

**COMPARISON CHART
MEDICARE COST AND MEDICARE+CHOICE PROGRAMS**

SUBJECT	MEDICARE+CHOICE	MEDICARE COST
Legal Authority	Sections 1851-1859 of the SSA and 42 CFR §422.1 et seq. M+CO must be State licensed or State certified as a risk-bearing entity allowed to offer health insurance or health benefits coverage on a prepaid basis. There is an exception to State licensure requirements for certain provider sponsored organizations (PSOs). 42 CFR §422.4 - §422.8	Section 1876 of the SSA and 42 CFR §417.400 et seq. HMO/CMP must be organized under State law and be a federally qualified HMO or a CMP. 42 CFR §417.404 - §417.418
Payment	Payments are risk-based. Section 1853 of the Social Security Act and 42 CFR §422.249 <u>et seq.</u>	Payments are cost-based. Section 1876(h)(1) of the Social Security Act and 42 CFR §417.530 <u>et seq.</u>
Minimum enrollment requirements	Have at least 5,000 enrollees (1,500 if a PSO) in an urban area, or at least 1,500 enrollees (500 if a PSO) in a rural area. Minimum enrollment waiver possible, for first three years “waiver” of minimum enrollment requirement possible. 42 CFR §422.514	Have at least 1,500 enrollees initially and at least 75 Medicare enrollees, or a plan acceptable to CMS for achieving 75 Medicare enrollees within two years. 42 CFR §417.413(c)
Re-contracting	M+CO that has terminated a prior M+C contract with CMS cannot have a new M+C contract for <u>two</u> years, unless CMS waives the prohibition due to “special considerations.” 42 CFR §422.512(e) - as amended by CMS-1181-F dated March 22, 2002.	No requirement.
Coverage for Out-of Network Services (that are not emergency or urgently needed services) <u>**MAJOR DIFFERENCE**</u>	In general, services obtained from non-network providers (when not referred) are not covered (with the exception of emergency, unforeseen urgently needed and certain other services that fit narrow exceptions).	Services obtained from non-network providers (when not referred) are covered under the fee-for-service program (and thus subject to Medicare-fee-for-service coinsurance and deductible requirements), unless they are emergency or unforeseen out-of-area urgently needed services.
Eligibility		
Eligibility without Medicare Part A	Individuals with Part A and Part B except grandfathered individuals who have Part B and were enrolled in a Medicare risk plan. Section	Individuals with Part A and Part B or individuals with only Part B may enroll. Sections 1876(a)(1)(A) and 1876(d) of the

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	1851(a)(3) of the Social Security Act and 42 CFR §422.50. [Additional exception is possible for employer group members with Part B only under a section 617 BIPA waiver plan. Section 617 of BIPA added §1857(i) to the Social Security Act.]	Social Security Act and 42 CFR §417.422.
ESRD	Individuals who have ESRD are not eligible to enroll in an M+CO unless they were enrolled in the organization at the time they were determined to have ESRD or are enrolled in an M+CO that is terminating or discontinuing a plan in the area in which the individual resides (nonrenewal or service area reduction). Individuals with ESRD who are enrolled in a plan of an M+CO can switch enrollment to another plan of the same organization. Section 1851(a)(3)(B) of the Social Security Act and 42 CFR §422.50.	Individuals who have ESRD are not eligible to enroll in a Cost HMO or CMP unless they were enrolled in the HMO or CMP at the time they were determined to have ESRD. Individuals with ESRD who are enrolled in a Cost HMO or CMP may switch enrollment to another “plan” of the same organization. Section 1876(d) of the Social Security Act and 42 CFR §417.423. Enrollment in §1876 cost HMOs/CMPs is at the organization (not the “plan”) level.
Hospice election	Individuals who have made a hospice election may enroll in an M+CO. Sections 1851(a)(3) and 1853(h) of the Social Security Act.	Individuals who have made a hospice election may not enroll in a Cost HMO or CMP. Individuals who make a hospice election during an enrollment period may remain with the Cost HMO or CMP. 42 CFR §417.423
Enrollment/Disenrollment		
Open enrollment periods	M+COs must participate in a coordinated annual election period (AEP) each November. For calendar years 2002 - 2004 the AEP will be from November 15 - December 31. In addition, an M+CO must accept enrollment whenever an individual is eligible to change his/her election or make an election during an initial coverage election period (ICEP), a special election period (SEP), or any other election period as specified in law and	A Cost HMO or CMP must have an annual open enrollment period of at least 30 days duration each year. Cost HMOs and CMPs may choose to have open enrollment periods of longer duration. Section 1876 (c)(3)(A)(i) and 42 CFR §417.426(a). [Capacity limit restricting enrollment is possible per 42 CFR 417.426(b). “Reserved” vacancies during capacity limit possible per 42 CFR §417.426(c).]

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	<p>regulations. Section 1851(e) of the Social Security Act (as amended by §532 of the Public Health Security and Bioterrorism Preparedness and response Act of 2002) and 42 CFR §422.62. [Capacity limit restricting enrollment is possible per 42 CFR §422.60(b). “Reserved” vacancies during capacity limit not permitted. However, §617 BIPA [§1857(i)] employer group only plans are allowed.]</p>	
<p>Enrollment/disenrollment effective dates</p>	<p>If an M+C eligible individual submits a complete election form at any time during a month, the individual’s enrollment (or disenrollment) is effective the first day of the following month. However, elections made during the AEP are generally effective on the following January 1. 42 CFR §422.68(c). Medicare Managed Care Manual, Chapter 2, §30.5</p>	<p>If a beneficiary submits a complete enrollment form before the monthly cut-off date (which varies usually between the 10th and the 16th of the month), the beneficiary’s enrollment is effective the first day of the following month. If a beneficiary submits a complete enrollment form after the cut-off date, enrollment is effective the first day of the 2nd month after the month of submission. 42 CFR §417.450(a)(2). Disenrollments are effective the first day of the following month. HMO/CMP Manual §2002 and 42 CFR §417.461(a)(2).</p> <p>Note: Effective November 15, 2002, Cost HMOs/CMPs have been granted the option of continuing to follow Cost enrollment effective date rules, or to adopt M+C enrollment effective date rules. The new option includes:</p> <ul style="list-style-type: none"> • consistent 1st of the next month enrollment effective dates, • January 1 effective date <u>option</u> for enrollments throughout the AEP, and • acceptance of prospective enrollment applications for individuals newly entitled to Medicare (up to 3 months).

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		<ul style="list-style-type: none"> • acceptance of prospective enrollment applications from employer group members (up to 3 months). <p>If a Cost HMO/CMP adopts M+C rules, notice to CMS RO is required. M+C option must be elected for full contract year, unless good cause for change can be shown. See Director of Health Plan Policy Group memo of November 22, 2002, for additional requirements.</p>
Lock-in	<p>From 1998 through 2004, the number of elections or changes that an M+C eligible individual may make is not limited. During 2005 an individual may change his or her election only once during the open enrollment period (OEP), (e.g., the first 6 months of 2005, and first 3 months of subsequent years). This limitation does not apply to the AEP and special election periods. Section 1851(e)(2)(A) and (e)(2)(B) of the Social Security Act.</p>	<p>Medicare beneficiaries may disenroll from a Cost HMO or CMP at any time to return to Medicare fee-for-service. If the Cost HMO or CMP has an open enrollment period, a Medicare beneficiary may enroll in the Cost HMO or CMP during that period. Medicare beneficiaries who disenrolled from a cost HMO or CMP to Medicare FFS may re-enroll in a Cost HMO or CMP during an open enrollment period. Disenrollments from an M+CO to join a Cost HMO or CMP or disenrollments from a Cost HMO or CMP to enroll in an M+CO are subject to the M+C lock-in provisions beginning in 2005. 42 CFR §417.426.</p>
Special election periods	<p>An M+CO must allow individuals eligible to change their election because of a “special election period” (SEP) to enroll. E.g., individuals who were members of an M+CO or a Cost HMO or CMP that is withdrawing from the service area, or individuals who have moved out of their M+CO’s service area. Section 1851(e)(4) of the Social Security Act and 42 CFR §422.68.</p>	<p>Cost HMOs and CMPs are only obligated to accept enrollees during their open enrollment periods. (see discussion above.) No special enrollment periods apply. 42 CFR §417.426.</p>

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Enrollee opportunities to voluntarily disenroll	Beginning in 2005, individuals enrolled in an M+CO may only disenroll during OEPs, AEPs, SEPs, and ICEPs. Prior to 2005 (through December 2004) individuals can disenroll at any time. Section 1851(e) of the Social Security Act as amended by §532 of the Public Health Security and Bioterrorism Preparedness Act of 2002 and 42 CFR §422.68.	No restrictions on disenrollment from Cost HMOs and CMPs.
Involuntary disenrollment for failure to pay premium	When an enrollee fails to pay the basic or supplementary premiums, the M+CO may disenroll the enrollee. In certain limited cases the M+CO may convert the enrollee to the basic benefit package, if the enrollee does not pay the premium for an optional supplemental benefit package. 42 CFR §422.74(d) and section 50.3.1 of Chapter 2 of the Medicare Managed Care Manual.	When an enrollee fails to pay the premium the Cost HMO or CMP may disenroll the beneficiary. If an enrollee fails to pay the premium for optional supplemental benefits, but pays the basic premium and other charges, the HMO/CMP may discontinue the optional benefits upon proper advance notice to the beneficiary but may not disenroll the beneficiary. 42 CFR §417.460(c)
Involuntary disenrollment for failure to pay copays/deductibles	Not allowed in the M+C program.	Cost HMO/CMP may disenroll for failure to pay required copays/deductibles as long as policy is clearly communicated in member materials (Evidence of Coverage) and as long as proper disenrollment procedure is followed. 42 CFR §417.460(b)(1)(i) and (c)
Notice prior to involuntary disenrollment for failure to pay premium [or copays/deductibles - Cost HMOs/CMPs only]	M+COs must send a notice of nonpayment to the enrollee within 20 days of the date the payment was due. The M+CO may only disenroll the individual if it has not received payment within 90 days. 42 CFR §422.74(d) and Chapter 2 of the Medicare Managed Care Manual, section 50.3.1.	Cost HMOs and CMPs must make a reasonable effort to collect the unpaid amount. CMS considers a reasonable effort to have been made if the HMO/CMP mails a notice of disenrollment for failure to pay premium 20 days prior to the proposed disenrollment date. HMO/CMP Manual §2004.2; 42 CFR §417.460(c)

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<p>Involuntary disenrollment for move or absence from service area</p> <p><u>**MAJOR DIFFERENCE**</u></p>	<p>An M+CO must disenroll an individual if the individual has permanently moved from the plan's service area or if the individual has left the plan's service area for more than 6 months, unless the individual is residing in the plan's continuation area or the plan offers a visitor's program, in which case the individual can remain enrolled for up to 12 months. 42 CFR §422.54 and §422.74(b)(2)(i) and (d)(4)</p>	<p>A Cost HMO or CMP must disenroll an individual if the individual has permanently moved from the HMO's/CMP's service area. An uninterrupted absence of 90 days is deemed to be a permanent move and the individual must be disenrolled unless the HMO/CMP offers an extended absence option, as discussed below. 42 CFR §417.460 and HMO/CMP Manual §2004.3</p>
<p>Services provided to members outside of the service area or continuation areas and extended absence options</p>	<p>M+COs may offer a continuation area option through which members who <i>permanently</i> reside in the continuation area may remain enrolled in the M+CO. At a minimum, Medicare-covered services must be provided or arranged for. 42 CFR §422.54</p>	<p>Cost HMOs or CMPs that choose to offer an extended absence option may retain members who <i>temporarily</i> (more than 90 days but less than one year) leave the service area by either paying for all covered services for such members based on mutually agreeable restrictions or by providing services through an affiliated organization. 42 CFR §417.460(f)(1) and HMO/CMP Manual §2004.4</p>
<p>Health Services</p>		
<p>Basic benefit package</p>	<p>M+COs must cover all Medicare covered benefits in the basic benefit package of all plans. M+COs are permitted to require Medicare enrollees to pay for mandatory supplemental benefits and may offer optional supplemental benefits. 42 CFR §422.101 and §422.102</p>	<p>Cost HMO/CMP must offer at least one basic benefit package in all parts of its Medicare service area that contains only Medicare covered benefits. Cost HMO/CMP may also offer optional supplemental benefits. 42 CFR §417.440 and section 1876(c)(2)(A) of the Social Security Act</p>
<p>Emergency services</p>	<p>Emergency services are covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition.</p> <p>An emergency medical condition is a medical condition manifesting itself by acute symptoms</p>	<p>Emergency services means covered inpatient or outpatient services that are furnished by an appropriate source other than the HMO or CMP and that meet the following conditions:</p> <p>(1) Are needed immediately because of an injury or sudden illness. AND</p> <p>(2) Are such that the time required to reach the HMO's or CMP's providers or suppliers (or</p>

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	<p>of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—(1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. 42 CFR §422.113</p>	<p>alternatives authorized by the HMO or CMP) would mean risk of permanent damage to the enrollee’s health. Once initiated, the services continue to be considered emergency services as long as transfer of the enrollee to the HMO’s or CMP’s source of health care or authorized alternative is precluded because of risk to the enrollee’s health or because transfer would be unreasonable, given the distance and the nature of the medical condition. 42 CFR §417.401</p> <p>Such services must be, <u>or appear to be</u>, needed immediately. HMO/CMP Manual §2206</p>
Urgently needed services	<p>Urgently needed services are covered services that are not emergency services as defined under M+C law, provided when an enrollee is temporarily absent from the M+CO’s service (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization’s provider network is temporarily unavailable or inaccessible) when the services are medically necessary and immediately required--</p> <p>(A) As a result of an unforeseen illness, injury, or condition; and</p> <p>(B) It was not reasonable given the circumstances to obtain the services through the organization offering the M+C plan. 42 CFR §422.113</p>	<p>Urgently needed services means covered services that are needed by an enrollee who is temporarily absent from the HMO’s or CMP’s geographic area and that--</p> <p>(1) Are required in order to prevent serious deterioration of the enrollee’s health as a result of unforeseen injury or illness; and</p> <p>(2) Cannot be delayed until the enrollee returns to the HMO’s or CMP’s geographic area. 42 CFR §417.401</p>
Post-stabilization services	M+COs must pay for post-stabilization services in certain instances in which the M+CO has not pre-approved the services	No specific requirement. Under the §1876 program there is no specific mention of “post-stabilization” services. However, services are

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	and/or in certain instances where the services are non-emergency services provided by a non-network provider. 42 CFR §422.113(c)	covered if they continue to be emergent or urgent. Also, medically necessary follow-up care to emergency and urgent care is covered, if the care cannot be delayed without adverse medical effects. Additional services are covered, if they are authorized by the HMO/CMP. HMO/CMP Manual §2105
Out-of-area renal dialysis **MAJOR DIFFERENCE**	M+COs must pay for routine out-of-area renal dialysis when a member is temporarily outside of the service area. 42 CFR §422.100(b)	Routine out-of-area renal dialysis is covered only under original Medicare.
Initial health assessment	An M+CO must make a “best-effort” attempt to conduct an initial health assessment of all new enrollees within 90 days of the effective date of enrollment. 42 CFR §422.112(b)(4)(i)	No requirement.
Pap tests and screening mammographies	M+COs must allow in network direct access to routine and preventive women’s health care services <u>and</u> screening mammographies. 42 CFR §422.112(a)(3); 42 CFR §422.100(h)	Cost HMOs/CMPs must permit in network direct access only to screening mammographies. Pap tests must be offered, but there is no direct access requirement for Cost enrollees. OPL 57
Influenza and pneumococcal vaccines	M+COs must allow in network direct access to influenza <u>and</u> pneumococcal vaccines and may not impose cost sharing on either. 42 CFR §422.100(h)	Cost HMOs/CMPs must permit in network direct access to influenza vaccines and may not impose cost-sharing. OPL 56
Payment for hospital and SNF services	M+CO must pay for all covered hospital and SNF services directly. 42 CFR §422.100 and §422.101	Cost HMOs/CMPs may choose to pay all hospitals and SNFs directly, or to have the Medicare Fiscal Intermediary pay directly. 42 CFR §417.532(c)
Benefit changes	M+COs must send notices concerning changes in the next year’s benefits and premiums for receipt by October 30. 42 CFR §422.111(d)(2) - as amended by the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.	Cost HMOs and CMPs must send notices concerning changes in the next year’s benefits at least 30 days prior to the effective date. For changes in benefits and premiums at the beginning of the year, notice must be sent by December 2. HMO/CMP Manual §5200.14;

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		42 CFR §417.436(c)
Organization Determinations and Appeals		
Disputes subject to appeal <u>**MAJOR DIFFERENCE**</u>	Disputes concerning payment or coverage of basic benefits, mandatory and optional supplemental benefits are all subject to appeal. 42 CFR §422.566(a)	Only disputes concerning Medicare covered services (or services the member <u>believes</u> are Medicare covered services) are subject to Medicare appeal process. Disputes concerning other benefits are subject to the Cost HMO's/CMP's internal grievance process. 42 CFR §417.606(a) and (b)
Initial (organization) determination -- time frame Note: See Provider Relations section (below) for claims processing time frames.	An M+CO must generally make an initial determination on a standard request for services as expeditiously as the enrollee's health requires but no later than 14 days from the request. An M+CO must generally make an initial determination on a request for an expedited determination within 72 hours. 42 CFR §422.568, §422.572 and §422.520	A Cost HMO/CMP must make initial determinations concerning standard requests for services within 60 days. A Cost HMO/CMP must generally make an initial determination on a request for an expedited organization determination as expeditiously as the enrollee's health condition requires, but within 72 hours of the request. 42 CFR §417.608 and §417.609
Time extensions for organization determinations	<p>On a both a standard and expedited request for service the M+CO may extend the time frame by up to an additional 14 calendar days, if the enrollee requests the extension or if the organization justifies the need for additional information and how the delay is in the interest of the enrollee. 42 CFR §422.568</p> <p>On a standard request for payment, an extension is not permitted for any reason. 42 CFR §422.568(b) and 42 CFR §422.520</p>	<p>For expedited requests for services, an extension of up to 10 working days is permitted, if requested by the enrollee or if the HMO/CMP finds that additional information is necessary and the delay is in the interest of the enrollee. 42 CFR §417.609(c)(3)</p> <p>For standard requests for payment and services, an extension is not possible. 42 CFR §417.608(c)</p>
Reconsidered determinations -- time frame	An M+CO must generally make a reconsidered determination on a standard request for services as expeditiously as the enrollee's health condition requires, but no later than 30 days from the date it receives the request and	A Cost HMO or CMP must make reconsidered determinations on standard requests for services and payment of claims within 60 days. A Cost HMO or CMP must generally make a determination on a request for an expedited

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	<p>on a request for payment of a claim within 60 days. An M+CO must generally make a determination on a request for an expedited reconsidered determination as expeditiously as the enrollee’s health condition requires but no later than 72 hours after receiving the request. 42 CFR §422.590</p>	<p>reconsidered determination as expeditiously as the enrollee’s health condition requires, but within 72 hours of the request. 42 CFR §417.617 and §417.620</p>
Time extensions for reconsiderations	<p>The M+CO may extend the time frame for standard reconsidered determinations for services by up to 14 calendar days, if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee. The M+CO may not extend the time frame for reconsidered claims beyond 60 days. 42 CFR §422.568 and §422.590</p>	<p>For good cause shown, CMS may extend the time frame for standard reconsidered determinations. The HMO/CMP must actively seek a CMS extension or the time frame cannot be extended. 42 CFR §417.608 and §417.620(d), (e) and (f)</p> <p>For expedited reconsiderations an extension of up to 10 working days is permitted if requested by the enrollee or if the HMO/CMP finds that additional information is necessary and the delay is in the interest of the enrollee. 42 CFR §417.617(c)(3)</p>
Appeals related to Part A IP Hospital and SNF services	<p>Both the immediate QIO/PRO <u>or</u> the expedited reconsideration process (but not both) available for disputes related to “early discharge” from an inpatient hospital setting. 42 CFR §422.622(a)</p> <p>For all other payment disputes related to IP hospital and SNF services, the normal M+C appeals process is followed. 42 CFR §422.560 - §422.622</p>	<p>Both the immediate QIO/PRO <u>or</u> the expedited reconsideration process (but not both) available for disputes related to “early discharge” from an inpatient hospital setting. 42 CFR §417.604(b)</p> <p>For all other payment disputes related to IP hospital and SNF services, the normal HMO/CMP appeals process is followed EXCEPT when the HMO/CMP has elected billing option one per 42 CFR §417.532(c)(1). 42 CFR §417.600 - §417.638</p>
Provider Relations		
Contracts	To meet CMS requirements, the following	To meet CMS requirements, the following

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	<p>elements <u>must</u> appear in all M+CO contracts with providers:</p> <ul style="list-style-type: none"> • Contracting providers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records. • Contracts must specify a M+CO prompt payment requirement. • Contracts must hold Medicare members harmless for payment of fees that are the legal obligation of the M+CO. (Such provision will apply but not be limited to insolvency of the M+CO, contract breach, and provider billing, whereby no legal cause of action will be asserted against a beneficiary.) Language substantially similar to NAIC hold-harmless and continuation-of-benefits model language is required in all cases. • Contracts must contain accountability provisions specifying: <ol style="list-style-type: none"> 1. that first tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions [42 CFR §422.502(i)(4)(v)], and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 6 years; 2. that the M+CO oversees and is accountable to CMS for any functions and responsibilities described in the M+C regulations [42 CFR §422.502(i)(3)(ii)(A)]; and 	<p>elements <u>must</u> appear in all contracts between Cost HMOs/CMPs and providers of health services:</p> <ul style="list-style-type: none"> • Provider must agree to serve HMO/CMP members for a specific period of time • Provider must agree to provide services to all members, including Medicare • Provider must agree to not bill HMO/CMP members. Language substantially similar to NAIC hold-harmless and continuation-of-benefits model language only required if provider contract is used as beneficiary protection in case of insolvency. • Provider must agree to review by and cooperate with utilization management and quality assurance committee/staff. • Payment for services must be stated and incentive arrangements must be described, if any. • Contract must be signed and dated by both the HMO/CMP and the contracting provider. <p>42 CFR §417.407(f), §417.120(a) and §417.122(a) and (b)</p> <p>CMS (provider contract) Guidance dated June 16, 1994</p>

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	<p>3. that M+COs that choose to delegate functions must adhere to the delegation requirements in the M+C regulations [42 CFR §422.502(i)(3)(iii); §422.502(i)(4)].</p> <ul style="list-style-type: none"> • Contracts must specify that providers agree to comply with the M+C organization's policies and procedures. <p>OPL #77</p>	
Time frame for payment to non-contracting providers	An M+CO must generally make an initial determination on a request for payment of a “clean” claim from a non-contracting provider within 30 days and all other claims from non-contracting providers within 60 days. 42 CFR §422.520(a)	A Cost HMO or CMP must make an initial determination on a request for payment of a “clean” claim from a non-contracting provider within 30 days and all other claims from non-contracting providers within 60 days. Article IV.J.5. of the §1876 Cost contract with CMS
Amount of payment to non-contracting providers	In general an M+CO is responsible for payment for covered items and services to non-contracting providers of such payment amount (less any cost sharing due from the enrollee) as would otherwise be authorized under Parts A and B (including any permitted balance billing.) - Section 1852(a)(2)(A) of the Social Security Act. Providers are required to accept this payment as payment in full - §1852(k) and §1866(a)(1)(O) of the Social Security Act.	In general a Cost HMO/CMP is required to pay (less applicable member copays) no more for physicians services and renal dialysis services furnished by non-contracting physicians, providers of services and renal dialysis facilities than would be paid by original Medicare (including any permitted balance billing) - Section 1876(j) of the Social Security Act. In general, in so far as a Cost HMO/CMP is responsible for payment to a non-contracting hospital or SNF, Medicare charge limits would also apply - §1866(a)(1)(O) of the Social Security Act and OPL #43.
Provider participation	An M+CO must provide for the participation of individual physicians, and the management and members of groups of physicians, through reasonable procedures that include: (1) Written notice of rules of participation including	No requirement.

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	<p>payment and credentialing; (2) Prior written notice of material changes in participation rules. (3) Written notice of adverse physician participation decisions. (4) A process for appealing adverse decisions, including the right of physicians and other health care professionals to present information and their views on the decision. 42 CFR §422.202</p>	
Changes to provider network	<p>An M+CO must make a “good faith” effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination date to all enrollees who are seen on a regular basis by the provider. This includes all M+C eligible individuals who are members of a primary care professional’s patient panel. 42 CFR §422.111(e)</p>	<p>No specific requirement. However, see HMO/CMP Manual section 2210 for general guidance on notification requirements when rules change mid-year. Also, for continuity of care purposes, an HMO/CMP would need to notify members of primary care physician terminations. 42 CFR §417.106(c), 42 CFR §417.418(b) and 42 CFR §417.416(c)(3)</p>
Physician incentive plan regulation	<p>Applies. 42 CFR §422.208 and §422.210</p>	<p>Applies. 42 CFR §417.479</p>
Credentialing	<p>An M+CO must have written policies and procedures for the selection and evaluation of providers. These policies must conform with the detailed credential and recredentialing requirements set forth in the regulations. Basic benefits must be furnished through providers that meet the applicable conditions of participation. Institutional providers of basic benefits must be Medicare certified. 42 CFR §422.204; 42 CFR §422.100(i)</p>	<p>Cost HMOs and CMPs must furnish the required services to its enrollees through providers and suppliers that meet applicable Medicare statutory definitions and implementing regulations. 42 CFR §417.416</p>
Anti-discrimination	<p>An M+CO may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an M+CO declines to include a</p>	<p>No requirement.</p>

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	provider in its network, it must furnish written notice of the reason for the decision. 42 CFR §422.205	
Anti-indemnification	An M+CO may not contract or otherwise provide for a provider to indemnify the organization against any civil liability for damage caused to an enrollee as a result of the M+CO's denial of medically necessary care. Section 1852(j)(5) of the Social Security Act and 42 CFR §422.212	No requirement.
Marketing		
Terminology		
contracting entity	Medicare+Choice Organization (M+CO) - a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the M+C contract requirements. 42 CFR 422.2	Cost Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) - an HMO or CMP that has in effect a cost contract with CMS under section 1876 of the Act and subpart L of the 417 section of the 42 CFR. 42 CFR 417.401
what the member enrolls in	M+C plan - a health benefits coverage offered under a policy or contract by an M+CO that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area (or segment of a service area) of the M+C plan. 42 CFR 422.2	Cost Health Maintenance Organization (HMO) or Competitive Medicare Plan (CMP) - enrollment under the §1876 Medicare Cost program is at the organization, and not the plan, level. The Cost HMO/CMP enrollee can also be said to have enrolled in a "Cost plan" or "Cost plan benefit package."
other types of plans	M+C Private Fee-for-Service (PFFS) M+C Preferred Provider Organization (PPO) M+C Provider Sponsored Organization (PSO)	None
Prior approval	An M+CO must submit all marketing materials to CMS for approval prior to use/distribution. If CMS does not disapprove the materials	A Cost HMO/CMP must submit all marketing materials to CMS for approval prior to use/distribution. If CMS does not disapprove

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	within 45 days, they are deemed approved. If an M+CO submits material that follows CMS model language without modification, and CMS does not disapprove the materials within 10 days, they are deemed approved. 42 CFR 422.80 and Section 1851(h) of the Social Security Act	the materials within 45 days, they are deemed approved. 42 CFR §417.428
Deemed approval (across service area) - 1-stop shopping	If material is approved (or not disapproved within the applicable time frame) with respect to an M+C plan in an area, it is deemed approved in all other areas covered by the plan and organization except for any portion that is specific to an area. 42 CFR §422.80(d) and §1851(h)(3) of the Social Security Act	No provision.
Physician/Provider Marketing	CMS has concerns and generally discourages physician/provider marketing. However, despite concerns certain activities are specifically permitted. See section 50.2 of Chapter 3 (Marketing) of the Medicare Managed Care Manual.	CMS has concerns and generally discourages physician/provider marketing. However, despite concerns certain activities are specifically permitted. See section 50.2 of Chapter 3 (Marketing) of the Medicare Managed Care Manual.
Disclosure		
Evidence of coverage/annual disclosure	Required. 42 CFR §422.111(a) and (b)	Required. 42 CFR §417.436(a) and (b)
Disclosure of appeal and grievance data	M+COs must disclose to beneficiaries upon request grievance and appeals data including the number of disputes and disposition of disputes in the aggregate. 42 CFR §422.111(c)(3)	No requirement.
Notice of health plan withdrawal	M+COs must provide enrollees with 90 days notice prior to their withdrawal from the M+C program or the service area in which the enrollee resides. 42 CFR §422.506	Cost HMOs and CMPs must provide enrollees with 60 days notice prior to their withdrawal from the program or the service area in which the enrollee resides. 42 CFR §417.492
Provision of information concerning other health plans	M+COs must disclose to beneficiaries upon request: (1) a list of M+C plans that are or will be available to residents of the service area in	No requirement.

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	the following calendar year and specified information about those plans to facilitate a comparison; and (2) a general description of benefits, enrollment rights and requirements concerning Medicare Supplemental plans and Medicare Select policies. 42 CFR §422.111(e)	
Notice of changes in rules	M+COs must notify enrollees of any changes in rules at least 30 days in advance. If the change will take effect on January 1, 2003, 2004 or 2005, the M+CO must notify enrollees by the previous October 30. See the June 25, 2002 MCO letter explaining CMS implementation of §532 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002. If the change will take effect on January 1, 2006, or on January 1 of any later year, then the M+CO must notify enrollees by the previous October 15. 42 CFR §422.111(d)	Cost HMOs and CMPs must notify enrollees of any changes in rules at least 30 days in advance. 42 CFR §417.436(c)
Disclosures concerning quality assurance	M+COs must disclose to each enrollee at the time of enrollment and annually thereafter a description of the quality assurance program. 42 CFR §422.111(b)(9)	No requirement to disclose.
Disclosures concerning utilization review	M+COs must disclose to beneficiaries upon request the procedures the organization uses to control utilization and costs. 42 CFR §422.111(c)(2)	No requirement to disclose.
Disclosures of physician incentive plan data	M+COs must disclose to Medicare beneficiaries who request it the following information: (1) whether the M+CO uses a physician incentive plan that affects the use of referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) if the M+CO was required	Cost HMOs/CMPs must disclose to Medicare beneficiaries who request it the following information: (1) whether the M+CO uses a physician incentive plan that affects the use of referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) if the M+CO was required

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	to conduct a survey, a summary of the survey results. 42 CFR §422.210(b)	to conduct a survey, a summary of the survey results. 42 CFR §417.479(h)(3)
Disclosure of quality and performance indicators	M+COs must disclose to beneficiaries upon request and to the extent they are available the following: (1) disenrollment rates for the previous 2 years; (2) enrollee satisfaction; (3) health outcomes; (4) plan level appeals information; (5) a recent record of plan compliance with M+C regulatory requirements; and (6) other performance indicators. 42 CFR §422.111(f)(10)	No requirement for Cost HMOs and CMPs to provide the information to enrollees. However, CMS posts information concerning performance indicators, disenrollment rates, and enrollee satisfaction as part of its Medicare Compare database.

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Quality		
Quality assessment and performance improvement (QAPI)	M+COs must conduct quality assessment and performance improvement (QAPI) projects under QISMC. Medicare Managed Care Manual, Chapter 5 and 42 CFR §422.152(d)	No requirement.
Standards for quality assurance programs	M+COs must have arrangements for ongoing quality assurance programs that include specified elements. Section 1852(e) of the Social Security Act and 42 CFR §422.152	Cost HMOs and CMPs must have arrangements for ongoing quality assurance programs that include specified elements. 42 CFR §417.106 and 42 CFR §417.418
HEDIS, CAHPS and HOS	M+COs must report on specified HEDIS measures, CAHPS and HOS. See OPL #131	Cost HMOs and CMPs must report on specified HEDIS measures (which are different than those for M+COs - e.g., Cost HMOs and CMPs do not report on inpatient measures), CAHPS and HOS. See OPL #131
Relationship with peer review organizations (PROs)/Quality Improvement Organizations (QIOs)	Each M+CO must, for each M+C coordinated care plan it operates, have a written agreement with an independent quality review and improvement organization. 42 CFR §422.154	No requirement for a written agreement with an independent quality review and improvement organization. The Agreement between CMS and a Cost HMO or CMP must provide that the HMO or CMP will comply with the requirements for “PRO” review of services furnished to Medicare enrollees. 42 CFR §417.478 and Article IV.B. of the section 1876 Cost contract with CMS.
Compliance and Sanctions		
Compliance plan	M+COs must have a compliance plan that meets specified criteria including the appointment of a compliance officer and employee training. 42 CFR §422.501(b)(3)(vi)	No requirement.
Sanction authority	CMS has authority to impose civil monetary penalties on M+COs for specific violations. 42 CFR §422.752(a)	CMS does not have authority to impose civil monetary sanctions on Cost HMOs and CMPs. CMS may refer the issue to the OIG, which has the authority to impose civil monetary penalties on Cost HMOs and CMPs.

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Specific grounds for imposition of intermediate sanctions	CMS may impose intermediate sanctions (in the form of suspending marketing and enrollment) on an M+CO for failure to comply with the requirements that prohibit interference with a providers' advice to enrollees or for employing or contracting with an individual who is excluded from Medicare under section 1128 or 1128A of the Social Security Act (or with an entity that employs or contracts with such an individual) for the provision of health care, utilization review, medical social work or administrative services. In addition, CMS may suspend enrollment and marketing if the M+CO engages in any of the activities that are grounds for termination of the contract. 42 CFR §422.752(b)	42 CFR §417.500(g) Failure to comply with the requirements that prohibit interference with a providers' advice and employing or contracting with individuals excluded under 1128 or 1128A are specific grounds for intermediate sanctions for Cost HMOs and CMPs (in the form of suspending marketing and enrollment). See 42 CFR §417.500(d).
Grounds for contract termination	CMS may terminate an M+CO's contract if the M+CO engages in any of the activities set forth in the column at the right (for Cost HMOs and CMPs) and any of the following: (1) committing or participating fraudulent or abusive activities affecting the Medicare program, including submission of fraudulent data; (2) experiencing financial difficulties so severe to impair its ability to make health services available to the point of posing a risk to enrollee health; (3) failing to comply with the requirements relating to grievances and appeals; (4) failing to provide valid encounter data; (5) failing to implement an acceptable quality assessment and performance improvement program; (6) substantially failing to comply with the prompt payment	CMS may terminate a Cost HMO or CMP's contract if the HMO or CMP: (1) fails substantially to carry out the terms of the contract (2) carries out the contract in a manner that is inconsistent with the effective and efficient implementation of [section 1876 of] the Act; or if (3) CMS determines that the HMO or CMP no longer meets the requirements of [section 1876 of] the Act for being a contracting organization. 42 CFR §417.494(b)

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	requirements in §422.520 or with the service access requirements in §422.112 or §422.114; (7) failing to comply with the requirements regarding physician incentive plans in §422.208; or (8) substantially failing to comply with the marketing requirements in §422.80. 42 CFR §422.510(a)	
Certification of data	An M+CO's CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers must request payment under the contract on a document that certifies (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of relevant data that CMS requests. Such data include specified enrollment information, encounter data, and other information that CMS may specify. 42 CFR §422.502(l)	No similar requirement. However, an Medicare Cost HMO/CMP's "final" cost reports must be independently certified. 42 CFR §417.576
Miscellaneous		
Part B premium reduction as a benefit	M+COs are permitted to offer Part B premium reduction as an indirect benefit to enrolled Medicare members. Can only be offered as an "additional" benefit and must be offered in a uniform manner to all enrollees of a plan. Section 1854(f)(1)(E) of the Social Security Act.	No similar provision.
State premium taxes	No premium tax, fee, or other similar assessment may be imposed by any State or political subdivision or other governmental authorities with respect to any payment CMS makes on behalf of M+C enrollees. 42 CFR §422.404 and §1854(g) of the Social security Act.	Payments by CMS to a cost contractor for covered services rendered to Medicare enrollees do not properly constitute premiums and, thus, should not subject to state and local premium taxes. Premium taxes assessed against a Medicare HMO/CMP for member premiums are allowable costs, if there are no exemptions under state or local law that an HMO/CMP can use to legally avoid the

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		assessment of a premium tax. Generally, the amount CMS will reimburse a Cost HMO/CMP for properly assessed premium taxes is only the amount of the assessment that is applicable to premiums charged to Medicare enrollees for covered services. See Chapter 17, subchapter B sections 410 and 410.1 of the Medicare Managed Manual.
Guaranteed issue Medigap rights upon nonrenewal	Members of a non-renewing M+C plan have specific “guarantee issue” Medigap rights. §1882(s)(3)(A), (B) and (C) of the Social Security Act	Members of a non-renewing Cost HMO/CMP have specific “guarantee issue” Medigap rights. §1882(s)(3)(A), (B) and (C) of the Social Security Act
Preemption	<p>The rules, contract requirements, and standards established under the M+C program explicitly supersede:</p> <p>(A) Any <u>inconsistent</u> State laws, regulations, contract requirements (General theories of preemption would apply), and</p> <p>(B) All State laws pertaining to the following areas:</p> <ul style="list-style-type: none"> - Benefit requirements, including cost-sharing requirements - Requirements relating to inclusion or treatment of providers - Coverage determinations, including related appeals and grievance processes - Marketing <p>42 CFR §422.402</p>	<p>No explicit preemption provision. General theories of preemption would apply.</p> <p>Note that §1876(c)(2)(A)(i) and (ii) of the Social Security Act require Cost HMOs/CMPs to offer a “Medicare only” package. In so far as states mandate certain non-Medicare benefits, these non-Medicare benefits can only be offered as optional supplemental benefits. Also see 42 CFR 417.440(b)(2).</p>

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Return to “home” SNF	An M+CO is required to provide “coverage for post-hospital extended care services” through a “home skilled nursing facility” in certain cases where an enrollee elects to receive services through such a facility and where the facility agrees to accept the M+CO’s contracted payment rate. Section 1852(l) of the Social Security Act.	No similar provision.
Employer group only plans permitted	M+COs are permitted to create plans in which only employer group members may enroll. These employer group only plans may have distinct benefits, premiums and copays and may be available in service areas that are not served by plans available to individual enrollees. Section 1857(i) of the Social Security Act.	Cost HMOs/CMPs must offer employer group members at least the basic benefit package offered to individual Medicare members. Cost HMOs/CMPs may also offer “extra” benefits to employer group members beyond those benefits offered to individual Medicare members. Such “extra” benefits are not supplemental benefits, are not offered pursuant to the Social Security Act and are therefore not subject to CMS review or approval. HMO/CMP Manual (HCFA Pub. #75) §2109.1
New contracts and service area expansions	M+COs can sign new contracts with CMS and expand service areas into new counties within an existing State and also into new states - provided M+C requirements are met.	CMS is prevented from signing new contracts with section 1876 Cost HMOs/CMPs effective August 5, 1997 - the date the BBA was signed into law. Existing Cost HMOs/CMPs will currently “sunset” on 12/31/2004. Existing Cost HMOs/CMPs can expand their service areas through September 1, 2003 - provided applicable standards are met. Section 1876(h)(5)(B) and (C) of the Social Security Act as amended by §634 of BIPA.
Records retention	In general, records related to enrollment/disenrollment, financial records, other records, documents and any other evidence of accounting procedures and practices must be retained for at least six years.	In general, a Cost HMO/CMP must retain records and make them available for CMS inspection for the current contract period and the prior three contract periods. Records are to be retained and available for CMS inspection

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	42 CFR §422.502(d) and (e)	for three years after final “cost” settlement. 42 CFR 417.482(f), articles IV.E.4. and 5. of the section 1876 Cost contract with CMS.
Encounter data	M+COs must submit encounter data to CMS in order to allow CMS to provide for risk adjustment. Section 1853(a)(3)(B) of the Social Security Act.	No requirement.
User fees	The Secretary is authorized to charge a fee to each M+CO equal to the organization’s pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect for beneficiary education activities. Section 1857(e)(2) of the Social Security Act	No provision.