The Eighteenth Annual
Northeast
Home Health
Leadership Summit

The Quest for Success Under PDGM

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Panel Introductions and the "Buzz"

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Leadership under PDGM

Being an effective leader requires attention to detail, strong planning and evaluation skills, action initiation, and providing direction for your agency's future (a little bit of everything!). Transitioning to PDGM is no different.

We would like to provide a framework for "leading" under PDGM and identified 4 leadership perspectives for the important changes your agency needs to address. We call them the 4 Leadership "A"s:

- Assessment- What are we seeing in the first few weeks under PDGM across the country and in your agencies?
- Analysis- How is this impacting/ disrupting your 'status quo'? What is your data telling you?
- Action- How are you implementing change to adjust to what you're learning from your assessment and analysis?
- Advocacy- What actions in the broader policy/regulatory realm are necessary to bring changes to improve sustainability, quality, innovation, etc.

Leadership under PDGM

Challenges we plan to address using the Four Leadership "A"s:

- Questionable Encounters (QE's)
- OASIS and Diagnosis Coding
- LUPA Utilization
- KPI's and Benchmarking
- Billing/Cash Flow
- Staffing

Reserving Time for Questions to the Panel as part of the Presentation

Questionable Encounters

Assessment:

- Initial Unacceptable Diagnoses

Periods	Code	Description	Compared CY 2018 Top 10
907	M62.81	Muscle weakness (generalized)	1
441	R53.1	Weakness	6
402	R68.89	Other general symptoms and signs	New
223	R55.	Syncope and collapse	New
205	M54.5	Low back pain	3
203	R69.	Illness, unspecified	New
195	R26.9	Unspecified abnormalities of gait and mobility	7
174	R26.89	Other abnormalities of gait and mobility	2
167	R29.6	Repeated falls	4
156	Z51.89	Encounter for other specified aftercare	New
3,073			

Source: SHP National Data Base of PDGM Unacceptable Dx's run as of January 8, 2020

Questionable Encounters

Analysis:

- M68.2-Muscle Weakness
  - Old problem-New Education
  - Can be coded as a secondary diagnosis if not integral to the primary diagnosis
  - Congestive Heart Failure, COPD are commonly occurring co-morbidities is the muscle weakness the actual reason for care?
- R-Codes are signs and symptoms
  - R53.1-Weakness
  - R68.89-Other General Signs and Symptoms
  - R69-Illness Unspecified
  - CMS expects specific reasons for care
- Z51.89-Other Specified Aftercare
  - The Why-

Questionable Episodes

Analysis:

R26.89	C79.49	G89.3
Other Abnormalities of Gait and Mobility	Secondary Malignant Neoplasm of other parts of the nervous system	Neoplasm Related Pain (acute) (chronic)
Questionable Episode	MMTA-Infectious	MMTA-Other

R26.89 Questionable Episode

Patient was a therapy referral

Patient had abnormality of gait

Patient is having pain

Patient has cancer of the nervous system

Correct Diagnosis to C79.49

Questionable Encounters

Analysis:

M62.81

ATORVASTATIN ORAL	6047
FUROSEMIDE ORAL	5801
GABAPENTIN ORAL	5221
HYDROCODONE-ACETAMINOPHEN ORAL	4362
LEVOTHYROXINE ORAL	4159
ASPIRIN ORAL	4038
POTASSIUM CHLORIDE ORAL	4025
AMLODIPINE ORAL	3868
LISINOPRIL ORAL	3787
OMEPRAZOLE ORAL	3428

Questionable Encounters

Action:

- Education
  - Purist Coders vs Extremist Coders
    - Purist
      - Appropriate and Payable
    - Extremist
      - Not on a list; it's not coded
      - Superficial Rules
- Workflow
  - Pre-assessment Coding
  - Intake

Advocacy:

- Payment model updated based on statistical analysis each year.
- Collect the data and clinical rationales
- NAHC: PDGM Diagnosis Workgroup

OASIS and Diagnosis Coding

Assessment:

- Timeliness
  - 5 day window for assessment
  - RAP Turn Around
- Completeness
  - Corrections to a minimum
  - Inconsistency in clinical record

Analysis:

- Timeliness
  - Turnaround Time
  - Commonalities-specific disciplines
- Completeness
  - Clinical Understanding of the OASIS
  - Inconsistency and Congruency

OASIS and Diagnosis Coding

Action:

- Case Conference
  - When
  - What
  - Why
- Clinician Education
  - Always Ongoing
  - Evaluate Understanding
  - Ride Along

Advocacy:

- OASIS Quality Measure and Maintenance Project
- OASIS E-Most Significant and Expansive Change in 20 Year History

LUPA Utilization

Assessment:

It is a little early to get a read on LUPA rates. A couple of perspectives can be made looking at data from prior periods.

Clinical Group	All	Period 1	Period 2	Period 3	Period 4	Period 5+
MMTA - Other	7.8%	9.2%	12.0%	3.1%	7.8%	4.5%
Neuro Rehab	7.6%	8.5%	10.0%	2.4%	7.1%	4.7%
Wounds	8.3%	8.4%	14.3%	4.8%	10.2%	5.1%
Complex Nursing	20.0%	9.5%	14.1%	18.1%	14.6%	23.1%
MS Rehab	9.3%	9.7%	12.2%	2.2%	7.8%	2.9%
Behavioral Health	7.8%	8.5%	10.2%	3.8%	7.4%	7.1%
MMTA - Surgical Aftercare	11.2%	9.3%	17.5%	3.6%	9.8%	4.1%
MMTA - Cardiac	7.4%	8.1%	11.9%	3.3%	7.8%	3.7%
MMTA - Endocrine	7.0%	8.0%	12.1%	3.2%	7.3%	3.8%
MMTA - GI/GU	9.9%	9.3%	12.8%	5.6%	8.9%	9.3%
MMTA - Infectious	10.8%	8.1%	12.4%	6.1%	8.9%	16.0%
MMTA - Respiratory	7.8%	8.0%	11.8%	3.0%	7.4%	3.2%
Overall Average	**8.9%**	**8.8%**	**12.4%**	**3.9%**	**8.3%**	**7.3%**

Source: SHP National Data Base CY 17,18; CY2019 Final Rule

LUPA Utilization

Assessment:

Top Ten by PDGM HHRG and by Period Sequence

Period 1

HHRG	Clinical Group	Percent
1FB3	Behavioral Health	17.1%
1DA1	Complex Nursing	15.5%
3DA2	Complex Nursing	14.7%
1DB2	Complex Nursing	14.4%
1DC1	Complex Nursing	14.4%
1DA2	Complex Nursing	14.4%
1DEB1	Complex Nursing	14.0%
2AB3	MMTA-Other	12.2%
4AB3	MMTA-Other	12.2%
2IB3	MMTA-Endocrine	11.9%

Period 2

HHRG	Clinical Group	Percent
4EA1	MS Rehab	50.8%
4FB3	Behavioral Health	50.0%
4GB2	MMTA-Surg Aftercare	45.9%
4EB1	MS Rehab	45.0%
4GA1	MMTA-Surg Aftercare	44.6%
4GC1	MMTA-Surg Aftercare	41.6%
4IA1	MMTA-Endocrine	40.6%
4BA2	Neuro Rehab	40.4%
4BA3	Neuro Rehab	40.2%
4GB1	MMTA-Surg Aftercare	40.0%

Period 3

HHRG	Clinical Group	Percent
4DC3	Complex Nursing	26.7%
4DB3	Complex Nursing	25.0%
4BB3	Neuro Rehab	25.0%
3DA2	Complex Nursing	23.0%
3DC1	Complex Nursing	22.0%
3DB2	Complex Nursing	21.6%
3DC2	Complex Nursing	20.8%
4IB3	MMTA-Endocrine	19.2%
3DB1	Complex Nursing	19.0%
3DA1	Complex Nursing	18.4%

Source: SHP National Data Base - Preview Report (CY19); CY2020 Final Rule

LUPA Utilization

Analysis:

- In many cases the LUPA rates are lower than it had been under PPS on average. Review where your rates may be higher than the benchmarks. Keep in mind the $ impact depends on the case-mix adjusted PDGM rate and the LUPA rate. Comparing one visit less than the threshold can be a swing of $800 – $2,500. First period financial impacts will be higher.

Action:

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

- Root cause analysis – review cases that may have been preventable
  - Does patient's clinical picture match visit utilization provided?
  - Was LUPA a result of missed visits, staffing issues, not homebound, patient refusal?
  - Did patient require more visits to meet goals/improve outcomes?

- Build workflows around these inappropriate LUPA cases – i.e. late institution, 2nd period, surgical aftercare. Track patients in high rate, high volume periods prior to starting the subsequent 30-day period (24th – 27th day).

LUPA Utilization

Advocacy:

- In the CY 20 Final Rule, CMS noted an expected LUPA rate of 7.1% with a behavioral adjustment of 1.88% of revenue. Represents ~$35.87 per 30-day payment.

- Need to track this closely – CMS calculated that 1/3rd of LUPA 1-2 visits from threshold will get extra visits.

- Using National Rates and 2.5 as a LUPA visit average, the rate would need to drop to 4.6% to approximate the behavior change CMS is predicting. With the CY 20 rule where the behavioral adjustment was cut in half, the rate would be 5.9% for CY 2020.

KPI's and Benchmarking

Assessment:

PDGM introduced new payment components and 30-day periods
But…OASIS assessments did not change
New PDGM terminology requires a facelift to your KPIs and Dashboards
Early metrics to consider:

- Claims and $ at MAC in queue to be paid
- Days to RAP and Final by early/late periods
- "Unacceptable" primary Dx's
- Cash Days on Hand

Metrics that cross the fiscal year may not be easily blended i.e. Case-mix weight
Consider size and scope of your operations
Track and trend against expectations (budget)
Identify and report on metrics that addresses the priorities of your organization

"Measure only what you're going to manage; manage only what matters"

KPI's and Benchmarking

Analysis:

Compare to national and state benchmarks for variances:

- Payment Periods by:
  - Clinical Group
  - Early/Late
  - Community/Institution
  - Functional Impairment level
  - Comorbidity Adjustment
- LUPA Rates by Clinical Group
- LUPA Rates by Periods and Stays
- Length of Stay and Periods
- Periods per Stay
- Case-mix weight by Period and Stay
- Single period stays
- Functional Impairment Scoring
- Visits per Period Sequence
- Visits by Discipline per Stay
- Therapy visit ratios
- Visit Intensity (Front loading/Per week)
- Efficiency Metrics (Best Practice)
- Period and Stay costs/margin
- Outcomes by Clinical Group
- Revenue by:
  - PDGM HHRG
  - Period Sequence
  - Stay (Episode of Care)
  - LUPA/PEP/Outlier
- Diagnoses per patient and△ RAP to Final

KPI's and Benchmarking

Action:

- Update or create reporting based on the right level of detail for your audience – Board, Execs, Directors, Staff.
- Identify unexpected variances or trends heading in the wrong direction. Plan for midcourse corrections where necessary.
- Update your Forecasts with up-to-date information. Will help to inform next year's budget process.

Advocacy:

- Support NAHC on real-time tracking in responding the behavioral adjustments. Share your data as appropriate.
- Respond with comments to the CY 2021 Proposed Rule on Behavioral Adjustments

Billing/Cash Flow

Assessment:

- Billing (general)
  - Some initial issues with:
    - iQIES
    - Some clearinghouses
    - Some EMRs
- Medicare
  - Confirmed that RAPs and claims have successfully been billed
  - RAP payments have been issued
  - Final claim payments going to holding status
- Medicare Advantage
  - Some payors having issues with claim submissions
  - Lack of clarity regarding PDGM approach

Billing/Cash Flow

Analysis:

- Cash Flow – how are you/will you be impacted?
- Variables
  - Days to RAP
  - Days to Final Claim
  - Cash Mix Change
  - Volume (census/periods per patient)
- Building a model
  - Assumptions
    - RAPs pay 7 days after submission
    - Final Claims pay 14 days after submission
    - Daily billing of RAPs and Finals
  - Need to determine variables listed above

Billing/Cash Flow

Analysis:

- Cash Flow example – $5,000,000 annual Medicare revenue

Days to RAP – 7 days → Days to FC – 14 days → Case Mix Impact- Unchanged → Periods Per Patient – 1.7

	Dec	Jan	Feb	Mar	Apr	May	Jun	2020 Summary
NEW Monthly Cash	$ 416,667	$ 324,137	$ 262,027	$ 465,246	$ 405,090	$ 418,593	$ 405,090	$ 4,764,733
Monthly Cash Difference from 2019		$ (92,529)	$ (154,640)	$ 48,579	$ (11,577)	$ 1,926	$ (11,577)	$ (235,267)
		-22%	-37%	12%	-3%	0%	-3%	-4.7%
Average Daily Cash	$ 13,441	$ 10,456	$ 9,035	$ 15,008	$ 13,503	$ 13,503	$ 13,503	$ 13,053

Billing/Cash Flow

Action:

- Maintain a cash flow budget
- Manage unbilled
- Closely monitor MA billing
- Focus on non-traditional Medicare A/R

Advocacy:

- Push Medicare Advantage payors for PDGM payment
- Push non-Medicare for better rates
- Telehealth reimbursement
- Value based reimbursement
- Notice of Admission penalty

Staffing

Assessment:

- Therapy – not the same reaction as PDPM

Analysis:

- Therapy
  - Adjustments to therapy staffing model
  - PTAs/COTAs?
  - Per diem vs. full-time
- Revenue Cycle
  - Intake
  - Document Management
  - QA
  - Billing
- Clinical Staffing
  - Management
  - Home health aides

Staffing

Action:

- Determine if staffing needs to be updated based on early results of PDGM
  - Potential "warning signs"
    - Increase in:
      - Days to RAP
      - Days to Final Claim
      - LUPA Percentage
      - Missed Visits
    - Decrease in Census
- For the changes you did make, analyze the results

Advocacy:

- What direct or indirect effect on staffing occur at your agency that CMS didn't consider? Share this information to promote advocacy efforts

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Questions?

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Thank You!

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