The Importance of Effectively Managing Pass-Through Expenses for the Hospice Agency

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Objectives:
- Define the Hospice Agency’s Responsibilities concerning hospice patients in a nursing home facility
- Examine how Medicaid Room and Board rates are determined by THHS and for a hospice patient specifically
- Evaluate Methods of accounting for Medicaid Room and Board as a part of the hospice’s general operating receipts and disbursements
- Introduce Fiduciary Accounting as a way of Accounting for the Medicaid Room and Board
- Apply fiduciary accounting to specific patient scenarios especially to difficult payment situations because of changes in Rug rates, NH levels and ZPICs

§418.112 Condition of participation:
Hospices that provide hospice care to residents of a SNF/NF or ICF/IID

Standard: Professional management.
The hospice must assume responsibility for professional management of the resident’s hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §§418.100 and 418.108.

Medicare Benefit Manual
Chapter 9; Hospice Section 20.3 - Rev 1, 10-01-2003.
The State Medicaid Agency pays the hospice the daily amount allowed by the State for room and board while the patient is receiving hospice care, and the hospice pays the facility. Room and board services include the performance of personal care services, assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident’s room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.

The Process
Admit Medicaid Eligible NH Patient on to Hospice Care
- Have Patient (or MPOA) to sign Form 3071 - Individual Election/Cancellation/Update
- Have attending physician to sign Form 3074 - Physician Certification of Terminal Illness
- Signed 3071 and 3074 are submitted to TDADS through the TMHP website
- Nursing home MDS for a patient being admitted to hospice services
- Medicaid is updated and funds are determined
What is a Rug?

Stands for Resource Utilization Group
Based upon the MDS form which is federally mandated
Reflects the resident’s functional ability
Identifies cost of providing care based on resources used
I.E. – How much assistance/medical care does the nursing home need to provide

Factors

- ADL score
- Certain Special Treatments
- Certain Diagnosis/Conditions
- Therapy
- Rehabilitation Nursing Program / Restorative Nursing
- Depression / Mood
- Behavior
- Cognitive Impairment

34 levels of care with in 7 major categories with corresponding payment

- $55555 - Extensive Services (3) - SE1, SE2, SE3 (27%)
- $5555 - Rehabilitation (14) - RAD, RAC, RAR, RAA
- $555 - Special Care (9) - SMC, SSB, SSA
- $55 - Clinically Complex (5) - CC1, CC2, CR1, CR2, CA1 (12%)
- $5 - Impaired Cognition (4) - IA1, IA2
- $5 - Behavioral Problems (4) - BA1, BA2, BB1, BB2
- $ - Reduced Physical Function (10) - PE1, PE2, PD1, PD2, PO1, PC1, PB1, PB2, PA1, PA2

Insurance Add On

Nursing homes also can get an additional $1.61 per day for nursing homes that verify both professional and general liability insurance coverage acceptable to HHSC.

- $1.53 per diem for professional liability
- $0.14 per diem for general liability

Issues

- Medicaid Eligibility Service Authorization Verification
  - Hospice Service Authorization for "Daily Care” with effective dates covering days hospice services were provided.
  - Note: This WILL NOT show up unless a complete and accurate 3071 AND 3074 has been filed and processed

- Medicaid Eligibility that started on or before the hospice election day

- Medical Necessity on or before date of service

- Insurance that is not long term care eligible

- Rug Level for days of service

- Applied Income $0 or an Amount can not be "No Data"

- Long Term Care

- Medicaid Pending Patients
- Short Stay Patients (1 day)
- Take-backs from Medicaid – CIPR Report
- Retroactive changes in Rug Rates
- Retroactive changes in Nursing Home Levels or Insurance Add On's

ZPICs / Rug Audits – the nursing home gets audited but the Hospice get hit with the change in Rug Rate

Mesav – Medicaid Eligibility Service Authorization Verification

For a facility to be Authorized to Bill for Medicaid Room and Board Services the following MUST appear on the MESAV:

- Hospice Service Authorization for “Daily Care” with effective dates covering days hospice services were provided.
- Medicaid Eligibility that started on or before the hospice election day
- Medical Necessity on or before date of service
- Insurance that is not long term care eligible
- Rug Level for days of service
- Applied Income $0 or an Amount can not be “No Data”
Traditional Accounting View

The Hospice has contracted with the nursing home to provide personal care services
- Medicaid Room and Board Receipts are recognized as Revenue
- Disbursement to the Nursing Homes are recognized as Expenses
- Come really from the wording in the regulations:
  "take into account the room and board furnished by the facility… Room and board services include performance of personal care services, including activities in the areas of daily living, in socializing activities, administration of medications, maintaining the cleanliness of a resident’s room, and supervision and assistance in the use of durable medical equipment and prescribed therapies."

Problems with Traditional View

- Distortion of Benchmarks
  - % of Revenue
  - Not truly earned Revenue
  - Not the two different cycle to this type accounting
  - Revenue/Account Receivable
  - Billing Department
  - Expenses/Disbursement
  - Accounts Payable Department
  - Theoretically the difference between the income and expense should be 5%
  - Doesn’t Work – The Patient actually pays part of the 5% through their spend down!!
- Reconciling the Revenue with the Expenses when they are in two different accounts
  - Usually requires three person
  - Very time consuming
- Agencies Operating Cash Accounts are used.
  - No easy follow through with take-backs and adjustments

Pass-Through Accounting: Current Popular Accounting View

- Current Popular Accounting View
- The only part on the books should be the % that hospice must pay to the nursing home over 95% of rug received by Medicaid
- Better recognition of earned income for benchmarks, etc.
- Usually 5%
- Agencies Operating Cash Account is used
- Everything is just kind of netted into one number
- Often the cash receipt and cash disbursement functions are still separate

Escrow Accounting

- Definition: An item such as money or a piece of property that has been transferred to a third party with the intention of delivering to a grantee as part of a binding agreement.
- Money is being received by Medicaid on behalf of the patient for room and board services provided "to the patient"
  - Not earned by Hospice
  - Not really Hospice’s money
  - Placed in a Separate Account
  - Impose Escrow for parties
  - Accounted for Separately from the Hospice’s Operations

What Does This Involve?

- Separate Bank Account
- Tracking receipt and disbursement by patient
- No accounts payable process
- Bank Statement is a double check for over and under payments

Benefit

- Faster turn around to the nursing home
- Automatic Reconciliation by Patient between money received from Medicaid and money disbursed to nursing home
- Able to adjust patient account for take-backs due to change in rug rate, nursing home level, or applied income
- Able to know immediately what needs to be recouped from the nursing home
Excel Worksheet Handout

Example

Shiela Zila is a resident at Grace Nursing Home and was admitted onto Dove Hospice on March 12, 2015.

Sheila has Medicaid Room and Board.

Dove Hospice filed a 3071 signed by Sheila and the attending and medical director have signed the 3074 that she is hospice appropriate.

Grace Nursing Home has submitted a new MDS.

On March 28th, Dove Hospice pulls a Mesav and notes that they have authorization for Hospice Nursing Facility. Sheila’s RUG rate is a CC1 and she is required to pay $356 each month as applied income.

Grace Nursing Home is a Level 7 with insurance nursing home.

Example Continued

TDADS pays Dove Hospice $455.04 for Sheila Zila for the March 12-15 dates of services and $1,478.72 for the dates of service of March 15-31.

On April 1st, Sheila’s rug changed to a CC2 and applied income stayed the same.

When paid by TDADS it was noted that Grace Nursing Home had lost its insurance add on as of March 12th and November 66.44 X 3.81, if paid back for the March 12-15 period resulting in a net payment of $406.67, $25.76 was taken back for the 16-31 period resulting in a net payment of $1,452.80 and the April 19th paid at an unexpected $117.45 rate versus the $117.45 resulting in a net payment of $1,471.10.

Other “Pass-Through”

General In-Patient Care with Contracted Facilities

- Communicate WITH BILLING at time of admission to GIP
- Related – Not Related
- If you bill for GIP and the Hospital billed Medicare then that is DOUBLE BILLING
- Someone Needs to Back Out

Respite Care in a Contracted Facility

- Not so much an issue because the facility knows it is respite
- Days Covered for billing may be different
- Cannot be greater than 100% Medicare Rate unless there is additional services
- This should be addressed in the contract
- Different from how you handle Room and Board

Other “Pass-Through”

Medical Director and Consulting Physician Billing

- Documentation Required
- Communication with Patient
- Allowable Medicare Rate
- Other at $0
- Doctor is not able to bill Patient
- Double billing
- Contract Required

INCOME SHOULD EQUAL EXPENSE!!!

- Need to identify why there is a difference
- Look at Your Revenue and Recurring Future Collection
- Old Bills

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