Advanced Revenue Cycle Management

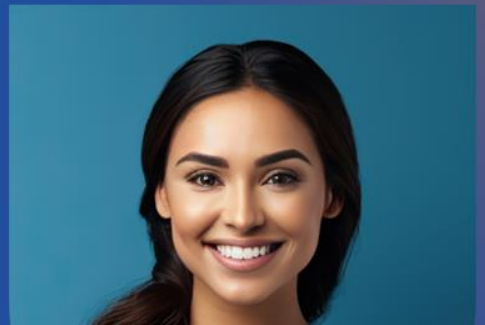
GATEWAY
Home Health Coding & Consulting

PAISLEY & ELM, LLC
MEDICARE COST REPORT SPECIALIST

Medicare Hospice Cost Reports and CAP Reports Overview

Joseph Kenny, CPA, CMA, CCRS
Managing partner at Paisley & Elm, LLC.

https://www.medcostreports.com/contact/



Next Webinar Schedule

- **February 8th**
  2024 Superbowl of Hospice Knowledge

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ARCM Advanced Revenue Cycle Management

REGISTRATION PAGE

Joseph Kenny

CPA, CMA, CCRS

- Joseph R. Kenny is the managing partner at Paisley & Elm, LLC. His practice focuses on Medicare Cost Reports, Medicaid Cost Reports, CAP Reports and accounting services for Health Care businesses.

Cost Reports:

- Skilled Nursing Facilities
- Home Office
- Critical Access Hospitals
- Federally Qualified Health Centers
- Home Health Agencies
- Hospice Agencies
- Community Mental Health Centers
- Renal Dialysis Centers

Additional areas of concentration:

- Medicare Compliance
- Medicare Bad Debt Analysis and Consulting
- Medicare and Medicaid Cost Report Reviews
- Analytical Reviews of Cost Report Data
- Hospice CAP Reports

Key Expertise

Paisley & Elm's practice is largely concentrated on preparing CMS Medicare cost reports, and Medicaid Cost Reports for clients that participate in the Medicare/Medicaid Programs.

The practice assists clients in:

1. Medicare cost reporting
2. Medicare Audits
3. Medicare Overpayments/ settlements.

Mr. Kenny has had over twenty-nine (29) years of experience in the Medicare field, filing over 4,000 Medicare cost reports with following intermediaries (MACs):

- National Government Services (NGS)
- Noridian
- Novitas
- Palmetto GBA
- Cigna Government Services (CGS)
- First Coast (FCSO)

Medicare Hospice Cost Reports and Cap Reports Overview

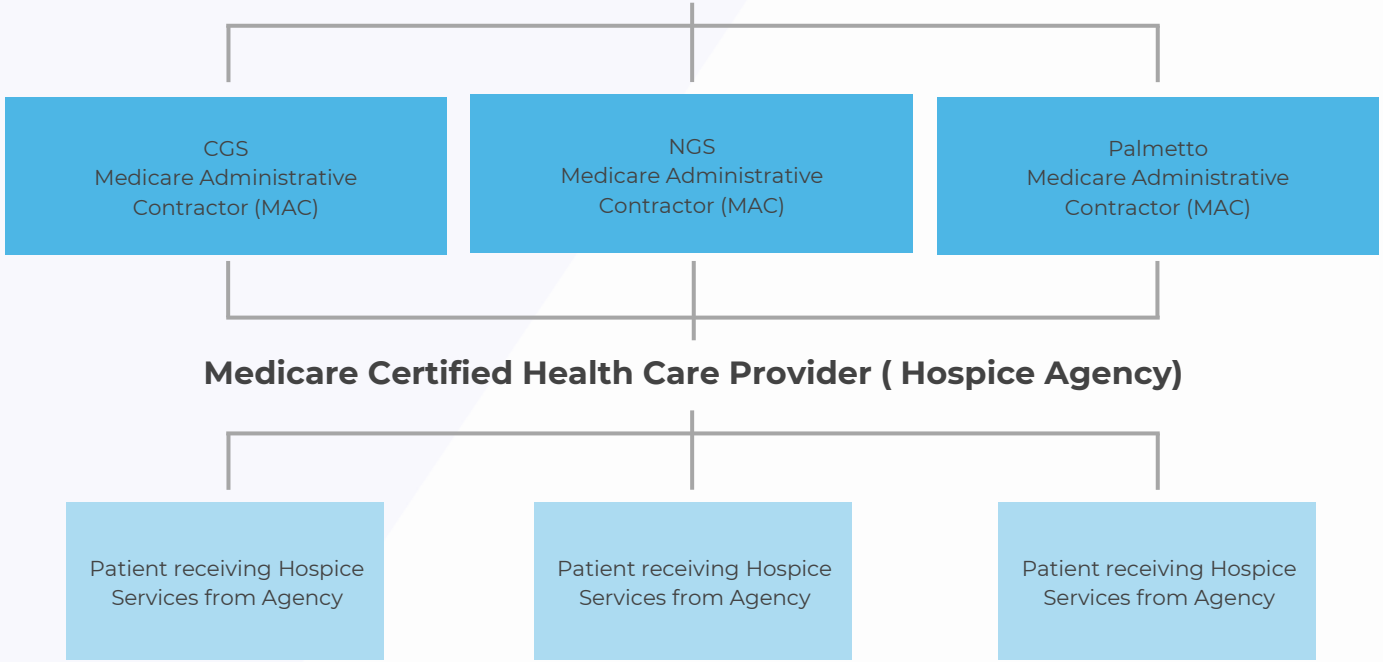
I. Background and Operational Environment

II. Hospice CAP Reports

III. Hospice Medicare Cost Report

IV. Management Reports

Centers for Medicare and Medicaid Service (CMS)



Congressional Budget Office
Baseline Projections

Medicare

- Medicare is the federal health insurance program for people who are 65 or older, for younger people with certain disabilities, and for people of any age with end-stage renal disease. The program has three principal components:

  Part A (Hospital Insurance), Part B (Medical Insurance, which covers doctors' services, outpatient care, and other medical services), and Part D (which covers outpatient prescription drugs).

  Part A benefits are paid from the Hospital Insurance Trust Fund
  (funded largely through payroll taxes); Part B and Part D benefits are paid from the Supplementary Medical Insurance Trust Fund (about 25 percent funded by premiums paid by enrollees and about 75 percent funded from general revenues).

By Fiscal Year, Billions of Dollars

	Actual, 2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024-2028	2024-2033
BUDGET INFORMATION														
Medicare Totals														
Mandatory Outlays[a]	975	1,008	1,012	1,128	1,201	1,290	1,460	1,402	1,587	1,702	1,828	2,088	**6,091**	**14,698**
Discretionary Outlays	8	9	9	9	10	10	10	11	11	12	12	13	**48**	**107**
Gross Outlays	983	1,017	1,021	1,137	1,211	1,300	1,470	1,413	1,598	1,714	1,840	2,100	**6,139**	**14,804**
Total Offsetting Receipts[b]	-231	-182	-185	-211	-218	-238	-258	-280	-303	-328	-357	-391	**-1,110**	**-2,769**
Net Outlays (Gross outlays minus receipts)	752	834	836	926	992	1,062	1,212	1,134	1,295	1,385	1,483	1,710	**5,028**	**12,035**
Net Mandatory Outlays	744	826	828	917	983	1,052	1,202	1,123	1,284	1,373	1,471	1,697	**4,982**	**11,930**
Components of Mandatory Outlays														
Benefits Part A	389	401	399	437	464	493	547	530	587	622	659	739	**2,340**	**5,477**
Part B	466	488	490	545	585	637	729	707	810	878	953	1,096	**2,986**	**7,430**
Part D	118	116	120	143	149	157	181	162	186	199	214	250	**750**	**1,761**
Total Benefits	973	1,006	1,009	1,125	1,198	1,288	1,457	1,399	1,584	1,699	1,825	2,085	**6,077**	**14,669**
Mandatory Administration[c]	2	2	3	3	2	3	3	3	3	3	3	3	**14**	**29**
Total Mandatory Outlays	975	1,008	1,012	1,128	1,201	1,290	1,460	1,402	1,587	1,702	1,828	2,088	**6,091**	**14,698**
Components of Benefits														
Hospital Inpatient Services	143	144	149	152	157	163	169	176	183	190	198	209	**790**	**1,746**
Skilled Nursing Facilities	28	27	26	27	27	27	28	29	30	31	31	33	**135**	**289**
Physician Fee Schedule	74	72	71	70	70	71	73	75	77	79	82	86	**355**	**754**
Hospital Outpatient Services	60	62	64	69	74	81	88	96	105	115	127	141	**376**	**960**
Home Health Agencies	16	16	15	15	15	15	16	16	17	18	18	19	**76**	**164**
Group Plans (Includes Medicare Advantage)[d]	422	454	447	528	578	636	758	694	823	893	968	1,142	**2,947**	**7,467**
Part D[e]	118	116	120	143	149	157	181	162	186	199	214	250	**750**	**1,761**
Low-income subsidy (Non-add)	42	41	40	26	22	22	25	23	27	29	31	36	**135**	**281**
Other Services[f]	112	115	117	121	128	138	144	151	163	174	187	205	**648**	**1,528**
Total Benefits	973	1,006	1,009	1,125	1,198	1,288	1,457	1,399	1,584	1,699	1,825	2,085	**6,077**	**14,669**
Components of Offsetting Receipts														
Part A Premiums	-4	-5	-5	-5	-5	-5	-6	-6	-6	-7	-7	-8	**-26**	**-60**
Part B Premiums and Inflation Rebate Collections[g]	-130	-137	-143	-151	-164	-180	-196	-213	-232	-252	-274	-301	**-834**	**-2,106**
Part D Premiums and Inflation Rebate Collections[h]	-6	-6	-6	-22	-14	-15	-16	-18	-19	-21	-23	-25	**-73**	**-179**
Part D Payments by States	-13	-15	-18	-20	-20	-21	-23	-24	-25	-27	-29	-31	**-102**	**-238**
Payments Recovered from Providers[i]	-77	-20	-13	-14	-15	-16	-18	-19	-21	-23	-25	-27	**-76**	**-191**
Total	-231	-182	-185	-211	-218	-238	-258	-280	-303	-328	-357	-391	**-1,110**	**-2,769**

By Fiscal Year, Billions of Dollars														
	Actual, 2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024-2028	2024-2033
Memorandum:														
Capitation Payments (Number per year)[k]	13	12	11	12	12	12	13	11	12	12	12	13	n.a.	n.a.
Payment Updates and Changes in Price Indexes (Percent)														
PPS Market Basket Increase	2.7	4.1	4.0	3.6	3.5	3.4	3.4	3.4	3.4	3.3	3.3	3.3	n.a.	n.a.
PPS Update Factor	2.5	4.3	3.5	3.1	2.8	2.7	2.7	2.7	2.5	2.7	2.6	2.4	n.a.	n.a.
10-Year Moving Average of Multifactor Productivity[l]	0.7	0.3	0.5	0.5	0.7	0.7	0.7	0.7	0.9	0.7	0.7	0.9	n.a.	n.a.
Average Monthly Enrollment in a Fiscal Year (Millions of people)														
Part A	64	65	67	68	70	71	73	74	75	77	78	79	n.a.	n.a.
Part B	59	60	61	63	64	66	67	69	70	71	72	73	n.a.	n.a.
Part D[m]	51	52	53	54	56	57	58	60	61	62	62	63	n.a.	n.a.
Memorandum:														
Part D Low-Income Subsidy	13	13	13	14	14	14	15	15	15	15	16	16	n.a.	n.a.
Group Plan Enrollment[n]	29	31	33	35	37	38	40	41	42	43	44	45	n.a.	n.a.
Hospital Insurance Trust Fund														
Beginning-of-Year Balance	136	178	191	222	237	251	263	242	261	247	224	187	n.a.	n.a.
Noninterest Income (Mostly payroll taxes)	433	412	428	450	475	501	524	547	571	597	622	649	**2,378**	**5,364**
Interest	3	7	8	9	9	10	9	9	9	9	8	5	**45**	**85**
Total Income	436	419	435	459	485	511	533	556	581	605	630	654	**2,423**	**5,449**
Outlays	394	406	405	444	470	499	554	537	595	629	667	747	**2,372**	**5,547**
Surplus or Deficit (-)	42	13	30	15	14	12	-21	19	-14	-24	-37	-93	**50**	**-99**
End-of-Year Balance	178	191	222	237	251	263	242	261	247	224	187	93	n.a.	n.a.

Components may not sum to totals because of rounding; CMS = Centers for Medicare & Medicaid Services; MA = Medicare Advantage; PPS = Prospective Payment System; n.a. = not applicable.

See next page for notes.

Congressional Budget Office
Baseline Projections

Medicare

A. Mandatory outlays include the effects of sequestration on spending for Medicare benefits under the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

B. Offsetting receipts include premiums, rebates paid to the federal government by drug manufacturers whose products have prices that exceed an inflation-adjusted benchmark price, payments from states to Medicare Part D on behalf of enrollees who are eligible both for Medicare and for Medicaid, and amounts paid to providers and later recovered.

C. Mandatory outlays include those for quality improvement organizations, certain activities against fraud and abuse, and certain administrative activities funded in authorization acts.

D. On February 1, 2023, CMS announced changes for calendar year 2024 that would result in slower growth in payments to MA plans than projected in CBO's February 2023 baseline. On March 31, 2023, CMS announced that some of those changes would phase in over three years, along with other changes. Because of when its baseline was finalized, CBO's updated projections reflect the changes announced on February 1, 2023, but not those announced on March 31, 2023.

E. Consists of payments to prescription drug plans and employer group waiver plans and for the retiree drug subsidy and the low-income subsidy.

F. Includes ambulance services, ambulatory surgical centers, community mental health centers, durable medical equipment, federally qualified health centers, hospice services, hospital outpatient services that are not paid for using the outpatient PPS, independent and physician in-office laboratory services, outpatient dialysis, outpatient therapy services, certain Part B prescription drugs, rural health clinic services, and the payment of Part B premiums for qualifying individuals.

G. Part B premium receipts include income-related premiums.

H. Part D premium receipts include income-related premiums but not premiums that enrollees pay directly to their plans or premiums covered by the low-income subsidy. Under current law, the Secretary of the Department of Health and Human Services has the authority to delay until December 31, 2025, the invoicing of rebate amounts for Part D drug inflation rebates. As a result, CBO projects larger collections of those rebates in 2025.

Congressional Budget Office
Baseline Projections

Medicare

I. Recoveries are amounts that are paid to providers and later recovered; they are included in the total for mandatory Medicare spending. CBO counts the initial payment of such amounts as outlays for benefits and subsequent recoveries as offsetting receipts to conform to reporting in Monthly Treasury Statements. In the past, Medicare's trustees have reported benefits net of recoveries; those reports have not treated the recoveries as offsetting receipts.

J. The Accelerated and Advance Payment Program paid providers in advance of future claims. Those payments increased outlays in 2020. Recoupment of those payments is reflected as a recovery in 2021, 2022, and 2023.

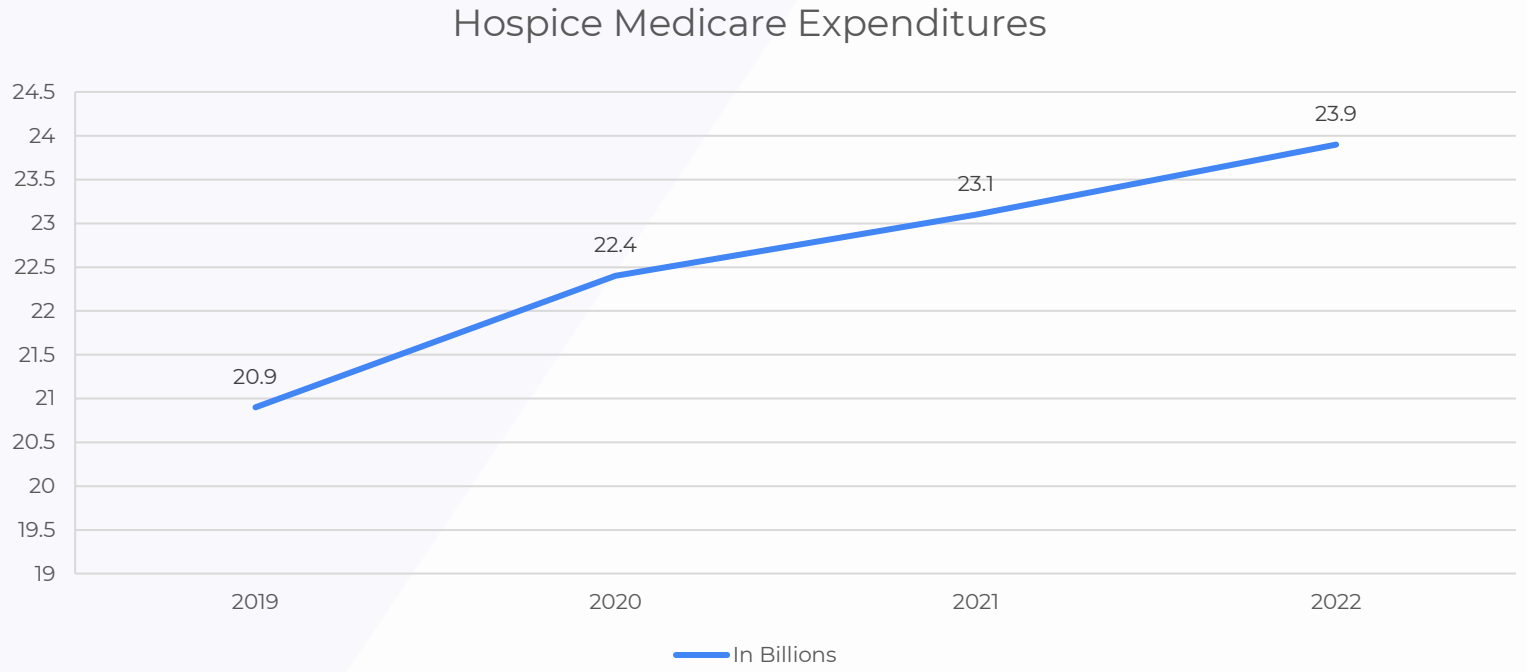
K. Capitation payments to group health plans and prescription drug plans for the month of October are shifted into the preceding fiscal year when October 1 falls on a weekend.

L. The inflation-based updates to payment rates for certain services and providers are adjusted by the 10-year moving average of multifactor productivity, including inpatient acute hospitals, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation hospitals, home health agencies, psychiatric hospitals, hospice care, dialysis, outpatient hospitals, ambulance services, ambulatory surgical center services, and certain durable medical equipment. The adjustment for multifactor productivity is included in the PPS update factor shown above, as well as other legislated changes to the payment update.

M. Includes people enrolled in stand-alone prescription drug plans, MA plans with prescription drug coverage, employer group waiver plans, and the retiree drug subsidy.

N. Includes MA plans, cost contracts, and demonstration contracts covering Medicare Parts A and B. Does not include Health Care Prepayment Plans, which cover Part B services only.

Hospice Expenditure - Medicare Only



Centers for Medicare and Medicaid Services (CMS).

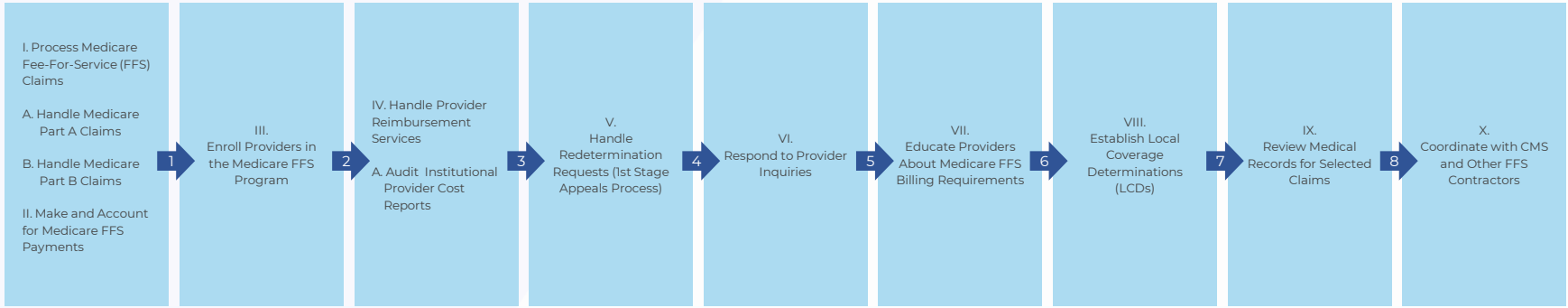
CMS is the federal agency that provides health coverage to more than 100 million through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace

The agency makes sure its contractors and state agencies properly administer Medicare program after Congress Appropriates funds for each year.

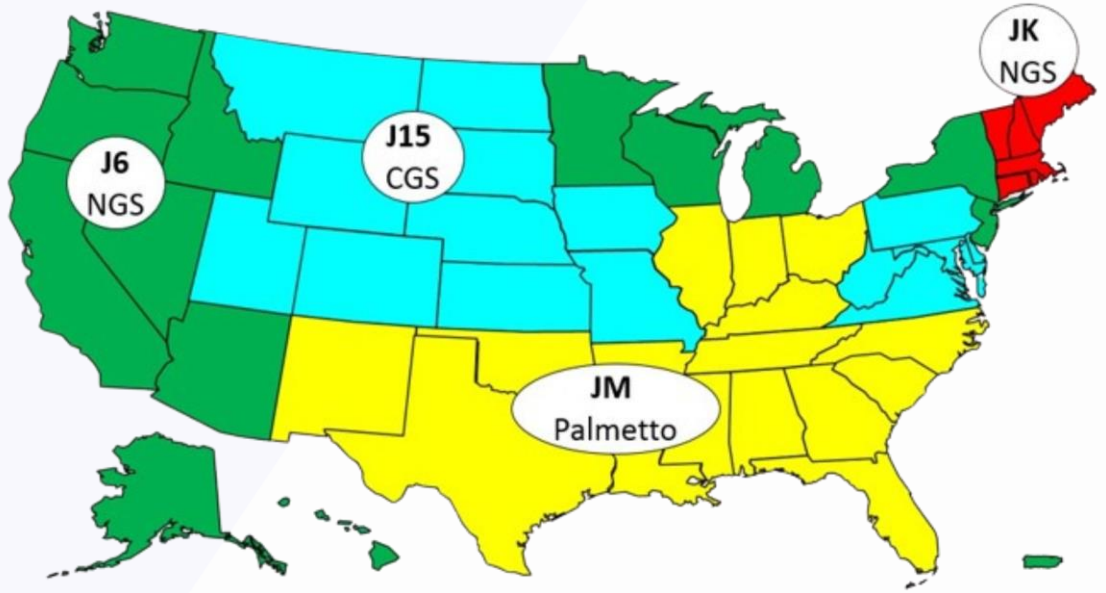
CMS Contracts with the Medicare Administrative Contractors (MAC) to fund the Medicare Certified Providers who deliver the care and for compliance with the rules and regulations for a Certified healthcare provider.

Also, CMS works in partnership with the entire health care community to improve quality, equity and outcomes in the health care system for the United States.

Roles of Medicare Administrative Contractors (MACs):



Home Health & Hospice MAC Jurisdictions



The Provider Reimbursement Manual Section 15 part I:

- Generally, details guidelines for provider reimbursement by Medicare.
- It includes specifics on cost reporting, allowable costs, direct and indirect costs, and the apportionment of overhead costs.
- It is crucial for healthcare providers to comply with these regulations to ensure proper reimbursement

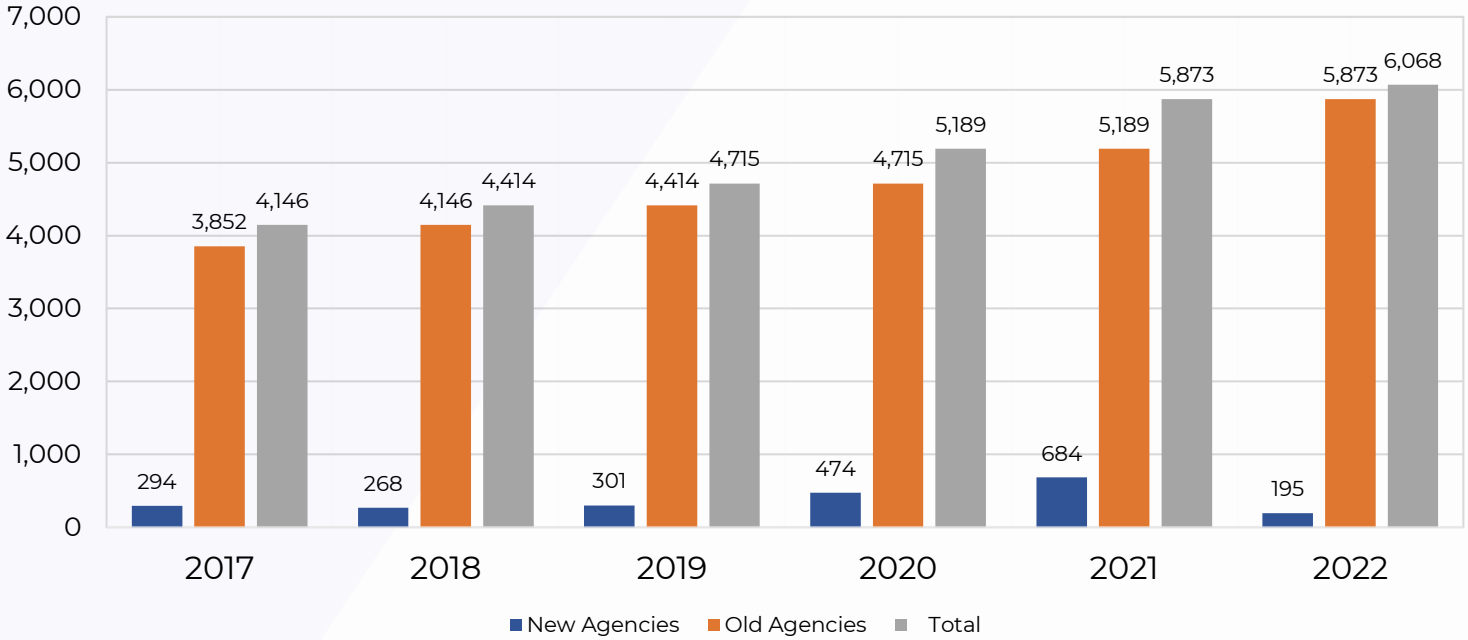
The Provider Reimbursement Manual Section 15 part II:

- Typically elaborates on Medicare payment policies and reimbursement methodologies for specific types of healthcare providers and services.
- It provides detailed instructions on rate setting, cost allocation, and payment adjustments, helping to ensure consistent and fair reimbursement practices across different healthcare settings.
- Provides forms and specific instructions on each type of Cost Report.

Medicare Certified Hospice Providers

	2017	2018	2019	2020	2021	2022
New Agencies	294	268	301	474	684	195
Old Agencies	3,852	4,146	4,414	4,715	5,189	5,873
Total	4,146	4,414	4,715	5,189	5,873	6,068

Medicare Certified Agencies



Summary of Operational Environment:

Congressional Appropriations

- Money is appropriated by Congress for the Medicare program.

Medicare Financial Overview

- FY 2022 Medicare outlays are $975 Billion.
- Projected outlays are $2.1 Trillion in 10 years.

Administrative Structure

- The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.
- CMS contracts with Medicare Administrative Contractors (MACs) for program functions.

Regulatory Framework

- Provider Reimbursement Manual Section 15 (Parts I and II) outlines rules and regulations for Medicare provider Cost Reports.

Hospice Agencies

- There is a 46% increase in agencies from 2017 to 2022.
- Payments to Hospice Agencies will decrease over time.
- With the growth in new Hospice Agencies, existing agencies face reduced reimbursements and increased competition.

Hospice CAP Reports

- Overview
- CAP Limit
- Due Date
- Forms
- Extended Repayment Requests
  - Forms
  - Instructions
  - Interest Rates
- Look back period

Hospice CAP Overview

- **Aggregate Cap Calculation**
  - Applicability
    - Pertains to overall aggregate Medicare payments made to a Medicare-certified hospice.
    - Calculation
      - Multiply the statutory cap amount by the number of beneficiaries in the cap period.
      - Compare the calculated amount to the payments received.
    - Cap Amount
      - Statutory cap amount is updated and published annually.
      - Data Sources
        - The PS&R system provides reports containing necessary data in the Miscellaneous Reports section.

Hospice CAP Overview

- **Aggregate Cap Calculation**
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      - Data Sources
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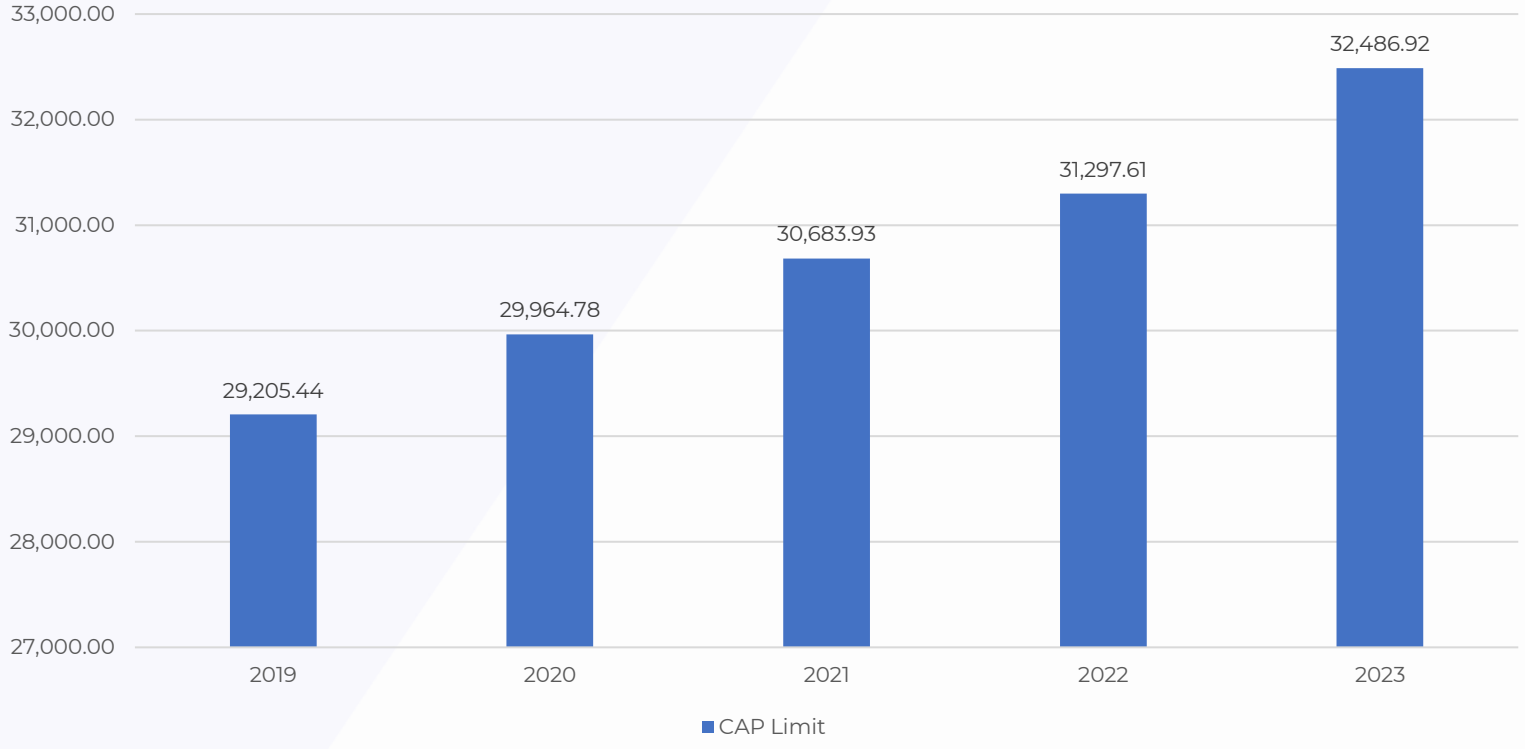
Hospice CAP Overview

- **Beneficiary Count**
  - Determining the Number of Beneficiaries
    - Utilize either the Proportional Method or the Streamlined Method.
- **Proportional Method (Commonly Applied to Most Hospices)**
  - Applicability
    - Applies to each hospice individually.
  - Calculation
    - Count the number of Medicare beneficiaries.
    - Determine the fraction representing the portion of a patient's total days of care across all hospices and all years.
    - Focus on the patient's time spent in the specific hospice during the cap year (October 1 to September 30).

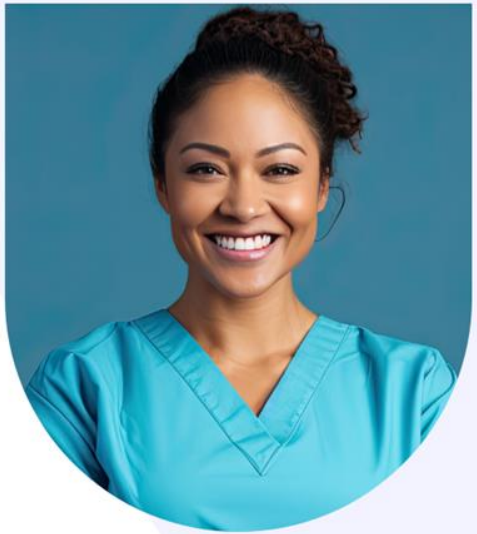
Hospice CAP Limits



Hospice CAP Due Date

- **Due Date**
- The 2023 provider self-determined aggregate cap limitation report is due on February 28, 2024
- **CAP Period**
- The cap period is 10/01 through 9/30 for the cap year (i.e., for 2023 cap period, this is 10/01/2022 through 9/30/2023)
- **Hospice Beneficiary Count Report –**
  - Beneficiary Identification Period for the 2023 cap year the period is 10/01/2022 through 9/30/2023)
- **Payments**
  - Paid date - use the date of the report run (Current Date).
  - Must be on or after 01/1/2024 to make a valid 2023 report.

Sample CAP Report



Extended Repayment Requirements

- The provider shall furnish (for ERS request of 6 months to 11 months follow requirements 1-3. For ERS requests over 11 months follow requirements 1-13):

1. Copy of overpayment letter.
2. Signed Amortization Schedule.
3. First Installment payment.
4. Balance Sheets.
5. Income Statements.
6. Cash Flow Statements.
7. Projected Cash Flow Statements.
8. List of Restricted Cash Funds.
9. List of Investments.
10. List of notes and mortgages payable.
11. Related party agreements for loans/receivables.
12. Related party agreements for expenses.
13. Percentage of occupancy for payer type.
14. Interest Rate per HHS as of December 31, 2023 – 12.125%

CAP Look Back Period

- MAC's calculate each hospice's aggregate cap amount for a specific cap year a total of four times:

1. Initial cap calculation year
2. Three lookback years.

For example, the initial cap calculation for 2014 was performed after the 2014 cap year had ended.
For cap year 2015, the MAC performs a lookback of 2014.
For cap year 2016, the MAC performs lookbacks of 2015 and 2014.
For cap year 2017, the MAC performs lookbacks of 2016, 2015, and 2014.
After the third lookback, the MAC will not review the cap calculation for the initial cap year again.

As a result, the 2017 cap calculation was the final lookback at 2014.

Hospice Medicare Cost Report

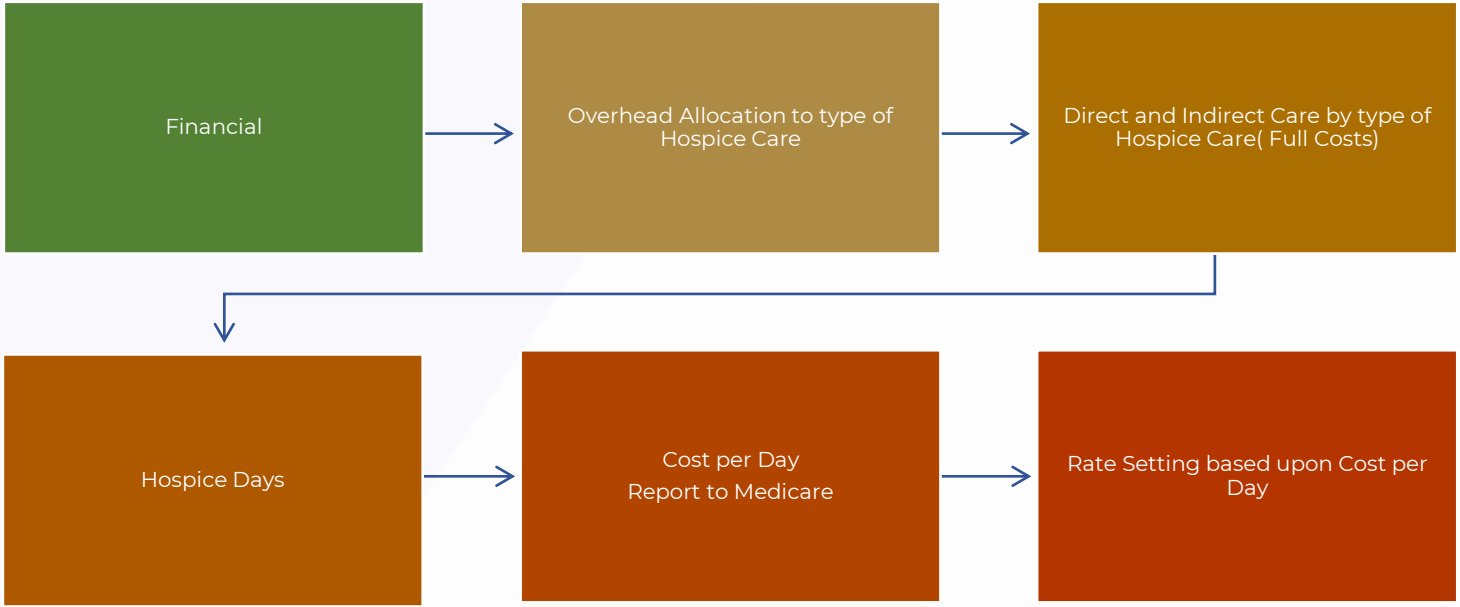
I. Purpose of the Cost Report

II. Overview of all Schedules

III. Sample Worksheets

IV. Due Date

Purpose of the Cost Report



Hospice Cost Report Forms Overview

Medicare Cost Report

Form CMS 1984-14 -Hospice Cost Report

Worksheet

- S Series
  - S
  - S-1
  - S-2
- A – Series
  - A
  - A-1
  - A-2
  - A-3
  - A-4
  - A-6
  - A-8
  - A-8-1
- B – Series
  - B
  - B-1
- C – Series
  - C
- F – Series
  - F
  - F-1
  - F-2

Agency Level

Certification Page
Hospice Days-CBSA
Preparer and Other Information

Expenses

All-Agency Expenses
Expense – Continuous Care
Expense – Routine Care
Expense – Inpatient Respite
Expense – General Inpatient
Reclassification of Expense
Adjustments to Expense
Related Party Disclosures

Allocation of Overhead Expense

Actual Dollar Allocation
Statistical Basis for Allocation

Per Diem Cost

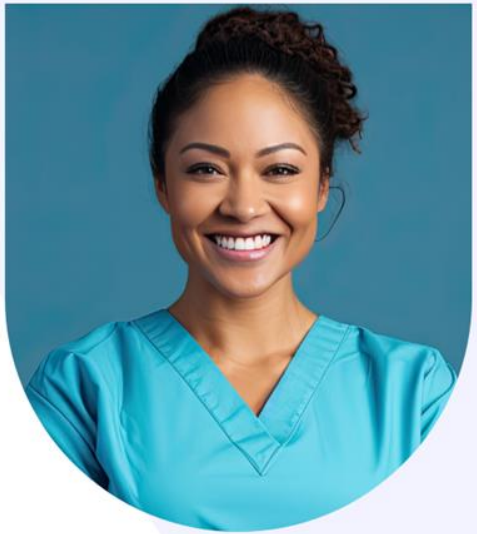
Cost Per Day by type of care and in total

Financial Statements

Balance Sheet
Changes in Fund Balance
Income Statement

Selected Medicare Cost Report Worksheets

Cost Report Forms



Hospice Cost Report Due Date

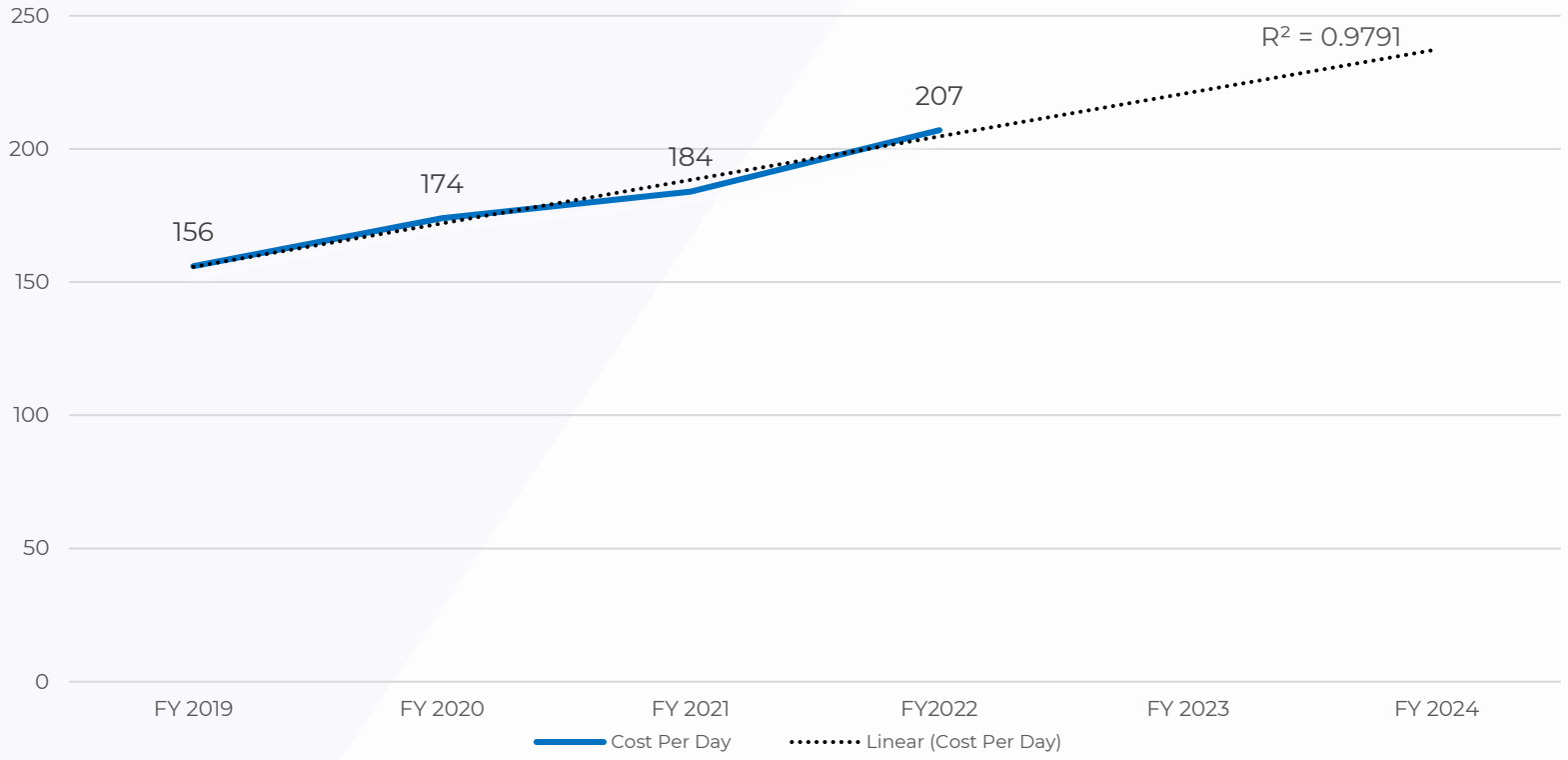
The cost report must be submitted within five months of the cost reporting fiscal year end or 60 days after a cost report reminder letter is sent to the provider by the MAC — whichever is later.

Hospice Management Reports-Medicare Cost Report

Reports from Medicare Cost Report Data

- Cost per Day – Regression Analysis
- Cost per Day- Total – Direct Care – Indirect Care
- Cost per Day – Direct Labor
- Cost Per Day compared to Group
- Cost/Volume/Profit

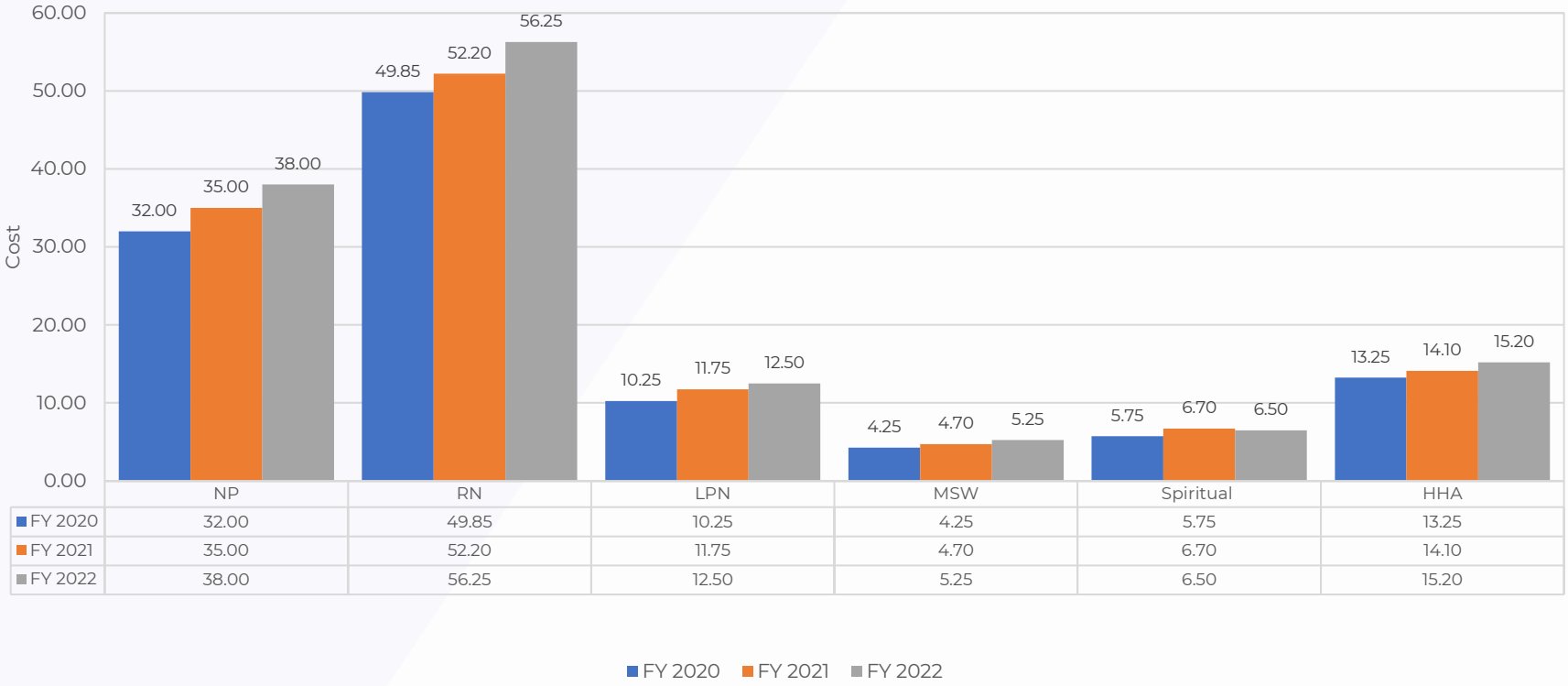
Regression Analysis - Total Cost Per Day



Cost Per Day

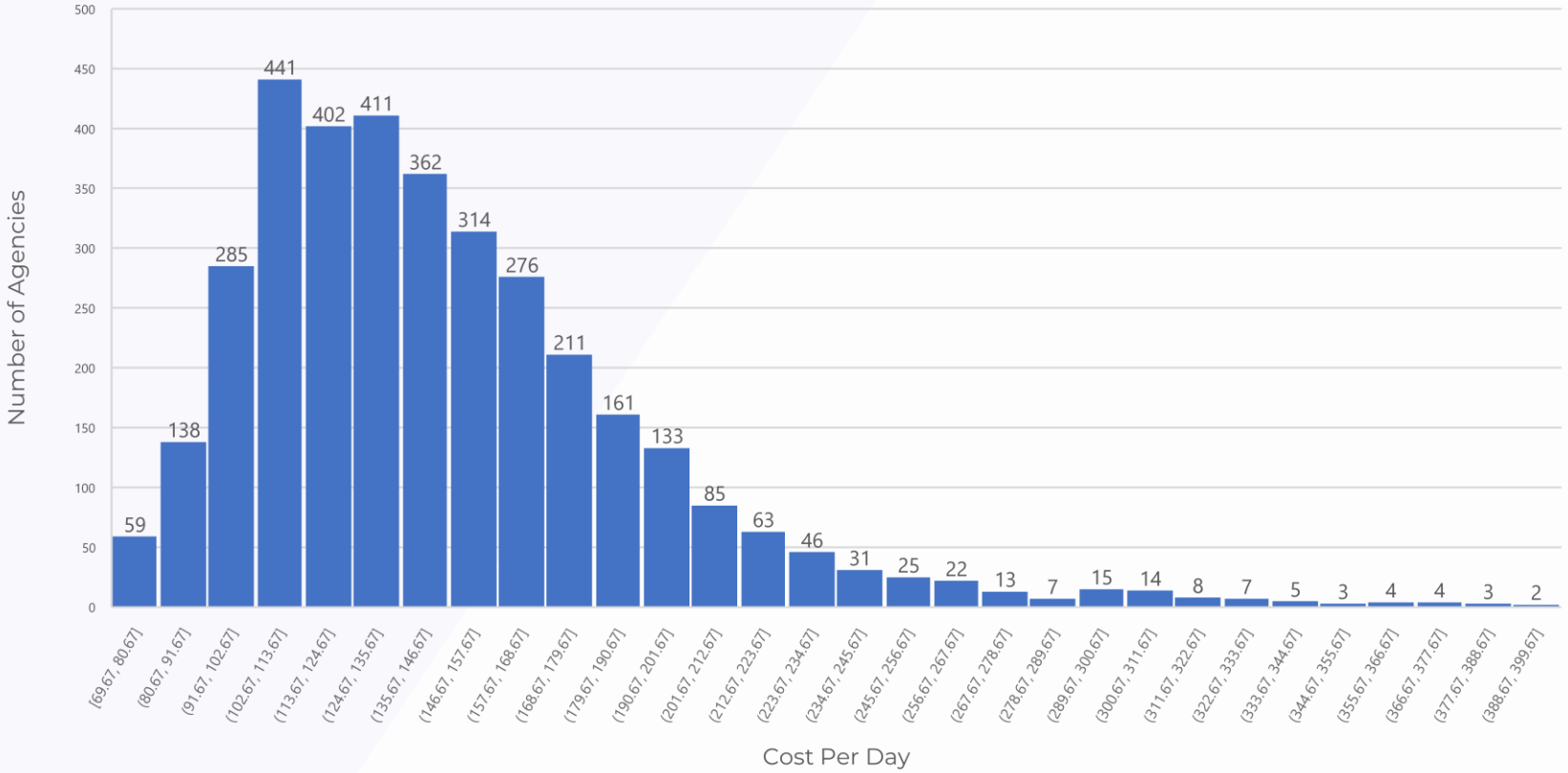
	Direct Care	Indirect Care	Total Cost Per Day
FY 2019	101.00	55.00	156.00
FY 2020	99.00	75.00	174.00
FY 2021	122.00	62.00	184.00
FY 2022	125.00	82.00	207.00

Direct Labor Cost Per Day



	NP	RN	LPN	MSW	Spiritual	HHA
FY 2020	32.00	49.85	10.25	4.25	5.75	13.25
FY 2021	35.00	52.20	11.75	4.70	6.70	14.10
FY 2022	38.00	56.25	12.50	5.25	6.50	15.20

Hospice Total Cost Per Day



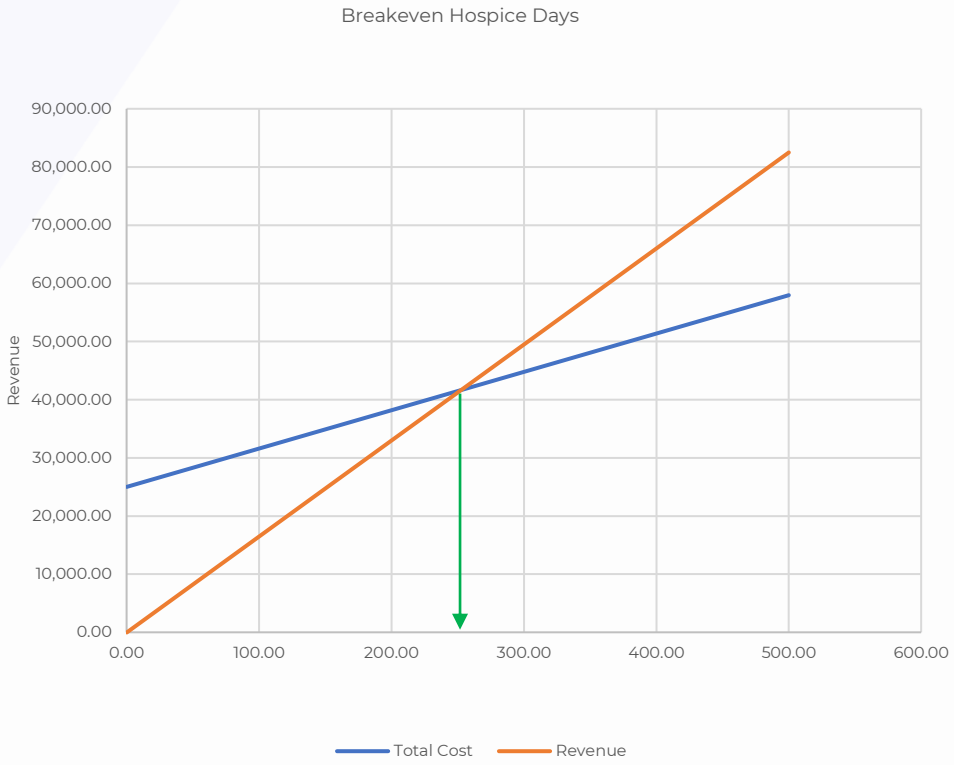
Hospice Breakeven Days

Data

Revenue Per Day	165.00
Administrative Cost	25,000.00
Variable Costs Per Day(Direct Expenses	66.00
Contribution Margin Per Day	99.00

Breakeven Point = Fixed Costs/CM per unit = 253.00

Breakeven Sales = 253 X 165.00 = 41,745.00



Hospice Management Reports-Financial Statements

Reports from Financial Statement Data

- **General Key Metrics from Financials**
  - Financial Ratios
    - Profitability – Net Profit, EBITA
    - Leverage- Debt to Equity
    - Liquidity – Current Ratio
    - Efficiency – Accounts Receivable Turnover

Hospice Management Reports-Financial Statements

Reports from Financial Statement Data

Financial ratios are key tools used to evaluate the financial health of a company. They can be categorized into several types:

1. **Liquidity Ratios:** These ratios measure the ability of a company to meet its short-term obligations.
   - Current Ratio: Current Assets / Current Liabilities
   - Quick Ratio (Acid-Test Ratio): (Current Assets - Inventories) / Current Liabilities
2. **Profitability Ratios:** These ratios assess a company's ability to generate earnings relative to its revenue, operating costs, and equity.
   - Net Profit Margin: Net Income / Revenue
   - Return on Assets (ROA): Net Income / Total Assets
   - Return on Equity (ROE): Net Income / Shareholder's Equity
3. **Leverage (Debt) Ratios:** These ratios evaluate the degree of a company's financing with debt relative to its equity.
   - Debt to Equity Ratio: Total Debt / Total Equity
   - Interest Coverage Ratio: Earnings Before Interest and Taxes (EBIT) / Interest Expenses

Hospice Management Reports-Financial Statements

Reports from Financial Statement Data

Financial ratios are key tools used to evaluate the financial health of a company. They can be categorized into several types:

4. **Activity Ratios:** These ratios measure how efficiently a company utilizes its resources.
   - Accounts Receivable Turnover: Net Credit Sales / Average Accounts Receivable
   - Accounts Payable Turnover: Total Purchases / Average Accounts Payable

5. **Coverage Ratios:** These ratios assess a company's ability to service its debt and other obligations.
   - Times Interest Earned Ratio: EBIT / Interest Expenses
   - Debt Service Coverage Ratio: Net Operating Income / Total Debt Service

Summary

Operational Environment –

- Medicare FY 2023 – 1 Trillion.
- Medicare FY 2033 – 2 Trillion.
- Hospice Medicare Only FY 2019 20.9 Billion.
- Hospice Medicare Only FY 2022 23.9 Billion.
- **Competition –**
  - Growing
    - FY 2017 4,146 Hospice Agencies.
    - FY 2022 6,068 Hospice Agencies.
    - 46% Increase in 5 years.
- **Payment Structure –**
  - Congressional Pressure to reduce Medicare Payments.
  - Future Payments will be reduced to balance budget.
- **Future –**
  - Agencies will have to be competitive to survive the reduction in future payments and increased competition.
- **Best Practices –**
  - Use data from the Medicare Cost Report.
  - Have accurate data from financial statements for the Cost Report.
  - Management needs to benchmark key metrics and monitor for deviations.

THANK YOU

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