How to Create Comprehensive Resource-Based Hospice Charge Structures

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Objectives

// Describe the historic disincentives for hospice providers to create coherent charge structures and ongoing changes within Medicare that make development of such structures increasingly important

// Discuss the organizational benefits and uses of a comprehensive resource-based charge structure for hospices

// Outline approaches to developing a resource-based hospice charge structure and essential inputs

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The Basics of Charges

// Standard charge for services
// Does not necessarily equal payment rates

= Net Payment/Revenue

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The Basics of Charges

// Charge considerations
   // Medicare and other payer payments
   // Covered services
   // Non-covered services
   // Coinsurances
   // Separately billable services
   // Payment modifications
   // Strategy and approach

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Typical Charges in Hospice

Medicare predominant payer

Daily rate for each day the beneficiary is enrolled in the hospice benefits

Four levels of care

// Routine
// Continuous
  // Exception to daily rate, pays hourly
// Inpatient respite
// General inpatient

Typical Charges in Hospice

The easy route to charges

Vast majority set charge structure based on daily payment rates of Medicare

Why?

// It is so easy
// It works!
  // As long as Medicare payment methodology remains essentially the same and other payers are insignificant)
// Revisions are simple
  // Follow Medicare rate changes each October 1
// Why create more effort when vast majority is Medicare
  // Just make charges = payment rates (no contractual adjustments)
Other Considerations for Hospice

// Medicare hospice payments
// Not intended to cover all hospice/palliative care services provided to Medicare beneficiaries
// Coinsurance to patients at 5% the cost of drugs and prescriptions
// Max of $5 per prescription
// Can bill patients 5% of the payment made by Medicare for respite care
// Bereavement services not included
// Palliative care services not included
// Room & board for other than short-term inpatient care
// Services and/or goods unrelated to the terminal illness
// Personal care items, personal telephones, rent, etc.

Increased Data Collection on Hospice Claims

- Visits reported for RN, NP, LPN, HHA, SW, Physician
- Includes charges for the visits

2008
- Visit reporting expanded to more personnel
- Time of visits reported at 15-minute increments
- Location of service

2014
- Drug charges reported for injectable, non-injectable and infusion
Increased Data Collection on Hospice Claims

// Why is this data being reported?
// How were the charges determined?
    // For visits, charge for visits or 15 minute increments?
// Did you establish a reasonable and customary charge?
    // Does it matter?
// Do you have a uniform charge structure?
    // Does it matter?

Direction of Medicare Hospice Payment Methods

// Payment rates/model to be modified based on the data collected (no earlier than 10/1/13 per ACA)
    // Likely 3 to 5 years out
    // Want to see new cost report and claims data
// Anticipate change in daily rates
    // Timing of days (beginning, middle, end)
    // U-shape or other modified per-diem
Definition of Customary Charge

A rate or charge for a service that is based on some resource utilization characteristic, cost, or other unit of measure that represents an amount that the Company (Organization) would expect to receive from a payor that has sufficient resources to make payment and there is no negotiated contract in place. It provides for cost recovery and profit (margin potential) but is market driven.

Charges for Other Provider Types

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>SNFs</th>
<th>HHAs</th>
<th>Private Duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily rates (by unit)</td>
<td>Daily rates (by unit)</td>
<td>Visit rates and resource utilization</td>
<td>Visits or hourly rates</td>
</tr>
<tr>
<td>Resource utilization (i.e., lab, x-ray, supplies, anesthesia, etc.)</td>
<td>Resource Utilization</td>
<td>Medicare for most – net episode rate</td>
<td>Resource utilization</td>
</tr>
</tbody>
</table>

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Why Change Hospice Charge Methodology?

- Information to make management decisions
  - Monitoring costs for better cost management
  - Margin analysis on different patient populations
  - Per day cost monitoring doesn’t cut it
- Negotiations with payers for alternative payments
  - Medicare refinement, Medicare and/or Medicare managed care, Commercial, etc.
- Better tracking of the real cost of charity, bad debts, and other lost charges

An Alternative Approach to Hospice Charges

- Charges for direct services provided to patients

<table>
<thead>
<tr>
<th>Nursing</th>
<th>Patient Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aides</td>
<td>Imaging</td>
</tr>
<tr>
<td>Social Services</td>
<td>Chemotherapy</td>
</tr>
<tr>
<td>Spiritual Counseling</td>
<td>Radiation Therapy</td>
</tr>
<tr>
<td>Bereavement</td>
<td>Medical Supplies</td>
</tr>
<tr>
<td>Therapies</td>
<td>Labs &amp; Diagnostics</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Inpatient</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Case Management</td>
</tr>
<tr>
<td>DME/Oxygen</td>
<td>And more....</td>
</tr>
</tbody>
</table>
Basis of Charges

// Services
    // Nursing, etc.
    // Visits or times/duration

// Goods
    // Cost based fee-schedule

// Other considerations
    // Office time, travel time, mileage incurred

// Parallel it to professional services
    // Time plus charges

Step 1: Assessment of Charge Need

// Determine charges required to provide revenue at amounts currently being produced
    a) Identify direct patient care services provided at your hospice and the cost
       ➢ Where can you secure this information?
    b) Identify direct client service utilization
       ➢ Hours, visits, etc.
    c) Determine cost per direct client service utilization statistics (measures)
Step 1: Assessment of Charge Need

// What is in the cost?
  // Salaries, wages and employee benefits
  // Contracted services
  // Mileage reimbursement
  // Non-chargeable supplies
  // Other
  // Administrative and facility overhead allocation
  // How about a margin? (later)

Step 1: Assessment of Charge Need

// Non-personnel costs
  // The costs incurred under the assumption that they can be separately billed (charge established)
    // Pharmacy
    // HME
    // Inpatient

// Patient care administration (case management)
  // Total costs/patient days
Step 2: Draft Charge

// Create an initial charge

// Determine that reimbursement is sufficient

// Compare the draft charges to all operating costs

// Exclude non-hospice, non-reimbursable activities from costs

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Step 2: Draft Charge

// Comparative Charge

// Determine what percentage of charge relates to direct service costs versus overhead

// Create a model to cover direct, administrative and overhead, and desired profit margin

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct expenses</td>
<td>55%</td>
</tr>
<tr>
<td>Administrative expenses</td>
<td>25%</td>
</tr>
<tr>
<td>Margin/profit</td>
<td>20%</td>
</tr>
</tbody>
</table>

// Remember charity and bad debts

// Compute new charges based on the desired mix

// Model prospective financial statements

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Information Available From Alternative Approach

// Cost to serve respective patients
   // With appropriate charges, can review charges to identify
      patients representing a financial loss or gain, and the extent
      of the loss or gain
// Costs to serve groups of patients
   // Length of stay
   // Nature of illness

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Information Available From Alternative Approach

// Cost coverage by services
   // Nursing, etc.
   // Reflection of utilization
// More accurate computation of charity care
   // For financial reporting
Information Available From Alternative Approach

Alternative contracting capabilities with payers

Resource utilization rather than patient days

Discounts on charges
  Similar to certain third-party payers at hospitals

Discounts on certain services but not others

Combination contracts
  Charges not-to-exceed day rates
  Other maximum charge arrangements

Charge Structure Example

Personnel (hourly rates for direct service)

Personnel (hourly rates for direct and support service)

Personnel (visit rates)

Ancillary (set rate based on cost)(cost X 3)

Case management fee (daily rate)

Inpatient (daily rate)

Respite care (daily rate)

Physician services (fee schedule)
Reminder

// Charges don’t have to equal payments
  // Charges
  // Contractual adjustments
  // Charity care
  // Bad debts

The Alternatives

// Daily charge based on initial days, last days, days in a nursing home setting, an/or other modifications based on hospice payment rate changes
// If such is the case, how do you determine when and if you are making money?
// A resource-based charge structure provides substantial information for analysis, budgeting, and reporting
No Mandate for Charges

Hospices have the flexibility to use “what is” approach to charges

Best approach would be:

- Assume only hospice in the country
- Everyone paid full charges for service
- How would you charge to effectively cover costs and provide margins for growth and returns?
Thank you

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