HOSPICE MEDICARE CHANGES

HEALTH FINANCIAL SYSTEMS USER MEETING 2015

SIGNIFICANT HOSPICE CHANGES

Time of the Hospice

Cost Report changes represent essentially a revision of the entire report.

CAP Reporting and management of the CAP has entered a new era.

Payment revisions will have significant impact on many financial aspects of hospices.

BRIEF COST REPORT HISTORY

The "new" CMS-1984-14 represents the third design of the Hospice Cost & Data Report.

The new report is the result of provisions of the Affordable Care Act ("ACA") which mandates cost reporting revisions to be used for monitoring and revising hospice payments no earlier than October 1, 2013.

Spring 2013 – first revision, modified in November 2013.

Many comments were submitted to the Spring version resulting in substantial changes.

Essentially no revisions made to the November 13, 2013 version, based on comments.

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MAJOR IMPACT OF NEW REPORT

The final report is a substantial revision – essentially a new report with a focus on level of care ("LOC") costing.

The new report (CMS-1984-14) is effective for cost reporting periods beginning on or after October 1, 2014.

The report requires substantial review and potential changes to chart of accounts to accommodate the new cost centers and LOC reporting.

The report also requires development of additional statistics as well as enhancement of new statistics for purposes of cost reclassifications and allocations.

Form 339 eliminated – pertinent questions have been incorporated into the cost report.

Fast food approach to cost reporting will not work with the new cost report.

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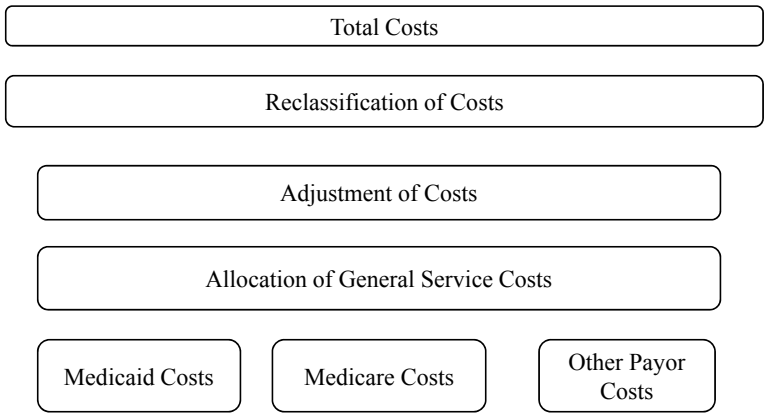
COST REPORTING PROCESS



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HOSPICE COST REPORT TEMPLATE

The U.S. Centers for Medicare and Medicaid Services ("CMS") has designed the Hospice Cost & Data Report to accomplish LOC costing using the existing cost reports of hospitals and skilled nursing facilities as the template.

While the cost reporting process has not changed, the extent of the information and details of the process are significantly altered.

Important – cost reports will be used for rate-setting. **Focus should be on legitimately classifying costs as hospice costs and not over-costing to nonreimbursable activities.**

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WORKSHEET SUMMARY

Worksheet S series (statistics, general information, and questionnaire)

Worksheet A – Summary of all costs, reclassifications and adjustments

Worksheets A-1, A-2, A3, and A-4 (patient care service costs by level of care)

Worksheet A-6 (reclassifications)

Worksheet A-8 (adjustments to expenses)

Worksheet A-8-1 (related party transactions)

Worksheets B and B-1 (allocation of general service costs)

Worksheet C – costs by payor source

Worksheet F series (financial statements)

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GENERAL SERVICE COST CENTERS

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

Capital related - building	**Nursing administration**
Capital related - equipment	**Routine medical supplies**
Employee benefits	**Medical records**
Administrative - general	**Staff transportation**
Plant operations & maintenance	**Volunteer services coordination**
Laundry and linen services	**Pharmacy**
Housekeeping	**Physician administrative**
Dietary	**Patient/residential care**

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NON-REIMBURSABLE COST CENTERS

- Bereavement program
- Volunteer program
- Fundraising
- Hospice/Palliative fellows
- Palliative care program
- Other physician services
- Residential care
- Advertising
- Telehealth/telemonitoring
- Thrift store
- Nursing facility room and board

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PATIENT CARE COST CENTERS

Inpatient care - contracted	
Physician services	Other counseling
Nurse practitioner	Aide and homemaker
Registered nurse	DME/Oxygen
LPN/LVN	Patient transportation
Physical therapy	Imaging services
Occupational therapy	Labs and diagnostics
Speech therapy	Medical supplies – non-routine
Medical social services	Outpatient services
Spiritual counseling	Palliative radiation therapy
Dietary counseling	Palliative chemotherapy

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IMPORTANCE OF THE CHART OF ACCOUNTS

A comprehensive chart of accounts includes segregation of all expenses to feed the cost centers on Worksheet A. The costs for each cost center, lines 25 through 46, would segregate costs by level of care. Otherwise, a plan for the reclassification of costs becomes important.

Note – If essentially all the services provided are routine home care, the cost report is simplified.

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KEY ASPECTS OF COST REPORTING

Chart of accounts (addressing all cost centers as applicable and level of care (LOC) costing to the extent cost beneficial).

Planning for alternatives to LOC costing (using reclassification of costs, statistical methods for reclassification, etc.).

Ensuring required statistics are available.

Key sample cost allocation problems:

- Movable equipment costs,
- Plant operation and maintenance (post administration), and
- Volunteer coordination costs.

CAP REPORTING AND MANAGEMENT

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Hospice Aggregate CAP

Why should all hospices be engaged in monitoring and managing their organization's aggregate CAP?

- **The percent of hospices exceeding the CAP is trending upward.**
- **Many hospices are still unaware of CAP liabilities until they receive notification from the MAC. Likewise, inaccurate computations can lead hospices to believe they are OK when, in fact, a liability is forthcoming.**
- **Due to IMPACT Act (Public Law 113-185), CAP value will grow more slowly in coming years, more hospices may be hit with overpayments.**
- **Hospices with aggregate CAP liabilities will be required to address a portion of their overpayment obligations in March of each year, with final overpayment determined at a later date.**
- **CMS' application of sequester to over-CAP hospices is increasing CAP-related liabilities.**

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Hospice Aggregate CAP

MedPAC/CMS tracking CAP data. CMS found percent of hospices exceeding CAP trends upward:

2006 – 9.1%
2009 – 12.8%
2011 – 10.5%
2012 – 11.6%

Over CAP hospices: These are predominantly for-profit with a VERY long length of stay, and a VERY high profit margin (before repayment).

Percent of over-CAP hospices is still a minority of hospices BUT increasing in number; furthermore, an increasing number of hospices are getting closer to hitting CAP (Abt 2014, for CMS).

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Hospice Aggregate CAP

CAP historically has been updated annually by the BLS medical expenditure category of the Consumer Price Index for all Urban Consumers (CPI-U).

Beginning with accounting years starting on or after Sept. 30, 2016 (until Oct. 1, 2025) the aggregate CAP will be updated by the net hospice market basket index (result of IMPACT Act of 2014).

The impact with be a decrease in the percentage of increase each year.

Remember the CAP is a national computation with no modification based on the location of the patient even though daily payment rates are influenced by the location of the patient.

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Hospice Aggregate CAP

CMS FY2015 Hospice Wage Index/Payment Rule:

- Effective for the 2014 and subsequent CAP years, each hospice must calculate its aggregate CAP.
- Calculation made NO SOONER than 3 months following close of CAP year (Jan. 31). Earliest date to secure PS&R data.
- CAP calculation must be provided NO LATER than 5 months following the close of the CAP year (March 31).
- Hospices are to use pro forma spreadsheets supplied by CMS. The spreadsheet and instructions are not expected until last minute due to payment-related issues.

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CAP Management Activities

Estimating CAP during the year.

Preparing CAP Report for submission to the MAC.

Estimating final CAP liability.

Monitoring previous year CAP liabilities (can be recomputed for three years).

Conversion from Streamlined to Proportional Methods?

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CAP Management Process

If your hospice is substantially under the CAP, the management process may be as easy as being alert and filing the annual CAP Report.

Simple monitoring tool:
- Admissions/Average Daily Census (trends)
- Higher percentage is positive, lower percentage negative

If your hospice is over the CAP or approaching the CAP, the management process becomes a periodic event addressing estimates, overpayments, and prior year CAP modifications.

If ERS is currently used or planned to be used, financial records must be adequate, possibly updated to include accrual-basis financial statements for ongoing reporting to the MAC. Hospices should consider accrual-basis financial statements (annually or more often especially if accounting records maintained throughout the year on the cash-basis).

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REVISIONS TO HOSPICE REIMBURSEMENT

Hospice payment revision:
- **Effective January 1, 2016, payments for routine home care days will be two-tiered**
  - **$186.84/day for the first sixty days of care**
  - **$146.83/day for days 61 and each additional day**
- **Sixty Day Rule – Patients discharged and readmitted without a 60 day gap in care is considered an extension of the initial episode.**
- **Service Intensity Adjustment – Routine home care days during the last 7 days ending due to death are eligible for an SIA. The SIA is equal to the continuous home care hourly payment rate multiplied by the amount of direct patient care actually provided by an RN and/or social worker up to 4 hours/day.**

CAP Year – Effective with the 2017 CAP Year the CAP Year is modified to end on September 30, 2017 (currently the CAP Year ends on October 31st).

Implication of the New Rule

Hospices with shorter lengths of stay will be most positively impacted.

Hospices over CAP will be impacted (cash flow) during the episode of care; however, total payments will remain unchanged as ultimate reimbursement will still be at the CAP.

CAP Comparison:

- 173 days to reach individual beneficiary CAP at national routine home care rates.
- 172 days to reach individual beneficiary CAP at national rate – prechange.
- More hospices will exceed the CAP under the new payment methodology (shorter stays will drive reimbursement toward CAP)

PIP Calculation Impact

PAYMENT COMPARISON

Days	***Old***	***New***	***Increase (Decrease)***
20	$ 3,237.80	$ 3,736.80	$ 499.00
40	$ 6,475.60	$ 7,473.60	$ 998.00
60	$ 9,713.40	$ 11,210.40	$ 1,497.00
80	$ 12,951.20	$ 14,147.00	$ 1,195.80
100	$ 16,189.00	$ 17,083.60	$ 894.60
120	$ 19,426.80	$ 20,020.20	$ 593.40
150	$ 24,283.50	$ 24,425.10	$ 141.60
170	$ 27,521.30	$ 27,361.70	$ (159.60)
200	$ 32,378.00	$ 31,766.60	$ (611.40)

PAYMENT COMPARISON

Days	Old	New	Increase (Decrease)	Old Per-day	New Per-day
20	$ 3,237.80	$ 3,736.80	$ 499.00	$ 161.89	$ 186.84
40	$ 6,475.60	$ 7,473.60	$ 998.00	$ 161.89	$ 186.84
60	$ 9,713.40	$ 11,210.40	$ 1,497.00	$ 161.89	$ 186.84
80	$ 12,951.20	$ 14,147.00	$ 1,195.80	$ 161.89	$ 176.84
100	$ 16,189.00	$ 17,083.60	$ 894.60	$ 161.89	$ 170.84
120	$ 19,426.80	$ 20,020.20	$ 593.40	$ 161.89	$ 166.84
150	$ 24,283.50	$ 24,425.10	$ 141.60	$ 161.89	$ 162.83
160	$ 25,902.40	$ 25,893.40	$ (9.00)	$ 161.89	$ 161.83
170	$ 27,521.30	$ 27,361.70	$ (159.60)	$ 161.89	$ 160.95
172	$ 27,845.08	$ 27,655.36	$ (189.72)	$ 161.89	$ 160.79
200	$ 32,378.00	$ 31,766.60	$ (611.40)	$ 161.89	$ 158.83

ENHANCED FINANCIAL MANAGEMENT

Cost Reporting:

- Increased accounting record requirement
- Increased complexity of cost reporting (many current cost report preparers are not adequately skilled to prepare the new report)

CAP

- More hospices will exceed CAPs, CAP management will be increasingly important

Payment System:

- Budgeting more difficult
- PIP management more difficult
- Accounts receivable management more difficult (claims adjustments, estimating claims adjustments)