PDGM NATIONAL SUMMIT
A REVOLUTION IN MEDICARE HOME HEALTH PAYMENT

Kansas City, Missouri
January 24, 2019

Missouri Alliance for
HOME CARE

HOMECARE&HOSPICE
National Association for Home Care & Hospice

Forum
of State
Associations
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

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PDGM OVERVIEW

Mark Sharp, BKD

CY2019 Final Medicare Home Health Rate Rule…and Much More

- Published October 31, 2018
- https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24145.pdf
- Includes:
  - CY 2019 rates (2.2% increase over 2018)
  - Rural add-on
  - HHVBP demonstration program fine tuning
  - Quality measures modifications
  - 2020 Payment Model Reform
  - Home Infusion Therapy benefit
  - Physician certification/recertification documentation standards

Medicare Home Health Payment Reform: 2020

- **Planning ongoing for several years**
- **New model intended to address:**
  - Access to care for vulnerable patients
  - Elimination of therapy volume as payment rate determinant
    - Longstanding MedPAC, CMS, Congressional, and Industry concerns

Bipartisan Budget Act of 2018 (BiBA)

- **Mandates payment model reform**
  - 2020
  - Budget neutral transition
  - Behavioral adjustment guardrails
  - Stakeholder involvement
  - Prohibits therapy volume thresholds for payment amount
  - 30-day payment unit
- **MBI (inflation update) set at 1.5% in 2020**

PDGM Model: HHGM Revisited

- **Patient-Driven Groupings Model (PDGM)**
  - 432 payment groups
  - Episode timing: "early" or "late"
  - Admission source: community or institutional
  - Six Clinical groupings (7 subgroups in MMTA)
  - Functional level (OASIS based)
  - Comorbidity adjustment: secondary diagnosis based

PDGM NOTABLES

- **Therapy volume domain eliminated**
- **Cost per minute + NRS approach to resource use**
- **30 day periods within 60 day episode**
- **Regression analysis (2017 base)**

PDGM NOTABLES

- **Budget Neutral transition**
- **Behavioral Adjustments (6.42%???)**
  - Diagnosis coding
  - Comorbidities
  - LUPA avoidance

- **$1753.68 "unit of payment" ($1607 w/HHGM) if at 2019 (2020 TBD)**
- **LUPA: 2-6 visits @ 10th percentile value of total visits in payment group**
- **RAP continues except for new HHAs**
- **Outlier based on 30 day unit of payment**

PDGM Behavioral Adjustment/Rates: NPRM

Behavioral Assumption	30-day Budget Neutral (BN) Standard Amount	Percent Change from N... Behavioral Assumptions
No Behavioral Assumptions	$1,873.91	
LUPA Threshold (1/3 of LUPAs 1-2 visits away from threshold get extra visits and become case-mix adjusted)	$1,841.05	-1.75%
Clinical Group Coding (among available diagnoses, one leading to highest payment clinical grouping classification designated as principal)	$1,793.69	-4.28%
Comorbidity Coding (assigns comorbidity level based on comorbidities appearing on HHA claims and not just OASIS)	$1,866.76	-0.38%
Clinical Group Coding + Comorbidity Coding	$1,786.54	-4.66%
Clinical Group Coding + Comorbidity Coding + LUPA Threshold	$1,753.68	-6.42%

PDGM Measure: Timing of Care

TABLE 34: AVERAGE RESOURCE USE BY TIMING (30-DAY PERIODS)

Timing	Average Resource Use	Frequency of Periods	Percent of Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Early 30-Day Periods	$2,113.66	2,785,039	32.3%	$1,236.30	$1,232.23	$1,866.79	$2,707.04
Late 30-Day Periods	$1,311.73	5,839,737	67.7%	$1,125.44	$534.82	$987.94	$1,735.69
Total	$1,570.68	8,624,776	100.0%	$1,221.38	$679.12	$1,272.18	$2,117.47

PDGM Measure: Source of Admission

TABLE 37: AVERAGE RESOURCE USE BY ADMISSION SOURCE (14 DAY LOOK-BACK; 30 DAY PERIODS) ADMISSION SOURCE: COMMUNITY, INSTITUTIONAL, AND OBSERVATIONAL STAYS
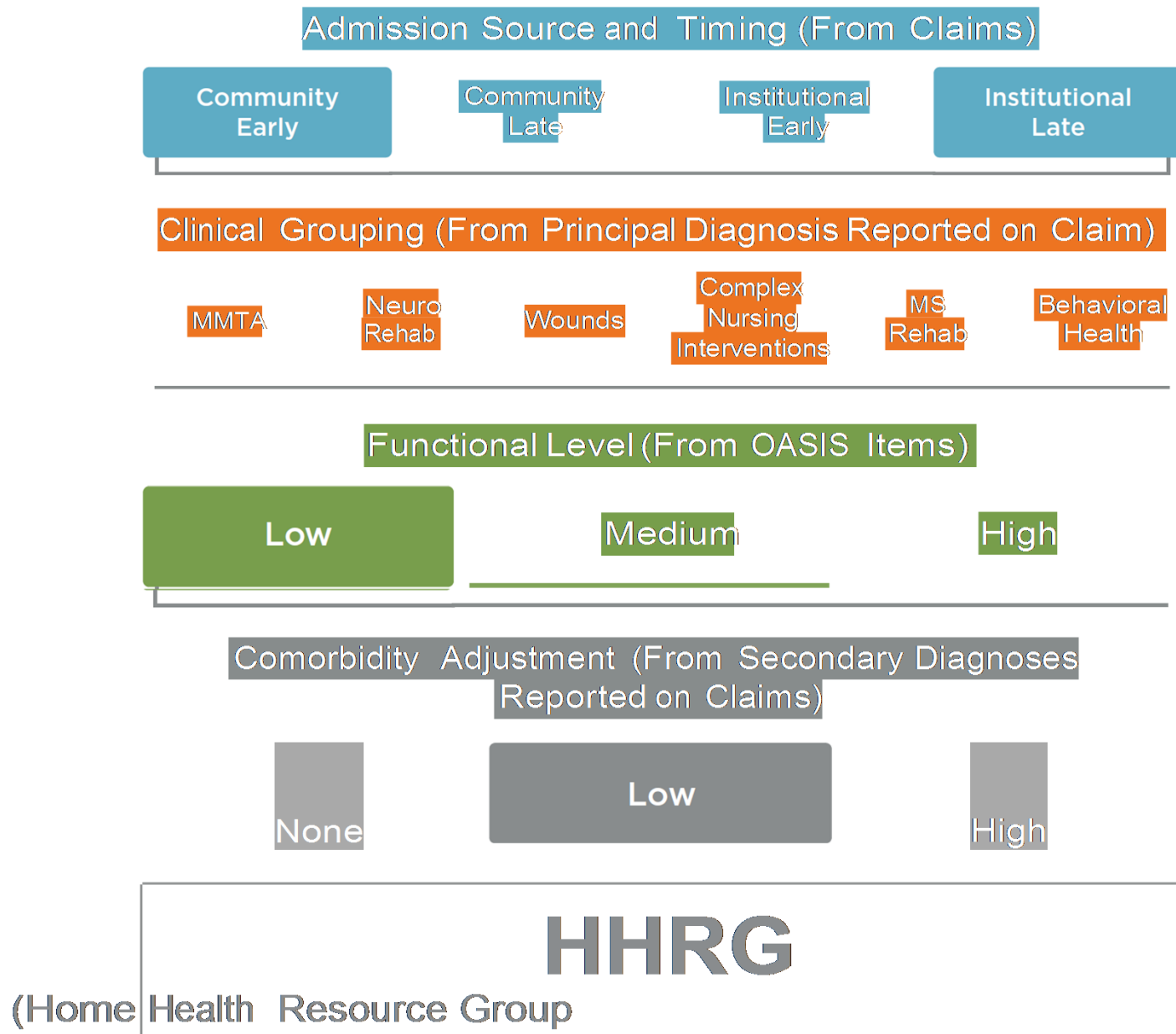
	Average Resource Use	Number of 30-day Periods	Percent of 30-day Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Community	$1,350.90	6,242,043	72.4%	$1,114.94	$564.31	$1,048.86	$1,799.27
Institutional	$2,171.00	2,215,971	25.7%	$1,303.24	$1,246.05	$1,920.06	$2,791.91
Observational Stays	$1,820.06	166,762	1.9%	$1,180.96	$960.15	$1,589.08	$2,399.68
Total	$1,570.68	8,624,776	100.0%	$1,221.38	$679.12	$1,272.18	$2,117.47

PDGM Measure: Source of Admission

TABLE 35: AVERAGE RESOURCE USE BY ADMISSION SOURCE (14 DAY LOOK-BACK; 30 DAY PERIODS) ADMISSION SOURCE, COMMUNITY AND INSTITUTIONAL ONLY

	Average Resource Use	Frequency of Periods	Percent of Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Community	$1,363.11	6,408,805	74.3%	$1,119.20	$570.26	$1,062.05	$1,817.75
Institutional	$2,171.00	2,215,971	25.7%	$1,303.24	$1,246.05	$1,920.06	$2,791.91
Total	$1,570.68	8,624,776	100.0%	$1,221.38	$679.12	$1,272.18	$2,117.47

FIGURE 4: STRUCTURE OF THE PDGM

Admission Source and Timing (From Claims)

Community Early | Community Late | Institutional Early | Institutional Late

Clinical Grouping (From Principal Diagnosis Reported on Claim)

MMTA | Neuro Rehab | Wounds | Complex Nursing Interventions | MS Rehab | Behavioral Health

Functional Level (From OASIS Items)

Low | Medium | High

Comorbidity Adjustment (From Secondary Diagnoses Reported on Claims)

None | Low | High

HHRG

(Home Health Resource Group

PDGM ESTIMATED IMPACTS

	Number of Agencies	PDGM
Free-Standing/Other Vol/NP	1,055	1.8%
Free-Standing/Other Proprietary	8,377	-0.9%
Free-Standing/Other Government	252	0.6%
Facility-Based Vol/NP	590	2.8 %
Facility-Based Proprietary	64	4.0%
Facility-Based Government	182	3.9%

PDGM Estimated Impacts

Facility Location: Region of the Country (Census Region)		
New England	355	2.0%
Mid Atlantic	480	2.4%
East North Central	2,019	-1.3%
West North Central	706	-4.2%
South Atlantic	1,647	-5.1%
East South Central	423	1.0%
West South Central	2,753	4.6%
Mountain	679	-5.0%
Pacific	1,417	3.8%
Outlying	41	10.6%

Concerns/Issues

- Impact on therapy patients
  - Regression-based methodology includes therapy volume
  - Change in costing methodology reduces case weights, i.e. payment amounts
- Incentives to focus on inpatient discharges and avoid community admissions
- LUPA structure change
- Clinical groupings heavy on MMTA
- Big swings for some HHAs
- Behavioral adjustment "wild card"

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA –Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA –Respiratory	Assessment, evaluation, teaching, and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

PDGM Advocacy Plan

- Legislative Action
- S.3458. (Kennedy-R.LA/Cassidy-R.LA)
- S.3545 (Collins-R.ME/ Nelson-D.FL/ Stabenow-D.MI)
- HR.6932 Abraham/ Buchanan/Sewell/DesJarlais/Graves

- Behavioral adjustment only after change
- Phase-in adjustments greater than 2 points

PDGM Tools

- https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1689-P.html
  - CY2019 HH PPS Wage Index [ZIP, 105KB]
  - CY2019 HH PPS Proposed Case-Mix-Weights [ZIP, 13KB]
  - PDGM Grouper Tool [ZIP, 1MB]
  - CY 2019 through CY 2022 Rural Add-on Payments: Analysis and Designations [ZIP, 479KB]
  - PDGM Weights and LUPA Thresholds [ZIP, 30KB]
  - PDGM Agency-Level Impacts, Estimated for CY 2019 [ZIP, 1MB]
  - Summary of the Home Health Technical Expert Panel Meeting [PDF, 1MB]

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PDGM NATIONAL SUMMIT
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FINANCIAL MODEL

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Glossary

- GAAP – Generally Accepted Accounting Principles

- HHA – Home health agency

- LUPA – Low utilization payment adjustment

- PDGM – Patient Driven Groupings Model

- PEP – Partial episode payment

- PPS – Prospective Payment System

Accounting Model

- Revenue recognition methodology
  - For HHA financial statement reporting under GAAP
    - Medicare cost reporting requires GAAP financial reporting
  - Daily recognition of revenues over period of payment
    - PPS = 60-days
    - PDGM = 30-days

Accounting Model

- Balance sheet accounts
  - Cash
  - Accounts receivable
  - Revenue, unearned

- Income statement
  - Revenue, earned
  - Contractual adjustments

Accounting Model

- Revenue, unearned
  - Balance sheet account used to adjust accounts receivable balance for portions revenues not yet earned due to 30-day prorated revenue recognition methodology
  - May also be referred to as 'deferred revenue'

Accounting Model

- Revenue, earned
  - Earned portion of revenues based on 30-day prorated revenue recognition methodology

- Contractual adjustments
  - Adjustments to earned revenues
    - Sequestration
    - LUPAs, PEPs, or outliers
    - Other adjustments

Accounting Model

Example: 01/15/20 SOC, $1,800 expected period payment

Account	01/31/20	02/29/20	03/31/20
Cash	$ 0	$ 1,080	$ 1,800
Accounts receivable	$ 1,800	$ 720	$ 0
Revenue, unearned	(780)	0	0
Net receivables	$ 1,020	$ 720	$ 0
Revenue, earned	$ 1,020	$ 1,800	$ 1,800
Cont. adjustments	0	0	0
Net revenues	$ 1,020	$ 1,800	$ 1,800
	($1,800 ÷ 30 days x 17 days = $1,020)	$1,800 ÷ 30 days x 13 days = $780)	

Note: See appendix slides for additional detailed accounting examples

Accounting
Model
Appendix

Accounting Model Appendix
Example Accounting Entries

Example Episode Information

Start of Care Date: 01/15/20
Discharge Date: 03/03/20

PDGM Payment Period	Start Date	End Date	Expected RAP Payment	Actual RAP Payment	Expected Period Payment	Actual Period Payment
Payment Period 1	01/15/20	02/13/20	$ 1,080	$ 1,080	$ 1,800	$ 1,764
Payment Period 2	02/14/20	03/03/20	$ 600	$ 600	$ 1,200	$ 490

Accounting Model Appendix
Example Accounting Entries

Monthly Accounting Entries		

January	Debit	Credit
1. 01/15/20 Accounts receivable	$ 1,800	
Revenue, unearned		$ 1,800

To record full expected payment for period one when request for anticipated payment (RAP) is billed on 01/25/20.

	Debit	Credit
2. 01/31/20 Revenue, unearned	$ 1,020	
Revenue, earned		$ 1,020

To recognize earned revenue for period one at end of month.
($1,800 ÷ 30 days x 17 days of earned revenue in January = $1,020)

Account Balance Summary

Cash	$ -
Accounts receivable	$ 1,800
Revenue, unearned	$ (780)
Net receivables	$ 1,020
Revenue, earned	$ (1,020)
Contractual adjustments, sequestration	$ -
Contractual adjustments, other	$ -
Net revenues	$ (1,020)

Accounting Model Appendix
Example Accounting Entries

Monthly Accounting Entries		
February	Debit	Credit
1. 01/25/20 Cash	$ 1,080	
Accounts receivable		$ 1,080
To record receipt of RAP payment for period one. *($1,800 expected payment x 60% = $1,080)*		
2. 02/13/20 Revenue, unearned	$ 780	
Revenue, earned		$ 780
To recognize remaining earned revenue for period one. *($1,800 expected payment ÷ 30 days x 13 days of earned revenue in February = $780)*		
3. 02/14/20 Accounts receivable	$ 1,200	
Revenue, unearned		$ 1,200
To record full expected payment for period two when RAP is billed on 02/18/20.		
4. 02/24/20 Cash	$ 600	
Accounts receivable		$ 600
To record receipt of RAP payment for period two. *($1,200 expected payment x 50% = $600)*		

Accounting Model Appendix
Example Accounting Entries

5.	02/29/20	Revenue, unearned		$	640	
		Revenue, earned				$ 640

To recognize earned revenue for period two at end of month.
($1,200 expected payment ÷ 30 days x 16 days of earned revenue in February = $640)

Account Balance Summary

Cash	$ 1,680
Accounts receivable	$ 1,320
Revenue, unearned	$ (560)
Net receivables	$ 760
Revenue, earned	$ (2,440)
Contractual adjustments, sequestration	$ -
Contractual adjustments, other	$ -
Net revenues	$ (2,440)

Accounting Model Appendix
Example Accounting Entries

Monthly Accounting Entries		

March	Debit	Credit
1. 02/28/20 Cash	$ 684	
Contractual adjustments, sequestration	$ 36	
Accounts receivable		$ 720
To record receipt of claim payment for period one.		
($1,764 final payment after sequestration - $1,080 previously paid RAP)		
2. 03/04/20 Revenue, unearned	$ 560	
Revenue, earned		$ 560
Contractual adjustments, other	$ 700	
Accounts receivable		$ 700
To recognize remaining earned revenue for period two and adjust for decrease in expected payment due to low utilization payment adjustment (LUPA).		
($1,200 original expected period payment - $500 LUPA adjusted period payment = $700 adjustment)		

Accounting Model Appendix
Example Accounting Entries

3. 03/23/20 Contractual adjustments, sequestration $ 10
                Accounts receivable $ 100
                   Cash $ 110

    To record receipt of claim payment for period two.
    ($490 final payment after sequestration - $600 previously paid RAP)

Account Balance Summary

Cash	$ 2,254
Accounts receivable	$ -
Revenue, unearned	$ -
Net receivables	$ -
Revenue, earned	$ (3,000)
Contractual adjustments, sequestration	$ 46
Contractual adjustments, other	$ 700
Net revenues	$ (2,254)

BILLING IMPACT

Billing Impact

- For billing purposes, PDGM will keep the RAP/Final billing methodology
  - CMS estimates the median time to submit a RAP is 12 days
  - 5% of RAPs not submitted until after day 60

- Billing requirements remain the same for final claim:
  - Completed and successfully transmitted OASIS assessment
  - Compliant face-to-face certification
  - Signed and dated orders
  - Signed and dated plan of care

Billing Impact

- Newly certified agencies as of 1/1/2019 will not receive RAP payments under PDGM but required to submit a "no pay" RAP
  - Potential phase-out of RAPs in the future
  - Potential RAP replacement of Notice of Admission in the future

- RAP Auto-cancel rules still apply
  - Claim not received within the greater of 60 days from the end date or 60 days after RAP paid date (whichever is greater)

Billing Impact

- Medicare claims processing system will check for the presence of an acute/post-acute Medicare claim for an institutional stay occurring within 14 days of the HH admission on an ongoing basis and automatically assign the claim as "community" or "institutional" appropriately.
  - Claims with a non-Medicare institutional stay 14 days prior to home health admission would need an occurrence code on the claim to process as "institutional"
  - OASIS will not be utilized in evaluating admission source info
  - Inconsistent language throughout the final rule if you should or should not bill with the occurrence codes or have Medicare automatically process claims appropriately – look for more guidance to come out regarding approach

Billing Impact

- Clinical Groupings and Comorbidity Adjustment based on the diagnoses on the CLAIM, not the OASIS
  - Up to 25 diagnosis codes can be entered on claim compared to 6 on OASIS

- Diagnosis Changes Between Initial and Subsequent Period
  - "If a home health patient has any changes in diagnoses (either principal or secondary), this would be reflected on the home health claim and the case mix weight could change accordingly."
  - "However, we would expect that the HHA clinical documentation would also reflect these changes and any communication/coordination with the certifying physician would also be documented."

CASH FLOW IMPACT

Cash Flow Impact

- Timeline Variables
  - RAP Billing
    - OASIS Completion/QA, receipt of verbal orders
      - PDGM RAP 2 in most cases will use the same OASIS as PDGM RAP 1 leading to quicker billing timeline
  - Final Claim Billing
    - Timely receipt of signed orders
    - Timely completion of F2F
    - Timely receipt of visit and supply information

Cash Flow Impact

- Sample Billing Timeline

Type	Start Date	End Date	Bill Date	Paid Date	Total Days to Pay from Start
PPS RAP	Day 1	Day 1	Day 7	Day 14	14
PPS Final Claim	Day 1	Day 60	Day 67	Day 81	81
PDGM RAP 1	Day 1	Day 1	Day 7	Day 14	14
PDGM FC 1	Day 1	Day 30	Day 44	Day 58	58
PDGM RAP 2	Day 31	Day 31	Day 34	Day 41	11
PDGM FC 2	Day 31	Day 60	Day 67	Day 81	51

Cash Flow Example Scenario

- Assumptions
  1. PPS - 1 RAP/1 FC per day
  2. Length of Stay = 60 days
  3. $3,300/PPS Claim ($1,980 RAP/$1,320 FC)
  4. PDGM – 1 admission per day
  5. $1,900/PDGM 1 Claim ($1,140 RAP/$760 FC)
  6. $1,400/PDGM 2 Claim ($700 RAP/$700 FC)
  7. Billing Timeline Assumptions Outlined on Prior Slide

Cash Flow Example Scenario

	Dec	Jan	Feb	Mar	Apr
PPS – RAP Reimbursement	$61,380	$29,700			
PPS – Final Claim Reimbursement	$40,920	$40,920	$36,960	$29,040	
PDGM – RAP 1 Reimbursement		$19,380	$31,920	$35,340	$34,200
PDGM – Final Claim 1 Reimb			$1,520	$23,560	$22,800
PDGM – RAP 2 Reimbursement			$13,300	$21,700	$21,000
PDGM – Final Claim 2 Reimb				$7,000	$21,000
Total	$102,300	$90,000	$83,700	$116,640	$99,000
$ Difference from December		($12,300)	($18,600)	$14,340	($3,300)
% Difference from December		-12%	-18%	14%	-3%
Daily Cash	$3,300	$2,903	$2,989	$3,763	$3,300
Daily Cash % Diff from Dec		-12%	-9%	14%	0%

IMPACT ASSESSMENT

Base Line Assessment Periods

Medicare Statistics						
Medicare PDGM Periods						
Clinical Group	**Period 1**	**Period 2**	**Period 3**	**Period 4**	**Total**	
Behavioral Health Care	16	8	5	2	**31**	
Complex Nursing Interventions	3	3	2	1	**9**	
MMTA- Surgical Aftercare	137	65	23	8	**233**	
MMTA- Cardiac/Circulator	215	164	78	29	**486**	
MMTA- Endocrine	42	28	16	6	**92**	
MMTA- GI/GU	122	70	37	14	**243**	
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	85	65	40	14	**204**	
MMTA- Other	46	26	14	5	**91**	
MMTA- Respiratory	178	116	51	19	**364**	
Musculoskeletal Rehabilitation	405	233	61	20	**719**	
Neuro/Stroke Rehabilitation	135	92	44	17	**288**	
Wound	94	82	59	27	**262**	
Questionable Encounters	155	77	40	19	**291**	
TOTAL	**1,633**	**1,029**	**470**	**181**	**3,022**	

Allocation of Questionable Encounters

Clinical Group	Period 1	Period 2	Period 3	Period 4	Patients Total	Period 1	Period 2	Period 3	Period 4
Behavioral Health Care	1.1%	0.8%	1.2%	1.2%	16	2	1	1	-
Complex Nursing Interventions	0.2%	0.3%	0.5%	0.6%	3	-	1	1	-
MMTA- Surgical Aftercare	9.3%	6.8%	5.3%	4.9%	137	14	5	2	1
MMTA- Cardiac/Circulator	14.5%	17.2%	18.1%	17.9%	215	23	13	7	3
MMTA- Endocrine	2.8%	2.9%	3.7%	3.7%	42	4	2	1	1
MMTA- GI/GU	8.3%	7.4%	8.6%	8.6%	122	13	6	3	2
MMTA- Infectious Disease/Neoplasms/Blood-forming Diseases	5.8%	6.8%	9.3%	8.6%	85	9	5	4	2
MMTA- Other	3.1%	2.7%	3.3%	3.1%	46	5	2	1	1
MMTA- Respiratory	12.0%	12.2%	11.9%	11.7%	178	19	9	5	2
Musculoskeletal Rehabilitation	27.4%	24.5%	14.2%	12.3%	405	42	19	6	2
Neuro/Stroke Rehabilitation	9.1%	9.7%	10.2%	10.5%	135	14	7	4	2
Wound	6.4%	8.6%	13.7%	16.7%	94	10	7	5	3
Questionable Encounters					155				
TOTAL	100.0%	100.0%	100.0%	100.0%	1,633	155	77	40	19

Total PDGM Periods

Medicare PDGM Periods						
Clinical Group	**Period 1**	**Period 2**	**Period 3**	**Period 4**	**Total**	
Behavioral Health Care	18	9	6	2	**35**	
Complex Nursing Interventions	3	4	3	1	**11**	
MMTA- Surgical Aftercare	151	70	25	9	**255**	
MMTA- Cardiac/Circulator	238	177	85	32	**532**	
MMTA- Endocrine	46	30	17	7	**100**	
MMTA- GI/GU	135	76	40	16	**267**	
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	94	70	44	16	**224**	
MMTA- Other	51	28	15	6	**100**	
MMTA- Respiratory	197	125	56	21	**399**	
Musculoskeletal Rehabilitation	447	252	67	22	**788**	
Neuro/Stroke Rehabilitation	149	99	48	19	**315**	
Wound	104	89	64	30	**287**	
TOTAL	**1,633**	**1,029**	**470**	**181**	**3,313**	

PDGM Non-LUPA Periods Percentage

Medicare Statistics Full Periods				
Medicare PDGM Periods				
Clinical Group	Period 1	Period 2	Period 3	Period 4
Behavioral Health Care	100.0%	60.0%	100.0%	100.0%
Complex Nursing Interventions	100.0%	100.0%	100.0%	100.0%
MMTA- Surgical Aftercare	97.6%	80.0%	93.3%	100.0%
MMTA- Cardiac/Circulator	97.0%	83.5%	95.9%	89.7%
MMTA- Endocrine	91.2%	94.4%	80.0%	100.0%
MMTA- GI/GU	95.7%	83.0%	87.0%	100.0%
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	93.5%	92.3%	92.3%	100.0%
MMTA- Other	100.0%	94.1%	100.0%	100.0%
MMTA- Respiratory	95.5%	79.8%	93.8%	94.7%
Musculoskeletal Rehabilitation	95.3%	76.6%	92.7%	65.0%
Neuro/Stroke Rehabilitation	92.5%	86.2%	92.6%	94.1%
Wound	95.3%	82.0%	100.0%	92.6%
Questionable Encounters	93.2%	76.8%	95.2%	94.7%
TOTAL	95.3%	81.5%	93.8%	91.7%

PDGM Non-LUPA Periods

Medicare PDGM Full Periods						
Clinical Group	Period 1	Period 2	Period 3	Period 4		Total
Behavioral Health Care	18	6	6	2		32
Complex Nursing Interventions	3	4	3	1		11
MMTA- Surgical Aftercare	148	56	24	9		237
MMTA- Cardiac/Circulator	231	148	82	29		490
MMTA- Endocrine	42	29	14	7		92
MMTA- GI/GU	130	64	35	16		245
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	88	65	41	16		210
MMTA- Other	51	27	15	6		99
MMTA- Respiratory	189	100	53	20		362
Musculoskeletal Rehabilitation	426	193	63	15		697
Neuro/Stroke Rehabilitation	138	86	45	18		287
Wound	100	73	64	28		265
TOTAL	1,564	851	445	167		3,027

PDGM Revenue Per Non-LUPA Period

Medicare PDGM Non-LUPA Periods Reimbursement Rates				
Clinical Group	**Period 1**	**Period 2**	**Period 3**	**Period 4**
Behavioral Health Care	2,414	1,916	2,400	1,511
Complex Nursing Interventions	2,103	1,568	1,740	2,610
MMTA- Surgical Aftercare	2,703	1,717	2,128	2,101
MMTA- Cardiac/Circulator	2,800	1,940	2,120	1,968
MMTA- Endocrine	2,785	1,862	1,859	1,902
MMTA- GI/GU	2,628	1,936	2,216	2,070
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	2,673	1,974	2,116	1,828
MMTA- Other	2,542	1,957	2,212	1,593
MMTA- Respiratory	2,730	1,858	2,146	2,007
Musculoskeletal Rehabilitation	2,789	1,863	2,168	2,328
Neuro/Stroke Rehabilitation	2,926	2,205	2,453	2,253
Wound	2,957	2,382	2,312	2,406

PDGM Total Revenue – Non-LUPA Periods

Medicare PDGM Full Periods Reimbursement						Total
Clinical Group	**Period 1**	**Period 2**	**Period 3**	**Period 4**		**Total**
Behavioral Health Care	43,456	11,493	14,402	3,023		**72,373**
Complex Nursing Interventions	6,310	6,271	5,221	2,610		**20,412**
MMTA- Surgical Aftercare	400,086	96,140	51,083	18,913		**566,221**
MMTA- Cardiac/Circulator	646,822	287,063	173,817	57,059		**1,164,761**
MMTA- Endocrine	116,954	54,002	26,033	13,314		**210,302**
MMTA- GI/GU	341,703	123,876	77,543	33,116		**576,238**
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	235,247	128,331	86,752	29,256		**479,585**
MMTA- Other	129,642	52,840	33,183	9,561		**225,225**
MMTA- Respiratory	516,021	185,838	113,750	40,136		**855,745**
Musculoskeletal Rehabilitation	1,187,943	359,655	136,560	34,921		**1,719,080**
Neuro/Stroke Rehabilitation	403,806	189,628	110,379	40,556		**744,369**
Wound	295,724	173,852	147,987	67,378		**684,941**
TOTAL	**4,323,714**	**1,668,989**	**976,708**	**349,841**		**7,319,252**

PDGM LUPA Period Percentage

Medicare Statistics				
Medicare PDGM LUPA Periods				
Clinical Group	Period 1	Period 2	Period 3	Period 4
Behavioral Health Care	0.0%	40.0%	0.0%	0.0%
Complex Nursing Interventions	0.0%	0.0%	0.0%	0.0%
MMTA- Surgical Aftercare	2.4%	20.0%	6.7%	0.0%
MMTA- Cardiac/Circulator	3.0%	16.5%	4.1%	10.3%
MMTA- Endocrine	8.8%	5.6%	20.0%	0.0%
MMTA- GI/GU	4.3%	17.0%	13.0%	0.0%
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	6.5%	7.7%	7.7%	0.0%
MMTA- Other	0.0%	5.9%	0.0%	0.0%
MMTA- Respiratory	4.5%	20.2%	6.3%	5.3%
Musculoskeletal Rehabilitation	4.7%	23.4%	7.3%	35.0%
Neuro/Stroke Rehabilitation	7.5%	13.8%	7.4%	5.9%
Wound	4.7%	18.0%	0.0%	7.4%
Questionable Encounters	6.8%	23.2%	4.8%	5.3%
TOTAL	4.7%	18.5%	6.2%	8.3%

PDGM Total LUPA Period

Medicare PDGM LUPA Periods						
Clinical Group	Period 1	Period 2	Period 3	Period 4		Total
Behavioral Health Care	-	3	-	-		3
Complex Nursing Interventions	-	-	-	-		-
MMTA- Surgical Aftercare	3	14	1	-		18
MMTA- Cardiac/Circulator	7	29	3	3		42
MMTA- Endocrine	4	1	3	-		8
MMTA- GI/GU	5	12	5	-		22
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	6	5	3	-		14
MMTA- Other	-	1	-	-		1
MMTA- Respiratory	8	25	3	1		37
Musculoskeletal Rehabilitation	21	59	4	7		91
Neuro/Stroke Rehabilitation	11	13	3	1		28
Wound	4	16	-	2		22
TOTAL	69	178	25	14		286

PDGM Revenue per LUPA Period

Medicare PDGM LUPA Periods Reimbursement Rates				
Clinical Group	**Period 1**	**Period 2**	**Period 3**	**Period 4**
Behavioral Health Care	146	146	146	146
Complex Nursing Interventions	212	212	212	212
MMTA- Surgical Aftercare	534	159	164	162
MMTA- Cardiac/Circulator	469	157	497	148
MMTA- Endocrine	548	164	233	199
MMTA- GI/GU	362	151	151	151
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	516	145	362	254
MMTA- Other	150	150	150	150
MMTA- Respiratory	479	155	150	142
Musculoskeletal Rehabilitation	631	160	298	161
Neuro/Stroke Rehabilitation	531	156	322	164
Wound	435	284	293	301

PDGM Total Revenue - LUPA Periods

Medicare PDGM LUPA Periods Reimbursement						
Clinical Group	Period 1	Period 2	Period 3	Period 4		Total
Behavioral Health Care	-	439	-	-		439
Complex Nursing Interventions	-	-	-	-		-
MMTA- Surgical Aftercare	1,602	2,230	164	-		3,997
MMTA- Cardiac/Circulator	3,282	4,550	1,492	443		9,766
MMTA- Endocrine	2,190	164	698	-		3,053
MMTA- GI/GU	1,812	1,817	754	-		4,382
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	3,097	724	1,087	-		4,907
MMTA- Other	-	150	-	-		150
MMTA- Respiratory	3,835	3,878	451	142		8,306
Musculoskeletal Rehabilitation	13,242	9,416	1,193	1,129		24,979
Neuro/Stroke Rehabilitation	5,838	2,027	967	164		8,997
Wound	1,742	4,550	-	602		6,893
TOTAL	36,638	29,945	6,807	2,480		75,869

PDGM Total Revenue - All Periods

Medicare PDGM - Total Reimbursement			
Clinical Group	**Full Episodes**	**LUPA Episodes**	**Total**
Behavioral Health Care	72,373	439	72,812
Complex Nursing Interventions	20,412	-	20,412
MMTA- Surgical Aftercare	566,221	3,997	570,217
MMTA- Cardiac/Circulator	1,164,761	9,766	1,174,527
MMTA- Endocrine	210,302	3,053	213,355
MMTA- GI/GU	576,238	4,382	580,621
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	479,585	4,907	484,492
MMTA- Other	225,225	150	225,376
MMTA- Respiratory	855,745	8,306	864,051
Musculoskeletal Rehabilitation	1,719,080	24,979	1,744,059
Neuro/Stroke Rehabilitation	744,369	8,997	753,366
Wound	684,941	6,893	691,834
TOTAL	**7,319,252**	**75,869**	**7,395,121**

PDGM Visits Per Period 1st and 2nd Period

Medicare Visits 1st Period						
Clinical Group	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide	Total Visits
Behavioral Health Care	4.82	4.73	3.00	-	1.18	0.45	14.18
Complex Nursing Interventions	6.50	5.50	4.00	-	-	-	16.00
MMTA- Surgical Aftercare	5.33	4.89	2.90	-	0.21	0.43	13.76
MMTA- Cardiac/Circulator	5.63	6.03	3.34	-	0.58	0.98	16.56
MMTA- Endocrine	5.47	4.29	2.44	-	1.06	0.65	13.91
MMTA- GI/GU	4.65	5.47	2.70	-	0.53	0.73	14.08
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	5.85	3.66	2.71	-	0.35	0.47	13.05
MMTA- Other	5.00	5.97	3.62	-	0.68	0.65	15.91
MMTA- Respiratory	5.08	6.35	3.50	-	0.63	0.72	16.28
Musculoskeletal Rehabilitation	3.06	8.09	3.05	-	0.26	0.71	15.17
Neuro/Stroke Rehabilitation	3.52	6.83	3.88	-	0.38	1.02	15.63
Wound	6.81	3.16	2.05	-	0.59	0.70	13.31

Medicare Visits 2nd Period						
Clinical Group	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide	Total Visits
Behavioral Health Care	3.40	0.60	1.40	-	1.00	-	6.40
Complex Nursing Interventions	4.00	2.50	3.50	-	-	-	10.00
MMTA- Surgical Aftercare	3.46	2.08	0.98	-	0.12	0.28	6.92
MMTA- Cardiac/Circulator	3.43	2.64	0.86	-	0.31	0.45	7.70
MMTA- Endocrine	4.44	2.50	1.17	-	0.61	0.39	9.11
MMTA- GI/GU	2.34	3.19	1.02	-	0.23	0.34	7.13
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	4.18	3.00	1.08	-	0.15	0.36	8.77
MMTA- Other	4.12	3.53	0.76	-	0.35	0.29	9.06
MMTA- Respiratory	2.99	2.75	0.64	-	0.25	0.40	7.04
Musculoskeletal Rehabilitation	1.22	3.67	0.81	-	0.11	0.30	6.12
Neuro/Stroke Rehabilitation	2.00	3.08	1.37	-	0.22	0.37	7.03
Wound	6.34	1.50	0.78	-	0.42	0.46	9.50

PDGM Visits Per Period 3rd and 4th Period

Medicare Visits 3rd Period						
Clinical Group	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide	Total Visits
Behavioral Health Care	5.00	4.33	2.67	-	1.67	1.33	15.00
Complex Nursing Interventions	8.00	6.00	3.00	-	-	-	17.00
MMTA- Surgical Aftercare	4.87	3.00	1.73	-	0.53	0.40	10.53
MMTA- Cardiac/Circulator	5.24	2.94	1.53	-	0.24	0.41	10.37
MMTA- Endocrine	4.90	2.60	2.30	-	0.30	0.70	10.80
MMTA- GI/GU	4.43	3.70	1.91	-	0.65	1.04	11.74
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	5.08	2.65	1.62	-	0.38	0.31	10.04
MMTA- Other	4.89	4.44	2.56	-	0.56	2.44	14.89
MMTA- Respiratory	3.94	3.41	1.66	-	0.50	1.28	10.78
Musculoskeletal Rehabilitation	2.59	5.37	1.80	-	0.24	0.73	10.73
Neuro/Stroke Rehabilitation	2.30	5.96	2.33	-	0.26	1.26	12.11
Wound	7.97	1.81	0.81	-	0.28	0.56	11.44

Medicare Visits 4th Period						
Clinical Group	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide	Total Visits
Behavioral Health Care	2.50	2.00	-	-	1.00	0.50	6.00
Complex Nursing Interventions	8.00	10.00	3.00	-	-	-	21.00
MMTA- Surgical Aftercare	5.50	3.63	1.38	-	1.00	0.50	12.00
MMTA- Cardiac/Circulator	4.24	3.62	1.07	-	0.24	0.07	9.24
MMTA- Endocrine	6.83	1.33	0.17	-	0.17	0.67	9.17
MMTA- GI/GU	4.07	3.79	2.36	-	0.29	0.64	11.14
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	3.64	3.00	0.50	-	0.36	-	7.50
MMTA- Other	2.00	2.00	0.20	-	-	1.80	6.00
MMTA- Respiratory	3.95	2.63	0.79	-	0.53	0.37	8.26
Musculoskeletal Rehabilitation	2.60	3.15	1.10	-	0.35	0.55	7.75
Neuro/Stroke Rehabilitation	1.76	3.29	1.41	-	0.18	0.59	7.24
Wound	6.67	2.30	0.93	-	0.19	0.59	10.67

PDGM Visits Period 1st and 2nd Period

Medicare Visits 1st Period							
Clinical Group	**Skilled Nursing**	**Physical Therapy**	**Occupational Therapy**	**Speech Therapy**	**Medical Social Services**	**Home Health Aide**	**Total Visits**	**Periods**
Behavioral Health Care	87	85	54	-	21	8	255	18
Complex Nursing Interventions	20	17	12	-	-	-	48	3
MMTA- Surgical Aftercare	804	739	438	-	32	65	2,078	151
MMTA- Cardiac/Circulator	1,341	1,435	794	-	139	232	3,941	238
MMTA- Endocrine	252	198	112	-	49	30	640	46
MMTA- GI/GU	628	738	364	-	72	98	1,900	135
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	550	344	255	-	33	44	1,227	94
MMTA- Other	255	305	185	-	35	33	812	51
MMTA- Respiratory	1,000	1,250	690	-	124	143	3,206	197
Musculoskeletal Rehabilitation	1,368	3,616	1,363	-	116	317	6,780	447
Neuro/Stroke Rehabilitation	524	1,017	579	-	57	151	2,328	149
Wound	709	328	213	-	62	73	1,385	104
Total	**7,537**	**10,071**	**5,058**	**-**	**739**	**1,195**	**24,600**	**1,633**

Medicare Visits 2nd Period							
Clinical Group	**Skilled Nursing**	**Physical Therapy**	**Occupational Therapy**	**Speech Therapy**	**Medical Social Services**	**Home Health Aide**	**Total Visits**	**Periods**
Behavioral Health Care	31	5	13	-	9	-	58	9
Complex Nursing Interventions	16	10	14	-	-	-	40	4
MMTA- Surgical Aftercare	242	146	69	-	8	20	484	70
MMTA- Cardiac/Circulator	608	468	152	-	55	80	1,364	177
MMTA- Endocrine	133	75	35	-	18	12	273	30
MMTA- GI/GU	178	243	78	-	18	26	542	76
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	293	210	75	-	11	25	614	70
MMTA- Other	115	99	21	-	10	8	254	28
MMTA- Respiratory	374	344	80	-	31	51	879	125
Musculoskeletal Rehabilitation	308	925	205	-	29	75	1,542	252
Neuro/Stroke Rehabilitation	198	305	136	-	21	37	696	99
Wound	564	134	69	-	37	41	846	89
Total	**3,060**	**2,962**	**947**	**-**	**248**	**373**	**7,591**	**1,029**

PDGM Visits Period 3rd and 4th Period

Clinical Group	Medicare Visits 3rd Period							
	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide	Total Visits	Periods
Behavioral Health Care	30	26	16	-	10	8	90	6
Complex Nursing Interventions	24	18	9	-	-	-	51	3
MMTA- Surgical Aftercare	122	75	43	-	13	10	263	25
MMTA- Cardiac/Circulator	446	250	130	-	21	35	881	85
MMTA- Endocrine	83	44	39	-	5	12	184	17
MMTA- GI/GU	177	148	77	-	26	42	470	40
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	223	117	71	-	17	14	442	44
MMTA- Other	73	67	38	-	8	37	223	15
MMTA- Respiratory	221	191	93	-	28	72	604	56
Musculoskeletal Rehabilitation	173	360	121	-	16	49	719	67
Neuro/Stroke Rehabilitation	110	286	112	-	12	60	581	48
Wound	510	116	52	-	18	36	732	64
Total	**2,193**	**1,697**	**801**	**-**	**175**	**374**	**5,240**	**470**

Clinical Group	Medicare Visits 4th Period							
	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide	Total Visits	Periods
Behavioral Health Care	5	4	-	-	2	1	12	2
Complex Nursing Interventions	8	10	3	-	-	-	21	1
MMTA- Surgical Aftercare	50	33	12	-	9	5	108	9
MMTA- Cardiac/Circulator	136	116	34	-	8	2	296	32
MMTA- Endocrine	48	9	1	-	1	5	64	7
MMTA- GI/GU	65	61	38	-	5	10	178	16
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	58	48	8	-	6	-	120	16
MMTA- Other	12	12	1	-	-	11	36	6
MMTA- Respiratory	83	55	17	-	11	8	174	21
Musculoskeletal Rehabilitation	57	69	24	-	8	12	171	22
Neuro/Stroke Rehabilitation	34	63	27	-	3	11	137	19
Wound	200	69	28	-	6	18	320	30
Total	**755**	**548**	**193**	**-**	**58**	**82**	**1,637**	**181**

PDGM Total Visits All Periods

Clinical Group	Total Visits							
	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide	Total Visits	Periods
Behavioral Health Care	152	120	83	-	42	17	415	27
Complex Nursing Interventions	68	55	38	-	-	-	160	7
MMTA- Surgical Aftercare	1,217	992	563	-	63	99	2,934	221
MMTA- Cardiac/Circulator	2,530	2,269	1,111	-	223	349	6,482	415
MMTA- Endocrine	516	326	188	-	73	58	1,161	76
MMTA- GI/GU	1,048	1,189	556	-	120	176	3,090	211
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	1,125	719	409	-	67	83	2,402	164
MMTA- Other	456	482	245	-	53	89	1,324	79
MMTA- Respiratory	1,677	1,840	879	-	194	273	4,863	322
Musculoskeletal Rehabilitation	1,907	4,970	1,713	-	169	453	9,212	699
Neuro/Stroke Rehabilitation	866	1,670	853	-	94	260	3,743	248
Wound	1,983	647	362	-	123	168	3,282	193
Total	**13,545**	**15,279**	**7,000**	**-**	**1,221**	**2,024**	**39,068**	**2,662**

PDGM Direct Care Productivity

	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide
Total Work Days	260	260	260	260	260	260
Non-Work Days						
PTO	20	20	20	20	20	20
Holidays	6	6	6	6	6	6
Personal Days	10	10	10	10	10	10
Time Available for Work	224	224	224	224	224	224
Administrative Time	9	9	9	9	9	9
Time Available to Visit	215	215	215	215	215	215
Budgeted Productivity per Day (Un-Weighted)	4.70	4.60	5.00	4.50	2.30	4.30
Total Visits Per FTE	1,011	989	1,075	968	495	925

PDGM Direct Care FTE Calculation

	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide
Total Visits	13,545	15,279	7,000	-	1,221	2,024
Visits Per FTE	1,011	989	1,075	968	495	925
Required FTEs	13.40	15.45	6.51	-	2.47	2.19
Actual FTEs	11.75	14.00	6.00	-	-	2.50
Per Diem Requirement	1.65	1.45	0.51	-	2.47	(0.31)

PDGM Per Diem Calculation

	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide
Total Visits	13,545	15,279	7,000	-	1,221	2,024
Visits Per FTE	1,011	989	1,075	968	495	925
Actual FTEs	11.75	14.00	6.00	-	-	2.50
Total Visits Per FTE	11,873	13,846	6,450	-	-	2,311
Per Diem Visits	1,671	1,433	550	-	1,221	-

PDGM Direct Care Cost Calculation

	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide
FTEs	11.75	14.00	6.00	-	-	2.50
Full Time Staff - Hourly Rate	$ 32.06	$ 46.22	$ 43.06	$ 42.46	$ 28.64	$ 13.86
Number of hours worked per year	2,080	2,080	2,080	2,080	2,080	2,080
Total Full Time Salaries & Wages	783,546	1,345,926	537,389	-	-	72,072
Taxes & Benefits	24%	24%	24%	24%	24%	24%
Total Full Time Benefits	185,700	318,985	127,361	-	-	17,081
Per Diem Visits	1,671	1,433	550	-	1,221	-
Per Diem Staff - Hourly Rate	42.28	69.43	66.07	66.14	57.53	16.93
Total Per Diem Salaries & Wages	70,656	99,491	36,306	-	70,251	-
Taxes & Benefits	14%	14%	14%	14%	14%	14%
Total Per Diem Taxes	9,680	13,630	4,974	-	9,624	-
Total	1,049,583	1,778,032	706,030	-	79,876	89,153

PDGM Other Direct Care Cost Calculation

	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide
Total Visits	13,545	15,279	7,000	-	1,221	2,024
Milage Cost Per Visits	2.73	2.60	2.53	3.10	3.62	2.62
Required FTEs	36,977	39,725	17,709	-	4,420	5,303
Billable Supply Cost Per Visits	2.04	2.04	2.04	2.04	2.04	2.04
Required FTEs	27,631	31,169	14,279	-	2,491	4,129
Routine Supply Cost Per Visits	1.03	1.03	1.03	1.03	1.03	1.03
Required FTEs	13,951	15,737	7,209	-	1,258	2,085

PDGM Impact Assessment

	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical Social Services	Home Health Aide	Total
Medicare Revenue							7,395,121
Full Time Staff - Hourly Rate	783,546	1,345,926	537,389	-	-	72,072	2,738,934
Per Diem Staff - Hourly Rate	70,656	99,491	36,306	-	70,251	-	276,705
Taxes & Benefits	195,380	332,615	132,335	-	9,624	17,081	687,036
	1,049,583	1,778,032	706,030	-	79,876	89,153	3,702,674
Mileage	36,977	39,725	17,709	-	4,420	5,303	104,134
Billable Supplies	27,631	31,169	14,279	-	2,491	4,129	79,699
Routine Supplies	13,951	15,737	7,209	-	1,258	2,085	40,240
	1,128,141	1,864,664	745,228	-	88,045	100,670	3,926,748
Gross Margin							3,468,373
							46.90%

WHAT IF SCENARIO

Overarching Principle

All financial recommendations and strategies should consider proper **balance** of desired results

PDGM What if Scenario

Medicare Statistics

Medicare PDGM Episodes

Clinical Group	Patient Total	% to total	Adjustments	Period 4	Adjusted Patients	Period 1	Period 2	Period 3	Period 4
Behavioral Health Care	18	1.10%		1.10%	18	100.0%	50.0%	33.3%	11.1%
Complex Nursing Interventions	3	0.18%		0.18%	3	100.0%	133.3%	100.0%	33.3%
MMTA- Surgical Aftercare	151	9.25%	-1.00%	8.25%	135	100.0%	46.4%	16.6%	6.0%
MMTA- Cardiac/Circulator	238	14.57%	6.00%	20.57%	336	100.0%	74.4%	35.7%	13.4%
MMTA- Endocrine	46	2.82%		2.82%	46	100.0%	65.2%	37.0%	15.2%
MMTA- GI/GU	135	8.27%		8.27%	135	100.0%	56.3%	29.6%	11.9%
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	94	5.76%		5.76%	94	100.0%	74.5%	46.8%	17.0%
MMTA- Other	51	3.12%		3.12%	51	100.0%	54.9%	29.4%	11.8%
MMTA- Respiratory	197	12.06%	3.00%	15.06%	246	100.0%	63.5%	28.4%	10.7%
Musculoskeletal Rehabilitation	447	27.37%	-8.00%	19.37%	316	100.0%	56.4%	15.0%	4.9%
Neuro/Stroke Rehabilitation	149	9.12%		9.12%	149	100.0%	66.4%	32.2%	12.8%
Wound	104	6.37%		6.37%	104	100.0%	85.6%	61.5%	28.8%
TOTAL	**1,633**	**100.00%**	**0.00%**	**100.00%**	**1,633**				

PDGM What if Scenario

Medicare PDGM Episodes							
Clinical Group	Period 1	Period 2	Period 3	Period 4	Total	Prior Amount	Increase (Decrease)
Behavioral Health Care	18	9	6	2	**35**	35	-
Complex Nursing Interventions	3	4	3	1	**11**	11	-
MMTA- Surgical Aftercare	135	62	22	8	**227**	255	(28)
MMTA- Cardiac/Circulator	336	250	120	45	**751**	532	219
MMTA- Endocrine	46	30	17	7	**100**	100	-
MMTA- GI/GU	135	76	40	16	**267**	267	-
MMTA- Infectious Disease/Neoplasms/Blood-forming Dise	94	70	44	16	**224**	224	-
MMTA- Other	51	28	15	6	**100**	100	-
MMTA- Respiratory	246	156	70	26	**498**	399	99
Musculoskeletal Rehabilitation	316	178	47	16	**558**	788	(230)
Neuro/Stroke Rehabilitation	149	99	48	19	**315**	315	-
Wound	104	89	64	30	**287**	287	-
TOTAL	**1,633**	**1,052**	**497**	**192**	**3,373**	**3,313**	**60**

PDGM What if Scenario

	What If?	Base Line	Total
Medicare Revenue	7,522,764	7,395,121	127,643
Full Time Staff - Hourly Rate	2,738,934	2,738,934	-
Per Diem Staff - Hourly Rate	309,950	276,705	33,246
Taxes & Benefits	691,590	687,036	4,555
	3,740,475	3,702,674	37,801
Mileage	106,571	104,134	2,437
Billable Supplies	81,470	79,699	1,771
Routine Supplies	41,135	40,240	894
	3,969,650	3,926,748	42,903
Gross Margin	3,553,113	3,468,373	84,740
	47.23%	46.90%	0.33%

Cost Considerations

- Adjustments in forecasted costs due to PDGM should be considered
  - Changes in direct costs for episode management
    - Adjustments to visit utilization
      - Fewer therapy visits?
      - Additional visits from LUPA management?
      - Resources committed for overall episode management
      - Shifts in clinical grouping changing the patient mix
  - Changes in indirect costs for back office efforts
    - Intake or marketing strategies
    - Changes in revenue cycle management
    - Initiatives for coding, order, supply and episode management
    - Investments in technology and data resources

PDGM NATIONAL SUMMIT
A REVOLUTION IN MEDICARE HOME HEALTH PAYMENT

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PDGM NATIONAL SUMMIT
A REVOLUTION IN MEDICARE HOME HEALTH PAYMENT

CLINICAL ASPECTS OF PDGM
Karen Vance, BKD
Laura Page-Greifinger, Quality In Real Time

Overview

With the implementation of PDGM there are many challenges that agencies will face from a clinical vantage point.

Documentation, coding, care planning and care coordination are at the top of the list of best practice clinical strategies that will need to be reviewed.

This session will take a look into the interdisciplinary care planning, case conferencing and case management that are going to be imperative in effectively transitioning to the PDGM model.

Objectives

- Outline the ICD-10 Coding & OASIS ADL Section Impact on the Home Health Resource Group (HHRG) under PDGM.

- Describe how interdisciplinary care planning can manage cost effective and appropriate skill mix, including therapy utilization.

- Define the Clinical Manager role in the Clinical Team's success under PDGM, including the significance of effective case conferencing and case management.

- Outline best practice clinical strategies for managing LUPA thresholds as defined by PDGM.

PDGM Coding Impact

Overview

- Two of five broad categories calculating PDGM grouping models are factored on diagnosis coding
- Coding is based off the claims however the diagnoses on the POC needs to match the claim
- Several vendors/agencies are continuing to work with NAHC to work edit the acceptable primary diagnosis list & obtain further clarification

Breakout of Acceptable Primary Diagnosis
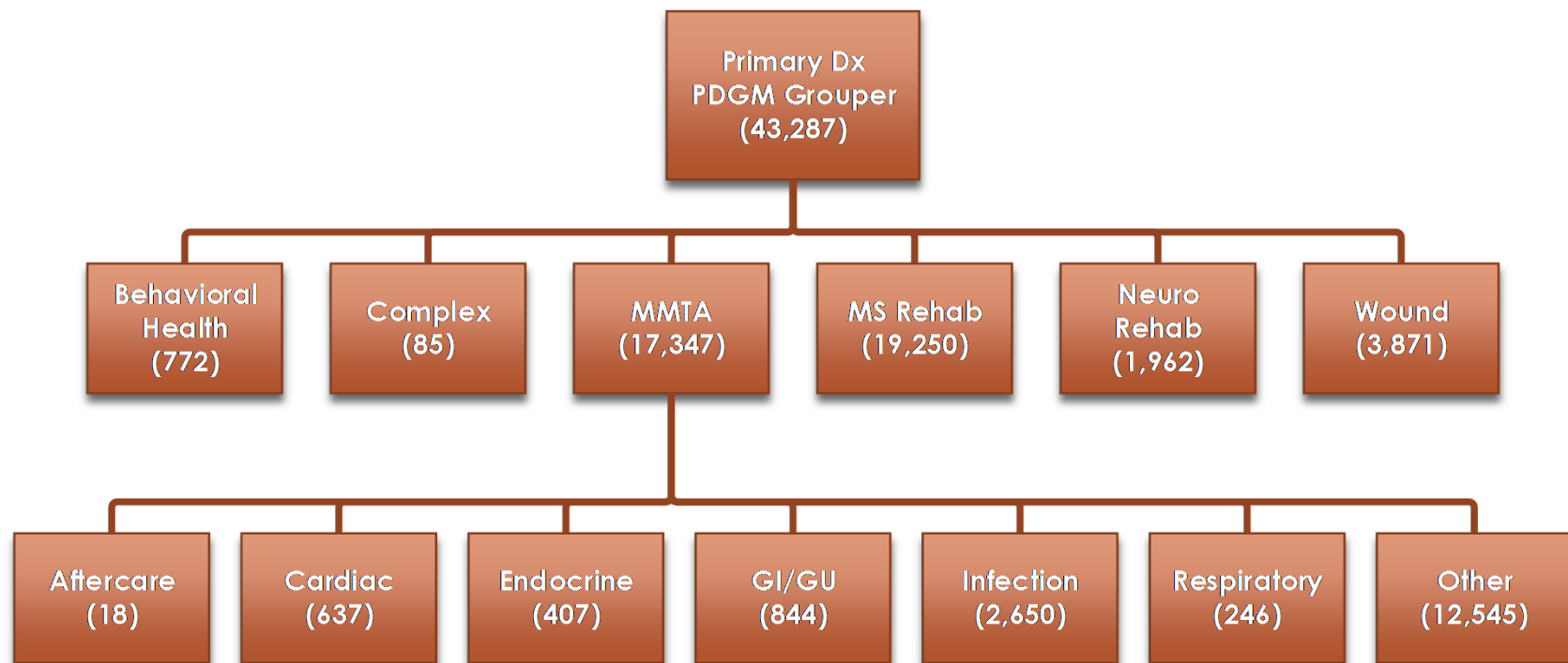
Unspecified/Symptom Codes

- CMS expects whenever possible, the more specific codes to be used
- They see code descriptions with "unspecified" in general not to be valid
- Some unspecified codes are allowed in such cases when the exact types of injury is unknow i.e. fractures
- They do expect home health clinicians to report laterality even if not documented by the provider
- CMS expects clinicians to investigate the cause of symptom codes, obtain provider confirmation and assign that code

Muscle Weakness (M62.81)

- CMS has been citing since 2008 their concern with this code
- Has been in the top 5 primary diagnoses over the past several years
- CMS believes muscle wasting and atrophy codes would be more appropriate
- Agencies should begin to transition to those codes in 2019

Changes in Primary Diagnosis

- "If the primary diagnosis changes between the first and the second 30-day periods, then the claim for the second 30-day period would reflect the new diagnosis and the providers would not change the claim for the first 30-day period"

- "A follow-up assessment would be submitted at the start of the second 30-day period to reflect the changes in the functional level and the second 30-day claim would be grouped into its appropriate case-mix group accordingly"

Comorbidity Codes

- New language: "secondary diagnoses are only to be reported if they are conditions that affect patient in terms of requiring clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring"
  - Previous language include "potentially affect the patient's care"

Comorbidity Adjustment

- No Comorbidity Adjustment
- Low Comorbidity Adjustment
  - One or more of 13 subgroups met
  - Consists of one dx from subgroup
    - Example: I11.0 Hypertensive heart disease with heart failure
- High Comorbidity Adjustment
  - One or more of 34 subgroup interactions met
  - Consist of one dx from two different subgroup
    - Example: J44.9 Chronic obstructive pulmonary disease, unspecified & L89.212 Pressure ulcer of right hip, stage 2

Comorbidity Adjustment

- Only one comorbidity adjustment allowed
- Highest level will be assigned
- Adjusted payment amount is the same across the level adjustment
- CMS will continue to monitor if additional levels or subgroups need adjusting
- It is important to continue to follow coding guidelines and assign appropriate diagnosis in order to provide CMS data for analysis in the future

Additional Considerations

- Make sure codes are updated as needed within the 30-day payment periods to ensure capture of proper case-mix group
- Claims with unacceptable primary diagnoses will be returned to the provider (RTP) and not considered a denial
- RTP claims can be recoded with more appropriate code as long as there is appropriate supporting provider documentation
- Coding guidelines still must be followed

ADLs for PDGM

Patient Driven Groupings Model (PDGM)

- Functional Level (OASIS Items) – (Low, Medium, High)
    - Anticipates roughly 33% of periods of care will fall into each of the categories
    - M1800-M1860 and M1033 are OASIS-D Items proposed for use in determining Functional Level under PDGM

OASIS Scoring - Functional

OASIS Points Table

Variable	Response Category	Responses	Points
M1800: Grooming	1	2, 3	4
M1810: Current Ability to Dress Upper Body	1	2, 3	6
M1820: Current Ability to Dress Lower Body	1	2	5
	2	3	11
M1830: Bathing	1	2	3
	2	3, 4	13
	3	5, 6	21
M1840: Toilet Transferring	1	2, 3, 4	4
M1850: Transferring	1	1	4
	2	2, 3, 4, 5	8
M1860: Ambulation/Locomotion	1	2	10
	2	3	12
	3	4, 5, 6	24
M1033: Risk of Hospitalization	4 or more items checked	From 1-7	11

Functional Grouping

MMTA - Surgical Aftercare	**Low**	**0-24**
	Medium	**25-37**
	High	**38+**
MMTA - Cardiac and Circulatory	**Low**	**0-36**
	Medium	**37-52**
	High	**53+**
MMTA - Endocrine	**Low**	**0-51**
	Medium	**52-67**
	High	**68+**
MMTA - Gastrointestinal tract and Genitourinary system	**Low**	**0-27**
	Medium	**28-44**
	High	**45+**
MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases	**Low**	**0-32**
	Medium	**33-49**
	High	**50+**
MMTA - Respiratory	**Low**	**0-29**
	Medium	**30-43**
	High	**44+**
MMTA - Other	**Low**	**0-32**
	Medium	**33-48**
	High	**49+**

Functional Grouping

Behavioral Health	**Low**	**0-36**
	Medium	**37-52**
	High	**53+**
Complex Nursing Interventions	**Low**	**0-38**
	Medium	**39-58**
	High	**59+**
Musculoskeletal Rehabilitation	**Low**	**0-38**
	Medium	**39-52**
	High	**53+**
Neuro Rehabilitation	**Low**	**0-44**
	Medium	**45-60**
	High	**61+**
Wound	**Low**	**0-42**
	Medium	**43-61**
	High	**62+**

Key to Accurate Payment is Accurate Data

- Interdisciplinary collaboration key under OASIS D and for best practice care planning under PDGM.
  - Can use case conferences on new SOCs for a 'consensus review' of items
  - Other time & cost-effective options are secure texting, EMR care coordination, etc.
- Assessing by observation is the ONLY method for accuracy
- Comprehensive ADL (OASIS) Assessment education program developed by therapists (PT & OT) for RNs with return demonstration
- Discipline-neutral (RN, PT, ST, OT) **competence in OASIS assessment process** is critical to gain and sustain accuracy

Key to Accurate Payment is Accurate Data

- Dressing items include "ability to get clothes out of closets/drawers"
  - e.g., letting go of the walker while tugging on that drawer that sticks?
- Start by asking the patient about his/her routine:
  - e.g., where, when, and how do they go about their ADL routine
  - What have they changed about their routine and how recently?

Key to Accurate Payment is Accurate Data

- Assessing ADLs in isolation does not capture accurate performance within the patient's daily routine
    - e.g., assessing patient with COPD for showering in a 'dry run' does not capture the effects of standing 20 minutes in warm moist air
    - e.g., assessing cardiac and respiratory patients in any ADLs will look different depending on the time of day, possibly affecting MMTA groupings

Reflect on Own Data Collection Practice

- Unless prevented by state regulation, "Therapy Only" patients should be admitted by a PT (unless by ST) and ADL assessment completed by a therapist.
- Even if your therapists don't collect OASIS data on therapy only cases, assure ALL therapists are trained in OASIS item specific guidance to contribute to data accuracy collected by nurses
- Even if the GG items don't affect payment, consistency with OASIS is noted in medical review (remember response numbers are reversed!)

Reflect on Own Data Collection Practice

- REMEMBER, the OASIS captures resources (payment) needed by the agency for episode of care, AND resources (help) needed by family to keep patient safely in his/her own home
  - Does the patient need assist from someone in the same room?
  - Does the patient need assist from someone in the same house?
  - Does the patient need assist for occasional reminders?

Interdisciplinary Care Planning

*For Best Skill Mix, including Therapy Utilization

*For Best Clinical Outcomes

* For Best Financial Outcomes

Where is Your Influence of Control?

- Influence on Revenue (payment)
  - Interdisciplinary collaboration on OASIS data collection
  - Interdisciplinary collaboration on correct selection of diagnoses
- Influence on Expenses (costs)
  - Interdisciplinary coordination of care to reinforce, but not duplicate
  - Interdisciplinary skill mix for the best person doing the right thing

Where is Your Influence of Control?

- Influence on Quality (outcomes)
  - Interdisciplinary coordinated plans of action focused on 'at-risk' outcomes
  - Interdisciplinary reinforcement of patient engagement in the plan of care

Collaboration on Key OASIS Items

- Review OASIS prior to data being transmitted
- Have a consensus discussion among all who saw the patient
- Ensure those who don't regularly collect data know the intent of each OASIS item and the response selections
- Resolve discrepancies by referring to the Guidance Manual

Collaboration on Key OASIS Items

- Consider conditions present
  - Observation versus patient report
  - Time of day
  - Other variables, i.e., cueing, instructions, supervision, etc.
- Identify the most appropriate diagnoses are listed

Interdisciplinary Care Coordination

- Coordinate visits for daily coverage, *if necessary*, in first weeks to reduce hospitalization, not just frontloading nursing visits
- Identify risks and discuss the role each person who walks in the house has in reducing hospitalization risks
- Share and discuss what the patient identifies as his/her goal

Interdisciplinary Care Coordination

- Coordinate with Remote Patient Monitoring, reducing need for additional visits
- Identify generalized skill sets to be reinforced each visit (vital signs, medication adherence, etc.)
- Identify unique skill sets and when to capitalize on each discipline

Interdisciplinary Approach to Outcomes

- Interdisciplinary participation on QAPI committee
- Identify targeted 'at risk' outcomes for improvement
- List parameters identifying patients 'at risk' for outcome decline
- Develop Plans of Action to impact outcomes on 'at risk' patients

Interdisciplinary Approach to Outcomes

- Influence outcomes for 'at risk' patients before they occur
- Develop culture of patient engagement in individualized plans of care for optimized participation and ownership in managing conditions
- Taper frequencies to allow patients to better 'self-manage' and increase 'in-between visit progress'

Therapy Contribution to Outcomes

- Therapists must learn to connect their practice to outcomes achieved replacing number of visits performed
- Consider appropriate plans of care for the typical chronic conditions prevalent in home health, not just "muscle weakness"
  - Pursed lip breathing for respiratory conditions
  - Energy conservation for all chronic conditions

Therapy Contribution to Outcomes

- Medication routines as the most important activity of daily living
- Increased general activity integrated into daily routines instead of the 'HEP'
- Home modification to improve safety intuitively
- Partner with the Aide to reinforce newly acquired skills by the patient, such as transfers, dressing, bathing, etc.

Byproduct of Interdisciplinary Care

- Get the right payment
  - Collaboration on data and coding accuracy
- Use the payment right
  - Coordinate discipline skill mix and visits
  - Reduced number of visits per patient through tapered frequency

Byproduct of Interdisciplinary Care

- Improve clinical outcomes
  - Integrated approach focuses on targeted outcomes
  - Patient engagement improves management of condition
- Improve financial outcomes by doing what's right for the patient

PDGM Clinical Operations

*Role of Case Manager and Clinical Manager in PDGM Implementation

What is Case Management?

- Collaborative process to assess, plan, implement, coordinate, monitor and evaluate options and services to meet the patient's health needs

- An entire interdisciplinary team working toward collaborative goals determined by the patient, family and healthcare team

- Management of a <u>team</u> of patients by the Clinical Manager and <u>individual caseloads</u> by the Primary Case Manager (Primary Care Clinician)

Case Management Components

- Primary Case Manager
    - Primary Care Clinician for patient
        - RN unless Therapy-Only
    - Responsible for coordination of care provided
- Team
    - Disciplines assigned to patient
    - Goal driven rather than task oriented > coordinated care
        - Works together to meet patient care goals
        - Supports patient-centric care
        - Focuses on improvement in patient outcomes and optimal service delivery

Case Management Components

- Visit clinicians
  - May be utilized by an agency to support Primary Clinician (ex: RN/LPN, PT/PTA, OT/COTA)
  - Remote Patient Monitoring possibly utilized
- Small teams=consistency of staff

Case Management Process

- Begins at time of referral and continues through discharge
- Responsibility of entire team
- Each team member plays integral role:
  - Achieve highest quality
  - Best clinical outcome
  - Highest patient/family satisfaction
  - Efficient use of resources

Benefits of Case Management

- Patient and Family Centered Care
  - Core concepts are central to care/case management
    - Patient centric care
    - Dignity and respect
      - Active listening-respect patient/family goals
    - Information sharing
      - Timely and meaningful sharing of information between team members and practitioners

Benefits of Case Management

- Participation
  - Patients/families are encouraged/supported in participating in decision making and care planning
- Collaboration
  - Patient/family centered care drives implementation of programs, care delivery methods, education/training

- Improved visit utilization/episode management

ROLE OF THE PRIMARY CASE MANAGER
IN CASE MANAGEMENT AND PDGM

Primary Case Manager

- Primary Care Clinician with responsibility for the patient's total plan of care
- Pairs with Visit Clinicians from all disciplines who provide care to patients based on plan of care
  - Considering Remote Patient Monitoring
- Works collaboratively to implement and revise plan of care with all team members
- Works to keep team members to ensure continuity of care, goal achievement, patient and staff satisfaction

Primary Case Manager

- Patient advocate from Admission to Discharge
- Professionally accountable and responsible for the patient's continuity of care
- Develops a therapeutic relationship with the patient and patient's family/caregiver
  - Involving them in the patient's care

Primary Case Manager

- Manages collaborative decision-making
  - During the <u>entire</u> length of stay/episode
- Identifies the patient's unique health needs and priorities, establishes an individualized plan of care, and <u>communicates</u> that plan to other members of the team
- Communicates the case manager role with patient, family and members of multi-disciplinary team

Primary Case Manager Skill Set

- Skilled communicator
- Skilled clinician
- Critical thinker
- Skilled in patient assessments/OASIS
- Utilizes sound judgment
- Skilled in documentation
- Understands Reimbursement Complexities
- Understands Episodic Management
- Self-directed and innovative
- Effective decision maker
- Organized
- Excellent time management skills
- Empowered and accountable

Primary Case Manager Responsibilities

- Accuracy of SOC OASIS
  - Discuss with therapy functional assessment
- Realistic Goals
  - Discuss with patient and team
- Teamwork
  - Align and Reinforce
  - Facilitate interdisciplinary communication and coordination

Primary Case Manager Responsibilities

- Case Conferencing
  - Admission
  - Every 2 weeks
  - Prior to discharge
- Accuracy of Transfer/Discharge OASIS

THE CLINICAL MANAGER ROLE
IN CASE MANAGEMENT AND PDGM

Role of the Clinical Manager

- Clinical oversight, metric achievement, staff development and supervision, daily team management
- Oversight of Patient assignment to case managers
- Review/assessment with case managers for plan of care and visit utilization
- Monitors coordination and implementation of care plan, recerts, discharge planning and related activities

Role of the Clinical Manager

– Reviews staff assignments, caseloads and team productivity to promote efficient use of resources

– **HOLD STAFF ACCOUNTABLE:**

  ▪ Visit utilization, care plan updates, coordination, documentation (timeliness, completion, accuracy),follow up, management/monitoring of patient outcomes/satisfaction

Clinical Manager Role - Outcomes

- Clinical Managers can have a significant impact on the quality outcomes for team
    - Front line – oversee where the action is
    - Oversee care being provided by staff
    - Know strengths and weaknesses of staff
        - Know who needs more training
        - Know who your experts are

Clinical Manager Role - Outcomes

– Can make an immediate impact on outcomes
  - Assigning of cases
  - Overseeing caseloads with Case Managers
  - Providing feedback and guidance
    o Clinical care
    o Best use of resources
      ➤ Staff, Supplies

IMPORTANT NOTICE

STRATEGIES FOR EFFECTIVE CASE MANAGEMENT/ UM/EPISODE MANAGEMENT OVERSIGHT

Case Management Process (Examples)

- Patient Care Conferences
  - Interdisciplinary conferences and individual case review updates and care conferences are essential to obtain information for care planning and achieving collaborative goals
- **ONE SIZE DOES NOT FIT ALL**

Case Management Process (Examples)

- Agencies need to determine the best way to ensure:
    - Interdisciplinary team communication
    - Care Coordination
    - OASIS Accuracy
    - Accurate Care Plans
    - Appropriate Visit Utilization and Service Delivery
    - Compliance with Regulatory and Documentation requirements
    - Optimal Patient Care Outcomes

Case Management Process (Examples)

Team Update/Case Conference
- Led by case manager assigned to patient every week or biweekly and includes all Pod members in person, by phone or tele-meeting.
- Within 1 week to ensure OASIS accuracy and care plan updates.
- Agency may choose to conduct daily clinical pod huddles for staffing and pertinent updates.

Individual Case Review
- May be held by Primary Care Clinician & Clinical Manager within 24 hours of admission, prior to recert/discharge & at least biweekly.

Case Management Process (Examples)

- Preparation includes review of patient record, new or change in symptoms, diagnoses, caregiver or status, living environment; and verification of orders, visits and supervisory visits
- Discussion includes patient goals, expected timetables, current assessment, barriers to care, Discharge plan team goals and implementation strategies
- Ensure optimal Utilization Management/Episode Management/Resource utilization.
- Consider use of Remote Patient Monitoring

Utilization Management (UM)

- UM activities evaluate many aspects of patient care
  - Timeliness of services
  - Number of visits per episode
  - Number of visits per discipline
  - Costs per episode
  - Length of stay
  - LUPA management*
- UM oversight is the responsibility of the Clinical Manager and Case Manager with individual responsibility of visits by each discipline

UM Implementation Strategies

- Areas of Focus under PDGM (Concurrent):
  - Length of Stay (Managing visit frequency in 30 day episode.
  - LUPAs*
  - Outliers
  - Wound Care
  - Patients with chronic illness (CHF/COPD/DM)
  - History of frequent hospitalizations
  - More than 5 prescription medications daily
  - Caregiver/living situation concerns

UM Implementation Strategies

- Areas of Focus (Retrospective):
  - Emergent Care
  - Acute Care Hospitalization
  - Falls
  - Other adverse events

Key Things to Know About PDGM/LUPAs

- LUPA thresholds range between 2-6 visits under PDGM

- PDGM LUPA 'speak' is that you will be paid by the visit for visits less than the threshold (EX: A '4 visit LUPA' means reimbursement by the visit if below 3 visits)

- LUPA thresholds vary based on clinical grouping and episode timing

- Clinical Groupings with highest LUPA % are in complex nursing, MS Rehab and in Wounds clinical groupings(2nd 30-day period)

- LUPA thresholds will be evaluated annually by CMS

Are Your LUPAs Appropriate?

- Randomly review about 25 episodes with LUPAs monthly for next 2 months

- Determine if LUPAs are clinically appropriate by asking these questions:
  - Was the episode front loaded "if clinically appropriate" at SOC/ROC to potentially reduce chance for rehospitalization?
  - Does patient's clinical picture match visit utilization provided?
  - Was LUPA a result of missed visits, staffing issues, not homebound, patient refusal, and/or scheduling issues?
  - Did patient require more visits to meet goals/improve outcomes?
  - Were the right disciplines added at SOC/ROC?

- From findings of audit, determine your internal benchmark and, develop an action plan to address trends in <u>inappropriate</u> LUPAs cases

HHRG Payment Followed By 30-Day Period LUPA Payments

- Analyze 2017 data to determine which 30-day periods may fall into LUPA episodes
- For LUPA episodes of 2 or < visits in 2nd 30-day period, determine if those visits are impacting clinical outcomes of the patient
- If you moved those 1-2 visits into first 30-day period, would it impact the patient's outcomes?
- Case Management remains essential for each 30-day period

Critical Success Factors

The success of the Case Management process is dependent on:

- Seamless, consistent and timely communication
- Care coordination between disciplines/team
- Efficient and effective patient visit scheduling
- Staff continuity

Critical Success Factors

- Clinical Manager support and oversight
- Management information availability and monitoring
- Understanding the clinical team impact on outcomes

Failure of any single factor can result in failure of the entire process.

Questions?

PDGM NATIONAL SUMMIT
A REVOLUTION IN MEDICARE HOME HEALTH PAYMENT

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PDGM NATIONAL SUMMIT
A REVOLUTION IN MEDICARE HOME HEALTH PAYMENT

PDGM OPERATIONS INTAKE

Raymond Belles, BKD
Aaron Little, BKD

PDGM Rule changes will affect the overall strategy & practices of how Home Health Providers approach referral development and the characteristics of what defines a desirable referral source.

Considerations may include the:
- Clinical complexity of the referral source's patients;
- Quality of patient transition processes;
- Extent the referral source's patients are the result of an acute admission;
- Frequency of referral source's patients that had home health services in the preceding 60 days; and
- Ability to rely on the diagnosis documentation provided by the referral source.

Outline of Impact Areas

- Clinical Grouping by Diagnosis Code and Reimbursement
- Comorbidities & the Completeness of Referral Information
- Early vs. Late Episode Determination
- Community vs. Institution Determination
- Internal PDGM Steering Committee
- Relationships/Marketing
- Education for Referral Sources
- Intake Checklist "must haves"
- Keys to Success

Clinical Grouping

Episodes are grouped into one of twelve Clinical Groupings:

- Musculoskeletal rehabilitation

- Neuro/stroke rehabilitation

- Wounds

- Complex nursing interventions

- Behavioral health care

- 7 Distinct Medication management, teaching, and assessment (MMTA)

Clinical Grouping (From Principal Diagnosis Reported on Claim)					
Neuro Rehab	Wounds	Complex Nursing Interventions	MS Rehab	Behavioral Health	MMTA - Other
MMTA - Surgical Aftercare	MMTA - Cardiac and Circulatory	MMTA - Endocrine	MMTA - GI/GU[1]	MMTA - Infectious Disease[2]	MMTA - Respiratory
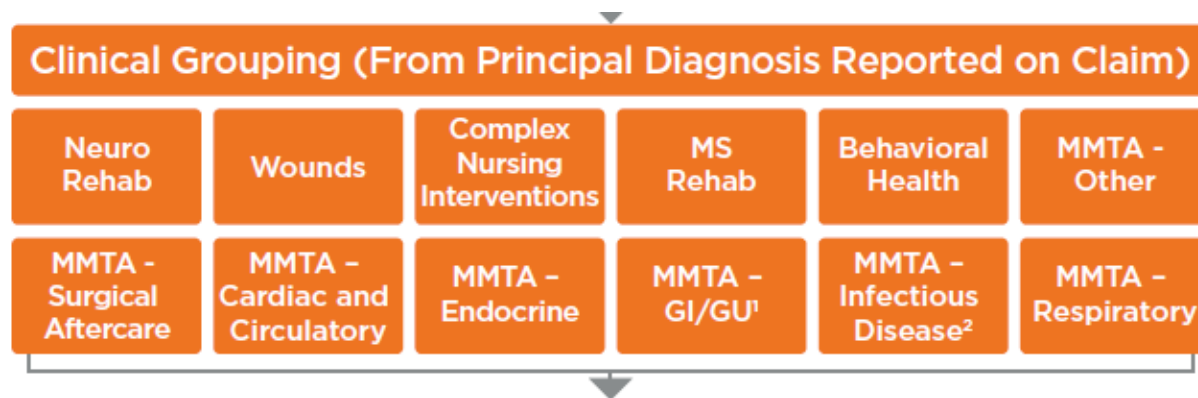
Source: CMS.gov

Clinical Grouping

Estimated Periods by Clinical Grouping Provided by CMS
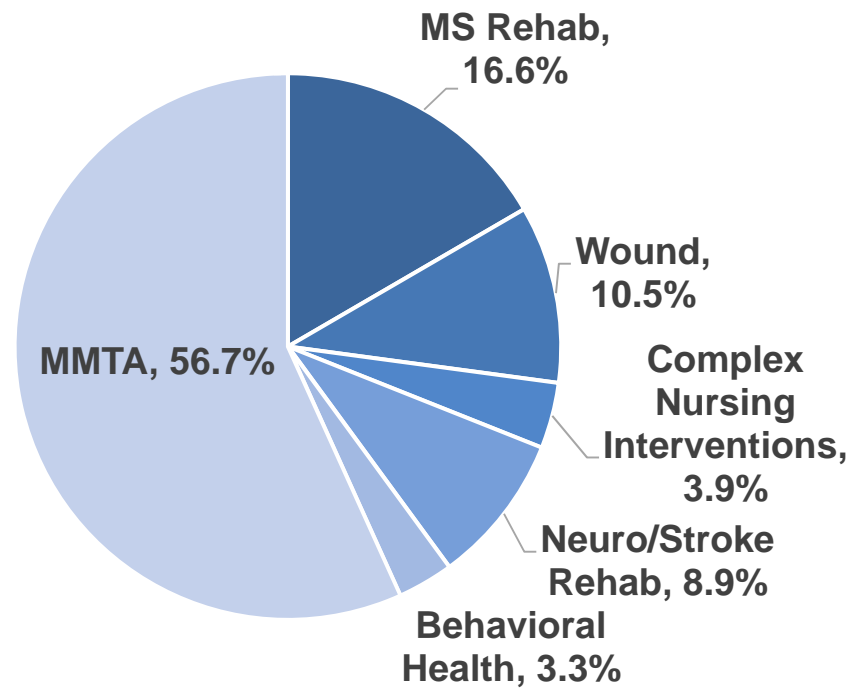
Source: CMS.gov

Clinical Grouping

- Primary Diagnosis Determines Clinical Grouping

- If Primary diagnosis code is not considered a HH diagnosis code episode will not be paid

- Top Paying Clinical Grouping only accounts for 10.5% of patients

Ave. Reimbursement by Clinical Group

Clinical Group	Amount
Wounds	$1,972.00
Neuro	$1,890.05
MS Rehab	$1,778.11
MMTA Endocrine	$1,776.88
MMTA Surgical Aftercare	$1,677.71
MMTA Respiratory	$1,600.94
MMTA Cardiac	$1,588.79
MMTA Infectious	$1,585.27
MMTA GI/GU	$1,584.33
MMTA Other	$1,567.92
Complex Nursing	$1,495.33
Behavioral Health	$1,494.80
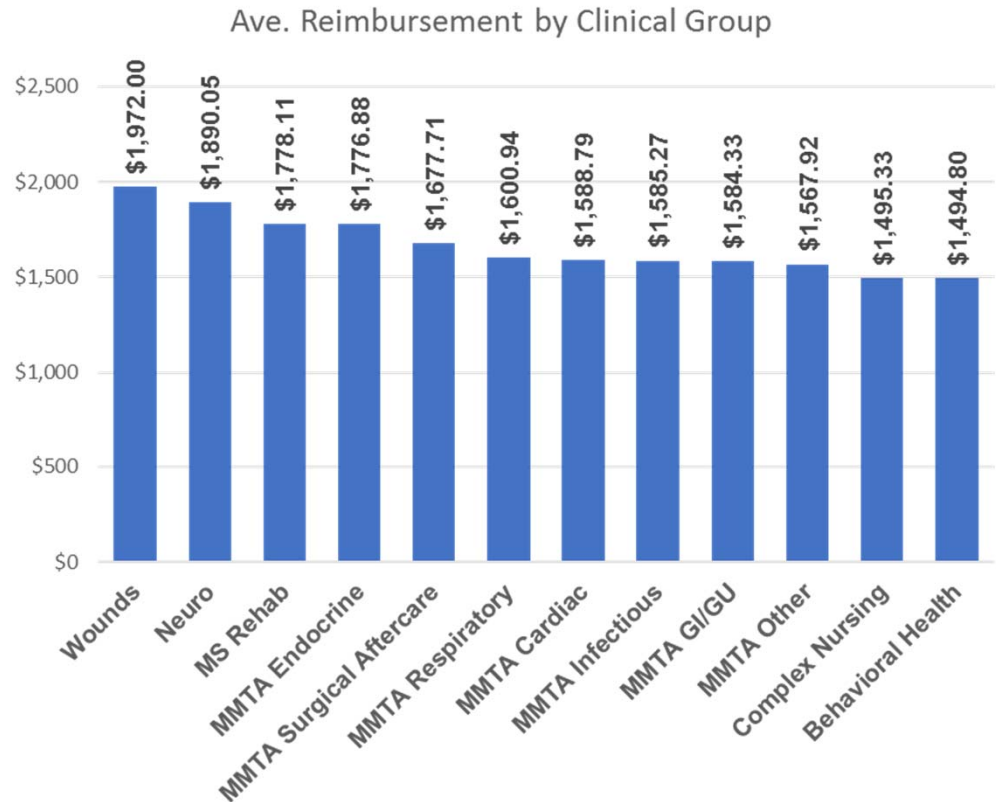
Source: 2017 Claims Data

Clinical Grouping

- Evaluation of Referral Sources:
  - What Clinical Groupings will be referred by which physicians and facilities
  - Therapy Visits no longer major driver for reimbursement
    - Increase focus on management of therapy
    - Overall utilization management and best practice
  - Wound care now top paying clinical grouping
    - Effective management of service, can be costly
  - Need to collect significant amount of data for coding
    - Primary & up to 24 Secondary Diagnosis

Comorbidities

- Up to 24 Additional Diagnosis Codes can be used to support Comorbidity Add-Ons
  - Referral Sources to include on referral form, how does agency confirm completeness & accuracy?
  - Special consideration needs to be given to each code when developing the plan of care

Comorbidity	None	One	Two or More
Recast claims data: Average full period payment	$1,642.03	$1,716.06	$1,998.19
Average Comorbidity add-on	-	$74.03	$356.16

Source: 2017 Claims Data

Early vs. Late Determination

- Currently, an episode is considered early for the first **120 days** of care
  - PDGM changes this to **30 day billing periods**
    - Only the first claim is early
    - 34% average reduction in reimbursement for early / late change

Early vs. Late	Average Full Period Payment
EARLY	$2,147.39
LATE	$1,428.37

Source: 2017 Claims Data

Institutional vs. Community

- Only the 1st 30-day period will be considered **"Institutional"**
  - All subsequent periods to be considered "Community"

Community vs. Institutional	Average Full Period Payment
Institutional	$2,260.65
Community	$1,545.51

Source: 2017 Claims Data

- Determination made by looking back at 14 days prior to admission to look for institutional stay

Payment Impact:
1st 30 day period vs. 2nd 30 day

Primary Dx Infection of amputation stump, right lower extremity

- Early & Institution – $2,112.75
  - 11 Visits
  - Clinical Grouping = MMTA Infection
  - Low Comorbidity
  - Functional Score of 41
- Late & Community -- $1,146.40
  - 11 Visits
  - Clinical Grouping = MMTA Infection
  - Low Comorbidity
  - Functional Score of 41

Relationships/Marketing

- Evaluation of current referral sources and primary diagnosis of patient population

- Assess referral market and ability to strengthen referral relations

- Explore joint venture opportunities with acute settings to increase institutional referrals

Develop Internal Steering Committee for PDGM Focus

- Identify key members across the agency
  - Sales/Intake
  - Clinical Operations
  - Quality
  - Finance/Revenue Cycle
- Collaborate on drivers and obstacles

Intake Referral Process

- Changes to Process
- Ease of Referral
- Development of Checklist
  - What are the key components needed to support coding, determination of institutional vs community, etc.
  - Asking the right questions and gathering the right information vs just accepting what is sent over
- Create "scripting" for intake staff to use with referral sources

Must Have Items on Checklist

- Primary diagnosis for home health
- Query for any general diagnoses
- Physician face-to-face encounter note: reason for home health (diagnosis) aligns with primary diagnosis
- Source of referral: community/institutional
- Services requested: validated by diagnoses /conditions
- Facility/physician documents to support the need for home health and the services ordered

Education for Referral Sources

- About PDGM and the impact on home health
- Referral checklist of crucial information
- Analytics of the referral's patients and how they compare to your agency patient population
  - Community vs Institutional
  - Top diagnosis codes
  - Specialty programs
- Why to refer to your agency
  - STAR ratings, HH Compare, etc.

Keys to Success

- The following areas are key to intake success:
  - Training and Staffing Needs
  - Organization Structure – Central vs Regional
  - Evaluation of Staff
  - Tools to Increase Efficiency

Keys to Success

- Training and Staffing Needs
  - Staff/Referral sources need to understand PDGM
  - Drivers of Revenue (Community vs. Institutional, Early vs. Late, Coding and comorbidities etc.)
  - Potential for higher admissions and fewer recerts
  - Greater understanding of coding and requirements
  - Employees with coding expertise and customer service focused
  - Reduction in Intake Efficiency
    - Calls to referrals for more info; increased coding

Keys to Success

- Central vs. Regional Intake Model
  - Central:
    - Creation of subject matter experts
    - Allow for prioritization of referrals over other duties
    - Ability to flex with volume/increased admissions

  - Regional (agency level):
    - Opportunity to strengthen referral source relations
    - Individualized training
    - Utilization of liaisons within facilities

Keys to Success

- Evaluation of Staff
    - Quality Assurance reviews of information gathered
    - Post-intake evaluation of the following information to review quality and potential missed reimbursement:
        - Referral Source
        - Episode Timing
        - Coding (including comorbidities)

Keys to Success

- Tools to Improve Efficiency
  - EMR feature functionality
  - Utilization of a Document Management Systems
  - Increase e-Referrals
  - Establish referral checklist to streamline

Downstream Effect from Intake

- It All Starts at Intake
  - Correct Determinations to Prevent Billing/Revenue Issues:
    - Early vs. Late Period
    - Community vs. Institutional
    - Coding – Homecare Primary Diagnosis and all comorbidities
    - Paperwork correct & complete

Glossary

- CMS – Centers for Medicare & Medicaid Services

- CWF – Common working file

- EMR – Electronic medical record software system

- HH – Home health

- HHA – Home health agency

- HIPPS – Health Insurance Prospective Payment System

- IPF – Inpatient psychiatric facility

- IRF – Inpatient rehabilitation facility

Glossary

- LTCH – Long term care hospital

- LUPA – Low utilization payment adjustment

- MAC – Medicare Administrative Contractor

- MA – Medicare Advantage

- NRS – Nonroutine medical supplies

- OASIS – Outcome and Assessment Information Set

- PDGM – Patient Driven Groupings Model

- PEP – Partial episode payment

Glossary

- PPS – Prospective Payment System

- QIES – Quality Improvement and Evaluation System

- RAP – Request for anticipated payment

- ROC – Resumption of care

- SNF – Skilled nursing facility

PDGM Revenue Cycle
SOC or Recertification 30-Day Payment Periods

Intake
- Medicare eligibility confirmed
- Prior inpatient discharge data confirmed
- Payment period timing confirmed

Clinical assessment
- Medicare coverage confirmed by clinical assessment
- Clinical grouping determined by diagnosis coding
- Functional payment score determined by OASIS data collection

Order management
- Receipt of compliant physician signed & dated certifications, orders, & FTF documentation confirmed

Billing, collecting & payment posting
- RAP & claim billed
- Claims validated against OASIS in QIES
- Final claim payment adjusted based on potential adjustment factors

PDGM Revenue Cycle
Subsequent 30-Day Payment Periods

Scheduling
- New payment period determined

Clinical assessment
- Continued Medicare coverage confirmed by clinical team
- Clinical grouping determined by diagnosis coding
- Functional payment score determined by most recently completed OASIS

Order management
- Timely receipt of physician signed & dated certifications, orders, & FTF documentation confirmed

Billing, collecting & payment posting
- RAP & claim billed
- Claims validated against OASIS in QIES, *if applicable*
- Final claim payment adjusted based on potential adjustment factors

PDGM Revenue Cycle
30-Day Payment Periods

60-Day Episode

OASIS

| 10 | | | 15 | | | 20 | | | 25 | | | 30 | | | 35 | | | 40 | | | 45 | | | 50 | | | 55 | | | 70

OASIS

Front-loaded visits

Tapered visits

Order management

SOC or recertification 30-day payment period

Subsequent 30-day payment period, if applicable

RAP

1 | | | | | | | 15 | | | | 20 | | | | 25 | | | | 30

Claim

RAP

Claim

1 | | | | | | | 15 | | | | 20 | | | | 25 | | | | 30
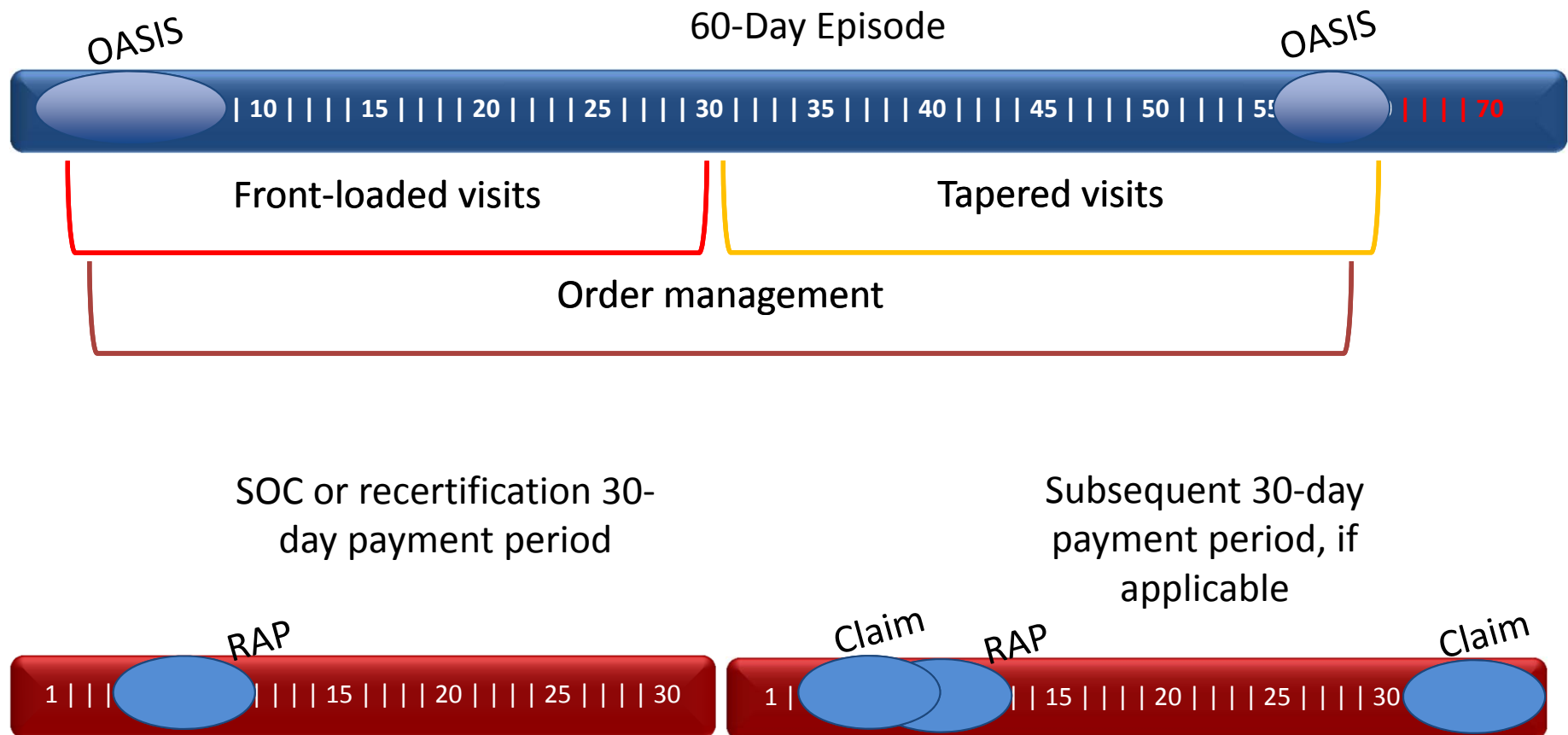
Admission Source
& Timing

Admission Source

- Definition
  - Institutional payment periods
    - SOC or recertification 30-day payment periods
      - Acute or post-acute inpatient discharge 14 days prior to period
    - Subsequent 30-day payment periods
      - Acute inpatient discharge 14 days prior to period
      - Post-acute inpatient stay during HH episode requires discharge from HH services
    - Institutional designation applies to inpatient stays covered by all payers
  - Community payment periods
    - All other payment periods

Admission Source

- Data collection points
  - Required for each 30-day payment period
    - SOC or recertification 30-day payment periods
      - Intake & clinical assessment process
        - » Admission source data required on OASIS assessment
    - Subsequent 30-day payment periods
      - Clinical assessment process

Admission Source

- Claim coding requirements
  - Inpatient discharge dates required to be reported on claims when inpatient stay paid by payer other than Medicare
    - Occurrence codes PROPOSED to report inpatient discharge dates, *if applicable*
  - PENDING CMS GUIDANCE inpatient discharge dates optional to be reported on claims when inpatient stay paid by Medicare
    - Correct payment to HH for institutional status dependent on inpatient facility to correctly submit claim

Timing

- Definition
  - Early payment periods
    - SOC period only
      - Must be more than 60 days between end of one period & start of another period
  - Late payment periods
    - All subsequent periods
    - SOC period
      - If less than 60 days since end of prior period
  - Episode timing applies only to traditional Medicare covered HH services

Timing

- Data collection points

  – Required for each 30-day payment period

- Claim coding requirements

  – Similar to reporting of episode timing under PPS

    • Claims paid according to Medicare CWF history

Claims Submission & Payment Processing

RAPs

- Required for each 30-day payment period
  - CMS indicated median of 12 days to bill RAPs based on 2017 claims data
  - Not subject to 14-day payment floor & typically pay in 7 to 10 days
  - No payment for HHAs Medicare certified in 2019 or thereafter
    - HHAs required to submit "no-pay" RAPs
- Could potentially be phased out pending future rulemaking
  - RAPs possibly eventually replaced by a Notice of Admission billing transaction

RAPs

- Billing requirements
  - SOC or recertification payment periods
    - Same as current PPS requirements
  - Subsequent payment periods
    - Updated inpatient discharge &/or diagnosis coding documented, *if applicable*
    - OASIS assessment has been completed, *if applicable*
      - *When applicable,* payment for functional score used from ROC or other follow-up OASIS rather than SOC or recertification OASIS
    - First billable visit has been completed

RAPs

- Billing requirements (continued)
  - Must be in "paid" status before corresponding claim can be billed & paid
  - Subject to auto-cancellation & payment recoupment by MAC when corresponding claim is not successfully received timely
    - 60 days from end date of 30-day payment period, or
    - 60 days from date RAP is paid,
    - Whichever date is greater

RAPs

- Example 1
  - 01/05/20 SOC visit
  - 01/12/20 SOC OASIS completed & POC sent to physician

    01/13/20 Payment period 1 RAP billed
    01/23/20 Payment period 1 RAP paid

  - 01/21/20 Transfer OASIS completed

    02/04/20 Payment period 2 begins
    02/07/20 First billable visit performed
    02/08/20 Payment period 2 RAP billed
    02/18/20 Payment period 2 RAP paid

  - 01/24/20 ROC OASIS completed
  - 03/01/20 discharge

RAPs

- Example 2
  - 01/05/20 SOC visit
  - 01/12/20 SOC OASIS completed & POC sent to physician
  - 03/01/20 discharge

01/13/20 Payment period 1 RAP billed
01/23/20 Payment period 1 RAP paid

02/04/20 Payment period 2 begins
02/07/20 First billable visit performed
02/08/20 Payment period 2 RAP billed
02/18/20 Payment period 2 RAP paid

Claims

- Required for each 30-day payment period
  - Not required to be billed sequentially
    - Required to have corresponding RAP in "paid" status
  - Subject to 14-day payment floor
  - Paid full claim amount less recoupment of RAP payment
  - Subject to payment recoding & adjustments, *if applicable*
- Continue to be subject to 2% payment reduction for sequestration

Claims

- Billing requirements
  - All payment periods subject to same billing requirements as PPS claims

  - OASIS validation
    - Claims for SOC or recertification 30-day payment periods subject to OASIS validation
      - Same requirements as current PPS claims
    - PENDING CMS GUIDANCE regarding claims for subsequent 30-day payment periods

Payment Recoding

- Claim payments subject to recoding
  - Payment period timing
    - Claim payments to be automatically recoded for early or late status based on paid claims history on Medicare CWF
  - Admission source
    - Claim payments to be automatically recoded for community or institutional status based on paid claims history on Medicare CWF
      - Unless appropriate occurrence codes billed on claim to indicate inpatient discharge covered by payer other than Medicare

Payment Adjustments

- LUPAs & add-on
  - Paid same methodology as PPS but LUPA threshold applied to case-mix specific 30-day payment period

- PEPs
  - Paid same methodology as PPS but prorated over 30-day payment period

- Outliers
  - Paid same methodology as PPS but outlier cost & threshold measured over 30-day period

Claims

- Example 1
  - 01/05/20 SOC visit
  - 01/12/20 SOC OASIS completed & POC sent to physician

    01/13/20 Payment period 1 RAP billed
    01/23/20 Payment period 1 RAP paid

  - 01/21/20 Transfer OASIS completed

    02/03/20 Payment period 1 ends
    02/04/20 Payment period 2 begins
    02/07/20 First billable visit performed
    02/08/20 Payment period 2 RAP billed
    02/13/20 Payment period 1 claim billed
    02/18/20 Payment period 2 RAP paid
    02/28/20 Payment period 1 claim paid

  - 01/24/20 ROC OASIS completed
  - 03/01/20 discharge

    03/01/20 Payment period 2 ends
    03/10/20 Payment period 2 claim billed
    03/25/20 Payment period 2 claim paid

Claims

- Example 2
  - 01/05/20 SOC visit
  - 01/12/20 SOC OASIS completed & POC sent to physician
  - 03/01/20 discharge

01/13/20 SOC RAP billed
01/23/20SOC RAP paid

02/03/20 Payment period 1 ends
02/04/20 Payment period 2 begins
02/07/20 First billable visit performed
02/08/20 Payment period 2 RAP billed
02/13/20 Payment period 1 claim billed
02/18/20 Payment period 2 RAP paid
02/28/20 Payment period 1 claim paid
03/01/20 Payment period 2 ends
05/03/20 Payment period 2 RAP auto-canceled
05/15/20 Payment period 2 RAP rebilled
05/25/20 Payment period 2 RAP repaid
05/30/20 Payment period 2 claim billed
06/13/20 Payment period 2 claim paid

Claims Submission & Payment Processing

Revenue Cycle Operational Issues

- Data collection timing
  - Admission source & timing data collection required for each 30-day payment period
  - Diagnosis coding requirements for billing transactions
- Documentation management
  - POC remains applicable for 60-day episode vs. 30-day payment period while interim orders may apply to only one 30-day payment period
  - Visit & NRS documentation confirmation required for billing each 30-day payment period vs. 60-day episode

Revenue Cycle Operational Issues

- Personnel demands
  - Additional billing & payment posting transactions due to shorter payment periods of only 30-days vs. 60-days

- Cash flow issues
  - Smaller, more frequent RAP & claim payments
  - No RAP payments for HHAs Medicare certified in 2019 & thereafter
    - Additional issues created for payment posting functions

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PDGM OPERATIONS
ORDER MANAGEMENT

Order Management Gap Analysis

- What is your frequency for sending orders out?
  - As frequently as possible but no less than twice a week
- How are orders sent out and received? – mail, fax, courier, email, portal
- What is current average return time?
  - Varies on method of delivery and receipt
  - Goal should be less than 7 days
- What education needs to take place with physicians?

Order Management Gap Analysis

- Who verifies the physician signed **and** dated the orders?

- How do you track orders being returned?
  - Utilize EMR to track orders not separate spreadsheets

- What are agencies timelines for following up on outstanding orders?

- Does agency have a designated person for follow up?

Order Management Best Practice

- Utilizing EMR/third party software track date sent – this is counted as day 1
- Day 7 – orders not back are resent
- Day 14 – orders not back are resent with call to physician office to confirm receipt and follow up status
- Day 21 – orders not back - notify clinical manager who places follow up call to physician office
- Day 28 – orders not back – Clinical Leader contacts physician office
- Other things to consider:
  - Each step is documented in EMR
  - During monthly staff meetings discuss with clinical managers, case manager, intake and other staff on any trends with outstanding orders

PDGM NATIONAL SUMMIT
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PDGM OPERATIONS
SUPPLY MANAGEMENT

Non Routine Supply

- PDGM payment includes NRS in methodology
- Patient Grouping most likely to require high NRS
  - Wound and Complex Nursing
    - These groups comprise 14% of all 30 day periods of care
    - 47% of all NRS charges fall into these groups
- LUPA payment includes NRS reimbursement in per visit cost
- Agencies need to ensure that supply cost is included on claims

Gap Analysis: Supply Management

- How are supplies requisitioned?
  - How do you ensure supplies used are attached to patient claim ?
  - How does staff report and request "trunk stock" usage?
- Do you have onsite supply closet?
  - How do you control access?
- Do you utilize drop shipping supplies?
- Do you have a supply formulary and how often do you review?
- Do you have "rules" in place related to quantity or dollar limits assigned to each order?
  - Who is allowed to override this?

Supply Management Best Practice

- Medical Supplier
  - Drop shipment available
  - Clinician direct order
  - Formulary with nonformulary supply approval rights assigned to clinical manager
  - Emergency supply closet stock at minimum – avoid specialty wound products
    - If specialty wound product ordered request interim order for stocked dressing until available
- If you using supply closet:
  - Closet is locked with only designated staff access
  - Written supply request completed prior to removal of supplies
  - Minimum stock levels
  - Designated nonclinical person to manage supplies
  - Car stock must submit request for refill that indicates patient and supplies used

Supply Management Best Practice

- Reports
  - Monthly review by patient/clinician level
  - Monthly review of supply closet utilization
  - Monthly to quarterly review of cost by diagnosis
  - Quarterly nonformulary supply usage
- Minimum Annual Review
  - Supply utilization with supplier
  - Cost comparison with supplier
  - Shipping fees
  - Formulary Update

LUPA Thresholds

- Variable thresholds based on HHRG
  - Different level for each of the 432 HHRGs
  - Utilize 10th percentile value of visits for each threshold
  - LUPA reimbursement is per visit (as prior PPS)

LUPA Thresholds

Visit Threshold	HHRGs	%
2	94	21.8%
3	128	29.6%
4	137	31.7%
5	63	14.6%
6	10	2.3%

LUPA Thresholds by Clinical Group

Clinical Group	2	3	4	5	6
Behavioral Health	12	9	15		
Complex	16	13	6	1	
MMTA - Cardiac	6	9	17	4	
MMTA - Endocrine	4	14	13	5	
MMTA - GI/GU	9	12	13	2	
MMTA - Infectious	10	21	5		
MMTA - Other	5	11	10	10	
MMTA - Respiratory	9	8	16	3	
MMTA - Surgical Aftercare	9	10	12	5	
MS Rehab	7	3	8	12	6
Neuro	6	5	9	12	4
Wound	1	13	13	9	
Grand Total	94	128	137	63	10

Where to Start With Managing LUPA

- Start with LUPA analysis on 2017 LUPA data from CMS as snapshot
- Develop dashboard for ongoing team management (finance/clinical)
- Dashboard evaluation includes:
  - Timing of the LUPA in payment period (Days 1-30, early/late)
    - Days from SOC evaluations completed
    - Visit frequency of disciplines
    - Diagnosis
  - LUPA Anticipated or Unanticipated
  - Reasons for LUPA
    - Homebound status
    - Physician request discharge
    - Patient refusal
  - Were patient outcomes achieved?

Where To Start: Managing LUPAs

- Education Opportunities:
  - Clinical managers/clinical staff on LUPA impact both financially and on patient outcomes
  - Physicians on PDGM changes
- High LUPA (greater 10%) develop Performance Improvement Project with clinical department based on findings from evaluation of LUPAs

Evaluate Total Cost of Care

- Evaluate organization wide productivity
- Evaluate discipline utilization
- Evaluate length and frequency of visits by diagnosis
- Evaluate back office processes and staffing
- Evaluate mileage reimbursement
- Evaluate supply cost

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PDGM Data Analytics

Aaron Little, BKD

Data Analytics

- Presentation Outline
  - CMS Data Resources
  - Impact Analysis
  - PDGM Analysis using 2017 Claims
  - Visit Utilization
  - Questionable Encounters
  - LUPA Deep Dive
  - Marketing Insights
  - Other Analyses

CMS Data Resources

1. PDGM Grouper Tool CY 2019
- https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
- Simple to use Excel File that calculates your case-mix weights and HIPPS codes under PDGM
- Use the 80/20 Rule to calculate the case-mix weights for your most seen patients under different scenarios
- Can be used to help compare the expected reimbursement to your current HH PPS revenues
- Use to evaluate your agency revenue differences for budgeting and decision making

PDGM Grouper Tool CY 2019

Steps to navigate the PDGM Grouping Tool, enter the following:

1. Number of Visits for the 30 days period
2. Timing of the 30-Day Period: Early/Late
3. Admission Source: Community or Institutional
4. Clinical Grouping: The principle Dx code expected on the claim
5. Comorbidity Adjustment: Up to 24 secondary Dx codes
6. OASIS Items-Functional Level: Check box for Risk of Hospitalization and select scores from the other seven M-Items

→ Automatically calculates HIPPS code and case-mix weight

HIPPS Code	
1st position (Source & Timing)	2
2nd position (Clinical Group)	A
3rd position (Functional Level)	C
4th position (Comorbidity)	1
5th position (Placeholder)	1
HIPPS Code	2AC11
Case-mix weight	1.4415

PDGM Grouper Tool CY 2019

Use the tool to compare your PDGM revenue to current HH PPS reimbursement under different scenarios

Example: ICD-10: Z47.1 - Aftercare following joint replacement surgery- $3,298 average payment under current reimbursement (Northeast)

Aftercare Scenarios	Period 1		Period 2		Rev.	Variance	
	HIPPS	C.M.W.	HIPPS	C.M.W.		$	%
1. Inpatient, 60 days, high function, not comorbid, no LUPA	2EC11	1.5276	4EC11	1.3884	$ 5,547	$ 1,825	49%
2. Same as 1, <30 days	2EC11	1.5276			$ 2,906	$ (816)	-22%
3. Same as 2, low comorbidity	2EC21	1.5272			$ 3,019	$ (702)	-19%
4. 1. Inpatient, 60 days, med function, not comorbid, no LUPA	2EB11	1.3845	4EB11	1.2453	$ 5,002	$ 1,281	34%
5. Same as 4, <30 days	2EB11	1.3845			$ 2,634	$(1,088)	-29%
6. Same as 5, high comorbidity	2EB31	1.5692			$ 2,985	$ (737)	-20%

CMS Data Resources

2. Home Health PPS Limited Data Set (LDS)

- https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/Home_Health_PPS_LDS.html
  - Media: DVD
  - Cost: $1,200
  - Data Format: Comma separated variable block (CSV) with SAS® read-in program
  - Available: CY 2017

- Data file was constructed by splitting the current 60-day home health episodes into two 30-day

Home Health PPS LDS

Information on the file includes:

- Start and end dates of the 30-day periods and 60-day episodes
- Wage index value associated with each episode/period
- Information regarding the resource use of the episode/period
- Payment adjustors used for the episode/period
- HIPPS codes

- Case-mix weights
- Indicators for whether the episode/period receives a payment adjustment (LUPA, PEP, outlier)
- Actual and simulated payments for the episode/period
- Information on number and length of visits that occur during the episode/period
- Select information from the OASIS that is used in the payment system

Home Health PPS LDS

- Examine the differences in payment to provide great detail for budgeting for episodes starting in CY 2020
- Evaluate the cases where revenue changes are significant
- Add your specific costs per visit to determine your profitability by the different PDGM components
- Identify the Primary Diagnostic codes that are not considered PDGM "appropriate" for home health for coding
- Use as a basis for projecting your budgets impacted by PDGM
- Create a "Sensitivity" model for evaluating changes in your Plan of Care (POC)

CMS Data Resources

3. PDGM Agency Level Impact
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/PDGM-Agency-Level-Impacts.zip
- Look up your agency by CMS Customer Number (CCN) to see the financial impact between HH PPS payments compared to a projected PDGM 30 day period payments (uses CY 2017 data)

PDGM Impact Analysis- Summary

- The PDGM Impact Analysis was performed using the Home Health PPS Limited Data Set (LDS) that CMS released with the 2019 Final Rule
- The percent change in reimbursement is based on the projected PPS reimbursement compared to the projected PDGM reimbursement from the LDS
- The 0-25, 25-75, and 75-100 represents HHA's in the top 25%, middle 50%, and bottom 25%, respectively, based on the projected percent change in reimbursement

- From the Summary table it is clear that the higher the percentage of PDGM episodes that only have one 30 day period (last 30 days or less and only receive one payment) have a more negative average change in reimbursement

PDGM Impact Analysis Summary						
	PPS Episodes	1st 30 Day Periods	2nd 30 Day Periods	Total 30 Day Periods	% of Episode w/o 2nd 30 Day Period	% Change in Reimbursement
0-25	701,255	701,255	584,746	1,286,001	14.1%	26.0%
25-75	3,720,884	3,720,884	2,529,511	6,250,395	27.3%	1.9%
75-100	1,209,942	1,209,942	819,894	2,029,836	31.2%	-14.1%
National	5,632,081	5,632,081	3,934,151	9,566,232	22.4%	1.6%

PDGM Impact Analysis- Source & Timing

- From the Admission Source and Admission Timing tables below it is clear that HHA's with higher percentage of patients classified as institutional and early in the PDGM model do not necessarily have a higher percent change in reimbursement

- There is very little difference between the percentage of periods comparing institutional versus community and early versus late for HHAs in 25-75% and 75% - 100%.

Impact Analysis by Admission Source						
	Institutional PDGM Periods	Community PDGM Periods	Total PDGM Periods	% of Institutional Periods	% of Community Periods	% Change in Reimbursement
0-25	205,280	1,078,097	1,283,377	13.8%	86.2%	26.0%
25-75	1,789,974	4,456,582	6,246,556	24.9%	75.1%	1.9%
75-100	512,294	1,514,634	2,026,928	24.2%	75.8%	-14.1%
National	2,507,548	7,049,313	9,556,861	22.0%	78.0%	1.6%

Impact Analysis by Admission Timing						
	Early PDGM Periods	Late PDGM Periods	Total PDGM Periods	% of Early Periods	% of Late Periods	% Change in Reimbursement
0-25	269,338	1,014,039	1,283,377	21.1%	78.9%	26.0%
25-75	2,155,181	4,091,375	6,246,556	33.4%	66.6%	1.9%
75-100	715,393	1,311,535	2,026,928	37.9%	62.1%	-14.1%
National	3,139,912	6,416,949	9,556,861	31.5%	68.5%	1.6%

PDGM Impact Analysis- Clinical Group

- The LDS assigns "Questionable Encounters" to the clinical group of first secondary diagnosis that can be classified and uses that to derive the projected reimbursement

- The top quartile has the highest skilled nursing and other visit utilization per episode and the lowest therapy visit utilization per episode

- The top 25% has the lowest percent of Musculoskeletal Rehab and Questionable Encounter episodes

Top 25% by Clinical Group							
Clinical Group	PPS Episodes	% of PPS Episodes	% Change in Reimbursement	SN Visits per PPS Episode	Therapy Visits per PPS Episode	Other Visits per PPS Episode	Total Visits per PPS Episode
MMTA - Endocrine	55,748	7.9%	38.8%	10.9	2.2	1.9	15.0
Wound	55,714	7.9%	37.8%	14.4	2.1	2.2	18.7
Complex Nursing Interventions	9,027	1.3%	32.9%	8.7	1.9	2.3	13.0
Neuro/Stroke Rehabilitation	43,766	6.2%	26.7%	8.1	5.7	2.9	16.7
MMTA - Other	90,607	12.9%	25.8%	9.1	2.2	1.9	13.2
MMTA - Cardiac/Circulator	131,203	18.7%	23.9%	9.1	2.5	2.1	13.7
MMTA - Infectious Disease	28,910	4.1%	23.3%	9.1	2.3	1.9	13.3
MMTA - Respiratory	57,097	8.1%	21.4%	8.7	2.7	2.0	13.4
MMTA - GI/GU	28,113	4.0%	21.3%	9.1	2.4	2.0	13.5
Behavorial Health Care	11,330	1.6%	19.2%	8.0	2.3	2.3	12.6
Questionable Encounters	75,331	10.7%	17.0%	8.3	4.3	2.1	14.8
Musculoskeletal Rehabilitation	94,132	13.4%	16.5%	8.0	5.3	2.1	15.4
MMTA - Surgical Aftercare	16,071	2.3%	11.5%	10.5	3.7	1.3	15.5
Total	701,255	100.0%	26.0%	9.4	3.1	2.1	14.6

PDGM Impact Analysis- Clinical Group

- Comparing the 25% to 75%:
  - The average therapy utilization per episode quartile all clinical groups is almost doubled (3.1 to 6.4)
  - This is most significant for MMTA- Surgical Aftercare (3.7 to 5.8), Musculoskeletal Rehab (5.3 to 9.7) and Questionable Encounters (4.3 to 8.7)
  - The percent of episodes increased for both Musculoskeletal Rehab (13.4% to 17.6%) and Questionable Encounters (10.7% to 13.4%) increased more significantly than any other clinical groups

25% to 75% by Clinical Group							
Clinical Group	PPS Episodes	% of PPS Episodes	% Change in Reimbursement	SN Visits per PPS Episode	Therapy Visits per PPS Episode	Other Visits per PPS Episode	Total Visits per PPS Episode
Complex Nursing Interventions	71,322	1.9%	27.6%	7.9	2.8	2.3	13.1
Wound	344,220	9.3%	24.7%	13.9	3.8	1.9	19.6
MMTA - Endocrine	138,181	3.7%	15.5%	11.7	5.5	1.9	19.1
MMTA - Infectious Disease	169,888	4.6%	7.9%	8.6	4.8	1.6	15.1
MMTA - Other	252,787	6.8%	5.3%	9.5	5.5	1.9	16.8
MMTA - Cardiac/Circulator	568,307	15.3%	5.3%	8.9	5.6	2.0	16.5
MMTA - GI/GU	159,018	4.3%	4.6%	8.2	5.6	1.8	15.7
MMTA - Respiratory	300,264	8.1%	2.4%	8.0	6.3	1.9	16.1
Behavorial Health Care	71,402	1.9%	1.5%	6.7	5.9	2.2	14.7
Neuro/Stroke Rehabilitation	296,472	8.0%	0.7%	6.5	10.8	2.5	19.8
MMTA - Surgical Aftercare	177,677	4.8%	-0.1%	9.1	5.8	1.1	16.0
Questionable Encounters	493,414	13.3%	-6.4%	6.4	8.7	2.0	17.0
Musculoskeletal Rehabilitation	655,395	17.6%	-6.5%	6.1	9.7	1.8	17.6
Total	3,720,884	100.0%	1.9%	8.6	6.4	1.9	16.9

PDGM Impact Analysis- Clinical Group

- Comparing the 75% to 100%:
  - The average therapy utilization per episode across all clinical groups increased (6.4 to 9.5)
  - This is most significant for Neuro/Stroke Rehab (10.8 to 14.2), Musculoskeletal Rehab (9.7 to 12.4), Questionable Encounters (8.7 to 12.2), MMTA- Surgical Aftercare (5.8 to 8.0) and MMTA- Respiratory (6.3 to 9.7)
  - The percent of episodes increased for both Musculoskeletal Rehab (17.6% to 22.1%) and Questionable Encounters (13.4% to 20.2%) increased more significantly than any other clinical groups

75% to 100% by Clinical Group							
Clinical Group	PPS Episodes	% of PPS Episodes	% Change in Reimbursement	SN Visits per PPS Episode	Therapy Visits per PPS Episode	Other Visits per PPS Episode	Total Visits per PPS Episode
Complex Nursing Interventions	17,402	1.4%	17.3%	8.0	4.6	2.1	14.7
Wound	101,670	8.4%	11.2%	14.1	6.0	1.8	21.9
MMTA - Endocrine	38,484	3.2%	-0.6%	13.9	8.8	1.8	24.4
MMTA - Infectious Disease	37,434	3.1%	-4.3%	8.2	7.5	1.6	17.3
MMTA - GI/GU	39,159	3.2%	-8.0%	7.5	8.5	1.6	17.7
MMTA - Other	65,102	5.4%	-8.6%	10.0	8.7	1.7	20.4
MMTA - Cardiac/Circulator	136,850	11.3%	-10.2%	8.1	9.1	1.8	19.0
MMTA - Surgical Aftercare	41,803	3.5%	-10.3%	8.5	8.0	1.0	17.5
Behavorial Health Care	25,850	2.1%	-10.7%	5.5	9.3	1.6	16.4
Neuro/Stroke Rehabilitation	113,256	9.4%	-11.8%	5.0	14.2	2.2	21.5
MMTA - Respiratory	73,763	6.1%	-12.2%	7.1	9.7	1.5	18.3
Musculoskeletal Rehabilitation	267,446	22.1%	-17.0%	4.6	12.4	1.5	18.4
Questionable Encounters	244,252	20.2%	-19.2%	4.7	12.2	1.5	18.4
Total	1,209,942	100.0%	-14.1%	8.0	9.5	1.7	19.2

PDGM Impact Analysis- Clinical Group

- The national by clinical group:
    - MMTA- Surgical Aftercare, Musculoskeletal Rehab and Questionable Encounters are the only clinical groups with a projected decreased percent change in reimbursement
    - Musculoskeletal Rehab and Questionable Encounters represent the two highest volumes of episodes within the LDS
    - Musculoskeletal Rehab and Questionable Encounters represent the second and third highest therapy visits per episode, respectively

National by Clinical Group							
Clinical Group	PPS Episodes	% of PPS Episodes	% Change in Reimbursement	SN Visits per PPS Episode	Therapy Visits per PPS Episode	Other Visits per PPS Episode	Total Visits per PPS Episode
Complex Nursing Interventions	144,472	2.6%	26.0%	8.1	3.1	2.3	13.4
Wound	501,604	8.9%	24.4%	14.1	4.0	1.9	20.0
MMTA - Endocrine	185,692	3.3%	17.3%	12.0	5.5	1.9	19.4
MMTA - Infectious Disease	251,088	4.5%	8.3%	8.6	4.9	1.7	15.3
MMTA - Other	382,553	6.8%	6.9%	9.5	5.5	1.9	16.8
MMTA - Cardiac/Circulator	764,612	13.6%	6.0%	8.7	5.7	2.0	16.4
MMTA - GI/GU	324,778	5.8%	5.4%	8.3	5.6	1.8	15.7
Neuro/Stroke Rehabilitation	399,164	7.1%	3.5%	6.5	10.5	2.5	19.5
MMTA - Respiratory	125,365	2.2%	3.4%	7.9	6.3	1.8	16.0
Behavorial Health Care	421,058	7.5%	2.2%	6.6	6.0	2.1	14.7
MMTA - Surgical Aftercare	326,771	5.8%	-0.7%	9.2	6.0	1.1	16.3
Musculoskeletal Rehabilitation	854,992	15.2%	-3.8%	6.2	9.3	1.8	17.3
Questionable Encounters	915,718	16.3%	-4.0%	6.4	8.5	1.9	16.8
Total	5,632,081	100.0%	1.6%	8.6	6.4	1.9	17.0

PDGM Impact Analysis- Therapy Utilization & LUPAs

- This table reflects that the new LUPA thresholds in the PDGM will have a significant impact on the percentage change in reimbursement
  - HHAs must recognize the threshold (for each 30 day period) based on the projected HIPPS code for each patient

Impact Analysis LUPA								
	PPS LUPA Episodes	PPS LUPA %	1st 30 Day LUPA Periods	2nd 30 Day LUPA Periods	Total 30 Day LUPA Periods	PDGM LUPA %	Change in LUPA %	% Change in Reimbursement
0 to 25%	48,246	6.4%	37,668	35,732	73,400	5.3%	-1.1%	26.0%
25% to 75%	337,143	7.7%	255,944	252,689	508,633	7.3%	-0.4%	1.9%
75% to 100%	82,931	6.0%	63,291	71,545	134,836	6.5%	0.5%	-14.1%
National	468,320	6.9%	356,903	359,966	716,869	6.6%	-0.4%	1.6%

- This table summarizes the therapy utilization impact and reflects that the removal the therapy threshold also has a significant impact on the percentage change in reimbursement

Therapy Utilization			
	PPS Episodes	1st 30 Day Periods	2nd 30 Day Periods
0-25%	3.1	1.9	1.1
25% - 75%	6.4	4.8	2.7
75%-100%	9.5	7.5	4.5
National	6.4	4.7	2.8

PDGM Impact Analysis- Skilled Nursing Utilization

Top 25% by Skilled Nursing Visits			
	PPS Episodes	% of PPS Episodes	% Change in Reimbursement
0 Visits	20,440	2.9%	-4.5%
1-5 Visits	135,492	19.3%	12.1%
6-10 Visits	392,477	56.0%	25.7%
11-15 Visits	98,514	14.0%	27.4%
16-20 Visits	29,828	4.3%	25.0%
21+ Visits	24,443	3.5%	13.1%

25% to 75% by Skilled Nursing Visits			
	PPS Episodes	% of PPS Episodes	% Change in Reimbursement
0 Visits	393,236	10.6%	-15.1%
1-5 Visits	1,113,113	29.9%	-3.3%
6-10 Visits	1,398,484	37.6%	3.6%
11-15 Visits	490,182	13.2%	12.8%
16-20 Visits	173,464	4.7%	19.3%
21+ Visits	152,034	4.1%	12.0%

75% to 100% by Skilled Nursing Visits			
	PPS Episodes	% of PPS Episodes	% Change in Reimbursement
0 Visits	234,848	19.4%	-20.8%
1-5 Visits	389,538	32.2%	-15.3%
6-10 Visits	353,201	29.2%	-10.1%
11-15 Visits	127,246	10.5%	-0.1%
16-20 Visits	52,937	4.4%	7.0%
21+ Visits	52,068	4.3%	5.5%

National by Skilled Nursing Visits			
	PPS Episodes	% of PPS Episodes	% Change in Reimbursement
0 Visits	648,524	11.5%	-13.9%
1-5 Visits	1,638,143	29.1%	-2.4%
6-10 Visits	2,144,162	38.1%	5.7%
11-15 Visits	715,942	12.7%	13.3%
16-20 Visits	256,229	4.5%	17.7%
21+ Visits	228,545	4.1%	10.6%

PDGM Impact Analysis- Therapy Utilization

Top 25% by Therapy Visits			
	PPS Episodes	% of PPS Episodes	% Change in Reimbursement
0 Visits	418,399	59.7%	41.8%
1-4 Visits	66,477	9.5%	31.3%
5-8 Visits	83,710	11.9%	10.8%
9-13 Visits	75,823	10.8%	-2.9%
14-19 Visits	42,637	6.1%	-11.2%
20+ Visits	14,148	2.0%	-11.6%

75% to 100% by Therapy Visits			
	PPS Episodes	% of PPS Episodes	% Change in Reimbursement
0 Visits	238,654	19.7%	25.1%
1-4 Visits	116,530	9.6%	20.2%
5-8 Visits	184,307	15.2%	-7.3%
9-13 Visits	240,554	19.9%	-16.5%
14-19 Visits	258,373	21.4%	-21.6%
20+ Visits	171,459	14.2%	-22.2%

25% to 75% by Therapy Visits			
	PPS Episodes	% of PPS Episodes	% Change in Reimbursement
0 Visits	1,190,900	32.0%	33.4%
1-4 Visits	514,930	13.8%	27.6%
5-8 Visits	650,400	17.5%	1.7%
9-13 Visits	630,454	16.9%	-9.1%
14-19 Visits	475,577	12.8%	-16.2%
20+ Visits	258,279	6.9%	-19.8%

National by Therapy Visits			
	PPS Episodes	% of PPS Episodes	% Change in Reimbursement
0 Visits	1,847,953	32.8%	33.4%
1-5 Visits	697,937	12.4%	26.7%
6-10 Visits	918,417	16.3%	1.7%
11-15 Visits	946,831	16.8%	-9.4%
16-20 Visits	776,587	13.8%	-16.3%
21+ Visits	443,886	7.9%	-18.3%

Data & Provider Cohort Source Data

- All data is sourced from National CMS 2017 claims data

- Average Reimbursement
  - Full episodes only (LUPAs excluded from data)

- Volume
  - PPS episodes have been recast to 30-Day periods

- Provider Size Cohorts are based on:
  - Specific CMS provider numbers
  - Recasted to 30-Day period volume based on national 2017 CMS PPS claims data

- Diagnosis Code Methodology
  - Secondary diagnosis code was utilized when primary diagnosis was a Questionable Encounter

645 - 44,183
30-Day
Periods

- Top 25% (76%-100%)

279 - 644
30-Day
Periods

- 51-75%

95 - 278
30-Day
Periods

- 26-50%

1- 94
30-Day
Periods

- Bottom 25%
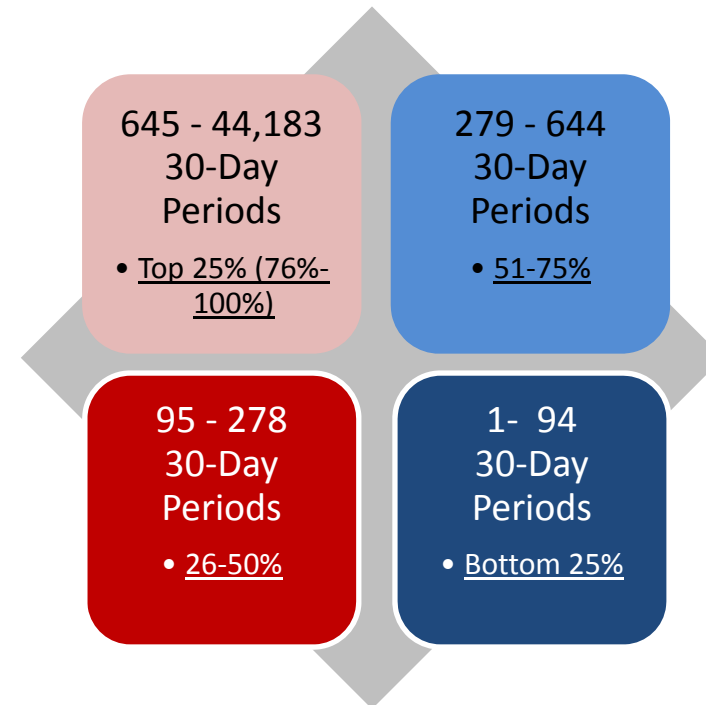
Clinical Grouping Data – National

Reimbursement & 30-Day Period Volume by Clinical Groupings
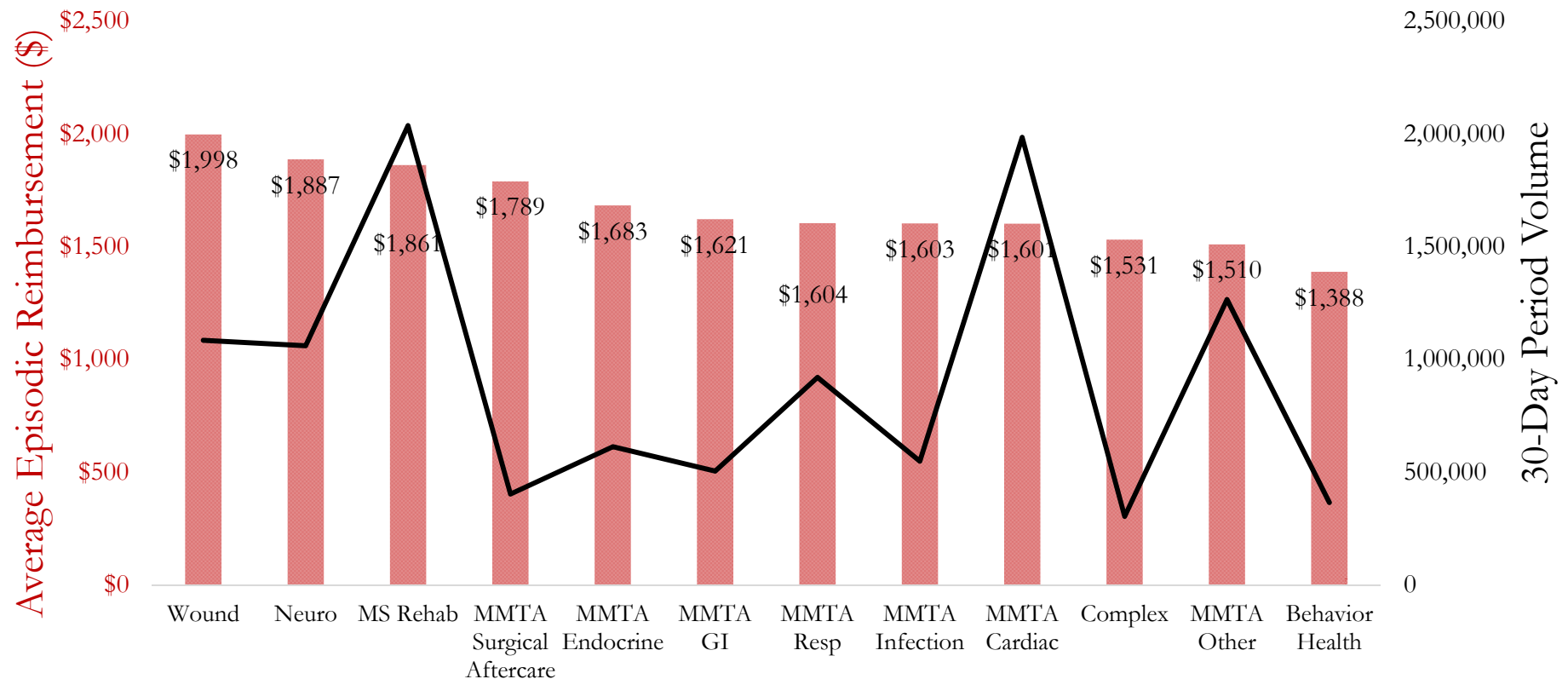
Clinical Grouping Top Diagnosis Data – National
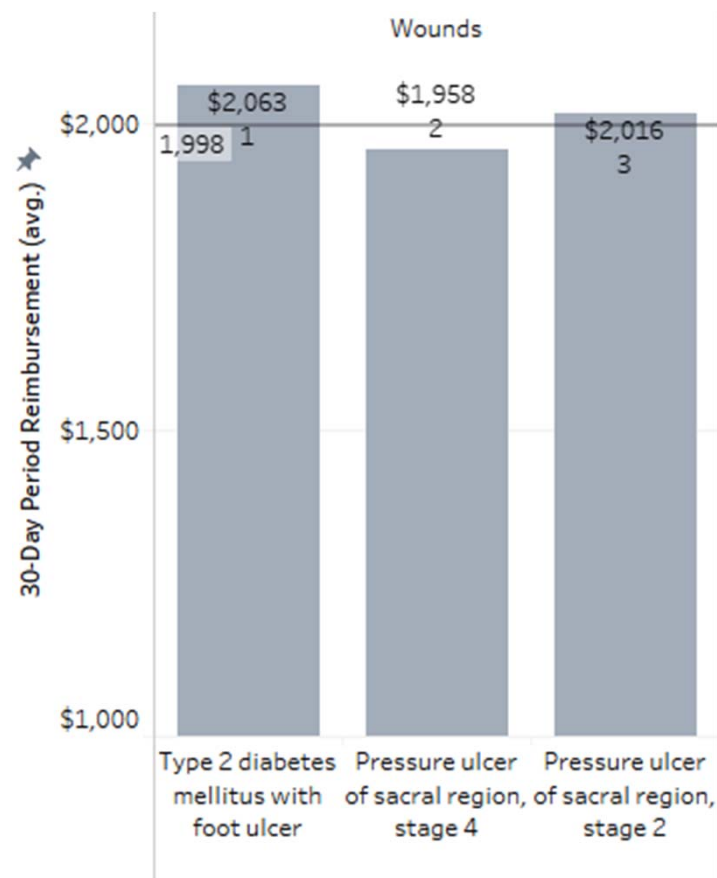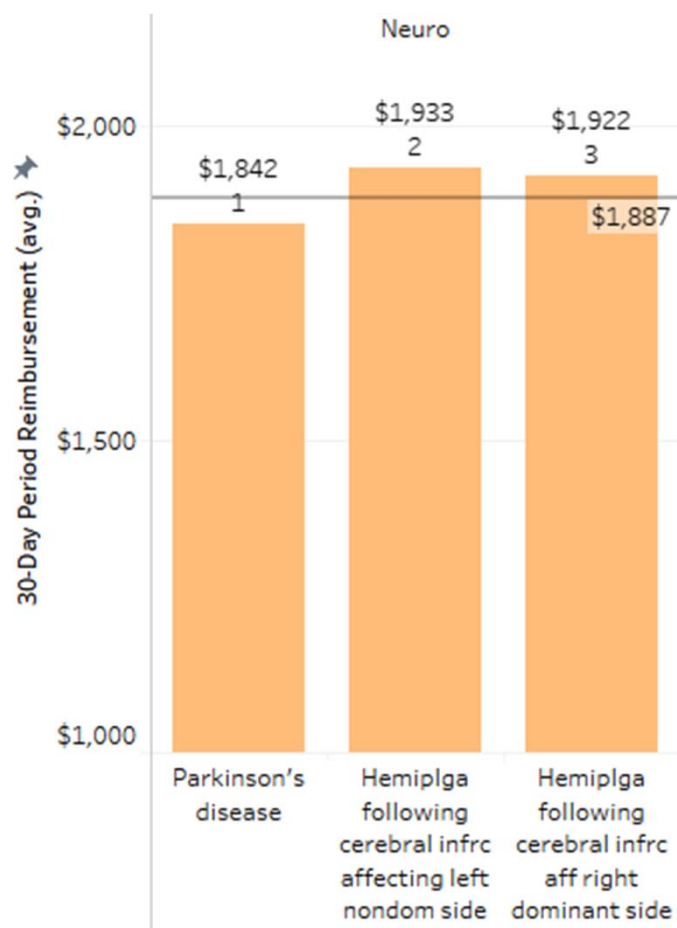
*Line represents national reimbursement average

Clinical Grouping Top Diagnosis Data – National

*Line represents national reimbursement average

Clinical Grouping Top Diagnosis Data – National
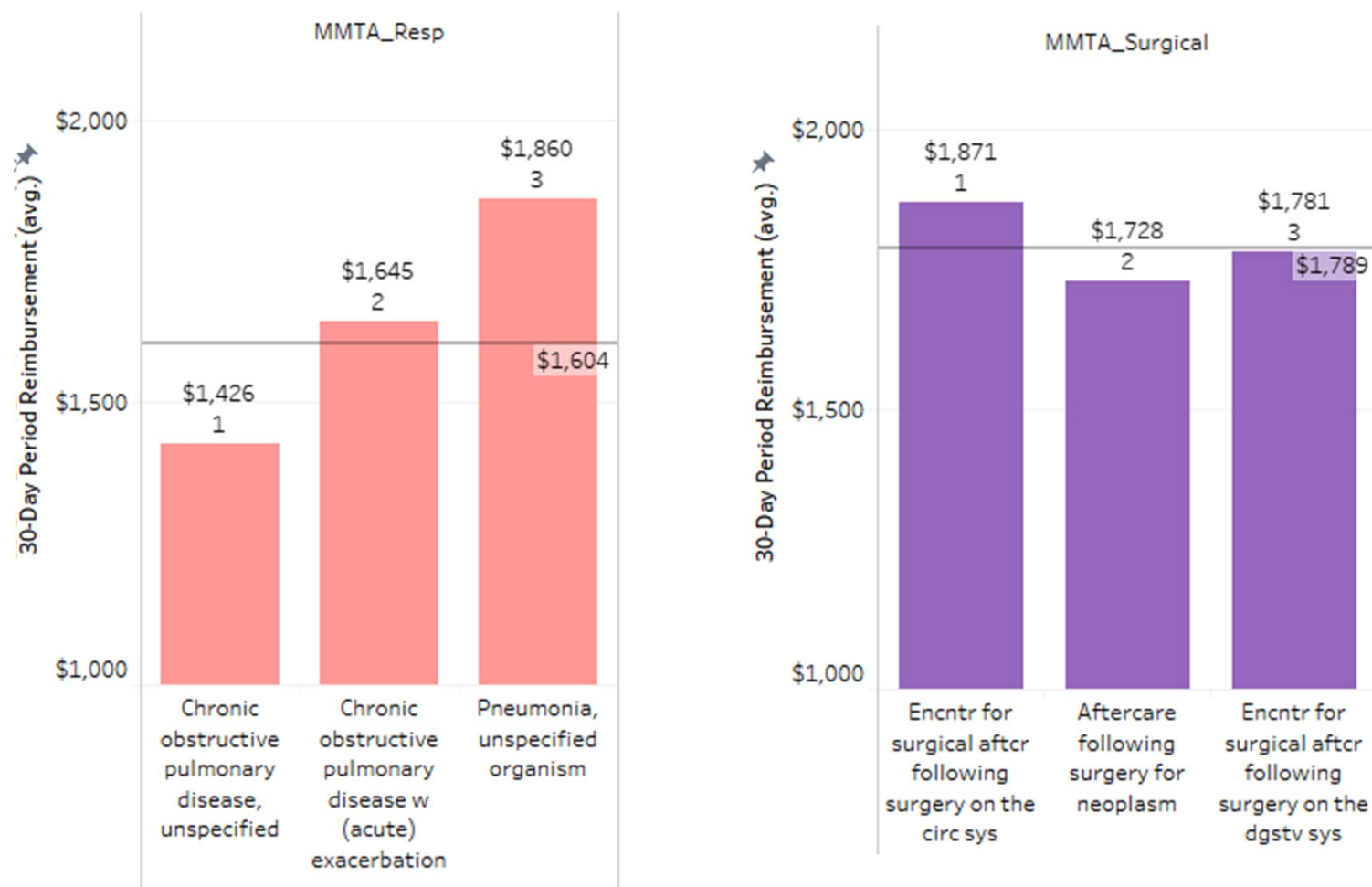
*Line represents national reimbursement average

Clinical Grouping Top Diagnosis Data – National
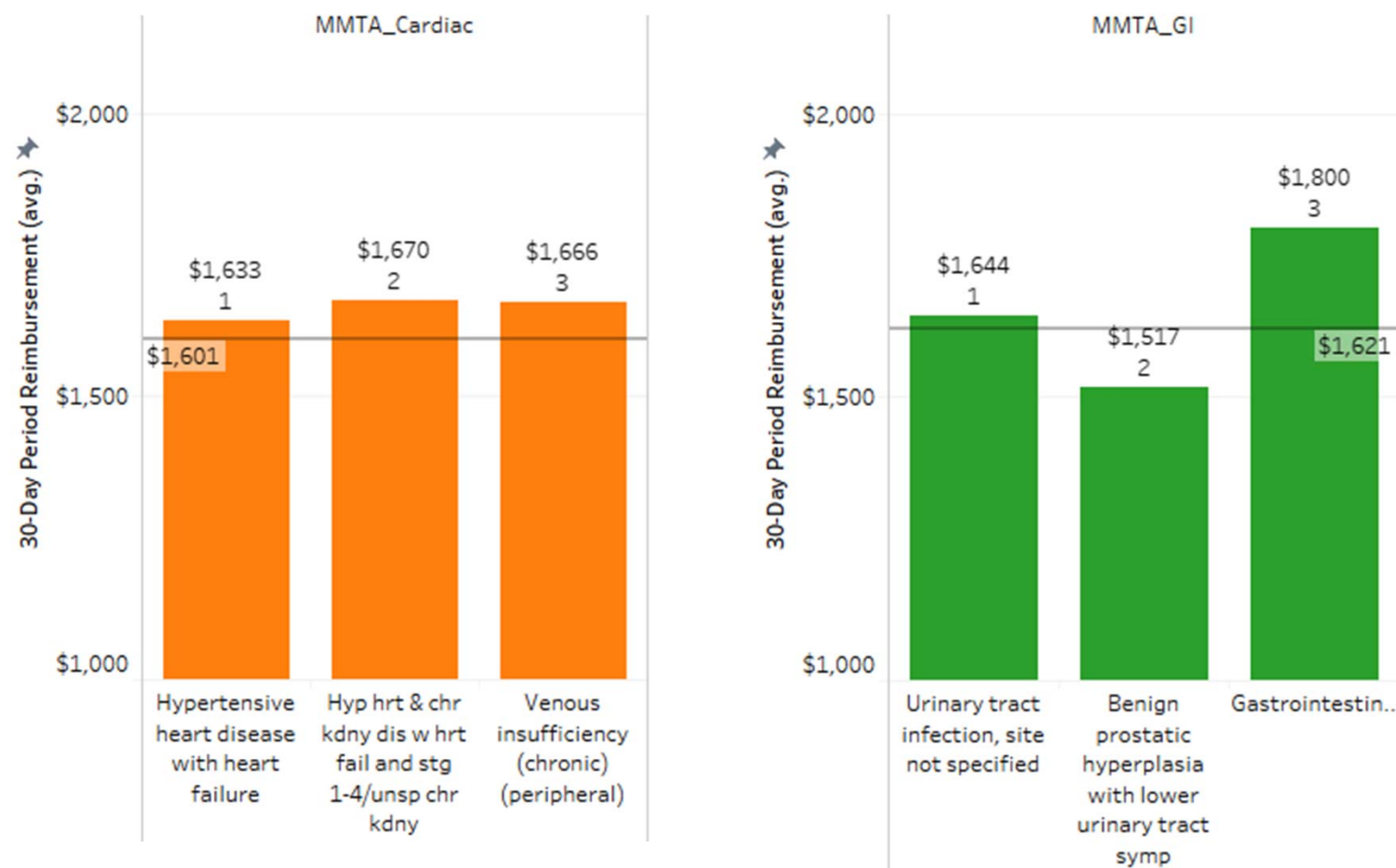
*Line represents national reimbursement average

Clinical Grouping Top Diagnosis Data – National

*Line represents national reimbursement average

Clinical Grouping Top Diagnosis Data – National
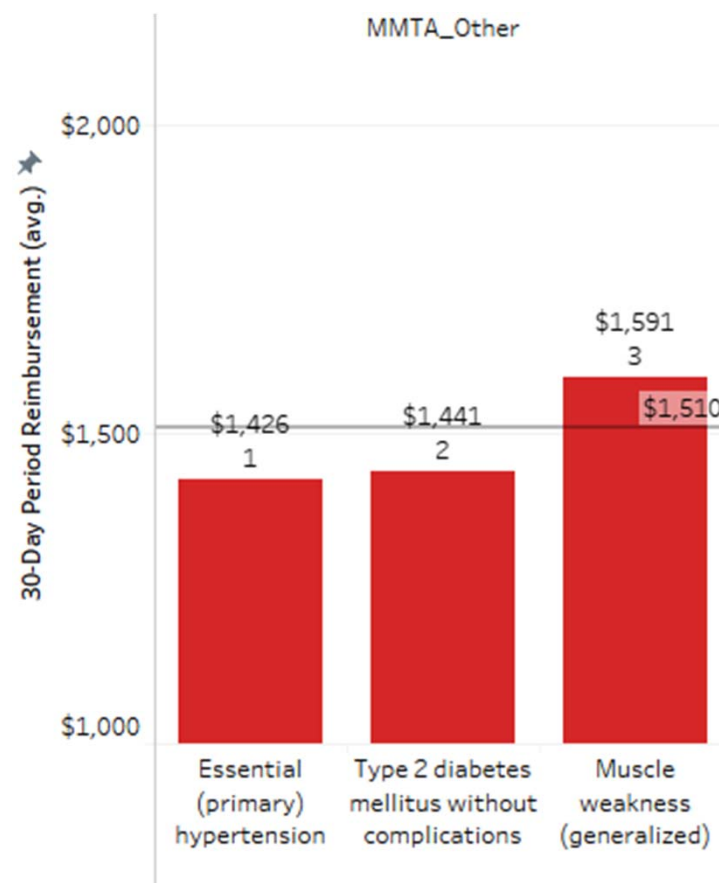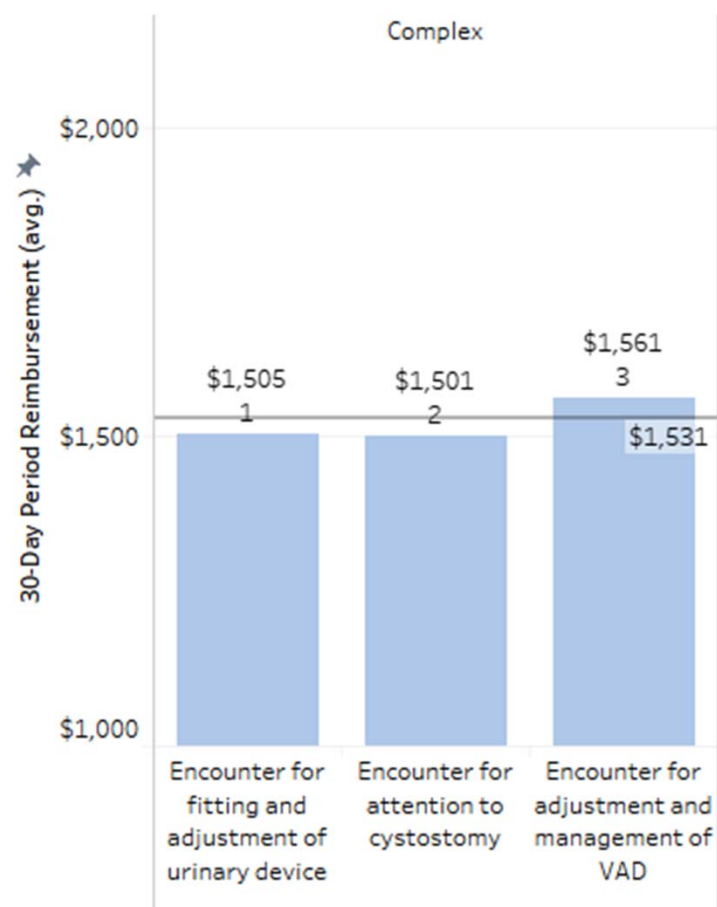
*Line represents national reimbursement average

Clinical Grouping Data – Cohorts

Reimbursement by Clinical Groupings (Provider Cohort)

Average Episodic Reimbursement ($)

	Neuro	Wound	Complex	MSRehab	Behavior	Cardic	Endocrine	GI/GU	Infec	Other	Resp	Surgical
0 To 25	$1,842	$1,971	$1,446	$1,735	$1,397	$1,531	$1,648	$1,529	$1,555	$1,471	$1,510	$1,728
26 to 50	$1,832	$1,943	$1,463	$1,741	$1,388	$1,527	$1,644	$1,511	$1,514	$1,471	$1,524	$1,689
51 to 75	$1,860	$1,969	$1,495	$1,799	$1,384	$1,548	$1,654	$1,559	$1,531	$1,482	$1,549	$1,701
76 to 100	$1,899	$2,009	$1,543	$1,895	$1,389	$1,625	$1,703	$1,649	$1,627	$1,526	$1,626	$1,805

■ 0 To 25   ■ 26 to 50   ■ 51 to 75   ■ 76 to 100

Functional Level Data – National

Reimbursement & 30-Day Period Volume by Functional Level

	Low	Medium	High
Reimbursement	$1,499	$1,722	$1,932

Average Episodic Reimbursement ($)

30-Day Period Volume

Low
Functional Level Case Mix Impact

Medium
Functional Level Case Mix Impact

High
Functional Level Case Mix Impact
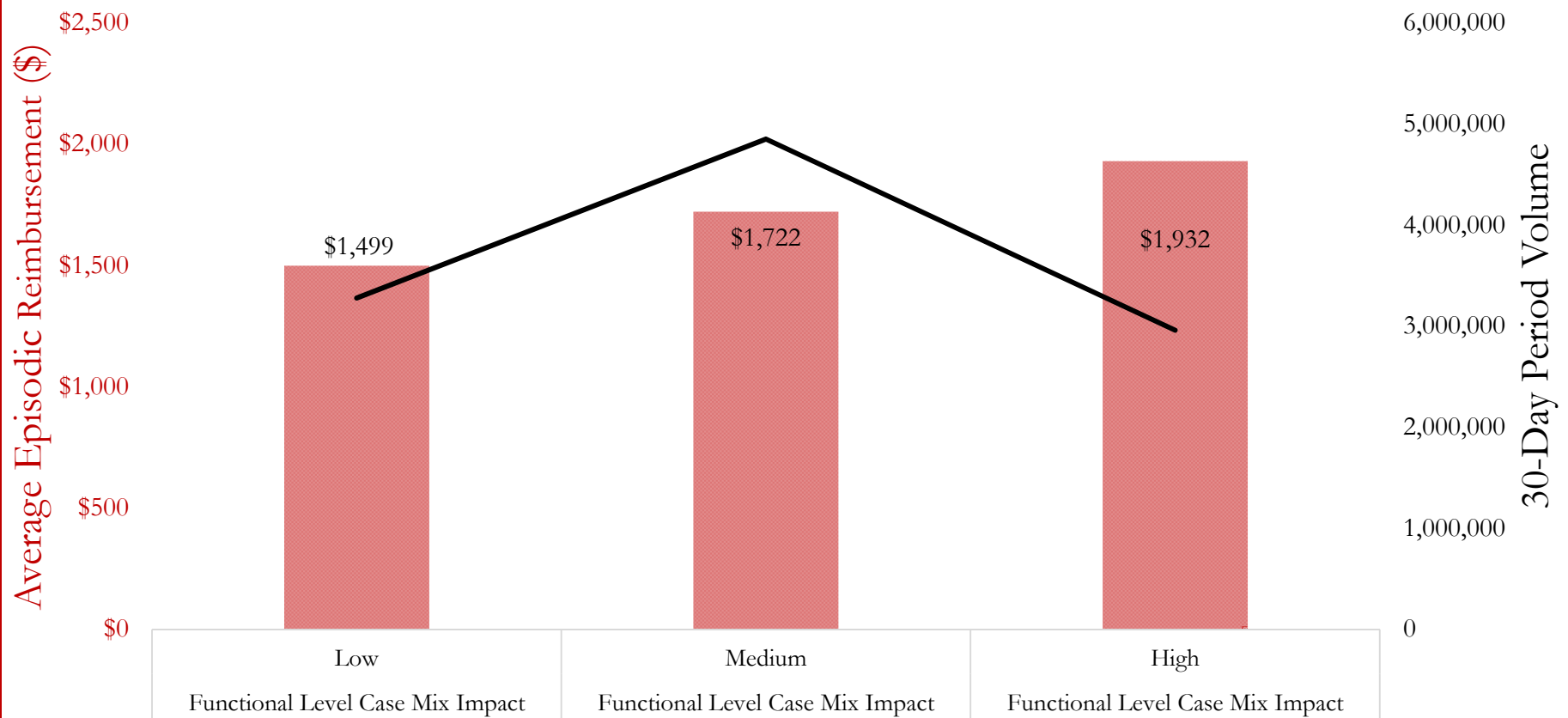
Functional Level Top Diagnosis Data – National

*Line represents national reimbursement average
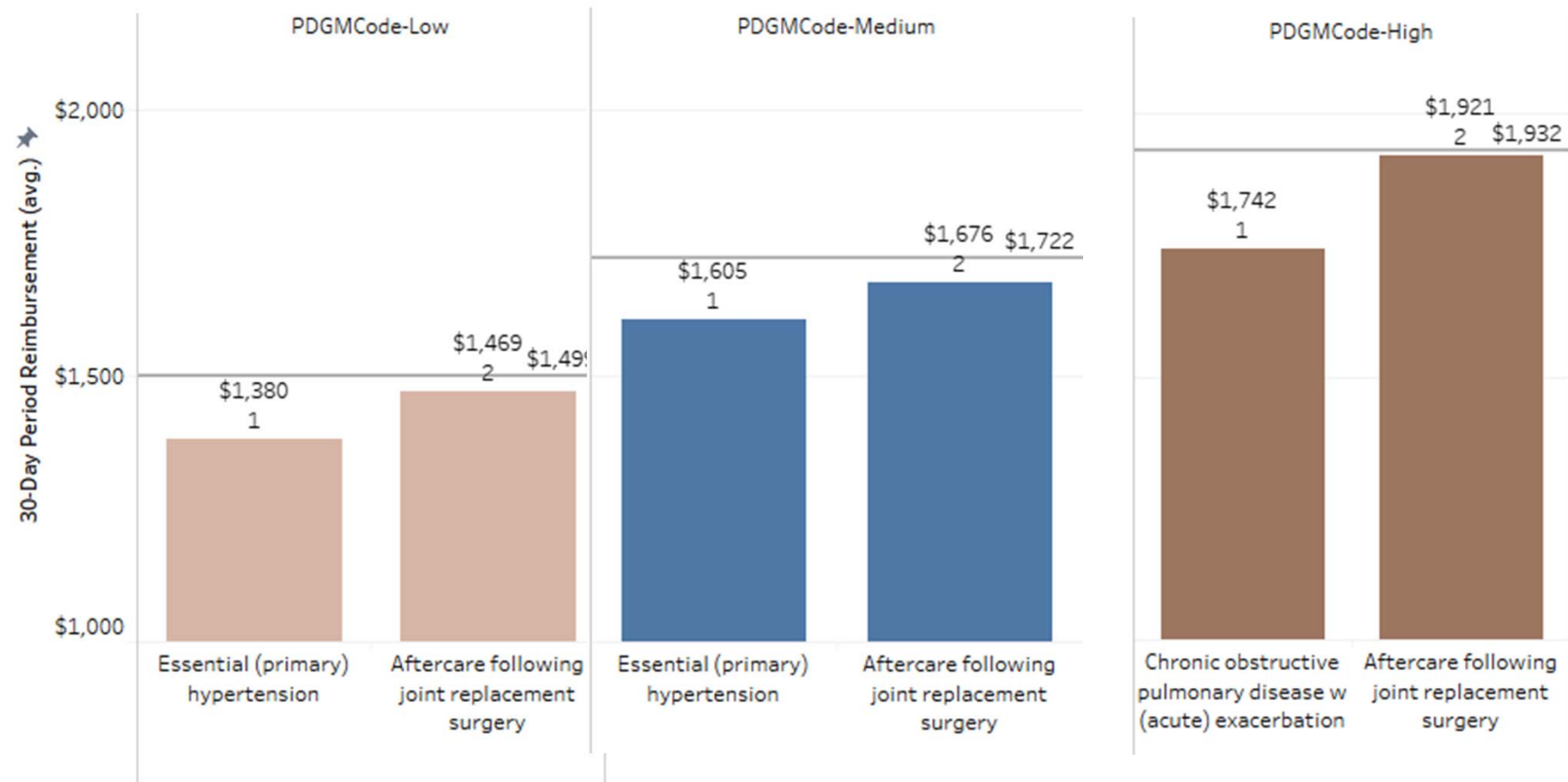
Functional Level Data – Cohorts

Reimbursement by Functional Level (Provider Cohort)

Average Episodic Reimbursement ($)

	PDGMCode-Low	PDGMCode-Medium	PDGMCode-High
0 To 25	$1,438	$1,666	$1,874
26 to 50	$1,428	$1,664	$1,873
51 to 75	$1,457	$1,687	$1,895
76 to 100	$1,523	$1,738	$1,946

■ 0 To 25   ■ 26 to 50   ■ 51 to 75   ■ 76 to 100
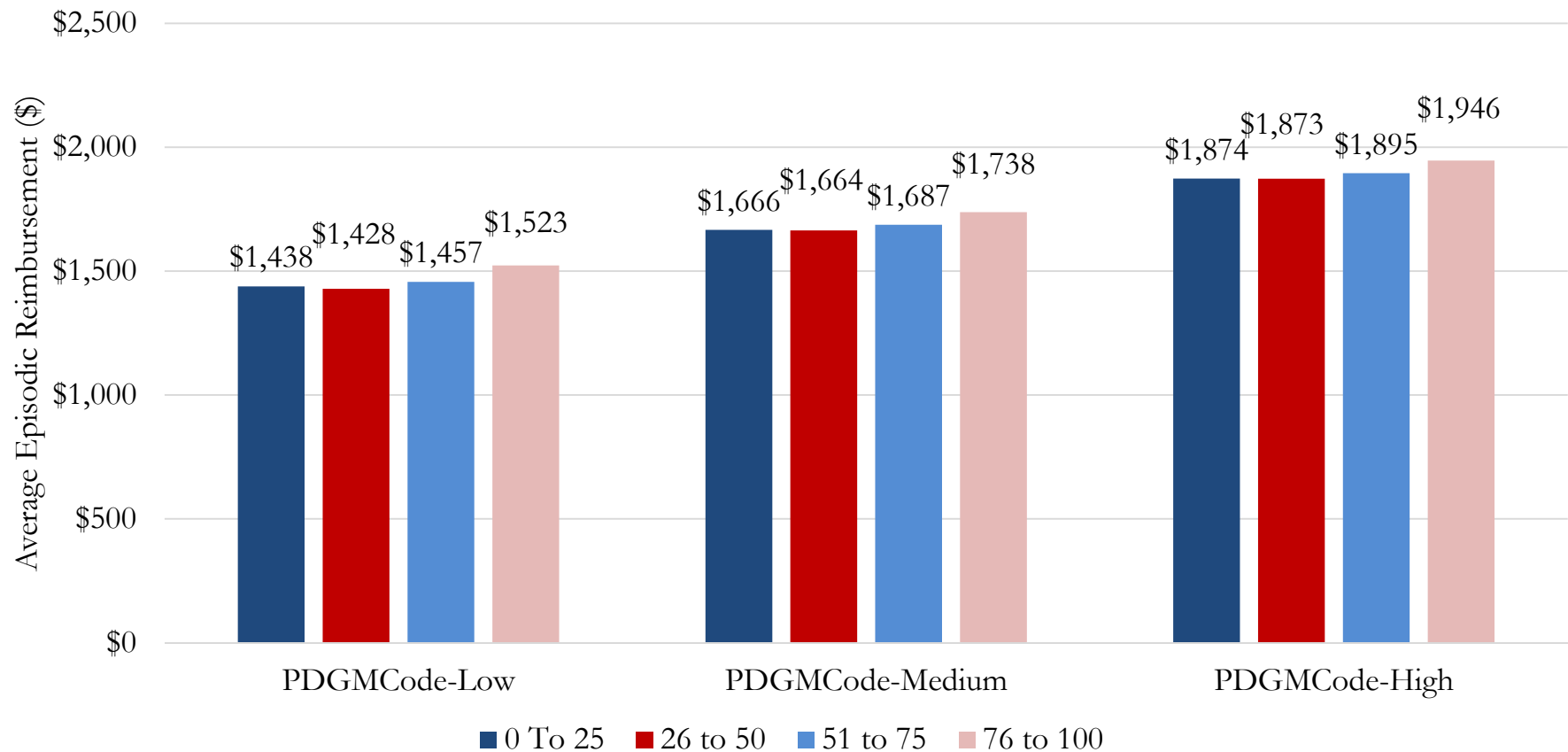
Admission Source & Timing Data – National

Reimbursement & 30-Day Period Volume by Admission Source
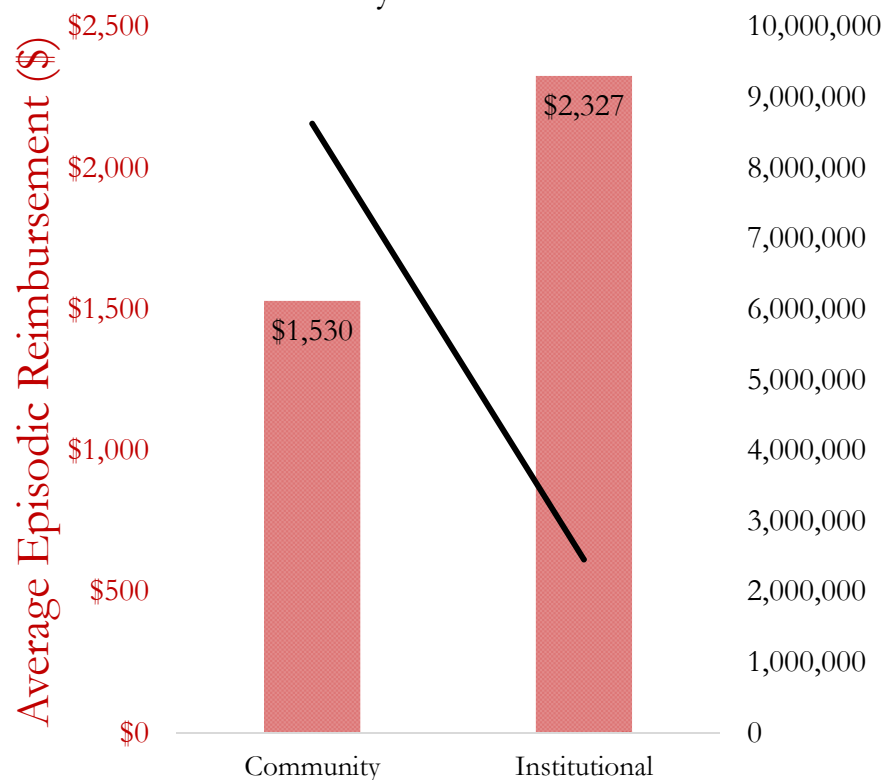
Reimbursement & 30-Day Period Volume by Episode Timing

Average Episodic Reimbursement ($)

30-Day Period Volume

Community: $1,530
Institutional: $2,327

Early: $2,231
Late: $1,428

Admission Source & Timing Top Diagnosis Data – National

Admission Source: top 3 diagnosis codes (by volume)
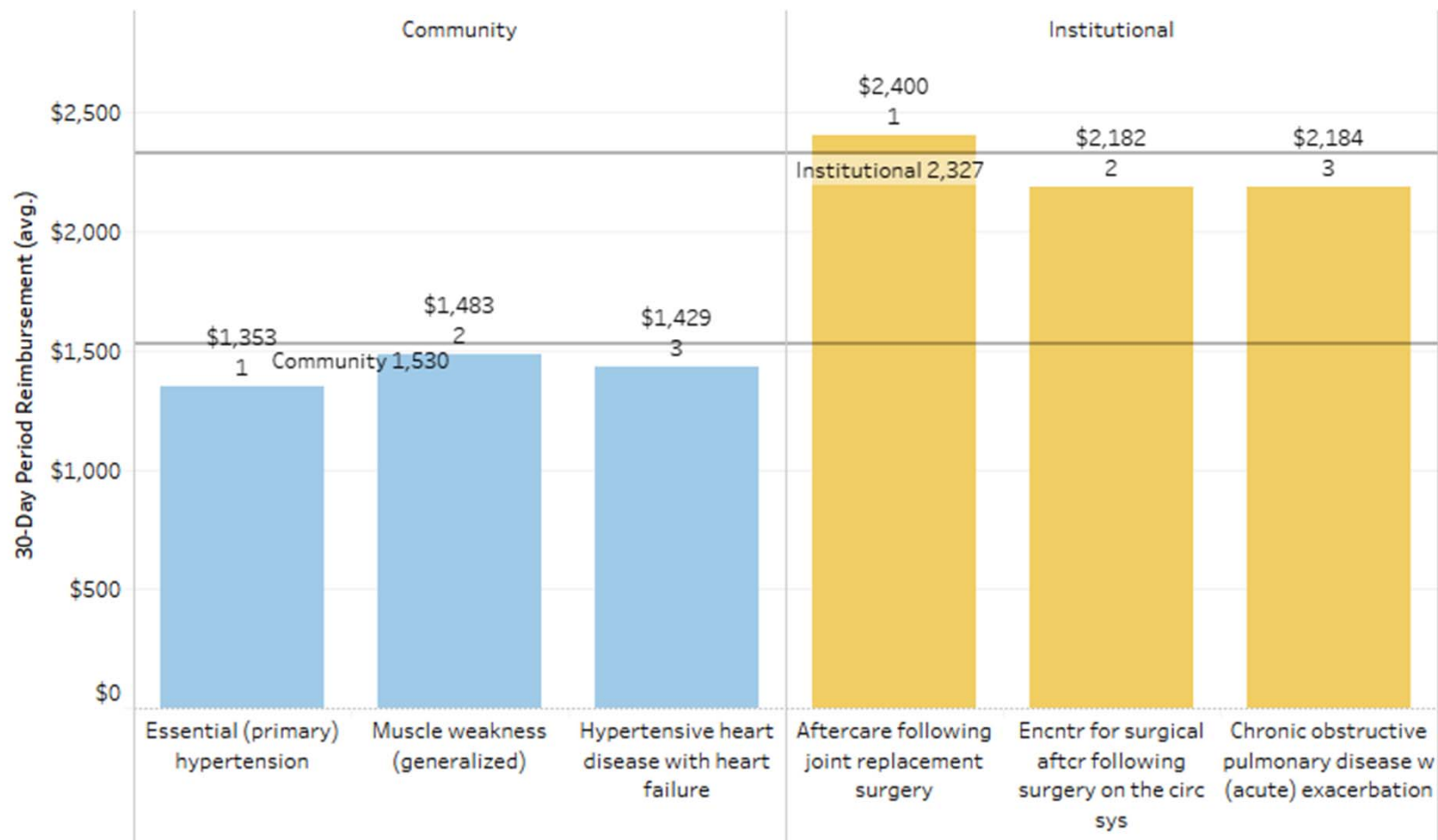
*Line represents national reimbursement average

Admission Source & Timing Top Diagnosis Data – National

Admission Timing: top 3 diagnosis codes (by volume)
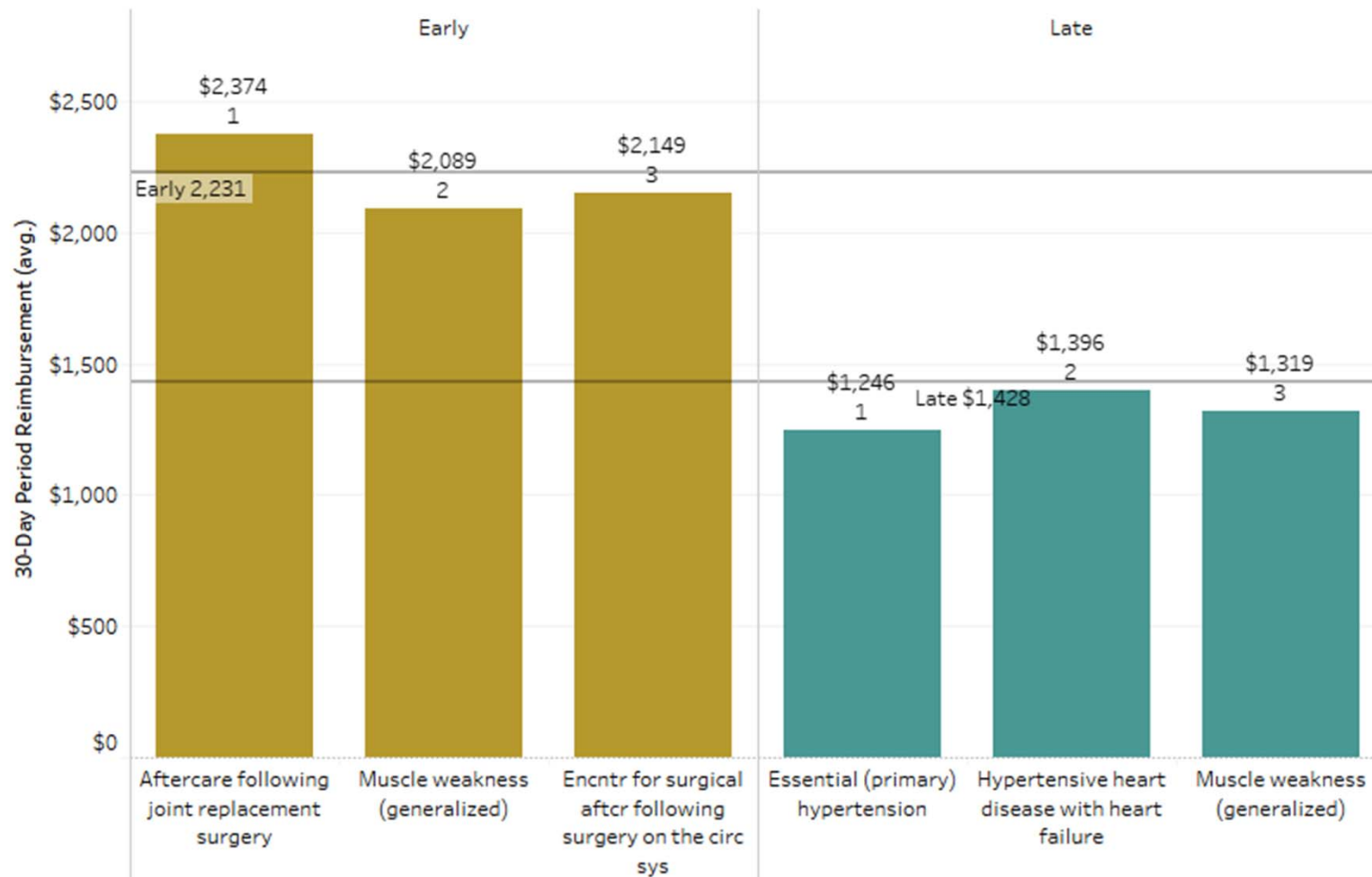
*Line represents national reimbursement average

Admission Source & Timing Data – Cohorts

Reimbursement by Admission Source (Provider Cohort)
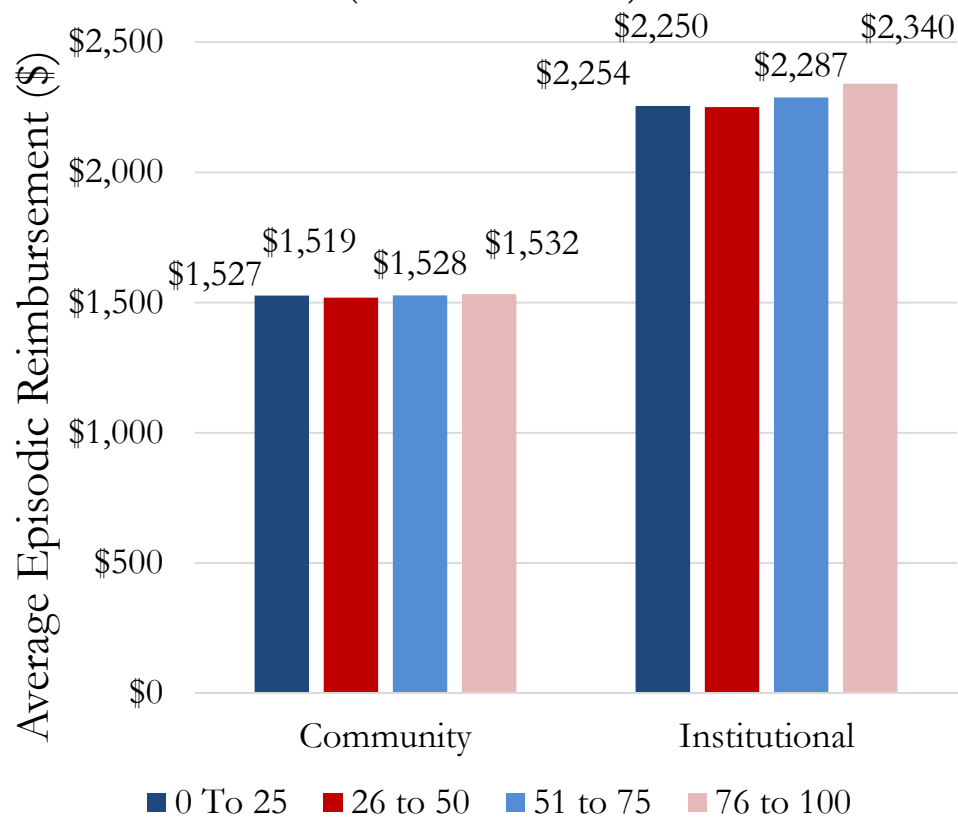
Reimbursement by Episode Timing (Provider Cohort)

Legend: 0 To 25 | 26 to 50 | 51 to 75 | 76 to 100
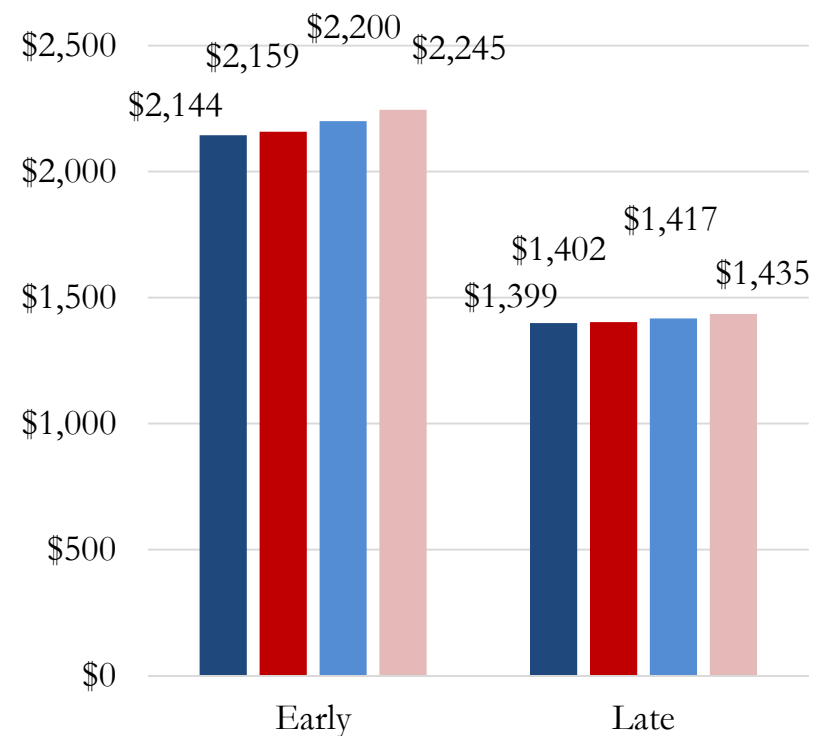
Comorbidity Level Data – National

Reimbursement & 30-Day Period Volume by Comorbidity Level

No — No Comorbidities	Low — Low Comorbidities	High — High Comorbidities
$1,666	$1,727	$1,937

Average Episodic Reimbursement ($)

30-Day Period Volume
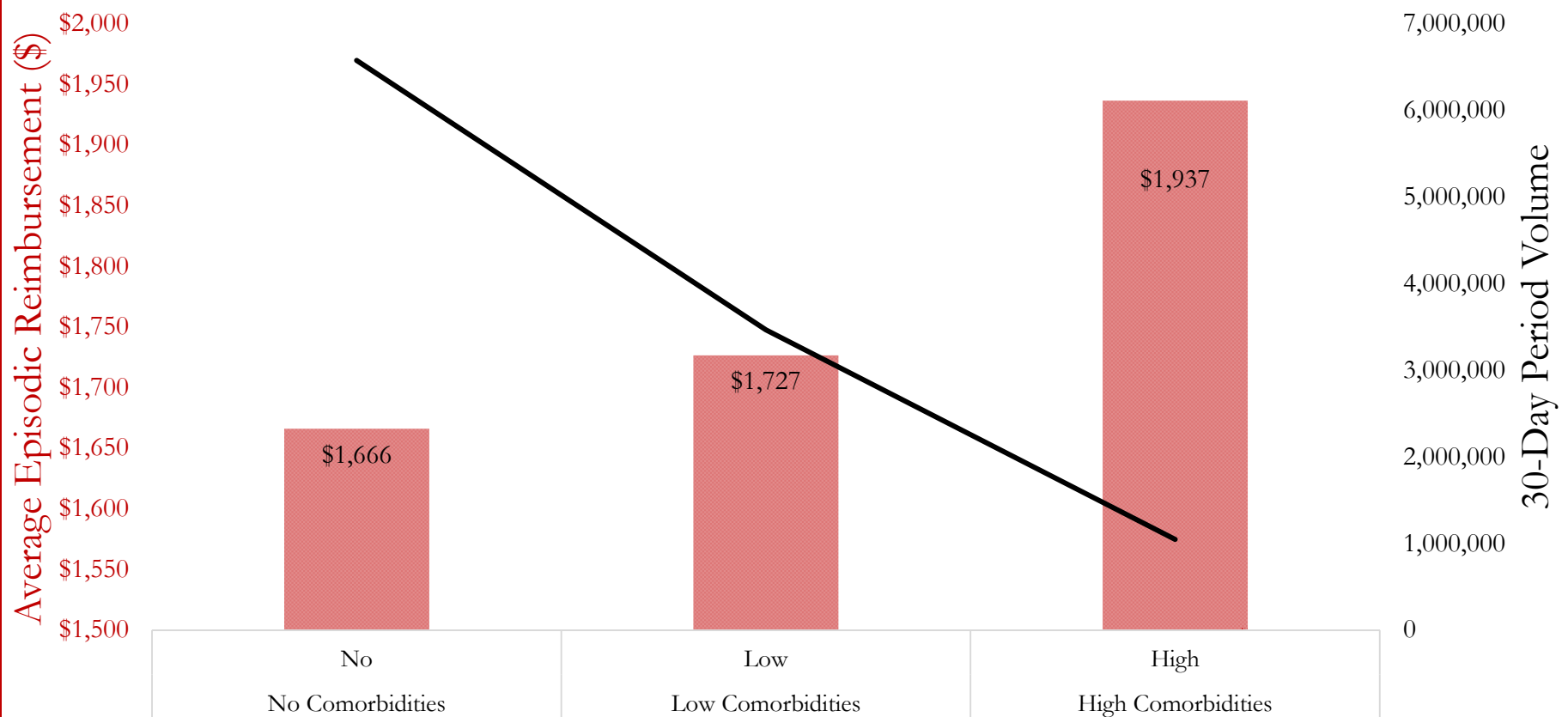
Comorbidity Level Top Diagnosis Data – National
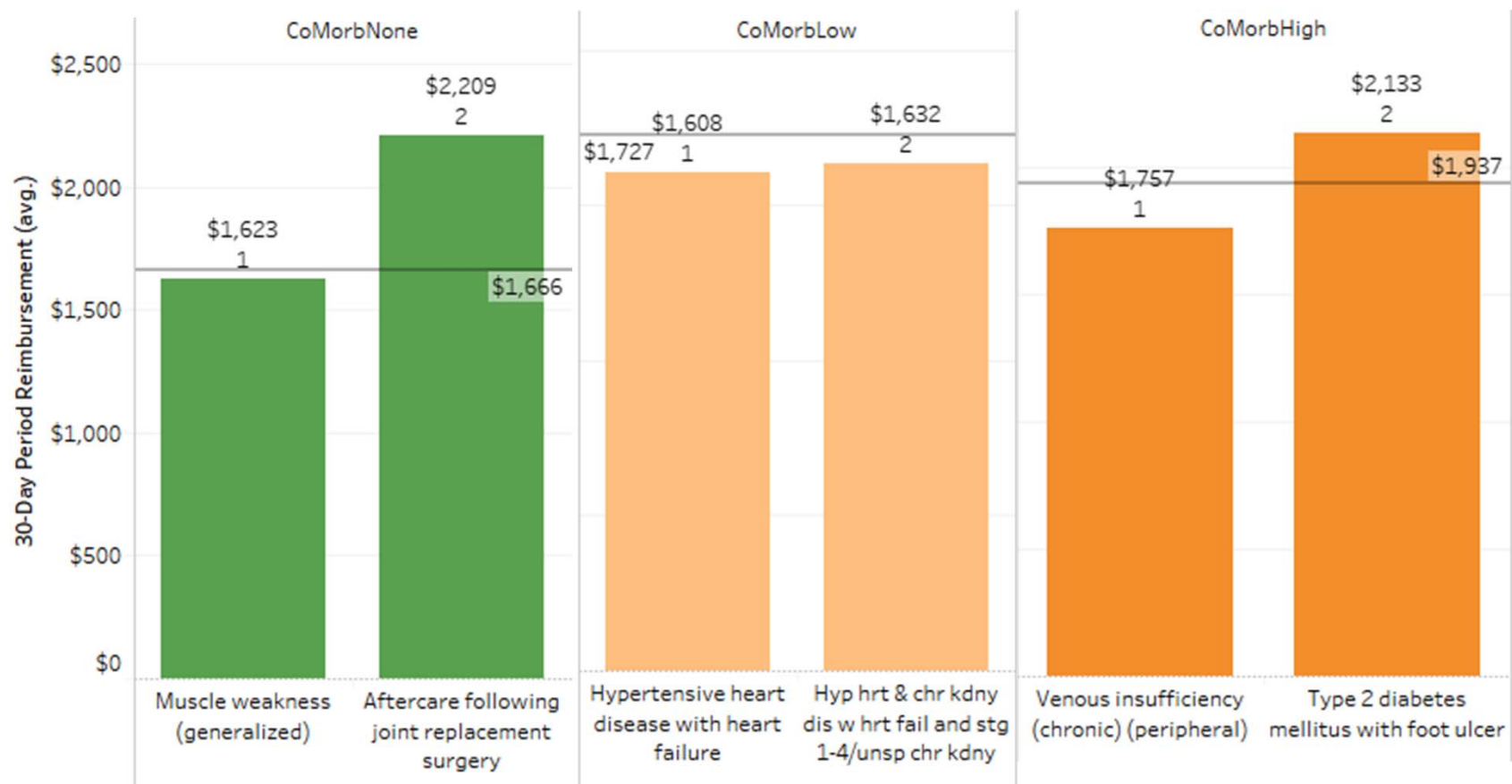
*Line represents national reimbursement average

Comorbidity Level Data – Cohorts

Reimbursement by Comorbidity Level (Provider Cohort)

Average Episodic Reimbursement ($)

	No	Low	High
0 To 25	$1,591	$1,678	$1,926
26 to 50	$1,590	$1,662	$1,903
51 to 75	$1,621	$1,684	$1,902
76 to 100	$1,690	$1,743	$1,946

Legend: ■ 0 To 25   ■ 26 to 50   ■ 51 to 75   ■ 76 to 100

Payment Periods by Clinical Group

Clinical Groups by Early and Late Periods
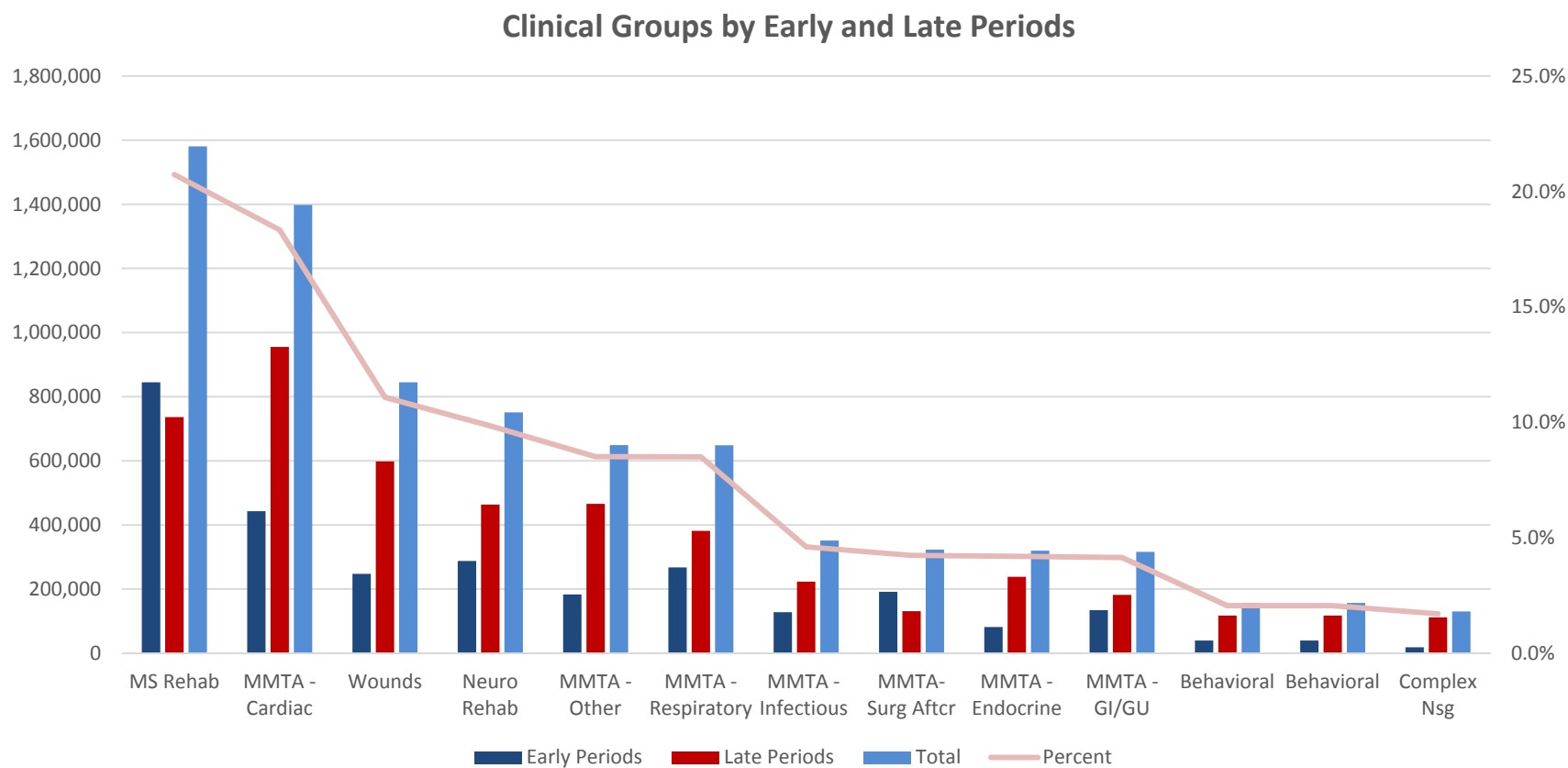
Source: CMS Virtual Data Research Center - ResDac

Avg Visits by Clinical Group and Payment Period

Early vs. Late Periods
Average Visit Volume By Clinical Group

Legend: Avg Early Visits, Avg Late Visits, Total
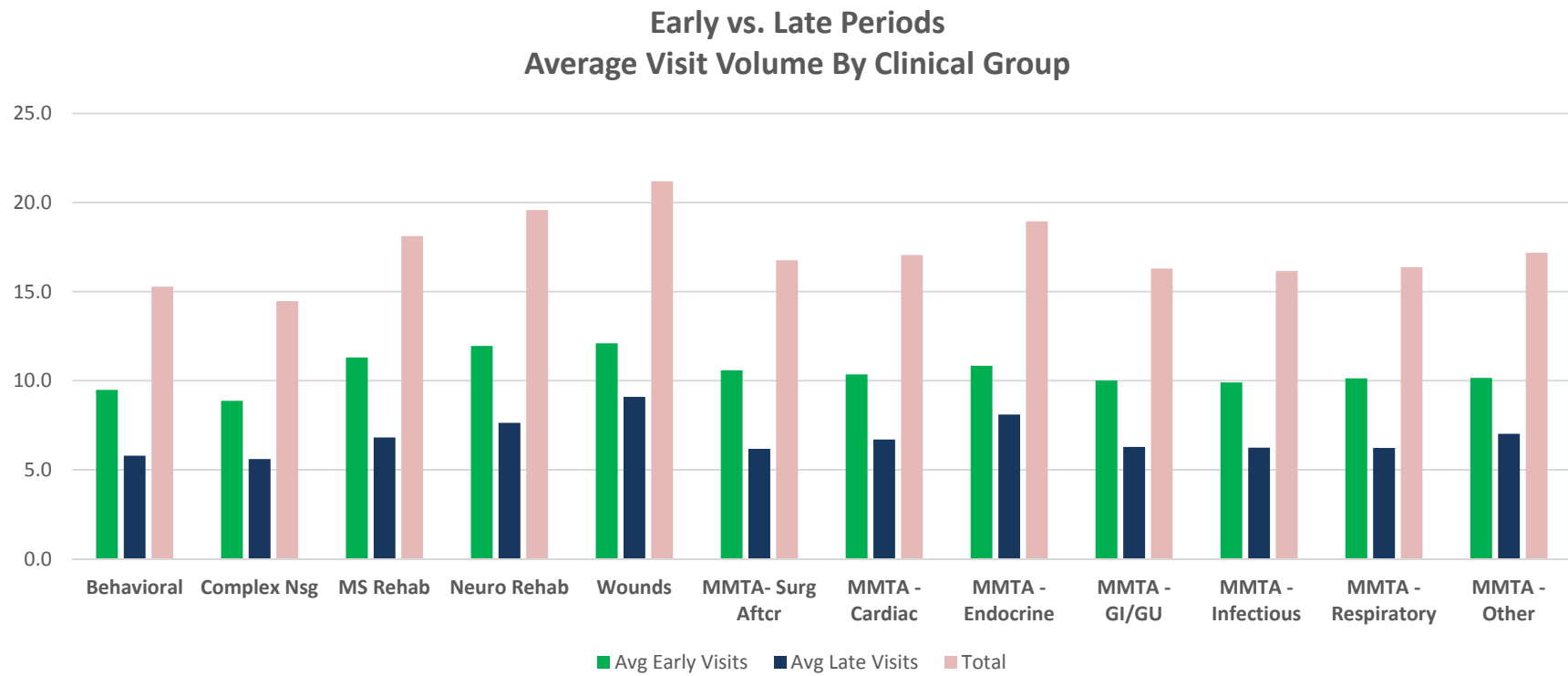
Source: CMS Virtual Data Research Center - ResDac

Institutional vs. Community Admissions by Clinical Group
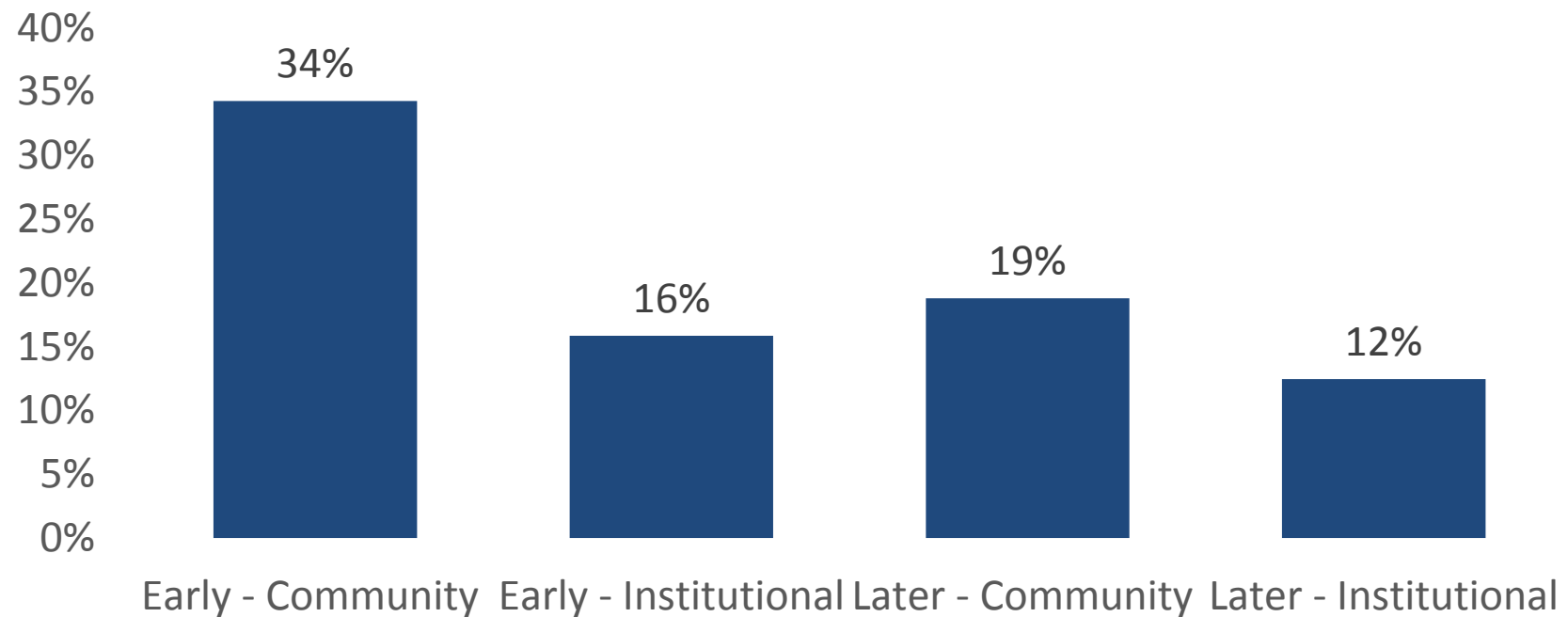

Institutional Vs. Community Payment Periods
by Clinical Group
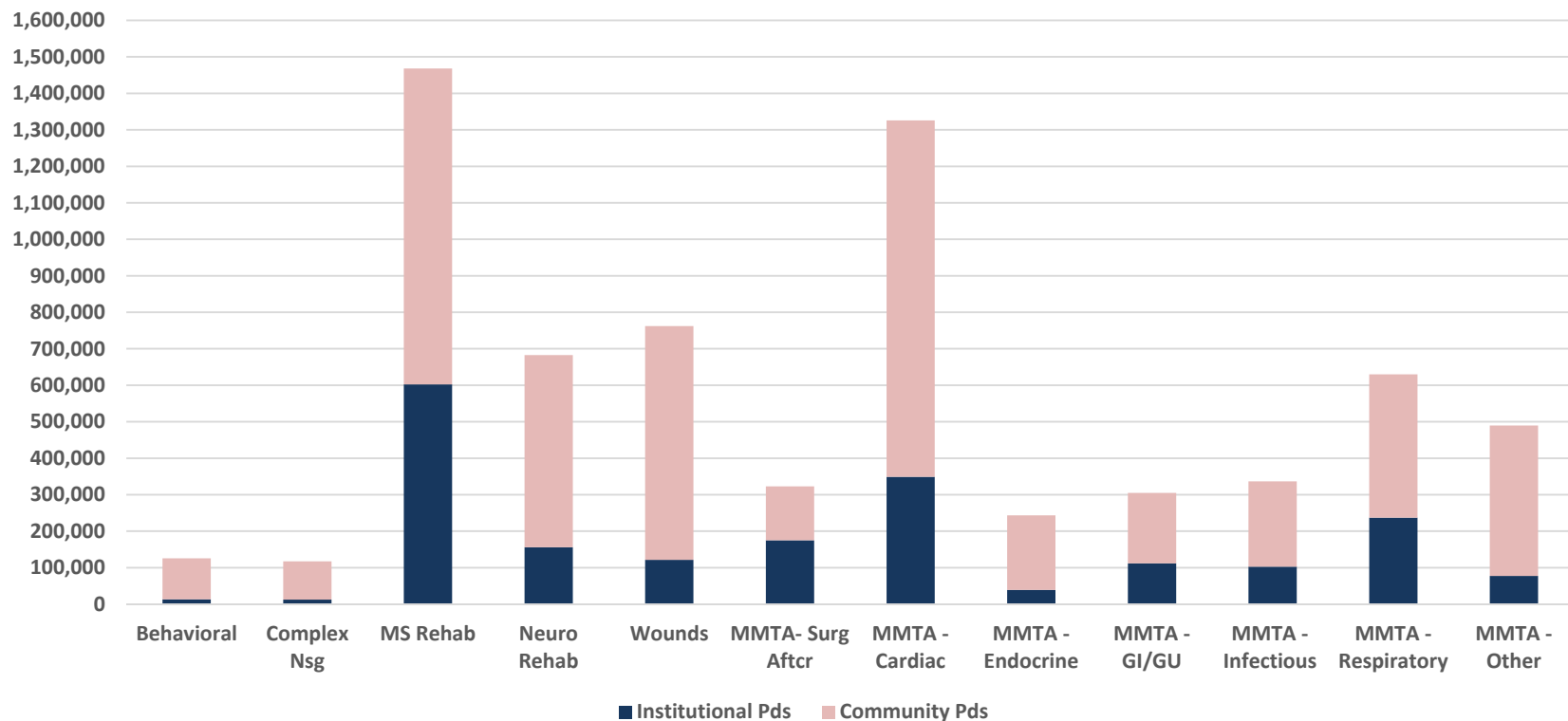
Source: CMS Virtual Data Research Center - ResDac

Comorbidities – Avg Visits by Clinical Group

GROUP	Avg Visits	High/Interactive Comorbidities	Avg Case Mix	Low/Single Comorbidity	Avg Case Mix	No Comorbidity	Avg Case Mix
Wounds	10.1	28.2%	1.5013	38.0%	1.3762	33.7%	1.3166
Neuro Rehab	9.4	9.6%	1.4730	34.0%	1.3479	56.4%	1.2883
MMTA - Endo	9.2	12.0%	1.3817	38.3%	1.2567	49.7%	1.1971
MS Rehab	9.0	4.8%	1.3476	28.6%	1.2226	66.6%	1.1629
MMTA – Surg Aftercare	8.6	7.0%	1.1839	37.6%	1.0589	55.5%	0.9993
MMTA - Other	8.2	5.2%	1.2690	33.1%	1.1439	61.8%	1.0843
MMTA - Cardiac	8.0	14.4%	1.2525	48.9%	1.1275	36.7%	1.0679
MMTA - Resp	7.9	6.9%	1.2212	43.0%	1.0962	50.1%	1.0366
MMTA- GI/GU	7.8	8.2%	1.2119	35.8%	1.0869	56.1%	1.0273
MMTA - Infect	7.6	6.5%	1.2313	34.4%	1.1062	59.2%	1.0466
Behavioral	7.3	3.2%	1.1932	26.4%	1.0682	70.4%	1.0086
Complex Nsg	6.3	17.3%	1.2423	34.8%	1.1173	48.0%	1.0577

Source: CMS Virtual Data Research Center - ResDac

"Questionable Encounter" Primary Dx Codes

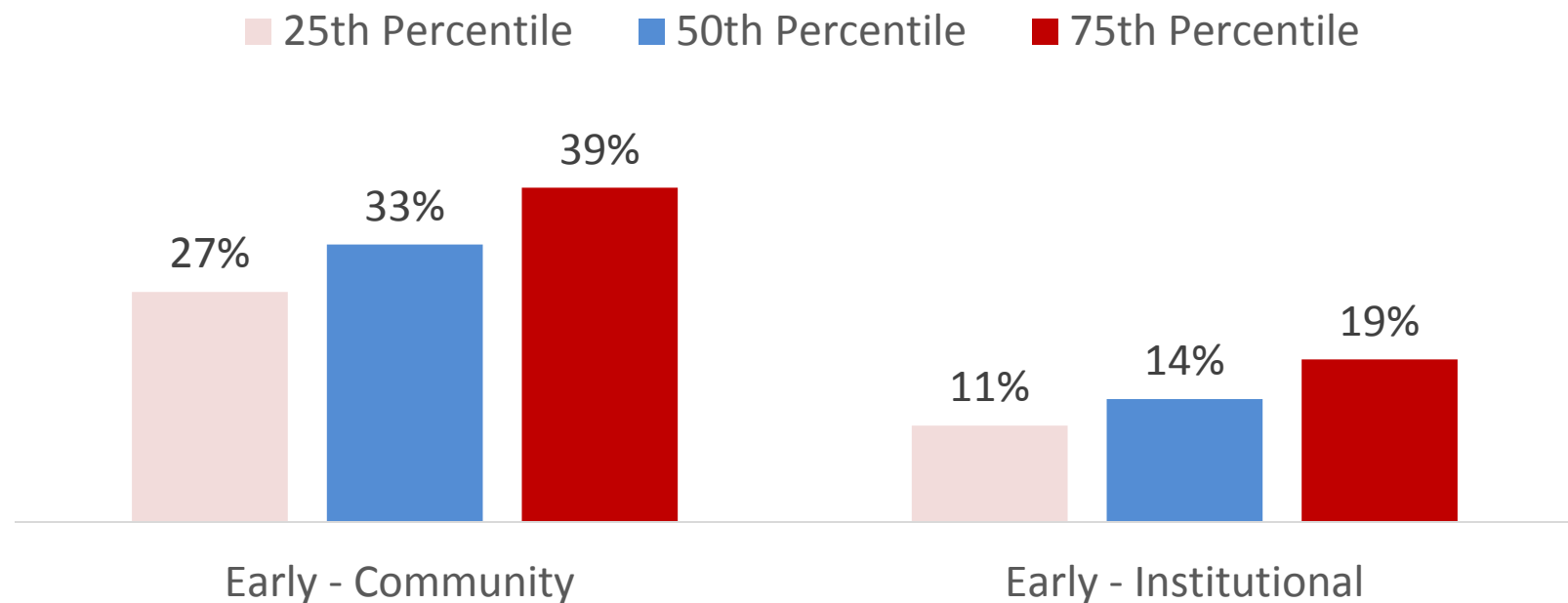|	Early - Community	Early - Institutional	Later - Community	Later - Institutional
	34%	16%	19%	12%

Data source: ABILITY Network, national client database, 2017 episodes

"Early" = SOC
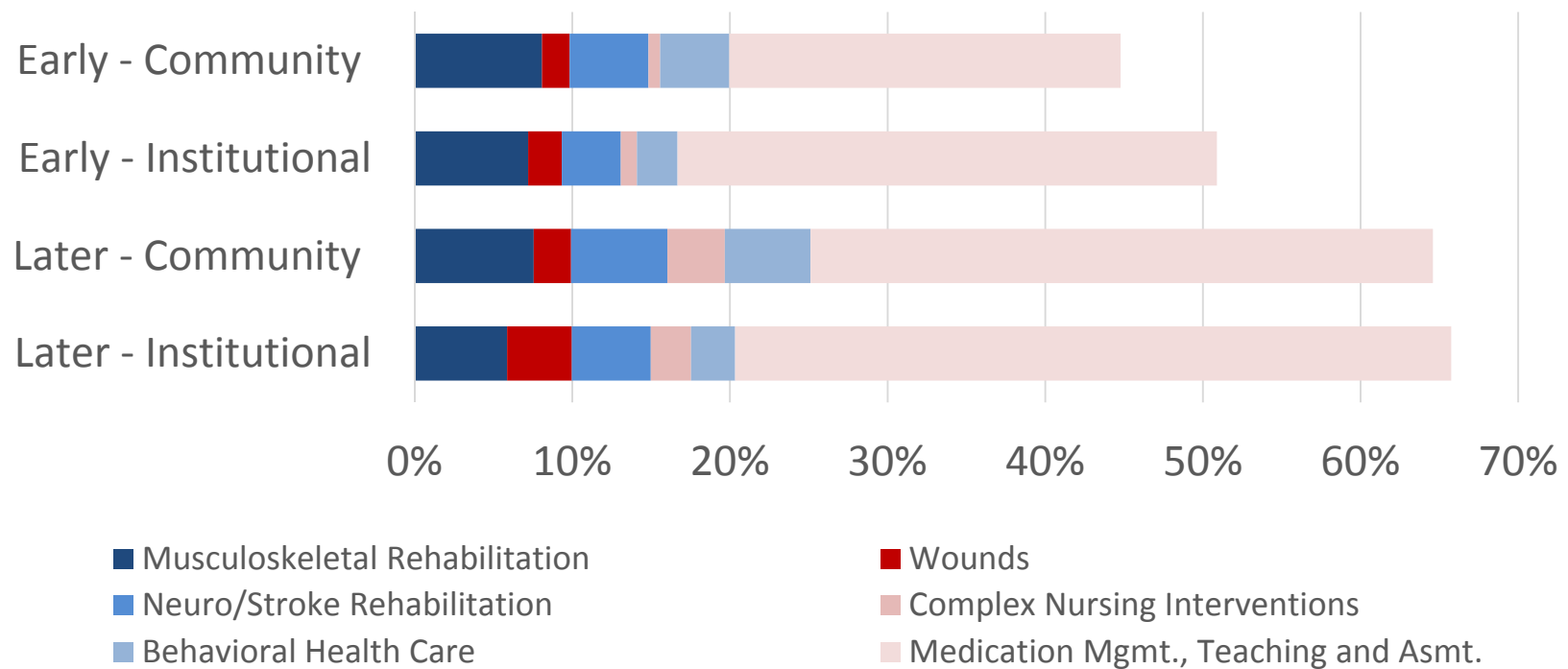"Later" = Recert or ROC

Agency-Level Range in "QE" Frequency

- 25th Percentile
- 50th Percentile
- 75th Percentile

Early - Community: 27%, 33%, 39%

Early - Institutional: 11%, 14%, 19%

"Early" = SOC
"Later" = Recert or ROC

Data source: ABILITY Network, national client database, 2017 episodes

"Questionable Encounter" Primary Dx Codes

First Secondary Diagnosis, when primary = not PDGM group

Chart categories (bar chart):
- Early - Community
- Early - Institutional
- Later - Community
- Later - Institutional

X-axis: 0% 10% 20% 30% 40% 50% 60% 70%

Legend:
- Musculoskeletal Rehabilitation
- Wounds
- Neuro/Stroke Rehabilitation
- Complex Nursing Interventions
- Behavioral Health Care
- Medication Mgmt., Teaching and Asmt.
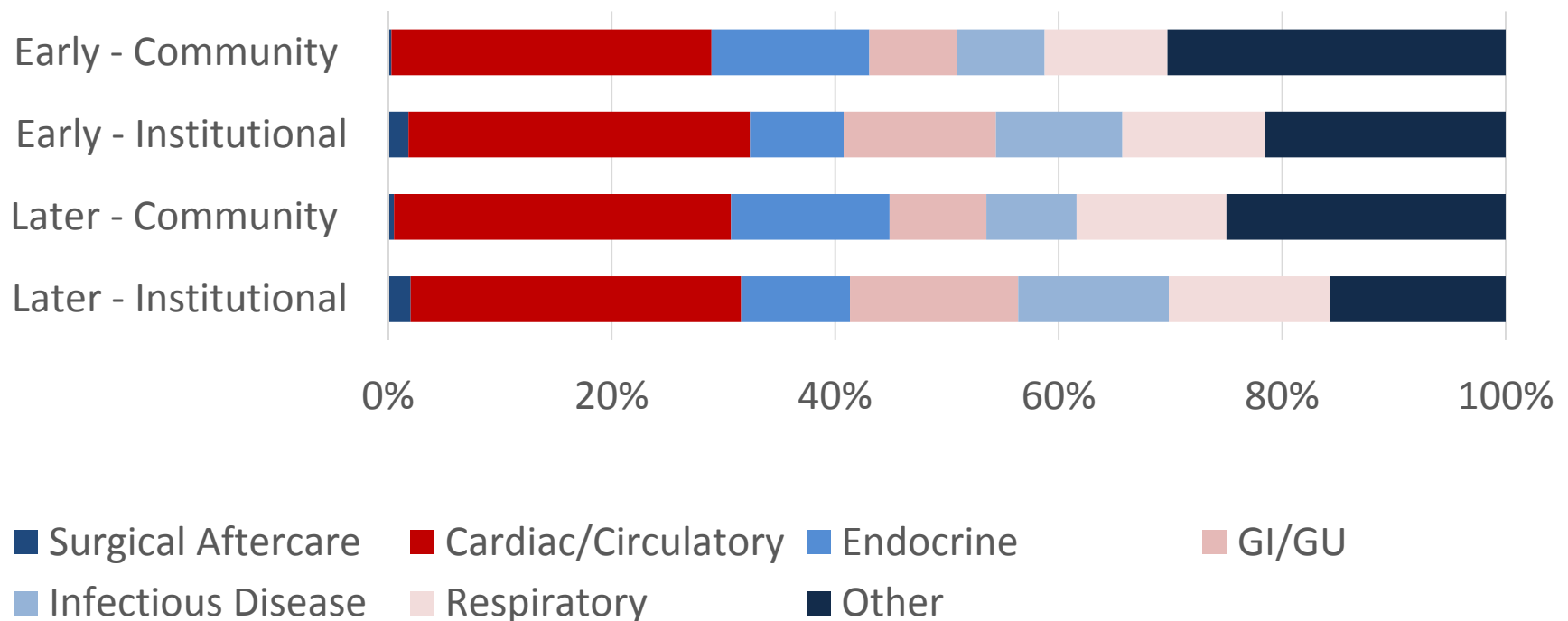
Data source: ABILITY Network, national client database, 2017 episodes

"Early" = SOC
"Later" = Recert or ROC

LUPA Analysis

PDGM Clinical Grouping	PPS Episodes			PDGM Periods		
	25th Percentile	Median	75th Percentile	25th Percentile	Median	75th Percentile
Behavioral health	0.0%	0.0%	12.0%	0.0%	9.5%	20.0%
Complex nursing	0.0%	9.7%	22.2%	0.0%	14.3%	26.0%
MMTA – Cardiac	0.0%	5.5%	9.8%	5.4%	10.6%	16.2%
MMTA – Endocrine	0.0%	2.5%	9.5%	2.9%	11.1%	19.0%
MMTA – GI/GU	0.0%	5.5%	14.0%	0.0%	11.1%	19.5%
MMTA – Infectious	0.0%	8.3%	17.6%	0.0%	11.7%	20.0%
MMTA – Respiratory	0.0%	5.6%	11.1%	4.1%	10.3%	16.7%
MMTA – Surgical aftercare	0.0%	0.0%	5.0%	0.0%	4.5%	9.8%
MMTA – Other	0.0%	4.8%	9.7%	5.6%	11.7%	18.4%
MS rehab	0.0%	4.0%	7.3%	6.2%	11.4%	17.1%
Neuro rehab	0.0%	3.9%	8.3%	4.2%	9.7%	16.2%
Wounds	0.0%	4.8%	9.1%	4.9%	10.5%	15.9%
All clinical groupings	0.0%	4.3%	10.5%	3.2%	10.4%	17.6%

Data source: CMS 2017 Home Health Claims – OASIS LDS file

LUPA Analysis

PDGM Clinical Grouping	PDGM Early Periods			PDGM Late Periods		
	25th Percentile	Median	75th Percentile	25th Percentile	Median	75th Percentile
Behavioral health	0.0%	0.0%	12.5%	0.0%	7.7%	23.1%
Complex nursing	0.0%	0.0%	13.3%	0.0%	14.9%	30.8%
MMTA – Cardiac	0.0%	9.4%	16.7%	4.0%	10.1%	17.9%
MMTA – Endocrine	0.0%	5.0%	20.0%	0.0%	9.5%	20.0%
MMTA – GI/GU	0.0%	0.0%	14.3%	0.0%	11.1%	23.1%
MMTA – Infectious	0.0%	0.0%	14.3%	0.0%	11.5%	23.1%
MMTA – Respiratory	0.0%	6.7%	14.5%	0.0%	10.0%	20.0%
MMTA – Surgical aftercare	0.0%	0.0%	5.0%	0.0%	3.2%	14.1%
MMTA – Other	0.0%	10.7%	20.0%	3.3%	10.6%	20.2%
MS rehab	2.2%	10.1%	17.7%	4.4%	11.5%	20.3%
Neuro rehab	0.0%	7.7%	15.4%	1.6%	9.1%	18.0%
Wounds	0.0%	7.1%	16.5%	3.2%	10.1%	16.5%
All clinical groupings	0.0%	5.9%	15.4%	0.0%	10.0%	20.0%

The heading "LUPAs by PDGM Payment Element" spans the table.

Data source: CMS 2017 Home Health Claims – OASIS LDS file

LUPA Analysis

PDGM Clinical Grouping	PDGM Community Periods			PDGM Institutional Periods		
	25th Percentile	Median	75th Percentile	25th Percentile	Median	75th Percentile
Behavioral health	0.0%	8.8%	20.0%	0.0%	0.0%	2.7%
Complex nursing	0.0%	14.3%	30.9%	0.0%	0.0%	14.0%
MMTA – Cardiac	4.7%	10.6%	18.0%	0.0%	7.7%	14.3%
MMTA – Endocrine	1.1%	10.7%	20.6%	0.0%	0.0%	12.5%
MMTA – GI/GU	0.0%	11.1%	22.9%	0.0%	0.0%	14.3%
MMTA – Infectious	0.0%	11.5%	22.6%	0.0%	0.0%	14.3%
MMTA – Respiratory	2.0%	10.5%	20.0%	0.0%	5.3%	13.6%
MMTA – Surgical aftercare	0.0%	0.0%	13.5%	0.0%	0.0%	5.7%
MMTA – Other	5.0%	11.9%	20.0%	0.0%	0.0%	14.3%
MS rehab	5.6%	12.0%	19.7%	0.0%	8.2%	15.6%
Neuro rehab	3.1%	9.3%	16.7%	0.0%	4.0%	14.6%
Wounds	4.0%	10.4%	16.7%	0.0%	2.4%	14.3%
All clinical groupings	0.0%	10.5%	20.0%	0.0%	0.0%	13.5%

Data source: CMS 2017 Home Health Claims – OASIS LDS file

LUPA Analysis

PDGM Clinical Grouping	Frequency of LUPAs by LUPA-Visit Threshold					
	2-Visit Threshold		3-Visit Threshold		4-Visit Threshold	
	No. of Weights	LUPA %	No. of Weights	LUPA %	No. of Weights	LUPA %
Behavioral health	12	4.9%	9	2.0%	15	4.3%
Complex nursing	16	12.7%	13	4.2%	6	3.8%
MMTA – Cardiac	6	16.8%	9	14.8%	17	30.4%
MMTA – Endocrine	4	3.1%	14	12.3%	13	4.4%
MMTA – GI/GU	9	5.8%	12	3.9%	13	7.3%
MMTA – Infectious	10	6.5%	21	7.1%	5	1.1%
MMTA – Respiratory	9	9.4%	8	5.2%	16	15.9%
MMTA – Surgical aftercare	9	1.9%	10	1.4%	12	2.6%
MMTA – Other	5	10.9%	11	9.7%	10	9.2%
MS rehab	7	17.7%	3	2.2%	8	5.6%
Neuro rehab	6	8.8%	5	5.2%	9	7.1%
Wounds	1	1.5%	13	32.0%	13	8.3%
All clinical groupings	94	100.0%	128	100.0%	137	100.0%

Data source: CMS 2017 Home Health Claims – OASIS LDS file

LUPA Analysis

Frequency of LUPAs by LUPA-Visit Threshold						
	5-Visit Threshold		6-Visit Threshold		All Thresholds	
PDGM Clinical Grouping	No. of Weights	LUPA %	No. of Weights	LUPA %	No. of Weights	LUPA %
Behavioral health	0	0.0%	0	0.0%	36	3.5%
Complex nursing	1	0.1%	0	0.0%	36	7.9%
MMTA – Cardiac	4	7.0%	0	0.0%	36	16.3%
MMTA – Endocrine	5	4.5%	0	0.0%	36	5.0%
MMTA – GI/GU	2	0.2%	0	0.0%	36	4.7%
MMTA – Infectious	0	0.0%	0	0.0%	36	4.8%
MMTA – Respiratory	3	0.5%	0	0.0%	36	8.0%
MMTA – Surgical aftercare	5	2.1%	0	0.0%	36	1.8%
MMTA – Other	10	17.4%	0	0.0%	36	10.8%
MS rehab	12	41.9%	6	88.5%	36	19.3%
Neuro rehab	12	14.6%	4	11.5%	36	8.7%
Wounds	9	11.7%	0	0.0%	36	9.2%
All clinical groupings	63	100.0%	10	100.0%	432	100.0%

Data source: CMS 2017 Home Health Claims – OASIS LDS file

Sales & Marketing Approach

Admission Source:

- Institutional: Discharged from an institutional setting (hospital, SNF, IRF, LTCH) in the 14 days prior to the HH admission
- Community: No institutional stay in the 14 days prior to the admission and Subsequent periods of an institutional discharge

Analyze the Admission Source for your agency to determine if a shift in targeted referral sources could provide a positive impact for the agency overall.

Source	Percent	Payment
Community	74.7%	$1,573
Institutional	25.3%	$2,434
		$861

Source: 2017 Medicare Final Claims Data, including additional impact analysis files from CMS.

Sales & Marketing Approach

Therapy Thresholds: Elimination of added reimbursements for therapy thresholds

If your agency is heavy on therapy cases, consider expanding targeted referral sources to improve the overall business mix in your agency.

Therapy Visits	60-Day Payment	PDGM Payment	Difference	% of Total Annual Episodes	% of Similar Episodes with 2nd 30-day Period
0	$1,792	$2,507	$714	33.7%	75.5%
1-5	$1,838	$2,393	$555	15.0%	38.8%
6-9	$2,834	$2,839	$4	16.5%	52.8%
10-13	$3,614	$3,245	-$368	13.1%	77.5%
14-19	$4,205	$3,415	-$790	13.9%	92.3%
20+	$5,443	$3,771	-$1,672	7.9%	98.9%

Source: 2017 Medicare Final Claims Data, including additional impact analysis files from CMS.

Sales & Marketing Approach

<u>Therapy Thresholds:</u> Elimination of added reimbursements for therapy thresholds

If your agency is heavy on therapy cases, consider expanding targeted referral sources to improve the overall business mix in your agency.

Providers where over 50% of Episodes include 10 or more therapy visits	**48.7%**

Source: 2017 Medicare Final Claims Data, including additional impact analysis files from CMS.

Sales & Marketing Approach

Diagnosis Groupings Analysis:

Top three diagnosis groups with the greatest expected *positive* reimbursement impact (of top 20 diagnosis groupings, based on primary dx code, by volume)

Dx Grouping	60-Day Payment	PDGM Payment	Delta	Claim Volume	% of with 2nd 30-day Period
Chronic Ulcer of Skin	$2,854	$3,534	$680	185,146	80.13%
Urinary and Genital Disorders	$1,813	$2,359	$546	74,028	86.25%
Diabetes with Complications	$2,676	$3,160	$484	262,049	83.19%

Source: 2017 Medicare Final Claims Data, including additional impact analysis files from CMS.

Sales & Marketing Approach

<u>Dx Groupings Analysis:</u>

Top three diagnosis groups with the greatest ***negative*** reimbursement impact (of top 20 diagnosis groupings, based on primary dx code, by volume)

Dx Grouping	60-Day Payment	PDGM Payment	Delta	Claim Volume	% of with 2nd 30-day Period
Other Aftercare	$2,846	$2,642	($204)	535,523	39.79%
Other Connective Tissue Disease	$3,297	$2,829	($468)	205,306	69.29%
Stroke	$3,865	$3,431	($434)	159,954	74.16%

Source: 2017 Medicare Final Claims Data, including additional impact analysis files from CMS.

Changes in NRS Payments

- Currently, non-routine supplies (NRS) are paid separately from the HHRG payment, based on a case-mix model that calculates 6 different levels of payment from $ to $

- Under PDGM, NRS payments will be paid prospectively, but combined with the overall resource

- NRS cost is generated by taking NRS charges on claims and converting them to costs using a NRS cost-to-charge ratio that is specific to each HHA

- NRS is factored into the average resource use; NRS costs are reflected in the average resource use that establishes the case-mix weights (Cost per Minute + NRS)

Changes in Non-Routine Supply Payments

- Breakouts by the 12 clinical categories

Clinical Group	Payment Episodes Count	PPS NRS Amount	Average NRS	PDGM CMW Period 1	PDGM CMW Period 2
QE	421,859	$ 10,680,159	$ 25.32		
MMTA - Other	178,610	$ 5,084,473	$ 28.47	1.08	0.78
Neuro Rehab	264,850	$ 7,065,653	$ 26.68	1.32	0.97
Wounds	263,542	$ 42,549,542	$ 161.45	1.29	1.04
Complex Nursing	42,295	$ 4,850,223	$ 114.68	0.96	0.78
MS Rehab	603,921	$ 17,023,243	$ 28.19	1.31	0.87
Behavioral Health	62,137	$ 1,231,416	$ 19.82	0.93	0.68
MMTA - Surgical Aftercare	152,770	$ 9,794,603	$ 64.11	1.29	0.80
MMTA - Cardiac	434,989	$ 21,033,383	$ 48.35	1.12	0.80
MMTA - Endocrine	94,006	$ 2,990,522	$ 31.81	1.10	0.82
MMTA - GI/GU	121,491	$ 5,475,608	$ 45.07	1.19	0.79
MMTA - Infectious	125,107	$ 8,020,678	$ 64.11	1.12	0.77
MMTA - Respiratory	241,633	$ 5,937,708	$ 24.57	1.19	0.80
Grand Total	**3,007,210**	**$ 141,737,211**	**$ 47.13**	**1.21**	**0.85**

Data source: Strategic Healthcare Programs (SHP), national client database, 2017 episodes excluding LUPA, PEP, Outliers

PDGM NATIONAL SUMMIT
A REVOLUTION IN MEDICARE HOME HEALTH PAYMENT

Contact

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Overview

- What to Expect from Your Business Partner

- What You Should Consider

  - Leverage Business Partner Events

  - Engage Early and Often

  - Policy and Procedure

  - Timelines

- Engagement

  - Referral Source

  - Field Staff

Things to Expect from Your Business Partner

- Acknowledgement of their awareness (yes – make sure they know!)

- Periodic communication regarding business partner specific impacts:
  - Plans and schedules
  - Status
  - Educational or informational sessions (e.g., webinars)

Leverage Business Partner Education Events

- Regulatory related
  - Ideally, your business partner should not present anything you don't know. The key here is to evaluate how well your business partner understands PDGM:
    - Can they enumerate the significant aspects of PDGM?
    - Are they able to respond effectively to questions regarding interpretations?

- Specific to your EMR
  - Your business partner should, with increasing specificity over time, enumerate planned solution changes.
  - You can plan the impact to training, policy, and procedure based on what your business partner is and is not implementing.

Engage Early and Often

- Leverage product design sessions, if offered
  - Attend "whiteboarding" or wireframe reviews of planned enhancements
    - Be vocal – business partners can't design well in a vacuum
    - Share operating needs, such as real-time management reporting and analysis tools

- Participate in business partner calls
  - Many solicit and/or share regulatory interpretations
  - Help business partners prioritize EMR capabilities to:
    - Ensure compliance
    - Support efficiency
    - Reduce operational burden

Policy and Procedure

- Accept that there will be policy and procedure changes required, regardless of how well your business partner supports PDGM

- Determine how you can leverage your business partner's solution to assess and manage:

  - 30 days periods of care, including recertification activities
  - LUPAs
  - Sophisticated wounds
  - Productivity, missed visits, timely in-home documentation
  - Orders and claims management (in a compressed timeframe)
  - Billing changes
  - Financial reporting - revenue recognition
  - Coding (Flow from referral, clinical processes, through to claims drives CMS behavioral adjustment assumptions)

Policy and Procedure

- Support for:
  - Functional levels/limitations and comorbidities
  - Plans of Care, based on patient clinical grouping, comorbidity coding
    - Care map/Pathways and impact to late episode LUPAs
    - Complex episode nursing and therapy interventions
  - Hospitalization Risk Stratification refinement

Timing Expectations

- It is reasonable to expect

Business Partner Announcement	Timeframe
PDGM impact models	CY2018 Q4
PDGM release schedules	CY2018 Q4 or CY2019 Q1 at the latest
Pilot or beta testing opportunities	CY2019 Q3
Production release of a PDGM solution	CY2019 Q4

Other Technology Considerations

- Thoroughly compare PDGM against your business partner's current and proposed solution

- If there are gaps, identify other technology solutions you may need to comply (or survive). For example:
  - Digital communication and documentation flows,
  - Revenue cycle management,
  - Productivity reporting and analytics, and
  - Patient risk stratification to leverage appropriate levels of:
    - Telemonitoring
    - Virtual interactive visits

- Identify integrated workflows with your electronic health record

Referral Source Engagement

- Educate your referring physician on PDGM

- Patient status transparency

- Integration of key workflows

  - Referral

  - Discharge

- Network membership

  - Carequality, Commonwell, and SureScripts

  - Regional and local Health Information Exchanges

Field Staff Engagement

- Evaluate new controls and decision support available at point of care

- Review your field staff's workflow and your point-of-care data collection, make relevant changes, and provide necessary training.

- Identify impacted communication practices

Asking the Hard Questions

- What is your business partner's track record with other regulations?

- What reserves for capital or operating expenses may be necessary as part of your PDGM upgrade?

- Do you have the skills internally? For example:

  – Report writing to supplement business partner reporting

  – Coding and QA

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