10 - Reasonable Cost-Based Payments - General

(Rev. 4, 10-01-01)

Chapter 17, Subchapter A, sets forth the rules CMS follows in determining the amount CMS will pay to TEFRA cost-based Health Maintenance Organizations and Competitive Medical Plans (HMO/CMPs) for services furnished on a reasonable cost basis. Chapter 17, Subchapter A, deals with general requirements, bill processing options, budget and enrollment forecasting, interim payments and reports, adjustments of payments, interim settlement procedures, final certified cost reports, final settlement, general payment principles for cost-based HMO/CMPs, the prudent buyer principle, reimbursable costs, record keeping, and accounting standards.

Chapter 17, Subchapter B, gives the provider payment principles applicable to cost-based contracts, references specific cost topics in the Medicare Provider Reimbursement Manual, Pub 15, and provides specific guidelines on provider of services, physician and other Part B service costs and costs related to enrollment, marketing, membership, and reinsurance for cost-based HMO/CMPs. Chapter 17, Subchapter C, covers cost apportionment for cost-based HMO/CMPs. Chapter 18 will provide guidance on Health Care Prepayment Plans (HCPPs), including payment of reasonable cost, allowable costs and cost apportionment.

Background

HMO/CMPs are public or private entities that are organized under the laws of a State to provide health services on a prepayment basis to enrolled members. These HMO/CMPs are eligible to enter into contracts with the Secretary of the Department of Health and Human Services under §1876 of the Social Security Act (the Act) to furnish services to Medicare beneficiaries. Originally, §1876 of the Act provided two methods of payment for services furnished to Medicare enrollees of HMO/CMPs, reasonable cost reimbursement (TEFRA cost-based) and risk-based payment. The Balanced Budget Act of 1997 (BBA) removed the risk-based option under Section 1876 and replaced it with the Medicare+Choice program in §§1851 - 1859 of the Act. The BBA also included provisions for phasing out the §1876 cost-based HMO/CMPs. Chapter 17 of the manual is in effect for cost-based HMO/CMPs with active contracts until December 31, 2004, and through any applicable audit periods for that contract year. Cost-based HMO/CMPs are paid the reasonable cost actually incurred in providing Medicare covered services to Medicare enrollees. These organizations are paid each month, in advance, an interim per capita rate for each Medicare enrollee. The total monthly payment is determined by multiplying the interim per capita rate by the number of the HMO/CMP's Medicare enrollees, plus or minus adjustments made by CMS. Further adjustments may be made at the end of the contract period to bring the interim payments made to the HMO/CMP during the period into agreement with the reimbursement amount determined payable to the HMO/CMP for services rendered to Medicare enrollees during that period. Total payment is calculated based on the HMO/CMP's final certified cost report.

In addition, the HMO/CMP may furnish services to Medicare beneficiaries who are not enrolled in the organization. Since payment to the HMO/CMP under §1876 of the Act is limited to the HMO/CMP's Medicare enrollees, services furnished to non-enrolled Medicare beneficiaries are outside the scope of the HMO/CMP's agreement with the

Secretary. Medicare payment for services furnished to non-enrolled beneficiaries are made through the original Medicare Fee-For-Service (FFS) payment system in accordance with the usual Medicare payment process.