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EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE HOME CARE

Optimizing Payor Sources for Diversification and Profitability

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About the Presenter

- Thomas Rose is CEO & President of 21st Century Health Care Consultants
  - Former Army Special Forces Officer (Green Berets)
  - General Electric companies
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    - Senior Director FP&A
    - VP Operations
    - Chief Financial Officer of GE's $2B asset management company.
- Two decades of business leadership
- B.S. Degree in Management from Methodist University
- MBA from Webster University
- Private Equity Certificate from Wharton School
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Session Description and Learning Objectives

- This session discusses the importance of diversifying your agency's payor sources and measuring and tracking them individually for their respective profitability. This session will provide a high-level overview of the payor sources available to homecare agencies, some of the benefits and challenges of each.

- Learning Objectives:
  - Learn and become familiar with the various payor sources available to your agency
  - Learn how to understand and monitor profitability by payor source
  - Learn how to optimize your payor source mix and how to monitor it for optimal profitability

Government Payor Sources

- Medicare
- Medicaid
- Home- and Community-Based Services (HCBS) Waivers
- Self- (or Patient)-Directed Care
- Veterans Affairs (VA)
- TRICARE

Private Payor Sources

- Medicare Advantage (MA) Insurance
- Private Insurance
- Long-Term Care Insurance
- Federal or State Worker's Compensation Insurance
- Managed Care Organizations (MCOs)
- Private Pay

Medicare – Largest Source of Funds

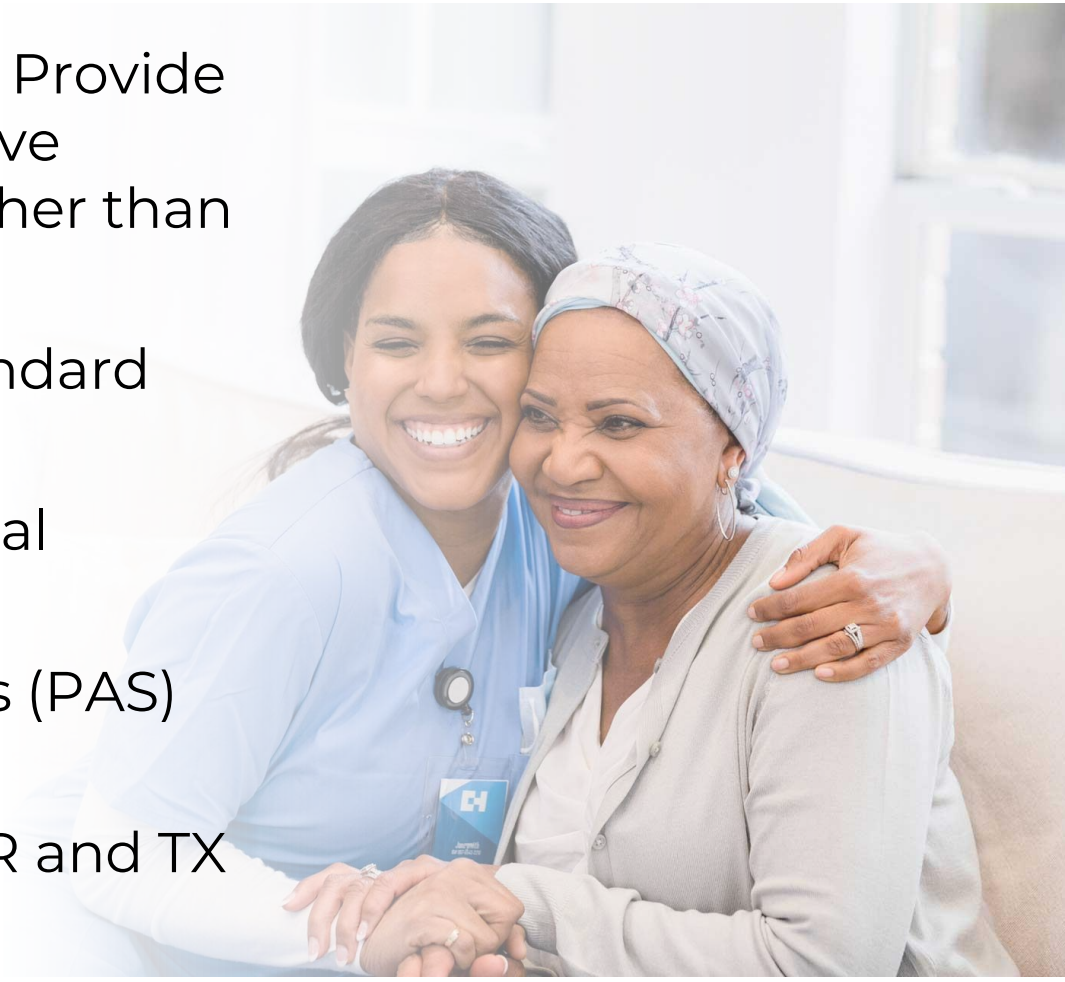
- **Coverage**: Medicare covers 100% of home health medical costs
- **Rates**: Medicare pays a national standardized rate
- **Covered home health services** include: Medically necessary part-time or intermittent skilled nursing care
- **Additional ADL Support**: Part-time or intermittent home care ADL support available
- **Medicare Certification**: Agencies must be Medicare certified

Medicaid – State Run Federal Program

- **State Medicaid Programs**: Depending on the state, Medicaid applies to Skilled Home Health agencies that are Medicare certified.
- **Home Health services** may include:
  - Home Health visits (skilled nursing and home health aide) for Medicaid recipients ages birth through end of life
  - Private duty nursing and personal care services for Medicaid recipients under 21 years old.
- **Typical Services**: home health care and more

HCBS Waivers

- **Home and community-based services** (HCBS): Provide opportunities for Medicaid beneficiaries to receive services in their own homes or communities rather than institutions or other isolated settings.
- **1915(c)**: Programs: Provide a combination of standard medical services and non-medical services.
- **1915(i)**: Adds a combination of acute-care medical services and long-term services.
- **1915(j)**: Self-directed personal assistance services (PAS) are personal care and related services.
- **1915(k)**: Community First Choice. CA, MD, MT, OR and TX



Self or Patient Directed Care

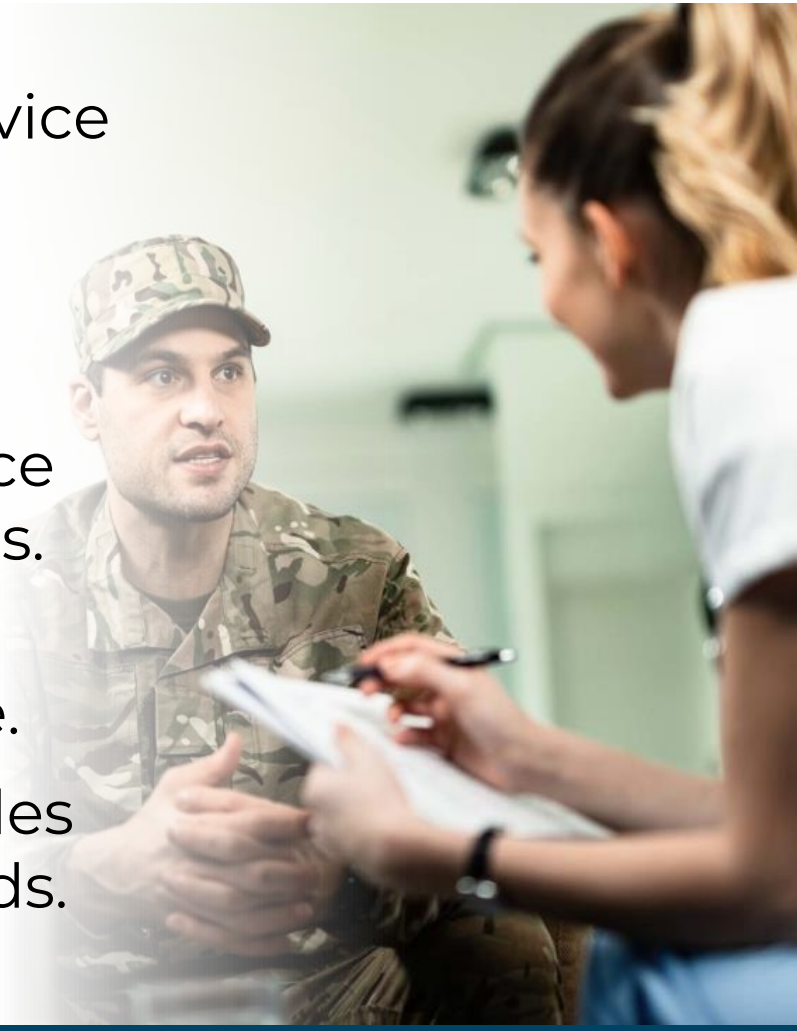
- **Self-directed Medicaid Services**: Means that participants have decision-making authority and take direct responsibility to manage their services.
- **Guidelines**: Each Medicaid funding authority has different guideline.
- **Support broker/consultant/counselor** must be available to each individual who elects the self-direction option.
- **Financial Management Services** (FMS) must be available to assist individuals in exercising budget authority.

Veterans Affairs (VA)

- The VA provides various benefits to eligible veterans, including home health care under certain circumstances.
- **Homemaker and Home Health Aide Care** (H/HHA) program: Helps veterans remain independent while they continue to live in their own homes.
- **Aid and Attendance Pension**: An additional monetary benefit—for eligible wartime veterans and their surviving spouses.
- **Program of Comprehensive Assistance for Family Caregivers** (PCAFC): Benefits for the Primary family caregiver.
- **Veteran Directed Care** (VDC) program

Military TRICARE

- **TRICARE** is a health care program for uniformed service members, retirees, and their families.
- **TRICARE** covers active and reserve duty military members, spouses and family.
- **TRICARE for Life** covers retired and some post service military members, spouses and families and survivors.
- **Home Health Care**: The services covered under TRICARE are the same as those covered by Medicare.
- **Extended Care Health Option** (ECHO): ECHO provides financial assistance to beneficiaries with special needs.



Medicare Advantage

- **Medicare Advantage**, also known as "Part C", is a type of health plan offered by private companies that provides all the benefits of Original Medicare
- **Medicare Advantage** plans are managed by private insurance companies that contract with Medicare.
- These plans must cover all the same services as Original Medicare (hospital stays and medical services)
- Many companies offer MA plans
- MA plans reimburse up to 40% less than Medicare

Private Insurance

- **Private insurance** plans typically cover skilled nursing care, therapy services, and personal care assistance.
- **Credentialing**: Agency must often become a credentialed provider
- **Verification**: It's crucial to verify the specific coverage to understand what services are eligible for billing.
- **Important Considerations**:
- Coverage variations
- Medical necessity
- Patient consent
- Compliance with Regulations
- Accurate billing

Long-Term Care Insurance

- Long-Term Care Insurance policies can cover a wide range of benefits.
- The Client Requires Help with Specific Daily Activities
- The Client is Diagnosed with Severe Cognitive Impairment

Workers Compensation Insurance

- **Federal**: The U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP) administers the Federal Employees' Compensation Act (FECA).
- **State**: Each state in the U.S. handles its own workers' compensation rules.
- **Private insurance companies**: These companies set their own prices and approve or reject customers.
- **State-funded workers' compensation insurance**: If a private carrier can't provide coverage, a state fund can help.
- **Competitive state-funded workers' comp**: In this case, the state offers coverage from both a private carrier and a state program.

Managed Care Organizations (MCOs)

- **Managed Care** is the primary delivery system for Medicaid enrollees in most states.
- **MCOs** are contracted organizations that provide Medicaid health benefits and other services to state Medicaid agencies.
- **General Requirements**:
  - Home Care/Home Health Agency licensure (state dependent) is required
  - Some states require accreditation (e.g. ACHC, CHAP, TJC) for Medicaid approval or credentialing
  - In states without licensure or accreditation proceed directly to the application

Private Pay

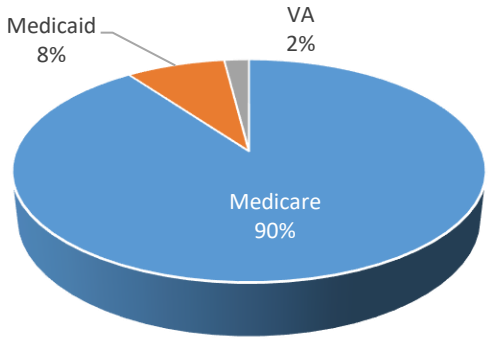
- **Private Pay**: A person or their family may pay for long-term care and home healthcare services on their own.
- **Funding Sources** Agencies Should Discuss with Clients:
  - Private funds
  - Home Equity loans
  - Life Insurance Conversions
  - Older Americans Act (OAA)
  - Social services block grant programs
  - Community organizations
  - Veterans Administration

Why The Need for Diversification?

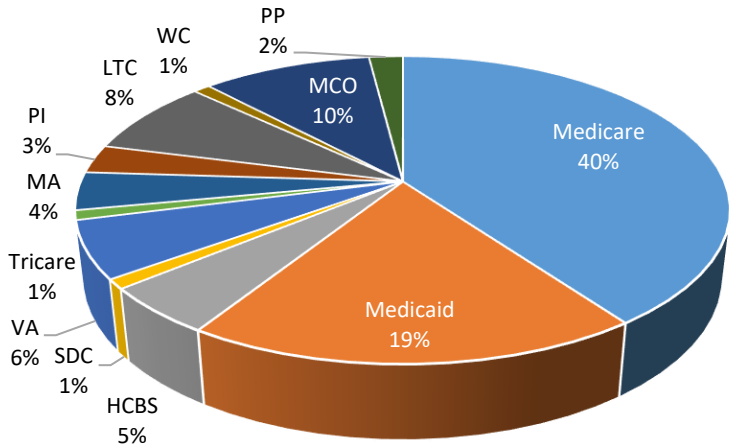
1. Risk Mitigation
Payor concentration creates risk because it positions the agency to lose a significant revenue source if that payor is lost

2. Competitive Advantage
The more payors an agency can accept creates market opportunities otherwise Unavailable

3. Higher Profitability
Optimizing higher margin payors and clients creates higher profits so long as support costs are understood and managed



Versus



4. Caregiver Retention
Caregiver satisfaction and retention are critical in our industry. An agency's ability to offer higher pay rates and varying opportunities supports retention.

5. Increased Referrals
The more payor sources an agency accepts, allows for a more diverse array of referral sources

6. Business Stability
As payor sources shift and government rules change, a broader mix of payors minimizes disruption

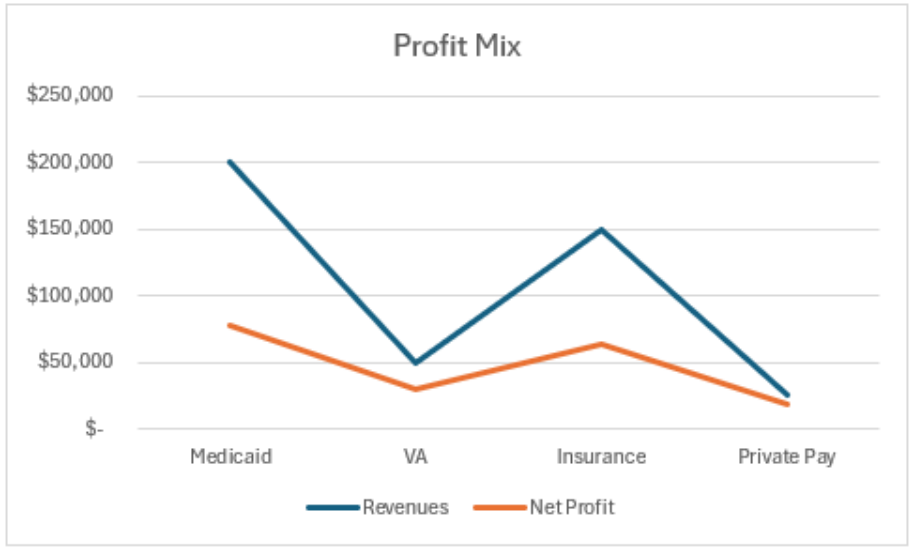
Key Metrics and Why

- **Payer mix** refers to the proportion of revenue generated by different types of payers
- **Payer mix analysis** allows healthcare organizations to evaluate their financial performance, identify areas of improvement, and make informed decisions to optimize their revenue.
- **Identify Trends and Opportunities** for Improvement
- **Develop Strategies** for optimizing payer mix
- **Key Metrics to Evaluate**:
  - Payer Mix Percentage
  - Payer Mix Margin
  - Payer Mix Shift
  - Denial Rate

Payor Mix Percentage

	Medicaid	VA	Insurance	Private Pay	Total
Gross Revenues	**$ 200,000**	**$ 50,000**	**$ 150,000**	**$ 25,000**	**$425,000**
Billable Hours	7,500	1,200	4,200	450	13,350
Non-billable Hours (5%)	375	60	420	5	860
Total Hours	7,875	1,260	4,620	455	14,210
Hrs/Week/Client	35	16	10	40	
Census	214	75	420	11	
Rev/Billable Hrs	$ 27	$ 42	$ 36	$ 56	$ 160
Rev/Total Hrs	$ 25	$ 40	$ 32	$ 55	$ 153
Caregiver Cost $15/hr	**118,125**	**18,900**	**69,300**	**6,818**	**$213,143**
Gross Profit	**$ 81,875**	**$ 31,100**	**$ 80,700**	**$ 18,183**	**$211,858**
Gross Margin Bill Hrs	***41%***	***62%***	***54%***	***73%***	***50%***
Customer Acq. Cost/Ea	$ 5	$ 15	$ 12	$ 25	
Customer Acq. Cost Total	**$ 1,071**	**$ 1,125**	**$ 5,040**	**$ 281**	
Office Processing Hours/Client	1	0.25	2	0.1	
Office Processing Hours $15/hr	**$ 3,214**	**$ 281**	**$ 12,600**	**$ 17**	**$ 16,112**
Total SG&A	**$ 4,286**	**$ 1,406**	**$ 17,640**	**$ 298**	$ 23,630
Net Profit	**$ 77,589**	**$ 29,694**	**$ 63,060**	**$ 17,884**	$188,227
Net Margin	***39%***	***59%***	***42%***	***72%***	***44%***

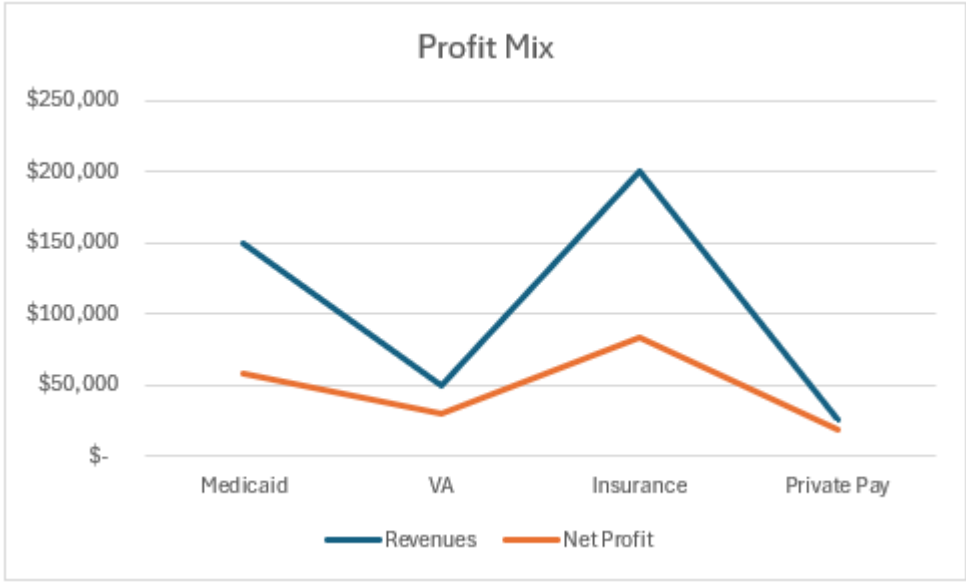
	Medicaid	VA	Insurance	Private Pay	Total
Revenues	$ 200,000	$ 50,000	$ 150,000	$ 25,000	$425,000
% of Total	47%	12%	35%	6%	
Net Profit	$ 77,589	$ 29,694	$ 63,060	$ 17,884	$188,227
% of Total	41%	16%	34%	10%	



Payor Mix Shift

	Medicaid	VA	Insurance	Private Pay	Total
Gross Revenues	**$ 150,000**	**$ 50,000**	**$ 200,000**	**$ 25,000**	**$425,000**
Billable Hours	5,625	1,200	5,600	450	12,875
Non-billable Hours	281	60	560	5	906
Total Hours	5,906	1,260	6,160	455	13,781
Hrs/Week/Client	35	16	10	40	
Census	161	75	560	11	
Rev/Billable Hrs	$ 27	$ 42	$ 36	$ 56	
Rev/Total Hrs	$ 25	$ 40	$ 32	$ 55	
Caregiver Cost $15/hr	**88,594**	**18,900**	**92,400**	**6,818**	**$206,711**
Gross Profit	**61,406**	**31,100**	**107,600**	**18,183**	**218,289**
Gross Margin Bill Hrs	***41%***	***62%***	***54%***	***73%***	***51%***
Customer Acq. Cost/Ea	$ 5	$ 15	$ 12	$ 25	
Customer Acq. Cost Total	**$ 804**	**$ 1,125**	**$ 6,720**	**$ 281**	
Office Processing Hours/Client	1	0.25	2	0.1	
Office Processing Hours $15/hr	**$ 2,411**	**$ 281**	**$ 16,800**	**$ 17**	**$ 19,509**
Total SG&A	**$ 3,214**	**$ 1,406**	**$ 23,520**	**$ 298**	$ 28,439
Net Profit	**$ 58,192**	**$ 29,694**	**$ 84,080**	**$ 17,884**	$189,850
Net Margin	***39%***	***59%***	***42%***	***72%***	***45%***

	Medicaid	VA	Insurance	Private Pay	Total
Revenues	$ 150,000	$ 50,000	$ 200,000	$ 25,000	$425,000
% of Total	35%	12%	47%	6%	
Net Profit	$ 58,192	$ 29,694	$ 84,080	$ 17,884	$189,850
% of Total	31%	16%	44%	9%	



Payor Mix Analysis

- Where Is Growth Maximized by Payor Type?
  - Assume growth into Medicaid, Private Pay and VA
  - Assume Caregiver Shortage
  - Assume Average Rates and Margins

	Hourly Rate	Gross Profit	Gross Margin	Hrs/Week	Wks/Yr	Annualized GP
Medicaid	$ 25.00	$ 5.00	20%	40	52	$ 10,400
Private Pay	$ 45.00	$ 15.00	33%	20	52	$ 15,600
VA	$ 35.00	$ 20.00	57%	12	52	$ 12,480

	GP Growth Goal	Gross Revenues	Hours Billed	New Clients	Hours/Client	2080 Hours GP
Medicaid	$ 100,000	$ 500,000	20,000	10	40	$ 10,400
Private Pay	$ 100,000	$ 300,000	6,667	6	20	$ 31,200
VA	$ 100,000	$ 175,000	5,000	8	12	$ 41,600

	Caregiver 40 Hrs	Caregivers/ $100K GP
Medicaid	1 Client	9.6
Private Pay	2 Clients	3.2
VA	3 Clients	2.4

Source: Greg Bean, Paradigm VA Presentation 2024

Medicare Versus Medicare Advantage

Gross Margin (GM) = Revenue – Direct Costs

Did You Know… Traditional Medicare GM is 40-45% while Medicare Advantage is 30-32%

Back-Office Staffing Impact Should be Considered – A Cost You May Not Measure

	Traditional Medicare	**Medicare Advantage**	
Insurance Verification	1 FTE per 100 Daily Referrals	1 FTE per 40-45 Daily Referrals	2.3 More FTE
Initial Authorization	No Staff Needed	1 FTE per 20-25 Daily Admissions	4 More FTE
Ongoing Authorization	No Staff Needed	1 FTE per 250 Average Daily MA Census	0.4 More FTE
Billing, Collections, Cash Posting	1 FTE per $15-20M in Annual Revenue	1 FTE per $5-10M in Annual Revenue	3 More FTE

10 More FTE Required

Source: Greg Bean, Paradigm VA Presentation 2024

Accurate Analysis and Tracking

- Key Performance Indicators (KPIs)
  - Payer mix by admissions & revenue
  - Payer mix by marketers and referral sources
  - Visits by Discipline
  - Episodic
  - PDGM metrics
  - Pay per Visit
  - Visits per patient
  - Visit volumes by location
  - Visits with latency tail to determine latency of revenue cycle

KPIs Considerations

- PDGM versus MA Pay per Visit Providers
- What were the differences?
- Moving from a predominately PDGM Home Health agency, to an MA provider
- Shift in focuses around KPIs
- Contracts: Episodic, Pay per Visit or Hybrid

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Thank you

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