CMS Manual System

Pub. 100-16 Medicare Managed Care

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

Transmittal: 52 **Date: May 7, 2004**

I. SUMMARY OF CHANGES:

NEW/REVISED MATERIAL - EFFECTIVE DATE: May 7, 2004

Chapter 17A - TEFRA Cost-Based Payment Process and Principles

Table Of Contents - Added line item for new §5.

Section 5 - Special Rules for HMO/CMP Payments to Department of Veterans Affairs Facilities - Added a new section regarding the general rule that Medicare payments may not be made to any Federal provider of services for any item or service that such provider is obligated by law, or contract with the United States, to render at public expense.

Chapter 17B - Payment Principles for Cost-Based HMO/CMPs

Table Of Contents - Added line item for §300.

Section 300 - Duplicate Payment Detection for Cost Contracting HCPPs and HMOs/CMPs:

Added fourth bullet regarding claims for home health services received on or after January 1, 2004.

Added "or intermediary" at the end of the second sentence as an exception to Part B bills which must be processed.

Added HCPP's (Health Care Prepayment Plan) to the section title and throughout the section to indicate HCPPs' inclusion in these instructions.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	Chapter 17a / Section 5 / Special Rules for HMO/CMP Payments to Department of Veterans Affairs Facilities
R	Chapter 17b / Section 300 / Duplicate Payment Detection for Cost Contracting HCPPs and HMOs/CMPs

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Medicare Managed Care Manual

Chapter 17, Subchapter A
TEFRA Cost-Based Payment Process and Principles

Last Updated - Rev. 52, 05-07-04

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5 - Special Rules for HMO/CMP Payments to Department of Veterans Affairs Facilities

(Rev. 52, 05-07-04)

Section 1814(c) of the Social Security Act (the Act) sets forth the general rule that Medicare payments may not be made to any Federal provider of services for any item or service that such provider is obligated by law, or contract with the United States, to render at public expense. The Department of Veteran Affairs (VA) is a federal provider of services that is obligated by law to render services to veterans at public expense. This means that an HMO/CMP may not use Medicare funds to pay the VA Healthcare System for VA-covered services rendered to veterans who are also HMO/CMP enrollees. This

rule prevails for both elective services and the emergency services rendered by the VA to veteran HMO/CMP enrollees.

An HMO/CMP enrollee who is enrolled in the VA Medical Benefits Plan has dual entitlement to separate government-funded health care systems. This means that the individual may elect to receive his or her health care either through the VA system or through his or her HMO/CMP. If the individual elects to receive routine or non-emergency services through the VA system, the VA would be obligated by law to pay for those services and the HMO/CMP would not be permitted to claim costs for such services on its Medicare cost report.

Similarly, the HMO/CMP is not permitted by law to pay the VA system for emergency services rendered by the VA to veterans who are HMO/CMP enrollees. This holds true regardless of the circumstances underlying the enrollee's presentation to the VA. Thus, the prohibition against payment to the VA prevails whether the enrollee self-presented to the VA (e.g., walk-in patient), was directed there by a treating physician, or was brought to the VA by ambulance.

While the HMO/CMP cannot be obligated to pay the VA directly for services rendered to veteran HMO/CMP enrollees, the HMO/CMP may be obligated to indemnify its enrollees for cost-sharing expenses assessed by the VA for emergency services. Federal regulation 42 CFR 417.414(c) obligates the HMO/CMP to indemnify enrollees for payment of any fees that are the legal obligation of the HMO/CMP for services furnished by providers that are not contracted with the HMO/CMP. HMOs/CMPs are also legally obligated to cover both contracted and non-contracted emergency and urgently needed services. Pursuant to 42 CFR 417.436(a) and 417.452(a), HMOs/CMPs may be obligated to indemnify enrollees for VA-imposed cost-sharing, which should not exceed cost-sharing levels imposed in fee-for-service Medicare.

Non-Veteran HMO/CMP Enrollees

The rules governing HMO/CMP responsibility for payment differs for services rendered by the VA to non-veteran HMO/CMP enrollees. The rule at §1814(c) ***of the Act*** *prohibiting payment has no application to non-veterans. Non-veteran enrollees are covered under §1814(d)* ***of the Act****, which permits payment to be made to hospitals not contracted with Medicare for emergency services rendered to Medicare beneficiaries. Under 42 CFR 417.414(c), HMOs/CMPs are responsible for covering emergency and urgently needed services rendered to enrollees. HMOs/CMPs are obligated to reimburse the VA for such services, and would be expected to coordinate care of non-veteran enrollees who are in a VA hospital due to an emergency as it would in any other non-contracted or out-of-network hospital.*

Section 1814(h) of the Social Security Act Exception

The rules governing HMO/CMP responsibility for payment for services rendered by the VA to non-veteran HMO/CMP enrollees also contain a provision at §1814(h) of the Act

for circumstances in which a non-veteran is admitted to a VA hospital when both the individual and the VA mistakenly believe that the individual is entitled to VA benefits when in fact they are not. The §1814(h) of the Act exception only applies to the unusual situation in which an HMO/CMP enrollee who is a non-veteran is mistakenly admitted to a VA hospital for a service that does not require pre-authorization by their HMO/CMP. The CMS expects that this situation would be very rare.

Note that different rules would apply to MA organizations offering employer group plans under §1857(i) of the Act - so called BIPA 617 waiver plans. Such plans are not available to 1876 cost HMOs/CMPs.

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Chapter 17, Subchapter B
Payment Principles for Cost-Based HMO/CMPs

Last Updated - Rev. 52, 05-07-04

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300 - Duplicate Payment Detection for Cost Contracting *HCPPs and* HMO*s*/CMPs

(Rev. 52, 05-07-02)

Several entities may have jurisdiction over the processing and payment of Part B bills for an HMO*'s*/CMP's members. This could result in duplicate payments to either the physician, supplier, or to the enrollee. It is incumbent that *HCPPs and* HMO*s*/CMPs establish a system to preclude or detect duplicate payments.

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

- Claims for services by an independent physical therapist;
- Claims for outpatient blood transfusions;
- Claims from physicians for dialysis and related services provided through an approved dialysis facility;
- *Claims for home health services received on or after January 1, 2004; 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 *HCPP or* HMO/CMP, not the carrier. The *HCPP or* HMO/CMP should perform several duplicate check functions after it receives paid claims information. If the *HCPP or* 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 *HCPP or* 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.
