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

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
17 - A	30		
	30.1.2		
	30.2.1		
17 - B	220		
	300		
17 - C	90		
	120		

Red italicized font identifies new material.

CLARIFICATION - EFFECTIVE/IMPLEMENTATION DATE: Not Applicable.

Subchapter A

Section 30 - Recovery of Overpayment - In the first bullet of the second paragraph, deleted the parenthetical phrase "(including one CMS authorized 30-day extension)."

Section 30.1.2 - Definition of Final Determination - In the first bullet, deleted the word "both" and changed the words "and either" to "which includes." Added to item 2 of the second bullet "by CMS after the cost report if filed." The first three paragraphs directly after the bulleted list regarding a final determination deeming to have been made if the HMP/CMP did not dispute an interim settlement within 15 days, have been deleted.

Section 30.2.1 - Accrual of Interest - In the fifth paragraph, deleted the parenthetical phrase "(plus a single extension of time not to exceed 30 days if granted for good cause.)"

Subchapter B

Section 220 - Determining Deductibles and Coinsurance - Added amounts to the Actuarial Value chart for the years 2001 through 2003. In addition, in the last sentence in the paragraph before the table, replaced "2000" with "2003" indicating that the chart is being updated. In the paragraph following the table, rewrote the first sentence to indicate the cost-based HMP/CMP will also calculate the Mental Health Copayment and all Part B coinsurance applicable to carrier and intermediary paid bills.

Section 300 - Duplicate Payment Detection for Cost Contracting HMO/CMPs - Deleted first bullet after second paragraph indicating claims involving outpatient psychiatric service claims are no longer exceptions to being processed as nonprovider Part B bills.

Subchapter C

Section 90 - Emergency and Urgently Needed Medical Services and Other Covered Medical Services for Which the Cost-Based HMO/CMP Assumes Financial Responsibility - Changed the section title by changing the words "Medicare Managed Care" to "Cost-Based".

Section 120 - Alternate Allocation and Apportionment Methods - In the first paragraph, second sentence, inserted the phrase "which represents a departure from the method used in the previous cost reporting period" clarifying that we are discussing a change in the method of apportionment used by the HMO/CMP from the last cost reporting period.

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Chapter 17 Subchapter A

TEFRA Cost-Based Payment Process and Principles

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30 - Recovery of Overpayment

(Rev. 17, 01-01-03)

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; 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.

30.1.2 - Definition of Final Determination

(Rev. 17, 01-01-03)

For purposes of this section, a final determination is deemed to occur:

- Upon the issuance of a Notice of Program Reimbursement (NPR) *which includes:*
  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 *by CMS after the cost report is filed.*

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

30.2.1 - Accrual of Interest

(Rev. 17, 01-01-03)

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 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.

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Chapter 17 Subchapter B

Payment Principles for Cost-Based HMO/CMPs

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220 - Determining Deductibles and Coinsurance

(Rev. 17, 01-01-03)

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 2003, 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
2001	*$ 7.56*
2002	*$ 7.64*
2003	*$ 7.54*

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

To compute the HMO/CMP Medicare enrollees' premiums, add the total Part A and Part B deductible and coinsurance for the organization's incurred costs, and the Part A and

Part B deductible and coinsurance for costs paid by the fee-for-service system on the organization's behalf.

From this total, subtract the HMO/CMP's Medicare enrollees' 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

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300 - Duplicate Payment Detection for Cost Contracting HMO/CMPs

(Rev. 17, 01-01-03)

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 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.

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Chapter 17 Subchapter C

Cost Apportionment for Cost-Based HMO/CMPs

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90 - Emergency and Urgently Needed Medical Services and Other Covered Medical Services for which the *Cost-Based* HMO/CMP Assumes Financial Responsibility

(Rev. 17, 01-01-03)

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.

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120 - Alternate Allocation and Apportionment Methods

(Rev. 17, 01-01-03)

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*, which represents a departure from the method used in the previous cost reporting period,* 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.