10.2 - Bill Processing Options

(Rev. 4, 10-01-01)

A Medicare contract with CMS must state on an individual provider basis whether the HMO/CMP elects:

- To have CMS pay on the behalf of the HMO/CMP, hospitals and SNFs for covered items and services furnished to the HMO/CMP's Medicare enrollees (Option 1); or
- To assume responsibility for paying some or all of these providers directly for covered items and services furnished to the HMO/CMP's Medicare enrollees (Option 2). Under this option, the HMO/CMP must specify each hospital and/or SNF for which the HMO/CMP will assume the responsibility of paying for the services rendered by that hospital or SNF.

The HMO/CMP must modify its contract with CMS for any changes in its election 90 days prior to the beginning of the contract period for which the change would be effective. Regardless of the bill option elected, the HMO/CMP must comply with the requirements in Chapter 17, Subchapter C.

10.2.1 - Direct Payment by the HMO/CMP to Hospital and Skilled Nursing Facilities (SNFs)

(Rev. 4, 10-01-01)

If the HMO/CMP elects to pay hospital and SNF providers directly for covered items and services (Bill Processing Option 2), the HMO/CMP must:

- Determine the eligibility of the HMO/CMP's Medicare enrollees to receive covered items and services through the HMO/CMP;

- Make proper coverage decisions and appropriate payments for covered items and services for which the HMO/CMP's Medicare enrollees are eligible;
- Assure that these providers maintain and furnish appropriate documentation of physician certification and recertification, as required under Subpart B; 42 CFR, Part 424 (Certification and Plan of Treatment Requirements); and
- Carry out any other procedures that CMS may require from time to time.

CMS will determine whether the HMO/CMP has the experience and capability to efficiently and effectively carry out the responsibilities specified above.

10.2.2 - Services Furnished Directly or Through Arrangement

(Rev. 4, 10-01-01)

The cost-based HMO/CMP contract with CMS must provide that, in paying for services furnished to the HMO/CMP's enrollees, the HMO/CMP is responsible for:

- Determining the eligibility of individuals to receive such items and services through the HMO/CMP;
- Making proper coverage decisions and appropriate payment for items and services for which the HMO/CMP's Medicare enrollees are eligible; and
- Carrying out any other procedures that CMS may require from time to time.

All health care services furnished by the HMO/CMP may be provided through facilities directly (facilities that are owned or related through common control) or under arrangement. An arrangement is defined as a written agreement executed between the HMO/CMP and another entity in which the other entity agrees to furnish specified services to the HMO/CMP's Medicare enrollees; however, the HMO/CMP retains responsibility for those services.

10.2.3 - Direct Payment by CMS (Hospital and SNF Services)

(Rev. 4, 10-01-01)

If CMS determines that the HMO/CMP is not carrying out its bill processing operations properly (or does not have the experience or capability to do so in the future), CMS may require the HMO/CMP to elect to have CMS pay the HMO/CMP's hospital and SNF providers directly (Bill Processing Option 1). If the HMO/CMP refuses this election, CMS may decline to enter into a contract or may terminate the contract.