Medicare Managed Care:

A Regulatory Overview
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NAIC
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The growth in the percent of Medicare beneficiaries enrolled in the Medicare managed care program is expected to continue. In 1985, 3.5 percent of Medicare beneficiaries were enrolled in Medicare managed care plans. By December 1, 1996, approximately 12 percent of the 37 million Medicare beneficiaries were receiving their health care through managed care plans. The vast majority of Medicare beneficiaries who have enrolled in a Medicare managed care plan are receiving health care services from a managed care organization which has contracted with the Health Care Financing Administration or a risk as opposed to cost basis.

Even more noticeable is the number of organizations which have begun or plan to offer services to Medicare enrollees. In June 1985, there were 174 prepaid organizations which participated in the Medicare managed care program and provided services to nearly 1.2 million enrollees. As of December 1, 1996, 336 prepaid organizations were contracting with the Medicare program and providing services to nearly 4.8 million enrollees. Approximately 70 percent of the member organizations of the American Association of Health Plans currently provide or plan to provide managed care services to Medicare beneficiaries by 1997.

The rate of growth has been most significant in states with high or long-standing commercial managed care penetration such as Arizona, California, Hawaii, and Oregon. Industry watchers expect Medicare managed care to expand into eastern markets.

What types of organizations may contract with the Health Care Financing Administration to deliver managed care services to Medicare beneficiaries?

Section 1876 of the Social Security Act (42 U.S.C. §1395mm) and the implementing regulations (42 C.F.R. 417.1 et seq.) authorize the Department of Health and Human Services (HHS) Health Care Financing Administration (HCFA) to enter into Medicare managed care risk or cost contracts with federally qualified HMOs or competitive medical plans (CMPs) to arrange

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1 This document provides general information on the Medicare Managed Care program. It is an educational document developed for the membership of the National Association of Insurance Commissioners and is intended to be updated by the NAIC on a periodic basis. This document is not a comprehensive, exhaustive summary of any of the components of the Medicare Managed Care program or the relevant regulatory issues. The information provided in this document was gathered from some of the relevant laws and through conversations with a few state regulators and HCFA officials.


3 Health Care Financing Administration, U.S. Department of Health and Human Services, Medicare Managed Care Report (As Of December 1, 1996) [HCFA Report]. The Medicare program consists of aged, disabled, and end stage renal disease (ESRD) beneficiaries. In 1995, approximately 95 percent of Medicare managed care enrollees were aged beneficiaries. 1996 Statistical Supplement, at 129.

4 HCFA Report

5 HCFA Report

or deliver services to beneficiaries. These organizations must make adequate provision against the risk of insolvency, have sufficient administrative capacity to carry out contractual requirements, and assure that they do not have any agents, managers, or owners who have been convicted of Medicare or Medicaid fraud. They must also have adequate network arrangements, quality improvement programs, and appeals and grievance processes. In addition to their internal quality improvement and complaints processes, the managed care organizations are subject to external quality monitoring by an independent review organization (called peer review organizations or PROs) in every state and beneficiaries have full Medicare appeal rights beyond what is offered by the plan. At least 50 percent of the entity’s total membership must be enrolled from sources other than Medicare and Medicaid. Under limited circumstances, HCFA may waive this 50 percent requirement.  

HCFA may also enter into agreements on a non-risk basis with health care prepayment plans that comply with § 1882 of the Social Security Act and with federal and state Medicare supplement insurance requirements.

HCFA’s Office of Research and Demonstrations recently began a demonstration project called Medicare Choices. The Medicare Choices demonstration is designed to expand the types of managed care plans and methods of payment available in the Medicare managed care program. Most of the organizations that have been selected are either organizations sponsored by or in partnership with providers.

Who may enroll in Medicare managed care programs?

Medicare beneficiaries who have a right to enroll with a contracting organization are those individuals enrolled under Medicare Part A and Part B or enrolled under Part B only (except those medically determined to have end-stage renal disease or those beneficiaries who have elected to receive hospice care prior to enrollment). Medicare beneficiaries include persons 65 years of age and older and certain persons under 65 and on Medicare due to disabilities. Medicare contracting organizations must provide an annual open enrollment period of at least 30 consecutive days for Medicare beneficiaries during each contract year, but can enroll beneficiaries at any time if the HMO’s or CMP’s Medicare enrollment capacity has not been reached. During open enrollment, the HMO or CMP must enroll eligible Medicare beneficiaries in the order in which their applications are received and until enrollment capacity is reached.

7 42 U.S.C. § 1395nn(b). Federally qualified HMOs must meet the requirements of the federal HMO Act 42 U.S.C. § 300e as well as the Medicare requirements outlined in 42 U.S.C. § 1395mm. The requirements for Competitive Medical Plans (CMPs) are not as extensive as those for HMOs. 42 C.F.R. § 417.407 (1995).
8 Id. and 42 C.F.R. § 417.412. It should be noted that risk plans must assume full financial risk on a prospective basis.
9 42 U.S.C. § 1395mm(6)(2) and 42 C.F.R. § 417.413(d).
10 For further information see discussion on Health Care Prepayment Plans in this document.
11 Specifically, Medicare Part A benefits (hospital insurance) are “provided automatically to persons 65 years of age or over and to most persons who are disabled for at least 24 months who are entitled to Social Security or Railroad Retirement Benefits” 1996 Statistical Supplement at 1. Part B benefits (supplemental medical insurance) “are available to almost all resident citizens 65 years of age or over; to certain aliens 65 years of age or over — even those who are not entitled to Part A services; and to disabled beneficiaries entitled to Medicare Part A.” 1996 Statistical Supplement at 2.
12 42 C.F.R. § 417.426.

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HMOs and CMPs may only close their Medicare enrollment when it would result in the organization exceeding the 50 percent requirement of its Medicare enrollment capacity, not meeting other qualifying conditions, or becoming significantly unrepresentative of the general population in the organization’s geographic area. HMOs and CMPs may not impose waiting periods on eligible beneficiaries for Medicare covered services related to a preexisting conditions under the Medicare managed care program.

What kind of benefits may managed care contractors provide?

HCFA may enter into capitation contracts with HMOs or CMPs to provide benefits to eligible Medicare beneficiaries. The beneficiaries must receive all benefits and services covered under Medicare Part A and Part B. Except, if the beneficiary is only enrolled under Medicare Part B, the enrollee need only receive services covered under Part B. In addition, the HMO or CMP is not obligated to provide or arrange hospice care. The managed care plan can supplement Medicare benefits with optional supplemental benefits not covered by fee-for-service Medicare. Managed care plans may and sometimes are required to provide additional benefits or to reduce beneficiary cost-sharing.

Under what circumstances may Medicare beneficiaries disenroll or be disenrolled from a Medicare managed care program?

Medicare beneficiaries have the right to disenroll from an HMO or CMP at any time. Disenrollment becomes effective the first day of the month following the plan’s receipt of a signed and dated disenrollment request in a format established by HCFA. However, an HMO or CMP may not request or encourage a Medicare beneficiary to disenroll except under very limited circumstances. The HMO or CMP may disenroll a Medicare enrollee under certain conditions when the beneficiary fails to pay premiums or other charges. In addition, disenrollment may occur when the beneficiary’s entitlement has ended or the beneficiary commits fraud. HMOs and CMPs may also disenroll Medicare enrollees for cause. For cause circumstances are those in which the enrollee engages in disruptive or unruly behavior. Disenrollment on a for cause basis may only occur after efforts have been made to resolve the problem and extenuating circumstances have been considered. The documentation supporting disenrollment by an HMO or CMP for cause is reviewed by HCFA.

Also, when the HMO or CMP receives written notification that an enrollee has permanently moved out of the HMO or CMP service area, the HMO or CMP must disenroll the Medicare beneficiary. However, the law provides an exception to this rule. When an enrollee will be absent from the geographic service area for an uninterrupted period of more than 90 days but less than one year, the HMO or CMP and the enrollee may agree that the enrollee will be retrained.

17 42 C.F.R. § 417.424(a).
18 42 U.S.C. § 1395mm(c)(2)(A).
19 42 C.F.R. § 417.414(b)(3). A Medicare beneficiary that is enrolled under the Medicare managed care program can receive hospice services that are reimbursed through Medicare’s fee-for-service program.
20 42 C.F.R. § 417.461.
21 42 C.F.R. § 417.460.
by the HMO or CMP. The HMO or CMP that makes this exception for these temporarily absent enrollees must do so for all Medicare enrollees who are absent temporarily. Nevertheless, the HMO or CMP can limit the use of this exception to those enrollees who will be located in a geographic area where an affiliated HMO or CMP (i.e., an organization under common membership or control) is located.18 If the enrollee is absent from the retaining HMO or CMP’s service area for more than one year, the HMO or CMP must disenroll the Medicare beneficiary.

Other instances where the HMO or CMP must disenroll a Medicare beneficiary involves when the enrollee is no longer entitled to Medicare Part B benefits, dies, or does not convert to the HMO or CMP’s Medicare risk contract provisions. When an HMO or CMP converts from a cost to a risk contract, if the nonrisk Medicare beneficiary refuses to convert to the risk provisions, the HMO or CMP may disenroll the beneficiary when HCFA determines that nonrisk enrollees must be converted.19

Medicare Managed Care: Risk Contracts

What are Medicare risk contracts?

Under a Medicare risk contract, HCFA pays HMOs/CMPs to provide all applicable Medicare benefits to Medicare beneficiaries on a capitated basis (per member per month). In exchange for this prospective payment, the HMO/CMP, with a few exceptions, assumes all financial risk associated with the health care for Medicare enrollees.

What enrollment requirements must a managed care organization meet to be awarded a risk contract?

To be awarded a Medicare risk contract, an HMO or CMP must also have at least 5,000 non-Medicare and non-Medicaid eligible members.20 Except, the Secretary of DHHS may contract with an organization with as few as 1,500 members if the organization resides in a primarily rural area.21

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18 For further information, see HCFA Office of Managed Care Operational Policy Letter #42, Visitor Program -- Affiliate Option, November 5, 1996.
19 42 C.F.R. § 417.413(b). HMOs or CMPs that apply for a second contract may, under certain circumstances, not have to demonstrate again that they have met the commercial enrollee requirement.
20 42 U.S.C. § 1395mm(g) and 42 C.F.R. § 417.413(b). According to the regulation, an entity is rural if at least 50 percent of its enrollees reside in nonmetropolitan areas, those areas which are not part of Metropolitan Statistical Area (MSA) and that does not contain a city whose population exceeds 50,000 individuals. 42 C.F.R. § 417.413(b)(3).
What requirements are placed on beneficiaries enrolled in a Medicare managed care risk plan?

Enrollees are restricted ("locked-in") to the managed care organization's network, except for emergency and out-of-area urgently-needed services. Unless the Medicare managed care plan offers a point-of-service (POS) benefit, reimbursement will not be provided for health care services received outside of the network, except under emergency or urgent conditions, when the beneficiary is out of the area.22

The POS benefit enables an enrollee to seek care outside of the network for specified services. When so doing, the enrollee is responsible for a greater portion of the cost of the care received. Medicare risk plans can offer point-of-service benefits either as an optional supplemental benefit, mandatory supplemental benefit, additional benefit, or employer financed benefit. (For additional information, see HCFA's Guidelines on The Point of Service Benefit for Medicare Beneficiaries Enrolled in Risk Plans).

What additional kind of benefits may managed care risk plans provide?

In addition to the benefits required by the Medicare program (Part A and B services), the risk HMO/CMP may offer optional supplemental benefits and mandatory supplemental benefits which are approved by the Secretary of DHHS. Mandatory supplemental benefits are additional benefits that the beneficiary obtains by enrolling in the plan. Mandatory supplemental benefits may only be disapproved if the Secretary concludes that the offering of the services will substantially discourage enrollment.23 The managed care entity can offer mandatory supplemental benefits either at no extra cost to the beneficiary or the plan can require the beneficiary to purchase the benefits as a condition of enrolling in the plan. The plan's premium usually includes the cost of these additional benefits. Plans may also offer optional supplemental benefits. These additional benefits are purchased at the option of the beneficiary.24

How are payments calculated for risk contracts?

Currently, payments to Medicare risk HMOs and CMPs are based on 95 percent of the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is the rate Medicare estimates it would pay if services were provided on a fee-for-service basis. The AAPCC differs by county and is further adjusted by other characteristics such as age, sex, Medicaid status, or type of

22 For emergency care, a beneficiary can receive care outside of the managed care network when within and without of the service area. With respect to urgent care, beneficiaries can only receive care outside of the managed care network when outside of the service area.
24 For additional information on HCFA benefit policy, see HCFA Office of Managed Care Policy Letter #30 [revised] Clarification of HCFA Benefit Policies (Definitions), October 28, 1996.

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enrollee institutional status. This reimbursement mechanism is currently under review by HCFA.25 Any savings demonstrated by the HMO/CMP must be used to provide additional benefits to enrollees. Savings are the difference between the HMO's/CMP's average per capita rates of payment (APR) and the weighted average of the per capita rates based on the organization's expected Medicare enrollment distribution for that year (called adjusted community rate - ACR). Additional benefits can be in the form of a reduction in premium or other charges (such as copayments), benefits other than those covered under Part A or Part B, or a combination. The HMO/CMP also has the option, which is rarely used, of requesting a reduction in its monthly payment from HCFA if its ACR is less than its APR.26 Further, the HMO/CMP has another rarely used option of setting aside funds in the Benefit Reserve Stabilization Fund.

What is the future of Medicare risk contracts?

The Medicare risk program has become the predominant form of Medicare managed care contracting. Enrollment in Medicare risk contracts has increased substantially in the past few years. Since January 1, 1993, enrollment in risk plans has doubled.27 As of December 1, 1996, 241 plans held risk contracts. The interest of managed care health plans in entering into Medicare risk contracts is expected to continue to grow.

Medicare Managed Care: Cost Contracts

What are Medicare cost contracts?

Under a Medicare cost contract, HCFA pays HMOs/CMPs the reasonable costs of the services it provides to Medicare enrollees. The payments also include administrative costs. HMOs/CMPs contract on a cost basis when it chooses to do so, does not have sufficient number of enrollees to contract on a risk basis, or the Secretary of DHHS is not confident that the entity has the capacity to bear the risk.28 In some cases, a managed care organization will begin its relationship with the Medicare managed care program through a cost contract and switch to a risk contract once it has become comfortable with its Medicare managed care operations.

25 See Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem, United States General Accounting Office, November 1995 for an overview of perceived shortcomings in compensation formula.
26 42 C.F.R. § 417.592.
27 1996 Statistical Supplement at 127.
28 42 U.S.C. § 1395mm(b)(1).

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What enrollment requirements must a managed care organization meet to be awarded a cost contract?

To be awarded a Medicare cost contract, an HMO/CMP must have at least 1,500 non-Medicare and non-Medicaid eligible enrollees and reach acceptable Medicare enrollment over a period of time.28

What requirements are placed on beneficiaries enrolled in a Medicare managed care cost plan?

Medicare beneficiaries are not subject to the same restrictions under cost contracts that they are subject to under risk contracts. Enrollees who participate in Medicare cost HMOs/CMPs are not "locked in" to receiving care exclusively from the HMO/CMP. If the Medicare beneficiary decides to obtain services from a non-affiliated provider, fee-for-service Medicare will pay for services obtained from non-affiliated providers of the cost-based HMO/CMP. However, the deductibles and copayments are the responsibility of the Medicare beneficiary.29 If the HMO/CMP refers a beneficiary to a non-affiliated provider for a specific service not provided within the network, the provider will receive reimbursement from the HMO/CMP.

What additional benefits may managed care cost contracts provide?

Unlike risk HMOs/CMPs, cost HMOs/CMPs are not required to provide additional benefits free of charge. However, they must offer a basic package of Part A and Part B benefits and may offer a broader package of health care benefits which could be purchased for an additional charge.

How are payments calculated for cost contracts?

The HMO/CMP receives a monthly amount for each Medicare enrollee which is based on the estimated per capita cost of providing services to the Medicare enrollees. A final adjustment is made to this amount as the end of the contract period.31 The adjustment reflects the difference between the total monthly payments and the actual amount of reimbursement due for the care provided to each enrollee.32 The HMO/CMP can request in writing to HCFA that the Medicare fiscal intermediary or carrier make payments directly to the hospitals and skilled nursing facilities on behalf of the HMO/CMP. If this is done (and it usually is), the reimbursement to the HMO/CMP will be reduced accordingly.33

28 42 C.F.R. § 417.411(c).
29 Id.
30 42 C.F.R. § 417.532(b). As is the case with Medicare risk contracting organizations, HMOs or CMPs that apply for a second contract must, under certain circumstances, not have to demonstrate again that they have met the commercial enrollee requirement.
31 Id.
32 42 C.F.R. § 417.532(c).

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What is the future of Medicare cost contracts?

As of December 1, 1996, there were only 36 Medicare cost contracts. Discussions have been held from time to time about phasing out cost contracts. Their future is unclear at this time.

Medicare Managed Care: Health Care Prepayment Plan Agreements

What are Health Care Prepayment Plan contracts?

Health Care Prepayment Plans (HCPP) enter into agreements with Medicare on a non-risk basis to provide Part B services only to Medicare beneficiaries. They are reimbursed on a reasonable cost basis. Unlike HMOs and CMPs engaged in risk and cost contracts under § 1876 of the Social Security Act, the requirements for HCPPs are minimal, HCPPs are not required to provide all of the services available that are covered by Medicare Part B, although some go as far as providing all Part B services and arranging for Part A services. In addition, HCPPs may limit enrollment to a particular group of beneficiaries such as union members.

What is the future of Health Care Prepayment Plans?

Under the Social Security Amendments of 1994, HCPPs were made subject to Medigap requirements effective January 1, 1996. Because Medigap requirements (except for Medicare Select) prohibit the use of networks and require coverage of both Part A and Part B services, the future existence of HCPP agreements is in question. However, it should be noted that union and employer-related plans organized under § 1882(g)(1) of the Social Security Act and risk or cost contracts organized under § 1876 of the Social Security Act are not required to comply with Medigap requirements. It should also be noted that Medicare beneficiaries who were enrolled in an HCPP when the Social Security Amendments of 1994 became effective had the option of remaining in the HCPP. As of December 1, 1996, there were only 50 HCPPs.

In addition to the managed care program administered by the federal Department of Health and Human Services Health Care Financing Administration, Medicare beneficiaries that choose not to enroll in a Medicare managed care plan and to remain in fee-for-service Medicare will have another managed care option. Some fee-for-service Medicare beneficiaries purchase Medicare supplemental insurance (also called “Medigap”) to cover Medicare coinsurance and deductibles and services not covered by Medicare. Federal law allows up to 16 standardized Medigap policies to be sold in a particular state. A particular form of Medicare supplemental insurance offered in some states, called Medicare SELECT, involves managed care concepts. It


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was created by Congress in the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) as a demonstration project.

Medicare Select

**What is Medicare SELECT?**

Medicare SELECT policies are a form of standardized Medicare supplemental insurance that involves a managed care component. In order to receive full coverage for benefits and a discounted premium rate under the Medigap policy, the policyholder must use a network of preferred providers (except in cases of emergent or urgent out-of-area care). If a Medicare SELECT enrollee does not use a preferred provider, the company that issued the Medicare supplemental policy may or may not reimburse for all or part of the out-of-network care. Medicare will pay its portion of the bill irrespective of whether the supplemental services are obtained out-of-network.

**How does the Medicare SELECT program differ from the Medicare managed care program?**

Medicare SELECT differs from Medicare managed care in several respects. Medicare SELECT is a policy that covers the cost of services not covered by the Medicare program. Under Medicare managed care, managed care plans may provide services not covered by Medicare without additional cost to the Medicare beneficiary and waive Medicare's deductible and coinsurance amounts (although the plan may impose a monthly premium and/or nominal cost-sharing requirements). Additionally, Medicare SELECT policies reimburse providers on a fee-for-service basis; in contrast, Medicare managed care plans provide services on a prepaid basis and often capitate providers. Further, if a Medicare SELECT enrollee receives care out-of-network, the Medicare program will pay the cost-sharing for all services covered by the Medicare program. However, it will generally not do so if a Medicare managed care enrollee obtains services out-of-network. Finally, Medicare SELECT policies are regulated at both the federal and state level, while the Medicare managed care program is regulated predominantly at the federal level.

**What is the future of Medicare SELECT?**

Medicare SELECT began as a demonstration project in 15 states in 1992 and was authorized for all 50 states in 1995. The program will become permanent in 1998 unless HHS determines that Medicare costs have significantly increased, access and quality have significantly decreased, or premiums are not less expensive than under traditional Medigap policies.

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State Regulation and Medicare Managed Care

With the increased activity in the Medicare managed care market, states are seeking more information on the structure of the Medicare managed care program and its impact on their regulatory responsibilities. Below is a preliminary, initial review of state regulatory issues related to Medicare managed care plans derived from a preliminary review of the law, conversations with HCFA representatives, and a small sample of state insurance regulators.

What kinds of state laws are specifically prohibited by federal law?

Federal law specifically prohibits six types of state laws if they prevent federally qualified HMOs from operating as HMOs. Under 42 U.S.C. § 300e-10, states cannot prevent federally qualified health maintenance organizations from operating as HMOs through laws which:

(A) require as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,
(B) require that physicians constitute all or a percentage of its governing body,
(C) require that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity,
(D) require that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, or
(E) impose requirements which would prohibit the entity from complying with the requirements of title XIII of the Public Health Service Act (also known as the federal HMO Act).

Under 42 U.S.C. § 300e-10(b), states are also prohibited from preventing a federally qualified HMO from "soliciting members through advertising its services, charges, or other nonprofessional aspects of its operations."

Further, under the Supremacy Clause of the United States Constitution, state laws cannot conflict with federal law. However, if the federal government has not wholly preempted the field, states may impose more stringent standards than imposed by federal law.

What state law requirements are Medicare managed care plans specifically required to meet?

In addition to meeting federal requirements, HMOs or CMPs which offer services to Medicare beneficiaries must be "organized under the laws of any State." While the scope of the term "organized under the laws of any State" is not defined in statute or regulations, the term does encompass a requirement that managed care organizations must comply with the relevant state licensure requirements. For example, HMOs which contract with the Medicare program must be licensed under state HMO laws. HCFA also requires organizations which offer a POS benefit to comply with state laws which apply to POS benefits.

35 42 C.F.R. § 417.407(a).
What is the role of state insurance regulators in the review of applications submitted by managed care organizations that want to participate in a Medicare managed care program?

Applications submitted by managed care organizations that want to participate as a Medicare contractor are reviewed by the Operations and Oversight Team and the Payment and Audit Team of HCFA’s Office of Managed Care and the relevant HCFA regional office. These entities review the application and perform a site visit.

States do not have a formal role to play in the application review process. Nevertheless, HCFA consults with states when it has a question or concern about an application. States which require that the managed care organization submit its application to the insurance department cannot with HCFA when the application raises a concern as well. In an effort to improve coordination between state and federal regulators, HCFA recently sent a letter to the NAIC requesting that states share information with HCFA when state authorities place plans on a “watch list”. HCFA officials have stated that the federal agency will likewise share information with state regulators on plans that are in a corrective action status.

Although states do not have a formal role to play in the application review process, HCFA does require that plans submit financial materials submitted to and approved by the state insurance department. These materials are used by HCFA as documentation for the Medicare rate approval process.

What role do states play in approving the reimbursement rates for Medicare managed care plans or the premiums charged to Medicare managed care beneficiaries?

As with the application review process, states do not have a formal role to play in the rate approval process. States are, however, concerned that the reimbursement rates are adequate and that the premium levels are reasonable. If a state has a concern, it may communicate it to the appropriate federal officials.

Who approves the marketing and advertising materials related to a managed care organization’s Medicare managed care services?

Medicare regulations require HCFA to review and approve marketing materials and impose specific requirements on Medicare managed care plans regarding marketing activities. The plans must adequately describe rules, procedures, benefits, fees, and other information to enrollees in writing, notify the public of their enrollment period, and inform prospective enrollees that they may choose to terminate or refuse to renew their contract with HCFA and that such termination or non-renewal may terminate an individual’s enrollment in the plan. Medicare regulations also establish activities in which the plans may not engage such as discriminatory practices, misrepresentations, offers of gifts greater than ten dollars ($10) to induce enrollment, door-to-door solicitation, or distribution of marketing materials disapproved by HCFA.

\[37\] 42 C.F.R. § 417.428.
States are particularly concerned that advertising material is not deceptive and contains adequate disclosure. Consequently, some states review such materials closely to ensure that the materials conform to both state and federal laws. Some HCFA regional offices have issued marketing guidelines. HCFA is currently working with the managed care industry and beneficiary community to standardize threshold federal marketing guidelines for the Medicare managed care program.

What is the role of state insurance regulators when a managed care organization is being investigated by the federal government for lack of compliance with federal Medicare laws?

The HCFA central and regional offices investigate those managed care entities which are out of compliance with federal law. No formal mechanism exists through which states are notified that federal investigations are underway regarding a particular plan. As previously mentioned, federal and state regulators seek to share relevant information on an informal basis.

What is the regulatory interaction between the Medicare managed care program and Medicare Supplementation laws?

The presence of Medicare managed care provides Medicare beneficiaries with an affordable alternative form of coverage to the purchase of Medicare suplemental policies. The interplay between Medicare managed care and Medicare supplement laws brings some issues of concern for state insurance regulators. For instance, state insurance regulators are concerned that beneficiaries who switch from Medicare managed care to Medicare fee-for-service may be hindered from obtaining Medicare supplement insurance. Medicare supplement laws only permit beneficiaries to enroll in a Medicare supplement plan without being subject to medical underwriting criteria within the first six months after attaining the age of 65 and enrolling for benefits under Part B. Consequently, if a beneficiary enrolls first in a Medicare managed care program and decides to switch to Medicare fee-for-service more than six months after reaching age 65, a beneficiary seeking Medicare supplement insurance may not qualify for supplemental insurance, may be subject to a preexisting waiting period, or may be quoted a higher, potentially

36 42 U.S.C. § 1395zzta(a)(2)(A) (1995 supp.). Specifically, the legislative language states that:
(a) Preexisting condition limitations and limitations on medical underwriting

(2)(A) The issue of a Medicare supplemental policy may not deny or condition the issuance or effectiveness of a Medicare supplemental policy, because of health status, claims experience, receipt of health care, or medical condition in the case of an individual for whom an application is submitted prior to or during the 6 month period beginning with the first month as of the first day on which the individual is 65 years of age or older and is enrolled for benefits under part B of this subchapter.

(B) Subject to subparagraph (C), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a preexisting condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before the policy became effective.

(C) If a Medicare supplemental policy or certificate replaces another such policy or certificate which has been in effect for 6 months or longer, the replacing policy may not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new policy or certificate for similar benefits.

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affordable, premium rate. Congress and the NAIC are considering looking into these portability issues in 1997.

If the Medicare managed care plan terminates its contract or agreement with HCFA, the managed care plan must provide for supplemental coverage for benefits related to preexisting condition exclusion periods for either six months or the duration of the exclusion period, whichever is less.

**What are some regulatory approaches states have used that relate to Medicare managed care activities?**

The plans that participate in the Medicare managed care program are required to be licensed under state law. Those managed care plans that offer point of service products, must comply with any state laws that apply to those products. In addition to these basic requirements, a small sample of states illustrate the different areas regulators have focused on relating to Medicare managed care activity. Arizona, for instance, reviews an HMO's marketing materials closely to ensure that they comply with state laws and guidelines in addition to the federal law. If the state insurance department has concerns related to the marketing materials, they may request that the managed care organization make changes or may discuss those concerns with the appropriate HCFA regional office.

Some states, such as New York, require that the managed care organization file with the state their Medicare managed care contract and premium rate filings. The state of Illinois treats Medicare managed care contracts as it does any other contract and requires that managed care organizations submit their Medicare managed care contract to the Illinois Department of Insurance for approval. Additionally, in Illinois, Medicare managed care beneficiaries must receive the state’s mandated benefits in addition to the basic benefits required by HCFA. Where state and federal laws have differed, such as with respect to appeals processes and the ability for the beneficiary to prereview the contract, the state has modified its requirements to comply with federal law in the Medicare managed care context.

The state of Wisconsin, which has a federal waiver which allows it to approve standardized supplemental benefits plans that differ from the 10 standardized products established under federal law, sets minimum standards for Medicare risk and cost contracts and regulates the supplemental segments of the Medicare managed care arrangements under its Medicare replacement policy provisions. An HMO receive state approval for their contracts and policy forms prior to receiving final approval from HCFA. In their review, Wisconsin looks closely for proper disclosures by Medicare managed care contractors.
Appendix

Sample Medicare Managed Care
HMO/CMP Contract
HEALTH INSURANCE BENEFITS FOR THE AGED AND DISABLED
(Contract With Eligible Organization Pursuant to
section 1876 of the Social Security Act)

CONTRACT (No. H____)

Between

The Secretary of the Department of Health and Human Services,
who has delegated authority to the Administrator of the
Health Care Financing Administration, hereinafter referred to as HCFA

and

(hereinafter referred to as the Organization).

The Secretary and the Organization, a health maintenance organization or competitive medical
plan which has been determined to be an eligible organization by the Administrator of the Health
Care Financing Administration under CFR 417.406, agree to the following for the purposes of
section 1876 of the Social Security Act:
(Contract # H___ Contract Period ___/___ - ___/___)

Article I

Term of Contract

The contract shall begin on __________, and end on __________. The contract will be automatically renewed for successive periods of one year unless the Organization or HCFA gives written notice of intention not to renew the contract at least 90 days before the end of the current period. (Additional requirements concerning nonrenewal of contracts, binding on both HCFA and the Organization, may be found at 42 CFR 417.492.) This contract supersedes any previous contract under sections 1833 or 1876 of the Social Security Act (the Act).

Article II

Election of Payment Method

Under section 1876(a) of the Act the Organization may elect a method of payment for which it is eligible and qualified, and will be accordingly governed by the statute and regulations which pertain to that method. The Organization agrees to receive payment:

(initial one selection below)

___ 1. On a risk basis under section 1876(g) of the Act, subject to the provisions of Article V;

___ 2. On a reasonable cost basis under section 1876(h) of the Act, subject to the provisions of Article VI and its implementing regulations at 42 CFR 417.530-417.576.

Select one option (see 42 CFR 417.532(c)):

___ 1. (direct payment of Organization's providers by HCFA)

___ 2. (direct payment of Organization's providers by the Organization)

If option 2, list names of providers to be paid by the Organization:

__________

(list others separately)

___ 3. On a risk basis under section 1876(g) for new Medicare enrollees and payment on a reasonable cost basis for unconverted, current non-risk Medicare enrollees, subject to the provisions of Articles V and VI.
Article III

Geographic Area

The Organization agrees that the contract shall be effective for the geographic area described in the attachment to this contract. (Modifications to the geographic area during the period of the contract are governed by Article VII.)

Article IV

General Conditions

A. The Organization agrees to comply with the law, regulations, and general instructions of the Health Care Financing Administration (HCFA) which concern the participation of health maintenance organizations (HMOs) and competitive medical plans (CMPs) in the Medicare program.

B. As part of its ongoing quality assurance program:

1. The Organization agrees to comply with the requirements for Peer Review Organization (PRO) review of services furnished to Medicare enrollees as set forth in Subchapter D of Chapter IV, Title 42, Code of Federal Regulations 417.478(a).

2. The Organization shall furnish to the Peer Review Organization (PRO) requested on-site access to or copies of patient care records and other pertinent data, and permit the PRO or its subcontractor to examine its operations and records as necessary for the PRO to carry out its functions under the Act.

3. Each organization receiving payment on a risk basis will maintain a written agreement with a utilization and quality control Peer Review Organization with which HCFA has a contract under Part B of Title XI of the Act for the area in which the Organization is located. In accordance with sections 1154(a)(4)(B) and (a)(14) of the Act, the agreement must provide for the review of services (including both inpatient and outpatient services) provided by the organization pursuant to this contract for the purpose of determining whether such services meet professionally recognized standards of health care, including whether appropriate services have not been provided or have been provided in inappropriate settings. The agreement must also provide for review by the PRO of all written complaints filed by Medicare beneficiaries or their representatives about the quality of services provided by the Organization. The cost of such agreement will be paid by HCFA directly to the PRO on behalf of the Organization.

4. Each Organization receiving payment on a risk basis must ensure that all hospitalization data required on HCFA Form 1450 (UB-82) for Medicare enrollees discharged between April 1, 1987 and July 31, 1988 is submitted to the fiscal intermediary or other HCFA designated entity.
5. Each Organization receiving payment on a risk basis must provide the hospital with any information necessary for the completion of HCFA Form 1450 (UB-82) which the hospital must submit to the intermediary for any discharges after July 31, 1988.

For purposes of this section, Peer Review Organization (PRO) is also deemed reference to other appropriate entities with which HCFA has contracted pursuant to Section 1154(a)(4)(C) of the Act.

C. The Organization agrees to comply with:

1. Sections 1318(a) and (c) of the Public Health Service Act which pertain to disclosure of certain financial information;

2. Sections 1301(c)(1) and (c)(8) of the Public Health Service Act, which relate to fiscal, administrative, and management requirements and liability arrangements to protect all members of the organization; and to notify HCFA 66 days prior to any changes in its insolvency arrangements; and

3. The reporting requirements in 42 CFR 417.126(a) which pertain to the monitoring of an organization's continued compliance. For purposes of this paragraph, references in that section to an "HMO" are also deemed references to a "CMP."

D. The Organization agrees to comply with Title VI of the Civil Rights Act of 1964 (and pertinent regulations at 45 CFR Part 80), section 504 of the Rehabilitation Act of 1973 (and pertinent regulations at 45 CFR Part 84), and the Age Discrimination Act of 1975 (and pertinent regulations at 45 CFR Part 91).

E. The Organization agrees to the following:

1. HCFA may evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services furnished under the contract to the Organization's Medicare enrollees;

2. HCFA may evaluate, through inspection or other means, the facilities of the organization when there is reasonable evidence of some need for that inspection;

3. HCFA, the Comptroller General, or their designees may audit or inspect any books and records of the organization or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract;

4. HCFA may evaluate, through inspection or other means, the enrollment and disenrollment records for the current contract period and three prior periods, when there is reasonable evidence of some need for that inspection;
5. The right to inspect, evaluate, and audit, will extend through three years from the date of the final settlement for any contract period unless -

a. HCFA determines there is a special need to retain a particular record or group of records for a longer period and notifies the Organization at least 30 days before the normal disposition date;

b. There has been a termination, dispute, fraud, or similar fault by the Organization, in which case the retention may be extended to three years from the date of any resulting final settlement; or

c. HCFA determines that there is a reasonable possibility of fraud, in which case it may reopen a final settlement at any time.

F. The Organization shall submit to HCFA (in such form and detail as the HCFA shall prescribe in regulations and general instructions), the following reports:

1. Data pertaining to health insurance claim numbers from beneficiaries, which shall be transmitted initially and on a continuing basis, as required to annotate the health insurance master file;

2. Statistical data on provider services and on medical and other services;

3. Enrollment and actuarial data; and

4. Any other reports or data that HCFA may require.

G. The Organization agrees to report all enrollment, disenrollment, and other beneficiary characteristic records according to HCFA program instructions. All records must be transmitted 1) through an approved HCFA systems contractor, or 2) over data transmission lines directly to HCFA, or 3) on magnetic tape unless otherwise prescribed by HCFA. All electronic transmissions and tapes must be totally compatible and consistent with the relevant HCFA computer record systems.

H. The Organization shall furnish to organizations serving as carriers and intermediaries under Title XVIII, information necessary to allow the carriers or intermediaries to make proper payment under Title XVIII for Medicare beneficiaries enrolled in the Organization.

I. The Organization agrees to require all entities related to the Organization, as determined under 42 CFR 417.484 (a), to agree that -

1. HCFA, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent books, documents, papers, and records of the subcontractor involving transactions related to the subcontractor; and
2. The right under this section to information for any particular contract period will exist for a period equivalent to that specified in section E(5) of this Article.

J. The Organization agrees -

1. To submit to HCFA -
   a. All financial information required under 42 CFR 417.530 through Section 417.576 and for final settlement; and
   b. Any other information necessary for the administration or evaluation of the Medicare program.

2. To comply with the requirements set forth in 42 CFR Part 420, Subpart C, pertaining to the disclosure of ownership and control information;

3. To comply with the requirements of the Privacy Act, as implemented by 45 CFR Part 5b and Subpart B or Part 401 of 42 CFR, with respect to any system of records developed in performing carrier or intermediary functions under 42 CFR 417.532 and section 417.533, and

4. To meet the confidentiality requirement of 42 CFR 482.24 for medical records and for all other information on enrollees, not covered under item 3 above, that is contained in its records or obtained from HCFA or others.

5. To provide prompt payment (consistent with the provisions of section 1816(o)(2) and 1842(c)(2)) of claims submitted for services and items furnished to individuals pursuant to this contract, if the services or items are not furnished under a contract between the Organization and the provider or supplier.

K. Pursuant to 42 CFR 417.476 conditions of qualification set forth at 42 CFR 417.410 through section 417.418 may be waived by HCFA. However, for each of such qualifying conditions waived, this contract must contain -

   1. The specific terms of the waiver;
   2. The expiration date of the waiver;
   3. Any other information required by HCFA.

L. The Organization shall provide and supply (1) full and complete information as to ownership of a subcontractor with whom such organization has had during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (2) full and complete information as to any significant business transactions during the five year period ending on the date of HCFA’s request, between the Organization and any wholly-owned supplier or between the Organization and any subcontractor. The required
information must be provided in the manner required under section 1866(b)(2)(c)(ii) of the Act.

M. The Organization shall notify HCFA of loans and other special financial arrangements which are made between the Organization and subcontractors, affiliates and related parties.

N. The Organization agrees -

1. That for the duration of the contract, the Organization shall have an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under Medicare or Medicaid. HCFA may suspend enrollment or payment to the Organization or terminate this contract if this requirement is not met.

2. To submit quarterly reports of its commercial enrollment, Medicaid enrollment and Medicare enrollment in the geographic area defined by Article III of this contract.

O. The Organization agrees that no marketing material may be distributed by an organization to (or for the use of) individuals eligible to enroll or enrolled in the organization under this contract unless at least 45 days before the distribution, the Organization has submitted the material to HCFA for review, and HCFA has not disapproved the distribution of the material.

P. The Organization agrees to allow eligible beneficiaries to enroll under this contract during any open enrollment period required by HCFA through regulations. The Organization agrees to accept beneficiaries up to the limit of its capacity as approved by HCFA.

Q. Upon termination of this contract, the Organization agrees:

1. To give its Medicare enrollees a written notice of the termination at least 60 days before the termination date;

2. To be responsible for the cost of the notice;

3. To submit a copy of the notice to HCFA for review;

4. If the Organization is a risk contractor, to include with the required notice a written description of alternatives available for obtaining Medicare services after termination.

R. The Organization hereby provides assurances to HCFA that in the event the Organization ceases to provide items and services under this contract, the Organization shall provide or arrange for supplemental coverage of benefits under Title XVIII of the Act related to a pre-existing condition with respect to any exclusion period, to all individuals enrolled with Medicare Contract, 8/94
the entity who receive benefits under Title XVIII, for the lesser of six months or the
duration of such period.

S. The Organization agrees to review and act upon requests for reconsideration from its
Medicare enrollees within 60 days of receipt of the reconsideration request for the
provision or payment of services or items which were initially denied. In those cases
where the Organization will continue to deny services or items or payment for services or
items, in whole or in part, the Organization must forward the beneficiaries’ reconsideration
requests along with the Organization’s written explanation and documentation to HCFA or
its contractor within 60 days of receipt of the reconsideration request.

In those cases where HCFA or its contractor determines that the Organization should
provide services or items previously denied, or HCFA or its contractor determines that the
Organization has financial liability for services or items received, the Organization must
pay for or provide those services to the beneficiary within 60 days of the receipt of
HCFA’s or its contractor’s determination.

Services previously denied will be arranged by the Organization in a manner consistent
with services normally provided by the Organization.

T. If any Medicare beneficiaries residing in the Organization’s service area are members of
another risk-based contracting organization which nonrenews or terminates its contract,
your Organization (if under a risk-based contract) agrees to hold a special 30-day
terminations open enrollment period to enroll those Medicare beneficiaries enrolled in the
other risk-contracting organization at the time of termination or nonrenewal of the other
organization’s contract.

This requirement will apply only to those Medicare beneficiaries enrolled in the other risk-
sharing contracting organization who reside in your Organization’s service area. The
terminations open enrollment period must be conducted during the period designated by
HCFA. You will be given notice 30 days before the start of the open enrollment period.

This does not preclude an organization from requesting a capacity waiver as described at
42 CFR 417.426(b)(1).

U. As part of advance directives requirements, the Organization agrees:

1. To inform all Medicare enrollees at the time of enrollment of their right (under
State law whether statutory or recognized by the courts of the State) to accept or
refuse treatment and to execute an advance directive, such as living wills or
durable powers of attorney, and of the Organization’s written policies on
implementation of that right;

2. To document in the individual’s medical records whether or not an individual has
executed an advance directive;
3. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive;

4. To comply with State law (whether statutory or recognized by the courts of the State) on advance directives; and

5. To provide (individually or with others) for education for staff and the community on advance directives.

V. The Organization, if it has a risk contract, agrees not to employ or contract with, directly or indirectly, entities or individuals excluded from participation in Medicare or Medicaid under sections 1128 or 1128A of the Act, for the provision of health care, utilization review, medical social work, or administrative services.

Article V
Conditions For Payment on a Risk Basis

The following conditions apply to the Organization if it selected, in Article II of this contract, to be paid on a risk basis method under section 1876(g) of the Act, or if it selected to be paid on a risk basis and paid on a reasonable cost basis for unconverted, current non-risk Medicare enrollees:

A. Except as provided for in Article V.(D), HCFA shall make payment under this contract for services rendered to Medicare enrollees on a risk basis as provided in regulations.

B. The Organization agrees to maintain, and make available to HCFA upon request, books, records, documents, and other evidence of accounting procedures and practices that:

1. Are sufficient to -

   a. Establish component rates of the adjusted community rate (ACR) for determining additional and supplementary benefits; and

   b. Determine the rates utilized in setting premiums for State insurance agency purposes.

2. Include at least any records or financial reports filed with other Federal agencies or State authorities.

C. The Organization has the right to appeal a determination that the Organization's ACR computation is not acceptable, pursuant to the provisions of 42 CFR 417.594(e)(2).

D. To the extent that the Organization's members are unconverted, current non-risk Medicare enrollees, the Organization agrees to fully comply with the conditions in Article VI.
E. The Organization agrees, as required by section 1876(g)(2) of the Act, that if the ACR (as reduced for the actuarial value of the coinsurance and deductibles) is less than the average of the per capita rates of payment to be made under section 1876(a)(1) for Medicare members enrolled under the risk basis method of payment, the Organization shall provide its Medicare members with additional benefits described at section 1876(g)(3), selected by the Organization, and which HCFA finds are at least equal in value to the difference between the average per capita payment and the adjusted community rate (as so reduced). This condition shall not apply to an organization which agrees to accept a lesser payment to the extent that there is no longer a difference between the average per capita payment and the adjusted community rate (as so reduced).

F. The Organization agrees-

1. To publicly offer and provide at least the level of Medicare covered benefits approved in the ACR. The Organization may choose to offer more services or to impose lower premiums or other charges (in the form of deductibles or coinsurance) than approved in the ACR.

However, such complimentary services or waived premiums or other charges must be approved in advance by HCFA and remain in effect throughout the contract period.

The only mid-year changes that are permitted are those which are entirely advantageous to Medicare enrollees. Premiums and copayments may be reduced at any time during the year, but once they are reduced, they cannot be increased later on during the same contract period. Benefits for which there is no charge may be added at any time during the contract period, but also must remain in place for the remainder of the contract period. HCFA should be advised of any expanded benefits or decreases in premiums or copayments arising in the middle of a contract period.

Waived premiums and complimentary services provided solely to members of an employer group are governed by the Organization's contract with the employer.

2. Nothing in this article may be interpreted as a waiver or compromise of any appeal rights to which the Organization may be entitled under Title XVIII of the Act and implementing regulations.

Article VI

Conditions of the Reasonable Cost Method of Payment

The following conditions apply to the Organization if it selected in Article II of this contract to be paid on the Reasonable Cost Method under section 1876(h) of the Act, or if it selected to be paid on a risk basis and paid on a reasonable cost basis for unconverted, current non-risk Medicare enrollees:
A. HCFA shall make payment under this contract for services rendered to Medicare enrollees on a reasonable cost basis as provided in regulations.

B. The Organization agrees to maintain books, records, documents, and other evidence of accounting procedures and practices that -

1. Are sufficient to -
   a. Ensure an audit trail; and
   b. Properly reflect all direct and indirect costs claimed to have been incurred under the contract; and

2. Include at least records of the following:
   a. Ownership, organization, and operation of the Organization's financial, medical and other recordkeeping systems;
   b. Financial statements for the current contract period and three prior periods;
   c. Federal income tax or information returns for the current contract period and three prior periods;
   d. Assets acquisition, lease, sale, or other action;
   e. Agreements, contracts, and subcontracts;
   f. Franchise, marketing, and management agreements;
   g. Schedules of charges for the Organization's fee-for-service patients;
   h. Matters pertaining to costs of operations;
   i. Amounts of income received, by source and payment;
   j. Cash flow statements;
   k. Any financial reports filed with other Federal programs or State authorities.

C. The Organization has the right to appeal any final determination of costs pursuant to the reimbursement appeals procedures contained in the regulations at 42 CFR Part 405, Subpart R.

D. The Organization shall make available for the purposes specified in paragraphs 1-4 of section D of Article IV, its premises, physical facilities, and equipment, its records relating
to its Medicare enrollees, the records specified in 42 CFR 417.480, and any additional relevant information that HCFA may require.

E. The Organization agrees that -

1. Upon HCFA's request it will provide, subsequent to an accounting period, an independently certified financial statement of its per capita incurred cost, based on the types of components of expenses otherwise reimbursable under Title XVIII, for providing services described in section 1876(a)(1), including its method of allocating costs between individuals enrolled under this section and other individuals enrolled with the Organization, such statements to be provided in accordance with accounting procedures prescribed by HCFA;

2. Failure to report such information may be deemed evidence of likely overpayment upon which basis collection action may be taken;

3. The required financial statements will be consolidated to include an accounting for the costs of entities related to the Organization by common ownership or control;

4. Allowable costs for a related organization may not include costs for the types of expense otherwise reimbursable under Title XVIII, in excess of an amount which would be determined to be reasonable in accordance with regulations;

5. In any case in which compensation is paid substantially in excess of what is normally paid for similar services by similar practitioners, such compensation may, as appropriate, be considered a distribution of profits.

F. The Organization agrees to comply with the requirements of section 1833(q)(1)(A) of the Act and its implementing regulations, 42 CFR 417.800 through 42 CFR 417.810, for members who have not been converted from any previous Health Care Prepayment Plan (HCPP) contract(s) or arrangement(s).

Article VII
Modification, Termination or Non-renewal

This contract may be modified at any time by written consent of both parties (the Organization and HCFA). If the contract is modified, the Organization must notify its Medicare enrollees of any changes that HCFA determines are appropriate for notification. It may be terminated by either party in accordance with the provisions of 42 CFR 417.494 or a decision by either party not to renew the contract may be made in accordance with the provisions of 42 CFR 417.492.

Article VIII
Any revisions to applicable provisions of Title XI or Title XVIII of the Act, Title XIII of the Public Health Service Act, implementing regulations, policy issuances and instructions apply as of their effective date.

Article IX

General Contracting Requirements

A. FACILITIES NONDISCRIMINATION CLAUSE

The following provisions are applicable to and shall be included in all leases of real estate entered into for the administration of this agreement:

"As used in this clause, the term 'Facility' means stores, shops, restaurants, cafeterias, restrooms, and any other facility of a public nature in the building in which the space covered by this lease is located.

"The lessor agrees that he will not discriminate by segregation or otherwise against any person or persons because of race, color, religion, sex, or national origin in furnishing or by refusing to furnish, to such person or persons, the use of any facility including any or all services, privileges, accommodations, and activities provided thereby. Nothing herein shall require the furnishing to the general public of the use of any facility customarily furnished by the lessor solely to tenants, their employees, customers, patients, clients, guests and invitees.

"It is agreed that the lessor's noncompliance with the provisions of this clause shall constitute a material breach of this lease. In the event of such noncompliance, the lessee may take appropriate action to enforce compliance, may terminate this lease or may pursue such other remedies as may be provided by law. In the event of termination, the lessor shall be liable for all excess costs of the lessee in acquiring substitute space. Substitute space will be obtained in as close proximity to the lessor's building as is feasible and moving costs will be limited to the actual expenses thereof as incurred.

"The lessor agrees to include, or to require the inclusion of the foregoing provisions of this clause (with the terms "lessor" and "lessee" appropriately modified) in every agreement or concession pursuant to which any person other than the lessor operates or has the right to operate any facility. Nothing herein contained, however, shall be deemed to require the lessor to include or require the inclusion of the foregoing provisions of this clause in any existing agreement or concession arrangement or one in which the contracting party other than the lessor has the unilateral right to renew or extend the agreement or arrangement, until the expiration of the existing agreement or arrangement and the unilateral right to renew or extend. The lessor also agrees that it will take any and all lawful actions as expeditiously as possible with respect to any such agreement as the contracting agency may direct to enforce this clause, including but not limited to termination of the agreement or concessions and institution of court action."

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B. DISCLOSURE OF INFORMATION

The following clause shall be included in all subcontracts entered into either for the performance of functions required for the administration of this agreement or where a subcontractor, his agents, officers or employees might reasonably be expected to have access to information within the purview of section 1106 of the Social Security Act and regulations prescribed pursuant thereto:

"The contractor agrees to establish and maintain procedures and controls so that no information contained in its records or obtained from HCFA or from others in carrying out the terms of this subcontract shall be used by or disclosed by it, its agents, officers, or employees except as provided in said section 1106 of the Social Security Act and regulations prescribed thereunder."

C. AUTOMATIC TERMINATION OF SUBCONTRACT CLAUSE

The following provision are applicable to and shall be included in all subcontracts entered into hereafter (except for the purchase of items and equipment), including leases of real property which exceed the term of this agreement except where HCFA agrees to its omission. Failure of the Contractor to include the clause in such subcontract without the written agreement of HCFA to its omission, shall make the related costs incurred after the effective date of the nonrenewal or termination, unallowable.

Notwithstanding the following, if the Contractor wishes to continue the subcontract relative to its own business after the contract between HCFA and the Contractor has been terminated or nonrenewed, it may do so provided it assures HCFA in writing that HCFA’s obligations will terminate at the time the Medicare contract terminates or is nonrenewed subject to the termination cost provisions provided for in the contract.

The clause is as follows: "In the event the Medicare contract between HCFA and (Name of Contractor) is terminated or nonrenewed, the contract between (Name of Contractor) and (Name of Firm) will be terminated unless HCFA and (Name of Contractor) agree to the contrary. Such termination shall be accomplished by delivery of written notice to (Name of Firm) of the date upon which said termination will become effective."

D. PROHIBITION AGAINST USE OF HCFA FUNDS TO INFLUENCE LEGISLATION OR APPROPRIATIONS

The following provision is applicable to this agreement:

No part of any funds under this agreement shall be used to pay the salaries or expenses of any Contractor, or any agent acting for the Contractor, to engage in any activity designed to influence legislation or appropriations pending before the Congress.

Lobbying costs are defined in and are unallowable in accordance with Federal Acquisition Regulation 31-205-22.
E. LIQUIDATED DAMAGES IN SUBCONTRACTS

The following provisions are applicable to and shall be included in any subcontract entered into or renewed under this agreement containing a liquidated damages provision which related solely to Medicare:

The Health Care Financing Administration (HCFA), after consultation with the Contractor, shall have the right to determine that the specified levels of performance have not been attained by the subcontractor. In such event, HCFA may direct the Contractor to notify the subcontractor of HCFA's determination that liquidated damages apply and to set-off the liquidated damages against the subcontractor. HCFA shall reimburse the Contractor for all reasonable costs relating to this activity and shall honor any judgement or award rendered against the Contractor directly resulting from the enforcement of such provision as directed by HCFA. Failure of the Contractor to timely comply with such direction, shall constitute cause for the application of any and all administrative, statutory, and judicial remedies which may be available to HCFA pursuant to this agreement, including but not limited to, offsetting an amount equivalent to the amount of such unenforced liquidated damages. In the event that such offset is made, the Contractor shall be obligated to continue to perform all terms and conditions of this agreement without additional payment from HCFA attributable to such offset amounts.
F. FEDERAL ACQUISITION REGULATIONS INCORPORATED BY REFERENCE

This agreement incorporates the following clauses by reference with the same force and effect as if they were given in full text. Upon request, HCFA will make their full text available:

FEDERAL ACQUISITION REGULATION
(48 CFR CHAPTER 1) CLAUSES

52.222-26 Equal Opportunity (April 1984)
52.203-1 Officials Not to Benefit (April 1984)
52.203-5 Covenant Against Contingent Fees (April 1984)
52.219-8 Utilization of Small Business Concerns and Small Disadvantaged Business Concerns (April 1984)
52.219-9 Small Business and Small Disadvantaged Business Subcontracting Plan (April 1984)
52.220-3 Utilization of Labor Surplus Area Concerns (April 1984)
52.220-4 Labor Surplus Area Subcontracting Program (April 1984)
52.222-3 Convict Labor (April 1984)
52.222-21 Certification of Nonsegregated Facilities (April 1984)
52.222-35 Affirmative Action for Special Disabled and Vietnam Era Veterans (April 1984)
52.222-36 Affirmative Action for Handicapped Workers (April 1984)
52.203-7 Fees or Kick-Backs By Subcontractors (Anti-Kickback Act (41 U.S.C. 51-54) (April 1984)
52.219-13 Utilization of Women-Owned Small Businesses (April 1984)
52.245-5 Government Property (April 1984) Applicable only to Contractors that have been furnished Government property.
(Contract # H Contract Period, __/__/ __/__/ )

Signature of the official authorized to request a change in the banking information needed for HCFA payment to your Organization.

____________________________
Printed name

____________________________
Signature

Date

In witness whereof, the parties hereby execute this contract.

For the Organization:

____________________________
Printed name

____________________________
Signature

Date

____________________________
Organization

____________________________
Address

For the Health Care Financing Administration:

____________________________
Date

Director, Operations and Oversight Team
Office of Managed Care

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