Medicaid Pediatric PDN: Meeting Patient Needs Within Budget

Bob LeBeau
Managing Partner
Oakmark Advisors, LLC
Tampa, FL

Karen A. McKinney, MSN, RN
President
Pediatric Special Care
Southfield, Michigan

Lisa Fowler
Division Director, Minnesota
BAYADA Pediatrics, Burlington, NJ

Pediatric PDN Financial Benchmarks
Controlling the Controllable
Managing the Rest

Bob LeBeau
Managing Partner
Oakmark Advisors LLC
Tampa, Florida
FINANCIAL BENCHMARKING IN PRIVATE DUTY NURSING
OBSERVATIONS AND OPPORTUNITIES FROM A M&A PERSPECTIVE

Sales Revenue

COGS

Operating Expenses

Net Income From Operations

Medicaid Pediatric PDN: Meeting Patient Needs within Budget
## PDN Frequent Adjustments to Revenue

- Timely Filing
- Overlapping hours
- Authorizations Exceeded
- Authorizations not Obtained
- Orders not Received timely
PDN Revenue Cycle Management

• Personnel costs for claims verification
• Review of narrative notes/flow-sheets for compliance with POC and substantiation of medical necessity
• Unique State/Payer requirements for hours per day vs per week vs per month
• Use of EVV/Telephony to automate confirmations of shift times
• MD/Case Management portals to facilitate re-authorizations and timely orders
• Automation of cash application to patient accounts and claim resubmissions for short pays

Current Challenges to Proper Reimbursement

• Dual Eligibility demonstration projects
• Trends limiting RN use
• LPN vs RN utilization monitoring
• SNF/Subacute cost comparisons
• Payers using incorrect labor factors for LPNs and RNs
• No industry advocacy – no perception of provider gaps
• No industry quality outcomes
• No industry benchmarks for preventable hospitalization savings
Other Current Challenges to Proper Reimbursement

- Missed shifts - a medical and fiscal liability
- Qualified family member utilization
- Technology requirements and assessment/intervention standards
- Lack of payer awareness of unreimbursed expenses relating to:

  Accreditation
  Onboarding including Competency Testing
  Equipment Training
  Pre-Admission Support
  Family Training and Education
  Clinical Supervision/Care Coordination
  Clinical Preceptors/Mentoring

<table>
<thead>
<tr>
<th>PDN COGS</th>
<th>Typical Benchmark Range</th>
<th>Delta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Labor</td>
<td>55% to 60% of Revs</td>
<td>Rising due to Acute hospital wages</td>
</tr>
<tr>
<td>Overtime</td>
<td>3% to 10% of DL &lt;3% goal</td>
<td>Offset mediated by onboarding costs</td>
</tr>
<tr>
<td>Nurse Mileage</td>
<td>&lt;1%</td>
<td></td>
</tr>
<tr>
<td>Workers Comp</td>
<td>2% to 3%</td>
<td></td>
</tr>
<tr>
<td>FICA/SUTA/FUTA</td>
<td>7.65% plus 1.5% to 3%</td>
<td></td>
</tr>
<tr>
<td>G/P Liability</td>
<td>.5% to 1%</td>
<td></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>&lt;.1%</td>
<td>Non-billable vs. billable</td>
</tr>
<tr>
<td>PDN COGS</td>
<td>Typical Benchmark Range</td>
<td>Delta</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Medical Waste</td>
<td>&lt;.1%</td>
<td></td>
</tr>
<tr>
<td>Contracted Services</td>
<td>0% to 15%</td>
<td>SN vs. PT/OT</td>
</tr>
<tr>
<td><strong>Nurse Medical</strong></td>
<td>0% to 3%</td>
<td></td>
</tr>
<tr>
<td><strong>Nurse Dental</strong></td>
<td>0% to 1%</td>
<td></td>
</tr>
<tr>
<td><strong>Nurse Vision</strong></td>
<td>0% to 3%</td>
<td>+ 0-5% with mandate</td>
</tr>
</tbody>
</table>

These COGS typically add 16% to 18% to the direct labor costs of your gross field staff labor.

These expenses are not incurred by independent contractors that in many states are participating in PDN service delivery often at the same reimbursement a licensed agency receives.
<table>
<thead>
<tr>
<th>PDN Operating Expenses (OPEX)</th>
<th>Typical Benchmark Range</th>
<th>Delta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Salaries/Wages</td>
<td>12% to 20% of Revs</td>
<td></td>
</tr>
<tr>
<td>Internal “Burden”</td>
<td>15% to 20% of Int. Salaries and Wages</td>
<td></td>
</tr>
<tr>
<td>Rent/Lease Expenses</td>
<td>1% to 2%</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Supplies</td>
<td>&lt; 1%</td>
<td></td>
</tr>
<tr>
<td>Advertising/Recruiting Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation Expense</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medicaid Pediatric PDN: Meeting Patient Needs within Budget

<table>
<thead>
<tr>
<th>PDN Operating Expenses (OPEX)</th>
<th>Typical Benchmark Range</th>
<th>Delta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Software</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Payroll Services</td>
<td>&lt; .5%</td>
<td></td>
</tr>
<tr>
<td>Bank Charges/Interest Expense</td>
<td>&lt; .5%</td>
<td></td>
</tr>
<tr>
<td>Taxes</td>
<td>&lt; .5%</td>
<td></td>
</tr>
<tr>
<td>Education and training</td>
<td>.25% to 1%</td>
<td></td>
</tr>
<tr>
<td>Auto Expenses/Travel</td>
<td>.5% to 1%</td>
<td></td>
</tr>
<tr>
<td>Consulting/Accounting/Legal</td>
<td>.5% to 2%</td>
<td></td>
</tr>
</tbody>
</table>

Medicaid Pediatric PDN: Meeting Patient Needs within Budget
Consolidated OP EX

- Typically between 18% and 25% of Revenues
- Agencies should be able to target 20% OP EX factor once established
- Some items are fixed expenses while others are variable
- These variable expense items are opportunities for efficiency planning

<table>
<thead>
<tr>
<th>PDN Operating Expenses (OPEX)</th>
<th>Typical Benchmark Range</th>
<th>Delta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensing/Accreditation</td>
<td>&lt;1%</td>
<td></td>
</tr>
<tr>
<td>Meals and Entertainment</td>
<td>&lt;1%</td>
<td>Internal vs External</td>
</tr>
<tr>
<td>Printing/Forms</td>
<td>&lt;.5%</td>
<td></td>
</tr>
<tr>
<td>Dues and Subscriptions</td>
<td>&lt;.5%</td>
<td></td>
</tr>
<tr>
<td>Background checks/Screenings</td>
<td>&lt;.5%</td>
<td></td>
</tr>
</tbody>
</table>
Ranges from a M&A perspective

- Gross Profit: 18% to 42%
- Net Income from Operations: 2% to 21%
- Net Income after write-offs: -5% to 20.5%

Hallmarks of Higher Performing PDN Providers

- Defined Performance Indicators for such factors as case level DL/OT/Missed Shifts/Unplanned hospitalizations
- Efficient use of Internal FTEs with activity documentation and emphasis on Per-Diems in the field
- Medicaid MCO contracting above Medicaid FFS rates
- Cohesive relationships and support between Clinical and Operational team members
- Aligned goals for employees
- Low turnover of branch level staff
- Willingness to change
Putting the Pieces Together

• Efficient, quality focused providers of PDN services have demonstrated the following financial performance milestones:
  • NI of 8% to 14%
  • Exit point transactional values of 60% to 80% of PDN revenues equating to 6x-7x EBITDA

Sample

• $3M revenue PDN HHA
• Census of 25 PDN patients
• GP of 30% (with DL of 60%)
• OP EX of 20%
• NI of 10%
• Bad Debt expense of 1%
• EBITDA of $305,000
• Transactional valuation of 6X = $1,830,000 or 61% of revenues
### PDN Closing Observations: Keep A Vision Toward the Future

- Fragmentation with lower competition profile
- Barriers to entry /risk profile
- Increasing sector interest as a diversity play to offset Medicare centric models
- Favorable support from PPACA Medicaid expansion and ACO/Payer risk bundling

---

### PDN Closing Observations

- Short-term pricing pressure will lead to long-term support
- Providers will need to be willing to share risk
- Providers will be willing to share risk with data and incentives
- Technology will be the key to both operational efficiencies/NI as well as the basis for new revenue growth
- Opportunities for PDN to serve as base for new revenue streams in Adult PDN, HME, Enteral Nutrition, Respiratory Support, School Nursing
- Continued opportunity to provide acute level of in-home care in the best clinical and psychosocial environment for the benefit of the children and families we serve
How a Private Duty Nursing Company Makes it Effective

Karen A. McKinney, MSN, RN
President
Pediatric Special Care
Southfield, Michigan

“If it were easy, everyone would be doing it”
Personnel

• Office Staff
  - Minimal number
  - Cross train
  - Agency core beliefs

• Field Staff
  - Hourly rate must be profitable
  - Agency orientation, vent training and patient orientation
  - Overtime must be managed

Insurances

• Workers Comp

• Unemployment
Risk Management

- Case Selection
- Staff Safety
- Clinical Risks

Alternative Services

- Sick Child Care
- Extended Care Facilities
- Infusion
- DME
DME Services

- A different but similar pediatric service
- Not beds, walkers, or canes but vents, pulse ox’s and apnea monitors

“Confronting Uncertainty
Courage Required”

Lisa Fowler
Division Director, Minnesota
BAYADA Pediatrics, Burlington, NJ
Patient Protection and Affordable Care Act (PPACA) known as “Obamacare”

Why?
• Improve population health
• Decrease fragmentation & improve patient care outcomes
• Current system is unsustainable

How?
• Value-based purchasing
• Evidence-based practice
• Medicaid expansion
• Exchanges
• Individual/employer mandates

The Problem

Our health care system is the most costly in the world but ranks 37th in population health.

The Solution?

Value-based purchasing = Access + Quality Cost
What does this Mean for Pediatric Home Care: The Good News and The Bad News

The bad news...
Cost containment pressures will NOT go away.

The good news...
Pediatric PDN home care is part of the solution. We extend access and offer high quality, cost-effective care for complex children.

The savings opportunity may be in adult care but pediatrics is along for the ride!

US Health Care = $2.7 Trillion*

$900 Billion in Medicare and Medicaid
$366 Billion Medicaid on adults and children
$79 Billion in Medicaid on children
$32 Billion in Medicaid on children with medical complexity

*Source: Children’s Hospital Association
Children with Medical Complexity

Although no standard definition exists for medical complexity, 4 cardinal domains characterize CMC/CCC*, as follows:

1. Chronic severe health conditions
2. Substantial health service needs
3. Major functional limitations
4. High health resource utilization

CMC = Children with Medical Complexity
CCC = Children with Chronic Complex Conditions

*Source: CHA Special Report: The Landscape of Medical Care for Children with Medical Complexity, Berry et al, June 2013

Emerging Delivery Models for Complex Pediatrics

Emerging Models

- Providers as payers
- Medical homes/care coordination
- Pediatric accountable care networks
- Other incentive-based contract models
- CHA proposal to Congress
Emerging Payment Models for Value-based Purchasing

Sam Ho, Chief Clinical Officer at UnitedHealthcare

"UnitedHealthcare states it will ramp-up value-based contracts from 1-2% currently to 50-70% in 2015.

According to Sam Ho, Chief Clinical Officer at UnitedHealthcare, This is not just an exercise or pilot, [this] represents a significant change in the architecture of compensation models to doctors and hospitals."


Where does pediatric home care fit?
What do all payers have in common?
Alignment of higher quality and lower cost.

What are the implications/opportunities for pediatric home care?

Focus on pediatric home care outcomes and effective interventions

- Identify Quality Measures
- Collect Data
- Data Analysis
- Effective Interventions

"Tell our story with data"
Joint Data Initiative with the Children’s Hospital Association

**CHA/PHIS Data**
- 2007 – Q1 2013
- 150 Children’s Hospitals
- 11,000 discharges

**BAYADA Data**
- 2007 – Q1 2013
- 18,000 clients
- 3,500 matches

**Outcomes**
- Reduced LOS
- Reduced Hospitalizations
- Other Findings

**Goal:** Measure the impact/benefit of PDN home care for complex children.

---

**BAYADA Pediatrics Pilot Data Initiative**

**Measuring Re-hospitalizations for Complex Children**

186 hospitalizations 2012 – Q3 2013
- Planned 93
- Unplanned: not preventable 56
- Unplanned: potentially preventable 37

- Clinically-driven 19
- Non-clinically driven 18

**Medicaid Pediatric PDN: Meeting Patient Needs within Budget**
What is the route to incentive payments for pediatric home care?

- What are the right domains?
- What data do we have now?
- What data do we need in the future?
  - Re-hospitalization
  - Hospital-free days
  - Infection rates
  - Family satisfaction
- What can our payer partners tell us?
- What models are most advantageous?