

### § 417.533

### 42 CFR Ch. IV (10–1–23 Edition)

to the interim per capita cost rate determined in accordance with § 417.570.

(2) CMS 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, CMS 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 CMS.

(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 CMS.

(f) *Review of HMO's or CMP's bill processing capabilities.* If the HMO or CMP elects to pay providers directly, CMS 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 CMS.* (1) If the HMO or CMP elects to have CMS pay for provider services, CMS 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, CMS 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 emergency or urgently needed services under § 417.558).

(h) *Payment for services furnished to Medicare beneficiaries not enrolled in the HMO or CMP.* CMS pays the HMO or CMP for services it furnishes to Medicare beneficiaries who are not its enrollees through the HMO's or CMP's Medicare intermediary or carrier, as appropriate.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 53 FR 6648, Mar. 2, 1988; 58 FR 38082, July 15, 1993; 60 FR 46230, Sept. 6, 1995]

### § 417.533 Part B carrier responsibilities.

In paying for Part B services furnished to its enrollees by suppliers, the HMO or CMP must—

(a) Determine the eligibility of individuals to receive those services through the HMO or CMP;

(b) Make proper coverage decisions and appropriate payment as authorized under § 421.200 of this chapter for the services for which its Medicare enrollees are eligible; and

(c) Carry out any other procedures that CMS may require.

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

### § 417.534 Allowable costs.

(a) *Definition—Allowable costs* means the direct and indirect costs, including normal standby costs incurred by the HMO or CMP, that are proper and necessary for efficient delivery of needed health care services. They include the costs of furnishing services to the HMO's or CMP's Medicare enrollees,