

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

not paid based on a fee schedule 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 as defined in 42 CFR 413.13(b) or customary charges as defined in the 42 CFR 413.13(e).

**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 line 10 of Part II.

### Line Descriptions

Line 1--This line provides for the computation of reasonable cost of program services. Enter the cost of services from Worksheet H-6, Part I as follows:

For cost reporting periods beginning prior to October 1, 1997:

If Worksheet H-6, Part I, column 12, line 7 is less than column 12, line 14, transfer (aggregate program cost):

<u>To Worksheet H-7, Line 1</u>	<u>From Worksheet H-6,</u>
Col. 1, Part A	Part I, col. 9, sum of lines 7, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 7, 15, and 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, sum of lines 7, 15, and 16

If column 12, line 14 is less than column 12, line 7, transfer (aggregate program limitation):

<u>To Worksheet H-7, Line 1</u>	<u>From Worksheet H-6</u>
Col. 1, Part A	Part I, col. 9, sum of lines 14, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 14, 15, and 16
Col. 3, Part B - Subject to deductible and coinsurance	Part I, col. 11, sum of lines 14, 15, and 16

For cost reporting periods beginning on or after October 1, 1997:

If Worksheet H-6, Part I, column 12, line 7 plus the sum of columns 9, 10, and 11, line 15 is less than column 12, line 14 plus the sum of columns 9, 10, and 11, line 15 or column 2, line 19, transfer (aggregate program cost): Do not include in the calculations below the subscripted columns reported on Worksheet H-6 for services rendered on and after October 1, 2000 except for line 16 or 16.01, column 11, osteoporosis drug costs.

For the following vaccines administered on or after January 1, 2003, enter on line 1, only the cost of pneumococcal and influenza vaccines and their administration reported on Worksheet H-6, line 16, column 10.01 (for cost reporting periods ending on or after April 30, 2005 (T14) transfer column 10, not column 10.01 (eliminated)) and osteoporosis drug costs reported on Worksheet H-6, line 16, column 11. Enter no other costs on this line as drugs for hepatitis are fee reimbursed, and all other services are PPS reimbursed.

For cost reporting periods ending on or after July 1, 2006 (see §3647, line 13), transfer the cost of pneumococcal, influenza, and hepatitis vaccines from Worksheet H-6, *Part I*, column 10, line 16, to column 2 of this worksheet, and the cost of osteoporosis drugs from worksheet H-6, column 11, line 16 to column 3 of this worksheet. *Also for cost reporting periods that overlap July 1, 2006 for the portion of the reporting period before July 1, 2006*, transfer the administration of pneumococcal and influenza vaccines from worksheet H-6, *Part I*, column 10, line 16.20, to column 2.

To Worksheet H-7, Line 1From Worksheet H-6,

Col. 1, Part A

Part I, col. 9, sum of lines 7, 15, and 16

Col. 2, Part B - Not subject to deductibles and coinsurance

Part I, col. 10 &amp; 10.01, sum of lines 7, 15, and 16

Col. 3, Part B - Subject to deductibles and coinsurance

Part I, col. 11, lines 15 and 16 added to Part III, sum of columns 3.01 and 4, line 4 for services rendered prior to January 1, 1999

If column 12, line 14 plus the sum of columns 9, 10, and 11 line 15 is less than column 12, line 7 plus the sum of columns 9, 10, and 11 line 15 or column 2, line 19, transfer (aggregate program limitation):

To Worksheet H-7, Line 1From Worksheet H-6,

Col. 1, Part A

Part I, col. 9, sum of lines 14, 15, and 16

Col. 2, Part B - Not subject to deductibles and coinsurance

Part I, col. 10, sum of lines 14, 15, and 16

Col. 3, Part B - Subject to deductibles and coinsurance

Part I, col. 11, lines 15 and 16 added to Part III, sum of columns 3.01 and 4, line 4 for services rendered prior to January 1, 1999

If Column 2, line 19 is less than column 12, line 7 or line 14 plus the sum of columns 9, 10, and 11 line 15 apportion the amount to Part A and Part B in proportion to the Part A and Part B costs reported in columns 9 and 10, line 7 of Worksheet H-6, Part I. Add the amount reported in columns 9 and 10, line 16 to Parts A and B (Not subject to deductible and coinsurance). Enter in column 3 (subject to deductible and coinsurance) the sum of Worksheet H-6, Part I, column 11, lines 15 and 16 and Part III, columns 3.01 and 4, line 4.

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-I, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §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. For cost reports that overlap October 1, 2000, enter only the charges for services rendered prior to October 1, 2000. For cost reporting periods beginning on or after October 1, 2000, enter only the charges associated with osteoporosis drugs which continue to be cost reimbursed. For services rendered on or after January 1, 2003, enter the charges for applicable Medicare covered pneumococcal and influenza vaccines (from worksheet H-6, Part I, line 16, column 7.01 (column 7 for cost reporting periods ending on or after 4/30/2005 as column 7.01 is eliminated)).

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.

Effective for cost reporting periods ending on or after July 1, 2006, in column 2, enter the charges for Medicare covered pneumococcal, influenza, and hepatitis B vaccines (from worksheet H-6, lines 16 and 16.20, column 7). In column 3, enter the charges for Medicare covered osteoporosis drugs (from worksheet H-6, 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 workmens' 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:

- o Workmens' compensation,
- o No fault coverage,
- o General liability coverage,
- o Working aged provisions,
- o Disability provisions, and
- o 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.

**3648.2 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. For services rendered on or after October 1, 2000 this line will only include the osteoporosis drug reduced by primary payor amounts.

Lines 10.01 through 10.14--Enter in column 1 only for lines 10.01 through 10.06, 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 10.07 through 10.10, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 10.12 through 10.14 the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 10.12 through 10.14 do not include any payments associated with services paid under bill type 34X. Obtain these amounts from your PS&R report.

Line 11--Enter in column 2 the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

**NOTE:** If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 11 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 it on this line.

Line 13--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 15--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 11 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 it on this line.

Line 17--Enter the reimbursable bad debts in the appropriate columns. If recoveries exceed the current year's bad debts, line 17 will be negative.

Line 17.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 17. (4/1/2004b)

Line 19--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §132.) Enter the amount of any excess depreciation taken as a negative amount.

Line 20--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in program utilization. Submit the work papers which have developed this amount. (See CMS Pub. 15-I, §132.)

Line 21--Enter any other adjustments. For example, enter an adjustment from changing the recording of vacation pay from the cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.)

Include on this line, for cost reporting periods beginning in Federal fiscal year 2000 only, the special payment for Outcome and Assessment Information Set (OASIS) determined by multiplying the Medicare unduplicated census count on Worksheet S-4, column 2, line 2 and subscripts times \$10 reduced by the amount received on April 1, 2000. Do not include this interim payment on Worksheet H-8 but attach separate documentation supporting the payment.

Line 22--Enter the result of line 18 plus or minus lines 19 and 21, minus line 20.

Line 23--Using the methodology explained in §120, enter the sequestration adjustment.

Line 24--Enter line 22 minus line 23.

Line 25--Enter the interim payment amount from Worksheet H-8, line 4. For intermediary final settlement, report on line 25.01 the amount from line 5.99. For titles V and XIX, enter the interim payments from your records.

Line 26--The amounts show the balance due the provider or the program. Transfer to Worksheet S, Part II.

Line 27--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) A schedule showing the supporting details and computations for this line must be attached.