Medicare Certified Hospices

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All hospices</td>
<td>2,255</td>
<td>3,250</td>
<td>3,585</td>
<td>3,727</td>
<td>3,925</td>
<td>5.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>For profit</td>
<td>672</td>
<td>1,676</td>
<td>2,054</td>
<td>2,199</td>
<td>2,411</td>
<td>12.9</td>
<td>5.6</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>1,324</td>
<td>1,337</td>
<td>1,314</td>
<td>1,318</td>
<td>1,314</td>
<td>0.1</td>
<td>-0.3</td>
</tr>
<tr>
<td>Government</td>
<td>257</td>
<td>237</td>
<td>217</td>
<td>209</td>
<td>200</td>
<td>-1.2</td>
<td>-2.5</td>
</tr>
<tr>
<td>Freestanding</td>
<td>1,069</td>
<td>1,103</td>
<td>1,249</td>
<td>1,243</td>
<td>2,844</td>
<td>10.1</td>
<td>4.7</td>
</tr>
<tr>
<td>Hospital based</td>
<td>156</td>
<td>183</td>
<td>180</td>
<td>177</td>
<td>176</td>
<td>-2.0</td>
<td>-3.6</td>
</tr>
<tr>
<td>Home health based</td>
<td>378</td>
<td>443</td>
<td>486</td>
<td>492</td>
<td>503</td>
<td>2.3</td>
<td>2.1</td>
</tr>
<tr>
<td>SNF based</td>
<td>22</td>
<td>21</td>
<td>21</td>
<td>23</td>
<td>25</td>
<td>-0.7</td>
<td>1.8</td>
</tr>
<tr>
<td>Urban</td>
<td>1,424</td>
<td>2,190</td>
<td>2,536</td>
<td>2,670</td>
<td>2,824</td>
<td>6.3</td>
<td>4.0</td>
</tr>
<tr>
<td>Rural</td>
<td>788</td>
<td>1,012</td>
<td>986</td>
<td>983</td>
<td>978</td>
<td>3.6</td>
<td>-0.6</td>
</tr>
</tbody>
</table>

Note: SNF (skilled nursing facility). Numbers may not sum to totals because of missing data or provider characteristics for a small number of providers.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, and the standard analytic file of hospice claims from CMS.
Medicare Certified Hospices

**Table 12-5**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of hospice users (in millions)</td>
<td>0.534</td>
<td>1.219</td>
<td>1.274</td>
<td>1.315</td>
<td>7.8%</td>
<td>4.5%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Total spending (in billions)</td>
<td>$2.9</td>
<td>$13.8</td>
<td>$15.1</td>
<td>$15.1</td>
<td>15.2%</td>
<td>9.3%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Average length of stay among decedents (in days)</td>
<td>53.5</td>
<td>86.3</td>
<td>88.0</td>
<td>87.8</td>
<td>4.4%</td>
<td>2.0%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Median length of stay among decedents (in days)</td>
<td>17</td>
<td>17</td>
<td>18</td>
<td>17</td>
<td>0 days</td>
<td>1 day</td>
<td>-1 day</td>
</tr>
</tbody>
</table>

**Note:** Average length of stay is calculated for decedents who used hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime. The number of hospice users, total spending, and average length of stay displayed in the table are rounded; the percent change is calculated using unrounded data.

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims standard analytic file from CMS.

**PROPOSED FY2016 Hospice Payment Rule/Update to HQRP**

- All dx. codes on claims
- RHC payment modifications
- Hospice payment rates
- Service intensity add-on (SIA)
- HQRP – submission requirements & public reporting comments
- Align aggregate and inpatient cap year with the federal fiscal year
- Modify the economic index used for the aggregate cap calculation per IMPACT Act
PROPOSED FY2016 Payment Rule
CMS Comments

Continuing CMS concern regarding

Unbundling of the Medicare Hospice Benefit

It is our general view that hospices are required to provide virtually all the care that is needed by terminally ill patients.” Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis; all conditions are considered to be related to the terminal illness.
It is also the responsibility of the hospice physician to document why a patient's medical needs will be unrelated to the terminal prognosis.

Hospices may not be conducting comprehensive assessments as required.
Hospices may not be updating the plan of care as required.

To recognize the conditions that effect an individual’s terminal prognosis.
PROPOSED FY2016 Payment Rule
Diagnosis Codes on Claims

ALL diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual

• Mental health disorders and conditions
• Comorbidities
• Hospices required to assess the patient’s physical, emotional, spiritual and psychosocial well-being
• One diagnosis on claims
  – CY2012 – 72% of claims
  – FY2013 – 67% of hospices
  – FY2014 – 49% of claims

CMS will continue to monitor
## PROPOSED FY2016 Payment Rule
### Payment Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Proposed Rates</th>
<th>Proposed SIA budget neutrality factor adjustment (1-0.0081)</th>
<th>Proposed FY 2016 hospice payment update percentage</th>
<th>Proposed FY2016 Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>RHC 1-60 days</td>
<td>$187.63</td>
<td>X 0.09853</td>
<td>X 1.018</td>
<td>$188.20</td>
</tr>
<tr>
<td>651</td>
<td>RHC 61+ days</td>
<td>$145.21</td>
<td>X 0.9967</td>
<td>X 1.018</td>
<td>$147.34</td>
</tr>
</tbody>
</table>

---

## PROPOSED FY2016 Payment Rule
### Payment Rates – Day Count

Days tied to beneficiary

60 day gap
PROPOSED FY2016 Payment Rule
Payment Rates

<table>
<thead>
<tr>
<th>Description</th>
<th>FY2015 Payment Rate</th>
<th>Proposed Rates</th>
<th>(1-0.0081)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous Home Care</td>
<td>$929.91</td>
<td>X 1.018</td>
<td>$946.65</td>
</tr>
<tr>
<td>Full Rate = 24 hours of care</td>
<td></td>
<td></td>
<td>$39.44 Hourly</td>
</tr>
<tr>
<td>Inpatient Respite</td>
<td>$164.81</td>
<td>X 1.018</td>
<td>$167.78</td>
</tr>
<tr>
<td>General Inpatient Care</td>
<td>$708.77</td>
<td>X 1.018</td>
<td>$721.53</td>
</tr>
</tbody>
</table>

Four criteria must be met:
1. The day is billed as a RHC level of care day;
2. The day occurs during the last 7 days of life (and the beneficiary is discharged dead);
3. Direct patient care is provided by a RN or a social worker that day (in person); and
4. The service is not provided in a SNF/NF.
PROPOSED FY2016 Payment Rule
Payment Rates - SIA

• In addition to per diem rate
• Maximum of four hours
• Calculated:

\[ \text{Hourly CHC rate} \times \text{Hours of direct patient care by RN/SW} \]

PROPOSED FY2016 Payment Rule
Payment Rates - CBSA

• Proposed transition using 50/50 blend of existing and new CBSA designations in FY2016
• Fully transition to new CBSA designations in FY2017
• Changes for some areas from rural to urban

National Association for Home Care & Hospice 2015
PROPOSED FY2016 Payment Rule
Payment Rates – Aggregate Cap

- Align aggregate cap year with federal fiscal year
- 2015 aggregate cap: $27,135.96
- 2016 anticipated aggregate cap: $27,624.41
- Rebasing?

---

Medicare Certified Hospices – Aggregate Cap

<table>
<thead>
<tr>
<th>TABLE 12-7</th>
<th>Hospices that exceeded Medicare’s annual payment cap, selected years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2002</td>
</tr>
<tr>
<td>Percent of hospices exceeding the cap</td>
<td>2.6%</td>
</tr>
<tr>
<td>Average payments over the cap per hospice exceeding the cap (in thousands)</td>
<td>$470</td>
</tr>
<tr>
<td>Payments over the cap as percent of overall Medicare hospice spending</td>
<td>0.6%</td>
</tr>
<tr>
<td>Total Medicare hospice spending (in billions)</td>
<td>$4.4</td>
</tr>
</tbody>
</table>

Note: The cap year is defined as the period beginning November 1 and ending October 31 of the following year.

Source: MedPAC analysis of 100 percent hospice standard analytical file (claims) data, Medicare hospice cost reports, and Provider of Services file data from CMS. Data on total spending for each fiscal year from the CMS Office of the Actuary.
PROPOSED FY2016 Payment Rule
HQRP Update - HIS

• No new HIS measures
• 30 day submission deadline
• 2% penalty if not meeting submission requirements
• HIS submissions and payment penalty
  January 1, 2016 to December 31, 2016 - 70%
  January 1, 2017 to December 31, 2017 – 80%
  January 1, 2018 to December 31, 2018 – 90%

PROPOSED FY2016 Payment Rule
HQRP Update - HIS

High priorities for future measure development:
• Patient-reported pain outcome measure that incorporates patient and/or proxy report regarding pain management;
• Claims-based measures focused on care practice patterns including skilled visits in the last days of life, burdensome transitions of care for patients in and out of the hospice benefit, and rates of live discharges from hospice;
• Responsiveness of hospice to patient and family care needs; and
• Hospice team communication and care coordination.
PROPOSED FY2016 Payment Rule
HQRP Update - CAHPS

Payment:
• FY 2018 APU - January – December 2016
• FY 2019 APU - January – December 2017
• No late submissions

Oversight Activities:
• Propose to publish a list of hospices meeting requirements
• Provider level reports in CASPER

PROPOSED FY2016 Payment Rule
HQRP Update

Public reporting?
Hospice Compare
Current Hospice Hot Topics

NOE and NOTR

Attending physician information

NOE/NOTR

- Verify eligibility
- Process to ensure submission as soon as possible
- Check and re-check for errors
- Modify policies and procedures to reflect requirements, exceptions, and modified processes and procedures
- Submit stories to Katie@nahc.org or TMF@nahc.org
Election Statement & Attending Physician – CR 9114

- Election statement must include
  - patient’s choice of attending physician (sufficient detail)
  - with patient acknowledgement that attending is their choice
- Change in designated attending form
  - Signed statement
  - Sufficient detail
  - Date change is to be effective
  - Patient acknowledgment that change is their choice
- Patient not required to change attending when entering GIP
  - if attending does not have privileges or is not available, CoPs require that medical director takes on role of attending
- CoP deferral to medical director may conflict with physician payment policies allowing substitute

Attending Physician

- Educate all staff
  - Patient’s right to choose – or not choose
  - How to handle admissions
  - How to handle changes in level of care in contracted facilities and the inpatient unit
  - How to recognize and handle situations when the attending physician is unavailable
Possible Definitions – Terminal Illness

• “Abnormal and advancing physical, emotional, social and/or intellectual processes which diminish and/or impair the individual’s condition such that there is an unfavorable prognosis and no reasonable expectation of a cure;

• not limited to any one diagnosis or multiple diagnoses, but rather it can be the collective state of diseases and/or injuries affecting multiple facets of the whole person, are causing progressive impairment of body systems, and there is a prognosis of a life expectancy of six months or less”.

Possible Definitions – Related Conditions

“Those conditions that result directly from terminal illness; and/or

– result from the treatment or medication management of terminal illness; and/or

– which interact or potentially interact with terminal illness; and/or

– which are contributory to the symptom burden of the terminally ill individual; and/or

– are conditions which are contributory to the prognosis that the individual has a life expectancy of 6 months or less”.
Hospice PEPPER

- April 2015
- Must obtain electronically
- Target areas
  - Live discharges, excluding
    - Transfers, revocations, discharge for cause, out of service area

Hospice PEPPER

- Target areas
  - Long lengths of stay
  - CC provided in an ALF
  - RHC provided in an ALF
  - RHC provided in a NF
  - RHC provided in a SNF
MedPAC

- Advisory capacity
- Payment should better reflect cost of care
- Recommend elimination of payment update FY2016
- Repeat previous recommendations
  - Medical review of hospices with high proportion of long LOS patients
  - Eliminate MA hospice carve-out

MedPAC

- Recommend hospice be included in the hospital transfer discharge policy
- Projecting average margin of 6.6% in 2015
- Comments
  - For-profit v. non-profit
  - Expand hospice benefit while maintaining patient choice
  - No barriers to capital/entry into market
OIG

- Length of stay
- Location of care
- Patient eligibility
- Personnel qualifications (and other applicable regulations)

OIG ALF Report

RECOMMENDATIONS

- Reform payments to reduce the incentive for hospices to target beneficiaries with certain diagnoses and those likely to have long stays
- Target certain hospices for review,
- Develop and adopt claims-based measures of quality
- Make hospice data publicly available for beneficiaries
- Provide additional information to hospices to educate them about how they compare to their peers
OIG ALF Report Findings

• Payments in ALFs more than doubled in 5 years
• Most beneficiaries in ALFs had diagnoses that typically require less complex care
• Hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs

OIG ALF Report Findings

• Typically provided <5 hours of visits/week
• Visit mix was heavily hospice aides
• For-profit hospices received much higher Medicare payments per beneficiary than nonprofit hospices
OIG Plan 2015

• Some for-profit hospices stand out for their use of the most expensive level of hospice care.
• Many for-profit hospices targeted ALFs.
• Review of Hospice GIP
  – Assess the appropriateness of hospices’ general inpatient care claims
  – Review content of election statements for hospice beneficiaries who receive general inpatient care
  – Review hospice medical records to address concerns that this level of hospice care is being misused or overused

What To Expect
What To Expect

- Steps toward value-based purchasing
- Steps toward public quality reporting
- Increased scrutiny
- Steps toward payment reform

What To Expect

- Population health management
- Transitional care programs/programs expanding into homecare
- Palliative care
- Innovation
  - Medicare Care Choices Model
  - 140 hospices
501: Hospice Summer Camp 2015

Thomas E. Boyd, MBA, CFE
Simione Healthcare Consultants
877-424-6527
tboyd@simione.com

Dawn Michelizzi
VNA of Greater Philadelphia
215-581-2324
dmichelizzi@vnaphilly.org

NAHC FMC Conference
Gaylord Opryland - Nashville
June 28 – 30, 2015

40.2 million people in the USA (13% of the population) are 65 or older.

Source: US Department of Labor
The US population of 65 and older will double during the next 30 years – by 2040, one in five Americans (about 81.2 million people, or 20% of the population) will be 65 or older!

Source: US Department of Labor

Change in US Population
2005-2050

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seniors (65 and Older)</td>
<td>58.30%</td>
</tr>
<tr>
<td>Working Adults (18-65)</td>
<td>-7.90%</td>
</tr>
<tr>
<td>Children (17 and Younger)</td>
<td>-8.00%</td>
</tr>
</tbody>
</table>

Source: US Department of Labor
### Hospice Use and Expenditures

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hospice Users (In Millions)</td>
<td>0.534</td>
<td>1.315</td>
</tr>
<tr>
<td>Total Spending (In Billions)</td>
<td>$2.9</td>
<td>$15.1</td>
</tr>
<tr>
<td>Average Length of Stay Among Decedents (In Days)</td>
<td>53.5</td>
<td>87.8</td>
</tr>
<tr>
<td>Median Length of Stay Among Decedents (In Days)</td>
<td>17</td>
<td>17</td>
</tr>
</tbody>
</table>

MedPAC March 2015

### Increase in Total Number of Hospice Driven by Growth in For-Profit Providers

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Hospices</td>
<td>2,255</td>
<td>3,925</td>
</tr>
<tr>
<td>For Profit</td>
<td>672</td>
<td>2,411</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>1,324</td>
<td>1,314</td>
</tr>
<tr>
<td>Government</td>
<td>257</td>
<td>200</td>
</tr>
<tr>
<td>Freestanding</td>
<td>1,069</td>
<td>2,844</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>785</td>
<td>553</td>
</tr>
<tr>
<td>Home Health Based</td>
<td>378</td>
<td>503</td>
</tr>
<tr>
<td>SNF Based</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Urban</td>
<td>1,424</td>
<td>2,824</td>
</tr>
<tr>
<td>Rural</td>
<td>788</td>
<td>978</td>
</tr>
</tbody>
</table>

MedPAC March 2015
### Hospice Medicare Margins

<table>
<thead>
<tr>
<th>Type</th>
<th>2005</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4.6%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Freestanding</td>
<td>7.2</td>
<td>13.3</td>
</tr>
<tr>
<td>Home Health Based</td>
<td>3.1</td>
<td>5.5</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>-9.1</td>
<td>-16.8</td>
</tr>
<tr>
<td>For Profit (All)</td>
<td>9.9</td>
<td>15.4</td>
</tr>
<tr>
<td>Freestanding</td>
<td>10.3</td>
<td>16.5</td>
</tr>
<tr>
<td>Nonprofit (All)</td>
<td>1.0</td>
<td>3.7</td>
</tr>
<tr>
<td>Freestanding</td>
<td>3.8</td>
<td>7.7</td>
</tr>
<tr>
<td>Urban</td>
<td>5.1</td>
<td>10.3</td>
</tr>
<tr>
<td>Rural</td>
<td>0.2</td>
<td>7.8</td>
</tr>
</tbody>
</table>

MedPAC March 2015

### Hospice Costs Per Day by Type of Provider

<table>
<thead>
<tr>
<th>Type</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Hospices</td>
<td>$146</td>
</tr>
<tr>
<td>Freestanding</td>
<td>140</td>
</tr>
<tr>
<td>Home Health Based</td>
<td>156</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>189</td>
</tr>
<tr>
<td>For Profit</td>
<td>132</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>164</td>
</tr>
<tr>
<td>Urban</td>
<td>148</td>
</tr>
<tr>
<td>Rural</td>
<td>131</td>
</tr>
</tbody>
</table>

MedPAC March 2015
### Percent of Medicare Decedents Who Used Hospice

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Beneficiaries</td>
<td>22.9%</td>
<td>44.0%</td>
<td>45.2%</td>
<td>46.7%</td>
<td>47.3%</td>
</tr>
</tbody>
</table>

MedPAC March 2015

### Hospice Length of Stay

<table>
<thead>
<tr>
<th>Type of Hospice</th>
<th>Average Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Profit</td>
<td>105</td>
</tr>
<tr>
<td>Nonprofit</td>
<td>68</td>
</tr>
<tr>
<td>Freestanding</td>
<td>91</td>
</tr>
<tr>
<td>Home Health Based</td>
<td>68</td>
</tr>
<tr>
<td>Hospital Based</td>
<td>59</td>
</tr>
</tbody>
</table>

MedPAC March 2015
# Hospices that Exceed Medicare’s Annual Payment CAP, Selected Years

<table>
<thead>
<tr>
<th>Category</th>
<th>2002</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Hospices Exceeding the CAP</td>
<td>2.6%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Total Medicare Hospice Spending</td>
<td>$4.4</td>
<td>$15.0</td>
</tr>
<tr>
<td>(In Billions)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MedPAC March 2015

---

# Medicare Hospice Spending in 2013

<table>
<thead>
<tr>
<th>In Billions</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Hospice users in 2013</td>
<td>$15.1</td>
</tr>
<tr>
<td>Beneficiaries with LOS &gt; 180 days</td>
<td>8.8</td>
</tr>
<tr>
<td>Beneficiaries with LOS ≤ 180 days</td>
<td>6.2</td>
</tr>
</tbody>
</table>

MedPAC March 2015
Overview: Why Cost Report Reform?

- Currently there is no monetary settlement purpose to the filing of a hospice provider cost report. Medicare Hospice payment is made based on a flat per diem rate, by each of the four levels of care.
- Section 3132 of the Affordable Care Act requires that CMS collect appropriate data and information to facilitate hospice payment reform.
- ABT Technical Report found many erroneously completed hospice cost reports which could not be included in the study.
- “Useful Data” is needed for effective payment reform.
  - Claims Data
  - Cost Report Data
  - Quality Data
Cost and General Instructions

- **CMS 15 – Provider Reimbursement Manual Parts 1 and 2:**
  - **Part 1:**
    - Defines reasonable costs of providing services to Medicare patients, including “Allowable” versus “Non-allowable.”
    - Requirement to file cost reports.
    - Allocation statistics used in cost determinations.
    - Provider rights in payment disputes.
  - **Part 2:**
    - General instructions on the cost report and their forms.


Cost Report Form

- **Highlights of the Form CMS 1984-14 include:**
  - Reporting by Level of Care
  - New General Service Cost Centers
  - Expanded Direct Patient Care Cost Centers
  - Expanded Non-Reimbursable Cost Centers
  - Different / Revised Worksheets
Hospice Cost Report Includes Expanded Level 1 Edits

An electronic version of the Cost Report, which is required, cannot be generated by cost reporting software if it contains a Level 1 edit error. The enhancement of Level 1 edits, increases the quality of the Cost Report submission. The edits are available at:


The Hospice Cost & Data Report ("Cost Report"), effective for cost reporting periods beginning on or after October 1, 2014, includes the following Level 1 edits, among others:
Hospice Cost Report Includes Expanded Level 1 Edits

- If patient days are reported for any Level of Care ("LOC"), costs must be reported on the applicable LOC worksheet (A-1, A-2, A-3, and A-4) and vice versa.

- Costs are required to be reported on Worksheet A for Employee Benefits, Administrative and General, Plant Operation & Maintenance, Volunteer Services Coordination, Pharmacy, Registered Nurses, Aides and Homemakers, DME/Oxygen, and Labs and Diagnostics.

- If contracted inpatient costs are reported, contracted days must be reported and vice versa.

Cost Report Worksheets

- Worksheet S - Certification Page
- Worksheet S-1 - General Agency Info & Statistics
- Worksheet S-2 - Hospice Reimbursement Questionnaire
- Worksheet A - Reclassification and Adjustment of TB Expenses
- Worksheet A-1 - Continuous Home Care
- Worksheet A-2 - Routine Home Care
- Worksheet A-3 - Inpatient Respite Care
- Worksheet A-4 - General Inpatient Care
- Worksheet A-6 - Reclassifications
- Worksheet A-8 - Adjustments to Expenses
- Worksheet A-B-1 - Related Party or Home Office Costs
- Worksheet B - Cost Allocation
- Worksheet B-1 - Cost Allocation (Statistical Basis)
- Worksheet C - Cost per Diem Calculation
- Worksheet F - Balance Sheet
- Worksheet F-1 - Statement of Changes in Fund Balance
- Worksheet F-2 - Income Statement
Worksheet S – Certification page

- When the cost report is completed and exported to a CD for encryption, this page of the cost report must be signed by an Administrator or Officer for the provider.
- Remember it is best to sign this page in BLUE ink.
- False Claims Act
  - Financial Incentive for Whistleblowers:
    - Persons filing under the Act stand to receive a portion (usually about 15-25 percent) of any recovered damages.
  - Key Provision:
    - Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim.
  - Knowing and knowingly is defined that a person, with respect to information:
    - Has actual knowledge of the information;
    - Acts in deliberate ignorance of the truth or falsity of the information; or
    - Acts in reckless disregard of the truth or falsity of the information,
    - No proof of specific intent to defraud is required.

Worksheet S-1 Part I: Hospice Identification Data

- On this worksheet you will enter the following identifiable information about your agency:
  - Agency Name
  - Address
  - CMS Certification Number (CCN) formerly known as the Medicare Provider Number
  - Date hospice began operation
  - Certification Date (Medicare & Medicaid)
  - Cost Reporting Period
  - Malpractice
    - Does the facility legally carry malpractice insurance?
    - Is the malpractice insurance based on:
      - Claims made
      - Occurrence
    - Enter the amounts of the following:
      - Premiums
      - Paid Losses
      - Self Insurance
    - How are premiums and paid losses reported?
      - A&G
      - Other (Identify)
Worksheet S-1 Part I: Hospice Identification Data

- On this worksheet you will enter the following identifiable information about your agency:

  ✓ Type of Control
    - Nonprofit (Church or other)
    - Proprietary (Individual, Corporation, Partnership or Other)
    - Governmental (Federal, City, County, State or Other)

  ✓ CBSA (Core Based Statistical Area) Information
    - Number of CBSAs where Medicare services were provided
    - List each of those CBSAs

Worksheet S-1 Part II: Hospice Identification Data

- For Part II, you will enter the Statistical Data for Enrollment Unduplicated Days by Payer and by level of care.

  ✓ The Unduplicated Days need to be broken out by the following levels of care:
    - Continuous Home Care
    - Routine Home Care
    - Inpatient Respite Care
    - General Inpatient Care

  ✓ The three Payer categories that the Unduplicated Days need to be identified by are:
    - Medicare
    - Medicaid
    - Other

NOTE: The Inpatient days entered in Part III must be included in the appropriate days in Part II.
### Worksheet S-1 Part III: Hospice Identification Data

- For Part III, enter the contracted days by payer for inpatient services at a contracted facility.
  - The Inpatient Days (Inpatient Respite Care & General Inpatient Care) need to be identified by the following payers:
    - Medicare
    - Medicaid
    - Other

**NOTE:**

The Inpatient days entered in Part III must be included in the appropriate days in Part II.

### Worksheet S-2: Hospice Reimbursement Questionnaire

- This worksheet collects organizational, financial and statistical information.
- The first set of questions deal with:
  - Change of ownership
  - Terminating participation in the Medicare program
- The next group of questions relate to your financials.
  - Do you have financial statements prepared by a CPA?
    - If so, are they audited, compiled or reviewed?
  - Is there a difference between the total expenses and total revenue reported on the cost report and the financial statements?
Worksheet S-2: Hospice Reimbursement Questionnaire

- Following the financial questions are questions relating to your PS&R.
  - Was only the PS&R used to complete the cost report.
  - Was the PS&R used for totals to complete the cost report.
- Finally, the last part to complete for the questionnaire is information about who prepared the cost report.
  - Name and Title
  - Contact Information

Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

- The cost center line items are segregated into three sections:
  - General Service cost centers
  - Direct Patient Care Service cost centers
  - Non-Reimbursable cost centers
- General Service cost centers include expenses incurred in operating the program as a whole that are not related directly to patient care.
- Direct Patient Care Service costs are reported by line on Worksheets A-1, A-2, A-3, and A-4. These costs must then be summed and put on Worksheet A.
- Non-Reimbursable cost centers include costs of non-reimbursable services and programs.
### Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

#### General Service Cost Centers

- **Line 1: Cap Rel. Costs-Bldg. & Fixtures**
  - *Rent, bldg. insurance, depreciation for facilities*
    - **Includes Inpatient Facility**
    - **Excludes residential care facility, when the unit is separate and distinct and is used for resident care services only (ie. routine home care).** These costs would then be recorded on Line 66 (residential care).
    - **Pre-allocation of expenses may have to be made if**
      - *Inpatient Facility does Routine and Continuous Care*
      - *Residential Care facility houses your entire operations*
    - **Nurses also go outside the residence to visit patients in their homes in the community**

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#### General Service Cost Centers – Continued

- **Line 2: Cap Rel. Costs-Moveable. Equip**
  - *Leases, depreciation, personal property taxes*
  - *Same issues at above*

- **Line 3: Employee Benefits**
  - *Payroll taxes, Pension, Health Ins., Workmen’s Comp Ins., etc.*

- **Line 4: Administrative & General**
  - *Costs administrative in nature that benefit the entire entity, i.e. accounting, legal, human resources, data processing, office supplies, malpractice insurance, help wanted ads, etc.*
  - *Does not include marketing and advertising costs that are not related to patient care, fundraising costs, or other costs that should be reported in a non-reimbursable cost center.*
Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

- General Service Cost Centers – continued
  - Line 5: Plant Operation and Maintenance
    - Utilities, repairs, cleaning, maintenance
  - Line 6: Laundry & Linen
    - Commonly seen with an inpatient facility or residence
  - Line 7: Housekeeping
    - Commonly seen with an inpatient facility or residence.
  - Line 8: Dietary
    - Commonly seen with an inpatient facility or residence. Cost of meal preparation
  - Line 9: Nursing Administration
    - Cost of overall management of nursing
    - If a nurse is doing both administration and hands-on care, salary cost must be segregated

Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

- General Service Cost Centers – continued
  - Line 10: Routine Medical Supplies
    - Items such as gloves, masks, cotton swaps, i.e. not traceable to an individual patient
  - Line 11: Medical Records
    - Cost of personnel handling medical records
  - Line 12: Staff Transportation
    - Mileage paid to employees, vehicle leases.
    - Do not report patient transportation costs on this line; they are reported on line 39
Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

➢ General Service Cost Centers – continued

✓ Line 13: Volunteer Service Coordination
  ○ Salary cost of volunteer coordinator, as well as recruitment and training cost of the volunteers.

✓ Line 14: Pharmacy
  ○ Cost of drugs (both prescription & OTC), personnel and services
  ○ Do not report the cost of chemotherapy, it is reported on line 45.

✓ Line 15: Physician Administrative Services
  ○ Cost of the medical director and physicians of the IDT team who participate in the establishment, review and updating of plans of care, supervising care and establishing policies.

Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

➢ General Service Cost Centers – continued

✓ Line 16: Other General Services (specify)

✓ Line 17: Patient Residential Care Services
  ○ This line is not to be utilized on Worksheet A. This cost center is only utilized on Worksheet B to accumulate in-facility costs not separately identified as IRC, GIP, or residential care services.
Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

➢ Direct Patient Care Service Cost Centers

✓ Line 25: Inpatient Care- Contracted
  o Cost paid to another facility (hospital, skilled nursing facility) for inpatient respite or general inpatient care. This is the contract rate paid to the facility while your patient is there.

✓ Line 26: Physician Services
  o Cost of physician and nurse practitioners providing physician services for direct patient care services.

✓ Line 27: Nurse Practitioner
  o Cost of nursing care only. If performing physician care services they must be reported on Line 26 (Physician Services)

Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

➢ Direct Patient Care Service Cost Centers

✓ Line 28: Registered Nurse
  o Cost of nursing care provided by RN's only.

✓ Line 29: LPN/LVN
  o Cost of nursing care provided by LPN’s or LVN’s only.

✓ Line 30: Physical Therapy

✓ Line 31: Occupational Therapy

✓ Line 32: Speech/Language Pathology

✓ Line 33: Medical Social Service
Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

- Direct Patient Care Service Cost Centers – continued
  - Line 34: Spiritual Counseling
  - Line 35: Dietary Counseling
  - Line 36: Counseling Other
  - Line 37: Hospice Aide and Homemaker Services
    - Includes PCA and household services
  - Line 38: Durable Medical Equipment/Oxygen
  - Line 39: Patient Transportation
  - Line 40: Imaging Services

Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

- Direct Patient Care Service Cost Centers – continued
  - Line 41: Labs and Diagnostics
  - Line 42: Medical Supplies-Non-routine
    - Supplies specific to a patient’s plan of care
  - Line 43: Outpatient Services
  - Line 44: Palliative Radiation Therapy
    - Patient on hospice benefit and not in palliative program
  - Line 45: Palliative Chemotherapy
    - Patient on hospice benefit and not in palliative program
  - Line 46: Other Patient Care Services (specify)
Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

- Non-reimbursable Cost Centers – continued
  - Line 66: Residential Care
    - Cost of residential care for patients on routine home care level of care living in the hospice, not receiving inpatient services
    - Costs include operation of facility.
    - Do not report direct care services here.
    - Do not report laundry, housekeeping or dietary services here.
  - Line 67: Advertising
    - Non-allowable community education, business development, marketing and advertising cost.

Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

- Non-reimbursable Cost Centers – continued
  - Line 68: Telehealth / Telemonitoring
    - Cost include salaries of staff monitoring and leases or depreciation of equipment
  - Line 69: Thrift Store
    - All costs associated with the operation of the store, i.e., salaries, supplies, etc.
  - Line 70: Nursing Facility Room and Board
    - Patients on hospice benefit live in a nursing facility
    - Must include the full amount paid to facility
Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

➤ The Flow of Worksheet A

✓ Worksheet A consists of seven columns of information
  o Column 1 - Salaries
  o Column 2 - Other
  o Column 3 - Subtotal
  o Column 4 - Reclassifications
  o Column 5 - Subtotal
  o Column 6 - Adjustments
  o Column 7 - Total

Worksheet A: Reclassification & Adjustment of Trial Balance Expenses

➤ These Worksheets are utilized to record Direct Patient Care costs by each level of care
  ✓ Worksheet A-1 - Continuous Home Care
  ✓ Worksheet A-2 - Routine Home Care
  ✓ Worksheet A-3 - Inpatient Respite Care
  ✓ Worksheet A-4 - General Inpatient Care

➤ Worksheets consists of seven columns of information
  ✓ Column 1 - Salaries
  ✓ Column 2 - Other
  ✓ Column 3 - Subtotal
  ✓ Column 4 - Reclassifications
  ✓ Column 5 - Subtotal
  ✓ Column 6 - Adjustments
  ✓ Column 7 - Total

➤ Line numbers are consistent on all four worksheets
Worksheet A-6: Reclassifications

- Worksheet A-6 is used when a shift of costs between cost centers is needed.
- This worksheet can be left blank if no reclasses need to be made.
- Most reclasses of costs should be made on the trial balance directly.
- The main reason to utilize this worksheet include:
  - To reclass the proper cost of medical supplies.
  - To reclass employee salary and benefits for an employee who is working in more than one cost center.
  - For example, if a Bereavement Coordinator is also doing Spiritual Counseling.

Worksheet A-8: Adjustments to Expenses

- Any Non-Allowable expenses (anything not related to patient care) need to be entered onto worksheet A-8.
- Key questions to ask when considering if expenses are Allowable vs. Non-Allowable:
  - Expenses must be prudent and reasonable
  - Expenses must be related to patient care
  - If no specific Medicare rule, defer to GAAP
  - There are some differences from the IRS.
Examples of Non-Allowable Expenses include:

- Interest Income
  - Offset interest expense
- Other income – non patient related
  - Offset administrative expense such as medical records copying fees
- Bad Debts
- Lobbying
  - Some of your association membership dues are non-allowable due to political lobbying activities.
- Marketing / Advertising
  - Keep separate trial balance accounts for different types of advertising: recruitment vs. marketing
- Management Fees
  - Home Office costs are allowable

Additional examples of Non-Allowable Expenses include:

- Alcoholic beverages
- Gifts and donations
- Penalties & Fees
- Income taxes
- Excessive owners compensation
- Board of directors fees
- Acquisition related costs
- Start up costs
- Depreciation method other than straight line method only

For further information, refer to CMS Publication 15-1 and 15-2.
Rules and Regulations can be found at cms.gov/Manuals/PBM/list.asp
Worksheet A-8-1: Related Organizations and Home Office Costs

➢ What is a Related Party?
   ✓ Common ownership or control.
   ✓ Related to the provider means that the provider, to a significant extent, is associated with or affiliated with, or has control of, or is controlled by, the entity or individual furnishing the services, facilities or supplies.
   ✓ Family relationship

Worksheet A-8-1: Related Organizations and Home Office Costs

➢ What is a Home Office Organization?
   ✓ Chain organization with 2 or more entities.
   ✓ Can include non healthcare organization.
   ✓ Home office organizations are centralized management service organizations that provide services to multiple related providers.
   ✓ Costs of the home office organization are reported as related party transactions.
   ✓ A Medicare designated home office files a cost report (CMS Form 287-05) which is the allocation of shared costs to the related entities benefitting from shared services.
Worksheets B and B-1

- **Worksheet B**
  - Worksheet B shows the allocation of the General Service Cost Centers to the Level of Care and Non-Reimbursable cost centers.

- **Worksheet B-1**
  - Statistical Bases for allocation of the General Service Cost Centers.

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Worksheets B-1

- **Statistical bases:**
  - Capital Related Building & Fixtures – Square Feet
  - Capital Related Moveable Equipment – Dollar Value
  - Employee Benefits – Gross Salaries
  - Admin & General – Accumulated Costs
  - Plant, Operations, & Maintenance – Square Feet
  - Laundry & Linen – In-Facility Days
  - Housekeeping – Square Feet
  - Dietary – In-Facility Days
  - Nursing Administration – Direct Nursing Hours
  - Routine Medical Supplies – Patient Days
  - Medical Records – Patient Days
Worksheets B-1

- Statistical bases continued:
  - Staff Transportation - Mileage
  - Volunteer Services Coordinator – Hours of Service
  - Pharmacy – Charges
  - Physician Admin Services – Patient Days
  - Other General Services – Specify Basis
  - Patient/Residential Care Services – In-Facility Days
  - Housekeeping – Square Feet
  - Dietary – In-Facility Days
  - Nursing Administration – Direct Nursing Hours
  - Routine Medical Supplies – Patient Days
  - Medical Records – Patient Days

Worksheet C:
Calculation of Per Diem Cost

- The Average Cost per Diem is calculated by level of care and in total.

- This worksheet will provide you the following 5 Cost per Diems:
  - Continuous Home Care Cost per Diem
  - Routine Home Care Cost per Diem
  - Inpatient Respite Care Cost per Diem
  - General Inpatient Care Cost per Diem
  - Total Average Cost per Diem

- The Cost per Diems are compiled in the aggregate.
  - The calculation uses the total cost from worksheet B and the total unduplicated days by level of care.
Worksheet F: Balance Sheet

- Report the Balance Sheet.
  - Be sure that these amounts are consistent with the hospice’s financial statements.
  - The balance sheet does not have to be audited.

- Identify the appropriate line to enter the amounts on.

- Make sure that this worksheet actually balances.

- The fund balance should agree with the fund balance on worksheet F-1.

What are the Comments, Issues and Challenges?

- Validity of information: CMS underestimates the time and cost burden of providers becoming educated, developing and implementing then monitoring systems for process and technology changes required to comply with new reporting requirements.

- Worksheet S-1: Gathering ALOS data is valuable industry benchmarking. ALOS should be calculated and reported based on discharged patients and their days.
Worksheet A: Pharmacy is classified as a General Service cost center. This should be a Direct Patient Care Service cost center. As a General Service cost center, the allocation statistic on Worksheet B-1 is “charges”.

- Many providers contract drugs on a “per diem”, or, census basis.
- Medication profile may not change as patients move across levels of care.

Worksheet A: Physician Services are differentiated between direct patient care activities and supervisory / administrative activities. Administrative activities have a General Service line assignment (#15), but instructions at line # 26 indicate that administrative activities be reclassed to line # 4, Admin & General.

Refined reporting on facilities: contracted (Inpatient Care line # 25) as well as owned/leased (Building & Fixtures line # 1, MVBLE Equipment line #2, Plant Operation & Maintenance line # 5, Laundry line # 6, Housekeeping line # 7, Dietary line # 8).
What are the Comments, Issues and Challenges?

- Many different types of facilities:
  - Residential only, RHC provided, no other activities occur.
  - Residential only, RHC provided, building also houses administrative offices for hospice program.
  - Inpatient Facility only, GIP and Respite are provided, no other activities occur.
  - Inpatient Facility only, GIP and Respite provided, building also houses administrative offices for hospice program.
  - Inpatient Facility with multiple levels of care provided (RHC, GIP and Respite), no other activities occur.
  - Inpatient Facility with multiple levels of care provided (RHC, GIP and Respite), building also houses administrative offices for hospice program.

What are the Comments, Issues and Challenges?

- Different challenges for each scenario
  - Straightforward: All building costs are reported on line # 66, all other hospice program space and equipment costs are on appropriate lines and allocated to appropriate cost centers.
What are the Comments, Issues and Challenges?

- Different challenges for each scenario

  ✓ Complicated: Worksheets B and B-1 allow for allocation of costs from Build & Fix (line 1), Moveable Equipment (line 2), Admin & General (line 4), Plant Operations & Maintenance (line 5) to Patient/Residential Care Services (line 17), Respite (line 52), GIP (line 53), and Residential Care (line 66).

    ○ Square feet can be determined to be residential (patient rooms, laundry room, kitchen, supply closets, etc./common rooms), direct care staff offices (nurses, social workers, Bereavement and Spiritual counselors, etc.), as well as volunteer coordinator and administrative staff offices.

    ○ Direct care staff square feet/office space must be translated into level of care square feet.

    ○ Plant Operations & Maintenance (line 5) is after Admin & General (line 4), which indicates you cannot allocate any Plant Operations & Maintenance costs to administrative even though the residence encompasses the hospice program’s administrative offices.

What are the Comments, Issues and Challenges?

- All other scenarios: Building costs of the facility and all other locations/spaces occupied are reported on lines #1 and #5 and allocated to appropriate lines on Worksheet B based on square feet.

  ✓ Plant Operations & Maintenance (line 5) is after Admin & General (line 4), which indicates you cannot allocate any Plant Op & Maintenance costs to administrative even though the facilities/locations encompass the hospice program’s administrative offices.
What are the Comments, Issues and Challenges?

- Line #2 Moveable Equipment: Statistical basis is dollar value.

- Most hospice providers who do **not operate any type of facility** generally have equipment which is administrative in nature (copiers, computers, printers, etc.), or can be related to a discipline (nurses computers, etc.).

- There may be some minor medical equipment.
  - The form does not allow for the allocation of equipment depreciation cost to be allocated to RHC or CCHC. What if the hospice provider did no GIP or Respite? Where does medical equipment cost go?

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What are the Comments, Issues and Challenges?

- Providers that do operate a facility of any type, especially ones with RHC, GIP and Respite, are not likely to have equipment that is specific to any one level of care.
  - Items like whirlpools, patient lifts etc. are shared across levels of care.

- Current 1984-99 instructions provided for either dollar value or square feet to be used as an allocation statistic. Alternatives are possible, but must obtain prior approval.

- Line #5 Plant Operations & Maintenance is **after** Administrative & General, line #4. If your only space costs are related to your administration and there is no facility operation, there is no mechanism to assign square feet for Plant costs to Administrative & General.
What are the Comments, Issues and Challenges?

- Line # 7 Housekeeping: Statistic for allocation is square feet. Same concerns as noted for lines 1 and 5.

- Line # 9 Nursing Administration: Statistic is “Direct Nursing Hours”. Instructions fail to explicitly include Aides, even though Nursing supervises the Aides.

- Line # 11 Medical Records: Statistic is Patient Days.

  ✓ “Medical Records” personnel are not always exclusively responsible for medical records. The evolution of EHR and POC technology has changed and job responsibilities are often combined with clinical team support duties including scheduling, communication triage, documentation tracking, etc.

  ✓ This implies time studies to properly segregate activities.

What are the Comments, Issues and Challenges?

- Line # 12 Staff Transportation: Statistic is Mileage. Instructions do not clarify how to allocate by level of care when staff see patients on multiple levels of care in multiple locations:

  ✓ RN sees 1 GIP patient in a GIP facility.

  ✓ RN then drives to a SNF where a RHC patient is visited. The RN then walks down the hall and sees a Respite patient in same facility.

  ✓ The RN then drives to a private residence to visit a RHC patient.
What are the Comments, Issues and Challenges?

- Line # 13 Volunteer Coordination: Statistic for allocation is Volunteer Hours of Service. Most hospice providers have volunteers that perform administrative support duties. Because line # 13 is located after Administrative & General line # 4, it is impossible to properly allocate Volunteer Coordination costs to Administrative & General.

What are the Comments, Issues and Challenges?

- Line 67 Advertising: costs include non-allowable community education, business development, marketing and advertising (PRM 15-1 chapter 21 section 2136)

  ✓ Segregate recruitment advertising, professional contacts to advise of covered services & informational listings (allowable) from advertising to increase market share, publicity and promotional (non-allowable) in the general ledger

  ✓ Non-allowable vs. Non-reimbursable: Palmetto instructs to remove non-allowable from the cost report. (PRM 16-1 chapter 23 section 2302.8) Cost Center = organizational unit ....having a common functional purpose for which direct and indirect costs are accumulated....
    - Remove cost from cost report vs. allocate overhead to a cost center
What are the Comments, Issues and Challenges?

Process Changes: Accounts Payable will need to carefully review invoices for patient care services and code up front to appropriate level of care.

- Patient Transportation line # 39: Track cost by level of care patient goes to. May go from home/RHC to GIP facility and then back to home/RHC.
- DME should be charged to level of care patient is on when item delivered.

What are the Comments, Issues and Challenges?

System Changes for Payroll: Direct care staff by level of care:

- Time records: plan now for how to keep records. Paper/Manual? Part of IT Solution? Are you on POC/ EHR? Can your vendor accommodate system changes to assist with tracking information by level of care?
- Will need to be more specific for segregating RNs, LPNs/LVNs, and NPs.
  - Time records will need to be maintained to further segregate NP’s salaries into nursing services and physician services.
  - Time records will need to be maintained for other employees who work in multiple cost centers (i.e., Spiritual Counselor is also Bereavement Counselor, etc.).
What are the Comments, Issues and Challenges?

- General Ledger Chart of Accounts expansion is required to report Direct Patient Care Services costs by level of care
  
  - 42 CFR Section 413.20 states that the principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program.
  - 42 CFR Section 413.24 This must be based on their financial and statistical records which must be capable of verification by qualified auditors.
  - Worksheet A: “...provides for recording the trial balance of expense accounts from the hospice accounting books and records.”
  - Worksheets A-1, A-2, A-3 & A-4: Enter salaries & costs from the hospice accounting records and/or trial balance.

What are the Comments, Issues and Challenges?

- General Ledger Chart of Accounts expansion is required to report revenues on Worksheet F-2:
  
  - Gross Patient Service Revenue
    - By Payer: Medicare, Medicaid, Other
    - By Level of Care: RHC, CC, GIP, Respite
  - Contractual Allowances
  - Net Patient Service Revenue
  - Other Revenue
    - Hospice Physician
    - Room & Board
    - Palliative Consults
    - Donations
    - Rebates/Refunds
    - Investment
    - Government Appropriations
    - Other (Grants, Fundraising, Memorials, Contributions, etc.)
What are the Comments, Issues and Challenges?

- Education of clinical staff regarding the challenges of having to keep details.
- Major overhaul of the general ledger chart of accounts to accommodate capturing cost by level of care.
  - Key areas:
    - Salaries
    - Staff Transportation
    - Contracted Services
    - DME/Oxygen
    - Non-routine medical supplies
- Look at your computer systems:
  - Are you using them to full capacity?
  - Will system modifications be required?

Strategies for Direct Patient Care Costs

- Remember that all direct costs MUST BE broken out by level of care

- Smaller hospice agencies typically will have:
  - Contracted Inpatient Costs
  - Routine Home Care
  - Continuous Home Care
Strategies for Direct Patient Care Costs

➤ Remember that all direct costs MUST BE broken out by level of care

➤ Information can be captured by:
  ✓ Use of time studies
  ✓ Statistical methodologies
  ✓ Coding of invoices upfront by A/P staff in great level of detail
  ✓ Developing of spreadsheets for tracking costs
  ✓ Inpatient costs are tracked separately between contracted facility versus owned facility

Strategies for Direct Patient Care Costs

➤ Inpatient Contracted – Line 25
  ✓ Contracted costs paid to the facility is broken out between
    o Respite (Worksheet A-3)
    o General (Worksheet A-4)

  ✓ Hospice staff seeing patients in the contracted setting
    o RN seeing a patient Respite services would be captured on Worksheet A-3, Line 28.
Strategies for Direct Patient Care Costs

- Physician Services – Line 26
  - Direct Care Only
    - Includes both Physician and Nurse Practitioners
    - Nurse Practitioner is providing physician services only
  - Don’t include costs of administrative and general supervisory activities
    - Plans of Care
    - ITD meetings
  - Utilization of a “time study” to properly capture costs.
  - Conflict in cost report instructions between Lines 26 and 15 as to the reporting of the administrative and general supervisory activity.

- Nurse Practitioner – Line 27
  - Direct Nursing Care only
  - Don’t include costs of providing Physician Services
  - Challenges in capturing costs
    - Nurse practitioner is performing physician services, as well as direct nursing care across different levels of care.
      - Cost would need to be captured in 3 cost centers
        - Physician Admin Services
        - Physician Services
        - Nurse Practitioner
  - Utilization of a “time study” to properly capture costs.
Strategies for Direct Patient Care Costs

- RN’s and LPN/LVN – Lines 28 and 29
  - Nursing Care must be captured by different skill levels
    - RN
    - LPN/LVN
  - Challenges: by the end of the day the RN has
    - Visited a patient at home on RHC
    - Visited a patient at SNF on RHC
    - Visited a patient at SNF on Respite
  - Set up payroll by skill level
    - Utilization of a “time study” to properly capture costs by level of care.
  - Utilizing outside vendors: invoices will need to capture
    - Skill Level (RN, LPN/LVN)
    - Level of Care

Strategies for Direct Patient Care Costs

- Physical, Occupational and Speech Therapies – Lines 30, 31 and 32
  - Set up payroll by skill level
    - Utilization of a “time study” to properly capture costs by level of care.
  - Utilizing outside vendors invoices will need to capture
    - Discipline Level
    - Level of Care
Strategies for Direct Patient Care Costs

- Medical Social Service – Line 33
  - Challenge: A Medical Social worker could perform an array of duties, at various levels of care, in various settings, (Home, SNF, Community at large)
    - Social Work
    - Spiritual Counseling
    - Bereavement
  - Utilization of a “time study” to properly capture costs must be very detailed, however it is also very time consuming.

Strategies for Direct Patient Care Costs

- Spiritual Counseling – Line 34
  - Challenge: Clergy could perform an array of duties at various levels of care and in various settings, (Home, SNF, Community at large)
    - Spiritual Counseling
    - Bereavement
  - Utilization of a “time study” to properly capture costs must be very detailed, however it is also very time consuming.
Strategies for Direct Patient Care Costs

- Dietary Counseling – Line 35
  - Services performed by a Dietician/Nutritionist or RN
  - Utilization of a “time study” to properly capture costs.

- Counseling – Other – Line 36
  - Physician Ordered, patient specific, relieves pain and suffering
    - Massage Therapy
    - Music, Art or Pet Therapy

Strategies for Direct Patient Care Costs

- Hospice Aide and Homemaker Services – Line 37
  - Services can be performed by:
    - Home Health Aides
    - Homemakers
    - CNA’s (Certified Nursing Assistants)
  - Setup payroll by skill level
    - Utilization of a “time study” to properly capture costs by level of care.

  - Outside vendors invoices will need to capture:
    - Level of Care
Strategies for Direct Patient Care Costs

- DME/Oxygen – Line 38
  - ✔ Report the costs by the level of care the patient was receiving at the time the DME/oxygen was delivered
  - ✔ Challenge – if the level of care changes (went from RHC to CHC)
    - ○ Must proportion costs based upon level of days
    - ○ Develop internal spreadsheet to capture invoices by patient by level of care
  - ✔ If a small hospice with no owned facilities, tracking would be between RHC and CHC
  - ✔ If you owned a facility and beds were utilized for all types of care an internal spreadsheet would be more detailed and intense

- Patient Transportation – Line 39
  - ✔ Ambulance costs
    - ○ Must be reported to the level of care when the patient is transported
  - ✔ Challenge – when the patient is transferred to another level of care. Patient has gone from RHC to Respite and then back RHC.
    - ○ Can proportion costs be based upon level of days
    - ○ Develop internal spreadsheet to capture invoices by patient by level of care
Strategies for Direct Patient Care Costs

- Imaging Services, Labs and Diagnostics, Outpatient Services – Lines 40, 41 and 43
  - Challenge – costs are very patient specific
    - Develop internal spreadsheet to capture invoices by patient by level of care
  - If a small hospice with no owned facilities tracking would be between RHC and CHC
  - If you owned a facility and beds were utilized for all types of care internal spreadsheet would be more detailed and intense

Strategies for Direct Patient Care Costs

- Medical Supplies – Non-routine – Line 42
  - Medical supplies are patient specific in relationship to their plan of care.
    - Develop internal spreadsheets to capture invoices by patient by level of care
  - Cost report instructions allow for cost to be allocated to each level of care based on patient days.

- Palliative Radiation and Palliative Chemotherapy – Line 44 and 45
  - Don’t be confused by the term “palliative” here.
  - These lines are for reporting radiation and chemotherapy therapy costs for patients who are on the hospice benefit.
Challenges of Statistical Allocation Basis

- Majority of hospices don’t operate any type of facilities.
- Face great statistical challenges in the following areas:
  - **Cap Related Building & Fixtures – Square Feet**
    - Step-down does not allow costs to be allocated to:
      - Direct care staff by level of care
      - Routine or Continuous Home Care
    - Develop alternative methods:
      - Determine costs based upon square feet to be allocated by disciplines externally to direct care staff. Once cost is determined can you then allocate based on patient days to get cost by level of care? Reclassification would then be made on Worksheet A-6, reducing Line 1, and increasing appropriate lines by level of care.

<table>
<thead>
<tr>
<th>Square Footage</th>
<th>Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin &amp; General</td>
<td>500</td>
</tr>
<tr>
<td>RN</td>
<td>350</td>
</tr>
<tr>
<td>HHA</td>
<td>150</td>
</tr>
<tr>
<td><strong>Total Square Feet</strong></td>
<td><strong>1,000</strong></td>
</tr>
<tr>
<td>Cap Related Expenses</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

**Calculation for Reclassification**

<table>
<thead>
<tr>
<th>Square Feet</th>
<th>% of Square Feet</th>
<th>Cap Rel Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin &amp; General</td>
<td>500</td>
<td>50%</td>
</tr>
<tr>
<td>RN</td>
<td>350</td>
<td>35%</td>
</tr>
<tr>
<td>HHA</td>
<td>150</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,000</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Days</th>
<th>% Days</th>
<th>RN</th>
<th>HHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine</td>
<td>11,520</td>
<td>96%</td>
<td>$6,720</td>
</tr>
<tr>
<td>Continuous</td>
<td>480</td>
<td>4%</td>
<td>$ 280</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,000</strong></td>
<td><strong>100%</strong></td>
<td><strong>$7,000</strong></td>
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</table>
Challenges of Statistical Allocation Basis

Recall the Exam Entry

<table>
<thead>
<tr>
<th>Explanation</th>
<th>Code</th>
<th>Cost Center</th>
<th>Line #</th>
<th>Amount</th>
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</thead>
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<tr>
<td>Reclass RN Cap Rel costs</td>
<td>A</td>
<td>RN</td>
<td>28</td>
<td>$6,720</td>
</tr>
<tr>
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<tr>
<td>Reclass HHA Cap Rel costs</td>
<td>B</td>
<td>HHA</td>
<td>37</td>
<td>$ 120</td>
</tr>
</tbody>
</table>

Challenges of Statistical Allocation Basis

- **Capital Related Moveable Equipment – Dollar Value (Square Feet)**
  - Previous cost report CMS 1984-99 allows for statistic to be either dollar value or square footage.
  - If we choose square footage, prior approval is needed.
  - Step-down does not allow costs to be allocated to:
    - Direct care staff by level of care
    - Routine or Continuous Home Care
  - Develop alternative methods:
    - Determine costs based upon square feet to be allocated by disciplines externally to direct care staff. Once cost is determined can you then allocate based on patient days to get cost by level of care? Reclassification would then be made on Worksheet A-6, reducing Line 2, and increasing appropriate lines by level of care.
Challenges of Statistical Allocation Basis

➢ Plant, Operation, Maintenance – Square Feet
  ✓ Previous cost report CMS 1984-99 allowed for step-down to take place prior to A&G.
  ✓ Step-down does not allow costs to be allocated to:
    o Administrative and General
    o Direct care staff by level of care
  ✓ Develop alternative methods:
    o Determine costs based upon square feet to be allocated by disciplines externally to direct care staff. Once cost is determined can you then allocate based on patient days to get cost by level of care? Reclassification would then be made on Worksheet A-6, reducing Line 5, and increasing appropriate lines by level of care.

Challenges of Statistical Allocation Basis

➢ Nursing Administration
  ✓ Statistical Basis is defined as direct nursing hours.
  ✓ Should the inclusion of HHA/HMRK hours also be included in the statistical base? In most instances the nursing administration oversees them. Instructions need clarification.
  ✓ Use of direct payroll hours.
Challenges of Statistical Allocation Basis

- Staff Transportation
  - Statistical Basis is mileage.
  - Have to account for mileage by level of care.
  - Does not allow for assignment to:
    - Administrative staff
    - Direct Care staff
  - Develop alternative methods:
    - Costs allocated externally to determine admin and direct care staff.
    - A reclassification would then be made on Worksheet A-6, reducing Line 12 and increasing the appropriate lines by level of care.

- Volunteer Service Coordination
  - Statistical Basis is hours of service.
  - Under the Conditions of Participation a hospice provider is required to maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked. Refer to 42 CFR 418.78.
  - The structure of B-1 will not allow for the allocation of Volunteer time directly to the A&G cost center. This cost center is allocated after A&G cost center. An alternative method would have to be developed to properly allocated costs; this could be done as reclassification (A-6).
  - While there is no formal reporting requirement to CMS, providers will be required to produce this information on survey.
Challenges of Statistical Allocation Basis

- Pharmacy
  - Statistical Basis is charges.

- As noted in the CMS Transmittal 2747 dated July 26, 2013, (change request 8358) there will be additional reporting requirements for hospice claims. Mandatory beginning April 1, 2014. Providers are required to report on claims on injectable prescription drugs (0250), medication refills on infusion pumps (0294) and injectable drugs (0636).

2307. Direct Assignment of General Service Costs (Excerpt)

The costs of a general service cost center need to be allocated to the cost centers receiving service from that cost center. This allocation process is usually made, for Medicare cost reporting purposes, through cost finding using a statistical basis that measures the benefit received by each cost center. Alternatives to cost finding as described below may be used where appropriate after obtaining intermediary approval. The provider must make a written request to its intermediary and submit reasonable justification for approval of the change no later than 90 days prior to the beginning of the cost reporting period for which the change is to apply. The intermediary must respond in writing to the provider's request, whether approving or denying the request, prior to the beginning of the cost reporting period to which the change is to apply.
2302.9 General Service Cost Centers

Those organizational units which are operated for the benefit of the institution as a whole. Each of these may render services to other general service areas as well as to special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant and maintenance of plant. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

Making Changes to Statistical Allocation Basis

- Any changes from the recommended statistical allocation basis and/or the order in which the cost centers are allocated can be made as long as prior approval has been granted from the MAC. Refer to CMS Pub 15-1, Chapter 23 §2313.

  ✓ A written request to the MAC must be made 90 days prior to the end of the cost reporting period.
    o Must include supporting documentation to establish that the new method is more accurate.

  ✓ MAC has 60 days from receipt of the request to make a decision or the change is automatically accepted.
2313. Changing Basis for Allocating Cost Centers or Order in which Cost Centers are Allocated (Excerpt)

When a provider wishes to **change its statistical allocation basis** for a **particular** cost center and/or the **order in which the cost centers are allocated** because it believes the change will result in more appropriate and more accurate allocations, the provider must make a written request to its intermediary for approval of the change **ninety (90) days prior to the end of that cost reporting period**. The intermediary has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. The change should not result in inappropriately shifting costs.

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**Home Health and Hospice (HH+H) Jurisdictions (Administered by A/B MACs) as of October 2013**

NGS J6 - Alaska, American Samoa, Guam, Hawaii, and Northern Mariana Islands

NGS JK - Puerto Rico and US Virgin Islands
Cost Report Preparation:

It is important to remember that the cost report is used by CMS for the recalibration and updating of the PPS rates. If you outsource the process, make sure to get at least two or three quotes from qualified experienced firms that provide cost report preparation services. Consider contacting your national or state association for associate members that provide this service. Negotiate a lower rate with your current vendor that excludes unnecessary travel costs. Determine if your staff is capable of doing the cost report internally and consider having them participate in education (seminars, webinars, programs) on the cost report offered by the industry associations and consultants.
§2302.1
Accrual Basis of Accounting

Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid. Section 2305ff sets forth special rules regarding recognition of expenses under the Medicare program relating to liquidation of liabilities.

Provider Reimbursement Manual (CMS-Pub. 15-1)

Making the Necessary Changes

- Time and money investment
  - Revising chart of accounts
  - Adjusting data collection methods
    - Payroll
    - Charges and utilization
    - Statistics
  - Reviewing agency processes
  - Providing staff training
Thank You

- The following people have contributed to the information disseminated by this program.
  - Bob Simione
  - Lisa Lapin
  - Maureen Laskowski
  - Brian Martin
  - Mark Sharp
  - Ted Cuppett
  - Hospice Clients - Painfully

Speaker Information

Thomas E Boyd, MBA, CFE
Vice President of Reimbursable Services

Simione Healthcare Consultants
50 Professional Center Drive, Suite 200
Rohnert Park, CA 94928

877-424-6527 / 707-585-9317
707-585-7633
tboyd@simione.com
www.simione.com
Hospice cost reports and the impact on providers

The Visiting Nurse Association of Greater Philadelphia

• The revised Hospice Cost and Data Report effective for cost reporting periods beginning on or after October 1, 2014.

• The Visiting Nurse Association of Greater Philadelphia fiscal year ends in June.
• Non-profit, audited financial statements.
• Use PS&R for cost report and outsource
• Our cost report period starts July 1, 2015.
• The VNA Hospice Financial Statements
  – Hospice Consolidated Programs
    • Hospice In-Home Program
    • Hospice In Patient Program
    • Hospice Palliative Care Program
      – Non-reimbursable
      – Hospital contract for program expense
      – VNA bills part B for Physician and Nurse Practitioner
    • Key Statistics for each program vs. budget

Key Stats will be needed to break down cost by level of care – example of some of VNA’s key stats
• New - Unduplicated days to be broken out by the levels of care:
  — Continuous Home Care
  — Routine Home Care
  — Inpatient Respite Care
  — General Inpatient Care
• GL current XX-XX-XXXXXX-XXX
• VNA will use the last segment of the general ledger for levels of care

Hospice Cost Report - Impact on The VNA of Greater Philadelphia

• Revenues also need to be broken out
• The three payer categories for unduplicated revenue days are identified as Medicare, Medicaid, and Other
  – This is currently done at the VNA for Revenue.
  – Currently VNA does separate financial statements for the IPU, In-Home and Palliative care.
Expense Breakdown

- New General service cost centers:
  - Laundry & linen - IPU
  - Housekeeping - IPU
  - Dietary - IPU
  - Routine Medical Supplies –not traceable to patient
  - Medical Records –cost of personnel
  - Pharmacy

The VNA has broken down expenses for the past few years to improve the profit margin in the IPU. With breaking out expense we are able to see trends that should match our census month to month.

Expense Breakdown

- New General service cost centers:
  - Employee Benefits
  - Nursing Administration – cost of overall management of Nursing
    - IPU Manager will have to have split time between management and covering shift in the IPU
  - Staff Transportation

- The VNA has broken down expenses for the past few years through payroll accounts to match the general ledger accounts. We will have to allocate the payroll based on days for levels of care. We are always trying to improve our process.
Direct Patient Care Cost

• New direct patient cost centers:
  – Nurse Practitioner
  – Registered Nurse
  – LPN/LVNs
  – Nursing will be broken down into the three new centers. Currently our Nurse Practitioner's are allocated by percent to the IPU, In Home and our Hospital Palliative Care program. We will have to allocate the payroll based on days for levels of care, when we can not charge time directly.
  – The VNA also has a time sheet and we will be doing a time study for our Nurse Practitioners and Physicians.
  – When a Nurse Practitioner performs physician care services they must be reported under physician care.

Hospice Cost Report - Impact on The VNA of Greater Philadelphia

Direct Patient Care Cost

• Medical Social Services
  – Various levels of care
  – Various settings
  – and
  -Social work
  -spiritual Counseling
  -Bereavement

VNA time study for MSW that cross over settings

Hospice Cost Report - Impact on The VNA of Greater Philadelphia

115

116
Direct Patient Care Cost

• Counseling Other
  – Massage Therapy
  – Music Therapy
  – Pet Therapy
  – Art Therapy
Physician ordered, patient specific

Mostly contracted services – can be directly allocated to level of care for IPU or In Home

Direct Patient Care Cost

• Patient Transportation
  • Currently by IPU or In-Home, contracted will be allocated by level of care at start of services.

• Medical Supplies
  VNA – will allocate directly when able
  VNA – other expense allocated on level of care based on patient days (Clearing account)
Direct Cost by level of care

- Capture information by:
  - Developing of spreadsheets for tracking cost
  - Coding of invoices upfront by staff in great level of detail
  - Statistical methodologies
  - Use of time studies

Non-reimbursable Cost Centers

- Expanded new cost centers
  - Advertising
  - Hospice/Palliative Medicine Fellow
  - Nursing Facility Room and Board
  - Other Physician Services
  - Palliative Care program
  - Residential Care
  - Telehealth/Telemonitoring – includes cost of staff monitoring, leases, depreciation
  - New general ledger accounts set up as needed
Physician

- Physician Administrative Services
  - Cost of the physicians of the IDT team who participate in the review, updating, supervision of care and plans of care
  - Establishing policies

- The VNA also has a time sheet and we will be doing a time study for our Nurse Practitioners and Physicians

Direct Patient Care Service Centers

- Inpatient Care – Contracted
  - Paid to another facility for inpatient respite or general inpatient care where patient reside

  - The VNA will have to set up new general ledger accounts.
  - Hospice staff will review invoices for approval and level of care.
Chart of Accounts

• The key to successful transition
  – Sufficient detail for your needs
    • So you don’t have to back track
    • For cost report purposes
    • For management purposes

Chart of Accounts

• Keep revenue and costs in the right buckets
  – Revenues by service and payer
  – Costs by type of costs per cost reporting and management needs
    • General service
    • Direct patient care services
    • Nonreimbursable services
    • Unallowable costs
  – Match cost buckets with revenue buckets
Chart of Accounts

- Reimbursable direct patient care services
  - Broken down by level of care
  - Sample accounts for registered nurse wages

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5020 - 00</td>
<td>Salaries - registered nurses (general)</td>
</tr>
<tr>
<td>5020 - 10</td>
<td>Salaries - registered nurses (routine)</td>
</tr>
<tr>
<td>5020 - 20</td>
<td>Salaries - registered nurses (continuous)</td>
</tr>
<tr>
<td>5020 - 30</td>
<td>Salaries - registered nurses (I/P respite)</td>
</tr>
<tr>
<td>5020 - 40</td>
<td>Salaries - registered nurses (GIIP)</td>
</tr>
</tbody>
</table>

Chart of Accounts

- Sample of tracking wages and travel by level of care (the old fashioned way)
Chart of Accounts

- Nonreimbursable versus unallowable
  - Nonreimbursable receives allocation from general service costs
  - Unallowable costs removed and do not receive allocation from general service costs
  - Be sure chart of accounts maintains detail to easily identify unallowable costs too

Speaker Information

- Dawn Michelizzi
- The Visiting Nurse Association of Greater Philadelphia
- Senior Vice President fro Finance/Chief Financial Officer
- E-mail: Dmichelizzi@vnaphilly.org
- Phone: 215-581-2324
Who’s in the room...

INTRODUCTION

Inpatient Unit Planning

HCC = HOSPICE CARE CENTER
Agrace HospiceCare
Madison, Wisconsin

Gilchrist Hospice Care
Towson, Maryland
Hospice of Palm Beach County
Palm Beach, Florida

Midwest Palliative & Hospice CareCenter
Glenview, Illinois
VNA of Philadelphia
Philadelphia, PA

Maitri Compassionate Care
San Francisco, CA
Penn Wissahickon Hospice
Penn Hospice at Rittenhouse – Philadelphia, PA

Caveats

• “If you’ve seen one HCC, you’ve seen one hospice care center.”
• Beware of extrapolations based upon someone else’s experience
• Regulations vary by jurisdiction and are continually evolving – please don’t take our comments as legal advice
Inpatient Unit Planning

CONTEXT

Continuum

<table>
<thead>
<tr>
<th>Portfolio of Options</th>
<th>Scattered Contract Beds</th>
<th>Dedicated Contract Beds</th>
<th>Leased Unit</th>
<th>Free-Standing Facility</th>
<th>Continuous Care</th>
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<tbody>
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<td>.circle</td>
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<td>.circle</td>
<td>.circle</td>
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<tr>
<td>Specialized Setting</td>
<td>.circle</td>
<td>.circle</td>
<td>.circle</td>
<td>.circle</td>
<td>.circle</td>
</tr>
</tbody>
</table>
What we know dimly...

- Majority admit only at GIP level of care
- A few residential only facilities
- Average size: 13 beds
- Beds as a percent of ADC = 7%; higher with multiple facilities
- Respite care is rare

From NHPCO data set - 2007

Reasons for developing HCC...

- Operational/regulatory need – e.g. no contracts, lack of available beds
- Mission need – serving those without an appropriate home environment
- Strategic: pre-empting or creating barrier to entry
- Financial: source of revenue
Typical Phases

Demand

Value Engineering

Fund-Raising Feasibility

Financial

Inpatient Unit Planning

PROJECTING DEMAND
First things first...

- Research state regulations on certificate of need/other restrictions on number of facilities or number of beds per facility
- If CON, know cycles, formulas, process
- Research what type of license you need for the inpatient unit

Demand is a function of several major factors

\[ \text{DEMAND} = f(\ ) \]

- Demographics
- Market Dynamics
  - Hospice
  - Health Facility

*Essentially fixed for GIP*
Estimate demand by level of care

- Sources
  - Current utilization
  - Increased utilization
  - Other hospices
  - Unserved potential

- Benchmark (caution)

Cuation: With fixed demand, the percentage of GIP is a function of bed capacity

Percentage GIP is a function of bed capacity
Caution: Define your referral zone wisely – Referral Zone 1

Define your referral zone 2
Define your referral zone 3

Cuaion: potential for patients from other hospices

Leaest controllable/reliable...
Capacity is not only based upon projected demand

• Bed Capacity = Demand + Goals*

* Indigent Care
* Break Even
* Strategy
* System Benefit

** Regulations

Inpatient Unit Planning

CAPITAL AND OPERATING BUDGETS
Capital Cost Estimate Iterations

- Preliminary
  - One or more facility options
  - Beds as determined by demand projections
  - Make versus buy services/flexibility considerations (sf, equipment)
    - Usually a combination of “real” and projected costs
- After site selection, work with architect and construction company to update costs
- Update periodically as you move more expenses from estimated to bid or contracted costs

Capital Cost Elements

Land

Construction/Renovation
- Site prep/remediation
- Utilities/parking/grounds
- “Soft” costs (Design, Permits, Inspections, Licenses)
- “Hard” construction/renovation costs
- Owner’s Representative

Furniture/Equipment
- Furnishings
- Equipment: HVAC, kitchen, security, patient, IT, Telecomm (including off-site connectivity/expansion requirements)

Interest

Contingency/Reserve
Financing

Construction Costs
- Lease: Determine how much build-out the landlord could pay for and pass through in lease expense
- New Construction:
  - Internal reserves
  - Capital campaign
  - Construction loans and/or mortgages
  - Federal/State/Local grants
  - Tax exempt financing if not for profit agency
  - Sale/leaseback of facility
  - Developer lease arrangement

Furniture and Equipment
- Purchase vs Operating Lease

Operating Budget: Revenues
- Core Hospice Reimbursement
  - Level of care mix
  - Payer mix
  - Projected change in reimbursement over time
- Physician Billing
- Room and Board for RHC patients
  - “Rack rate”
  - Sliding scale policy
  - Process
Operating Budget: Expenses

- Staffing
  - Staffing ratios
  - Non-productive time/Replacement for direct care staff
  - Shift differentials
  - Benefits
- Patient-related expenses
  - Pharmacy (higher than agency average)
  - HME/Medical supplies
  - Transport

Operating Costs: Expenses (cont’d)

- Facility
  - Dietary
  - Linen/Laundry
  - Utilities (including biohazardous waste, phone/television)
  - Building & Grounds (including snow removal, monitoring/inspections)
- Depreciation/Interest Expense
- Inflation
Costs Over Time

• Establish a timetable for pre-opening costs
  • Construction
  • Furniture and equipment
  • Staff recruitment and training/orientation
  • Marketing
• Allow for ramp up in patient census/increased levels of GIP
• Include a replacement schedule for furniture and equipment into your long range forecast (including HVAC, roof, etc)

Scenario Planning

• Seek advice from other existing providers and consultants concerning their costs - this serves as a reality check for the initial budget (but account for differences in local needs/costs)
• Develop multiple scenarios that change assumptions for key variables
  • Beds
  • Level of care mix
  • Staffing ratios
  • Room and board/collection rates
  • Financing costs
Trends in facility development

An Evolving Story

• Once upon a time...one HCC in a region, viewed as a community resource
• Today: often multiple, competing HCCs
• GIP utilization grew with availability of HCCs
• Today: while overall GIP utilization is increasing, GIP in individual HCCs is generally contracting
  • Changes in interpretation of GIP qualifications
  • Increased scrutiny
  • Competition
• On the other hand, higher consumer expectations for HCC to be available
Quality of care is the key, not number of fountains and jacuzzis

Neither do facilities need to be on large acreage with pastoral settings
Key goals should be serene and peaceful

Images courtesy of Kwan Hemi Architecture/Planning, Inc.; photography: Lance W. Keimig

Dispersed facilities – Hospice of Palm Beach County

1 Free-standing facility (36 beds)
6 Hospital-based units (12-18 beds)
Total: 108 beds
Distributed facilities – Hospice of the Valley, Phoenix

2006: 159 beds at 16 sites

Hospices will be more creative to reduce cost of facilities
Hospices will explore strategic partnerships

- Hospitals, Nursing Facilities, Retirement Communities
- Anchor tenants
- Multi-hospice collaboration

Hospices will finance their projects creatively

- Tax-exempt bonds
- Donor/partner development and leaseback
- Federal assistance – especially HCOF
Hospices will explore green building

- Reflective ENERGY STAR rooftop covering
- Efficient cooling system
- Limited Parking
- Shelled space
- Multi-purpose space
- Bike parking
- Additional green & open space
- Native garden includes rain garden and rain barrels
- Skylights
- Access to public transit

Image courtesy of the Center for Neighborhood Technology (www.cnt.org)

Hospices will design flexibility into constructed facilities

- Shelled space
- Multi-purpose space
You can never build enough storage space

Where are we going to put all this stuff?!!

Comments/questions...
Providing Palliative Care – Key Considerations

Bill Musick, Senior Associate and Project Manager

Contributors:
Walter Borginis, Carla Braveman, Sharyl Kooyer, Cheryl Leslie, Pam Meliso,
Bill Musick (Editor in Chief), Shawn Ricketts, Lisa Roberts, Joshua Sullivan
Objectives

Caveats

• “If you’ve seen one palliative care program, you’ve seen one palliative care program.”
• Regulations vary by state and by payer and are continually evolving – please don’t take our comments as legal advice
• Beware of relying too much upon someone else’s experience
Questions in the room...

Palliative Care Models

CONTEXT
What?

Advanced Illness Management

Manageable, early, stable conditions

Disease Progression

Disease Modifying Treatment

Serious, progressive conditions that limit daily activities

Death

Palliative Care

Diagnosis of Life-threatening or Debilitating Illness or Injury

Terminal Phase of Illness

Hospice Care

Bereavement Support

What is Palliative Care?

Center to Advance Palliative Care (CAPC)

Specialized care for people with serious illnesses

• Focused on relief from the symptoms, pain, and stress of a serious illness
• goal is to improve quality of life for both the patient and the family
• provided by a team of doctors, nurses and other specialists who provide an extra layer of support at any age and at any stage in a serious illness and can be provided along with curative treatment
• support patient and family, not only by controlling symptoms, but also by helping to understand treatment options and goals
**What is Palliative Care?**

Center to Advance Palliative Care (CAPC)

• The palliative care team provides:
  
  • Expert management of pain and other symptoms
  
  • Emotional and spiritual support
  
  • Close communication
  
  • Help navigating the healthcare system
  
  • Guidance with difficult and complex treatment choices

**Variations**

• Setting

• Task-specific (Advanced Directives vs P&SM)

• Disease-specific (Cancer vs CHF)

• Symptom-specific (Pain)

• Delivery method (Face to face, telephonic, video)
Palliative Care

HOW TO MAKE MONEY BREAK EVEN
GET PAID

Payment

Billable Entitlement Programs

- Medicare Part B
  - Physician/NP
  - LCSW (using mental health billing codes only)
- Medicare Part A - Home Health
- Concurrent Hospice Care
  - Medicaid Pediatric Concurrent Care
  - Commercial Insurers
  - CMS Demonstration Project??
Payment (continued)

Entrepreneurial

• Contracts
  • Commercial Insurer
  • Hospital/Health System
  • Innovation Award/ACO/Bundled Payment
• Philanthropic
  • Research
  • Foundations
• Private Pay Fee for Service (Concierge)

Cost Avoidance in Lieu of Payment

System-wide Cost Savings/Outcomes vs. Net Investment in Palliative Care
Palliative Care

WHO and WHY are KEY

Why?

• Service Goals
  • Unmet need
  • Move “upstream”
  • Discharge option

• Financial Goals
  • Loss is OK (at least to start)
  • Break even
  • Financial contribution
Who?

- All with need
- Top potential for savings
- Segmented population

Examples of Delivery Models

Palliative Care
Examples: Advance Care Planning

Gundersen Health System’s Respecting Choices Program

Example: UPHS CLAIM Project

University of Pennsylvania Health System CLAIM Project (Comprehensive Longitudinal Advanced Illness Management)

• Home Health-based program with supplemental disciplines

• Cancer

• Goal: reduce unnecessary end of life care costs and decreased quality of life

• Seed funding: Health Care Innovation Awards

• Long-term: Cost avoidance, outcome improvements
Example: Lehigh Valley Health Network

• Optimizing Advanced Complex Illness Support (OACIS)

• Three-pronged service
  • OACIS Home-Based Consult Service
  • OACIS/Palliative Medicine Inpatient Consult Service
  • Palliative Care Outpatient Clinic (PCOC) – Cancer Center

• Medical Director, APNs, RN Case Manager

• Cost avoidance/improved outcomes

Examples: Entrepreneurial Services

• Contractual arrangements by hospices/home health agencies to provide a combination of:
  • Billable physician/NP services with
  • Hospital payment for social work/chaplain and/or physician/NP administrative time

• Palliative care providers at risk for achieving savings through identification and care of high-cost chronic care patients (insurer or health system, ACO)
Comments/questions...

Palliative Care

PLANNING AND DEVELOPMENT CONSIDERATIONS
Issues in Financial Viability

- Incomplete payment mechanisms
- Optimal utilization of high-cost providers
- Over-extending services
  - Services provided
  - Patients served

Tips from the field

Payment

- Do not expect PC to generate a profit
- Do bill Part A and/or B and do it well (attention to accuracy and coding)
- Don’t give away PC - get a fair payment from hospitals
- Require hospital partners to measure the impact of PC
Tips

• Focus on local needs

• Look for creative leveraging of
  • Other community resources
  • All possible funding sources

• When possible, shoot bullets first, then cannon balls

Tips (continued)

• Think outside of legacy models

• Hospital executives rank trust and compatible culture of partners higher than logistics/systems

• Value of practice management
Messaging Tips

Especially for hospice providers...

• No one knows what you will and will not do as a palliative care provider – tell them

• Providers and consumers do not understand palliative care or hospice – saying one is not the other is not a clarification

• Avoid describing palliative care as ‘hospice light’ – it is exactly as it sounds – less - and not as good as should be expected

Contact Information

Bill Musick
BMusick@CorridorGroup.com
(888) 942-0405 (toll-free)

corridor
CMS Proposed FY 2016 Hospice Payment Rule

Walter W. Borginis, III, CPA, CGMA
The VNA of Greater Philadelphia
2015 FMC Hospice Summer Camp

PROPOSED FY2016 PAYMENT RULE
Hospice Payment

WAGE INDEX:

• Fy2015 values based on 2000 Census Core-Based Statistical Areas (CBSAs)
• Transition to 2010 CBSAs – starts with FY2016
• FY2016 will reflect 50/50 blend of 2000/2010 CBSAs to minimize dramatic value
• FY2017 full transition 2010 CBSAs
PROPOSED FY2016 Payment Rule
Aggregate Cap

HOSPICE AGGREGATE CAP:

• REMINDER: For 2016 – 2025 cap years, aggregate Cap will grow by net hospice market basket (required by IMPACT Act of 2014) For 2016 increase is 1.8%
• 2015 aggregate cap: $27,135.96
• 2016 aggregate cap: $27,624.41
• CMS proposes shift of cap year (inpatient and aggregate) to federal fiscal year by 2018 cap year

PROPOSED FY2016 Payment Rule
Aggregate Cap

CMS MAY CONSIDER FUTURE CHANGES:

• Adjust aggregate Cap by wage index
• Rebase aggregate Cap
• Use cost report data to establish average episode cost for use as cap value
PROPOSED FY2016 PAYMENT RULE
Payment Reform - CMS’ Charge

PAYMENT REFORM: ACA – Section 3132
• Collect data to revise payment
• Reform payment for RHC no sooner than 10/2013
  ➢ Revisions may adjust daily payments to reflect resource use (U- or tier-shaped model)
  ➢ In first year, revisions must be budget neutral

PROPOSED FY2016 Payment Rule
Payment Reform

TIERED MODEL CONCERNS:
• 2012 – 14% of beneficiaries received no skilled visits in last 2 days of life
• Additional end of life payment should be contingent on service provision
• Operational concerns
  ➢ Tiered payment requires major systems changes, claim reprocessing due to sequential billing rules
PROPOSED FY2016 Payment Rule
Payment Reform

CMS PROPOSAL TO REFORM ROUTINE HOME CARE PAYMENT:

- Two payment rates for RHC
  - Days 1 – 60 of “episode” - $188.20
  - Days 61 and thereafter of “episode” - $147.34

  Hospice days continue to follow patient (discharge/revocation) if readmit occurs within 60 days of discharge

PROPOSED FY2016 Payment Rule
Payment Reform

SERVICE INTENSITY ADD-ON (SIA):

- Additional payments for up to 4 hours of care at hourly CHC rate ($39.44) for the last 7 days of life if:
  1. The day is billed as RHC
  2. The day occurs during the last 7 days of life (beneficiary is discharged dead)
  3. Direct patient care provided by RN or SW
  4. The service is not provided in a SNF/NF
PROPOSED FY2016 Payment Rule
Payment Reform

BUDGET NEUTRALITY:

• Required in first year of payment reform
• Budget neutrality is applied to all of RHC to allow for SIA
• Budget neutrality between the 2 RHC rates and the SIA will be applied annually going forward

PAYMENT REFORM – OTHER OPTIONS CONSIDERED:

• Higher RHC rate to first 30 days of episode (marginal costs continue to decline through day 60)
• Require 90 days off service to start clock again for higher RHC rate
• Deny higher RHC rate for patients served in NF/SNF
• Apply SIA to first 2 days where new readmission occurs (1.26% impact on rates rather than 0.81%)
### PROPOSED FY2016 Payment Rule
#### Payment Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Proposed Rates</th>
<th>Proposed SIA budget neutrality factor adjustment (1-0.0081)</th>
<th>Proposed FY 2016 Hospice payment update percentage</th>
<th>Proposed FY2016 Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>RHC 1-60 days</td>
<td>$187.63</td>
<td>X 0.09853</td>
<td>X 1.018</td>
<td>$188.20</td>
</tr>
<tr>
<td>651</td>
<td>RHC 61+ days</td>
<td>$145.21</td>
<td>X 0.9967</td>
<td>X 1.018</td>
<td>$147.34</td>
</tr>
</tbody>
</table>

### PROPOSED FY2016 Payment Rule
#### Payment Rates

<table>
<thead>
<tr>
<th>Description</th>
<th>FY2015 Payment Rate</th>
<th>Proposed Rates</th>
<th>(1-0.0081)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous Home Care Full Rate = 24 hours of care</td>
<td>$929.91</td>
<td>X 1.018</td>
<td>$946.65</td>
<td>$39.44 Hourly</td>
</tr>
<tr>
<td>Inpatient Respite</td>
<td>$164.81</td>
<td>X 1.018</td>
<td>$167.78</td>
<td></td>
</tr>
<tr>
<td>General Inpatient Care</td>
<td>$708.77</td>
<td>$1.018</td>
<td>$721.53</td>
<td></td>
</tr>
</tbody>
</table>
PROPOSED FY2016 Payment Rule
Payment Reform

PROPOSED FY2016 PAYMENT RATES:
• Average impact of 1.3% – subject to change
• Portion of payment must be adjusted by wage index
• Payment rates do NOT reflect impact of sequester
• Hospices failing to meet quality reporting requirements subject to additional 2 percentage point payment reduction

Questions?

Walter W. Borginis, III, CPA, CGMA
wborginis@vnaphilly.org
501: Hospice Summer Camp
Monitoring Financial Operations

VNA Philly History

<table>
<thead>
<tr>
<th>Year</th>
<th>Gross Margin</th>
<th>Net Margin</th>
<th>Revenue % change to prior year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>34.8%</td>
<td>3.1%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>2011</td>
<td>37.6%</td>
<td>0.6%</td>
<td>4.0%</td>
</tr>
<tr>
<td>2012</td>
<td>41.4%</td>
<td>7.6%</td>
<td>9.0%</td>
</tr>
<tr>
<td>2013</td>
<td>40.2%</td>
<td>5.3%</td>
<td>3.3%</td>
</tr>
<tr>
<td>2014</td>
<td>41.3%</td>
<td>6.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>2015</td>
<td>42.4%</td>
<td>7.4%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>
Where do I start?

- All Financial Cost Data should be easily accessible and broken out.
  - General Ledger
  - Payroll Software
- Identify Critical Financial KPI Indicators
  - Keep it Simple
  - Focus on Revenue & Cost Drivers
- Automate your reports
  - Excel
- Compare to Benchmark Data

Establish Your Reporting Process

- What drives your processes?
  - Financial – Revenue & Costs
  - Operational – Census, Productivity & Compliance
- Determine Responsibilities
  - Management, Directors & Staff
- Determine Frequency
  - Daily, Weekly, Monthly, Quarterly
Reporting

“I’ll pause for a moment so you can let this information sink in.”

Quarterly Net Margin FY12 and FY14 (FY end June 30)
Benchmark Comparisons
- Research benchmark sources available
  - NAHC, NHPCO, OCS, SHP, Financial Monitor, MVI, Cost Report data
  - Understand data elements and calculations
    - Need to ensure apples to apples comparison
    - Who are you comparing to?
      - Geography, Payer Mix, Profit Status, Agency Type, Revenue Size
  - Remember benchmarks are the median

Financial Benchmarking
- Board – Update on the Industry
- Executive – Overall Health of the Agency
  - Profitability & Cash
- Middle Management – Hold Staff Accountable
  - Set Goals based on benchmark data – key revenue and cost drivers.
- Staff – Performance
  - Productivity
  - Caseload
Reporting benchmarks

- Customize based on target audience
- Customize based on desired reaction
  - Extract most important information
  - Focus on the inefficiencies in that period
  - Create urgency!
- Advanced PDF software
  - Many options (Foxit PhantomPDF Standard)

Gross Margin

- Gross Margin is where you need to start in any financial analysis.
- Everyone’s performance has an affect on Gross Margin.
- Direct revenue minus direct expenses
  - Direct Revenue – All Net Payer Revenue
  - Direct Expenses – Salaries, payroll taxes, workers compensation, benefits, contract, mileage and supply costs from direct patient care
Gross Profit Margin Benchmarks

- Gross Profit Margin
  - VNA Philly actual compared to benchmarks

![Gross Profit Margin Chart]

Direct Costs

- Hospice Direct Cost Per Day
  - Total Direct – $107
    - Routine Day – $86
    - General Inpatient – $675
    - Respite Inpatient – $155
  - Ancillary Cost (In Home Hospice)
    - Total – $20.00

![Direct Cost Chart]
**Net Profit Margin Benchmark**

- Hospice National Benchmarks
- VNA Philly actual compared to benchmarks

![Net Profit Margin Overall Chart](image)

**Total Indirect Costs**

- Cost as a % of Total Revenue
- Agencies with no Home Office Costs
  - Total – 36% of Revenue
    - Salaries – 17%
    - Benefits – 4%
    - Other Admin – 15%
Monitoring Results

- Include benchmark goals on monthly financial reports

- Create dashboards
  - Daily/Weekly based on need
  - Keep very straightforward
  - Compare goal to estimate based on current data
    - Check accuracy after close—within 5%

Productivity & Staffing Ratios

<table>
<thead>
<tr>
<th>Productivity</th>
<th>Hospice</th>
<th>NHPCO*</th>
<th>Hospice Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>3.8</td>
<td>2.6</td>
<td>4 to 5</td>
</tr>
<tr>
<td>Aides</td>
<td>3.6</td>
<td>4.1</td>
<td>4 to 5</td>
</tr>
<tr>
<td>MSW</td>
<td>2.15</td>
<td>2.2</td>
<td>2 to 3</td>
</tr>
<tr>
<td>Chaplains</td>
<td>n/a</td>
<td>2.9</td>
<td>3 to 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caseloads</th>
<th>Hospice</th>
<th>NHPCO*</th>
<th>Hospice Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>9.7</td>
<td>11 to 13</td>
<td>13</td>
</tr>
<tr>
<td>Aides</td>
<td>6.1</td>
<td>10 to 12</td>
<td>12</td>
</tr>
<tr>
<td>MSW</td>
<td>21.6</td>
<td>25 to 30</td>
<td>28</td>
</tr>
<tr>
<td>Chaplains</td>
<td>36.4</td>
<td>30 to 50</td>
<td>32</td>
</tr>
</tbody>
</table>

*2009 National Hospice and Palliative Care Organization
Monitoring Results

- Hospice caseload

<table>
<thead>
<tr>
<th>As of Payroll Ending 6/2/2014</th>
<th>Actual Caseloads per FTE</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>12.0</td>
<td>13.0</td>
</tr>
<tr>
<td>Aides</td>
<td>11.1</td>
<td>10.12</td>
</tr>
<tr>
<td>MSW</td>
<td>27.3</td>
<td>30.0</td>
</tr>
<tr>
<td>Chaplains</td>
<td>48.9</td>
<td>32.0</td>
</tr>
</tbody>
</table>

- Mileage per visit

<table>
<thead>
<tr>
<th>Visits announcement</th>
<th>7,970</th>
<th>8,264</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miles exp.</td>
<td>$14,907</td>
<td>$12,711</td>
<td>$11</td>
</tr>
<tr>
<td>Cost per visit</td>
<td>$1.19</td>
<td>$1.62</td>
<td>19.2%</td>
</tr>
</tbody>
</table>

Monthly Reports

Hospice In Home Program
Dashboard
For the Month Ending June, 2014

<table>
<thead>
<tr>
<th>Actual Per Day</th>
<th>Budget Per Day</th>
<th>Variance Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy/Drugs</td>
<td>12.48</td>
<td>9.08</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>2.28</td>
<td>2.14</td>
</tr>
<tr>
<td>DME</td>
<td>6.36</td>
<td>6.09</td>
</tr>
<tr>
<td>Ambulance</td>
<td>0.47</td>
<td>0.47</td>
</tr>
<tr>
<td>Cost Per Day-Direct</td>
<td>86.32</td>
<td>85.52</td>
</tr>
<tr>
<td>Cost Per Day-Indirect</td>
<td>61.62</td>
<td>64.30</td>
</tr>
<tr>
<td>Cost Per Day-Total</td>
<td>148.05</td>
<td>150.29</td>
</tr>
<tr>
<td>Average Length of Stay (discharged patients)</td>
<td>59.00</td>
<td></td>
</tr>
<tr>
<td>Average Daily Census</td>
<td>187.19</td>
<td>182.30</td>
</tr>
<tr>
<td>Conversion Ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td>1,078</td>
<td>1,140</td>
</tr>
<tr>
<td>Admissions</td>
<td>866</td>
<td>914</td>
</tr>
<tr>
<td>Conversion Ratio</td>
<td>80.3%</td>
<td>80.2%</td>
</tr>
</tbody>
</table>
### Monthly reports

In Home Hospice
For the Month Ending June, 2014

<table>
<thead>
<tr>
<th>Daily Net Revenue</th>
<th>Actual Per Day</th>
<th>Budget Per Day</th>
<th>Variance Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$161.61</td>
<td>$162.39</td>
<td>$(0.78)</td>
</tr>
<tr>
<td>Bad Debt Expense</td>
<td>$0.11</td>
<td>$0.47</td>
<td>0.36</td>
</tr>
<tr>
<td>Nursing</td>
<td>31.51</td>
<td>31.01</td>
<td>(0.50)</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>8.95</td>
<td>10.10</td>
<td>1.16</td>
</tr>
<tr>
<td>MSW</td>
<td>6.68</td>
<td>6.73</td>
<td>0.05</td>
</tr>
<tr>
<td>PT/OT/ST/Phib</td>
<td>0.34</td>
<td>0.48</td>
<td>0.13</td>
</tr>
<tr>
<td>Contract Physician</td>
<td>1.08</td>
<td>1.08</td>
<td>(0.01)</td>
</tr>
<tr>
<td>Chaplain/Bereavement Services</td>
<td>3.93</td>
<td>4.13</td>
<td>0.20</td>
</tr>
<tr>
<td>Other Contract Services</td>
<td>1.62</td>
<td>2.91</td>
<td>1.09</td>
</tr>
<tr>
<td>Benefits</td>
<td>10.78</td>
<td>11.78</td>
<td>1.01</td>
</tr>
<tr>
<td>Total Direct Services</td>
<td>65.08</td>
<td>40.3%</td>
<td>68.22</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>2.28</td>
<td>2.14</td>
<td>(0.15)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>12.48</td>
<td>9.08</td>
<td>(3.41)</td>
</tr>
<tr>
<td>DME</td>
<td>6.36</td>
<td>6.09</td>
<td>(0.27)</td>
</tr>
<tr>
<td>Other Program Supplies</td>
<td>0.11</td>
<td>-</td>
<td>(0.11)</td>
</tr>
<tr>
<td>Total Direct Supplies</td>
<td>21.24</td>
<td>13.1%</td>
<td>17.31</td>
</tr>
<tr>
<td>Gross Margin Per Patient Day</td>
<td>75.29</td>
<td>46.6%</td>
<td>76.86</td>
</tr>
<tr>
<td>Total G &amp; A</td>
<td>61.62</td>
<td>38.1%</td>
<td>64.30</td>
</tr>
<tr>
<td>Total Cost Per Day</td>
<td>148.05</td>
<td>150.29</td>
<td>2.24</td>
</tr>
<tr>
<td>Net Margin Per Patient Day</td>
<td>13.56</td>
<td>8.4%</td>
<td>12.09</td>
</tr>
</tbody>
</table>

### Daily Reports

#### August IPU Census

- Daily Census
- Census needed remainder of month to break-even
- Actual average daily census

![August IPU Census Graph](image)
Expense Containment Strategy

**Warning:**
Cost reductions are just one part of a comprehensive plan to deal with these Medicare payment reductions and unfunded mandates.

You must build revenues in order to avoid a death spiral on continual cost reductions.

Everyone should be involved
- Executive Management
- Clinical Directors
- Financial Directors

Need buy in from everyone when it comes to cost review.
- Analyze what would happen based on industry changes if all cost remained the same.
- Determine if something must be done!
Steps to lower expenses:
Flex direct care expenses in response to volume changes.

Seek ways to lower overhead expenses.

Expense Containment Strategy

- Non Employee Direct Costs
  - Medical Supplies/Pharmacy/DME
    - Send out an RFP to determine if you are getting the best deal
    - Review your formularies
  - Look at transportation costs
    - Are you reimbursing at the IRS allowable or less than that?
    - Do you have an automated way of tracking mileage for accurate recording?
    - Do you randomly audit mileage?
Organizational Administrative and General Cost Analysis

行政和一般费用分析

Questions?

- Josh Sullivan JSullivan@vnaphilly.org

THANK YOU!