Medicare Payment Rate Rebasing - What you know and what you should know!

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Owner and President of Home Health Strategic Management

Objectives

• What will rebasing look like in the coming years?
• The impact on agencies beginning in 2014.
• Projected effects on agencies in 2015 and beyond.
• Strategies to prepare for future rate reductions.
This is probably how we all feel……

Medicare Rate Rebasing

• Here is what we know… for now!!
  → FY 2016 (3rd year of rebasing cuts)
    • Rate reduction of $80.95
    • Market Basket Index estimated 2.5%
    • Productivity Negative Adjustment .5%
    • Sequestration 2%
  → FY 2017
    • Same as FY 2016
Medicare Rate Rebasing

• Here is what we know… for now!!!
  → FY 2018
    • Market Basket Index capped at 1%
    • 2% Sequestration
  → FY 2019 and beyond
    • Market Basket Index 2%
    • Productivity Negative Adjustment .5%
    • 2% Sequestration

The Impact in 2014

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
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<tbody>
<tr>
<td>Gross Margin</td>
<td>41.6%</td>
<td>41.9%</td>
</tr>
<tr>
<td>Net Margin</td>
<td>2.1%</td>
<td>5.1%</td>
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### The Impact in 2014

<table>
<thead>
<tr>
<th>Gross Margin:</th>
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<th>2014</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>50.0%</td>
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<tr>
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<td>42.8%</td>
<td>38.8%</td>
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<tr>
<td>Medicaid</td>
<td>12.8%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Commercial/Other</td>
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<table>
<thead>
<tr>
<th>Net Margin:</th>
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<th>2014</th>
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<tbody>
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<td>15.5%</td>
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<td>Medicare Advantage</td>
<td>6.0%</td>
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<tr>
<td>Medicaid</td>
<td>-40.5%</td>
<td>-31.5%</td>
</tr>
<tr>
<td>Commercial/Other</td>
<td>-26.8%</td>
<td>-23.3%</td>
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### The Impact in 2014

<table>
<thead>
<tr>
<th>Payor Mix (based on patients):</th>
<th>2013</th>
<th>2014</th>
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<tbody>
<tr>
<td>Medicare</td>
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<td>67.0%</td>
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<tr>
<td>Medicare Advantage</td>
<td>9.0%</td>
<td>13.0%</td>
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<tr>
<td>Medicaid</td>
<td>10.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Commercial/Other</td>
<td>16.0%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>
Projected Impact

- Assumptions
  - Payer mix unchanged
  - No volume or case mix change
  - 3% Salary increase
  - 6.6% Taxes and Benefits increase
  - No other cost increase

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Margin</td>
<td>39.7%</td>
<td>37.4%</td>
<td>35.8%</td>
<td>34.7%</td>
</tr>
<tr>
<td>Net Margin</td>
<td>1.0%</td>
<td>-3.2%</td>
<td>-6.2%</td>
<td>-8.5%</td>
</tr>
</tbody>
</table>
Where do I start?

- All Financial Cost Data should be easily accessible and broken out.
  - General Ledger
  - Payroll Software
- Identify Critical Financial KPI Indicators:
  - Keep it Simple
  - Focus on Revenue & Cost Drivers
- Automate your reports:
  - Excel
  - Reporting software’s
  - Outside vendors
- Compare to Benchmark Data

Work as a Team

- Everyone should be involved.
  - Executive Management
  - Clinical Directors
  - Financial Directors
- Need buy in from everyone when it comes to cost review.
  - Analyze what would happen based on industry changes if all cost remained the same.
  - Determine if something must be done!
Benchmark Comparisons

• Research benchmark sources available
  → Understand data elements and calculations
    • Need to ensure apples to apples comparison.
  → Who are you comparing to?
    • Geography, Payer Mix, Profit Status, Agency Type, Revenue Size.
  → Remember benchmarks are the median
    • Always strive to be in the top 10 to 20%.

Gross Margin

• Gross Margin is where you need to start in any financial analysis.
• Everyone’s performance has an affect on Gross Margin.
• Direct revenue minus direct expenses
  → Direct Revenue - All Net Payer Revenue.
  → Direct Expenses - Salaries, payroll taxes, workers compensation, benefits, contract, mileage and supply costs from direct patient care.
Where to look next?

- Revenue
  - Admissions
  - Payer Mix
  - Case Weight Mix
- Costs
  - Payment Models
  - Staffing
  - Productivity
  - Supplies

Costs

- Review your payment models
  - Pay Per Visit
  - Salary
  - Hourly
  - Contract Services
- Productivity
  - Visits per day
- Telemonitoring
- Benefit Plans
- Supply and Mileage Costs
Caution

- Cutting direct staff salary and benefits can result in:
  - High employee turnover
  - Cutting corners in patient care
  - Overworked staff
- All will have a negative impact on productivity and quality.

Direct Cost Per Visit Home Health

<table>
<thead>
<tr>
<th>Discipline</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>$93</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$94</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$97</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>$111</td>
</tr>
<tr>
<td>Medical Social Worker</td>
<td>$133</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>$40</td>
</tr>
<tr>
<td>Supplies</td>
<td>$2.65</td>
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</table>
### Productivity Home Health Visits Per Day

<table>
<thead>
<tr>
<th>Discipline</th>
<th>National</th>
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<tbody>
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<td>Skilled Nursing</td>
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<tr>
<td>Physical Therapy</td>
<td>4.8</td>
</tr>
<tr>
<td>Occupational Therapy</td>
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</tr>
<tr>
<td>Speech Therapy</td>
<td>4.9</td>
</tr>
<tr>
<td>Medical Social Worker</td>
<td>2.4</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>4.6</td>
</tr>
</tbody>
</table>

### Visits by Payer

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Medicare</th>
<th>Medicare Advantage</th>
<th>Medicaid</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>5.9</td>
<td>5.8</td>
<td>5.1</td>
<td>4.9</td>
</tr>
<tr>
<td>Therapy</td>
<td>5.0</td>
<td>4.3</td>
<td>2.1</td>
<td>3.5</td>
</tr>
<tr>
<td>Medical Social Worker</td>
<td>.1</td>
<td>.1</td>
<td>.1</td>
<td>.1</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>1.0</td>
<td>.6</td>
<td>.5</td>
<td>.1</td>
</tr>
</tbody>
</table>
Productivity

- Is there enough support to facilitate productivity?
  → Do the teams have adequate clerical support to minimize clinician time spent on non-clinical tasks?
  → Are clinical support resources available to assist the team with problems in the field?
  → Do clinicians have reliable communication tools such as cell phones, pagers, or email?
  → Do you use telehealth?
  → Are there other technologies available to increase productivity?
  → Are clinicians properly utilizing technology during the visit?
  → Is documentation done in the patient’s home or at the clinicians home?

Productivity (cont’d)

- What are the barriers to meeting productivity?
  → Average miles per visit
  → Time available to visit
  → Patient acuity
  → Supply ordering
  → Software or hardware issues
  → Duplication of paperwork
Productivity (cont’d)

• What are the pitfalls of increasing productivity?
  → Incentives which reward the number of visits without considering outcomes.
  → Cutting corners on patient care.
  → Impact on patient or consumer satisfaction.

Non Employee Costs

• Medical Supplies
  → Send out an RFP to determine if you are getting the best deal.
  → Review your formularies.
• Look at transportation costs
  → Are you reimbursing at the IRS allowable or less than that?
  → Do you have an automated way of tracking mileage for accurate recording?
  → Do you randomly audit mileage?
  → Will leasing cars result in lower costs?
How To Identify Areas Of Improvement

• Need information to make sound business decisions.
• Information should be simple and easy to understand.
• Detail analysis is for the finance department.

Strategies to Make Change Gross Margin

• What do you notice about gross margin?
  → As there continues to be rate pressure, margins will decline if we operate “as we always have”.
• Look at the correlation of revenue to gross payroll.
  → Gross payroll/revenue.
  → Is the percentage increasing?
### Strategies to Make Change Gross Margin

- We saw an increasing percentage so what did we do?
  - Case Weight
  - Adjustments
  - Productivity
  - Benefits
  - Scheduling

### Strategies to Make Change Gross Margin

- Productivity
  - Once revenue is addressed time to look at expenses.
  - Don’t be afraid of the productivity issue.
  - Common Pitfalls:
    - Not getting buy in from managers.
    - Allowing the staff to dictate the weighting (if you chose to weight).
    - Not being consistent in monitoring.
    - Ignoring caseloads.
Strategies to Make Change Gross Margin

• Productivity - The Calculation
  →Visits/(hours worked/8)
  • Assuming 8 hour days.
  • Excludes vacation, sick and PTO time.
  • Includes Overtime.
  • Assumes no weighting.

<table>
<thead>
<tr>
<th>Full Time</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
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</thead>
<tbody>
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<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>B</td>
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<td>4.2</td>
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<td>C</td>
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<td>4.3</td>
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<td>D</td>
<td>1.5</td>
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<td>2.7</td>
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<tr>
<td>E</td>
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<td>2.0</td>
<td>4.8</td>
</tr>
<tr>
<td>F</td>
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<td>I</td>
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<td>3.4</td>
<td>3.9</td>
<td>3.8</td>
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<tr>
<td>J</td>
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<td>2.2</td>
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<tr>
<td>Total</td>
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<td>2.9</td>
<td>3.1</td>
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Strategies to Make Change Gross Margin

• What does it cost?

<table>
<thead>
<tr>
<th>Employee</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2.1</td>
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<td>1.8</td>
<td>1.8</td>
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<tr>
<td>B</td>
<td>1.3</td>
<td>0.8</td>
<td>0.1</td>
<td>1.5</td>
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<tr>
<td>C</td>
<td>2.1</td>
<td>0.5</td>
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<td>0.7</td>
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<tr>
<td>D</td>
<td>3.5</td>
<td>2.1</td>
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<td>G</td>
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<td>1.4</td>
<td>1.0</td>
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<td>H</td>
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<td>1.6</td>
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<td>1.2</td>
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<td>J</td>
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<td>2.8</td>
<td>2.9</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>2.1</strong></td>
<td><strong>1.9</strong></td>
<td><strong>1.6</strong></td>
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</tbody>
</table>

Strategies to Make Change Gross Margin

• What does it cost?

<table>
<thead>
<tr>
<th>Employee</th>
<th>Week 1</th>
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<td><strong>Total</strong></td>
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<td><strong>$8,694</strong></td>
<td><strong>$7,980</strong></td>
<td><strong>$6,552</strong></td>
<td><strong>$383,040</strong></td>
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</tbody>
</table>

*assumes $42/visit
**assumes 48 weeks available to work
Strategies to Make Change Gross Margin

• Productivity Roadblocks
  → No accounting for overtime.
  → The “what if” factor.
  → Managers not sending the correct message.
  → No enforcement of the standard.

• Scheduling
  → Effects both productivity and mileage expense.
  → Do you automate your scheduling?
  → Does the driving pattern make sense?
  → What is the ROI on leasing cars vs. paying mileage in the most efficient scheduling model?
Strategies to Make Change Gross Margin

• Review
  → Direct Payroll
    • Productivity/Overtime/Caseloads
  → Payroll Taxes and Benefits
    • Retirement plans/health insurance increase
  → Travel
    • Scheduling/lease vs. pay mileage

Net Margin

• Management/Finance Responsibility
  → Are you staffed properly based on projected patient volume and payer mix?
  → Have you reviewed your non employee costs?
  → Are your operations and reporting automated?
  → Where are their strengths and weaknesses with in your documentation and reporting processes?
  → Breaking down you cost by department and type.
Net Margin

- Must look at the whole picture when reviewing indirect costs.
  → The cost compared to the benchmark
  → The performance of the department
  → The affect on incoming revenue
  → Staffing of the organization (overworked staff = cash flow and compliance issues)
  → The future of the industry
    - What are partners looking for?
    - What roles/responsibilities will be more on the executive team?
    - What will be centralized?

Back Office Cost

- When reviewing and benchmarking back office costs remember to consider:
  → Paper vs. Electronic Record
  → Volume of Non-Medicare Claims
  → Authorizations/Payer Setup
  → Paper vs. Electronic Submission of Claims
  → Staff Effectiveness
  → Staff Training
  → Effective Reporting
  → Outsourcing options
Marketing Costs

- National - 2.16%
- Top Performers - 3.83%
- Hold Marketers accountable for admission NOT referrals.
- Educate your marketing team on the importance of Medicare admissions compared to Managed Care/Medicaid.
- Review Admissions per Marketing FTE
  - → 30 Admission per Month per Marketing FTE
  - → 60 Admission per Month per Marketing FTE - Best Practice
  - → 80% Referral to Admission Conversion Ratio
- Review your Advertising Campaigns - do they generate business?
- Review any Marketing cuts and their impact on revenue.
- Who will be your future Marketers - CEO, President, Owners.

Intake Department

- Benchmark - 2.30%.
- Collections start with Intake!
- Review amount of denied authorization and reauthorizations.
- Ensure proper authorization process is in place for non Medicare patients.
Billing Department

- Billing Department - 1.16%
- Accounting Department - .85%
  - Review days sales outstanding.
    - Overall - 63 days.
    - Best Practice - 35 days.
  - Review bad debt as a % of revenue (.91%).
  - Review days from SOC to RAP and EOE to final claim.
    - Days to RAP - 8 Days - Best Practice.
    - Days to Final - 12 Days - Best Practice.
  - Ensure all claims are sent electronically (non-Medicare as well).
  - Evaluate staff - do you have the right person for the job?
  - No other task - just collections.

Clinical Supervision/Support/QI

- Benchmark - 9.2% of Total Revenue
  - Supervisors must hold clinicians accountable to productivity standards.
  - Coordinators must schedule staff to be efficient to achieve productivity measures.
  - Support staff must assist with any field issues.
  - QI must ensure that clinicians and staff are compliant with all rules and regulations.
  - Outsource coding function?
  - Maximize case weight mix.
Information Technology

• Home Health
  → National - 1.58%

<table>
<thead>
<tr>
<th>Total IT Cost as a % of Revenue</th>
<th>Average Gross Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>5% or More</td>
<td>31%</td>
</tr>
<tr>
<td>2.5% to 5%</td>
<td>39%</td>
</tr>
<tr>
<td>1.0 to 2.5%</td>
<td>46%</td>
</tr>
<tr>
<td>Less than 1%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Information Technology

• Educate and train your clinicians and back office staff on how to best use the EMR system to create efficiencies.
• Outsource hardware and server support.
• Research new technology that can improve efficiencies:
  → Patient Portals
  → Telehealth
  → New devices/Applications
### Other Staffing Costs

- Executive Management - 3.30%
- Medical Records - .59%
- HR/Education/Recruitment - 1.02%
- Development & Fundraising .44%
- Other Office Support - 2.75%
- Home Office - 10.20% (Hospital, Home Office or Management Allocation)

### Non Employee Costs

- Space Occupancy - 1.96%
  - Rent or Own Space?
  - Mobile work staff.
  - Utilities & Maintenance Fees.
  - Renegotiate interest rates.
- Legal/Audit/Professional Fees - .71%
### Non Employee Costs

- Liability Insurance - .39%
- Interest Expense - .20%
- Bad Debt - .93%
- Equipment Purchase/Lease/Repairs - .40%
- All Other Admin - 2.4%

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**Payment Rebasing:**
What you need to know to control Case-Mix today & tomorrow

A. Cisneros – HHFMA
Arnie Cisneros

• 30 year Home Health rehab clinician
• 30 year Home Health contract Provider
• Home Health Strategic Management (2004)
• Hospital-2-Home Strategic Management (2014)
• Pioneer ACO (x3) — Post — Acute Strategist
• Model 2 BPCI Award — DMC — DRG 469/470
• JUMP = Joint Utilization Management Program

RATIONALE FOR ADOPTING PROGRESSIVE HH CASE-MIX INDEX MANAGEMENT STRATEGY
Rationale for HH CMI Strategy

• Rebasing Changes/Industry Changes
• Decreased HH Margins will continue
• HH Evolution limits legacy practices
• ACA changes to care landscape ARRIVE!
• Readmission Focus limits care volumes
• Alternative Payment Models 2018 (90%)
• Episodic Care limits Post-Acute autonomy
• Absence of Volume increases CMI value

Rationale for HH CMI Strategy

• Clinical Content dictates CMI
• Successful CMI strategy = Clinical Focus
• Clinical Concerns - OASIS, Care Volumes
• Not all clinicians or Programs are equal
• Nursing/Therapy Control/Mgmt required
• New Era – Case-Mix - sign of quality care
HOME HEALTH CASE-MIX INDEX REBASING: REALITIES & CONCERNS

Case-Mix Realities & Concerns

• CMI creates ID/Payslip of Patient Program
• 2014 Rebasing reduces CMI over 3 yrs
• Yearly reductions to continue thru 2017
• Case-Mix – OASIS, Coding, Rehab
• Utilization Review (UR) controls Case-Mix
• UR - CMI mgmt care standard outside HH
• HH UR = Progressive CMI Management
Case-Mix Realities & Concerns

- Case-Mix – Two sided coin – clinical/fiscal
- Clinical Content dictates CMI
- Successful CMI strategy = Clinical Focus
- Clinical Concerns - OASIS, Care Volumes
- Not all clinicians or Programs are equal
- Nursing/Therapy Control/Mgmt required
- New Era – Case-Mix - sign of quality care

HH Case-Mix Legacy

- HH CMI Initiated 1999 PPS Introduction
- 1999 Average HH Case-Mix 1.0
- Average (mean) acuity level at that time
- Post-Acute Patient Acuity vs MD Referral
- 1999 HH (65/35 Post-Acute)
- Current HH population (65% MD Referral)
- UR changes - >50% Post-Acute Caseload
- HH agency cant change to UR model
HISTORY OF UTILIZATION REVIEW IN HEALTH CARE

Utilization Review

Creates episode expectations and specific care plans for programming based on QA identified clinical concerns or deficits; manage and share those expectations with front line clinical staff prior to care initiation.
Hx of Utilization Review

- Effects on Providers across Care Continuum
- Acute Care DRG History – 77%
- In-patient Rehab Care - >50%
- Sub-Acute Rehab – SNF - > 50%
- Home Health - ??ACOs/Bundles/Value-based??
- Patients/Care Needs/Community Rx - constants
- 1984 - No one predicted < 4 day hospital LOS

CMI Management Outside of HH

- UR Case-Mix mgmt - healthcare standard
- Acute Care – DRG Management (UR)
- IRF – Care/Rehab control - 3 hrs (UR)
- SNF – MDS (Volume/Freq/Acuity) (UR)
- HH – lacks comparable control (Care staff)
- Case-Mix will define HH of tomorrow
- Case-Mix currently a front-line staff issue
UTILIZATION REVIEW IN HOME HEALTH

Utilization Review in Home Health

The development and delivery of Home Health services created from a Utilization Review, PPS - compliant perspective. Patient centered, case managed care; modified in an ongoing manner for patient response to treatment. UR-Managed HH produces levels of clinical/fiscal outcomes not regularly seen in homecare as it creates the episodic programs of the future.
UR in Home Health Philosophy

• Assure Combined Clinical/Fiscal PPS Programs
• Manage PPS Home Health model Intrinsics
• UR Admission Profile/Global Programming
• Control Nursing Volumes – Therapy Volumes
• Manage your clinicians & patients - in episode
• Abandon Clinician-Managed Care Beliefs
• Create a “Discharge for Outcomes” culture

CASE MIX INDEX
FACTS FOR CREATING FISCAL/CLINICAL IMPROVEMENTS IN HOME HEALTH
CMI Facts for Home Health

- National OASIS accuracy level – basis for CMI
- Nursing Accuracy – Appropriate Clinical Volume
- Rehab Accuracy – “F” /Clinical Volume/”S”
- UR HH = the EXACT OPPOSITE of HH legacy
- ALL Agencies struggle in these areas
- Case-Mix irrelevant to clinical staff members
- Intrinsic Change can’t keep up w Industry needs

CASE MIX INDEX ELEMENTS AND THE BASIS FOR FISCAL & CLINICAL CHANGE IN HOME HEALTH
HH Utilization Review CMI Elements

- OASIS Real-time Management
- Nursing Volumes reflect deficits/managed care
- PPS-compliant, global rehab programming
- Collaborative care production
- Post-Acute care planning vs 60-day cert
- Safety – Based Rehab Frequencies — Obj POC
- In-Episode clin management - response to care

CASE-MIX RESULTS FROM UR-BASED CARE PRODUCTION
HH Utilization Review CMI Elements

Gross CMI - UR Increase
36%

Gross HHRG - UR Increase
41%

HH Average UR CMI
HH Average UR HHRG

Utilization Review in Home Health (How it Works)
Weighted UR Home Health Episode

Utilization Review in Home Health

- Intake Management
- OASIS Accuracy / Utilization Review Control
- OASIS QA Real — Time Management
- Proportional Care Plan Production
- Management of Nursing/Rehab Volumes
- Safety — Based Clinical Frequencies
- Provider — Managed Scheduling/Productivity
Utilization Review in Home Health

- Frequency/Duration Control Nursing/Rehab
- Coding Accuracy
- Billing Performance
- IT management for Clinical Control
- Optimization (not Maximization) of PPS model
- Discharge for Outcomes
- Changing legacy of clinician – centered care

DOES YOUR AGENCY STILL ALLOW FRONT-LINE STAFF WRITE THEIR OWN PROGRAM ORDERS?
WHO IS ASSURING SKILLED AND CONTEMPORARY CARE CONTENT IN YOUR PROGRAMS?

CAN YOU MANAGE TO IMPROVE YOUR CARE?
Simione™ Healthcare Consultants provides solutions for your core home care and hospice challenges—organizational, financial, sales & marketing, technology, and mergers & acquisitions. Over 1000 organizations use our practical insight and tools to reduce costs, mitigate risk and improve efficiencies to steward the way they conduct business.

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