Medicare Managed Care Manual

Chapter 8 - Payments To Medicare Advantage Organizations

Table of Contents
(Rev. 118, 09-19-14)

Transmittals for Chapter 8

10 - General Payment Rules

10.1 - Plan Types

10.2 - Overview of Rates and Payments

10.3 - Payment Areas

10.4 - Pre-MMA Geographic Adjustment of Payment Areas for MA Local Plans

20 - Methodology for Determining Annual Capitation Rates

20.1 - Capitation Rate Terminology

20.2 - Determination of Annual Capitation Rates

20.3 - Types of Capitation Rates

30 - Announcement of Annual MA Capitation Rates and Benchmarks and Announcement of Changes in Payment Methodology

40 - Adjustments to Annual MA Capitation Rates

40. 1 - Adjustment to National Per Capita MA Growth Percentage for Over or Under Projections

40.2 - Adjustment to FFS Capitation Rates for VA and DOD Military Facility Services to Medicare-Eligible Beneficiaries

40.3 - Adjustment to MA Capitation Rates for County Mergers

40.4 - Adjustment to MA Capitation Rates for National Coverage Determinations and Legislative Changes in Benefits

40.4.1 - Rules for Payment of NCDs and LCBs Not Meeting “Significant Cost” Threshold

40.4.2 - Rules for Payment of “Significant Cost” NCDs and LCBs

40.4.3 - Special Rules for the September 2000 NCD on Clinical Trials

40.4.4 - Category B Investigational Device Exemption (IDE) Trials

40.5 - Budget Neutral (BN) Risk Adjustment

50 Adjustment to MA Payments Under the CMS-HCC Risk Adjustment Models

60 - General Rules for Calculating MA Plan Payments

60.1 - Bidding Rules for Coordinated Care Plans (CCPs) and Private Fee-For-Service (PFFS) Plans

60.2 - Bid-Based Payment Rules for CCPs and PFFS Plans

60.3 - The Geographic ISAR Adjustment: Determining Plan-specific Payment Rates for CCPs and PFFS Plans

60.3.1 - Calculation of ISAR Factors and Payment Rates

60.3.2 - Alternative ISAR Adjustment Option for Regional Plans

60.4 - Government Premium Adjustment for CCPs and PFFS Plans With Bids Over Benchmarks

60.5 - Bidding Rules for Medical Savings Account (MSA) Plans

60.6 - Bid-Based Payment Rules for MSA Plans

70 - Special Payment Rules

70.1 - Out-of-Service Area Enrollees

70.2 - Enrollees with ESRD

70.3 - Enrollees Electing Hospice

70.3.1 - CMS' Payments to Hospice Programs

70.3.2 - Hospice and PACE Enrollees

70.4 – Adjustment of Monthly Payments for Medicare Secondary Payment Status

70.4.1 – Working Aged Adjustment

70.4.2 - Working Aged and Working Disabled Adjustment Under the CMS-HCC Model

80 - Adjustment of Payments to Reflect the Number of Medicare Enrollees

90 - Risk Sharing with MA Regional Plans

100 - Regional Plan Stabilization Fund Payments

110 - Special Rules for Payments to Federally-Qualified Health Centers

120 - Special Rules for Coverage That Begins or Ends During an Inpatient Hospital Stay

130 - Special Rules for MA Payments to Department of Veterans Affairs Facilities

140 - Source of Payment and Effect of MA Plan Election on Payment

140.1 Source of Payments

140.2 - Payments to the MA Organization

140.3 - Only the MA Organization is Entitled to Payment

150 - Special Rules for Payment to MA Organizations for Direct Graduate Medical Education Costs

Tables and Figures

Table 1. Phase-Out Schedule for Budget Neutral Risk Adjustment.....13

Table 2. CMS-HCC Risk Adjustment Models 15

Figure 1. Part C Payments for CCPs and PFFS Plans 17

NOTE: This initial version of the chapter does not include all details of MA payment calculations, in particular details on the risk adjustment method. Future updates will incorporate topics such as frailty adjustment, the ESRD risk model, FFS normalization, and provisions in the Deficit Reduction Act of 2005, and the Tax Relief and Health Care Act of 2006 are not included in this version.

Chapter 8 sets forth the policies and methods CMS follows in determining the amount of payment a Medicare Advantage (MA) organization will receive from CMS for coverage of non-prescription drug benefits for Medicare beneficiaries who are enrolled in coordinated care plans (including MA regional plans), private fee-for-service plans, and medical savings account plans offered by the organization. Topics include calculation of annual MA capitation rates, plan-specific payment rates, adjustments to payment rates (including risk adjustment), and other payment rules.

See http://www.cms.hhs.gov/EmpGrpWaivers/ on the CMS Web site for guidance specific to employer and union group health plans.

The regulations that govern these policies and methods are set forth in Part 422 Subparts G and J of the Code of Federal Regulations, and are based primarily on §§1853, 1854, and 1858 of the Social Security Act (the Act), as amended by the Medicare Modernization Act (MMA) of 2003.

10 - General Payment Rules
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

CMS makes advance monthly payments to an MA organization for each enrollee in an MA plan for coverage of original Medicare benefits in an MA payment area for a month.

In the case of an enrollee in an MA-PD plan, the MA organization also receives payment for coverage of Part D prescription drug benefits, including: direct and reinsurance subsidy payments for qualified prescription drug coverage, and reimbursement for the beneficiary drug premium, and the cost sharing reductions applicable to low-income individuals enrolled in the plan.

10.1 - Plan Types
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

This chapter discusses payment rules for the three general types of MA plans:

1. Coordinated Care Plan (CCP), which includes HMOs, HMO-POS plans, PPOs (both local and regional), provider-sponsored organizations (PSOs), and special needs plans (SNPs);

2. Private Fee-for-Service (PFFS) Plan; and

3. Medical Savings Account (MSA) Plan, which is a combination of a high deductible health plan for coverage of original Medicare benefits and a deposit into the enrollee medical savings account.

Religious-Fraternal Benefit (RFB) Society Plans offered by RFB societies, defined in Chapter 1 of the manual may be any of the 3 types of MA plans (CCP, PFFS, or MSA plan), and are subject to the payment rules pertaining to the plan type.

Under Section 1859(e)(4), as implemented at 422.304(c)(3), CMS is required to adjust MA payment rates to RFB plans to appropriate levels, taking into account "the actuarial characteristics and experience" of RFB enrollees. This provision pre-dates implementation of risk adjustment by CMS. In 2006 CMS implemented the third generation risk adjustment model, the CMS-HCC model discussed in 42 CFR 50. CMS will adjust payments to RFB society plans to account for the actuarial characteristics of their enrollees using this model. Application of this model will appropriately adjust payments to RFB societies for the characteristics of their RFB plan enrollees.

10.2 - Overview of Rates and Payments
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Effective CY 2006 and subsequent years, CMS makes advance monthly per capita payments for aged and disabled enrollees based on the bidding methodology established by the MMA. Under the bidding methodology, CMS' payment to MA organizations for each

aged and disabled plan enrollee are no longer based directly on the MA capitation rates published annually in the Announcement of Calendar Year Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Rather, the amount of CMS' payment is determined by the relationship of the plan bid to the benchmark amount, as explained in Chapter 7 on MA Bidding (forthcoming) and as summarized in §60 of this chapter.

Thus, effective 2006 the annual MA capitation rates are used for three purposes:

1. **Calculation of the plan-specific benchmark for coverage of aged and disabled enrollees**, which are compared to plan bids to determine whether there are savings and rebate dollars to fund coverage of non-Medicare covered benefits or whether the beneficiary must pay a plan premium for basic A/B benefits. See §60 for an overview of bids and benchmarks.

2. **Calculation of plan-specific geographic Intra-Service Area Rate (ISAR) adjustment factors**, which are used to produce the aged/disabled county payment rates specific to each plan for CCPs and PFFS plans. See §60.6 on the ISAR adjustment and plan-specific county payment rates.

3. **Calculation of ESRD payments**, which are determined outside of the bidding process using State capitation rates for enrollees in dialysis and transplant status and the county capitation rates for enrollees in functioning graft status. This use of capitation rates for ESRD payments is in effect until CMS exercises its authority under §1853(a)(1)(H) of the Act, implemented at 42 CFR 422.254(a)(2), to incorporate ESRD enrollee costs into the bidding process.

10.3 - Payment Areas

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

MA local area. The MA local area is the payment area for MA local plans. The MA local area is defined at 42 CFR 422.252 as a county or an equivalent geographic area specified by CMS.

MA region. The MA region is the payment area for a MA regional plan. The MA regions are established by CMS.

Special payment area for ESRD enrollees. Special payment areas may apply to ESRD enrollees regardless of whether they belong to a local or regional MA plan. Per 42 CFR 422.204(d), the payment area for ESRD enrollees is a State or other geographic area specified by CMS.

Effective January 1, 2005, the payment area for ESRD enrollees in dialysis and transplant status is the State, District of Columbia, or territory. The payment area for ESRD enrollees in functioning graft (post-transplant) status is the county or equivalent area.

10.4 - Pre-MMA Geographic Adjustment of Payment Areas for MA Local Plans

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

This provision was mandated by the Balance Budget Act of 1997, and implemented at 42 CFR 422.304(e)(2). It should not be confused with the geographic Intra-Service Area Rate (ISAR) adjustment applied under the current bidding methodology, which is implemented at 42 CFR 422.308(d) and discussed here in §60.6.

A State's chief executive may request, no later than February 1 of any year, a geographic adjustment of the State's payment areas for MA local plans for the following calendar year. The chief executive may request any of the following adjustments to the payment area:

(i) A single statewide MA payment area;

(ii) A metropolitan-based system in which all non-metropolitan areas within the State constitute a single payment area and any of the following constitutes a separate MA payment area:

(A) All portions of each single Metropolitan Statistical Area within the State.

(B) All portions of each Metropolitan Statistical Area within each Metropolitan Division within the State.

(iii) A consolidation of noncontiguous counties.

In response to the request, CMS makes the payment adjustment requested by the chief executive. This adjustment cannot be requested or made for payments to regional MA plans.

Budget Neutrality Requirement for State-requested Payment Areas. If CMS adjusts a State's payment areas, CMS at that time, and each year thereafter, adjusts the capitation rates so that the aggregate Medicare payments do not exceed the aggregate Medicare payments that would have been made to all the State's payments areas, absent the geographic adjustment. As long as the chief executive's request for new payment areas remains in effect, this budget neutral adjustment is made annually.

Terminology. "Metropolitan Statistical Area" and "Metropolitan Division" mean any areas so designated by the Office of Management and Budget in the Executive Office of the President.

The only MMA amendment to this provision is that State-requested special payment areas apply to local plans, not regional plans. If a State elects this option, the capitation rates based on the adjusted payment areas would apply to benchmark calculations for every local MA plan offered in the State.

20 - Methodology for Determining Annual Capitation Rates
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

20.1 - Capitation Rate Terminology
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

FS Capitation Rate. Per 42 CFR 422.306(b)(2), the FFS rate is 100 percent of the adjusted average per capita cost (AAPCC) for the MA local area, (as determined under §1876(a)(4) of the Act), based on 100 percent of FFS costs for individuals who are not enrolled in an MA plan for the year, with the following adjustments:

i. Adjusted as appropriate for the purposes of risk adjustment (see §50);

ii. Adjusted to exclude costs attributable to payments for direct graduate medical education, defined in section 1886(h) of the Act; and

iii. Adjusted to include CMS' estimate of the amount of additional per capita payments that would have been made in the MA local area if Medicare-entitled individuals who were also eligible to receive benefits at VA and DOD military facilities had not received services from these facilities (see §40.4).

Rebasing FFS Rates. CMS must rebase the FFS rates no less frequently than every 3 years. CMS has the authority to determine how often to rebase the FFS rates within this 3-year window. Rebasing the FFS rates means that CMS retabulates the per capita FFS expenditures for each county and equivalent area so that the FFS rates reflect more recent growth trends in FFS expenditures.

National Per Capita MA Growth Percentage. Per 42 CFR 422.308(a), the National Per Capita MA Growth Percentage for a year, applied to determine the annual capitation rates, is CMS' estimate of the rate of growth in per capita expenditures for an individual entitled to benefits under Part A and enrolled in Part B. CMS may make separate growth estimates for aged enrollees, disabled enrollees, and enrollees with ESRD status.

Minimum Percentage Increase Rate. Per 42 CFR 422.304(a), the minimum percentage increase rate is the greater of 102 percent of the MA capitation rate for the preceding year or the MA capitation rate for the preceding year increased by the national per capita MA growth percentage for the year.

20.2 - Determination of Annual Capitation Rates
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

There are two rules for determining annual MA capitation rates for 2005 and subsequent years.

- The annual MA capitation rate for an MA local area will be the minimum percentage increase rate, except for years when CMS rebases the FFS rates.

- In rebasing years, the annual MA capitation rate is the greater of the minimum percentage increase rate or the FFS rate.

Areas with upward growth trends in FFS expenditures in the year(s) since CMS last rebased the FFS rates could have local FFS growth trends that are larger than the national MA growth trend for that year. Other counties may see a negative trend from the previous to the current FFS trend in local expenditure growth, resulting in a decline in the FFS rate. However, in cases where a county's FFS rate declines from the previous year, the county would receive the minimum percentage increase rate.

20.3 - Types of Capitation Rates

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

From 2000 through 2006 (and through 2007 for PACE organizations and certain demonstrations), CMS applies two methods for adjusting capitation payments for aged and disabled enrollee health status: the demographic method, which is being phased-out over this 8 year period while the risk adjustment method is being phased-in. Effective January 1, 2007, payments for aged and disabled MA plan enrollees will be fully adjusted under the CMS-HCC risk adjustment model. That is, effective January 1, 2007, only risk rates are used in MA bidding and payment under Part C.

Effective January 1, 2008, payments for PACE organizations and certain demonstrations will be fully adjusted under the CMS-HCC risk adjustment model.

For ESRD payments under Part C, risk adjustment has been phased-in on a different schedule. Age/sex adjustments were applied effective January 1, 2002. Effective January 1, 2005 with the introduction of the ESRD CMS-HCC model, payments were fully risk-adjusted for all MA plans, PACE organizations, and certain demonstrations.

Therefore, CMS publishes several types of capitation rates each year, which can be found on the CMS Web site at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/

- Demographic Rates: CMS publishes aged Part A and Part B rates; and disabled Part A and Part B rates. These demographic rates are not used to determine bids and payments beginning with CY 2007 (with exceptions noted above), but CMS will continue to publish these rates because they are used to determine the amount of the budget neutrality adjustment to the risk rates (described in 42 CFR 40.10).

- Risk Adjustment Rates: Aged-disabled Part A and aged-disabled Part B county rates; and ESRD Part A and Part B State rates.

30 - Announcement of Annual MA Capitation Rates and Benchmarks and Announcement of Changes in Payment Methodology

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Announcement of Calendar Year Medicare Advantage Capitation Rates. As set forth in 42 CFR 422.312, and 42 CFR 422.312(a)(2), not later than the first Monday in April each year, CMS announces to MA organizations and other interested parties the following information for each MA local area for the following calendar year:

(i) The annual MA capitation rate;

(ii) The risk and other factors to be used in adjusting those rates for payments for months in that year; and

(iii) An explanation of assumptions used to determine the capitation rates and a description of the risk and other factors.

Advance Notice of Changes in MA Payment Methodology. No later than 45 days before making the Announcement of Calendar Year Medicare Advantage Capitation Rates, CMS notifies MA organizations of changes it proposes to make in the factors and the methodology it used in the previous determination of capitation rates. The MA organizations have 15 days to comment on the proposed changes.

Regional Benchmark Announcement. Before the beginning of each annual, coordinated election period (see Chapter 2 of the Manual), CMS will announce the MA regional benchmark amount for the year for each MA region.

40 - Adjustments to Annual MA Capitation Rates

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

40. 1 - Adjustment to National Per Capita MA Growth Percentage for Over or Under Projections

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Section 1853(c)(6)(C) of the Act, implemented at 42 CFR 422.308(b), provides for adjustments to MA capitation rates to reflect revisions to prior years' projections of growth rates. The minimum percentage increase rates, and in rebasing years the FFS rates, must be adjusted to reflect any differences between the projected National Per Capita MA Growth Percentages for that year and previous years, and the current estimates of those percentages for those years. CMS may not make this adjustment for years before 2004.

Corrections to prior years' estimates can be found in Enclosure I of the annual Announcement of Calendar Year MA Capitation Rates, found on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/.

40.2 - Adjustment to FFS Capitation Rates for VA and DOD Military Facility Services to Medicare-Eligible Beneficiaries

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

In determining the FFS capitation rates for a year, the annual per capita rate of payment shall be adjusted to reflect the estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved if individuals entitled to Medicare benefits had not received services from facilities of the Veterans Administration (VA) or Department of Defense (DOD). The Medicare Advantage FFS capitation rates for certain areas, based on historical FFS claims data, may not reflect the added cost to MA plans that cover services for such dually-eligible enrollees who might have obtained these services from a VA or DOD facility if they were in the FFS program.

Incorporating costs associated with Medicare-covered services provided to beneficiaries in VA and DOD facilities into the MA payment methodology is a multi-year project requiring development of methods for matching coverage determinations and pricing of services, because coverage and pricing rules differ for Medicare and the VA and DOD. CMS continues to work on obtaining and analyzing the data. From 2004 through 2008, the adjustment is zero.

40.3 - Adjustment to MA Capitation Rates for County Mergers
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

If a county merges with another county, future MA payment rates will be calculated only for the county whose Social Security Administration State and county code survives the merger.

40.4 - Adjustment to MA Capitation Rates for National Coverage Determinations and Legislative Changes in Benefits
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

See Chapter 4, 42 CFR 90 for definitions and guidance on National Coverage Determinations (NCDs) and legislative change in benefits (LCBs). As set forth in 42 CFR 422.308(g), if CMS determines and announces that an NCD or LCB meets the one of the criteria for "significant cost," an MA organization is not required to assume risk for the costs of that item or service until the contract year for which MA capitation rates are appropriately adjusted to take into account the cost of the NCD or LCB.

The term "significant cost," as it relates to a particular NCD or legislative change in benefits, means either of the following:

1. The average cost of furnishing a single service exceeds a cost threshold that for calendar years 1998 and 1999 is $100,000, and for calendar year 2000 and subsequent calendar years is the preceding year's dollar threshold adjusted to reflect the national per capita growth percentage (described at 42 CFR 422.308(a)); or

2. The estimated cost of Medicare services furnished as a result of a particular NCD or LCB represents at least 0.1 percent of the national average per capita costs.

40.4.1 - Rules for Payment of NCDs and LCBs Not Meeting "Significant Cost" Threshold

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

If CMS determines that an NCD or LCB does not meet the "significant cost" threshold, the MA organization is required to assume risk for the costs of that service or benefit as of the effective date stated in the NCD or specified in the legislation.

If the MA organization does not provide or arrange for the service consistent with CMS' NCD or LCB, enrollees may obtain the services through qualified providers not under contract to the MA organization.

40.4.2 - Rules for Payment of "Significant Cost" NCDs and LCBs

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

Before Adjustments to Annual MA Capitation Rate Are Effective. Before the contract year when the MA capitation rates have been adjusted to take into account the significant cost NCD or LCB, the following rules apply to such services.

1. Medicare payment for the service or benefit is:

   - In addition to the capitation payment to the MA organization; and
   - Made directly by the fee-for-service contractors to the provider furnishing the service or benefit in accordance with original Medicare payment rules, methods, and requirements.

2. Costs for NCDs or LCBs for which CMS *MACs* will not make payment and are the responsibility of the MA organization are defined in §90.2 of Chapter 4.

3. Costs for NCDs or LCBs for which CMS fee-for-service contractors will make payment are:

   - Costs relating directly to the provision of services related to the NCD or LCB that were non-covered services prior to issuance of the NCD or LCB; and
   - A service that is not included in the MA capitation rate.

After Adjustments to the Annual MA Capitation Rates Are in Effect. When CMS makes an adjustment to capitation rates, or other payment adjustments, to account for the cost of the NCD or LCB, the MA organization is required to assume risk for the costs of that service or benefit as of the effective date of the adjusted capitation rates.

40.4.3 - Special Rules for the September 2000 NCD on Clinical Trials

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

CMS will make payments for MA enrollees on a fee-for-service basis for covered clinical trial costs under the September 2000 NCD. This policy is in effect until further notice. In CY 2000, CMS determined that the cost of covering these new benefits was not included in the 2001 MA capitated payment rates, and since this cost met the threshold for "significant cost" under 42 CFR 422.109(a), Medicare paid for covered clinical trial services outside of the capitated payment rate. CMS continues the policy of making payments on a fee-for-service basis for covered clinical trial items and services provided MA enrollees until further notification, because the capitation rates have not been appropriately adjusted to account for costs of this NCD, as required under §1853(c)(7) of the Social Security Act (the Act).

Medicare *MACs* made payments on behalf of MA organizations directly to providers of covered clinical trial services, on a fee-for-service basis.

Payment for covered clinical trial services furnished to beneficiaries enrolled in Medicare managed care plans is determined according to the applicable fee-for-service rules, except that MA enrollees are not responsible for meeting either the Part A or Part B deductible (i.e., the deductible is waived). The MA enrollees are liable for the coinsurance amounts applicable to services paid under their plan rules (which may be the Medicare fee-for-service rules).

40.4.4 - Category B Investigational Device Exemption (IDE) Trials

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

Medicare Advantage organizations should not confuse clinical trial coverage under the September 2000 NCD with Medicare's policy on IDE (Investigational Device Exemption) coverage. Category B IDE trials have been covered, at contractor discretion (within CMS's rules and guidelines), since November 1, 1995, under 42 CFR 405.201 to 405.215. Category B IDE costs are included in the Medicare Advantage (MA) payment rates. Therefore, these claims are not paid on a fee-for-service basis by *MACs*. The MA organizations can apply plan rules, including prior authorization rules, when determining whether to cover an enrollee's participation in a Category B IDE trial.

40.5 - Budget Neutral (BN) Risk Adjustment

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Beginning in 2003, CMS has implemented risk adjusted payments in a budget neutral manner. The budget neutrality factor is estimated as the difference between aggregate payments to organizations using 100 percent demographic payments, and aggregate

payments to plans using 100 percent risk adjustment payments expressed as a percent of risk adjusted payments. CMS estimates a single BN factor for all MA plan enrollees.

In 2007, CMS begins phasing out risk adjustment budget neutrality. The phase-out will be completed by 2011, when plans will receive no budget neutrality payment adjustment. The budget neutrality phase-out is summarized in the table below. As required by the Deficit Reduction Act of 2005, this is an acceleration of the phase-out schedule described in the February 18, 2005, CY2006 Advance Notice.

Table 1. Phase-Out Schedule for Budget Neutral Risk Adjustment

Year	Budget Neutrality Percentage
2007	55%
2008	40%
2009	25%
2010	5%
2011	0%

50 Adjustment to MA Payments Under the CMS-HCC Risk Adjustment Models

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

The 1997 BBA and later legislation required CMS to adjust per-beneficiary capitation payments with a risk adjustment methodology using diagnoses to measure relative risk due to health status instead of just demographic characteristics such as age, sex, and Medicaid eligibility. Risk adjustment using diagnoses provides more accurate payments for MA organizations, with higher payments for enrollees at risk for being sicker, and lower payments for enrollees predicted to be healthier. CMS gradually implemented risk adjustment models from 2000 through 2005, on the following schedule.

Aged/disabled enrollees

- From 2000 through 2003, CMS implemented the PIP-DCG risk adjustment model based only on inpatient diagnoses.

- Effective January 1, 2004, CMS implemented the CMS-HCC models based on diagnoses from inpatient, outpatient, and physician settings.

ESRD enrollees

- From 2002 through 2004, CMS applied age/sex factor adjustments to ESRD State rates.

- Effective January 1, 2005, CMS implemented the ESRD CMS-HCC models based on diagnoses from inpatient, outpatient, and physician settings, and distinguishing dialysis, transplant, and functioning graft statuses.

In selecting the CMS-HCC risk adjustment models, the goal was to select clinically sound models that improve payment accuracy while minimizing the administrative burden on MA organizations. The aged/disabled and ESRD CMS-HCC models are revisions of the Hierarchical Condition Category (HCC) model originally developed by Health Economics Research, Inc. The CMS-HCC models function by categorizing International Classification of Diseases codes into disease groups called Hierarchical Condition Categories (HCCs). Each HCC includes diagnosis codes that are related clinically and have similar cost implications. The CMS-HCC models are prospective in the sense that they use diagnosis information from a base year to predict costs for the next year. Models of this type are largely driven by the costs associated with chronic diseases, and they capture the systematic risk (costs) associated with Medicare populations.

The CMS-HCC models are selected significant disease models because they incorporate a limited subset of ICD diagnosis codes. In the aged/disabled models these codes are placed into approximately 70 disease groups. The ESRD models have approximately 67 disease groups, depending on the subpart of the model.

The CMS-HCC risk adjustment model consists of a set of risk factors (relative cost factors) for each HCC and each demographic characteristic in the model. When the diagnosis codes for a particular beneficiary are input to the model, the output is a risk score that reflects the beneficiary demographic characteristics and combination of HCCs associated with the beneficiary for the data collection year. The beneficiary's risk score for a year is a measure of expected health status.

To further improve payment accuracy, CMS developed separate models for different populations with different cost patterns than the general Medicare population:

Full risk models predict future costs using both diagnostic data and demographic characteristics. Full risk models for aged, disabled, and functioning graft beneficiaries are estimated separately for community and long-term institutional settings. The full risk model applied to ESRD dialysis and transplant enrollees does not distinguish community versus institutional settings.

New enrollee models are applied to MA enrollees with less than 12 month of Part B eligibility. These models predict future costs using only demographic characteristics, not diagnoses, because CMS does not have the latter information for these beneficiaries. Specifically, for purposes of risk adjustment new enrollees are newly-eligible disabled or age-in beneficiaries with less than 12 months of Medicare entitlement during the data collection year.

Table 2 below lists the CMS-HCC models used to calculate risk scores for MA plans. The factors for each HCC model can be found on the CMS website at

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

Table 2. CMS-HCC Risk Adjustment Models

Enrollee Type	Model
Aged & Disabled	Full-Risk Community Model
	Full-Risk Long-term Institutionalized Model
	New Enrollee Model
ESRD Dialysis (Also applies to those in transplant status.)	Full-risk Dialysis Model
	New Enrollee Dialysis Model
ESRD Transplant Status	Special Payment Factors
`Functioning Graft	Full-Risk Community Model
	Full Risk Long-term Institutionalized Model
	New Enrollees - apply aged/disabled model

Risk Scores Adjust Payments. Beneficiary risk scores are used to adjust each plan's base payment rate for member health status, the first step in determining the per-person per-month payment to MA organizations, PACE organizations and certain demonstrations. See §60 on payment calculation rules for MA plans.

CMS uses demographic and diagnostic information from original Medicare and from all MA organizations a beneficiary may have joined (taken from diagnostic data submitted by the organizations) to determine the appropriate risk score for each beneficiary. The risk score is computed for each beneficiary for a given year and applied prospectively. The risk score generally follows the beneficiary for one calendar year. Since all Medicare beneficiaries have risk scores (including new enrollees), information is immediately available for payment purposes as beneficiaries join an MA organization or move among organizations. When an MA organization forwards beneficiary enrollment information to CMS, CMS then sends the organization the appropriate risk scores for the beneficiary, as well as the resultant payment.

Risk Adjustment Participant Guide and Model Software. See the Participant Guide, available at http://www.csscoperations.com/new/usergroup/july2006_regtrn/raps-participant-guide_081606.pdf for details on the CMS-HCC risk adjustment models and for guidance on data submission and CMS payments to MA organizations (including the fee-for-service normalization factor applied in the payment calculation). The risk model diagnosis codes and CMS-HCC model software are available on the CMS Web site at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

60 - General Rules for Calculating MA Plan Payments
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

See Chapter 7 of the manual (forthcoming) for information on the bidding methodology. In short, under the bidding methodology each plan's bid for coverage of Part A and Part B benefits (i.e., its revenue requirements for offering original Medicare benefits) is compared to the plan benchmark (i.e., the upper limit of CMS' payment, developed from the county capitation rates in the local plan's service area or from the MA regional benchmarks for regional plans). The purpose of the bid-benchmark comparison is to determine whether the plan must offer supplemental benefits or must charge a basic beneficiary premium for A/B benefits.

60.1 - Bidding Rules for Coordinated Care Plans (CCPs) and Private Fee-For-Service (PFFS) Plans
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

- If the plan A/B bid is less than plan A/B benchmark, 75% of that difference is "rebate" that must be used to offer mandatory supplemental benefits or premium reductions. The other 25% is retained by the Trust Funds as savings.

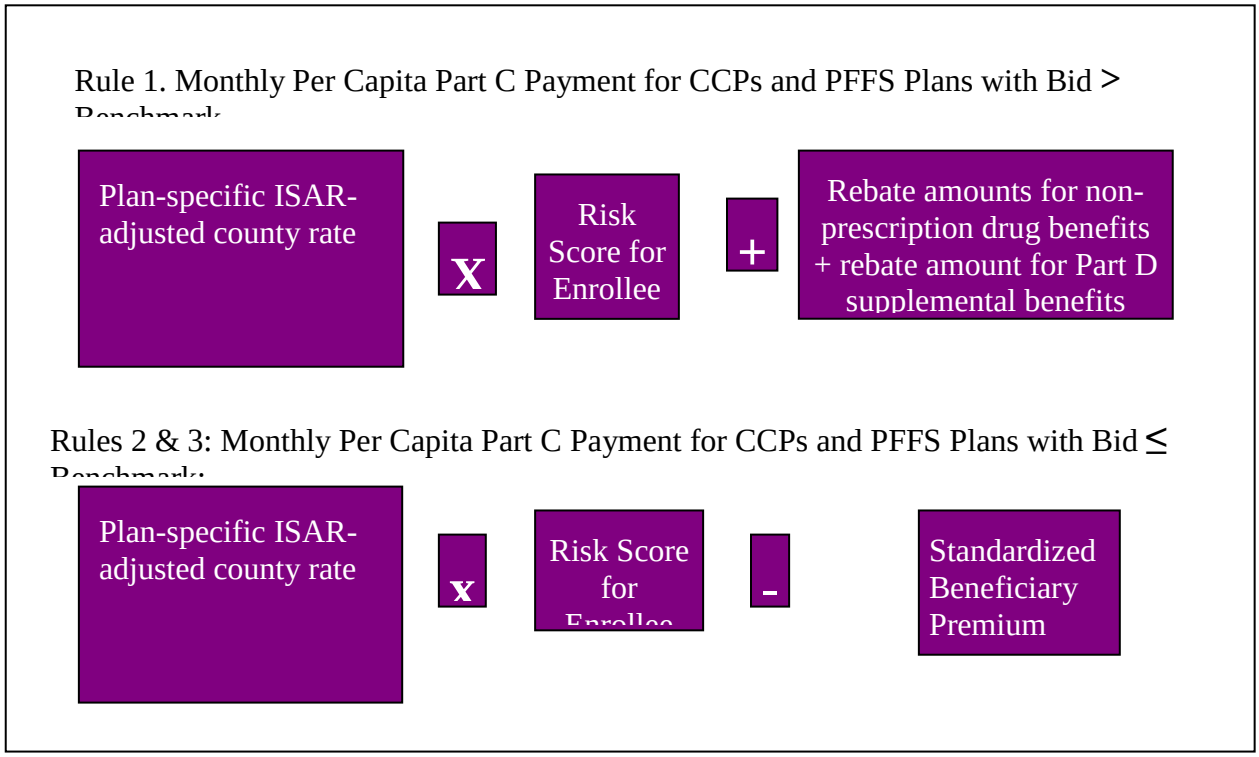
- If the plan A/B bid is greater than the plan A/B benchmark, the plan must charge a basic beneficiary premium for A/B benefits, where the premium is defined as the standardized bid minus the standardized benchmark.

60.2 - Bid-Based Payment Rules for CCPs and PFFS Plans
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Effective CY 2006, there are three general Part C payment rules for bid-based payments for aged and disabled enrollees of CCPs and PFFS plans, summarized in Figure 1. See §70.2 for ESRD Enrollee Payment Rules and §70.3 for payment rules for enrollees who have elected hospice.

Under the bidding methodology, per capita payment rates are plan-specific, because they are calculated as the standardized ("1.0") plan bid multiplied by the plan's county ISAR factor. (See §60.3.1 on the ISAR factor.)

Figure 1. Part C Payments for CCPs and PFFS Plans



Rule 1. Payment of bid for plans with bids below benchmark. CMS's advance monthly payment for an enrollee is:

- The standardized bid for the plan (referred to at 42 CFR 422.304 as the unadjusted MA statutory non-drug monthly bid amount) adjusted by the county ISAR factor for the enrollee's county of residence, and adjusted by the enrollee's risk score. Figure 1 refers to this quantity as the plan-specific ISAR-adjusted county rate; plus

- The rebate amounts allocated to non-prescription drug benefits (reduction of A/B cost sharing and reduction of premiums for additional non-drug benefits) and the Part D supplemental benefit.

The amount by which the plan reduces enrollees' Part B premium is a foregone revenue that remains in the Treasury, allowing CMS and SSA to decrease the enrollee's Part B premium by this amount. The amount by which the plan reduces the basic Part D premium is reflected in CMS' Part D payment to the plan.

Rule 2. Payment of bid for plans with bids equal to the benchmark. CMS's advance monthly payment for an enrollee is the standardized bid, adjusted by the county ISAR factor for the enrollee's county of residence, and adjusted by the enrollee's risk score.

Rule 3. Payment of benchmark for plans with bids above the benchmark. CMS's advance monthly payment for an enrollee is:

- The standardized bid for the plan adjusted by the county ISAR factor for the enrollee's county of residence, and adjusted by the enrollee's risk score; minus

- The standardized beneficiary basic A/B premium, which is the difference between the standardized A/B bid and the standardized A/B benchmark.

Note on terminology. For bid-equal-benchmark plans and bid-above-benchmark plans, the statute describes the base payment as the standardized benchmark, described at 42 CFR 422.304 as the unadjusted MA statutory non-drug monthly benchmark amount.

Here, we apply bid-based logic to describe payment formulas for Rules 2 and 3 – where the bid minus the basic beneficiary premium is the benchmark. For Rule 2 plans with bid-equal-benchmark, the beneficiary premium is zero. For Rule 3 plans, the bid-based logic is that the plan receives its bid through two revenue streams: (1) CMS' benchmark payment and (2) the enrollee premium payment. See §60.4 on the government premium adjustment for Rule 3 plans.

Payment calculation in CMS' systems are determined separately for Part A and Part B. Part-B only plans are paid the Part B portion of the payment.

60.3 - The Geographic ISAR Adjustment: Determining Plan-specific Payment Rates for CCPs and PFFS Plans

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Under §1853(a)(1)(F) of the Social Security Act, implemented at 42 CFR 422.308(d), payments to organizations for enrollees in CCPs and PFFS plans must be adjusted to take into account variations in MA capitation rates among counties in a plan's service area or segment of a service area.

The MA organizations must submit a single bid for each MA local plan and each MA regional plan. In preparing their bids, MA organizations make assumptions about the likely differences in costs between low-cost and high-cost areas in the service area, and assumptions about the relative distribution of enrollment from these different areas. If their enrollment estimates prove incorrect, their costs could be significantly higher (or lower) than originally anticipated.

The purpose of the ISAR adjustment is to adjust payments to compensate for any variation between the expected enrollment mix (by county) that formed the basis of a plan's bid and the actual enrollment mix by county. The geographic ISAR adjustment converts a plan's single bid for the service area into county payment rates that are unique to the plan. The plan-specific county rates reflect the plan's projections of average required revenue. The idea is that these plan-specific county payment rates will better reflect the relative cost of doing business in the respective counties than a single, average rate across the service area (the bid).

60.3.1 - Calculation of ISAR Factors and Payment Rates
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

The following calculations are performed in the MA bid pricing tool. Plan-specific county ISAR factors are developed, both for local and regional plans, according to a formula that ensures that the plan-specific county rates tie back to the plan's bid, and these factors are applied to the plan bid.

ISAR Factors - The county ISAR factor is the ratio of the MA capitation rate for the county to the weighted average of all MA capitation rates in the plan's service area. The weights used for both local and regional plans ISAR factors are the plan's projected enrollment in each county.

The weighted average of all the county ISAR factors for a plan's service area must equal 1.0.

Payment Rates - For multi-county local plans and for regional plans, each plan-specific county payment rate equals the standardized A/B bid multiplied by the county ISAR factor. Each county in the plan's service area has an ISAR factor and a plan-specific payment rate.

60.3.2 - Alternative ISAR Adjustment Option for Regional Plans
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

A plan bid represents a statement of the average per member revenue that it needs to provide original Medicare benefits. Particularly for regional plans covering a wide geographic area, underlying the single bid there could be significant variation in costs across the geographic area that the organization is required to serve.

Using the MA capitation rates as a basis for the ISAR adjustment presumes that the variation in these rates among counties measures the variation in plan revenue needs across different counties. Because regional plans have service areas established by CMS, while local plan service areas are selected by MA organizations, MA organization may opt to use an alternative methodology for calculating the geographic ISAR adjustment for their regional plans. In the event that an MA organization believes that the variation in MA rates among the counties in the region covered by its regional plan is not an accurate reflection of the variation in its projected revenue needs in the region, the organization can request to have payments geographically adjusted at the county level using an organization-determined statement of the relative revenue needs for the provision of Medicare-covered services in the service area. (Note that organization-determined ISAR factors, like the MA rate-based ISAR factors, will result in a different average payment to the plan only if the actual enrollment mix differs from the projected mix that formed the basis of the plan bid.)

CMS reviews the organization-provided ISAR factors for reasonableness and actuarial soundness. CMS also reviews enrollment projections for all plans, both those with ISAR factors based on the MA capitation rates and those with ISAR factors that are determined by the MA organization for a particular regional plan. The MA organizations will be

required to provide support for the organization-determined ISAR factors (such as the projected utilization and cost by service category for each county), and CMS reserves the right to ask for additional detail and documentation of organization-determined factors during bid negotiation or during an audit. Approval of these factors will be contingent on the comprehensiveness, actuarial soundness, and reasonableness of the MA organization's cost, utilization and enrollment assumptions, and associated documentation.

60.4 - Government Premium Adjustment for CCPs and PFFS Plans With Bids Over Benchmarks

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Organizations with plan A/B bids above the plan A/B benchmark must charge a uniform basic beneficiary premium. Because beneficiary premiums are standardized to the average beneficiary, i.e., they are not adjusted for individual health status, organizations with bids above the benchmark will be subject to an additional adjustment to their payments pursuant to section §1853(a)(1)(G) and implemented at 42 CFR 422.308(e).

This adjustment, referred in statute to the "adjustment relating to risk adjustment" and in regulation as the "government premium adjustment," will adjust an organization's payment upward or downward to ensure that the organization's revenue needs are met with regard to that portion of their payment coming from the basic premium, regardless of whether the plan enrolls more or less healthy beneficiaries. Organizations with bids at or below the benchmark do not charge a basic premium, and therefore are not subject to this adjustment.

Conceptually, this adjustment is the difference between the risk adjusted beneficiary basic premium and the beneficiary basic premium actually paid by enrollees, which is a standardized amount (based on a "1.0" beneficiary). This incremental payment is ISAR-adjusted to reflect differences between projected and actual enrollment.

Rule 3 of §60.4 states that for plans that must charge a basic beneficiary premium, the standardized premium amount is subtracted from the risk-adjusted plan-specific county payment rate. This equation builds in the government premium adjustment because the adjusted county rate includes the amount that is the difference between the risk-adjusted beneficiary premium and the standardized beneficiary premium.

60.5 - Bidding Rules for Medical Savings Account (MSA) Plans

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

For both standard and demonstration MSA plans, if the plan A/B bid is less than the plan A/B benchmark, 100% of that difference is the monthly deposit amount that CMS contributes to the enrollee's Medical Savings Account for each month of enrollment in the contract year.

CMS makes an annual lump-sum deposit in each MSA for standard MSA plans. An MA organization offering an MSA demonstration plan may select this annual lump-sum

approach or offer a proposal for payment of deposit amounts subject to CMS review and approval.

60.6 - Bid-Based Payment Rules for MSA Plans
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

CMS will make the following two types of payments for MSA plan enrollees. See §70.2 for ESRD enrollee payment rules and §70.3 for payment rules for enrollees who have elected hospice.

- Monthly prospective capitation payment, which is the plan's bid for coverage of original Medicare benefits under a high-deductible health plan. These payments must be adjusted by the enrollee's risk score, as required under §1853(a)(1)(B)(iii) of the Act and 42 CFR 422.304(c)(2).

- Annual lump-sum deposit to the enrollees' MSA, calculated as the difference between the plan A/B bid and plan A/B/ benchmark, annualized, reflects the plan's projected average level of risk. The monthly value of the MSA deposit is the same for each plan member. CMS transmits to MA organizations the annual MSA amounts to be deposited into enrollees' accounts.

MSA plan capitation payment aged and disabled enrollees: (Standardized benchmark * enrollee's risk factor) minus monthly deposit amount.

Annual Lump Sum Deposit Payment. Monthly deposit amount * number months of enrollment.

Payment calculation in CMS' systems are determined separately for Part A and Part B. Part-B only plans are paid the Part B portion of the payment.

70 - Special Payment Rules
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

70.1 - Out-of-Service Area Enrollees
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

An MA plan enrollee must, with limited exceptions, permanently reside in the plan's service area. (For a summary of the circumstances when an MA plan may have out-of-area enrollees, see §20.3 of Chapter 2.)

Beginning in 2006, CMS will make payments based on the counties in a plan's service area, which is the geographic basis for the estimated revenue requirements in the plan's bid. In the event there are plan enrollees with State-county codes outside the plan's service area – which could happen for limited reasons discussed in Chapter 2, CMS will use the service-area standardized A/B bid, instead of a plan-specific county rate (the bid adjusted by the county's ISAR factor) to calculate the payment amount. (As discussed above, for

plans with bids greater than their benchmarks, the standardized beneficiary A/B premium will be subtracted from the bid.)

The MA organization is responsible for determining where an enrollee permanently resides. When an organization sees in the CMS monthly payment reports that the standardized A/B bid is the base payment – because the enrollee's State/county code is 99999 (county unknown) or an out-of-service area State/county code, the organization should seek information from the enrollees as to whether they are still permanent residents of the plan's service area, and confirm the correct State/county code. If the beneficiary continues to be a permanent resident in the plan's service area, the MA organization should use CMS' existing process for requesting a State/county code change to return the enrollee code to the correct permanent county of residence (see Chapter 19), to ensure that the appropriate ISAR-adjusted county rate is used to determine payment for the enrollee.

70.2 - Enrollees with ESRD

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

For the purpose of MA payment, "ESRD beneficiaries" means beneficiaries with ESRD, whether entitled to Medicare because of ESRD, disability, or age, and includes beneficiaries in dialysis, transplant, and post-transplant functioning graft statuses. Beginning in CY 2006, CMS has the authority to determine whether and how to incorporate costs for ESRD enrollees into the bidding methodology, per 42 CFR 422.254(a)(2). To date, ESRD enrollee costs have not been included in plan bids for non-prescription drug benefits, and CMS continues to pay MA organizations for ESRD plan enrollees using the MA capitation rates.

Below are four payment rules for ESRD beneficiaries, two for CCP and PFFS plan enrollees, and two for MSA plan enrollees.

ESRD Payment Rules for CCPs and PFFS Plans. Beginning in CY 2005, with the introduction of the ESRD risk adjustment model, CMS pays the appropriate MA capitation rate, adjusted for enrollee risk.

- Rule 1 enrollees in dialysis and transplant status. CMS pays the State capitation rate for the enrollee State (or territory) of residence, adjusted by the enrollee's risk score, minus the amount of any rebate dollars (if any) allocated to reduce plan enrollees' Part B premium and/or Part D basic premium.

- Rule 2 for ESRD enrollees in functioning graft status. CMS pays the county capitation rate for the enrollee county of residence, adjusted by the enrollee's risk score, minus the amount of any rebate dollars (if any) allocated to reduce plan enrollees' Part B premium and/or Part D basic premium.

The amount by which the plan reduces enrollees' Part B premium is a foregone revenue that remains in the Treasury, allowing CMS and SSA to decrease the enrollee's Part B

premium by this amount. The amount by which the plan reduces the basic Part D premium is reflected in CMS' Part D payment to the plan.

ESRD Payment Rule for MSA Plans. CMS pays the appropriate MA capitation rate, adjusted for enrollee risk.

- Rule 3 for enrollees in dialysis and transplant status. CMS pays the State capitation rate for the enrollee State of residence, adjusted by the enrollee's risk score, minus the plan's monthly deposit amount.

- Rule 4 for enrollees in functioning graft status. CMS pays the county capitation rate for the enrollee county of residence, adjusted by the enrollee's risk score, minus the plan's monthly deposit amount.

70.3 - Enrollees Electing Hospice

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Enrollees Electing Hospice in CCP and PFFS Plans. Effective CY 2006 for CCP and PFFS plans, during the time the hospice election is in effect, CMS pays the MA organization the portion of the monthly payment attributable to the rebate, minus the amounts (if any) of rebate allocated to reduce the Part B premium and the Part D basic premium, plus the amount of the subsidy CMS pays the MA organization for a plan enrollee related to basic prescription drug coverage (if the enrollee is in an MA-PD plan).

- The amount by which the plan reduces enrollees' Part B premium is foregone revenue that remains in the Treasury, allowing CMS and SSA to decrease the enrollee's Part B premium by this amount. The amount by which the plan reduces the basic Part D premium is reflected in the Part D payment to the plan.

- Regarding the Part D benefit, if an MA-PD plan enrollee electing hospice needs prescription drugs for conditions not related to hospice care, these costs are the MA organization's responsibility (to the extent that the drugs are covered under Part D or under the plan). CMS pays MA-PD organizations the Part D subsidy for all enrollees, including those electing hospice.

Enrollees Electing Hospice in an MSA Plan. Beneficiaries who have elected hospice are not allowed to enroll in an MSA plan. Members may elect hospice and remain in the MSA plan. CMS' monthly capitation payment will be zero, because there is no portion of the monthly payment from CMS for the high deductible health plan that is attributable to supplemental benefits. Moreover, MSA plans cannot offer Part D coverage.

70.3.1 - CMS' Payments to Hospice Programs

(Rev. 118; Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010); Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012 (for ASC X12 5010))

The hospice is paid through the original Medicare program, subject to the usual rules of payment, for hospice care furnished to the Medicare enrollee. See the Medicare Claims Processing Manual, Chapter 11 on Hospice on the CMS Web site at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html

Section 40.2.2(B) of Chapter 11 notes that Medicare hospices will bill the *A/B MAC (HH)* for Medicare beneficiaries who have coverage through managed care just as they do for beneficiaries with fee-for-service coverage.

Original Medicare pays physicians, providers and suppliers for other Medicare-covered services furnished to enrollees who have elected hospice. "Other services" refer to non-hospice A/B services that are not related to the terminal illness.

For other Part B services furnished to enrollees who have elected hospice, original Medicare will also pay the MA organization to the extent a claim has been reassigned to the MA organization. Under §1861(u) of the Act, Part A claims from "providers of services" cannot be reassigned.

The MA organization is responsible for making available to its members who have elected hospice all Medicare-covered non-hospice services and also any non-hospice services that are not Medicare-covered, but that are offered as supplemental benefits under the plan. For example, services provided by an attending physician to an MA enrollee who has elected hospice are considered non-hospice services, if the physician is not employed or contracted by the enrollee's hospice program, and may be reimbursed by original Medicare.

Since an MA organization cannot bill *an A/B MAC (A),* nor can an *A/B MAC (A)* make payments to MA organizations, below are examples of how MA organizations may choose to handle billing for non-hospice ("other") services by <u>contracted</u> providers:

- The MA organization can authorize the provider (e.g., hospital or physician) or supplier to bill the *MAC* directly. (In such a situation, the MA organization might also choose to incorporate rate adjustments in contracts to account for the provision of non-hospice services by providers and suppliers that bill original Medicare directly.)

- In the case of physician and supplier services, the MA organization may direct them to submit claims for non-hospice services to the MA organization. The MA organization would bill the *A/B MAC (B)* and make payments to the physicians/suppliers.

Under original Medicare (and thus under the MA program during hospice elections), the beneficiary is responsible for certain cost sharing for hospice services:

- Co-pay for Part B drugs and biologicals: No more than $5 for each drug and other similar products for pain relief and symptom control.

- Co-pay for a respite care day: 5 percent of the payment that Medicare makes for a respite care day, not to exceed the hospital inpatient deductible.

70.3.2 - Hospice and PACE Enrollees

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

CMS will not make payments to Program of All-inclusive Care for the Elderly (PACE) organizations for enrollees who have elected hospice. Enrollees in PACE organizations must elect either their PACE organization or the hospice benefit as their provider of Medicare services. An enrollee who elects to enroll in hospice is thereby disenrolled from the PACE benefit. However, PACE organizations provide a service similar to hospice known as "end-of-life-care."

70.4 – Adjustment of Monthly Payments for Medicare Secondary Payment Status

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

70.4.1 – Working Aged Adjustment

(Rev. 112, Issued:05-10-13, Effective:10-01-13, Implementation: 10-07-12-Coding Changes to create the new field in the CWF feed to MBD will be made in October; January 6, 2014- The utility and cleanup will he completed as part of the January release)

CMS makes a payment adjustment for managed care enrollees who are working aged or disabled and covered under another's employment insurance. Beneficiaries are "working aged" if they are aged 65 or older, currently working for an employer with 20 or more employees, and have health insurance coverage through the employer's group health plan. Medicare-eligible spouses who are aged 65 or older, with health insurance coverage under a currently employed spouse's employer group health plan (if that employer has 20 or more employees) are also assigned working aged status (even if the currently employed spouse is under 65 years of age and not yet entitled to Medicare). Disabled beneficiaries covered under other employment insurance benefits will only appear as "disabled" in MSP files.

Medicare spending for these beneficiaries is significantly lower than spending for other beneficiaries because other insurers are primary to Medicare. In 1995, working aged status was added as a factor for adjusting payments to managed care organizations with §1876 risk contracts. However, in 2010, CMS started reducing payments for MSP on a beneficiary instead of contract basis. MSP information received from insurance companies, the beneficiaries themselves, and managed care plans are used to adjust individual beneficiary payment amounts.

CMS sends plans monthly reports that include all of the beneficiaries where Medicare is the Secondary Payer. These reports are explained in depth in the Plan Communications User Guide. If plans disagree with CMS' determination that their enrollees have other employer insurance coverage, they can submit a correction via ECRs as described in the IOM, Chapter 5.1 of Publication 100-05 Medicare Secondary Payer Manual.

70.4.2 - Working Aged and Working Disabled Adjustment Under the CMS-HCC Model

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

From 2000 through 2005, CMS adjusted the demographic portion of the payment to MA organizations for their MA plans with contract-level working aged (WA) factor.

CMS determined that for the risk adjusted portion of the payments, adjusting only for the proportion of working aged enrollees is not appropriate because the risk adjustment rates are based on combined costs for aged and disabled beneficiaries. Effective 2006, CMS revised the prior MSP methodology for the aged (the working aged adjustment) to include the disabled.

For CY 2006, CMS applies two contract-level MSP factors applied to adjust payments to the MA organization:

- CMS continues to apply a contract-level working aged (WA) adjustment factor to demographic payments; and

- CMS applies a contract-level MSP adjustment factor, based on the proportion of WA and working disabled (WD) enrollees, to the risk adjusted payments.

Effective 2007, MA plans move to 100 percent risk-adjusted payments, so CMS applies a single contract-level MSP factor to adjust payments based on the proportion of WA and WD enrollees.

Each MA organization surveys a cohort of its aged and disabled members and reports to CMS those with coverage primary to Medicare due to WA and WD status. The MSP status of non-responders to the survey is determined from the Common Working File. Using this information, CMS then calculates a contract-level WA/WD payment adjustment factor by comparing prospective monthly blended payments with no WA/WD adjustment to monthly payments with a WA/WD adjustment for those identified as MSP.

80 - Adjustment of Payments to Reflect the Number of Medicare Enrollees

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Per 42 CFR 422.308(f), CMS makes retroactive adjustments to the aggregate monthly payments to take into account any difference between the actual number of Medicare enrollees in a plan, and the number on which CMS had based the organization's advance monthly payment.

CMS applies payment rates and adjustment factors applicable to the month of enrollment. Monthly payments to MA organizations reflect all beneficiaries with an effective enrollment in the MA plan in question for the month for which payment is made, including

those whose enrollment was effective prior to that month, and those for whom enrollment is effective as of that month.

90 - Risk Sharing with MA Regional Plans

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Section 1858(c) of the Social Security Act provides for risk sharing under Part C to be in effect for regional MA plans 2006 and 2007, if specific plan costs are above or below specific risk corridors. The risk corridors are symmetrical in that the government pays organizations if costs are above a target, while it recoups its share of the savings when costs are below a target.

Following are the steps involved in calculating risk corridor payments for MA regional plans.

Calculate the target ratio. The following are the key elements used to determine the risk sharing target ratio for a regional MA plan. Please note that the values are expressed on a per-member, per-month (PMPM) basis:

- Projected allowed medical expense is equal to the projected medical expense in the plan A/B bid for benefits covered under original Medicare, plus the medical component of rebatable integrated benefits. Rebatable integrated benefits are non-drug supplemental benefits that are funded through beneficiary rebates and are: (i) additional medical benefits not covered under the original Medicare program option; or (ii) expenditures by the plan for cost sharing reductions for A/B benefits.

- Projected allowed revenue is equal to the projected allowed medical expense plus projected non-medical expense and projected gain/loss margin included in: (i) basic plan bid, and (ii) rebatable integrated benefits.

- The risk sharing target ratio is calculated as the projected allowed medical expense divided by the projected allowed revenue.

- The risk sharing target amount is the actual allowed revenue multiplied by the risk sharing target ratio.

- The actual covered revenue equals the net government capitation payments (including capitation payments, rebates allocated to buy-down supplemental A/B benefits, and government premium adjustment) plus basic enrollee premium revenue.

- The basic enrollee premium revenue represents premiums billed and does not include an offset for uncollected premiums. An organization sets policy for the management of uncollected premiums, and this is an administrative expense. Thus, this "offset" amount should be left out of risk sharing. This is consistent with CMS' guidance for pricing of the Part D benefit.

As an attachment to the MA bid submission, an MA organization offering a regional plan must include a description of the methodology that will be used to develop actual revenue and medical expense to be included in risk sharing reconciliation.

Calculate associated risk corridor limits. The first threshold upper limit is 103 percent of the target amount, and the second threshold upper limit is 108 percent of the target amount. Similarly, the first threshold lower limit is 97 percent of the target amount, and the second threshold lower limit is 92 percent of the target amount.

Calculate allowed risk corridor costs. The MA organizations will report to CMS the actual allowed revenue and medical expense for the regional plan that were incurred during the contract year and processed within 12 months after the end of the contract year. For example, any medical expenses incurred during 2006 and paid by December 31, 2007 will be reported as an actual incurred claim. Allowed medical expense will reflect reimbursements received, or expected to be received, by the plan under coordination of benefits, subrogation, reinsurance, Part B Rx rebates, or other sources. Further, excluded from medical expenses will be expenditures for case management and disease management services that are not considered to be an enrollee "encounter."

The calculation of the actual plan revenue and medical expense will be verified by an independent auditor, paid for by the plan.

CMS Application of Risk Corridors. First, CMS determines where actual allowed medical expenses are relative to thresholds, then calculates a payment adjustment. If actual allowed medical expenses fall within 3 percent of the target amount (above or below it), there is no risk sharing of additional cost or "savings." If actual allowed medical expenses are more than 3 percent outside the risk sharing target (above or below it), costs or savings will be shared in accordance with the following provisions:

- Actual allowed medical expense greater than 103 percent of target amount and less than or equal to 108 percent of target amount: CMS pays the MA organization 50 percent of the difference between actual allowed medical expense and 103 percent of target amount.

- Actual allowed medical expense greater than 108 percent of target amount: CMS pays the MA organization 2.5 percent of target amount plus 80 percent of the difference between actual allowed medical expense and 108 percent of target amount.

- Actual allowed medical expenses less than 97 percent of the target amount and greater than or equal to 92 percent of the target amount: CMS applies a negative adjustment to the plan payment of 50 percent of the difference between 97 percent of target amount and actual allowed medical expense.

- Actual allowed medical expenses less than 92 percent of target amount: CMS applies a negative adjustment to the plan payment of 2.5 percent of target amount plus 80 percent of difference between 92 percent of target amount and actual allowed medical expense.

Medicare Advantage organizations offering regional plans should use actual claims data to calculate allowed medical expenses and may include an adjustment for claims incurred during the contract period that remain unpaid (but which the organization has a reasonable expectation of paying) as of the reconciliation date, which is 12 months beyond the end of the contract period. The MA organizations may build-in a reasonable level of claim reserves when calculating the allowed medical expenses for purposes of regional plan risk corridor payments. Accompanying the reconciliations shall be exhibits and data (that is, "claim triangles") that support development of the claim reserves. The reserves, and supporting data, will be reviewed by CMS' Office of the Actuary (OACT). If these amounts are in question, the reconciliation will be considered to be preliminary and a cash settlement will occur with a final settlement to take place 12 months later. The reconciliation exhibit will be audited by an independent Certified Public Accountant, at the expense of the MA organization.

100 - Regional Plan Stabilization Fund Payments
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Section 221 of the MMA added §1858(e) to the Act to create a new MA Regional Plan Stabilization Fund. The purpose of the fund is to provide financial incentives to MA organizations to offer MA regional PPO plans in each MA region, and to retain MA regional PPO plans in regions with relatively low MA market penetration. Specifically, the MMA authorizes CMS to make a 1-year "national bonus payment" to an organization(s) that offers an MA regional PPO plan in each MA region in a given year (if there was no such plan offered in one or more regions in the previous year). If no national bonus payment is made in a given year, CMS may use the fund to increase payments to MA regional PPO plans offered in regions that did not have any MA regional PPO plans offered in the prior year. Finally, to encourage plans to remain in regions with relatively low MA market penetration and few MA regional PPO plans, CMS may make retention payments from the fund to MA regional PPO plans that notify CMS of their intent to exit a region prior to the bidding deadline.

Section 301 of Division B, Title III, of the Tax Relief and Health Care Act of 2006 – enacted December 20, 2006 – delayed Stabilization Fund payments until January 1, 2012.

110 - Special Rules for Payments to Federally-Qualified Health Centers
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Per 42 CFR 422.316, FQHCs will receive a "wrap-around payment" from CMS representing the difference (if any) between what they are paid by an MA organization, including beneficiary cost sharing, and 100 percent of their "reasonable costs" of providing care to patients served at the centers who are enrolled in an MA plan at a minimum on a

quarterly basis. The FQHC must have a written agreement with the MA organization offering the plan concerning the provision of this service (including the agreement required under §1857(e)(3) of the Act and as codified in 42 CFR 422.527).

The MA organizations that contract with FQHCs must pay the FQHCs an amount that is not less than the level and amount of payment they would make for the services if furnished by an entity providing similar services that was not an FQHC. This is designed to avoid an agreement between an MA organization and an FQHC for payment of an artificially low rate, with the knowledge that the FQHC would receive supplemental payments from us resulting in a total of 100 percent cost reimbursement.

The PFFS plans that have "deemed" networks must pay what the FFS Medicare program pays to the "provider in question," per 42 CFR 422.114(a)(2)(i). Therefore, there would be no wrap-around payment for FQHCs treating PFFS patients under a "deemed" contract because the FQHC would be receiving full payment from the plan.

120 - Special Rules for Coverage That Begins or Ends During an Inpatient Hospital Stay

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Applicability. Per 42 CFR 422.318, this provision applies to inpatient services in a subsection (d) hospital as defined in §1886(d)(1)(B) of the Act, a psychiatric hospital described in §1886(d)(1)(B)(i) of the Act, a rehabilitation hospital described in §1886(d)(1)(B)(ii) of the Act, a distinct part rehabilitation unit described in the matter following clause (v) of §1886(d)(1)(B) of the Act, or a long-term care hospital (described in §1886(d)(1)(B)(iv)).

Coverage that begins during an inpatient stay. If coverage under an MA plan offered by an MA organization begins while the beneficiary is an inpatient in one of the facilities described under Applicability:

- Payment for inpatient hospital services continues to be the responsibility of original Medicare or the previous MA organization, as appropriate, until the date of the beneficiary's discharge.

- The MA organization offering the newly elected MA plan is not financially responsible for the inpatient hospital services until the date after the beneficiary's discharge. Original Medicare or the previous MA organization is financially responsible for inpatient hospital services for that beneficiary for that inpatient episode, even if it extends beyond the effective date of a beneficiary's MA election.

- The MA organization offering the newly-elected MA plan is paid the full amount otherwise payable under Part C.

Coverage that ends during an inpatient stay. In the case where a beneficiary's MA plan election ends while he or she is a hospital inpatient, the MA organization remains responsible for payment for inpatient hospital services furnished by a hospital after expiration of enrollment until the date of discharge. Payment for these services would not be made by original Medicare under Medicare's PPS system. The MA organization that no longer enrolls the member receives no payment from CMS or the beneficiary for the period after coverage ends.

130 - Special Rules for MA Payments to Department of Veterans Affairs Facilities

(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Section 1814(c) of the Social Security Act (the Act) sets forth the general rule that Medicare payments may not be made to any Federal provider of services for any item or service that such provider is obligated by law, or contract with the United States, to render at public expense. The Department of Veteran Affairs (VA) is a federal provider of services that is obligated by law to render services to veterans at public expense. The CMS has clarified that an MA organization is an entity that "stands in the shoes" of Medicare, and is considered a federal provider of services for purposes of this general rule. This means that an MA organization may not use Medicare funds to pay the VA Healthcare System for VA-covered services rendered to veterans who are also MA organization enrollees. This rule prevails for both elective services and the emergency services rendered by the VA to veteran MA enrollees.

An MA enrollee who is enrolled in the VA Medical Benefits Plan has dual entitlement to separate government-funded health care systems. This means that the individual may elect to receive his or her health care either through the VA system or through his or her MA plan. If the individual elects to receive routine or non-emergency services through the VA system, the VA would be obligated by law to pay for those services and the MA organization would not be permitted to reimburse for such services under the same law.

Similarly, the MA organization is not permitted by law to pay the VA system for emergency services rendered by the VA to veterans who are MA enrollees. This holds true regardless of the circumstances underlying the enrollee's presentation to the VA. Thus, the prohibition against payment to the VA prevails whether the enrollee self-presented to the VA (e.g., walk-in patient), was directed there by a treating physician, or was brought to the VA by ambulance. However, see Chapter 7 (forthcoming) for a discussion of the situation where an MA plan enrollee with VA coverage is assessed cost sharing by the VA for receipt of emergency services and this cost sharing exceeds MA plan levels of cost sharing.

Non-Veteran MA enrollees. The rules governing MA organizations' responsibility for payment differs for services rendered by the VA to non-veteran MA enrollees. The rule at §1814(c) of the Act prohibiting payment has no application to non-veterans. Non-veteran enrollees are covered under §1814(d), which permits payment to be made to hospitals not contracted with Medicare for emergency services rendered to Medicare beneficiaries. Under 42 CFR 422.100 and 422.113, MA organizations are responsible for covering

emergency and post-stabilization care services rendered to enrollees. MA organizations are obligated to reimburse the VA for such services, and would be expected to coordinate care of non-veteran enrollees who are in a VA hospital due to an emergency as it would in any other non-contracted or out-of-network hospital.

Exception Under Section 1814(h) of the Act. The rules governing MA organizations' responsibility for payment for services rendered by the VA to non-veteran MA enrollees also contain a provision at §1814(h) of the Act for circumstances in which a non-veteran is admitted to a VA hospital when both the individual and the VA mistakenly believe that the individual is entitled to VA benefits when in fact they are not. The §1814(h) exception only applies to the unusual situation in which an MA Organization enrollee who is a non-veteran is mistakenly admitted to a VA hospital for a service that does not require pre-authorization by their MA Organization plan. The CMS expects that this situation would be very rare.

140 - Source of Payment and Effect of MA Plan Election on Payment
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

140.1 Source of Payments
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Per 42 CFR 422.322(a), payments for original fee-for-service benefits to MA organizations and to MA Medical Savings Accounts are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund in proportions determined by CMS that reflect the relative weights that benefits under Part A and Part B represent of the actuarial value of total Medicare benefits.

Payments to MA organizations for statutory drug benefits provided under an MA-PD plan are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

140.2 - Payments to the MA Organization
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Per 42 CFR 422.322(b), CMS' payments under a contract with an MA organization for original fee-for-service benefits to MA organizations with respect to an individual electing an MA plan offered by the organization, are instead of the amounts that, in the absence of the contract, would otherwise be payable under original Medicare for items and services furnished to the individual.

This statement is subject to the following provisions set forth in the Act, and implemented at 42 CFR Parts 412, 413, and 422:

- 412.105(g) detailing payments made to a hospital for indirect medical costs for discharges of managed care enrollees;

- 413.86(d) concerning calculations of payments to hospitals for graduate medical education costs;

- 422.109 concerning National Coverage Determinations and legislative changes in benefits;

- 422.318 on special rules for coverage that begins; or ends during an inpatient hospital stay; and

- 422.320 on special rules for hospice care.

140.3 - Only the MA Organization is Entitled to Payment
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

Per 42 CFR 422.322(c), only the MA organization is entitled to receive payment from CMS under title XVIII of the Act for items and services furnished to the individual. This statement is subject to provisions set forth in the MA regulations:

- 422.314 on special rules for beneficiaries enrolled in MA MSA plans;

- 422.318 on special rules for coverage that begins or ends during an inpatient hospital stay;

- 422.320 on special rules for hospice care; and

- 422.520 detailing the MA prompt payment provisions specifying conditions under which CMS may make direct payments to providers or MA private-fee-for service plan enrollees.

This statement is also subject to the following provisions of the Act: §1886(d) concerning additional payment amounts to any subsection (d) hospital with an approved medical residency training program for applicable discharges of MA enrollees; and §1886(h)(3)(D) concerning calculations of payments to hospitals for direct graduate medical education costs.

150 - Special Rules for Payment to MA Organizations for Direct Graduate Medical Education Costs
(Rev. 89; Issued: 11-02-07; Effective/Implementation: 11-02-07)

This provision was mandated by the Balance Budget Act of 1997, and is implemented at 42 CFR 422.324. The MMA did not amend this provision. These rules should not be confused with the medical education adjustments to the FFS capitation rates, defined at §20.2.

The MA organizations may receive direct graduate medical education payments for the time that residents spend in non-hospital provider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs if all of the following conditions are met:

1. The resident spends his or her time assigned to patient care activities;

2. The MA organization incurs "all or substantially all" of the costs for the training program in the non-hospital setting as defined at 42 CFR 413.86(b); and

3. There is a written agreement between the MA organization and the non-hospital site that indicates the MA organization will incur the costs of the resident's salary and fringe benefits, and provide reasonable compensation to the non-hospital site for teaching activities.

An MA organization's allowable direct graduate medical education costs, subject to the redistribution and community support principles specified in 42 CFR 413.85(c), consist of:

1. Residents' salaries and fringe benefits (including travel and lodging where applicable); and

2. Reasonable compensation to the non-hospital site for teaching activities related to the training of medical residents.

The direct graduate medical education payment is equal to the product of:

1. The lower of:

    - The MA organization's allowable costs per resident as defined in paragraph (c) of this section; or

    - The national average per resident amount; and

2. Medicare's share, which is equal to the ratio of the number of Medicare beneficiaries enrolled to the total number of individuals enrolled in the MA organization.

Direct graduate medical education payments made to MA organizations under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R118MCM	09/19/2014	Conversion from ICD-9 to ICD-10 and from ASC X12 Version 4010 to 5010	Upon Implementation of ICD-10	N/A
R116MCM	02/28/2014	Conversion from ICD-9 to ICD-10 and from ASC X12 Version 4010 to 5010 – Rescinded and replaced by Transmittal 118	10/012014	N/A
R112MCM	05/10/2013	Adding MSP Validity to the CWF to MBD Feed	10/07/2013	N/A
R89MCM	11/02/2007	Chapter 8, “Payment to Medicare Advantage Organizations”	11/02/2007	N/A
R39MCM	11/14/2003	Mandatory and Optional Supplemental Benefits	N/A	N/A
R25MCM	06/13/2003	Initial Issuance of Chapter	N/A	N/A

Back to top of chapter