

Line 13.--Enter the unduplicated count of all patients receiving home visits or other care provided by employees of the SNF-based HHA or under contractual arrangement in the appropriate column for the entire cost 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 may not equal the sum of the title XVIII and all other patient census counts. For purposes of calculating the unduplicated census count, if a beneficiary has received health care by more than one HHA, you must prorate the unduplicated census count based on the ratio of visits provided by this SNF-based HHA to the total visits furnished to the beneficiary by all HHAs so as to not exceed a total of one. For example, if an HHA furnishes 100 visits to an individual beneficiary in Maryland during the cost reporting period and the same individual received a total of 400 visits (the other 300 visits were furnished in Florida during the cost reporting period), the reporting HHA would count the beneficiary as a .25 (100 divided by 400) in the unduplicated census count for Medicare beneficiaries for the cost reporting period. Round the result to two decimal places, e.g., .2543 is rounded to .25. A SNF-based HHA must query the beneficiary to determine if he or she has received health care from another HHA during the year, i.e., Maryland versus Florida for beneficiaries with seasonal residence.

4901.52 Part II - Employment Data FTEs.

Line 1.--Enter the total number of hours in a normal workweek (i.e. 40 hours per week or 35 hours per week).

Line 2 through 20.--Provide statistical data related to the human resources of the SNF-based HHA. The human resources statistics are required for each of the job categories specified on lines 2 through 19. Enter any additional categories needed on line 20 and its subscripts.

Report in column 1 the FTE employees on the SNF-based HHA's payroll. These are staff for which an IRS Form W-2 is issued.

Report in column 2 the FTE contracted and consultant staff of the SNF-based 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., .04447 is rounded to .04. 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.

4901.53 Part III - CBSA Data.

Line 1.--Enter the total number of CBSAs where Medicare covered services were provided during this cost reporting period. CBSA codes are five-character numeric codes that identify the geographic area at which Medicare covered services are furnished. Obtain these codes from your contractor.

Line 2.--List all CBSA codes where Medicare covered home health services were provided during the cost reporting period. Line 2 contains the first code. Enter one CBSA code on each line. If additional lines are needed, subscript line 2 beginning with lines 2.01, 2.02 etcetera, as necessary, entering one CBSA code on each subscripted line. Obtain these codes from your contractor.

4901.54 Part IV - PPS Activity Data.

The statistics required on this worksheet pertain to home health services reimbursed under the HHA PPS in accordance with §1895 of the Act. Depending on the services provided by the SNF-based HHA the data to be maintained for each period of care payment category for each covered discipline include aggregate program visits, corresponding aggregate program charges, total visits, total charges, total episodes/period and total outlier periods, and total non-routine medical supply charges.

All data reported in Part IV must be associated only with episodes/periods of care that end during the cost reporting period for payment purposes. Similarly, when an episode/period of care begins in one cost reporting period and ends in the subsequent cost reporting period, all data required in Part IV of this worksheet associated with that episode/period will appear in the cost reporting period on the PS&R in which the episode/period of care ended.

HHA Visits.--See the second paragraph of §4901.50 for the definition of an HHA visit.

Period of Care. Home health services under a plan of care are paid based on a 30-day period of care (beginning on or after January 1, 2020) as required by section 1895(b)(2)(B) of the Act, as amended by section 51001(a)(1) of the Bipartisan Budget Act (BBA) of 2018. A beneficiary can be covered for an unlimited number of non-overlapping periods of care. For periods of care beginning on or after January 1, 2020, the duration of a period must end by the 30th day from the start of care.

Periods of care may be shorter than 30 days. For example, a period may end earlier than the 30th day in the case of a transfer to another HHA, or a discharge and readmission to the same HHA, and payment is pro-rated for these shortened periods, in which more home care is delivered in the same period. In such cases, payment will be pro-rated.

Low Utilization Payment Adjustments (LUPA). If an HHA provides fewer than the threshold of visits specified for the period's home health resources group (HHRG), they will be paid a standardized per visit payment. Such payment adjustments are called LUPAs.

Partial Period Payment (PEP). A partial period payment adjustment occurs when a patient has been discharged and readmitted to home care within the same 30-day period of care; or when a patient transfers to another HHA during a 30-day period of care.

Use lines 1 through 12 to identify the number of visits and the corresponding visit charges for each discipline for each episode/period payment category. Lines 13 and 15 identify the total number of visits and the total corresponding charges, respectively, for each period payment category. Line 16 identifies the total number of periods completed for each period payment category. Line 17 identifies the total number of outlier periods completed for each period payment category. Outlier periods do not apply to: 1) Full Periods without Outliers, and 2) LUPA Periods. Line 18 identifies the total non-routine medical supply charges incurred for each period payment category. The statistics and data required on this worksheet are obtained from the PS&R report.

Columns 1 through 4.--Enter in the appropriate columns 1 through 4, lines 1 through 12, the number of aggregate program visits furnished in each period of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each period of care payment category. The visit counts and corresponding charge data are mutually exclusive for all period of care payment categories.

Line 13.--Enter in columns 1 through 4 for each period of care payment category, respectively, the sum total of visits from lines 1, 3, 5, 7, 9, and 11.

Line 14.--Enter in columns 1 through 4 for each period of care payment category, respectively, the sum total of other charges for all other unspecified services reimbursed under HHA PPS.

Line 15.--Enter in columns 1 through 4 for each period of care payment category, respectively, the sum total of charges for services from lines 2, 4, 6, 8, 10, 12, and 14.

NOTE for lines 16 and 17: The standard periods entered on line 16 and outlier periods entered on line 17 are mutually exclusive.

Line 16.--Enter in columns 1, 3, and 4, for each period of care payment category identified, respectively, the total number of standard periods of care rendered and concluded in the SNF-based HHA's cost reporting period.

Line 17.--Enter in columns 2 and 4 for each period of care payment category identified, respectively, the total number of outlier periods of care rendered and concluded in the SNF-based HHA's cost reporting period. Outlier periods do not apply to columns 1 and 3 (Full Periods without Outliers and LUPA Periods, respectively).

Line 18.--Enter in columns 1 through 4 for each period of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the SNF-based HHA's cost reporting period.

Column 5.--For each of lines 1 through 18, enter the sum of the amounts from columns 1 through 4.