The Rate Reductions of 2011 & Beyond…
Approaches for Success

As we all know by now, the Base Rate for 2011 has been reduced by an effective 5.226% taking all of the compounding of changes into consideration. This includes the 3.79% "creep" adjustment, the recapture of the 2.5% outlier factor and the net market basket increase of 1.1%. Many agencies are going to struggle with this reduction, but still remain profitable. There will be an increase in the number of agencies operating with negative margins over and above the current 33% losing money on Medicare. This will likely be further challenged, not by just the cost of the added therapy evaluations on or before the 13th and 19th visits, because of the reductions in the case weights for those patients no longer crossing over the 14th and 20th visit thresholds.

But what about the likely rate reductions for 2012 and 2013 before the impending rebasing of HHPPS for 2014 mandated by the Affordable Care Act of 2010? There will be continued 1% reductions of the Market Basket before the rebasing, but will there be market basket increases for those years considering the political climate in congress given the results of the recent election? What can you expect for 2012 and 2013? More of the same! And probably between 4.00% - 5.00%! Why? CMS chose not to address any "creep" adjustment for 2012 and 2013 in its just released final rule most likely because they want to examine more current data from the next subsequent annual period before addressing those rates. It is also likely that the current therapy measurements that affects the base rates will be drastically changed as part of the rebasing. So, what should you be doing?

Project and Analyze the Effects of the Rate Reductions beginning with 2011 and use the annualized costs from 2010. The same exercise for 2012 and 2013 using a conservative estimate for the rate reductions from the proceeding year's estimated rates. Measure the changes in the Gross Profit percentages. This process will identify your agency's financial exposure over the three year period and the areas of clinical and administrative operations and processes that might warrant review for improved efficiencies. The "way we've always done it" may not work any longer.

Control the Direct Cost per Visit for each discipline and non-routine medical supplies. This comes down to re-examining the actual average daily hands-on visits per day per clinician, their average daily patient census and their patients' outcomes. Measure, evaluate and benchmark each of the incremental cost components that make up the direct cost per visit for each discipline. Measure and evaluate any overtime salary and payroll tax components relative to the visits performed and the average daily hands-on visits per day per clinician. This may indicate the need to consider changing the compensation model to one that incentivizes productivity, case capacity and outcomes, including the immediate supervisory staff. The most successful compensation program is on that completely aligns with clinical operations and outcomes.

The Clinical Management and Case Conference Model may not be achieving optimum utilization of clinician and non-routine medical supplies resources to control the visits per episode and maximize clinical outcomes. Generally, a Primary Care field clinician model best achieves these results, beginning

with the admission, the vast majority of routine follow-up visits and the discharge unless the patient is discharged by another discipline. This model includes all patient case management by the primary care field clinician. Efficiencies of technology and process improve clinician performance including aircards, power cords for automobile power sources and eliminating the need for clinicians to pick up non-routine medical supplies for their patients, which can reduce productivity by at least one visit for each day they come into the office for this purpose and unnecessarily increase the cost of the supplies to the agency.

The Assessment of Functional Limitations is most often performed by RNs, even when therapy has been ordered. Unless the RN has been inserviced and taught these techniques by a PT and or OT which should be mandatory, it is likely that this initial assessment – evaluation is not as accurate as if completed by a therapist. The therapist's assessment should be discussed and considered by the RN before completion and submission of the admission or recertification OASIS. At least a 24 hour window for the therapy assessment best accomplishes this goal. The result will be a more accurate base assessment from which the outcomes are measures that will give credit for the actual outcomes achieved. The financial outcome will be a more accurate case weight and likely improved revenues under the current HHPPS and an opportunity to benefit from the Value Based Purchasing (P4P) model that will become part of the payment system. Benchmarking the clinical outcome results identifies the target areas for improvement opportunities.

The "Transitions in Care" Rules that go into effect for hospitals present a great opportunity to achieve increased market share and develop alliances with hospitals and health systems to prevent their patients from having unplanned re-hospitalizations. Home health clinical practice standards that integrate telehealth, not just as an add-on, will provide the technology that can achieve these goals when coupled with a Primary Care field clinician model. Hospitals have already started looking for partners to achieve their goals.

Positioning for Rebasing, yet to be modeled, is the goal for the next three year period. Identifying the areas for change and making those improvements while maintain positive margins will be a challenge for many agencies. Utilizing all available resources and technology while keeping an open mind to change will be a key to a successful conversion to a rebased 2014.