

Medicare Managed Care Manual

Chapter 17, Subchapter C

Cost Apportionment for Cost-Based HMO/CMPs

Last Updated - Rev. 17, 01-01-03

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10 - Cost Apportionment for Cost-Based Health Maintenance Organization and Competitive Medical Plans (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 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 [42 CFR 417.558](#).)

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 [section 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](#), section 160), membership costs (as defined in Chapter 17, [Subchapter B](#), section 180), 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 section 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. 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.