

The Domino Effect

Industry Impact of New Home Health PPS



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INTRODUCTION

Changes to Medicare home health prospective payment will be felt across the industry. While home health providers are preparing for changes in Medicare reimbursement that may alter their revenues by up to 30% in 2008, the impact will not be limited to the cash flow management and profit and loss statements of the individual organizations. The effect of the recent Center for Medicare and Medicaid (CMS) change to the Medicare prospective payment system (PPS) in home health published on August 23, 2007 will be felt across the industry. As agencies are preparing to handle the financial and associated resource management challenges, a big window of opportunity opens for the vendors, consultants, and suppliers who work with the home care industry.

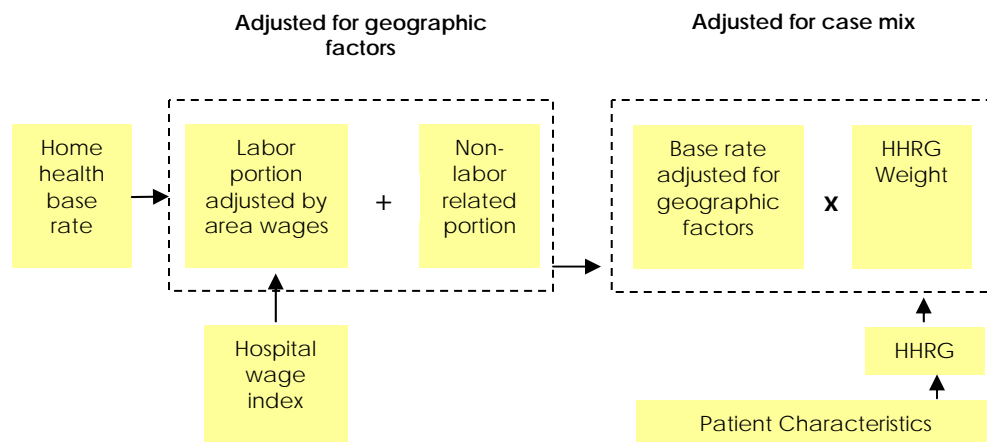
Medicare beneficiaries comprise almost 75% of the patients receiving care from home health agencies in the United States. As such, the home health PPS final rule compels home health agencies to invest time in understanding the rule and its impact on their financial performance. Most agencies are taking this opportunity to re-evaluate their approach to delivering high quality patient care while at the same time ensuring the financial health of their organization.

This period of evaluation and adjustment will create a domino effect across the broader industry as agencies reconsider the value of current vendor relationships, try new approaches to clinical care and staffing, rely on associations and other advocacy organizations for leadership, and look to consultants for guidance. Further, as agencies work through this change to the payment system, undoubtedly some will fair well while others will not, impacting the investment and merger and acquisition communities.

HOME HEALTH PPS PAYMENT BASICS

To understand the impact of the changes to the prospective payment system (PPS), it is important to first understand the basic way in which PPS operates in home health. Agencies receive payment from Medicare to cover an episode of care up to 60-days long for each beneficiary referred for home health services. The episode payment consists of an annually established base payment rate that is adjusted for the specific characteristics of each patient, including their geographic location (**Figure 1**).

Figure 1 - Basics of Home Health PPS*



*Figure 1 was adapted from figure appearing in Payment Basics: Home Health Care Services Payment System. MedPAC, September 2006.

Base Episode Payment. The base episode payment rate is updated annually based on the projected change in the home health market basket. The market basket measures changes in the prices of goods and services bought by home health agencies.

Geographic Adjustment. The intent of the geographic adjustment is to account for labor cost differences in local markets where the home health services will be delivered. This is done by dividing the base episode payment into labor and non-labor portions. The labor portion is then adjusted by a version of the hospital wage index. The adjusted labor portion is then added to the non-labor portion for the “total” episode payment.

Patient-level Adjustment. The patient-level adjustment for each episode is calculated based on specific data gathered about the patient at the start of home care (SOC) and the start of subsequent episodes. This patient-level data assigns the episode into a specific case-mix category called a Home Health Resource Group (HHRG), each of which has an associated case weight. The case weight is used to adjust the episode payment based on the anticipated costs of the care needs of the patient.

In short, agency location and the types of patients cared for by an agency can lead to increases or decreases in their average per patient episode payments.

KEY PPS CHANGES

Although the final PPS rule presents a myriad of modifications to the existing payment system, the key changes can be summarized as:

1. decreased base payment rates over next four years,
2. changes to consideration of therapy that result in a more gradual increase in payment for these services,
3. a new, distinct non-routine supply add-on payment,
4. increased weighting of the labor portion of the payment, and
5. increased complexity of case-mix point calculations and HHRG assignment.

Decreased base payment. In its analysis of PPS from the original implementation date (October 1, 2000) to 2005, CMS discovered an unexpected increase in average case weights and associated payments. The research further showed that only a portion of the increase could be attributed to actual changes in the patient population, changes for which you would expect an increase in case weight and payments. CMS found the rest of the increase to be “nominal” or not real.

In an attempt to adjust for the nominal aggregate changes in case mix growth, CMS is implementing a decrease in the base PPS episodic payment, designed to bring payment rates back to their expected level. Instead of a dramatic single cut in payment in 2008, CMS will implement a 2.75 percent decrease in base payment in each of the next three years (2008, 2009, and 2010) and a 2.71 percent decrease in the base payment in the fourth year (2011).

This change, as much as any other within the context of this rule, will have a long-term and relatively dramatic impact on the industry. Many studies have found that individual agencies have a wide range of profit margin on Medicare patient care and on their overall operations. A consistent decrease in reimbursement, especially combined with an almost certain increase in the cost of providing care, over four years is sure to challenge even the most financially successful organizations.

Smart organizations that look to increase efficiencies will be able to maintain strong financial performance, despite the grim outlook for reimbursement. Increased efficiencies may be found in creative, lower cost approaches to providing care, tools and systems that decrease the amount of time required to invest in patient services, cost-effective supplies, elimination of unnecessary expenses, and better contract rates.

Therapy thresholds. In today's PPS structure, high therapy utilization, defined as 10 or more visits within a single episode of care, has a dramatic impact on reimbursement rates. In fact, that single patient characteristic can change the episodic Medicare payment amount by more than \$2,200.

In the new 2008 PPS structure, there are several therapy thresholds that impact payment amount. Medicare reimbursement is altered based on therapy utilization at 6, 7, 10, 11, 14, 16, 18, and 20 visits.

The biggest impact of this difference is a more gradual increase in payments due to therapy utilization. Rather than one big jump at 10 visits, we see incremental increases in payment at multiple points. This change also results in a payment structure that looks a little bit more like fee-for-service, basing payment on services provided rather than the characteristics of the patient at start of care.

The change in thresholds alters the relationship between therapy services and reimbursement. Over the past 6 years, many providers designed clinical pathways for therapy-appropriate patients around the 10-visit threshold. As 2008 and the new therapy thresholds approach, several of those organizations will likely be rethinking how they distribute therapy services to all patients.

Non-routine supply add-on. When CMS first introduced the prospective payment system to home health in 2000, they bundled a reimbursement line item to cover non-routine supplies as a part of the standard base episodic payment. This approach meant that the base payment and the supply component of that payment were adjusted equally for each episode. There was no way for the payment system to recognize a case of patient care that might be more visit-intensive, but require fewer supplies, or vice versa.

In the new system designed for 2008, non-routine supplies (NRS) have been "un-bundled" from the base payment. The payment for NRS is subject to a new adjustment algorithm of its own, and there are many examples of patient conditions where the case weight is higher than average but the NRS severity weight is lower, or the opposite. Sophisticated agencies will be reacting to this change by more closely tracking the cost of patient supplies in relationship to the specific NRS add-on amount.

Increased weighting of labor portion. Under the final PPS rule, a greater proportion of the base episode rate will be adjusted for differences in local area labor costs. Specifically, beginning in 2008, 77.082% of base episode payment will be adjusted by a version of the hospital wage index, as compared to 76.775% in 2007.

This change will slightly benefit agencies that have a high portion of episodes with a wage adjustment greater than one, which is mostly representative of agencies that serve urban areas. On the flip side, agencies that serve a lot of patients living in rural locations or places where the wage adjustment is less than one will see slightly lower payments because of this change in the rule.

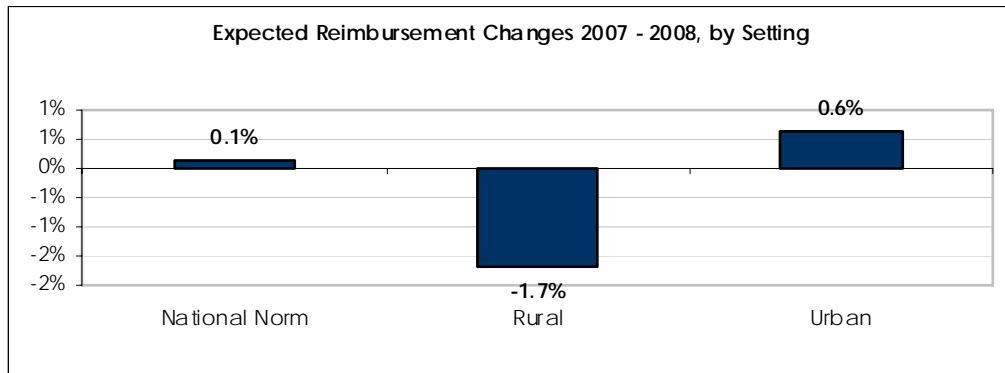
Complex case-mix calculations. The final PPS rule substantially increases the complexity by which patients are assigned to different Home Health Resource Groups and the subsequent assignment of case weights that adjust their episode payments. For starters, the new methodology moves from a single-equation model to a multiple-equation model and produces 153 possible case mix groups compared to 80 under the old rule. Changes to the variables included and excluded in the new case-mix model add further complexity to the new case-mix calculation. Of particular note, unlike today where only the highest scoring clinical diagnosis receives points, data from primary, secondary, and payment diagnoses will now be incorporated in a compound fashion.

The increased complexity can be translated into a population of industry professionals that needs to be educated on the new system and a need for more complicated information and software systems to manage the more detailed and integrated standards. The other major implication of the additional complexity is a renewed emphasis on accurate data collection by field staff and coding specialists.

PROJECTED FINANCIAL IMPACT

The financial impact of final PPS changes will be felt by agencies across the country, but in a variable manner. Analysis shows that nationally we should expect a moderate change of about a 0.1% increase in base payment. Rural agencies, however, are actually expected to experience a decrease in average payments next year, while urban agencies as a whole expect payments to increase. See **Figure 2**.

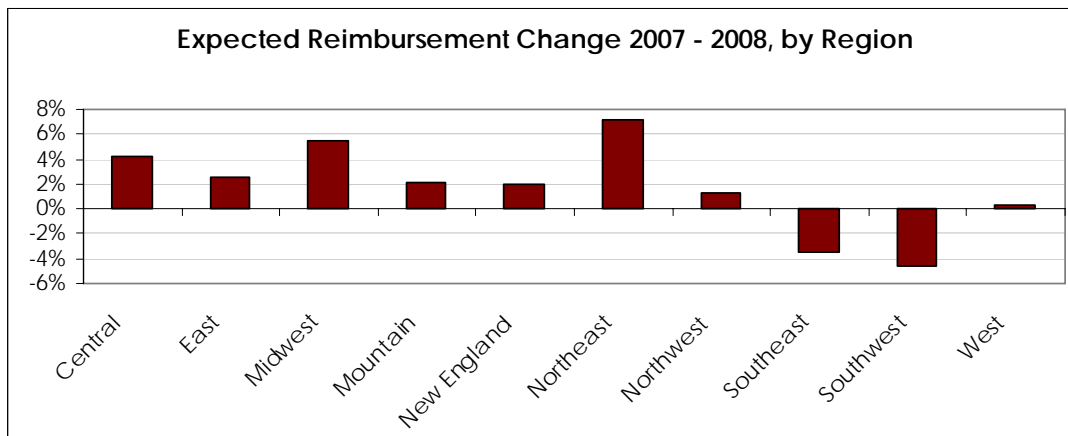
Figure 2



Differences in reimbursement experienced by agencies may be more dramatic than industry-level statistics show us. Analysis shows that, in the extreme, some agencies may experience a loss or gain of more than 20% of their reimbursement. It is likely, however, that about half of all agencies will see no more than a 5% change (positive or negative).

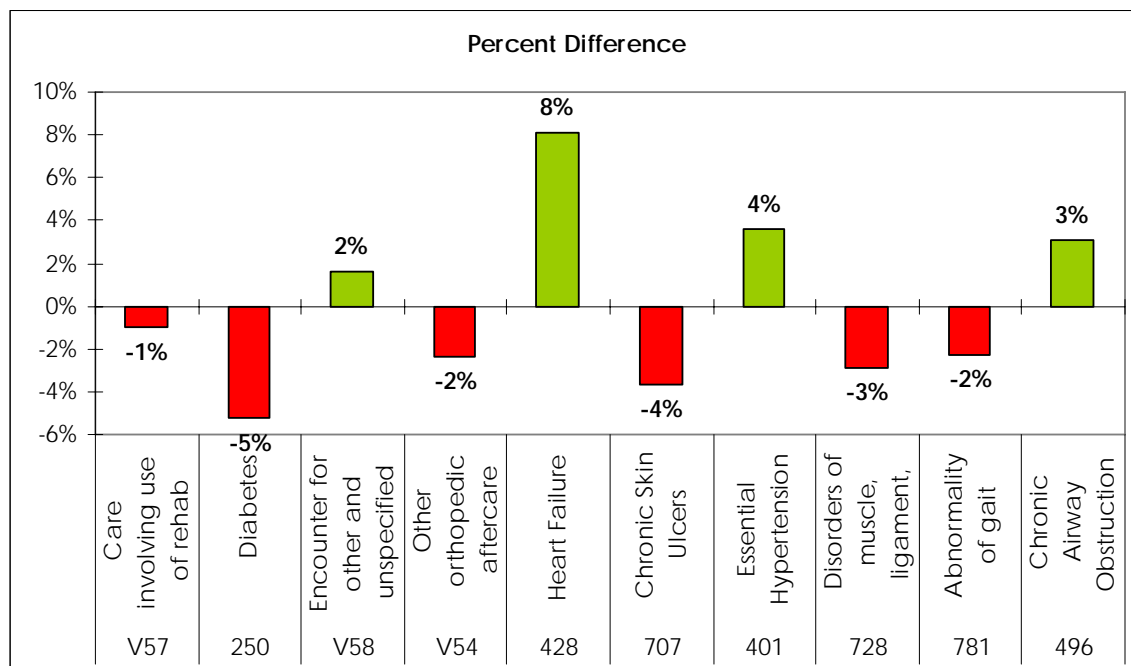
The level of impact will vary substantially by Medicare region. As depicted in **Figure 3**, agencies in the Northeast, Central and Midwest will expect to see the highest overall increases in average episodic payment, while those in the South and Southwest will likely see overall decreases.

Figure 3



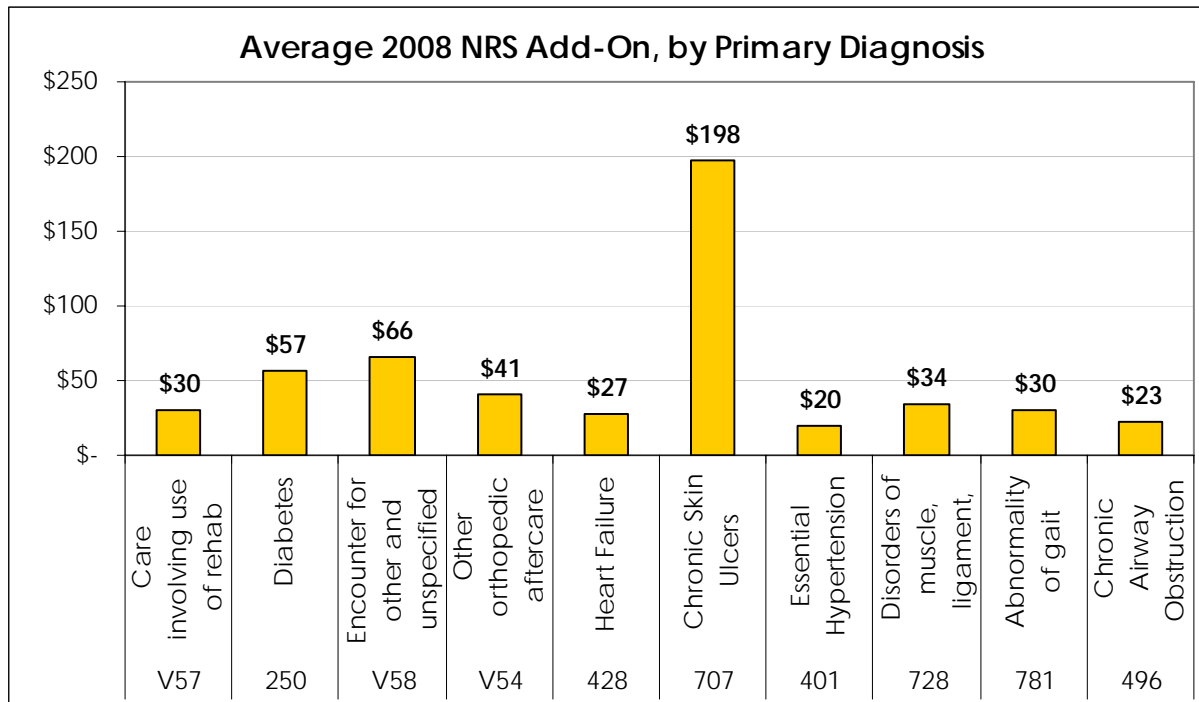
In addition to geographic location, agency-level differences in reimbursement will vary by patient populations served. As depicted in **Figure 4**, not all patient conditions will experience the same change in payment with the implementation of the new PPS. As a general rule, more acute conditions that are likely to receive more therapy visits – represented by diagnoses such as rehab aftercare (ICD-9 code V57), abnormality of gait (781), and musculoskeletal conditions (728) – will receive less reimbursement in 2008 compared to today. On the flip side, more chronic diagnoses – such as heart failure (428), essential hypertension (401), and chronic obstructive pulmonary disease (496) – should, as a general rule, receive higher reimbursement. It is important to note that neither of those guidelines are steadfast standards, as evidenced by the expected decrease in payment for two common chronic conditions, diabetes (250) and chronic skin ulcers (707).

Figure 4



The amount of the non-routine supply add-on reimbursement also varies dramatically by primary diagnosis, as exhibited in **Figure 5**. Not surprisingly, patients with a primary diagnosis of chronic skin ulcers (ICD-9 707) who often need expensive wound treatment supplies have the highest average NRS add-on amount, followed not so closely by patients receiving home health for an encounter for other and unspecified aftercare (V58), a diagnosis that involves a lot of surgical wound after care.

Figure 5



Figures 6 and 7 demonstrate the dramatic change in average per episode reimbursement as a result of the change in the therapy visit thresholds. Each graph shows the average PPS reimbursement per episode based on the number of therapy visits provided during the episode. Figure 6, with the large jump at 10 visits, is representative of today's payment environment. Figure 7, with multiple smaller increases, is representative of the expected payment values in 2008.

Figures 6 and 7

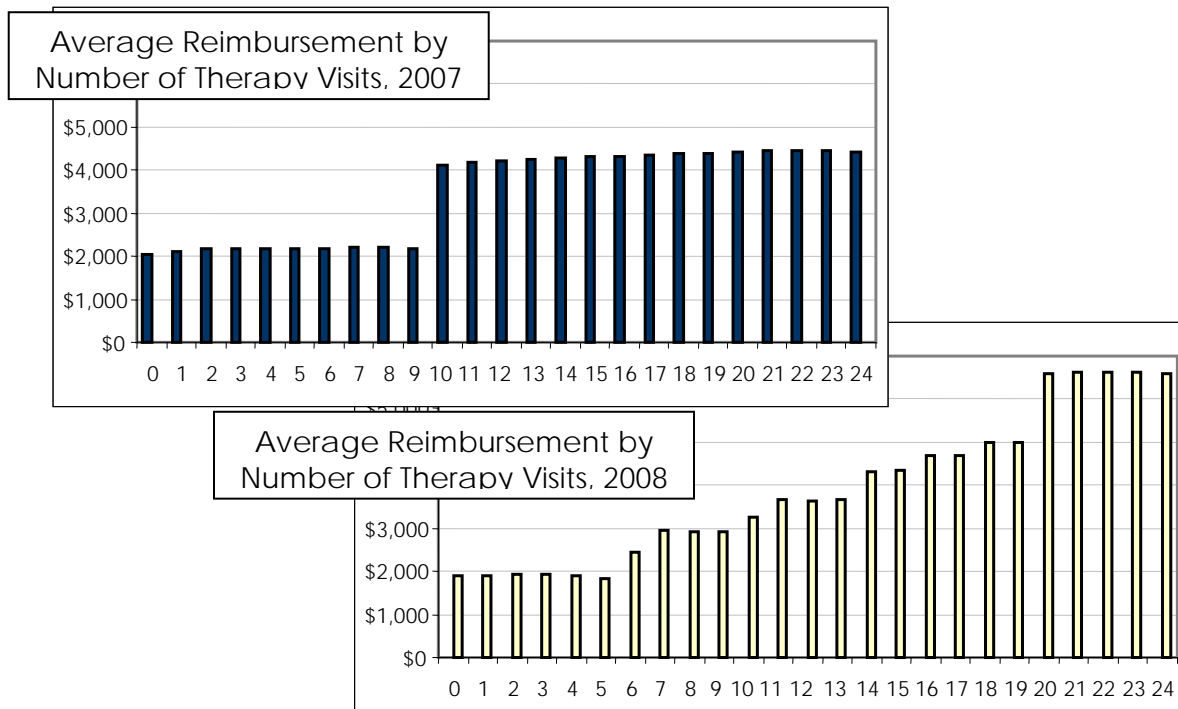
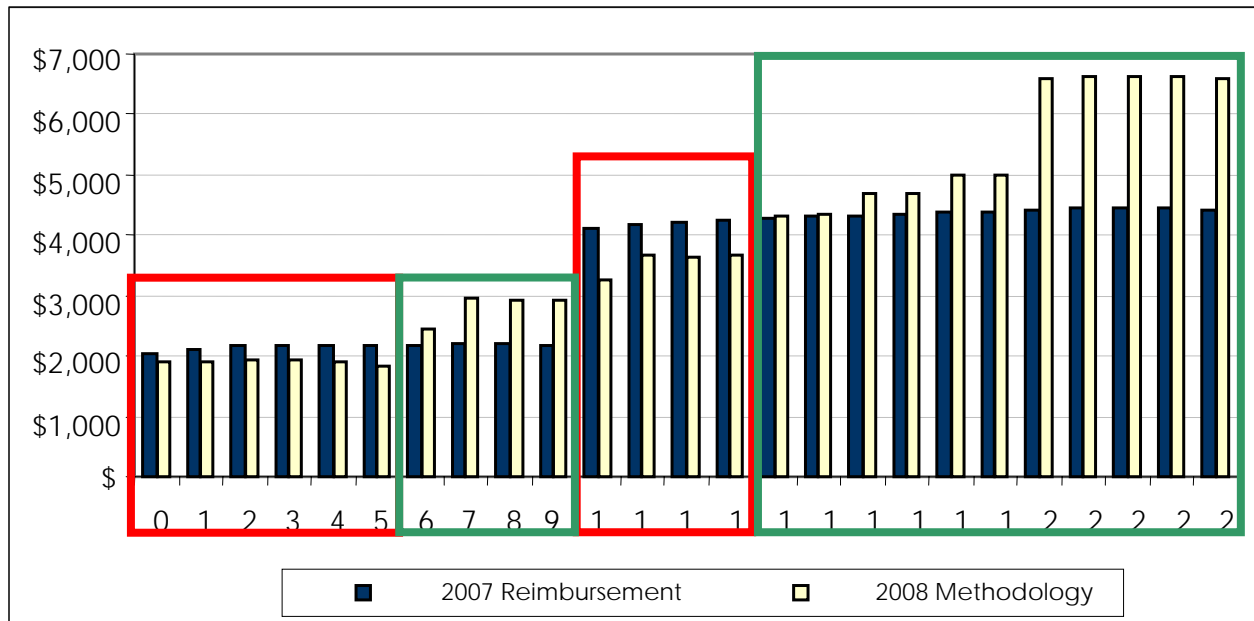


Figure 8 continues to provide eye-opening insight into the impact of the change in the PPS regulations, highlighting at what therapy levels payment is expected to increase compared to where it is expected to decrease. According to this analysis, in 2008 episodes receiving 0 – 6 therapy visits, and 10 – 13 therapy visits will be reimbursed less than they are today. On the flip side, episodes with 7 – 9 or 14 or more therapy visits should be receiving a higher reimbursement in a few months.

This generalization, more than any other, is a strong guideline for a positive or negative outlook for reimbursement as a result of the PPS changes. More than region, affiliation, setting, or diagnosis distribution, an agency’s distribution of episodes along the range of therapy visits levels can provide insight into the expected impact of PPS 2008. Even this, however, is not a certain indication of expected performance.

Figure 8 Changes in Reimbursement by Total Therapy Visits



Data Notes Data for the preceding analyses was based on information in the proprietary OCS data warehouse, which includes more than 1.25 million cases of care completed in 2006 by 2,000 provider locations. Metrics for 2007 were calculated using the current PPS methodology and 2007 base payment rate. Metrics for 2008 were calculated using the 2008 PPS methodology and base payment rate (including a 3% market basket increase and 2.75% “case mix creep” decrease) as defined in the final rule published in August 2007. For both 2007 and 2008 metrics, data was representative of standard episodes (excluding LUPAs, PEPs, and the outlier payment for outlier episodes).

BUSINESS OPPORTUNITIES ABOUND

With the new PPS rule going into effect January 2008, the window of opportunity to prepare for the new payment structure is narrow. While short, this period, as well as the first several months of 2008, offers an exceptional opportunity for businesses serving the home health industry to demonstrate how they can bring value to their current and prospective clients. Here are just a few examples of how agencies may turn to different business partners for aid as they face the challenge of preparing for the final PPS rule:

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- Look for medical information software (MIS) vendors to incorporate new PPS calculations and updated data verifications that reflect nuances of the final rule
- Seek consultants to help evaluate the financial impact of new rule and create proactive business plans
- Search for care delivery tools that reduce cost and maintain or increase quality care (for example, disease management, point of care devices, clinical pathways, and telehealth)
- Ask supply vendors for tools and information to help them better track and report on the cost and cost effectiveness of different approaches to caring for wound care patients

Loyalty during this time of transition may also be at risk, as agencies are refining their operations and partnerships. Business partners can firm their relationships with home health agencies by being well-educated on the changes and sensitive to the disruption organizations are facing as they preparing. They can further demonstrate the value of their services to these organizations by showing agencies how they can effectively assist during this time of transition and stepping beyond the expected behavior to help their clients and partners navigate the transition.

The new rule will also present opportunities for those involved with the investment and merger and acquisitions worlds. Many important questions relating to the change remain unanswered or unclear or, in some instances, even unasked. Which agencies will perform well under the new rule? Which will not? What actions are indicators that an agency will be able to weather the change successfully? What trends might should raise flags of concern? Financial consultants will want to look to available data and expert insight in order to advise clients on opportunities and risks in the home health market. In some instances, this may translate into investment advice. In others, it may translate into identifying potential agencies for merger or acquisition efforts.

OCS AS A STRATEGIC BUSINESS PARTNER

Keys to being an effective business partner are a clear understanding of the new PPS rule, familiarity with agency operations and care delivery practices, and access to patient-level data to model the impact of the new rule on agency performance – be it in terms of financial health, patient outcomes, or patient satisfaction. Healthcare information services companies, such as Outcome Concept Systems (OCS), can enhance the effectiveness of business partners meeting agency needs.

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With the most comprehensive data warehouse of home care information, OCS is poised to be a strategic partner with agencies as well as businesses serving the home health industry. Day-after-day, OCS demonstrates a clear ability to leverage its data and industry expertise to provide value to a broad range of interested parties. As one recent example, within days of the releases of the proposed rule in April 2007 and the final rule in August 2007, OCS provided its home health agency clients with a series of individualized PPS Impact Reports and financial modeling tools detailing how each might fare under the newly published 2008 PPS rule. Beyond its provider client base, OCS has also helped the Medicare Payment Advisory Commission (MedPAC), financial analysts, and a number of large chains of providers meet the challenge of analyzing the projected impact of the proposed and final rules to facilitate their ability to respond to CMS about the integrity of the proposed changes and to prepare for the new year.

CHALLENGE AND OPPORTUNITY

The change to the home health PPS rule brings with it challenges and opportunities for both providers and their business partners alike. While the basic framework by which PPS works will be, in essence, unaltered, each piece of the framework has been restructured. From a provider perspective, the need to adapt to these changes while preserving financial health and the ability to deliver quality care will frame these changes primarily as challenges to be overcome. From a non-provider perspective, however, the challenges faced by providers present opportunity to flex industry expertise, strike strategic alliances, and do business.

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