4045. WORKSHEET H-4 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

This worksheet provides for the reimbursement calculation of titles V; XVIII, Parts A and B; and XIX. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

Worksheet H-4 consists of the following two parts:

Part I - Computation of the Lesser of Reasonable Cost or Customary Charges
Part II - Computation of HHA Reimbursement Settlement

4045.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--Services not paid based on a fee schedule or the OPPS are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the providers 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: Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider only completes lines 1, 2, and 9, of Part I. Transfer the resulting cost to Part II, line 10.

Line Descriptions

Line 1--This line provides for the computation of reasonable cost reimbursed program services. Enter the cost of services from Worksheet H-3, Part I, as follows:

To Worksheet H-4, Line 1	From Worksheet H-3,
Col. 1, Part A	Part I, col. 9, line 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, line 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, line 16

The above table reflects the transfer of the cost of pneumococcal, influenza, and COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19, from Worksheet H-3, Part I, column 10, line 16, to column 2 of this worksheet, and the cost of hepatitis B vaccines and injectable osteoporosis drugs from worksheet H-3, Part I, column 11, line 9, to column 3 of this worksheet.

Lines 2 through 6--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1. 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.

Enter only the charges for applicable Medicare covered pneumococcal, influenza, COVID-19, and hepatitis B vaccines and injectable osteoporosis drugs and monoclonal antibody products for treatment of COVID-19, which are all cost reimbursed.

Line 2--Enter from your records in the applicable column the program charges for Part A, Part B not subject to deductibles and coinsurance, and Part B subject to deductibles and coinsurance.

Enter in column 2, the charges for Medicare covered pneumococcal, influenza, COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19 (from Worksheet H-3, line 16, column 7). In column 3, enter the charges for Medicare covered hepatitis B vaccines and osteoporosis drugs (from Worksheet H-3, line 16, column 8).

Lines 3 through 6--These lines provide for the reduction of program charges when the provider does not actually impose such charges (in the case of most 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 5 is greater than zero, multiply line 2 by line 5, and enter the result on line 6. Providers which do impose these 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 3, 4, and 5, but enter on line 6 the amount from line 2. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 6 exceed the actual charges on line 2.

Line 7--Enter in each column the excess of total customary charges (line 6) over the total reasonable cost (line 1). In situations when, in any column, the total charges on line 6 are less than the total cost on line 1 of the applicable column, enter zero on line 7.

Line 8--Enter in each column the excess of total reasonable cost (line 1) over total customary charges (line 6). In situations when, in any column, the total cost on line 1 is less than the customary charges on line 6 of the applicable column, enter zero on line 8.

Line 9--Enter the amounts paid or payable by workers' compensation and other primary payers where program liability is secondary to that of the primary payer. There are several situations under which program payment is secondary to a primary payer. Some of the most frequent situations in which the Medicare program is a secondary payer include:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are considered to be nonprogram services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. The provider notes this on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, no primary payer payment is entered on line 9.

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 primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payer payment does not satisfy the beneficiary's liability, include the covered days and charges in both program visits and charges and total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 9, to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 9 the primary payer payments that are credited toward the beneficiary's deductible and coinsurance. The primary payer rules are more fully explained in 42 CFR 411.

4045.2 Part II - Computation of HHA Reimbursement Settlement.--

Line 10--Enter in column 1 the amount in Part I, column 1, line 1, less the amount in column 1, line 9. Enter in column 2, the sum of the amounts from Part I, columns 2 and 3, line 1, less the sum of the amounts in columns 2 and 3, on line 9. This line will only include pneumococcal, influenza, hepatitis B and injectable osteoporosis drugs reduced by primary payer amounts.

Lines 11 through 24--Enter in column 1 only, for lines 11 through 14, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 only, on lines 15 and 16, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 18 through 20, the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 18 through 20, do not include any payments associated with services paid under bill type 34X. Obtain these amounts from your PS&R report.

Line 21--Enter in column 2, the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

Line 22--Sum lines 10 through 20 minus line 21.

Line 23--If there is an excess of reasonable cost over customary charges in any column on line 8, enter the amount of the excess in the appropriate column.

Line 24--Sum line 22 minus line 23.

Line 25--Enter in column 2, all coinsurance billable to program beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of the costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 21, and primary payment amounts in column 3, line 9, from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter the result on this line.

Line 26--Sum line 24 minus line 25.

Line 27--In column 2, enter the allowable bad debts in the appropriate columns. If recoveries exceed the current year's bad debts, line 27 will be negative.

Line 27.01--In column 2, enter the result of line 27 (including negative amounts) times 65 percent.

Line 28--In column 2, enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be included in the amount reported on line 27.

Line 29--Enter the result of line 26 plus 27.01.

Line 30--Enter any other adjustments. Enter reductions to expenses as an absolute value and additions to expenses as a negative.

Line 30.50--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 on or after January 1, 2017, on line 30.99 or line 31.02, accordingly.

Line 30.99--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 31--Enter the result of line 29, minus line 30, and minus lines 30.50, and 30.99.

Line 31.01--Enter the sequestration adjustment amount from the PS&R report (claims-based amount). 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, the sequestration adjustment is 1 percent for the portion of the cost reporting period from April 1, 2022, through June 30, 2022; and 2 percent for the portion of the cost reporting period on or after July 1, 2022.

Line 31.02--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 31.75--For cost reporting periods that overlap or begin on or after May 1, 2020, calculate separately in columns 1 and 2 the sequestration adjustment for non-claims based amounts as [(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 the sum of line 10, column 1; or line 10, column 2, plus line 27.01, column 2]. If the sum is less than zero, do not calculate the sequestration adjustment. 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 the sum of line 10, column 1; or line 10, column 2, plus line 27.01, column 2]; 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 the sum of (line 10, column 1; or line 10, column 2, plus line 27.01, column 2].

Line 32--Enter the interim payment amount from Worksheet H-5, line 4. For contractor final settlement, report on line 33 the amount from Worksheet H-5, line 5.99. For titles V and XIX, enter the interim payments from your records.

Line 34--The amounts show the balance due the provider or the program by entering the result of line 31 minus the sum of lines 31.01, 31.02, 31.75, 32, and 33. Transfer to Worksheet S, Part III, line 9, as applicable.

Line 35--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. 15-2, chapter 1, §115.2.) A schedule showing the supporting details and computations for this line must be attached.

4046. WORKSHEET H-5 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.)

The column headings designate two categories of payments: Part A and Part B.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor. Do not include on this worksheet any payments made for DME or medical supplies charged to patients that are paid on the basis of a fee schedule.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA for cost and HHA PPS reimbursed services. The amount entered reflects payments for all episodes concluded in this fiscal year. **Do not include any payments received for fee scheduled services.** The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from your interim payments due to an offset against overpayments applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to the appropriate column on Worksheet H-4, Part II, line 32.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-5. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR CONTRACTOR. (EXCEPTION: IF WORKSHEET S, PART I, LINE 5, IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the NPR has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter in column 2 the amount on Worksheet H-4, Part II, column 1, line 34. Enter in column 4 the amount on Worksheet H-4, Part II, column 2, line 34.

NOTE: On lines 3, 5, and 6, when an amount is due from the provider to the program, show the amount and date on which you agree to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the total of the amounts on lines 4, 5.99, and 6. Enter in column 2, the amount on Worksheet H-4, Part II, column 1, line 31 less the amount on lines 31.01 and 31.02. Enter in column 4, the amount on Worksheet H-4, Part II, column 2, line 31, less the amount on lines 31.01 and 31.02.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.