HHFMA White Paper on Cost Containment Practices

Walter Borginis III, CPA, Chief Editor

Joe Calcutt, Chair, Innovations Committee

William Dombi, JD, Editor

Josh Sullivan, Editor

Other Contributors:

Jeffrey Aspacher

Pat Laff, CPA

Ramsey Badre

Larry Leahy

Sarani Banerji

Bill Musick

Mary Bartlett

Mark Sharp, CPA

Tom Boyd

Bob Simone

Melinda Gaboury, COS-C

Rob Simione, CPA

Anne Hochsprung

Contents

Introduction:

This HHFMA white paper is a collection of the best cost containment practices for home and hospice agencies. As we face reduced Medicare payments and more managed care patients at lower reimbursement, many agencies are challenged to produce acceptable financial results. Many of the ideas contained in this paper were compiled by studying the slides from the last several years of the NAHC Financial Management Conferences. A word of caution: you cannot simply cut your way out of financial difficulties. This will eventually become a death spiral for your agency. You must look at ways to increase your revenues in order to get back to full health. While you are waiting for these revenue initiatives to bear fruit, however, it always pays to reduce your costs to appropriate levels.

A. Cost Management by Benchmarking

With the recent CMS rebasing rule for Home Health, it will become increasingly important for Home Health agencies to focus on cost management. The final rule will lower Medicare reimbursement in 2014, 2015, 2016 and 2017 by 3.5 percent per year. Hospice programs are likely to face reimbursement changes as well when CMS looks to implement a new payment system. While the Affordable Care Act authorized CMS to create a new payment model "no earlier than" October 1, 2014, it appears that hospice payment reform is still a few years off. However, CMS has made it clear that it will take administrative steps to extensively review claims, shift costs previously borne by Medicare Parts A, B, and D to hospices, and increased data demands that will lead to higher costs for the hospices.

As a result, both home health agencies and hospices must focus on achieving cost efficiencies while still providing quality care to their patients. This will be vital to their survival as these cuts, along with continued increases in staffing and other costs, threaten the ability of Home Health Agencies and Hospices to continue to provide care in their respective communities. Cost management is a very challenging objective, but the intent of this document is to provide insight, strategic planning, and industry benchmarks as guidance for continued quality care at a lower more efficient cost.

1. Gross Margin/Direct Cost/Indirect Cost

Before evaluating costs, it is important to take the top down approach. This helps determine specific areas where a provider can become cost efficient. There are two types of cost that an agency incurs, namely: direct and indirect. Direct operational expenses include salaries, benefits, payroll tax, workers compensation insurance, contract services, mileage and supplies for direct care staff. Important decisions that face Home Health and Hospice agencies as it concerns to direct cost include:

- Staffing---Salary, hourly or a pay per visit model
- Employee benefits
- Supply cost management
- Productivity
- Transportation costs
- Hospices: pharmacy, durable medical equipment and ancillary costs

Indirect costs are related to the support costs of an organization. Costs such as clinical management, finance, revenue cycle management, intake, marketing, occupancy, professional fees and insurance would be included as indirect. The staffing cost associated with indirect support costs are the responsibility of management's decisions on hiring levels, compensation, benefits and professional service usage. Other indirect cost such as occupancy, taxes, and utilities are considered fixed costs, since they do not vary in size with revenue volumes.

Breaking out these costs will give an agency the ability to determine its Gross Margin. Calculating Gross Margin and comparing it to national benchmarks is the first step to measure and manage an organization's performance and determine what type of costs need to be reviewed for possible reductions. Gross Margin should not be considered just a "financial" metric, but as a metric to hold everyone accountable.

By definition, Gross Margin is the difference between revenue and direct costs for an agency. As a result, the main drivers for Gross Margin are reimbursement for services rendered to patients and the corresponding cost for providing these services. This metric is directly correlated with the performance of the various departments within the organization. For example, while an agency's intake and marketing costs are not included in the gross margin calculation, these department activities are major drivers for admissions and payer mix, which directly correlates with the reimbursement totals. In the same fashion, the agency's clinical and billing management performance will drive case weight mix and timely collections, which also directly relate to higher reimbursement amounts. As for costs, the major drivers will be productivity, staffing, benefits, supplies and mileage. The clinical operations team should be responsible for achieving set productivity targets, which will impact the cost value. Salaries for direct care are the largest expense item for Home Health and Hospice agencies. According to industry benchmarks, a Home Health or Hospice agency will spend approximately 44% of revenue on direct staff salaries and contracts. Management must also decide what compensation model, e.g. salary, hourly, or pay per visit, works best for their agency. In addition, the executive management team's decisions on mileage reimbursement and supply contracts will drive the other direct cost values.

The agency's ability to maintain a targeted Gross Margin in line with industry benchmarks is an important concept for all employees and management to understand. Gross Margin has a direct effect on the ability to provide increases in salaries and employee benefits. When setting up a targeted Gross

Margin, the agency should verify that realistic performance goals are used in the calculation. It is advisable to use national and local benchmarks when setting these targets and goals. The national benchmark (or average) according to the Simione Financial Monitor as of June 30th, 2013 for Gross Margin is 40% of net revenue. When Gross Margin falls short of the target or benchmark, the agency should review each department's performance indicators. This process will help the agency understand if the issue is revenue or cost related. If it is revenue related, it will be important to review payer mix, case weight for Home Health, and census. If it is cost related, an agency should review their productivity, staffing models, employee benefit structures, supply and purchased services expenses.

2. Cost Benchmarks

Arthur C. Nielsen, Market Researcher & Founder of A C Nielsen once stated "The price of light is less than the cost of darkness". This quote could not be truer for the Home Health and Hospice industry. Data analytics and benchmarks are vital to the survival of agencies facing Medicare rate and volume reductions. While many agencies are able to generate their own internal dashboards and analytics, they should take advantage of available benchmarking sources to review their performance with external sources. Not only should they look at comparisons with operational and revenue benchmarks, but also cost benchmarks.

It is very important when evaluating cost benchmarks to perform the proper due diligence. There are several areas where agency types, regions and affiliations can deeply influence their cost structure. For example, agencies that are freestanding should not be compared with hospital based agencies. Freestanding agencies incur all of their internal costs, such as human resources, information systems, billing, marketing and rent. As a result, they have capability to break out these costs and have a true Net Margin calculation. Agencies that are hospital based or affiliated receive a cost allocation from their parent organization. This cost may be in the form of an annual percentage that may be based on revenue, direct cost, or space occupancy. A hospital based agency does not have much control over this allocation and should include it as a separate item on their Income Statement. Presenting the allocation separately will allow for analysis of the margin on both a pre- and post- allocation basis.

An agency's location can have an impact on its cost structure. Agencies that are located in rural areas will have higher mileage costs than their urban-located counterparts. On the other hand, urban agencies may have higher wages and larger staffing models to serve more patients. Another difference from a cost perspective relating to region or location is the competition within the regional market. For example, agencies that are in highly competitive markets will likely have to spend more dollars on sales and marketing and intake. Payer mixes could also have a direct outcome on cost. In areas where there are higher amounts of non-Medicare patients, costs for billing, authorizations and collections could be significantly higher.

As a result of these cost differences, agencies must very carefully review who they are benchmarking against. Agencies should be able to compare both locally and to similar agency types.

Agencies should not just include the cost benchmark, but also the corresponding performance indicator. This will allow them to better understand the performance benefit vs. cost. For example, an agency may have higher marketing cost than its competitors within their region. Before deciding to change the cost structure for marketing, they should review their market share, referral to admission conversion ratios, and their census. If an agency is spending more money on a specific area of the organization and achieving excellent performance, they probably should not make changes in their cost structure. If the agency in the example above cut marketing costs, it may lead to a decrease in market share and revenues that is far greater than the cost cut.

Based on the NAHC cost management work group survey, the following Gross Margin benchmarks for home health and hospice agencies were gathered for year-end 2012 results:

National Benchmarks for Gross Margin Year Ending 2012

Benchmark	National	Rural	Urban
Gross Margin	40%	36.4%	40%

Gross Margin by % of Medicare Revenue (Appendix A)

Benchmark	< 15%	15-30%	31-50%	51-75%	< 75%
Gross Margin	6.1%	2.0%	16.3%	65.3%	10.2%

Also the following cost benchmarks are taken from the 2011 CMS cost report database.

Cost as a % of Total Revenue Year Ending 2011

	Salaries	Employee Benefits	Purchased Services	Transportation
Cost as % of Revenue	54.4%	6.9%	10.2%	1.6%

Keep in mind that benchmarks should be used as guidelines to help agencies make better cost management decisions. Agencies should use only the most recent benchmarks available as they will truly represent what is going on today in the Home Health and Hospice industries. It is very important to verify that in the benchmarking process your agency has an "apples to apples" comparison. Agencies should verify that they have the same data components and are using the identical calculation. Be very careful to follow the cost definitions given by the benchmark source in order to insure that you are comparing the same items. Benchmarks can provide a great deal of value to your agency. In an industry that is constantly changing from a reimbursement and regulation standpoint, it is vital to have the most up to date benchmark data will keep you informed on best practices.

We will now turn our focus to individual cost containment and management ideas sorted by cost category. This will give you a real sense of items to consider in evaluating your current costs.

B. Management of Direct Costs

1. Payroll Costs Associated with Clinical Staff—Nursing costs:

Most of direct costs consist of payroll and payroll related costs, like taxes and employee benefits, related to the delivery of clinical services to patients. Of these costs, the largest portion is devoted to nursing costs.

Nursing staff is compensated in a number of ways. They could be hourly, salaried, pay per visit or some hybrid. Caution must be exercised in order to comply with wage and hour laws, especially in the construction of any hybrid compensation models.

Hourly compensation for home health and hospice agencies is very straightforward and rules related to overtime must be followed. State law must be followed where overtime pay is required for any time worked over eight hours per day. Federal law focuses overtime on a 40 hour work week. This is distinct than the more liberal 8 and 80 rules that are applied to facility based health care providers. Productivity under hourly pay must be closely monitored and managed. This is a real challenge for most agencies.

Salaried nurses can be exempt from overtime provided the FLSA rules are followed. This method of pay creates the same need for managing productivity as hourly pay. In addition, salary pay creates an issue of how to cover weekends. Typically, days of work within the week are traded or additional pay on a pro-rated basis may be offered to compensate for the weekends worked. Some compensation models also offer a per visit bonus for salaried nurses who make more visits over a set amount per week. This bonus will encourage nurses to accept new patients late in the day as well as help with overall productivity. Compensation methods should be reviewed by competent legal counsel in order to ensure compliance with state and federal laws.

The emerging newer model of compensation pay is pay per visit for both home health and hospice. This method involves paying nurses a set amount for each visit performed and may also include a separate payment for case management for each assigned patient on a four week or monthly basis. The set amount may be adjusted in some models to provide higher amounts for the start of care or recertification visits. These visits tend to be different due to nature of the work performed and the time needed to complete the OASIS. The pay per visit may be set to include time off, like sick, vacation and holiday pay. Some models pay time off based on the average number of visits per day performed by that nurse on a daily basis over the last quarter. In general, pay per visit staff will complete more visits per day than hourly or salaried nurses, since the pay per visit provides a strong incentive to be more productive. Be aware that pay per visit nurses will demand greater efficiency in scheduling, technology support and supply ordering in order to assist them in making more visits per day. They may also express concerns over the size of the territory they are asked to cover. Be sure to anticipate these requests by auditing how things work and make the necessary adjustments to be more efficient. In short, automate almost everything.

It is important to include some provision in calculating per visit rates for meeting and training time. Some agencies make the mistake of paying for meeting and training time on an hourly basis, thereby ruining the entire pay per visit system for purposes of wage and hour compliance. It is best to estimate the total hours spent in meetings during the year and then incorporate the pay for that time into the per visit rate calculation. In order to improve efficiency, telephonic meetings with nurse managers for both individuals and teams should be considered to maximize time available for actual patient visits.

Due to potential problems in getting the pay per visit nurses to spend the appropriate time in opening or recerting new episodes, many models include a case management bonus as well as a higher opening visit payment. Some also include quality bonuses based upon patient outcomes. These incentives are meant to align everyone's priorities with the agencies and ensure that no one is able to game the system by doing a lot of short revisits.

Another caution is to be sure to monitor and manage how the pay per visit staff is using their higher productivity. Agencies find that nurses converting to pay per visit will increase their number of visits made per day. Productivity may jump from 5 to 8 visits per day under this model. As a result, it is important to manage this new visit capacity and the medical necessity of each visit so that visits are used to open and maintain new episodes and not simply to add unnecessary visits to existing episodes with no additional increase in rev-

enue. Some agencies actually establish a reasonable and flexible cap on total visits made in a day in order to preserve quality standards and patient satisfaction.

Given the financial pressures of a reduced Medicare payment, both home health and hospice agencies should evaluate the use of telemonitoring equipment as a potential substitute for nursing visits. Many patients like the concept that they are being monitored daily. In addition, these systems provide alerts to the agency that are helpful in identifying patient needs and potential crisis situations. By evaluating the costs for telemonitoring equipment against the cost of a nursing visit, an agency can determine the potential return for adding this equipment. Be sure that you consider the potential impact on the agency's volume of LUPA episodes. If the use of telemonitoring reduces the visits per episode below the four-visit LUPA threshold, the agency will suffer a financial penalty for its efforts at cost reduction. Medicare currently does not recognize either the cost or the visit substitution benefit of telemonitoring. Remember that many managed care insurance companies do not pay for monitoring and you should discuss with the plans the need for adding this option to your existing contracts.

Here is another caution on pay per visit related to wage and hour laws. As tempting as it may be, pay per visit cannot be withheld for visits that are provided by the staff without proper authorization from a managed care company. Nor can it be withheld for undocumented visits if the recording of the visit in the agency's patient information system is late or incomplete.

In order to monitor overall effectiveness of nursing staff, many agencies rely on report cards that are developed for each nurse. These report cards for home health include productivity measures, quality outcomes, the timeliness of paperwork submission, patient satisfaction scores, HHRG case weights, LUPA percentages and other measurements that clearly identify your top performers as well as highlight problem areas that need additional training.

In building a budget for home health nursing staff, it is important to follow certain staffing benchmarks. In general, you should plan for one RN for 23 to 27 patients. Also, one RN patient care manager or supervisor for 200 to 250 patients. In hospice, the numbers are 12 to 14 patients per RN. These are general industry rules that may vary under specific circumstances. They were confirmed by the survey taken as part of this paper and is attached.

2. Payroll Costs of Other Clinicians:

The next biggest component of clinical staff for home health agencies are the therapists—Physical, Speech and Occupational. These therapists are considered professional, exempt staff and can follow any of the pay models discussed under nursing. Common methods of compensation are either pay per visit or salary with a bonus for visits over a set amount per week. However, if you choose to pay any of these therapists on an hourly basis, you will subject the agency to the payment of overtime. It would also be difficult to justify implementing different compensation methods on a per person basis within one skilled group.

While therapy salary expense can vary greatly as a percent of total clinical salaries among different sized agencies, CMS calculated therapy as 40% of the total cost of an episode. Many agencies choose to forego the hiring of therapists and use outside contracted therapists for these services. While the use of contracted staff may become more manageable from a visit perspective, this practice often makes it difficult for the agency to maintain clinical control over the services and visit data collection may be more difficult to obtain. In addition, hourly rates for contracted staff can be quite high and often exceed the reimbursement provided to the agency by a managed care payer. Beware of agencies that charge on an hourly basis as you will have to carefully monitor productivity in order to keep costs within a reasonable range.

Home Health Aides, Licensed Practical Nurses (LPN), Licensed Vocational Nurses (LVN), Physical Therapy Assistants (PTA), Speech Therapy Assistants (STA) and Occupational Therapy Assistants (COTA) are considered non-exempt paraprofessionals and must be paid overtime pay for any time worked in those functions in excess of 8 hours per day under some state laws and/or 40 hours per week under federal wage and hour laws. While these clinicians can be paid on a per visit basis, all hours worked must be tracked. Under this model of pay, all hours worked that qualify for overtime must be paid at overtime rates. Note that vacation, holiday or sick time paid does not count in the 40 hour per week limitation, unless required under a union contract agreement. In the event that the clinician is paid on a per visit basis, the effective hourly rate must be calculated using the Fair Labor Standards Act (FLSA) guidelines. This calculation uses all amounts paid for time worked during the pay period and divides that by the hours worked to determine the effective hourly rate. This rate is then used to calculate overtime pay. As a result, paying paraprofessionals on a pay per visit basis requires extra diligence to stay in compliance with wage and hour laws.

After nurses, the next biggest components of clinical professional staff for hospice agencies are the medical social workers and the spiritual counselors. Every hospice is required to have a core clinical team composed of the positions of physician, nurse, social worker and spiritual counselor. Social workers and spiritual counselors are considered also professional and exempt staff, and can follow any of the pay models discussed under nursing.

Establishing a guideline to pay social workers on a per visit basis is more complex than a per visit approach for other professionals. Phone calls are reported as separate visits when made to the patient or the patient's family, provided that they are necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care. For this reason, most hospices pay

social workers either on a salary or hourly basis plus overtime if incurred.

Nevertheless, to enhance productivity incentives, implementing a per visit compensation approach for social workers is still possible and arguably desirable, and perhaps can be more cost effective than salary or hourly basis. Using a weighted per visit average approach to pay for the total of home and phone visits is one way to accomplish the outcome; or alternatively, simply paying only for the actual home visit while factoring the phone visits time into the pay rate. Establishing two distinct per visit pay rates, one for home visits and one for phone visits is also a consideration, and perhaps the most equitable of the three approaches.

Compensation on a per visit basis can be more cost effective than salary or hourly, provided that management is very proactive by enhancing scheduling efficiency, controlling the ordering and provision of drugs, DME's and supplies, and providing adequate technology support. Management should be careful that employees don't game the system by substituting home visits for phone visits, depending on the particular compensation formula used.

Spiritual counseling is considered as a direct patient care service cost center by CMS in the current and proposed cost reports, but there is no requirement to include visits or any other spiritual counseling information when submitting patient claims. Nevertheless, compensation for spiritual counselor services can be significant for many hospices. Similar to other disciplines, the pay per visit approach would be most cost effective with appropriate management input. Some hospices have been successful (or perhaps lucky) in securing voluntary spiritual counseling services, while others have been able to obtain an agreement for an annual token amount to be paid to members of the clergy to provide all needed visits and services, which still exempts the hospice from having to contend with any overtime considerations.

Visiting services as well as drugs and DME are significant cost components in providing care to the terminally ill; so, adequate attention needs to be devoted in this area in order to achieve positive margins. Using BKD's 2012 hospice benchmarking*, direct costs as percent of revenues are displayed below.

Description	Direct Cost/Revenue Per Day	Cost Per Day As Percent Of Revenue Per Day
Nursing Services	$33.04	21.4%
Medical Social Services	5.31	3.5
Spiritual Counseling	3.07	2.0
Aide/Homemaking Services	9.49	6.2
Drugs	6.69	4.3
DME	5.46	3.5
Revenue	154.06	

*The data above are based on National medians.

Note that it may be appropriate on a patient by patient basis to mix your clinician pool with the less costly paraprofessional staff members to reduce the overall cost of care as long as patient outcomes and satisfaction are not compromised. In many instances, Registered Nurses and Physical, Occupational or Speech Therapists are only necessary for visits that require a professional evaluation such as at intake (except OT), discharge, readmission or resumption of care. As a result, paraprofessionals can be utilized for most skilled visits. Their use will help reduce your overall costs. In addition, hospitals are currently reducing the number of paraprofessionals they use, thereby making them more available for hire than professional staff. Care must be taken to follow the supervisory requirements of paraprofessionals by professional staff as set by state regulations.

3. Transportation Costs:

There are several ways to compensate employees for mileage driven while making home visits. One method is to pay a set rate per mile. The maximum rate per mile is set each year by the Internal Revenue Service. This rate is considered a return of cost to the recipient and is not taxable. The IRS also states that mileage begins at the home of the first visit, since commuting expenses are not reimbursable on a tax free basis. Many agencies set the per mile rate below the IRS rate. Other agencies do a cost study on the actual average amount of miles driven per visit. Using this average, they calculate a flat rate per visit and pay that amount. The rates per visit can be zoned for each service area. This method is also tax free for IRS purposes if the amount is based on actual mileage and costs.

Many agencies take advantage of software that calculates the true mileage amounts on a given day based upon the visits that are scheduled. They report that this software has greatly reduced mileage reimbursement overall. In place of such software, an internal audit of actual mileage as compared to mileage reported may have the same impact of lowering reported mileage.

Some agencies lease or purchase cars for clinical staff that drive long distances. In order to evaluate this option, you should look at average reimbursement paid per person on an annual basis and compare that to the cost of the leased car, including lease costs, maintenance, insurance and gas. Remember to follow the IRS rules on employer provided cars, which includes taxation on any commuting miles. This may be avoided by requiring the cars to be left at the agency's offices each night. Some agencies report that they have decorated the leased cars with

their logos and that has increased the agency's visibility.

Agencies should also be cognizant on transportation costs that somewhat indirect such as the cost of non-owned auto insurance to cover liability risks for the company and lost visits or substitution staff when employee-owned vehicles breakdown. The factors related to transportation costs can become very complex, but the impact on an agency's bottom line warrants a careful consideration of all the options available to meet this need.

4. Medical Supplies, Drugs and DME:

Medical supplies are paid by Medicare for home health claims in accordance with the patient's Non-Routine Supply severity level as determined by the completed OASIS. Most managed care companies exclude these supply costs from their payments to home health agencies. The goal for home health and hospice should be obtaining medical supplies, drugs and DME at the best price with the most efficient method of delivery. Long gone are the days of the agency maintaining a large inventory of supplies, drugs and DME in an office based supply room. With the growth in the use of computer technology, many vendors offer the ability to have on-line ordering against a formulary of supplies created by the agency. This is usually accompanied by a reduction in the number of supply vendors and the creation of a supply formulary in order to consolidate usage and gain the best prices. Be sure to deal with a vendor that has a system that warns you about non-formulary supply orders and large orders over a set dollar limit when these orders are placed. This will insure that the formulary, where you have negotiated your best discounts based upon annual volumes of usage, is being used and that supply orders that may extend well beyond the episode's timeframe or contain quantity errors are prevented before they are placed. Under these systems, the supplies are shipped directly to the patient's home. It is important to deal with a vendor that can promptly bill the agency electronically by patient with an interface to your agency's IT system.

For managed care payers that allow billing for supplies separately, make sure that a good system is in place to properly bill for supplies used. Some supply vendors will ship the supplies needed directly to the patient. Some suppliers will directly bill the managed care company under their own contracts. This insures that the supply is appropriately billed and that the agency does not receive a charge for those supplies.

All RN field staff should maintain trunk supplies, as identified by a formulary developed by the agency based on patient usage. These supplies can be used upon admission. Upon reordering, they are charged to the patient, but delivered back to the nurse. A word of caution-- you will need to develop a policy on when rush orders may be used. These orders typically include a higher cost for express delivery. Without a policy governing use of rush orders, clinical staff may place unnecessary rush orders and the agency will see a real increase in supply costs.

In light of the recent and ongoing cuts in Medicare reimbursement levels, be honest with your supply vendors and ask for price reductions. You will be surprised by what you can achieve in this area!

Hospices are responsible for medical supplies as well as pharmacy and durable medical equipment costs. Since hospices are paid on a per diem basis, many agencies have found that contracting with suppliers of pharmacy and DME is better suited to per diem arrangements. These contracts provide for flat rates per day and usually include all supplies ordered. Per Diem contracts also allow you to align your costs in these areas with the relevant benchmarks. Be careful to review all of your bills under these arrangements since patients may be left on service for too long or billing for excluded items may also occur. There are also companies that specialize in the management of DME needs for hospice patients. They typically offer savings below your existing costs, but you should evaluate this claim carefully and include specific criteria for delivery promptness and accuracy in any contract for DME.

Hospices should also evaluate the costs associated with the delivery of items to a patient's home. It is frequently more cost effective to have these items drop shipped directly to the patient's home rather than use hospice staff to deliver these items.

Pay particular attention to the drugs usage and cost. The national median cost of drugs ($6.69 per day in 2012) incurred by hospices is likely to expand significantly in 2014 going forward, due to the December 6, 2013 CMS memorandum which announced the enforcement of Part A hospice per diem responsibility to pay for all Part D drugs given to hospice beneficiaries. Drugs used prior to hospice election that are discontinued by the hospice interdisciplinary group become beneficiary liability. Similarly, a drug will be patient liability if it is not on the hospice formulary, and the patient refuses to try the hospice formulary first. The hospice is not liable to pay for drugs that are for the treatment of a condition not related to the terminal illness. However, the standard on items and services that are not related to the terminal condition is foggy at best. It appears that the emerging standard is one where the hospice will be responsible for virtually all drugs used by the patient. Again, particular attention to drug usage is important.

5. Cell Phones, Air Cards and Power Cords:

Many agencies supply all field clinicians with cell phones and air cards to access the internet on their laptops. Access to the internet will allow field staff to transfer patient files and access email. These items constitute a large expense. Careful and constant review of the vendors in your area can produce significant savings. You should also consider testing which vendor has the strongest internet signal in your area in order to create the greatest efficiency for your laptop users. Whenever possible, agencies should select laptops with built in air cards to reduce air card losses or breakage issues. Power cords that allow laptops to recharge in a field clinician's car

enable constant battery strength to stay connected.

In negotiating your contract, be concerned about monthly charges as well as your monthly allotment of minutes and data. The value of a low monthly fee may be offset by high usage charges. To assist in reducing usage, many agencies have strict policies against personal use including downloading movies and other personal items. Be aware that most carriers charge a half a minute or some like fraction for texting. This could add up to a significant amount, which could be largely personal. In addition, please remember that texts are not HIPAA compliant. Cell phones should have password protection and the ability of the agency's office to remotely delete the entire memory of a lost phone in order to remain HIPAA complaint and protect patient related information.

Some agencies reimburse staff for business use of personal phones and for use of their home internet connections. The drive to pay per visit for clinical staff has made efficiency paramount and as a result, agency supplied phones and cards are becoming a requirement. This area requires constant and diligent negotiations in order to maintain the best prices.

C. Management of Employee Health Insurance, Workers Compensation and Insurance Costs:

Insurance and related areas are frequently large components in an agency's overall cost structure. These include health care costs, professional and general liability insurance and worker's compensation. While there may be limited opportunities to reduce some of these costs, there are some approaches agencies should consider in seeking cost reductions in these areas.

1. Employee Healthcare Cost Opportunities:

Agencies should consider the following when looking to reduce the costs of providing health care to their employees and their dependents. These could be applicable whether agencies purchase their insurance or are self-insured.

Evaluate your health insurance broker relationship

This could generate savings in multiple ways:

The first is to consider the cost of your broker in providing their services in obtaining insurance? Different brokers have different compensation arrangements, both in their direct fee structure and in the commissions paid by insurance companies directly to them. These amounts are frequently negotiable with the brokers on both types of their compensation. When the commissions paid by the insurancecompanies are reduced, the amounts charged by the insurance company are reduced accordingly. An agency may benefit by seeking a bid from several brokers.

Second, some brokers may be more effective in securing better opportunities in areas such as networks with better discounts as well as providing analysis and recommendations on benefit plan designs that may enhance employee wellness while reducing costs.

Review your health benefit plan design

It is important to understand the elements of your health plan design and its impacts on your cost. A strong broker or health insurance company can provide granular data that is usable to modify your benefit plan design to benefit both employees and the agency's cost structure. This data includes brand vs. generic pharmacy expenses, disease categories with the highest costs, etc. There are frequently elements of plan design, such as deductibles and co-payment levels that can have material positive impacts on overall costs.

There are a number of consultants with specialized knowledge that may assist with this analysis. An agency may consider using one to provide valuable technical assistance in such a highly complex topic.

One important additional consideration in plan design is the impact on recruitment and retention of key staff. Changes in benefit plan design and costs to employees may create unintended dissatisfaction and turnover.

Some of the actions agencies have taken in this area include the following:

- analysis of switching to being self-insured
- moving to another payer network for greater discounts (i.e. Blue Cross from Cigna if Blue Cross has better contracting in your market)
- increasing co-payments on high cost areas such as emergency room visits and on brand name drugs when not prescribed
- prior approval processes for expensive diagnostic studies such as CAT scans
- increasing employee portion of health care costs for employees whose spouses can be covered at their employer
- increasing employee wellness programs to reduce health care expenditures for conditions such as hypertension, smoking related illnesses
- introducing wellness programs with bonuses for healthy behaviors or loss of a bonus for bad practices
- conducting an audit of all dependents covered under your healthcare plan in order to verify the eligibility of all those listed.

2. Professional and General Liability Insurance:

Agencies should conduct the same analysis on their brokerage relationships as with health care costs. Consider paying the broker on a fixed fee rather than straight commissions, which rise with premium increases thereby creating a perverse incentive for the broker. The selected brokers should also bid their coverage aggressively with multiple providers in order to obtain the best pricing. Agencies should evaluate the levels of their coverage for risk transference versus the costs.

A key aspect of this is the amount of self insured retention versus premium costs.

Determine if your broker is really working hard for you to reduce costs. The broker should not just be rolling coverage over each renewal period with the same insurance companies. Negotiate annual fees with the broker rather than straight commissions to reward broker performance because they should not get more simply if premiums increase. This will help align their incentives with yours. Ask your broker for cost reduction ideas on your existing policies. They should pursue all active markets each year to see how competition impacts on premiums. Compare the costs of insurance under various deductibles and determine which is most cost effective at a reasonable risk level.

Programs should be in place to reduce the possibility of professional and general liability incidents that may result in losses as well as higher premium cost. Insurance providers frequently offer programs that can be utilized to support agency efforts. These programs have been found to have benefits and may be free as part of the policy. There are also loss prevention specialists that can provide specialty services as needed to reduce loss exposures.

One area to consider is the inclusion of non-owned auto under the general liability policy. This protects the agency from litigation arising from auto accidents involving field staff while traveling between visits.

Another area is the purchase of Officers and Directors Insurance, which protects the Board, its officers and management from litigation arising from their decisions or actions in running the agency.

Finally, careful consideration should be given to the purchase of cyber insurance. This coverage protects the agency from the high costs associated with the release of HIPAA protected patient data. These costs and fines associated with an accidental breach like a lost laptop computer could be very substantial.

3. Workers Compensation Insurance:

Workers compensation costs are typically areas where costs may be lowered from existing rates. There are many commonalities with the professional and general liability areas. These include receiving several pricing options from carriers and actively reducing loss amounts.

The key item in workers compensation is having an aggressive loss prevention program in place. The loss as a percentage of payroll is the most important indicator. There are risk management consultants who help agencies implement and maintain these programs. There are loss prevention specialists that are available as well. In home care and hospice, the primary areas of focus would include auto accident reduction, employee safety and employee bio-mechanics. Safety programs and an aggressive light duty return to work program are key ingredients to reducing your overall claims.

Consider the use of physical assessments of all new staff in order to insure that they can meet the defined physical requirements of their job. This assessment should also be applied to injured workers when they are ready to return to work.

D. Management of Indirect Costs:

Indirect benchmarks:

Benchmarks are a good way to isolate expenses when deciding where to focus cost savings initiatives. These are some key indirect benchmarks for freestanding home health and hospice agencies courtesy of the Simione Financial Monitor for the 2nd quarter in 2013. Expenses are the average percent of overall net revenue.

Clinical Support and Supervision. 10.6%
Executive Management 3.9%
Sales, Marketing and Intake 6.3%
Information Systems. 2.7%
Office support 2.6%
Accounting/GL/AP/PR/Billing 1.8%
HR, Recruiting, Education 1.0%

1. Occupancy:

Given the current economy and the many vacant offices, you should discuss renegotiating your lease with your landlord even if that means extending the length of the lease in order to gain concessions. Be sure to include in your negotiations charges for overhead, maintenance fees, utilities, etc. If your lease is ending soon, consider relocating or buying in addition to renewing your lease. Be aggressive in securing an initial free rent period in a new lease. Pursue subletting space, if possible, as a means of reducing lease costs. Seek to downsize your office space. Make sure that all of the medical supply storage space is still needed. Have clinicians sync computer devices via web cards in order to reduce office space needed for field staff. Use electronic storage of medical records to reduce overall space needs. Review office spaces that could be converted to a time shared space for multiple employees.

For an agency that owns a building, care must be taken to properly maintain the building and its exterior surroundings. Comprehensive bidding processes for the purchase of services will deliver the best opportunity for cost efficiencies.

2. Office supplies:

Reduce office supply costs by creating a Green Task Force to "go green". This task force does a periodic sweep of all the desks in the office to put excess office supplies back into a central supply room. This will reduce unnecessary purchases and discourage hoarding of excessive supplies that won't be used for years. An alternative to office sweeps would be to have the purchasing manager ask around for old supplies before buying new ones. Purchase Green Print computer software that forces print previews so wasted printing does not occur. Set defaults on printers and copiers to print double

sided copies and use only black ink. Utilize electronic physician's order tracking systems to reduce paper. Review the processes from intake to cash posting to reduce duplicate paperwork. Create a standard list that restricts supplies that can be ordered from the vendor to avoid expensive luxury items.

3. Administrative staffing:

Review processes for inefficiencies. Ask why things are done that way, and reduce the "because that is the way it has always been done" processes. Review all job descriptions to determine if a position is over/under staffed. Monitor FTEs compared to benchmarks. Consider consolidating departments under one level of management, for example, consider the potential mergers of Intake/Authorizations/Medical Records, Billing/Finance, or QA/PI/Case Managers.

4. 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.

5. Information Technology Systems:

Agencies must weigh the benefits of investing in new technology when looking to cut expenses. Be aware of new technologies that can improve overall efficiency of staff and improve productivity. The value of adding telemonitoring equipment was discussed earlier in Section B 1. These types of savings are not explicit and must be considered when comparing an agency's cost structure to benchmarks. Investing in new technologies can also bond customers and referral sources to that agency, especially in the use of web portals. Substantial savings from your vendors can be achieved over time if you are aggressive in negotiations. Ask for multiple year renewals with no increase in annual maintenance charges. Be aware of competitors pricing and use it in negotiations with your vendor to get concessions. When adding on new features, use that as leverage to get current contracts extended with no annual increase. In reviewing your information needs, you may find that one vendor may not be able to supply all of your data needs. As a result, consideration of an interfaced OASIS scrubber and an Outcome analyzer may be necessary.

6. Banking:

It is important to meet with the bank's assigned loan officer and develop a good relationship. Help them understand the challenges faced by the agency and how you are addressing them. Keep them advised of all problems as they occur and always be truthful. On the fee front, it pays to constantly review what you are being charged and to establish if the fees are worth the effort. For example, automatic sweeps to overnight investments may cost more than the income they generate. Instead, you should use cash flow estimates to determine if any of your cash can be invested for 90 days or more in a CD or Treasury at little or no cost. Be sure to use ACH's instead of wire transfers to reduce your fees. Mandate direct deposit for staff in order to reduce operating costs of issuing checks. Use electronic on-site check deposits to reduce trips to the bank branch. Meet with the bank's cash management experts to see if they can offer ideas to save fees. Compare different banks fee schedules in order to negotiate concessions or make changes. Keep current with new bank offers. Investigate using credit card systems to pay your vendors as many offer cash back rewards for using their services.

7. Marketing:

This expense as a percentage of revenue can vary significantly between different agencies based on size, location, and hospital affiliation. It is important to understand these factors when comparing an agency's costs to a national benchmark data. A freestanding agency in an urban area that has many competitors may have substantially higher marketing costs than a rural agency that is affiliated with the only hospital in town. It could do more harm than good to make cuts to marketing expenses without an in-depth understanding of the impact it will have on revenue. That is why it is important to monitor each marketer's effectiveness in producing admitted Medicare referrals. Consider using information systems that monitor referral source contacts by person. Incentive programs should be based on the number of admissions instead of the number of referrals. This ensures that there is in fact revenue generated by the incentive paid out. Marketing positions should only be reduced if it is known that the gross margin lost from the admissions generated is less than the cost of the position. If a cut is made, review payer mix by referral source and look to eliminate or reduce those that refer poorer payer mix patients.

E. Management of Back Office Costs:

When dealing with back office structure, you need to clearly define what you are looking at. For purposes of this writing, the back office will be addressed as the billing/collections department.

Understanding how the Billing/Collections Department work flow takes place will go a long way in helping to analyze the cost effectiveness of the department.

A few things that must be considered:

- Paper vs. Electronic Record
- Volume of Non-Medicare Claims
- Authorizations/Payer Setup

- Paper vs. Electronic Submission of Claims
- Staff Effectiveness
- Staff Training
- Effective Reporting

1. Paper vs. Electronic Record

Many agencies throughout the country are still maintaining 100% paper medical records. Some are on partial paper/partial electronic and others are headed swiftly toward a 100% electronic medical record. In any of the above scenarios, the fact remains that there are different levels of involvement that the Billing/Collections Department will have in getting the record prepared for claims transmission. In working toward controlling the cost of this department, directives must be put into place that define the exact responsibilities of each staff member in the flow of the chart from intake all the way through billing. This will vary from agency to agency, but there must be consideration of this factor when determining the cost of billings and collections. If everything is input and pre-billing audits are occurring outside the department, there will be much less cost allocated to the department than if the department is responsible for inputting all visit notes and conducting pre-billing audits, in addition to, the actual billing and collections.

2. Volume of Non-Medicare Claims

Agencies, that have a high volume of Non-Medicare (defined as NOT TRADITIONAL MEDICARE PART A), will have higher cost for the billing/collections department. Collections will be the primary reason for this increase in cost. There are many more hours of collection time in the case of Non-Medicare claims. An agency that is 85% Traditional Medicare and 15% Non-Medicare will have a billing/collections department that looks completely different than an agency that is 45% Traditional Medicare and 55% Non-Medicare. This statement is by no means an effort to support agencies moving to higher volumes of Traditional Medicare. In today's reimbursement world agencies cannot continue to make that push. However, understand that with the diversification of payers comes increased cost in this department.

3. Authorizations/Payer Setup

While this topic may be considered Revenue Protection vs. Cost Management, the cost that is incurred annually for staff members to constantly have to research, re-file claims, make numerous phone calls, etc., in pursuit of dollars that would have already been paid if appropriate authorizations had been obtained and/or payer setup information had been correct is astronomical.

Collections begin at intake. The appropriate prior authorizations, verifications, etc. must take place. Keep in mind, this statement is not referring solely to Non-Medicare payers, but to Traditional Medicare, as well. While Traditional Medicare does not require preauthorization it does need to be verified that the patient has Medicare coverage and that a Medicare Advantage Plan/HMO has not been elected by the patient. The bullet points below itemize many of the key factors in attaining appropriate information that could escalate the number of claims being paid prior to having to "collect" it.

Proper Authorizations are a must and the following are key areas of concern:

- Customer Service should be able to verify the patient has coverage and the dates covered
- Verify the ID # - most likely no longer the patient's Social Security # due to security
- Verify correct spelling of patient's name per the insurance company's records
- Does the company require 1500 or UB-04 forms?
- A fax of the authorization from the insurance company is ideal
- What are timely filing requirements?
- Confirm electronic transmission or paper claims
- Confirm address to send information if paper copies of notes/authorizations, etc. must be sent
- Many times the Authorization # is related to a specific billing code – Ask what billing codes are required?
- Just because authorization has been supplied does not mean services will be paid. Case Manager may not be aware that policy has termed…… SOLUTION: Verifications at the beginning of each month!

4. Paper vs. Electronic Submission of Claims

There are not many, if any, agencies that still submit claims to Traditional Medicare on paper, but it is shocking how many agencies are still submitting paper claims to Non-Medicare payers. The cost efficiencies that come from having payers setup for electronic submission are astronomical for some agencies, but even beyond that, the cash flow increase may be surprising. Example: an agency submitting paper claims to the state Medicaid program was receiving payments in 6 weeks from date of submission. Once the agency was setup on electronic submission of claims, the agency was receiving EFT payments in 4 days! The amount of time it was taking for the department to submit the claims on paper, the postage costs, etc. were dramatically decreased by simply contacting the payer and acquiring the information needed to obtain electronic submission rights and making it happen.

5. Staff Effectiveness

Agencies need to do a hardcore evaluation of each and every staff member and their effectiveness in the position they currently hold. This can be done through reporting, detailed timesheets, collection effort results, etc. Do you have the correct staff members in the correct positions for their abilities, knowledge and personality? Collectors are born to be collectors, collectors are not trained. They may be trained to be more effective collectors, but a non-collector cannot be made an effective collector. Collectors are the most impor-

tant position in the department, especially in the case of high Non-Medicare volume.

The first rule of maximizing collection efforts is to have a true collector at the helm. There are a few traits of a collector that cannot be ignored. If these personality traits are not evident in the "collector" then the person is most likely not a true "collector":

- Tenacious
- Determined
- Relentless
- Charming
- Hard Core
- Knowledgeable

One of the favorite terms for a true collector—**BULLDOG!**

In order for a collector to be successful, the appropriate tools must be available:

- Accurate Receivable Reports
- Access to all Contracts w/rates
- Timely Copies of EOBs & Remit
- Accurate Recording of Authorizations and Verifications in system
- Adequate time to perform duties – NOT other assignments
- Effective tracking system for follow-up work done

The other key position that cannot be ignored or casually hired is the Management of this department. Technically, the Management of ANY department is a key position! The one huge mistake that agencies often make is putting people into positions of management when the person being put in place is NOT a manager. SKILLS in the management of people have to be the TOP priority when hiring a manager! They may have years of home health and/or hospice experience, but it they do not have the skill set to be a true manager you are wasting time and MONEY by hiring them for that position!

6. Staff Tools & Training

In the discussion of appropriate tools being required, for the most part, agencies do not allow clinicians to go without what they need to do their job. Why should the billing/collections staff be any different? In many cases the collectors simply need ADEQUATE time in the day to perform the duties required of the position. Priorities being changed to other duties cause major back up and eventually the purpose of the position has been destroyed. In some agencies, the billing department has also been responsible for inputting and transmitting OASIS data to the state, which adds a whole different slant to the cost structure of the department. Staff should be allowed to perform the duties aligned with billing and collections.

Most agencies spend many dollars and many hours educating clinicians! How much money does your agency spend on educating billing and collections staff? What is the last conference or seminar or even teleconference that the agency paid to have billing and collections staff attend? Regulations continuously change! Updates and additional training are continuously needed for the Billing & Collections Department!

7. Effective Reporting

One thing that is extremely important in the life of billing and collections is sufficient reporting. Through requiring specific reporting on a daily, weekly and monthly basis, agencies can be confident in what the job billers and collectors are doing. Following are some key reports to monitor:

- Daily reporting should include providing a listing of all episodes that are ready for claims to be filed, but cannot be filed due to all of the edits not being cleared by the personnel responsible for the pre-billing audits and monitoring of physician's orders.
- For home health, weekly reporting should include reports on how many admissions and re-certifications were done in the previous week compared to how many RAPs and Final Claims that were billed. In addition, the weekly reporting should require a recap of the cash that came in from the previous week and how many RAP take backs were a part of that. Comparing the admission and re-certs to the billing puts things into sharp perspective. Directors and Administrators should be informed that billing is not occurring and why. RAPs cannot be filed until the first visit of the episode has been documented, OASIS is in the computer and the CMS 485/Plan of Care is finalized and SENT to the physician for signature. As long as the billing department is doing their job then the reasons for not getting RAPs filed is a clinical issue.
- Monthly reporting, from a collection standpoint, should include a detailing of every claim that is over a certain number of days old on the aging. Some agencies start with anything over 150 days old, which includes both Medicare and Non-Medicare payers. Eventually that goal should be a detail of anything over 90 days old. This detail will include the claim information and most importantly the last time a collection effort was made and the current collections status.
- Benchmarks to monitor: Average day in Accounts Receivable, Number of days to bill a RAP (measured from start of episode date), Number of days to bill a Final Claim (measured from end of episode date); for Medicare home health, consider a RAP receivable and an End of Episode receivable monitor, since a clean RAP is payable in 5 to 7 days and a clean EOE is payable in 14 days.

Conclusion

As members of HHFMA, we believe that this white paper provides a tremendous and powerful tool for member agencies to use to analyze and control their costs in response to the numerous challenges to their existing payment streams. This work product is the result of a great group effort. The task force established to create this paper worked very well together in an effort to capture all of the relevant ideas and concepts necessary to insure a successful cost management program. Everyone made valuable contributions in order to help us all prosper. We hope you enjoy using this valuable tool and would appreciate any additional suggestions you may have.

Appendix A

Gross Margin-Direct Cost Drivers Survey Summary

49 total responses, all calculated results are the median, excluding invalid answers.

This data sample size is not large enough yet to drill down on certain organization characteristics with the objective to draw conclusions with reasonable validity. Please complete the survey at this link if your agency has not already because this will be updated based on new responses:

https://www.surveymonkey.com/s/8KLHYVC

1. Please indicate the location of your Medicare certified home health agency

Urban 77.6% Rural 22.4%

2. In which State(s) do you operate?

Alabama	1.4%	Kansas	2.8%	Ohio	15.3%
Alaska	1.4%	Kentucky	1.4%	Oklahoma	1.4%
Arizona	2.8%	Maine	1.4%	Oregon	1.4%
Arkansas	1.4%	Maryland	4.2%	Pennsylvania	4.2%
California	4.2%	Massachusetts	2.8%	Rhode Island	2.8%
Colorado	2.8%	Michigan	4.2%	South Carolina	4.2%
Connecticut	2.8%	Mississippi	1.4%	Tennessee	1.4%
Florida	1.4%	Missouri	4.2%	Texas	4.2%
Georgia	2.8%	Montana	1.4%	Virginia	1.4%
Hawaii	1.4%	New Jersey	1.4%	Washington	2.8%
Illinois	4.2%	New Mexico	1.4%	West Virginia	1.4%
Indiana	2.8%	North Carolina	2.8%	Wisconsin	1.4%

3. What is your gross margin as a percentage of revenue (net patient revenues less salaries, benefits, payroll tax, workers comp, contract services, mileage/transportation, and supplies for direct care staff?

National 40%

Rural 27.5%

Urban 41%

4. What is your Medicare home health service revenue as a percentage of Total Revenue?

	Count	Percent
less than 15%	3	6.1%
15-30%	1	2.0%
31-50%	8	16.3%
51-75%	32	65.3%
Greater than 75%	5	10.2%
Total	49	

5. What is your all payer net patient revenue per direct care FTE?

$129k

6. What is your bad debt as a percentage of net patient revenue?

1.0%

7. What is the primary method of compensation for your Direct Staff Nursing (RN, LPN, LVN)?

	Count	Percent
Per visit	20	40.8%
Per hour	17	34.7%
Salary	11	22.4%
Other	1	2.0%

8. What is the primary method of compensation for your Direct Staff Therapy including therapy assistants?

	Count	Percent
Per visit	25	51.0%
Per hour	9	18.4%
Salary	13	24.5%
Other	3	6.1%

9. What is the primary method of compensation for your Direct Staff Medical Social Services?

	Count	Percent
Per visit	16	33.3%
Per hour	14	29.2%
Salary	17	35.4%
Other	1	2.1%

10. What is the primary method of compensation for your Direct Staff Home Health Aide?

	Count	Percent
Per visit	12	24.5%
Per hour	36	73.5%
Salary	1	2.0%
Other	0	0.0%

11. What is your average per discipline number of visits per Medicare episode excluding LUPAs?

Nursing 8.5

Physical Therapy. 4.5

Speech-Language Pathology . . . 0.2

Occupational Therapy 1.2

Medical Social Services. 0.2

Home Health Aide 1.9

12. What is the total number of Medicare episodes?

1,300 annual

13. What is the percentage of LUPA Medicare opening episodes?

11.0%

14. What types of clinical service contact do you provide your patients?

	Count	Percent
Visits only	14	28.6%
Visit and telephonic	4	8.2%
Visit, telephonic and tele-monitoring	21	42.9%
Visit and tele-monitoring	10	20.4%

15. How do you measure nursing productivity?

	Count	Percent
Per visit per day	29	60.4%
Point system	13	27.1%
other	1	2.1%
Other (please specify)	5	10.4%

16. What is your staffing ratio for the following?

Manager to staff nurse . . . . . About 1 to 9

Patients to Nurse (Nurse caseload) . . . . . About 23

Patients per manager (Manager caseload) . . . About 180

17. What does your service delivery team look like?

	Count	Percent
Integrated delivery team: Nurse, Therapists, Home Health Aide, MSS, Care Manager	42	85.7%
Siloed approach: Nurse separate from other disciplines	5	10.2%
Other (please specify)	2	4.1%