

Supporting Statement – Part A
Prepaid Health Plan Cost Report
CMS-276, OMB 0938-0165

Background

This March 2025 iteration proposes to revise our active collection of information request.

The Cost Report outlines the provisions for implementing Sections 1876 (h) and 1833(a)(1)(A) of the Social Security Act (“the Act”). Organizations contracting with the Secretary under Sections 1876 and 1833 of the Act provide health services on a prepayment basis to enrolled members and are required to submit adequate cost and statistical data, based on financial records, in order to be reimbursed on reasonable cost basis by CMS. Organizations include: Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) under Section 1876 and Health Care Prepayment Plans (HCPPs) under Section 1833. These entities may be collectively referred to as “Managed Care Organizations” or “MCOs”.

The cost and statistical data are completed by MCOs and submitted to CMS within the cost report (Form 276).

This iteration proposes to revise all worksheets associated with Form 276 (Prepaid Health Plan Cost Report). Such changes have no impact on our per response time estimates. See section 15 (below) for details.

A. Justification

1. Need and Legal Basis

HMO/CMPs contracting with the Secretary under Section 1876 of the Act are required to submit a budget and enrollment forecast, semi-annual interim report, 4th Quarter interim report¹, and a final certified cost report in accordance with 42 CFR 417.572 – 417.576.

The submission, receipt and processing of the cost reports is imperative to determine if MCOs are paid on a reasonable basis for the covered services furnished to Medicare enrollees. CMS reviews the data submitted within the cost reports to establish monthly payment rates, monitor interim rates, and determine the final reimbursement.

HCPPs contracting with the Secretary under Section 1833 of the Act are required to submit a budget and enrollment forecast, semi-annual interim report, and Final Cost Report in accordance

¹ CMS has waived this annual submission. The decision to waive the 4th Quarter interim report was made more than 10 years ago. While accuracy of payments and reconciling costs was a lot more time sensitive due to the manual effort and resources it took for oversight of the program at the time, it was determined to be unnecessary and a drain on resources to have a plan fill it out and have CMS review when the final cost report is very close to being due a few months later. CMS has also started relying more heavily on IT/data systems to enhance and streamline our oversight and CR payment reconciliation. There is no value to performing this 4th interim review at this time. There is no timeline/date for re-entry at this time.

with 42 CFR 417.808 and 417.810.

2. Information Users

The reporting requirements of a prepaid health care plan that has contracted with CMS are specifically defined in §§417.572, 417.574, 417.576, and 417.808. For reimbursement purposes, these plans can be grouped into two major categories HMOs/CMPs and HCPPs.

An HMO/CMP is a health care delivery system that furnishes directly or arranges for the delivery of the full spectrum of Part A and/or Part B health services to an enrolled population. If it elects and qualifies to contract with the Secretary, it can receive reimbursement for all covered services furnished to a Medicare enrollee.

An HCPP is a health care delivery system that furnishes directly or arranges for the delivery of certain physician and diagnostics services up to the full spectrum of non-provider Part B health services to an enrolled population.

Cost plans (HMO/CMP/HCPPs) are public or private entities that are organized under the laws of a State to provide health services on a prepayment basis to enrolled members. These cost plans are eligible to enter into contracts with the Secretary of the Department of Health and Human Services established under Sections 1876 and 1833 of the Act to furnish services to Medicare beneficiaries. Collectively these plans are referred to as cost-based Managed Care Organizations (MCOs).

CMS is responsible for the receipt and processing of cost reports (Form 276, as attached to this collection of information request) that are prepared and submitted by HMOs/CMPs under Section 1876 of the Act and by HCPPs under Section 1833 of the Act. CMS reimburses these organizations on a reasonable cost basis. Form 276, provided by CMS as Excel worksheets, covers the prescribed format for the cost reports. Electronic copies of the worksheets for each category of filing are accessible through CMS' Health Plan Management System (HPMS).

The cost report worksheets are designed to be of sufficient flexibility to take into account the diversity of operations, yet provide the necessary cost and statistical information to enable CMS to determine the proper amount of payment to the Plan. Cost-based MCOs must submit through HPMS an annual Budget and Enrollment Forecast, a semi-annual interim report, and a Final Cost Report to CMS, all of which are attached to this collection of information request.

Budget Forecast

The HMO or CMP must submit an annual operating budget and enrollment forecast, in the form and detail required by CMS, at least 90 days before the beginning of each contract period.

An HCPP must submit to CMS an annual operating budget and enrollment forecast, in the form and detail specified by CMS, at least 60 days before the beginning of each contract period.

The forecast must be based on financial and statistical data and records that can be verified if

CMS requires a detailed review of supporting records. The budget forecast establishes reasonable interim payment rate & suggests Medicare deductible & co-insurance premium.

Interim Cost Reports

All Cost-based MCOs are required to submit a semi-annual interim cost report. Semi-annual interim cost reports are due 60 days after the close of the first 6 months of the contract period for HMOs/CMPs and 45 days for HCPPs after the close of the first 6 months of the contract period. The semi-annual interim report is used to evaluate the payment rate and adjust if necessary.

The objective for submitting interim reports is to avoid having excessive balances due to or from the plan at the end of the reporting period.

Final Cost Report

The HMO or CMP must submit to CMS an independently certified Final Cost Report and supporting documents, in the form and detail required by CMS, no later than 180 days after the end of each contract period.

An HCPP must submit to CMS a Final Cost Report and supporting documents in the form and detail specified by CMS, no later than 120 days following the close of a contract period. An independent certification is not required for HCPPs.

The Final Cost Report provides an accumulation of costs of services for the contract year. The Final Cost Report should include the per capita costs incurred in furnishing covered services to its Medicare enrollees for the contract year. After receipt of acceptable reports, CMS determines the total payment due the MCOs for furnishing covered services to its Medicare enrollees and makes a retroactive adjustment to bring interim payments into agreement with the payable amount due the MCOs.

Summary:

Cost-based MCOs are paid in advance each month based on an interim per capita rate for each Medicare enrollee. Monthly payment to the plan is determined by multiplying the interim per capita rate by the number of Medicare enrollees for the month. Retroactive adjustments can be made any time before final settlement with the organizations during or after the cost reporting period. Total Medicare reimbursement for cost-based MCOs is based on the information reported on the plan's Final Cost Report. Final settlement is authorized based on reconciliation of interim payments and Medicare reimbursable costs per the Final Cost Report, normally at the conclusion of an audit.

MCOs are reimbursed for the reasonable cost of the covered services furnished to their Medicare enrollees. All necessary and proper expenses of the plan in providing Medicare-covered services are recognized. The determination of reasonable costs is based on Medicare reimbursement principles addressed in 42 CFR part 417, Medicare Managed Care Manual, subparts N and O for HMOs/CMPs and subpart U for HCPPs. The cost report (Form 276) and instructions provide

detailed reporting and calculation requirements.

3. Use of Information Technology

This collection of information currently requires electronic submission; CMS has automated the cost report process through the Health Plan Management System (HPMS) and requires that Section 1876 and 1833 cost plans to electronically submit the cost reports (budget forecast, semi-annual interim report, and final cost report) to CMS. HPMS is a web-enabled information system and data exchange mechanism that serves a critical role in both the ongoing operations and for data related to MCOs. By serving as the centralized repository for Medicare Managed Care data, HPMS provides its users with access to this information and an analytical framework for exploring data. The cost report process has been automated to reduce processing time.

Form 276, provided by CMS as excel worksheets, covers the prescribed format for the cost reports and are provided in Excel format. Electronic copies of the worksheets for each category of filing are accessible through CMS' Health Plan Management.

4. Duplication of Efforts

This report will be used to establish the reasonable cost of delivering covered services furnished to Medicare enrollees. This will be done on a prospective, interim and retrospective basis to ensure that payment to these organizations does not exceed reasonable cost of services. At this time, no other forms have been developed that can be used to establish the reasonable cost of providing covered services to a Medicare enrollee by an HMO/CMP or HCPP.

5. Small Businesses

The cost report has been developed with a view toward minimizing the reporting for small businesses.

6. Less Frequent Collection

Without these worksheets, CMS would not have documentation needed to reimburse the organizations on a reasonable cost basis. All physician services would have to be billed through the area carrier on a fee-for- service basis. In addition, the organizations could not be reimbursed for any service furnished by a provider of service (hospital, SNF, and HHA). Legislation as it now exists, could not be implemented.

The submission dates for the cost reports differ depending on the type of delivery system:

A. HMO/CMP

- a. Budget Forecast - Due 90 days prior to the beginning of the contract period
- b. Semi-Annual Interim - Due 60 days after the close of each quarter
- c. Final - Due 180 days after the close of the contract period; the report must be certified

B. HCPP

- a. Budget Forecast - Due 60 days prior to the beginning of the contract period
- b. Semi-Annual Interim - Due 45 days after the close of the first six-month period of a contract period
- c. Final - Due 120 days after the close of the contract period

7. Special Circumstances

There are no other special circumstances for the submission of Cost Reports other than those already contained in:

- Sections 1876 and 1833 of the Act;
- Title 42 Code of Federal Regulations (CFR) Part 417- HMOs, CMPs, and HCPPs;
- Publication #100-16 Medicare Managed Care Manual Chapters 17a-17d and Chapters 18a-18c.;
- Other related CMS manuals, instructions, and memorandums relating to HMOs, CMPs, and HCPPs.

8. Federal Register/Outside Consultation

The 60-day notice published in the Federal Register on March 21, 2025 (90 FR 13367). Comments must be received by May 20, 2025.

9. Payments/Gifts to Respondents

There has been no decision to provide any payment or gift to respondents. As part of contracting with the Secretary under Sections 1876 and 1833 of the Act, MCOs are required to submit cost reports. The submission, receipt and processing of the cost reports is imperative to determine if MCOs are paid on a reasonable basis for the covered services furnished to Medicare enrollees. CMS reviews the data submitted within the cost reports to establish monthly payment rates, monitor interim rates, and determine the final reimbursement.

10. Confidentiality

Medicare cost reports are subject to requests made under the Freedom of Information Act; however, they have been protected from disclosure under 42 CFR 5.65 Exemption four: Trade secrets and confidential commercial or financial information. The report includes commercial and financial information considered confidential but that is mandatory for an organization to report to seek reimbursement on a reasonable cost basis as an HMO and as an HCPP.

11. Sensitive Questions

This report form does not request any information that is of a sensitive nature. No questions were asked dealing with religious or political beliefs, sexual behavior and attitudes, or other matters

commonly considered private.

12. Burden Estimates

Wage Estimates

To derive average costs, we are using data from the U.S. Bureau of Labor Statistics' (BLS's) May 2023 National Occupational Employment and Wage Estimates for all salary estimates (https://www.bls.gov/oes/2023/may/oes_nat.htm). In this regard, the following table presents BLS' mean hourly wage along with our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

Table 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Accountants and Auditors	13-2011	43.65	43.65	87.30

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent to account for fringe benefits and other indirect costs that vary from employer to employer and because methods of estimating these costs vary widely from study to study. We believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

The hourly labor rate reflects the use of accounting and audit professionals for the preparation, completion, and submission of Form 276.

Collection of Information Requirements and Associated Burden Estimates

The estimated burden for the preparation of the Cost Report is dependent on the type of Cost Report being submitted and the type of Plan (HMP/CMPs or HCPPs) completing the report.

It is estimated that it will take HMO/CPPs a total of 648 hours to complete the reports; there are 6 HMO/CMPs; and it will take approximately 108 hours (24 hours for the Budget Forecast, 4 hours for the Semi-annual Interim Report, and 80 hours for the Final Cost Report) to submit the required Cost Reports.

It is estimated that it will take HCPPs a total of 480 hours to complete the reports; there are 6 HCPPs and it will take approximately 80 hours (16 hours for the Budget Forecast, 4 hours for the Semi-annual Interim Report, and 60 hours for the Final Cost Report) to submit the required Cost Reports.

The time required to complete this information collection is estimated to average 36 hours for HMOs/CMPs and 26.67 hours for HCPPs per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

The cost to submit the Cost Reports for HMO/CPPs is estimated at \$56,570 (648 hours * \$87.30 an hour) and the cost to HCCPs is estimated at \$41,904 (480 hours * \$87.30 an hour). Overall, we estimate a burden of 1,128 hours (648 hr + 480 hr) at a cost of \$98,474 (\$56,570 + \$41,904).

Burden Summary

<u>HMO/CMPs</u>	<u>Budget Forecast</u>	<u>Final Cost Report</u>	<u>Semi-Annual Interim Report</u>	<u>TOTAL</u>
Avg. Completion Time Per Report (Hours) (a)	24	80	4	108
Estimated Number of Respondents for FY 25 (b)	6	6	6	6
Total Annual Responses	6	6	6	18
Annual Frequency of Reporting (c)	<u>1</u>	<u>1</u>	<u>1</u>	<u>n/a</u>
Time (hr) (d = a x b x c)	144	480	24	648 hr
Labor (\$/hr) (e)	87.30	87.30	87.30	n/a
Cost (\$) (d x e)	12,571	41,904	2,095	\$56,570

<u>HCCPs</u>	<u>Budget Forecast</u>	<u>Final Cost Report</u>	<u>Semi-Annual Interim Report</u>	<u>TOTAL</u>
Avg. Completion Time Per Report (Hours)	16	60	4	80
Estimated Number of Respondents for FY 25 (b)	6	6	6	6
Total Annual Responses	6	6	6	18
Annual Frequency of Reporting (c)	<u>1</u>	<u>1</u>	<u>1</u>	<u>n/a</u>
Time (hr) (d = a x b x c)	96	360	24	480
Labor (\$/hr) (e)	87.30	87.30	87.30	n/a
Cost (\$) (d x e)	8,381	31,428	2,095	\$41,904

Collection of Information Instruments and Instruction/Guidance Documents

Prepaid Health Plan Cost Report (Form 276)

The report consists of the following worksheets:

- Instructions (Revised)
- Budget Forecast (Revised)
- Interim Cost Report (Revised)
- 4th Quarter Interim Cost Report (Revised)
- Final Cost Report (Revised)

We only have crosswalks for the cost reports to show what was updated, which was only dates for this submission. We can't do track changes in excel, so redline versions are not possible for the cost reports

13. Capital Costs

There is no capital costs associated with this collection.

14. Cost to Federal Government

These annual costs are incurred in processing information contained on the form, particularly with regard to the collection of the additional data necessary to meet the law. Effective fiscal year 2006, this function has been contracted out due to A-76 study.

MCOs	Final	Budget Forecast & Semi-Annual Interim	Sum of Total Hours
1. Estimated Number of Respondents - HMO/CMP	6	6	
2. Responses per Respondents	1	2	
3. Total # of Responses	6	12	
4. Processing Hours Per Response	20	8	
5. Total # of Hours - HMO/CMP	120	96	216
6. Estimated Number of Respondents – HCPP	6	6	
7. Responses Per Respondents	1	2	
8. Total # of Responses	6	12	
9. Processing Hours Per Response	16	8	
10. Total # of Hours- HCPP	96	96	192
11. Grand Total (Line 5 + Line 10)	216	192	408
12. Avg. Cost Per Hour (refer to Adjusted Hourly Wage in Table 1)	\$87.30	\$87.30	\$87.30

13. Line 11 x 12 (Rounded)	\$18,857	\$16,792	\$35,619
14. Estimated Printing			\$2,000
15. Total Cost to Government			\$37,619

15. Changes to Burden

This March 2025 iteration proposes minor changes to the worksheets and instructions (see the attached Crosswalks for details). The changes have no impact on our per response time estimates.

Since our last submission to OMB, two cost-based MCOs have terminated, which has affected the estimated total number of respondents. As a result, the estimated number of respondents for HMO/CMPs have been reduced from 10 to 6 since our last submission, and the number of respondents for HCPPs have been reduced from 9 to 6. As such, our total time estimate was impacted because of reduction in the number of respondents/responses.

16. Publication/Tabulation Dates

There are no publication plans for this data.

17. Expiration Date

The expiration date is displayed on all cost reports.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collections of Information Employing Statistical Methods

The compilation of the cost reports and worksheets in Excel may require the use of Excel formulas or analytical functions; but its completion should not require any overly complicated statistical analysis. The use of statistical methods and level of difficulty of compilation will be dependent on the size and complexity of the Plan's financial records and related statistics.