

§ 417.526

provided in § 417.444, after the HMO or CMP enters into a risk contract.

[60 FR 46229, Sept. 6, 1995]

§ 417.526 Payment for covered services.

Subpart O of this part set forth the principles that HCFA follows in determining Medicare payment to an HMO or CMP that has a reasonable cost contract. Subpart P of this part describes the per capita method of Medicare payment to HMOs or CMPs that contract on a risk basis.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985; as amended at 58 FR 38080, July 15, 1993; 60 FR 46229, Sept. 6, 1995]

§ 417.528 Payment when Medicare is not primary payer.

(a) *Limits on payments and charges.* (1) HCFA may not pay for services to the extent that Medicare is not the primary payer under section 1862(b) of the Act and part 411 of this chapter.

(2) The circumstances under which an HMO or CMP may charge, or authorize a provider to charge, for covered Medicare services for which Medicare is not the primary payer are stated in paragraphs (b) and (c) of this section.

(b) *Charge to other insurers or the enrollee.* If a Medicare enrollee receives from an HMO or CMP covered services that are also covered under State or Federal worker's compensation, automobile medical, or any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the HMO or CMP may charge, or authorize a provider that furnished the service to charge—

(1) The insurance carrier, employer, or other entity that is liable to pay for these services; or

(2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or other entity.

(c) *Charge to group health plans (GHPs) or large group health plans (LGHPs).* An HMO or CMP may charge a GHP or LGHP for covered services it furnished to a Medicare enrollee and may charge the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP for these covered services if—

(1) The Medicare enrollee is covered under the plan; and

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(2) Under section 1862(b) of the Act, HCFA is precluded from paying for the covered services .

(d) *Responsibilities of HMO or CMP.* An HMO or CMP must—

(1) Identify payers that are primary to Medicare under section 1862(b) of the Act;

(2) Determine the amounts payable by these payers; and

(3) Coordinate the benefits of its Medicare enrollees with these payers.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46229, Sept. 6, 1995]

Subpart O—Medicare Payment: Cost Basis

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

§ 417.530 Basis and scope.

This subpart sets forth the principles that HCFA follows to determine the amount it pays for services furnished by a cost HMO or CMP to its Medicare enrollees. These principles are based on sections 1861(v) and 1876 of the Act and are, for the most part, the same as those set forth—

(a) In part 412 of this chapter, for paying the costs of inpatient hospital services which, for cost HMOs and CMPs, are considered "reasonable" only if they do not exceed the amounts allowed under the prospective payment system; and

(b) In part 413 of this chapter, for the costs of all other covered services.

[60 FR 46230, Sept. 6, 1995]

§ 417.531 Hospice care services.

(a) If a Medicare enrollee of an HMO or CMP with a reasonable cost contract makes an election under § 418.24 of this chapter to receive hospice care services, payment for these services is made to the hospice that furnishes the services in accordance with part 418 of this chapter.

(b) While the enrollee's hospice election is in effect, HCFA pays the HMO or CMP on a reasonable cost basis for only the following covered Medicare services furnished to the Medicare enrollee:

(1) Services of the enrollee's attending physician if the physician is an employee or contractor of the HMO or CMP and is not employed by or under contract to the enrollee's hospice.

(2) Services not related to the treatment of the terminal condition for which hospice care was elected or a condition related to the terminal condition.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 46230, Sept. 6, 1995]

§ 417.532 General considerations.

(a) *Conditions and criteria for payment.*

(1) The costs incurred by the HMO or CMP to furnish services covered by Medicare are reimbursable if they are—

(i) Proper and necessary;

(ii) Reasonable in amount; and

(iii) Except as provided in § 417.550, appropriately apportioned among the HMO's or CMP's Medicare enrollees, other enrollees, and nonenrolled patients.

(2) In determining fair and equitable payment for the HMOs or CMPs, HCFA generally applies the cost payment principles set forth in § 413.5 of this chapter.

(3) In judging whether costs are reasonable, HCFA applies the weighted average of the AAPCCs of each class of the HMO's or CMP's Medicare enrollees (as defined in § 417.582) for the HMO's or CMP's geographic area as an absolute limitation on the total amount payable.

(b) *Method and amount of payment to the HMO or CMP.* (1) HCFA makes interim per capita payments each month for each Medicare enrollee, equivalent to the interim per capita cost rate determined in accordance with § 417.570.

(2) HCFA adjusts the interim per capita rate as necessary during the contract period and makes final adjustments at the end of the contract period.

(3) In determining the amount due the HMO or CMP, HCFA deducts from the reasonable cost actually incurred by the HMO or CMP for covered services furnished to its Medicare enrollees, an amount equal to the actuarial value of the applicable Medicare Part A and Part B deductible and coinsurance amounts that would have applied

to the covered services for which payment is being made if these enrollees had not enrolled in the HMO or CMP or another HMO or CMP.

(c) *Election by HMO or CMP.* An HMO or CMP must elect, on an individual provider basis, one of the following methods for payment for hospital and SNF services it furnishes to Medicare enrollees:

(1) Direct payment by HCFA.

(2) Direct payment by the HMO or CMP.

(d) *Notice of election.* The election must be made in writing before the beginning of the contract period and is binding for that period.

(e) *Payment by HMO or CMP.* If the HMO or CMP elects to pay providers directly, as provided in paragraph (c) of this section, it must—

(1) Determine the eligibility of its Medicare enrollees to receive covered services through the HMO or CMP;

(2) Make proper coverage decisions and appropriate payments, in accordance with §§ 421.100 and 421.200 of this chapter, for the services furnished to its Medicare enrollees;

(3) Ensure that providers maintain and furnish appropriate documentation of physician certification and recertification, to the extent required under subpart B of part 424 of this chapter; and

(4) Carry out any other procedures required by HCFA.

(f) *Review of HMO's or CMP's bill processing capabilities.* If the HMO or CMP elects to pay providers directly, HCFA determines whether the HMO or CMP has the experience and capability to carry out the responsibilities specified in paragraph (e) of this section in an efficient and effective manner.

(g) *Direct payment by HCFA.* (1) If the HMO or CMP elects to have HCFA pay for provider services, HCFA pays each provider on a reasonable cost basis or under the PPS system, whichever is appropriate for the particular provider under part 412 or part 413 of this chapter.

(2) In computing the Medicare payment to the HMO or CMP, HCFA deducts these payments and any other payments made by the Medicare intermediary or carrier on behalf of the HMO or CMP (such as payment for