CMS Medicare Manual System

Pub. 100-6 Financial Management

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
1		Entire Chapter	

CLARIFICATION - EFFECTIVE/IMPLEMENTATION DATE: Not Applicable.

Medicare contractors only: these instructions should be implemented within your current operating budget.

This transmittal includes chapter 1 of the restructured Medicare Financial Management Manual.

The completed manual includes ten chapters containing all CMS instructions to carriers and intermediaries about CMS requirements described in the table below. This material was derived from the source material as shown in the last column.

While this revision updates and reorganizes text from current manuals, it includes no new procedures. It is a reorganization and compilation of these instructions into a single financial management manual for intermediaries and carriers. Where there are differences in carrier and intermediary requirements, we distinguish to which contractor the instructions apply. Contractors should send any questions or suggestions for improvement to their ROs.

This manual is designed primarily for display on the Internet. The following changes from past paper manual protocols are used as a result of the Internet environment.

- Redline - It is not possible to place a vertical bar in the left margin on Internet documents. Therefore changed text is identified by red, italic font. Note that redline is not used on this initial transmittal because all the text is new.

- Displaying change dates - The date and revision number for the last change in the section or subsection is shown after each section/subsection heading instead of at the bottom of the page.

- Page numbers - are not applicable for Internet documents.

- Distribution of printed copies is discontinued.

Also for the initial issuance a cross-reference is placed after each section heading to identify the source from where the material originated. This will be eliminated as subsequent transmittals replacing the same sections are released.

As the ten chapters are distributed the current financial instructions in PMs and the Carrier and Intermediary Manuals will be deleted.

Chapter	**Chapter Title**	**Source**
1	Budget Preparation	MIM-1, Chapters 1, 2, & 6 MCM-1, Chapters 1, 2, & 6
2	Budget Execution	MIM-1, Chapter 3 and 5 MCM-1, Chapter 3 and 5
3	Overpayments	MIM-2, Chapter 3, MIM-3, Chapter 8 MCM-3, Chapter 7
4	Debt Collection	MIM-2, Chapter 3 MCM-3, Chapter 7
5	Financial Reporting	MIM-1, Chapters 4 & 9 MCM-1, Chapters 4 & 9
6	Workload Reporting	MIM-3, Chapter 9 MCM-3, Chapter 13
7	Internal Control Requirements	New Material Issued With This Manual (CR 2231)
8	General Audit Guidelines	MIM-2, Chapter 1, MIM-4, Chapter 1
9	Intermediary Procedures for Provider Audits	MIM-4, Chapter 2
10	Provider Statistical & Reimbursement Report	MIM-2, Chapter 3

MIM = Medicare Intermediary Manual, CMS Pub 13, e.g., MIM-1 is Part 1 of CMS Pub 13

MCM = Medicare Carrier Manual, CMS Pub 14, e.g., MCM-2 is Part 2 of CMS Pub 14

Medicare Financial Management

Chapter 1 - Budget Preparation - Intermediaries and Carriers

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NOTE: Revision 1, the initial issuance of this chapter, includes a cross reference to the source sections in current manuals. The manual is identified by A1, A2, A3, or A4 for Intermediary Manual Parts 1 through 4; or by B1, B2, B3 or B4 for Carriers Manual Parts 1 through 4. This indicator is followed by a dash and the related section number.

10 - General

(Rev. 1, 08-30-02)

A1-1200, B1-4200

The Secretary is authorized to make funds available for administrative costs related to the functions contractors perform as stipulated in the Agreement under the provisions of title XVIII of the Social Security Act. Funds available for this purpose are in the DHHS Appropriation Act. These funds are provided for a fiscal year (FY) beginning October 1. They are not available for obligation and expenditure until released by the Office of Management and Budget in an apportionment that is made on a quarterly basis to preclude an expenditure rate that exceeds the appropriation. Medicare administrative funds will be requested separately for program management (PM) and Medicare Integrity Program (MIP). Contractors shall report this on CMS's activity level budget and cost reporting system - Contractor Administrative-Budget and Financial Management System (CAFM II).

The Anti-Deficiency Act, 31 USC 1341, provides that no government official or employee may authorize or create an obligation, or make or cause to make an expenditure in excess of an apportionment of appropriated funds. To enforce this prohibition, the Act requires administrative discipline of government officials and employees who inadvertently exceed their authority, and criminal penalties for those who do so knowingly and willfully.

In order for the Secretary to ensure that adequate funds are available and trust funds are efficiently used for the administration of the Federal Health Insurance Program, the contractor shall submit an estimate of administrative costs that are anticipated for the ensuing FY. Predicate the annual budget on the budget and performance requirements (BPRs) issued by CMS and on its previous Medicare cost and productivity experience. It shall consider unusual or non-recurring type activities that could be part of the historical cost data.

The Secretary will pay contractors for necessary and proper costs of administration as determined by the Principles of Reimbursement in Appendix B of the contract/agreement. The amount of the settlement is subject to audit. Thus, the inclusion of funds in an approved budget or in a subsequent cost statement does not constitute a final determination as to the allowability of such costs. However, it is intended that a mutual agreement on the estimate will facilitate fiscal planning by both the contractor and CMS, and provide a basis for common understanding for determining administrative costs.

The Secretary may also enter into fixed price or other non-cost related agreements. The instructions that follow do not pertain to non-cost related agreements, unless specifically designated in the individual contract.

10.1 - Budget Forms Supply

(Rev. 1, 08-30-02)

A1-1200.1, B1-4200.1

Copies of all forms referred to in the ensuing sections can be obtained from the CAFM II System.

20 - The Budget Cycle

(Rev. 1, 08-30-02)

A1-1201, B1-4201

The following annual budget calendar establishes approximate target dates for each phase of the budget cycle to insure an orderly workflow during the planning, preparation, and review of budgets. This calendar may be supplemented and revised in the annual BPRs letter.

- The contractor shall submit workload estimates (if requested) - February/March.

- BPRs transmitted to contractor - May/June. (Included in the BPRs is information relative to statement of work, level of effort, program emphases, new program developments and specific recommendations regarding activities of individual contractors.)
- Contractor shall submit budget requests (BRs) - June/July.
- Negotiations - July through September. Negotiations proceed directly between the contractor and the RO. The RO reaches agreement with the contractor in regard to date, time, and location for negotiations. The contractor shall conduct negotiations by telephone, correspondence, on-site visits or at the RO.
- Notice of Budget Approvals (NOBA) sent to contractor - September/October. In the absence of a NOBA, a continuing resolution letter will provide interim funding.
- Budget distribution - 30 days after the contractor receives its initial annual NOBA.
- Budget distribution approval - 30 days after distribution is received by the RO.

To aid the contractor in its preparation and timely submission of required budget preparation reports, see §270 for a checklist of the due dates and material to submit.

30 - Role of The Regional Offices (RO)

(Rev. 1, 08-30-02)

A1-1202, B1-4202

The ROs have the responsibility of negotiating and approving contractor budgets. The Office of Financial Management has the authority to negotiate and approve budgets for the Blue Cross/Blue Shield Association.

40 - Introduction of Activity Level Budget and Cost Reporting

(Rev. 1, 08-30-02)

A1-1203, B1-4203

Costs are allocated and reported separately by PM and MIP functions and activities. Contractors and CMS are not allowed to co-mingle the PM and MIP funding that is appropriated separately by Congress. PM provides funding for claims processing functions, and MIP provides funding for payment safeguard functions. A function is a unique operation that is separately identifiable, such as Claims Payment or Appeals. An activity is defined as a subcategory of a Medicare function. The activities available to a contractor may vary depending upon the functions performed by that contractor. A

listing of activities is available within the CAFM II reporting system utilized for Medicare contractor budget and cost reporting.

50 - General CAFM II System Information

(Rev. 1, 08-30-02)

A1-1204, B1-4204

CAFM II is an integrated, mainframe based software system utilized by CMS for the budget, cost, and funds disbursement reporting requirements for both local contractors operating under the terms of the current Medicare contract and those contractors operating under a standard government contract generally pursuant to a solicitation.

50.1 - Budget and Cost Reports

(Rev. 1, 08-30-02)

A1-1204.1, B1-4204.1

The same multi-purpose format is used for the BR, the supplemental budget request (SBR), the Interim Expenditure Report (IER), and the final administrative cost proposal (FACP). The NOBA will be issued on a FY basis, and will provide a cumulative, quarterly distribution of the budgeted funds. Funds will be drawn, via Smartlink, in line with anticipated expenses not to exceed the cumulative, quarterly distribution on the NOBA.

CAFM II requires contractors to identify and report costs on an activity level basis with detailed cost reporting and will sum these costs by function. The system will then generate a separate PM and/or MIP budget that the contractor will certify for accuracy of costs requested. The CAFM II User Manual contains instructions for accessing and inputting data into CAFM II and §§90 and 100 of this manual contain general instructions for completing the screens.

60 - List of Acronyms

(Rev. 1, 08-30-02)

A1-1205, B1-4205

The following are acronyms that are used frequently throughout the Budget Preparation chapter:

ABCR	Administrative Budget and Cost Report
ALJ	Administrative Law Judge
BD	Budget Distribution
BI	Benefits Integrity

BPRs	Budget and Performance Requirements
BR	Budget Request
CAFM II	Contractor Administrative-Budget and Financial Management System
CASR	Contractor Auditing and Settlement Report
CCR	Cost Classification Report
CMS	Centers for Medicare and Medicaid Services
CFR	Code of Federal Regulations
CO	Central Office
COB	Coordination of Benefits
CROWD	Contractor Reporting of Operational and Workload Data
CWF	Common Working File
EDP	Electronic Data Processing
EMC	Electronic Media Claims
FACP	Final Administrative Cost Proposal
FAR	Federal Acquisition Regulations
FM	Facilities Management
FY	Fiscal Year
G&A	General and Administrative
IER	Interim Expenditure Report
PM	Program Management
MR	Medical Review
MIP	Medicare Integrity Program
MSP	Medicare Secondary Payer
NOBA	Notice of Budget Approval
OIG	Office of Inspector General
PET	Provider Education and Training
PI	Productivity Investment

PRRB	Provider Reimbursement Review Board
RO	Regional Office
ROI	Return on Investment
SBR	Supplemental Budget Request
UPIN	Unique Physician Identification Number

70 - Exhibit of Administrative Budget and Cost Report, Activity Form

(Rev. 1, 08-30-02)

A1-1210, B1-4210

CONTRACTOR NAME		ADMINISTRATIVE BUDGET AND COST REPORT			IER	ACTIVITY
ADDRESS LINE 1		MEDICARE CONTRACTORS			EIN: XXXXXXXXXXXX	
ADDRESS LINE 2		INTERIM EXPENDITURE REPORT			ACCEPT DATE:	
CONTRACTOR NO:	PART:	FUND YR:	REPORT YR:	MONTH:	SUPPLE NO:	
######	X	XXXX	XXXX	XX	XX	CAFM II

ACTIVITY CODE: XXXXX DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

COST ITEM (A)	TOTAL ACTIVITY COST (B)
SALARIES/WAGES	___________
FRINGE BENEFITS	___________
EDP EQUIPMENT	___________
SUBCONTRACTS	___________
OTHER DIRECT COSTS (SEE SCHEDULE A)	___________
OTHER COSTS (SEE SCHEDULE B)	___________
NON-COB CREDITS (SEE SCHEDULE C)	___________
OVERHEAD	___________
G&A	___________
FEES/PROFIT	___________
TOTAL COST	___________
OTHER ADJUSTMENTS (SEE SCHEDULE D)	___________
FORWARD FUNDING	___________
TOTAL ADJUSTED COST	___________

WORKLOAD	
WORKLOAD 1	___________
WORKLOAD 2	___________
WORKLOAD 3	___________
HOURS	
DIRECT	________
INDIRECT	________
SUBCONTRACTS	________
OVERHEAD/G&A	________

REMARKS:

80 - Completing the Administrative Budget and Cost Report - Activity Form

(Rev. 1, 08-30-02)

A1-1211, B1-4211

A - General

The Administrative Budget and Cost Report (ABCR) is intended for multiple-use. It is used for the following specific annual, periodic, and monthly reports the contractor submits.

- Budget Request (BR). See §230;
- Supplemental Budget Request (SBR). See §240;
- Interim Expenditure Report (IER). See Chapter 2, §60; and
- Final Administrative Cost Proposal (FACP). See Chapter 2, §130.

For all of these uses, funding and costs are reported separately by PM and MIP functions and activities. Funding and costs for PM and MIP must be kept separate and may not be co-mingled.

The contractor shall transmit the ABCR form for all budget reports electronically using the CAFM II System. See §§270 and Chapter 2, §180 for due dates.

B - Identification of Costs

The ABCR identifies activities within each Medicare function. For each activity, the following costs are separately identified: salaries and wages, fringe benefits, Electronic Data Processing (EDP) equipment, other direct costs, other costs, non-Coordination of Benefits (COB) credits, overhead, general & administrative (G&A), fee/profit, total cost, other adjustments, forward funding, and total adjusted cost. Each Activity Screen also identifies up to three discrete workloads and direct, indirect, subcontract, and overhead/G&A hours.

The contractor shall separately identify costs in the BR, IER, and FACP pending a determination of allowability by CMS. It shall identify these costs in the remarks section.

The principles for determining allowable administrative costs are in Part 31 of the Federal Acquisition Regulation (FAR), as codified in Title 48, and in the contract/agreement. In accordance with the FAR, costs are directly charged, where it is possible to do so, and are allocated where it is not. Costs are assigned to various Medicare activities on this basis.

The identification of unallowable costs is in Chapter 2, Budget Execution, § 200.3. The contractor shall treat them as follows:

- It shall not include costs that the Secretary has determined to be unallowable or that it and CMS have mutually agreed are not allowable; and

- It shall separately identify costs in the BR, IER, and FACP that have been previously withheld by CMS pending a final determination of allowability. It shall identify these costs in the Remarks section.

NOTE: The contractor shall round all cost entries to the nearest hundred dollars in the BR and SBR.

90 - Explanation of Entries on the Activity Form

(Rev. 1, 08-30-02)

A1-1212, B1-4212

90.1 Title and Use

(Rev. 1, 08-30-02)

A1-1212.1, B1-4212.1

The title of the report, ABCR, and the use, i.e., BR, SBR, IER, or FACP.

90.2 - Contractor Number

(Rev. 1, 08-30-02)

A1-1212.2, B1-4212.2

The five-digit Medicare number assigned.

90.3 - Contractor Name

(Rev. 1, 08-30-02)

A1-1212.3, B1-4212.3

The contractor organization's official name.

90.4 - Activity Code

(Rev. 1, 08-30-02)

A1-1212.4, B1-4212.4

A 5-digit code identifying each activity. A listing of codes is available within CAFM II. The first digit of an activity code identifies the activity as a PM activity (odd numbers) or a MIP activity (even numbers). The second digit identifies the Medicare function, e.g., claims processing, appeals, etc. The last three digits refer to the specific activity or project within each function.

90.5 - Funding FY

(Rev. 1, 08-30-02)

A1-1212.5, B1-4212.5

The FY for which funds are requested or to which costs are being reported.

90.6 - Reporting FY

(Rev. 1, 08-30-02)

A1-1212.6, B1-4212.6

The FY during which the funds are requested or during which costs are being reported.

90.7 - Report Month

(Rev. 1, 08-30-02)

A1-1212.7, B1-4212.7

The calendar month during which costs are being reported.

90.8 - Acceptance Date

(Rev. 1, 08-30-02)

A1-1212.8, B1-4212.8

The date CAFM II accepts the report.

90.9 - Cost Categories

(Rev. 1, 08-30-02)

A1-1212.9, B1-4212.9

The contractor shall report costs as defined below unless defined differently in its contract.

A - Salaries/Wages

It shall include salaries, wages, bonuses, and incentive compensation payments to directors, officers, and employees. It shall include charges made by agencies furnishing temporary help and premium pay for time worked; overtime premium including premium for Saturdays, Sundays, and holidays; and shift premiums. It shall include pay for time not worked, i.e., rest periods, lunch periods, jury, and voting allowance. It shall include vacations, sick leave, holidays, and military leave. It shall report salaries and wages in accordance with the FAR 52.216-7(b). It shall report fringe benefits on the fringe benefit line. It shall include all employees' salaries and wages except as noted in §§90.9H (Overhead), 90.9I (General and Administrative), and 90.9P (Hours-Direct, Indirect, Subcontracts, and Overhead /G&A - Exception).

B - Fringe Benefits

It shall include payments made to, or for the benefit of, employees over and above normal salaries and wages. For example, contributions to employee insurance and pension plans, post retirement benefits other than pensions, payroll taxes, supplemental unemployment benefit plans, death benefits, and separation pay allowances. It shall include such costs for all employees except as noted in §§90.9H (Overhead), 90.9I (General and Administrative), and 90.9P (Hours-Direct, Indirect, Subcontracts, and Overhead/G&A - Exception).

C - Electronic Data Processing (EDP) Equipment

It shall include rental/leases, depreciation, or the cost of maintenance and repairs, insurance (if separately identifiable), systems software charges, personal property taxes, and use charges. It shall include costs of mainframe and mainframe peripherals, personal computers, local area networks (LAN), imaging equipment, printers, optical discs, optical character recognition (OCR) equipment, and lap top computers. It shall report facilities management (FM) subcontracts under subcontracts.

D - Subcontracts

It shall include all subcontract costs such as those involving computer operations, EDP software, data entry, and provider auditing which require notification per the Medicare contract/agreement. In addition, it shall include subcontracts in excess of $25,000 for services related to all functions and duties whether approval is required or not. It shall exclude services for janitorial, cafeteria, maintenance and other subcontracts such as leases and rentals (see Other Direct Costs). It shall exclude EDP equipment subcontracts that are charged to EDP equipment but include FM subcontracts and shared processing arrangements.

E - Other Direct Costs

It shall include all other costs **not** included in the categories described above. This includes, but is not limited to: leases for space and equipment, depreciation for company owned space and equipment (except EDP equipment), return on investment, taxes (except personnel taxes reported in fringe benefits), insurance (other than that reported in fringe benefits or EDP equipment), dues to professional, trade, and business associations, net food service costs (cafeteria and subsidized eating facilities), travel, communications, postage, office supplies, material, medical review consultants and other consultants under $25,000, printing costs excluding equipment, and general maintenance, janitorial and security activities.

F - Other Costs

It shall use this category only with the concurrence of CMS. Most contractors are not required to use this category. This category may include other indirect costs, excluding overhead and general and administrative costs that a contractor might propose.

G - Non-COB Credits

It shall include the applicable portion of any income, rebate, allowance, or other credits related to total operations. It shall not report COB credits in this category (See §190, Certification Form.)

H - Overhead

It shall include all personal and non-personal service costs related to service departments and financial, accounting, and statistical activities as described below.

1. Service Departments

It shall include all data related solely to the following service areas which support other operations:

- **Personnel** - Recruiting, testing, hiring, orientation, centralized training staff, maintaining employment files, administration of employee services such as library, recreation unit, cafeteria, health unit, and employee publications.
- **Methods and Procedures** - Review and analysis of manual (non-EDP) systems.
- **Storeroom** - Receipt, maintenance, and issuance of materials and supplies. It shall **not** include the cost of the materials or supplies. They are included in the areas where used.
- **Printing and Duplication** - To the extent possible, it shall distribute the costs related to printing to the appropriate line item responsible for the end product.
- **Purchasing** - If a separate unit, it shall include all activities related to procurement of materials, supplies, furniture, equipment, and services. This involves only the purchasing activity, not the cost of the purchases.
- **Switchboard** - If a separate centralized unit, it shall **not** include the costs of telephone service identified with other operations.
- **Mailroom and Interoffice Messengers** - It shall include the cost and other data related to the activity, unless they can be directly assigned to specific lines. It shall include the cost of activities such as incoming (receipt, open, sort, batch, and deliver) as well as outgoing mail. It shall **not** include the cost of postage identified with other operations.
- **Word Processing Centers**

2. Financial, Accounting, and Statistical Departments

Includes accounting for and control of benefits, record keeping, and other fiscal tasks.

- **Accounting for and Control of Benefits** - It shall include benefit disbursements, reissued checks, bank reconciliations, postpayment review of benefit disbursements for internal control purposes, and overpayment recoupments relating to individual billings.

- **Record Keeping Tasks** - It shall include general and cost accounting, payroll, inventories (financial, not bills), and receipt of other funds, maintenance of petty cash, and other non-benefit-related disbursements.

Other Fiscal Tasks - It shall include budget preparation and cost reporting, internal fiscal audits, company wide audit by CPA firms, and statistics maintained and reports prepared in this operation, and external audit liaison with the OIG and GAO.

3. Legal

General corporate legal costs allowable and allocable to Medicare, excluding provider cost report appeals, and other activities directly identifiable to other operations (e.g., reconsiderations, reviews and hearings).

I - General and Administrative

It shall include total cost allocated to Medicare for the following:

1. General Management

Individuals responsible for **overall** corporate or Medicare matters. It shall prorate the cost of individuals responsible for more than one operation, but not responsible for overall corporate or Medicare matters to the operations for which they are responsible. It shall charge the Medicare Coordinator (the person responsible for the overall Medicare operation) to General and Administrative.

2. Contractor Operations Specialist

It shall include the cost of contractor operations specialists, CMS on-site representatives, including the cost of services and space furnished to CMS.

J - Fee/Profit

It shall include only if allowed by contract/agreement, but only when payable from the Government. (Also see Other Adjustments below.)

K - Total Cost

The sum of A-J above. Total cost excludes those accruals included in Other Adjustments and Forward Funding, as defined below.

L - Other Adjustments

It shall include items for which reimbursement is not yet due per 48 CFR 52.216-7(b), but which should be accrued to the period being reported. For example, it shall include subcontract costs for which services have been received, but payment has not been made to the subcontractor or fees which have been earned (non-COB credits and fee/profit), but for which payment is not payable by CMS. CMS will provide guidance as to which activity to report for fee/profit.

M - Forward Funding

It shall include the outstanding costs to be incurred for CMS-approved items for which funding has been received, but the services extend into the subsequent FY. As costs are incurred, these costs should be reported in A through J thus reducing the forward funding balance. This category is not applicable to the budget request. If CMS has approved projects for forward funding, then costs must be reported on the September IER and the FACP.

N - Total Adjusted Cost

The sum of K through M above. See Note in Chapter 2, §130 for instructions for administrative draws.

O - Workloads 1-2-3

Some activities may not have discrete workloads; other activities may have several workloads and some only one workload. The contractor shall not fill in unless directed by CMS. Workloads for bills/claims, inquiries, and appeals will be pre-filled from workload reporting data drawn from Contractor Reporting of Operational and Workload Data (CROWD) reports. Other workloads will be input by the contractor as directed by CMS. See §100 for specific workloads to report.

P - Hours-Direct, Indirect, Subcontracts, and Overhead/G&A

It shall separately identify productive hours associated with salaries and wages and overhead/G&A. It shall compute estimated hours per employee in accordance with the Schedule of Net Hours Available, Form CMS-3258. (See §200.) It shall round net productive hours to the nearest hour. It shall use Indirect and Subcontracts Hours only with the concurrence of CMS.

It shall include hours directly assigned or otherwise allocated to a particular activity during the FY. It shall include or exclude, as appropriate, personnel hours loaned and borrowed by each operation. It shall include hours incurred by temporary help furnished by outside organizations. For this reporting requirement, temporary help must meet all the following criteria:

- Directly supervised by contractor personnel;
- Services performed on contractor premises;
- Used for limited time periods; and
- Obtained from an outside agency.

The contractor shall distinguish between temporary help and certain types of subcontractors, such as data entry, where the services are used as an interim measure to alleviate peak period workloads. Subcontract personnel provide a product **or** service, but do not meet the criteria for temporary help. Examples of subcontractors are: programmers who contract to provide software, but are not under direct control of contractor personnel, and clerical personnel working offsite.

Exception: The contractor shall not report hours for employees assigned to general maintenance, janitorial and security activities as they relate to its facility's upkeep and protection. It shall include related personal service costs (salaries, wages, and fringe benefits) as part of Other Direct Costs.

90.10 - Allocation of Overhead and General and Administrative Costs

(Rev. 1, 08-30-02)

A1-1212.10, B1-4212.10

The contractor shall allocate overhead and general and administrative costs to all activities. These allocations should be based on the ratio of each activity's total costs to the sum of all activity costs. Included in costs are salaries and wages, fringe benefits, EDP Equipment, other direct costs, other costs (if applicable), and non-COB credits. It shall exclude subcontract costs from the calculation.

For example, a contractor performs only a bills/claims payment activity and an appeals activity. The Total Costs prior to " other adjustments" of salaries and wages, fringe benefits, EDP equipment, other direct costs, other costs, and non-COB credits equals $1,000,000 for the Bills/Claims Payment and the subcontract cost is $100,000. The same costs for appeals are $250,000 and $25,000. Overhead for this period totaled $75,000 and general and administrative (G&A) totaled $25,000.

	Salaries & Wages, etc.	**Overhead Allocated**	**Percent Allocated**	**G&A Allocated**	**Percent Allocated**	**Sub-contracts**	**Total Cost**
Bills/Claims Payment	$1,000,000	$60,000	80%	$20,000	80%	$100,000	$1,180,000
Appeals	250,000	15,000	20%	5,000	20%	25,000	295,000
Total Cost	$1,250000	$75,000	100%	$25,000	100%	$125,000	$1,475,000

In this example, 80 percent of the overhead and 80 percent of the general and administrative costs were allocated to Bills/Claims Payment because salaries & wages, etc. are that percentage of the basis. Subcontract costs, other adjustments and forward funding are not considered in this allocation.

100 - Description of Operations

(Rev. 1, 08-30-02)

A1-1213, B1-4213

The following provides short descriptions of each function. Operations are first separated into PM or MIP and then by function into activities. Each function may include multiple activities. A list of activity codes is available in CAFM II. The contractor shall always refer to the General Instructions and/or the BPRs for the most current description of the activities for each function.

Once operational costs are segregated into PM or MIP, activities may be reported as either:

- An operational functional activity;
- A PI activity; or
- A special project activity.

In addition, as directed by CMS, certain specific costs must be identified and accumulated from one or more of the activities and reported a second time for informational purposes on the Miscellaneous Schedule. (See §160.1.)

After the appropriate activity is selected, cost items are reported in categories on the Activity Form in CAFM II. See §90.9 for a description of cost categories. Each activity includes the usual direct and indirect charges associated with it. When staff personnel have more than one area of responsibility, the contractor shall allocate their time and cost equitably to the operations involved.

A variety of notification methods will be used to update required cost reporting (i.e., CAFM II "News," the BPRs, and other performance instructions). CAFM II will have a current list of updated activities, including additions or changes in the PI activities, special project activities, functional activities, and informational reporting on the Miscellaneous Schedule.

100.1 - Bills/Claims Payment Function (Summary Level Code 11000)

(Rev. 1, 08-30-02)

A1-1213.1, B1-4213.1

The contractor shall include the following:

The Bills/Claims Payment function includes the costs and workload(s) associated with processing Medicare bills/claims. The activities included in this function range from provider enrollment, the receipt of initial bills/claims to the production of check or EFT payment and remittance advice and Medicare Summary Notice. This function also includes the costs for the common working file host and the UPIN Registry.

100.2 - Appeals Function (Summary Level Code 12000)

(Rev. 1, 08-30-02)

A1-1213.2, B1-4213.2

The appeals function includes the costs and workload(s) to efficiently and effectively control and respond to requests for appeal of Medicare determinations. This includes all Part A reconsiderations and ALJ hearings processed and all activities related to the Part B review and hearing process. For intermediaries, the costs of provider appeals related to cost report settlements should be included as part of the Provider Settlements activity in the Audit function.

100.3 - Inquiries Function (Summary Level Codes 13000 and 33000)

(Rev. 1, 08-30-02)

A1-1213.3, B1-4213.3

The inquiries function includes the costs and workload(s) associated with inquiries including Medicare customer service or billing/claims inquiries from beneficiaries or providers by telephone, correspondence, walk-in or on-line inquiry. The costs of inquiries received in the Medical Review (MR), Medicare Secondary Payer (MSP), and Benefit Integrity (BI) departments should be charged to those activities. The carrier shall charge the cost of beneficiary inquiries to obtain participating physician/supplier information to participating physicians. However, it shall charge the costs of toll-free lines and equipment to receive phone or electronic inquiries relating to the participating physician activity and the costs of general inquiries from physicians to Inquiries.

100.4 - PM - Provider Education and Training (PET) Function (Summary Level Code 14000)

(Rev. 1, 08-30-02)

A1-1213.4, B1-4213.4

The PM - PET function includes the costs for education and training directed at providers, groups of providers, and in some cases, individual providers depending on the scope of the problems or need for education. Costs of PET are allocated to both PM and to MIP. Refer to §100.11 for MIP PET discussion.

100.5 - Provider Reimbursement Function (Summary Level Code 16000)

(Rev. 1, 08-30-02)

A1-1213.5

See §340.3. The Provider Reimbursement function (intermediaries) includes costs and workload(s) for establishing and maintaining providers' accounting systems, submitting cost reports for quality assurance and provider audits, maintaining records and files for hospital-based physicians, and performing hospital cost reporting activities.

100.5.1 - Participating Physicians Function (Summary Code 15000)

B1-4213.5

The participating physician function (carriers) includes the costs for the continuation of the annual participating enrollment, limiting charge monitoring activities and the dissemination of participation information.

100.6 - Productivity Investments (PI) Function (Summary Level Code 17000)

(Rev. 1, 08-30-02)

A1-1213.6, B1-4213.6

The contractor shall include the cost of activities related to the development and implementation of approved PIs and administrative enhancements as directed by CMS.

A - Activity Codes for PIs

Activity codes for PIs will be assigned to approved projects. A list of approved PIs will be available in CAFM II. The contractor shall use only approved PI codes. The miscellaneous PI activity code may be used only on the initial BR and the SBR for projects that have not been approved and do not have an assigned PI activity code. It shall not use the miscellaneous PI Activity Code on an IER or FACP.

1 - PIs include administrative enhancements and legislative mandates directed by CMS that are considered essential for maintenance of effective program operations. They do not necessarily generate program savings.

2 - PIs may include activities that affect more than one Medicare function and are administered as a PI.

3 - PIs also include systems conversions and transitions. See D below.

B - PI Funding

PI funding is generally for first year start up costs only. Funding for subsequent years is generally treated as an ongoing cost, not a PI, and should be included as an ongoing operational cost in the contractor's BR. If PI funding after the first year is requested, a schedule with funding for each FY should be included in the initial request for funding. If CMS determines that PI funding for subsequent FYs is authorized, the contractor should include the PI funding authorized in its BR every year it is authorized.

C - PI Costs

The contractor shall report fully allocated costs for each PI including any appropriate overhead. It shall submit a schedule of all non-incremental costs and hours for any PI request that equals or exceeds a threshold of $100,000 or 5 percent of the total PM NOBA, net of credits. It shall include at least the following in the schedule:

1 - The amount of the non-incremental costs and hours applicable to each activity/function to equal the total non-incremental cost of the PI.

2 - A description of the non-incremental costs by cost category. See §90.9.

3 - If the amount of the non-incremental cost is zero, the contractor shall explain.

If the PI is approved, the applicable non-incremental costs and hours will be reclassified in the NOBA from each applicable activity/function to the approved PI. If the request is for a MIP PI (see §100.13), the contractor shall use the total MIP NOBA for the threshold amount rather than the PM NOBA. If a NOBA has not yet been issued for the FY, it shall base the threshold calculation on the initial BR. If PI funding is received through a CMS distribution, rather than in response to a contractor request, the contractor shall provide the non-incremental cost schedule upon request from CMS.

D - System Conversions and Transitions

The following costs are included in systems conversions and transitions and may also apply to other projects:

- **Project Management Costs** - Costs of essential staff/management project support;
- **Software Installation Costs** - Costs for installing and testing the software;
- **File Conversion Costs** - Costs for converting to the new system including the costs of mapping, software development and testing;
- **Interface Development and Implementation Costs** - Costs to interface with external programs e.g., for electronic data interchange, check writing, 1099 preparation, other reports and forms;
- **Training Costs** - Costs of staff training including train the trainer, technical staff and user staff training costs; and
- **Other Costs** - Costs of provider education, outreach, and post- implementation problem resolution.

E - Cost-Benefit Documentation for PI Projects

1 - General

Before funding will be approved for a project that is proposed by a contractor, it must be demonstrated to be cost-beneficial. A project will generally only be approved if the net present value (NPV) for the project is equal to or greater than zero. The present value of the savings is at least equal to the costs of implementation when both are discounted to the same start date. As a general rule, CMS will consider only projects having a positive NPV over 2 years. However, the contractor shall provide probable costs and savings taken over all years of the project.

This documentation does not supplant the existing prior approval process or the threshold amounts specified in the Medicare contract/agreement for system enhancements and subcontracts.

2 - Applicability

The contractor shall include cost-benefit documentation with all requests for PI funds. The amount of the documentation required depends on the estimated cost and complexity

of the project. Administrative enhancements and systems transitions directed by CMS are not subject to this cost-benefit test unless specifically required by CMS.

3 - Documentation

The contractor shall document cost-benefit analysis using NPV calculations of costs and savings discounted to the start date. A narrative explanation of cost-benefit analysis should identify the assumptions for the analysis such as the start date, discount rate, and costs and savings in each fiscal year. The contractor shall include the following items in documentation:

- Estimated Cost - The contractor shall show cost items in categories reported for activities. See §90.9 for cost categories. It shall provide underlying cost details and the assumptions on which they are based for each material cost item. It shall include personnel, machine time, materials and outside services in the estimate of costs. It shall also include EDP charges and overhead. For capital expenditures in excess of $500, it shall use standard procedures for establishing the asset's useful life and for the depreciation schedule. CMS pays expenses when incurred; the contractor shall include the proper depreciation and return on investment for the period before implementation in its analysis.

- Administrative Cost Savings - The contractor shall outline any savings in staff time, postage, and computer time. It shall include only cost reductions, not cost avoidance. It shall reduce these savings by increases in administrative costs attributable to the project (e.g., temporary productivity losses due to learning curve, "downtime" for problem resolution, and depreciation for equipment purchased).

- Benefit Savings - The contractor shall estimate the amount of benefit savings, if any, which result from preventing or recovering erroneous payments, based on policy in effect at the time of the analysis.

- Discount Rate - The contractor shall use the interest rate applicable under the Prompt Payment Act to discount both the savings and costs to the start date. The interest rate is published in the "Federal Register."

- Start Date - This is the point in time where the project first incurs costs and is the date in time used to determine the Net Present Value of the project.

F - PI Workload

The contractor shall report no workload unless directed by CMS.

100.7 - Medicare Program Administration Function (Summary Level Code 19000)

(Rev. 1, 08-30-02)

A1-1213.7, B1-4213.7

The contractor shall use this summary level code only with the concurrence of CMS.

100.8 - Medical Review (MR) Function (Summary Code 21000)

(Rev. 1, 08-30-02)

A1-1213.8, B1-4213.8

MR is the efforts taken to prevent, identify, and address claim errors made by providers including manual or automated review of claims to ensure that payments are made for services that are covered and correctly coded. (For further information see the Program Integrity Manual.)

100.9 - Medicare Secondary Payer (MSP) Function (Summary Level Code 22000)

(Rev. 1, 08-30-02)

A1-1213.9, B1-4213.9

The MSP function includes the costs and workload(s) for recovery activities related to working aged; disabled; ESRD; workers' compensation; auto/liability/no fault; and other activities related to MSP and identified by CMS.

100.10 - Benefit Integrity (BI) Function (Summary Level Code 23000)

(Rev. 1, 08-30-02)

A1-1213.10, B1-4213.10

The Benefit Integrity function includes the costs and workload(s) associated with receiving and processing complaints or allegations of Medicare fraud and abuse and maintenance of associated databases. BI also includes self-initiated data analysis to detect potential fraud and maintenance of associated databases, and the development of cases for referral or further action. See work specifically required in §3900.

100.11 - MIP - Provider Education and Training (PET) Function (Summary Level Code 24000)

(Rev. 1, 08-30-02)

A1-1213.11, B1-4213.11

The MIP - PET function includes the costs for education and training directed at providers, groups of providers and, in some cases, individual providers depending on the scope of the problems or need for education to avoid and detect waste, fraud, and abuse. Costs of PET are allocated to both PM and to MIP.

100.12 - Audit Function (Summary Level Code 26000)

(Rev. 1, 08-30-02)

A1-1213.12

The Audit function (intermediaries) includes the costs and workload(s) for Provider Desk Reviews, Audits and Settlements. See §290.

100.13 - MIP Productivity Investments Function (Summary Level Code 27000)

(Rev. 1, 08-30-02)

A1-1213.13, B1-4213.12

The contractor shall use these lines only with specific authorization by CMS for MIP PI. See the Program Integrity Manual for discussion of the PI activities.

100.14 - MIP-Medicare Program Administration (Summary Level Code 29000)

(Rev. 1, 08-30-02)

A1-1213.14, B1-4213.13

The contractor shall use this summary level code only with the concurrence of CMS.

110 - Exhibit of Special Projects Form

(Rev. 1, 08-30-02)

A1-1214, B1-4214

CONTRACTOR NAME		ADMINISTRATIVE BUDGET AND COST REPORT			IER		SPECIAL
ADDRESS LINE 1		MEDICARE CONTRACTORS			EIN:	XXXXXXXXXXXX	
ADDRESS LINE 22		INTERIM EXPENDITURE REPORT			ACCEPT DATE:		
CONTRACTOR NO:	PART:	FUND YR:	REPORT YR:	MONTH:	SUPPLE NO:		
######	X	XXXX	XXXX	XX	XX		CAFM II

PM SPECIAL PROJECTS SCHEDULE

CODE	DESCRIPTION	SALARIES/ FRINGE	SUBCONT	OTHER	TOTAL	WORKLOAD
18XXX	XXXXXXXXXXXXXXX	________	________	________	________	________
18XXX	XXXXXXXXXXXXXXX	________	________	________	________	________
18XXX	XXXXXXXXXXXXXXX	________	________	________	________	________
18XXX	XXXXXXXXXXXXXXX	________	________	________	________	________
18XXX	XXXXXXXXXXXXXXX	________	________	________	________	________
18XXX	XXXXXXXXXXXXXXX	________	________	________	________	________
18XXX	XXXXXXXXXXXXXXX	________	________	________	________	________
18XXX	XXXXXXXXXXXXXXX	________	________	________	________	________
18XXX	XXXXXXXXXXXXXXX	________	________	________	________	________
18XXX	XXXXXXXXXXXXXXX	________	________	________	________	________
18000	TOTAL	________	________	________	________	________

REMARKS:

110.1 - Completing the Special Projects Form

1214.1, B1-4214.1

A - General

This schedule is used to identify special project activities. Special projects are defined as those activities which may be of critical importance from an operational standpoint but which are not materially significant from a financial standpoint viewed in the context of the contractor's contract/agreement and its requirements. Therefore, reduced budget and cost reporting is required. Special projects may relate to any underlying Medicare function and/or to a specific activity. Because of the non-material (financial) nature of the activity, the contractor shall charge only direct costs and specifically identifiable and incremental overhead/G&A costs to the activity.

B - Uses

The schedule will be used only if there are special project activities to report. It will generally not be used for the BR but may be used for any or all of the following: SBR, NOBA, IER, and FACP. It shall not be used for cost reporting purposes unless funds are provided in the NOBA.

C - Explanation of Entries on Special Projects Schedule

1 - Code - Special projects are assigned to the 18000 series for PM activities and to the 28000 series for MIP activities. See §90.4 for a further discussion of activity codes.

2 - Description - Brief description of the activity.

3 - Productive Hours -The contractor shall include all productive hours. (See §90.9P.)

4 - Salaries/Fringe Benefits - The contractor shall include all salaries, wages and fringe benefits. (See §90.9 A-B.)

5 - Subcontracts - The contractor shall include all subcontract costs. (See §90.9D.)

6 - Other Costs - The contractor shall include all costs and, if applicable, non-COB credits not included in personal service costs and subcontracts. This may include: EDP equipment, other direct costs, other costs, non-COB credits and incremental overhead/G&A. It should not confuse this cost category with the "other costs" reported on the Activity Screen. See §§90.9C and 90.9E-I. It shall also include any adjustments or forward funding when appropriate on the FACP. (See §90.9L-M.)

7 - Total Cost - The sum of salaries/fringe benefits, subcontract and all other costs above. Note that special project activity costs are NOT included in any other activity and must be separately reported on this schedule and that total costs should equate to total costs as defined in §90.9K and not to Total Adjusted Cost as defined in §90.9N.

8 - Workload - The contractor shall report the related workload if appropriate.

120 - Exhibit of Schedule of Other Direct Costs (Schedule A)

(Rev. 1, 08-30-02)

A1-1215, B1-4215

CONTRACTOR NAME		ADMINISTRATIVE BUDGET AND COST REPORT			IER	SCH A
ADDRESS LINE 1		MEDICARE CONTRACTORS			EIN: XXXXXXXXXXXX	
ADDRESS LINE 2		INTERIM EXPENDITURE REPORT			ACCEPT DATE:	
CONTRACTOR NO:	PART:	FUND YR:	REPORT YR:	MONTH:	SUPPLE NO:	
######	X	XXXX	XXXX	XX	XX	CAFM II
ACTIVITY CODE:	XXXXX	DESCRIPTION:	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			

OTHER DIRECT COSTS - SCHEDULE A

CODE (A)	DESCRIPTION (B)	COSTS (C)
XXX	DIRECT COST ITEM 1	____________
XXX	DIRECT COST ITEM 2	____________
XXX	DIRECT COST ITEM 3	____________
XXX	DIRECT COST ITEM 4	____________
XXX	DIRECT COST ITEM 5	____________
XXX	DIRECT COST ITEM 6	____________
XXX	DIRECT COST ITEM 7	____________
XXX	DIRECT COST ITEM 8	____________
XXX	DIRECT COST ITEM 9	____________
999	MISCELLANEOUS	____________
	TOTAL OTHER DIRECT COSTS	____________

REMARKS:

120.1 - Completing the Schedule of Other Direct Costs (Schedule A)

(Rev. 1, 08-30-02)

A1-1215.1, B1-4215.1

A - General

The contractor shall use this schedule to identify specific other direct costs included in the Other Direct Costs line of the Activity Screen as defined in §90.9 E. A separate Schedule A is completed for each activity requiring the specific identification of Other Direct Costs.

B - Uses

The contractor shall complete this schedule only with the concurrence of CMS. It may not be required of all contractors. If required, the schedule may be used for the BR, SBR, IER and/or FACP.

C - Explanation of Entries on the Schedule A

1 - Code - A three-digit code identifying each cost item. The contractor shall use 999 to identify all remaining costs not requiring specific identification.

2 - Description - A brief description of the discrete cost item. Types of costs to be reported are described in §90.9 E and may also include such items as consultant fees, cost of money and travel depending on the nature of the contractor's contract. Those items requiring identification will depend on contract needs, materiality and other considerations. The classification of costs in the contractor's cost accounting system, government regulations and the contract will determine whether the cost is classified as an Other Direct Cost.

3 - Total Cost - The contractor shall report the total cost for each item. The total for all Other Direct Costs, including those reported under 999 if applicable, must agree with the total reported on the Other Direct Costs line of the Activity Screen.

130 - Exhibit of Schedule of Other Costs (Schedule B)

(Rev. 1, 08-30-02)

A1-1216, B1-4216

CONTRACTOR NAME		ADMINISTRATIVE BUDGET AND COST REPORT			IER	SCH B
ADDRESS LINE 1		MEDICARE CONTRACTORS			EIN: XXXXXXXXXXXX	
ADDRESS LINE 2		INTERIM EXPENDITURE REPORT			ACCEPT DATE:	
CONTRACTOR NO:	PART:	FUND YR:	REPORT YR:	MONTH:	SUPPLE NO:	
######	X	XXXX	XXXX	XX	XX	CAFM II

ACTIVITY CODE: XXXXX DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

OTHER COSTS - SCHEDULE B

CODE (A)	DESCRIPTION (B)	COSTS (C)
XXX	DIRECT COST ITEM 1	____________
XXX	DIRECT COST ITEM 2	____________
XXX	DIRECT COST ITEM 3	____________
XXX	DIRECT COST ITEM 4	____________
XXX	DIRECT COST ITEM 5	____________
XXX	DIRECT COST ITEM 6	____________
XXX	DIRECT COST ITEM 7	____________
XXX	DIRECT COST ITEM 8	____________
XXX	DIRECT COST ITEM 9	____________
999	MISCELLANEOUS	____________
	TOTAL OTHER DIRECT COSTS	____________

REMARKS:

130.1 - Completing the Schedule of Other Costs (Schedule B)

(Rev. 1, 08-30-02)

A1-1216.1, B1-4216.1

A - General

The contractor shall use this schedule to identify specific other costs included in the Other Costs line of the Activity Screen as defined in §90.9 F. A separate Schedule B is completed for each activity requiring the specific identification of other costs.

B - Uses

The contractor shall complete this schedule only with the concurrence of CMS. It may not be required of all contractors. If required, the schedule may be used for the BR, SBR, IER and/or FACP.

C - Explanation of Entries on the Schedule B

1 - Code - A three-digit code identifying each cost item. The contractor shall use 999 to identify all remaining costs not requiring specific identification.

2 - Description - A brief description of the discrete cost item. Types of costs to be reported are described in §90.9 F. Those items requiring identification will depend on the nature of the contractor's contract/agreement, materiality and other considerations. The classification of costs in its cost accounting system, government regulations and the contract/agreement will determine whether the cost is classified as an Other Cost.

3 - Total Cost - The contractor shall report the total cost for each item. The total for all Other Costs, including those reported under 999 if applicable, must agree with the total reported on the Other Direct Costs line of the Activity Screen.

140 - Exhibit of Schedule of Non-COB Credits (Schedule C)

(Rev. 1, 08-30-02)

A1-1217, B1-4217

CONTRACTOR NAME		ADMINISTRATIVE BUDGET AND COST REPORT			IER	SCH C
ADDRESS LINE 1		MEDICARE CONTRACTORS			EIN: XXXXXXXXXXXX	
ADDRESS LINE 2		INTERIM EXPENDITURE REPORT			ACCEPT DATE:	
CONTRACTOR NO:	PART:	FUND YR:	REPORT YR:	MONTH:	SUPPLE NO:	
######	X	XXXX	XXXX	XX	XX	CAFM II
ACTIVITY CODE:	XXXXX	DESCRIPTION:	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			

NON-COB CREDITS - SCHEDULE C

CODE (A)	DESCRIPTION (B)	COSTS (C)
XXX	DIRECT COST ITEM 1	____________
XXX	DIRECT COST ITEM 2	____________
XXX	DIRECT COST ITEM 3	____________
XXX	DIRECT COST ITEM 4	____________
XXX	DIRECT COST ITEM 5	____________
XXX	DIRECT COST ITEM 6	____________
XXX	DIRECT COST ITEM 7	____________
XXX	DIRECT COST ITEM 8	____________
XXX	DIRECT COST ITEM 9	____________
999	MISCELLANEOUS	____________
	TOTAL OTHER DIRECT COSTS	____________

REMARKS:

140.1 - Completing the Schedule of Non-COB Credits (Schedule C)

(Rev. 1, 08-30-02)

A1-1217.1, B1-4217.1

A - General

The contractor shall use this schedule to identify specific Non-COB Credits included in the Non-COB Credit line of the Activity Screen as defined in §90.9 G. A separate Schedule C is completed for each activity requiring the specific identification of Non-COB Credits.

B - Uses

The contractor shall complete this schedule only with the concurrence of CMS. It may not be required of all contractors. If required, the schedule may be used for the BR, SBR, IER and/or FACP.

C - Explanation of Entries on the Schedule C

1 - Code - A three-digit code identifying each credit item. The contractor shall use 999 to identify all remaining credits not requiring specific identification.

2 - Description - A brief description of the discrete credit item. Types of credits to be reported are described in §90.9 G. Those items requiring identification will depend on the nature of the contractor's contract, materiality and other considerations.

3 - Total Credits - The contractor shall report the total credit for each item. The total for all Non-COB Credits, including those reported under 999 if applicable, must agree with the total reported on the Non-COB Credits line of the Activity Screen.

150 - Exhibit of Schedule of Other Adjustments (Schedule D)

(Rev. 1, 08-30-02)

A1-1218, B1-4218

CONTRACTOR NAME		ADMINISTRATIVE BUDGET AND COST REPORT			IER	SCH D
ADDRESS LINE 1		MEDICARE CONTRACTORS			EIN: XXXXXXXXXXXX	
ADDRESS LINE 2		INTERIM EXPENDITURE REPORT			ACCEPT DATE:	
CONTRACTOR NO:	PART:	FUND YR:	REPORT YR:	MONTH:	SUPPLE NO:	
######	X	XXXX	XXXX	XX	XX	CAFM II

ACTIVITY CODE: XXXXX DESCRIPTION: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

OTHER ADJUSTMENTS - SCHEDULE D

CODE (A)	DESCRIPTION (B)	COSTS (C)
XXX	DIRECT COST ITEM 1	
XXX	DIRECT COST ITEM 2	
XXX	DIRECT COST ITEM 3	
XXX	DIRECT COST ITEM 4	
XXX	DIRECT COST ITEM 5	
XXX	DIRECT COST ITEM 6	
XXX	DIRECT COST ITEM 7	
XXX	DIRECT COST ITEM 8	
XXX	DIRECT COST ITEM 9	
999	MISCELLANEOUS	
	TOTAL OTHER DIRECT COSTS	

REMARKS:

150.1 - Completing the Schedule of Other Adjustments (Schedule D)

(Rev. 1, 08-30-02)

A1-1218.1, B1-4218.1

A - General

The contractor shall use this schedule to identify specific Other Adjustments included in the Other Adjustments line of the Activity Screen as defined in §90.9L. A separate Schedule D is completed for each activity requiring the specific identification of Other Adjustments.

B - Uses

The contractor shall complete this schedule only with the concurrence of CMS. It may not be required of all contractors. Although described in this section, the schedule will not be used in budget preparation. It may be used for the IER and/or FACP.

C - Explanation of Entries on the Schedule D

1 - Code - A three-digit code identifying each adjustment item. The contractor shall use 999 to identify all remaining adjustments not requiring specific identification.

2 - Description - A brief description of the adjustment item. Types of adjustments to be reported are described in §90.9 L. Those items requiring identification will depend on the nature of the contractor's contract, materiality and other considerations.

3 - Total Adjustments - The contractor shall report the total adjustment for each item. The total for all Other Adjustments, including those reported under 999 if applicable, must agree with the total reported on the Other Adjustments line of the Activity Screen.

160 - Exhibit of the Miscellaneous Cost Schedule

(Rev. 1, 08-30-02)

A1-1219, B1-4219

Contractor Name: ____________________	Administrative Budget And Cost Report	Miscellaneous Schedule
Address Line 1: ____________________	Medicare Contractor	Accept Date: __/__/____
Address Line 2: ____________________	Budget Request	EIN: ______________

Contractor No: _______ Funding FY: ____ Reporting FY: ____ Month: __ Supplement No: ___

****

Code	Description	Costs	Workload
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
__________	______________________	______________	______________
	Net Hours Available:	______________	

****

Remarks: ______ ____

____

____

____

____

____

____

****

160.1 - Completing the Miscellaneous Cost Schedule

(Rev. 1, 08-30-02)

A1-1219.1, B1-4219.1

A - General

The contractor shall use this schedule to identify specific "miscellaneous cost items." This is a single stand-alone schedule and it does NOT tie to any Activity Screen. CMS will specify any miscellaneous cost items to be reported.

B - Uses

The schedule is for tracking ANY miscellaneous costs within one or more activities that need to be separately identified but are already included in the total costs of those activities. It is used for the following specific annual, periodic, and monthly reports the contractor submits to CMS.

- Budget request - See §230
- Interim Expenditure Report - See Chapter 2, §60.
- Final Administrative Cost Report - See Chapter 2, §60.

C - Explanation of Entries

1 - Code - A miscellaneous code is assigned within the 10000 series for PM activities, the 20000 series for MIP activities, and the 51000 series if it pertains to both PM and MIP. The code is followed by a 2-digit code to identify specific cost items. CMS will identify miscellaneous codes to report. See §90.4 for further discussion of activity codes.

2 - Description - Brief description of the activity.

3 - Costs - The contractor shall include personal service, subcontract and all other costs as appropriate. Miscellaneous costs should include accruals.

4 - Workload - The contractor shall report the related workload if appropriate.

5 - Net Hours Available - The contractor shall report the number of net hours available per employee. (See §200.1.)

170 - Exhibit of Cost Classification Report, Form CMS-2580

(Rev. 1, 08-30-02)

A1-1220, B1-4220

CONTRACTOR NAME — ADMINISTRATIVE BUDGET AND COST REPORT — FACP — COST CLASS
ADDRESS LINE 1 — MEDICARE CONTRACTORS — EIN:XXXXXXXXXXXX
ADDRESS LINE 2 — FINAL ADMINISTRATIVE COST PROPOSAL — ACCEPT DATE:
CONTRACTOR NO: ###### — PART: X — FUND YR: XXXX — REPORT YR: XXXX — MONTH: XX — SUPPLE NO: XX — CAFM II

COST CLASSIFICATION REPORT

CLASSIFICATION	COST (A)	OVERHEAD / G& A (B)	TOTAL OTHER ADJUSTMENTS (C)	TOTAL ADJUSTED COSTS (D)
1. SALARIES AND WAGES	______	______	______	X,XXX,XXX,XXX
2. FRINGE BENEFITS	______	______	______	X,XXX,XXX,XXX
3. FACILITIES OR OCCUPANCY	______	______	______	X,XXX,XXX,XXX
4. EDP EQUIPMENT	______	______	______	X,XXX,XXX,XXX
5. SUBCONTRACTS	______	______	______	X,XXX,XXX,XXX
6. OUTSIDE PROFESSIONAL SERVICES	______	______	______	X,XXX,XXX,XXX
7. TELEPHONE AND TELEGRAPH	______	______	______	X,XXX,XXX,XXX
8. POSTAGE AND EXPRESS	______	______	______	X,XXX,XXX,XXX
9. FURNITURE AND EQUIP (NOT EDP)	______	______	______	X,XXX,XXX,XXX
10. MATERIALS AND SUPPLIES	______	______	______	X,XXX,XXX,XXX
11. TRAVEL	______	______	______	X,XXX,XXX,XXX
12. RETURN ON INVESTMENT	______	______	______	X,XXX,XXX,XXX
13. MISCELLANEOUS	______	______	______	X,XXX,XXX,XXX
14. OTHER	______	______	______	X,XXX,XXX,XXX
15. CREDITS	______	______	______	X,XXX,XXX,XXX
16. FORWARD FUNDING	______	______	______	X,XXX,XXX,XXX
17. TOTAL	______	______	______	X,XXX,XXX,XXX

AVERAGE UNDEPRECIATED BALANCE OF ASSETS ALLOCABLE TO MEDICARE ______
PORTFOLIO RATE OF RETURN ______

TOTAL RETURN ON INVESTMENT ______

PENSION COSTS ______

REMARKS:

180 - Completing the Cost Classification Report, Form CMS-2580

(Rev. 1, 08-30-02)

A1-1221, B1-4221

The contractor shall submit the Cost Classification Report (CCR), Form CMS-2580, with estimated costs identified by major classifications. It shall submit it with both the BR and the FACP.

NOTE: Only one combined PM/MIP CCR is required with the BR and the FACP.

The contractor shall round entries to the nearest $100 for the budget request and nearest $1 for the FACP.

180.1 - Column A

(Rev. 1, 08-30-02)

A1-1221.1, B1-4221.1

This column will sum all activities to equal Total Adjusted Cost less Overhead, General and Administrative and Other Adjustments. The following fields will be pre-filled: Salaries and Wages, Fringe Benefits, EDP Equipment, Subcontracts, Credits and Forward Funding. The contractor will identify and enter Other Direct Costs among the following applicable cost classification categories: Facilities and Occupancy, Outside Professional Services, Telephone and Telegraph, Postage and Express, Furniture and Equipment, Materials and Supplies, Travel, Return on Investment, Miscellaneous and Other. See §§90.9 and 180.5 for a description of each cost classification category.

180.2 - Column B

(Rev. 1, 08-30-02)

A1-1221.2, B1-4221.2

The contractor shall use this column to allocate total Overhead and General and Administrative costs from all activity forms to the applicable cost classification categories. See §§90.9 and 180.5.

180.3 - Column C

(Rev. 1, 08-30-02)

A1-1221.3, B1-4221.3

The contractor shall use this column to allocate total Other Adjustments from all Activity Forms to the applicable cost classification categories. (See §§90.9 and 180.5.) It shall not use this column in the budget request (BR).

180.4 - Column D

(Rev. 1, 08-30-02)

A1-1221.4, B1-4221.4

The sum of columns A-C to equal Total Adjusted Costs for all Activity Forms.

180.5 - Cost Classification Categories

(Rev. 1, 08-30-02)

A1-1221.5, B1-4221.5

A.	Salaries and Wages	See §90.9.
B.	Fringe Benefits	See §90.9. The contractor shall include the portion of fringe benefits allocated for contributions to employee pension plans. Also, it shall separately identify pension plan expense.
C.	Facilities and Occupancy	The contractor shall include: • Rent-leasehold; • Amortization-leasehold improvements; • Depreciation or rental of company-owned buildings; • Real estate and property taxes; • Insurance on property; • Power, heat and light; • Personal service costs and/or facility service agreements related to general maintenance, janitorial and security; • Repairs; and Other - licenses or permits related to buildings or their components.
D.	EDP Equipment	See §90.9.
E.	Subcontracts	See §90.9.
F.	Outside	The contractor shall include charges for professional services

	Professional Services	rendered by outside consultants. This includes medical and management-type consultants.
G.	Telephone and Telegraph	Self explanatory
H.	Postage and Express	Self explanatory
I.	Furniture and Equipment, Other Than EDP	The contractor shall include: • Rental or depreciation; • Expense items under $500; • Maintenance and repairs; and • Use charges. Examples of items that fall within the category of furniture and equipment are: • Desks and chairs; • Office machines--typewriters, calculators; • Filing cabinets; and • Microfilm equipment. The contractor shall capitalize and depreciate furniture and equipment costing $500 or more per item and with a useful life of more than 1 year. It shall not include the expense of leased and company-owned autos.
J.	Materials and Supplies	The contractor shall include all expendable items such as general office supplies and EDP supplies.
K.	Travel	The contractor shall include costs for transportation, meals, and lodging. It shall include the cost of leased autos and all costs associated with company-owned vehicles. It shall **not** include personal service costs related to individuals in travel status.

L. Return on Investment (ROI)

If applicable, the contractor shall include charges related to application of the investment rate of return to the average undepreciated balance of capitalized assets for the period. It shall calculate ROI using the portfolio rate of return for the contract period instead of the treasury rate. It shall include the following ROI schedule.

ROI Calculations FY:

Average undepreciated balance of assets allocable to Medicare.	($ A)
Contractor's portfolio rate of return for the contract period	(B) %
Total ROI (A x B).	$ ________

M. Miscellaneous

The contractor shall include:

- Taxes, other than personnel and real property;
- Insurance, other than that included in §§180.2, 180.3, and 180.4;
- Dues to professional, trade, and business associations;
- Net food service costs (cafeteria and subsidized eating facilities); and
- All other costs not specifically identified elsewhere. Contractor shall specifically identify all other costs over $2,500 in Remarks.

N. Other

The contractor shall identify in Remarks Section.

This is reserved and should not be used without explicit approval of CMS.

O. Credits

The contractor shall include the applicable portion of any income, rebate, allowance, or other credits related to total operations. This includes, but is not limited to, Medicare data used for complementary health insurance and/or Medicaid claims processing by it or another organization. The credits reported must equal the total COB credits reported on the certification schedule, plus the sum of non-COB credits included on the activity forms. (See §§90.9G and 190.C.)

P. Forward Funding

See §90.9. The contractor shall use this category only with the FACP

FACP.

180.6 - Total

(Rev. 1, 08-30-02)

A1-1221.6, B1-4221.6

The sum of the items on Form 2580. The amount in Column D must be identical to the Total Cost of the Budget Request or Total Adjusted Costs of the FACP.

180.7 - Pension Costs

(Rev. 1, 08-30-02)

A1-1221.7, B1-4221.7

The contractor shall identify pension plan expenses included in fringe benefits, Column D.

180.8 - Remarks

(Rev. 1, 08-30-02)

A1-1221.8, B1-4221.8

The contractor shall include any appropriate comments.

190 - Exhibit of Certification Form

(Rev. 1, 08-30-02)

A1-1222, B1-4222

CONTRACTOR NAME		ADMINISTRATIVE BUDGET AND COST REPORT			NOBA	CERTIFICATION
ADDRESS LINE 1		MEDICARE CONTRACTORS			EIN: XXXXXXXXXXXX	
ADDRESS LINE 2		NOTICE OF BUDGET APPROVAL			ACCEPT DATE:	
CONTRACTOR NO:	PART:	FUND YR:	REPORT YR:	MONTH:	SUPPLE NO:	
######	X	XXXX	XXXX	XX	XX	CAFM II

CREDIT ITEM	AMOUNT
Complementary Credit:	
MEDICAID:	
MEDIGAP:	
Total Credits:	

PM ACTIVITY SUMMARY BY FUNCTION

CODE	DESCRIPTION	PROD. HOURS	TOTAL COST	WORKLOAD
11000	BILLS/CLAIMS PAYMENT			
12000	APPEALS			
13000	INQUIRIES			
14000	PROVIDER EDUCATION/TRAINING			
15000	PARTICIPATING PHYSICIAN			
16000	PROVIDER REIMBURSEMENT			
17000	PRODUCTIVITY INVESTMENTS			
18000	SPECIAL PROJECTS			
19000	MEDICARE PROGRAM ADMIN			
	CREDITS			
TOTAL				

CUMULATIVE QUARTERLY DISTRIBUTIONS

FY	FIRST QTR	SECOND QTR	THIRD QTR	FOURTH QTR

I CERTIFY TO THE BEST OF MY BELIEF OR KNOWLEDGE THAT THIS DATA IS ACCURATE, COMPLETE, AND CURRENT AS OF THE DATE OF THE EXECUTION OF THIS CERTIFICATE.

CERTIFYING OFFICIAL ______________________

TITLE ______________________

REMARKS:

190.1 - Completing the Certification Form

(Rev. 1, 08-30-02)

A1-1222.1, B1-4222.1

A - General

There are four sections that are utilized by the user to generate the PM certification. They are: Credit, Activity Summary by Function, Administrative Funds Drawn and Certification Screen. For MIP, there are three sections. They are: Activity Summary by Function, Administrative Funds Drawn and Certification Screen.

For PM, the user will enter the COB credits. After the user has entered all COB credit information, the system will sum the data to a "face sheet" amount by Medicare function, for Total Cost and Total Adjusted Cost, including a separate line for COB credits. The contractor will attest to the accuracy of the data included in the report by completing a certification statement.

B - Uses

The form will be used for the BR, SBR, IER, and FACP.

C - Completing the Certification Section

1 - Credit Amount

The contractor shall enter the cumulative amount of cash received for Complementary Credit and Medicaid to equal total credits. The user must also enter the amount of accrued credits in total. Accrued credits represent outstanding receivables (invoices that have been billed but payments have not been received as of report date). This section must be completed prior to generation of the Certification Section.

2 - Activity Summary By Function Section

This is a system-generated area. The system will sum the data to a total face sheet by Medicare function. No input is required by the user; however, the total must tie to subsidiary records.

3 - Administrative Funds Drawn Section

This section is completed only for the IER. (See Chapter 2, §60.6.)

4 - Certification Section

The contractor shall enter name of Certifying Official and Title. An authorized official signs and dates the hard copy report and retains a copy in file.

5 - Remarks Section

The contractor shall complete this section when appropriate.

200 - Exhibit of Schedule of Net Hours Available, Form CMS-3258

(Rev. 1, 08-30-02)

A1-1223, B1-4223

SCHEDULE OF NET HOURS AVAILABLE

MEDICARE CONTRACTORS

Contractor Name and Address:

Identification Number Fiscal Year

Contractor #

1. Period	October	October-November	October-December	October-January	October-February	October-March	October-April	October-May	October-June	October-July	October-August	October-September
2. Cumulative Days Per Period												
3. Less - Weekends												
4. Holidays												
5. Average Vacations												
6. Average Sick Leave												
7. Other Leave - Average												
8. Total Days Off												
9. Days Available												
10. Working Hours Per Day												
11. Less Authorized Breaktime												
12. Net Cumulative Daily Hrs Available												
13. Net Hours Available Per Employee (Item 12 x Item 9)												

If the working hours per day or net daily hours available is not the same for all periods this should be explained under the remarks section. Working hours per day should reflect no more than a normal working day.

REMARKS:

FORM HCFA 3258

200.1 - Completing the Schedule of Net Hours Available

(Rev. 1, 08-30-02)

A1-1223.1, B1-4223.1

This form is not a required attachment to the initial Budget Request unless specifically requested by the contractor's RO. It is provided here for illustration purposes since the net hours available figure must appear on the BR. It is calculated as described below.

NOTE: The net hours available reported on each IER and the FACP will be based upon the net hours available shown on the contractor's initial BR.

A.	Contractor Name and Address	Contractor enters the organization's official name and address.
B	Identification Number	Contractor enters the five-digit Medicare-assigned contractor number.
C.	Fiscal Year	Contractor enters the fiscal year that corresponds to the administrative budget and cost report
D.	Line 1 - Period	Contractor indicates the months involved.
E.	Line 2 - Cumulative Days per Period	Contractor indicates the calendar count of days involved
F.	Line 3 - Weekends	Contractor indicates the calendar count of weekend days involved.
G.	Line 4 - Holidays	Contractor indicates the calendar count of holidays involved.
H.	Line 5 - Average Vacation	Contractor indicates the average vacation per employee based on personnel records.
I	Line 6 - Average Sick Days	Contractor indicates the average sick days per employee based on personnel records.
J.	Line 7 - Other Leave Average	Contractor indicates the average days used for other leave per employee based on personnel records.
K.	Line 8 - Total Days Off	Sum of lines 3, 4, 5, 6, and 7.
L.	Line 9 - Days Available	Line 2 minus Line 8
M.	Line 10 - Working Hours Per Day	Contractor enters the normal working hours per day.

N.	Line 11 - Authorized Break-time	Contractor enters the amount of time employees are authorized to use for nonproductive purposes, e.g., coffee breaks.
O.	Line 12 - Net Cumulative Daily Hours Available	Line 10 minus Line 11.
P.	Line 13 - Net Hours Available Per Employee	Line 12 multiplied by Line 9.

210 - Contractors Performing Services for Other Medicare Contractors

(Rev. 1, 08-30-02)

A1-1230, B1-4230

Where services such as bill processing, EDP services, provider audit, or appeals processing are performed by one contractor for another, the following budget preparation procedures apply.

210.1 - Servicing Contractor

(Rev. 1, 08-30-02)

A1-1230.1, B1-4230.1

The servicing contractor furnishes the receiving contractor an appropriate estimate of the costs described in §90.9 by activity.

The estimates are submitted on the Activity Form by cost category. For provider audit, it furnishes the Contractor Auditing and Settlement Report with applicable activities and columns completed. (See §290.) The estimate for these services includes all direct, and an equitable share of indirect, costs expected. All estimates are in accordance with the principle that neither the contractor providing the service nor the contractor receiving the service incurs a profit or loss on the transaction. The contractor shall **not** include related estimated costs as part of its budget submission. It shall furnish this information to the receiving contractor.

210.2 - Receiving Contractor

(Rev. 1, 08-30-02)

A1-1230.2, B1-4230.2

The receiving contractor includes the estimated costs, furnished by the servicing contractor, as a subcontract cost and identifies the servicing contractor in the Remarks section of that Activity Form.

220 - Budget Justification

(Rev. 1, 08-30-02)

(Rev. 1, 08-30-02)

A1-1240, B1-4240

The annual BPRs describes the statement of work and level of effort for each Medicare function to which the contractor must adhere. The General Instructions section of the BPRs details the narrative, analysis, worksheets and data requirements that constitute the general instructions for the budget justification. Additional requirements may be identified in each functional area. The contractor shall refer to the BPRs for the current year's budget justification requirements.

230 - Completing the Budget Request

(Rev. 1, 08-30-02)

A1-1255, B1-4255

The contractor uses this basic document for submitting the annual estimate of costs for administrative functions and duties related to the Medicare program. The format and related explanations must furnish sufficient information to permit a meaningful review of the estimates. The information requested and as supplemented by the BPRs form the basis for the budget data for each FY.

The base period for preparation and comparison of the BR is the prior year's budget unless otherwise stated in the BPRs. The contractor shall consider its most recent experience in preparing financial cost estimates.

230.1 - Transmittal

(Rev. 1, 08-30-02)

A1-1255.1, B1-4255.1

The contractor shall transmit the complete BR consisting of the activity forms and supporting schedules via CAFM II. (See §270.)

230.2 - Hard Copy Requirements

(Rev. 1, 08-30-02)

A1-1255.2, B1-4255.2

The contractor shall submit the original to the RO and one copy to CO of all forms, all supporting schedules, and all narrative justifications that are **not** transmitted via CAFM II. It shall address CO hard copies to:

> Centers for Medicare & Medicaid Services
> Division of Financial Operations, OFM
> 7500 Security Boulevard
> Baltimore, Maryland 21244

230.3 - Activities

(Rev. 1, 08-30-02)

A1-1255.3, B1-4255.3

Descriptions of these items are in §100.

230.4 - Hours

(Rev. 1, 08-30-02)

A1-1255.4, B1-4255.4

The contractor shall enter hours as developed using instructions in §90.9P. It shall round to the nearest hour

230.5 - Costs

(Rev. 1, 08-30-02)

A1-1255.5, B1-4255.5

The contractor shall enter costs and credits as in §90.9. It shall round entries to the nearest hundred dollars.

230.6 - Workload

(Rev. 1, 08-30-02)

A1-1255.6, B1-4255.6

The contractor shall enter the workloads for the budget period. (See §90.9O.)

230.7 - Net Hours Available (Miscellaneous Section)

(Rev. 1, 08-30-02)

A1-1255.7, B1-4255.7

The contractor shall enter the number of net productive hours required to convert total productive hours to equivalent staff-years for the budget period. (See §200.)

230.8 - Narrative and Financial Analysis Requirements

(Rev. 1, 08-30-02)

A1-1255.8, B1-4255.8

The contractor shall include a narrative analysis (budget justification) that summarizes the funding and workload requested for each line of operation. The analysis shall provide information that fully justifies its request, includes all required forms as defined herein,

and meets the requirements stated in the annual BPRs. Operations personnel should actively participate in the development of the BR.

If CMS workload volumes are supplied and those volumes are acceptable, no volume analysis is required. Requests for changes in workload from any CMS provided volumes must be supported by a volume analysis that includes the historical data used to make the projection, a description of the forecast methodology used and the actual forecast computation. This applies to all line items with identifiable workload volumes.

230.9 - Financial Information Survey

(Rev. 1, 08-30-02)

A1-1255.9, B1-4255.9

This survey must be completed and submitted in hard copy as an attachment to the contractor's initial BR.

A - If the contractor has a new severance policy in place or its previous severance policy has been updated, it shall:

- State the effective date for the new or updated severance policy.
- Summarize its severance/separation pay policy including both management and staff. State the length of service criteria, types of cost covered by the policy, the effective date of the policy and any other criteria used in determining the amount of payment. Identify and discuss any related benefits which may be payable to or on behalf of the employee beyond the standard severance payment(s).
- Attach a dated extract of its corporate severance pay policy and any related benefits payable to or on behalf of the employee related to the severance or separation.
- If there is no change since the submission of the initial BR for last year, state "No Change."

B - The contractor shall estimate the number of direct Medicare employees (excluding temporaries) in this BR FY, the average number of years that staff and management have been employed full time on the Medicare contract and average number of years each has been with the corporation:

- No. of direct Medicare employees: Staff _____ Management _____
- Avg. yrs. employed Full Time with Medicare: Staff _____ Management _____
- Avg. yrs. employed with corporation: Staff _____ Management _____

C - The contractor shall indicate whether, during the last two years or for this BR, it has acquired or intends to acquire (through lease or purchase) any Electronic Data Processing

Equipment (as reported on the Cost Classification Report, see §180.4) or any EDP operations change which will result in a TOTAL charge (not annual depreciation) to the Medicare program exceeding $500,000?

Yes or No _________

If yes, it shall state the following:

- Month and year of acquisition:
- Type of acquisition (new lease, replacement lease, purchase):
- Reason for acquisition (obsolescence, overcapacity):
- Amount included in this BR for the equipment or operations change: $_______.
- Total number of depreciable years _________
- Number of depreciable years remaining:__________

NOTE: Any response to the above does not constitute prior notice/approval as required by the contract.

D - The contractor shall provide a breakdown of the "average un-depreciated balance of assets" **allocated** to Medicare as included in the Cost Classification Report (CCR) for this BR (See §180.51.)

Facilities or Occupancy:	$ ______
Furniture and Equipment:	$ ______
Electronic Data Processing Equipment:	$ ______
Other (specify):	$ ______
Total (agree to CCR):	$ ______

E - The contractor shall identify all leases or rentals in effect in this BR FY for facilities/occupancy, furniture and equipment, EDP equipment, and Other where the annual charge to Medicare for this BR FY will equal or exceed $500,000. It shall provide the annual amount included in the FY BR and lease/rental expiration month and year. If none, it shall state none.

NOTE: The contractor's RO may require a listing of all subcontracts/leases for review. The contractor shall contact its RO if it is in doubt.

F - In conjunction with the facilities and occupancy costs, provided as Item 3 on the Cost Classification Report, the contractor shall summarize the Medicare costs by general categories below. It shall include base and budget period costs:

It shall complete the following information:

Indicate Base Period you are using: ___________

1. Depreciation and Rent or Lease:

- Depreciation Base Period:_______ Budget Year: _______

(Use when buildings and land are owned. Building costs are total costs excluding interest expenses, but including parking lots, landscaping, etc.)

- Rent or Lease: Base Period: _______ Budget Year: _______

(Use when facilities are rented either from an outside source or an affiliate. These costs include amortization of leasehold improvements.)

2. Utility Costs: Base Period: _______ Budget Year:________

(Report power, heat, and light for owned space and where not included in rental or lease costs.)

3. Other Costs: Base Period: _______ Budget Year: _______

(This includes items such as janitorial services, security, carpentry, plumbing, electrical and all work associated with non-permanent type partitioning and moving operations within the building, if not included in the rental or lease cost.)

4. Total Costs: Base Period: _______ Budget Year: _______

(Total cost of 1 through 3 to agree with Facility and Occupancy costs reported on the Cost Classification Report.)

5. Cost Per Net Usable Square Foot: See Appendix B, Article X.B. of the Medicare contract/agreement for the definition of net usable space.

Base Year: Total Cost: ______ Square Feet: _____ Cost Per Sq. Foot: ____

Budget Year: Total Cost: ______ Square Feet: _____ Cost Per Sq. Foot: ____

240 - Additional Instructions Pertaining To Supplemental Budget Requests (SBRs)

(Rev. 1, 08-30-02)

A1-1256, B1-4256

A. - General

These instructions pertain to SBRs filed after action is taken on the initial BR discussed in §230. An SBR is a contractor's request for additional funding after the FY has begun. The SBR is a request for additional funding for one or more activities. To the extent that the request, if approved, would result in a reclassification of the non-incremental costs and hours charged to other activities/functions, the contractor shall submit a schedule of non-incremental costs in accordance with §100.6C. It is not copied from either the

NOBA or the BR. The contractor shall use the BPRs as a basis for providing its SBR justification. A SBR is generally filed after the contractor receives a NOBA for the full FY and it determines that there are insufficient funds to perform the statement of work outlined in the BPRs and the NOBA. A SBR may also be required if there is a special project for which it would like to request funding. Refer to §100.6 regarding PIs.

An SBR may also be required in response to a CMS-generated request that a contractor perform a specific task. Such a CMS-generated request should be in writing and may include written procedures, manual issuances or any written request for work pertaining to special projects.

A copy of the SBR, with rationale, must be sent to both the contractor's RO and CO at the time the SBR is transmitted via CAFM II. It shall send a copy to CO to the same address that it sends its BR. See §230.2 for address.

B - Definitions

The contractor shall base the SBR on the latest released NOBA or negotiated budget and any outstanding SBRs. An SBR is appropriate if there is a need for a change in total funding, a transfer of funds among functions, and/or a change in workload. The contractor shall select the correct activity code and enter incremental costs including hours and workload. It shall annotate in the Remarks section of the Activity Screen the NOBA number on which the current SBR is based.

Example:

An SBR requesting additional Claims funding of $200,000, workload of 150,000 along with additional telephone inquiries funding of $100,000 and workload of 25,000 would be transmitted as follows:

Activity Code 11001, (Bills/Claims Processing): $200,000 Workload 150,000

Activity Code 13001, (Telephone Inquiries): $100,000 Workload 25,000

Remarks: This SBR is based on NOBA #1.

The contractor shall not include funding previously requested and denied unless it is specifically re-requesting funding for this item and has provided a revised budget justification to support the request.

C - Shared Systems

CMS requires that each user group designate one of its members to submit SBRs for systems improvements on behalf of the group or, if the servicing subcontractor (the subcontractor performing the systems improvement work) is also a Medicare contractor, that the SBR be submitted by that Medicare contractor.

If the servicing subcontractor is a commercial vendor, the SBR must be submitted by the designee on behalf of the group through the designee's parallel RO or the designated RO

with a copy to CO. If the servicing subcontractor is another Medicare contractor, that contractor submits the SBR to its parallel RO or the designated RO with a copy to CO.

In all cases, the SBR submitted is consolidated to include the request for the servicing subcontractor and any related funds requested by the other user group members. However, the consolidated SBR will clearly state the amount(s) requested on behalf of each user as well as the servicing subcontractor, any unique user expenses for each user pertaining to the shared system activity, and delineate projected savings for each user.

All funding through the NOBA is to the designee or Medicare contractor. Cost reporting corresponds to the NOBA. User unique expenses such as training and/or related travel are funded directly to each user with costs reported accordingly. This applies even though the requested funds are included in the consolidated SBR.

The designated contractor is responsible for amending its subcontract with the maintenance vendor, requesting prior approval if the project costs exceed its threshold in the prime contract and accounting for proper expenditure of the project funds.

D - Minimum Documentation Requirements - Justification

A complete SBR must include transmission on CAFM II and submission of a written justification supporting the request. An appropriate official must submit the justification. (See Chapter 2, Budget Execution.) The justification must provide sufficient detail for each cost category (see §90.9 and below) and explicitly link the request to the BPRs and/or general instructions that require the work and cost.

If the request equals or exceeds the smaller of $100,000 or 5 percent of the total PM or MIP NOBA, whichever is applicable, the contractor shall define the major steps necessary to accomplish the proposed effort (at least 3 steps) and provide an operational and financial rationale which addresses each of the cost categories for each step. If the activity cannot be broken down into at least 3 steps, it shall explain why not.

The operational rationale should explain the scope and types of efforts contemplated. The financial rationale should explain how the estimated funding needs were determined for each cost category through the identification of assumptions, supporting information and calculations used to arrive at the estimated amounts.

1 - Salaries/Wages and Fringe Benefits

The contractor shall provide job classes, number of employees (actual or FTEs), rates, period of work, major deliverables and/or milestones with dates. It shall discuss any premium payments. (These two cost categories may be combined.)

2 - EDP Equipment

The contractor shall discuss how the amount was determined or allocated and identify any extraordinary items required. If any equipment is to be leased or purchased, it shall provide details and, if appropriate, include a cost-benefit analysis.

3 - Subcontracts

The contractor shall identify subcontractor, scope, major deliverables, period of work and rates.

4 - Other Direct Costs

The contractor shall discuss how the amount was determined or allocated and any extraordinary items required. If any items are to be leased or purchased, it shall provide details and, if appropriate, include a cost-benefit analysis.

5 - Overhead/G&A

The contractor shall discuss how the amount was determined or allocated and any extraordinary items required. (These two cost categories may be combined.)

6 - Hours

The contractor shall identify and discuss both direct and subcontract hours.

7 - Workloads

The contractor shall identify and discuss all significant workloads.

250 - The Notice of Budget Approval (NOBA)

(Rev. 1, 08-30-02)

A1-1261, B1-4261

A NOBA is issued by CMS to notify contractors of approved amounts for PM and MIP administrative expenses for the FY, including the amount of funds certified to be available. Contractors are not authorized to incur expenses in excess of the total certified amount for PM or MIP. PM and MIP funding must not be co-mingled and this limitation, therefore, applies to each separately. In addition, the contractor shall refer to the BPRs and/or the contract/agreement for the authority to shift funds among PM or MIP functions.

The first NOBA issued for a FY is given a supplemental number of "0". Subsequent NOBAs are numbered sequentially. Where agreement on a budget cannot be reached, CMS issues a NOBA for less than the full FY year pending completion of negotiations. These NOBAs are annotated as a **partial** approval in the "Remarks" section and numbered as above. CMS may issue NOBAs for less than a full FY when necessary.

All dollar amounts will be rounded to the nearest hundred, hours to the nearest hour, and bills payment workload to the nearest hundred. The end of FY NOBA is not rounded. There are separate summary screens and certifications for PM activities and MIP activities.

The NOBA displays information by function and activity. See §100 for definitions of functions and activities. For each function and activity, hours, total cost, and workload will be displayed. The hours, total cost, and workload shown for a function is the sum of the data input for the activities for that function.

250.1 - End of FY NOBA

(Rev. 1, 08-30-02)

A1-1261.1, B1-4261.1

When claimed costs are less than the total approved for the FY, CMS issues a revised NOBA reducing the FY funding to the amount claimed on the FACP. This reduction keeps the amount of obligated funds to a minimum, thereby permitting maximum flexibility in the use of appropriated funds. If the contractor subsequently finds that not all costs have been claimed, it submits a revised FACP.

If the administrative cost reported in the October - September IER or FACP exceeds the total approved budget, the contractor shall justify the over expenditure to the RO with a copy to CO. CMS reviews the over expenditure for adherence to contract provisions on prior notice and abatement and other considerations and, where appropriate, issues a revised NOBA that enables the contractor to draw additional funds.

The incidences of such end-of-year over-expenditures are few since notification is necessary more than 60 days prior to the end of the FY if either CMS or the contractor expects that the budgeted amounts are not sufficient to cover administrative costs.

250.2 - Cumulative Quarterly Distribution

(Rev. 1, 08-30-02)

A1-1261.2, B1-4261.2

This indicates the approved cumulative quarterly distribution for PM and/or MIP. Funds should not be drawn in excess of the lesser of the quarterly distribution or the contractor's expenses. The quarterly distributions for PM and MIP are separate.

The PM and MIP distributions and costs must be treated separately in determining the amounts to draw for administrative expenses for each.

250.3 - Certifying Official

(Rev. 1, 08-30-02)

A1-1261.3, B1-4261.3

This signature indicates approval of the NOBA by the delegated RO official. In many cases the contractor will not receive a signed copy of the NOBA. The RO will "release" the NOBA within CAFM II, which signifies certification and will include the official's name and title. An explanation of the nature of the NOBA will be included in the Remarks section on this certification page. The RO will notify the contractor via phone or e-mail when the NOBA has been certified and released in CAFM II.

260 - Exhibit of Budget Distribution Form

(Rev. 1, 08-30-02)

A1-1265, B1-4265

CONTRACTOR NAME ADMINISTRATIVE BUDGET AND COST REPORT BD
ADDRESS LINE 1 MEDICARE CONTRACTORS EIN: XXXXXXXXXXXX
ADDRESS LINE 22 BUDGET DISTRIBUTION ACCEPT DATE:
CONTRACTOR NO: PART: FUND YR: SUPPLE NO:
X XXXX XX CAFM II

BASED ON NOBA SUPPLEMENT NO: XX

PROGRAM MANAGEMENT COST SUMMARY BY FUNCTION

CODE	DESCRIPTION	PERIOD 1	PERIOD 2	PERIOD 3	PERIOD 4
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X

WORKLOAD SUMMARY BY FUNCTION

1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X
1XXXX	XXXXXXXXXXXXXXXXXXXXXXXXXX	XXX.X	XXX.X	XXX.X	XXX.X

I CERTIFY TO THE BEST OF MY BELIEF OR KNOWLEDGE THAT THIS DATA IS ACCURATE, COMPLETE, AND CURRENT AS OF THE DATE OF THE EXECUTION OF THIS CERTIFICATE.

CERTIFYING OFFICIAL ______________________________

TITLE ______________________________

REMARKS:

260.1 - Completing the Budget Distribution (BD)

(Rev. 1, 08-30-02)

A1-1265.1, B1-4265.1

A - General

The contractor shall transmit BD reports with all data elements completed for approval 30 days after receipt of the initial annual NOBA. If a supplemental NOBA is received, the contractor should review the BD percentage and update, as necessary, and resubmit. If a contractor receives more than one NOBA in any 2-week period, it shall prepare a BD only for the latest one. Notification of the BD periods can be found in CAFM II. CAFM II has standard reports to identify which activity or function codes are part of the BD, the required reporting period and the specified tolerances for these periods.

B - Explanation of Entries on Budget Distribution

1	Code	A 5-digit code identifying each function. The PM function codes are 11000-19000 and the MIP function codes are 21000-29000. See §90.4 for further discussion of function codes.
2.	Description	Brief description of the function.
3	Period 1	Percentage of NOBA contractor estimates to be expended through the first period.
4.	Period 2	Percentage of NOBA contractor estimates to be expended through the second period.
5.	Period 3	Percentage of NOBA contractor estimates to be expended through the third period.
6.	Period 4	Percentage of NOBA contractor estimates to be expended through the entire FY. (Should not exceed 100 percent.)
7.	Transmittal	Contractor shall transmit the BD via CAFMII. Hard copies are not required in the RO or CO. Contractor shall retain a signed hardcopy in its files.
8.	Budget Distribution Approval	CMS approves periodic allocations based on acceptable data submitted. Notification of acceptance or non-acceptance is provided by CMS within 30 days following receipt. The RO indicates acceptance/non-acceptance on CAFM II. If a contractor's BD is not approved by the RO, it will also be notified by letter or telephone.
9.	Redistribution of Funds Required -	If the annual estimate is adequate, but budgeted funds must be redistributed between periods, the contractor shall submit the

Annual Budget Adequate	budget distribution form and include an explanation in the remarks for the periods remaining in the FY. The RO should be notified of this redistribution. The contractor will be notified of acceptance or non-acceptance of the report.

270 - Budget Preparation Check List for Program Management And Medicare Integrity Program

(Rev. 1, 08-30-02)

A1-1267, B1-4267

FORM NAME	DUE TO	DUE DATE
Initial Budget Request - Activity Forms - (with following attachments as required by CMS)	CMS	June/July
Miscellaneous Schedule Special Projects Schedule (if applicable) Certification Schedule Cost Classification Report (CMS-2580)		
Intermediaries - CASR (CMS-1525A) Intermediaries - Provider Reimbursement Profile (CMS-1531) Intermediaries - Schedule of Providers Serviced (CMS-1531A) Other Information as Requested in the BPRs		
Notice of Budget Approval	Contractor	October 1 and thereafter as needed
Activity Summary Certification Schedule		
Budget Distribution with following attachments	CMS	30 days after initial annual NOBA received and as needed thereafter
Intermediaries - CASR - (CMS-1525A)		
Supplemental Budget Request - See §240		

280 - Exhibit of Contractors Auditing and Settlement Reports Form CMS-1525A

(Rev. 1, 08-30-02)

A1-1268

CONTRACTOR AUDITING AND SETTLEMENT REPORTS

CONTRACTOR NO: FISCAL YEAR: MONTH:

CIER
ACCEPTANCE DATE:
SUPPLEMENTAL NO: CASR

NET HOURS AVAILABLE: ----------

FINANCIAL AUDIT COST (COL 1-8) — DATA AUDIT (COL 9-13)

	1 HOSPITAL SINGLE	2 HOSP PPS MULTI-FAC	3 HOSP OTHER MULTI-FAC	4 SNF	5 HHA	6 CHAIN HO.OFFICE	7 OTHER	8 SUBTOTAL	9 OTHER	10 OTHER	11 OTHER	12 OTHER	13 OTHER	14 GRAND TOTAL
1. INVENTORY														
A. NO.OF PROV.	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
B. RPTS.DUE	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
C. RPTS.RECD.	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
D. UNST.C.R.	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
E. UNST.PR.PD	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
F. PPS/EI/FRS	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	XXXXXXX	----------	XXXXXXX

	1	2	3	TOTAL
PROPRIETARY	----------	----------	----------	----------
NON-PROPRIETARY	----------	----------	----------	----------
TEACHING	----------	----------	----------	----------
SWING BEDS	----------	----------	----------	----------
URBAN HOSP	----------	----------	----------	----------
RURAL HOSP	----------	----------	----------	----------

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
2. DESK REVIEWS														
A. UNITS	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
ETUNIT	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
SNF	XXXXXXX	----------	----------	----------	----------	XXXXXXX	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
HHA	XXXXXXX	----------	----------	----------	----------	XXXXXXX	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
OTHER	XXXXXXX	----------	----------	----------	----------	XXXXXXX	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
B. TOTAL COST	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
C. UNIT COST	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
D. TOTAL HRS.	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
E. AVG.UNIT HR	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
. PROBLEM RESOLUTION														
A. UNITS	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
ETUNIT	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
SNF	XXXXXXX	----------	----------	----------	----------	XXXXXXX	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
HHA	XXXXXXX	----------	----------	----------	----------	XXXXXXX	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
OTHER	XXXXXXX	----------	----------	----------	----------	XXXXXXX	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
B. TOTAL COST	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
C. TOTAL HRS.	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
. ONSITE REVIEWS														
A. UNITS	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
ETUNIT	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
SNF	XXXXXXX	----------	----------	----------	----------	XXXXXXX	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
HHA	XXXXXXX	----------	----------	----------	----------	XXXXXXX	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
OTHER	XXXXXXX	----------	----------	----------	----------	XXXXXXX	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
. TOTAL COST	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------
. TOTAL HRS.	----------	----------	----------	----------	----------	----------	----------	----------	----------	XXXXXXX	----------	XXXXXXX	----------	----------

CMS - The preceding exhibit appeared in Medicare Intermediary Manual Transmittal 130 as it is shown above. If you can obtain a .gif file or something similar showing the exhibit in a more readable form, we will arrange to place it on CMS's WEB page. Or give us a clean copy and we will make the image.

290 - Instructions for Completing the Contractor Auditing And Settlement Report (CASR) - Form CMS-1525A

(Rev. 1, 08-30-02)

A1-1269

A - General

This report reflects the budgeted and incurred costs for the total contractor auditing and settlement function by type of activity, and type of provider or reporting entity. It provides cumulative supportive detail for amounts reported on lines 5, 6, and 7 of the Administrative Budget and Cost Report, Form CMS-1523. It also reports the cost effectiveness or savings of the auditing and settlement function. The following are the basic budget and cost report uses for the CASR:

1. **CASR Budget Request (CBR) -** Contractor shall complete the columns on the form for each type of reporting entity and the total column. If it submits a revised CMS-1523, which affects lines 5, 6, and 7 on CMS-1523; it shall submit a revised CASR as well.

2. **CASR Notice of Budget Approval (CNOBA) -** The RO provides the approved budget data for each type of provider or entity for costs, hours, unit costs, unit hours, and workload information. The RO and contractor must work together to develop an approved CNOBA for input by the contractor. Savings data is to be shown in line 17, the reconciliation of CMS-1525A and CMS-1523 costs. Line 14g, net savings, is not required to be completed. No CASR is required when there is partial approval of the budget.

3. **CASR Budget Distribution (CBD) -** Complete distributions for the Oct-Dec, Oct-Mar, and Oct-Jun periods of the fiscal year. An Oct-Sept distribution is not required since the CNOBA will be used for the full year. Contractor shall submit CBDs within 30 days after the NOBA is received. Contractors must project savings for each period and report these savings on line 17, the reconciliation of 1525A and 1523 costs.

4. **CASR Interim Expenditure Report (CIER) -** Contractor shall complete all columns and line items for each reporting period of the FY and submit the CIER within 30 days after the end of each reporting period.

B - Types of Providers or Reporting Entities

1. Financial Audit Cost Columns 1-7 (Counted when calculating savings ratio)

    - Hospital - Single;

- Hospital - PPS multi-facility;
- Hospital - Other multi-facility;
- SNF (Freestanding and part of Health Care Complex);
- HHA (Freestanding and part of Health Care Complex);
- Chain Home Office and LPIC (Limited Purpose Insurance Co.); and
- Other (Includes Physical Therapy (PT), Comprehensive Outpatient Rehabilitation Facility (CORF), End Stage Renal Dialysis (ESRD), Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Organ Procurement Agency (OPA), HISTO Lab providers, and other providers as directed by CMS.

2. Data Audit Columns 9-13 - (Not counted when calculating the savings ratio). Use these columns as directed by CMS. Columns 9-13 are reserved for Special Audit Initiatives to be used pursuant to special instructions issued by CMS.

C - Fixed Price Contractor Instructions

Contractor shall submit CASRs as follows:

- It shall submit CBRs of projected workloads for the 3rd, 6th, 9th, and 12th cumulative monthly periods, by July 1 each FY, or as instructed by CMS. Estimates of costs need not be included.
- It shall submit informational CIERs for the same reporting periods, 30 days after the end of the period being reported.

290.1 - Transmittal

(Rev. 1, 08-30-02)

A1-1269.1

Contractor shall transmit the CMS-1525A to the CASR system via M204 using STAR records to create the report. (See §360 and CASR User's Guide.)

290.2 - Explanation of Line Items on Form CMS-1525A

(Rev. 1, 08-30-02)

A1-1269.2

A - Heading

1. Contractor Name and Address - Name and location of the reporting office.
2. Date Prepared - Year, month, and day.
3. Identification Number

- Assigned 5-digit contractor number.

- EIN -Contractor's employer identification number required by the Internal Revenue Service.

4. Fiscal Year - Applicable FY.

5. Reporting Period - When the report is used to support the CBD or CIER, the numbers (1) through (4) for the cycling period being reported.

6. Report Use - Correct number corresponding to the report used. When the report is used to support the CBR, CBD, CNOBA, or CIER, the contractor shall complete "status" and indicate by number:

   - For initial, use O; and

   - For supplemental, use 1 through 30.

7. Net Hours Available - The same net hours developed for the CMS-1523 reports, i.e., Budget Request, Budget Approval, IER, and Budget Distribution. (See §90.9P.)

NOTE: Contractors shall submit the CIER for cumulative periods ending with the 3rd, 6th, 9th, and 12th months of the FY. They shall submit the CBD for cumulative periods ending with the 3rd, 6th, 9th, and 12th months of the FY. For the 12th cumulative month of the FY, they shall submit the CNOBA.

B - Activity

1. Inventory

a. Number of Providers - Number of active providers and entities for which "tie in" notices are approved. For the initial CBR only, the anticipated number of new Medicare providers from item 11 of the Provider Reimbursement Profile (PRP). The contractor shall count each provider only once, but count multi-facility providers separately. Number of providers (item 8a), plus hospices and ASCs, is the same as used for the provider reimbursement workload, item 8G of the CMS-1523. Hospital-based HHAs are to be counted by the contractor who maintains the audit and reimbursement functions and not by the contractor processing the bills. Excluded units and swing-bed units are counted as a provider. (See Subsection 1.f. below.)

b. Cost Reports Due - The budgeted and actual number of cost reports due from providers and entities for the reporting period (**period** means the Federal government FY, which runs from October 1st to the following September 30). Includes reports due in prior periods but not received. One provider may have several cost reports due. Provider-based facilities are not counted as separate cost reports.

- **Provider Continues to Participate in Program -** Cost reports are "currently due" the last day of the third month following the close of the period covered by the report, or 30 days after that date if an extension is granted by CMS.

  Where a hospital, hospital-based SNF, or hospital-based HHA submits a certified cost report that has been audited by independent auditors of the hospital, the cost report is "currently due" on the last day of the fourth month following the close of the period covered by the report, or 30 days after that date if an extension is granted.

- **Provider Agreement to Participate in Program Terminates (Voluntarily or Involuntarily) or Provider Experiences Change of Ownership -** Cost reports are "currently due" 45 days following the effective date of termination of the provider agreement or change of ownership.

  Cost reports are "currently due" if received before the date that they are due. When a provider fails to submit a cost report and the case is turned over to the appropriate RO, the report is not entered as "currently due." When the reports are secured from providers by the RO and referred to the contractor, or if the reports are filed directly with the contractor, they are considered "due."

c. Costs Received - The budgeted and actual number of cost reports received from providers and entities during the reporting period. Provider-based facilities are not counted as separate cost reports.

d. Unsettled Cost Reports - The budgeted and actual number of cost reports received, but not yet settled, as of the end of the reporting period. Includes reports received in prior periods, but not settled. (See NOTE following subsection f. below) Provider-based facilities are not counted as separate cost reports.

e. Unsettled Cost Reports from Prior Periods - The estimated or actual backlog of unsettled reports received from prior periods, but not settled as of the end of the CASR reporting period. Contractor shall not count provider-based facilities as separate cost reports.

f. PPS Hospital, Excluded Units, Freestanding Facilities - The number of PPS hospitals included in 1a, single hospitals. Includes the number of multi-facility PPS hospital excluded units that are counted separately in 1a. Contractor shall show the number of freestanding SNFs and HHAs in 4f and 5f that are also included in 4a and 5a. Swing-beds are counted in the Inventory section.

NOTE: For budget purposes, the contractor shall perform an inventory reconciliation to insure that unsettled cost reports from prior FYs are included in the new FY count. The CIER reflects only actual statistics.

Number of hospitals-proprietary, nonproprietary, and teaching refers to hospitals only. Hospital proprietary and hospital-nonproprietary must equal line 1a, columns 1, 2, and 3, less excluded units and swing-beds. Urban and rural hospitals must equal the proprietary and nonproprietary count.

2. Desk Reviews

Contractor shall include all procedures used to determine the necessity of an audit, including:

- Automated desk review (but not including reworking of cost reports);
- Initial review to make sure the cost report is complete and acceptable;
- Math check;
- Initial, tentative settlement determination including any reworking of cost report, but no collections or payment processing;
- Comparative analysis of provider costs, charges, and statistics;
- Professional review;
- Professional desk review, including resolution of points raised and cleared via phone or letter, and the review of supplementary schedules;
- The determination of whether an audit is to be made, and if so, its scope (including the selection of audit steps);
- Preparation of all known adjustments resulting from the desk review, but not including the reworking of the cost report; and
- Final review and approval of these procedures by a supervisor or other designated employee.

a. Units - Contractor shall record a unit count (cost reports) when the desk review procedures are performed and an audit, problem resolution, onsite review, or settlement can be initiated. This is the same count used for item 5G of the applicable CMS-1523 Report (Budget request, NOBA, IER, Distributions) and **does not** include any count for provider-based facilities. Counts for excluded units, SNFs, HHAs, and other are FYI and are **not** included in line 2a, Units.

b. Total Costs - Costs (in-house and subcontract) incurred during the review period for the desk reviews. Includes all travel, training, and miscellaneous costs incurred. Overhead related to this function is reported on line 11. Travel includes all transportation, meals, lodging, per diem, and automobile expenses incurred by employees in the performance of their duties. Training includes both formal and on-the-job.

c. Unit Cost - Total Costs (b) divided by Units (a).

d. Total Hours - Total productive hours (in-house and subcontract) for direct and indirect staff allocated to desk review activities.

e. Average Unit Hours - Total Hours (d) divided by Units (a).

3. Problem Resolutions

All activities after the desk review, but prior to settlement, for purposes of resolving problems or updating files in its office, but **not** at the provider's location. However, if it is subsequently decided to go onsite, then, all problem resolution costs and hours are reported in "Onsite Reviews."

a. Units - The number of problem resolution cost reports. This count is **not** added to desk review counts and **does not** include any count for provider-based facilities. Contractor shall not include counts for excluded units, SNFs, HHAs, and Other in line 3a, units.

b. Total Costs - All costs (in-house and subcontract) incurred during the reporting period from the completion of desk review to the point where the cost report is ready for settlement. Contractor shall not report Travel, Training, and Miscellaneous (TTM) costs separately. It shall include them on this line. It shall report overhead related to this function on line 11. It shall include problem resolution costs with provider desk review costs, line 5, in the applicable CMS-1523 Reports.

c. Total Hours - Total productive hours (in-house and subcontract) for direct and indirect staff allocated to problem resolution activities.

4. Onsite Reviews

All activities after desk review, but prior to settlement, for purposes of resolving problems or updating files **on site**. Onsite review provides for up to 40 hours at the provider's location (excluding travel time). Once a review at the provider's site has been determined to be necessary, all time subsequent to desk review and prior to settlement is charged to on-site review. Contractor shall not charge any hours to problem resolution.

a. Units - The number of onsite review cost reports. This count is **not** added to desk review counts and **does not** include any count for provider-based facilities. Counts for excluded units, SNFs, HHAs, and Other are FYI and are **not** included in line 4a, Units.

b. Total Costs - All onsite costs (in-house and subcontract) incurred during the reporting period from completion of the desk review up to 40 hours at the provider's location. Includes TTM also. Contractor shall report overhead related to this function on line 11. It shall include onsite costs with provider desk review costs, line 5, in the applicable CMS-1523 reports.

c. Total Hours - Total productive hours (in-house and subcontract) for direct and indirect staff allocated to onsite review activities.

5. Audits

Includes all procedures performed on a cost report, after determination of the audit scope, which required over 40 Medicare hours for verification of records at the provider's

location (excluding travel time). An audit includes all work efforts subsequent to the desk review completion up to, but not including, the reworking of the cost report. Procedures to include are:

- Preliminary audit work, including the review of provider's CPA report and/or work-papers, changes to prewritten audit program, writing of audit program.
- All onsite work;
- Exit conference;
- Preparation of audit adjustment report;
- Final review of the above procedures and results by the supervisor or other designated employee; and
- After desk review, no time is to be charged to problem resolution or on-site reviews.

a. Units Started - An audit is started when the entrance conference is held at the provider's location.

b. Units Completed - An audit is completed when the auditor concludes the onsite examination of the provider's records, holds an exit conference, and leaves the facility to prepare the audit report even though subsequent visits to the facility may be necessary to clarify points raised during review and preparation of the report.

   For chain providers, an audit of the provider is completed even if allocations of home office costs were not audited. However, if provider records are located at the home office and the contractor is unable to audit the provider's costs, the audit cannot be recorded as completed until those records are reviewed.

c. Equivalent Complete Units - Calculated by adding the "Audits Started" to the "Audits Completed" and dividing the result by two. This is the same count as used for item 6G of the applicable CMS-1523 Report (Budget Request, NOBA, IER, Distribution) and **does not** include any count for provider-based facilities. Does not include counts for excluded units, SNFs, HHAs, and other in lines 5a, Units Started or 5b, Units Completed.

d. Total Costs - All costs (in-house and subcontract) incurred during the reporting period from the completion of the desk review to the point where the cost report is ready for settlement. Includes all travel, training, and miscellaneous costs incurred. Contractor shall report overhead related to this function on line 11.

e. Unit Cost - Total Costs (d) divided by Units (c).

f. Total Hours - Total productive hours (in-house and subcontract) for direct and indirect staff allocated to the audit activities.

g. Average Unit Hours - Total Hours (f) divided by Equivalent Units (c).

6. Settlements

All work performed on a cost report after the completion of a desk review, problem resolution, onsite review, and/or audit, if necessary, and after the exit conference. Does not include any appeal or hearing work. Settlement activities include:

- Reworking/review of the cost report (after desk review or audit);
- Final review - clerical and professional;
- The expression by the auditor of an opinion as to whether the provider's Statement of Reimbursable Costs presents fairly the provider's Medicare payable costs or the disclaimer of an opinion because of the limited scope of audit performed.
- Preparation of settlement forms;
- Photocopying and assembling the cost report;
- Preparation and typing of all transmittal letters (including Notice of Amount of Program Reimbursement (NPR) and Management Letter);
- Final review of the above procedures and results by the supervisor or other designated employee.

a. Units - Number of cost reports settled. A report is settled when the NPR is mailed or transmitted. This is the same count as used for item 7G of the applicable CMS-1523 Report (Budget Request, NOBA, IER, Distribution), and **does not** include any count for provider-based facilities. Does not include counts for excluded units, SNFs, HHAs, and Other on line 6a, Units.

b. Total Costs - Includes all costs (in-house and subcontract) incurred during the reporting period in the making of cost report settlements as well as travel, training, and miscellaneous costs incurred. Contractor shall report overhead related to this function on line 11.

c. Unit Costs - Total Costs (b) divided by Units (a).

d. Total Hours - Total productive hours (in-house and subcontract) for direct and indirect staff allocated to settlement activities.

e. Average Unit Hours - Total hours (d) divided by Units (a).

7. Intermediary Hearings

a. Units Received - A hearing is "received" when the written request for a hearing is received.

b. Units Pending - Estimated or actual number of hearings pending.

c. Units Completed - A hearing is "completed" when the amount in dispute is finally determined and settled either through mutual agreement or through the Hearing Officer's decision.

d. Total Costs - All costs (in-house and subcontract) incurred during the reporting period from receipt of the hearing request to resolution of the dispute. Include travel, training, and miscellaneous costs incurred. Contractor shall report overhead related to this function on line 11.

e. Total Hours - Total productive hours (in-house and subcontract) for direct and indirect staff allocated to these activities.

8. PRRB Hearings

a. Units Received - A hearing is "received" when the PRRB sends an acknowledgement letter to the provider that a hearing is granted.

b. Units Pending - Estimated or actual number of PRRB Hearings pending.

c. Units Completed A hearing is "completed" when the item and amount in dispute are resolved by the PRRB or settled through mutual agreement.

d. Total Cost - All costs (in-house and subcontract) incurred during the reporting period, from receipt to the resolution of provider hearing, as well as travel, training, and miscellaneous costs incurred. Includes any costs associated with pursuing this with the Administrator or the Courts. Contractor shall report overhead related to this function on line 11.

e. Total Hours - Total productive hours (in-house and subcontract) for direct and indirect staff allocated to the PRRB activities.

9. Reopenings

Include all costs related to activities in discussing, reviewing, and revising items in a cost report for which an NPR has been issued. However, it is not a reopening when actions on a cost report are taken subsequent to filing an appeal notice with the appropriate hearing body, up to the issuance of the appeal decision, rejection of the appeal or administrative resolution. In these instances, it is considered an Intermediary Hearing or PRRB Hearing. It is a reopening when action to revise the cost report to incorporate the appeal decision is instituted.

Reopenings are usually initiated by one of the following:

- Provider request to amend cost report. (If made within 1-year of the NPR, contractor shall not count as a reopening and include adjustments in the savings data items 14b, 14c.);
- Fraud and abuse investigation;
- Adjustment of home office costs;

- Intermediary hearing decision;
- PRRB decision;
- RO or CO directive as a result of the Quality Assurance Program;
- Subsequent intermediary activity; or
- Adjustments of Limited Practice Insurance Company costs (Captive Insurance Company).

a. Units Received - A reopening is "received" when a reopening is initiated by issuance of a notice of reopening to the provider or when an amended report filed by a provider is accepted. Contractor shall count multi-facility providers as one cost report when the parent facility and attached facility are reopened.

b. Units Completed - A reopening is completed when a Notice of Correction (revised NPR) is issued or when it states in a letter that the reopening is completed with no change in payment or when the amended report is rejected.

c. Total Cost - All costs (in-house and subcontract) incurred during the reporting period from issuance of the notice of reopening or acceptance of an amended provider cost report until the issuance of the NPR or letter indicating that the reopening is completed. Contractor shall report overhead related to this function on line 11.

d. Total Hours - Total productive hours (in-house and subcontract) for direct and indirect staff allocated to reopening activities.

10. Special Audit Initiatives

Total costs, and total hours only in columns 10 and 12 or as instructed by CMS for special audit initiatives. Contractor shall report only those initiatives approved by CMS for the current budget year. Overhead costs for special audit initiatives are reported on line 11. Costs reported in special audit initiatives must result in costs reported in the addendum, line 16.

11. Overhead

a. All Costs - Contractor shall enter overhead costs allocated to provider audit functions on lines 1-10. It shall report overhead for each type of provider/special audit initiative and in total. For CASR reporting, overhead is defined in §120 and must agree with overhead costs shown in the Schedule of Credits, EDP, and Overhead, Form CMS-1523B, lines 5, 6, and 7. (See §160.2.)

b. All Hours - Total productive hours as detailed for 11a.

12. Totals

a. Total Costs - The sum of the costs for lines 1-11.

b. Total Hours - The sum of the Total Productive Hours for lines 1-11.

The Total Cost and Total Hour data on the CMS-1525A must agree with the corresponding data (sum of lines 5, 6, and 7) on the CMS-1523. In order to reconcile the total hours, subtract the subcontract hours listed on line 13b below. See reconciliation on line 17.

13. FYI - Subcontract

a. Costs - Total subcontract costs already included in 12a, above.

b. Total Hours - Subcontract hours as in 12b, above.

14. Savings Data

For the CIER, the contractor shall report only the data required on the basis of the mailed NPR. It shall make separate entries for cost reports settled without audit and with audit. It shall not include adjustments from Intermediary and PRRB Hearings or from sequestrations. It shall furnish data for each type of provider category in which one or more settlements have occurred and for the "Total" column.

Total Savings Data includes columns 1-7, but combines column 6, Chain Home Office and LPICs, with column 7, "Other." The Chain HO intermediary reports the cost of auditing a Chain HO. However, the Chain HO costs and any adjustments as a result of audit are allocated to the chain providers and reported by their intermediaries.

a. Costs Claimed - Amount of Medicare reimbursement claimed by providers on the cost reports (settled in the reporting period) which have been desk reviewed and, where applicable, audited. Contractor shall make an entry when the NPR is mailed **and** corresponding adjustments, if applicable, determined. Once an amount related to a cost report is entered on this line, it shall enter any subsequent revisions (even during later reporting periods) to the claimed payment amount in item b or c, as applicable.

b. Increasing Adjustment - The contractor shall select cost reports settled during the reporting period, which contain a net increasing adjustment to the payment claimed. It shall enter their sum, including increases in payment caused by revisions to previously issued NPRs (regardless of the year in which the previous NPR was issued), but excluding adjustments from Intermediary and PRRB Hearings and sequestrations.

c. Decreasing Adjustment - The contractor shall select cost reports settled during the reporting period, which contain a net decreasing adjustment to the payment claimed. It shall enter the total of the decreases, including decreases in payment caused by revisions to previously issued NPRs (regardless of the year in which the previous NPR was issued, but excluding adjustments from Intermediary and PRRB Hearings and sequestrations.

NOTE: The contractor shall not report increasing and decreasing adjustments within a cost report. It shall include only the net increase or decrease for a cost report in b or c above, as applicable.

d. Allowed: a + b - c

e. Savings: a - d

f. Adjustments Under Appeal or in Cover Letter - Non-allowable amount that the provider included in the cost report in order to establish an appeal issue. (See Provider Reimbursement Manual, II, §115.)

g. Total Savings: e - f. The sum of the Without Audit and Audited Savings in the total columns equals the total audit savings. Report negative amounts in brackets.

15. Savings Ratio

Contractor shall divide item 14g, total column, (the Sum of Without Audit and Audited Savings) by item 12a, Column 8 - (Financial Audit Cost). This represents the number of program dollars saved for every audit dollar expended. For example, item 14g, total, is $300,000,000 ($50,000,000 Without Audit and $250,000,000 Audited) and item 12a, Column 8, is $60,000,000; the savings ratio is 5.0 to 1. Entries are rounded to one decimal place, and negative ratios are reported in brackets.

16. Addendum

Reported by contractor only as directed by CMS.

17. Reconciliation of CMS-1525A and CMS-1523

The STAR System includes all calculations needed for this reconciliation except for the overhead, which is computed by the contractors. Contractor shall reconcile the costs with the corresponding costs on the CMS-1523 report.

It shall show all aspects of the savings ratio calculation: Financial costs (line 12A column 8); Data Audit Costs (line 12A column 14 less column 8); Total Costs (line 12A column 14) and Total Savings (line 14 total no audit and audit). It shall enter savings ratios by dividing total savings by Financial Audit Costs and also by dividing total savings by total costs.

18. Pass-Through Costs

Contractor shall enter the "As Filed" and "Settled" DRG, outlier and pass-through costs reflected on the provider's cost report.

19. Urban/Rural Costs/Savings

Contractor shall enter from settled cost reports Urban and Rural hospital adjusted costs and savings by hospital categories: Proprietary and Nonproprietary; Teaching and Non-teaching; Multi-facility PPS and Multi-Facility other.

20. Urban/Rural Savings Ratios

Contractor shall enter the savings ratios by hospital categories as developed using data in line 19 and dividing savings by the adjusted costs claimed.

300 - Exhibit of Audit Selection Criteria Report - Intermediaries Only

(Rev. 1, 08-30-02)

A1-1270

Reserved for Audit Selection Criteria Report

310 - Completing the Audit Selection Criteria Report (ASCR)

(Rev. 1, 08-30-02)

A1-1271

A - General Instructions

Contractor shall use the report to show all the provider cost reports from high to low, by Medicare dollars at risk. The ASCR will be extracted from the System Tracking for Audit and Reimbursement (STAR) and submitted to the CMS BPO Bulletin Board 30 days after the end of the fiscal year, i.e., October 30.

B - Specific Instructions

The contractor shall complete the columns on the ASCR as follows:

- Provider Number - It shall enter provider's number;
- FYE - It shall enter provider's year end;
- Provider Type - It shall enter appropriate STAR code and appropriate audit selection criteria (ASC) code(s);
- POA Code - Indicates the designated activity; (P) problem resolution, (O) on-site review, or (A) audit. A blank indicates desk reviewed only.
- Medicare Dollars Claimed - It shall enter the Medicare dollars claimed from the audited cost report. Use DRG column for DRG and outlier benefit payments. It shall use pass-through column for PPS pass-through costs, and Cost-Based column for all other provider costs claimed;
- Utilization - It shall enter days or visits, as appropriate, for the total patient population and for the Medicare population. It shall indicate the percent of Medicare utilization;
- Notice of Amount of Program Reimbursement (NPR) Date - It shall enter date of NPR; and
- Cost Savings/Dissavings - It shall enter the dollar amount of adjustments to payment as a result of the NPR.

310.1 - Audit Selection Priorities

(Rev. 1, 08-30-02)

A1-1271.1

A - General

The contractor shall use the ASCR to decide which providers to audit. This determines the audit matrix within the BPRs. It shall base audit decisions upon the results (problems discovered) of its uniform desk review, professional surveys of filed cost reports, and prior audit/review findings.

B - Audit Group

The audit group provides for planning audits/initiatives that must be performed either because a special circumstance requires immediate audit attention, e.g., termination, merger, fraud or abuse, new providers, or because of special CMS instructions. The audit group is defined yearly in the CMS Budget Performance Requirements (BPR guidelines). Generally, existence of a special circumstance dictates that an audit is necessary. However, the contractor shall use discretion in this area, especially where there is a short period cost report from a new provider, a relatively small amount of Medicare payment, low Medicare utilization, or involvement of OIG or GAO, prohibiting an audit.

310.2 - Level of Audit Effort

(Rev. 1, 08-30-02)

A1-1271.2

Instructions require that the level of audit effort be determined by the results of the desk review or professional survey process, taking into account the priority, audit cost-to-audit savings ratio, and the level of budget resources available. In most situations, audits are limited. However, compliance with the Government Auditing Standards must be considered in all provider audits.

320 - Exhibit of Provider Reimbursement Profile - Form CMS-1531, Provider Reimbursement Profile

(Rev. 1, 08-30-02)

A1-1272

Reserved for Contractors Auditing And Settlement Reports

330 - Provider Reimbursement Profile (PRP) - Form CMS-1531

(Rev. 1, 08-30-02)

A1-1273

330.1 - Introduction

(Rev. 1, 08-30-02)

A1-1273.1

The contractor shall use the Provider Reimbursement Profile (PRP) to develop the reimbursement portion of its Administrative Budget and Cost Report (Form CMS-1523, line 8). It shall use data shown on the profile to evaluate the amount of its budget request, and provide CMS with cost and statistical data for managing the contractor budget process. (See §10.)

The RO will discuss the contractor's profile with it to reach an agreement on the level of services it will provide based upon the number of providers it services. This ensures that its plan for performing reimbursement activities meets the objectives of the Medicare program, and that the level of resources it requires is commensurate with its provider workload. It shall submit final PRP when the initial CNOBA is received. The PRP must be reconcilable with the CNOBA. (Schedule of Providers Serviced is also required.)

330.2 - General Instructions

(Rev. 1, 08-30-02)

A1-1273.2

The contractor shall complete the PRP annually in accordance with CMS's general budget instructions and Contractor Budget Guidelines. It shall transmit the completed profile to the CASR System via M204.

It shall accompany each submission of the PRP with a **Schedule of Providers Serviced**. It shall complete the schedule based upon its projection of the number of providers (by category shown on the schedule) it will be servicing as of October 1 of the FY. The number of providers shown on the schedule must correspond to the number of providers shown in line C11 of the profile. The contractor shall **not** include anticipated new Medicare providers, line C12.

It shall discuss in the budget narrative any issue pertaining to the profile or schedule which requires additional explanation.

NOTE: The contractor shall submit an approved PRP with the initial CASR Notice of Budget Approval (CNOBA).

330.3 - Completing the Provider Reimbursement Profile

(Rev. 1, 08-30-02)

A1-1273.3

All hours shown on the PRP are to be productive hours as defined in §90.6. The contractor shall allocate managerial and clerical time that is not directly assigned to reimbursement activities based upon accumulative hours (direct hours per activity to total direct hours of all activities).

A - Interim Rate Determination - Lines 1 and 2

This provides for an hourly breakout of all time spent on interim rate reviews. Hours shown on lines 1 and 2 reflect the average of the time spent on all interim rate activities for an individual provider during the budget period.

1 - Periodic Interim Payment (PIP) Interim Rate Reviews

The contractor shall show all time spent performing PIP calculations and interim rate review functions. Include hours for regular PIP calculations, outpatient interim rate reviews, retroactive lump sum adjustments, and PIP Quality Assurance/Criteria compliance. For PPS hospitals which remain on PIP, it shall include hours spent for calculating PPS pass-through payments, calculations to revise blended rates for regulation changes, calculations for revising the provider's case-mix index, and calculation of the PPS pass-through per diem used for Medicare Certificate of Benefits (MCOB) purposes.

2 - Other Interim Rate Reviews

The contractor shall show all time spent performing non-PIP interim rate reviews. It shall include hours for all interim rate calculations and resulting retroactive lump sum adjustments. For PPS, non-PIP hospitals, it shall include hours spent on calculations to revise blended rates for regulation changes, calculation of PPS pass-through payments, and for calculating the PPS pass-through per diem used for MCOB purposes. It shall include all hours expended for calculating special payment rates (e.g., hospice rates, ESRD composite rates, and ASC facility rates).

B - Other Provider Services - Lines 3-8

This provides for an hourly breakout of all other reimbursement activities (other than interim rate reviews). The hours shown on each line reflect the average time spent per provider as follows:

1 - Line 3 - Overpayment Recoupment

The contractor shall show the average number of hours for overpayment recoupment activities. This includes recoupment of overpayments pertaining to cost report settlements in addition to uncollectible overpayment cases.

It shall include hours for all overpayment recoupment processing, including:

- Interest assessment;
- Processing of extended repayment schedules;
- Obtaining promissory notes;
- Preparation of case files and RO referrals;
- Handling all overpayment recoupment records and forms;
- Handling of all provider telephone/written inquiries relating to overpayments;
- Internal interface hours; and
- Monitoring of payouts to providers having overpayments for offset purposes.

It shall not include time for preparation of the Quarterly Provider Overpayment Report (POR). (This is reflected on line 7.)

2 - Line 4 - Support Service (i.e., PS&R - HCRIS)

The contractor shall show the number of hours required for the PS&R system, HCRIS, and any other systems providing support service.

a. **PS&R System** - Contractor shall include all hours spent on maintaining the PS&R system. This includes:

- Hours spent reconciling vouchers to the monthly PS&R reports for each provider;
- Receiving PS&R reports;
- Separating reports;
- Filing and mailing appropriate reports to providers;
- Correcting PS&R reports, as necessary;
- Researching and resolving discrepancies;
- Maintaining and updating PS&R files, revenue codes, and provider file;
- Implementing and testing PS&R updates to software; and
- Interface with EDP staff.

NOTE: Contractor shall not include hours or costs in its reimbursement budget request for purposes of maintaining or operating PS&R Systems other than the National Uniform PS&R System, i.e., a dual provider statistical system.

b. **HCRIS** - Contractor shall include all hours spent for generating the HCRIS portion of the automated cost report program for the "as submitted" data (if required), the finalized cost report, and for any reopenings/resubmissions. It shall include hours spent for CMS interface, computer vendor interface, internal monitoring of HCRIS, and software

implementation of HCRIS. It shall not include time spent for input of the "as submitted" cost report data or for input of adjustments that generate the finalized cost report.

3 - Line 5 - Provider Consulting Service

Contractor shall show the average hours spent for training, establishing and maintaining provider accounting systems, and other consultative services (See §100.8A, Line 4).

4 - Line 6 - Provider-Based Physician (PBP)

Contractor shall include time spent in maintaining records and files for provider-based physicians. It shall include all hours pertaining to PBP functions including:

- Review of new contracts received;
- Time allocations received;
- Updating PBP summary sheets/records;
- Processing Reasonable Cost Exception requests;
- Review and resolution of atypical time allocations, and implementation of new or revised PBP regulations;
- Handling of all provider written/telephone inquiries, interfacing with internal staff; and
- Performance of all necessary CRCC functions. (See Provider Reimbursement Manual-1, §2182.)

5 - Line 7 - Miscellaneous Contractor Activity

Include the average hours required for each of the following.

a. Cost Report Mailing - Contractor shall include all hours spent on obtaining the provider's cost report including: the initial mailing of the cost report package; issuance of cost report submission reminder letters; issuance of all cost report demand letters; processing of cost report extension requests; and coordination of payment suspension due to delinquent cost report submission.

b. Cost Limit and Caps - Contractor shall include all hours spent on calculating cost limits and caps including time for calculating HHA limits, SNF routine cost limits, TEFRA limits and revisions, and contracted therapy limits. It shall include all time spent on handling of exceptions/exemptions. Also, it shall include time for applying all hospice annual limits. (See The Medicare Claims Processing Manual, Chapter 2, Inpatient Hospital Billing.)

c. Reports - Contractor shall include all time expended in preparing Audit and Reimbursement reports.

d. Freedom of Information (FOI) Requests - Contractor shall include all time expended on FOI requests including receipt of requests; scheduling; issuing delay letters, if necessary; compiling the data requested; photocopying, completing CMS forms; and answering all FOI telephone inquiries.

e. Special Data Requests and Projects - Contractor shall include special data requests or projects initiated by CMS; the processing of accelerated payments; calculating any reimbursement items not previously identified, such as disproportionate share hospital adjustments for PPS or additional payment calculations for PPS sole community hospitals (SCH) experiencing a decrease in discharges.

Other Activities - Include hours spent on implementing new regulations. This includes:

- Assimilating data and reading;
- Preparing summaries of the "Federal Register" and determining ramifications to operations;
- Inquiries to resolve items or obtain clarifications;
- Modifying and testing computer systems to ensure regulations compliance. Contractor shall not include any EDP staff time or costs.
- Nonmanagement and nonclerical staff meetings and training/development;
- Clerical staff supporting provider reimbursement services. This includes all typing, filing, telephone answering functions as well as any other clerical services provided that have not been included in any of the categories above; and
- Provider Reimbursement supervisory/management staff time not already included within the other categories shown above.

6 - Line 8 - Total Other Services

Contractor shall show the total of the hours for lines 3 to 7.

C - Number of Providers (Based Upon the Schedule of Providers Serviced) Lines 9 through 13

1 - Line 9 - PIP

2 - Line 10 - Non-PIP

- Providers requiring interim rate review; and
- Providers not requiring interim rate review, e.g., ESRD, hospice, and LPIC.

3 - Line 11 - Total Providers; Sum of lines 9 and 10

4 - Line 12 - Anticipated New Medicare Providers (new to the program)

5 - Line 13 - Projected Providers (line 11 plus line 12)

D - Computation - (By Hours)

Line 14 - Multiply PIP Providers by PIP Review Hours (line 9 x line 1).

Line 15 - Multiply Non-PIP Providers Requiring Interim Rate Review by the Other Interim rate Review Hours (line 10a + line 12 x line 2).

Line 16 - Multiply Total Other Services Hours by Total Projected Providers (lines 8 x 13).

Line 17 - Total Hours (add lines 14, 15, and 16).

Line 18 - Establish a cost per hour based upon salaries and fringe benefits.

Line 19 - Direct Costs - Multiply total hours by cost per hour (lines 17 x 18).

Line 20 - Overhead - Show total overhead cost applicable to the reimbursement functions above.

Line 21 - Total Costs - Sum of lines 19 and 20.

340 - Exhibit of Schedule of Providers Serviced - Form CMS-1531A

(Rev. 1, 08-30-02)

A1-1274

THIS SPACE IS RESERVED FOR

FORM CMS-1531A

Reserved for Contracting Auditing and Settlement Reports

350 - Instructions for Using the System for Tracking Audit and Reimbursement (STAR)

(Rev. 1, 08-30-02)

A1-1275

A - General

STAR is an automated system developed for the purpose of streamlining the Medicare cost reporting process. STAR captures historical and current Medicare provider information and tracks time spent by the contractor in audit and reimbursement activity for each cost report. The STAR User's Manual serves as the contractor's instructions for implementing the program functions within the STAR system. It uses the STAR system to upload data to the CASR subsystem on the CMS mainframe. It uses the BPO Bulletin Board System (BBBS) as instructed in the STAR User's Manual or in the BBBS User's Guide.

CMS created the STAR Alert newsletter to clarify instructions in the STAR User's Manual and the intermediary manual pertaining to output reports created by STAR. The STAR Alert is issued several times a year and addresses concerns about various audit issues that may arise during the fiscal year (FY).

B - Uploading CASR Data to Central Office

The contractor uses STAR to upload the required CASR information to the CMS mainframe in accordance with §360 and the STAR User's Manual. The STAR Maintenance Group provides:

- All Medicare Part A intermediaries with the software required to produce the necessary files for transmission to the CASR subsystem on the CMS mainframe computer, or the BPO Bulletin Board;
- All additional instructions on usage of the software; and
- All changes or additions to the STAR user's manual.

C - STAR Time System

- All FIs must use the Time System;
- The FI enters time spent by employees on a particular administrative function, e.g., desk reviews, field audits, and settlements, in accordance with the STAR User's Manual; and
- Uses information tracked in the Time System in the Contractor Performance Evaluation Program scoring procedures.

D - Required Fields in STAR

The FI completes the following screens, with their corresponding fields, in the STAR program to ensure that all providers are properly documented in the system and that the resulting reports and/or records are current and accurate:

1. Screen Number 1

    Provider Number

    Change of Ownership (COO) Code (assigned by system)

    Long Name

    Short Name

    Provider Address

    Provider Type

    Control Type

    Tax Number

    Chain Number and Name (If Applicable)

    Certification Date

    Tie-In Date

    Tie-Out date and reason (If Applicable)

    Previous FI (if Known)

    Transferred to FI (if Known)

    Office Codes

2. Screen Number 2

    Default Address

3. Screen Number 3

    Interim Payment Pay Method

    Periodic Interim Payment In and Out Dates

4. Screen Number 4

    Cost Report Due

    Cost Report Received

    Cost Report Rejected

Refiled Cost Report Received

Desk Review Completed

Problem Resolution/Onsite/Audit (POA) Status Code

POA Start

POA Complete

Suspension by CMS

Reason of Suspension

Audit/No Audit Hours

Audit/Travel Hours

Audit/Travel Costs

FI Hearing Start

FI Hearing Complete

Provider Reimbursement Review Board (PRRB) Hearing Start

PRRB Hearing Complete

Tentative Date

Bill Date (If Applicable)

Amount Approved

5 Screen Number 5

FY Start (If not a full year)

Fiscal Year End Last Audited

Beds

Appeal Cost

Low/No Utilization

As Filed

Reimbursement Cost (All providers except Home Office (HO))

Total Cost (HO only)

6. Screen Number 6

Complete screen with DRGs, pass-thrus, and cost-based amounts for all PPS hospitals and their excluded units (provider types 05, 06, and 08), finalized after 10/1/90. Reopening information is required only if the Notice of Change-Program Reimbursement (NOC-PR) is within same fiscal year as the original NPR.

7. Screen Number 7

   PPS/Exempt/Waiver (PEW) Code 1234

   Metropolitan Statistical Area (MSA) Area

   (9999 if Rural--only Rural codes must be entered)

8. Screen 8

   Finalized and Reopenings

   Patient Days/Visits

   Title 18 Days/Visits

   Sequestration

   Reimbursement Cost (All Providers except HO)

   Total Cost (HO only)

   Interim Payments

   TEFRA Incentive

   Notice of Program Reimbursement/Notice of Correction-Program Reimbursement

   Reopening Letter Date

   Reopening Reason

   STAR Time Codes

   > The STAR Time System is mandated because time recorded in the STAR Time System for providers is used by CASR, CRS and CPEP programs. Time codes are stored in each user's lookup.dbf file.

E - Required Output Records in STAR

The FI produces the following output records using STAR:

1. CASR

   a. CASR Budget Request (CBR)

   b. CASR Budget Distributions (CBDs)

c. CASR Interim Expenditure Reports (CIERs).

2. Schedule of Providers Serviced (SPS).

3. Provider Reimbursement Profile (PRP).

4. Audit Selection Criteria Report (ASCR).

   To be submitted to the BBBS 30 days after the end of the fiscal year.

5. Hearing and Reopening Log.

   Due Upon request from Central Office (CMS).

6. Tentative Settlement Logs.

   Due upon request from CMS.

7. Hearing and Reopening Aging Report.

   Due upon request from CMS.

8. Cost Report Settlement Log (CRSXXXXX.DBF, where X is the FI's five digit contractor number).

   Due to the BBBS 15 days after the end of the quarter.

9. PRRB Negative Savings Audit Trail.

   Due upon request from CMS.

10. Other Files as requested by CMS.

360 - Instructions for Using the Contractor Auditing and Settlement (CASR) Subsystem

(Rev. 1, 08-30-02)

A1-1276

A - General

The CASR system is an automated reporting sub-system on CMS's mainframe M204 computer system. The contractor shall use the CASR system to electronically submit required audit data to central office by the specified due dates. The CASR User's Guide serves as the contractor’s instructions for using the CASR System.

User's Guides are supplied to all Part A intermediaries by the Bureau of Data Management and Strategy (BDMS). BDMS also issues any changes or updates to the CASR User' Guides.

B - The contractor shall transmit the following CASR reports to CMS in accordance with §§290, 320, and 340

- The CASR Budget Request (CBR), as directed by CMS;
- The CASR Budget Distributions (CBD), for the first, second, and third quarters;
- The CASR Notice of Budget Approval (CNOBA) for the fourth quarter;
- The CASR Interim Expenditure Report (CIER) for the first, second, third, and fourth quarter;
- The Provider Reimbursement Profile (PRP) with the initial CBR and CNOBA; and
- The Schedule of Providers Serviced (SPS) with each PRP.

PRINCIPLES OF REIMBURSEMENT FOR ADMINISTRATIVE COSTS

370 - General

(Rev. 1, 08-30-02)

A1-1100, B1-4100

The principles for determining allowable administrative costs are listed in Part 31 of the Federal Acquisition Regulation (FAR), as codified in Title 48 of the Code of Federal Regulations (CFR), along with the contract as interpreted and modified in Appendix B. Costs will be allocated separately by program management (PM) and Medicare integrity program (MIP) functions and activities.

Notice is hereby given to all Medicare contractors that on-going operations and projects should be completed at or under budget. If a contractor exceeds either its PM or its MIP budget, the U.S. Government will be under no obligation to fund the cost overrun except in strict accordance with the Medicare contract/agreement. Contractors are required to provide CMS timely notice of at least 60 days prior to the date funds are exhausted, along with a fully documented and justified Supplemental Budget Request that provides CMS time to analyze and recommend action to avoid the projected cost overrun. In your assessment of when funds will be exhausted, PM and MIP must be evaluated separately. (See §240.)

380 - Interest Rates In Calculating Debt Due To The Government

(Rev. 1, 08-30-02)

A1-1110, B1-4110

Notice of interest rates for debts due the government pursuant to Federal debt collection procedures in the Prompt Payment Act are supplied to contractors by CMS for each rate period and as published in the “Federal Register." Do not confuse these rates with those for overpayment or underpayment determinations established under §117 of the Tax Equity and Fiscal Responsibility Act.

390 - Travel Costs

(Rev. 1, 08-30-02)

A1-1120, B1-4120

Travel costs are generally limited to the rates as set forth in the Federal Travel Regulations (FTR). See FAR 31.205-46 for complete information, limitations, and exceptions. The FTR per diem limits from January 1995 to present can be found at the GSA website: www.policyworks.gov under the Office of Government-wide Policy. Only the most current mileage rate for use of privately owned automobiles is included on this website. Mileage rates for prior periods are listed below:

Period	Rate
September 17, 1989 to June 29, 1991	24 cents per mile
June 30, 1991 to December 31, 1995	25 cents per mile
January 1, 1995 to June 6, 1996	30 cents per mile
June 7, 1996 to January 13, 2000	31 cents per mile
January 14, 2000	32 cents per mile

400 - Calculating Return on Investment Where the Contractor's Year for Insurance Commission Filing Differs from the Medicare Contract Year

(Rev. 1, 08-30-02)

A1-1130, B1-4130

The contractor shall compute the rate of return on investment in accordance with Appendix B of the contract/agreement. If the contractor's accounting year is different from its Medicare contract year, CMS recommends the following weighted average calculation:

Assumption: Rate of return for October 1, 1998, to December 31, 1998, is 10 percent.

Rate of return for January 1, 1999, to September 30, 1999, is 8 percent.

Calculation of weighted average:

10 (Percent) x 3 (months) = 30%

8 (Percent) x 9 (months) = 72%

Total 102%

102% divided by 12 (months) = 8.5% (weighted average)

410 - Cost of Project Exceeds Estimates

(Rev. 1, 08-30-02)

A1-1140

Contractors are expected to complete productivity investment projects at, or under, budget. In some cases (e.g., large consolidations) it may be appropriate for the regional office (RO) to negotiate a Memorandum of Advance Agreement that sets out the statement of work and sets an upper limit for allowable costs.

FINANCIAL POLICIES FOR COORDINATION OF MEDICARE AND OTHER INSURANCE PROGRAMS

440 - Introduction

(Rev. 1, 08-30-02)

A1-1600, B1-4600

This chapter sets forth the financial policies and principles used by Medicare contractors furnishing title XVIII claims information for complementary health insurance or Federal grants-in-aid program purposes and for integrating the Medicare program with these programs.

450 - Coordination of Medicare and Complementary Insurance Programs

(Rev. 1, 08-30-02)

A1-1601, B1-4601

The release of title XVIII claims information for complementary health insurance purposes is permitted (under specified conditions) by Regulation No. 1 (Disclosure of Official Records and Information). This section establishes financial policies concerning identification of costs related to the release of this information by the contractor.

A contractor may release Medicare claims information for complementary insurance purposes to a complementary insurer, including its own complementary insurance operation, to beneficiaries, their authorized representatives, and to Social Security offices (SSOs).

A complementary insurer must pay the required charges for the release of Medicare claims information. The Medicare program absorbs charges for supplying duplicate Medicare Summary Notice (MSN) or billing forms to beneficiaries, their authorized representatives, and to SSOs. (See Medicare Bill Processing, Chapter 21, Medicare Summary Notice).) If a contractor has a written agreement with a complementary insurer to provide Medicare claims information, it may not charge a fee to anyone, other than the complementary insurer, for this effort.

A - Release to an Outside Organization

Under appropriate conditions, the contractor is **required** to release Medicare billing information to another insurer that may or may not be a Medicare contractor or a local Government agency which is **not** participating in a Federal grants-in-aid program. This may involve occasional requests for claims information and arrangements for the routine release of information on **every** bill on which the requestor is identified as the complementary insurer. CMS assumes that complementary insurers desiring the routine release of Medicare claims information will accept these Medicare claim records in electronic format.

1. Where complementary insurers **occasionally** request Medicare claims information, the contractor shall furnish it at a standard charge of $1.70 per item. (The standard charge is intended to cover the costs of processing, handling, correspondence, files search, and copying.) It is the contractor's responsibility to determine that the request meets the conditions for the release of confidential information and to bill and account for resulting revenues.

2. Where a complementary insurer routinely desires to have Medicare claims information, the contractor shall charge the standard rate set forth in the initial budget and performance requirements (BPR) package for that fiscal year. It shall charge the costs of releasing claims information to outside organizations to the Medicare program, and credit income to the program. The chief difference between the above alternatives is the willingness of the requestor to accept and pay for information on **selected** bills (including paper claims) or **all** bills (electronic transfers) designating the requestor as complementary insurer.

3. To ensure that direct costs are covered for low volume complementary insurers, contractors may charge the standard rate per claim or a monthly fee of $100.00, whichever is greater, for electronic or manual claims.

B - Cost Accounting

Charges to the complementary insurer are based on a standard rate, established by CMS, in an effort to distribute the costs to Medicare and the complementary insurer in a manner that reflects the benefits each receives. Where mutual benefit is derived, full cost sharing is required.

CMS has established a standard rate to charge Part A complementary insurers. The rate is computed based on the following criteria from the Final Administrative Cost Proposal (FACP) - Administrative Budget and Cost Report, Activity Form:

Intermediaries	**Carriers**
Form CMS 1523	Form CMS 1524
Lines 1-2 (less 8.5 percent of line 1)*	Lines 1-3 (less 50 percent of line 3)**
Schedule D, Line 1	Schedule D, Line 1
Schedule E, Line 1	Schedule E, Line 1
Schedule E, Line 3	Schedule E, Line 3
Form CMS-2580	Form CMS-2580
Postage	Postage

*17 percent of line 1 is attributable to inquiries.

**Only 50 percent of inquiries are attributable to the adjudication of Medicare claims.

The sum of these costs will be divided by the claims payment workload to determine a unit cost. (Postage is a subtraction to the formula.)

The complementary insurance rate will be the determined shared cost (50 percent) of the national average cost per claim of all contractors, computed in accordance with the criteria contained in this section. The rate will be reviewed and updated bi-annually and will be included in the initial BPR package each fiscal year. CMS has determined that the above criteria are necessary to fulfill normal claims processing requirements and are of mutual benefit to Medicare and the complementary insurer.

The contractor shall include the credit for Medicare claims information transferred on the appropriate line of the face-sheet and Schedule A of Form CMS 1523 or 1524 for each reporting use of the form (Budget Request (BR), Interim Expenditure Report (IER), and FACP). On an annual basis, the contractor shall report the detail of these credits on the credit schedule report of Form CMS 1523 or 1524 (FACP).

The interim amount to credit to the Medicare program for each fiscal year is based on the initial BR for that fiscal year.

C - Audits

The Office of Inspector General (OIG) will audit the complementary credits applied, verify application of the standard rate of charge, and report any findings in the audit report. If no OIG audit is performed, the Regional Office (RO) will also review and verify this information when performing risk assessments. The RO will negotiate settlement of any finding in this area as part of the audit or risk assessment resolution process.

The contractor shall maintain the following for reviews by the OIG, Office of Actuary (OA), CMS, or other interested parties:

- Copies of all crossover agreements with complementary insurers; and
- Evidence of beneficiary authorization to release Medicare information to the complementary insurer. (The complementary insurance plan brochure or agreement may be used if it contains a general statement authorizing the release.)

  Where the contractor desires to combine into one MSN/EOMB benefit data from both the complementary program and the Medicare program, it must meet these conditions:

- Title XVIII program identity is maintained;
- The combined notice clearly explains title XVIII payment action; and
- The combined notice effectively informs the individual of their title XVIII appeal rights.

The contractor is required to submit for approval to the CMS RO a proposed combined notice (with examples of its use) as well as a copy of the regular notice where a beneficiary does not have complementary insurance.

D - Fixed Price Contractors

If a contractor is operating under a fixed-price contract, it is subject to these provisions in determining charges for transferring Medicare information to its own and/or another complementary insurer. These provisions must be considered in preparing a request for proposal (RFP). The price proposed should be net of any anticipated credits for complementary insurance.

460 - Coordination of Medicare with The Federal Grants-In-Aid Program (Medicaid)

(Rev. 1, 08-30-02)

A1-1602, B1-4602

CMS furnishes Medicare billing information to State agencies or their fiscal agents for Medicaid purposes at no charge to the State or claims submitter. This section establishes the policy related to transmitting the Medicare billing information to Medicaid. (See The Medicare Claims Processing Manual, Chapter 22, Medicare Summary Notices and other Beneficiary Notices) for requirements for disclosure.)

460.1 - Furnishing Title XVIII Claims Information

(Rev. 1, 08-30-02)

A1-1602.1, B1-4602.1

The contractor shall furnish Medicare billing information to Medicaid upon request of the State agency or its fiscal agents. It shall provide it at no charge to Medicaid as long as the information can be used in the format given by Medicare:

- A copy of the billing/claims form;
- A copy of the Medicare Summary Notice;
- A copy of the billing form and any attachments thereto; or
- Electronic transfer containing the information described in Claims Processing Manual Chapter 28.

Where the State has the systems capacity to process data generated in electronic media, the contractor shall provide the information at no charge. Where the State does not have the capacity to process electronic data but must use hardcopy, there is no charge for the information. If, however, the State or its fiscal agent has the capacity to process electronic data, but requests the information on hardcopy, the contractor shall charge the State $.30 per claim for the information furnished. The RO has the responsibility of determining whether the States have the systems capacity.

Some State agencies may want the contractor to furnish the information in a format other than the standard format described in Claims Processing Manual Chapter 28. If the contractor is willing to undertake such additional services for the State, it shall develop an agreement with the State. It shall include terms by which the State will reimburse it on a reasonable cost basis for the additional service provided. The cost includes both direct and indirect costs.

460.2 - Treatment of Administrative Cost of Furnishing Information to State Agencies

(Rev. 1, 08-30-02)

A1-1602.2, 4602.2

The contractor shall charge the administrative costs incurred in furnishing billing information for Federal grants-in-aid program purposes, including the cost of transfer, to the title XVIII program in the appropriate departments.

It shall treat amounts collected from State agencies for information furnished on hardcopy where the State has the systems capacity to process electronic data as a credit to Medicare. It shall report this on Form CMS-1523B/1524B in the credit section.

The contractor shall deposit in its regular bank account amounts collected from State agencies for additional services performed. It shall clearly identify those funds as to source and purpose to facilitate auditing. The funds must be deposited in the regular bank account because the cash outlay for the cost of furnishing billing/claims information comes initially from this account.

460.3 - Cost of a Separate Claims Process

(Rev. 1, 08-30-02)

A1-1602.3, B1-4602.3

Where a State agency selects a Medicare contractor as its agent and a claims process separate from the Medicare claims process is developed, the cost of all functions performed in this separate process are a direct charge to the State agency. Arrangements for billing State agencies for the cost of this claims process are the contractor's responsibility. When Medicare billing information is transferred to the separate claims process, the provisions of §460.1 apply.

It is possible that some operations for the separate title XVIII and medical assistance claims may be performed in the same department, possibly by the same clerk. For example, upon completion of the title XVIII claim and transfer of billing information, it may be necessary to return the claim to the files maintenance section to determine eligibility and status in the medical assistance program. Where common cost centers exist, it is the contractor's responsibility to identify the effort expended for each program and charge costs from these costs centers to the appropriate program. The cost includes both direct and indirect costs.

460.4 - Integrated Claims Processing Systems

(Rev. 1, 08-30-02)

A1-1602.4, B1-4602.4

Where a State agency selects a Medicare contractor as its fiscal agent and the contractor has an integrated claims processing system, Medicare pays the full cost of operations which are required for processing title XVIII claims even though the operations benefit both the title XVIII and State medical assistance programs. Integrated operations generally include receiving, screening, determination of amount of payment, and portions of the keypunching and data processing functions. The contractor shall analyze integrated operations carefully in order to identify any functions that are not required under title XVIII but have been superimposed on the normal title XVIII claims process. For example, special coding required by the State agency, additional key punching and data processing necessary as a result of this coding, preparation of a separate check, and other similar activities are extra, identifiable functions not required in the title XVIII claims process and are not reimbursable by Medicare. State agencies are responsible for administrative costs of all extra, identifiable functions that the contractor performs while processing combined claims.

The contractor shall furnish a letter of intent to the State agency. It shall clearly indicate any extra, identifiable functions that are part of integrated operations and are performed for medical assistance program purposes. It shall indicate any operations separate and apart from the integrated claims process that are performed solely for the State agency. The contractor and the State agency are responsible for establishing the terms of the

agreement and the method of reimbursement. When negotiations have been completed, the contractor shall forward two copies to the servicing RO.

460.5 - Other Services

(Rev. 1, 08-30-02)

A1-1602.5, B1-4602.5

Where the contractor performs any other services for State agencies which are not related to the title XVIII claims process, the cost of such services cannot be charged to title XVIII. The contractor shall identify these services and charge directly for them where possible. It shall charge the full cost, rather than add-on cost, to the State agency. The cost includes both direct and indirect costs. It shall have the State agency prepare a letter of intent with which it clearly defines the services the contractor is to perform and the method of reimbursement.

470 - Principles for Sharing Costs of Physician Profiles

B1-4603

Section 470§§ applies to carriers only.

Carriers are authorized to release physician charge information to other parties under certain circumstances. The purpose of this section is to establish the policy for the release of this information.

470.1 - Release of Physician Profile Information to Title XIX Agencies and to TRICARE Fiscal Intermediaries

B1-4603.1

Medicare carriers are authorized to release physician charge information to State agencies that need this data to make medical assistance payments under title XIX, and to TRICARE fiscal intermediaries for use in administering the Civilian Health and Medical Program of the Uniformed Services. (See The Medicare General Information, Eligibility and Entitlement Manual, Chapter 6, for disclosure requirements.)

The State agency and/or TRICARE fiscal intermediary should reach an agreement with the Medicare carrier on the cost involved prior to furnishing the data. Extra and identifiable costs associated with the retrieval and transfer of information include such things as programming, assembling the data, handling, correspondence, files search and copying. These costs will be charged to the State agency and to TRICARE. (In the Final Administrative Cost Proposal, notation should be made if information was furnished to title XIX agencies or the TRICARE fiscal intermediaries and the cost of retrieving and furnishing the information should be shown.)

A carrier may have an integrated claims process; that is, it may process title XVIII and title XIX claims concurrently and mutual benefit may be derived from various operations in the claims process. In such cases, cost allocation is required in accordance with §470.2.

In any case in which determination of the actual cost of disclosing information would interfere with efficient administration, such cost may be fixed at an amount estimated not to exceed actual cost. The information may be released after payment of such amount. If collection costs are disproportionately high or would interfere with efficient administration, payment of up to $300 per annum may be waived.

470.2 - Principles for Sharing Costs of Physician Profiles When Used for Medicare and the Carriers' Regular Business

B1-4603.2

Criteria for the determination of reasonable charges for the Part B program required carriers to secure and maintain data. These criteria also emphasize that data supporting the customary charge of the physician are to be obtained from all sources available to the carrier so that the customary charge will reflect the charge made generally to the physician's patients for a particular service.

Where several programs or lines of business derive mutual benefits from the use of physician profile data, the following principle should be observed to assure equitable distribution of costs:

Where physician profiles established on data derived in whole or in part from the Medicare program are used by a carrier in any other program or business, cost sharing is required. The cost chargeable to the Medicare program will be determined by the volume of Medicare claims processed to the total claims processed for all lines of business using the physician profile data.

The Secretary and the Secretary's delegated subordinates have a contractual right to information necessary to insure program continuity and to insure maximum efficiency and effectiveness. If a change of carriers in an area were to occur, it might be necessary to transfer to the succeeding carrier appropriate data to assure that no disruption of reasonable charge determinations would result. Such data would be protected from unwarranted disclosure under Administration regulations on confidentiality.

480 - Coordination of Medicare and Medicare Supplemental (Medigap) Health Insurance Policies

B1-4607

The transfer of title XVIII claims information to Medicare supplemental insurers is **required** (under specified conditions) by §1842(h)(3)(B) of the Social Security Act, as enacted by §4081 of OBRA 87.

- The physician or supplier involved must be a participating, physician or supplier,

- The beneficiary must assign Medigap benefits to the physician or supplier, and
- The policy named by the beneficiary must be a true Medigap policy to the exclusion of employer coverage and plans operated by labor organizations.

A - Authorization for Payment to the Participating Physician or Supplier

A Medicare beneficiary who has a Medigap policy may authorize the participating supplier of services to file a claim on their behalf and to receive payment directly from the Medigap insurer instead of through the beneficiary. (A supplier of services for this purpose may be a physician, a diagnostic laboratory, or a supplier of other services, but not a "provider of services".) In such cases, the carrier shall transfer Medicare claims information to the Medigap insurer. The Medigap insurer pays the supplier of services directly, and must pay the carrier for its costs in supplying the information subject to limitations.

The carrier shall not transfer or use the information without the beneficiary's authorization. The supplier of services must furnish the required authorization(s) or certify that they are on file at the supplier's location.

The carrier shall not transfer claims that it pays or denies 100% unless it has a written agreement with the Medigap insurer that stipulates that such claims are to be transferred at the request and expense of the named insurer.

B - Cost Accounting

When the Medigap insurer has an existing complementary arrangement with the carrier (including an agreement to pay it the costs of transferring complementary information) and the specifications for transfer are met, the carrier shall bill the Medigap insurer for the complementary costs plus any additional costs incurred for the Medigap claim. When the Medigap insurer does not have an existing complementary agreement, the carrier shall establish procedures for transferring the information and for billing the Medigap insurer.

The carrier shall charge Medigap insurers the same rate that it charges for complementary insurance. It shall add any additional costs incurred specifically for the Medigap claim, e.g., additional keying, billing, and mailing, subject to a cap of $1.00 total per claim.

It shall account for the actual costs involved, but bill the Medigap insurer no more than $1.00 per claim except in the circumstances stated below. The $1.00 per claim charge includes the cost of setting up a system to transfer the claim information to the Medigap insurer.

Under the terms of a written agreement with the insurer, the carrier may charge more than $1.00 if the Medigap insurer requests special formatting or other special handling. The carrier shall not charge these costs to Medicare. It shall bill the Medigap insurer in a separate billing.

The carrier shall transfer claims information to Medigap insurers at least monthly. Its frequency of billings depends upon the volume of claims transferred. If the volume

increases, it shall increase its billing frequency. It shall not bill the Medigap insurer until the amount billed offsets the cost of billing.

The carrier shall not pursue collection for claims transferred erroneously. These include:

- Beneficiary no longer insured by insurer,
- Claims paid 100% by Medicare, unless the carrier has a written agreement with the Medigap insurer which stipulates that such claims are to be transferred at the request and expense of the named insurer,
- Claims denied 100% by Medicare (this does not include non-payment because of the deductible), unless the carrier has a written agreement with the Medigap insurer which stipulates that such claims are to be transferred at the request and expense of the named insurer,
- Incorrect beneficiary or provider number,
- Incorrect address,
- Named policy is not a Medicare supplemental policy, and/or
- Duplicate of claim already filed by beneficiary.

The carrier shall not charge Medigap insurers interest for late payment (amounts not paid within 30 days). It shall report any late unpaid charges to the insurance department of the State in which the policyholder resides. The State insurance department has responsibility for enforcement of the Medigap provision. If it does not accept jurisdiction, the carrier shall inform the appropriate RO.

The RO will contact the CMS for assistance in determining the department of jurisdiction. If the problem remains unresolved, the carrier shall treat it as a CMS debt under 42 CFR 401.601 - 625.

The carrier shall charge its system's start-up costs, which have been approved by CMS, to Medicare.

The carrier shall reduce the appropriate line on the Administrative Budget and Cost Report, Form CMS 1524, for Medicare credits received from transferred Medigap claims information. It shall report these credits on line 15 of Form CMS 2580, Cost Classification Report (CCR). It shall submit a supplemental schedule with both the fiscal year budget request and the CCR identifying:

- Gross volume of Medigap claims transferred,
- Number of Medigap claims returned,
- Net volume of Medigap claims transferred,
- Costs incurred for Medigap,

- Gross Medigap user-fee assessed,
- Amounts credited for returned Medigap claims,
- Net Medigap user-fee assessed, and
- Medigap User-fees collected.

C - Audits

For reviews by the OIG, OA, CMS or other authorized parties, the carrier shall maintain details of the procedures used in filing and processing claims, and making payments, including:

- A narrative of the work flow and the work performed in each activity,
- The number of personnel involved in each activity,
- The procedures which prevent use or disclosure of title XVIII claims information as proscribed by Subpart B of 42 CFR Part 401 and 45 CFR Volume 1, Parts 5 and 5b, and
- Samples of all payment notices.

To combine into one MSN benefit data from the complementary insurance, Medigap, and the Medicare programs, the MSN must ensure that:

- Title XVIII program identity is maintained,
- The combined notice clearly explains title XVIII payment action, and
- It effectively informs the individual of title XVIII appeal rights.

The carrier shall submit to its RO for prior approval its proposed combined notice as well as a copy of the regular notice where a beneficiary does not have Medicare supplemental insurance.

490 - Establishing a Common Provider Audit Program.

(Rev. 1, 08-30-02)

A1-1603

The following material (sections 490 through 500) applies to providers on prospective payment or cost reimbursement.

Title XVIII of the Social Security Act requires that participating health care institutions (providers) be reimbursed on a reasonable cost basis and to achieve this a comprehensive provider audit program has been established. Some grant-in-aid programs, namely title V (the maternal child health services and crippled children's programs) and title XIX

(Medicaid), also require that hospitals and possibly some other providers be reimbursed on a reasonable cost basis. Other third party payers may also have the same requirement. The common provider audit program is established to reduce the cost of provider auditing to participating third party payers and avoid duplicate auditing effort. The purpose then is to have one audit of a participating provider, which will serve the needs of all participating programs reimbursing the provider for services rendered.

490.1 - Policies for Implementation of a Common Provider Audit Program for Titles V, XVIII and XIX of the Social Security Act

(Rev. 1, 08-30-02)

A1-1603.1

Agreement has been reached between the Health Services and Mental Health Administration, PHS (title V), the Medical Services Administration, SRS (title XIX), and the Centers for Medicare and Medicaid Services, on basic policy governing the common audit program. This common audit policy has four basic elements: (a) cost sharing, (b) desk review, (c) field audit, and (d) final settlement.

490.2 - Cost Sharing

(Rev. 1, 08-30-02)

A1-1603.2

The costs incurred in auditing providers performing services for more than one of the above programs are to be shared on the basis of the amount of reimbursement (benefits paid) to individual providers by the respective programs.

Any proposed modification to this method of sharing costs of audit will be evaluated on the basis of its merits. Alternative methods proposed should adhere to the basic principle that audit dollars are expended to protect the integrity of benefits paid.

Costs to be shared include all costs incurred from the point of securing the cost report from the provider through the publishing and distribution of the audit findings (or cost settlement data where no audit is performed). If final settlement is included in the common audit program, these costs should also be shared.

There have been some questions concerning the definition of reimbursement (benefits paid). Reimbursement by the program means the dollar amounts of payments made from program funds at final settlement and should include payments to providers for inpatient and outpatient services and, if applicable, combined physician billing.

490.3 - Desk Review

(Rev. 1, 08-30-02)

A1-1603.3

The desk review capability of the intermediary will be used for the principal, intensive review of the cost reports submitted by the providers. The purpose of the review will be to determine (l) acceptability of the cost report, (2) need for a field audit, and (3) if an audit is to be performed, the depth of the audit.

490.4 - Field Audit

(Rev. 1, 08-30-02)

A1-1603.4

The participants shall evaluate the existing field audit capability of intermediary in-house staff, State audit staff, or a subcontracted audit firm, in regard to their past experience with the audit capabilities to be used. Every effort should be made to utilize qualified field audit capability available from the State agencies. CMS expects intermediaries to avoid the more costly audit firm subcontracts wherever possible.

490.5 - Final Settlement

(Rev. 1, 08-30-02)

A1-1603.5

All participants in the common audit program are to receive copies of the audit findings or cost settlement data where no audit is performed. The audit workpapers are also to be available if needed to proceed with settlement. The final settlement may or may not be undertaken jointly as agreed upon by the parties. Where independent settlements are to be made, there should be coordination among the participants to review the findings, insure consistent treatment, and discuss the effects of proposed settlements on each program.

490.6 - Implementing a Common Audit Program

(Rev. 1, 08-30-02)

A1-1603.6

CMS has contracted with intermediaries to perform certain functions required under title XVIII. The title V and XIX programs, which use State funds in conjunction with Federal funds, are administered by the States; therefore, an agreement should be executed between the intermediaries and the State agencies or their fiscal agents, whoever has the responsibility for auditing providers under titles V and XIX, to delineate the procedures to be followed, costs to be shared, method of payment for services, coordination necessary, and such other items as may be necessary for a complete understanding of what is expected of each party.

A model agreement (Exhibit l) is furnished as a guide in the preparation of the agreement.

Where the intermediary is also the fiscal agent for the State and responsible for the audit of providers under title V and/or title XIX, a common audit agreement is still necessary and should be submitted to CMS for review before being effectuated.

In all cases, two copies of the executed agreement should be forwarded to the CMS regional office. The regional office will forward one of the copies to the Division of Contractor Operations so the common audit program can be monitored on a nationwide basis to assure consistent application of policy.

490.7 - Contacting State Agencies or Their Fiscal Agents

(Rev. 1, 08-30-02)

A1-1603.7

In those instances where the intermediary is also the State's fiscal agent and responsible for audit of the providers, there should be no difficulty working out an agreement which would be acceptable to the State and CMS. Where the intermediary has established contacts with the State agencies responsible for grants-in-aid programs, the feasibility for a common audit program should be explored with them. If the intermediary has not established contact with the State agencies, they should request assistance from their CMS regional office of their progress toward the establishment of a common audit program. Multi-State intermediaries should contact the appropriate fiscal specialist in the CMS central office for assistance and reporting progress.

490.8 - Points to Remember in Discussions with Other Parties

(Rev. 1, 08-30-02)

A1-1603.8

Initially, we anticipate that State agencies will not be familiar with our comprehensive desk review procedures and suggest that the intermediary arrange to meet with the State agency to explain the title XVIII procedures. The intermediary should ask the Health Insurance Regional Office to coordinate such a meeting with the titles V and XIX Regional Offices.

In those instances where the intermediary is also the State's fiscal agent for one of the titles other than title XVIII and also has the responsibility for auditing, there will be no coordination problem. However, where the State agency does its own auditing or uses a different fiscal agent, the State agency may decide to permit the intermediary to use the title XVIII guides or they may wish, at least initially, to designate someone to review the desk review determinations with the intermediary. In any event, the intermediary should cooperate and attempt to resolve any conflict as to either the necessity or scope of audit through explanation of the determination made. Note that any audit felt necessary should benefit all titles in proportion to their share of the costs.

The agreement with the State agencies should specify that either party may request a special audit of a provider or an abnormal exploration of a particular cost in a routine audit, so long as the requesting party assumes responsibility for the additional cost.

490.9 - Release of Final Settlement Data for Periods Ending Prior to January l, 1970 to State Agencies Signing Agreements

(Rev. 1, 08-30-02)

A1-1603.9

Final settlement data, whether audited or based on the decision to not audit, pertaining to cost reports for periods ending prior to January l, 1970, **with the exception of those audited cost reports based on combined reporting forms**, can be released without charge to State agencies signing an agreement for a common audit.

It is expected that any cost reports for periods prior to January l, 1970, not yet audited, will have the title XIX or V information added and the cost reports will then be handled as a common audit.

490.10 - Release of Final Settlement Data for Periods Ending After December 31, 1969 to State Agencies Signing Agreements

(Rev. 1, 08-30-02)

A1-1603.10

Final settlement data for periods ending after December 31, 1969,which contain only title XVIII information will be released to States signing agreements as follows:

A. Data for final settlement based on comprehensive desk review information only will be furnished with costs of acquiring and developing the information to be shared on the basis of reimbursement by the respective programs.

B. Data for final settlement to be based on audited cost information will be furnished with cost of the field audit only to be shared on the basis of reimbursement by the respective programs. The desk review data will be included without charge.

490.11 - Treatment of Administrative Costs Accrued in the Operation of a Common Audit Program

(Rev. 1, 08-30-02)

A1-1603.11

Administrative costs accrued in the operation of a common audit program are to be shared as indicated in §490.2 above and only that portion of the cost for which Medicare is responsible should be shown on the Interim Expenditure Report (Form CMS 1527) and the Final Administrative Cost Proposal (Form CMS 1615).

490.12 - Treatment of Receipts for Final Settlement Data Released to State Agencies

(Rev. 1, 08-30-02)

A1-1603.12

Amounts collected for furnishing final settlement data under Section 490.10 above are to be deposited in the intermediary's Medicare bank account. Funds so deposited must be clearly identified as to source and purpose to facilitate auditing. The funds must be deposited in the Medicare account because the cash outlay for the cost of obtaining the information was charged to Medicare. Funds received for this purpose should be shown as a separate credit item on the Interim Expenditure Report (Form CMS-1527) and the Final Administrative Cost Proposal (Form CMS 1615).

500 - Coordination of Final Settlement Data Without A Common Audit Program

(Rev. 1, 08-30-02)

A1-1604

There may be instances where a State agency or their fiscal agents may not find it feasible to participate in a common audit program, yet desire the title XVIII final settlement information.

It is recognized that the title XVIII final settlement data (whether it be audited data or comprehensive desk review data) will not contain all the data required by State agencies or their fiscal agents to make settlements under their programs. Title XVIII final settlement information may be released to State agencies or their agents with charges for the information to be determined as follows:

1. **Release of final settlement data based on comprehensive desk review only** - The cost of acquiring and developing the information is to be shared on the basis of reimbursement to the individual provider by the respective programs. Our review and appraisal reveals that in the comprehensive desk review process little effort is expended in verifying strictly title XVIII information and that most of the effort would benefit all programs equally.

2. **Release of final settlement data based on audited cost information** - The cost of field audit only is to be shared on the basis of reimbursement to the individual provider by the respective programs. The desk review data will be included without charge.

500. l - Treatment of Administrative Costs and Receipts for Furnishing Settlement Information Where There is No Common Audit Program

(Rev. 1, 08-30-02)

A1-1604.1

Administrative cost incurred in furnishing settlement information should be charged to the title XVIII audits of providers' function. Amounts collected for furnishing this information must be deposited in the intermediary's Medicare bank account. Funds so deposited must be clearly identified as to source and purpose to facilitate auditing. The

funds must be deposited in the Medicare account because the cash outlay for the cost of obtaining the information was charged to Medicare. Funds received for this purpose should be shown as a separate credit item on the Interim Expenditure Report (Form CMS-1527) and the Final Administrative Cost Proposal (Form CMS-1615).

510 - Reporting Costs for Assistance Provided QIOs

A3-1610

Section 249F of Public Law 92-603 provides for the establishment of Quality Improvement Organizations. These organizations require varying amounts of assistance from intermediaries.

Intermediaries incurring costs in providing assistance to QIOs (including planning, conditional, and operating) should use the guidelines provided below in reporting costs on their Estimate of Administrative Costs, Cumulative Interim Expenditure Report and Budget, and Final Cost Proposals. Funds have not been included in CMS's allocation for contractor operations to provide assistance to QIOs. Therefore, requests from PROs for data as described in B below should not be undertaken until agreement for reimbursement of costs incurred has been reached with the QIO. It is suggested that this agreement be included in the Memorandum of Understanding.

Assistance to QIOs will generally fall into two categories:

A - Activities Which Are to be Charged to Medicare

Incidental items will be charged to Medicare on regular lines. Such items include general discussions on the Memorandum of Understanding, available data, operating procedures, meetings to discuss specific agenda items, phone calls, etc. Similar items, but involving more than an incidental amount of time, staff, or cost such as an all day meeting, a series of meetings to discuss and explain available data, etc., should be identified, reported on the QIO line and charged to Medicare.

B - Activities Which Are to be Charged to QIOs

This category consists of data requested by the QIO for use in carrying out their function such as photocopying existing data, special computer runs, and other similar requests for information. As indicated above, an agreement regarding requests and reimbursement for costs incurred for completing the requests should be reached in advance and with CMS RO concurrence, is to be incorporated in a Memorandum of Understanding. The costs for this type of data are to be billed directly to the QIO and an informational report of the costs incurred is to be attached to the Medicare fiscal reports to CMS. Costs for this type of activity are not to be charged to Medicare.

520 - Exhibits

(Rev. 1, 08-30-02)

A1-1699

Exhibit l - Agreement for Common Audit Under Titles X, XVIII and XIX

Agreement for Common Audit Under Titles V, XVIII and XIX

WHEREAS the Secretary of Health, Education and Welfare has the responsibility for the administration of titles V, XVIII and XIX of the Social Security Act and has urged coordination of these programs to the extent practicable;

WHEREAS it is required that under titles V, XVIII and XIX participating health care institutions, hereinafter referred to as providers, are to be reimbursed for inpatient services on a reasonable cost basis;

WHEREAS representatives of the Social Security Administration, the Medical Services Administration and the Maternal and Child Health Services of the Department of Health, Education, and Welfare have agreed that whatever audit of providers is required should serve the purpose of the three programs;

WHEREAS the (name of intermediary or intermediaries), hereinafter referred to as the intermediary, has entered into an agreement with the Secretary of Health, Education, and Welfare to act as the fiscal intermediary under title XVIII, and that the intermediary is contractually obligated to make such audit of records of providers of services as is necessary to assure that the facilities are being reimbursed in accordance with the provisions of the Act and the Regulations promulgated pursuant thereto;

WHEREAS the Secretary has authorized intermediaries and State agencies to enter into agreements for use of common audit information under titles V, XVIII and XIX and sharing of such audit costs;

THEREFORE, the intermediary and the (name of State agency or agencies), hereinafter referred to as the ____, hereby agree to the following:

1. The intermediary shall have responsibility for performance of desk reviews of provider cost reports to determine their acceptability and for deciding the need for and scope of field audits. It is expected that the intermediary will arrange for appropriate consultation with the (name of State agency or agencies) in arriving at its decision regarding need for or scope of any audit.

2. The intermediary and the (name of State agency or agencies), shall select a mutually acceptable audit capability to be used in the conduct of field audits,

including the consideration of the intermediary's and the State agency's in-house audit staff. The intermediary and the (name of State agency or agencies) shall enter into any subcontracts which might be necessary to accomplish field audits under the common audit program, in accordance with their responsibilities under their agreements with the Secretary of Health, Education, and Welfare for administration of their respective programs. (Administration of subcontracts will be arranged between the intermediary and State agency.)

3. Cost sharing

   a. The cost of common audits, including desk review, field audit activities, and, if applicable, final settlement activities, will be shared by the intermediary and the (State agency or agencies);

   b. The cost to each party to this agreement will be based upon the ratio of benefits paid to individual providers by titles V, XVIII, and XIX for the period covered by the cost report;

   c. (This provision will set forth the mutually satisfactory arrangements to be reached whereby each party contributes its share of the audit costs on a timely basis.)

4. This agreement shall begin on (date) and end on (date) . It will automatically be renewed for successive periods of one year unless the intermediary or the State agency(s) gives written notice of intention not to renew the agreement at least 90 days before the end of the current period.

5. Any costs incurred as a result of termination of this agreement will be shared on an equal basis.

6. Final settlement with the providers will be made (by the intermediary for all parties/or separately). (If separate settlements are to be made, the following should be added, "Coordination of settlements by the intermediary and the (State agency or agencies) will be necessary to insure consistent treatment of questioned items.")

7. The provisions of the Agreement shall be applicable only in connection with the audit of those providers receiving reimbursement under title XVIII and at least one of the other titles referred to in this agreement.

(Intermediary)

BY: __________________________
(name and title of Intermediary's authorized representative)

(State Agency)

BY :__________________________
(name and title of the authorized State representative)