

§ 417.574 Interim settlement.

(a) *Determination.* Within 30 days following the receipt of the HMO's or CMP's final interim cost and enrollment reports, CMS will make an interim determination of the estimated amount payable to the HMO or CMP for the reasonable cost of covered services furnished to its Medicare enrollees during the contract period. CMS will base the determination on the interim cost report and enrollment data submitted by the HMO or CMP, and any other relevant data CMS finds appropriate. For this purpose, CMS will accept costs as reported, subject to later review or audit, unless there are obvious errors or inconsistencies.

(b) *Payment.* Any difference between the total amount of interim payments and the amount found payable on the basis of the interim determination under paragraph (a) of this section, must be paid by the HMO or CMP or will be paid by CMS, whichever is appropriate, no later than 30 days after CMS's determination.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

§ 417.576 Final settlement.

(a) *General rule.* Final settlement and payment of amounts due the HMO or CMP or the appropriate Medicare trust funds are made following the HMO's or CMP's submission and CMS's review of an independently certified cost report and supporting documents as described in paragraph (b) of this section.

(b) *Certified cost report as basis for final settlement—*(1) *Timing of cost report.* The HMO or CMP must submit to CMS an independently certified cost report and supporting documents, in the form and detail required by CMS, no later than 180 days after the end of each contract period, unless CMS extends the period for good cause shown by the HMO or CMP.

(2) *Content of cost report.* The cost report and supporting documents must include the following:

(i) The per capita costs incurred in furnishing covered services to its Medicare enrollees, determined in accordance with subpart O of this part and including—

(A) The costs incurred by entities related to the HMO or CMP by common ownership or control; and

(B) For reports for cost-reporting periods that begin on or after January 1, 1996, the costs of hospital and SNF services paid by Medicare's intermediaries under the option provided by § 417.532(d).

(ii) The HMO's or CMP's methods of apportioning cost among Medicare enrollees, and nonenrolled patients, in accordance with the payment procedures specified in this subpart (as, applicable, in parts 412 and 413 of this chapter); and

(iii) Any other information required by CMS.

(3) *Failure to report required financial information.* If the HMO or CMP fails to submit the required cost report and supporting documents within 180 days (or an extended period approved by CMS under paragraph (b)(1) of this section), CMS may—

(i) Consider the failure to report as evidence of likely overpayment; and

(ii) Initiate recovery of amounts previously paid, or reduce interim payments, or both.

(c) *Final determination and adjustment.*

(1) After receipt of acceptable reports as specified in paragraph (b) of this section, CMS determines the total payment due the HMO or CMP for furnishing covered services to its Medicare enrollees (which is subject to the audit provisions of this subpart) and makes a retroactive adjustment to bring interim payments into agreement with the payable amount due the HMO or CMP.

(2) A final settlement may be made with the HMO or CMP even though a provider that is not owned or operated by the HMO or CMP or related to the HMO or CMP by common ownership or control and that provides services to the HMO's or CMP's Medicare enrollees has not had a final settlement with CMS under parts 412 and 413 of this chapter for services furnished by the provider to Medicare beneficiaries who are not enrolled in the HMO or CMP. In this situation—

(i) CMS must be satisfied that the costs of covered services furnished to the HMO's or CMP's Medicare enrollees, as shown in the reports specified in

paragraph (b) of this section, are reasonable and that the interest of the Medicare program would best be served by not delaying final settlement with the HMO or CMP until there is a final settlement with the provider for services furnished to Medicare beneficiaries not enrolled in the HMO or CMP; and

(ii) Prompt settlement with the HMO or CMP would be in the best interest of the Medicare program if, for instance, the provider's costs represent an insignificant portion of total payment due to the HMO or CMP; or if CMS is satisfied that the provider's costs, as shown in the reports specified in paragraph (b) of this section, will not be modified, to any significant extent, by the final settlement with the provider under parts 412 and 413 of this chapter.

(d) *Notice of amount of payment.* The notice of amount of Medicare payment—

(1) Explains CMS's determination regarding total Medicare payment due the HMO or CMP for the contract period covered by the financial information specified in paragraph (b) of this section;

(2) Relates this determination to the HMO's or CMP's claimed total payable cost for that period;

(3) Explains the amounts and reasons, by appropriate reference to law, regulations, and Medicare program policy and procedures, if the determined amounts differ from the HMO's or CMP's claim; and

(4) Informs the HMO or CMP of its right to a hearing in accordance with the requirements specified in § 405.1801(b)(2) of this chapter

(e) *Basis for retroactive adjustment.* (1) CMS's determination (as contained in the notice of amount of Medicare payment) constitutes the basis for making retroactive adjustments to any Medicare payment made to the HMO or CMP during the period to which the determination applies.

(2) Further payments to the HMO or CMP may be withheld or offset in order to recover, or to aid in the recovery of, any overpayment identified in the determination as having been made to the HMO or CMP, even if the HMO or CMP requests a hearing in accordance with the requirements specified in § 405.1801(b)(2) of this chapter.

(3) Any withholding continues until the earliest of the following occurs:

(i) The overpayment is liquidated.

(ii) The HMO or CMP enters into an agreement with CMS to refund the overpaid amount.

(iii) CMS, on the basis of subsequently acquired information, determines that there was no overpayment.

(iv) The decision of a hearing specified in paragraph (d)(4) of this section is that there was no overpayment.

[50 FR 1346, Jan. 10, 1985, as amended at 51 FR 34833, Sept. 30, 1986; 58 FR 38082, July 15, 1993; 60 FR 34888, July 5, 1995; 60 FR 46231, Sept. 6, 1995; 73 FR 30267, May 23, 2008]

Subpart P—Medicare Payment: Risk Basis

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

§ 417.580 Basis and scope.

(a) *Basis.* This subpart implements those portions of section 1876 (a), (e), and (g) of the Act that pertain to the amount CMS pays an organization for its Medicare enrollees who are enrolled on a risk basis.

(b) *Scope.* This subpart sets forth—

(1) Method of payment;

(2) Procedures for determining the HMO's or CMP's payment rate; and

(3) Procedures for determining the additional benefits (and their value) the HMO or CMP must provide to its Medicare enrollees.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46231, Sept. 6, 1995]

§ 417.582 Definitions.

As used in this subpart—

AAPCC stands for adjusted average per capita cost.

ACR stands for adjusted community rate.

Actuarial factors means factors such as the age, sex, and disability level distribution of the population and any other relevant factors that CMS determines have a significant effect on the level of utilization and cost of health services.

APCRP stands for average of per capita rates of payment.

Class of Medicare enrollees means a group of Medicare enrollees of an HMO or CMP that CMS constructs on the basis of actuarial factors.

Similar area means an area similar to the HMO's or CMP's geographic area but free from special characteristics that would distort the determination of the AAPCC.

U.S. per capita incurred cost means the average per capita cost, including intermediary or carrier administrative costs, incurred by Medicare, as determined on an accrual basis, for covered services furnished to Medicare beneficiaries nationwide during the most recent period for which CMS has complete data.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46232, Sept. 6, 1995]

§ 417.584 Payment to HMOs or CMPs with risk contracts.

Except in the circumstances specified in § 417.440(d) for inpatient hospital care, and as provided in § 417.585 for hospice care, CMS makes payment for covered services only to the HMO or CMP.

(a) *Principle of payment.* CMS makes monthly advance payments equivalent to the HMO's or CMP's per capita rate of payment for each beneficiary who is registered in CMS records as a Medicare enrollee of the HMO or CMP.

(b) *Determination of rate.* (1) The annual per capita rate of payment for each class of Medicare enrollees is equal to 95 percent of the AAPCC (as determined under the provisions of § 417.588) for that class of Medicare enrollees.

(2) CMS furnishes each HMO or CMP with its per capita rate of payment for each class of Medicare enrollees not later than 90 days before the beginning of the HMO's or CMP's contract period.

(c) *Adjustments to payments.* If the actual number of Medicare enrollees differs from the estimated number on which the amount of advance monthly payment was based, CMS adjusts subsequent monthly payments to take account of the difference.

(d) *Reduction of payments.* If an HMO or CMP requests a reduction in its monthly payment in accordance with

§ 417.592(b)(2), CMS reduces the amount of payment by the appropriate amount.

(e) *Determination of rate for calendar year 1998.* For calendar year 1998, HMOs or CMPs with risk contracts will be paid in accordance with principles contained in subpart F of part 422 of this chapter.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 52 FR 8901, Mar. 20, 1987; 58 FR 38082, July 15, 1993; 60 FR 46232, Sept. 6, 1995; 63 FR 35067, June 26, 1998]

§ 417.585 Special rules: Hospice care.

(a) No payment is made to an HMO or CMP on behalf of a Medicare enrollee who has elected hospice care under § 418.24 of this chapter except for the portion of the payment applicable to the additional benefits described in § 417.592. This no-payment rule is effective from the first day of the month following the month of election to receive hospice care, until the first day of the month following the month in which the enrollee resumes normal Medicare coverage.

(b) During the time the election is in effect, the HMO or CMP may bill CMS on a fee-for-service basis (subject to the usual Medicare rules of payment) but only for the following covered Medicare services:

(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 the enrollee elected hospice care or a condition related to the terminal condition.

(3) Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again.

(c) Payment for hospice care services furnished to Medicare enrollees of an HMO or CMP is made to the Medicare-participating hospice elected by the enrollee.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 46232, Sept. 6, 1995]

§ 417.588 Computation of adjusted average per capita cost (AAPCC).

(a) *Basic data.* In computing the AAPCC, CMS uses the U.S. per capita incurred cost and adjusts it by the factors specified in paragraph (c) of this section to establish an AAPCC for each class of Medicare enrollees.

(b) *Advance notice to the HMO or CMP.* Before the beginning of a contract period, CMS informs the HMO or CMP of the specific adjustment factors it will use in computing the AAPCC.

(c) *Adjustment factors—(1) Geographic.* CMS makes an adjustment to reflect the relative level of Medicare expenditures for beneficiaries who reside in the HMO's or CMP's geographic area (or a similar area). This adjustment is based on reimbursement for Medicare covered services and uses the most accurate and timely data that pertain to the HMO's or CMP's geographic area and that is available to CMS when it makes the determination.

(2) *Enrollment.* CMS makes a further adjustment to remove the cost effect of all area Medicare beneficiaries who are enrolled in the HMO or CMP or another HMO or CMP.

(3) *Age, sex, and disability status.* CMS makes adjustments to reflect the age and sex distribution and the disability status of the HMO's or CMP's enrollees based on Medicare program experience and available data that indicate cost differences that result from those factors.

(4) *Other relevant factors.* If accurate data are available and appropriate, CMS makes adjustments to reflect welfare and institutional status and other relevant factors.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38083, July 15, 1993; 60 FR 46232, Sept. 6, 1995]

§ 417.590 Computation of the average of the per capita rates of payment.

(a) *Computation by the HMO or CMP.* As indicated in § 417.584(b), before an HMO's or CMP's contract period begins, CMS determines a per capita rate of payment for each class of the HMO's or CMP's Medicare enrollees. In order to determine the additional benefits required under § 417.592, weighted averages of those per capita rates must be computed separately for enrollees enti-

tled to Part A and Part B, and for enrollees entitled only to Part B. Except as provided in paragraph (b) of this section, the HMO or CMP must make the computations.

(b) *Computation by CMS.* If the HMO or CMP claims to have insufficient enrollment experience to make the computations required by paragraph (a) of this section, and CMS agrees with the claim, CMS makes the computations, using the best available information, which may include the enrollment experience of other risk HMOs and CMPs.

[58 FR 38075, July 15, 1993]

§ 417.592 Additional benefits requirement.

(a) *General rules.* (1) An HMO or CMP that has an APCRP (as determined under § 417.590) greater than its ACR (as determined under § 417.594) must elect one of the options specified in paragraph (b) of this section.

(2) The dollar value of the elected option must, over the course of a contract period, be at least equal to the difference between the APCRP and the proposed ACR.

(b) *Options—(1) Additional benefits.* Provide its Medicare enrollees with additional benefits in accordance with paragraph (c) of this section.

(2) *Payment reduction.* Request CMS to reduce its monthly payments.

(3) *Combination of additional benefits and payment reduction.* Provide fewer than the additional benefits required under paragraph (b)(1) of this section and request CMS to reduce the monthly payments by the remaining difference between the APCRP and the ACR.

(4) *Combination of additional benefits and withholding in a stabilization fund.* Provide fewer than the additional benefits required under paragraph (b)(1) of this section, and request CMS to withhold in a stabilization fund (as provided in § 417.596) the remaining difference between the APCRP and the ACR.

(c) *Special rules: Additional benefits option.* (1) The HMO or CMP must determine additional benefits separately for enrollees entitled to both Part A and Part B benefits and those entitled only to Part B.

(2) The HMO or CMP may elect to provide additional benefits in any of the following forms—

(i) A reduction in the HMO's or CMP's premium or in other charges it imposes in the form of deductibles or coinsurance.

(ii) Health benefits in addition to the required Part A and Part B covered services.

(iii) A combination of reduced charges and additional benefits.

(d) *Notification to CMS.* (1) The HMO or CMP must give CMS notice of its ACR and its weighted APCRP at least 45 days before its contract period begins.

(2) An HMO or CMP that elects the option of providing additional benefits must include in its submittal—

(i) A description of the additional benefits it will provide to its Medicare enrollees; and

(ii) Supporting evidence to show that the selected benefits meet the requirements of paragraph (a)(2) of this section with respect to dollar value equivalence.

[60 FR 46232, Sept. 6, 1995]

§ 417.594 Computation of adjusted community rate (ACR).

(a) *Basic rule.* Each HMO or CMP must compute its basic rate as follows:

(1) Compute an initial rate in accordance with paragraph (b) of this section.

(2) Adjust and reduce the initial rate in accordance with paragraphs (c) and (d) of this section.

(b) *Computation of initial rates.* (1) The HMO or CMP must compute its initial rate using either of the following systems:

(i) A community rating system as defined in § 417.104(b); or

(ii) A system, approved by CMS, under which the HMO or CMP develops an aggregate premium for all its enrollees and weights the aggregate by the size of the various enrolled groups that compose its enrollment.

(For purposes of this section, enrolled groups are defined as employee groups or other bodies of subscribers that enroll in the HMO or CMP through payment of premiums.)

(2) Regardless of which method the HMO or CMP uses—

(i) The initial rate must be equal to the premium it would charge its non-Medicare enrollees for the Medicare-covered services;

(ii) The HMO or CMP must compute the rates separately for enrollees entitled to Medicare Part A and Part B and for those entitled only to Part B; and

(iii) The HMO or CMP must identify and take into account anticipated revenue from health insurance payers for those services for which Medicare is not the primary payer as provided in § 417.528.

(3) Except as provided in paragraph (b)(4) of this section, the HMO or CMP must identify in its initial rate calculation, the following components whose rates must be consistent with rates used by the HMO or CMP in calculating premiums for non-Medicare enrollees:

(i) Hospital services (services covered under Medicare Part A and Part B shown separately).

(ii) Physicians' services.

(iii) Other medical services (for example, X-ray and laboratory services).

(iv) Home health services.

(v) Out-of-plan claims for emergency services.

(vi) Skilled nursing care services.

(vii) Ambulance services.

(viii) Other Medicare covered services.

(ix) General and administrative.

(x) Noncovered Medicare services (for example, eyeglasses).

(xi) Services for which Medicare is the secondary payer.

(xii) Enrollee liabilities (for example, deductibles, coinsurance, or copayments) for covered services.

(4) An HMO or CMP that does not usually separate its premium components as described in paragraph (b)(3) of this section may calculate its initial rate with the methods it uses for its other enrolled groups if the HMO or CMP provides CMS with the documentation necessary to support any adjustments the HMO or CMP makes to the initial rate in accordance with paragraph (e) of this section.

(5) The initial rate calculation must not carry forward any losses experienced by the HMO or CMP during prior contract periods. The HMO or CMP

must submit supporting documentation to assure CMS that rates do not include past losses but only premiums for the price of additional benefits and services of the upcoming contract period.

(c) *Adjustment of initial rates*—(1) *Purpose of adjustment.* The purpose of adjustment is to reflect the utilization characteristics of Medicare enrollees.

(2) *Adjustment by the HMO or CMP.* The HMO or CMP may adjust the rate for a particular service using more than one of the following factors if they do not duplicate each other:

(i) *Unit of service.* If the HMO or CMP purchases or identifies services on a unit of service basis and the unit of service is defined the same for all enrollees, the HMO or CMP may make an adjustment in its initial rate to reflect the number of units of services furnished to its Medicare enrollees in comparison to those furnished to other enrollees.

(ii) *Complexity or intensity of services.* The HMO or CMP may make an adjustment to reflect the differences in the complexity or intensity of services furnished to its Medicare enrollees if the calculation of its initial rate includes the elements of this adjustment.

(3) *Support documentation.* All adjustments made by the HMO or CMP must be accompanied by adequate supporting data. If an HMO or CMP does not have sufficient enrollment experience to develop this data, it may, during its initial contract period, use documented statistics from a nationally recognized statistical source.

(4) *Adjustment by CMS.* If the HMO or CMP does not have adequate data to adjust the initial rate calculated under paragraph (b) of this section to reflect the utilization characteristics of its Medicare enrollees, CMS will, at the HMO's or CMP's request, adjust the initial rate. CMS adjusts the rate on the basis of differences in the utilization characteristics of—

(i) Medicare and non-Medicare enrollees in other HMOs or CMPs; or

(ii) Medicare beneficiaries (in the HMO's or CMP's area, or State, or the United States) who are eligible to enroll in an HMO or CMP and other individuals in that same area, or State, or the United States.

(d) *Reduction of adjusted rates.* The HMO or CMP or CMS further reduces the adjusted rates by the actuarial value of applicable Medicare deductibles and coinsurance.

(e) *CMS review*—(1) *Submission of data.* The HMO or CMP must submit its ACR and the methodology used to compute it for CMS review and approval, and must include adequate supporting data.

(2) *Appeals procedures.* (i) If CMS determines that an HMO's or CMP's ACR computation is not acceptable, the HMO or CMP may, within 30 days after receipt of notice of the determination, file with CMS a request for a hearing.

(ii) The request must state why the HMO or CMP believes the determination is incorrect, and include any supporting evidence the HMO or CMP considers pertinent.

(iii) A hearing officer designated by CMS conducts the hearing in accordance with the hearing procedures set forth in §§405.1819 through 405.1833 of this chapter.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46232, Sept. 6, 1995]

§417.596 Establishment of a benefit stabilization fund.

(a) *General.* If an HMO or CMP is required to provide its Medicare enrollees with additional benefits as described in §417.592, the organization may request that CMS withhold a part of its monthly per capita payment in a benefit stabilization fund. The fund will be used to prevent excessive fluctuation in the provision of those additional benefits in subsequent contract periods.

(b) *Notification to CMS.* An HMO's or CMP's request to have monies withheld in a benefit stabilization fund must be made when the HMO or CMP notifies CMS under §417.592(d) of its ACR and its APCRP in preparation for its next contract period.

(c) *Limitations on the amounts withheld*—(1) *Limit per contract period.* Except as provided in paragraph (c)(3) of this section, CMS does not withhold in a benefit stabilization fund more than 15 percent of the difference between an HMO's or CMP's ACR and its APCRP for a given contract period.

(2) *Cumulative limit.* If CMS has established a benefit stabilization fund for an HMO or CMP, it does not approve a request for withholding made by that HMO or CMP for a subsequent contract period that would cause the total value of the benefit stabilization fund to exceed 25 percent of the difference between the HMO's or CMP's ACR and the average of its per capita rates of payment for that subsequent contract period.

(3) *Exception.* CMS may grant an exception to the limit described in paragraph (c)(1) of this section if an HMO or CMP can demonstrate to CMS's satisfaction that the value of the additional benefits it provides to its Medicare enrollees fluctuates substantially in excess of 15 percent from one contract period to another.

(d) *Financial management of benefit stabilization funds.* (1) The amounts withheld by CMS to establish and maintain a benefit stabilization fund are in the custody of the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

(2) The amounts withheld in a benefit stabilization fund are accounted for by CMS in accounts in which interest does not accrue to the HMO or CMP.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended by 56 FR 46571, Sept. 13, 1991; 58 FR 38083, July 15, 1993; 60 FR 46233, Sept. 6, 1995]

§ 417.597 Withdrawal from a benefit stabilization fund.

(a) *Notification to CMS.* An HMO's or CMP's request to make a withdrawal from its benefit stabilization fund for use during a contract period must be made when the HMO or CMP notifies CMS of its ACR and its ACPRP for that contract period. In making its request, the HMO or CMP must—

(1) Indicate how it intends to use the withdrawn amounts;

(2) Justify the need for the withdrawal in terms of stabilizing the additional benefits it provides to Medicare enrollees;

(3) Document the HMO's or CMP's experience with fluctuations of revenue requirements relative to the additional benefits it provides to Medicare enrollees; and

(4) Document its experience during the contract period previous to the one for which it requests withdrawal to ensure that the HMO or CMP will not be using the withdrawn amounts to refinance losses suffered during that previous contract period.

(b) *Criteria for CMS approval.* CMS approves a request for a withdrawal from a benefit stabilization fund for use during the next contract period only if—

(1) The HMO's or CMP's average of its per capita rates of payment for the next contract period is less than that of the previous contract period;

(2) The HMO's or CMP's ACR for the next contract period is significantly higher than that of the previous contract period; or

(3) The HMO's or CMP's revenue requirements for the next contract period for providing the additional benefits it provided during the previous contract period is significantly higher than the requirements for that previous period and the ACR for the next contract period results in an additional benefits package that is less in total value than that of the previous contract period.

(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