

4054. WORKSHEET J-2 - COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS

Use this worksheet only if you operate a hospital-based CMHC. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

4054.1 Part I - Apportionment of CMHC Cost Centers.--

Column 1--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 28. To facilitate the apportionment process, the line numbers are the same on both worksheets. Do not transfer lines 19 and 20 from Worksheet J-1.

Column 2--Enter the charges for each cost center. Obtain the charges from your records.

Column 3--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for title V in column 4 and title XIX in column 8. Enter 0 (zero) for each line in column 6 for title XVIII charges as CMHCs are reimbursed under the OPPS. Not all facilities are eligible to participate in all programs.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, by the ratio in column 3.

Line 20--Enter the totals of lines 1 through 19 in columns 1, 2, and 4 through 9.

4054.2 Part II - Apportionment of Cost of CMHC Services Furnished by Shared Hospital Departments.--Use this part only when the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the hospital's CMHC.

Column 3--For each of the cost centers listed, enter the ratio of cost to charges that is shown on Worksheet C, Part I, column 9, from the appropriate line for each cost center.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for title V in column 4, and title XIX in column 8. Enter 0 (zero) for each line in column 6 for title XVIII charges as CMHCs are reimbursed under the OPPS.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, respectively, by the ratio in column 3.

Line 28--Enter the totals for columns 4 through 9.

Line 29--Enter the total costs from Part I, columns 5, 7, and 9, line 20, plus columns 5, 7, and 9, line 28, respectively, and transfer to Worksheet J-3, line 1.

4055. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT – COMMUNITY MENTAL HEALTH CENTER PROVIDER SERVICES

Submit a separate Worksheet J-3 for each title (V, XVIII, or XIX) under which reimbursement is claimed. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

Line 1--Enter the cost of the component's services from Worksheet J-2, Part II, line 29 from columns 5, 7, or 9, as applicable (column 5 for title V, column 7 for title XVIII (enter 0 (zero)), and column 9 for title XIX).

Line 2--Enter the gross PPS payments received for services rendered during the cost reporting period excluding outliers. Obtain this amount from the PS&R and/or your records.

Line 3--Enter the total outliers payments received. Obtain this amount from the PS&R and/or your records.

Line 4--Enter the amounts paid and payable by workers' compensation and other primary payers where program liability is secondary to that of the primary payer (from your records).

Line 5--Title XVIII CMHCs enter the result obtained by subtracting line 4 from the sum of lines 2 and 3. Titles V and XIX providers not reimbursed under PPS enter the total reasonable costs by subtracting line 4 from line 1.

Line 6--Enter the charges for the applicable program services from Worksheet J-2, sum of Parts I and II, columns 4, 6, and 8, as appropriate, lines 20 and 28.

Lines 7 through 10--These lines provide for the reduction of program charges where the provider does not actually impose charges on most of the patients liable for payment for services on a charge basis or fails to make reasonable efforts to collect such charges from those patients. If line 9 is greater than zero, enter on line 10, the product of multiplying the ratio on line 9 by line 6.

Providers that do impose charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 7, 8, and 9, but enter on line 10, the amount from line 6. (See 42 CFR 413.13(e).) In no instance may the customary charges on line 10 exceed the actual charges on line 6.

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3), and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-1, chapter 25, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Lines 11 and 12--Lines 11 and 12 provide for the computation of the lesser of reasonable cost or customary charges as defined in 42 CFR 413.13(a).

Enter on line 11, the excess of total customary charges (line 10) over the total reasonable cost (line 5). In situations where the total charges on line 10 are less than the total cost on line 5, enter zero (0) on line 11.

Enter on line 12, the excess of total reasonable cost (line 5) over total customary charges (line 10). In situations when in any column the total cost on line 5 is less than the customary charges on line 10, enter zero (0) on line 12.

NOTE: CMHCs not subject to reasonable cost reimbursement do not complete lines 11 and 12.

Line 13--Enter the total reasonable costs from line 5.

Line 14--Enter the Part B deductibles billed to program patients (from your records) excluding coinsurance amounts.

Line 16--If there is an excess of reasonable cost over customary charges, enter the amount from line 12.

Line 18--CMHCs enter 0 (zero) as these services are reimbursed under the OPPS. For titles V and XIX, enter 100 percent less the applicable coinsurance.

Line 19--Enter the actual coinsurance billed to program patients (from your records).

Line 20--For title XVIII, enter the difference of line 17 minus line 19. For titles V and XIX, enter the difference of line 18 minus line 19.

Line 21--Enter allowable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records). If recoveries exceed the current year's bad debts, line 21 will be negative. (See CMS Pub. 15-1, chapter 3.)

Line 22--Enter the result of line 21 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 23--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 21.

Line 24--Enter the result of line 20 plus line 21. For cost reporting periods beginning on or after October 1, 2012, enter the result of line 20 plus line 22.

Line 25--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (see CMS Pub. 15-1 chapter 21, §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 25.50--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 25.99 or line 26.02, accordingly.

Line 25.99--Enter any demonstration payment adjustment amounts for 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.

Line 26--Enter the result of line 24 plus or minus line 25, and minus lines 25.50 and 25.99.

Line 26.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 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)) times line 26]. Do not apply the sequestration calculation when gross reimbursement (line 26) is less than zero.

Line 26.02--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 27--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4.

Line 28--For contractor final settlement, report on this line the amount from Worksheet J-4, line 5.99.

Line 29--Enter the balance due provider/program (line 26 minus lines 26.01, 26.02, 27 and 28), and transfer this amount to Worksheet S, Part III, columns as appropriate, lines as appropriate.

Line 30--Enter the program reimbursement effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with CMS Pub. 15-2, chapter 1, §115.2. Attach a schedule showing the supporting details and computation.