

4106 WORKSHEET S-4 - SNF-BASED HOME HEALTH AGENCY STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under titles V, XVIII, and XIX. The statistics required on this worksheet pertain to a SNF-based home health agency. The data maintained is dependent upon the services provided by the agency, number of program home health aide hours, total agency home health aide hours, program unduplicated census count, and total unduplicated census count. In addition, FTE data are required by employed staff, contracted staff, and total. Complete a separate Worksheet S-4 for each SNF-based home health agency.

Line 1--Enter the county of residence.

Line 2--Enter the number of hours applicable to home health aide services.

Line 3--Enter the unduplicated count of all individual patients and title XVIII patients receiving home visits or other care provided by employees of the agency or under contracted services during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count (column 5, line 3) may not equal the sum of columns 1 through 4, line 3. For purposes of calculating the unduplicated census, if a beneficiary has received healthcare in more than one CBSA, you must prorate the count of that beneficiary so as not to exceed a total of (1). A provider is to also query the beneficiary to determine if he or she has received healthcare from another provider during the year, e.g., Maine versus Florida for beneficiaries with seasonal residence.

Lines 4 through 20--Lines 4 through 20 provide statistical data related to the human resources of the HHA. The human resources statistics are required for each of the job categories specified in lines 5 through line 20.

Line 4--Enter the number of hours in your normal work week.

Report in column 1 the full time equivalent (FTE) employees on the HHA's payroll. These are staff for which an IRS Form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the HHA.

Compute staff FTEs for column 1 as follows. Add all hours for which employees were paid and divide by 2080 hours. Round to two decimal places, e.g., .4452 is rounded to .45. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked and divide by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

Line 21--Enter the number of CBSAs that you serviced during this cost reporting period.

Line 22--Identify each CBSA where the reported HHA visits are performed by entering the 5 digit CBSA code and Non-CBSA (rural) code as applicable. Subscript the lines to accommodate the number of CBSAs that you provide services. Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the rural CBSA code is 99921.

PPS Activity Data--Applicable for Medicare Services

In accordance with 42 CFR §484.200(a) and §1895 of the Social Security Act, home health agencies transitioned from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. The data to be maintained, depending on the services provided by the agency, includes the number of aggregate program visits furnished in each episode of care payment category for each covered discipline, the corresponding aggregate program charges imposed in each episode of care payment category for each covered discipline, total visits and total charges for each episode of care payment category, total number of episodes and total number of outlier episodes for each episode of care payment category, and total medical supply charges for each episode of care payment category.

HHA Visits--See CMS Pub. 15-2, Chapter 32, §3205, for the definition of an HHA visit

Episode of Care--Under home health PPS the 60 day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full length episode will be 60 days. An episode begins with the start of care date and must end by the 60th day from the start of care.

Less than a full Episode of Care--When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

An episode may end before the 60th day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a partial episode payment (PEP) adjustment.

Use lines 23 through 34 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 35 and 37 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 35 identifies the total number of episodes completed for each episode payment category. Line 39 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do not apply to: 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 40 identifies the total medical supply charges incurred for each episode payment category. Column 5 displays the sum total of data for columns 1 through 4. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report.

When an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all statistical data (i.e., cost, charges, counts, etc...) associated with that episode of care will appear on the PS&R of the fiscal year in which the episode of care is concluded. Similarly, all data required in the cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during the fiscal year. Title XVIII visits reported on this worksheet must equal the sum of the title XVIII visits reported on Worksheet H-3, sum of columns 6 and 7 line 7.

Columns 1 through 4--Enter data pertaining to title XVIII patients only. Enter, as applicable, in the appropriate columns 1 through 4, lines 23 through 34, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episodes of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only Episodes) will not include any visit counts and corresponding charges that appear in column 5

Line 35.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the sum of total visits from lines 23, 25, 27, 29, 31 and 33.

Line 36.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the charges for services paid under PPS and not identified on any previous lines.

Line 37.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the sum of total visit charges from lines 24, 26, 28, 30, 32, 34 and 36.

Line 38.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the total number of episodes (standard/non-outlier) of care rendered and concluded in the provider's fiscal year.

Line 39.--Enter in columns 2 and 4 for each episode of care payment category identified, respectively, the total number of outlier episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

NOTE: Lines 38 and 39 are mutually exclusive.

Line 40.--Enter in columns 1 through 4 for each episode of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 5.--Enter on lines 23 through 40, respectively, the sum total of amounts from columns 1 through 4.