Medicare Managed Care Manual

Chapter 17, Subchapter A

TEFRA Cost-Based Payment Process and Principles

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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.

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 §1876 of the Social Security Act (the Act) to furnish services to Medicare beneficiaries. Originally, §1876 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 Section 1876 and replaced it with the Medicare+Choice program in §§1851 - 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 §1876 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 section 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 section 20.1.2.)

20.1 - Reasonable Cost Payments

(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 section 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 sections 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 Section 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. 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 1966, 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 - Interest Charge 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. 67, Issued: 08-12-05; Effective: 10-01-04)

The 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. *Effective October 1, 2004, interest will be assessed only for full 30-day periods when payment is not made on time*. 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, *only one month* of interest will be assessed.

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 both 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 - 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 under (§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:
    - The HMO/CMP defaults on an installment, and
    - 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. 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.

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.

30.5 - 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 - Reasonable Cost Payments

(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

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 42 CFR 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;
- Minutes from the Board of Directors' meetings taking place during the contract period.