Session 318 - How to Prepare Your Hospice for the Revised Cost Reporting Requirements (Part 1)

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Revised Hospice Cost Reporting

• Accumulation of information for purposes of payment modifications required by the Affordable Care Act (“ACA”)
• First draft of new report released in the Spring of 2013
• Subsequent to comment period, second draft released in November 2013.
• Focus of cost report to secure information based on level of care (“LOC”) which can be used for payment rate modification.
Final Report Released

- Essentially no changes from November 2013 draft
- Effective for cost reporting periods beginning on or after October 1, 2014 (freestanding providers only)
- Facility (provider) based hospice cost reports delayed pending design and comment period (will look like freestanding cost report)

General Cost Reporting Requirements

- Cost report to be submitted within 5 months of cost reporting year-end
- Provisions have been established for “Low Utilization” and “No Utilization” cost reports
- Cost reports must be prepared on an accrual basis of accounting
- Failure to submit timely cost reports will result in a reduction, and potential elimination of Medicare payments
- Ultimately, failure to file will result in all interim payments deemed to be overpayments
Cost Reporting Process Remains Unchanged

- Total costs reported
- Cost are reclassified to conform to the cost centers identified in the cost report
- Costs are adjusted based on rules, regulations, and instructions
- General service costs are allocated to all activities conducted by the Organization
- Costs are attributed to payer source
- Many changes inside of the process:
  - Hospice cost report now takes on the look of a Skilled Nursing Facility Cost Report – far exceeds the complexity of the Home Health Agency Cost Report by design and due to the nature of hospice services provided

Three Groupings of Costs

- The revised cost report, like the current report, requires all costs of the hospice to be segregated into three (3) general groups:
  - General service cost centers
    - Commonly referred to as overhead
  - Patient service cost centers
    - Direct hospice patient care activities
  - Non-reimbursable cost centers
    - Activities other than those deemed to be part of the hospice benefit for which Medicare payments are made
Worksheet A

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
<th>Column 5</th>
<th>Column 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry 1</td>
<td>Entry 2</td>
<td>Entry 3</td>
<td>Entry 4</td>
<td>Entry 5</td>
<td>Entry 6</td>
</tr>
<tr>
<td>Entry 7</td>
<td>Entry 8</td>
<td>Entry 9</td>
<td>Entry 10</td>
<td>Entry 11</td>
<td>Entry 12</td>
</tr>
</tbody>
</table>

Worksheet A

<table>
<thead>
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<th>Column 1</th>
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<td>Entry 9</td>
<td>Entry 10</td>
<td>Entry 11</td>
<td>Entry 12</td>
</tr>
</tbody>
</table>
General Issues

- Substantial expansion of cost centers and information accumulation
- Room and board revenue and expenses are separately reported
- Form 339 (Provider Reimbursement Questionnaire) eliminated - pertinent questions built into the cost report itself
- Expansion of statistics:
  - Pharmacy charges
  - Square footage (detail will be needed)
  - Hours of patient care (allocation of nursing administration costs)
  - Contracted general inpatient and inpatient respite care days
- Most talked about: Level of Care ("LOC") reporting of patient care expenses

General Service Cost Centers

- General Service Cost Centers expanded from 6 cost centers to 16 cost centers:

<table>
<thead>
<tr>
<th>Capital related - building</th>
<th>Nursing administration (new)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital related - equipment</td>
<td>Routine medical supplies (new)</td>
</tr>
<tr>
<td>Employee benefits (new)</td>
<td>Medical records (new)</td>
</tr>
<tr>
<td>Administrative - general</td>
<td>Staff transportation</td>
</tr>
<tr>
<td>Plant operations &amp; maintenance</td>
<td>Volunteer services coordination</td>
</tr>
<tr>
<td>Laundry and linen services (new)</td>
<td>Pharmacy (moved)</td>
</tr>
<tr>
<td>Housekeeping (new)</td>
<td>Physician administrative (new)</td>
</tr>
<tr>
<td>Dietary (new)</td>
<td>Patient/residential care (new)</td>
</tr>
</tbody>
</table>
General Service Cost Centers

- The hospice’s chart of accounts should specifically identify costs that are required to be reported as General Service Costs.
- The extent of the breakdown of expenses by the hospice is entirely up to the hospice; however, these costs must be reported as salaries and wages and other costs.
- The hospice is not required to report costs in non-applicable cost centers:
  - Medical records
  - Dietary
  - Housekeeping
  - Laundry and Linen

Other General Service Cost Center Comments

- General service costs are reported directly on Worksheet A (not by LOC).
- You must report Administrative and General, Volunteer Services Coordination, Pharmacy and Plant Operation and Maintenance costs (Level 1 Edit).
- If you have a separate Human Resources or Payroll activity which can be costed, these activity costs (salaries and other) are reported with Employee Benefits.
- These costs will ultimately be allocated to all activities conducted by the Organization based on prescribed or altered statistics.
- No cost can be reported on Worksheet A as Patient/Residential Care.
Patient Care Cost Centers

- The chart of accounts must identify each of these cost components.
- The costs applicable to each cost center can be segregated into as much detail as desired; however, the chart of accounts must distinguish salaries and wages from other costs.
- These costs are reported by LOC on four (4) separate worksheets; A-1, A-2, A-3, and A-4 (different from General Service Cost Centers and Non-Reimbursable Cost Centers).

<table>
<thead>
<tr>
<th>Inpatient care – contracted (new)</th>
<th>Physician services</th>
<th>Other counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse practitioner (new)</td>
<td>Aide and homemaker</td>
<td></td>
</tr>
<tr>
<td>Registered nurse</td>
<td>DME/Oxygen</td>
<td></td>
</tr>
<tr>
<td>LPN/LVN (new)</td>
<td>Patient transportation</td>
<td></td>
</tr>
<tr>
<td>Physical therapy</td>
<td>Imaging services</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>Labs and diagnostics</td>
<td></td>
</tr>
<tr>
<td>Speech therapy</td>
<td>Medical supplies – non-routine</td>
<td></td>
</tr>
<tr>
<td>Medical social services</td>
<td>Outpatient services</td>
<td></td>
</tr>
<tr>
<td>Spiritual counseling</td>
<td>Palliative radiation therapy (new)</td>
<td></td>
</tr>
<tr>
<td>Dietary counseling</td>
<td>Palliative chemotherapy (new)</td>
<td></td>
</tr>
</tbody>
</table>
Reporting Patient Care Costs

- Chart of accounts should identify Patient Care Costs (by cost center) by LOC where possible
- Expense accounts for patient care cost centers need to include accounts by level of care (LOC) or you need to identify those not segregated by LOC for reclassification of costs, i.e.:
  - RN Salaries General
  - RN Salaries Continuous Care
  - RN Salaries Routine Home Care
  - RN Salaries Inpatient Respite Care
  - RN Salaries General Inpatient Care
- For those patient care costs, in total or in part, not segregated by LOC a plan will need to be established to get costs to LOC

Reporting Patient Care Costs

- Required LOC costing (planning required):
  - Direct costing in the accounting records by LOC (salaries and other costs)
  - Reclassification of costs by LOC in the accounting records where direct costing cannot be achieved or cannot be achieved in a cost effective manner
  - Reclassification of costs on the cost report by LOC where direct costing cannot be achieved or can most effectively be handled on the cost report
- Key – integrity of the financial information reported to the Medicare program (remember - information will be used for rate setting)
- Level 1 edits – RN, aides and homemakers, DME/Oxygen, and Lab
**Non-Reimbursable Cost Centers**

<table>
<thead>
<tr>
<th>Bereavement program</th>
<th>Residential care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer program</td>
<td>Advertising (new)</td>
</tr>
<tr>
<td>Fundraising</td>
<td>Telehealth/telemonitoring (new)</td>
</tr>
<tr>
<td>Hospice/Palliative fellows (new)</td>
<td>Thrift store (new)</td>
</tr>
<tr>
<td>Palliative care program (new)</td>
<td>Nursing facility room and board (new)</td>
</tr>
<tr>
<td>Other physician services (new)</td>
<td>Other</td>
</tr>
</tbody>
</table>

- Minimum chart of accounts requirements (you can capture as much detail as you want):
  - Salaries and wages
  - Other
- These costs are reported directly on Worksheet A – you can maintain as much detail as you want or need for other purposes
- Marketing and Advertising (New) – reasoning for making it its own cost center
- Room and board payments reported as non-reimbursable cost center
Final Chart of Account Comments

- Make certain that the chart of accounts covers all the necessary General Service and Non-Reimbursable Cost Centers
- Modify chart of accounts for Patient Care Service Cost Centers - identify by LOC where possible - discuss with cost report preparer how those not identifiable by LOC will be handled
- Segregate all facility-related costs by facility (maintain options for reporting these costs)
- Chart of accounts should be sufficient for internal reporting, cost report, tax reporting, and external financial reporting - cost reporting requirements are not the only driver

Allocation of General Service Costs

- General service costs are allocated based on statistics
- Statistics required:
  - Square footage (by facility) identifying room (space), dimensions of the room, computed square feet, and use of the room. This will allow preparer to classify the square footage
  - Dollar value (segregate property and equipment and lease payments by cost center) - alternative discussed in Part 2
  - Volunteer hours (purpose and number of hours)
  - Patient care hours (LOC) - alternative discussed in Part 2
  - Pharmacy charges (LOC) - standard charges of the hospice - alternative discussed in Part 2
  - Miles traveled in owned/lease vehicles, miles paid to staff (cost center and LOC - alternative discussed in Part 2
  - Patient days:
    - By LOC and payor source
    - In-facility days by LOC (by facility)
    - Contract days (inpatient respite and general inpatient)
Statistical Issues

- Operation and maintenance costs allocated after administrative-general costs have already been allocated
- Volunteer services coordination costs allocated after administrative-general costs have already been allocated
- Dollar value
- Pharmacy charges by LOC
- Patient care staff time by LOC
- Mileage by LOC

Revenue (Income) Accumulation

- Revenue reporting expanded to include:
  - Revenue (standard charges by LOC, by payor)
  - Contractual adjustments
  - Charity care reductions
  - Room and board revenue (Medicaid)
Outcome of the Revised Report

- Identification of Medicare revenue/Medicare expenses (margin on services)
- Identification of cost-per-day by LOC
  - Concern – general inpatient and inpatient respite care costs; how high will they be – how could this influence rates
  - Fortunately – most administrative costs are not allocated to contracted inpatient and contracted inpatient respite care costs
- Increased Level 1 edits will cause some control over quality:
  - Patient days' cost comparisons

Let’s Get Prepared

- Step 1 – Review and modify your chart of accounts to be effective with the beginning of your cost reporting year:
  - Revenue accounts need to be sufficient to report revenues as required on Worksheet F-2 (level of care for Medicare, Medicaid, and Other payors)
    - Revenue (gross) by LOC
  - Expense account categories need to be established for each applicable cost center:
    - General Service Cost Centers
    - Patient Care Cost Centers
    - Non-reimbursable Cost Centers
  - General Service and Non-Reimbursable Cost Centers are not segregated by LOC
  - Patient care costs need to be reported by LOC – directly or through other method
Let’s Get Prepared

Step 2 - Review statistical requirements
- Determine approach to upgrading or securing required statistics
- Where statistics cannot be secured, determine other action steps
- Other action steps may include:
  - Work around, i.e. patient care hours (nursing administration)
  - Work around, i.e. per-diem pharmacy costs, where available
  - Request for alternative statistics for allocation of costs
- Certain cost allocations may not yield meaningful results or distort costs, i.e. volunteer hours in tax-exempt hospice
  - Request for change in allocation of costs may be appropriate

Let’s Get Prepared

- Secure as much information as possible – we are spending considerable time as are other significant cost report preparers. Various consultants may develop different approaches to deal with certain cost reporting difficulties. **Key - best reports possible**
- Make certain cost report preparer (internal or external) is involved in the planning process (to the extent necessary) to ensure you will be able to submit an acceptable and appropriate cost report for the upcoming cost reporting year
- The report is a substantial expansion; however, it can be handled if planning occurs - **the sky is not falling**