CHAPTER 23

INSTRUCTIONS FOR THE PREPAID HEALTH PLAN COST REPORT
FORM CMS-276-25

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2300 INTRODUCTION

The reporting requirements of a prepaid health care plan that has contracted with CMS are specifically defined in 42 C.F.R. §417.572, §417.574, §417.576, §417.808 and §417.810. Further, if reporting requirements are communicated in the form of a Health Plan Management System (HPMS) memorandum, please contact CMS for further guidance. For reimbursement purposes, these plans can be grouped into two major categories - Health Maintenance Organizations/Competitive Medical Plans (HMOs/CMPs) and Health Care Prepayment Plans (HCPPs). Collectively these plans are referred to as cost-based Managed Care Organizations (MCOs). Briefly, the reporting requirements for each category are:

Cost Report	HMO/CMP Reporting Requirement	HCPP Reporting Requirement	Worksheets	42 CFR Section
1. Budget Forecast	No later than 90 days prior to the beginning of the contract period	No later than 60 days prior to the contract period	S, A and B	§417.572 and §417.808
2. Semi-Annual Interim Report	The Semi-Annual Interim is due no later than 60 days after the close of the first 6 months of the contract period	The Semi-Annual Interim is due no later than 45 days after the close of the first 6 months of the contract Period	S and C	§417.572
3. 4th Quarter Interim Report	The 4th Quarter Interim report must be filed, using the worksheets for the Final Cost Report, no later than 60 days after the close of the contract period.	HCPPs are not required to file 4th Quarter Interim Final report.	S, D thru N	§417.572
4. Final Cost Report	No later than 180 days after the close of the contract period. This cost report must be certified by an independent certified public accountant (42 CFR §417.576 (b))	No later than 120 days after the close of the contract period	S, D thru N	§417.576 and §417.810

If a plan fails to submit the budget and enrollment forecast on time, CMS may (1) establish an interim per capita rate of payment on the basis of the best available data and adjust payment on the basis of that rate until the required reports are submitted and a new interim per capita rate can be established; or (2) if insufficient data exists on which to base an interim rate, inform the plan that interim payments will not be made until the required reports are submitted (42 C.F.R. §417.572(b) and 42 CFR §417.808). Per 42 CFR 417.572 (c)(2), CMS may reduce or waive the frequency of the reports that are required under section 42 CFR 417.572 (c)(1), if CMS determines, based on the HMO's or CMP's reporting experience, there is good cause to do so. This

includes the Semi-Annual and 4th Quarter Interim reports. Plans should monitor the issuance of CMS's guidance for waivers pertaining to the Interim reports.

If a plan fails to submit the final cost report and supporting documentation on time, CMS may consider the failure to report as evidence of likely overpayment; and (1) initiate recovery of amounts previously paid, or (2) reduce interim payments, or (3) both (42 C.F.R. §417.576(b)(3) (42 C.F.R. §417.810 (b)(4)). CMS may extend the period for filing the cost report for good cause shown by the Plan (42 C.F.R. §417.576(b)(1)) (42 C.F.R. §417.810 (b)(4)). However, interest on the amount owed will still accrue per the regulations (42 C.F.R. 405.378).

Form 276-16, provided by CMS as excel worksheets, covers the prescribed format for the cost reports and are provided in Excel format. Electronic copies of the worksheets for each category of filing are accessible through CMS' Health Plan Management System (HPMS). HPMS is a web-enabled information system and data exchange mechanism that serves a critical role in both the ongoing operations and for data related to MCOs. By serving as the centralized repository for Medicare Managed Care data, HPMS provides its users with access to this information and an analytical framework for exploring data. If the cost report worksheets require modification to accommodate a Plan's unique reporting requirements, written approval must be obtained from CMS in advance of the contract period to which the report applies. CMS' approval of an alternative cost report may be granted if the alternative format presents cost and statistical data in the same detail as the prescribed format. In addition, CMS must be assured that such an alternative format can be used equitably to determine the proper amount of reimbursement for covered services furnished to Medicare enrollees.

Methods of allocation and apportionment of costs set forth in these worksheets **are not optional**, they are required for the determination of reimbursement. If the Plan wishes to use an alternative method of allocation or apportionment or to change the approved method of allocation or apportionment from the prior contract year, **CMS' advance approval is required**. A method of apportionment or allocation of costs, other than the prescribed methods may be used if it results in a more accurate and equitable apportionment of allowable costs and is justifiable from an administrative and cost standpoint. The Plan's request for such a change must be received by CMS at least ninety (90) days prior to the beginning of the first affected reporting period. The HMO/CMP's request must state the specific change it desires and explain how this will result in a more accurate and equitable apportionment or allocation. If CMS approves use of a different method, the HMO or CMP may not revert to another method without first obtaining CMS's approval (42 C.F.R. §417.566) (42 C.F.R. §417.804). CMS's initial approval is conditional upon further analysis and/or final audit determinations of the apportionment methodology.

The cost report worksheets are designed to be of sufficient flexibility to take into account the diversity of operations, yet provide the necessary cost and statistical information to enable CMS to determine the proper amount of payment to the Plan. These worksheets accommodate the various bill processing options described in the Medicare Managed Care Manual (Pub. 100-16, Chapter 17a, §10.2)(Pub. 100-16, Chapter 18a, §10.2). Therefore, the Plan may not be required to complete all worksheets. The Plan should confirm the particular reporting requirements applicable to which lines must be completed by discussing them in detail with the CMS auditor assigned to the Plan. This discussion should take place prior to the contract period. To avoid any later misunderstanding, the Plan should submit written confirmation of the conclusions reached to CMS. However, CMS's initial confirmation or understanding of the requirements does not preclude CMS from further analysis and/or final audit determinations of the reporting requirements. The Plan must submit all worksheets. Where appropriate, Plans should enter "NA" on those worksheets that are not used.

The Plan's cost reporting requirements in no way supplant the specific reporting requirements applicable to providers of services under the Medicare program. Each provider of services, whether owned or operated by the Plan, must comply with its own cost reporting requirements. (The Provider Reimbursement Manual, Pub. 15-2, sets forth these requirements in detail). The costs and statistics submitted for provider services furnished to enrollees are summaries of the information set forth in the provider cost reports and/or Bill Summary Report using the options detailed for Worksheet J.

The following sections explain how to fill out each individual worksheet for each category of reporting.

2302 WORKSHEET S - CERTIFICATION PAGE

Line 1 - Name and Address of Plan - Enter the name and address including any trade name of the plan, if applicable.

Line 2 - Reporting Period and Plan Number - Enter the reporting period starting and ending dates. Enter the Plan identification number.

Line 3a - Type of Report - Identify the type of report you are filing: Budget Forecast, Interim Report, or Final Cost Report. See Section 2300, for the required worksheets that are filed with the type of report identified.

Line 3b - Bill Processing Option - Indicate the bill processing option selected by the plan. For a description of the different options available, refer to Chapter 17a, Subchapter A, Section 10.2 and/or Chapter 18a, Subchapter A, Section 10.2 of the Medicare Managed Care Manual (Pub. 100-16).

Line 3c - Reimbursement Under - Indicate by selecting from the drop down list the appropriate section of the Social Security Act under which the plan is seeking reimbursement. Section 1876 is for Health Maintenance Organizations and Competitive Medical Plans (HMOs/CMPs). Section 1833 is for Health Care Prepayment Plans (HCPPs).

Certification Statement - The certification must be prepared, signed and uploaded in a PDF format into HPMS after the worksheets have been completed in their entirety. The individual signing the certification must be an officer or responsible person authorized to act as an agent of the organization.

2303 WORKSHEET A - BUDGET FORECAST

This worksheet is provided to forecast the allowable Medicare costs per member per month (PMPM) that will be paid on an interim basis during the period covered by the report. The worksheet uses a prior year's final cost report, as revised by CMS if applicable, as a basis for establishing forecasted Medicare costs. If the Plan finds that this worksheet produces results that are not reflective of the forecasted period, use Column 4 of Part II to make the necessary adjustments to correlate the financial data to the forecasted period. Adjustments in Column 4 of Part II must be supported by additional submitted documentation. For cost Plans that are new to the Medicare program and have no historical cost and statistical data as the basis for the current year budget, these Plans must instead use the final cost report form to project the current year budgeted figures. The period's budgeted cost and statistical data are entered into the final cost report form to generate the Medicare interim

PMPM amount from Worksheet M. All applicable worksheets must be filed as required by the instructions for that final cost report form, if used for budget purposes.

Since this form is used by HCPPs, HMOs, and CMPs, not all lines and columns will apply to all plans. This worksheet is only prepared in the submission of the Budget Forecast**.** If the prior year's final cost report submission is delinquent at the due date of the budget, the budget will be automatically rejected until the final cost report is submitted.

2303.1 Part I - Prior Year Cost & Statistical Data

In the Part I heading, enter the fiscal year-end date from which all of the cost and statistical data reported in this part are taken. The prior year cost and statistical data must be taken from the period ending two (2) years prior to the budget period. For example, if the budget forecast is for the period January 1 through December 31, 2025, the final cost report for the period January 1 through December 31, 2023 will be used. Since the costs entered in columns 1 through 6 are taken from the final cost report covering the period January 1 through December 31, 2023, the plan should enter this period in the Part I heading. This final cost report should be used for all data requested in Part I.

Column and Line Descriptions

Column 1 - Trial Balance Per Books - Enter in this column the Trial Balance Per Books taken from Worksheet E, Column 1 of the prior year final cost report approved by CMS, plus or minus Reclassifications from Column 2. Adjustments from Column 3 of the Final Report should not be included in Column 1 of the Budget Report. Cost data should be grouped using the same method of groupings used for Medicare costs on that prior year final cost report submitted to CMS. The amount for Part B Deductible and Coinsurance on Services Paid by CMS' MAC reported on Worksheet E, Line 16 of the prior year final cost report must be included with the amount reported for Non-provider costs on the Budget Forecast Worksheet A, Part 1, Line 5. The elements of the Special Administrative Costs reported on Line 26 of the prior year final cost report must be broken out on Lines 7a thru 7c of the Budget Forecast.

Line 1 – 4 Providers – Enter the cost incurred for the Part A provider services such as Hospital Costs, Skills Nursing Facilities and Home Health Agencies. All other Part A providers cost incurred should be entered on Line 4.

Line 5 – Non-Providers – Enter the cost incurred for Part B provider services such as Clinics, Physicians Groups, Individual Physicians, Certified Labs, Durable Medical Equipment, etc.

Line 6 – Plan Administration – Enter the cost incurred for plan administration and reported on Worksheet E (Line 25) of the prior year final cost report.

Line 7A – Accretion/Deletion – Enter the actual cost incurred for reporting increases and decreases in the number of Medicare enrollees according to 42 CFR. §417.550(b)(1).

Line 7b - Cost Report Certification – Enter the cost incurred for the independent certified public accountant to certify the final cost report submitted to CMS to the extent that it is for Medicare purposes

according to 42 C.F.R. §417.550(b)(2). This applies only to 1876 contracts (HMOs and CMPs) (42 CFR.§417.576(b)(1)).

Line 7c – Other – Enter the cost incurred for reporting special data that CMS requires solely for program planning and evaluation and is reimbursed 100% by Medicare according to 42 CFR.§417.550 (d).

Line 8 – Part B Costs Not Subject to Coinsurance – Enter the Part B cost not subject to coinsurance reported on prior year final cost report Worksheet E, Line 19, column 1 and 2.

Line 10 - Total Cost - The total cost on this line must equal Column 1, Line 29 on Worksheet E of the prior year final cost report.

Column 2 - PMPM Cost - Enter on Line 0 the Total Member Months shown on the prior year final cost report Worksheet L, Column 5, Line 1. The worksheet formulas divide the cost on each line in Column 1 by the Total Member Months on Line 0 and the results are entered in this column, lines as appropriate.

Column_3 - Total Medicare PMPM Cost - The worksheet calculates the sum of Columns 4 plus 5 on the lines as appropriate.

Column 4 - Medicare Part A PMPM Cost - Enter in this column the Medicare Part A cost PMPM taken from the appropriate lines of Worksheet M, Column 2 of the prior year final cost report. This column is not applicable to HCPPs.

Line 10 - Total Cost (Column 4) - The total PMPM amount on this line must equal Column 2, Line 7 on the Worksheet M of the prior year final cost report.

Column_5 - Medicare Part B PMPM Cost - Enter in this column the Medicare Part B cost PMPM taken from the appropriate lines of Worksheet M, Column 3 of the prior year final cost report. The following cost centers should be combined on the Budget Forecast:

- Part B Deductible on Services Paid by CMS' MAC reported on Line 5a of the prior year final cost report must be included with the amount reported for Nonprovider costs in Column 5 on the Budget Forecast Line 5.
- Medicare Bad Debts reported on Line 16, Worksheet M of the prior year final cost report must be included with the amount reported for Plan Administration costs in Column 5 on the Budget Forecast Line 6.

The elements of the Special Administrative Costs reported on Line 15 of the prior year final cost report must be broken out on Lines 7a thru 7c of the Budget Forecast.

Line 8 (Column 5) – Enter in this column the Part B Costs Not Subject to Coinsurance PMPM reported on Worksheet M, Line 16a of the prior year final cost report.

Line 10 - Total Cost (Column 5) - The total PMPM amount on this line must equal Column 3, Line 7 plus Lines 15, 16, and 16a on the Worksheet M of the prior year final cost report.

Column_6 - Medicare Ratio - The worksheet calculates the ratio of the Medicare PMPM amounts to the total by dividing each line of Column 3 by each line of Column 2. All ratios must be rounded to 4 decimal places.

Column 7 - Medicare Part A Ratio - The worksheet calculates the ratio of the Medicare Part A PMPM Cost in Column 4 to the Total Medicare PMPM cost in Column 3. All ratios must be rounded to 4 decimal places.

2303.2 Part II – Budget Year Cost & Statistical Data

This part determines the interim payment rate by applying the ratios developed in Part I to the projected costs for the period covered by the Budget Forecast Report to derive the estimated Medicare costs for the period. Projected costs shown in Column 1 of this part should be classified in the same manner as Column 1 in Part I (including reclassifications, and Part B Deductible and Coinsurance on Services Paid by CMS' MAC included with the amount reported for Non-provider costs on Line 5) plus expected Third Party Insurer Revenue. The assumption being used in Part II is that the relative ratio of Medicare costs to total costs should remain fairly constant. Column 4 is provided for those instances where the relative ratio is expected to vary significantly for a given line item. Adjustments made in Column 4 must be supported by an attached worksheet.

Column and Line Descriptions

Column_1 - Total Projected Cost (Lines 1-10) - Enter the projected trial balance of expenses for the period covered by the Budget Forecast Report. The cost data should be grouped using the same method of groupings used in Part I, Column 1. Please note that costs of Prescriptions covered by Part B, but are not reimbursed 100%, should be placed in Line 5 "Non-Providers".

Line 7A – Accretion/Deletion – Enter the projected reasonable cost for reporting increases and decreases in the number of Medicare enrollees according to 42 C.F.R. §417.550(b)(1).

Line 7b - Cost Report Certification - Enter the projected reasonable cost for the independent certified public accountant to certify the final cost report submitted to CMS to the extent that it is for Medicare purposes according to 42 C.F.R. §417.550(b)(2). This applies only to 1876 contracts (HMOs and CMPs) (42 C.F.R. §417.576(b)(1)).

Line 7c – Other – Enter the projected reasonable cost for reporting special data that CMS requires solely for program planning and evaluation and is reimbursed 100% by Medicare according to 42 C.F.R. §417.550 (d).

Please note that the plan must request in advance for special admin cost to be included on the cost report and should include an estimate of total special admin costs to be incurred in the budget year. A worksheet showing how these amounts were determined must be attached in order to include it in the budget forecast. Supporting documentation for 'Other' costs must be provided at the time of submission.

Line 8 – Part B Costs Not Subject to Coinsurance - Enter in column 1 the amount of Part B costs not subject to coinsurance. This would include clinical diagnostic lab tests according to §1833(a)(2)(D) of the Social Security Act, some preventive services, services/drugs covered 100% by Medicare, and influenza and pneumonia shots, for example. A worksheet showing how this amount was determined must be attached in order to include it in the budget forecast.

Column 2 - Projected PMPM Cost - Enter on Line 0 the Total Member Months projected for the period that were used in developing the projected trial balance of expenses in Column 1. The worksheet calculates the projected PMPM cost by dividing the costs in Column 1, lines as appropriate, by the Total Member Months on Line 0.

Column_3 - Medicare Projected PMPM Cost - The worksheet calculates the Medicare portion of the total costs PMPM by multiplying the Total Projected PMPM Cost in Column 1 by the prior period ratio of Medicare cost to total cost from Part I, Column 6, lines as appropriate.

Column 4 - PMPM Adjustment - The plan may adjust the costs calculated in Column 3 for any amount believed to be necessary to produce a more appropriate Medicare cost per member month for the budget period. Adjustments can be positive and negative. Due to changing facts and circumstances, a plan may find it necessary to adjust the Medicare cost for a given period of time.

For example, a health plan may find that an adjustment made on the prior year's final cost report (Worksheet E, Column 3) significantly impacts cost centers represented on the budget Worksheet A, Part 1, Column 1. In this scenario, due to the fact that these costs were excluded (per the Cost Report Instructions, Part I, Column 1 – Trail Balance Per Books), a health plan can use Column 4 to make adjustments for these impacts. These PMPM adjustment amounts must be calculated on the supporting worksheet and brought forward to Column 4 in Part II. All rationale and backup information that verify the need and amount of the adjustment must be submitted with the Budget Forecast.

Column 5 - Adjusted Medicare PMPM Cost - The adjusted Medicare PMPM is calculated in this column by adding the amounts in Columns 3 plus 4 on the lines as appropriate.

> **Line 12 - Estimated Deductibles & Coinsurance** - The worksheet enters on Line 12 the amount computed from Part III, Column 1, Line 13 minus Line 12.
>
> **Line 14 - Medicare Primary Rate** – Column 5 is the sum of the interim PMPM payment rates calculated on the worksheet (Column 6 and Column 7) determined by multiplying the Part A and Part B Medicare PMPM cost net of coinsurance and deductible on Column 6 and 7, Line 13 by the ratio of the Medicare Part A and Part B primary member months to the total Part A and Part B member months from Part IV, Column 1 and 2, Line 4.

Column 6 - Medicare Part A PMPM Cost - The Medicare Part A PMPM amounts are calculated by multiplying the total Medicare PMPM Cost in Column 5 by the prior period Medicare Part A Ratio determined in Part I, Column 7, on the lines as appropriate.

> **Line 9 - Third Party Insurer Revenue** - These services pertain to only two categories of services for which Medicare has a secondary liability: (1) services covered by workers' compensation; and (2) services covered by auto medical, no fault, or any liability insurance. The amount to be entered as "Third Party Insurer Revenue" must be determined by the Plan by multiplying the amount in Column 5 times the result of dividing the amount on the prior year final cost report Worksheet L, Column 1, Line 16 by Column 3, Line 16. A worksheet must be attached showing this calculation. The "Third Party Insurer Revenue" is the amount received for those services that are not paid fully by the insurer.

Column 7 - Medicare Part B PMPM Cost - The worksheet calculates the Medicare Part B PMPM amounts by subtracting the PMPM amounts for Medicare Part A in Column 6 from the Total Medicare PMPM in Column 5 for each line in Column 7.

Line 12 - Estimated Deductibles & Coinsurance - The worksheet calculates the Standard Part B Deductible (Provided by CMS) and Coinsurance amount by subtracting the Standard Medicare Part A Deductible and Coinsurance in Column 6 from the Total Deductible and Coinsurance in Column 5.

2303.3 Part III - Deductible and Coinsurance

Part III is used to calculate the projected Medicare deductible, coinsurance, and copayment on covered Medicare benefits incurred by the Plan during the budgeted period.

Line Descriptions

Line 1 - Total Estimated Part A Deductible and Coinsurance - Enter in Column 2 the budgeted amount for Part A deductible and coinsurance. Attach a worksheet showing how this amount was determined.

Line 8 - Part B Standard Deductible - Enter in Column 3 the Part B Standard Deductible published by CMS for the budgeted period.

Line 9 - Part B Blood Deductible PMPM - Enter in Column 3 the projected Part B Blood Deductible PMPM for the budgeted period. Attach a worksheet showing the calculation of this amount.

Line 12 - Part B Coinsurance on MAC Paid Bills PMPM - Enter in Column 3 the Part B Coinsurance on MAC Paid Bills PMPM for the budgeted period. This is the same type of cost found on Worksheet G, Part I, Line 23 of the final cost report. Attach a worksheet showing the calculation of this amount.

2303.4 Part IV - Membership

Part IV is used to report the projected number of Medicare member months for the budgeted period.

Line Descriptions

Line 1 - Total Medicare Member Months - Enter the total projected number of Medicare member months, used to develop the budget, for Part A in Column 1 and for Part B in Column 2.

Line 2 - Medicare Secondary Liability Member Months - The Medicare program is usually the primary payer for covered Medicare services provided to Medicare members of an HMO/CMP or an HCPP. However, there are five categories of services for which Medicare is secondary payer (42 CFR §417.528)(Pub. 100-16, Chapter 17b, §300.1; 300.6.1)(Pub. 100-16, Chapter 18b, §140.1; 140.6.1). These are:

(1) Services covered by worker's compensation, including black lung benefit programs;
(2) Services covered by Employer Group Health Plans (EGHPs) in the case of end-stage renal disease beneficiaries during a period of up to 30 months;
(3) Services covered by auto medical, medical malpractice, no fault, or any liability insurance;

(4) Services covered by EGHPs in the case of employed beneficiaries and the dependents of the employed beneficiary;
(5) Services covered by "large group health plans" (LGHPs) in-case of disabled beneficiaries under 65 and whose LGHP is based on the beneficiaries current employment status or their family members

An HMO/CMP or HCPP need not coordinate benefits in situations where the probability of recovery is highly unlikely or the amount recoverable does not exceed the cost to pursue the claim. However, according to 42 CFR §417.528, no payment will be made to a cost-based Plan for services to the extent that Medicare is not the primary payer under the provisions of Section 1862 (b) of the Social Security Act. In addition, no payment can be made for services not covered by Medicare. Therefore, enter on Line 2 the number of Medicare member months of those beneficiaries the plan has identified to CMS as a Medicare enrollee that can be classified in categories 2, 4 and 5 above.

2303.5 Part V - Annual-Projections

Part V is provided to develop ratios that will be used in the Plans' Interim Cost Report. The unit of fluctuation ratio is the ratio of the total projected Medicare PMPM net of estimated deductible and coinsurance to the total estimated PMPM cost for the entire 12 months of the contract period. The ratio calculated by this worksheet in Column 2, Line 2 derives the Medicare PMPM amount in the Interim Cost Report that is used to establish the Interim Payment Rate.

2304 WORKSHEET B – DETERMINATION OF VOLUNTARY UNDER COLLECTIONS AND PREMIUM DETERMINATIONS

This Worksheet is provided for HMO/CMPs and HCPPs to compute a voluntary under-collection and establish a premium that will cover all the projected costs in this budget on Worksheet A, all parts, recoup any under collections from a prior period, and/or adjust the current calculations for any over collections from the immediate prior period. Line 2 allows the inclusion of any prior under (over) collections.

NOTE: This worksheet is to be completed in conjunction with Worksheet A – Current Budget Forecast and Worksheet N – Final Cost Report from the most recently completed final cost report.

Line Descriptions

Line 2 – (Over)/Involuntary Under Collection for the Period - Enter the amount of the over/under collection reported on Worksheet N, Column 3, Line 11 or 12b of the most recent Final Cost Report. For example, in preparing the Budget Forecast for contract year 2025, the period January 1 through December 31, 2023 is the most recent Final Report period. The over collection reflected on the Worksheet N, Part I, Column 3, Line 11 or Involuntary under collection on 12b of the Final Report for the 2023 contract period is entered on this Line 2. Please note that Line 2 should either be line 11 or 12b of Worksheet N. Line 11 should be input in the case of an over-collection in the prior period, and Line 12b should be used in the case of an involuntary under-collection. Per the Managed Care Manual, Chapter 17b, §210.1 and Chapter 18b, §100.1, plans should refund an over-collections to the beneficiary or adjust future premiums.

Any over collection from a prior period should be expressed as a negative number and any involuntary under collection should be expressed as a positive number.

Line 3 – Medicare Member Months for the Period – Enter the Medicare Member Months from the period reported on Worksheet L, Column 2, Line 1 of the Final Cost Report. For example, in preparing the Budget Forecast for contract year 2025, the period January 1 through December 31, 2023 is the most recent Final Report period. The Medicare Member Months reflected on Worksheet L, Column 2, Line 1 of the Final Report for the 2023 contract period is entered on Line 2.

Line 7 - Total Amount to be Charged Including Medicare Enrollee Copayments - Enter the PMPM amount the Plan intends to charge. A worksheet must be attached to support the determination of the amount. This worksheet must segregate the total amounts to be charged Medicare enrollees for covered services into two categories: 1) the monthly premium per Medicare enrollee for covered services, and 2) the average actuarial value of all deductibles, coinsurance, and co-payments for covered services to be charged each Medicare enrollee each month. This included Medicare enrollee co-payments collected by someone other than the plan (e.g. co-payments collected for a doctor office visit by the physician's office).

Note: The Total Amount to be Charged Including Medicare Enrollee Copayments, reported on Line 7, should not be greater than the Total Allowed to be Collected During the Budget Period, on Line 6. If the number entered on Line 7 is greater than the amount on Line 6 a warning message will be populated and the plan should analyze and adjust the amount.

2305 WORKSHEET C - INTERIM REPORTING

In accordance with 42 C.F.R. 417.572(c)(1), an HMO or CMP must submit an interim cost report on a quarterly basis in the form and detail prescribed by CMS. These quarterly interim cost reports must be submitted no later than 60 days after the close of each quarter of the contract period. Under subsection 42 C.F.R. 417.572 (c)(2) CMS may reduce the frequency of the reports if CMS determines there is good cause for doing so.

Under 42 C.F.R.417.808(c), an HCPP must submit an interim cost report and enrollment data in the form and detail prescribed by CMS applicable to the first 6 months of the contract period. The interim cost report must be submitted no later than 45 days after the close of the first 6-month period of the HCPP's reporting period.

Each interim cost report must be submitted using this Worksheet C and the Worksheet S indicating in Section 3 this is an interim report. These worksheets must be used by all HMOs, CMPs and HCPPs in order to fulfill their requirement to submit interim cost reports. The objective for submitting interim reports is to avoid having excessive balances due to or from the plan at the end of the reporting period. For HMO and CMP, the final interim cost report for the 12-month period of the contract must be filed on Worksheet S and D through M; the same worksheets used for the final cost report submission.

2305.1 Part I - Costs

All amounts entered in this part must be YTD cumulative amounts for the period being reported on. If the Plan is aware of circumstances that will likely occur and will have a material impact on costs after the interim reporting period, an adjustment should be made to reflect the estimated impact of this change on the interim per capita rate. Workpapers supporting the estimation of the impact adjustment must be submitted with the interim cost report; otherwise the adjustment will not be allowed.

Line Descriptions

Lines 1 through 8 - The amounts entered are actual amounts incurred in the interim reporting period. The trial balance underlying the amounts on these lines and showing the grouping of individual expense items into each cost center must be submitted with the interim cost report.

Line 9 - This line accumulates the actual total costs reported on Lines 1 through 8.

Line 10 - Cost per Member Month - The worksheet calculates the total per member month amount by dividing the total cost on Line 9 by the total member months in Part II, Line 1.

Line 11 - Ratio From Budget Forecast - Enter on this line the amount reflected on the Budget Forecast for the contract period on Worksheet A, Part V, Column 2, Line 2.

Line 12 - Medicare Costs - This is the Medicare PMPM amount calculated on the worksheet by multiplying the Total Cost PMPM amount on Line 10 by the Medicare ratio on Line 11.

Line 13 - Payment Rate - This is the Medicare primary payment rate calculated on the worksheet by multiplying the Medicare PMPM amount on Line 12 by the ratio of Medicare primary member month to the total Medicare member months in Part II, Line 5.

Line 14 - Current Payment Rate - Enter the current Medicare PMPM payment rate on this line.

2305.2 Part II - Membership

Member month amounts reported on these lines should reflect cumulative member months for the period covered by the report. A member month is defined as each month a person is a member of the plan. For example, if a Medicare beneficiary was a member of the plan for the six-month period covered by the interim cost report, the plan would report a total of six Medicare member months.

Line Descriptions

Line 1 - Total Member Months - Enter the total Medicare and non-Medicare member months on this line.

Line 2 - Total Medicare Member Months - Enter on this line the information requested for those Medicare enrollees that are enrolled in the Supplemental Medicare Insurance (Part B) Program under Medicare. Part B Member Months should always equal Total Medicare Member Months.

Line 3 - Medicare Member Months (Secondary) - The Medicare program is usually the primary payer for covered Medicare services provided to Medicare members of an HMO/CMP or an HCPP. However, there are five categories of services for which Medicare is secondary payer (42 CFR §417.528)(Pub. 100-16, Chapter 17b, §300.1; 300.6.1)(Pub. 100-16, Chapter 18b, §140.1; 140.6.1). These are:

(1) Services covered by worker's compensation, including black lung benefit programs;
(2) Services covered by Employer Group Health Plans (EGHPs) in the case of end-stage renal disease beneficiaries during a period of up to 30 months;
(3) Services covered by auto medical, medical malpractice, no fault, or any liability insurance;

(4) Services covered by EGHPs in the case of employed beneficiaries and the dependents of the employed beneficiary
(5) Services covered by "large group health plans" (LGHPs) in-case of disable beneficiaries under 65 and whose LGHP is based on the beneficiaries current employment status or their family members

An HMO/CMP or HCPP need not coordinate benefits in situations where the probability of recovery is highly unlikely or the amount recoverable does not exceed the cost to pursue the claim. However, according to 42 CFR §417.528, no payment will be made to a cost-based Plan for services to the extent that Medicare is not the primary payer under the provisions of Section 1862 (b) of the Social Security Act. In addition, no payment can be made for services not covered by Medicare. Therefore, enter on Line 3 the number of Medicare member months of those beneficiaries the plan has identified to CMS as a Medicare enrollee that can be classified in categories 2, 4, and 5 above.

Line 4 - Medicare Member Months (Primary) - The worksheet calculates the Medicare primary member months by subtracting the Medicare secondary member months on Line 3 from the total Medicare member months on Line 2.

Line 5 - Ratio - The worksheet calculates on this line the ratio of Medicare primary member months to the total Medicare member months. This ratio is used in Part I to determine the Medicare primary payment rate for the period being reported.

2306 WORKSHEET D - PLAN STATISTICS

Worksheet D is provided for HMO/CMPs and HCPPs to list the providers and suppliers that are frequently used by the plan. In addition, the statistics should be grouped appropriately so that they tie to Worksheet K. Statistics on Worksheet D and K should have a direct relationship to the costs that flow to Column 6 on Worksheet K.

Note: Please note that for the completion of this worksheet, Medicare statistics should exclude any claims processed by MACs for services provided to Plan enrollees.

2306.1 Part I - Plan Statistics - List Of Providers

This worksheet is provided for only HMOs/CMPs to list the providers that are frequently used by the plan. HCPPs do not complete this worksheet since their reimbursement is limited to the reasonable cost of non-provider services covered under Part B of the Social Security Act. Therefore, HCPPs should mark Line 1 with N/A. HMOs/CMPs with bill processing option #1 reported in Worksheet S, Section 3b do not complete Sections A (Hospitals and SNFs) and B (HHA's and Other).

Column Descriptions

For the category descriptions below the "*LIST OF PROVIDERS*" column for plans with bill processing option #2 only, list all hospitals and skilled nursing facilities rendering services to the plan's Medicare enrollees under category "*A. HOSPITALS & SNFS*". List all Home Health Agencies under category "*B. HHA*" and all others (specifying Name & Type) under category "*C OTHER (SPECIFY NAME AND TYPE)*" on the continuation page of Part I - Plan Statistics - "*LIST OF PROVIDERS.*"

Column_1 – Provider Number - Enter the Medicare provider billing number assigned to the provider.

Column 2 – Relationship - Enter the relationship code for that provider. If the provider is owned or controlled by the plan or if the plan is owned or controlled by the provider, enter the code ”O.” For a full description of Medicare's rules defining “ownership” or "control", refer to the Provider Reimbursement Manual (PUB 15-I) Chapter 10. Where the code “O” is entered, the Worksheet H, Section A. must be answered “Yes.” If there is no relationship between the plan and the provider other than contractual, enter the code “P”.

Column_3 – Bills Processed By - Enter the code (“H” or “P”) representing the bill processing option selected by the plan. If the plan has elected to process the bills (Option 2) of the provider, enter the code “P”. If the plan has elected to have CMS process the bills (Option 1) of the provider, enter the code “H”**.** This coding must be consistent with that reported In Section 3b on Worksheet S. For a description of the different options available, refer to Chapter 17a, Subchapter A, Section 10.2 of the Medicare Managed Care Manual (Pub 100-16).

Column 4 – Total Days - For category A, "*Hospitals & SNFs*", enter the total number of inpatient days used by all enrolled plan members. This figure should include all of the days used whether or not the plan has been billed by the provider due to timing delays. For categories B and C, enter the total statistical unit for all enrolled plan members used to apportion the costs of that provider type.

Column 5 – Total Medicare - For category A, "*Hospitals & SNFs*", enter the total number of inpatient days for all Medicare enrollees. For categories B and C, enter the total applicable statistical units for all Medicare enrollees.

Column 6 – Covered Medicare Primary - The Medicare program is usually the primary payer for covered Medicare services provided to Medicare members of an HMO/CMP. However, there are five categories of services for which Medicare is secondary payer (42 CFR §417.528, Pub. 100-16, Chapter 17b, §300.1; 300.6.1, Pub. 100-16, Chapter 18b, §140.1; 140.6.1). These are:

(1) Services covered by workers’ compensation, including black lung benefit programs;
(2) Services covered by Employer Group Health Plans (EGHPs) in the case of end-stage renal disease beneficiaries during a period of up to 30 months;
(3) Services covered by auto medical, medical malpractice, no fault, or any liability insurance; and
(4) Services covered by EGHPs in the case of employed beneficiaries and the dependents of the employed beneficiary.
(5) Services covered by “large group health plans” (LGHP) in-case of disable beneficiaries under 65 and whose LGHP is based on the beneficiaries current employment status or their family members

An HMO/CMP need not coordinate benefits in situations where the probability of recovery is highly unlikely or the amount recoverable does not exceed the cost to pursue the claim. However, according to 42 CFR §417.528, no payment will be made to a cost-based HMO/CMP for services to the extent that Medicare is not the primary payer under the provisions of Section 1862 (b) of the Social Security Act. In addition, no payment can be made for services not covered by Medicare.

Therefore, enter in Column 6 the number of days or statistical units used by Medicare enrollees for which Medicare has primary liability and the days or statistical units that are covered by the Medicare program.

Additionally, include in this column services covered by employer groups (categories 2, 4 and 5). The cost of these services will be removed through the apportionment on Worksheets K, L and M.

Column 7 – Covered Medicare Secondary - Enter only those inpatient days or statistical units for which Medicare has no liability for categories 1 and 3 mentioned above. Refer to Chapter 17, Subchapter B, Sections 310 through 350, and Subchapter F, Section 70 of the CMS Managed Care Manual Pub #100-16 for a detailed discussion of the coordination of benefits provisions under Medicare. Non-covered services should not be included in Column 7. Therefore, the addition of Column 6 plus Column 7 will be less than Column 5 by the number of non-covered inpatient days or statistical units used by the Medicare enrollee.

There are circumstances where plans are able to isolate the costs and statistical units of non-covered services and/or those services for which Medicare is secondary payer. The plan may elect to exclude those statistical units from the total on Worksheet D, Part I, Column 4 and the costs associated with them from total costs on Worksheet E through adjustments on Worksheet G. If that election is made then it must be disclosed in the footnotes to the HMO/CMP certified cost report. Where this occurs, Columns 5 and 6 on these Worksheets will be the same amount and there will be no entry in Column 7.

2306.2 Part II - Plan Statistics – List Of Suppliers

This worksheet is provided for all plans, including HCPPs, to list the suppliers that are frequently used by the plan's membership (i.e. the most utilized). The column headings for Columns 4 through 7 are the same as those for the "*LIST OF PROVIDERS*" (see § 2306.1 above). These suppliers shall be separated by the **CMS APPROVED** type of statistic used to apportion your costs on Worksheet K. For example if you are currently approved to use “FFS” as your allocation statistic for the Physician Group Cost Center, you must use “FFS” as your apportionment statistic regardless of the arrangement. However, if you have prior approval for the use of multiple statistics in one cost center, please separate as suggested in the following example. Example: Fee For Service arrangements should be listed individually or grouped together if the providers use the same statistic for utilization; however, a Capitated arrangement that has separate statistics for utilization (e.g. Visits, encounters, claims) should be listed on a different line and shall not be included under the Fee For Service line. Be careful of Capitated arrangements that may have different statistics (ex. Encounters/visits vs. claims) as this is a different statistic as well. The utilization statistic between the plan and provider determines which providers should be grouped together. If there are various statistics that cannot be grouped under either Fee For Service or Capitation (ex. RVU’s, Claims, Services, etc.) then Option “C-Other-Specify” should be used. The plan should then specify what type of statistic is used on Worksheet K column 1 for the corresponding cost centers.

Line Description

For the category descriptions below "LIST OF SUPPLIERS", list all suppliers of health services rendering services to the plan's Medicare enrollees as follows:

Category A -Physician Services
Category B -Certified Labs
Category C -X-ray units
Category D -Others (Specify Type)

All related suppliers should be identified by placing an “R” next to their name.

Column Descriptions

Column 1 – Type of Group - Enter the type of supplier that can be grouped by using the following codes:

A = IPA
B = Group Practice
C = Staff *
D = Individual Practitioners**

* All services rendered by the staff of the plan should be grouped on one line in each category (if necessary) and identified as either "staff" or "clinic".

** All individual practitioners should be grouped on one line in each category if the plan uses the same statistic and identified as "*Individual Practitioners*".

Column 2 – Payment Mechanism and Column 3 – How Physicians Paid - For each supplier listed, identify the method the plan is paying the supplier (Column 2) and the method the supplier is paying physicians (Column 3). Use the following codes:

"A" for fee-for-service payments

"B" for capitation payments

"C" for other methods - specify the type of method being used

Please note that the Letter Codes entered into Columns 1 & 2 are REQUIRED, and will be used to summarize the data entered at the bottom of each section. If Columns 1 & 2 are not entered, the data will not be included in the summary. The summary data is linked/transferred to Worksheet K to ensure that Worksheets D and K match/tie as is required. Group/Payment type allows for one statistic to be used. If you have approval and require additional statistic types within a Cost Center, please contact your CMS servicing auditor for direction.

For Column 3 only, use "D" when the plan is an HCPP, a physician group pays its physicians on a fee-for-service basis, and an exception to the Subpart E limits has been granted. The exception would be granted under 42 C.F.R. 417.802 after CMS has determined that the Physician Group has an agreement that includes acceptance by its members, to effective incentives designed to avoid unnecessary or unduly costly utilization of health services. **A copy of the determination letter must be attached to Worksheet D**.

For Column 4 only. The plan should have indicated whether CMS has determined that the physician group has an agreement, that includes acceptance by its members, to effective incentives designed to avoid unnecessary or unduly costly utilization of health services. A copy of the determination letter should be attached to this Worksheet D and Column 4 for that physician group should not be completed.

The plan can use supplemental Worksheet D-part II to provide additional explanation regarding the method utilized to pay the supplier (Column 2) and the method the supplier used to pay physicians (Column 3), specifically, when the method used for payments is other than fee-for-service or capitation payments.

Category E – Membership

Column Descriptions

Column 1- Medicare Part A - Enter the information requested for those Medicare enrollees that are eligible to receive payment for covered services under Part A of the Medicare Program.

Column 2 – Medicare Part B - Enter the information requested for those Medicare enrollees that are enrolled in the Supplemental Medicare Insurance (Part B) Program under Medicare. Part B Member Months should always equal Total Medicare Member Months.

Line Descriptions

Line 1 – Total Medicare Member Months - Enter in the appropriate column Medicare enrollee member months. A member month is defined as each month a person is a member of the plan. For example, if a Medicare beneficiary was a member of the plan for the twelve month period covered by the report, the plan would report a total of 12 Medicare member months for that individual.

Line 2 – Medicare Secondary Liable (Employee Groups) Member Months - Enter the number of member months of Medicare enrollees who are members of an employer group and Medicare is secondarily liable for their services. These are the Medicare member months associated with Categories (2), (4) and (5) described above in Section 2306.1 Part I - Plan Statistics - List Of Providers for the Column 6 description.

Line 3 – Medicare Primary Member Month - The worksheet calculates the Medicare primary member months by subtracting the Medicare secondary liable member months on Line 2 from the total Medicare member months on Line 1 for each column.

Line 4 - Ratio – The worksheet calculates the ratio of the Medicare primary member months to total Medicare member months by dividing Line 3 by Line, 1. All Ratios must be reported to four decimal places.

2307 WORKSHEET E - SUMMARY TRIAL BALANCE

This worksheet is provided to:

- Record the operating expenses of the Plan according to Generally Accepted Accounting Principles,
- Summarize reclassification and adjustments of expenses in accordance with the Medicare Principles of Reimbursement, and
- Establish the ful1 cost of services for Medicare apportionment after reclassification into the appropriate cost center.

The necessary reclassifications and adjustments needed for certain accounts detailed and summarized on Worksheets F and G are brought forward to this worksheet. The allocation of Administrative and General (A & G) costs on Worksheet I are brought forward to this worksheet after the reclassifications and adjustments are made. Cost allocations are made in this cost report in two steps:

1. Functional allocations to cost centers
2. Pool allocation of remaining A & G costs

* Direct allocations may also be accomplished but must be made as prescribed in Section 2307 A. of the Provider Reimbursement Manual (PUB 15-I).

The cost centers on this worksheet are listed in a manner to facilitate the transfer of costs to subsequent worksheets. Column 7 displays the worksheet and line number reference to which each entry in Column 6 is transferred. Not all of the cost centers will apply to all plans.

Column and Line Descriptions

Column 1 – Trial Balance - Enter on the appropriate lines the total costs the plan incurred during the reporting period. These costs that are entered must agree with the plan's audited accounting records maintained under Generally Accepted Accounting Principles without any adjustments. The plan must maintain a worksheet that groups costs from the audited trial balance of expenses to the various cost centers on this worksheet. Any needed reclassifications, adjustments and allocations must be recorded in Columns 2, 3, and/or 5, as appropriate.

Column 2 – Reclassifications (Wkst F) - Reclassification made among the cost centers in Column 1 which are needed to affect proper cost allocations are brought forward from the summary on Worksheet F, Page 5. The Worksheet F series has been provided to help the plans complete the reclassifications needed which affect the appropriate cost centers. Reductions to cost centers should be shown in brackets ( ). The net total of the entries in Column 2 must equal zero on Line 29.

Column 3 – Adjustments (Wkst G) – The adjustments summarized on Worksheet G, Part II are brought forward to the appropriate lines in Column 3. The amounts of any adjustments are those needed to determine allowable costs for apportionment under the Medicare Principles of Reimbursement. The Worksheet G series and Worksheet H (if applicable) are provided to help the plans to complete the proper adjustments to the costs recorded in Column 1 in accordance with the Medicare Principles of Reimbursement.

Column 4 – Allowable Costs – The cost report calculates adjustments to Column 1 made in Columns 2 and 3 and enters the net balance to Column 4.

Column 5 – A&G Allocation (Wkst I, Part I) – The cost report brings forward the amounts resulting from the allocation of Administrative and General Costs shown on Line 28 Column 4 from the Worksheet I, Part I Column 7. Worksheet I is provided to allocate A & G costs to those cost centers receiving a benefit from the A&G costs. Reductions to cost centers must be shown in brackets ( ). The net total of the entries on Column 5 must equal zero on Line 29.

Column 6 – Totals – The allocated A&G costs in Column 5 are adjusted to the amounts in Column 4 and extend to Column 6.

Lines 1 and 2 – Inpatient and Outpatient Hospital - Enter on these lines the costs incurred by the plan, and reflected in the accounting records, for services furnished through a Hospital. Only Plans electing billing option #1 in section 3(b) on Worksheet S, may use these forms. Those Plans electing Billing Option 2 must use the CMS alternative Worksheets E through M. Instructions for these Option 2 alternative worksheets are included as Appendix A.

Lines 3 and 4 – Other Provider Costs - Enter on the appropriate lines the cost of services incurred by the plan, and reflected in the accounting records, for services furnished through a Skilled Nursing Facility or Home Health Agency. Adjustments on Worksheet G must be made to Lines 3 and 4 that include those adjustments necessary to remove the cost of non-covered services and the cost of services to non-Medicare patients. As a result of these adjustments, only the reimbursable portion of Skilled Nursing Facility or Home Health Agency services will be reflected in Column 4 and will flow to Worksheet J from Column 6 after cost finding.

Lines 5 thru 13a – Non-Provider Costs - Enter on the appropriate lines the cost of services incurred by the plan, and reflected in the accounting records, for services furnished by a non-provider. Separate lines are provided for the different types of suppliers of services. Services may be furnished by the plan through its own employees, under arrangements with related and/or unrelated parties, or a combination of both. Payment arrangements with each non-provider type and/or service arrangement may vary. If this occurs and the plan has approval from CMS to fragment the apportionment for a specific type(s) of payment and/or service arrangement on Worksheet K, then these lines must be subscripted for each of the specific type of payment and/or service arrangement consistent with those on Worksheet K.

Line 14 - Emergency-Urgently Needed Services - Enter the costs of services furnished in an emergency or urgently needed situation that were provided out-of-plan on an infrequent basis. Services of this type that were furnished by in-plan providers or suppliers would be entered on Lines 1 through 13, as appropriate. The cost of those services that would be entered on Lines 1 through 13 but were furnished out-of-plan in an emergency or urgently needed situation will be recorded on this line.

Line 15 – Mental Health Services - Enter on Line 15 the cost of both the professional and non-professional components of mental health services. The amount in Column 6 will be entered on Worksheet K, Line 24.

Please note that the Mental Health limitation no longer exists as of 2014, and Medicare will pay outpatient mental health services at the same level as other standard Part B Services.

Note: Claims involving outpatient psychiatric services should no longer be processed by the MAC.

Line 16 – Deductible and Coinsurance on claims processed by MACs - From time to time, bills for Part B services for which the plan has responsibility are processed by the CMS MACs. In addition, certain services must be billed to the MACs (Medicare Managed Care Manual (Pub. 100-16, Chapter 17b, §300)(Pub. 100-16, Chapter 18b, §140)). Line 16 is provided for the plan to enter the deductible and coinsurance amounts paid by the plan for those services processed through the MACs. The Adjustment in Column 3 is made to eliminate the amount of Part B coinsurance included in these costs. Entries in Column 6 will be brought forward to Worksheet L.

Line 17 – Medicare Bad Debts - Enter in Column 1 the total bad debt expense recorded in the records. The bad debt adjustment on Worksheet G should result in the Allowable Medicare Bad Debts (net of bad debt recoveries) for premiums, dues, and co-payments charged to Medicare enrollees being reflected in Column 4. The amount of allowable bad debts for a Medicare enrollee may not exceed three times the monthly rate (or its equivalent if the premium is payable on other than a monthly basis) for the actuarial value of the deductible and coinsurance amounts. Any bad debt related to a service furnished to a Medicare enrollee of the HMO/CMP or HCPP and claimed on a cost report submitted for payment by a provider or other facility paid on a cost basis

may not be claimed as a bad debt by the plan. See the CMS Managed Care Manual Pub #100-16, Chapter 17, Subchapter B, Section 220.1 for further discussion on Bad Debts.

Line 18 - Blood Deductible - Enter the amount of the beneficiary's share of the cost for the first three pints of blood, if not replaced.

Line 19 – Part B Costs not Subject to Coinsurance – Enter the Part B Costs not Subject to Coinsurance. The amount in Column 6 will flow to Worksheet L, Line 21 and then Worksheet M, Line 16. For example, this would include clinical diagnostic lab tests according to §1833(a)(2)(D) of the Social Security Act, some preventive services according to 42 CFR §405.2449, services/Part B drugs covered 100% by Medicare, and influenza and pneumonia shots. Please note that the reclassifications to this line and amounts transferred to worksheets L and M should include Medicare only amounts. An attached worksheet showing these separate items and amounts needs to be submitted along with any Fourth Quarter Interim and Final Cost report.

Line 20 – Non-Allowable Costs – Enter any non-allowable costs on this line. The amount in Column 6 will not flow to other worksheets, as these costs are not reimbursable. These costs would consist of the adjustments for non-allowable costs that were previously made on Worksheet G. The term non-allowable and non-covered cannot be used interchangeably to report costs on this cost center as both claims would be treated differently on the cost report. Non-covered services such as vision or dental services, etc. should be reported on their corresponding costs center so that the ratios are equitably apportioned on Worksheet K as well as in order to receive their fair share of Administrative and General Costs.

Line 21 through 23 - These lines are provided for the reporting of costs of any other provider or supplier of health services rendering services to the plan's membership that are not reflected in Lines 1 through 18. The type of organization paid and the kind of services rendered must be entered in the far left column. If additional lines are needed, a supplemental schedule should be included reflecting the different cost centers summarized on lines 21 through 23 on Worksheet E. Adjustments and reclassifications to any summarized cost centers on these lines should also be included on the supplemental schedule.

Entries in Column 6 for reimbursable services will be brought to Worksheet J or Worksheet K, as appropriate.

Line 25 – Plan Administration - These costs benefit the total enrolled population of the plan and have no direct relationship to medical care or services. Plan administration includes the total costs incurred for enrollment, marketing, membership, administering the plan and the following types of costs:

- Directors' salaries
- Executive and staff administrative salaries
- Organizational management costs
- Organizational costs
- The cost of preparing cost reports and cost report analyses
- Management information systems
- Research and development to expand the HMO
- Feasibility studies
- Studies conducted on utilization
- Grant and loan applications
- Grant and loan administration

- Actuarial studies
- Allowable Premium taxes
- Enrollment and marketing
- Any other costs incurred for the benefit of the entire enrolled population

Entries in Column 6 will be brought to Worksheet L, Line 3.

Line 26 – Special Administrative Costs - Enter the special Medicare Program costs which are fully reimbursable by the program as described in the Medicare Managed Care Manual Pub #100-16, Chapter 17, Subchapter B, Section 200 and 42 C.F.R. §417.550. These costs include:

1. The reasonable cost of reporting increases and decreases in the number of Medicare enrollees according to 42 C.F.R. §417.550(b)(1)..
2. The reasonable cost incurred solely for the purpose of independently certifying the Medicare cost report to the extent that it is for Medicare purposes. Please note that this applies only to the HMO/CMP. If the certification cost appears unreasonable, the HMO or CMP will be required to provide supporting documentation including, no less than three quotes from independent CPA firms in order to justify its cost.
3. The reasonable cost of reporting special data required from HMO/CMPs by Medicare solely for program evaluation and planning purposes specifically requested and approved by CMS. Detailed description and breakdown of the costs must be provided at the time of submission.

Please note that prior approval of special administration costs is required through inclusion of such costs in the annual budget forecast. Entries in Column 6 will be brought to Worksheet L, Line 6.

NOTE: The Special Administration Costs Tab contained in the 4th Quarter and Final Cost Reports must be completed including a schedule showing the details and computation of the special administration costs.

Line 28 – Administrative & General Costs – Enter on this line all other Administrative and General costs not included on Lines 25 and 26 above. These costs generally bear a **significant** relationship to the medical services furnished by the plan. Include only those costs which are necessary and proper to the efficient management of all services. All costs that do not pertain to the health plan or are non-allowable must be adjusted out in Column 3. As a result of the cost finding that occurs on Worksheet I and is brought forward to this Worksheet in Column 5, the amount in Column 6 for this line must equal zero.

42 CFR 417.564(b) provides the following examples of Administrative & General costs:

(i) Facility costs
(ii) Interest expense
(iii) Medical record costs
(iv) Centralized purchasing costs
(v) Accounting and data processing costs
(vi) Other administrative and general costs that are not included in Plan Administration.

2308 WORKSHEET F - RECLASSIFICATIONS

This worksheet provides for the reclassification of costs reported on Worksheet E to the appropriate cost centers. These reclassifications are necessary for subsequent allocations and apportionments. Review Section 2307 for the description of possible A & G allocations for inclusion as items of reclassification. Direct allocations should be made to those cost centers actually benefiting from the cost.

Worksheet F should be completed to the extent that costs are not included in the proper cost centers.

Submit with the cost report, copies of any workpapers used to compute the reclassifications affected on this worksheet.

Column Descriptions

Enter the explanation of the reclassification.

Column 1 - Enter a letter (A, B, etc) on each line used in Column 2 to identify each reclassification entry.

Explain the reason for the reclassification entry just to the left of Column 1. If more than one cost item is being reclassified, the plan should identify each item reclassified.

Column 2 - All cost centers being adjusted should be identified in this column. The names of these cost centers should correspond to the names used on Worksheet E.

Column 3 - List the line number from Worksheet E for each cost center identified in Column 2 of this worksheet.

Columns 4 and 5 - These columns are provided to record the amount of increase (Column 4) or decrease (Column 5) for each cost center listed in Column 2.

Examples of the six most common reclassification are as follows:

1. Special Administrative costs must be removed from the Administrative and General cost center. A reclassification should be made to increase Line 26 of Worksheet E and a corresponding reclassification to decrease Line 28 of Worksheet E. (See Instructions for Worksheet E, Line 26 for definition of Special Administrative Cost).

2. Certain insurance costs must be removed from the A & G cost center and placed in the cost centers benefiting from these costs. Malpractice insurance should be allocated to the various service components of the plan based on quotes from the plan's insurance company. For example, if the plan's insurance company states that 50 percent of the malpractice insurance premiums is for insuring the plan against claims arising out of inpatient hospital services, then the plan must allocate 50 percent of the insurance to Inpatient Hospital (line 1 of Worksheet E).

3. Space cost should be reallocated to the cost centers occupying the space.

4. Reclassify interest expenses to the cost centers benefiting from the loan for which interest is incurred. Some plans may prefer to have interest in the A & G cost centers due to further needed adjustments on Worksheet G for investment income.

5. Marketing, Membership, and Enrollment costs should be reclassified to Plan Administration.

6. All other Plan Administration type of costs should be reclassified from Administrative and General to Plan Administration**.** These costs would include, but are not limited to, grievance procedures, actuarial costs and any other A & G costs that benefit the entire population. (See Section 2307 for more detailed descriptions).

Line Descriptions

Lines 1 through 50; 54-109; 111-166 & 168-223 - Enter on these lines the reclassification entries. All explanations of reclassification entries and related cost center increases and decreases must be completed on the page the entry began on.

Lines 53, 110, 167 and 224- Total - Columns 4 and 5 must equal for all entries

2309 WORKSHEET G - ADJUSTMENTS TO EXPENSES

2309.1 WORKSHEET G, PART I - ADJUSTMENT TO EXPENSES

This worksheet provides for adjustments to the cost centers listed on Worksheet E. These adjustments, which are required under the Medicare Principles of Reimbursement, are to be made on the basis of "cost" or "amount received." Enter the total "amount received" (revenue), only if the cost (including direct cost and all applicable overhead) cannot be determined, otherwise enter the "cost." Once an adjustment to an expense is made on the basis of "cost," the plan may not in future cost reporting periods determine the required adjustment to the expense on the basis of "revenue." The following symbols are to be entered in Column 1 to indicate the basis for adjustment: "A" for cost; and "B" for amount received. Line description indicate the more common activities which affect allowable costs, or result in costs incurred for reasons other than patient care and thus, require adjustments.

Types of items to be entered on Worksheet G are: (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, grants, gifts, etc.; (3) those items needed to adjust expenses in accordance with the Medicare Principles of Reimbursement; and (4) those needed to reduce the plan's costs for medical and other health care services to reasonable amounts. (5) Provider relief fund payments to assist with increased expenses as a result of the a Pandemic. These should be reported on "G-Supporting Worksheet" with a corresponding adjustment on Worksheet G so the payment received offsets the increased expenses.

Where an adjustment to an expense affects more than one cost center, the plan should either (1) record the adjustment to each cost center on a separate line on Worksheet G, or (2) enter the total adjustment on line as appropriate and attach a supporting worksheet showing the required adjustments to the various cost centers affected. In this latter situation, enter on the appropriate line in Column 1, the words "Supporting Worksheet Attached." With respect to Line 10, Worksheet H is supporting documentation for any required entry.

Column Descriptions

Columns 3 and 4 - Indicate the cost center title and line number of Worksheet E to which the adjustments are to be made.

Line Descriptions

Line 1 - Investment income on restricted and unrestricted funds which are commingled with other funds must be applied against, but should not exceed, the total interest included in allowable costs.

The investment income on restricted and unrestricted funds which are commingled with other funds should be applied against the appropriate cost centers on the basis of the ratio that interest expense charged to each cost center bears to the total interest expense charged to all of the plan's cost centers.

Lines 2 thru 7, 9, and 11 thru 18 - Enter on these lines any additional adjustments required by the Medicare Principles of Reimbursement. Explanations of the necessary adjustments can be found in Pub. 15-1.

Line 8 - Enter the allowable home office costs which have been allocated to the plan. Additional lines should be used to the extent that various plan cost centers are affected. **A copy of the home office cost report must be attached to Worksheet G.**

Line 19 - Enter the cash received from imposition of interest, finance or penalty charges on overdue receivables. This income must be used to offset the cost of the cost center to which the charges apply.

Line 20 - Enter the payments received from physicians who assume the operating costs of a hospital department.

Line 21 - Enter the amount of any contributions to a risk pool that is not going to be distributed one year after the close of the plan's reporting period.

Line 22 - For those HCPPs that are limited in reimbursement to the MAC screens, enter the amount of payments made to suppliers of health care that exceed the Medicare charge screens under Subpart E of the Medicare regulations. These amounts may be entered here with attached detail worksheets or on Worksheet K.

Line 23 - Enter on this line the Part B coinsurance the plan paid for those services processed by CMS' MACs for those services rendered to the plan's population that are the responsibility of the plan. See instructions to Line 16, Worksheet E.

Line 24 - This line is provided for those plans that have paid for physical therapy services. Worksheet A-8-3 of the Hospital cost report Form CMS-2552 must be submitted to have any physical therapy costs allowed. For further instructions on the type of adjustment needed, refer to PUB 15-1 Chapter 4

Line 25 - The plan should enter all types of reinsurance including stoploss insurance. These costs are not allowable.

Line 26 - Where depreciation expense computed in accordance with the Medicare Principles of Reimbursement differs from depreciation expense per the plan's books, enter the difference on line 27; e.g., such difference could be due to the provider using the optional allowance for depreciation or non-approved accelerated methods. An attached worksheet showing these separate items and amounts needs to be submitted along with any Fourth Quarter Interim and Final Cost report.

Line 27 - Enter the cost incurred for non-covered purchased services. This line should be used if the remaining purchased services are to be apportioned on a basis that would not eliminate these service costs. An attached worksheet showing these separate items and amounts needs to be submitted along with any Fourth Quarter Interim and Final Cost report.

NOTE: Most costs in this category should be reclassified on Worksheet F, to the applicable cost center of Worksheet E, rather than be adjusted out on this line.

Line 28 - Use this line to adjust cost claimed to allowable Medicare Bad Debts described in Worksheet L. (Refer to instructions for Worksheet L, Line 9 for allowability of Medicare Bad Debts.)

Lines 29 thru 48; 52-105; 107-160 & 162-215 - Enter any other adjustments not listed on Lines 1 through 28 and attached supporting worksheets where applicable.

2309.2 WORKSHEET G. PART II - SUMMARY OF ADJUSTMENTS

This part of the worksheet summarizes all adjustments included in Part I by cost center line in Column 2 and transfers the amount to Worksheet E Column 3.

COLUMN DESCRIPTIONS

Cost Center - The cost centers provided are the same cost centers used on Worksheet E.

Column 2 – The worksheet sums the adjustment amounts from Part I by cost center line as indicated in Column 4. Both negative and positive amounts are added together. If the sum of the amounts is a negative number, it will be shown in brackets ( ).

Column 4 - Shows the line numbers to which the amounts in Column 2 are to be transferred to Worksheet E.

2310 WORKSHEET H - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the plan by organizations related to the plan by common ownership or control. In addition, certain information concerning the related organizations with which the plan has transacted business should be shown.

Part A - Must be completed by all plans. If the answer to Part A is "yes", Parts B and C must also be completed and submitted with the cost report. If the answer to Part A is "no", no other parts need be completed.

Part B - Cost applicable to services, facilities, and supplies furnished to the plan by organizations related to the plan by common ownership or control are includable in the allowable cost of the plan at the cost to the related organization. However, such costs must not exceed the amount a prudent and cost-conscious buyer would pay for comparable services, facilities, or supplies that could be purchased elsewhere and should be allocated on an equitable basis. Transfer the amounts in Column 5, Line 17 to Worksheet G, Part I, Column 2, Lines 10.

COLUMN DESCRIPTIONS

Column 1 - Enter the applicable cost center name from Worksheet E.

Column 2 - Enter the associated expense item incurred as a result of transaction with the related organization.

Column 3 - Enter the claimed costs applicable to the related party transaction for the item included on Column 2. Please note that the costs that are included on this column must agree with the plan's audited accounting records maintained under Generally Accepted Accounting Principles.

Column 4 - Enter the applicable costs incurred as a result of the related organization that is allowable for reimbursement. Please note that the claimed expenses of the related party included in the reimbursable cost are limited to actual cost incurred by the related organization and must not exceed the price of comparable services, facilities or supplies that could be purchased elsewhere as outlined above.

Column 5 – The Net Adjustment is calculated based on the amounts entered on Column 3 and 4. Transfer these amounts to Worksheet G, Part I, Column 2, Lines 10.

Part C - This part is used to show the interrelationship of the plan to organizations furnishing services, facilities, or supplies to the plan. The requested data relative to all individual, partnerships, corporations, or other common ownership having either a related interest to the plan, a common ownership of the plan, or control over the plan, must be shown in Columns 1 through 6, as appropriate.

Only those columns which are pertinent to the type of relationship which exists should be completed.

Column Descriptions

Column 1 - Enter the appropriate symbol which describes the interrelationship of the plan to the related organization.

Column 2 - If the symbol A, D, E, F, or G, as appropriate, is entered in Column 1, enter the name of the related individual in Column 2.

Column 3 - Enter the percentage of ownership of the plan

Column 4 - Enter the name of the related organization.

Column 5 - Enter the percentage of ownership of the related organization.

Column 6 - Enter the type of business, such as physician group, pharmacy, hospital, management company, etc.

If additional lines are required to disclose all related parties, they can be entered on the supplemental Worksheet H-part C tab included on the cost report.

2311 WORKSHEET I - ALLOCATION-AND STATISTICS FOR A & G ALLOCATION

This worksheet is used to allocate those remaining A & G costs on Line 28 Column 4 of Worksheet E. Allocation statistics will be placed on Part II. Each cost item identified will be allocated to the various cost centers by using the unit cost multiplier technique.

Part II will be used to accumulate the statistics that will be used to allocate the costs on Part I. A unit cost multiplier will be developed by dividing the cost to be allocated by the total statistics of those costs. In reality the unit cost multiplier is nothing more than the amount of cost dollars per unit of statistic. Cost figures for each line of Worksheet E will be computed by multiplying the unit cost multiplier by the statistics in Part II on a line-by-line basis.

Depending on the complexity of the Plan's A&G expense structure, the allocation of A&G expense is generally accomplished in a three step process as follows:

First (Direct Allocations/Reclassifications through Worksheet F) - Expenses that are incurred exclusively for and directly identifiable to a single cost objective are allocated to that cost objective. Refer to Section 2307 A. of the Provider Reimbursement Manual for specific direction on utilization and approval of direct allocation of A&G expense.

Second (Functional Allocations) - Remaining expenses not directly identifiable to a single cost objective are allocated to multiple cost objectives based on a measure of usage or benefits received, e.g., facilities & occupancy / square footage.

Third (Residual or Pooled Allocation) - All remaining expenses not identified and allocated as direct or functional, as described above, are considered residual or pooled and are allocated across all cost objectives.

Direct assignment of A&G costs to cost centers receiving those A&G services must be based on actual auditable usage. Estimates (ex. Time studies or other statistical surrogates) are not acceptable and may not be used. In addition, direct assignment of costs must be made as part of the ongoing normal accounting process, not only as period ending adjusting entries. If records to support this are not maintained, no direct assignment of cost is allowed for the reporting period.

The above specifications should be applied for all direct allocation of A&G costs, but in particular, when allocating costs to Medicare only lines such as Line 16 – DED+CO on claims processed by MACs and Line 19 – Part B Costs not Subject to Coinsurance. Additionally, if the A&G allocation is higher than the amount listed for the corresponding cost center, then please provide an explanation on Worksheet I-Supplemental Descriptions, specifically when allocating cost to Medicare only lines such as Line 16 and Line 19.

If the Plan utilizes any allocation method other than pooled A&G allocation, provide a detailed explanation of the allocation methodology on Worksheet I-Supplemental Description for each cost center represented on Worksheet I (see 42 CFR 417.564 for guidance on A&G allocation). The Plan shall describe the specific business component A&G cost, allocation statistic and justification logic used in determining reasonable allocation in relation to the benefits received by component.

Please note A & G is not to be allocated to special administration and plan administration.

2311.1 PART I - ADMINISTRATIVE AND GENERAL COST-ALLOCATION

The allocated costs are computed on Part I using the unit cost multiplier technique described briefly above and in more detail below. Columns 1 through 4 represent those costs that can be allocated using a functional allocation. Please note if column 4 is used, you are required to specify the functional allocation. If statistics are not available, then these cost items should be allocated using the pool allocation in Column 6, and Columns 1 through 4 should be annotated with "Statistics not available."

Columns 1 through 4 are totaled in Column 5. This column will be used on Part II to properly allocate all remaining A & G using the pool allocation.

The figures developed for Column 7 should be transferred to Worksheet E, Column 5, lines as appropriate.

2311.2 PART II - ADMINISTRATIVE AND GENERAL STATISTICS

The allocation bases indicated in the column headings are accepted and recommended bases for the allocating of costs to the benefiting cost centers. If other bases are desired, the plan must seek approval from CMS to use any other bases. Requests for a change in method from the most recent prior year must be submitted to CMS 90 days prior to the beginning of the period for which the change is to apply.

Enter the statistics for each cost center in the applicable column. Enter the costs to be allocated by that method on Line 30. The unit cost multiplier for each column (1 through 4 and 7) is determined by dividing the total cost to be allocated on Line 30 by the total statistics on Line 29. More than one column may be used if various statistics are used for different types of costs. For costs that are not allocated based on a specific statistic, the pooled allocation method will be used in Column 7.

For example, if the total costs to be allocated are $50,000 (Line 30) and the total statistical units being used to allocate that cost are 75,000 units (Line 29), then the unit cost multiplier would be .6667 (50,000/75,000 carried to 4 decimal places). If the number of statistical units that were properly allocated to Inpatient Hospital are - 30,000 units (Line 1), the entry for Part I, Line 1, would be $20,001 (30,000 x . 6667).

2312 WORKSHEET J - SUMMARY OF PROVIDER COSTS

The worksheet is specifically designed for HMOs/CMPs to report provider costs paid by the HMO/CMP. **HCPPs should not complete this worksheet.** An HMO/CMP may elect under option 1 for CMS to process the bills for services rendered by hospitals, SNFs and HHAs. This election is made prior to the beginning of a contract year in writing. All other In-plan and Emergency and Urgently Needed Provider Services must be paid by the HMO/CMP. Billing Option 1 HMO/CMPs and HCPPs will not complete the entire worksheet. Since Billing Option 1 HMO/CMPs and HCPPs may pay for the Medicare deductible and coinsurance for services rendered in a provider setting, the worksheet should only be completed to the extent of the deductible amounts.

When an HMO/CMP elects option 2, it will process bills from Hospitals, SNFs and HHAs it has elected to pay directly. The HMO/CMP must use the alternative cost report forms for Billing Option 2 Plans for filing with CMS. These alternative forms will enable Billing Option 2 Plans to report the providers' separate apportionment and settlement worksheets identifying the plan's costs of services according to Medicare Principles of Reimbursement. Instructions for the Option 2 alternative worksheets are included in Appendix A.

Column Descriptions

Providers - List the name of the provider on the lines under the appropriate provider type heading.

Column 1 – Provider Number – Enter the Medicare provider billing number.

Column 2 – Reimbursable Part A – Not used for Option 1 Plans.

Column 3 – Part A Deductible and Coinsurance - Enter the Part A deductible and coinsurance incurred by the plan for services rendered in the provider setting.

Column 4 – Reimbursable Part B – Not used for Option 1 Plans.

Column 5 – Part B Deductible - Enter Part B deductible only. Part B coinsurance should not be included on this line.

Line Descriptions

Line 1 –Medicare Member Months - The number of Medicare member months from Worksheet D, Part II Section E. Membership, Line 3 are transferred to this line.

Line 2 – Hospitals - Enter the hospital facilities on lines 3 through 47 and the related information for columns 3 and 5 for the hospital facilities being reimbursed through this cost report. See Appendix A for instructions for Option 2 Plans using the CMS required alternative worksheets.

Line 48 - Total Hospital Cost – The worksheet adds the hospital Part A deductibles and coinsurance and the Part B deductibles for those hospitals reported.

Line 49 – Cost PMPM – The worksheet calculates the reimbursable hospital cost PMPM by dividing the total reimbursable hospital cost on Line 48 by the respective Medicare primary member months on Line 1.

Line 51 – Skilled Nursing Facilities - Enter the skilled nursing facilities on lines 52 through 61 and the related information for columns 3 and 5 for the skilled nursing facilities being reimbursed through this cost report.

Line 63 – Cost PMPM – The worksheet calculates the reimbursable skilled nursing facilities cost PMPM by dividing the total reimbursable skilled nursing facilities cost on Line 62 by the respective Medicare primary member months on Line 1.

Line 65 – Home Health Agencies – Option 1 Plans do not need to complete this section. Option 2 Plans please see Appendix A for instructions on the CMS required alternative worksheets for the home health agencies being reimbursed through this cost report.

Line 78 – Other Providers - Enter the name and type on lines 79 through 89 and the related information for columns 1 through 5 for each provider being reimbursed through this cost report. Examples of the types of providers reported in this section are Comprehensive Outpatient Rehabilitation Facilities (CORF), Outpatient Rehabilitation Provider, etc.

2313 WORKSHEET K - SUMMARY APPORTIONMENT OF NONPROVIDER COSTS

This worksheet apportions non-provider medical and other health service costs reimbursed under Part B of the Social Security Act to the Medicare program. These apportioned costs are then summarized, and the PMPM amount is calculated and transferred to the settlement sheet on Worksheet M.

Cost and statistical information used in the apportionments transfer to this worksheet from other worksheets on which they are developed. The worksheet transfers statistical information from Worksheet D, Part II. There should be no differences between Worksheet D, Part II and Worksheet K statistics. The worksheet transfers cost information from Worksheet E, Column 6. There should be no variances between these amounts.

Column and Line Descriptions.

Column 1 – Statistic Used - Enter on the spaces provided the type of statistic being used to apportion the particular cost item in the far left column. For example, a plan may elect to apportion clinic services furnished directly on a physician-visit basis. The plan should enter in Column 1, Line 1 "visits."

The appropriate code, as explained in footnote (1) of Worksheet D, Part II, should be entered just left of Column 1.

Column 2 – Total Statistics - Enter the total statistics for each supplier from Worksheet D, Part II, Column 4.

Column 3 – Covered Medicare Enrollee Statistics - Enter the covered Medicare enrollee statistics for each supplier from Worksheet D, Part II Column 6.

Column 4 – Subpart E Limits - This column should be completed (1) by only those HCPPs that do not have a written exception to these limits from CMS and pay for supplier services on a fee-for-service basis or (2) those that pay for supplier services on a basis other than on a fee-for-service basis and that supplier pays its members on a fee-for-service basis. In these cases, reimbursement to the plan cannot exceed what a MAC would have paid for these services. For each supplier, the HCPP should enter the sum of what the MAC would have paid for each service rendered. If the HCPP cannot provide the requested information, a zero should be placed in Column 4 and Column 7.

If the HCPP has been granted an exception to this limitation, the document granting the exception for each supplier should be attached to the report form and Column 4 should not be completed for that specific group of costs to which the exception applies.

In addition, HMOs/CMPs must complete Line 22 for Emergency-Urgently Needed Services rendered after April 1, 1990. Payment for these services is limited to the reasonable cost for such services or the Medicare prospective payment as provided for in 42 C.F.R. Parts 405, 412, and 413. There is an exception to this limitation on the basis of advantages gained by the HMO/CMP according to 42 C.F.R.417.558. Refer to Managed Care Manual Pub# 100-16, Chapter 17, Subchapter 17C, §80 and §90 for further discussion on this exception.

Column 5 – Ratio – The worksheet calculates the Medicare percentage as follows for each cost center:

Lesser of Column 3 or Column 4
Column 2

All ratios are carried out 4 decimal places.

Column 6 – Total Costs – The Total Costs for apportionment are brought forward to this column for each supplier cost center from Worksheet E Column 6.

Column 7 – Medicare Costs – The worksheet calculates the Medicare portion of the total cost for each supplier cost center by multiplying (Column 5 times Column 6) and enters the result in this column.
Line 24 – Mental Health Services - Enter the cost portion for the professional and non-professional compensation paid that is in the total Mental Health cost on Worksheet E, Column 6, Line 15.

Please note that the Mental Health limitation no longer exists as of 2014, and Medicare will pay outpatient mental health services at the same level as other standard Part B Services.
Line 36 – Member Months Part B – The worksheet transfers the total Part B member months from Worksheet D, Part II, Section E, Column 2, Line 1.The total Medicare member months are used instead of the primary Medicare member months in order to reflect the effect of the MSP Employer Group member months on the determination of the PMPM cost.

2314 WORKSHEET L - SUMMARY OF MISCELLANEOUS ITEMS

This worksheet is provided for the recording of certain miscellaneous items. The majority of this worksheet is formula-driven; however, certain items do need further clarification.

Line 1 - Enter on this line for Column 4 the amount of non-Medicare member enrollee months. A member month is defined as each month a person is a member of the plan. For example, if a non-Medicare plan beneficiary was a member of the plan for the twelve month period covered by the report, the plan would report a total of 12 non-Medicare member months for that individual. Membership, Line 1, Column 5 calculates the total member months based on these amounts.

Line 9 - Enter the Part A and Part B Allowable Medicare Bad Debts (net of bad debt recoveries) for premiums, dues, and co-payments charged to Medicare enrollees. The amount of allowable bad debts for a Medicare enrollee may not exceed three times the monthly rate (or its equivalent if the premium is payable on other than a monthly basis) for the actuarial value of the deductible and coinsurance amounts. Any allowable bad debts claimed on a cost report submitted by a provider or other facility reimbursed on a cost-based may not be claimed as a bad debt by the plan.

Line 15 - Enter the amount of Part A and Part B third party insurer revenue received for those services that are not paid fully by the insurer. These services pertain to only two categories of services for which Medicare has a secondary liability (see sections 2306.1 (Column 6) and 2306.2 (Column 6) for further details) and were counted in Column 6 of Worksheet D.

2315 WORKSHEET M - SETTLEMENT SHEET

This worksheet provides for the final computations necessary to determine the balance due the plan or CMS.

Column Descriptions

Column 1 - This column identifies the worksheet from which the information for Columns 2-4 are taken.

Column 2 - Total Medicare Part A per member per month costs.

Column 3 - Total Medicare Part B per member per month costs.

Column 4 - Sum of Columns 2 and 3, where appropriate.

Line Descriptions

Most of the lines are formula-driven and are taken from other parts of the report.

Line 9 - Enter the Part B standard deductible that is calculated and determined by CMS each year.

Line 12 - The Part B coinsurance is computed.

Line 22 – Enter the net payments received from CMS. This includes total interim payments from CMS less any adjustments or payments for prior years.

Line 24 - Enter the calculated sequestration amount on this line for the applicable year.

Lines 25-29 - If your plan returned money to CMS, report these amounts on Lines 25 through 29 and attach a schedule listing the amount, date of transaction, reason for return, and method of payment (wire or check).

If the plan has any protested items, enter the program payment effect. Estimate the payment effect of the nonallowable protested items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. A schedule must be attached showing the details and computation of the protested amount.

2316 WORKSHEET N - MEDICARE PREMIUM RECONCILIATION

The purpose of this form is to perform an annual premium reconciliation to determine net over or under collection of premiums for the reporting period.

All over collections of premiums must be returned to the Medicare enrollee. The Plan may select, with prior approval, one of three methods to refund over collections. The three methods are:

1. By a lump sum payment to the enrollee;
2. By a premium adjustment to the individual enrollee's or all enrollees future years' premiums; or
3. By a combination of premium adjustment and lump sum payment.

If over-collections are not refunded to the enrollees through lump payments or reduction in future years' premiums, CMS can reduce plan payments and arrange for repayment to the beneficiary (42 CFR §417.456(f)).

Under-collections are broken down between intentional (voluntary) and unintentional (involuntary) amounts. Unintentional under collections of premiums will be collected from the Plan's Medicare enrollees by an adjustment to its Medicare enrollee's future premiums. However, the Plan must collect the under collections through premium adjustments no later than 24 months following the end of the contract period in which they were due. Intentional under collections of premiums cannot be recouped by the HMO/CMP or HCPP from the Medicare enrollee.

Please note that amounts related to Part D premiums/dues and supplemental benefits should never be reported on Worksheet N. The premiums/dues reported on Worksheet N (Lines 1-6) shall only reflect those amounts deemed reimbursable by regulation for the individual MCO filling out this Worksheet. So, HMO/CMPs shall only report those premiums/dues that reflect the amounts related to Part A (if provided) and Part B. HCPPs shall only report the amounts related to Part B premiums/dues. These premiums/dues amounts must be separated to calculate any over or under collection of Medicare premiums.

Column Descriptions

Column 1 – Enter the premiums, dues, and co-payments related to Medicare enrollees.

Column 2 – Enter the member months.

Column 3 – Summarizes the cost per member month.

Line Descriptions

Lines 1 and 2 - Enter on the appropriate lines the actual collections made on premiums, dues, and co-payments charged to Medicare enrollees or someone on behalf of the Medicare enrollee for all covered Medicare items and services.

Line 4 - Enter the charges for premiums, dues, and co-payments related to Medicare enrollees for months prior to the HMO's current reporting period, but not collected by the HMO before the current reporting period.

Line 6 - Enter the charges for premiums, dues and co-payments related to Medicare enrollees for months in the current reporting period, but not collected by the HMO as of the last day of the current reporting period.

Line 9a - This amount comes from Worksheet N, Line 11 or 12b of the Final Cost Report for the period ending 2 years before the ending date of the current cost report. For example, if the final cost report is for 2024, then Line 9a should be from Worksheet N of 2022. Line 11 from prior year should be input in the case of an over- collection in the prior period, and Line 12b should be used in the case of an involuntary under-collection.

Line 9b – This amount comes from Worksheet N, Line 0 of the Final Cost Report for the period ending 2 years being the ending date of the current cost report. For example, if completing the final cost report for 2024, then the member months entered on Line 9b should be from Worksheet N of 2022.

Terminating Plans – Terminating plans shall include the involuntary under/ (over) collection from two years prior, and also add to this the under/(over) collection from the immediate prior year (WS N, Line 11 or 12b). For example, if completing the terminating final cost report in 2024, under/(over)collections should reflect amounts for 2022, as well as 2023. In order to correctly calculate the gross collections from the prior periods, the following calculation must be followed. The sum of gross under/ (over) collections

shall manually be entered on Line 9c **only** for terminating plans (do not complete lines 9a and 9b, your CMS servicing auditor will assist with updating line 9c). Terminating plans must also submit supporting documentation for the amount entered on line 9c.

Prior Periods	Under/(Over) Collection PMPM (A)	Prior Period MM (B)	Gross Under/ (Over) Collection
2022	$	MM	A * B
2023	$	MM	A * B
			Sum of above

Line 12 - Enter on Line 12 the amount of voluntary under collections reported on Line 8 of Worksheet B of the budget forecast covering the current year. (For example, if you are preparing the 2024 4th quarter or final cost report, then the 2024 budget should be used on this line). Lines 12a and 12b will automatically calculate the actual voluntary under collection and the involuntary under collection to be recouped during the subsequent period, respectively.

2317 CERTIFICATION BY INDEPENDENT AUDITOR

One-hundred-eighty days after the close of the contract period, an HMO/CMP must submit a final cost report that has been certified by an independent auditor.

NOTE: The Certification must be performed by an Independent Auditor. Therefore, the Certification must be performed by someone other than the person / audit firm that prepared / assisted with the preparation of the Final Cost Report. In addition, if the certification of the cost report is not determined to be independent, CMS will not pay the certification cost.

Additionally, CMS will only consider reimbursement reasonable for the certification steps completed using the certification standards issued by CMS.

APPENDIX A – OPTION 2 INSTRUCTIONS

The instructions below for Option 2 plans only include items that differ from the preceding instructions for Option 1 plans. All instructions besides these below apply to both Option 1 and Option 2 plans. The alternative cost report forms required for Option 2 plans must be obtained directly from CMS personnel as they are not available via HPMS.

2307 WORKSHEET E - SUMMARY TRIAL BALANCE

Lines 1 and 2 – Inpatient and Outpatient Hospital - Enter on these lines the costs incurred by the plan, and reflected in the accounting records, for services furnished through a Hospital. The plan must isolate and record those costs for inpatient on Line 1 and outpatient services on Line 2 that are subject to rate of increase ceiling pursuant to §1886(b) and PPS pursuant to §1886(d) from those that are not subject to those statutory payment methods. The purpose for isolating these amounts is to properly apply the lesser of cost or changes (Section 233 of the Medicare statutes) to those costs of services incurred by Hospitals that are not subjected to those provisions.

Adjustments on Worksheet G must be made to Lines 1 and 2 that include those necessary to remove the cost of non-covered services and the cost of services to non-Medicare patients. As a result of these adjustments, only the reimbursable portion of Hospital services will be reflected in Column 4 and will flow to Worksheet J from Column 6 after cost finding.

2312 WORKSHEET J - SUMMARY OF PROVIDER COSTS

When an HMO/CMP elects Option 2, it will process bills from Hospitals, SNFs and HHAs it has elected to pay directly. The HMO/CMP must acquire from these providers separate apportionment and settlement worksheets identifying the plans costs of services according to Medicare Principles of Reimbursement. HMOs/CMPs must enter into agreements with these providers so that the reporting requirements outlined in items 1 through 4, as follows, can be maintained.

1. Data Collection Requirements. - A provider furnishing services to an HMO/CMP Medicare enrollee is required to maintain separate statistics for the Medicare enrollees. These statistics will be maintained in such type, detail and form as required for the provider's other Medicare patients. Separate statistics must be accumulated for each HMO/CMP with which the provider has an agreement.

2. Filing Requirements for Provider Using Form CMS 2552. – Hospitals, Hospital-Based Skilled Nursing Facility, and Hospital-Based Home Health Agency complexes will continue to use the Form CMS-2552. These hospitals will prepare their cost reports and submit them to their MAC just as they do now.

   In addition, providers must prepare a separate set of apportionment and settlement worksheets to determine costs of the HMO/CMP Medicare enrollees. The worksheets will apportion the costs of each cost center between the HMO/CMP Medicare enrollees and all other provider patients. A separate set of worksheets will be needed for each HMO/CMP with whom the provider has an

agreement. Providers should make sure that payment for a covered service rendered to a Medicare beneficiary is not made more than once.

3. Filing Requirements for Providers Using Other Cost Report Form. - Providers using substitute cost reports, other than Form CMS-2552 will utilize the principles outlined for the Form CMS-2552. That is, separate apportionment and settlement worksheets will be prepared by the provider for each HMO/CMP. Each set of worksheets will apportion the costs of the appropriate cost centers between the applicable group of HMO/CMP Medicare beneficiaries and all of the providers' patients.

   In seeking reimbursement for home health services furnished to the HMO/CMP Medicare enrollees, the HMO should attach the appropriate forms used by the home health agency to obtain reimbursement from the Specialty MAC for services furnished to Medicare beneficiaries who are not HMO/CMP enrollees. These forms must reflect the cost of services furnished only to the Medicare enrollees of the HMO/CMP.

4. MAC Final Settlement with the Provider. - In making final settlement with the provider, the MAC will treat services furnished to HMO enrollees as if the services were furnished to non-Medicare beneficiaries, where the services are paid by the HMO/CMPs. For services furnished to HMO/CMP enrollees, the provider will be reimbursed for such services under the terms of its arrangement with the HMO/CMP and the payment to the provider need not be limited to cost. However, CMS payment to the HMO/CMP for such services will be limited to the amount the MAC would have paid the provider for furnishing the services, except where the HMO can demonstrate to the satisfaction of CMS that payment in excess of what the MAC otherwise would have paid is reasonable on the basis of advantages gained by the HMO/CMP. These advantages gained must be real and verifiable.

The HMO/CMP must use the alternative cost report forms for Billing Option 2 Plans for filing with CMS. These alternative forms will enable Billing Option 2 Plans to report the providers' separate apportionment and settlement worksheets identifying the plan's costs of services according to Medicare Principles of Reimbursement. The apportionment and settlement sheets from each provider must be attached to Worksheet J. When the HMO/CMP submits its fourth quarterly cost report, apportionment and settlement sheets for the provider may not be available. In this case, the HMO/CMP should use the best information available at the time.

Column Descriptions

Column 2 – Reimbursable Part A – Enter total Part A reimbursable costs obtained from the provider for which the plan is responsible. If the plan is using the Bill Summary Method for the Provider in Column 1, attach additional sheets identifying any difference between the entry in this column and the information contained in the Bill Summary Report.

Line Descriptions

Line 2 - Hospitals subject to rate of increase ceiling pursuant to 1886(b) or PPS pursuant to §1886(d) – As explained in Section 2307 the Medicare reimbursable costs for hospital services must be separated between those subject to the rate of increase ceiling or PPS from those that are not. The lesser of cost or charges

provisions do not apply to those hospital costs that are subject to the rate of increase or PPS provisions. The hospitals and the related information for columns 1 through 5 for those hospitals subject to the rate of increase or PPS provisions must be reported under this line heading.

Line 33 - Hospitals not subject to rate of increase ceiling pursuant to 1886(b) or PPS pursuant to §1886(d) – Enter the hospitals and the related information for columns 1 through 5 for those hospitals that are not subject to the rate of increase or PPS provisions must be reported under this line heading.

Line 46 - Total Medicare Customary Charges – Enter the customary charges of the hospitals not subject to rate of increase ceiling pursuant to 1886(b) or PPS pursuant to §1886(d**)** that are uniformly imposed and collected from a substantial percentage of patients that are liable for payment on a charge basis. Refer to the Pub #15-1, Section 2606 for descriptions and definitions for Customary Charges. The charges are recorded in the aggregate for all services whose costs are entered on Lines 34 through 44.

Line 47 - Lesser of Medicare Reasonable Cost or Customary Charges – The worksheet calculates the lower of line 45 or line 46 and enters the result on this line.

Line 48 - Total Hospital PPS and Non-PPS Cost – The worksheet adds the hospital PPS and non-PPS amounts on Lines 31 and 46 to derive the total reimbursable hospital cost for the period.

Line 49 – Cost PMPM – The worksheet calculates the reimbursable hospital cost PMPM by dividing the total reimbursable hospital cost on Line 48 by the respective Medicare primary member months on Line 1.

Line 51 – Skilled Nursing Facilities - Enter the skilled nursing facilities on lines 52 through 61 and the related information for columns 1 through 5 for the skilled nursing facilities being reimbursed through this cost report.

Line 63 - Total Medicare Customary Charges – Enter the customary charges of the skilled nursing facilities that are uniformly imposed and collected from a substantial percentage of patients that are liable for payment on a charge basis. Refer to the Pub #15-1, Section 2606 for descriptions and definitions for Customary Charges. The charges are recorded in the aggregate for all services whose costs are entered on Lines 52 through 61.

Line 64 - Lesser of Medicare Reasonable Cost or Customary Charges – The worksheet calculates the lower of line 62 or line 63 and enters the result on this line.

Line 65 – Cost PMPM – The worksheet calculates the reimbursable skilled nursing facilities cost PMPM by dividing the total reimbursable skilled nursing facilities cost on Line 64 by the respective Medicare primary member months on Line 1.

Line 67 – Home Health Agencies - Enter the home health agencies on lines 68 through 76 and the related information for columns 1 through 5 for the home health agencies being reimbursed through this cost report.

Line 78 - Total Medicare Customary Charges – Enter the customary charges of the home health agencies that are uniformly imposed and collected from a substantial percentage of patients that are liable for payment on a charge basis. Refer to the CMS Pub #15-1, Section 2606 for descriptions and definitions for Customary Charges. The charges are recorded in the aggregate for all services whose costs are entered on Lines 52 through 61.

Line 79 - Lesser of Medicare Reasonable Cost or Customary Charges – The worksheet calculates the lower of line 77 or line 78 and enters the result on this line.

Line 80 – Cost PMPM – The worksheet calculates the reimbursable home health agencies cost PMPM by dividing the total reimbursable home health agencies cost on Line 64 by the respective Medicare primary member months on Line 1.

Line 82 – Other Providers - Enter the name and type on lines 83 through 93 and the related information for columns 1 through 5 for each provider being reimbursed through this cost report. Examples of the types of providers reported in this section are Comprehensive Outpatient Rehabilitation Facilities (CORF), Outpatient Rehabilitation Provider, etc.

2313 WORKSHEET K - SUMMARY APPORTIONMENT OF NONPROVIDER COSTS

Column 8 – Medicare Customary Charges – Enter in this column for each supplier cost center the customary charges of the supplier that are uniformly imposed and collected from a substantial percentage of patients that are liable for payment on a charge basis. Refer to the Provider Reimbursement Manual Pub #15-1, Section 2606 for descriptions and definitions for Customary Charges. The charges are recorded in the aggregate for all services whose costs are entered on Lines 1 through 34.

Column 9 – Lesser of Cost or Charges - The worksheet calculates the lesser of the Medicare cost in Column 7 or the customary charges in Column 8 and enters the result in this column for each of the supplier cost centers.