

## 3647. WORKSHEET H-6 - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs to titles V, XVIII, and XIX. Titles V and XIX use the columns identified as Part A for each program.

3647.1 Part I - Computation of Lesser of Aggregate Program Cost, Aggregate of Program Limitation Cost, or Per Beneficiary Cost Limitation--This part provides for the computation of the reasonable cost limitation to designated program patient care visits and is required by 42 CFR 413.30 and 42 CFR 413.53. For cost reporting periods beginning on or after October 1, 1997, §4601 of the Balanced Budget Act requires a home health agency to be paid based on the lesser of aggregate Medicare cost, aggregate Medicare limitation or the agency specific per beneficiary annual cost limit applied to the unduplicated census count.

Cost Per Visit ComputationColumn Descriptions

Column 1--Enter the cost for each discipline from Worksheet H-5, Part I, column 29, lines as indicated. Enter the total on line 7.

Column 2--Where the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the hospital's HHA, complete the amounts entered on lines 2 through 4 in accordance with the instructions contained in §3647.2. Enter the total on line 7.

Column 3--Enter the sum of columns 1 and 2.

Column 4--Enter the total agency visits from your records for each type of discipline on lines 1 through 6. Total visits reported in column 4 reflect visits rendered for the entire fiscal year and equal the visits reported on S-3, Part I, regardless of when the episode was completed.

Column 5--Compute the average cost per visit for each type of discipline. Divide the number of visits (column 4) into the cost (column 3) for each discipline.

Columns 6 and 9--To determine title XVIII, Part A, V, and XIX cost of service, multiply the number of covered visits in completed episodes made to beneficiaries (column 6) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 9.

**NOTE:** Statistics in column 7, lines 1 through 16, reflect statistics for services that are part of a home health plan, and thus not subject to deductibles and coinsurance. OBRA 1990 provides for the limited coverage of injectable drugs for osteoporosis. While covered as a home health benefit under Part B, these services are subject to deductibles and coinsurance. Report charges for osteoporosis injections in column 8, line 16, in addition to statistics for services that are not part of a home health plan.

Columns 7 and 10--To determine the Medicare Part B cost of service, not subject to deductibles and coinsurance, multiply the number of visits made in completed episodes to Part B beneficiaries (column 7) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 10. Note if the PS&R reports Part B services separately as "subject to and not subject to" deductibles and coinsurance, add the two reports together for each discipline.

For cost reporting periods that overlap October 1, 2000:

Columns 6, 7, 9, 10 and 12--Subscript these columns and report visits and cost for services rendered prior to October 1, 2000 in columns 6, 7, 8, 9, 10, and 12. For services rendered on and after October 1, 2000 enter visits and costs in columns 6.01, 7.01, 9.01, 10.01, and 12.01. No subscripting

is required for cost reporting periods beginning on or after October 1, 2000.

**NOTE:** For cost reporting periods which overlap October 1, 2000, the sum of visits reported in columns 6 and 7 and subscripts (if applicable) may not equal the corresponding amounts on Worksheet S-4, column 7, lines 21, 23, 25, 27, 29 and 31, respectively since those visits are reported based upon the completion of the episode during the fiscal year. However, for cost reporting period beginning on or after October 1, 2000, sum of visits reported in columns 6 and 7 must equal the corresponding amounts on Worksheet S-4, column 7, lines 21, 23, 25, 27, 29 and 31, respectively. These visits are reported for episodes completed during the fiscal year.

Columns 8 and 11--Do not use these columns.

Column 12 and 12.01--Enter the total program cost for each discipline (sum of columns 9 and 10). Add the amounts on lines 1 through 6, and enter this total on line 7.

Cost Limitation Computation--Enter for each Metropolitan Statistical Area (MSA) the payment limitation for each discipline for lines 8 through 13. This is supplied by your intermediary. Subscript each discipline line to accommodate multiple MSAs serviced by your home health agency. For cost reporting periods beginning on and after October 1, 2000, the completion of the cost limitation section is no longer required.

#### Column Descriptions

Column 5--Enter the program limitation (see §1814(b)(1) of the Act) for each discipline on lines 8 through 13. Your fiscal intermediary furnishes these limits to you.

Columns 6 and 9--To determine the program cost limitation for title XVIII, Part A, V, and XIX cost of services, multiply the number of covered visits made to beneficiaries (column 6, lines 1 through 6) (from your records) by the program cost limit amount in column 5 for each discipline. Enter the product in column 9.

Columns 7 and 10--To determine the Medicare cost limitation for Part B cost of services, not subject to deductibles and coinsurance, multiply the number of visits to Part B beneficiaries (column 7, lines 1 through 6) (from your records) by the Medicare cost limit amount in column 5 for each discipline. Enter the product in column 10.

**NOTE:** Enter in columns 6, 7, 9, and 10 only, the visits rendered through September 30, 2000.

Columns 8 and 11--Do not use these columns for lines 1 through 14.

Column 12--Enter the total program cost limitation for each discipline and subscripts (sum of columns 9 and 10). Add lines 8 through 13 and subscripts, and enter this total on line 14.

Supplies and Drugs Cost Computation--Certain services covered by the program and furnished by a home health agency are not included in the cost per visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, develop and apply the ratio of total cost to total charges to program charges to arrive at the program cost for these services.

Column 1--Enter the facility costs in column 1, lines 15 and 16, from Worksheet H-5, Part I, column 29, lines 8 and 9, respectively. For cost reports that overlap October 1, 2000 subscript lines 15 and 16. For cost reporting periods beginning on or after October 1, 2000, do not subscript lines 15 and 16.

Column 2--Enter the shared ancillary costs from Worksheet H-6, Part II, column 3, lines 4 and 5, respectively.

Columns 3 through 5--In column 3, enter the total for lines *15, 16, and 16.20* of columns 1 and 2. *For cost reporting periods ending on or after July 1, 2006, enter in column 4 the total charges for lines 15, 16, and 16.20, respectively, in accordance with the chart under instructions for line 16.20. Refer to §3641, lines 13 and 13.20.* Develop a ratio of total cost (column 3) to total charges (column 4) (from your records), and enter this ratio in column 5.

Columns 6 through 8--Enter in the appropriate column the program charges for drugs and medical supplies charged to patients and not subject to reimbursement on the basis of a fee schedule.

#### Line Descriptions for Columns 6 through 8

Line 15--Enter the program covered charges for services rendered prior to October 1, 2000, for medical supplies charged to patients for items not reimbursed on the basis of a fee schedule.

Line 15.01-- Enter the program covered charges for services rendered on or after October 1, 2000, for medical supplies charged to patients for items not reimbursed on the basis of a fee schedule. For cost reporting periods beginning on or after October 1, 2000, continue to capture medical supply charges in columns 5, 6, and 7 for statistical purposes (has no reimbursement impact) as all medical supplies are covered under the PPS benefit for this period. Report charges only for the services rendered in that fiscal year end regardless of when the episode is concluded. For reporting periods that begin on or after April 1, 2001, eliminate line 15.01 and record all charge and resulting cost data on line 15.

Line 16--Enter the program covered charges for services rendered prior to April 1, 2001, for drugs charged to patients for items not reimbursed on the basis of a fee schedule. Enter in column 7 the charges for pneumococcal vaccine and its administration and influenza vaccine and its administration. Do not enter the charges for hepatitis B vaccine and its administration for services rendered on or after April 1, 2001. For cost reporting periods which overlap April 1, 2001, enter in column 8 the total charges for covered osteoporosis drugs for services rendered prior to April 1, 2001.

For services rendered on or after April 1, 2001 through December 31, 2002, do not enter any amounts in column 7 as pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration are reimbursed on a fee basis, but continue to enter in column 8 the charges for covered osteoporosis drugs as they remain cost reimbursed. (See §1833(m)(5) of the Act.)

For services rendered on and after January 1, 2003, do not enter in column 7 program charges for hepatitis vaccines and its administration as it is fee reimbursed. Enter in column 7 program charges for pneumococcal vaccines and its administration and influenza vaccine and its administration (cost reimbursed) for services rendered on or after January 1, 2003 through June 30, 2006 (for cost reporting periods ending on or after April 30, 2005 (T14) complete only column 7, not column 7.01 (eliminated)). Enter in column 8 the program charges for injectable osteoporosis drugs (cost reimbursed).

Effective for cost reporting periods ending on or after July 1, 2006 (see §3641, line 13), line 16 represents: pneumococcal, influenza, *and* hepatitis B vaccine *costs* and osteoporosis drugs, but not the administration of these vaccines. See the chart below for proper placement of charges.

Line 16.01-- For reporting periods that overlap April 1, 2001, enter the covered program charges for services rendered on or after April 1, 2001 for drugs charged to patients for items not reimbursed on the basis of a fee schedule in the applicable column. Report program charges for injectable drugs for osteoporosis only in column 8 for services rendered on or after April 1, 2001 through the fiscal year end. For reporting periods that begin on or after April 1, 2001, eliminate line 16.01 and record all charge and resulting cost data on line 16.

**NOTE:** For lines 15.01 and 16.01 use the same cost to charge ratio reported for lines 15 and 16 respectively.

Line 16.20.--Effective for cost reporting periods ending on or after July 1, 2006 (see §3641, line 13), line 16.20 represents the administration of pneumococcal, influenza, and hepatitis B vaccines. See the chart below for proper placement of charges.

Effective for cost reporting periods ending on or after July 1, 2006, enter vaccine charges according to the chart below:

**Vaccine Charges**

	<u>Column 7</u>	<u>Column 8</u>
Line 16	Enter charges for services on or after 7/1/2006 for hepatitis B vaccines.  Enter charges for the full fiscal year for pneumococcal and influenza vaccines.  Do not enter charges for pre 7/1/2006 hepatitis B vaccines.	Enter charges for the full fiscal year for osteoporosis drugs.
Line 16.20	Enter charges for pre 7/1/2006 pneumococcal and influenza vaccine administration.  Do not enter charges for the full fiscal year for hepatitis B vaccine administration.  Do not enter charges for services on or after 7/1/2006 for pneumococcal and influenza vaccine administration.  For fiscal years beginning on or after 7/1/2006 enter 0 (zero).	This location is shaded as the administration of the osteoporosis drugs is included in the skilled nursing visit.

Columns 6 and 9--To determine the program cost, multiply the program charges (column 6) by the ratio (column 5) for each line. Enter the product in column 9.

Columns 7 (and subscripts) and 10 (and subscripts)--To determine the Medicare Part B cost, multiply the Medicare charges (column 7) by the ratio (column 5) for each line. Follow the same procedure for the corresponding subscripts. Enter the product in column 10 (and 10.01 as applicable).

Columns 8 and 11--To determine the Medicare Part B cost, multiply the Medicare charges (column 8) by the ratio (column 5) for each line. Enter the result in column 11.

**Per Beneficiary Cost Limitation**

Line 17--Enter the Medicare unduplicated census count for services prior to October 1, 2000 only, from Worksheet S-4, column 2, line 2, for Medicare for cost reporting periods that overlap October 1, 2000. Subscript the line for multiple MSAs as they were reported on S-4 line 20. For cost reporting periods beginning on or after October 1, 2000, completion of the per beneficiary cost limitation data (lines 17 through 19) is no longer required.

Line 18--Enter the agency specific per beneficiary annual limitation supplied by your intermediary for each MSA.

Line 19--Multiply line 17 and subscripts by line 18 and subscripts. If there are multiple MSAs and lines 17 and 18 are subscripted, add them together and enter the result.

3647.2 Part II - Apportionment of Cost of HHA Services Furnished by Shared Hospital Departments--Use this part only where the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the hospital's HHA. Subscript lines 1-5, as applicable, if subscripted on Worksheet C, Part I.

Column 1--Where applicable, enter in column 1 the cost to charge ratio from Worksheet C, Part I, column 9, lines as indicated.

Column 2--Where hospital departments provide services to the HHA, enter on the appropriate lines the charges applicable to the hospital-based home health agency.

Column 3--Multiply the amounts in column 2 by the ratios in column 1, and enter the result in column 3. Transfer the amounts in column 3 to Worksheet H-6, Part I as indicated. If lines 1-5 are subscripted, transfer the aggregate of each line.

3647.3 Part III - Outpatient Therapy Reduction Computation--Services are subject to deductible and coinsurance net of operating and capital reductions. This section computes the payment and reduction (for services rendered on or after January 1, 1998) for Part B visit costs subject to deductibles and coinsurance for various home health services provided. For cost reporting periods that overlap the January 1, 1998 effective date, subscripting of columns 2 and 3 is required. For cost reporting periods beginning on or after January 1, 1998, no subscripting is required. For services rendered on and after January 1, 1999, these services are paid under a fee schedule. Report the visits incurred for purposes of balancing total visits with the cost report.

Column 2--Enter in column 2 the average cost per visit amount from Part I, column 5, lines 2 through 4 above.

Column 2.01--Enter in this column the number of visits rendered for each service prior to January 1, 1998.

Column 3--Enter the number of visits applicable to each service on and after January 1, 1998.

Column 3.01--Enter the result of multiplying column 2 by column 2.01.

Column 4--Multiply column 2 by column 3. Enter 90 percent of the result.

Column 5--Enter the number of visits on or after January 1, 1999.

Line 4--Enter the sum of lines 1 through 3.

### 3648. WORKSHEET H-7 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

This worksheet applies to title XVIII only and provides for the reimbursement calculation of Part A and Part B. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

Worksheet H-7 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

3648.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges--Services