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# CMS Manual System

## Pub. 100-16 Medicare Managed Care

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Department of Health &  
Human Services (DHHS)  
Centers for Medicare &  
Medicaid Services (CMS)

Transmittal 67

Date: August 12, 2005

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**SUBJECT: Changes in Requirements for Periodic Surveys of Current and Former Enrollees, and in the CMS Method for Calculating Interest on Overpayments and Underpayments to HMOs, CMPs and HCPPS.**

**I. SUMMARY OF CHANGES:** This revision eliminates the requirements in Chapter 6, for CAHPS surveys and for periodic surveys of current and former enrollees that have been required in connection with physician incentive plans. It also changes the method shown in Chapters 17A and 18A by which CMS calculates interest on overpayments and underpayments to HMO/CMPs and HCPPs. Effective October 1, 2004, interest will be assessed only for full 30-day periods when payment is not made on time.

**II. CHANGES IN MANUAL INSTRUCTIONS: (R = REVISED, N = NEW, D = DELETED)**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.*

**NEW/REVISED MATERIAL - EFFECTIVE DATE: August 1, 2005**

<b>R/N/D</b>	<b>CHAPTER/SECTION/SUBSECTION/TITLE</b>
R	6/80.1/Physician Incentive Plans
R	6/80.2/Disclosure of Physician Incentive Plans

**NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004**

<b>R/N/D</b>	<b>CHAPTER/SECTION/SUBSECTION/TITLE</b>
R	17A/30.1.1/The Basic Rules
R	18A/30.1.1/The Basic Rules

**III. ATTACHMENTS:**

	<b>Business Requirements</b>
<b>X</b>	<b>Manual Instruction</b>
	<b>Confidential Requirements</b>
	<b>One-Time Special Notification</b>

## **80 - Physician Incentive Plans**

### **80.1 - Requirements and Limitations**

*(Rev. 67, Issued: 08-12-05; Effective: 08-01-05)*

#### **Definitions**

**Bonus** means a payment made to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withhold.

**Capitation** means a set dollar payment per patient per unit of time (usually per month) paid to a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

**Physician Group** means a partnership, association, corporation, individual practice association, or other group of physicians that distributes income from the practice among members. An individual practice association is defined as a physician group for this section only if it is composed of individual physicians and has no subcontracts with physician groups.

**Physician Incentive Plan** means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.

**Potential Payments** means the maximum payments possible to physicians or physician groups including payments for services they furnish directly, and additional payments based on use and costs of referral services, such as withholds, bonuses, capitation, or any other compensation to the physician or physician group. Bonuses and other compensation that are not based on use of referrals, such as quality of care furnished, patient satisfaction or committee participation, are not considered payments in the determination of substantial financial risk.

**Referral Services** means any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish directly.

**Risk Threshold** means the maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. This is set at 25 percent risk.

**Substantial Financial Risk**, for purposes of this section, means risk for referral services that exceeds the risk threshold.

**Withhold** means a percentage of payments or set dollar amounts deducted from a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.

### **Applicability**

The requirements in this section apply to an MA organization and any of its subcontracting arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Subcontracting arrangements may include an intermediate entity, which includes, but is not limited to, an individual practice association that contracts with one or more physician groups or any other organized group, such as those specified at 42 CFR 422.4.

Note that there is a statutory prohibition on physician incentive plans for MA private fee-for-service plans. Accordingly, an MA private fee-for-service plan may not operate a physician incentive plan.

(Source: [§1859\(b\)\(2\)\(A\)](#); [42 CFR 422.208\(e\)](#).)

### **Basic Requirements**

Any physician incentive plan operated by an MA organization must meet the following requirements:

1. The MA organization makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.
2. If the physician incentive plan places a physician or physician group at substantial financial risk (as determined below) for services that the physician or physician group does not furnish itself, the MA organization must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection (as described below)
3. For all physician incentive plans, the MA organization provides to CMS the information specified in [§80.2](#).

### **Determination of Substantial Financial Risk**

Substantial financial risk occurs when risk is based on the use or costs of referral services, and that risk exceeds a risk threshold of 25 percent of potential payments. (Payments based on other factors, such as quality of care furnished, are not considered in this determination.)

The following incentive arrangements cause substantial financial risk within the meaning of this section, if the physician's or physician group's patient panel size is not greater than 25,000 patients (shown in the table below):

1. Withholds greater than 25 percent of potential payments.
2. Withholds less than 25 percent of potential payments if the physician or physician group is potentially liable for amounts exceeding 25 percent of potential payments.
3. Bonuses that are greater than 33 percent of potential payments minus the bonus.
4. Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula:

$$\text{Withhold \%} = -0.75 (\text{Bonus \%}) + 25\%.$$

5. Capitation arrangements, if:
  - a. The difference between the maximum potential payments and the minimum potential payments is more than 25 percent of the maximum potential payments; and
  - b. The maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group.
6. Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25 percent of potential payments.

### **Stop-Loss Protection Requirements**

The MA organization assures that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

1. Aggregate stop-loss protection must cover 90 percent of the costs of referral services that exceed 25 percent of potential payments.
2. For per-patient stop-loss protection if the stop-loss protection provided is on a per-patient basis, the stop-loss limit (deductible) per patient must be determined based on the size of the patient panel and may be a combined policy or consist of

separate policies for professional services and institutional services. In determining patient panel size, the patients may be pooled (as described below).

3. Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per patient deductible limit. The per-patient stop-loss deductible limits are as follows:

<b>Panel Size</b>	<b>Single Combined Deductible</b>	<b>Separate Institutional Deductible</b>	<b>Separate Professional Deductible</b>
1-1,000	\$6,000	\$10,000	\$3,000
1,001-5,000	30,000	40,000	10,000
5,001-8,000	40,000	60,000	15,000
8,001-10,000	75,000	100,000	20,000
10,001-25,000	150,000	200,000	25,000
>25,000	None	None	None

### **Pooling of Patients**

Any entity that meets the pooling conditions of this section may pool commercial, Medicare, and Medicaid enrollees or the enrollees of several MA organizations with which a physician or physician group has contracts. The conditions for pooling are as follows:

1. It is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group;
2. The physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled;
3. The terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled;
4. The distribution of payments to physicians from the risk pool is not calculated separately by patient category; and
5. The terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled.

## Sanctions

An MA organization that fails to comply with the requirements of this section is subject to intermediate sanctions.

(Source: [42 CFR 422.208.](#))

## 80.2 - Disclosure of Physician Incentive Plans

*(Rev. 67, Issued: 08-12-05; Effective: 08-01-05)*

### Disclosure to CMS

*Each organization will provide assurances satisfactory to the Secretary that physician incentive plan requirements are met. MA organizations must provide to CMS information concerning physician incentive plans as requested.*

### Disclosure to Medicare Beneficiaries

Each MA organization must provide the following information to any Medicare beneficiary who requests it:

1. Whether the MA organization uses a physician incentive plan that affects the use of referral services;
2. The type of incentive arrangement; *and*
3. Whether stop-loss protection is provided.

*In addition, MA organizations that are included in the Consumer Assessments of Health Plans Study (CAHPS) Survey should give Medicare enrollees a copy of the CAHPS enrollment survey results available on the [www.medicare.gov](http://www.medicare.gov) website or direct enrollees to where on the website CAHPS survey results for their plan may be found.*

(Source: [42 CFR 422.210.](#))

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## CHAPTER 17A

### 30.1.1 - The Basic Rules

*(Rev. 67, Issued: 08-12-05; Effective: 10-01-04)*

The CMS will charge interest on overpayments and pay interest on underpayments to HMO/CMPs, except as specified in [§§30.2.2](#) and [30.4](#).

Interest will accrue from the date of the final determination as defined in §30.1.2, and either will be charged on the overpayment balance or paid on the underpayment balance for each 30-day period that payment is delayed. *Effective October 1, 2004, interest will be assessed only for full 30-day periods when payment is not made on time.* For example, if there is an outstanding balance due CMS or the HMO/CMP for 45 days beginning on the day after the date of the final determination, *only one month* of interest will be assessed.

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## CHAPTER 18A

### 30.1.1 - The Basic Rules

*(Rev. 67, Issued: 08-12-05; Effective: 10-01-04)*

The CMS will charge interest on overpayments and pay interest on underpayments to HCPPs, except as specified in [§§30.2.2](#) and [30.4](#).

Interest will accrue from the date of the final determination as defined in §30.1.2, and either will be charged on the overpayment balance or paid on the underpayment balance for each 30-day period that payment is delayed. *Effective October 1, 2004, interest will be assessed only for full 30-day periods when payment is not made on time.* For example, if there is an outstanding balance due CMS or the HCPP for 45 days beginning on the day after the date of the final determination, *only one month* of interest will be assessed.