FAQs from the 2021 Home Care Cost Report September Outreach Session held on September 15, 2022

General

Q.1. Can I request an extension for the 9/20/22 cost report submission deadline?
A.1. Please send all extension requests to us-advrisknyshc@Kpmg.Com. In your request, please include the agency name, reason for the request, and date you are requesting to submit the cost report.

Q.12. If I am private pay only, am I required to submit the Home Care Cost Report?
A.12. If you only service private pay patients, you would not be required to complete the Home Care Cost Report.

Topic:
Web-based Tool

Q.2. Can I submit my cost report if there are outstanding validation warnings?
A.2. Yes. While DOH and KPMG encourage providers to correct all potential errors related to the warning messages before the September 20, 2022 submission deadline, providers may proceed with cost report submissions with warning messages.

Q.3. Can I edit my cost report after I've submitted?
A.3. Cost reports may not be unlocked on or after the submission due date, unless the agency is granted approval by DOH or subject to audit.

Q.4. Where can I access the 2021 Home Care Cost Report?
A.4. The Home Care Cost Report Tool can be accessed at the following link: https://desoto.certisphere.com/doh/HomeCareDashboard.html. Once you enter the link, please select the 2021 option to access the 2021 Home Care Cost Report.

Q.5. For question G.6 on the General Questionnaire, what internal and external audits are you referring to? Would the Home Care Cost Report audit from 2020 be included?
A.5. G.6 should include any audits performed on your agency in 2021 not including the audit of the Home Care Cost Report Audit itself.

Cost Reporting

Q.6. We are a CHHA agency that doesn't provide any pediatric services, but we are receiving a warning message to complete Schedule 5a. 1 "CHHA Pediatric Service Statistics." What should we do?
A.6. If you do not provide any pediatric services, you are not required to submit Schedule 5a.1. This message is intended to inform you that a schedule was left blank in case that was an oversight. The message does not prevent submission, so you may ignore it and proceed with cost report submission.

Q.7. If we don't have any non-allowable costs to report on Schedule 3, why is a warning message populating?
A.7. Schedule 3 should include your agency's total expenses, including direct care, program administration, and non-allowable costs. Some examples of non-allowable costs include meal expenses, marketing for the purposes of attracting new patients, political or charitable contributions, and costs related to non-allowable services such as private duty nursing. To help ensure you are accurately categorizing costs as allowable and non-allowable, we encourage you to review the complete list of non-allowable costs on pages 12 – 13 of the Home Care Cost Report Instructions.

Q.8. Should the revenue reported on Schedule 19 be the billed amount or the amount received?
A.8. The Home Care Cost Report should be completed using the accounting methodology used for your agency's financial statements. Therefore, if your financial statements are accrual based, then you should use the revenue you billed/accrued. If your financial statements are on a cash basis, then you should report revenue based on the actual amount received. The amount reported on Schedule 19 should tie to the amount reported per your financial statements.

Q.9. If a Managed Care Organization (MCO) has not increased their rate since 2013, can one assume that there is no WR&R revenue add-on? **A.9.** DOH includes a WR&R rate add-on in the rate for MCOs. As such, managed care agencies have a WR&R rate add-on and are expected to offset WR&R revenue on Schedule 3, regardless of the last increase.
Q.10. I received a warning message that Schedule 19 revenue should be consistent with the Schedule 5 statistics. What does that mean? **A.10.** Schedule 5 statistics are broken down by payor type (e.g., Medicaid or private pay), so the reporting of statistics by payor on Schedule 5 should be consistent with the reporting of revenue by payor on Schedule 19. For example, if there are service statistics in the Medicaid Fee-For-Service columns (001-003) on Schedule 5, the corresponding revenue for those service statistics should be reported in the Medicaid Fee-For-Service row (002) on schedule 19. If there are service statistics reported in the Medicaid Managed Care columns (004-006) on Schedule 5, the corresponding revenue for those service statistics should be reported in the Medicaid Managed Care row (003) on schedule 19. If the payor sources are inconsistent between these schedules (e.g., Schedule 5 shows Medicaid Fee-for-service statistics only but Schedule 19 shows Medicare revenue only), a warning message will populate.
Q.11. Should costs related to Traumatic Brain Injury (TBI) and Nursing Home Transition & Diversion (NHTD) services be reported in the “other non-allowable services” row 009 on Schedule 3? **A.11. Yes.** TBI and NHTD services are considered non-allowable on the Home Care Cost Report and should be reported in column 002 “Non-allowable Costs” on Schedule 3, within the “Other Non-allowable services” row 009.
Q.13 Where should telehealth expenses be reported on Schedule 3? **A.13.** DOH determined that if the telehealth services provided by the agency meets the Remote Patient Monitoring (RPM) conditions, then the costs should be reported as allowable. If they do not, then they do not meet RPM conditions and should be reported as non-allowable in Column 002 on Schedule 3.