CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 264	**Date: February 12, 2016**
	Change Request 9423

SUBJECT: Extended Repayment Schedule (ERS) Manual Updates

I. SUMMARY OF CHANGES: This Change Request (CR) includes updates and clarification to the ERS process that enhances management and procedure efficiency. It also updates policy language and standard practice found in Pub. 100-06, Chapter 4, Section 50.

EFFECTIVE DATE: March 14, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 14, 2016

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/revised 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	4/50/Establishing an Extended Repayment Schedule (ERS) - (formerly known as an Extended Repayment Plan (ERP)
R	4/50.1/ERS Required Documentation – Physician is a Sole Proprietor
R	4,50.2/ERS Required Documentation – Provider is an Entity Other Than a Sole Proprietor

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-06	Transmittal: 264	Date: February 12, 2016	Change Request: 9423

SUBJECT: Extended Repayment Schedule (ERS) Manual Updates

EFFECTIVE DATE: March 14, 2016*Unless otherwise specified, the effective date is the date of service.*
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I. GENERAL INFORMATION

A. Background: Overpayments are Medicare payments to a provider that are in excess of amounts due and payable under the statute and regulations. When an overpayment is determined, a demand letter is sent requesting repayment. A provider is expected to repay any overpayment promptly. If repaying an overpayment within 30 days would constitute a "hardship" for the provider, the provider may request an ERS at any time the overpayment is outstanding. Contractors and/or Regional Office staff shall review the request to determine if extending a repayment schedule is justified.

B. Policy: This CR clarifies, updates, and includes new instructions to chapter 4, sections 50 through 50.2.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9423.1	Contractors shall take any actions necessary to implement the attached instructions, primarily by ensuring that ERS requests are handled timely and all attached instructions are completed.	X	X	X	X					
9423.2	Contractors shall consider additional factors when reviewing an ERS request in addition to the hardship requirement.	X	X	X	X					
9423.3	Contractors shall consider a provider in default if they miss one (1) ERS payment (30 days past due date).	X	X	X	X					
9423.4	Contractors shall not offer an ERS for less than 6 months.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Theresa Carter, 410-786-7482 or theresa.carter@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Financial Management Manual
Chapter 4 - Debt Collection

50 - Establishing an Extended Repayment Schedule (ERS) - (formerly known as an Extended Repayment Plan (ERP)

(Rev.264, Issued: 02-12-16, Effective: 03-14, 16, Implementation: 03-14-16)

For purposes of these instructions, the term Provider, Physician and other Supplier will be referred to as "Provider".

For purposes of these instructions, the term Medicare Contractor will be referred to as "Contractor".

For the purposes of these instructions, the following definitions apply; See 42 C.F.R. § 401.607(c)(2) *and* (3):

Hardship exists when the total amount of all outstanding overpayments (principal and interest) not included in an approved, existing repayment schedule is 10 percent or greater than the total Medicare payments made for *1)* the cost reporting period covered by the most recently submitted cost report or *2)* the previous calendar year for a non-cost report provider *(see below 'additional factors to consider' when determining eligibility)*.

Extreme hardship exists when a provider qualifies as being in "hardship" as defined in the previous paragraph and a 36 month to 60 month extended repayment schedule (ERS) is *deemed eligible for approval consideration* by Medicare.

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Additional Factors to Consider:

The contractor shall evaluate the request based on the definitions written above in conjunction with the requirements found in sections 50-50.3 of this chapter. For a provider whose situation does not meet the definitions written above, the contractor shall evaluate the ERS request based on the requirements found in sections 50-50.3 of this chapter and consider the information in (i) – (iii) below, when deciding whether to grant an ERS.

The contractor shall determine the number, amount, and frequency of installment payments based on the information submitted by the debtor and on other factors such as:

(i) Total amount of the claim (overpayment);

(ii) Provider's ability to pay; and

(iii) Cost to CMS of administering an installment agreement.

The contractor shall document evaluation factors, including communication with CMS, used during the decision making process.

A provider is expected to repay any overpayment promptly. If repaying an overpayment within 30 days would constitute a "hardship" on the provider, a request for an ERS should be submitted immediately. However, *if the overpayment is outstanding and not referred to Treasury*, the provider may request an ERS *beyond 30 days*, and the contractor shall review that request. Instructions on how to apply for an ERS shall

be available on the contractors' websites for provider reference. Medicare demand letters shall refer providers to the contractors' website for detailed ERS instructions. *Contractors shall include in the ERS instructions a form in which the provider can elect to have their underpayments or manual refunds automatically applied to their overpayment (see section B below).* Providers shall be given the option to request a paper copy.

A. The following steps shall be implemented upon receipt of an ERS:

1. A provider shall submit a signed *ERS* request *which* include*s*:

    i. *the specific overpayment for which an ERS is being requested,*
    ii. *the number of months requested,*
    iii. *CMS required documents (see sections 50.1-50.2),*
    iv. *and a good faith payment equaling one month's payment of the providers requested terms with its request (ex. 36 month request = 1/36th minimum).*

    This is what constitutes a complete ERS.

2. Contractors shall evaluate *all* provider*s' request for an extended* repayment schedule *up to 60 months but shall only approve/disapprove ERS requests* of at least 6 months up to 36 months.

3. *Contractors shall refer ERS requests over 36 months (or an ERS that may need RO guidance) that are determined as eligible to their CMS Regional Office (RO), along with a recommendation. Contractors may not send request to the RO if they determine:*

    i. *that a providers request over 36 months is ineligible for approval due to not meeting the hardship criteria, or*
    ii. *the terms should be reduced less than 36 months, due to not meeting the extreme hardship criteria.*

4. *The RO* shall evaluate *and approve/disapprove* ERS requests up to 60 months (see 42 CFR 401-607(c)(2)(vi)).

5. CMS Central Office (CO) *may* evaluate ERS requests as needed or requested *by the RO.*

6. All ERS requests shall be reviewed and evaluated *for approval, disapproval, or referral to RO/CO* within 30 days of receipt of the complete request.

7. Providers may request a 6 month ERS without submit*ting financial documentation if they* meet the *hardship* qualifications *and* does not fall within a scenario found in section 50.3(1).

8. The Provider shall submit financial documentation *for ERS request longer than 6 months.*

9. The contractor *or RO* shall determine eligibility qualifications and the duration of the ERS based on its review of the provider's documentation *and any other information acquired (such as fraud information, claims data, overpayment history, etc.)*.

10. If an ERS is approved and a provider misses *one* installment payment *the provider is in default (refer to 42 CFR §401.613(2)(v)). The payment is considered missed if not received within 30 days after the payment due date. The contractor shall send a notice of default to the provider within 5 business days, suspend the ERS agreement, and immediately resume normal debt collection procedures.*

11. The contractor shall *consider a providers' request to reinstate the ERS, even after default. If*

reinstated, the provider may be required to submit new documentation to determine eligibility. The contractor shall determine to reinstate the original ERS agreement or revise the schedule, if approved. If revised, the contractor shall ensure that the revised terms does not extend the original and revised schedule beyond 60 months. The ERS will be closed with no reopening, if the provider were to default again on the reinstated request.

B. The following steps *shall be implemented* when reviewing and establishing an ERS:

1. *If a complete ERS request and a good faith check payment (see note a. below) are received, the contractor shall start reviewing the request immediately. The contractor shall accept the good faith payment(s) and suspend any recoupment during the review of the ERS.*

2. *Contractors shall review the complete ERS package to make a final decision within 30 business days of receipt. If the contractor needs additional time to review an ERS request, it shall work with their RO to determine a reasonable timeframe to complete.*

3. *If an ERS request is received with all documentation but no good faith payment (see note a. below) the contractor shall immediately place the provider on 30% recoupment during the review of the ERS.*

4. *If an incomplete ERS request is received the contractor shall review the submitted documentation, determine and request all missing documents, and immediately place the provider on no less than 30% recoupment. If the contractor requests additional documentation and the information is not received by the 16th day after the letter date, the contractor should close the request and resume collect activities.*

5. *Contractors shall review the ERS documents in detail to determine if there are any other documents needed. If additional documents are needed the contractors shall request additional documentation. The contractor should extend an additional 15 calendar days to receive the documentation from the provider before closing the request. Upon receipt, the contractor shall complete its review of the additional documentation within 5 business days. The contractor shall ensure that requesting additional documentation will not unnecessarily extend the decision making period. If the contractor needs additional time to conduct the review they shall work with their RO to determine a reasonable timeframe to complete.*

6. Contractors shall review and forward all ERS requests *that they recommend to the RO* for approval within 30 days of receiving a complete ERS request.

7. Contractors shall **NOT** refund any payments *received or recouped* that occurred while processing an ERS, but shall apply such amount(s) to the outstanding overpayment(s) *(apply to interest first then principal), unless CMS directs otherwise.*

8. If *the ERS request is* approved, the contractor shall establish an ERS to recover *the* remaining balance of an overpayment.

9. *Pre-accrued interest shall be recovered first before applying any payments to principal. Pre-accrued interest can either be recovered in one lump sum or over multiple months (not to exceed 3 months, unless directed by CMS), depending on a provider's ability to pay in full or over time.*

10. *Contractors shall ensure that interest continues to accrue on the overpayment until it is paid in full. While recovering the pre-accrued interest amounts, the contractor shall also recover the interest that continues to accrue on the outstanding principal balance. Once the pre-accrued*

interest is paid in full, the ERS (recovering principal and accruing interest) shall begin.

11. Approved ERS requests will run from the *ERS approval* date.

12. *If the ERS request is denied, the contractor shall continue with normal debt collection activities. Providers shall be permitted one additional ERS request for an overpayment, where a previous ERS was denied. If both ERS requests are denied, any additional ERS requests for that overpayment that a contractor deems should be considered shall be forwarded to the RO for review.*

13. *Contractors shall not automatically apply an underpayment due to a cost report or a manual refund due to over collection to the ERS overpayment. If the contractor determines a Medicare underpayment or manual refund after establishing an ERS, the contractor shall notify the provider in writing of the underpayment or manual refund. The contractor shall permit the provider 15 calendar days following the date of notification to submit a request with justification to either apply the underpayment or manual refund to the ERS or not.*

14. *If the provider does not respond in the required timeframe or has not submitted a form requesting to automatically apply the underpayment or manual refund to the ERS payments, the contractor shall immediately apply this amount to the ERS payments. If the provider responds timely, the contractor has 15 calendar days from the receipt date to determine if the provider's justification warrants a refund and complete to either apply the underpayment or manual refund to the ERS or refund the amount to the provider.*

15. *The Contractor shall send written notice of the determination to the provider explaining the rationale for the determination. The determination is not an initial determination and is not appealable.*

16. *The contractor shall not grant an ERS to a provider if there is a reason to suspect the provider may file for bankruptcy, cease to do business, discontinue participation in the Medicare program, if there is an indication of fraud and abuse committed against the Medicare program, or there is a previously defaulted ERS that was not resolved.*

NOTE(S):

a. *Good faith payments are monthly payments submitted by the provider while an ERS is in review. They should equal one month's payment of the providers requested terms; ex. 36 month request = 1/36th minimum good faith payment. Payments less than this amount are not considered a good faith payment. Payments shall continue to be submitted monthly while the ERS is being reviewed.*

b. *If under a 935 appeal the provider shall continue to submit good faith payments or ERS payments. These payments are considered voluntary payments and not 935 recoupments.*

50.1 – ERS Required Documentation --Physician is a Sole Proprietor

(Rev.264, Issued: 02-12-16, Effective: 03-14, 16, Implementation: 03-14-16)

A. The contractor shall require that the provider (physician/sole proprietor) furnish *the following* for ERS request of 6 months:

1. **Signed Proposed Amortization Schedule** – CMS requires a signed request including a proposed monthly term and payment installment schedule, as a provider's agreement to pay its overpayment through installment payments. *Signatures submitted in electronic form are permissible.*

2. **Installment Payments** – CMS requires the provider to submit the first installment payment (per the proposed amortization schedule), along with any future payments due while under review.

B. The contractor shall require that the provider (physician/sole proprietor) furnish the following for ERS request over 6 months:

1. ***Signed Proposed Amortization Schedule*** *– CMS requires a signed request including a proposed monthly term and payment installment schedule, as a provider's agreement to pay its overpayment through installment payments. Signatures submitted in electronic form are permissible.*

2. ***Installment Payments*** *– CMS requires the provider to submit the first installment payment (per the proposed amortization schedule), along with any future payments due while under review.*

3. **CMS-379 Form** - a completed CMS -379 Form. *The information requested on this form is necessary for the contractor to determine if the physician/sole proprietor will be able to make installment payments on a claim.*

4. **Financial Statements** - of Debtor.

5. **Income Tax Return** - a copy of the *provider's* income tax filing for the most recent calendar year.

6. **Loan Applications** – *Requests for extended repayment of 36 months or more*; at least one letter from a financial institution denying the provider's loan request for the amount of the overpayment.

50.2 - ERS Required Documentation– Provider is an Entity Other Than a Sole Proprietor

(Rev.264, Issued: 02-12-16, Effective: 03-14, 16, Implementation: 03-14-16)

A. The contractor shall require that the provider *(NOT a physician/sole proprietor) furnish the following for ERS request of 6 months:*

1. **Signed Proposed Amortization Schedule** – CMS requires a signed request including a proposed monthly term and payment installment schedule, as a provider's agreement to pay its overpayment through installment payments. *Signatures submitted in electronic form are permissible.*

2. **Installment Payments** – CMS requires the provider to submit the first installment payment (per the proposed amortization schedule), along with any future payments due while under review.

B. The contractor shall require that the provider (NOT a physician/sole proprietor) furnish the following for ERS request over 6 months:

*1. **Signed Proposed Amortization Schedule** – CMS requires a signed request including a proposed monthly term and payment installment schedule, as a provider's agreement to pay its overpayment through installment payments. Signatures submitted in electronic form are permissible.*

2. ***Installment Payments*** *– CMS requires the provider to submit the first installment payment (per the proposed amortization schedule), along with any future payments due while under review.*

3. **Balance sheets** - the provider's most current balance sheet and the balance sheet for the last complete Medicare cost reporting period or the most recent fiscal year).

NOTE:

If the time period between the two balance sheets is less than 6 months (or the provider cannot submit balance sheets prepared by its accountant), it must submit balance sheets for the last two complete Medicare cost reporting periods (for providers that file a cost report) or for the last two complete fiscal years (for providers that don't file a cost report).

4. **Income statements** - related to the balance sheets. CMS requires that both the balance sheets and income statements include similar agreement language:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS BALANCE SHEET OR INCOME STATEMENT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

CERTIFICATION BY OFFICER/ADMINISTRATOR OF PROVIDER(S)
(For physicians/suppliers, "CERTIFICATION BY OFFICER/OWNER OF DEBTOR(S))

I HEREBY CERTIFY that I have examined the balance sheet and income statement prepared by_____ and that to the best of my knowledge and belief, it is a true, correct, and complete statement from the books and records of the provider.

Signed
Officer/Administrator of Provider(s) Title
(For physicians/suppliers: Officer/Owner of Debtor(s) Title)
Date

5. **Statement of Sources and Application of Funds** - for the periods covered by the income statements (see Exhibit 2 for recommended format).

6. **Cash flow statements** - for the periods covered by the balance sheets (see Exhibit 3 for recommended format). If the date of the provider's request for an extended repayment schedule is more than 3 months after the date of the most recent balance sheet, a cash flow statement shall be provided for all months between that date and the date of the request.

7. **Projected cash flow statement** - from the date of the request and covering the remainder of the fiscal year. If fewer than 6 months remain, the provider shall include a projected cash flow statement for the following year. (See Exhibit 3 for recommended format.)

8. **List of restricted cash funds** - by amount as of the date of request and the purpose for which each fund is to be used. – *if applicable*

9. **List of investments** - by type (stock, bond, etc.), amount, and current market value as of the date of the report. – *if applicable*

10. **List of notes and mortgages payable** - by amounts as of the date of the report, and their due dates. – *if applicable*

11. **Schedule showing amounts** - due to and from related companies or individuals included in the balance sheets. The schedule should show the names of related organizations/persons, TIN and NPI numbers. It shall also show where the amounts appear on the balance sheet--such as Accounts Receivable, Notes Receivable, etc.

12. **Schedule showing types** - amounts of expenses (included in the income statements) paid to related organizations. The schedule shall show names of the related organizations, TIN and NPI numbers.

13. **Loan Applications** - Requests for extended repayment of *36* months or more; have the provider include at least one letter from a financial institution denying the provider's loan request for the amount of the overpayment.

14. **The percentage of occupancy**- by type of patient (e.g., Medicare, Medicaid, private pay) and total available bed days for the periods the income statements cover.

All financial records must be for the business participating in the program. It should not be for the owner if the business is a partnership or a corporation. If an outside facility manages the financial aspects of the business, the provider shall submit individual financial records as well as the financial records of the outside facility.