Cost Report Reform: Ready or Not?

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Session Objectives

- Describe the importance to CMS, the provider and the hospice industry of accurately completing a Medicare hospice cost report.
- Identify the data elements that are essential to collect in advance of needing to complete and file a Medicare hospice cost report.
- Recognize the changes providers will need to make within their own organizations to track and assemble data to facilitate Medicare hospice cost report completion and filing.

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Cost Report Reform: Why?

- 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

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Cost Report Reform: Why?

- Data Collection
  - Site of service by Level of Care
    - Private Residences
    - Hospice Residences
    - Assisted Living Facilities
    - Nursing Facilities
    - Hospitals
    - Hospice Inpatient Units (free-standing, contracted or owned/leased)
  - Services and resources provided per day by Level of Care
    - Visits by discipline
    - Length of visits at all time points within the total days of care provided
    - Ancillary services (Drugs, DME, Medical Supplies, Patient Transportation, Palliative Therapies, etc.)

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Cost Report Reform: Why?

- Data Collection
  - Costs associated with Level of Care
    - Cost per day
      - Direct cost per day
        - » Labor: by discipline
        - » Ancillary services
      - Indirect cost per day
        - » Increase in Administrative and Clinical Support staff to meet increasing regulatory/compliance requirements
- "Useful Data" must be gathered and reported in a consistent, accurate and timely manner.

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Cost Report Reform: Why?

- Objective is to collect better data to ensure that hospice payments are appropriate and adequate.
- With no current monetary "settlement" based on the cost report not all providers have been mindful about completing the cost report accurately.
  - Reference ABT Technical Report where many cost reports were trimmed out due to missing or unusual data.
  - This hurts the industry when lawmakers make decisions based on bad data!

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Cost Report Reform Time Line

- Cost Report Reform: Federal Register of April 29, 2013 and the Paperwork Reduction Act (PRA) November 22, 2013.
- Comments submitted by NHPCO, NAHC, providers, industry experts and consultants shared many common concerns:
  - CMS has underestimated the cost burden of complying with the revisions.
  - The quality of the instructions lack sufficient detail and clarity.
  - October 1, 2014 implementation date is an inadequate time frame for education, implementing processes and systems for data collection changes to provide accurate, reliable and useful information.

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Cost Report Reform: What's New

- 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

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Costs 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.

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Overview

- Who is required to file the cost report?
  - All providers participating in the Medicare program (CMS 15-1 Section 2413).
- Intent of Cost Report:
  - Information is submitted annually to CMS/MAC for settlement of costs relating to health care services rendered to Medicare beneficiaries.
    - Hospice is currently a "per diem" reimbursement with no settlement based on the cost report.
    - BUT! Governmental agencies such as MedPAC and CMS mine cost reports for data to make recommendations to Congress on the adequacy of payments to providers.
      - Payment reform for Hospice has been recommended.
      - Cannot stress enough the important of submitting ACCURATE data.

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Overview

- The cost report is submitted to CMS through your Medicare Administrative Contractor (MAC) to provide them with information on your costs, specifically those related to patient care.
- Cost Report Periods (CMS 15-1, Section 2414)
  - Annual reports cover a 12 consecutive month period of operations.
    - Providers may select any 12 month reporting period.
    - Recommend following accounting period used in operations
  - Cost reporting period can be from 1 to 13 months
    - New or terminating providers (CMS 15-1, Section2414.1 and 2414.2)
      - Final cost report
      - Change of ownership – partial cost report
        - » Stock purchase – No
        - » Asset purchase – Yes
  - The cost report due date does not have to match your fiscal year end but it is due 5 months after the close of your cost reporting period. It needs to be postmarked by this date.

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Overview

- While CMS says that the cost report may be submitted electronically, there are still a number of items that MUST be included:
  - Worksheet S (with the Encryption code) must be signed by an administrator.
    - Be sure to sign the document and not stamp it. CMS will deny your cost report for a stamp and not an original signature.
    - **BLUE** ink is recommended.
  - Working Trial Balance.
  - Crosswalk of expenses from Trial Balance to Worksheet A.
  - Financial Statements (Audited, Compiled or Reviewed if applicable).
  - Documentation for any reclassifications, adjustments or related organizations costs.
- The financials must all be on the accrual basis of accounting and not the cash basis.

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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-8-1 - 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

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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 printed and 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.

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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)

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Worksheet S-1 Part I: Hospice Identification Data

- On this worksheet you will enter the following identifiable information about your agency:
  - Are you claiming Home Office costs?
    - Provide identifying information about the Home Office
  - 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

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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

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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.

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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?
- 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

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Worksheet A: Reclassification and Adjustment of Trial Balance of 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.

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Worksheet A: Reclassification and Adjustment of Trial Balance of 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 (i.e., 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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Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

- General Service Cost Centers
  - Line 2: Cap Rel. Costs-Moveable Equipment
    - Leases, depreciation, personal property taxes, etc.
  - 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.







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Worksheet A: Reclassification and Adjustment of Trial Balance of 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.
  - 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.

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Worksheet A: Reclassification and Adjustment of Trial Balance of 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.
  - 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.

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Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

- Direct Patient Care Service Cost Centers
  - Line 25: Inpatient Care- Contracted
    - 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
    - Cost of physician and nurse practitioners providing physician services for direct patient care services.
  - Line 27: Nurse Practitioner
    - Cost of nursing care only. If performing physician care services they must be reported on Line 26 (Physician Services).
  - Line 28: Registered Nurse
    - Cost of nursing care provided by RN's only.
  - Line 29: LPN/LVN
    - 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

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Worksheet A: Reclassification and Adjustment of Trial Balance of 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
  - 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)

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Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

- Non-reimbursable Cost Centers
  - Line 60: Bereavement Program
    - Cost incurred for services both prior to and after the patients death.
  - Line 61: Volunteer Program
    - Cost such as supplies, food for meetings, etc.
    - Remember that recruitment and training costs are reported on line 13.
  - Line 62: Fundraising
  - Line 63: Hospice/Palliative Medicine Fellow
  - Line 64: Palliative Care Program
    - Costs of palliative care to non-hospice patients, including physician services.
  - Line 65: Other Physician Services
    - Provided outside of a palliative care program to non-hospice patients.

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Worksheet A: Reclassification and Adjustment of Trial Balance of 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.
  - Line 68: Telehealth / Telemonitoring
    - Cost include salaries and benefits of staff monitoring as well as 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.

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Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

- The Flow of Worksheet A
  - Worksheet A 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
  - Enter data directly in Columns 1 and 2 for:
    - General Service Cost Centers (lines 1-17)
    - Non-reimbursable Cost Centers (lines 60-71)
  - Direct patient care services costs (lines 25-39) flow directly from Worksheets A-1, A-2, A-3 and A-4 for all columns.
    - You enter the sum of the amounts from Worksheets A-1 through A-4 for salaries, other costs, reclassifications and adjustments in Columns 1,2, 4 and 6, as defined above.

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Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

- The Flow of Worksheet A
  - Column 3 is the subtotal of columns 1 & 2
  - Column 4 Reclassifications
    - Will flow directly from Worksheet A-6 for the General Service cost centers and Non-reimbursable cost centers.
    - For Direct Service cost centers will flow from the accumulation of Worksheets A-1, A-2, A-3 and A-4.
  - Column 5 is the subtotal of columns 3 & 4
  - Column 6 Adjustments
    - Will flow directly from Worksheet A-8 for the General Service cost centers and Non-reimbursable cost centers.
    - For Direct Service cost centers will flow from the accumulation of Worksheets A-1, A-2, A-3 and A-4.
  - Column 7 is the total of columns 5 and 6

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Worksheets A-1 to A-4: Direct Patient Care Costs

- 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, exactly the same as Worksheet A:
  - 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.

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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
- Information can be captured by:
  - Use of time studies
  - Statistical methodologies
  - Coding of invoices upfront by A/P staff with increased level of detail
  - Developing of spreadsheets for tracking costs

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Strategies for Direct Patient Care Costs

- Inpatient costs are tracked separately between contracted facility versus owned/leased facility.
- Inpatient Contracted – Line 25.
  - Contracted costs paid to the facility is broken out between:
    - Respite (Worksheet A-3)
    - General (Worksheet A-4)
  - Hospice staff seeing patients in the contracted setting:
    - RN seeing a patient on Respite services would be captured on Worksheet A-3, Line 28.
- 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 for the reporting of the administrative and general supervisory activity.

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Strategies for Direct Patient Care Costs

- 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 and all levels of care:
        - » Physician Administrative Services
        - » Physician Services
        - » Nurse Practitioner
  - Utilization of a "time study" to properly capture costs.

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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: Example - 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
- 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

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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.
- 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.

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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 by level of care.
- Counseling – Other – Line 36
  - Other counseling not already identified as spiritual, dietary or bereavement. Non-reimbursable must be reclassified.
- 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

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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):
    - May 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 that the patient is transported **to**.
  - Challenge – when the patient is transferred to multiple levels of care (i.e., patient has gone from RHC to Respite and then back RHC).
    - Develop internal spreadsheet to capture invoices by patient by level of care.

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Strategies for Direct Patient Care Costs

- Imaging Services, Labs and Diagnostics, Medical Supplies and Outpatient Services – Lines 40, 41, 42 and 43
  - Challenge – costs are patient specific in relationship to their plan of care.
    - Develop internal spreadsheet to capture invoices by patient by level of care.
    - Medical Supplies: Cost report instructions allow for cost to be allocated to each level of care based on patient days **if** not tracked by level of care.
- 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.

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Worksheet A-6: Re-classifications

- Worksheet A-6 is used when a shift of costs between cost centers is needed.
- This worksheet can be left blank if no re-classes need to be made.
- Most re-classes 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.
- To complete this worksheet, enter each reclass by assigning an alpha character starting with A.
- For each increase reclass, enter the amount in column 4 and the cost center line number in column 3.
- For each decrease reclass, enter the amount in column 7 and the cost center line number in column 6.
- In Column 8, enter the Level of Care (LOC) worksheet indicator when a reclass affects a direct patient care service cost center (lines 25 to 46).
- The LOC worksheet indicator corresponds with the LOC worksheet.
  - For Example, Worksheet A-1's indicator is 1 and Worksheet A-2's indicator is 2, etc.

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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.

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Worksheet A-8: Adjustments to Expenses

- 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.

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Worksheet A-8: Adjustments to Expenses

- Additional examples of Non-Allowable Expenses include:
  - Alcoholic beverages
  - Gifts and Donations
  - Penalties & Fees
  - Income Taxes
  - Excessive Owners Compensation
  - Excessive 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

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Worksheet A-8: Adjustments to Expenses

- In column 1, enter the basis for each adjustment.
  - Use "A" for cost.
  - Use "B" for revenue offset.
- Use column 2 to enter the amount of the adjustment.
  - When entering the amount, enter as a negative adjustment if the intent is to reduce the cost from the total.
- In column 4, enter the worksheet A line number. Column 3 will be the description.
- Identify and select the appropriate line to enter the adjustment on.
- If additional lines are needed, start by adding line 12, then 13, etc.

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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.
- 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.

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

- **Part I** relates to costs incurred and adjustments required as a result of transactions with related organizations or claimed home office costs.
  - In column 1, enter the cost center line number that needs to be adjusted. Column 2 will be the corresponding description.
  - Enter a description of the related organization or home office in column 3.
  - For column 4, enter the allowable costs.
    - The allowable costs are the actual costs incurred by the related organization or home office for the service.
    - This should exclude any markup or profit.
  - Column 5 should be the amount included on worksheet A for services, facilities and/or supplies acquired from related organizations or home office.
  - Column 6 is the result of column 4 minus column 5, which is the adjustment.
  - Column 7 should be used when the adjustment affects a direct patient care service cost center (lines 25 through 46).
    - The LOC worksheet indicator corresponds with the LOC worksheet.
      - For Example, Worksheet A-1's indicator is 1 and Worksheet A-2's indicator is 2, etc.

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

- **Part II** describes the interrelationship between the hospice and individuals, partnerships, corporations or other organizations having either a related interest, common ownership or control over the hospice.
  - Column I requires a symbol that represents the interrelationship between the hospice and the related organization or home office. The symbols are:
    - A: Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
    - B: Corporation, partnership or other organization has financial interest in provider.
    - C: Provider has financial interest in corporation, partnership, or other organization.
    - D: Director, officer, administrator or key person of provider or organization.
    - E: Individual is director, officer, administrator or key person of provider and related organization.
    - F: Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider.
    - G: Other (financial or non-financial) – specify.

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

- **Part II continued:**
  - If the symbol used in column 1 is A, D, E, F, or G, enter the name of the related individual in column 2.
  - For each related corporation, partnership or other organization, enter the corresponding name to column 4.
  - Columns 3 and 5 deal with the financial interest of the individual or corporation. In these columns, you will enter the percentage of ownership.
    - The percentage of ownership for an individual goes in column 3.
    - The percentage of ownership for a corporation goes in column 5.
  - For column 6, enter a brief description of the related organization.
    - For example, Medical drugs, Supplies, Laundry, Linen, etc.

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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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Worksheet B

- **The Flow of Worksheet B**
  - Note that the line numbers on Worksheet B do not replicate those of Worksheet A.
    - The General Services and Non-reimbursable cost cents lines are identical.
    - The Direct Care patient services are rolled up into the following lines:
      - Continuous Home Care
      - Routine Home Care
      - Inpatient Respite Care
      - General Home Care
  - For entering data in Column 0:
    - Lines 1-17 data is from Worksheet A, Column 7, Lines 1-17;
    - Line 50 data is from Worksheet A-1, Column 7, Line 100;
    - Line 51 data is from Worksheet A-2, Column 7, Line 100;
    - Line 52 data is from Worksheet A-3, Column 7, Line 100;
    - Line 53 data is from Worksheet A-4, Column 7, Line 100;
    - Lines 60 -71 data is from Worksheet A, Column 7, Lines 61-71.
  - Data for Columns 1-18 are then populated based upon data from Worksheet B-1.

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Worksheet B-1

- Allocation of General Service cost centers to Level of Care and Non-Reimbursable cost centers.
  - Based upon the step down methodology.
- Statistical bases:
  - Capital Related Bldg & Fixtures –Square Feet
  - Capital Related Mvble Equip – Dollar Value
  - Employee Benefits – Gross Salaries
  - Admin & General – Accumulated Costs
  - Plant, Ops, & Maint – 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

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Worksheet B-1

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

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Worksheet B-1

- **The Flow of Worksheet B-1**
  - The line numbers on Worksheet B-1 replicate those of Worksheet B.
  - Costs are transferred from Worksheet B, Column 0, Line numbers 1-17 to the corresponding columns on Worksheet B-1 Line 100.
  - The statistics are then entered on B-1 according to column and line numbers.
    - The Total Cost, Line 100 is divided by the Total Statistic, Line 29 to develop the Unit Cost Per Multiplier.
    - The individual statistic is then multiplied by the unit cost per multiplier to arrive at the cost to be reported on Worksheet B.

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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.
    - 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.

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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 Bldg & Fixtures –Square Feet
  - Step-down does not allow costs to be allocated to:
    - Direct care staff by discipline and 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.

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Challenges of Statistical Allocation Basis

Square Footage			
Admin & General	500	Patient Days	
RN	350	Routine	11,520
HHA	150	Continuous	480
Total Square Feet	1,000	Total Patient Days	12,000
Cap Related expenses	$ 20,000		

Calculation for Reclassification

	Square Feet	% of sq ft	Cap Rel Expenses
Admin & General	500	50%	$ 10,000
RN	350	35%	$ 7,000
HHA	150	15%	$ 3,000
	1,000	100%	$ 20,000

	Days	% Days	RN	HHA
Routine	11,520	96%	$ 6,720	$ 2,880
Continuous	480	4%	$ 280	$ 120
Total	12,000	100%	$ 7,000	$ 3,000

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Challenges of Statistical Allocation Basis

Reclassification Entry

			Increases		Decreases			
Explaination	Code	Cost Center	Line #	Amount	Cost Center	Line #	Amount	LOC WS Indicator
Reclass RN Cap Rel costs	A	RN	28	$ 6,720				2
Reclass RN Cap Rel costs	A	RN	28	$ 280				1
					Cap Rel Costs	1	$ 7,000	
Reclass HHA Cap Rel costs	B	HHA	37	$ 2,880				2
Reclass HHA Cap Rel costs	B	HHA	37	$ 120				1
					Cap Rel Costs	1	$ 3,000	

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Challenges of Statistical Allocation Basis

- Cap Related Mvble Equip – 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.

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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:
    - Administrative and General.
    - Direct care staff by level of 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 5, and increasing appropriate lines by level of care.

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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.

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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.

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Challenges of Statistical Allocation Basis

- 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.
- 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
      - Non-Injectable prescription drugs (0250)
      - Medication refills on infusion pumps (0294)
      - Injectable drugs (0636).

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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.

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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.

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Worksheet F-1: Statement of Changes in Fund Balance

- Enter the fund balance at the beginning of the period.
- The net income should agree with what is on Worksheet F-2, the Income Statement.
- If any additions or subtractions were made, enter those on the appropriate line.
- It is easiest to enter all of the amounts into column 1, the General Fund column.

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Worksheet F-2 Part I: Statement of Revenues and Operating Expenses

- There are 2 parts to this worksheet.
  - The first part is the Patient Revenues.
  - The second part is the Operating Expenses.
- Revenues: Enter the gross revenue amounts for each payer source need to be entered into the appropriate row by level of care.
- Every incoming revenue dollar needs to be recorded by payer and by level of care to be properly reported on the cost report.
- The Payer sources that need to be identified are:
  - Medicare
  - Medicaid
  - Other
- The rows are used for the levels of care:
  - Continuous Home Care
  - Routine Home Care
  - Inpatient Respite Care
  - General Inpatient Care
- The contractual allowances and discounts should be totaled by each payer regardless of level of care and entered into row 7.

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Worksheet F-2 Part I: Statement of Revenues and Operating Expenses

- Expenses: The total operating expenses should flow from the total expenses on worksheet A line 100 and column 3.
- There are two separate sections where you can either Add or Deduct expenses.
  - This would be for expenses that are recorded in a separate section of your audited financials and are not reported on worksheet A. (Bad Debt may be an example.)
  - If there is Other Income, enter that amount under the Deduct header and then specify the type and amount.

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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: Not currently on the form
  - 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.

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What Are the Comments, Issues and Challenges?

- Refined reporting on facilities: contracted (Inpatient Care line # 25) as well as owned/leased (Building & Fixtures line # 1, Mvbl Equipment line #2, Plant Operation & Maintenance line # 5, Laundry line # 6, Housekeeping line # 7, Dietary line # 8).
- Many different types of facilities:
  a) Residential only, RHC provided, no other activities occur.
  b) Residential only, RHC provided, building also houses administrative offices for hospice program.
  c) Inpatient Facility only, GIP and Respite are provided, no other activities occur.
  d) Inpatient Facility only, GIP and Respite provided, building also houses administrative offices for hospice program.
  e) Inpatient Facility with multiple levels of care provided (RHC, GIP and Respite), no other activities occur.
  f) Inpatient Facility with multiple levels of care provided (RHC, GIP and Respite), building also houses administrative offices for hospice program.

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What Are the Comments, Issues and Challenges?

- Different challenges for each scenario:
  a) Straightforward: All residential building costs are reported on line # 66, with all other hospice program space and equipment costs on appropriate lines and allocated to appropriate cost centers.
  b) Complicated: Worksheets B and B-1 allow for allocation of costs from Build & Fix (line 1), Mvble Equip (line 2), Admin & General (line 4), Plant Op & Maint (line 5) to Patient/Residential Care Svcs (line17), 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 Op & Maint (line 5) is after Admin & General (line 4), which indicates you cannot allocate any Plant Op & Maint costs to administrative even though the residence encompasses the hospice program's administrative offices.
  - 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 Op & Maint (line 5) is after Admin & General (line 4), which indicates you cannot allocate any Plant Op & Maint costs to administrative even though the facilities/locations encompass the hospice program's administrative offices.

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What Are the Comments, Issues and Challenges?

- Line # 2 Mvbl 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?
- 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 Op & 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.

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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.
- Line # 12 Staff Transportation: Statistic is Mileage. Line # 12 is after line # 4, Admin & General, precluding any allocation to line # 4. 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.

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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.
- 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.
- 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.

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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.).
- 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.
  - 42CFR 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.

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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.).

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Looking into the future, what will it take?

- Education of clinical staff regarding the challenges of having to keep details.
- Education of accounting staff / accounts payable.
- 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?

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Questions?

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