Medicare
Provider Reimbursement Manual - Part 1

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

Transmittal 436 **Date: March 2008**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2140.2 - 2140.3	21-25 - 21-25.1 (2 pp.)	21-25 - 21-25.1 (2 pp.)
2140.6 - 2142.6	21-27 - 21-30 (6 pp.)	21-27 - 21-30 (6 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* March 28, 2008

Since the PRM defines pension costs using ERISA terminology and the ERISA minimum and maximum cost limits, the GAAP terms have been replaced with the ERISA terms to prevent confusion with the pension costs determined for financial accounting purposes. Pension costs determined for financial accounting purposes are not appropriate for reporting pension costs for Medicare purposes because they are measured and assigned to periods on a different basis than used by ERISA, and the GAAP amortization amounts may not fall within the range required under §2142.5A. These clarification changes are used to state the original intent of the manual on how to report pension costs.

This transmittal corrects typographical errors, and replaces the term HCFA with CMS.

DISCLAIMER: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

For cost reporting periods beginning on or after January 1, 1996, this policy requires identification and disallowance of the portion of dues related to lobbying and political activities. For prior periods, the policy does not require identification but requires disallowance of any identified portion.

The policy in §2139.2 permitting providers to follow the rules of other government agencies on lobbying activities in determining unallowable lobbying costs under Medicare applies also to dues. In particular, for Federal income tax purposes, §13222 of the Omnibus Budget Reconciliation Act of 1993 generally requires tax-exempt organizations to report to their members the nondeductible portion of dues related to an organization's lobbying and political activities. The reporting required under that provision satisfies Medicare's requirement for identification of the portion of an organization's dues related to lobbying and political activities. If an organization is not required to report to its members for tax purposes, for Medicare purposes, the portion of dues for lobbying and political activities remains unallowable as if the organization were required to report. In such cases, a provider will need to request the information from the organization in order to report for Medicare purposes only the portion not related to lobbying and political activities.

In light of policy by *CMS* and other agencies requiring identification of the lobbying and political activities portion of an organization's dues, *CMS* believes it unlikely a provider will be unable to, or choose not to, identify such portion. However, if a portion is not identified for Medicare payment purposes and the intermediary is aware of the organization's ongoing lobbying or political activities, all costs associated with the provider's dues to the organization are unallowable unless the provider can document the unallowable portion for lobbying and political activities.

This policy is not limited to dues incurred by a provider on its own behalf. It applies also to dues a provider pays, as a business or fringe benefit expense, on behalf of its employees and officers in professional, trade, or other organizations to which they belong, e.g., associations of nurses, therapists, administrators, or accountants. Only the portion of the dues not related to lobbying or political activities of the organizations is an allowable cost.

2140. DEFERRED COMPENSATION

2140.1 Definition.--Deferred compensation is remuneration currently earned by an employee but which is not received until a subsequent period, usually after retirement. Accordingly, a deferred compensation plan defers the receipt of income beyond the year in which it is earned. The type of deferred compensation plan considered herein is not considered a qualified plan under Internal Revenue Service requirements. (See subchapter D, Internal Revenue Code of 1986, as amended, and regulations thereunder.) Qualified deferred compensation plans *that* meet the definition of a *defined benefit* pension plan are treated under §2142ff. *Qualified deferred compensation plans that meet the definition of a* qualified defined contribution deferred compensation plan *are treated under* §2141ff.

2140.2 Foreword.--Provider contributions for the benefit of employees under a deferred compensation plan are reimbursable when, and to the extent that, such costs are actually incurred by the provider. Such costs are found to have been incurred only if the requirements of §2140ff. are met. The requirements of this section are applicable not only to provider costs but also to direct patient care services furnished by hospital-based physicians who receive their remuneration from the hospital. (See §2140.5.) As a condition for provider reimbursement, deferred compensation plans must be funded. Provider payments

under unfunded deferred compensation plans are considered an allowable cost only when actually paid to the participating employee*s, or their beneficiaries,* and only to the extent considered reasonable. Also, only where deferred compensation is funded is the deferred portion of the hospital-based physician's total compensation included in determining a Part B reasonable charge for the physician's services to patients.

2140.3 Formal Plan.--In order to establish a formal deferred compensation plan, the provider is required to adequately communicate the proposed plan to all eligible employees, enabling them to make an informed decision on whether to participate in the plan. A formal plan is one that is provided for in a written agreement executed between the provider and the participating employees. It is a permanent plan which:

- o Prescribes the method for calculating all contributions to the fund established under the plan;
- o Is funded in accordance with the provisions of §2140.3B;
- o Provides for the protection of the plan's assets;
- o Designates the requirements for vested benefits;
- o Provides the basis for the computation of the amount of benefits to be paid; and
- o Is expected to continue despite normal fluctuations in the provider's economic experience.

A. Contributions.--Contributions to the plan may be made by the provider only, or by the provider and the employee. The provider's contribution is established by the terms of the deferred compensation agreement and made for the sole benefit of participating employees. An employee's contribution is generally a voluntary contribution to the fund established under the plan in addition to the provider's required contribution. For example, an employee may agree to a division of his $15,000 salary so that $12,000 is received as immediate remuneration, $1,000 is designated as a voluntary employee contribution, and the provider also contributes $2,000 to the deferred compensation plan on behalf of the employee. Of course, the employee's total compensation ($15,000 in the example) must be reasonable in relation to the services rendered by the employee to be allowable. Also, contributions by a provider to a deferred compensation plan on behalf of an employee-owner of a provider are considered to be a part of the owner's compensation and are subject to the test of reasonableness. (See §902.3.)

B. Funding of Deferred Compensation Plans.--

1. Provider Reimbursement for Deferred Compensation Plans.--A funded plan is one in which contributions are systematically made as a specific provision of the plan to a funding agency for the purpose of meeting retirement benefits. For Medicare purposes, a funding agency is a trustee, an insurance company, or a custodial bank account which provides for the accumulation of assets to be used for the payment of benefits under the deferred compensation plan. Accordingly, both provider and employee contributions to the deferred compensation plan must be used either to purchase an insured plan with a commercial insurance company, to establish a custodial bank account, or to establish a trust fund administered by a trustee. Past service costs are allowed in accordance with the provisions of §2142.5.

Recognition of a deferred compensation arrangement does not mean that a provider will incur a cost, which is allowable. For example, payments to a fund for a physician's direct patient care services are not an allowable provider cost. However, where the arrangement is recognized by the program, and the physician's compensation is determined to be reasonable in terms of the prudent buyer principles, then deferred compensation can be included in the physician's total compensation in determining his reasonable charge. However, if the deferred compensation is not recognized because it fails to meet all provisions of §2140ff, e.g., it is not funded, then deferred compensation cannot be included in the physician's compensation in determining his reasonable charge.

The Medicare program will not recognize an arrangement between the physician and the provider in which the physician is reimbursed from patient charges, *but* the provider does the billing, *as a* deferred compensation arrangement. For example, where the employment relationship between the provider and the provider-based physician is such that the provider is merely acting as the billing agent for the physician whose remuneration is derived from billing for his patient care services, the Medicare program will not recognize a deferred compensation plan for such remuneration. In order to be recognized as a deferred compensation plan, the compensation costs must be initially borne by the provider, i.e., the funds must not be dependent upon patient billings. As an example, if the hospital has agreed to pay a physician $30,000 for his services in the emergency room, the program would recognize a deferred compensation plan which defers a portion of the $30,000. The difference in recognition is that in the first example, the hospital is merely the conduit for a physician's billings for patient care; whereas, in the second example, the hospital has to pay the physician $30,000 regardless of the number of patients he treats.

In all matters affecting provider-based physician reimbursement, close coordination between the provider, the intermediary and the Part B carrier is necessary. The intermediary is responsible for insuring that the provider complies with the overall requirements of this section and for providing the carrier with data needed in determining reasonable charges.

2140.6 Guarantee Arrangements for Physician Emergency Room Services.--A provider may agree to guarantee a physician a specified amount of compensation for rendering emergency room services. Under the guarantee, the provider makes up any difference between the amount guaranteed and the total amount of physician's charges to all patients for services actually rendered. (See §2109.) Only the amount the provider pays to satisfy the guarantee is recognized as a provider cost.

Deferred compensation arrangements which are included in such guarantee arrangements are recognized by Medicare when (1) the terms of both the guarantee arrangements and the deferred compensation plan establish the amounts to be included at the beginning of the provider's accounting period, (2) the amount of deferred compensation is included in the guaranteed amount, and (3) the provider contributes to the fund established under the deferred compensation plan from its own funds.

The amount of deferred compensation, which the program recognizes, however, is limited to the amount by which the guarantee, including deferred compensation, exceeds the total billed by the provider to all patients for the physician's patient care services. The amount recognized may not exceed the amount of deferred compensation specified in the agreement. When the physician's charges to all patients equal or exceed the amount guaranteed by the provider, the

program does not recognize a deferred compensation payment because the funds are not provider generated. (It is the physician's charges to all patients, not the collections, which measure the guarantee.)

The following example illustrates how the amount of deferred compensation the program recognizes under guarantee arrangements can be determined in the three situations presented.

Provider A has an arrangement with Dr. X guaranteeing him/her $25,000 per year for emergency room patient care services. Under a deferred compensation agreement, up to $5,000 of the amount paid to meet the guarantee is considered deferred compensation.

	Situation A	Situation B	Situation C
Guaranteed Amount	$25,000	$25,000	$25,000
Total Services Billed (by physician or by provider)	$20,000	$23,000	$30,000
Amount Recognized by Program as Deferred Compensation	$ 5,000	$ 2,000	---

If the guarantee arrangements require the physician to render administrative services which are recognized as provider costs under Medicare, then the deferred compensation must be apportioned between Part A and Part B in the proportion that each bears to the total guarantee.

2141. DEFINED CONTRIBUTION DEFERRED COMPENSATION PLANS

2141.1 Definition.--Defined contribution deferred compensation plans include profit sharing, stock bonus, and other such defined contribution deferred compensation plans that meet Internal Revenue Service (IRS) or Employee Retirement Income Security Act (ERISA) requirements as qualified plans and have been so approved by the IRS. The plans provide for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to the participant's account. These deferred compensation plans, as well as the non-qualified deferred compensation plans described in §§2140ff, provide for the deferral of remuneration currently earned by an employee until a subsequent period (usually after retirement).

2141.2 Foreword.--Provider contributions for the benefit of employees under a defined contribution deferred compensation plan are allowable when, and to the extent that, such costs are actually incurred by the provider. Such costs may be found to have been incurred only if the requirements of this section are met.

2141.3 Formal Plan.--In order to establish a formal deferred compensation plan, the provider is required to adequately communicate the proposed plan to all eligible employees, enabling them to make an informed decision on whether to participate in the plan. No provision of the plan may discriminate in favor of certain employees, e.g., employees who are stockholders, supervisors, or highly paid personnel. A formal plan is one that is maintained by the provider and is provided for in a written agreement executed between the provider and the participating employees. It is a permanent plan which:

- Prescribes the method for calculating all contributions to the fund established under the plan;

- Is funded in accordance with the provisions of §2140.3B;

- Provides for the protection of the plan's assets;

- Designates the requirements for vested benefits;

- Provides the methods and procedures for payment to the employee of the amount in the employee's account; and

- Is expected to continue despite normal fluctuations in the provider's economic experience.

A. Contributions.--The provisions of §2140.3A must be met.

B. Funding of Deferred Compensation Plans.--The provisions of §2140.3B must be met.

C. Plan's Assets.--

1. Transactions.--The provisions of §2140.3.C.1 must be met.

2. Individual Participant's Account.--The plan must provide for an individual account for each participant and for benefits based solely upon the amount contributed to the participant's account. This includes any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to each participant's account.

3. Loans Made From Deferred Compensation Fund.--The provisions of §2140.3.C.3 must be met.

D. Vested Benefits.--The deferred compensation plan must specify the time and the manner in which the benefits are to become vested, e.g., after a predetermined number of years of employment, after a specific age is attained, or some combination of the two. The benefits that accrue to an employee upon retirement, termination of services due to disability, or other reasons (or *that* accrue to the employee's survivor in case of death) must be incorporated into the plan.

The immediate vesting of benefits is not required. However, the deferred compensation plan must provide that vesting of provider contributions occurs on or before the normal retirement age established by the provider and as defined in the plan.

The unconditional vesting of benefits is not required. Unconditional vesting of benefits means that once a participant's benefits are vested in accordance with the normal vesting schedule, there are no conditions incorporated in the plan which deprives the participant of such benefits.

Employee benefits must become fully vested upon any of these occurrences:

- The normal retirement age established by the provider;

- Termination of the deferred compensation plan;

- Complete discontinuance of contributions under the deferred compensation plan;
- Termination of the provider's participation in the Medicare program; or
- Change of ownership of the provider when the successor provider is unwilling or unable to continue the deferred compensation plan or alters the existing plan in any way.

Excess funds arising from the termination of a deferred compensation plan are subject to the provisions of §2140.3.D.

2141.4 Requirements to Fund Plan.--The provisions of §2140.4 must be met.

2141.5 Reimbursement of Hospital-Based Physician Patient Care Services.-- Contracts or agreements between hospital-based physicians and hospitals involve a variety of arrangements under which the physician is compensated by the hospital for the full range of services within the institution. The allocation of the hospital-based physician's compensation (including any portion subject to deferment) between services benefiting the institution and direct patient care is subject to the review and approval of the hospital's intermediary. Medicare does not accept an allocation, which attributes the physician's deferred compensation entirely to one type of service and the current compensation to the other. The amount deferred must be allocated in the same ratio that physician's total compensation is allocated between the two types of service.

Arrangements between the physician and the provider in which the physician is compensated solely from patient charges, although the provider, serving merely as a billing agent, does the billing, cannot include a deferred compensation arrangement, which will be recognized by the program. In order to be recognized as a deferred compensation plan, the compensation costs must be initially borne by the provider.

2141.6 Guarantee Arrangements for Physician Emergency Room Services.--The provisions of §2140.6 must be met.

2141.7 Effective Date.--The provisions of this section are effective for defined contribution deferred compensation plans established in cost reporting periods beginning on or after March 1, 1976.

2142. *DEFINED BENEFIT* PENSION PLANS

2142.1 Definition.--A *defined benefit* pension plan is a type of deferred compensation *plan, which* is established and maintained by the employer primarily to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Such a plan may include disability, withdrawal, option for lump-sum payment, or insurance or survivorship benefits incidental and directly related to the pension benefits. Such benefits are generally measured by, and based on, such factors as age of employees, years of service, and compensation received by the employees. A plan designed to provide benefits for employees or their beneficiaries to be paid upon retirement, or over a period of years after retirement shall be considered a *defined benefit* pension plan, if under the plan, either the benefits payable to the employee or the required contributions by the provider can be determined actuarially.

2142.2 Methods of Providing Benefits.—A *provider* who desires to provide retirement benefits for *its* employees may do so in several different ways. *The provider* may *have an unfunded defined benefit pension plan and* simply pay a pension directly to the employees*, or their beneficiaries,* i.e., without intervention of a trust. *The provider may have a funded defined benefit pension plan and* purchase annuities, establish a pension fund or trust, or combine these *funding* options.

2142.3 Pension Fund.--A pension fund is the portion of the pension cost accumulated in the hands of an organization, individual, or trust to be used for the purpose of meeting retirement benefits when they become due.

In order for a plan to be considered funded for purposes of Medicare cost reimbursement, the liability to be funded must have been determined, and the provider must be obligated to make payments into the fund. Funds existing at the discretion of the provider are not considered valid, and such plans are treated as *"unfunded" deferred compensation plans, and therefore, payments* are allowed only when paid to the *employees, or their beneficiaries See §2140.2.*

When the plan is represented by a fund, the corpus and income *from the fund* must not at any time be used other than for the exclusive benefit of the employees or their beneficiaries. (See §2140.3C.)

The treatment of interest and loans on the deposits in the pension fund is covered in §228.

2142.4 Plan Requirements.--The plan must meet all the requirements of a deferred compensation plan. The implementation of procedures for the allowability of pension plan payments in §2142.6 below are effective with cost reporting periods beginning on or after September 1, 1981.

A. Data Required.--The provider, without regard to its taxable or tax exempt status, must have available actuarial data containing at a minimum*:* the ERISA minimum and tax deductible maximum pension *contribution* specifying the normal cost*, the actuarial accrued liability, the actuarial and market value of assets* and the unfunded actuarial liability *or surplus assets.* If pension costs *included in the cost report for a period differ from the amount of pension cost funded for that period,* the provider must also have data available reconciling *the difference. This data should identify any excess funding from prior periods that is applied towards the funding of the current period's pension cost.*

B. Formal Plan.--The plan must meet the requirements of §2140.3. No provision of the plan may discriminate in favor of certain employees, such as employees who are officers, stockholders, supervisors, or highly paid personnel.

C. Employee Benefits.--Employees' rights must be nonforfeitable after such time as they vest under the plan; that is, not contingent on continuance of employment or other factors. (See §§2140.3D and E.)

2142.5 Pension Costs.—*The current period liability for pension cost is the sum of the amortization payment towards the unfunded actuarial liability, determined in accordance with §2142.5A, and the unliquidated normal cost, determined in accordance with §2142.5B. Provider payments of the current period liability for pension cost are allowable in the year accrued, provided the payment requirements in §2142.6 are met.*

A. Actuarial Accrued Liability.--The actuarial accrued liability is that portion of pension costs, actuarially determined, that is not provided for by current and future normal costs. *The unfunded actuarial liability (also known as the "unfunded actuarial accrued liability") is the excess (if any) of the actuarial accrued liability over the*

*actuarial value of plans assets. The excess (if any) of the actuarial value of plan assets over the actuarial accrued liability are surplus assets. Unfunded a*ctuarial accrued liabilities must be amortized ratably over a minimum of 10 years, or such shorter period prescribed by ERISA for particular actuarial liability adjustments, subject to the payment requirements in §2142.6A. *If there are surplus assets, the amortization payment for current period is zero.*

B. *Normal Costs*.--Normal cost is that portion of pension costs, actuarially determined, which is allocated to the current year, exclusive of any payment toward the unfunded actuarial accrued liability. *The normal cost for the current period liability is limited to the portion of the normal cost not liquidated by surplus assets.*

2142.6 Allowability of Payments.--

A. Payment Requirements.—*To be allowable, t*he provider must make payment of its current *period* liability for *pension* cost *determined in accordance with §2142.5* to the fund established for the pension plan in accordance with the provisions covering liquidation of *current period* liabilities established in §2305. The instructions require full liquidation of the liability within 1 year after the end of the cost reporting period in which the liability is incurred. An extension, not to exceed 3 years beyond the end of the cost reporting year in which the liability was incurred, may be granted by the intermediary for good cause if the provider, within the 1-year time limit, furnishes to the intermediary sufficient written justification (based upon documented evidence) for non-payment of the liability.

Payment must be made by check or other negotiable instrument, cash, or legal transfer of assets such as stocks, bonds, real property, etc. Where payment is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within the time limits specified in §2305. The valuation of stocks, bonds, real property, etc., transferred to the pension plan fund would be determined as of the date of transfer by the provider.

B. Less Than Total Payments.--Where the payment made is less than the *current liability for pension cost determined in accordance with §2142.5,* the payment will be considered to be applied first to the normal cost, and any remainder to allowable unfunded actuarial accrued liability. Any amounts paid toward the unfunded actuarial accrued liability will be considered as a proportional payment of the unfunded actuarial accrued liability and cannot be allocated to the unfunded actuarial accrued liability of any specific persons or any specific years.

C. Excessive Payments.--Where the payment made is more than the lesser of the tax deductible maximum or the *current period liability for pension cost determined in accordance with §2142.5,* the excess may be carried forward and considered as payment against the liability to the fund of the future period.

D. Payments to Surviving Spouse.--Payments made directly to the surviving spouse of an employee, and not out of a fund, will be recognized only if the payments are part of a plan approved by the Internal Revenue Service, and if the deceased employee had neither died nor retired before the effective date of the pension agreement.

E. Reasonable Compensation.--The payments made by the provider together with all other compensation paid to the employee must be reasonable in amount.

2142.7 Treatment of Pension Cost on the Cost Report.--Pension costs are in the nature of general administrative costs and generally should be so treated on the cost report.