

(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(d) *Form of payment.* Payment of monies withdrawn from a benefit stabilization fund is made, in equal parts, as an additional amount to the monthly advance payment made to the HMO or CMP under § 417.584 during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 not exceed or fall short of the appropriate per capita rate of payment for each Medicare enrollee of the HMO or CMP during the contract period. The HMO or CMP must submit any information or reports required by CMS to conduct the reconciliation.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38080, July 15, 1993; 60 FR 46233, Sept. 6, 1995]

Subpart Q—Beneficiary Appeals

§ 417.600 Basis and scope.

(a) *Statutory basis.* (1) Section 1869 of the Act provides the right to a redetermination, reconsideration, hearing, and judicial review for individuals dissatisfied with a determination regarding their Medicare benefits.

(2) Section 1876 of the Act provides for Medicare payments to HMOs and CMPs that contract with CMS to enroll Medicare beneficiaries and furnish Medicare-covered health care services to them.

(3) Section 234 of the MMA requires section 1876 contractors to operate under the same provisions as MA plans

where two plans of the same type enter the cost plan contract's service area.

(b) *Applicability.* (1) The rights, procedures, and requirements relating to beneficiary appeals and grievances set forth in subpart M of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(2) In applying those provisions, references to section 1852 of the Act must be read as references to section 1876 of the Act, and references to MA organizations as references to HMOs and CMPs.

[60 FR 46233, Sept. 6, 1995, as amended at 62 FR 23374, Apr. 30, 1997; 70 FR 4713, Jan. 28, 2005]

Subpart R—Medicare Contract Appeals

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

§ 417.640 Applicability.

(a) The rights, procedures, and requirements relating to contract determinations and appeals set forth in part 422 subpart N of this chapter also apply to Medicare contracts with HMOs or CMPs under section 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.

[75 FR 19803, Apr. 15, 2010]

Subparts S–T [Reserved]

Subpart U—Health Care Prepayment Plans

SOURCE: 50 FR 1375, Jan. 10, 1985, unless otherwise noted.

§ 417.800 Payment to HCPPs: Definitions and basic rules.

(a) *Definitions.* As used in this subpart, unless the context indicates otherwise—

Covered Part B services means physicians' services, diagnostic X-ray tests, laboratory, other diagnostic tests, and any additional medical and other

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health services, that the HCPP furnishes to its Medicare enrollees.

Health care prepayment plan (HCPP) means an organization that meets the following conditions:

(1) Effective January 1, 1999, (or on the effective date of the HCPP agreement in the case of a 1998 applicant) either—

(A) Is union or employer sponsored; or

(B) Does not provide, or arrange for the provision of, any inpatient hospital services.

(2) Is responsible for the organization, financing, and delivery of covered Part B services to a defined population on a prepayment basis.

(3) Meets the conditions specified in paragraph (b) of this section.

(4) Elects to be reimbursed on a reasonable cost basis.

Medicare enrollee means a beneficiary under Part B of Medicare who has been identified on CMS records as an enrollee of the HCPP. *Reporting period* means the period specified by CMS for which an HCPP must report its costs and utilization.

(b) *Qualifying conditions.* (1) Except as provided in paragraph (b)(2) of this section, an organization wishing to participate as an HCPP must—

(i) Enter into a written agreement with CMS as specified in § 417.801;

(ii) Furnish physicians' services through its employees or under a formal arrangement with a medical group, independent practice association or individual physicians; and

(iii) Furnish covered Part B services to its Medicare enrollees through institutions, entities, and persons that have qualified under the applicable requirements of title XVIII of the Social Security Act and section 353 of the PHS Act.

(2) An organization that, as of January 31, 1983, was being reimbursed on a reasonable cost basis under section 1833(a)(1)(A) of the Act, and that would not otherwise meet the conditions specified in paragraph (b)(1) of this section, may receive reimbursement on a reasonable cost basis as an HCPP, provided it files an agreement with CMS as required by § 417.801.

(c) *Payment of reasonable cost.* (1) Except as otherwise provided in this sub-

part, CMS pays an HCPP on the basis of the reasonable cost it incurs, as specified in subpart O of this part, for the covered Part B services furnished to its Medicare enrollees.

(2) *Payment for Part B services: Basic rules—(i) Cost basis payment.* Except as provided in paragraph (d) of this section, CMS pays an HCPP on the basis of the reasonable costs it incurs, as specified in subpart O of this part, for the covered Part B services furnished to its Medicare enrollees.

(ii) *Deductions.* In determining the amount due an HCPP for covered Part B services furnished to its Medicare enrollees, CMS deducts, from the reasonable cost actually incurred by the HCPP, the following:

(A) The actuarial value of the Part B deductible.

(B) An amount equal to 20 percent of the cost incurred for any service that is subject to the Medicare coinsurance.

(d) *Covered services not reimbursed to an HCPP.* (1) Services reimbursed under Part A are not reimbursable to an HCPP. CMS makes payment for these services directly to the hospital, or other provider of services, on a reasonable cost basis through the provider's Medicare fiscal intermediary (for more details, see parts 412 and 413 of this chapter).

(2) Covered Part B services furnished by a provider of services to an HCPP's Medicare enrollees are not payable to the HCPP. CMS makes payment for these services to the provider on behalf of the Medicare enrollee through the provider's Medicare fiscal intermediary. This requirement does not affect Medicare payment to the HCPP for physicians' services furnished to its Medicare enrollees for which the physicians are compensated by the HCPP.

(e) *Payment for services to nonenrollees.* CMS makes payment to an HCPP for covered Part B services furnished by the HCPP to a Medicare beneficiary who is not enrolled in the HCPP if the beneficiary assigns his rights to payment in accordance with § 424.55 of this

chapter. Payment is made on a reasonable charge basis through the HCPP's Medicare carrier.

[50 FR 1346, Jan. 10, 1985, as amended at 51 FR 34833, Sept. 30, 1986; 53 FR 6648, Mar. 2, 1988; 57 FR 7135, Feb. 28, 1992; 58 FR 38081, July 15, 1993; 60 FR 34888, July 5, 1995; 63 FR 35067, June 26, 1998; 63 FR 52611, Oct. 1, 1998]

§ 417.801 Agreements between CMS and health care prepayment plans.

(a) *General requirement.* (1) In order to participate and receive payment under the Medicare program as an HCPP as defined in § 417.800, an organization must enter into a written agreement with CMS.

(2) An existing group practice prepayment plan (GPPP) that continues as an HCPP under this subpart U must have entered into a written agreement with CMS within 60 days of January 31, 1983.

(b) *Terms.* The agreement must provide that the HCPP agrees to—

(1) Maintain compliance with the requirements for participation and reimbursement on a reasonable cost basis of HCPPs as specified in § 417.800;

(2) Not charge the Medicare enrollee or any other person for items or services for which that enrollee is entitled to have payment made under the provisions of this part, except for any deductible or coinsurance amounts for which the enrollee is liable;

(3) Refund, as promptly as possible, any money incorrectly collected as charges or premiums, or in any other way from Medicare enrollees in the HCPP in accordance with the requirements specified in § 417.456;

(4) Not impose any limitations on the acceptance of Medicare enrollees or beneficiaries for care and treatment that it does not impose on all other individuals;

(5) Meet the advance directives requirements specified in § 417.436(d) of this part;

(6) Establish administrative review procedures in accordance with §§ 417.830 through 417.840 for Medicare enrollees who are dissatisfied with denied services or claims; and

(7) Consider any additional requirements that CMS finds necessary or desirable for efficient and effective program administration.

(c) *Duration of agreement.* Except for the term of the initial agreement, the agreement is for a term of one year and may be renewed annually by mutual consent. The term of the initial agreement is set by CMS.

(d) *Termination or nonrenewal of agreement by CMS.* (1) CMS may terminate or not renew an agreement if it determines that—

(i) The HCPP no longer meets the requirements for participation and reimbursement as an HCPP as specified in § 417.800;

(ii) The HCPP is not in substantial compliance with the provisions of the agreement, applicable CMS regulations, or applicable provisions of the Medicare law; or

(iii) The HCPP undergoes a change in ownership as specified in subpart M of this part.

(2) CMS will give notice of termination or nonrenewal to the HCPP at least 90 days before the effective date stated in the notice.

(e) *Termination or nonrenewal of agreement by HCPP.* (1) If an HCPP does not wish to renew its agreement at the end of the term, it must give written notice to CMS at least 90 days before the end of the term of the agreement. If an HCPP wishes to terminate its agreement before the end of the term, it must file a written notice with CMS stating the intended effective date of termination.

(2) CMS may approve the termination date proposed by the HCPP, or set a different date no later than 6 months after that date. CMS makes this decision based on a finding that termination on a specific date would not—

(i) Unduly disrupt the furnishing of services to the community serviced by the HCPP; or

(ii) Otherwise interfere with the efficient administration of the Medicare program.

[50 FR 1375, Jan. 10, 1985, as amended at 57 FR 8202, Mar. 6, 1992; 58 FR 38081, July 15, 1993; 59 FR 49843, Sept. 30, 1994; 59 FR 59943, Nov. 21, 1994]

§ 417.802 Allowable costs.

(a) *General rule.* The costs that are considered allowable for HCPP reimbursement are the same as those for