INSTRUCTIONS FOR COMPLETING THE 2014 ANNUAL REPORT FOR HOSPICE PROVIDERS

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INSTRUCTIONS FOR COMPLETION OF THE 2014 ANNUAL REPORT FOR HOSPICE FACILITIES

Forms HPCE4

These instructions for the 2014 Annual Report for Hospice Providers are intended to assist in the completion and submission of accurate data. To ensure data integrity, and determine utilization rates of inpatient and outpatient hospice services, information reported must be consistent throughout the state. These instructions are intended to assist in the collection of data and in minimizing the number of errors. Should these instructions not address a particular concern, please request additional assistance by contacting the State Health Planning and Development Agency (SHPDA), Bradford L. Williams, at (334) 242-4103, bradford.williams@shpda.alabama.gov, or Karen McGuire at (334) 353-7585, karen.mcguire@shpda.alabama.gov.

One report must be filed for each provider issued CON Authority. Each satellite office operating under CON Authority granted to a parent (all providers operating under the same Medicare Provider Number) must be listed on Page 9, providing the name of the satellite provider(s) as indicated on the license issued by the Alabama Department of Public Health (ADPH), and the county of location.

Page 1

The agency identification number is assigned by SHPDA, and is referenced the "Subject" line of the e-mail containing links to the annual report and these instructions. The agency name must match the name on the license issued by the Alabama Department of Public Health (ADPH).

Mailing Address: Provide the complete mailing address to be used by SHPDA for mailing purposes. This address may be different from the physical address of the agency.

Physical Address: Provide the complete physical address of this agency as indicated on the ADPH license.

County of Location: Choose the county of physical location of the parent provider.

Facility Telephone: Provide the primary general telephone number of the provider, including the area code.

Facility Fax: Provide the primary general fax telephone number of the provider, including the area code.

The signatures and requested identifying information **must** be provided by two separate individuals. The primary preparer of the annual report will be contacted first for additional/corrected information. The administration official may be contacted in the event the preparer is unavailable or for informational purposes. If the report is prepared by the administrator, a separate second signature is still required, and may be provided by either another member of Administration, or by a corporate official. Legible e-mail addresses for both the preparer and second verifying administrative individual **must** be provided.

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SECTION A: PROGRAM

A1: Program Type

A. Agency Type: Indicate the structure of the hospice provider issued CON Authority.

B. Ownership: Provide the organizational structure of the provider as filed with the Secretary of State's Office, or as reported to the IRS in abstention of Secretary of State filing.

C. Waiting List: Indicate whether patients were placed on a waiting list for admission due to a temporary inability to provide needed services as a result of utilization of current available resources. Patients not placed on a waiting list but referred to another provider are not to be included.

A2: Licensed Inpatient Facilities

NOTE: *As of December 30, 2014, only four (4) providers had implemented CON Authorization to provide inpatient-level services.* For providers with CON Authorization to provide inpatient services, indicate the total number of Inpatient CON Authorized

beds reporting under the same Medicare Provider Number as all providers included in pages 1 and 9 of the annual report. Also provide breakdowns of CON Authorized inpatient beds according to structure of location of inpatient services.

For providers without separate CON Authorization to provide Inpatient-level care, "0" should be indicated in this section.

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SECTION B: PATIENT VOLUME

EXAMPLES:

In-Home Hospice Care:

Provider "A" holds CON-Authorization to provide In-Home level services only. All Routine and Continuous Care levels of care provided are to be reported under "In-Home Hospice Care".

Provider "B" holds CON Authorization to provide In-Home and Inpatient levels of care. All Routine and Continuous Care levels of care provided by Provider "B" are to be reported under "In-Home Hospice Care".

Contractual Inpatient Care:

Provider "A" holds CON-Authorization to provide In-Home level services only. All GIP and Respite levels of care provided by Provider "A", regardless of location of care, should be reported as Contractual Inpatient Care.

Provider "B" holds CON Authorization to provide In-Home and Inpatient levels of care. Inpatient-level care (GIP and Respite) provided in a location *other* than the CON-Authorized Inpatient facility under common ownership, is to be reported as "Contractual Inpatient Care".

Inpatient Hospice Care:

This level of care is not applicable to providers not holding CON-Authorization to provide Inpatient levels of care also.

Provider "B" holds CON Authorization to provide both in-Home and Inpatient levels of Care. Inpatient-level care (GIP and Respite) provided in the CON-Authorized Inpatient facility is to be repoted as "Inpatient Care". GIP and Respite levels of care must be provided in beds owned or leased (not contracted) by the hospice provider.

B1: Patients Served

a. Total New (Unduplicated) Admissions: Report the total number of patients admitted not previously served by this provider.

b. Re-Admissions (Duplicated Admissions) from Prior Years: Report the total number of patients re-admitted who were previously served by this provider but who were discharged/revoked/ transferred in a prior year.

c. Total (Unduplicated) Admissions During this Reporting Period: Sum Total New Unduplicated Admissions (B1a.) and Duplicated Admissions from Prior Years (B1b.).

d. Re-Admissions (Duplicated Admissions) from Current Reporting Year: Report the total number of patients previously served by this provider in the current reporting year, discharged/revoked/ transferred during the reporting year, and re-admitted during the same reporting year (initial admission has also been counted in B1a.).

e. Total Admissions for Reporting Period: Sum the Total Unduplicated Admissions during this Reporting Period (B1c.) and Duplicated Admissions from the current reporting period (B1d.). Admissions reported on Page 4, Sections B2 and B3, **MUST** equal the Admissions reported for this line-item.

f. Total Carryovers: Report the total number of patients under continuous admission status on both December 31, 2013, and January 1, 2014.

g. Total Unduplicated Patients Served During Reporting Period: Sum the Total Unduplicated Admissions during the Reporting Period (B1c.) and Total Carryovers (B1f.). Unduplicated Patients Served reported on Pages 7 – 7b, Section D1, **MUST** equal the Unduplicated Patients Served reported for this line-item.

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B2: Total Admissions by Race

Provide the total number of all Admissions, regardless of the year of Admission or number of Admissions, for the reporting period broken down by race. The Total Admissions **MUST** equal the Agency Total number of Admissions reported in Section B1e. A statement signed by an Administrative official must be attached for providers exceeding 10% of Total Admissions reported as "Other", stating that racial information is not collected on behalf of patients.

B3: Total Admissions by Age and Gender

Provide the total number of all Admissions, regardless of the year of Admission or number of Admissions, for the reporting period broken down by age groups and gender. The Total Admissions **MUST** equal the Agency Total number of Admissions reported in Section B1e.

B4: Deaths/Discharges

a. Total Deaths: Report the total number of Deaths occurring during the reporting period.

b. Total Live Discharges/Revocations/ Transfers: Report the total non-death discharges occurring during the reporting period.

c. Total Deaths/Live Discharges/ Revocations/Transfers: Sum of Total Deaths (B4a.) and Total Live Discharges/Revocations/Transfers (B4b.).

c. Total Patient Days (Deaths and Discharges): Report Total Patient Days of care provided, regardless of admission date or number of admissions, for all patients whose care ended (death/discharge/revocation/transfer) during the reporting period.

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C1: Patient Days by Level of Care

a. Routine Home Care Days: Provide the total number of Routine In-Home level care Patient Days provided during the reporting period.

b. Continuous Care Days Billed: Provide the total number of Continuous Care level care Patient Days billed during the reporting period. Continuous Care days **NOT** billed should be reported as Routine Home level care.

c. Total In-Home Patient Days: The sum of Routine Home Care Days (C1a.) and Continuous Care Days Billed (C1b.).

d. General Inpatient Days: The total number of GIP care days provided by a provider not also holding CON Authorization as an Inpatient facility; or GIP care days provided by a provider also holding CON Authorization as an Inpatient facility, but for which GIP care was provided in another location through contract (not the CON Authorized Inpatient facility).

e. General Respite Days: The total number of Respite care days provided by a provider not also holding CON Authorization as an Inpatient facility; or Respite care days provided by a provider also holding CON Authorization as an Inpatient facility, but for which Respite care was provided in another location through contract (not the CON Authorized Inpatient facility).

f. Total Contractual Inpatient Days: The sum of GIP (C1d.) and Respite (C1e.) care days provided by a provider not also holding CON Authorization as an Inpatient facility; or GIP and Respite care days provided by a provider also holding CON Authorization as an Inpatient facility, but for which GIP and Respite care was provided in another location through contract (not the CON Authorized Inpatient facility).

g. General Inpatient Days: The total number of GIP care days provided by a hospice also holding CON Authorization as an Inpatient facility.

h. Inpatient Respite Days: The total number of Respite care days provided by a hospice also holding CON Authorization as an Inpatient facility.

i. Total Inpatient Hospice Days: The sum of GIP (C1g.) and Inpatient Respite (C1h.) care days provided by a hospice also holding CON Authorization as an Inpatient facility.

j. Total Patient Care Days: The sum of Total In-Home Patient Days (C1c.), Total Contractual Inpatient Days (C1f.), and Total Inpatient Hospice Days (C1i.).

k. Routine Hospice Care Days Provided in a Skilled Nursing Facility (SNF): Report the total number of Routine Patient Care Days provided during the reporting period to patients whose residence is deemed to be a SNF. (Do not include contractual days for beds leased by an In-Home provider to provide inpatient level care services).

l. Total Percentage of In-Home Hospice Care Days provided in a Skilled Nursing Facility (SNF): Divide the Routine Hospice Care Days provided in a Skilled Nursing Facility (C1k.) by the Total Patient Care Days (C1j.) * 100 to determine percentage.

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C2: Patient Days by Reimbursement Source

Enter the number of Patient Care Days provided during the reporting period, broken down by the primary reimbursement source. The Totals reported **MUST** equal the Totals reported in Section C1j.

Indicate yes or no if this provider includes care provided when there is no primary source of reimbursement (charity care), and a primary source of

reimbursement of self-pay (private pay) as one source throughout this report.

C3: Patient Days by Diagnosis

Enter the total number of Patient Care Days provided for each listed Diagnosis. The Total Number of Patient Days **MUST** equal the Totals reported in Section C1j.

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Section D: Patient Location

D1: County of Residence: For the purposes of this report, only patients whose legal residence is in the State of Alabama should be reported. Data for **ALL** counties for which CON Authorization is held by providers (parent and any satellite offices) reporting under the Medicare Provider Number of this provider, must be included. For CON-Authorized counties in which no services were provided during the reporting period, enter "0".

Number of Deaths: Enter the number of Deaths occurring during the reporting period by county of residence. The total number of Deaths **MUST** equal the total number of Deaths reported in Section B4a.

Number of Live Discharges: Enter the number of Live Discharges/Revocations/Transfers of all patients for any reason other than death, occurring during the reporting period by county of residence. The total number of Live Discharges/Revocations/Transfers reported **MUST** equal the total number of Live Discharges/Revocations/Transfers reported in Section B4b.

Patient Days: Enter the total number of Patient Days of care provided occurring during the reporting period by county of residence. The total number of Patient Days **MUST** equal the total number of Patient Days reported in Section C1j.

Number of Patients Served: Enter the number of Unduplicated Patients Served by county of residence, counting each patient only once regardless of the number of Admissions during the reporting period. The total number of Patients Served **MUST** equal the total number of Patients Served reported in Section B1g.

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Section E: Agency Information

E1 Volunteer Services: Enter the total annual percentage of volunteer care hours provided to patients for the reporting period, as reported to CMS, for all providers under common CON Authorization as indicated on pages 1 and 9 of the report.

E2 Length of Service:

Average Length of Service (ALOS): Report the Average Length of Service for all patients who Died or were Discharged/Revoked/Transferred during the reporting period, regardless of Admission date. Total number of Patient Days reported in Section B4d. divided by the sum of Patients reported in Section B4c.

Median Length of Service (MLOS): Arrange the LOS numbers for all patients who Died or were Discharged/Revoked/Transferred during the reporting period from lowest to highest (1, 2, 3…), for each level of patient care provided. The number that falls in the exact middle of each list is the MLOS for the specified level of care.

Example 1 **- Odd number of patients:** Seven patients with the following LOS: 25, 34, 2, 17, 33, 60, 22. Arrange numbers in sequence from lowest to highest: 2, 17, 22, **25**, 33, 34, 60. The number 25 is the exact middle number in the list. Therefore, the median LOS is 25.

Example 2 **- Even number of patients:** Eight patients with the following LOS: 25, 34, 2, 17, 33, 60, 22, 35. Arrange numbers in sequence from lowest to highest: 2, 17, 22, 25, 33, 34, 35, 60. The numbers 25 and 33 share the middle position so the median falls between those two numbers. To determine the median LOS, add the two numbers and divide by 2 (25 + 33 = 58 / 2 = 29 [Median LOS])

Average Daily Census (ADC): Divide the total number of Patient Care Days (C1j.) by the number of days in the reporting period (365 or 366 for a leap year, or total days of service for partial year reporting).

Example: 28,756 patient days divided by 365 service days = ADC of 78.78.

SECTION E: REVENUES AND EXPENSES

(Amounts do not have to be audited)

DEFINITIONS:

Payroll: Total expenses for the reporting period spent on payroll for employees of the provider, including benefits.

Non-payroll: Total remaining expenses for the reporting period of the provider for all items except payroll, employee benefits, and transportation expenses.

Transportation: Total for transportation related expenses, including reimbursement mileage, vehicle

insurance coverage, vehicle purchases, maintenance costs, etc.

Bad Debt: Bad debt is defined by the *Alabama State Health Plan,* Section 410-2-2-.06, as "the unpaid charges/rates for services rendered from a patient and/or third party payer, for which the provider reasonably expected payment."

Charity: Charity is defined by the *Alabama State Health Plan*, Section 410-2-2-.06 as "health services for which a provider's policies determine that a patient is unable to pay. Charity Care could result from a provider's policies to provide health care services free of charge to individuals who meet certain pre-established criteria. Charity care is measured as revenue forgone, at full-established rates or charges. Charity care would not include contractual write-offs, but could include partial write-offs for persons unable to pay the full amount of a particular patient's bill."

All expenses reported should be rounded to whole numbers. Although considered acceptable accounting practices, for the purposes of this report all expenses should be reported as positive numbers; negative numbers should not be reported, but instead should be reported as revenue. Enter "0" for any breakdowns requested which are not applicable to this provider.

Medicare: Total reimbursements received during the reporting period from Medicare for services provided.

Medicaid: Total reimbursements received during the reporting period from Medicaid for services provided.

Commercial Insurance: Total reimbursements received during the reporting period from insurance coverage not classified as Medicare or Medicaid for services provided.

Private Pay: Total reimbursements received during the reporting period directly from the patient or patient's caregiver(s) for services provided.

Other: Any other revenues received during the reporting period not classified otherwise above, including donations and grants.

All revenues reported should be rounded to whole numbers. Although considered acceptable accounting practices, for the purposes of this report, all revenues should be reported as positive numbers; negative numbers should not be reported, but should be reported as expenses. Enter "0" for any breakdowns requested which are not applicable to this provider.

Page 9

Page 9 should be completed for all licensed providers for which singular CON-Authorization was granted (all providers reporting under the same Medicare Provider Number). Each licensed hospice provider reporting under the primary provider indicated on Page 1 **MUST** be listed on this page, indicating the county of administrative location for each additional provider listed. The parent provider indicated on Page 1 of this report should **NOT** be reported on this page.

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Checklist

The checklist will be populated automatically upon completion of the report. The checklist should be verified that sections equal numbers of Patient Days, Admissions, Unduplicated Patients Served, Deaths, and Live Discharges/ Revocations/Transfers reported throughout the Annual Report. The checklist is to be included with submission of the Annual Report.

REMINDERS

The annual report MUST be signed by both the preparer and an administrative official. Electronic signatures are acceptable.

Make and keep a copy of the completed report for the provider's records before submitting to SHPDA.

This report should be submitted to SHPDA only once via electronically, hard copy, or fax. The preferred method is electronic submission to karen.mcguire@shpda.alabama.gov. If submitted electronically please do not also submit via hard copy unless specifically requested to do so by SHPDA staff.