

4030.2 Part B - Medical and Other Health Services--Use Worksheet E, Part B, to calculate reimbursement settlement for hospitals, subproviders, and SNFs.

Use a separate copy of Worksheet E, Part B, for each of these reporting situations. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. Enter check marks in the appropriate spaces at the top of each page of Worksheet E to indicate the component program for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers. For purposes of prospective payment for outpatient services when the PCR transition date (applicable to cancer hospitals) (see the following paragraph), transitional outpatient payment calculation date, or geographic reclassification date (urban to rural only) (42 CFR 412.103 and 412.230), occurs at other than the cost report period beginning date, complete subscripted column 1.01 in addition to column 1, for lines 2 through 8 only. Order the subscripted columns chronologically as the transition dates or geographic reclassification dates correspond to your fiscal year. The dates should also agree with the format on Worksheet D, Part V, columns 2, 2.01, 2.02, 2.03, etc., if applicable.

In accordance with ACA 2010, §3138, cancer hospitals (as defined in 42 CFR 412.23(f)) must utilize a predetermined target PCR to calculate the corresponding transitional outpatient payment effective for services rendered beginning January 1, 2012. Where the cost reporting period overlaps a target PCR revision date, subscript column 1 as indicated in the preceding paragraph to correspond to each target PCR period.

**NOTE:** If you are not a cancer or children's hospital or covered by ACA §3121, do not complete lines 2 and 5 through 8.

#### Line Descriptions

Line 1--Enter the cost of medical and other health services for title XVIII, Part B. This amount also includes the cost of ancillary services furnished to inpatients under the medical and other health services benefit of Medicare Part B. These services are covered in this manner for Medicare beneficiaries with Part B coverage only when Part A benefits are not available. Obtain this amount from Worksheet D, Part V, line 202, columns 6 and 7, for hospitals and enter in column 1. For SNFs transfer the amount from Worksheet D, Part V, columns 6 and 7.

The following providers are temporarily eligible for hold harmless payments and must use columns 1 and 1.01 to correspond to the respective portion of the cost reporting period for lines 2 through 8. Rural hospitals with 100 or fewer beds whose reporting period overlaps December 31, 2012, are eligible through December 31, 2012; SCHs and EACHs regardless of bed size whose reporting period overlaps February 29, 2012, are eligible through February 29, 2012; and SCHs and EACHs with 100 or fewer beds whose reporting period overlaps December 31, 2012, are eligible through December 31, 2012, (Worksheet S-2, Part I, line 120, column 1 or 2 is "Y" for yes).

CAHs are not subject to transitional corridor payments, therefore, lines 2 through 9 do not apply to CAHs. Transfer Worksheet D, Part V, columns 6 and 7, line 202.

Line 2--Enter the cost of medical and other health services reimbursed under OPSS from Worksheet D, Part V, column 5, and applicable subscripts, line 202. Subtract from this amount outpatient pass through costs reported on Worksheet D, Part IV, line 200, column 13.

Line 3--Enter the gross OPSS payments received including payment for drugs and device pass through payments.

Line 4--Enter the amount of outlier payments made for OPPS services rendered during the cost reporting period.

Contractors only, add or subtract, as applicable, to the gross OPPS payments the total outlier reconciliation amount from line 94. Effective for cost reporting periods ending on or after September 30, 2017, do not include the outlier reconciliation amount on this line, but rather enter the amount on line 4.01.

Line 4.01--Contractor use only: Effective for cost reporting periods ending on or after September 30, 2017, for OPPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line 94.

Line 5--Enter the hospital specific payment to cost ratio provided by your contractor. If a new provider does not file a full cost report for a cost reporting period that ends prior to January 1, 2001, the provider is not eligible for transitional corridor payments and should enter zero (0) on this line. (See PM A-01-51.)

For a cancer hospital, enter the target PCR as published in the applicable OPPS final rule (or correction notice), and subscript column 1 for each PCR period when the cost reporting period overlaps a PCR revision date. Following is a table of the PCRs from CY 2012 through CY 2018.

<u>Calendar Year</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>
PCR	0.91	0.91	0.89	0.90	0.92	0.91	0.88

Line 6--Enter the result of line 2 times line 5.

If the sum of lines 3, 4, and 4.01, is less than line 6, complete lines 7 and 8; otherwise, do not complete lines 7 and 8.

Line 7--Enter the result of the sum of lines 3, 4, and 4.01, divided by line 6.

Line 8--Enter the transitional corridor payment amount calculated based on the following:

- a. If the sum of lines 3, 4, and 4.01, is less than the amount on line 6, and Worksheet S-2, Part I, line 3, column 4, response is 3 or 7 (cancer or children's hospital, respectively), enter the result of line 6 minus the sum of lines 3, 4, and 4.01.

In accordance with ACA 2010, section 3121, and MMEA of 2010, section 108, as amended by the Temporary Payroll Tax Cut Continuation Act of 2011, section 308, and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, the outpatient hold harmless provision is effective for services rendered from January 1, 2010, through February 29, 2012, to all SCHs and EACHs regardless of bed size; and from March 1, 2012, through December 31, 2012, to all SCHs and EACHs with 100 or fewer beds; and from January 1, 2010, through December 31, 2012, for rural hospitals with 100 or fewer beds.

- a. For services rendered January 1, 2010, through December 31, 2012, if Worksheet S-2, Part I, line 120, column 1 or 2, is "Y", enter 85 percent of the result of line 6 minus the sum of lines 3 and 4.

Line 9--Enter the outpatient ancillary pass through amount from Worksheet D, Part IV, column 13, line 200.

Line 10--If you are an approved CTC, enter the cost of organ acquisition from Worksheet D-4, Part III, column 2, line 69, when this worksheet is completed for the hospital. Do not complete this line for a hospital distinct part unit or subprovider. The Medicare program only reimburses CTCs for organ acquisition costs.

Line 11--Enter the sum of lines 1 and 10.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost or customary charges as defined in 42 CFR 413.13(a).

**NOTE:** CAHs are not subject to the computation of the lesser of reasonable costs or customary charges. If the component is a CAH, do not complete lines 12 through 20. Instead, enter on line 21 the amount computed on line 11.

Line Descriptions

**NOTE:** If the medical and other health services reported here qualify for exemption from the application of LCC (see 42 CFR 413.13(c)), also enter the total reasonable cost from line 11 directly on line 21. Still complete lines 6 through 16 to insure that you meet one of the criteria for this exemption.

Lines 12 through 20--These lines provide for the accumulation of charges which relate to the reasonable cost on line 11.

Do not include on these lines: (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3) and (2) charges to beneficiaries for excess costs. (See CMS Pub. 15-1, chapter 25, §§2570-2577.)

Line 12--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 3 and 4, line 202.

Line 13--If you are an approved CTC, enter the organ acquisition charges from Worksheet D-4, Part III, column 4, line 69, for the hospital.

Line 14--Enter the sum of lines 12 and 13.

Lines 15 through 18--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or fail to make reasonable efforts to collect such charges from those patients. If line 17 is greater than zero, multiply line 14 by line 17, and enter the result on line 18. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 15 through 17. Enter on line 18 the amount from line 14. In no instance may the customary charges on line 18 exceed the actual charges on line 14. (See 42 CFR 413.13(e).)

Line 19--Enter the excess of the customary charges over the reasonable cost. If line 18 exceeds line 11, enter the difference.

Line 20--Enter the excess of reasonable cost over the customary charges. If line 11 exceeds line 18, enter the difference.

Line 21--Enter the amount from line 11, less any amount reported on line 20 for hospital/services subject to LCC.

For hospital/services that are not subject to LCC in accordance with 42 CFR 413.13 (*e.g., nominal* charge public or private hospitals identified on Worksheet S-2, Part I, lines 155 through 161), enter the reasonable costs from line 11.

For CAHs enter on this line 101 percent of line 11.

Line 22--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

<u>Provider/Component</u>	<u>Title XVIII Hospital</u>	<u>Title XVIII Subprovider</u>	<u>Title XVIII SNF</u>
Hospital	Part I, col. 9, line 9, plus line 27; or Part II, col. 7, line 37; or Part III, col. 6, line 45	Part I, col. 9, lines 10, 11, or 12; or Part II, col. 7, lines 38, 39, or 40; or Part III, col. 6, line 46, 47, or 48	Part I, col. 9, line 13; or Part II, col. 7, line 41; or Part III, col. 6, line 49

Line 23--Teaching hospitals or subproviders participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 21. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 21.

Line 24--Enter the sum of lines 3, 4, 4.01, 8, and 9, all columns.

#### Computation of reimbursement Settlement

Line 25--Enter the Part B *deductible* and the Part B coinsurance *amounts* billed to Medicare beneficiaries. DO NOT INCLUDE *deductible* or coinsurance *amounts* billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for coinsurance, enter on this line the full coinsurance amount, not the discounted amount. *For provider Part B services exempt from LCC, enter only the Part B deductible amounts billed to the program beneficiaries, as reimbursement for those services is based on 80 percent of reasonable cost net of the Part B deductible amounts. Do not enter any Part B coinsurance amounts for those provider Part B services exempt from LCC.*

Line 26--Enter the deductible and coinsurance *amounts* relating to the amounts reported on line 24.

**NOTE:** If these services are exempt from LCC as a result of charges being equal to or less than 60 percent of cost (refer to Worksheet S-2, Part I, lines 155 through 161, columns 1 through 5, as applicable), enter the Part B *deductible amounts* billed to program beneficiaries only. Do not enter any Part B coinsurance. For CAHs, enter the *deductible amounts* on line 25, and the coinsurance *amounts* on line 26.

Line 27--Subtract lines 25 and 26 from lines 21 and 24, respectively. Add to that result the sum of lines 22 and 23.

**NOTE:** If these services are exempt from LCC, (line 21 minus line 25 minus Worksheet D, Part V, line 202, column 7) times 80 percent, then add back Worksheet D, Part V, line 202, column 7, plus lines 22 and 23. Add to that result line 24 minus line 26.

CAHs enter the lesser of (line 21 minus the sum of lines 25 and 26) or 80 percent times the result of (line 21 minus line 25 minus 101% of lab cost (Worksheet D, Part V, column 6, lines 60, 61, and subscripts) minus 101% of costs not subject to deductible and coinsurance (Worksheet D, Part V, column 7, line 202). Add back the aforementioned 101% of lab cost and 101% of cost not subject to deductibles and coinsurance. Add to that result the sum of lines 22 and 23.

Line 28--Enter in column 1, the amount from Worksheet E-4, line 50. Complete this line for the hospital component only.

Line 29--Enter in column 1, the amount from Worksheet E-4, line 36. Complete this line for the hospital component only.

Line 30--Enter in column 1, the sum of columns 1 and 1.01, lines 27 through 29.

Line 31--Enter the amounts paid or payable by workers' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, the services are treated as if they were non-program services for cost reporting purposes only. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient charges in total charges but not in program charges. In this situation, enter no primary payer payment on line 31. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered charges in program charges, and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 31 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 31.

Line 32--Enter line 30 minus line 31.

Line 33--Enter the amount of allowable bad debts for deductibles and coinsurance for ESRD services reimbursed under the composite rate system from Worksheet I-5, line 11.

Allowable bad debts (Exclude bad debts for professional services)

Line 34--Enter from your records allowable bad debts for deductibles and coinsurance net of recoveries for other services, excluding professional services. Do not include ESRD bad debts. These are reported on line 33. Bad debts associated with ambulance services rendered (since these costs are reimbursed on a fee basis) are not allowable. If recoveries exceed the current year's bad debts, lines 34 and 35 will be negative. (See CMS Pub. 15-1, chapter 3).

Line 35--Multiply the amount (including negative amounts) on line 34 times 70 percent (hospitals and subproviders only). The reduction does not apply to CAHs.

For cost reporting periods that begin on or after October 1, 2012, multiply the amount (including negative amounts) on line 34 times 65 percent (hospitals and subproviders only).

For CAHs with cost reporting periods beginning on or after October 1, 2012, multiply the amount on line 34 (including negative amounts) times 88 percent. For cost reporting periods beginning on or after October 1, 2013, multiply the amount on line 34 times 76 percent. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 34 times 65 percent.

For SNFs with cost reporting periods beginning prior to October 1, 2012, enter the amount on line 34. For cost reporting periods beginning on or after October 1, 2012, calculate this line as follows:  $[(\text{line 34} - \text{line 36}) * 65 \text{ percent}] + (\text{line 36} * 88 \text{ percent})$ . For cost reporting periods beginning on or after October 1, 2013, calculate this line as follows:  $[(\text{line 34} - \text{line 36}) * 65 \text{ percent}] + (\text{line 36} * 76 \text{ percent})$ . For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 34 times 65 percent.

Line 36--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only except for the calculation of dual eligible bad debts for SNFs cost reporting periods beginning on or after October 1, 2012. This amount must also be reported on line 34.

Line 37--Enter the sum of lines 32, 33 and 34 or 35 (hospitals and subproviders only). For cost reporting periods beginning on or after October 1, 2012, enter the sum of lines 32, 33 and 35. (hospital, CAH, subproviders and SNFs).

Line 38--Enter the MSP-LCC reconciliation amount. Obtain this amount from the PS&R.

Line 39--Enter any other adjustments. Specify the adjustment in the space provided.

Line 39.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 39.97 or line 40.02, accordingly.

Line 39.97--Enter any demonstration payment adjustment amounts for all demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R. Do not include payment demonstration adjustment amounts included on line 39.50.

Line 39.98--Enter from the PS&R, the partial or full credits received from manufacturers for replaced devices. See CMS Pub. 100-04, chapter 4, §61.3. This is captured for informational purposes only.

Line 39.99--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136-136.16, and 42 CFR 413.134(d)(3)(i).)

Line 40--Enter the result of line 37, plus or minus line 39 and its subscripts not previously identified (excluding line 39.98 that is for informational purposes only), minus lines 38, 39.50, 39.97, and 39.99.

Line 40.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows:  $[(2 \text{ percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)}) \text{ times line 40}]$ . Do not apply the sequestration calculation when gross reimbursement (line 40) is less than zero.

Line 40.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 41--Enter interim payments from Worksheet E-1, column 4, line 4. For contractor final settlements, enter the amount reported on line 5.99 on line 42. For contractor purposes, it will be necessary to make a reclassification of the bi-weekly pass through payments from Part A to Part B, and report that Part B portion on line 42. Maintain the necessary documentation to support the amount of the reclassification.

Line 43--Enter line 40 minus the sum of lines 40.01, 40.02, 41 and 42. Transfer this amount to Worksheet S, Part III, column 3, line as appropriate.

Line 44--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

Lines 45 through 89 were intentionally skipped to accommodate future revisions to this worksheet.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART B. LINES 90 THROUGH 94 ARE FOR CONTRACTOR USE ONLY.**

Line 90--Enter the original outlier amount from line 4 (sum of all columns) prior to the inclusion of line 94 of Worksheet E, Part B.

Line 91--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 4, §§10.7.2.2-10.7.2.4.

Line 92--Enter the rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 4, §§10.7.2.2-10.7.2.4.)

Line 93--Enter the time value of money.

Line 94--Enter sum of lines 91 and 93.

4031. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

4031.1 Part I - Analysis of Payments to Providers for Services Rendered--

Complete this worksheet for each component of the health care complex which has a separate provider or subprovider number as shown on Worksheet S-2, Part I. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. When the worksheet is completed for a component, show both the hospital provider number and the component number. Complete this worksheet only for Medicare interim payments paid by the contractor. Do not complete it for purposes of reporting interim payments for titles V or XIX or for reporting payments made under the composite rate for ESRD services. Providers paid on an interim basis on periodic interim payment (PIP) adjust the interim payments for MSP/LCC claims.

The following components use the indicated worksheet instead of Worksheet E-1:

- Hospital-based HHAs use Worksheet H-5.
- Hospital-based outpatient rehabilitation facilities use Worksheet J-4.
- Hospital-based RHCs/FQHCs use Worksheet M-5.
- Hospital-based FQHCs under FQHC PPS use Worksheet N-5.