

(c) *Basis for denial.* CMS does not approve a request for a withdrawal from a benefit stabilization fund if the withdrawal would allow the HMO or CMP to—

(1) Offer without charge the supplemental services it provides to its Medicare enrollees under the provisions of § 417.440 (b)(2) or (b)(3); or

(2) Refinance prior contract period losses or to avoid losses in the upcoming contract period.

(d) *Form of payment.* Payment of monies withdrawn from a benefit stabilization fund is made, in equal parts, as an additional amount to the monthly advance payment made to the HMO or CMP under § 417.584 during the period of the contract.

[58 FR 38075, July 15, 1993, as amended at 60 FR 46233, Sept. 6, 1995]

§ 417.598 Annual enrollment reconciliation.

CMS's payment to an HMO or CMP may be subject to an enrollment reconciliation at least annually. CMS conducts this reconciliation as necessary to ensure that the payments made do not exceed or fall short of the appropriate per capita rate of payment for each Medicare enrollee of the HMO or CMP during the contract period. The HMO or CMP must submit any information or reports required by CMS to conduct the reconciliation.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46233, Sept. 6, 1995]

Subpart Q—Beneficiary Appeals

§ 417.600 Basis and scope.

(a) *Statutory basis.* (1) Section 1869 of the Act provides the right to a redetermination, reconsideration, hearing, and judicial review for individuals dissatisfied with a determination regarding their Medicare benefits.

(2) Section 1876 of the Act provides for Medicare payments to HMOs and CMPs that contract with CMS to enroll Medicare beneficiaries and furnish Medicare-covered health care services to them.

(3) Section 234 of the MMA requires section 1876 contractors to operate under the same provisions as MA plans

where two plans of the same type enter the cost plan contract's service area.

(b) *Applicability.* (1) The rights, procedures, and requirements relating to beneficiary appeals and grievances set forth in subpart M of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(2) In applying those provisions, references to section 1852 of the Act must be read as references to section 1876 of the Act, and references to MA organizations as references to HMOs and CMPs.

[60 FR 46233, Sept. 6, 1995, as amended at 62 FR 23374, Apr. 30, 1997; 70 FR 4713, Jan. 28, 2005]

Subpart R—Medicare Contract Appeals

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

§ 417.640 Applicability.

(a) The rights, procedures, and requirements relating to contract determinations and appeals set forth in part 422 subpart N of this chapter also apply to Medicare contracts with HMOs or CMPs under section 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.

[75 FR 19803, Apr. 15, 2010]

Subparts S–T [Reserved]

Subpart U—Health Care Prepayment Plans

SOURCE: 50 FR 1375, Jan. 10, 1985, unless otherwise noted.

§ 417.800 Payment to HCPPs: Definitions and basic rules.

(a) *Definitions.* As used in this subpart, unless the context indicates otherwise—

Covered Part B services means physicians' services, diagnostic X-ray tests, laboratory, other diagnostic tests, and any additional medical and other

health services, that the HCPP furnishes to its Medicare enrollees.

Health care prepayment plan (HCPP) means an organization that meets the following conditions:

(1) Effective January 1, 1999, (or on the effective date of the HCPP agreement in the case of a 1998 applicant) either—

(A) Is union or employer sponsored; or

(B) Does not provide, or arrange for the provision of, any inpatient hospital services.

(2) Is responsible for the organization, financing, and delivery of covered Part B services to a defined population on a prepayment basis.

(3) Meets the conditions specified in paragraph (b) of this section.

(4) Elects to be reimbursed on a reasonable cost basis.

Medicare enrollee means a beneficiary under Part B of Medicare who has been identified on CMS records as an enrollee of the HCPP. *Reporting period* means the period specified by CMS for which an HCPP must report its costs and utilization.

(b) *Qualifying conditions.* (1) Except as provided in paragraph (b)(2) of this section, an organization wishing to participate as an HCPP must—

(i) Enter into a written agreement with CMS as specified in § 417.801;

(ii) Furnish physicians' services through its employees or under a formal arrangement with a medical group, independent practice association or individual physicians; and

(iii) Furnish covered Part B services to its Medicare enrollees through institutions, entities, and persons that have qualified under the applicable requirements of title XVIII of the Social Security Act and section 353 of the PHS Act.

(2) An organization that, as of January 31, 1983, was being reimbursed on a reasonable cost basis under section 1833(a)(1)(A) of the Act, and that would not otherwise meet the conditions specified in paragraph (b)(1) of this section, may receive reimbursement on a reasonable cost basis as an HCPP, provided it files an agreement with CMS as required by § 417.801.

(c) *Payment of reasonable cost.* (1) Except as otherwise provided in this sub-

part, CMS pays an HCPP on the basis of the reasonable cost it incurs, as specified in subpart O of this part, for the covered Part B services furnished to its Medicare enrollees.

(2) *Payment for Part B services: Basic rules—*(i) *Cost basis payment.* Except as provided in paragraph (d) of this section, CMS pays an HCPP on the basis of the reasonable costs it incurs, as specified in subpart O of this part, for the covered Part B services furnished to its Medicare enrollees.

(ii) *Deductions.* In determining the amount due an HCPP for covered Part B services furnished to its Medicare enrollees, CMS deducts, from the reasonable cost actually incurred by the HCPP, the following:

(A) The actuarial value of the Part B deductible.

(B) An amount equal to 20 percent of the cost incurred for any service that is subject to the Medicare coinsurance.

(d) *Covered services not reimbursed to an HCPP.* (1) Services reimbursed under Part A are not reimbursable to an HCPP. CMS makes payment for these services directly to the hospital, or other provider of services, on a reasonable cost basis through the provider's Medicare fiscal intermediary (for more details, see parts 412 and 413 of this chapter).

(2) Covered Part B services furnished by a provider of services to an HCPP's Medicare enrollees are not payable to the HCPP. CMS makes payment for these services to the provider on behalf of the Medicare enrollee through the provider's Medicare fiscal intermediary. This requirement does not affect Medicare payment to the HCPP for physicians' services furnished to its Medicare enrollees for which the physicians are compensated by the HCPP.

(e) *Payment for services to nonenrollees.* CMS makes payment to an HCPP for covered Part B services furnished by the HCPP to a Medicare beneficiary who is not enrolled in the HCPP if the beneficiary assigns his rights to payment in accordance with § 424.55 of this

chapter. Payment is made on a reasonable charge basis through the HCPP's Medicare carrier.

[50 FR 1346, Jan. 10, 1985, as amended at 51 FR 34833, Sept. 30, 1986; 53 FR 6648, Mar. 2, 1988; 57 FR 7135, Feb. 28, 1992; 58 FR 38081, July 15, 1993; 60 FR 34888, July 5, 1995; 63 FR 35067, June 26, 1998; 63 FR 52611, Oct. 1, 1998]

§417.801 Agreements between CMS and health care prepayment plans.

(a) *General requirement.* (1) In order to participate and receive payment under the Medicare program as an HCPP as defined in §417.800, an organization must enter into a written agreement with CMS.

(2) An existing group practice prepayment plan (GPPP) that continues as an HCPP under this subpart U must have entered into a written agreement with CMS within 60 days of January 31, 1983.

(b) *Terms.* The agreement must provide that the HCPP agrees to—

(1) Maintain compliance with the requirements for participation and reimbursement on a reasonable cost basis of HCPPs as specified in §417.800;

(2) Not charge the Medicare enrollee or any other person for items or services for which that enrollee is entitled to have payment made under the provisions of this part, except for any deductible or coinsurance amounts for which the enrollee is liable;

(3) Refund, as promptly as possible, any money incorrectly collected as charges or premiums, or in any other way from Medicare enrollees in the HCPP in accordance with the requirements specified in §417.456;

(4) Not impose any limitations on the acceptance of Medicare enrollees or beneficiaries for care and treatment that it does not impose on all other individuals;

(5) Meet the advance directives requirements specified in §417.436(d) of this part;

(6) Establish administrative review procedures in accordance with §§417.830 through 417.840 for Medicare enrollees who are dissatisfied with denied services or claims; and

(7) Consider any additional requirements that CMS finds necessary or desirable for efficient and effective program administration.

(c) *Duration of agreement.* Except for the term of the initial agreement, the agreement is for a term of one year and may be renewed annually by mutual consent. The term of the initial agreement is set by CMS.

(d) *Termination or nonrenewal of agreement by CMS.* (1) CMS may terminate or not renew an agreement if it determines that—

(i) The HCPP no longer meets the requirements for participation and reimbursement as an HCPP as specified in §417.800;

(ii) The HCPP is not in substantial compliance with the provisions of the agreement, applicable CMS regulations, or applicable provisions of the Medicare law. This includes, but is not limited to, the following:

(A) Failure to provide for and document adequate access to providers.

(B) Failure to comply with CMS requirements concerning provision of data and maintenance of records.

(C) Failure to comply with financial requirements specified at §417.806; or

(iii) The HCPP undergoes a change in ownership as specified in subpart M of this part.

(2) CMS will give notice of termination or nonrenewal to the HCPP at least 90 days before the effective date stated in the notice.

(e) *Termination or nonrenewal of agreement by HCPP.* (1) If an HCPP does not wish to renew its agreement at the end of the term, it must give written notice to CMS at least 90 days before the end of the term of the agreement. If an HCPP wishes to terminate its agreement before the end of the term, it must file a written notice with CMS stating the intended effective date of termination.

(2) CMS may approve the termination date proposed by the HCPP, or set a different date no later than 6 months after that date. CMS makes this decision based on a finding that termination on a specific date would not—

(i) Unduly disrupt the furnishing of services to the community serviced by the HCPP; or

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(ii) Otherwise interfere with the efficient administration of the Medicare program.

[50 FR 1375, Jan. 10, 1985, as amended at 57 FR 8202, Mar. 6, 1992; 58 FR 38081, July 15, 1993; 59 FR 49843, Sept. 30, 1994; 59 FR 59943, Nov. 21, 1994; 77 FR 22166, Apr. 12, 2012]

§ 417.802 Allowable costs.

(a) *General rule.* The costs that are considered allowable for HCPP reimbursement are the same as those for reasonable cost HMOs and CMPs specified in subpart O of this part, except those in §§ 417.531, 417.532 (a)(3) and (c) through (g), 417.536 (l) and (m), 417.546, 417.548, and 417.550(b)(2).

(b) *Physicians' services and other Part B supplier services furnished under arrangements—*(1) *Principle.* The amount paid by an HCPP for physicians' services and other Part B supplier services furnished under arrangements is an allowable cost to the extent it is reasonable.

(2) *Application: Payment on other than a fee-for-service basis.* If the HCPP pays for physicians' services and other Part B supplier services on other than a fee-for-service basis—

(i) Except as specified in paragraph (b)(2)(ii) of this section, the costs incurred by the HCPP may be considered reasonable if they—

(A) Do not exceed those that a prudent and cost-conscious buyer would incur to purchase those services; and

(B) Are comparable to costs incurred for similar services furnished by similar physicians and other suppliers in the same or a similar locality.

(ii)(A) If a physician group to whom the HCPP makes payment compensates its physicians on a fee-for-service basis, the HCPP's payment to the group may not exceed the reasonable charges for those services, as defined in subpart E of part 405 of this chapter.

(B) Payment in excess of the limits specified in paragraph (b)(2)(ii)(A) of this section is allowable if the group has procedures under which members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount paid by the HCPP is considered reasonable if it meets the

conditions specified in paragraph (b)(2)(i) of this section.

(3) *Application: Payment on a fee-for-service basis.* If the HCPP pays for physicians' services and other Part B supplier services on a fee-for-service basis—

(i) Except as specified in paragraph (b)(3)(ii) of this section, the costs incurred by the HCPP are considered reasonable if they do not exceed—

(A) The reasonable charges for those services, as defined in subpart E of part 405 of this chapter; and

(B) The amount that CMS would pay for those services if they were furnished to beneficiaries who are not enrolled in the HCPP and who receive the services from sources other than providers of services or other entities that are reimbursed on a reasonable cost basis.

(ii) Payment to a physician group organized on an individual-practice basis is not subject to the paragraph (b)(3)(i) of this section if the group pays its physicians on a fee-for-service basis and has procedures under which the members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In these cases, the amount paid by an HCPP is considered reasonable if it meets the conditions specified in paragraph (b)(2)(i) of this section.

[50 FR 1375, Jan. 10, 1985, as amended at 58 FR 38081, July 15, 1993]

§ 417.804 Cost apportionment.

(a) The HCPP follows the cost apportionment principles specified in §§ 417.552 through 417.566, except for provisions on provider costs and provisions on departmental apportionment.

(b) The HCPP may use a method for reporting costs that is approved by CMS. CMS bases its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

§ 417.806 Financial records, statistical data, and cost finding.

(a) The principles specified in § 417.568 apply to HCPPs, except those in paragraph (c) of that section.

(b) The HCPP may use a method for reporting costs that is approved by CMS. CMS bases its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

(c) An HCPP must permit the Department and the Comptroller General to audit or inspect any books and records of the HCPP and of any related organization that pertain to the determination of amounts payable for covered Part B services furnished its Medicare enrollees. For purposes of this requirement, the principles specified in §417.486 apply to HCPPs.

[50 FR 1375, Jan. 10, 1985, as amended at 58 FR 38081, July 15, 1993]

§417.808 Interim per capita payments.

The HCPP follows the principles specified in §§417.570 and 417.572 on interim per capita payments, except for the following:

(a) When applying these principles to HCPPs, the term “reporting period” should be used instead of the term “contract period” contained in that section.

(b) An HCPP must submit to CMS an annual operating budget and enrollment forecast, in the form and detail specified by CMS, at least 60 days before the beginning of each reporting period. A reporting period must be 12 consecutive months, except that the HCPP’s initial reporting period for participating in Medicare may be as short as 6 months or as long as 18 months.

(c) An HCPP must submit to CMS an interim cost report and enrollment data applicable to the first 6-month period of the HCPP’s reporting period in the form and detail specified by CMS. The interim cost report must be submitted not later than 45 days after the close of the first 6-month period of the HCPP’s reporting period.

(d) In lieu of an interim payment based on the actual monthly enrollment in an HCPP, CMS and the HCPP may agree to a uniform monthly interim reimbursement rate for a reporting period. This interim rate is based on the HCPP’s budget and enrollment forecast, if CMS is satisfied that the rate is consistent with efficiency and

economy, and will not result in excessive adjustment at the end of the reporting period.

§417.810 Final settlement.

(a) *General requirement.* CMS and an HCPP must make a final settlement, and payment of amounts due either to the HCPP or to CMS, following the submission and review of the HCPP’s annual cost report and the supporting documents specified in paragraph (b) of this section.

(b) *Annual cost report as basis for final settlement—*(1) *Form and due date.* An HCPP must submit to CMS a cost report and supporting documents in the form and detail specified by CMS, no later than 120 days following the close of a reporting period.

(2) *Contents.* The report must include—

(i) The HCPP’s per capita incurred costs of providing covered Part B services to its Medicare enrollees during the reporting period, including any costs incurred by another organization related to the HCPP by common ownership or control;

(ii) The HCPP’s methods of apportioning costs among its Medicare enrollees, enrollees who are not Medicare beneficiaries, and other nonenrollees, including Medicare beneficiaries receiving health care services on a fee-for-service or other basis; and

(iii) Information on enrollment and other data as specified by CMS.

(3) *Extension of time to submit cost report.* CMS may grant an HCPP an extension of time to submit a cost report for good cause shown.

(4) *Failure to report required financial information.* If an HCPP does not submit the required cost report and supporting documents within the time specified in paragraph (b)(1) of this section, and has not requested and received an extension of time for good cause shown, CMS may—

(i) Regard the failure to report this information as evidence of likely overpayment and reduce or suspend interim payments to the HCPP; and

(ii) Determine that amounts previously paid are overpayments, and make appropriate recovery.

(c) *Determination of final settlement.* Following the HCPP’s submission of

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the reports specified in paragraph (b) of this section in acceptable form, CMS makes a determination of the total reimbursement due the HCPP for the reporting period and the difference, if any, between this amount and the total interim payments made to the HCPP. CMS sends to the HCPP a notice of the amount of reimbursement by the Medicare program. This notice—

(1) Explains CMS's determination of total reimbursement due the HCPP for the reporting period; and

(2) Informs the HCPP of its right to have the determination reviewed at a hearing in accordance with the requirements specified in § 405.1801(b)(2) of this chapter.

(d) *Payment of amounts due.* (1) Within 30 days of CMS's determination, CMS or the HCPP, as appropriate, will make payment of any difference between the total amount due and the total interim payments made to the HCPP by CMS.

(2) If the HCPP does not pay CMS within 30 days of CMS's determination of any amounts the HCPP owes CMS, CMS may offset further payments to the HCPP to recover, or to aid in the recovery of, any overpayment identified in its determination.

(3) Any offset of payments CMS makes under paragraph (d)(2) of this section will remain in effect even if the HCPP has requested a hearing in accordance with the requirements specified in § 405.1801(b)(2) of this chapter.

(e) *Tentative settlement.* (1) If a final settlement cannot be made within 90 days after the HCPP submits the report specified in paragraph (b) of this section, CMS will make an interim settlement by estimating the amount payable to the HCPP.

(2) CMS or the HCPP will make payment within 30 days of CMS's determination under the tentative settlement of any estimated amounts due.

(3) The tentative settlement is subject to adjustment at the time of a final settlement.

[50 FR 1375, Jan. 10, 1985, as amended at 58 FR 38081, July 15, 1993; 73 FR 30267, May 23, 2008]

§ 417.830 Scope of regulations on beneficiary appeals.

Sections 417.832 through 417.840 establish procedures for the presentation

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and resolution of organization determinations, reconsiderations, hearings, Departmental Appeals Board review, court reviews, and finality of decisions that are applicable to Medicare enrollees of an HCPP.

[59 FR 59943, Nov. 21, 1994, as amended at 61 FR 32348, June 24, 1996]

§ 417.832 Applicability of requirements and procedures.

(a) The administrative review rights and procedures specified in §§ 417.834 through 417.840 pertain to disputes involving an organization determination, as defined in § 417.838, with which the enrollee is dissatisfied.

(b) Physicians and other individuals who furnish items or services under arrangements with an HCPP have no right of administrative review under §§ 417.834 through 417.840.

(c) The provisions of part 405 dealing with the representation of parties apply to organization determinations and appeals.

(d) The provisions of part 405 dealing with administrative law judge hearings, Medicare Appeals Council review, and judicial review are applicable, unless otherwise provided.

[59 FR 59943, Nov. 21, 1994, as amended at 70 FR 4713, Jan. 28, 2005]

§ 417.834 Responsibility for establishing administrative review procedures.

The HCPP is responsible for establishing and maintaining the administrative review procedures that are specified in §§ 417.830 through 417.840.

[59 FR 59943, Nov. 21, 1994]

§ 417.836 Written description of administrative review procedures.

Each HCPP is responsible for ensuring that all Medicare enrollees are informed in writing of the administrative review procedures that are available to them.

[59 FR 59943, Nov. 21, 1994]

§ 417.838 Organization determinations.

(a) *Actions that are organization determinations.* For purposes of §§ 417.830 through 417.840, an organization determination is a refusal to furnish or arrange for services, or reimburse the

party for services provided to the beneficiary, on the grounds that the services are not covered by Medicare.

(b) *Actions that are not organization determinations.* The following are not organization determinations for purposes of §§417.830 through 417.840:

(1) A determination regarding services that were furnished by the HCPP, either directly or under arrangement, for which the enrollee has no further obligation for payment.

(2) A determination regarding services that are not covered under the HCPP's agreement with CMS.

[59 FR 59943, Nov. 21, 1994]

§ 417.840 Administrative review procedures.

The HCPP must apply §422.568 through §422.626 of this chapter to—

(a) Organization determinations and fast-track appeals that affect its Medicare enrollees; and

(b) Reconsiderations, hearings, Medicare Appeals Council review, and judicial review of the organization determinations and fast-track appeals specified in paragraph (a) of this section.

[75 FR 19803, Apr. 15, 2010]

Subpart V—Administration of Outstanding Loans and Loan Guarantees

§ 417.910 Applicability.

The regulations in this subpart apply, as appropriate, to public and private entities that have loans or loan guarantees that—

(a) Were awarded to them before October 1986 under section 1304 or section 1305 of the PHS Act; and

(b) Are still outstanding.

[59 FR 49842, Sept. 30, 1994]

§ 417.911 Definitions.

As used in this subpart—

Any 12-month period means the 12-month period beginning on the first day of any month.

Expansion of services means—

(1) The addition of any health service not previously provided by or through the HMO, that requires an increase in the facilities, equipment, or health professionals of the HMO; or

(2) The improvement or upgrading of existing facilities or equipment, or an increase in the number of categories of health professionals, of the HMO so that the HMO could provide directly services that it previously provided through contract or referral or which it could not previously provide with its existing facilities or equipment.

First 60 months of operation or expansion means the 60-month period beginning on the first day of the month during which the HMO first provided services to enrollees, or in the case of significant expansion, first provided services in accordance with its expansion plan.

Health system agency means an entity that has been designated in accordance with section 1515 of the PHS Act; and the term *State health planning and development agency* means an agency that has been designated in accordance with section 1521 of the PHS Act.

Initial costs of operation means any cost incurred in the first 60 months of an operation or expansion that met any of the following requirements:

(1) Under generally accepted accounting principles or under accounting practices prescribed or permitted by State regulatory authority, was not a capital cost.

(2) Was required by State regulatory authority to meet reserves or tangible net equity requirements.

(3) Was for a payment made to reduce balance sheet liabilities existing at the beginning of the 60-month period, but only if—

(i) The payment had been approved in writing by the Secretary; and

(ii) The total of these payments did not exceed 20 percent of the amount of the loan.

(4) Was for a small capital expenditure, but only if—

(i) The cost had been approved in writing by the Secretary; and

(ii) The total of these costs did not exceed \$200,000 in any 12-month period, and \$400,000 during the first 60 months of operation or expansion.

Nonprofit as applied to a private entity, means a private agency, institution, or organization, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.