line 20 of Worksheet M-1, do not include the GME costs allocated to the RHC/FQHC in columns 21 and 22 of Worksheet B, Part I.

Line 16--Enter the sum of lines 14 and 15 to determine the total overhead costs related to the hospital-based RHC/FQHC.

Line 17--Do not complete this line. Per 42 CFR 413.78(a), the GME payment to the hospital includes all residents working in the hospital healthcare complex; therefore, no separate payment is made to the hospital-based RHC/FQHC for GME costs.

Line 18--Enter the amount from line 16.

Line 19--Enter the overhead amount applicable to hospital-based RHC/FQHC services. It is determined by multiplying the amount on line 13 (the ratio of hospital-based RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20--Enter the total allowable cost of hospital-based RHC/FQHC services, the sum of line 10 (cost of hospital-based RHC/FQHC health care services) and line 19 (overhead costs applicable to hospital-based RHC/FQHC services).

4068. WORKSHEET M-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES

This worksheet applies to title XVIII only and provides for the reimbursement calculation for services rendered. Use this worksheet to determine the interim all-inclusive rate of payment and the total program payment for the cost reporting period for each hospital-based RHC/FQHC reported.

Determination of Rate for Hospital-Based RHC/FQHC Services--Worksheet M-3 calculates the cost per visit for hospital-based RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line descriptions

Line 1--Enter the total allowable cost from Worksheet M-2, line 20.

Line 2--Report injection/infusion costs on this line from Worksheet M-4, line 15.

Line 3--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4--Enter the greater of the minimum or actual visits by the health care staff from Worksheet M-2, column 5, line 8.

Line 5--Enter the visits made by physicians under agreement from Worksheet M-2, column 5, line 9.

Line 6--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

For services rendered from January 1, 2010, through December 31, 2013, the maximum rate per visit entered on line 8 and the outpatient mental health treatment service limitation applied on line 14 both correspond to the same time period (partial calendar year). Consequently, both are entered in the same column and no further subscripting of the columns is necessary.

Lines 8 and 9--The payment limits are updated every January 1; however, the possibility exists that payment limits may also be updated other than on January 1. Complete columns 1, 2, and 3, if applicable (add column 3 for lines 8 through 14 if the cost reporting period overlaps three

payment limit periods) for lines 8 and 9, to identify costs and visits affected by different payment limits within a cost reporting period, as may be the case when implementing §130 of CAA 2021, effective for services rendered on or after April 1, 2021, where an RHC may span three payment limit periods within a single cost reporting period (see CR 12185, dated May 4, 2021, or subsequent applicable CRs). If only one payment limit is applicable during the cost reporting period (calendar year reporting period), complete column 2 only.

Line 8--Enter the per visit payment limit. Obtain this amount from your contractor.

NOTE: For services rendered prior to April 1, 2021, if you are based in a small hospital with less than 50 beds (the bed count is based on the same calculation used on Worksheet E, Part A, line 4), in accordance with 42 CFR 412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2.

NOTE: In accordance with §1833(f)(3) of the Act, as amended by §130 of the CAA 2021, effective for services on or after April 1, 2021, hospital-based RHCs with less than 50 beds (as calculated above) will have their per visit payment limit calculated in accordance with §1833(f)(3)(B) of the Act by their contractor. See CR 12185, dated May 4, 2021, or subsequent applicable CRs.

For hospital-based RHCs based in small urban hospitals transfer the adjusted cost per visit (line 7) to line 9, column 1 and/or 2.

Line 9--Enter the lesser of the amount on line 7 or line 8.

Calculation of Settlement.--Complete lines 10 through 29 to determine the total program payment due you for covered hospital-based RHC/FQHC services furnished to program beneficiaries during the reporting period. Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

Line descriptions

Line 10--Enter the number of program-covered medical visits from your records or the PS&R.

Line 11--Enter the subtotal of program cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered program beneficiary visits for hospital-based RHC/FQHC services during the reporting period).

Line 12--Enter the number of program-covered mental health visits from your records or the PS&R. Do not include IOP services/visits on this line.

Line 13--Enter the program-covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14--Enter the limit adjustment. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009, the limitation is 62.50 percent; services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013 through December 31, 2013, the limitation is 81.25 percent; and services on or after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health treatment service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

NOTE: Section 4104 of ACA eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. Hospital-based RHCs/FQHCs must provide detailed HCPCS coding for preventive services to ensure coinsurance and deductible are

not applied. Hospital-based RHCs/FQHCs must maintain this documentation to apply the appropriate reductions on lines 16.03 and 16.04.

Line 15--Do not complete this line. Per 42 CFR 413.78(a), the GME payment to the hospital includes all residents working in the hospital healthcare complex; therefore, no separate payment is made to the hospital-based RHC/FQHC for GME costs.

Line 16--For cost reporting periods that overlap January 1, 2011, enter in column 1, the sum of lines 11 and 14, column 1, and in column 2, the sum of lines 11 and 14, column 2. For cost reporting periods beginning on or after January 1, 2011, do not use column 1, and enter the total program cost in column 2. This is equal to the sum of the amounts in columns 1 and 2, respectively (and 3, if applicable), lines 11 and 14.

Line 16.01--Enter the total program charges from the contractor's records (PS&R). For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program charges for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in column 2.

Line 16.02--Enter the total program preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program preventive charges for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in column 2.

Line 16.03--Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1, and enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16, column 2.

Line 16.04--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non-preventive costs ((line 16, column 2, minus lines 16.03 and 18, column 2) times .80) in column 2.

Line 16.05--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter total program costs (line 16 times .80) for services rendered prior to January 1, 2011, in column 1, and enter the sum of lines 16.03 and 16.04, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the sum of lines 16.03 and 16.04, in column 2.

Line 17--Enter the primary payer amounts from your records.

Line 18--Enter the amount credited to the hospital-based RHC's program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the contractor from clinic bills processed during the reporting period. Hospital-based RHCs determine this amount from the interim payment lists provided by the contractor. Hospital-based FQHCs enter zero on this line as deductibles do not apply.

Line 19--Enter the coinsurance amount applicable to the hospital-based RHC/FQHC for program patient visits on lines 10 and 12 as recorded by the contractor from clinic/center bills processed during the reporting period. This line captures data for informational and statistical purposes only. This line does not impact the settlement calculation.

Line 20--Enter the net program costs, excluding injections/infusions. For cost reporting periods that overlap January 1, 2011, enter the result of subtracting the amount on line 17 from the amount on line 16.05, columns 1 and 2. For cost reporting beginning on or after January 1, 2011, enter the result of subtracting the amount on line 17 from the amount on line 16.05, column 2.

Line 21--Enter the amount from Worksheet M-4, line 16.

Line 21.50--Enter program RHC IOP OPPS payment amounts for IOP services rendered on or after January 1, 2024. For title XVIII, obtain this amount from the PS&R.

Line 21.55--Calculate the total program IOP services cost *in column 2* by multiplying program IOP visits (for title XVIII, from the PS&R) by the adjusted cost per visit on line 7. This amount is used for statistical purposes only. *For cost reporting periods ending on or after January 1, 2024, enter the program IOP visits (for title XVIII, from the PS&R) in column 1, and calculate the total program IOP services cost for column 2 by multiplying the visits in column 1 by the adjusted cost per visit from line 7.*

Line 21.60--Enter the IOP services *deductible and* coinsurance amount. For title XVIII amounts billed to Medicare beneficiaries, obtain this amount from your books and records or the PS&R.

Line 22--Enter the total allowable program cost, sum of the amounts on lines 20, 21, and 21.50, minus line 21.60.

Line 23--Enter your total allowable bad debts, net of recoveries, from your records. If recoveries exceed the current year's bad debts, line 23 will be negative. (See 42 CFR 413.89.)

Line 23.01--Enter the result of line 23 (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 24--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 23.

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. 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 sum of lines 22 and 23 plus or minus line 25, and minus lines 25.50 and 25.99. For cost reporting periods beginning on or after October 1, 2012, enter the sum of lines 22 and 23.01 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, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 26]. Do not apply the sequestration calculation when gross reimbursement (line 26) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 26]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 26].

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 from Worksheet M-5 made to you for covered services furnished to program beneficiaries during the reporting period (from contractor records).

Line 28--For contractor use only, enter the on line 5.99 of Worksheet M-5.

Line 29--Enter the total amount due to/from the program (line 26 minus lines 26.01, 26.02, 27, and 28). Transfer this amount to Worksheet S, Part III, column 3, line 10 and/or 11 as applicable.

Line 30--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated 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. 15-1, chapter 1, §115.2.) A schedule showing the supporting details and computations must be attached.

This page is reserved for future use.