Program M1200: HHA Cost Report and Its Effect on Your Payment Rates
4/26/2017 @ 2:15 pm

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VP of Reimbursable Services
Simione Healthcare Consultants

SESSION EVALUATIONS

Available 5 minutes before close of session
Access Session Evaluations using your CONFERENCE MOBILE APP

STEPS TO COMPLETE YOUR EVALUATION WILL BE SHOWN AT THE CLOSE OF THIS SESSION
OBJECTIVE 1

Discuss the purpose of the cost report and filing process.

OBJECTIVE 2

Discuss what is NEW:

- Worksheet S-2-1
- Worksheet O Series
OBJECTIVE 3

Review and discuss the CMS cost report filing documents and the CMS form 1728-94.

OBJECTIVE 4

Describe and discuss related issues:

- Compliance
- Management Information
What is the Intent of the Cost Report

Information is submitted annually to the Medicare Administrative Contractor (MAC) for settlement of costs relating to health care services rendered to Medicare beneficiaries.

Why is proper cost reporting important?
Rebasing the Rates

Required by Affordable Care Act
- Adjust payment rates to reflect average cost of episodes today
  - Phased in over a four-year period beginning in 2014
  - Max cut of 3.5% per year (14% total)

Used 2014 Medicare costs to arrive at costs
- Could only use 6,252 out of 10,327 after “trimming”
- Audited 98 cost reports from 2010 to assess accuracy
  - Suggest costs overstated by 8%
  - Eight agencies were turned over to ZPICS
Medicare Payment Advisory Commission

Service Volume (2015)

- 6.6 M episodes
- 3.5 M users
- 1.9 episodes per beneficiary
- 9.1 % of Medicare FFS spending
- $18.1 B spending (up from $17.7 in 2014)
- Some utilization decline in 5 states (TX, LA, IL, TN and FL)

(MedPAC 2017)

Medicare Payment Advisory Commission

Medicare Margins (2015)

- 15.6 % (10.8 % in 2014)
- 13.2 % rural
- 12.1 % Nonprofits
- 18.1 % marginal profit (efficient, high quality)

- 11.1 % estimated in 2017

(MedPAC 2017)
### NAHC Cost Report Data (2015): Freestanding HHAs

- Medicare Margin: 17.82 % (13.36 % 2014)
- Overall Margin: 4.78 % (4.98 % 2014)
- Visits Per Episode: 18.0 (18.9 2014) [w/o LUPA]
- Cost per Episode: $2,490.05 ($2,550.67 2014)
- Rev per Episode: $3,051.54 ($2,974.15 2014)

### NAHC Cost Report Data (2015): Freestanding HHAs

**Margin Range**

<table>
<thead>
<tr>
<th>Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 50 %</td>
<td>3.3 %</td>
</tr>
<tr>
<td>25 – 50 %</td>
<td>27.0 %</td>
</tr>
<tr>
<td>20 – 25 %</td>
<td>10.8 %</td>
</tr>
<tr>
<td>&lt; 0 %</td>
<td>23.0 %</td>
</tr>
</tbody>
</table>

**Losses on Outlier, LUPA and PEP episodes**
Performance of Relatively Efficient Home Health Agencies

<table>
<thead>
<tr>
<th>Provider Characteristics</th>
<th>All</th>
<th>Relatively Efficient Providers</th>
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<tbody>
<tr>
<td>Number of agencies</td>
<td>4,480</td>
<td>702</td>
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<tr>
<td>Medicare Margin (median)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>11.5%</td>
<td>21.8%</td>
</tr>
<tr>
<td>2012</td>
<td>12.4%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Quality (median)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization rate (2013)</td>
<td>26%</td>
<td>20%</td>
</tr>
<tr>
<td>Costs and Payments (median)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost per visit, standardized for wages (2013)</td>
<td>$145</td>
<td>$132</td>
</tr>
<tr>
<td>Patient severity case-mix index</td>
<td>1.00</td>
<td>1.03</td>
</tr>
<tr>
<td>Visits per Episode</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total visits per episode</td>
<td>16.8</td>
<td>15.5</td>
</tr>
<tr>
<td>Size 2013 (Number of 60-day payment episodes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>461.5</td>
<td>573</td>
</tr>
<tr>
<td>Mean</td>
<td>841</td>
<td>1,134</td>
</tr>
</tbody>
</table>

MedPAC March 2016

Preparation of the HHA Medicare Cost Report

**WHO HAS TO FILE?**

Medicare Certified

- Provider-Based
- Freestanding
General Requirements

Costs reports are filed annually

Cost report period is 12 months – may not match fiscal year

Cost report period can be from 1 to 13 months.

General Requirements

Less Than Full Cost Report

Low Medicare Utilization (LMU)
(Less than $200,000 in Medicare Reimbursement)

No Medicare Utilization (NMU)
The time required to complete this information collection is estimated to average 227 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.
## Preparation of the HHA Medicare Cost Report

1. Deadlines  
2. Rejection  
3. ECR Disks  
4. Software  
5. Signature  
6. Medicaid  
7. PS&R

## Cost Report Software

<table>
<thead>
<tr>
<th>Software Provider</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Financial Systems</td>
<td><a href="http://www.hfssoft.com">www.hfssoft.com</a></td>
</tr>
<tr>
<td>KPMG</td>
<td><a href="http://www.KPMG.com">www.KPMG.com</a></td>
</tr>
<tr>
<td>Manis &amp; Ryan</td>
<td><a href="http://www.manisandryan.com">www.manisandryan.com</a></td>
</tr>
<tr>
<td>Optimizer Systems</td>
<td><a href="http://www.optimizer.com">www.optimizer.com</a></td>
</tr>
<tr>
<td>Progressive Provider Services of Colorado</td>
<td><a href="http://www.ppsassistant.com">www.ppsassistant.com</a></td>
</tr>
</tbody>
</table>
Home Health and Hospice (HH+H) Areas (Administered by A/B MACs as of April 2015)

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

NGS J6 – Puerto Rico and US Virgin Islands
Medicare Administrative Contractors

- CGS: www.cgsmedicare.com
- National Government Services: www.ngsmedicare.com
- Palmetto GBA: www.palmettogba.com/medicare

Medicare Administrative Contractors

- NGSConnex web application
  - https://connex.ngsmedicare.com
- Palmetto GBA eServices
  - https://onlineproviderservices.com
- myCGS Portal
  - https://mycgswebportal.cms.gov
Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless if when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid. Section 2305ff sets forth special rules regarding recognition of expenses under the Medicare program relating to liquidation of liabilities.
What is to be filed with the Medicare Cost Report?

Financial Statements (Internal)
• Audit / Review / Compilation

Working Trial Balance
• Should be sufficient in detail to facilitate crosswalk from trial balance to Medicare cost report

Supporting schedules for reclasses and adjustments

Original signatures in **BLUE INK**

Chart of Accounts

**Uniform Chart of Accounts for Industry**

The National Association for Home Care & Hospice and the Home Care & Hospice Financial Managers Association released The Uniform Chart of Accounts. The purpose of creating a uniformity of financial reporting, Medicare cost reporting and financial analysis will allow for accurate data collection and analysis that can be used for improved business management and in advocacy efforts with the Center for Medicare and Medicaid Services (CMS) and Congress. The Uniform Chart of Accounts provides for all product lines that are considered to be included under their umbrella of Home Care.

[http://hhfma.org/memberresources/](http://hhfma.org/memberresources/)
Worksheet S-2-1
Reimbursement Questionnaire

Indicate whether the financial statements were prepared by a certified public accountant.

Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report, enter the date they will be available.

Enter the first name, last name and the title/position held by the cost report preparer.
Enter the employer/company name of the cost report preparer.
Enter the telephone number and email address of the cost report preparer.
NEW Worksheet S-2-1

To be completed by ALL HHAs

Financial Data and Reports

<table>
<thead>
<tr>
<th>Financial Data and Reports</th>
<th>YES</th>
<th>Type</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were the financial statements prepared by a Certified Public Accountant?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. If column 1 is yes, enter “A” for Audited, “C” for Complete, or “R” for Reviewed. Submit complete copy or enter date available in column 4. Use instructions. If no, see instructions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are the cost report total expenses and total revenues different from those on the final financial statements? Enter “Y” for yes or “N” for no in column 1. If yes, submit reconciliation.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NEW Worksheet S-2-1

To be completed by ALL HHAs

Cost Report Preparer Contact Information

<table>
<thead>
<tr>
<th>Cost Report Preparer Contact Information</th>
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</thead>
<tbody>
<tr>
<td>11. First name:</td>
</tr>
<tr>
<td>12. Employer:</td>
</tr>
<tr>
<td>13. Phone number:</td>
</tr>
</tbody>
</table>
Hospice Cost Report Worksheets

- Worksheet S - Certification Page
- Worksheet S-1, S-5 - General Agency Info & Statistics
- Worksheet S-2 - Hospice Reimbursement Questionnaire
- Worksheet A, O - Reclassification and Adjustment of TB Expenses
- Worksheet A-1, O-1 - Continuous Home Care
- Worksheet A-2, O-2 - Routine Home Care
- Worksheet A-3, O-3 - Inpatient Respite Care
- Worksheet A-4, O-4 - General Inpatient Care
- Worksheet A-6 - Reclassifications
- Worksheet A-8 - Adjustments to Expenses
- Worksheet A-B-1 - Related Party or Home Office Costs
- Worksheet B - Cost Allocation
- Worksheet B-1, O-6 - 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
Overview of Flow of Cost Report

1. Worksheet S - Certification
2. Worksheet S-2 - General Information
Overview of Flow of Cost Report

1. Worksheet S - Certification
2. Worksheet S-2 - General Information
3. Worksheet S-3 - Utilization Statistics

Overview of Flow of Cost Report

1. Worksheet S - Certification
2. Worksheet S-2 - General Information
3. Worksheet S-3 - Utilization Statistics
4. Worksheet A series - Trial Balance
Overview of Flow of Cost Report

Worksheet S - Certification
Worksheet S-2 - General Information
Worksheet S-3 - Utilization Statistics
Worksheet A series - Trial Balance
Worksheet B & B-1 - Cost Allocation & Finding
Worksheet C - Apportionment to Medicare
Overview of Flow of Cost Report

1. Worksheet S - Certification
2. Worksheet S-2 - General Information
3. Worksheet S-3 - Utilization Statistics
4. Worksheet A series - Trial Balance
5. Worksheet B & B-1 - Cost Allocation & Finding
6. Worksheet C - Apportionment to Medicare
7. Worksheet D & D-1 - Medicare Settlement

Overview of Flow of Cost Report

1. Worksheet S - Certification
2. Worksheet S-2 - General Information
3. Worksheet S-3 - Utilization Statistics
4. Worksheet A series - Trial Balance
5. Worksheet B & B-1 - Cost Allocation & Finding
6. Worksheet C - Apportionment to Medicare
7. Worksheet D & D-1 - Medicare Settlement
8. Worksheet F Series - Financial Statements
Worksheet S-3, Part 1

- **Patient Visit Statistics**: Number of visits and patients by DISCIPLINE.
- **Separate counts for Medicare & Other patients**.
- **Count visits “As rendered” basis – date of service**.

**NOTE**: Medicare Advantage patients are considered “Other / Non Medicare” for cost reporting purposes.

Worksheet S-3, Part 1

- **Patient Visit Statistics**: Unduplicated Census Count – Medicare & Other.
- **Patients counted ONCE per year**.
- **Home Health Aide Hours – Medicare & Other**.

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How to Count Visits on the MCR

- Only report “Billable” visits
- Supervisory visits should not be included unless skill rendered at the same time
- Can be more than one billable visit on the same day
- Count visits, NOT hours – this is VERY important

Definition of Home Health Visit (PRM 2302.15)

A personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a homebound patient on an outpatient basis to a hospice, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school when arrangements have been made by the home health agency for the furnishing of a covered service on an outpatient because it required the use of equipment which cannot be made readily available in the home.
Like vs. Non Like Kind Visits

**Medicare Eligibility Criteria**

- Confined to home
- Under care of a physician
- Intermittent SNC, PT, ST, or continuing OT
- Under a plan of care
- Furnished by or under arrangement by participating HHA

Like vs. Non-Like Kind Visits

Can be considered “like kind” if being homebound is the only criteria missing
### Worksheet S-3, Part II

#### Full Time Equivalents

- Total “paid hours” by employee type divided by 2,080 (Admin, SNC, PT, etc.)
- Separate amounts for employees vs. contract employees
- If hours not available, use one (1) hour per visit (rule of thumb)

### Productivity

<table>
<thead>
<tr>
<th>Role</th>
<th>Productivity</th>
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</thead>
<tbody>
<tr>
<td>RN</td>
<td>5.43</td>
</tr>
<tr>
<td>LPN</td>
<td>6.21</td>
</tr>
<tr>
<td>HCA</td>
<td>5.60</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>5.61</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>5.46</td>
</tr>
<tr>
<td>Social Worker</td>
<td>3.87</td>
</tr>
</tbody>
</table>

Source:
Home Care Salary & Benefits Report 2015-2016
[www.hhcsinc.com](http://www.hhcsinc.com)
Worksheet S-3, Part IV - PPS Activity Data

Summary of episodes completed during the cost reporting period on the accrual basis – can take from the PS&R report.

Medicare visits and charges by discipline and episode type
  • Full w/o Outlier, Full w/Outlier, LUPA and PEP

Number of Medicare episodes
Medical Supply Charges ($$)

Medicare Visit Statistics
- Total provider costs
- Categories of costs
- Reclassification of costs
- Adjustment of costs
- Apportionment of costs

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Worksheet A: Trial Balance of Expenses

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
<th>Column 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>Employee Benefits</td>
<td>Transportation</td>
<td>Contract Services</td>
<td>Other Costs</td>
</tr>
<tr>
<td></td>
<td>/ Payroll Taxes</td>
<td>(Mileage Reimbursement)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

General Service Cost Centers / Overhead Costs

- Line 1: Capital Costs – Building
- Line 2: Capital Costs – MME
- Line 3: Plant Operation & Maintenance
- Line 4: Transportation
- Line 5: Administrative & General

Be sure to classify ALL overhead type costs together.
Worksheet A: Trial Balance of Expenses

HHA Reimbursable Services / Direct patient Costs

Line 6       Skilled Nursing Care
Line 7       Physical Therapy
Line 8       Occupational Therapy
Line 9       Speech Therapy
Line 10      Medical Social Services
Line 11      Home Health Aide
Line 12      Medical Supplies
Line 13      Drugs – Flu, Pneumococcal and Calcimar injections – Vaccine supply cost only
Line 13.20   Vaccine Administration
Line 14      DME

Be sure to classify ALL overhead type costs together

Medical Supplies: Routine vs. Non Routine

Routine (non billable) Line 5

- Small quantities – not patient specific

Non Routine (Billable) Line 12

- Patient specific illness or injury
- Separately identifiable in patient records (POC)
- Must be ordered by the physician
- Separate charge

Notes: All payments for Medicare PPS episode include NRS Add-On. Many agencies are still not billing for NRS.
Examples of Non Routine Medical Supplies

- Dressings / Wound Care
- I.V. Supplies
- Ostomy Supplies
- Catheter and Catheter Supplies
- Syringes and Needles

Consolidated Billing List
http://www.cms.gov/homehealthpps/03_coding_billing.asp

Worksheet A: Trial Balance of Expenses

HHA Non Reimbursable Services - Non Like-Kind Services

<table>
<thead>
<tr>
<th>Line</th>
<th>Service Description</th>
</tr>
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<tbody>
<tr>
<td>17</td>
<td>Private Duty</td>
</tr>
<tr>
<td>22</td>
<td>Homemaker</td>
</tr>
<tr>
<td>23</td>
<td>Other Services</td>
</tr>
<tr>
<td>23.20</td>
<td>Telemedicine</td>
</tr>
<tr>
<td>25</td>
<td>Hospice – O Series (NEW)</td>
</tr>
</tbody>
</table>
Worksheet A-4: Reclassification of Expenses

Move costs between cost centers

Should do on the trial balance rather than this worksheet, e.g. medical supplies

Worksheet A-5: Adjustments to Expenses

Other income offsets

Non-allowable expenses

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Worksheet A-6 - Statement of Costs of Services from Related Organizations

(1) use the following symbols to indicate the interrelationship of the provider to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organizations 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 relative of such person has financial interest in related 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 nonfinancial) specify.

Worksheet A-6: Related Organizations & Home Office Cost Statement

• Report “amount charged” and “amount allowable”
• Identify related party by name and type of relationship
• Identify ALL related party costs even if qualify for Section 1010 Exception (amount charged – amount allowable)
• Compare to AFS footnotes
Worksheet A-6: Related Organizations & Home Office Cost Statement

Who 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 creates relatedness

Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

The term “control” includes any kind of control, whether of not it is legally enforceable and however it is exercisable or exercised. It is the reality of control which is decisive, not its form or the mode of its exercise.
### General Principle

Costs applicable to services, facilities and supplies furnished to the provider by a related party are includable only to the extent the related party incurred costs to provide the services, facilities and supplies.

*(profits related to such transactions are not allowable)*

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### Related Party transactions

- Adjust cost report to “related party” costs
- Interest on related party loans
- Exceptions to cost conversion (Section 1010)
  - Supplier – bona fide separate organization
  - Substantial part of business with other non related entities
    - Key criteria
  - Commonly obtained from other organizations
  - Charge is in line with open market

- If you meet **ALL** the 1010 exception criteria – no adjustment is necessary
Home Office Organizations

Home Office organizations are centralized management services to multiple related providers. A Medicare-designated home office files a cost report (Form 287-05) that is the allocation of these shared costs to the related entities benefitting from the shared services. The costs of home office organizations are reported as related party transactions.

The Home Office cost report can be complex as cost are allocated as follows:

- Direct
- Functional
- Pooled

Worksheet B and B-1: Allocation of Overhead Costs

- Allocation of overhead costs to patient care cost centers reimbursable and non reimbursable (Step-down Method – 2306.1)
- Statistical basis (unit cost multiplier)
  - Capital Costs – Building – Square Footage
    - Weighted average for mid year changes
  - Capital Costs – MME – Square footage or $ value (Location of equipment)
  - Plant Operation – Square Footage
  - Transportation – Mileage by cost center (pooled cars)
  - Administrative and General – Accumulated costs
Worksheet C

Average cost per visit

Cost of non-routine medical supplies

Cost of drugs (Calcimar, Flu vaccines, etc.)
Reimbursement for Vaccines

- Vaccine and Calcimar Injections
- Flu, Pneumococcal and Hepatitis B vaccines
  - 2 separate charges for Medicare
    - Vaccine (#636) – cost reimbursed
    - Administration (#771) – OPPS fee schedule
- Calcimar injections (Osteoporosis)
- Bill type 34X

Reimbursement for Vaccines

- These services are cost reimbursed through the Drugs cost center (line 13)
- Amounts reported for charges and payments on Worksheet C and Worksheet D-1 only relate to Vaccine supply (revenue code 636)
- Amounts for charges and payments for vaccine administration (revenue code 771 are EXCLUDED from the Medicare cost report)
- Charges must be the same for all payers – Cash versus accrual basis (gross up if not the same)
- Subject to cost or charge
- No coinsurance amounts applied
Worksheet D and D-1

**Worksheet D**
- Medicare PPS Payments by episode type (base payment and outlier portion)
- Lower of cost or charge comparison for Drug services on Worksheet C (Vaccine supply only #636)
- Computes Medicare settlement on Drugs

**Worksheet D-1**
- Total Medicare interim payments
- Part B – includes Drug payments with Part B PPS
- Payments (Vaccine supply only #636)

Medicare Settlement Data

- All Medicare settlement data should be on the accrual basis meaning that all claims data associated with episodes completed during the cost report period should be included even if paid in the subsequent year

- Reality, most agencies use the most recent available PS&R report for Medicare settlement data

- The Medicare Contractor (MAC) may adjust at final settlement. No reimbursement impact (except vaccine)
### Medicare Cost Report - EIDM

**EIDM**

[https://psr-ui.cms.hhs.gov](https://psr-ui.cms.hhs.gov)

### Worksheets F, F-1 and F-2

**Worksheet F**
- Balance Sheet

**Worksheet F-1**
- Income Statement (P&L)

**Worksheet F-2**
- Statement of Changes in the Fund Balance
  - **MUST** match internal financial statements
Common Cost Report Problems

- Inaccurate visit statistics – date of service / visits vs. units
- Cost and visit counts for “Like-kind” and “Non Like-kind” services not segregated – What are Non Like-kind services? (HCFA PM 97-11.60)
- Costs and utilization statistics not properly matched
- Inaccurate FTE calculations

Common Cost Report Problems

- Improper accounting method – Cash vs Accrual
- Improper classification of direct and indirect expenses. Double allocation to NRCC
- Costs not properly segregated on the trial balance. By discipline, by program Like-kind / Non Like-kind
- Costs not in the correct cost centers: Salaries, Transportation, etc.
Common Cost Report Problems

- Improper reporting of non-routine medical supply costs and charges
- Improper reporting of flu vaccine costs, charges and Medicare settlement data
- Telemedicine costs not properly reported
- Prior year adjustments made after cost report is filed (i.e. tax return extended)

Common Cost Report Problems

- Incorrect adjustments to adjust costs on Worksheet A-5
- Failure to identify all related party transactions section 1010 exception
- Cost per visit by discipline is unreasonable
- Improper use of the PS&R report
Common Cost Report Problems

- Worksheet F series not reconciled
- Balance Sheet
- Income Statement (P&L)
- Statement of Changes in Fund Balance
Compliance
Avoid False Claim Act

Reimbursement Rules have Not Changed, Only Payment Methodology!

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Adjustments to Expenses:
Cost Identified as Not Being Related to Patient Care

Two methods to treat Non-allowable expenses

- Remove from cost report via adjustment
- Non reimbursable cost center – picks up administrative overhead costs

Allowable vs. Non-Allowable Expenses

Expenses must be prudent and reasonable
Allowable vs. Non-Allowable Expenses

Expenses must be prudent and reasonable

Expenses must be related to patient care

If no specific Medicare rule, defer to GAAP
Allowable vs. Non-Allowable Expenses

Expenses must be prudent and reasonable

Expenses must be related to patient care

If no specific Medicare rule, defer to GAAP

Some differences from IRS

Allowable

Medical supply costs – Routine & Non Routine
Board of Director Fees
Medical Director Fees
Professional Advisory Group
Orientation and OJT
Education related costs
### Allowable vs. Non-Allowable Expenses

#### Allowable

- Patient Refunds – Not Expense, Revenue Reduction
- Interest Expense – Must Have Financial Need
- Franchise Fees – Not Income Based
- Sales Taxes
- Broad Based Healthcare Taxes
- Property Taxes

#### Allowable

- Civic Organizations
- Business Trade Organizations – Except % Related to Lobbying
- Organizational Costs
- Payments to Staff up to IRS Rates for Business use of Personal Vehicle
- Yellow Page Advertising
- Employee Recruiting
Allowable vs. Non-Allowable Expenses

Allowable

Deferred Compensation – When Funded
Public Image and Education

Allowable ? Maybe – Maybe Not

Life Insurance on key employees payable to the provider not allowable unless required by debt instrument

Legal Fees – depends on nature of activity

Expenses not liquidated within one year after the end of the cost reporting period in which they were reported as expenses are not allowable. They become allowable in the year liquidated. Exception can be requested

Owners compensation accrued at year end must be liquidated within 45 days of year end to be allowable.
### Allowable vs. Non-Allowable Expenses

<table>
<thead>
<tr>
<th><strong>Non - Allowable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest Income Offset</td>
</tr>
<tr>
<td>Other Income – Non Patient</td>
</tr>
<tr>
<td>Purchase Discounts and Rebates</td>
</tr>
<tr>
<td>Expense Refunds</td>
</tr>
<tr>
<td>Bad Debts</td>
</tr>
<tr>
<td>Alcoholic Beverages</td>
</tr>
</tbody>
</table>

### Allowable vs. Non-Allowable Expenses

<table>
<thead>
<tr>
<th><strong>Non - Allowable</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gifts and Donations</td>
</tr>
<tr>
<td>Fines and Penalties</td>
</tr>
<tr>
<td>Spousal Expenses – When not Employee or Contractor</td>
</tr>
<tr>
<td>Non Competition Agreements</td>
</tr>
<tr>
<td>Costs of Buying or Selling a Business</td>
</tr>
<tr>
<td>Mergers and Acquisitions</td>
</tr>
</tbody>
</table>
### Allowable vs. Non-Allowable Expenses

#### Non-Allowable

<table>
<thead>
<tr>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goodwill</td>
</tr>
<tr>
<td>Unsuccessful Beneficiary Appeals</td>
</tr>
<tr>
<td>Patient Solicitation Expense</td>
</tr>
<tr>
<td>Marketing Costs / Promos</td>
</tr>
<tr>
<td>Marketing Salaries &amp; Other Marketing Indirect Costs</td>
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<tr>
<td>Health Fairs</td>
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### Allowable vs. Non-Allowable Expenses

#### Non-Allowable

<table>
<thead>
<tr>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss on Disposal of Assets</td>
</tr>
<tr>
<td>Collection Agency Fees</td>
</tr>
<tr>
<td>Start Up Costs</td>
</tr>
<tr>
<td>Excessive Owner/Administrator Compensation</td>
</tr>
<tr>
<td>Taxes Based on Income</td>
</tr>
<tr>
<td>Penalties and Finance Fees</td>
</tr>
</tbody>
</table>
Allowable vs. Non-Allowable Expenses

Non-Allowable

- Franchise Fees Based on Income
- Entertainment
- Country Club Dues
- Social, Fraternal Organization Dues
- Lobbying Costs
- Interest Expense with Related Party

Non-Allowable

- Reorganization Costs
- Personal use of Company Owned Vehicle even if Reported as Salaries and Wages to the Employee (OBRA-97)
Depreciation Expense

- Straight Line method only
- AHA Useful lives
- Capitalization Policy - $5,000 & 2+ year life
  - Cannot have higher $$ threshold but may be lower
  - Different than IRS

Capitalization Policy

§108.1 Acquisitions

- If a depreciable asset has at the time of its acquisition an estimated useful life of at least two (2) years and a historical cost of at least $5,000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation. If a depreciable asset has a historical cost of less than $5,000, or if the asset has a useful life of less than two (2) years, its cost is allowable in the year it is acquired, subject to the provisions of §106.

Provider Reimbursement Manual (CMS-PUB. 15-1)
Cost Report Certification

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by (Provider Name(s) and Number(s)) for the cost reporting period beginning and ending and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.
Cost Report Certification

I further certify that I am familiar with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.
Iowa Home Health Company and Its President Agree To Pay $1,000,000 to Resolve Allegations They Sought Reimbursement for Inappropriate Costs

Ultimate Nursing Services of Iowa, Inc., and its president, Steven Tucker Anderson, have agreed to pay $1,000,000 to settle allegations they violated the False Claims Act.

The allegations relate to cost reports submitted by Ultimate Nursing for the period beginning January 1, 2011, and ending June 30, 2013. During this period, the company received payment for services to Medicaid beneficiaries in part through the submission of cost reports reflecting the costs associated with the provision of services and patient care. The government alleged that Ultimate Nursing’s cost reports for this period improperly resulted in payment for non-reimbursable travel and entertainment expenses and for non-reimbursable costs associated with services provided to Ultimate Nursing by other entities owned by Anderson or a family member.

“We will continue to use every resource available to ensure that all Iowa health care providers play by the same rules and that government money intended to pay for health care for Medicaid or Medicare beneficiaries is spent only for its intended purpose,” said United States Attorney Kevin W. Techau. “We also recognize the cooperation we received from the company and its president from the onset of this investigation and appreciate their willingness to work with us to address the issues raised by the investigation.”

The investigation was conducted in conjunction with the Health and Human Services Office of Inspector General. The claims settled by this agreement are allegations only, and there has been no determination of liability.

Released January 5, 2017 - The United States Attorney’s Office, Northern District of Iowa

Related Organization

- Whistle-blower claims 33 hospitals submitted more than $1B in fictitious costs
- He claims N.C. Baptist and Carolinas HealthCare violated the False Claim Act by “failing to disclose on their Medicare cost reports more than a billion dollars in related-party transactions”.

Becker’s Hospital Review 5/20/2016
Paying the Doctors

• **Texas physician convicted in Medicare fraud**

  • Warren Dailey, a family doctor from Houston, was found guilty Wednesday on charges including conspiracy to commit health care fraud and receiving kickbacks in a $900,000 Medicare fraud. Dailey falsely certified patients as homebound and accepted kickbacks in exchange for referring patients to Candid Home Health, which received $913,620 for the referred services, the indictment says.

  • **NOTE:** Dr. Dailey was sentenced to 63 months on July 20, 2016.

Paying the Doctors

• **Ohio home health operators face trial in alleged $7 M fraud**

  • Delores Knight of Cleveland Heights, Ohio, and her son Isaac Knight of Macedonia, Ohio, operators of a home health care firm, will go to trial in federal court this week on charges including health care fraud and conspiracy to commit health care fraud. The defendants allegedly forged documents and submitted more than $7 million in claims for unprovided health care services supposedly rendered to elderly and disabled patients, according to authorities. [The Plain Dealer (Cleveland)](1/9).
Paying the Doctors

- **Florida physician sentenced to prison in $30M Medicare fraud**
  - Henry Lora, former medical director of the Merfi clinic in Miami, was sentenced to nine years imprisonment and ordered to pay restitution of $30 million for defrauding the Medicare program. Lora and his co-defendants wrote prescriptions for un-provided or unnecessary home health care services in exchange for kickbacks and falsified records to indicate ineligible Medicare patients qualified for services, authorities say. Lora pleaded guilty earlier this year. [WTVJ-TV (Miami)](4/18)

- **Former Texas physician convicted in $375M Medicare, Medicaid fraud**
  - Jacques Roy, a former physician from Rockwell, Texas on Wednesday was found guilty of charges including health care fraud and making false statement. Roy, owner of DeSoto, Texas-based Medistat Group Associates, recruited fake patients and directed others to forge his signature and falsify records to indicate patients were eligible for home care, according to prosecutors. The operation resulted in almost $375 million being fraudulently billed to Medicare and Medicaid, the biggest home health fraud ever for both programs, investigators say. [The Dallas Morning News (free content)](4/13), [U.S. News & World Report/The Associated Press](4/13)

Paying for Referrals

- **Owner of Fla. Staffing firm gets 60 months in $2.3M Medicare fraud**
  - Carlos Nerey, owner of Miami-based staffing company Nerey Professional Services, was sentenced Friday to a 60-month prison term and ordered to pay restitution of $2,366,736 for his role in a Medicare fraud scheme. Nerey was convicted of receiving kickbacks in exchange for Medicare beneficiary referrals to Mercy home Care and D&D Home Health Care, including referrals for patients who were ineligible for home care services, between October 2014 and September 2015. [U.S. Department of Justice/News release](5/27)

- **Mich. Health firm owner sentenced to prison in $3.4M Medicare fraud**
  - Mohammad Rafiq of West Bloomfield, Mich., was sentenced Tuesday to serve a 57-month prison term for defrauding $3.4 million from Medicare. Rafiq, owner and operator of Perfect Home health Care, admitted to paying kickbacks to patient recruiters and physicians in exchange for Medicare patient referrals and false certifications for home health care, prosecutors said. Rafiq was also ordered to pay $3,471,906.03 in restitution and the same amount in forfeiture. [Patch.com/West Bloomfield, Mich.](4/6)
Office of Inspector General - OIG

• OIG reports $1B increase in health care fraud recoveries in 2016
  • Fraudulent payments and settlements recovered by the HHS increased by more than $1 billion in the first half of the 2016 fiscal year, according to the Office of Inspector General’s Semiannual Report to Congress. A total of $2.77 billion in expected recoveries was reported from October 1, 2015, to March 31, 2016, including $2.2 billion found through investigations and about $555 million recovered by audits, the report stated. McKnight’s Long-Term Care News (6/1)

• DOJ Announces $4.7B in FCA Recoveries
  • The Department of Justice announced that FY 2016 was its third best year in “False Claims Act History” with recoveries of more than $4.7 billion in settlements and judgments.

NAHC Data Compendium

Cost Report Data Reports

The NAHC COST REPORT DATA COMPENDIUM is an in-depth analysis of Medicare cost reports filed by home health agencies since the beginning of the HH PPS payment system in October 2000. NAHC has acquired nearly 150,000 filed cost reports to develop this Compendium.

The Compendium is a valuable tool for providers of services, consultants, health policy planners, home care advocates, investors, and trade associations looking to gain an understanding of the financial status of home health agencies. However, it must be understood this tool is not intended to be used to affect the planning and delivery of care to individual patients. It must be further understood that while the methodology used by NAHC to conduct this analysis has been validated the cost report data used is unaudited.

http://hhfma.org/memberresources/
The Medicare cost report is NOT just a “compliance” requirement that must be filed with CMS but can be a valuable tool to assist in budgeting, pricing and strategic analysis.

- Direct and indirect costs by discipline
  - (per hour and per visit)
- Fixed and variable costs
- Non-routine medical supplies

When looking at total cost, you should add back non-allowable expenses (marketing, donations, etc.)

- Cost per episode / Medicare margin
- Cost, revenue and margin by payer
- Service utilization per episode
## Cost Report Indicators

### Average Visits per Episode

<table>
<thead>
<tr>
<th></th>
<th>Full Episodes w/o Outliers (228 Episodes)</th>
<th>Total Episodes (302 Episodes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SNC</td>
<td>2,300</td>
</tr>
<tr>
<td></td>
<td>PT</td>
<td>1,381</td>
</tr>
<tr>
<td></td>
<td>OT</td>
<td>466</td>
</tr>
<tr>
<td></td>
<td>ST</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>MSW</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>HHA</td>
<td>1,174</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>5,367</strong></td>
<td><strong>23.54</strong></td>
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</tbody>
</table>

### Percent of Episodes by Type

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full w/o Outliers</td>
<td>228</td>
</tr>
<tr>
<td></td>
<td>Full w/Outliers</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>LUPA</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>PEP</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>302</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>
Cost Report Indicators

Computation of Cost per Visit

<table>
<thead>
<tr>
<th></th>
<th>Direct</th>
<th>Indirect</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNC</td>
<td>$54.49</td>
<td>$24.49</td>
<td>$78.98</td>
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<tr>
<td>PT</td>
<td>$75.00</td>
<td>$31.76</td>
<td>$106.76</td>
</tr>
<tr>
<td>OT</td>
<td>$72.00</td>
<td>$30.49</td>
<td>$102.49</td>
</tr>
<tr>
<td>ST</td>
<td>$73.00</td>
<td>$30.90</td>
<td>$103.90</td>
</tr>
<tr>
<td>MSW</td>
<td>$120.00</td>
<td>$50.80</td>
<td>$170.80</td>
</tr>
<tr>
<td>HHA</td>
<td>$33.01</td>
<td>$14.27</td>
<td>$47.47</td>
</tr>
</tbody>
</table>

Cost Report Indicators

Medicare Profit Margin

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare PPS Reimbursement</td>
<td>$649,607</td>
</tr>
<tr>
<td>Medicare PPS Cost</td>
<td></td>
</tr>
<tr>
<td>Visit Cost</td>
<td>$491,437</td>
</tr>
<tr>
<td>NRS Cost</td>
<td>$6,560</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$497,997</td>
</tr>
<tr>
<td>Medicare Profit Margin</td>
<td>$151,610</td>
</tr>
<tr>
<td>Medicare Margin %</td>
<td>23.3%</td>
</tr>
</tbody>
</table>
## Cost Report Indicators

### Total Profit Margin

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patient Revenue</td>
<td>$1,809,392</td>
</tr>
<tr>
<td>Total Operating Expense</td>
<td>$1,765,064</td>
</tr>
<tr>
<td>Net Operating margin</td>
<td>$44,328</td>
</tr>
<tr>
<td>Miscellaneous Income</td>
<td>$2,400</td>
</tr>
<tr>
<td>Net Income</td>
<td>$46,728</td>
</tr>
<tr>
<td>Net Income %</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

### Cost Analysis

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital</td>
<td>$55,500</td>
</tr>
<tr>
<td>Plant Operation / Maintenance</td>
<td>$10,400</td>
</tr>
<tr>
<td>Administration</td>
<td>$464,218  26.48%</td>
</tr>
<tr>
<td>Total Overhead Costs</td>
<td>$430,118  30.24%</td>
</tr>
<tr>
<td>Direct Costs</td>
<td>$1,222,646 69.76%</td>
</tr>
<tr>
<td>Total Costs</td>
<td>$1,752,764</td>
</tr>
<tr>
<td>Total patient Revenue</td>
<td>$1,809,392</td>
</tr>
<tr>
<td>Admin Costs as % of Revenue</td>
<td>25.66%</td>
</tr>
</tbody>
</table>
Cost Report Indicators

Profit By Episode Type

<table>
<thead>
<tr>
<th></th>
<th>Full w/o Outlier</th>
<th>Full w/Outlier</th>
<th>LUPA</th>
<th>PEP</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>$600,270</td>
<td>$26,195</td>
<td>$14,789</td>
<td>$8,353</td>
<td>$649,607</td>
</tr>
<tr>
<td>Cost</td>
<td>$444,324</td>
<td>$35,096</td>
<td>$12,822</td>
<td>$5,755</td>
<td>$497,997</td>
</tr>
<tr>
<td>Profit</td>
<td>$155,946</td>
<td>($8,901)</td>
<td>$1,967</td>
<td>$2,598</td>
<td>$151,610</td>
</tr>
</tbody>
</table>

Preparation of the HHA Medicare Cost Report

- The following five pages compare a Home Health Agency’s data to that made available by NAHC for national averages and to that existing for the state

- Disclosure of total average cost per visit (includes cost report allocated overhead)

- Average PPS visits per Medicare episode and average PPS visits per full Medicare episode

- PPS data including cost and payment per episode
### Preparation of the HHA Medicare Cost Report

#### Cost Report Data - Average Cost Per Visit

<table>
<thead>
<tr>
<th>Item</th>
<th>Average</th>
<th>National</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNC</td>
<td>$108.41</td>
<td>$142.69</td>
<td>$121.38</td>
</tr>
<tr>
<td>PT</td>
<td>$173.40</td>
<td>$126.45</td>
<td>$106.71</td>
</tr>
<tr>
<td>OT</td>
<td>$140.41</td>
<td>$128.31</td>
<td>$102.08</td>
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<tr>
<td>ST</td>
<td>$175.32</td>
<td>$142.56</td>
<td>$106.08</td>
</tr>
<tr>
<td>MSW</td>
<td>$120.24</td>
<td>$308.04</td>
<td>$154.09</td>
</tr>
<tr>
<td>AIDE</td>
<td>$ 83.69</td>
<td>$ 71.28</td>
<td>$ 65.54</td>
</tr>
</tbody>
</table>

#### Visits Per Episode

<table>
<thead>
<tr>
<th>Item</th>
<th>Average</th>
<th>National</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNC</td>
<td>10.97</td>
<td>9.15</td>
<td>9.7</td>
</tr>
<tr>
<td>PT</td>
<td>2.95</td>
<td>4.04</td>
<td>3.3</td>
</tr>
<tr>
<td>OT</td>
<td>1.07</td>
<td>0.73</td>
<td>0.5</td>
</tr>
<tr>
<td>ST</td>
<td>0.05</td>
<td>0.14</td>
<td>0.1</td>
</tr>
<tr>
<td>MSW</td>
<td>0.22</td>
<td>0.17</td>
<td>0.3</td>
</tr>
<tr>
<td>AIDE</td>
<td>2.46</td>
<td>4.31</td>
<td>8.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>17.72</td>
<td>18.54</td>
<td>22.50</td>
</tr>
</tbody>
</table>
Preparation of the HHA Medicare Cost Report

### Visits Per Full Episode

<table>
<thead>
<tr>
<th>Item</th>
<th>Average</th>
<th>National</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNC</td>
<td>12.00</td>
<td>8.7</td>
<td>9.1</td>
</tr>
<tr>
<td>PT</td>
<td>3.27</td>
<td>4.7</td>
<td>3.8</td>
</tr>
<tr>
<td>OT</td>
<td>1.19</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>ST</td>
<td>0.05</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>MSW</td>
<td>0.21</td>
<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>AIDE</td>
<td>19.51</td>
<td>19.3</td>
<td>22.3</td>
</tr>
</tbody>
</table>

### Average Per Episode

<table>
<thead>
<tr>
<th>Item</th>
<th>Average</th>
<th>National</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement</td>
<td>$ 2,558.99</td>
<td>$ 2,225.59</td>
<td>$ 2,227.37</td>
</tr>
<tr>
<td>Cost</td>
<td>$ 2,137.25</td>
<td>$ 1,977.66</td>
<td>$ 1,900.20</td>
</tr>
<tr>
<td>Profit</td>
<td>$ 421.74</td>
<td>$ 247.93</td>
<td>$ 327.17</td>
</tr>
<tr>
<td>Visits</td>
<td>17.72</td>
<td>18.5</td>
<td>22.40</td>
</tr>
<tr>
<td>Payment Per Full Episode</td>
<td>$ 2,776.62</td>
<td>$ 2,547.48</td>
<td>$ 2,574.49</td>
</tr>
<tr>
<td>% Profit Margin</td>
<td>16.5</td>
<td>1.53</td>
<td>5.34</td>
</tr>
</tbody>
</table>

© 2017 California Association for Health Services at Home
Preparation of the HHA Medicare Cost Report

<table>
<thead>
<tr>
<th>PPS Episodes</th>
<th>Item</th>
<th>Average</th>
<th>National</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Full w/o Outliers</td>
<td>85.56</td>
<td>78.51</td>
<td>77.07</td>
</tr>
<tr>
<td></td>
<td>% Full with Outliers</td>
<td>2.13</td>
<td>2.71</td>
<td>4.52</td>
</tr>
<tr>
<td></td>
<td>% LUPA</td>
<td>10.02</td>
<td>13.76</td>
<td>13.87</td>
</tr>
<tr>
<td></td>
<td>% PEP only</td>
<td>2.05</td>
<td>2.38</td>
<td>2.4</td>
</tr>
<tr>
<td></td>
<td>% SCIC within PEP</td>
<td>-</td>
<td>0.08</td>
<td>1.07</td>
</tr>
<tr>
<td></td>
<td>% SCIC</td>
<td>0.25</td>
<td>2.56</td>
<td>2.07</td>
</tr>
<tr>
<td></td>
<td>Supply Cost Per Episode</td>
<td>$132.55</td>
<td>$41.00</td>
<td>$26.44</td>
</tr>
</tbody>
</table>

Excerpt from HHFMA Whitepaper on Cost Containment Practices – July 2014

Cost Report Preparation:

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

2. How To Hire A Business Consultant
3. Medicare & Accrual Basis Accounting
4. Medicare PPS Rates & The Medicare HHA Cost Report
5. The Yes, But….

Please contact Cathy Spoon at cspoon@Simione.com to request a free copy of any of the above.

### Attachments A & B

- CMS Paper Manuals
- The Provider Reimbursement Manual 15 Part 2
- Chapter 32 HHA Cost Report Form 1728-94

[https://www.cms.gov/](https://www.cms.gov/)

Once at the CMS Home Page follow these steps to get to the paper manuals:
- Select Regulations & Guidance
- Under Guidance select Manuals
- Under Manuals select Paper-Based Manuals
- Under Publication select 15-2
- Under Downloads select Chapter 32 (T17)—Home Health Agency Cost Report Form 1728-94
Q&A TIME

SESSION EVALUATIONS

FILL OUT SESSION EVALUATIONS IN THE CONFERENCE MOBILE APP TO EARN YOUR CEUs

STEP 1: Select Session in App - Located in the Sessions Tab

STEP 2: Select “Take Survey” - Located at the Bottom of Screen

STEP 3: Complete Each of the 9 Questions to Receive CEUs

Not using the app? Stop by the App Help Desk.
Speaker Information

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CARE MONITORING THAT WORKS

KEEPING PEOPLE SAFE AND CONNECTED IN THE COMFORT OF THEIR HOME

INNOVATIVE SOLUTIONS FOR HOME HEALTH AND HOSPICE

EASILY ADOPTED

Our telehealth systems are simple to use with an intuitive interface for staff and great adaptability for patients’ needs.

CUSTOM INTEGRATION

Our experienced team addresses and analyzes your current workflow to seamlessly integrate it with the best telehealth system.

IMMEDIATE RESULTS

Go live with your telehealth system in just a couple of days, and with no upfront costs, you’ll notice results immediately!

HOME CARE MONITORING THAT WORKS!

- A turn-key home telehealth program enhancing care coordination with dedicated 24/7 RCC team.
- Track, trend & alert vitals and conditions.
- Reduce cost and manage resources.
- Gain a competitive advantage, allowing increased revenue and referrals.
- Meet the changing environment of post-acute care.
- Latest, intuitive telehealth system
- Over 20 home health customers to date!
- Over 590 patients served and 10,300 video calls rendered since April 2016!
- NO capital cost - NO set up fee!

LED THAN 2% READMISSION RATE!

Connected Home Living partners see a reduction in readmission rates, greater patient satisfaction and increased referrals. Our integration of Remote Care Coordinators and intuitive telehealth support your ability to achieve a premiere position in the market place. We provide 24/7 live monitoring and meaningful patient engagement, managing alerts, data and resources so that your staff can focus upon clinical interventions.

Each client is assigned a personal Remote Care Coordinator (RCC) working in concert with the health care team, family members and caregivers. The RCC becomes familiar with the client’s condition, lifestyle and preferences. The established rapport and understanding support rapid intervention and alignment of resources.

We complement your nursing care, therapy and physician visits by monitoring vital signs, medications, mental and physical state, on a daily basis, ensuring continuity of care and the best possible outcomes for patients.

DON’T WAIT! GET STARTED TODAY!

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