§ 422.318 42 CFR Ch. IV (10–1–10 Edition)

Special rules for coverage that begins or ends during an inpatient hospital stay.

(a) Applicability. This section applies to inpatient services in a “subsection (d) hospital” as defined in section 1886(d)(1)(B) of the Act, a psychiatric hospital described in section 1886(d)(1)(B)(i) of the Act, a rehabilitation hospital described in section 1886(d)(1)(B)(ii) of the Act, a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B) of the Act, or a long-term care hospital (described in section 1886(d)(1)(B)(iv)).

(b) Coverage that begins during an inpatient stay. If coverage under an MA plan offered by an MA organization begins while the beneficiary is an inpatient in one of the facilities described in paragraph (a) of this section—

(1) Payment for inpatient services until the date of the beneficiary’s discharge is made by the previous MA organization or original Medicare, as appropriate;

(2) The MA organization offering the newly-elected MA plan is not responsible for the inpatient services until the date after the beneficiary’s discharge; and

(3) The MA organization offering the newly-elected MA plan is paid the full amount otherwise payable under this subpart.

(c) Coverage that ends during an inpatient stay. If coverage under an MA plan offered by an MA organization ends while the beneficiary is an inpatient in one of the facilities described in paragraph (a) of this section—

(1) The MA organization is responsible for the inpatient services until the date of the beneficiary’s discharge;

(2) Payment for those services during the remainder of the stay is not made by original Medicare or by any succeeding MA organization offering a newly-elected MA plan; and

(3) The MA organization that no longer provides coverage receives no payment for the beneficiary for the period after coverage ends.

§ 422.320 42 CFR Ch. IV (10–1–10 Edition)

Special rules for hospice care.

(a) Information. An MA organization that has a contract under subpart K of this part must inform each Medicare enrollee eligible to select hospice care under § 418.24 of this chapter about the availability of hospice care (in a manner that objectively presents all available hospice providers, including a statement of any ownership interest in a hospice held by the MA organization or a related entity) if—

(1) A Medicare hospice program is located within the plan’s service area; or

(2) It is common practice to refer patients to hospice programs outside that area.

(b) Enrollment status. Unless the enrollee disenrolls from the MA plan, a beneficiary electing hospice continues his or her enrollment in the MA plan and is entitled to receive, through the MA plan, any benefits other than those that are the responsibility of the Medicare hospice.

(c) Payment. (1) No payment is made to an MA organization on behalf of a Medicare enrollee who has elected hospice care under § 418.24 of this chapter, except for the portion of the payment attributable to the beneficiary rebate for the MA plan, described in § 422.304(a)(3) or to zero for plans with no beneficiary rebate, described at § 422.304(a)(2); and

(2) During the time the hospice election is in effect, CMS’ monthly capitation payment to the MA organization is reduced to the sum of—

(i) An amount equal to the beneficiary rebate for the MA plan, as described in § 422.304(a)(3) or to zero for plans with no beneficiary rebate, described at § 422.304(a)(2); and

(ii) The amount of the monthly prescription drug payment described in § 423.315 (if any).
(3) In addition, CMS pays through the
catalyst Medicare program (subject to
the usual rules of payment)—
   (i) The hospice program for hospice
care furnished to the Medicare en-
rollee; and
   (ii) The MA organization, provider, or
supplier for other Medicare-covered
services to the enrollee.

§ 422.322 Source of payment and effect
of MA plan election on payment.

(a) Source of payments. (1) Payments
under this subpart for original fee-for-
service benefits to MA organizations
or MA MSAs are made from the Federal
Hospital Insurance Trust Fund or the
Supplementary Medical Insurance
Trust Fund. CMS determines the pro-
portions to reflect the relative weight
that benefits under Part A, and bene-
fits under Part B represents of the ac-
tuarial value of the total benefits
under title XVIII of the Act.

(2) Payments to MA-PD organiza-
tions for statutory drug benefits pro-
vided under this title are made from
the Medicare Prescription Drug Ac-
count in the Federal Supplementary
Medical Insurance Trust Fund.

(3) Payments under subpart C of part
495 of this chapter for meaningful use
of certified EHR technology are made
from the Federal Hospital Insurance
Trust Fund or the Supplementary Med-
ical Insurance Trust Fund. In applying
section 1833(1) of the Act under sec-
tions 1853(l) and 1886(n)(2) of the Act
under section 1853(m) of the Act, CMS
determines the amount to the extent
feasible and practical to be similar to
the estimated amount in the aggregate
that would be payable for services fur-
nished by professionals and hospitals
under Parts B and A, respectively,
under title XVIII of the Act.

(b) Payments to the MA organization.
Subject to §§ 421.105(g), 413.86(d), and
495.204 of this chapter and §§ 422.109,
422.316, and 422.320, CMS’ payments
under a contract with an MA organiza-
tion (described in § 422.304) with respect
to an individual electing an MA plan
offered by the organization are instead
of the amounts which (in the absence
of the contract) would otherwise be
payable under original Medicare for
items and services furnished to the in-
dividual.

(c) Only the MA organization entitled
to payment. Subject to §§ 422.314, 422.316,
422.318, 422.320, and 422.520 and sections
1886(d)(11) and 1886(h)(3)(D) of the Act,
only the MA organization is entitled to
receive payment from CMS under title
XVIII of the Act for items and services
furnished to the individual.

§ 422.324 Payments to MA organiza-
tions for graduate medical edu-
cation costs.

(a) MA organizations may receive di-
rect graduate medical education pay-
ments for the time that residents spend
in non-hospital provider settings such
as freestanding clinics, nursing homes,
and physicians’ offices in connection
with approved programs.

(b) MA organizations may receive di-
rect graduate medical education pay-
ments if all of the following conditions
are met:

   (1) The resident spends his or her
   time assigned to patient care activi-
   ties.

   (2) The MA organization incurs “all
   or substantially all” of the costs for
   the training program in the non-hos-
   pital setting as defined in § 413.86(b) of
   this chapter.

   (3) There is a written agreement be-
   tween the MA organization and the
   non-hospital site that indicates the MA
   organization will incur the costs of the
   resident’s salary and fringe benefits
   and provide reasonable compensation
to the non-hospital site for teaching
   activities.

(c) An MA organization’s allowable
direct graduate medical education
costs, subject to the redistribution and
community support principles specified
in § 413.85(c) of this chapter, consist of—

   (1) Residents’ salaries and fringe ben-
   efits (including travel and lodging
   where applicable); and

   (2) Reasonable compensation to the
   non-hospital site for teaching activi-
   ties related to the training of medical
   residents.