

§ 417.500 Intermediate sanctions for and civil monetary penalties against HMOs and CMPs.

(a) Except as provided in paragraph (c) of this section, the rights, procedures, and requirements related to intermediate sanctions and civil money penalties set forth in part 422 subparts O and T of this chapter also apply to Medicare contracts with HMOs or CMPs under sections 1876 of the Act.

(b) In applying paragraph (a) of this section, references to part 422 of this chapter must be read as references to this part and references to MA organizations must be read as references to HMOs or CMPs.

(c) In applying paragraph (a) of this section, the amounts of civil money penalties that can be imposed are governed by section 1876(i)(6)(B) and (C) of the Act, not by the provisions in part 422 of this chapter.

[75 FR 19803, Apr. 15, 2010]

Subpart M—Change of Ownership and Leasing of Facilities: Effect on Medicare Contract

§ 417.520 Effect on HMO and CMP contracts.

(a) The provisions set forth in subpart L of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(b) In applying these provisions, references to “M + C organizations” must be read as references to “HMOs and CMPs”.

(c) In § 422.550, reference to “subpart K of this part” must be read as reference to “subpart L of part 417 of this chapter”.

(d) In § 422.553, reference to “subpart K of this part” must be read as reference to “subpart J of part 417 of this chapter”.

[63 FR 35067, June 26, 1998]

Subpart N—Medicare Payment to HMOs and CMPs: General Rules

§ 417.524 Payment to HMOs or CMPs: General.

(a) *Basic rule.* The payments that CMS makes to an HMO or CMP under

this subpart and subparts O and P of this part for furnishing covered Medicare services are in place of any payment that CMS would otherwise make to a beneficiary or the HMO or CMP under sections 1814(b) and 1833(a) of the Act.

(b) *Basis of payment.* (1) CMS pays the HMOs or CMPs on either a reasonable cost basis or a risk basis depending on the type of contract the HMO or CMP has with CMS.

(2) In certain cases a risk HMO or CMP also receives payments on a reasonable cost basis for certain Medicare enrollees who retain nonrisk status, as 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 CMS 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) CMS 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

(2) Under section 1862(b) of the Act, CMS 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 CMS 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, CMS 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, CMS generally applies the cost payment principles set forth in §413.5 of this chapter.

(3) In judging whether costs are reasonable, CMS 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) CMS makes interim per capita payments each month for each Medicare enrollee, equivalent