach program to its membership must provide members with information on all levels of dual eligibility. It cannot withhold information sharing or assistance to members who may qualify as QI-1s or QI-2s, members who

may not provide additional revenue to the M+C organization through increased capitation payments.

40.5.3 - Disclosure to CMS

(Rev. 4, 10-01-01)

An M+C organization that would like to conduct such outreach must first submit a written proposal to its CMS CO Plan Manager and a copy to the RO Plan Manager. This proposal must include:

- A flow chart or written description of the entire outreach process including all the steps involved and parties responsible for each step;
- Draft model beneficiaries letters (if applicable), the number of beneficiaries targeted, their general locations (if effort targets more than one service area) and the date(s) on which the M+C organization will mail the letters;
- Telephone scripts to be used by parties conducting telephone outreach (if applicable);
- Description of contractual arrangements with all external entities involved in the outreach effort; and
- Written substantiation of member privacy protections.

CMS's CO and RO Plan Managers will review the proposal and draft documents and will respond in writing to the M+C organization within the 45-day time frames established for other marketing material. The M+C organization must receive CMS approval for all outreach documentation before using them in this outreach effort.

40.5.4 - Contact Initiation

(Rev. 4, 10-01-01)

An M+C organization may initiate outreach to its members through written communication and/or via the telephone. The M+C organization may not initiate outreach through door-to-door solicitation.

40.5.5 - Written Communication

(Rev. 4, 10-01-01)

An M+C organization may send outreach letters to targeted M+C enrollees. These letters must include the following information:

- Financial benefits and income/asset and other eligibility requirements;
- Telephone numbers for the appropriate State Medicaid Agency and/or the State Health Insurance Assistance Program (SHIP);

- A statement that all enrollee actions are voluntary and that the enrollee need not take further action if he or she chooses not to; and

- Assurance that the M+C organization will not share the information that the enrollee discloses.

- Any other information required by CMS.

Section 40.5.13 is a model outreach letter developed by CMS's Center for Medicaid and State Operations (CMSO). CMS encourages M+C organizations to use this letter as a template in developing outreach letters before submitting them to CMS for review.

40.5.6 - Telephone Communication

(Rev. 4, 10-01-01)

In all telephone communications, the M+C organization must:

- Clearly state that the beneficiary may voluntarily offer financial information necessary to receive a preliminary eligibility determination, but is not required to do so;

- Inform the member that the Organization cannot make a final eligibility determination; it can only provide an initial screening. It must explain that the member will have to submit a completed application to the appropriate State/county agency for a final determination and that the agency will notify the member of their eligibility status; and

- Discuss all levels of eligibility requirements and benefits regardless of whether or not the member's potential eligibility qualifies the M+C organization for the increase in capitation payment from CMS.

40.5.7 - Face-to-Face Contact

(Rev. 4, 10-01-01)

The M+C organization cannot conduct "door-to-door" solicitation to initiate the outreach program. However, if the enrollee verbally or in writing requests a home visit, a representative from the M+C organization may provide screening assistance in the home.

40.5.8 - Data Collection

(Rev. 4, 10-01-01)

CMS recognizes that in order to provide this screening service to its members, the M+C organization will have to gather some financial information from them. However, the organization cannot maintain this information after the screening process is complete, and cannot, under any circumstances, use this information for any purpose other than the screening.

40.5.9 - Application Completion

(Rev. 4, 10-01-01)

If the M+C member requests help, the M+C organization may assist the member with completing and submitting the required paperwork to the State/County for final eligibility determination. This may also take place in the member's home, but only if he or she requests the visit from the Organization.

40.5.10 - Delegation

(Rev. 4, 10-01-01)

An M+C organization may wish to contract with or delegate another entity to perform part or all of the dual eligibility outreach functions. Under this scenario, CMS will continue to hold the M+C organization responsible for ensuring that the delegated or contracted organization meets all the guidelines in this chapter, and that the M+C organization is protecting each enrollee from privacy violations. CMS reserves the right to review such delegation contracts to ensure these protections are in place.

40.5.11 - Dual Eligibility Reporting to CMS

(Rev. 4, 10-01-01)

M+C organizations normally responsible for submitting Medicaid eligibility data to CMS should not identify QI-1s or QI-2s because CMS does not consider these two categories of dual eligibles as eligible for the Medicaid adjustment factor. The Medicaid adjustment will be factored into the payment of all other categories of dual eligibles.

40.5.12 - Notification to Partners

(Rev. 4, 10-01-01)

If CMS approves the outreach initiative, the RO will furnish CMS's partners, specifically (SHIPs) and the appropriate State Medicaid Agency with copies of all outreach letters, the number and locations of letters being sent, and the dates on which the Organization is mailing them.

40.5.13 - Model Outreach Letter

(Rev. 4, 10-01-01)

August 25, 2000

Mr. Frank Smith
123 Maple Lane
Anywhere, USA 12345

Dear Mr. Smith,

Did you know you might be able to save up to $546 a year on Medicare expenses?

There are programs that save millions of people $45.50 to $546 in their Social Security checks, each year! If you answer "yes" to all three of these questions, then you may qualify for Savings for Medicare Beneficiaries.

- Do you have Medicare Part A, also known as hospital insurance? If you are eligible for Medicare Part A, but do not have it because you cannot afford it, you may still qualify because there is a program that will pay the Medicare Part A premium.

- Are you an individual with a monthly income of less than $1,238 or a couple with a monthly income of less than $1,661?

- Are you an individual with savings of $4,000 or less or a couple with savings of $6,000 or less? Savings include things like money in a checking account or savings account, stocks, or bonds. When you are figuring out your savings, do not include your home, a car, burial plots, up to $1,500 for burial expenses, furniture, or $1,500 worth of life insurance.

Enclosed is a brochure that gives you more information about the programs that can help you save on your medical expenses, information on who qualifies, and how to apply for the programs.

I hope you will call me between 9 a.m. and 5 p.m. Monday through Friday at (your phone number here) for more information or for help joining one of these programs. All information that you share will only be used to determine if you may be able to get help with your medical expenses. I will not share the information with anyone else.

I encourage you to call to see if you can receive help with your medical expenses, but the choice is yours. You are not required to call. If you like, you can also receive information about the programs by calling a representative of the State Health Insurance Assistance Program at (area code and phone number) or a State representative at [area code and phone number]. Deaf or hearing-impaired people who use a TTY/TDD can call Medicare's national help line at 1-800-486-2048. When you call, ask about programs that can help with Medicare expenses.

50 - Guidelines for Promotional Activities

(Rev. 4, 10-01-01)

This section reviews the use of promotional activities relating to the enrollment and retention of members. Section 50.1 of this section provides general guidance about promotional activities, while §50.2 provides specific guidance for provider promotional activities. Section 50.3 answers some frequently asked questions regarding all aspects of promotional activities. Section 50.4 provides specific guidance about value-added items and services, while §50.5 describes CMS's policy with respect to the use of independent insurance agents for marketing purposes. Definition and policy changes in this section are a result of compliance with directives from the Office of Inspector General regarding monitoring of Medicare managed care operations under several statutes that prohibit unlawful influence/inducement of Medicare beneficiaries.

50.1 - General Guidance About Promotional Activities

(Rev. 4, 10-01-01)

Promotional activities (including provider promotional activities) must conform to the requirements of §§1128A(a)(5) and 1128B(b) of the Act. Section 1128A(a)(5) of the Act provides for a civil monetary penalty against a person or entity that offers or transfers remuneration to a Medicare or Medicaid eligible individual that the person or entity knows or

should know is likely to influence such eligible individual to receive or order services from a particular provider. Section 1128B(b) of the Act, the Medicare and Medicaid anti-kickback statute, prohibits the offering or giving of remuneration to induce the referral of a Medicare or Medicaid beneficiary, or to induce a person to purchase, or arrange for, or recommend the purchase or ordering of an item or service paid in whole or in part by the Medicare or Medicaid programs. Additional prohibitions on the offering of monetary rebates or inducements of any sort to enrollees are contained in §1854(d) of the Act.

50.1.1 - Nominal Gifts

(Rev. 4, 10-01-01)

Many health plans/M+C organizations offer gifts to potential enrollees if they attend a marketing presentation. This is permitted as long as such gifts are of nominal value and are provided whether or not the individual enrolls in the health plan/M+C organization. Nominal value is defined as an item worth $15 or less, based upon the retail purchase price of the item. Local Medicare fee-for-service fiscal intermediary and/or carrier charge listings can be used to determine the value of medical services, examinations, laboratory tests, etc., associated with nominal value determinations in marketing scenarios. Cash gifts are prohibited including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates that can be readily converted to cash, regardless of dollar amount. The dollar amount associated with the definition will be periodically reassessed by CMS.

50.1.2 - Referral Programs

(Rev. 4, 10-01-01)

The following general guidelines apply to referral programs under which health plans/M+C organizations solicit leads from members for new enrollees. These include gifts that would be used to thank members for devoting time to encouraging enrollment. Gifts for referrals must be available to all members and cannot be conditioned on actual enrollment.

- Health plans/M+C organizations may not use cash promotions as part of a referral program.
- Health plans/M+C organizations may offer thank-you gifts of less than $15 nominal value (e.g., thank you note, calendar, pen, key chain) when an enrollee responds to a health plan/M+C organization solicitation for referrals. These thank you-gifts are limited to one gift per member, per year.
- A letter sent from the health plan/M+C organization to members soliciting leads cannot announce that a gift will be offered for a referral.

50.1.3 - Health Fairs and Health Promotional Events

(Rev. 4, 10-01-01)

Many health plans/M+C organizations are interested in offering health fairs or social events that promote health awareness and a sense of belonging among seniors. Health plans/M+C organizations may participate in such events as either the sole sponsor of the event or as a

member of a multiple-sponsor event. Application of the following CMS policies to the condition of sponsorship is indicated by (Sole-Sponsor) for sole sponsor events, (Multiple-Sponsor) for multiple-sponsor events, and (Both) where the policy applies to both single and multiple sponsor events. If an audience is comprised of the general public as well as Medicare beneficiaries, the following policies apply to the entire audience:

- Such events should be social and should not include a sales presentation. (Both) Response by a health plan/M+C organization representative to questions will not be considered a sales presentation if no enrollment form is accepted at the event. (Both)
- Advertisements for the event can be distributed to both members and non-members. (Both)
- The value of any give-away or free items (e.g., food, entertainment, speaker) cannot exceed $15 per attending person. For planning purposes, event budgets can be based on projected attendance. The cost of overhead for the event (e.g., room rental) is not included in the $15 limit. (Both)
- Pre-enrollment advertising materials (including enrollment forms) can be made available as long as enrollments are not accepted at the event. (Both)
- If offered, door prizes/raffles cannot exceed the $15 limit. (Sole-Sponsor) However, door prizes/raffles can exceed the $15 limit if a health plan/M+C organization contributes to a pool of cash for prizes or contributes to a pool of prizes such that the prize(s) is not individually identified with the health plan/M+C organization, but is identified with a list of contributors. A jointly-sponsored event may consist of the health plan/M+C organization and one or more sponsor participants who are not contracting providers with the health plan/M+C organization. A health plan/M+C organization may also contribute cash toward prize money to a foundation or another entity sponsoring the event. For example: A radio station, along with many sponsors, puts together a seniors fair. Anyone who attends may register for the door prize: a get-away weekend. The health plan/M+C organization may participate in the fair, contribute to the door prize, and permit attendees to register for the prize at its booth (as well as other sponsor booths). However, the health plan/M+C organization cannot claim to be the sole donor of the prize. It must be clear that the prize is attached to the seniors fair. No sales presentation may be made at the event. (Multiple-Sponsor)

50.1.3.1 - Employer Group Health Fairs

(Rev. 4, 10-01-01)

Enrollment restrictions (i.e., no sales presentations can be made or enrollment applications accepted at the meeting) do not apply to health fairs or other promotional events sponsored by an employer group or labor organization so long as the following requirements are met:

1. The meeting must be held solely for retirees and any active employees (and their spouses/interested decision makers) from the employer/labor organization. No "general public" persons may be solicited or invited to attend the meeting; and

2. The meeting may not be announced via "public media" vehicles. Potential employer group/labor organization retirees must be notified of the meeting by individual notification or by company/labor organization sponsored media such as a newsletter or similar targeted mailing/vehicle.

50.1.3.2 - CMS-Sponsored Health Information Fairs

(Rev. 4, 10-01-01)

The Centers for Medicare and Medicaid Services is required to conduct a nationally coordinated education and information campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process provided under the law for enrolling in Medicare+Choice plans. One of the coordinated education and information campaign activities is CMS sponsorship of Medicare+Choice Health Information Fairs.[14] While most CMS-sponsored M+C Health Fairs will be conducted immediately before and during the month of November each year (the Annual Election Period), occasionally CMS will sponsor Health Fairs as early as September and other times of the year. The following rules and procedures apply to CMS-sponsored Health Fairs, whenever they occur.

CMS will invite the M+C organizations to participate in the planning of local Health Fairs. M+C organization participation is optional, but it is important to get current contractors to the planning table. It is imperative that all CMS regions are consistent in applying participation guidelines at these CMS-Sponsored Health Fairs. Below are the guidelines. CMS retains the right to modify these guidelines if CMS encounters a new situation that must be addressed.

50.1.3.3 - Allowable Actions for Medicare + Choice Organizations

(Rev. 4, 10-01-01)

Medicare + Choice Organizations may do the following:

- Assist in the planning of local Health Fairs;
- Distribute health plan brochures and Enrollment by Mail Forms (EBMFs), while at the Health Fair.[15] They may also include in their handouts a reply card which may be given to interested beneficiaries for return to the organization via mail;
- Have a booth at the Health Fair;
- Distribute items with a total retail value of no more than $15. These items MUST be offered to everyone, (e.g., organizations can not give gifts to only those individuals who show interest;.
- Have any personnel present (i.e. marketing personnel, customer service personnel) as long as they adhere to these guidelines;
- Contribute funding for any Health Fair costs (i.e. purchasing of food; drawings, raffles, or door prizes for attendees which exceed the $15 nominal value requirement) as long as the recognition of the donation is to a number of entities (not just one particular M+C organization); and

- Market multiple lines of business in Medicare + Choice.

Medicare+Choice Organizations may not do the following:

- Give sales presentations;
- Collect enrollment applications. (Although EBMFs may be distributed, they may not be collected during CMS-sponsored Health Fairs);
- Collect names/addresses of potential enrollees. However, as noted above, they may distribute EBMFs and reply cards;
- Compare their benefits against other health plans. However, they may use comparative information which has been created by CMS (such as information from CMS's website) or information/materials which have been approved by CMS (i.e. the standardized Summary of Benefits);
- Third party created materials may not be used, unless they have been approved by CMS in advance; and
- Give individual gifts with a retail value of more than $15.00.

50.2 - Specific Guidance About Provider Promotional Activities

(Rev. 4, 10-01-01)

Some health plans/M+C organizations use their health plan/M+C organization providers to help them market their Medicare product. As used in this Guide, the term "provider" means all Medicare health plan/M+C organization contracting health care delivery network members; e.g., physicians, hospitals, etc. The purpose of this section is to specify what practices in this area meet both CMS requirements and the needs of the health plans/M+C organizations with respect to entities considered providers by health plans/MCOs.

CMS is concerned with provider marketing for the following reasons:

- Providers are usually not fully aware of all health plan/M+C organization benefits and costs; and
- A provider may confuse the beneficiary if the provider is perceived as acting as an agent of the health plan/M+C organization vs. acting as the beneficiary's provider.

Providers may face conflicting incentives when acting as a health plan/M+C organization representative since they know their patients' health status. Desires to either reduce out-of-pocket costs for their sickest patients, or to financially gain by enrolling their healthy patients may result in recommendations that do not address all of the concerns or needs of a potential health plan/M+C organization enrollee.

There are some permissible provider marketing activities, however. Listed below are some requirements for these, and the reasons they are permitted:

1. Health Fairs - At health fairs, provider groups and individual providers can give out health plan/M+C organization brochures including Enrollment by Mail Forms (EBMFs). Because they may not be fully aware of all benefits and costs of the various health plans/M+C organizations, providers or their representatives cannot compare benefits among health plans/M+C organizations in this setting. In addition, applications may not be taken at health fairs. (See the discussion of health fairs and health promotion events in §1 above.)

2. Provider Office Activities and Materials - In their own offices, provider groups and individual providers can give out health plan/M+C organization brochures, and posters announcing health plan/M+C organization affiliation (all of which must be exclusive of applications). Providers, their representatives and qualified health plan/M+C organization (marketing) representatives are all prohibited from taking applications in the place where health care is delivered, such as provider offices or hospital wards. This is to prevent Medicare beneficiaries from experiencing inappropriate pressure to enroll at the time that health care is being delivered. Providers cannot offer inducements to persuade beneficiaries to join health plans/M+C organizations or to steer beneficiaries to a specific health plan/M+C organization. To do so would be a violation of §1128B(b) of the Social Security Act.

   In addition, providers cannot offer anything of value to induce health plan/M+C organization enrollees to select them as their provider.

   When patients seek information or advice from their own physician regarding their Medicare options, physicians may engage in this discussion. Because physicians are usually not fully aware of all health plan/M+C organization or original Medicare benefits and costs, they are advised to additionally refer their patient to other sources of information, such as 1-800-MEDICARE, the State Health Insurance Assistance Program, and/or specific health plan/M+C organization marketing representatives. Additional information can also be found on CMS's website, www.medicare.gov. Physicians are permitted to printout and share information with patients from CMS's website.

3. Health Plan/M+C organization and Provider Co-Sponsorships - Providers and provider groups can co-sponsor an event, e.g., an open house or a health fair with a health plan/M+C organization. Providers and provider groups and health plans/M+C organizations can cooperatively market and advertise by such means as TV, radio, direct mail, testimonials, posters, fliers and print ads. All marketing materials describing the health plan/M+C organization in any way must get prior approval, should have the health plan's/M+C organization's name or logo on them as well as the provider's/provider group's name or logo, and must follow all of the rules in Chapter 3 - Guidelines for Advertising Materials. All materials mentioning the health plan/M+C organization are considered marketing materials and must therefore adhere to this Guide and have prior approval by CMS.

4. Providers/Provider Group Affiliation Information - Providers/provider groups can announce a new affiliation with a health plan/M+C organization to their patients. An announcement to patients of a new affiliation which names only one health plan/M+C organization may occur only once. Additional contacts from providers to their patients

regarding affiliation must include all the Medicare health plans/M+C organizations with which the provider contracts. This includes, for example, annual affiliation announcements, announcements that certain affiliations have terminated, and the display of health plan/M+C organization brochures/posters. If these communications describe health plans/M+C organizations in any way (as opposed to just listing them), they must be prior approved by CMS (see below).

5. Providers/Provider Group Comparative/Descriptive Information - Providers/provider groups may provide printed information to their patients comparing the benefits of different health plans/M+C organizations with which they contract. Such materials must have the concurrence of all health plans/M+C organizations involved and must be prior approved by CMS. The health plans/M+C organizations may want to determine a lead health plan/M+C organization to coordinate submission of these materials. CMS continues to hold the health plans/M+C organizations responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting medical groups and other health care providers. The providers/provider groups may not health screen when sending out such information to their patients. The reason for this is that any material sent to beneficiaries that talks about health plans/M+C organizations is marketing and health screening is a prohibited marketing activity.

The "Medicare and You" Handbook or "Medicare Compare Information" (from CMS's website, www.medicare.gov), may be distributed by providers/provider groups without additional approvals. There may be other documents that provide comparative/descriptive material about health plans, are of a broad nature, and are written by CMS or have been prior approved by CMS. These materials may be distributed by M+C organizations and providers without further CMS approval. Please advise your health plan/M+C organization providers and provider groups of the provisions of these rules.

50.3 - Answers to Frequently Asked Questions About Promotional Activities

(Rev. 4, 10-01-01)

1. **Q** - We purchased books on health maintenance that we plan to give away to anyone attending one of our marketing presentations, regardless of whether or not they enroll in our health plan/M+C organization. Because we purchased a large number of these books, we were able to buy them at a cost of $14.99 per book. However, on the inside jacket, the retail price is shown as $19.99. May we give these books away at our marketing presentation?

   A - No. The retail purchase price of the book is $19.99, which exceeds CMS's definition of nominal value.

2. **Q** - We are participating in a health fair during which we will have marketing staff present. During the fair, we will offer a number of free health screening tests to people who attend. The value of these tests, if purchased, would be considerably more than $15. Is this permissible?

   A - No. You may not offer these tests for free because their value exceeds CMS's definition of nominal value.

3. **Q** - At our health plan/M+C organization, we offer gifts of nominal value to people who call for more information. We then offer additional gifts if they come to marketing events. Each of the gifts meets CMS's definition of nominal value, but taken together, the gifts are more than nominal value. Is this permissible?

   A - Yes.

4. **Q** - Listed below are some possible promotional items to encourage people to attend marketing presentations. Are these types of promotions permissible?

   - Meals
   - Day trips
   - Magazine subscriptions
   - Event tickets
   - Coupon book (total value of discounts is less than $15)

   A - Yes. All these promotional items are permissible as long as they are offered to everyone who attends the event regardless of whether or not they enroll and as long as the gifts are $15 or less. Cash gifts are prohibited including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates that can be readily converted to cash, regardless of dollar amount.

5. **Q** - Can a health plan/M+C organization advertise eligibility for a raffle or door prize of more than nominal value for those who attend a marketing presentation if the total value of the item is less than $15 per person attending?

   A - No. You cannot have a door prize of more than nominal value. Such gifts or prizes are prohibited by CMS. However, the raffle or door prize can exceed the $15 limit if the M+C organization is jointly sponsoring the prize with other health plans/M+C organizations at a health fair. See §5.1 for a discussion of rules pertaining to health fairs.

6. **Q** - What about post-enrollment promotional activities? Are there any rules prohibiting such items or activities as coupon books, discounts, event tickets, day trips, or free meals to retain enrollees?

   A - Currently, the Medicare Managed Care Manual states that health plans/M+C organizations may not offer post-enrollment promotional items that in any way compensate beneficiaries for lower utilization of services. Any promotional activities or items offered by health plans/M+C organizations, including those that will be used to encourage retention of members, must be of nominal value, must be offered to all eligible members without discrimination, and must not be in the form of cash or other monetary rebates. The same rules that apply to pre-enrollment promotional activities apply to post-enrollment promotional activities.

7. **Q** - Can health plans/M+C organizations provide incentives to current members to receive preventive care and comply with disease management protocols?

A - Yes, as long as the incentives are:

1. Offered to current members only;

2. Not used in advertising, marketing, or promotion of the health plan/M+C organization;

3. Provided to promote the delivery of preventive care; and

4. Are not cash or monetary rebates.

NOTE: If these products are in the CMS approved contracted health plan/M+C organization benefit package (ACR and PBP) under "Preventive Services," the provision of such incentives are within the purview of the medical management philosophy of the M+C organization and do not require additional review by CMS for marketing accuracy/compliance. The nominal value rule does not apply.

8. **Q** - Can a health plan/M+C organization offer reductions in premiums or enhanced benefits based on the length of a Medicare beneficiary's membership in the health plan/M+C organization?

   A - No. Longevity of enrollment is not a basis for reductions in premium or enhanced benefits.[16]

9. **Q** - Can a health plan/M+C organization provide discounts to beneficiaries who prepay premiums for periods in excess of 1 month?

   A - No. Health plans/M+C organizations can not provide any discounts to Medicare beneficiaries for prepayment of premiums in excess of 1 month.

10. **Q** - Can a health plan/M+C organization take people to a casino or sponsor a bingo night at which the member's earnings may exceed the $15 nominal value fee?

    A - No. The total value of the winnings may not exceed $15 and the winnings cannot be in cash or an item that may be readily converted to cash.

11. **Q** - Can M+C organizations send a $1 lottery ticket as a gift to prospective members who request more information?

    A - Offering a $1 lottery ticket to prospective members violates the "no cash or equivalent" rule discussed above, whether or not the person actually wins since, generally, the "unscratched" ticket has a cash value of $1.

12. **Q** - Can M+C organizations pay beneficiaries that sign up to be "ambassadors" a flat fee for transportation?

    A - If the M+C organization employs a beneficiary to be an "ambassador" and travel reimbursement is part of the employment compensation, then CMS has no oversight over this issue. If the beneficiary is not considered an employee, then the M+C organization cannot pay the beneficiary, including reimbursement for transportation.

13. **Q** - Can M+C organizations hold marketing presentations in clinics or hospitals?

    A - Yes, marketing presentations are allowed in clinics, hospitals or physicians offices (or other health care delivery locations) provided that the presentations are held in common areas (i.e., community or recreational rooms) and that patients being treated at the facility are not coerced in to attending.

14. **Q** - Can M+C organizations that own nursing homes conduct health fairs and distribute enrollment forms to nursing home residents?

    A - Yes, M+C organizations that own nursing homes may conduct health fairs and distribute enrollment forms if the sales presentations are confined to a common area (i.e., community or recreational rooms) or if a member volunteered for an individual presentation. Promotional activities and sales presentations cannot be made in individual resident rooms without a prior appointment for a "home" visit. Such activities would be considered door-to-door solicitation and are prohibited. The M+C organization is required to meet all health fair/sales presentation and enrollment requirements as currently outlined in the Marketing Guide and regulations.

15. **Q** - What information should an active member be asked to release to a health plan/M+C organization concerning a potential member lead?

    A - The health plan/M+C organization can ask for referrals from active members, including names and addresses, but cannot request phone numbers. Health plans/M+C organizations can then use this information for soliciting by mail.

16. **Q** - Can physician groups that contract with health plans/M+C organizations hire marketing firms to cold call from non-health plan/M+C organization member listings?

    A - Yes, as long as the marketing guidelines for provider marketing are followed.

50.4 - Specific Guidance About Value-Added Items and Services

(Rev. 4, 10-01-01)

Value-Added Items and Services (VAIS) are items and services offered to M+C plan enrollees, by an M+C organization, that do not meet the definition of "benefits" under the M+C program and may not be funded by Medicare program dollars. Nonetheless, VAIS may be of value to some beneficiaries, and we do not wish to deprive Medicare enrollees of access to items and services commonly available to commercial enrollees. Examples of VAIS may include, but are not limited to discounts in restaurants, stores, entertainment, and travel or discounts on health club memberships and on insurance policy premiums. CMS permits VAIS to be offered to M+C enrollees under the rules outlined below.

VAIS are partly defined by what they are not - they are not benefits under the M+C program. The M+C regulations at §42 CFR 422.2 define benefits using a three-prong test:

1. Health care items or services that are intended to maintain or improve the health status of enrollees;

2. The M+C organization must incur a cost or liability related to the item or service and not just an administrative cost; and

3. The item or service is submitted and approved through the Adjusted Community Rate (ACR) process.

All three parts of the definition must be met for an item or service to be considered a benefit under M+C. If an item or service fails to meet one or more of these parts, it is not a benefit. However, it may be offered to M+C enrollees as a VAIS, subject to the restrictions that follow.

The following examples demonstrate the application of the three-prong test:

Example 1:

An M+C organization arranges for its enrollees a discount on all daily supplements purchased from a health food chain. The health food chain does not charge the M+C organization for this discount, and requires the M+C organization to develop a verification system so the health food chain can identify the organization's enrollees. The M+C organization incurs an administrative cost to develop the verification system, but does not incur a cost of providing or furnishing the daily supplement. Therefore, the discount on daily supplements would be considered a VAIS. The ACR submitted by the M+C organization may not reflect (as a Medicare enrollee benefit cost) the administrative cost.

Example 2:

An M+C organization arranges for its enrollees a 10 percent discount on eyeglasses purchased from a group of eye doctors. The physician group charges the M+C organization for the group's cost to administer the program, and requires the M+C organization to develop a verification system to identify the organization's enrollees. The M+C organization incurs two costs:

1. The M+C organization pays the physician group's administrative cost of administering the program; and

2. The M+C organization incurs the administrative cost for developing and providing the verification system.

Both of these costs are administrative in nature, and the M+C organization does not incur a cost of providing or furnishing the eyeglasses. Therefore, the discount on eyeglasses is considered a VAIS. The ACR submitted by the M+C organization should not reflect (as a Medicare enrollee benefit cost) either of the two administrative costs.

Example 2a:

Given the same circumstances outlined in Example 2 above, except, the amount paid to the physician group by the M+C organization includes an amount for the cost of the eyeglasses. In this case, the M+C organization does incur a cost of providing or furnishing the eyeglasses. Therefore, the 10 percent discount on eyeglasses is not considered a VAIS. The ACR submitted by the M+C organization should reflect the administrative costs it incurs and the amount paid to the physician group. The marketing materials should describe the eyeglass benefit with a 90

percent coinsurance. As with all benefits offered as part of an M+C plan, the Medicare enrollee must be afforded appeal rights for this benefit.

50.4.1 - Restrictions on Value-Added Items and Services

(Rev. 4, 10-01-01)

M+C organizations may make VAIS available to Medicare enrollees in accordance with the following guidelines:

- VAIS must be offered uniformly to all M+C plan enrollees and potential enrollees.
- M+C organizations may not describe VAIS as benefits. In accordance with 42 CFR 422.80(e)(iv), which states that M+C organizations may not engage in activities that could mislead or confuse Medicare beneficiaries, the M+C organization may not claim or imply that the VAIS are recommended by or endorsed by CMS or Medicare.
- The M+C organization must maintain confidentiality of enrollee records in accordance with §42 CFR 422.118 and other applicable statutes and regulations. The use or distribution of information about enrollees for non-plan purposes is prohibited. The M+C organization is thus prohibited from selling names, addresses, or information about the individual enrollees for commercial purposes. If the M+C organization uses a third party to administer VAIS, the M+C organization is ultimately responsible for adhering to and complying with confidentiality requirements.

50.4.2 - Relation of Value-Added Items and Services to Benefits

(Rev. 4, 10-01-01)

Because VAIS does not meet the definition of a benefit under the M+C program, neither the actual costs of the VAIS nor associated administrative costs may appear in the ACR. Furthermore, because they are not contained within the contracted health benefits package, these services are not subject to the Medicare appeals process.

Similarly, VAIS may not appear in the Plan Benefit Package (PBP). VAIS may not be described in Medicare Compare, the "Medicare and You" handbook, or the Standardized Summary of Benefits (including in the M+C organization special features §30 at the end).

All materials that describe the PBP must be approved in advance by CMS (see §42 CFR 422.80). This requirement does not apply to the content of descriptions of VAIS. However, any description of VAIS must be preceded by the following prominently displayed language:

- The products and services described on this page are neither offered nor guaranteed under the M+C organization's contract with the Medicare program, but are made available to all enrollees who are members of [Name of M+C organization].
- These products and services are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the [Name of M+C organization] grievance process.

- Should a problem arise with any value-added item or service, please call [Name of M+C organization] for assistance at [M+C organization customer service number]**.** Our customer service hours are [Enter hours].

50.4.3 - Operational Considerations Related to Value-Added Items and Services

(Rev. 4, 10-01-01)

M+C organizations can market, either through oral presentations or written materials, Value-Added Items and Services (VAIS), but cannot attach these materials to CMS-approved marketing materials; this includes the Summary of Benefits, Evidence of Coverage, and any other materials approved by CMS and distributed to beneficiaries. However, materials describing VAIS can be included in the same envelope (or, if the materials are distributed in person, with the same set of materials) with CMS-approved marketing materials.

CMS will not require prior approval of materials describing VAIS, since VAIS are not benefits as described within CMS regulations. CMS will review these materials on monitoring visits to ensure compliance with these requirements. CMS may initiate a monitoring visit if it becomes aware that materials have been distributed describing VAIS without the appropriate disclaimers or in violation of the requirements stated herein. CMS will also investigate complaints by beneficiaries regarding VAIS, just as it would other possible violations of CMS requirements.

50.4.4 - Value Added Items and Services Provided to Employer Groups

(Rev. 4, 10-01-01)

Value-added items and services may be offered to employer groups. Value-added items and services are offered outside the core benefit package, thus they are outside of CMS's purview.

50.4.5 - Application to Section 1876 (of the Act) Cost Plans

(Rev. 4, 10-01-01)

Value-added items and services may be offered by §1876 cost plans. However, VAIS are non-covered services for which §1876 cost plans are not reimbursed.

50.5 - Specific Guidance About the Use of Independent Insurance Agents

(Rev. 4, 10-01-01)

CMS's previous policy of discouraging the use of independent agents and brokers for marketing purposes is hereby rescinded. CMS recognizes that independent insurance agents can provide a necessary service to Medicare beneficiaries and potential enrollees. They can also be a valuable resource in helping to reach low-income and rural populations, persons with disabilities, and other special populations. Therefore, CMS urges M+C organizations to consider requiring specific M+C training for their contracted agents. This will ensure that appropriate information is being delivered to Medicare beneficiaries and potential enrollees.

Please note that CMS is aware that sales by independent insurance agents are typically tied to compensation and that agents are often given incentives to steer enrollees towards the carrier offering the most compensation. Further, independent insurance agents may be in a unique

position to "cherry pick," given their often longstanding relationships with clients. Additional operational guidelines to address these concerns will be forthcoming.

50.6 - Marketing of Multiple Lines of Business Under Medicare + Choice

(Rev. 4, 10-01-01)

M+C organizations may market multiple lines of business in accordance with the following.

Direct mail M+C marketing materials sent to current members describing other lines of business should contain instructions describing how individuals may opt out of receiving such communications. M+C organizations may apply this opt-out provision on an annual basis. The M+C organizations should make reasonable efforts to ensure that all individuals (including non-members) who ask to opt out of receiving future marketing communications, are not sent such communications.

Although M+C organizations may market other lines of business concurrently with M+C products, information regarding the other lines of business must be separate and distinct from M+C plan information.

M+C organizations should not include enrollment forms for non-M+C lines of business in any package marketing its M+C products, as beneficiaries might mistakenly enroll in the other option thinking they are enrolling in an M+C plan. Also, if information regarding M+C products and non-M+C lines of business are included in the same package, postage costs must be prorated so that costs of marketing non-M+C products are not included as "M+C plan-related" costs on Adjusted Community Rate (ACR) proposal submissions.

M+C organizations may market other lines of business concurrently with M+C products on the Internet, though to avoid beneficiary confusion, M+C organizations must continue to maintain a separate and distinct section of their Web site for M+C plan information only.

CMS will review the M+C organization's Web pages to ensure that M+C organizations are maintaining the separation between M+C plan information and information on other lines of business.

Endnotes

[1] The primary CMS/health plan contractual frame of reference in the Guide is a coordinated care plan contracting under the Medicare + Choice program. Where applicable, alternative language is provided for cost contractors as well as scenarios involving the point-of-service (POS) and Visitor Program features which may be applicable for M+C an/or cost contractors. **Back to Text**

[2] The guidelines throughout this document apply to Medicare + Choice Organizations (M+Cos) as well as Section 1876 of the Act cost contractors unless stated otherwise. Therefore, for ease of review and reference, the term "health plan" is used throughout the document to include requirements specific to both Medicare + Choice Organizations and §1876 cost contractors. **Back to Text**

[3] See §30 of the Chapter for specific application requirements for Outdoor Advertising (ODA.) **Back to Text**.

[4] Under M + C, individuals who are not already member - those that are grandfathered in - must have both Parts A and B of Medicare in order to eligible for enrollment. **Back to Text**.

[5] The health plan/M+C organization must be sure to offer adequate explanation of Medicare card use with out-of-plan utilization that is not an emergency or an urgently-needed service. **Back to Text**

[6] Note to health plan/M+C organization - CMS has the discretion to disapprove language based on site visit reviews identifying substantial deficiencies in health plan/M+C organization operations. **Back to text**.

[7] Note to health plan/M+C organization - A member of the health plan/M+C organization may use a superlative in relating their personal experience with the health plan/M+C organization so long as the testimonial is preceded with the phrase "in my opinion" (e.g., "I have been with the health plan/M+C organization for 10 years and in my opinion they have given me the best care possible.") If the member does not preface the superlative statement with the "in my opinion" phrase, the member must substantiate the statement with an acceptable qualifying information source. **Back to text**.

[8] Final Verification Review is outlined in OPL 99.106, Final Verification Review of Medicare Managed Care Marketing Materials, published on November 10, 1999 and available on the CMS website at: http://www.hcfa.gov/medicare/mgdcar1.htm **Back to text**.

[9] In accordance with the National Marketing Guidelines, this information should be provided in at least 12-point font size. **Back to text**.

[10] M+C organizations may choose to disseminate an errata sheet or addendum during the year to update members with respect to changes in provider's addresses and phone numbers. However, in accordance with 42 CFR 422.111(c), M+C organizations must make a good faith effort to disclose any changes to the provider information upon request and, under 422.111(e), must make a good faith effort to provide written notice at least 30 calendar days before the termination effective date. M+C organizations should consult the M+C regulations for further information. **Back to Text**.

[11] In accordance with the National Marketing Guidelines, the applicable TDD/TTY number must also be provided, including the hours of operation. **Back to text**.

[12] The monthly capitation rate for an M+C enrollee that CMS pays to the M+C organization is higher for an enrollee who is a Medicaid recipient because this beneficiary tends to have higher medical costs than a Medicare beneficiary who is not a Medicaid recipient. CMS does not pay the Medicaid adjustment factor for Qualified Individuals-2 or Qualified Individuals-1. **Back to text**.

[13] The Organization is ultimately responsible for outreach even if the task is delegated to another entity. See section on Delegation. **Back to text.**

[14] Section 1851(e)(3) of the Act and 42 CFR 422.10(b). **Back to text**.

[15] An Enrollment by Mail Forms (EBMF) may be either:

1) A specifically designed enrollment application form which is attached to health plan/M+C organization marketing materials; or

2) A standard health plan/M+C organization enrollment application form with instructions that the form must be mailed back to the health plan M+C organization.

The key feature of the EBMF is that it must be completed by the beneficiary in the absence of health plan/M+C organization marketing influences and returned to the health plan/M+C organization by mail. (Self-addressed, postage paid, return envelopes may be provided by the health plan/M+C organization.). **Back to text**.

[16] This "no" statement also applies to "zero" premium plans that might want to award a nominal value gift as a reward for longevity of enrollment. **Back to text**.

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Medicare Managed Care Manual

Chapter 17 Subchapter A

TEFRA Cost-Based Payment Process and Principles

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10 - Reasonable Cost-Based Payments - General

(Rev. 4, 10-01-01)

Chapter 17, Subchapter A sets forth the rules CMS follows in determining the amount CMS will pay to TEFRA cost-based Health Maintenance Organizations and Competitive Medical Plans (HMO/CMPs) for services furnished on a reasonable cost basis. Chapter 17, Subchapter A deals with general requirements, bill processing options, budget and enrollment forecasting, interim payments and reports, adjustments of payments, interim settlement procedures, final certified cost reports, final settlement, general payment principles for cost-based HMO/CMPs, the prudent buyer principle, reimbursable costs, record keeping, and accounting standards.

Chapter 17, Subchapter B gives the provider payment principles applicable to cost-based contracts, references specific cost topics in the Medicare "Provider Reimbursement Manual" Pub 15, and provides specific guidelines on provider of services, physician and other Part B service costs and costs related to enrollment, marketing, membership, and reinsurance for cost-based HMO/CMPs. Chapter 17, Subchapter C covers cost apportionment for cost-based HMO/CMPs. Chapter 18 will provide guidance on Health Care Prepayment Plans (HCPPs), including payment of reasonable cost, allowable costs and cost apportionment.

Background

HMO/CMPs are public or private entities that are organized under the laws of a State to provide health services on a prepayment basis to enrolled members. These HMO/CMPs are eligible to enter into contracts with the Secretary of the Department of Health and Human Services under §l876 of the Social Security Act (the Act) to furnish services to Medicare beneficiaries. Originally, §l876 of the Act provided two methods of payment for services furnished to Medicare enrollees of HMO/CMPs, reasonable cost reimbursement (TEFRA cost-based) and risk-based payment. The Balanced Budget Act of 1997 (BBA) removed the risk-based option under §1876 and replaced it with the Medicare+Choice program in §§1851 through 1859 of the Act. The BBA also included provisions for phasing out the §1876 cost-based HMO/CMPs. Chapter 17 of the manual is in effect for cost-based HMO/CMPs with active contracts until December 31, 2004, and through any applicable audit periods for that contract year. Cost-based HMO/CMPs are paid the reasonable cost actually incurred in providing Medicare-covered services to Medicare enrollees. These organizations 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 the HMO/CMP's Medicare enrollees, plus or minus adjustments made by CMS. Further adjustments may be made at the end of the contract period to bring the interim payments made to the HMO/CMP during the period into agreement with the reimbursement amount determined payable to the HMO/CMP for services rendered to Medicare enrollees during that period. Total payment is calculated based on the HMO/CMP's final certified cost report.

In addition, the HMO/CMP may furnish services to Medicare beneficiaries who are not enrolled in the organization. Since payment to the HMO/CMP under §l876 of the Act is limited to the HMO/CMP's Medicare enrollees, services furnished to non-enrolled Medicare beneficiaries are outside the scope of the HMO/CMP's agreement with the Secretary. Medicare payment for services furnished to non-enrolled beneficiaries are made through the original Medicare Fee-For-Service (FFS) payment system in accordance with the usual Medicare payment process.

10.1 - Reasonable Cost Payments

(Rev. 4, 10-01-01)

An HMO/CMP paid on a reasonable cost basis is paid the reasonable cost of the covered services it furnishes directly to or arranges for its Medicare enrollees. The determination of reasonable cost is based on the Medicare reimbursement principles which are used to calculate the reasonable cost of hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies(HHAs), and other entities paid by the Medicare program on a cost basis and also on principles contained in this manual. In addition to the costs directly related to the provision of health services, the costs incurred by the HMO/CMP such as marketing, enrollment, and membership expenses are also taken into account in determining reasonable costs.

The cost payment principles for cost-based HMO/CMPs are discussed in detail in Chapter 17, Subchapter B.

10.2 - Bill Processing Options

(Rev. 4, 10-01-01)

A Medicare contract with CMS must state on an individual provider basis whether the HMO/CMP elects:

- To have CMS pay on the behalf of the HMO/CMP, hospitals and SNFs for covered items and services furnished to the HMO/CMP's Medicare enrollees (Option 1); or

- To assume responsibility for paying some or all of these providers directly for covered items and services furnished to the HMO/CMP's Medicare enrollees (Option 2). Under this option, the HMO/CMP must specify each hospital and/or SNF for which the HMO/CMP will assume the responsibility of paying for the services rendered by that hospital or SNF.

The HMO/CMP must modify its contract with CMS for any changes in its election 90 days prior to the beginning of the contract period for which the change would be effective. Regardless of

the bill option elected, the HMO/CMP must comply with the requirements in Chapter 17, Subchapter C.

10.2.1 - Direct Payment by the HMO/CMP to Hospital and Skilled Nursing Facilities (SNFs)

(Rev. 4, 10-01-01)

If the HMO/CMP elects to pay hospital and SNF providers directly for covered items and services (Bill Processing, Option 2), the HMO/CMP must:

- Determine the eligibility of the HMO/CMP's Medicare enrollees to receive covered items and services through the HMO/CMP;
- Make proper coverage decisions and appropriate payments for covered items and services for which the HMO/CMP's Medicare enrollees are eligible;
- Assure that these providers maintain and furnish appropriate documentation of physician certification and recertification, as required under Subpart B; 42 CFR, Part 424 (Certification and Plan of Treatment Requirements); and
- Carry out any other procedures that CMS may require from time to time.

CMS will determine whether the HMO/CMP has the experience and capability to efficiently and effectively carry out the responsibilities specified above.

10.2.2 - Services Furnished Directly or Through Arrangement

(Rev. 4, 10-01-01)

The cost-based HMO/CMP contract with CMS must provide that, in paying for services furnished to the HMO/CMP's enrollees, the HMO/CMP is responsible for:

- Determining the eligibility of individuals to receive such items and services through the HMO/CMP;
- Making proper coverage decisions and appropriate payment for items and services for which the HMO/CMP's Medicare enrollees are eligible; and
- Carrying out any other procedures that CMS may require from time to time.

All health care services furnished by the HMO/CMP may be provided through facilities directly (facilities that are owned or related through common control) or under arrangement. An arrangement is defined as a written agreement executed between the HMO/CMP and another entity in which the other entity agrees to furnish specified services to the HMO/CMP's Medicare enrollees. However, the HMO/CMP retains responsibility for those services.

10.2.3 - Direct Payment by CMS (Hospital and SNF Services)

(Rev. 4, 10-01-01)

If CMS determines that the HMO/CMP is not carrying out its bill processing operations properly (or does not have the experience or capability to do so in the future), CMS may require the HMO/CMP to elect to have CMS pay the HMO/CMP's hospital and SNF providers directly (Bill Processing, Option 1). If the HMO/CMP refuses this election, CMS may decline to enter into a contract or may terminate the contract.

10.3 - Principles of Payments

(Rev. 4, 10-01-01)

Cost-based HMO/CMPs are paid each month, in advance, an interim rate for each Medicare enrollee. Retroactive adjustments are made during the year and at the end of the contract period to reconcile the interim payments made to the HMO/CMP with the amount determined payable to the HMO/CMP for services rendered to the HMO/CMP's Medicare enrollees during that period. Total reimbursement is calculated on the HMO/CMP's final certified cost report.

10.3.1 - Budget and Enrollment Forecast

(Rev. 4, 10-01-01)

Cost-based HMO/CMPs must submit an annual operating budget and enrollment forecast at least 90 days before the start of each contract year. The operating budget uses estimated costs. The budget and enrollment forecast must reflect the HMO/CMP's past experience and present the HMO/CMP's anticipated enrollment and costs (both total and Medicare) for the coming year. The reports are then used to compute the interim per capita rate. Its other purpose is to establish Medicare deductible and coinsurance premiums, including determining past over or under collections of such premiums and the budget period's voluntary undercollection of premium. If the annual budget and enrollment forecast is not submitted on a timely basis, CMS may:

- 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

- Advise the HMO/CMP if there is not enough data on which to base an interim rate, then interim payments will not be made until the required reports are submitted.

CMS reserves the right to examine all records and statistical data used by the HMO/CMP in completing these reports. To the extent the annual operating budget and enrollment forecast is accurate, interim payments will approximate the total CMS obligation.

10.3.2 - Interim Per Capita Rate

(Rev. 4, 10-01-01)

The interim per capita rate for a cost-based HMO/CMP is determined by dividing estimated reimbursable costs of providing Medicare-covered services to the HMO/CMP's Medicare enrollees by projected Medicare enrollee months for the contract period. Estimated reimbursable

costs and the projected number of Medicare enrollee months are derived from the HMO/CMP's annual operating budget and enrollment forecast. The number of Medicare enrollees may be compared to CMS's latest updated records of enrollment for reasonableness. These records will identify the number of Medicare beneficiaries CMS has identified as enrollees of the HMO/CMP.

10.3.3 - Interim Payment for Cost Reimbursed HMO/CMPs

(Rev. 4, 10-01-01)

At the beginning of each month, CMS will send the cost-based HMO/CMP an interim payment. This payment is established by multiplying the interim per capita rate (see §10.3.2) by the number of the HMO/CMP's Medicare members enrolled for that month. Each month CMS will determine the total number of Medicare beneficiaries enrolled in the HMO/CMP to date. This number is increased or decreased by any changes in enrollment submitted by the HMO/CMP or generated by CMS. In addition, certain retroactive adjustments will be made on an as needed basis.

10.4 - Electronic Transfer of Funds

(Rev. 4, 10-01-01)

CMS, in conjunction with the Department of Treasury, may utilize electronic funds transfers. Interim and other types of payments are electronically sent to HMO/CMPs through the Automated Clearing House (ACH). This process improves the efficiency of Federal financial management and also benefits the HMO/CMPs.

The ACH provides on-line access to the Federal Reserve Communications System (FRCS), allowing payments to be made to financial institutions with access to the FRCS. For financial institutions that do not have access to the FRCS, HMO/CMP payments can be paid through correspondent financial institutions or Federal Reserve Banks.

The ACH payment method eliminates mail and processing time associated with payment by check. The HMO/CMP receives a payment through the HMO/CMP's financial institution on the payment due date. This is a more secure and reliable method of making and receiving payment. HMO/CMPs electing the electronic transfer of funds must indicate this on the system setup sheet that is included in the contract application. To initiate this process, the HMO/CMP should contact the designated CMS Plan Manager.

10.5 – Payment Report

(Rev. 4, 10-01-01)

Each month CMS produces a payment report that explains how the interim payment is computed. (See Chapter 19 for a detailed description of the payment report.)

20 - Interim Cost and Enrollment Reports

(Rev. 4, 10-01-01)

In addition to the annual budget and enrollment forecast, the cost-based HMO/CMP is required to submit interim reports and enrollment data on a cumulative quarterly basis. CMS, in accordance with 42 CFR 417.572(c)(2), may reduce the frequency of the interim reporting requirements if it is determined that the HMO/CMP has an adequate ongoing accounting and enrollment data system that furnishes the records needed to verify the interim per capita rate. Generally, CMS 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 CMS within 60 days of the end of each HMO/CMP fiscal quarter. The reports may be used to adjust the interim rate. If the reports are not submitted timely, CMS 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.

The last interim cost and enrollment report submitted for a specific contract period will be the basis for an interim settlement with the HMO/CMP. (See §20.1.2.)

20.1 - Interim Cost Report for Experienced Medicare Cost-Based HMO/CMPs

(Rev. 4, 10-01-01)

If CMS reduces the frequency for submitting interim reports, the HMO/CMP will, nevertheless, be required to submit an interim cost report within 60 days of the end of its 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 the HMO/CMP. (See §20.1.2.)

20.1.1 - Adjustment of Payments

(Rev. 4, 10-01-01)

In order to maintain the interim payments at the level of current reasonable costs, CMS will adjust the interim per capita rate on the basis of adequate data supplied by the HMO/CMP in the interim estimated cost and enrollment reports or such other evidence that CMS 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 the HMO/CMP's 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 the HMO/CMP submits a revised budget or enrollment forecast indicating that an adjustment is needed to maintain payments at the level of current costs.

20.1.2 - Interim Settlement Procedures for Medicare Cost-Based HMO/CMPs

(Rev. 4, 10-01-01)

Within 30 days of receipt of the HMO/CMP's final interim cost report and enrollment data or, in the case in which the HMO/CMP is not submitting quarterly reports, within 30 days of receipt of the interim cost report, CMS will attempt to make a determination of the HMO/CMP's estimated reimbursable costs. Obvious errors and inconsistencies will cause delays in CMS's determination. This interim determination will be made on the basis of the interim cost report for the HMO/CMP referred to in §§20 and 20.1. For this purpose, costs are accepted as reported except for obvious errors or inconsistencies, subject to later audit or review.

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 the HMO/CMP throughout the contract period. If the HMO/CMP has been underpaid, CMS will pay the difference within 30 days of the determination. If the HMO/CMP has been overpaid, a refund is due CMS within 30 days of the determination or the due date of the report. The HMO/CMP may negotiate a repayment schedule with CMS if it is unable to pay the required amount by the 30-day deadline.

20.2 - Final Certified Cost Report

(Rev. 4, 10-01-01)

All cost-based HMOs and CMPs must submit an independently certified cost report and supporting documents to CMS no later than 180 days following the close of each contract period that detail cost, utilization, and enrollment data for the entire contract period. (See 42 CFR 417.576(b)(1).)

An extension of time (not to exceed 30 days) to submit the report may be granted, provided the HMO/CMP requests such extension before the due date of the cost report and shows good cause for the extension. The final cost report shall be in the form and detail required by CMS. This report will be used to make final settlement for the contract period and should include, but is not limited to, the following:

- The per capita costs incurred for the provision of covered services to the HMO/CMP's Medicare enrollees during the contract period, including costs incurred by another organization related to the HMO/CMP through common ownership or control;

- The final report should include a provision for “full reporting”, as required by 42 CFR 417.576(b)(2)(i)(B), and §4016 of CMS Pub. 75, Medicare Health maintenance Organization Manual;

- The HMO/CMP's methods of apportioning costs among Medicare and other enrollees, including non-enrolled patients receiving health care services on a fee-for-service or other basis; and,

- Such information on enrollment and other data that CMS may require.

The total reasonable costs, which the HMO/CMP incurs, that are related to the certification of the cost report are paid in full by CMS. However, other administrative costs incurred by the HMO/CMP in preparing the cost reports, and other data required by the program (other than costs related to reporting enrollment information) are included in Plan Administration. CMS has the right to reject the independently certified cost report if CMS has reason to believe the certifying firm was not independent of the HMO/CMP or if CMS believes there are significant deficiencies in the report which have not been properly addressed by the auditors. In addition, CMS may deny payment for those additional costs incurred by the HMO/CMP for a deficient certification.

Unless the HMO/CMP requests and receives an extension of time for submitting the certified cost report, CMS may consider the failure to report timely as evidence of a likely overpayment and may initiate recovery of amounts previously paid, reduce current interim payments, or both.

20.2.1 - Final Settlement Process - Medicare Cost-Based HMO/CMPs

(Rev. 4, 10-01-01)

Final settlement with a cost-based 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, CMS 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 the HMO/CMP even though a provider of services has not had a final settlement with CMS 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. CMS will only permit this exception if CMS is satisfied that prompt settlement would be in the best interest of the Medicare program, as shown by such factors as:

- The provider's costs represent an insignificant amount of the HMO/CMP's total payment; or

- CMS is satisfied that the provider's costs for serving the HMO/CMP's enrollees will not be modified significantly by the final settlement with the provider under 42 CFR Parts 412 and 413.

Final settlement for cost-based HMO/CMPs will equal the total reimbursable costs incurred by or on behalf of the HMO/CMP throughout the contract period for furnishing covered care to the HMO/CMP's Medicare enrollees (less applicable deductible and coinsurance). Once the final determination of reasonable costs is made, CMS will promptly notify the HMO/CMP by sending a Notice of Program Reimbursement (NPR). This notice will:

- Explain CMS's determination regarding total reimbursement, including an explanation of the computation of overpayments or underpayments;

- Relate this determination to the HMO/CMP claimed total reimbursement;

- Explain differences between the HMO/CMP's and CMS's determination; and
- Inform the HMO/CMP of its right to have the determination reviewed at a hearing.

20.2.2 - Final Settlement Payment for Medicare Cost-Based HMO/CMPs

(Rev. 4, 10-01-01)

If the final settlement determination is greater than payments already made to the HMO/CMP through monthly capitation payments and interim settlement, an underpayment will be declared, and CMS will make a lump-sum payment to the HMO/CMP.

Conversely, if the final settlement determination is less than the total payment made, the HMO/CMP has been overpaid, and CMS must recover the overpayment.

30 - Recovery of Overpayment

(Rev. 4, 10-01-01)

When a cost report has been filed by a HMO/CMP indicating an amount is due CMS, 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 l966, CMS must take timely collection action. Recovery will be undertaken even though the HMO/CMP disputes, in whole or in part, CMS's findings. As a matter of policy, CMS will attempt recoupment as quickly as possible.

If the HMO/CMP has been overpaid, a refund is due CMS. Generally, if repayment is made by the HMO/CMP within 30 days of notification by CMS 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 one CMS authorized 30-day extension); or
- The HMO/CMP and CMS must agree in advance to reduce interim payments over the next 30-day period to liquidate the overpayment.

When the HMO/CMP chooses to repay the debt in installments, it must document the need for such and must submit a written proposal, outlining repayment dates and amounts, including any interest. In no case may a repayment schedule be approved for a time period exceeding one year. CMS has the authority to approve or disapprove such repayment schedule and will notify the HMO/CMP 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 CMS (by NPR or otherwise) of the overpayment.

If subsequent information (e.g., the results of an audit) indicates an additional overpayment was made and the HMO/CMP chooses to repay this additional debt in installments, it must again document the HMO/CMP's 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.

CMS has the authority to reduce or suspend interim payments to the HMO/CMP if it does not make timely repayment of the debt and:

- Fails to submit a repayment schedule;
- Fails to receive CMS approval of a repayment schedule; or
- Fails to meet obligations under an approved repayment schedule.

In addition, CMS will send a letter to the HMO/CMP demanding immediate repayment of the entire amount owed or the immediate submission of a repayment schedule that assures recoupment of the entire amount of the overpayment within the original 1-year time frame previously established. (If CMS determines that recovery through a repayment program would be unsuccessful, CMS will simply demand immediate repayment of the entire amount.) The case will be referred to the Department of Justice (DOJ) for collection unless a satisfactory arrangement is worked out.

30.1 - Interest Charges for Medicare Overpayments/Underpayments

(Rev. 4, 10-01-01)

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 405.378 sets forth the rules for charging and payment of interest. The following subsections set forth the rules governing interest on overpayments/underpayments for HMO/CMPs.

30.1.1 - The Basic Rules

(Rev. 4, 10-01-01)

CMS will charge interest on overpayments and pay interest on underpayments to HMO/CMPs, except as specified in §§30.2.2 and 30.4.

Interest will accrue from the date of the final determination as defined in §30.1.2, 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 CMS or the HMO/CMP for 45 days beginning on the day after the date of the final determination, two full months of interest will be accrued.

30.1.2 - Definition of Final Determination

(Rev. 4, 10-01-01)

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 CMS after the cost report is filed:

- In the absence of a NPR, upon the issuance of either

    1. A written demand for payment; or

    2. A written determination of an underpayment.

    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 CMS 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 CMS, and

    2. Is not accompanied by payment in full.

        (If an additional overpayment or underpayment is determined by CMS, a final determination on the additional amount will be made.); or

- For a cost report that is not filed on time, the day following the due date of the cost report (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.)

Except as required by any subsequent administrative or judicial reversal, interest will accrue from the date of final determination as specified in this section.

30.2 - Rate of Interest

(Rev. 4, 10-01-01)

The interest rate on overpayments and underpayments will be the prevailing rate(s) specified in bulletins issued 8020.20 of the "Treasury Fiscal Requirements Manual". This rate is the higher of the rate as fixed by the Secretary of the Treasury after taking into consideration private consumer rates of interest or the current value of funds rate.

If a HMO/CMP signs a repayment agreement with CMS for the overpayment:

- The rate of interest specified in the agreement will continue unchanged if there is no default; and

- Interest on the balance of the debt may be changed to the prevailing rate if:

    1. The HMO/CMP defaults on an installment; and

    2. The prevailing rate in effect on the date the installment becomes overdue is higher than the rate specified in the agreement.

30.2.1 - Accrual of Interest

(Rev. 4, 10-01-01)

If a cost report is filed that does not indicate an amount is due CMS, but CMS 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 CMS, 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

- CMS and the HMO/CMP agree in advance to liquidate the overpayment through a reduction in interim payments over the next 30-day period.

If CMS determines that additional overpayments exist 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 CMS makes a final determination that an underpayment exists, interest to the HMO/CMP will accrue from the date of notification of the underpayment.

30.2.2 - Waiver of Interest Charges

(Rev. 4, 10-01-01)

When CMS makes a final determination that an overpayment or underpayment exists:

- Interest charges will be waived if the overpayment or underpayment is completely liquidated within 30 days from the date of the final determination; or

- CMS may waive interest charges if it determines that the administrative cost of collecting the interest 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 this section.

30.3 - Rules Applicable to Partial Payments

(Rev. 4, 10-01-01)

If an overpayment is repaid in installments or recouped by withholding from other payments due the HMO/CMP:

- Each payment or recoupment will be applied first to accrued interest and then to principal; and

- After each payment or recoupment, interest will accrue on the remaining unpaid balance.

30.4 - Exception to Applicability

(Rev. 4, 10-01-01)

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.

3.5 - Non-Allowable Interest Cost

(Rev. 4, 10-01-01)

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.

40 - CMS General Payment Principles

(Rev. 4, 10-01-01)

This section discusses general HMO/CMP payment principles including the prudent buyer principle, reimbursable costs, record keeping, and accounting standards for Medicare cost-based HMO/CMPs.

40.1 - Medicare Payment to Cost-Based HMO/CMPs

(Rev. 4, 10-01-01)

Medicare's payment to cost-based HMO/CMPs is based on the reasonable cost of providing Medicare-covered services to Medicare enrollees.

All necessary and proper expenses of the HMO/CMP in providing Medicare-covered services are recognized. The share of the total HMO/CMP cost that is borne by CMS is related to the Medicare-covered care furnished Medicare beneficiaries so that no part of their cost would need to be borne by other enrollees or non-enrolled patients. Conversely, costs attributable to other HMO/CMP enrollees and non-enrolled patients are not to be borne by Medicare.

The HMO/CMP payment principles take into account the special nature of HMO/CMPs by recognizing costs of marketing, enrollment, and certain other costs unique to the cost-based 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 the HMO/CMP must be consistently followed in subsequent periods. A change of method must have advance approval from CMS. Also, any request for a change in the method of handling a particular cost item, including the apportionment or allocation of such items, must be made 90 days prior to the beginning of the contract year in which the new method is proposed for use.

50 - Payment for Provider Services

(Rev. 4, 10-01-01)

The HMO/CMP may furnish hospital and other provider services through facilities that are owned and operated by the HMO/CMP or through arrangements with other providers. In either case, the calculation of Medicare's payment for services furnished to its 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 (Pub. 15), Part I, are to be used.

For provider services furnished through facilities owned or operated by the HMO/CMP or related to the HMO/CMP 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 Medicare HMO/CMP involvement. The allowable cost of the HMO/CMP in purchasing provider services through arrangements is described in Chapter 17 Subchapter B. The allowable cost of the HMO/CMP in furnishing provider services through facilities owned or operated by the HMO/CMP or related to it through common ownership or control is also described in Chapter 17 Subchapter B of this manual.

60 - Prudent Buyer Principle

(Rev. 4, 10-01-01)

The HMO/CMP is expected to minimize costs incurred in furnishing physicians' and other Part B supplier services to the HMO/CMP's Medicare enrollees so that actual costs:

- Do not exceed what a prudent and cost conscious buyer would incur; and

- Are comparable to costs incurred for similar services furnished by similar physicians or other suppliers 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.

70 - Allowable Costs

(Rev. 4, 10-01-01)

Allowable costs are those direct and indirect costs, including normal standby costs, which the HMO/CMP incurs and are proper and necessary to efficiently deliver needed health care. These costs include costs related to the care of beneficiaries that are normally paid by Medicare and other costs such as enrollment, membership, and similar costs unique to Medicare HMO/CMPs and necessary to the HMO/CMP's operations.

The types of items and costs generally incurred by a provider of service, in accordance with the principles of reimbursement for provider costs, are allowable to an HMO/CMP. These costs are allowable and reimbursable if incurred by the HMO/CMP, by providers of services, or other facilities owned or operated by the HMO/CMP through which covered care is furnished to its Medicare enrollees.

The allowable costs of an HMO/CMP are first determined in accordance with the principles set forth in 42 CFR Part 417 Subpart O and this manual. After those requirements are met, the Medicare principles of reimbursement as described in the "Provider Reimbursement Manual" (Pub. 15) are applicable if they are not in contradiction with the regulation and this manual. In addition, Generally Accepted Accounting Principles (GAAP) should be followed if instructions in the regulation or manuals do not instruct the HMO/CMP otherwise.

80 - Costs Not Reimbursable Directly to the Cost-Based HMO/CMP

(Rev. 4, 10-01-01)

In determining amounts due the HMO/CMP, certain costs are excluded from payments made directly to the HMO/CMP. The following subsections, while not necessarily all-inclusive, detail some of these costs.

80.1 - Deductibles and Coinsurance

(Rev. 4, 10-01-01)

In determining amounts due the HMO/CMP, 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 estimating this amount are contained in Chapter 17 Subchapter B, §220.

80.2 - Certain Provider Costs

(Rev. 4, 10-01-01)

A HMO/CMP has the option to have hospitals and SNFs, that furnish covered services to the HMO/CMP's Medicare enrollees, obtain payment directly from Medicare on the HMO/CMP's behalf (See Chapter 17 Subchapter B). When the HMO/CMP opts for this alternative, these providers are each paid the cost for the Medicare-covered services furnished to the Medicare enrollee. This determination is made using Medicare’s payment principles or Medicare’s prospective payments, as appropriate, and the amounts paid are deducted from the payments to the HMO/CMP.

80.3 - Costs in Excess of Annual Capitation Rate

(Rev. 4, 10-01-01)

In evaluating the reasonableness of costs for a cost-based HMO/CMP, CMS may take into account the cost-based HMO/CMP's per capita incurred costs for providing covered services to Medicare enrollees, in relation to the Adjusted Average Per Capita Cost (AAPCC) 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 a cost-based HMO/CMP rather than a strict payment limitation.

80.4 - Hospice Care Costs

(Rev. 4, 10-01-01)

If a Medicare enrollee of a cost-based HMO/CMP 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-based 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 by 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 cost-based HMO/CMP will be reimbursed in the usual manner.

80.5 - Medicare as Secondary Payer

(Rev. 4, 10-01-01)

Medicare does not pay the cost-based HMO/CMP for covered services for which Medicare is the secondary payer. For more information on Medicare as secondary payer, see Chapter 17 Subchapter B, and /or 42CFR 411.

90 - Financial Records, Statistical Data, and Cost Finding

(Rev. 4, 10-01-01)

The cost-based HMO/CMP must maintain sufficient and adequate financial and statistical records for CMS to make proper determinations of the costs incurred by the HMO/CMP in furnishing services, either directly or through arrangements, to its Medicare enrollees. The records must be retained for a period of at least 3 years following the issuance of a Notice of Program Reimbursement (NPR).

100 - Accounting Standards

(Rev. 4, 10-01-01)

The HMO/CMP's records must be capable of verification by qualified auditors and properly reflect all direct and indirect costs claimed by the HMO/CMP under the contract. This means that the HMO/CMP's cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, if a cost-based HMO/CMP is owned and operated by a Federal, State or local government agency and operates on a cash basis of accounting, CMS accepts cost data on this basis, subject to appropriate treatment of capital expenditures.

100.1 - Accrual Basis of Accounting

(Rev. 4, 10-01-01)

Under the accrual basis of accounting, 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.

100.2 - Cash Basis of Accounting

(Rev. 4, 10-01-01)

Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

110 - Adequate and Sufficient Records

(Rev. 4, 10-01-01)

Cost data developed by a cost-based HMO/CMP must be current, accurate, and in sufficient detail for CMS 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 if the HMO/CMP

makes a full disclosure to CMS of the significant changes in advance and secures approval for the change.

At a minimum, the following financial records/information must be maintained:

- Matters of ownership, organization, and operation of the HMO/CMP's financial, medical, and other record keeping systems;
- Financial statements for the current and prior three contract periods (this will include such things as management letter comments and access to related workpapers);
- Federal income tax or information returns for the current and prior three contract periods;
- Asset acquisition documents and leases;
- Agreements, contracts, and subcontracts;
- Franchise, marketing, and management agreements;
- Schedules of charges for the HMO/CMP's fee-for-service patients;
- Records pertaining to costs of operations;
- Amounts of income received by source and payment;
- Cash flow statements;
- Any financial reports filed with other Federal programs or State authorities; and
- Minutes from the Board of Directors' meetings taking place during the contract period.

Medicare Managed Care Manual

Chapter 17 Subchapter B

Payment Principles for Cost-Based HMO/CMPs

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

(Rev. 4, 10-01-01)

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

Under these principles, allowable costs are determined according to the Medicare principles of reimbursement as set out in the "Provider Reimbursement Manual" (Pub. 15) and Generally Accepted Accounting Principles (GAAP), in that order. Contracting organizations will be furnished a copy of the "Provider Reimbursement Manual" (Pub. 15) for reference to the principles of provider reimbursement.

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

(Rev. 4, 10-01-01)

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

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

30 - Data Collection Requirements

(Rev. 4, 10-01-01)

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

40 - Filing Requirements for Providers Using Form CMS-2552

(Rev. 4, 10-01-01)

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

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

In addition, the provider will prepare a separate set of apportionment and settlement worksheets apportioning the costs to the organization's Medicare enrollees. A separate set of worksheets will

be needed for each organization with which the provider has an agreement to have payment made directly by the HMO/CMP. Each set of worksheets will apportion each cost center between the applicable group of Medicare beneficiaries and all other provider patients.

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

(Total Costs) times (Charges for the HMO's Medicare enrollees)

= Total Charges

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

(Total Costs) times (Charges for Medicare patients that are not members of the HMO/CMP)

= Total Charges

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

50 - Filing Requirements for Providers Using Other Cost Report Forms

(Rev. 4, 10-01-01)

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

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

(Rev. 4, 10-01-01)

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

70 - Providers Receiving Payment Under the Prospective Payment System (PPS)

(Rev. 4, 10-01-01)

Payment to an HMO/CMP for provider services provided either directly or under arrangements shall be determined in accordance with 42 CFR, Parts 405, 412, or 413, as appropriate, unless the organization can demonstrate in accordance with 42 CFR 417.548 that payment in excess of the amount authorized is justified on the basis of advantages gained by the organization.

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

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

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

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

This rule applies to:

- Inpatient hospital and SNF services provided by facilities owned or operated by the HMO/CMP;

- Inpatient hospital and SNF services provided by facilities related to the HMO/CMP by common ownership or control; and

- Inpatient hospital and SNF services provided by facilities with which the HMO/CMP has an arrangement.

80 - Summary of Provider Reimbursement Principle Topics

(Rev. 4, 10-01-01)

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

Summary

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

TOPIC	Chapter Reference in Provider Reimbursement Manual, Part I
Prospective Payments	28

90 - Provider Services through Arrangements

(Rev. 4, 10-01-01)

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

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

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

1. The reasonable cost of furnishing such covered services (as determined under §1861(v) of the Act) for those providers currently paid on a reasonable cost basis, or

2. The payment amount determined under §1886 of the Act for those providers currently paid under Medicare's PPS or under an approved State reimbursement cost control system.

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

100 - Payments to Providers Participating Under §1886 of the Act

(Rev. 4, 10-01-01)

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

110 - Infrequently Purchased Provider Services

(Rev. 4, 10-01-01)

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

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

- The provider furnished services to the Medicare HMO/CMP enrollees on an infrequent basis;

- The charges represent an insignificant amount of payment to the HMO/CMP by Medicare; and

- The charges do not exceed the customary charges by the provider to other patients for similar services.

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

120 - Physician Services - General

(Rev. 4, 10-01-01)

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

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

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

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

(Rev. 4, 10-01-01)

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

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

- Are commensurate with amounts paid for similar items and services furnished by similar personnel and suppliers in the same or similar locality;

- Do not exceed those that a prudent and cost conscious buyer would incur to purchase those services.

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

(Rev. 4, 10-01-01)

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

- Do not exceed those that a prudent and cost conscious buyer would incur to purchase those services; and

- Are comparable to costs incurred for similar services furnished by similar physicians or other suppliers in the same or similar geographic area.

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

(Rev. 4, 10-01-01)

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

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

(Rev. 4, 10-01-01)

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

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

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

150.2 - Payment for Services Rendered on or After April 1, 1994, by Non-Contracted, Non-participating Physicians

(Rev. 4, 10-01-01)

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

160 - Enrollment and Marketing Costs

(Rev. 4, 10-01-01)

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

These costs do not include membership costs (see §18) or special costs (see §20).

170 - Initial Enrollment

(Rev. 4, 10-01-01)

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

180 - Membership Costs

(Rev. 4, 10-01-01)

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

190 - Reinsurance

(Rev. 4, 10-01-01)

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

190.1 - Self-Insurance

(Rev. 4, 10-01-01)

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

200 - Special Costs Paid In Full

(Rev. 4, 10-01-01)

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

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

- Medicare Enrollment Data -This is the reasonable cost of reporting individual Medicare beneficiary enrollment accretion and deletion data;

- Special Program Evaluation and Planning Data -This is the reasonable cost of special data required by CMS solely for Medicare program evaluation and planning purposes.

However, unless specifically provided for, this data does not include the data the organization is required to maintain and furnish under other sections of this manual; and

- Certification of Cost Report -This is the reasonable costs of certifying the organization's cost report. However, as indicated above, the reasonable cost of preparing this cost report is apportioned in accordance with Chapter 17 Subchapter C as applicable. CMS will pay in full under this section only those additional costs incurred by the organization that are related to the certification of that report.

210 - Beneficiary Liability

(Rev. 4, 10-01-01)

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

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

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

210.1 - Under and Over Collection of Premiums

(Rev. 4, 10-01-01)

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

- Adjust future years' premiums;

- Provide a lump sum payment to the enrollee; or

- A combination of premium adjustment and lump sum payment.

Unintentional (or involuntary) under collections of premiums may be collected from the HMO/CMP's Medicare enrollees by an adjustment to its Medicare enrollees' future premiums. However, the HMO/CMP must collect the under collections through premium adjustments no later than the end of the contract period following the contract period during which they were found to be due. Intentional (or voluntary) under collections of premiums cannot be recouped by the HMO/CMP from the Medicare enrollee.

220 - Determining Deductibles and Coinsurance

(Rev. 4, 10-01-01)

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

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

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

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

The HMO/CMP's use of this method will involve three major computations. The organization will first list the actual Part A deductible and coinsurance and Part B coinsurance for each provider furnishing services to its Medicare enrollees. Next, the organization will calculate the Part B deductible amount by multiplying the Medicare Part B monthly standard deductible amount (determined by CMS) by the organization's Part B Medicare enrollee months. The actuarial values of the Medicare Part B monthly deductible for the years 1985 through 2000, as determined by CMS, are:

Year	Actuarial Value
1985	$ 5.03
1986	$ 5.05
1987	$ 5.00
1988	$ 5.28
1989	$ 5.41
1990	$ 5.29
1991	$ 6.65
1992	$ 6.92
1993	$ 7.08
1994	$ 7.23
1995	$ 7.22
1996	$ 7.46
1997	$ 7.48
1998	$ 7.51
1999	$ 7.71
2000	$ 7.58

In the third major computation, the cost-based HMO/CMP will compute the Part B blood deductible amount, and the Part B coinsurance applicable to non-provider services. The sum of these three computations gives the Medicare Part A and Part B deductible and coinsurance amounts.

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

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

1. Factors

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

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

c = Total HMO/CMP Medicare enrollee co-payments;

d = HMO/CMP Medicare enrollee months; and

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

2. Computation

(a + b - c) divided by d = e

220.1 - Payment for Bad Debts

(Rev. 4, 10-01-01)

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

- They are attributable to Medicare deductible and coinsurance amounts for which the Medicare enrollee is liable; and

- The cost-based HMO/CMP has made a reasonable, but unsuccessful, effort to collect these amounts based on Chapter 3 of the "Provider Reimbursement Manual" (Pub. 15), §300.

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

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

230 - Limitation on Payment

(Rev. 4, 10-01-01)

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

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

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

240 - End Stage Renal Disease (ESRD)

(Rev. 4, 10-01-01)

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

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

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

250 - Limitations on Costs

(Rev. 4, 10-01-01)

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

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

260 - Physical and Other Therapy Services Furnished Under Arrangements

(Rev. 4, 10-01-01)

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

- Amounts equivalent to the salary and other costs that would have been incurred by the provider or other entity if the services had been performed in an employment relationship and

- An allowance to compensate for other costs an individual not working as an employee might incur in furnishing services under arrangements.

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

- When the services of a therapist or other health-related specialist are required only on a limited part-time basis or only intermittently and

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

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

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

270 - Allowable Cost for Drugs in a Provider Setting

(Rev. 4, 10-01-01)

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

- The actual cost;

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

- The maximum allowable cost limit.

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

280 - Lower of Costs or Charges

(Rev. 4, 10-01-01)

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

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

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

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

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

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

290 - The Prospective Payment System (PPS)

(Rev. 4, 10-01-01)

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

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

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

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

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

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

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

300 - Duplicate Payment Detection for Cost Contracting HMO/CMPs

(Rev. 4, 10-01-01)

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

or to the enrollee. It is incumbent that HMO/CMPs establish a system to preclude or detect duplicate payments.

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

- Claims involving outpatient psychiatric services;
- Claims for services by an independent physical therapist;
- Claims for outpatient blood transfusions;
- Claims from physicians for dialysis and related services provided through and approved dialysis facility; and
- Hospice care by Medicare participating hospices, except:

  (a) Services of the enrollee's attending physician if the physician is an employee or contractor of the organization and is not employed by or under contract to the member's hospice; and

  (b) Services not related to the treatment of, or a condition related to, the terminal condition.

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

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

300.1 - Coordination of Benefits

(Rev. 4, 10-01-01)

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

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

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

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

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

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

300.1.1 - Definition of Certain Terms Used in Coordination of Benefits

(Rev. 4, 10-01-01)

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

- Subrogation means the substitution of one person or entity for another.

300.2 - The Medicare HMO/CMPs' Obligations

(Rev. 4, 10-01-01)

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

- Identify payers that are primary to Medicare under §1862(b) of the Act;
- Determine the amounts payable by these payers; and
- Take steps in accordance with these instructions and the instructions in §§3407-34l9 and §§3489-3492 of the Medicare Intermediary Manual to assure that Medicare pays only secondary benefits when another insurer is primary payer.

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

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

(Rev. 4, 10-01-01)

All Medicare payments are contingent upon payment 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 l862(b) of the Act now expressly provides that:

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

300.4 - Other Provisions

(Rev. 4, 10-01-01)

Any claimant, including an individual who received services and the provider or supplier, has the right to take legal action against an Employer Group Health Plan (EGHP) or Large Group Health

Plan (LGHP) that fails to pay primary benefits for services covered by both the EGHP or LGHP, Medicare, and to collect double damages. (See §36.5.)

According to §2000 of the Internal Revenue Code (IRC), an excise tax may be imposed on any employer or employee organization that contributes to the nonconforming EGHP or LGHP during a calendar year. The amount of tax is 25 percent of the total amount that the employer or employee organization contributed to the EGHP or LGHP during that year. This tax penalty does not apply to Federal and other governmental entities.

300.5 - Conflicting Claims by Medicare and Other Third Parties

(Rev. 4, 10-01-01)

Situations may arise in which both Medicare and another insurer or State Medicaid agency have conditionally or erroneously paid for services, and the amount payable by the third party payer is insufficient to reimburse both programs. Under §l862(b)(2)(B) of the Act, Medicare has the right to recover its benefits from the responsible third party before any other entity, including a State Medicaid Agency. Also, Medicare has the right to recover its benefits from any entity, including a State Medicaid Agency that has been paid by the responsible third party. In other words, Medicare's recovery rights when another third party is primary payer take precedence over the rights of any other entity.

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

If Medicare and Medicaid both have claims against the responsible third party, Medicare's right to recover its benefits from another insurer or from a beneficiary that has been paid by another third party is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort, and therefore, does not pay its benefits until after Medicare has 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 §l862(b) of the Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) when payment can reasonably be expected by a third party which is primary to Medicare. If a third party that is primary payer pays promptly, Medicare makes no payment to the extent of the third party payment. Delay of the other payment does not change Medicare's ultimate obligation to pay the correct amount, if any, regardless of any Medicare payments conditionally made. Thus, when a responsible third party pays the charges, or if it pays less and the provider is obligated to accept that amount as payment in full, Medicare may not pay at all. Pro rata or other sharing of recoveries with third parties would have the effect of creating a Medicare payment when none is authorized under the law, or improperly increasing the amount of any Medicare secondary payment.

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

300.6 - Coordination with Worker's Compensation

(Rev. 4, 10-01-01)

Medicare may not pay for services that are payable under Workers' Compensation (WC) laws. Where the Medicare cost-based HMO/CMP coordinates its own health organization with WC coverage, it will use the procedures developed by its own organization to identify and recover costs for services furnished to Medicare members. When the Medicare cost-based HMO/CMP does not coordinate benefits for its own organization, it must establish reasonable screening procedures to identify potential WC liability situations. If it is determined that Medicare has paid for items or services which can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

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

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

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

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

300.6.1 - Definitions under WC

(Rev. 4, 10-01-01)

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

  The definition also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of l969 as amended (the Federal Black Lung

Program). These federal programs provide WC protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs (e.g., coal miners totally disabled due to pneumoconiosis; maritime workers, with the exception of seamen; employees of companies performing overseas contracts with the United States government; employees of American companies who are injured in an armed conflict; employees paid from non-appropriated Federal funds, such as employees of post exchanges; and offshore oil field workers). The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this provision. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this provision.

- Workers' Compensation Agency means any governmental entity that administers a Federal or State WC law. This term includes WC commissions, industrial commissions, industrial boards, WC insurance funds, WC courts and, in the case of Federal workers' compensation programs, the U.S. Department of Labor.

- Workers' Compensation Carrier means any insurance carrier authorized to write WC insurance under the State or Federal law, the State compensation fund in which the State administers the WC program, and the beneficiary's employer in which the employer is self-insured.

- Lump Sum Compromise Settlement is a settlement that provides less in total compensation than the individual would have received if the claim had not been compromised. This may occur when compensability is contested.

300.7 - Additional Processing Instructions

(Rev. 4, 10-01-01)

For further information on how to implement this Medicare secondary payer provision, refer to §§3407.2-34l7.2 of the Medicare Intermediary Manual. These sections include information regarding the method of calculating Medicare secondary payments, contested WC claims, lump sum commutations of future benefits, and the effect of a lump sum compromise settlement.

310 - Coordination for ESRD Patients

(Rev. 4, 10-01-01)

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

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

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

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

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

(Rev. 4, 10-01-01)

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

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

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

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

310.2 - Additional Processing Instructions

(Rev. 4, 10-01-01)

For further information on how to implement this Medicare secondary payer provision, refer to §§3490.3-3490.16 of the Medicare 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 l8-month period in which Medicare may be secondary, and the method of calculating the Medicare secondary payment.

320 - Coordination with No Fault Insurance

(Rev. 4, 10-01-01)

Medicare may not pay for any items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services, under any no fault insurance (including a self-insured organization). Medicare is secondary to no fault insurance even if State

law or a private contract of insurance stipulates that Medicare is primary. If Medicare payments have been made, but should not have been because they are excluded under this provision, or if the payments were made on a conditional basis, they are subject to recovery.

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

Expenses for services for which Medicare payment may not be made because payment has been made or can reasonably be expected to be made promptly under any no fault insurance are credited toward Part A or Part B deductible amounts. Inpatient care that is paid for by a third party payer is not counted against the number of days available to the beneficiary under Medicare Part A.

320.1 - Definition of Automobile and No Fault Insurance

(Rev. 4, 10-01-01)

- An automobile is defined for the purposes of this instruction, as any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

- No Fault Insurance is insurance coverage (including a self-insured plan) that pays for all or part of the medical expenses for injuries regardless of who may have been responsible for causing the accident. (This insurance is sometimes called personal injury protection (PIP), medical payments coverage, or medical expense coverage.)

320.2 - Additional Processing Instructions

(Rev. 4, 10-01-01)

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

330 - Benefit Coordination for Services Reimbursable under Liability Insurance

(Rev. 4, 10-01-01)

Under §l862(b)(2)(A) of the Act (42 U.S.C. l395y(b)(2)(A)), payment may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan (including a self-insured plan). All Medicare payments are contingent upon payment to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under a liability insurance policy or plan (including a self-insured plan).

Medicare is subrogated to the rights of the beneficiary and may also recover its benefits directly from liability insurance companies and self-insured plans, and from any entity, including the beneficiary, that has been paid by a liability insurer. Medicare's right to recover its benefits from liability insurers and from those who have been paid by liability insurers, takes precedence over the claims of any other party, including Medicaid.

Under this Medicare Secondary Payer (MSP) provision, the program is a claimant against the responsible party and the liability insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary. Medicare can be a party to any claim by a beneficiary or other entity against a liability insurer, can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare, and may seek recovery of conditional payments directly from the liability insurer. Section 1862(b) of the Act provides that any claimant has the right to take legal action against a liability insurer that fails to pay primary benefits for services covered by the insurer, and to collect double damages.

330.l - Definition Under Liability Insurance

(Rev. 4, 10-01-01)

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

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

- A Self-Insured Plan is a plan under which an individual or other entity is authorized by State law to carry its own risk instead of taking out insurance with a carrier. Authorized by State law means not prohibited by State law. The plan established for the Federal government under the Federal Tort Claims Act is also a self-insured plan.

- Uninsured Motorist Insurance is a liability insurance plan under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law.

- Under-Insured Motorist Insurance is optional liability insurance available in some jurisdictions under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.

- An accident is any occurrence or activity that the individual believes resulted in injury or illness for which he/she holds another party liable.

330.2 - Additional Processing Instructions

(Rev. 4, 10-01-01)

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

340- Benefit Coordination for Working Aged Individuals Entitled To Medicare

(Rev. 4, 10-01-01)

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

Medicare is secondary only if the individual is entitled to Medicare Part A. Generally, Medicare is not secondary for persons over age 65 who have ESRD.

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

340.1 - Application of 20-Employee Threshold

(Rev. 4, 10-01-01)

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

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

provided to self-employed persons by an employer of 20 or more employees must be primary to Medicare.

Assume for purposes of developing claims that, in the absence of evidence to the contrary, an employer in whose health organization a beneficiary is enrolled because of employment, meets the definition of employer and employs at least 20 people. An employer's allegation that the 20-employee requirement is not met, or a multi-employer organization's statement identifying specific members as employees of employers of fewer than 20 employees, can be accepted as a basis for making Medicare primary payments. Refer questionable cases to the CMS (RO).

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

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

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

340.2 - Definitions under EGHP

(Rev. 4, 10-01-01)

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

- **Employed** - For purposes of this discussion, encompasses not only employees, it also includes, subject to the special rules in this chapter, self-employed persons such as consultants, owners of businesses, directors of corporations, and members of the clergy and religious orders who are paid for their services by a religious body or other entity.
- **Employer -** Means, in addition to individuals and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, the individual States,

Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.

- **EGHP for the Working Aged**, means any health organization that is paid for by or contributed to by an employer of 20 or more employees and which provides medical care, directly or through other methods, such as insurance or reimbursement, to current or former employees or to current or former employees and their families. This includes a multi-employer plan (i.e., a plan sponsored jointly by employers and unions) and a multiple employer plan (i.e., a plan sponsored by more than one employer) which is sponsored by or contributed to by at least one employer that has 20 or more employees. Under §1862(b)(1)(A)(iii) of the Act, if a multi-employer plan or multiple EGHP can identify particular enrollees as employees of employers that do not meet the 20 employee threshold, the MSP rules do not apply to these enrollees and their spouses. However, the organization must elect this treatment for the exception to apply.

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

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

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

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

340.3 - Additional Special Rules Applicable to EGHPs

(Rev. 4, 10-01-01)

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

340.3.1 - Self-Employed Individuals

(Rev. 4, 10-01-01)

These are currently employed persons. It includes not only employees, but also self-employed persons such as directors of corporations and owners of businesses. If a self-employed individual

enrolls in an EGHP that meets the definition in this chapter, the employer plan is primary for that individual and the individual's spouse.

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

(Rev. 4, 10-01-01)

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

- Considered employed if they are receiving from a church, religious order or other employing entity cash remuneration for services rendered regardless of whether their earnings are exempt from Social Security coverage; and

- Considered retired if the church, religious order, or other employing entity states that the members are retired, and that they receive only retirement pay from the entity rather than remuneration for services rendered.

340.3.3 - Members of Religious Order Who Have Taken a Vow of Poverty

(Rev. 4, 10-01-01)

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

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

340.4 - Individuals Who Receive Disability Payments

(Rev. 4, 10-01-01)

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

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

Example

Adam Green stopped working because of disability in December l987 at age 66. His employer began paying him disability payments as of January l988. 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 l988. Beginning with July l988, Medicare becomes the primary payer as the sick payments are no longer considered wages under FICA.

350 - Additional Processing Instructions

(Rev. 4, 10-01-01)

For further information on how to implement this Medicare secondary provision, refer to §§349l.3-349l.l7 of the Medicare Intermediary Manual. These sections include, among other things, information regarding the individuals covered by this provision, the coordination of benefits with other insurers, the method of calculating the Medicare secondary payment, and special rules for services furnished by a source outside the prepaid EGHP.

350.1 - Benefit Coordination with a Large Group Health Plan

(Rev. 4, 10-01-01)

Under §l862(b)(1)(B) of the Act, Medicare is secondary payer to LGHPs for active individuals under age 65 entitled to Medicare on the basis of disability. Under the law, an LGHP may not take into account that an active individual is eligible for or receives benefits based on disability. The individual's coverage under the LGHP must be based on the individual's employment or the employment of a family member. Refer to §3492 of the Medicare Intermediary Manual for processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to an EGHP of 20 or more employees, substitute the term "large group health plan" for purposes of applying them to disabled individuals. This provision is effective for items and services furnished on or after January l, l987, and before October l, l995.

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

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

A group health plan that covers employees of at least one employer that had l00 or more employees on 50 percent or more of its business days during the preceding calendar year is considered to meet the above definition of an LGHP.

350.2 - A Nonconforming LGHP

(Rev. 4, 10-01-01)

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

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

350.3 - Definition of an Active Individual

(Rev. 4, 10-01-01)

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

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

350.4 - Definition of an Employee

(Rev. 4, 10-01-01)

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

350.5 - Special Rules for Individual Employee Status

(Rev. 4, 10-01-01)

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

- The individual is receiving payments from an employer which are subject to taxes under the Federal Insurance Contributions Act (FICA), or would be subject to such taxes except that the employer is one that is not required to pay such taxes under the IRC;
- The individual is termed an employee under State or Federal law or in accordance with a court decision;
- The employer pays the same taxes for the individual as he/she pays for actively working employees;
- The individual continues to accrue vacation time or receives vacation pay;
- The individual participates in an employer's benefit plan in which only employees may participate;
- The individual has rights to return to duty if his/her condition improves; and
- The individual continues to accrue sick leave.

350.5.1 - Individuals Not Subject to This Limitation on Payment

(Rev. 4, 10-01-01)

Medicare is not secondary for:

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

350.6 - Failure to Pay Primary Benefits

(Rev. 4, 10-01-01)

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

360 - Additional Processing Instructions

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

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

(Rev. 4, 10-01-01)

Separate from its subrogation rights, the Federal Government has an independent right to take legal action to recover payments from entities that are required or responsible to pay benefits primary to Medicare, but fail to do so. The Federal Government may recover double damages in this type of lawsuit pursuant to §1862(b)(2)(B)(ii) of the Act. Entities that are required or responsible to pay primary to Medicare include:

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

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

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

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

(Rev. 4, 10-01-01)

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

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

370.1 - Working Aged

(Rev. 4, 10-01-01)

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

370.2 - Disability

(Rev. 4, 10-01-01)

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

370.3 - End Stage Renal Disease (ESRD)

(Rev. 4, 10-01-01)

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

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

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

- Failure to make primary payment on behalf of an individual for whom Medicare is secondary;

- Providing secondary or complementary coverage to such an individual;

- Refusal to allow such an individual to enroll or re-enroll in the group health plan or large group health plan because of Medicare entitlement;

- Providing a different level of benefits for individuals for whom Medicare is secondary than it provides for other persons enrolled in the plan;

- Imposing limitations on benefits, exclusions of benefits, reductions in benefits, higher premiums, higher deductibles or coinsurance, longer waiting periods, lower annual or lifetime benefit limits, or more restrictive pre-existing illness limitations, or for persons for whom Medicare is secondary payer that are not applicable to others enrolled in the plan;

- Terminating coverage because a person has become entitled to Medicare; or

- Failure to cover routine maintenance dialysis services or kidney transplants.

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

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

380 - Applying Recoveries to the Cost Report

(Rev. 4, 10-01-01)

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

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

- The amount recoverable; or
- A member month ratio.

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

(Rev. 4, 10-01-01)

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

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

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

400 - Determining Total Costs for Comparison with Capitation Limits

(Rev. 4, 10-01-01)

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

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

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

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

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

(Rev. 4, 10-01-01)

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

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

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

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

(Rev. 4, 10-01-01)

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

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

be paid by CMS should be limited to that amount applicable to Medicare's deductible and coinsurance charged as a premium.

Medicare Managed Care Manual

Chapter 17 Subchapter C

Cost Apportionment for Cost-Based HMO/CMPs

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1 - Cost Apportionment for Cost-Based Health Maintenance Organization and Competitive Medical Plan (HMO/CMPs)

(Rev. 4, 10-01-01)

The term apportionment, as used here, refers to the process of distributing allowable costs among various groups of cost-based HMO/CMP patients. This chapter sets forth instructions for apportionment of the total allowable direct and indirect costs of the cost-based HMO/CMP among Medicare beneficiaries enrolled in the HMO/CMP, other enrollees, and any non-enrolled 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 Chapter 17 Subchapter B.

10.1 - Objectives of Apportionment

(Rev. 4, 10-01-01)

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 non-enrolled patients of the cost-based HMO/CMP; and

- Costs of services to non-Medicare enrollees and non-enrolled patients will not be borne by Medicare enrollees.

20 - Cost-Based HMO/CMP Services Furnished Non-enrolled Medicare Patients

(Rev. 4, 10-01-01)

The HMO/CMP may furnish services to Medicare beneficiaries who are not enrolled in the HMO/CMP's prepayment plan. Since the contract with CMS is limited to Medicare beneficiaries actually enrolled in the HMO/CMP, the cost apportionment process distinguishes between Medicare enrollees of the HMO/CMP and non-enrolled Medicare patients. For services furnished Medicare patients not enrolled in the HMO/CMP, Medicare payment is made through the Part A intermediary or Part B carrier, outside the scope of the cost-based HMO/CMP contract with CMS.

30 - Apportionment of Provider Services

(Rev. 4, 10-01-01)

A provider of services (e.g., a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation center) which furnishes services to the HMO/CMP 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 Medicare Provider Reimbursement Manual, Pub. 15 apply.

40 - Provider Services Furnished Directly by Cost-Based HMO/CMPs

(Rev. 4, 10-01-01)

When a provider owned or operated by the cost-based HMO/CMP, or related to the HMO/CMP by common ownership or control (referred to here as a "plan provider"), furnishes services directly to the HMO/CMP's 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 Medicare Provider Reimbursement Manual Pub. 15, 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 the HMO/CMP during the reporting period.

The essential difference between cost-based HMO/CMP and non-HMO/CMP (i.e., unrelated) providers is that a cost-based plan provider will, in effect, have two separate reimbursement settlements with the Medicare program. It will have one for Medicare patients who are not enrolled in the cost-based HMO/CMP, and one for Medicare beneficiaries who are cost-based HMO/CMP enrollees.

50 - Provider Services Furnished by the Cost-Based HMO/CMPs Through Arrangements

(Rev. 4, 10-01-01)

Costs of covered services the cost-based HMO/CMP furnishes to Medicare enrollees through arrangements with non-plan providers will, in most cases, be the amount the HMO/CMP pays the provider under its financial arrangement, to the extent it is found reasonable (subject to the rules in Chapter 17 (Subchapters A and B)). The apportionment process used to determine the reasonable cost of, or prospective payment for, provider services furnished to the 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 cost-based HMO/CMP enrollees, subject to the rules set forth in Chapter 17. However, if the special nature or terms of the cost-based HMO/CMP's financial arrangements with the provider would result in the Medicare program bearing the costs of delivering care to individuals other than Medicare enrollees of the cost-based HMO/CMP, the apportionment must be on some other appropriate basis approved by CMS intended to assure that the share allocated to the Medicare program does not include costs of delivering care to non-Medicare enrollees.

When the HMO/CMP elects to have hospital or skilled nursing facility providers seek reimbursement directly from the Fee-For-Service (FFS) system for covered services furnished to the HMO/CMP's Medicare enrollees, the share to be borne by CMS is the amount that the FFS system pays the provider. This will be determined on the same approved basis otherwise used by the hospital or skilled nursing facility provider in apportioning Medicare's share of allowable costs or the Medicare prospective payment for covered services furnished Medicare beneficiaries who are not enrollees of the HMO/CMP.

60 - Apportionment of Physician and Other Part B Services

(Rev. 4, 10-01-01)

The following sections set forth the requirements for apportionment of the allowable costs of physician services and other Part B services. In general, medical services are furnished through the HMO/CMP's medical service facility or through arrangements with a medical group or IPA.

70 - Apportionment of Medical Services Furnished Directly and Under Arrangements

(Rev. 4, 10-01-01)

The apportionment rules contained in this section shall apply to cost-based HMO/CMPs.

70.1 - Services Furnished Directly

(Rev. 4, 10-01-01)

The total allowable cost of Part B physician and supplier services (see Chapter 17, Subpart B, §§120-150) 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 non-enrolled patients.

The HMO/CMP must use a method for reporting costs and statistics that is approved by CMS. CMS will base its approval on findings 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 the HMO/CMP elects to use a relative value system to apportion costs, the HMO/CMP must use the entire system as described by the designer of the system, and obtain CMS approval before implementation.

70.2 - Services Furnished Under Arrangements

(Rev. 4, 10-01-01)

The Part B physician and supplier services that the cost-based HMO/CMP furnishes under arrangement are grouped into two categories for apportionment purposes. The basis the HMO/CMP uses to pay for a service determines in which category the service is grouped. The two categories are:

- Services furnished under an arrangement that provides for the cost-based HMO/CMP to pay for the service on a fee-for-service (FFS) basis; and

- Services furnished under an arrangement that provides for the cost-based HMO/CMP to pay for the service on some basis other than fee-for-service (FFS).

If the arrangement provides for the HMO/CMP to pay for these services on a FFS 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 Medicare-covered services furnished to Medicare enrollees to total charges for services furnished to all enrollees and non-enrolled patients. (See payment limitations contained in Chapter 17, Subchapter B, §§250-300). 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 CMS) to ensure 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 FFS, the reasonable cost the HMO/CMP pays, under the financial arrangement for the services furnished, shall be apportioned between Medicare enrollees and others based on the ratio of Medicare-covered services furnished to Medicare enrollees to total services furnished to all enrollees and non-enrolled patients. 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 CMS) to ensure that Medicare pays only for services furnished to Medicare enrollees.

80 - Emergency and Urgently Needed Provider Services, and Out of Area Provider Services for which the Cost-Based HMO/CMP Assumes Financial Responsibility

(Rev. 4, 10-01-01)

The Medicare FFS system may pay the providers for the reasonable cost of covered emergency or urgently needed services and other covered out of area services for which the cost-based HMO/CMP assumes financial responsibility and which are furnished to the HMO/CMP's Medicare enrollees.

Alternatively, the HMO/CMP may reimburse a provider for these services, in which case payment will be made to the HMO/CMP through the cost reporting mechanism. However, payment to the HMO/CMP 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 the HMO/CMP demonstrates to CMS's satisfaction that the excess payment is justified on the basis of advantages gained by the HMO/CMP. (See is 42 CFR 417.558.)

90 - Emergency and Urgently Needed Medical Services and Other Covered Medical Services for which the Medicare Managed Care HMO/CMP Assumes Financial Responsibility

(Rev. 4, 10-01-01)

Payments for services to non-plan physicians and suppliers for purchased services, such as emergency or urgently needed care outside the HMO/CMP or unusual specialty services not available within the HMO/CMP, are apportioned to Medicare enrollees in accordance with the principles set forth in §70 of this chapter. In most cases, this will limit CMS's payment to the HMO/CMP to what the FFS system would have paid for the service in that area.

100 - Apportionment of Administrative and General Costs Not Directly Associated With Providing Medical Care

(Rev. 4, 10-01-01)

Enrollment and marketing costs (as defined in Chapter 17 Subchapter B §16), membership costs (as defined in Chapter 17 Subchapter B §18), as well as other administrative and general costs of the HMO/CMP 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. These costs are classified as Plan Administration costs. Examples of such costs are:

- Directors' salaries and fees;
- Executive and staff administrative salaries;
- Organizational costs; and
- Other costs of administering the plan.

110 - Allocation and Distribution of Other Administrative and General Costs

(Rev. 4, 10-01-01)

Administrative and General (A&G) costs other than those described in §100 of this chapter 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 cost-based 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:

1. 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.

2. 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.

120 - Alternate Allocation and Apportionment Methods

(Rev. 4, 10-01-01)

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 CMS 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.

CMS's approval of a request to change methods will be given to the cost-based HMO/CMP in writing and is binding as of the approval date. 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 CMS approves a subsequent request to change methods.