HEALTHY BUSINESS SOLUTIONS

An Organizational, Operational and Financial Assessment of Home Health Operations : City of Berlin (NH) Health Department

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Strategic Options

1. Continue to operate a Health Department that provides Medicare certified services and health promotion activities.
2. Continue to operate a Health Department that provides health promotion activities only and develop an exit strategy for Medicare certified services.
3. Discontinue both Medicare certified services and health promotion activities.

Option 1: Continue to operate a Health Department that provides Medicare certified services and health promotion activities

- Pros
  - Retains long standing commitment to community supported by City Council
  - Commitment to dedicated and loyal employees
  - Partnerships with referral sources
  - Benefit to local hospital (AVH)
- Cons
  - Uncertain business opportunities
  - Lack of health / hospital system or network affiliation
  - Operating at a loss with no strategy for turn-around or growth
  - Need constant development of industry expertise and regulatory knowledge
  - Requires infusion of significant resources
    - Capital for equipment/technology/EMR
    - Training and education
  - Current processes and structure do not support current volume or growth
  - Evolving federal regulatory and fiscal changes

Option 2: Continue to operate a Health Department that includes providing health promotion activities only and develop an exit strategy for the Medicare certified services

- Pros
  - Continued presence preserves community perception that Health Department is there for those in need
  - Resources focused on successful activities
  - Taxpayer relief
  - Eliminates regulatory risk
  - Does not require infusion of resources
    - Capital
    - Personnel/Leadership/Training & Education
- Cons
  - Patient Access

Option 3: Discontinue both Medicare certified services and health promotion activities

- Pros
  - Taxpayer relief
  - Singular focus on Welfare and Inspections
  - No capital investments required
  - No major structural, operational changes needed to be made and maintained
  - Eliminates uncertainty of federal regulatory and fiscal environment
- Cons
  - Patient Access

Option 1: Critical Success Factors

- Essential Investment: Immediate need for Electronic Medical Record (EMR)
  - Barriers to overcome
    - City vendor selection process
    - Approval of funds
  - Immediate benefits
    - Increases clinician productivity resulting in increased admissions
    - Provides accurate and timely statistical information for decision support (KPIs)
    - Decreases Days in AR and increases cash flow
    - Facilitates regulatory compliance
    - Facilitates required data collection
    - Increases job satisfaction
  - Options
    - Outsource
    - Purchase and outsource OASIS review and Coding

Option 1: Critical Success Factors

Pricing Proposal for Outsource Solution

Investment Summary		
Solution Summary		Solution Suite
firstHOMECARE Software		6% of collections
firstCONNECT DDE Connectivity (included)		included
Medispan Drug Database		included
Electronic Billing and Remittance		included
Business Intelligence		included
Billing Services		included
Coding Services & OASIS Review		included
HHCAHPS Survey*		included
First CPO (Physicans Portal)		included
Total Monthly Solution Investment		6% of collections
St. Anthony's ICD-10 Database (Annual Fee)		included
Training - Options Listed Below		Solution Suite
On-Site (4 days) (Cost per day)		$1000 + expenses
Web-Based		included

Option 1: Critical Success Factors

- Monthly fee:
  - 6% of collections and is invoiced on the first day of each month (approx. $3,000/month).
  - Includes automated data transfer of monthly patient data for seamless survey experience.
- Pricing assumptions:
  - Home Health ADC = 63
  - Home Health Estimated Monthly Collections = $41,100
  - Home Health Providers = 1
- Term
  - 24 months
  - Home Health billing responsibility under the direction of Comptroller

Option 1: Critical Success Factors

- Options
  - Retain Interim Clinical Leader during Director's absence to monitor current supervision of home health services and begin to affect change
    - Implement Case Management model of care delivery with clinician self-scheduling to eliminate refusal of referrals and increase new business
    - Provide training on compliance for meeting regulatory requirements for clinical documentation
    - Facilitate EMR conversion
    - Establish best practices for pre-billing compliance
    - Mentor potential Clinical Supervisor candidate
    - Facilitate robust recruitment of Clinical Supervisor; showcase benefit package and pension
    - Change management
  - Investigate potential for shared management services with another home health agency

Option 1: Critical Success Factors

- Organizational Structure
  - The effectiveness of a home care organization's structure determines the efficiencies of its operating processes.
  - The successful management of the day-to-day clinical operations is dependent on the appropriate delegation of responsibility to key management and support positions.
  - Efficiencies and economies of scale are achieved through the efforts of personnel who have been assigned the accountability and responsibility for working toward established, common goals.
  - An effective structure will allow leadership levels to direct, manage, and supervise the organization towards its established goals

Option 1: Critical Success Factors

- Key Organizational Staffing Metrics
  - Administrator
    - ➢Meets state/federal qualifications:
    - ➢Plans, directs and evaluates the quality assured, clinically excellent, compliant, cost effective, and consumer satisfied services
    - ➢External focus responsibilities
    - ➢Current capacity for Health and Welfare duties

Option 1: Critical Success Factors

- Key Organizational Staffing Metrics
  - Clinical Supervisor
    - 1 FTE/150-225 census
    - Responsible for the development and ongoing competence of assigned team members in the provision of quality assured, organized, compliant, cost effective and customer-centric care.
    - Monitors and ensures coordination and implementation of established patient care plans, discharge planning, and related activities.
    - Is a resource to staff in matters of policies, procedures, regulations, and payer coverage issues and directs staff to appropriate resources to resolve problems.
    - Coordinates and conducts regularly scheduled multi-disciplinary case management conferences with assigned staff.
    - Supervises and ensures the timeliness, quality and compliance standards of documentation of assigned staff.
    - Monitors staffing patterns and needs using key performance indicators and maintains appropriate staffing levels to assure timeliness and quality of services provided.

Option 1: Critical Success Factors

- Key Organizational Staffing Metrics
  - Quality Assurance/Improvement Coordinator
    - 1 FTE/300 census
    - Develops, evaluates, and monitors the implementation of the agency's continuous quality management and Performance Improvement plan and program.
    - Prepares statistical reports on the results of utilization reviews, clinical record audits, post-payment compliance audits, customer satisfaction surveys, and the continuous quality management plan.
    - Directs, plans, and assures implementation of corrective action plans for trends and deficiencies identified through utilization review, clinical record audit, third-party payer claim denials, client satisfaction surveys, and the continuous quality management plan.
    - Directs, develops, and oversees all activities related to staff development, including individual/group training, standardized orientation program, and ongoing staff continuing educational and in-service requirements. Ensures the development of clinical expertise for all specialty programs.

Option 1: Critical Success Factors

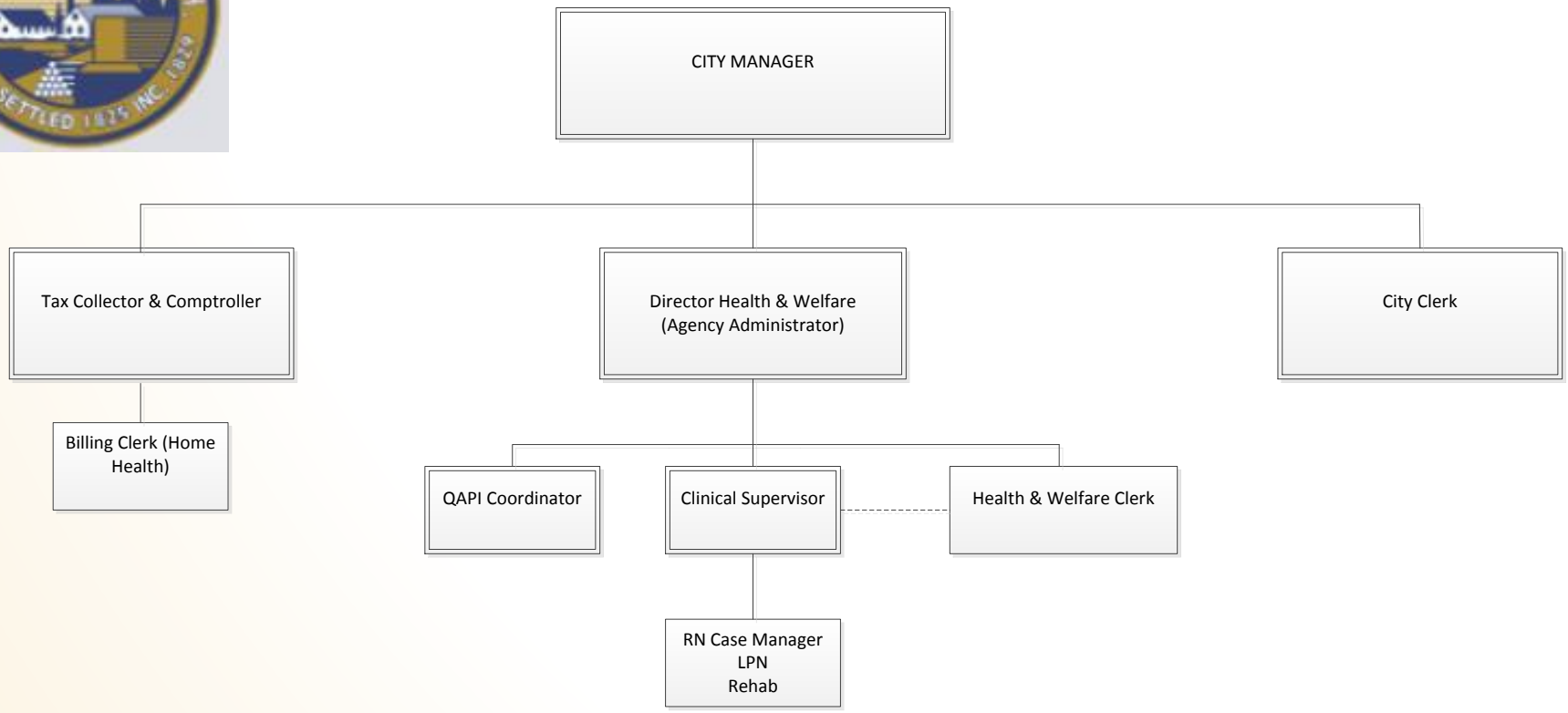
- Key Organizational Staffing Metrics
  - RN Case Manager
  - 1 FTE/20-25 patient caseload; 5 visits/day
    - Assumes responsibility from Start of Care through Discharge.
    - Assesses patient and caregiver needs at OASIS time points and throughout the episode.
    - Develops, communicates, and coordinates the plan of care with clinicians and other disciplines.
    - Attends and prepares for weekly case conference.
    - Manages internal and community resources needed to ensure implementation of the plan of care.
    - Communication/collaboration with patient, family, MD, other team members, and community resources.
    - Evaluation & follow up on all pertinent aspects of care (lab work, medication changes, sudden changes in status etc.).
    - Evaluate adherence to care plan including visit frequency, treatments, interventions and goals.
    - Medication reconciliation and management:

Option 1: Critical Success Factors

- Key Organizational Staffing Metrics
  - Clerk
    - 1 FTE/Clinical Team
    - Processes and coordinates all required clinical and other documentation and communication (paper and electronic) to facilitate complete, accurate, and timely flow of information.
    - This includes, but is not limited to, patient visit scheduling; assistance with MD orders management; pre-bill audit process; and general clerical support to Clinical Supervisor and assigned clinical Team.
    - General clerical duties to support Welfare Department
      - Telephone and reception duties
  - Billing Clerk
    - 1 FTE reports to Comptroller
    - Bills, collects and reports revenue and other statistical information

Option 1: Critical Success Factors

CITY OF BERLIN
HEALTH DEPARTMENT – RECOMMENDED STRUCTURE



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Option 1: Critical Success Factors

- Financial
  - Critical issue identified is Medicare Revenue Recognition.
    - Medicare revenue is booked when payments are received for RAPs and for Final Claims.
  - Medicare payments are made on the basis of a national standardized 60 day episode rate
    - 60 days beginning with the first billable visit and ending on the 60th day
    - Subsequent episodes begin on the first day following the end of the prior episode (day 61, 121, 181, etc.)

Option 1: Critical Success Factors

- National Standardized Rate is:
  - Adjusted for applicable case mix weight
  - Adjusted for wage index
- Case Mix Weight: determined by OASIS
- Wage Index adjusts for geographic differences in wages(Rural NH 2016 = 1.0041)
- Other payment drivers are intervening events to an episode

Option 1: Critical Success Factors

- Low Utilization Payment Adjustment **(LUPA)** occurs when patient receives 4 or less visits in an episode
  - Foley catheter changes
  - Monthly B12 injections
- **Therapy thresholds** of 14 and 20 or more visits results in increased payment rates, projected based on OASIS M02200
  - Incremental increased CMW and rates between thresholds
  - Claims adjustment based on number of therapy visits on final claim

Option 1: Critical Success Factors

- The episode is paid in 2 split payments:
  - Request for Anticipated Payment (RAP) at beginning of episode: locks in provider in Common Working File (Medicare database of beneficiaries)
    - » Best practice: submit within 7 days of SOC and paid within 3–5 days
  - Final Claim at end of episode: line item detailing of services delivered
    - » Best practice: submit within 14 days
- Payment split
  - First RAP = 60%, Final Claim = 40%
  - Subsequent RAP 50%, Final Claim = 50%
- **No RAP LUPA**:
  - Determine at start of care that patient will require 4 or less visits
  - May submit final claim only (no RAP) when signed physician orders are received

Option 1: Critical Success Factors

- RAPs
  - 3 items present
    - Locked/Finished OASIS Assessment
      - » 30 Days to transmit to state
    - First Visit
      - » Initial Episodes should be same as start of care date
      - » Subsequent episodes is the first visit performed within the episode
        - » HHRG Date on the claim must match date of first visit
    - Plan-of-care (485) has been mailed to the physician
- RAP will be cancelled and recovered unless the final claim for episode is submitted within the greater of 60 days from either the End of Episode, or issuance of RAP

Option 1: Critical Success Factors

- Final claim submission at EOE
  - End of 60 day episode
  - Earlier if patient is discharged goals met, or
  - Patient transfers to another provider
- All documentation returned and signed
  - Requires signed and dated plan of care and certification
  - All orders – initial and interim
  - 30-day Therapy reassessment is completed and signed
- Therapy assessments occurred and documented
- Face to face encounter occurred and documented

Option 1: Critical Success Factors

- All services must be in the EMR and verified
  - All visits performed are on the claim
    - All have notes
    - Frequency and duration match orders
  - Supplies used are present on the claim
- Pre bill audit:
  - Visits Ordered= Visits Scheduled
  - Scheduled = Performed
  - Performed = Documented
  - Documented = Billed
- RAP is recouped and final claim is paid
- Best Practice check Returned to Provider daily

Option 1: Critical Success Factors

- HHRG assignment driven on OASIS data
- Assigns patient to one of 153 patient HHRGs
- Measure 3 basic dimensions
  - Clinical severity factors
    - Primary and secondary diagnoses
    - Select OASIS items
  - Functional status factors
    - Select OASIS items
  - Service utilization factors
    - Number of therapy visits
- Goal: Match reimbursement to the actual resources used

Option 1: Critical Success Factors

- Four different types of episodes
- Therapy dictates the type of episode AND impacts case weight/payment

1st & 2nd Episodes "Early"		3rd or Later Episodes "Later"		All Episodes (Early/ Late)
1	2	3	4	5
0 – 13 Therapy Visits	14 – 19 Therapy Visits	0 – 13 Therapy Visits	14 – 19 Therapy Visits	20 + Therapy Visits

Option 1: Critical Success Factors

	1st & 2nd Episodes		3rd & 4th Episodes		All Episodes
	0 – 13 Therapy Visits	14 – 19 Therapy Visits	0 – 13 Therapy Visits	14 – 19 Therapy Visits	20 + Therapy Visits
S 1	0 to 5	14 to 15	0 to 5	14 to 15	20 +
S 2	6	16 to 17	6	16 to 17	
S 3	7 to 9	18 to 19	7 to 9	18 to 19	
S 4	10		10		
S 5	11 to 13		11 to 13		

Option 1: Critical Success Factors

- Financial Management
  - KPIs to manage the business
  - Episode Analysis
    - Profit & Loss analysis by episode type
    - Analysis of episodes by category
    - Utilization by episode type
      - What type of visits are provided?
      - What are the hours per visit per episode ?
      - What is your revenue and cost per hour?
  - Conduct a Payer Analysis
    - What is your mix of business?
    - What is the impact if volume switches?
    - What is the gross margin by payer type?

Option 1: Critical Success Factors

- Accounting for PPS Revenue
  - An episode may span 1, 2 or 3 accounting periods
  - Important to understand EMR options
  - Need to defer revenue
  - Episode payments determined up-front: OASIS
- Simione to provide calculator for HIPPS / HHRGs to Revenue for booking Medicare revenue at SOC
- Managing the Home Health Revenue Cycle
- Home Health Budgeting
- Medicare Filing Requirements
  - Cost Report
  - Credit Balance Reports

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Option 1: Critical Success Factors

- Medicare Reimbursement today and tomorrow:
  - PPS National Rate: National Standardized 60 day rate WITH quality reporting submission: $2,965.12
- Home Health Quality Reporting Program
  - National standardized 60 day rate WITHOUT meeting quality reporting submission requirements: $2,906.92
- Updated (recalibrated) case mix weights with annual payment rate updates
- Home Health Value Based Purchasing Model
- Pre Claim Review Demo
- Bundled payments

- Revenue Recognition: 60 Day Method Example
  - SOC is day 6 of month 1
  - Net HHRG is $2,800
  - # of days in 1st month = 30
  - Revenue for 1st month ended 24/60 x $2,800 = $1,120
  - # of days in2nd month = 31
  - Revenue for 2nd month ended 31/60 x $2,800 = $1,447
  - # remaining episode days in 3rd month = 5
  - Revenue for 3rd month ended 5/50 x $2,800 = $233
  - Estimate Revenue Adjustment % = 15%

- Revenue Recognition:

Month		Debit	Credit
1	PPS Medicare AR	$2,800	
	PPS Medicare Revenue		$1,120
	PPS Deferred Revenue		$1,680
To record Medicare Revenue and Accounts Receivable			
1	Cash	$1,680	
	PPS Medicare AR		$1,680
To record RAP payment received			
2	PPS Deferred Revenue	$1,447	
	PPS Medicare Revenue		$1,447
To relieve deferred revenue from month 1			

- Revenue Recognition

Month		Debit	Credit
3	PPS Deferred Revenue	$233	
	PPS Medicare Revenue		$233
To relieve deferred revenue from month 1			
3	Cash	$1,120	
	PPS Medicare AR		$1,120
To record final payment received (on adjustments)			
Or, assume PEP occurred:			
3	Cash	$980	
	PPS Allowance for Revenue Adjustments	$140	
	PPS Medicare AR		$1,120
To record final payment with PEP adjustment			

- Revenue Recognition
  - Percent may change monthly
  - Actual adjustments incurred are charged against allowance on balance sheet

Month		Debit	Credit
1	PPS Revenue Adjustments (I/S)	$168	
	PPS Allowance for Revenue Adjustments (B/S)		$168
To record estimate adjustment for month 1 ($1,120*15%)			
2	PPS Revenue Adjustments (I/S)	$217	
	PPS Allowance for Revenue Adjustments (B/S)		$217
To record estimate adjustment for month 2 ($1,447*15%)			
3	PPS Revenue Adjustments (I/S)	$35	
	PPS Allowance for Revenue Adjustments (B/S)		$35
To record estimate adjustment for month 3 ($233*15%)			

Option 1: Critical Success Factors

- Revenue Recognition:
  - Alternatives are possible
    - Recognize RAP A/R and Revenue at start of care, balance / adjustments at end of episode
    - Recognize based on average length of stay if shorter than 60 day episode
  - In the interim during any transition to an EMR/ outsourced billing solution minimum accountable activities include:
    - Expand current Medicare tracking sheet to include Case Mix Weight at SOC, at EOE.
    - Include SOC expected HHRG $ value, expected RAP amount as well as actual RAP amount and actual final claim amount.
    - Quantify SOC and EOE during month / # of episodes
    - Book revenue and expense on accrual basis and perform analysis to determine gross margin and identify payer Profit/Loss.
    - Monitor billing KPIs (time to bill, DSO)

Option 1: Critical Success Factors

- Key Performance Indicators
  - Trend agency performance monthly/benchmark quarterly
    - Gross Margin: Net Patient Service revenue less direct cost
      - Salaries, P/R Taxes and benefits, mileage, medical supplies
      - Within the control of clinical manager(s)
      - Overall and by payer
    - Net Margin: Same thing

- Key Performance Indicators

Margins	National	Region	Not for Profit
Gross Profit Margin	40%	40%	39%
Gross Margin Medicare	48%	51%	45%
Gross Margin Medicare Advantage	37%	35%	35%
Gross Margin Medicaid	31%	(11%)	22%
Gross Margin Other	25%	6%	23%
Net Profit Margin	(1%)	(1%)	(3%)
Net Profit Margin Medicare	9%	17%	6%
Net Profit Margin Medicare Advantage	0%	8%	(1&)
Net Profit Margin Medicaid	(29%)	(82%)	(32%)
Net Profit Margin Other	(28%)	(48%)	(33%)

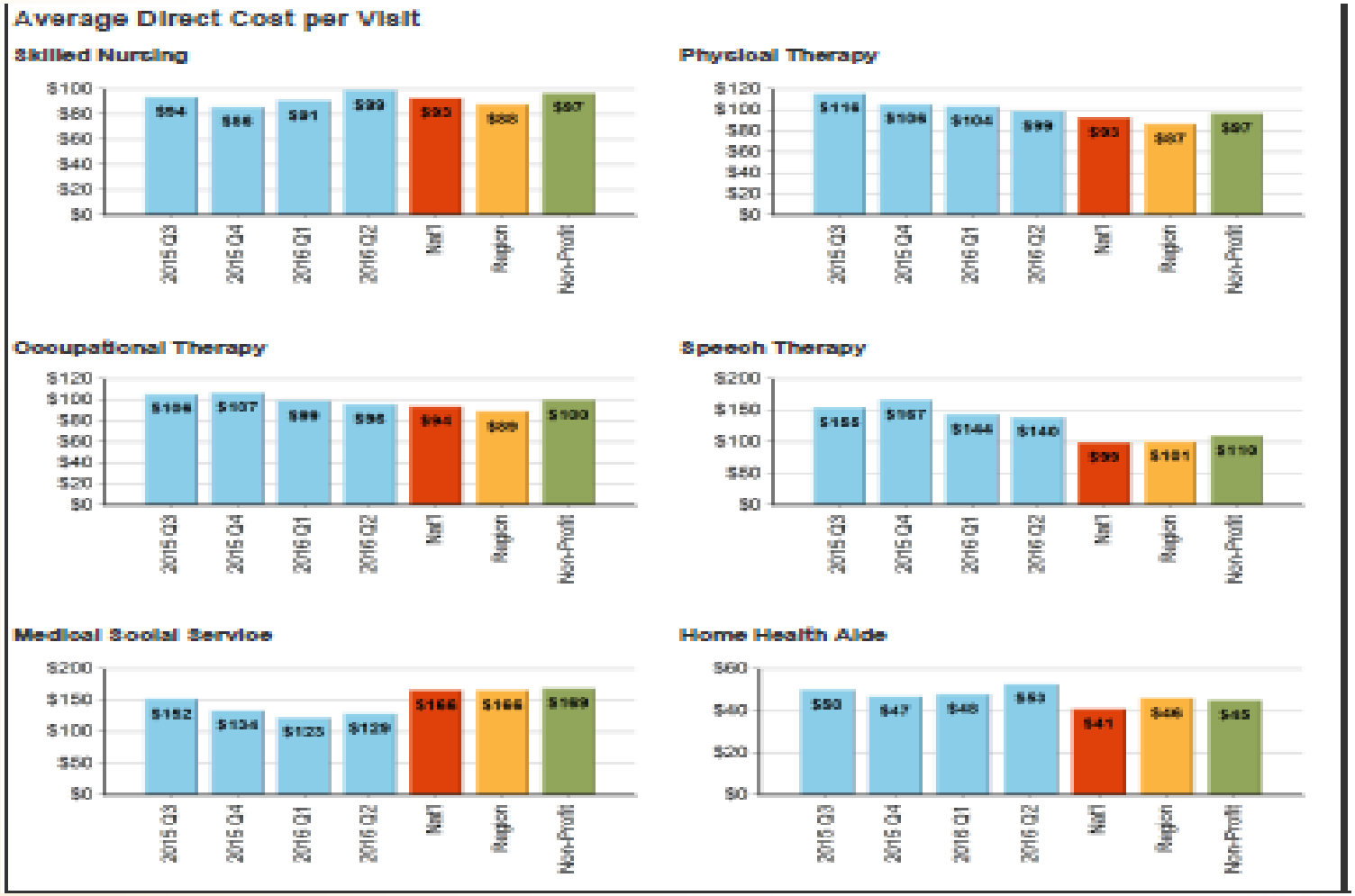
- Key Performance Indicators
  - Billing: DSO

Days Sales Outstanding	National	Region	Not for Profit
DSO – Overall	63	55	66
DSO – Medicare	56	54	56
DSO – Medicare Advantage	75	57	82
DSO – Medicaid	7	40	77
DSO - Other	102	76	105

- Key Performance Indicators
  - Payer and patient level Profit/Loss

Revenue & Cost per Patient	National	Region	Not for Profit
Revenue – Medicare	$2,378	$3,321	$2,268
Cost – Medicare	**2,175**	**2,886**	**2,130**
Revenue – Medicare Advantage	2,017	3,413	2,031
Cost – Medicare Advantage	**2,079**	**3,197**	**1,914**
Revenue – Medicaid	1,059	1,220	997
Cost - Medicaid	**1,412**	**2,071**	**1,412**
Revenue – Other	1,334	1,376	1,222
Cost – Other	**1,590**	**1,924**	**1,530**

- Key Performance Indicators: Direct Cost per Visit



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- Key Performance Indicators: Medicare Episodic

Medicare Episodic	National	Region	Not for Profit
SOC – CMW	.973	.954	1.010
EOE - CMW	1.03	1.05	.99
Reimbursement per Episode	$2,456	$2,895	$2,456
Cost per Episode	$2,410	$2,360	$2,448
Profit/Loss per Episode	**$46**	**$535**	**$8**
Nursing Visits per Episode	7.5	8.1	7.3
Therapy Visits per Episode	6.2	5.7	6.0
HHA Visits per Episode	1.3	2.6	1.3
Days from SCO to RAP	16	15	16
Days from EOE to Final Claim	23	29	22

Option 2: Critical Success Factors

- Essential Investment: Expertise to manage an exit strategy. Determine more efficient ways to manage health promotion activities.
  - Barriers to overcome
    - Assurance that all home health patients will be cared for by alternate provider(s)
  - Immediate benefits
    - Financial relief for taxpayers
    - No infusion of capital and personnel resources required
  - Options
    - Establish schedules versus drop-in for all services
    - Utilize perdiem nurses

Option 2: Critical Success Factors

- Operational and Organizational
  - Discontinue intake
  - Discharge/refer all patients
  - State/federal notifications
- Financial
  - Determine status of all billing activity for certified home health
  - Follow-up on all needed collections
  - Collect all data needed for final Medicare cost report; file final cost report for provider number “owner”.
  - Cost reports are due no later than 5 months following the effective date of the termination of the provider agreement or the change of ownership.

Option 3: Critical Success Factors

- Essential Investment: Expertise to manage an exit strategy.
  - Barriers to overcome
    - Assurance that all home health and all community health promotion patients will be cared for by alternate provider(s)
  - Immediate benefits
    - Financial relief for taxpayers
    - No infusion of capital and personnel resources required
  - Options
    - Not applicable

Option 3: Critical Success Factors

- Operational and Organizational
  - Same as #2
  - Establish alternate site(s) for health promotion services for community residents

- Financial
  - Same as #2

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