CMS Medicare Manual System
Pub. 100-16 Managed Care

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

Transmittal 30 **Date: SEPTEMBER 5, 2003**

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
18 Subchapter A		10 - 100	

NEW/REVISED MATERIAL - EFFECTIVE DATE: September 5, 2003

Chapter 18, Subchapter A, sets forth the rules CMS follows in determining the amount CMS will pay to Health Care Prepayment Plans (HCPPs) for services furnished on a reasonable cost basis. This chapter further describes general requirements, bill processing options, budget and enrollment forecasting, interim payments and reports, adjustments of payments, interim settlement procedures, final cost reports, final settlement, general payment principles for HCPPs, the prudent buyer principle, reimbursable costs, record keeping, and accounting standards.

Medicare Managed Care Manual

Chapter 18 Subchapter A

Cost-Based Payment Process and Principles

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10 - Reasonable Cost-Based Payments - General

(Rev. 30, 09-05-03)

Chapter 18, Subchapter A, sets forth the rules CMS follows in determining the amount CMS will pay to Health Care Prepayment Plans (HCPPs) for services furnished on a reasonable cost basis. Chapter 18, Subchapter A, deals with general requirements, bill processing options, budget and enrollment forecasting, interim payments and reports, adjustments of payments, interim settlement procedures, final cost reports, final settlement, general payment principles for HCPPs, the prudent buyer principle, reimbursable costs, record keeping, and accounting standards.

Chapter 18, Subchapter B, gives the provider payment principles applicable to cost-based contracts, references specific cost topics in the Medicare Provider Reimbursement Manual (Pub. 15), and provides specific guidelines on provider of services, physician and other Part B service costs, and costs related to enrollment, marketing, membership, and reinsurance for HCPPs. Chapter 18, Subchapter C, covers cost apportionment for HCPPs.

Background

The HCPPs are public or private entities that are organized under the laws of a state to provide health services on a prepayment basis to enrolled members. These HMO/CMPs are eligible to enter into agreement with the Secretary of the Department of Health and Human Services under §1833 of the Social Security Act (the Act) to furnish services to Medicare beneficiaries. Chapter 18 of the manual is in effect for HCPPs with active agreements and those who have left the program without final settlement. The HCPPs are paid the reasonable cost actually incurred in providing Medicare-covered services to

Medicare enrollees. These organizations are paid each month, in advance, an interim per capita rate for each Medicare enrollee. The total monthly payment is determined by multiplying the interim per capita rate by the number of the HCPP's Medicare enrollees, plus or minus adjustments made by CMS. Further adjustments may be made at the end of the contract period to bring the interim payments made to the HCPP during the period into agreement with the reimbursement amount determined payable to the HCPP for services rendered to Medicare enrollees during that period. Total payment is calculated based on the HCPP's final cost report.

In addition, the HCPP may furnish services to Medicare beneficiaries who are not enrolled in the organization. Since payment to the HCPP under §1833 of the Act is limited to the HCPP's Medicare enrollees, services furnished to nonenrolled Medicare beneficiaries are outside the scope of the HCPP's agreement with the Secretary. Medicare payments for services furnished to nonenrolled beneficiaries are made through the original Medicare Fee-For-Service (FFS) payment system in accordance with the usual Medicare payment process.

10.1 - Reasonable Cost Payments

(Rev. 30, 09-05-03)

An HCPP is paid the reasonable cost of the covered nonprovider Part B services it furnishes directly to or arranges for its Medicare enrollees. The determination of reasonable cost is based on the Medicare reimbursement principles which are used to calculate the reasonable cost of hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and other entities paid by the Medicare program on a cost basis and also on principles contained in this manual. In addition to the costs directly related to the provision of health services, the costs incurred by the HCPP such as marketing, enrollment, and membership expenses are also taken into account in determining reasonable costs.

The cost payment principles for HCPPs are discussed in detail in Chapter 18, Subchapter B.

10.2 - Bill Processing

(Rev. 30, 09-05-03)

The CMS will pay on the behalf of the HCPP, through its intermediaries, all provider costs for covered items and services furnished to the HCPP's Medicare enrollees. A limited number of nonprovider Part B services are paid by carriers (same as cost reimbursed HMOs/CMPs).

The HCPP agreement with CMS must provide that, in paying for services furnished to the HCPP's enrollees, the HCPP is responsible for:

- Determining the eligibility of individuals to receive such items and services through the HCPP;
- Making proper coverage decisions and appropriate payment for items and services for which the HCPP's Medicare enrollees are eligible; and
- Carrying out any other procedures that CMS may require from time to time.

All health care services furnished by the HCPP may be provided through facilities directly (facilities that are owned or related through common control) or under arrangement. An arrangement is defined as a written agreement executed between the HCPP and another entity in which the other entity agrees to furnish specified services to the HCPP's Medicare enrollees. However, the HCPP retains responsibility for those services.

10.3 - Principles of Payments

(Rev. 30, 09-05-03)

HCPPs are paid each month, in advance, an interim rate for each Medicare enrollee. Retroactive adjustments are made during the year and at the end of the contract period to reconcile the interim payments made to the HCPP with the amount determined payable to the HCPP for services rendered to the HCPP Medicare enrollees during that period. Total reimbursement is calculated on the HCPP's final cost report.

10.3.1 - Budget and Enrollment Forecast

(Rev. 30, 09-05-03)

The HCPPs must submit an annual operating budget and enrollment forecast at least 60 days before the start of each reporting period. The operating budget uses estimated costs. The budget and enrollment forecast must reflect the HCPP's past experience and present the HCPP's anticipated enrollment and costs (both total and Medicare) for the coming reporting period. The reports are then used to compute the interim per capita rate. Its other purpose is to establish Medicare deductible and coinsurance premiums, including determining past over or under collections of such premiums and the budget period's voluntary under collection of premium. If the budget and enrollment forecast is not submitted on a timely basis, CMS may:

- Establish an interim per capita rate of payment on the basis of the best available data and adjust payments based on such a rate until such time as the required reports are submitted and the new interim per capita rate can be established, or

- Advise the HCPP if there is not enough data on which to base an interim rate, then interim payments will not be made until the required reports are submitted.

The CMS reserves the right to examine all records and statistical data used by the HCPP in completing these reports. To the extent the annual operating budget and enrollment forecast is accurate, interim payments will approximate the total CMS obligation.

10.3.2 - Interim Per Capita Rate

(Rev. 30, 09-05-03)

The interim per capita rate for an HCPP is determined by dividing estimated reimbursable costs of providing Medicare-covered services to the HCPP's Medicare enrollees by projected Medicare enrollee months for the reporting period. Estimated reimbursable costs and the projected number of Medicare enrollee months are derived from the HCPP's annual operating budget and enrollment forecast. The number of Medicare enrollees may be compared to CMS' latest updated records of enrollment for reasonableness. These records will identify the number of Medicare beneficiaries CMS has identified as enrollees of the HCPP.

10.3.3 - Interim Payment for HCPPs

(Rev. 30, 09-05-03)

At the beginning of each month, CMS will send the HCPP an interim payment. This payment is established by multiplying the interim per capita rate (see §10.3.2) by the number of the HCPP's Medicare members enrolled for that month. Each month CMS will determine the total number of Medicare beneficiaries enrolled in the HCPP to date. This number is increased or decreased by any changes in enrollment submitted by the HCPP or generated by CMS. In addition, certain retroactive adjustments will be made on an as needed basis.

10.4 - Electronic Transfer of Funds

(Rev. 30, 09-05-03)

The CMS, in conjunction with the Department of Treasury, may utilize electronic funds transfers. Interim and other types of payments are electronically sent to HCPPs through the Automated Clearing House (ACH). This process improves the efficiency of Federal financial management and also benefits the HCPPs.

The ACH provides online access to the Federal Reserve Communications System (FRCS), allowing payments to be made to financial institutions with access to the FRCS. For financial institutions that do not have access to the FRCS, HCPP payments can be paid through correspondent financial institutions or Federal Reserve Banks.

The ACH payment method eliminates mail and processing time associated with payment by check. The HCPP receives a payment through the HCPP's financial institution on the payment due date. This is a more secure and reliable method of making and receiving payment. The HCPPs electing the electronic transfer of funds must indicate this on the system setup sheet that is included in the agreement application. To initiate this process, the HCPP should contact the designated CMS Plan Manager.

10.5 - Payment Report

(Rev. 30, 09-05-03)

Each month CMS produces a payment report that explains how the interim payment is computed. (See Chapter 19 for a detailed description of the payment report.)

20 - Interim and Final Cost and Enrollment Reports

(Rev. 30, 09-05-03)

In addition to the annual budget and enrollment forecast, the HCPP is required to submit one interim report that includes cost and enrollment data. The interim cost and enrollment report must be submitted to CMS within 45 days after the close of the first 6 month period of the HCPP's reporting period. The report may be used to adjust the interim rate. If the reports are not submitted timely, CMS may adjust the interim rate based on the best available information. An adjustment to the interim rate will remain in effect until such time as the required report is submitted. If there is not enough data available, interim payments will not be made.

20.1 - Adjustment of Payments

(Rev. 30, 09-05-03)

In order to maintain the interim payments at the level of current reasonable costs, CMS will adjust the interim per capita rate on the basis of adequate data supplied by the HCPP in the interim estimated cost and enrollment report or such other evidence that CMS may have which indicates that the rate based on actual costs is more or less than the current rate. Adjustments may also be made when there is:

- A material variation from the costs estimated when the annual operating budget was prepared;

- A significant change in the use of covered services by the HCPP's Medicare enrollees; or

- A change in the number of Medicare enrollees in the HCPP, and the per capita cost rate is affected.

The interim per capita rate is flexible and may be adjusted if the HCPP submits a revised budget and enrollment forecast indicating that an adjustment is needed to maintain payments at the level of current costs.

20.2 - Final Cost Report

(Rev. 30, 09-05-03)

All HCPPs must submit a final cost report and supporting documents to CMS no later than 120 days following the close of each reporting period that detail cost, utilization, and enrollment data for the entire reporting period. (See 42 CFR 417.810(b)).

An extension of time to submit the report may be granted provided the HCPP requests such extension before the due date of the cost report and shows good cause for the extension. The final cost report shall be in the form and detail required by CMS. This report will be used to make final settlement for the contract period and should include, but is not limited to, the following:

- The per capita costs incurred for the provision of covered services to the HCPP's Medicare enrollees during the contract period, including costs incurred by another organization related to the HCPP through common ownership or control;

- The HCPP's methods of apportioning costs among Medicare and other enrollees, including nonenrolled patients receiving health care services on a fee-for-service or other basis; and

- Such information on enrollment and other data that CMS may require.

The total reasonable costs, which the HCPP incurs, that are related to administrative costs incurred by the HCPP in preparing the cost reports, and other data required by the program (other than costs related to reporting enrollment information) are included in Plan Administration. The CMS has the right to reject the final cost report if CMS believes there are significant deficiencies in the report.

Unless the HCPP requests and receives an extension of time for submitting the final cost report, CMS may consider the failure to report timely as evidence of a likely overpayment and may initiate recovery of amounts previously paid, reduce current interim payments, or both.

20.2.1 - Final Settlement Process for Medicare HCPPs

(Rev. 30, 09-05-03)

Final settlement with an HCPP is based on information in the cost report, subject to the Medicare program's standard audit and retroactive adjustment procedures. In addition, CMS retains the right to conduct an independent audit of the information contained in the final cost report.

Final settlement for HCPPs will equal the total reimbursable costs incurred by or on behalf of the HCPP throughout the contract period for furnishing covered care to the HCPP's Medicare enrollees (less applicable deductible and coinsurance). Once the final determination of reasonable costs is made, CMS will promptly notify the HCPP by sending a Notice of Program Reimbursement (NPR). This notice will:

- Explain CMS' determination regarding total reimbursement, including an explanation of the computation of overpayments or underpayments;
- Relate this determination to the HCPP's claimed total reimbursement;
- Explain differences between the HCPP's and CMS' determination; and
- Inform the HCPP of its right to have the determination reviewed at a hearing.

20.2.2 - Final Settlement Payment for Medicare HCPPs

(Rev. 30, 09-05-03)

If the final settlement determination is greater than payments already made to the HCPP through monthly capitation payments, an underpayment will be declared, and CMS will make a lump-sum payment to the HCPP.

Conversely, if the final settlement determination is less than the total payment made, the HCPP has been overpaid, and CMS must recover the overpayment.

30 - Recovery of Overpayment

(Rev. 30, 09-05-03)

When a cost report has been filed by an HCPP indicating an amount is due CMS, or when the HCPP is notified by an NPR or otherwise that an overpayment has been made, the amount involved is a debt owed the United States Government. Under the Federal Claims Collection Act of 1966, CMS must take timely collection action. Recovery will be undertaken even though the HCPP disputes, in whole or in part, CMS' findings. As a matter of policy, CMS will attempt recoupment as quickly as possible.

If the HCPP has been overpaid, a refund is due CMS. Generally, if repayment is made by the HCPP within 30 days of notification by CMS of the overpayment, no interest will be charged. However, in order to avoid the imposition of interest if the overpayment arises out of the filing of a cost report:

- Full payment must be made by the due date of the cost report ; or
- The HCPP and CMS must agree in advance to reduce interim payments over the next 30-day period to liquidate the overpayment.

When the HCPP chooses to repay the debt in installments, it must document the need for such and must submit a written proposal, outlining repayment dates and amounts, including any interest. The CMS has the authority to approve or disapprove such repayment schedule and will notify the HCPP of its decision in writing. In addition, the proposed repayment schedule must be submitted:

- Within 30 days of the due date of the cost report; or
- Within 30 days of notification by CMS (by NPR or otherwise) of the overpayment.

If subsequent information (e.g., the results of an audit) indicates an additional overpayment was made and the HCPP chooses to repay this additional debt in installments, it must again document the HCPP's need and submit a written proposal within 30 days of the subsequent determination outlining repayment dates and amounts (including interest) for the additional amount owed.

The CMS has the authority to reduce or suspend interim payments to the HCPP if it does not make timely repayment of the debt and:

- Fails to submit a repayment schedule;
- Fails to receive CMS approval of a repayment schedule; or
- Fails to meet obligations under an approved repayment schedule.

In addition, CMS will send a letter to the HCPP demanding immediate repayment of the entire amount owed or the immediate submission of a repayment schedule that assures recoupment of the entire amount of the overpayment within the original one-year time frame previously established. (If CMS determines that recovery through a repayment program would be unsuccessful, CMS will simply demand immediate repayment of the entire amount.) The case will be referred to the Department of Justice (DOJ) for collection unless a satisfactory arrangement is worked out.

30.1 - Interest Charges for Medicare Overpayments/Underpayments

(Rev. 30, 09-05-03)

Section 117 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) requires interest payments for Medicare overpayments and underpayments. The 42 CFR 405.378 sets forth the rules for charging and payment of interest. The following subsections set forth the rules governing interest on overpayments/underpayments for HCPP.

30.1.1 - The Basic Rules

(Rev. 30, 09-05-03)

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

Interest will accrue from the date of the final determination as defined in §30.1.2, and either will be charged on the overpayment balance or paid on the underpayment balance for each 30-day period that payment is delayed. (Periods of less than 30 days will be treated as a full 30-day period, and the 30-day interest charge will be applied to any balance outstanding.) For example, if there is an outstanding balance due CMS or the HCPP for 45 days beginning on the day after the date of the final determination, two full months of interest will be accrued.

30.1.2 - Definition of Final Determination

(Rev. 30, 09-05-03)

For purposes of this section, a final determination is deemed to occur:

- Upon the issuance of a Notice of Program Reimbursement (NPR) which includes:

    1. A written demand for payment; or

    2. A written determination of an underpayment by CMS after the cost report is filed;

- In the absence of a NPR, upon the issuance of either:

    1. A written demand for payment; or

    2. A written determination of an underpayment by CMS after the cost report is filed.

Except as required by any subsequent administrative or judicial reversal, interest will accrue from the date of final determination as specified in this section.

30.2 - Rate of Interest

(Rev. 30, 09-05-03)

The interest rate on overpayments and underpayments will be the prevailing rate(s) specified in bulletins issued 8020.20 of the Treasury Fiscal Requirements Manual. This rate is the higher of the rate as fixed by the Secretary of the Treasury after taking into consideration private consumer rates of interest or the current value of funds rate.

If an HCPP signs a repayment agreement with CMS for the overpayment:

- The rate of interest specified in the agreement will continue unchanged if there is no default; and
- Interest on the balance of the debt may be changed to the prevailing rate if:
    1. The HCPP defaults on an installment; and
    2. The prevailing rate in effect on the date the installment becomes overdue is higher than the rate specified in the agreement.

30.2.1 - Accrual of Interest

(Rev. 30, 09-05-03)

If a cost report is filed that does not indicate an amount is due CMS, but CMS makes a final determination that an overpayment exists, interest will accrue beginning with the date of such final determination. Interest will continue to accrue during periods of administrative and judicial appeal and until final disposition of the claim.

If a cost report is filed and indicates that an amount is due CMS, interest on the amount due will accrue from the due date of the cost report unless:

- Full payment on the amount due accompanies the cost report; or
- CMS and the HCPP agree in advance to liquidate the overpayment through a reduction in interim payments over the next 30-day period.

If CMS determines that additional overpayments exist during the cost settlement process, interest will accrue from the date of each determination.

The interest rate on each of the final determinations of an overpayment will be the rate of interest in effect on the date the determination is made.

In the case of a cost report that is not filed on time, interest also will accrue on a determined overpayment from the day following the due date of the report to the time the cost report is filed.

If CMS makes a final determination that an underpayment exists, interest to the HCPP will accrue from the date of notification of the underpayment.

30.2.2 - Waiver of Interest Charges

(Rev. 30, 09-05-03)

When CMS makes a final determination that an overpayment or underpayment exists:

- Interest charges will be waived if the overpayment or underpayment is completely liquidated within 30 days from the date of the final determination; or

- CMS may waive interest charges if it determines that the administrative cost of collecting the interest exceeds the interest charges.

Interest will not be waived for that period of time during which the cost report was due, but remained not filed for more than 30 days, as specified in this section.

30.3 - Rules Applicable to Partial Payments

(Rev. 30, 09-05-03)

If an overpayment is repaid in installments or recouped by withholding from other payments due the HCPP:

- Each payment or recoupment will be applied first to accrued interest and then to principal; and

- After each payment or recoupment, interest will accrue on the remaining unpaid balance.

30.4 - Exception to Applicability

(Rev. 30, 09-05-03)

If an overpayment or an underpayment determination is reversed administratively or judicially, and the reversal is no longer subject to appeal, appropriate adjustments will be made for the overpayment or underpayment and the amount of interest charged.

30.5 - Nonallowable Interest Cost

(Rev. 30, 09-05-03)

Interest accrued on overpayments and interest on funds borrowed specifically to repay overpayments are not considered allowable costs to the HCPP, up to the amount of the overpayment, unless the HCPP had made a prior commitment to borrow funds for other purposes (e.g., capital improvements). However, when an overpayment determination is ultimately reversed in favor of the HCPP, interest paid on funds borrowed to repay the overpayment, and interest paid on funds borrowed to pay required interest on the overpayment, will be considered an allowable cost.

40 - CMS General Payment Principles

(Rev. 30, 09-05-03)

This section discusses general HCPP payment principles including the prudent buyer principle, reimbursable costs, record keeping, and accounting standards for Medicare HCPPs.

40.1 - Medicare Payments to HCPPs

(Rev. 30, 09-05-03)

Medicare's payment to HCPPs is based on the reasonable cost of providing Medicare-covered services to Medicare enrollees.

All necessary and proper expenses of the HCPP in providing Medicare-covered services are recognized. The share of the total HCPP cost that is borne by CMS is related to the Medicare-covered care furnished to Medicare beneficiaries so that no part of their cost would need to be borne by other enrollees or nonenrolled patients. Conversely, costs attributable to other HCPP enrollees and nonenrolled patients are not to be borne by Medicare.

The HCPP payment principles take into account the special nature of HCPPs by recognizing costs of marketing, enrollment, and certain other costs unique to the HCPP form of health delivery.

Under these principles, there may be more than one method of handling a particular cost item (including apportionment and allocation methods). The method elected by the HCPP must be consistently followed in subsequent periods. A change of method must have advance approval from CMS. Also, any request for a change in the method of handling a particular cost item, including the apportionment or allocation of such items, must be made 90 days prior to the beginning of the reporting year in which the new method is proposed for use.

50 - Prudent Buyer Principle

(Rev. 30, 09-05-03)

The HCPP is expected to minimize costs incurred in furnishing physicians' and other Part B supplier services to the HCPP's Medicare enrollees so that actual costs:

- Do not exceed what a prudent and cost conscious buyer would incur; and

- Are comparable to costs incurred for similar services furnished by similar physicians or other suppliers in the same or similar geographic area.

If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not paid under the Medicare program.

60 - Allowable Costs

(Rev. 30, 09-05-03)

Allowable costs are those direct and indirect costs, including normal standby costs, that the HCPP incurs and are proper and necessary to efficiently deliver needed health care. These costs include costs related to the care of beneficiaries that are normally paid by Medicare and other costs such as enrollment, membership, and similar costs unique to Medicare HCPPs and necessary to the HCPP's operations.

The allowable costs of an HCPP are first determined in accordance with the principles set forth in 42 CFR Part 417 Subpart U and this manual. After those requirements are met, the Medicare principles of reimbursement as described in the Provider Reimbursement Manual (Pub. 15) are applicable if they are not in contradiction with the regulation and this manual. In addition, Generally Accepted Accounting Principles (GAAP) should be followed if instructions in the regulation or manuals do not instruct the HCPP otherwise.

70 - Costs Not Reimbursable Directly to the HCPP

(Rev. 30, 09-05-03)

In determining amounts due the HCPP, certain costs are excluded from payments made directly to the HCPP. The following subsections, while not necessarily all-inclusive, detail some of these costs.

70.1 - Deductibles and Coinsurance

(Rev. 30, 09-05-03)

In determining amounts due the HCPP, an amount equal to the actuarial value of the deductible and coinsurance for which the Medicare enrollee would otherwise be liable, if not enrolled in the HCPP, is deducted. Procedures for estimating this amount are contained in Chapter 18, Subchapter B, §110.

70.2 - Hospice Care Costs

(Rev. 30, 09-05-03)

If a Medicare enrollee of an HCPP makes an election to receive hospice care services under §1812(d) of the Act, payment for these hospice care services is made to the Medicare participating hospice that furnishes the services, in accordance with 42 CFR Part 418 and the Hospice Manual. While the HCPP enrollee's hospice election is

in effect, the HCPP may only be paid for the following covered Medicare services furnished to such enrollee:

- Services of the enrollee's attending physician, if the physician is an employee or contractor of the HCPP and is not employed by or under contract to the enrollee's hospice; and
- Services not related to the treatment of the terminal condition for which hospice care was elected or a condition related to the terminal condition.

A Medicare beneficiary's hospice election may continue as long as the individual continues to desire to receive hospice services while terminally ill. Upon revocation of the election, the individual resumes normal Medicare coverage and any services provided by the HCPP will be reimbursed in the usual manner.

70.3 - Medicare as Secondary Payer

(Rev. 30, 09-05-03)

Medicare does not pay the HCPP for covered services for which Medicare is the secondary payer. For more information on Medicare as secondary payer, see Chapter 18 Subchapter B, and/or 42 CFR 411.

80 - Financial Records, Statistical Data, and Cost Finding

(Rev. 30, 09-05-03)

The cost-based HCPP must maintain sufficient and adequate financial and statistical records for CMS to make proper determinations of the costs incurred by the HCPP in furnishing services, either directly or through arrangements, to its Medicare enrollees. The records must be retained for a period of at least 3 years following the issuance of a Notice of Program Reimbursement (NPR).

90 - Accounting Standards

(Rev. 30, 09-05-03)

The HCPP's records must be capable of verification by qualified auditors and properly reflect all direct and indirect costs claimed by the HCPP under the agreement. This means that the HCPP's cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, if an HCPP is owned and operated by a Federal, state, or local government agency and operates on a cash basis of accounting, CMS accepts cost data on this basis, subject to appropriate treatment of capital expenditures.

90.1 - Accrual Basis of Accounting

(Rev. 30, 09-05-03)

Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

90.2 - Cash Basis of Accounting

(Rev. 30, 09-05-03)

Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

100 - Adequate and Sufficient Records

(Rev. 30, 09-05-03)

Cost data developed by an HCPP must be current, accurate, and in sufficient detail for CMS to make a proper determination of the HCPP's costs. Records must be maintained in a consistent manner from one reporting period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if the HCPP makes a full disclosure to CMS of the significant changes in advance and secures approval for the change.

At a minimum, the following financial records/information must be maintained:

- Matters of ownership, organization, and operation of the HCPP's financial, medical, and other record keeping systems;
- Financial statements for the current and prior three reporting periods (this will include such things as management letter comments and access to related workpapers);
- Federal income tax or information returns for the current and prior three reporting periods;
- Asset acquisition documents and leases;
- Agreements, contracts, and subcontracts;
- Franchise, marketing, and management agreements;
- Schedules of charges for the HCPP's fee-for-service patients;
- Records pertaining to costs of operations;

- Amounts of income received by source and payment;
- Cash flow statements;
- Any financial reports filed with other Federal programs or state authorities; and
- Minutes from the Board of Directors' meetings taking place during the reporting period.

To download the Filename R30a_MCM associated with this instruction, click here.

To download the Filename R30b_MCM associated with this instruction, click here.