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INSIDE

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American Health Consultants® is A Medical Economics Company

A shadow of things to come? Rehab home health enters prospective pay era

Staff productivity, expense reduction more important than ever

Hospital rehab administrators fearful of the impact of the prospective payment system need only look around the corner for a glimpse of things to come. The home health industry has been hit with prospective payment mechanisms for Medicare patients somewhat sooner, thanks to the interim payment system (IPS), the pre-prospective payment, cost-containment initiative from the Health Care Financing Administration (HCFA).

Life under IPS translates into a financial and operational juggling act for home health rehab providers. Agencies are dealing with across-the-board payment reductions, limitations on the number of patient visits, and staff training on how to use a new patient assessment instrument, OASIS (Outcome and Assessment Information Set), while grappling with ways to minimize the impact on quality of patient care. The OASIS instrument is a series of questions therapists must ask patients during an initial evaluation, at interim points, and upon discharge. Its goal is to assess the patient's health status and monitor improvements.

Agencies have responded in different ways, says **David Perry**, MS, PT, manager of physical therapy and occupational therapy at the

Executive Summary

Subject:
Interim payment system (IPS), a pre-prospective payment reimbursement system

Essential points:
- ❑ IPS is causing home health agencies to look at expense reductions, staff lay-offs or pay reductions, and automation as ways to cope.
- ❑ Many industry leaders say there are ways to succeed, including an increased focus on patient outcomes and encouraging therapists to make the system work for them.
- ❑ Many agencies say they are using the OASIS patient assessment tool even though the Health Care Financing Administration has delayed its implementation.

Visiting Nurse Association (VNA) of Southeast Michigan in Oak Park, MI, and treasurer of the American Physical Therapy Association (APTA) in Alexandria, VA.

HCFA statistics released earlier this year state that IPS will reimburse 93% of all home health agencies at less than their costs.

As with hospital rehab, government financing of care underwent a makeover following passage of the Balanced Budget Act of 1997. Traditionally, Medicare-certified home health services were paid based on agencies' reasonable costs capped at a national per-visit cost calculation. There was no limitation on the number of visits.

Under IPS, these agencies receive the lesser of their reasonable costs, a per-visit limit or a per-beneficiary limit.

Integration leads to efficiency, success

Although the much-publicized techniques of layoffs and salary reductions have prevailed at many agencies, organizations also are employing long-range strategies to increase staff efficiency and productivity.

"We are developing successful approaches," says **Karen Crockett Lindstrom**, PT, MBA, divisional director of professional support services for SunPlus Home Health Services in Burbank, CA. Lindstrom also is president of APTA's home health section. "We are spending more time coordinating care but are finding we can be successful under the IPS rates. It's extremely challenging because it takes constant surveillance of monitoring clinical functions and your business functions. Everything is integrated. It's critical to focus on good clinical care, but if your office functions are sloppy and you don't you get your bills out or actively collect [for money owed], you can lose or waste money."

Techniques that have worked well for SunPlus include:

• **Focusing even more on patient outcomes during weekly team meetings between clinicians and administrators.** Although team meetings have long been a staple of the rehab world, SunPlus managers have kept treatment discussions focused on how these are helping to achieve goals. The key is to have a strong manager leading the meetings who can step back and keep people on track, Lindstrom says.

• **Deciding more quickly which caregivers and which treatments to use on patients.** "We're saying, 'Let's look right away at what the patient's impairment is and what they need,'" Lindstrom explains. "We don't have time to waste on trying a few visits here and there for each discipline. We've got to focus much more quickly on meeting the needs of the patient and deciding which interventions will get you to these goals."

• **Expanding the involvement of physical therapists when appropriate.** This is done in several ways, Lindstrom says. Because Medicare regulations allow physical and speech therapists to open a case, those practitioners may do initial patient assessments, whereas in the past, skilled nurses may have been called in solely to evaluate a patient and open the case. Perry says VNA also has used that approach.

At Optima HomeCare, a division of WakeMed Hospital in Raleigh, NC, cross-training also has been an effective tool, says **Dottie Oakes**, RN, MS, executive director. "We have examined the scope of service for each discipline to evaluate maximum productivity. For example, if we have the physical therapist there for a visit, we consider whether they can be doing other things. They traditionally have focused on maximizing mobility and muscle strengthening, but there also are other functions they can perform well, such as wound care."

The best thing hospitals can do to prepare for the prospective payment environment is to develop a strategic plan that addresses expense management and monitoring clinical outcomes to assure they are maintaining quality care while operating cost-effectively, Oakes says. A strategic plan that addresses expense management, staff productivity, and clinical outcomes has prepared Optima for the impact of IPS, she says.

All three managers stress the importance of

COMING IN FUTURE MONTHS

- Transfer payment rules for hospitals causing confusion
- Coding tips for private practices
- Prospective payment update
- OASIS launch prompts privacy concerns
- More hospitals switching to product line management

communication between hospital rehab departments and home health facilities they use frequently. "Try to work . . . together as to how the whole continuum of care can operate more efficiently," Perry says.

Because Optima is affiliated with WakeMed Hospital, regular communication takes place between case managers at Optima and case managers at the hospital's rehab unit, Oakes says. It is important to share common goals and identify problems that affect patient care throughout the continuum. The solutions and the responsibility for patient outcomes are shared, she says. ■

Agencies using OASIS despite HCFA delay

Outcomes tool seen as valuable despite kinks

You've spent months studying and quizzing yourself for an upcoming professional licensing exam when your boss drops a bomb just days before the test. Your hospital's requirement for all managers to pass the exam has been put on hold until further notice, the announcement states. How many of you, if faced with this scenario, would take it anyway?

Quite a few, apparently. Officials from several home health agencies have told *Rehab Continuum Report* they plan to collect OASIS data on Medicare patients despite an April 27 announcement from the Health Care Financing Administration (HCFA) that its implementation would be delayed indefinitely. The controversial patient assessment instrument first must clear several more regulatory hurdles, including the Paperwork Reduction Act, according to the HCFA announcement.

Most observers believe the agency will take at least several months to address the farther-reaching concerns Congress and others have about the dimensions of OASIS (Outcome and Assessment Information Set). The home health industry has been protesting the size and scope of OASIS for months.

It was not until the extent of the OASIS collection requirements were splashed across the front page of *The Washington Post* in March that pressure on HCFA started to become unbearable. That story outlined the sensitive nature of the questions patients would be asked, such as the status of their personal finances and whether they have suicidal tendencies.

Regardless of these concerns, many home health agencies have decided to use the OASIS instrument as is to help measure their patient outcomes.

"There are some real opportunities from measuring outcomes through OASIS," says **Karen Crockett Lindstrom**, PT, MBA, divisional director of professional support services for SunPlus Home Health Services in Burbank, CA. Lindstrom also is president of the community home health section of the Alexandria, VA-based American Physical Therapy Association (APTA). SunPlus has received positive feedback from its clinicians on the way it integrated OASIS requirements into the company's existing patient assessment tool.

As a result, SunPlus is allowing its agencies to choose one of two options regarding data collection. Agencies may use the patient assessment instrument when doing admission and discharge evaluations, but they do not have to fill out the forms at interim points as initially required by HCFA. Or agencies may use the assessment tool throughout the patient's treatment, including at interim times. "Some agencies don't want to go back and change things again three months later" after HCFA lifts the OASIS delay, Lindstrom says.

Keeping OASIS eases transition

Optima Homecare, a division of WakeMed Regional Hospital in Raleigh, NC, also has decided to maintain OASIS measurement in order to make the transition easier on staff. "HCFA will have some tool of outcomes measurement based on OASIS. Once you have it in place, and have gone through the training time with your staff, why pull it?" asks **Dottie Oakes**, MS, RN, executive director of orthopedics and neuroscience at Optima Homecare.

Oakes says the OASIS tool takes staff an average of 30 minutes to complete. OASIS can be a valuable tool because it helps place outcomes in the spotlight, she says. It is especially important in a prospective payment environment because it focuses on balancing cost-cutting and patient outcomes.

Automation of OASIS data also has worked well for the Visiting Nurse Association (VNA) of Southeast Michigan in Oak Park, MI. Although some agencies developed three OASIS forms — one each for use upon admissions, interim

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measurements, and discharge — VNA chose to develop one tool, says **David Perry**, MS, PT, manager of physical therapy and occupational therapy. Staff completing the forms simply skip the questions that are not required for interim measurements, which are clearly marked on the sample form.

Like Optima HomeCare, VNA did not want to use the advantages it gained in training staff to use the form, Perry says. He suggests hospital rehab departments that will have to adapt to using the MDS-PAC patient assessment tool work out bugs in the system through small pilot groups. VNA began planning for OASIS implementation more than a year before its requirement by doing just that. ■

BBA means lost jobs, lost revenue, studies find

$71 billion in Medicare cuts expected

If you think rehab hospital officials have been grumbling about the Balanced Budget Act of 1997 (BBA) the past few months, you're right. But if you think they have no reason to grumble, you're wrong, according to two recently released studies from the American Hospital Association (AHA) and American Physical Therapy Association (APTA).

The BBA is projected to cut billions of dollars in hospital revenue, and unemployment among physical therapists practicing in facilities already operating under prospective payment has increased.

A study conducted for the AHA in Chicago finds that the BBA is projected to cut $71 billion in Medicare payments to hospitals, which may cause seven of 10 hospitals to have negative total Medicare margins within three years. The study concludes that for all hospitals, total Medicare margins are projected to be between -4.4% and -7.8% in 2002.

Both rural and urban hospitals will feel the brunt of that decline, the AHA study reports. Rural hospitals' total Medicare margins may drop to between -10.4% and -7.0% in 2002 as a result of BBA payment cuts, while urban hospitals' total Medicare margins in three years are predicted to range from -7.3% to -3.9%.

Some communities could lose services

In just one year, margins for hospital-based home health services are predicted to drop from -4.0% in 2000 to -11.6% in 2001, the study concludes. Medicare outpatient margins are estimated to drop to -28.8% if costs increase at their historical rate of growth or -0.3% if hospital costs increase more slowly.

"Hospitals don't want to compromise on quality or worker protections, but communities should be concerned that all of the types of services previously available may not be any longer," AHA president Dick Davidson said in a prepared statement.

Health care practitioners in skilled nursing facilities and home health care already are feeling the brunt of the BBA's impact **(see story, p. 81, on the BBA's affect on home health agencies)**. A study released in mid-May from the Alexandria, VA-based APTA says that approximately 3% of therapists responding to its member survey indicate they are unemployed. The unemployment rate compares to a 1.2% unemployment rate reported in an October 1998 APTA survey.

More than half of the unemployed respondents in the most recent survey (53%) said they were practicing in a skilled nursing facility, APTA reports. In addition, 20.1% of the respondents said their number of hours worked had been reduced involuntarily.

According to the May survey, approximately 78.6% of physical therapists are employed full time, a 2% decline from the October 1998 survey.

(*Editor's note: For a full copy of the Lewin Group study, visit AHA's Web site at www.aha.org.)* ■

Industry groups still seeking PPS formula

HCFA says decision still up in the air

With the Oct. 1, 2000, implementation deadline for the hospital rehab prospective payment system looming increasingly closer, industry arguments for a per-discharge payment methodology have picked up steam. At stake: how the Health Care Financing Administration (HCFA) pays hospitals and medical facilities for physical rehabilitation costs under Medicare.

The latest to enter the debate is U.S. Rep. Bill Thomas (R-CA), head of the House Ways and Means Subcommittee on Health. Thomas has urged HCFA to drop its traditional approach of a per-diem payment methodology, which pays set daily prices for rehabilitation services based on the type of service provided. Industry groups have long argued that a per-diem system will provide an incentive for hospitals to decrease daily costs, cut back on services provided each day, and even increase lengths of stay for rehab patients.

Taking the fight public

Under the per-episode methodology, however, prices would be based upon the entire cost of treating an injury.

"Having reviewed this issue thoroughly, I strongly urge you to implement a discharge-based system," Thomas wrote to HCFA administrator Nancy Ann DeParle in a letter published in *The Washington Times*. Calls to Thomas' office by *Rehab Continuum Report* were not returned.

"Rumor has it that the HCFA will go along with Mr. Thomas' recommendation," one Washington insider told *Rehab Continuum Report*. However, HCFA has not yet made a decision on the payment methodology issue, says HCFA spokesman **Craig Polotsky**.

Industry groups such as the American Hospital Association (AHA) in Chicago and the American Medical Rehabilitation Providers Association (AMRPA) in Washington, DC, continue to lobby HCFA heavily in favor of the per-episode payment methodology. AMRPA has posted data on its Web site that further support the issue **(see editor's note at right)**.

"HCFA asserts that a per-discharge approach may result in patients being discharged prematurely, or facilities stinting on care," a statement posted on the Web site reads. "AMRPA has noted that while the length of stay for rehab patients has dropped, functional improvement has remained the same."

Data posted on the Web site shows an AMRPA analysis of reports from 1990 to 1997 from the Uniform Data System for Medical Rehabilitation (UDSMR), which developed a functional outcomes measurement system widely used among rehab providers, the Functional Impairment Measurement (FIM). Information also is included from Medicare cost reports for a similar time period.

The American Hospital Association is concerned about cuts in outpatient hospital rates under the prospective payment system.

For Medicare UDSMR patients, the length of stay dropped from 28 days in 1990 to 17 days in 1997,AMRPA reports. For Medicare UDSMR patients from 1994 to 1998, the length of stay dropped from 19.7 days to 15.5 days. "In 1990, patients gained 23.2 FIM points for all patients, and in 1994, 21.4 points for Medicare patients in functional ability and [patients] demonstrated the same gain in 1997 and 1998 for Medicare with little or no change in the interim," AMRPA reports.

The AHA also is concerned about the cuts in outpatient hospital rates that will occur under prospective pay, says **Debra Williams**, senior associate director for policy. Williams says HCFA told AHA in mid-May that the calculations showed a planned 5.7% reduction in base pay to hospitals for outpatient services, rather than the previously believed 3.8% reduction. "It is our belief that HCFA wanted the system to be budget neutral, that it intended for hospitals to neither lose nor gain revenue," she says. As a result, she says, AHA will continue to push for changes to the outpatient PPS formula so hospitals are not unfairly penalized for decreasing Medicare beneficiary copayments.

The bottom line: It should be an interesting summer. Stay tuned.

(Editor's note: A full copy of the Medicare UDSMR data is available on AMRPA's Web site at www.amrpa.org.) ■

Motivating employees in era of Chicken Little

Stressing new projects, opportunities can work

If you're not careful, coming to work in the rehab business these days can lead to a serious depression or, at the least, an annoying headache that won't go away. Headlines screaming of declining unemployment rates among therapists, financial losses at rehab companies, and declining government reimbursements for rehab providers are enough to make anyone's head spin. How can you as a manager motivate employees in these trying times? It can be done, insist managers interviewed by *Rehab Continuum Report*.

An approach that works for **Karen Crockett Lindstrom**, PT, MBA, divisional director of professional support services for SunPlus Home Health Services in Burbank, CA, is to focus on the positive aspects of change. "Yes, the changes being forced upon us by prospective pay are painful to go through. But administrators who continue to focus staff on doing a better job and don't let them get stuck in thinking about how it used to be can succeed. It helps to go over [patients'] record reviews and see that patients are reaching their goals and that they're still getting good care. The bottom line is, we're still getting good outcomes."

Lindstrom also helps therapists recognize they have skill sets that reach beyond the traditional treatment and educational role. Therapists should be willing to take the lead and identify cost-effective solutions for hospital management or corporate clients.

"Therapists can serve as a case manager, just as many nurses have done in the past," she says. "The educational background, along with some continuing education courses, allow therapists to step into that role. This is actually a compliment and recognition of the skills and abilities of therapists. Expanding their skill set to be able to do this well will secure them a place in the health care environment of the future and will better secure their jobs long-term. If a therapist can be an active participant in coming up with solutions, they will become more valuable. It's an opportunity for therapists to grow and develop if they aren't already there."

Lindstrom says she also encourages therapists to work actively to help identify other treatment alternatives without taking on the case manager role. For example, a physical therapist could come up with a care plan that involves an initial assessment visit by a physical therapist, followed by several visits from a physical therapy assistant at a lower rate than the physical therapist normally would charge. If state regulations allow it, a physical therapy assistant can be a cost-effective option as long as there is adequate supervision by a physical therapist.

"If a physical therapist steps in this way and says, 'I can find a way to reduce your costs. I'll do the assessment, I'll supervise the physical therapy assistant, and I'll assure the service she is providing is appropriate,' this helps clients reach goals for less money. And the therapist becomes a resource in the process," Lindstrom says.

At Rehabilitation Affiliates in Wayne, PA, regional director **Wendy Coulter**, OT, MS, focuses on two areas: the job flexibility available to staff (Rehabilitation Affiliates is part of Jefferson Health Systems, an integrated delivery system) and getting clinical employees involved in program development.

Rotations let staff see the big picture

At Rehabilitation Associates, staff rotations are available every three to six months, Coulter says. Therapists can work in a freestanding rehab hospital, a home care setting, in long-term care, and in a teaching hospital. "It's exciting for people. They really get to look across the system and see where care is applied across the continuum. They feel they have an impact across several different areas," she says.

Coulter acknowledges that not every facility has this luxury. But another element of her motivational strategy could be transferred to organizations that are not part of an integrated delivery system. She encourages clinicians to get involved in program development, working with employees from several departments to help develop new products or services.

Coulter lists two examples of programs currently under development: an occupational rehab services area, which conducts assessments and treatment plans at area work sites, and a community-based pediatric program that includes an occupational therapy component for neonatology patients.

These programs help employees feel they are part of a bigger picture and can even open up

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new career paths, she says. "There are so many different roles therapists can play beyond traditional rehab, and this helps them branch out."

Lindstrom says there always will be jobs for good therapists. "I know how hard it is for people now to be able to not have jobs at their will. But I think it will actually raise our standard of performance. The therapists who are the best will get the work. They have to be good clinicians, have strong assessment skills, and be team players." ■

NovaCare study shows post-PPS FIM decline

Functional gains, treatment hours drop

A study by a NovaCare subsidiary offers support to a concern many rehab managers are voicing in light of life under a prospective payment system (PPS) environment: Functional gains do indeed decline, but not in direct proportion to reductions in the number of treatment hours.

Data from the study, which reviewed functional gains and length of treatment for more than 100,000 skilled nursing facility (SNF) rehabilitation patients, show that while there is room for productivity improvements in SNFs, reimbursement cuts implemented under PPS may have gone too far.

The bad news: Functional Independence Measurement (FIM) scores declined 15% for the more than 1,000 NovaCare patients studied between July 1998 and April 1999, says **Reg L. Warren**, PhD, vice president of outcomes research for The Polaris Group Inc., a subsidiary of NovaCare in King of Prussia, PA. Many rehab facilities used FIM scores as a way to measure the influence of therapy on patient activities of daily living skills such as dressing, toileting, and eating.

The good news: That's not quite as drastic compared to the 42% decline in the number of treatment hours delivered to those patients (34 average hours of patient care under PPS, compared with 58 hours previously). Clearly, the disparity shows there's room for greater efficiency in the rehabilitation process, Warren says.

Early indications are that an optimal threshold of care can be reached through a correct balance between reimbursement and utilization of therapy that is about halfway between current payment rates and the way SNFs were paid previously, Warren concludes.

An analysis of 1,311 patients under the PPS system and 208 patients under the cost-based system found that while the average patient age (82) and initial disability based on FIM measurements (61) were identical, functional outcomes following treatment declined from a 20-point gain in FIM scores to a 17-point gain in FIM scores. **(See chart, p. 92.)**

"That roughly correlates with an increase in the burden of care for these patients of nine to 10 minutes per day," Warren says. " If that care happens to be, for instance, in toilet transfers or communicating in an emergency situation, that can be a very predictive of whether a given patient can return to the community. (However, current levels of discharge to the community have not declined significantly.) The chart on p. 92 also reveals the following information:

1. The average number of days between a patient's initial admission to the hospital and his or her admission to a skilled nursing facility increased from 15 days to 17 days. That likely is due to the implementation of a transfer rule by the Health Care Financing Administration, Warren says. The transfer rule gives hospitals incentives to keep patients in certain diagnostic groups for a longer portion of their diagnostic group's length of stay.

2. Length of stay at NovaCare facilities was roughly the same — 28 days under PPS, compared with 27 days previously. Warren says he expects a trend in which providers will lengthen

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Executive Summary

Subject:
NovaCare study finds reimbursement cuts damaging functional outcomes in skilled nursing facilities.

Essential points:
- ❑ When prospective pay is implemented, therapists give more care than the facility is reimbursed for because they don't want to shortchange patients. That levels out over time as therapists become more comfortable operating in a capitated setting.
- ❑ NovaCare says the data provide hard evidence that changes are needed in the prospective payment system for skilled nursing facilities.

Benchmark: PPS vs. Cost-Based

Source: Graphs on pp. 92-93 are courtesy of The Polaris Group, a subsidiary of NovaCare in King of Prussia, PA.

Cost-Based Reimbursement
Average Minutes per Week by Admission FIM: SNF, Medicare A Patients

(Continued from page 91)

rehab lengths of stay in compensation for less treatment per day. However, it is unknown whether more treatment will offset the loss of intensity of the treatment.

Further data analyses of NovaCare patients found the following:

1. Utilization of various severity levels of patients varied greatly. Patients with either very low FIM scores (indicating they were severely disabled with little hope of significant improvement) and very high FIM scores (indicating disabilities were minimal) received less care than patients in the middle of the spectrum, who exhibited a fairly high level of disability but showed good potential for improvement.

2. Overall, patients received an average of 571 minutes of care a week, although patients with low FIM scores received 475 minutes of care per week while patients with high FIM scores received an average of 500 minutes of care per week. This inverse, U-shaped curve is somewhat parallel with trends under the cost-based system but at a lower overall utilization level, Warren says. That is, regardless of payment incentive, clinicians tend to administer treatment intensity in terms of their perception of patient need, which is influenced by their perception of patient disability (e.g., admission FIM score).

3. An optimal level of care for orthopedic patients studied was 60 hours. After that point, functional improvements leveled off. Unfortunately, reimbursement under PPS for these patients only totaled an average 38 hours. "That's why FIM gains dropped 25% for the orthopedics group," Warren points out. "Unfortunately, PPS is a per-diem rather than episodic payment system. This results in an almost microscopic focus on daily utilization and not upon case management of the post-acute care episode as a whole. As utilization levels are managed closer to the RUGs' [Resource Utilization Groups] caps, further decline in outcomes can be expected."

Initially, under a prospective pay system, therapists and other providers tend to deliver more care than they are reimbursed for. A utilization and admission FIM analysis of 1,311 PPS patients found that an average of 571 minutes of care a week was delivered, compared with the allowable reimbursement under RUGs, the PPS reimbursement system for SNFs, of 485 minutes of patient care. **(See chart, p. 93.)**

Those trends are similar to what rehabilitation providers experience as managed care markets emerge, Warren explains. Typically, if a facility increases the number of capitated contracts it has, therapists and other clinicians will not automatically reduce the amount of care they give to patients for fear of short-changing them.

"There's understandable resistance early on," he explains. "The key to getting buy-in from the clinical side of the process is to establish a baseline concerning outcomes [such as functional gains under cost-based standards], and then work together to change system inefficiencies and the clinical process itself to allow the same results with less utilization."

However, for each diagnostic group, there is a threshold at which further reduction of utilization has a negative effect on clinical results, no matter what you do. Prospective pay is no different, he says. "The way to find the optimal level of care is to experiment with utilization allowances defined by the payment system or contract using techniques like case management, data-based decision support, and support personnel."

Warren says the Polaris / NovaCare data provide a glimpse of what may occur in the prospective pay system for rehab hospitals. "But hospitals will probably be able to adapt more quickly because they already have better infrastructure in place, such as case managers." He says the response of hospitals also will be influenced by the impact of PPS on utilization relative to allowances under the Tax Equity and Fiscal Responsibility Act; if they are anywhere near the 40% reduction experienced by the SNF industry, quality is likely to suffer regardless of adjustments made.

Speaking of putting data to work, what does NovaCare plan to do with the results of its study? Warren says the SNF industry is using this type of data to make the regulatory community aware of the impact of current laws on SNF rehabilitation and the quality of patients' lives. ■

Need More Information?

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Are private therapists doomed to extinction?

Just as many physicians are questioning the future of the solo practitioner, some hospital-based therapists and administrators are wondering if the days of the private practice therapist are numbered. With increased paperwork demands by managed care organizations, declining reimbursements, and strong competition, can the private practice survive?

The answer, say therapists and consultants interviewed by *Rehab Continuum Report*, is an emphatic "yes."

"I think in the end that managed care has made us more efficient as outpatient providers," says **Larry Fronheiser**, PT, senior executive officer of Allegheny & Chesapeake Physical Therapists Inc. in Allegheny, PA, and chairman of the American Physical Therapy Association's private practice section. "Many private practitioners have done a pretty good job of coping with managed care because it has been insidious; it just didn't hit on January 1 like some of the Medicare provisions. So we've had the opportunity to adjust, figure out our costs, and take advantage of continuing education choices."

But private practices also serve Medicare patients and thus have been affected to varying degrees by provisions of the Balanced Budget Act (BBA) of 1997. Fronheiser says he typically divides private practice therapists into two groups: physical therapy independent practitioners and rehabilitation agencies. The agencies work substantially more with Medicare patients.

For rehab agencies, the $1,500 annual cap on each Medicare beneficiary's rehab services represented a 30% to 60% reduction in the practice's annual Medicare reimbursement, he says. As a result, many agencies have reduced the number of hours staff therapists work, eliminated staff positions, or switched therapists from a straight salary to hourly pay. **(For more on the $1,500 cap, see *Rehab Continuum Report*, May 1999, p. 57.)**

For independent practitioners, the $1,500 cap represented an increase, Fronheiser says. Those practitioners formerly had worked under constraints of a $900 annual per-beneficiary cap.

Independent practitioners also were affected favorably by a BBA provision that eliminated a requirement that the owner of a physical therapy independent practice must be on the premises in order for care to be delivered by a licensed physical therapist. As a result, many independent practices opened satellite offices after this provision went into effect Jan. 1. But they didn't escape the wrath of the BBA entirely. They now are dealing with legislation that requires a physical therapist in private practice to provide direct in-person supervision of rehab care delivered by physical therapy assistants.

"That's considered onerous," Fronheiser says. "If you sent a physical therapy assistant [alone] into a room to do a [patient] evaluation or deliver care, you can no longer do that. Some private practices who traditionally employed physical therapy assistants now are considering whether to even employ them."

Building alliances builds strength

The answer to dealing with the stricter and more time-consuming payer demands is similar to what physician practices have experienced in the last 10 years: The bottom line is that there is strength in numbers.

"Form alliances," says **Lyndean Lenhoff Brick**, JD, senior vice president and principal of Murer Consultants Inc., a rehab consulting firm in Joliette, IL. "It's very hard for a single-site PT to compete with someone with eight offices and 120 therapists. The number one thing a therapist needs to do is look around and see where there are direct alliances, whether it's with a local hospital or other independent practices."

Another option is to affiliate with a centrally managed physical therapy network such as PTPN in Woodland Hills, CA. This option works, Brick says, if you can quantify the benefits from affiliating with such an organization.

The initial push for independent practitioners to join a physical therapy network came about five years ago, Fronheiser says. "Now, we're kind of at a maturation point. People are evaluating their decision whether to join" in terms of whether they are getting their money's worth from the monthly fees that network affiliates must pay.

The main advantage of joining a network is leverage in managed care contracting, says **Nancy Rothenberg**, vice president of PTPN. "Over time, the managed care organizations prefer to deal with networks. Instead of having to deal with 300 therapists in a market individually, they just sign one contract. "Moreover, networks like PTPN can alleviate what's known as the managed care hassle factor: dealing with

credentialing, contract administration, claims issues, and other paperwork.

One practice that has made the affiliation strategy work is Lennox PT in Freehold, NJ. The practice is affiliated with PTPN, but the network is not its sole source of patients, says **Rita Pessel**, office manager at Lennox PT. At any given time, the practice has about 50 active patients through network contracts, out of a total patient volume of 65 to 100. "Through PTPN, we can choose whether or not to accept a [managed care] contract. Generally, we won't accept anything under $50 a treatment."

The practice has used two other strategies to remain competitive, Pessel says. First, it has kept its quality standards high. "I think we've kept our doors open because of our reputation. We won't shortchange anybody. Our owner doesn't want to differentiate patients between those who are managed care patients and those who aren't."

The practice also has a healthy volume due to returning former patients or referrals from former patients, Pessel says. "Some of these patients will return to Lennox PT even if the practice is not in their health insurance network because they have been satisfied with their level of care at Lennox PT, which is no comparison to the lack of attention with corporate PTs."

Networking reveals common interests

Networking with other practices also has worked well for Pessel. She and two other office managers formed an office managers' network eight years ago for practices within close proximity, which has been a good source of information and tips. The group grew from an initial membership of three office managers to 35 members. They meet quarterly or more often if there are pressing legislative issues that need to be discussed. Often, members of the group can find someone who has dealt with similar problems or learn names of helpful individuals at particular payers. ■

Need More Information?

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