

§ 417.496 Cost plan crosswalk.

(a) *General rules*—(1) *Definition*. Crosswalk means the movement of enrollees from one plan (or plan benefit package (PBP)) to another plan (or PBP) under a cost plan contract between the CMP or HMO and CMS. To crosswalk enrollees from one PBP to another is to change the enrollment from the first PBP to the second.

(2) *Prohibition*. (i) Crosswalks are prohibited between different contracts.

(ii) Crosswalks are prohibited between different plan IDs unless the crosswalk to a different plan ID meets the requirements in paragraph (c)(1)(i) of this section.

(3) *Compliance with renewal/non-renewal rules*. The cost plan must comply with renewal and nonrenewal rules in §§ 417.490 and 417.492 in order to complete plan crosswalks.

(b) *Allowable crosswalk types*. All cost plans may perform a crosswalk in the following circumstances:

(1) *Renewal*. A plan in the following contract year that links to a current contract year plan and retains the entire service area from the current contract year. The following contract year plan must retain the same plan ID as the current contract year plan.

(2) *Consolidated renewal*. A plan in the following contract year that combines 2 or more PBPs. The plan ID for the following contract year must retain one of the current contract year plan IDs.

(3) *Renewal with a service area expansion (SAE)*. A plan in the following contract year plan that links to a current contract year plan and retains all of its plan service area from the current contract year, but also adds one or more new counties. The following year contract plan must retain the same plan ID as the current contract year plan.

(4) *Renewal with a service area reduction (SAR)*. A plan in the following contract year that links to a current contract year plan and only retains a portion of its plan service area. The following contract year plan must retain the same plan ID as the current contract year plan. The crosswalk is limited to the enrollees in the remaining service area.

(c) *Exception*. (1) In order to perform a crosswalk that is not specified in

paragraph (b) of this section, a cost organization must request an exception. CMS reviews requests and may permit a crosswalk exception in the following circumstance:

(i) Except as specified in paragraph (c)(1)(ii) of this section, terminating cost plans offering optional benefits may transfer enrollees from one of the PBPs under its contract to another PBP under its contract, including new PBPs that have no optional benefits or optional benefits different than those in the terminating PBP.

(ii) A terminating cost plan cannot move an enrollee from a PBP that does not include Part D to a PBP that does include Part D.

(iii) If the terminated supplemental benefit includes Part D and the new PBP does not, enrollees must receive written notification about the following:

(A) That they are losing Part D coverage;

(B) The options for obtaining Part D; and

(C) The implications of not getting Part D through some other means.

(2) [Reserved]

[86 FR 6093, Jan. 19, 2021]

§ 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 con-

tract. 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