

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 105	Date: AUGUST 25, 2006
	Change Request 5130

SUBJECT: Benefits Payable Survey and Trending Analysis Procedures

I. SUMMARY OF CHANGES: This instruction is a manualization of annual instructions distributed via a Joint Signature memorandum (JSM/TDL 06470, 5-26-06) to submit benefits payable data on the Benefits Payable survey and contains new instructions that provides detail instructions for Medicare contractors to complete trending procedures on the benefits payable balances (i.e. claims on the payment floor, periodic interim payment (PIP), and outstanding checks) reported on the annual Benefits Payable survey.

NEW / REVISED MATERIAL

EFFECTIVE DATE: *September 30, 2006

IMPLEMENTATION DATE: September 30, 2006

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	5/Table of Contents
N	5/400.23/Exhibit 23 - Instructions for Benefits Payable Survey
N	5/400.24/Exhibit 24 - Benefits Payable Trending Analysis Procedures

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-06	Transmittal: 105	Date: August 25, 2006	Change Request 5130
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SUBJECT: Benefits Payable Survey and Trending Analysis Procedures

I. GENERAL INFORMATION

A. Background: This instruction is a manualization of annual instructions distributed via an annual Joint Signature Memorandum (JSM-05359, 05-23-05) to submit benefits payable data on the Benefits Payable survey and contains new instructions that provides detail instructions for Medicare contractors to complete trend analysis on the benefits payable balances (i.e. claims on the payment floor, periodic interim payment (PIP), and outstanding checks) reported on the annual Benefits Payable survey.

B. Policy: This transmittal will provide new instructions requiring Medicare contractors to complete trend analysis at year end on the benefits payable balances reported on the annual Benefits Payable survey. This requirement will provide CMS with reasonable assurance that reported balances are accurate and acceptable for inclusion in the calculation of the Medicare Incurred But Not Reported (IBNR) year-end estimate.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)							
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers			
					F I S S	M C S	V M S	C W F	
5130.1	Fiscal intermediaries shall provide the value of the first periodic interim payment (PIP) cycle paid in the ensuing month for the end of the month being reviewed on the Benefits Payable Survey – Attachment I	X							
5130.1.1	If the PIP payment cycle has not been run, fiscal intermediaries shall provide an estimate of the amount and are not to include pass through costs.	X							

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other DME MAC
						F I S S	M C S	V M S	C W F	
5130.2	Fiscal intermediaries that submit financial data via the Contractor Administrative, Budget and Financial Management (CAFM) system shall obtain the PIP amount from their shared system.	X								
5130.3	Fiscal intermediaries that submit financial data via HIGLAS shall obtain the PIP amount from their 810 interface report.	X								
5130.4	Medicare contractors shall provide the claims on the payment floor amount for both Health Insurance (HI) and Supplemental Medical Insurance (SMI), if applicable, on the Benefits Payable Survey – Attachment I, II, and/or III.	X		X	X					X
5130.5	Medicare contractors that submit financial data via CAFM shall obtain the claims on the payment floor amount from their shared system.	X		X	X					X
5130.5.1	Medicare contractors shall ensure that the amount reported on the survey for claims on the payment floor agrees to the amount reported on the year end Form CMS-750A and/or 750B, Statement of Financial Position.	X		X	X					X
5130.6	Medicare contractors that submit financial data via HIGLAS shall obtain the claims on the payment floor amount from their Summary 2 Trial Balance, GL account 216002, Entitlement Benefit Due/Payable – Adjudicated Claims.	X		X	X					X
5130.7	Medicare contractors that submit financial data via CAFM shall provide the amount of claims on hold for both HI and SMI, if applicable, on the Benefits Payable Survey – Attachment I, II, and/or III.	X		X	X					X
5130.8	Medicare contractors that submit financial data via CAFM shall obtain the claims on hold amount from their shared system.	X		X	X					X

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other DME MAC
						F I S S	M C S	V M S	C W F	
5130.8.1	Medicare contractors shall ensure that the amount reported on the survey for claims on hold reconciles to the applicable portion reported in the Other Liabilities (footnote) line of the year end Form CMS-750A and/or 750B, Statement of Financial Position.	X		X	X					X
5130.9	Medicare contractors shall provide the amount of outstanding checks and EFT payments for both HI and SMI, if applicable, on the Benefits Payable Survey – Attachment I, II, and/or III.	X		X	X					X
5130.10	Medicare contractors that submit financial data via CAFM shall obtain the outstanding check amount from their banking institution or internally generated documentation.	X		X	X					X
5130.10.1	Medicare contractors shall ensure that the amount reported on the survey for outstanding checks reconciles to the September Form CMS-1522, Monthly Contractor Financial Report.	X		X	X					X
5130.11	Medicare contractors that submit financial data via HIGLAS shall obtain the outstanding check amount from their Summary 2 Trial Balance, GL account 212001, Accounts Payable Disbursements in Transit.	X		X	X					X
5130.12	Medicare contractors shall provide the amount of Physician Scarcity Area (PSA) payments for both HI and SMI, if applicable, on the Benefits Payable Survey – Attachment I, II, and/or III.	X		X	X					X
5130.12.1	Medicare contractors shall provide the amount of Health Professional Shortage Area payments (HPSA) for both HI and SMI, if applicable, on the Benefits Payable Survey – Attachment I, II, and/or III.	X		X	X					X
5130.13	Medicare contractors that submit financial data via CAFM shall obtain the PSA and HPSA amounts from their shared system.	X		X	X					X

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other DME MAC
						F I S S	M C S	V M S	C W F	
5130.13.1	If the PSA/HPSA payments were disbursed on or before the last day of the quarter, Medicare contractors shall report an amount of zero on the survey.	X		X	X					X
5130.13.2	If the PSA/HPSA payments were disbursed on or after the first day of the quarter, Medicare contractors shall report the amount of payments made on the survey.	X		X	X					X
5130.14	Carriers shall provide a HPSA/PSA amount no later than 12:00 pm on October 9, 2006 or earlier if possible.			X						
5130.14.1	If the HPSA/PSA amount is not accurate because the HBSR0124 report has not been run or manual reconciliations/adjustments have not been completed, the carriers shall submit revised numbers by 12:00 pm on October 18, 2006.			X						
5130.14.2	If the carriers anticipate submitting a revised number, the carriers shall disclose that fact when submitting the original amount due on October 9, 2006.			X						
5130.15	Medicare contractors that submit financial data via HIGLAS shall obtain the PSA/HPSA amounts from their 810H file.	X		X	X					X
5130.15.1	If the PSA/HPSA payments were disbursed on or before the last day of the quarter, Medicare contractors shall report an amount of zero on the survey.	X		X	X					X
5130.15.2	If the PSA/HPSA payments were disbursed on or after the first day of the quarter, Medicare contractors shall report the amount of payments made on the survey.	X		X	X					X

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other DME MAC
						F I S S	M C S	V M S	C W F	
5130.18.3	Medicare contractors that submit financial data via HIGLAS shall also provide a footnote to disclose whether the reported TOPs amounts are included in the GL account 216002, Entitlement Benefit Due/Payable – Adjudicated Claims.	X								
5130.19	Medicare contractors shall submit their Time Account balances as of September 30, FY end as part of the Benefits Payable Survey - Attachment IV.	X		X	X					X
5130.20	Fiscal intermediaries shall prorate their Time Account balances as of September 30, FY end between HI and SMI on the Benefits Payable Survey – Attachment IV.	X								
5130.21	Medicare contractors shall submit the Benefits Payable Survey (Attachments I, II, and/or III) and the Time Account Balance information (Attachment IV) by the due date provided in the annual Joint Signature Memorandum outlining the accelerated financial reporting timeframes for FY end.	X		X	X					X
5130.22	Medicare contractors shall compare the value reported on the current FY Benefits Payable survey for (1) the value of the first PIP cycle paid in the ensuing month for the end of the month being reviewed; (2) the claims on the payment floor; and (3) the outstanding check balance to the amount reported on the prior FY’s Benefits Payable survey and calculate the dollar and percentage difference for each item.	X		X	X					X
5130.23	Medicare contractors shall record the calculated dollar and percentage differences for the PIP, claims on the payment floor, and outstanding checks in Exhibit 24 - Attachment I (for Part A), Attachment II (for Part B of A) and/or Attachment III (for Part B).	X		X	X					X

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other DME MAC
						F I S S	M C S	V M S	C W F	
5130.24	Medicare contractors shall verify that the dollar amounts for the PIP, claims on the payment floor, and outstanding checks are supported by lead schedules and/or detailed documentation.	X		X	X					X
5130.25	Medicare contractors shall correct any errors or misstatements identified in 5130.23 prior to the submission of the CMS-750 and the CMS-1522 reports and/or CMS Balance Sheet, CMS Income Statements and CMS Summary Trial 2 Balance.	X		X	X					X
5130.26	Fiscal intermediaries shall provide explanations for Periodic Interim Payment dollar amount changes that are at least +/- \$2 million dollars or equates to a 100 percentage change on Exhibit 24 - Attachment I and/or II.	X								
5130.27	Medicare contractors shall provide explanations for claims on the payment floor dollar amount changes that are at least +/- \$10 million dollars or equates to a 100 percentage change on Exhibit 24 - Attachment on I, II, and /or III.	X		X	X					X
5130.28	Medicare contractors shall provide explanations for outstanding check dollar amount changes that are at least +/- \$3 million dollars or equates to a 100 percentage change on Exhibit 24 - Attachment I, II, and/or III.	X		X	X					X
5130.29	Medicare contractors shall document all explanations required in 5130.6 through 5130.8 on Exhibit 24, Attachment IV – CMS Medicare Benefits Payable Trending Analysis Summary Memorandum.	X		X	X					X
5130.30	Medicare contractors shall have the CFO of Medicare Operations submit via email Attachments I, II, III, and IV to the Division of Financial Reporting and Policy (DFRP) contact identified in the annual JSM outlining the accelerated financial reporting timeframes for current FY financial reports.	X		X	X					X

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: An additional workload is associated with the new requirements for completing trend analysis at year end for benefits payable balances (i.e. claims on the payment floor, PIP, and outstanding checks) reported on the annual Benefits Payable survey.

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: September 30, 2006 Implementation Date: September 30, 2006 Pre-Implementation Contact(s): Linda Nash (410) 786-4166 Post-Implementation Contact(s): Linda Nash (410) 786-4166	No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.
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*Unless otherwise specified, the effective date is the date of service.

Attachments

CMS MEDICARE BENEFITS PAYABLE (Part A)
 CONTRACTOR ABC
 (PRINCIPAL)

Attachment I

SOURCE: H750A and 1522

SCOPE:

1st PIP cycle payment in the ensuing month: If dollar amount is at least +/- \$2 million or equates to a 100 percentage change.

claims on the payment floor: If dollar amount change is at least +/- \$10 million or equates to a 100 percentage change.

outstanding checks: If dollar amount change is at least +/- \$3 million or equates to a 100 percentage change.

	A	B	(A - B) C	(C/B) x 100% D	
	09/30/06	09/30/05	\$ Change	% Change	Note
1st PIP cycle payment	710,538	3,404,000	(2,693,462)	-79.13%	(1)
Claims on the payment floor	68,110,000	52,843,000	15,267,000	28.89%	(2)
Outstanding checks	58,238,000.00	56,750,000.00	1,488,000	2.62%	NER

NER - No explanation required

(1) PIP decreased by \$2.6 million due to the termination of one of their two PIP providers during FY 2006.

(2) Claims on the payment floor increased by \$15.2 million because in March 2005, the contractor changed their payment cycles from daily to once a week thus increasing the payment floor.

CMS MEDICARE BENEFITS PAYABLE (Part B of A)
 CONTRACTOR ABC
 (PRINCIPAL)

Attachment II

SOURCE: H750B of A and 1522

SCOPE:

claims on the payment floor: If dollar amount change is at least +/- \$10 million or equates to a 100 percentage change.

outstanding checks: If dollar amount change is at least +/- \$3 million or equates to a 100 percentage change.

	A	B	(A - B) C	(C/B) x 100% D	
	09/30/06	09/30/05	\$ Change	% Change	Note
Claims on the payment floor	94,635,000	76,106,000	18,529,000	24.35%	(1)
Outstanding checks	12,950,000.00	-	12,950,000	100.00%	(2)

NER - No explanation required

(1) Claims on the payment floor increased by \$18 million because the FY 2006 data includes one extra day of claims on the payment floor compared to FY 2005.

(2) Outstanding checks increased by \$12.9 million due to the fact that the workload from Contractor CYA transitioned to us as of 11/01/05.

CMS MEDICARE BENEFITS PAYABLE (PART B)
 CONTRACTOR ABC
 (PRINCIPAL)

Attachment III

SOURCE: H750B and 1522

SCOPE:

claims on the payment floor: If dollar amount change is at least +/- \$10 million or equates to a 100 percentage change.

outstanding checks: If dollar amount change is at least +/- \$3 million or equates to a 100 percentage change.

	A	B	(A - B) C	(C/B) x 100% D	
	09/30/06	09/30/05	\$ Change	% Change	Note
Claims on the payment floor	115,748,000	94,187,500	21,560,500	22.89%	(1)
Outstanding checks	250,050,000	220,292,000	29,758,000	13.51%	(2)

NER - No explanation required

(1) Claims on the payment floor increased by \$21.5 million due to a higher inventory of claims on the payment floor. At month end Sept. 2005, the volume of claims on the payment floor was 1,095,900 with an average payment per claim of \$75.40. At month end Sept. 2006, the volume of claims on the payment floor was 1,330,412 with an average payment per claim of \$77.75.

(2) Outstanding checks increased by \$29.7 million primarily because of \$28 million increase in Medicare payments issued in the month of September 2006 vs. September 2005.

Attachment IV – CMS Medicare Benefits Payable Trending Analysis

CMS Medicare Benefits Payable
Trend Analysis – Contractor ABC
For Year Ending _____

The following represents the summary for the changes in benefits payable data for the current fiscal year (FY). The following descriptions outline the underlying reasons for the changes in the IBNR balances:

Current FY to Prior FY (9/06 versus 9/05) – PART A

- 1 - PIP decreased by \$2.6 million due to the termination of one of their two PIP providers during FY 2006.
- 2 - Claims on the payment floor increased by \$15.2 million because in March 2005, the contractor changed their payment cycles from daily to once a week thus increasing the payment floor.

Current FY to Prior FY (9/06 versus 9/05) – PART B of A

- 1 - Claims on the payment floor increased by \$18 million because the FY 2006 data includes one extra day of claims on the payment floor compared to FY 2005.
- 2 - The increase in outstanding checks is due to the fact that EFTs do not clear HIGLAS for two business days. In the FISS environment, EFTs cleared immediately.

Current FY to Prior FY (9/06 versus 9/05) – PART B

- 1 - Claims on the payment floor increased by \$21.5 million due to a higher inventory of claims on the payment floor. At month end Sept. 2005, the volume of claims on the payment floor was 1,095,900 with an average payment per claim of \$75.40. At month end Sept 2006, the volume of claims on the payment floor was 1,330,412 with an average payment per claim of \$77.75.
- 2 - Outstanding checks increased by \$29.7 million primarily because of \$28 million increase in Medicare payments issued in the month of September 2006 vs. September 2005.

Prepared by: _____

CFO for Medicare Operations approval: _____

Medicare Financial Management Manual

Chapter 5 - Financial Reporting

Table of Contents (Rev.105, 08-25-06)

- 400.23 – Exhibit 23 – Instructions for the Benefits Payable Survey*
- 400.24 – Exhibit 24 – Benefits Payable Trending Analysis Procedures*

400.23 – Exhibit 23 – Instructions for the Benefits Payable Survey ***(Rev. 105, Issued: 08-25-06, Effective/Implementation: 09-30-06)***

CMS is required to prepare fiscal year financial statements in accordance the Office of Management and Budget's (OMB's) accelerated mandated schedule. In order to meet the accelerated timeframes, CMS requests specific contractor financial data for the preparation and audit of CMS' annual financial statements.

For inclusion in the year-end CMS financial statements, the Office of the Actuary (OACT) prepares the Medicare Incurred But Not Reported (IBNR) estimate which is based on actuarial estimates. Due to the complexity of the actuarial estimate and the availability of data, OACT prepares this estimate for yearend statements only. The Medicare IBNR estimate represents the amount of CMS claims incurred but not yet paid at the end of the fiscal year (FY) and is a summation of five different components:

- (1) the incurred to approval of payment amount – represents Medicare Services provided, for which, a corresponding claim has not been approved for payment and also is referred to as the incurred to approved amount;*
- (2) the retroactive settlements on cost reports amount – represents the estimated net liability for cost reports awaiting final settlement and is also referred to as the cost settlement amount;*
- (3) the approval to actual payment amount – represents the aggregate claims approved for payment, for which, the corresponding reimbursement has not been issued and is also referred to as the approved to paid amount;*
- (4) the paid to cleared amount – represents the aggregate claims for which checks have been issued, but have not cleared the Medicare contractor's financial institution and is also referred to as the outstanding checks amount; and*
- (5) the advance payments under Periodic Interim Payment (PIP) amount – represents the bi-weekly payments for estimated benefit payments for plans under such a payment plan and is also referred to as the PIP amount.*

The data required for items (3) through (5) is obtained directly from the Medicare contractors and is submitted via the Benefits Payable survey (Attachment I, II, and/or III). Typically, the survey is sent to the Medicare contractors in May or June of the current FY.

Due to the on-going transition to the Healthcare Integrated General Ledger Accounting System (HIGLAS) by the Medicare contractors, the data elements on the survey which are required for submission have been revised. Instructions for each data element on the attachments are discussed below.

- 1) *PIP – value of the first periodic interim payment (PIP) cycle paid in the ensuing month for the end of the month being reviewed. (**Fiscal intermediaries ONLY**)*

CAFM contractors should continue to utilize their shared system to obtain this amount. If the payment cycle has not been run, please provide an estimate of this amount. Do not include pass through costs.

HIGLAS contractors should obtain this amount from their 810 interface report. If the payment cycle has not been run, please provide an estimate of this amount. Do not include pass through costs.

- 2) *Claims on the payment floor – Adjudicated claims not yet paid for both Health Insurance (HI) and Supplemental Medical Insurance (SMI), if applicable.*

CAFM contractors should continue to utilize their shared system to obtain this amount. The amount reported on the survey must agree to the amount reported on the year-end Form CMS-750A and/or 750B, Statement of Financial Position.

HIGLAS contractors should obtain this amount from their Summary 2 Trial Balance, GL account 216002, Entitlement Benefit Due/Payable – Adjudicated Claims.

- 3) *Claims on Hold – This amount would include claims held resulting from Do Not Forward, providers being investigated for fraud, claims payments due to bankrupt providers. This amount does not include the amount for claims withheld for non-receipt of cost reports. Amounts must be provided for both HI and SMI, if applicable. (**CAFM Contractors only**).*

CAFM contractors should obtain this amount from their shared system. The amount reported on this survey must agree to the applicable portion reported on the Other Liabilities (footnote) line of the year end Form CMS-750, Statement of Financial Position. The amount should include claims held in accordance with CR 5047, Hold on Medicare Payments.

- 4) *Outstanding Checks – The amount of checks and EFT payments that have been issued, but have not cleared the Medicare contractor's banking institution. Amounts must be provided for both HI and SMI, if applicable.*

CAFM contractors should obtain this amount from their banking institution or internally generated documentation. The amount reported on the survey must agree to outstanding check amount reported on the September 1522, Monthly Contractor Financial Report.

HIGLAS contractors should obtain this amount from their Summary 2 Trial Balance, GL account 212001 - Accounts Payable Disbursements in Transit.

- 5) *Health Professional Shortage Area payments (HPSA) – the bonus amount paid to physicians for eligible services rendered in zip code areas that fall fully within a designated HPSA area or are dominant to the area based on a determination by the U.S. Postal Service **and/or**;*

*Physician Scarcity Area (PSA) – the bonus amount paid to the primary care and specialty physicians providing eligible services in the counties with the lowest 20% ratio of primary care or specialty physicians to Medicare beneficiaries **and/or**;*

*Transitional Outpatient Payments (TOPs) - the amount paid to rural hospitals having 100 or fewer beds that are not classified as a sole community hospital. **(Fiscal intermediaries ONLY)***

If PSA/HPSA and/or TOPs payments were disbursed on or before the last day of the quarter/month, enter amount as zero. If PSA/HPSA and/or TOPs payments are disbursed on or after the first day of the quarter/month, provide the amount of the payments. Contractors must provide these amounts for both HI and SMI, if applicable.

CAFM contractors should obtain this information from their shared system, if applicable.

HIGLAS contractors should obtain these amounts from their 810H and 810 files, if applicable. HIGLAS contractors should also provide a footnote to disclose whether the amounts indicated for these payments are included in GL account 216002, Entitlement Benefit Due/Payable – Adjudicated Claims.

Time Account Balances (Attachment IV)

The CMS reports the aggregate total Part A and total Part B Time Account balances as Medicare trust fund “Cash and Other Monetary Assets” on the balance sheet in its annual CMS Financial Report. Previously, these account balances were obtained from the Form CMS-750 reports; however, the year-end 750 due date is typically extended until after annual financial statements must be completed. Therefore, time account balances as of September 30, FY end, must be submitted as part of the attached Benefits

Payable Survey – Attachment IV. Fiscal intermediaries should prorate their time account balances between HI and SMI.

Due Dates

The annual Joint Signature Memorandum outlining the accelerated financial reporting timeframes for FY end Medicare contractor financial reports will provide the due date for the Benefits Payable Survey (Attachments I, II and/or III) as well as the Time Account Balance information (Attachment IV).

Contractor No. _____ **HI BENEFITS PAYABLE SURVEY**

INTERMEDIARY For Period Ending: **September 30, 20xx**

1. *PIP Providers*

Value of the First PIP Cycle Paid in the ensuing month for the end of the month being reviewed. (If the payment cycle has not been run, please provide an estimate of this amount. Do not include Pass Through Costs.) _____

NOTE: HIGLAS contractors should obtain this amount from their 810 interface file.

2. *Claims on the Payment Floor (in dollars)* _____

(CAFM Contractors – Amount must agree to amount reported on the September Form CMS-750)

NOTE: HIGLAS contractors should obtain this amount from their Summary 2 Trial Balance GL account 216002, Entitlement Benefit Due/Payable – Adjudicated Claims.

3. *Claims on Hold (in dollars) – CAFM contractors ONLY* _____

(Amount should be obtained from the Other Liabilities line on the Form CMS-751)

4. *Outstanding Checks (in dollars)* _____

(Amount must include outstanding EFTs and agree to the outstanding check amount on the September Form CMS-1522)

NOTE: HIGLAS contractors should obtain this amount from their Summary 2 Trial Balance GL account 212001, Accounts Payable Disbursements in Transit.

5. *PSA/HPSA/TOPS payments (in dollars)* _____

(If payments were disbursed on or before the last day of the quarter/month, enter amount as zero. If payments are disbursed after the 1st day of the quarter/month, provide the amount of the payments)

NOTE: HIGLAS contractors should obtain these amounts from their 810H and 810 files, if applicable. HIGLAS contractors should also provide a footnote to disclose whether the amounts indicated for these payments are included in GL account 216002, Entitlement Benefit Due/Payable – Adjudicated Claims

Contractor No. _____ **SMI BENEFITS PAYABLE SURVEY**

INTERMEDIARY For Period Ending: **September 30, 20xx**

1. *Claims on the Payment Floor (in dollars)* _____
(CAFM Contractors – Amount must agree to amount reported on the September Form CMS-750)

NOTE: HIGLAS contractors should obtain this amount from their Summary 2 Trial Balance GL account 216002, Entitlement Benefit Due/Payable – Adjudicated Claims.

2. *Claims on Hold (in dollars) – CAFM contractors ONLY* _____
(Amount should be obtained from the Other Liabilities line on the Form CMS-751)

3. *Outstanding Checks (in dollars)* _____
(Amount must include outstanding EFTs and agree to the outstanding check amount on the September Form CMS-1522)

NOTE: HIGLAS contractors should obtain this amount from their Summary 2 Trial Balance GL account 212001, Accounts Payable Disbursements in Transit.

4. *PSA/HPSA/TOPS payments (in dollars)* _____
(If payments were disbursed on or before the last day of the quarter/month, enter amount as zero. If payments are disbursed after the 1st day of the quarter/month, provide the amount of the payments)

NOTE: HIGLAS contractors should obtain these amounts from their 810H and 810 files, if applicable. HIGLAS contractors should also provide a footnote to disclose whether the amounts indicated for these payments are included in GL account 216002, Entitlement Benefit Due/Payable – Adjudicated Claims

Contractor No. _____ **BENEFITS PAYABLE SURVEY**

CARRIER **For Period Ending: September 30, 20xx**

1. *Claims on the Payment Floor (in dollars)* _____
(CAFM Contractors – Amount must agree to amount reported on the September Form CMS-750)

NOTE: HIGLAS contractors should obtain this amount from their Summary 2 Trial Balance GL account 216002, Entitlement Benefit Due/Payable – Adjudicated Claims.

2. *Claims on Hold (in dollars) – CAFM contractors ONLY* _____
(Amount should be obtained from the Other Liabilities line on the Form CMS-751)

3. *Outstanding Checks (in dollars)* _____
(Amount must include outstanding EFTs and agree to the outstanding check amount on the September Form CMS-1522)

NOTE: HIGLAS contractors should obtain this amount from their Summary 2 Trial Balance GL account 212001, Accounts Payable Disbursements in Transit.

4. *PSA/HPSA payments (in dollars)* _____
(If payments were disbursed on or before the last day of the quarter, enter amount as zero. If payments are disbursed after the 1st day of the quarter, provide the amount of the payments)

NOTE: HIGLAS contractors should obtain these amounts from their 810H and 810 files, if applicable. HIGLAS contractors should also provide a footnote to disclose whether the amounts indicated for these payments are included in GL account 216002, Entitlement Benefit Due/Payable – Adjudicated Claims

FEDERAL HEALTH INSURANCE TIME ACCOUNT

Contractor No. _____

INTERMEDIARY **For Period Ending: September 30, 20xx**

Part A Balance (in dollars) _____

Part B Balance (in dollars): _____

**FEDERAL SUPPLEMENTARY MEDICAL INSURANCE
TIME ACCOUNT**

Contractor No. _____

CARRIER **For Period Ending: September 30, 20xx**

Part B Balance (in dollars) _____

400.24 - Exhibit 24 – Benefits Payable Trending Analysis Procedures
(Rev. 105, Issued: 08-25-06, Effective/Implementation: 09-30-06)

Objective

To ensure that benefit payable balances reported on the survey are reasonable, Medicare contractors are required to perform trending procedures. Trending procedures can be used as an important tool to identify potential errors, omissions, system weaknesses, or inappropriate patterns of adjustments or accumulation. Trending procedures involve comparisons of current fiscal year (FY) benefit payable data to prior year benefit payable data submitted on the Benefits Payable surveys.

Compare Current Year Amounts with Comparative Financial Data

In comparing current-period financial results with prior-period financial results, there is an implied assumption that the volume of activity in the two periods is comparable. If there has been a substantial change in volume, it is necessary to take this change into account and to quantify the change, when making the comparisons. For example, if a contractor's PIP balance has increased by 10 percent, it is necessary to determine and document the reason for the increase. The increase may be the result of new PIP providers or increased settlement activity.

Understand Identified Variances and Document the Results

Medicare contractors must identify and provide an explanation for variances that meet the thresholds outlined in these procedures. If an explanation does not adequately describe the variance, the Medicare contractors must perform additional procedures such as a review of detail transactions to identify the underlying cause(s) of any unusual changes.

The causes for the variances should be quantified. For example, if the change was attributable to a change in the number of claim cycles, then include the number of additional claims on the payment floor attributed to the additional cycles as well as the reason why additional cycles were added.

Methodology

The primary reason for performing trend analysis is to focus on the change in the ending balances of PIP, claims on the payment floor, and outstanding checks. All explanations should be available for review by CMS, Office of the Inspector General, Government Accountability Office and /or other related parties.

Each Medicare contractor must perform the following steps on a year end basis, beginning with FY ending September 30, 2006. The CFO for Medicare Operations' must submit the explanations via email as evidence that he/she has reviewed the trending

explanations. To properly apply trending procedures, it is necessary to complete the following steps:

Benefits Payable Trending Analysis Procedures for FIs and carriers

Step (1)

Compare the value of the first PIP cycle paid in the ensuing month for the end of the month being reviewed, the claims on the payment floor amount, and the outstanding check amount reported on the current FY's Benefits Payable survey to the same line items reported on the prior year's Benefits Payable survey (i.e. 9/30/06 vs. 9/30/05) for all lines of business applicable to each contractor number. Calculate the dollar and percentage difference for each item. (See Attachments I, II, and III for the required formats).

NOTE: Trending on the amount of Claims on hold and Physician Scarcity Area (PSA) payments, Health Professional Shortage Area (HPSA) payments, and Transitional Outpatient Payments (TOPs) will not be required until FY 2007.

Step (2)

Verify that the dollar amount for each item is supported by lead schedules and/or detailed documentation. Any errors or misstatements identified as a result of this analysis must be corrected prior to the submission of the Form CMS-750 report, the Form CMS-1522 report and/or CMS Balance Sheet, CMS Income Statements and CMS Summary 2 Trial Balance.

Step (3)

PIP (for FIs only)

Provide explanations where the dollar amount change is at least +/- \$2 million or equates to a 100 percentage change.

Claims on the payment floor

Provide explanations where the dollar amount change is at least +/- \$10 million or equates to a 100 percentage change.

Outstanding checks

Provide explanations where the dollar amount change is at least +/- \$3 million or equates to a 100 percentage change.

Step (4)

Document conclusions in a summary memorandum (See Attachment IV) to be included with Attachments I, II, and III and provide to the CFO for Medicare Operations for submission to CMS.

Due Date

The analysis must be submitted by the CFO of Medicare Operations via email to the Division of Financial Reporting and Policy (DFRP) contact identified in the Joint Signature Memorandum outlining the accelerated financial reporting timeframes for Medicare contractor financial reports and is due the day following the submission of the Benefits Payable Survey by 8:00 pm Eastern Daylight Time. If a copy of the analysis is signed by the CFO, scanned, and attached to the email sent to the DFRP contact, the CFO is not required to send the email directly. If this date occurs on a holiday or a weekend, the analysis must still be submitted by this due date. Please notify the DFRP contact if a problem arises.

The DFRP contact will review the summary memorandums and the analysis schedules and may request additional explanations and/or documentation to support the Medicare contractors' analysis schedules. The DFRP contact will contact the Medicare contractor by phone to request any additional documentation needed to support existing variances. A response is requested as soon as possible, but no later than two days from the day of request.