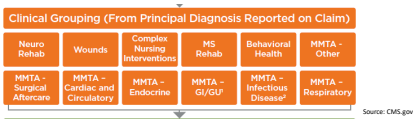
PDGM Measure: Clinical Grouping

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)



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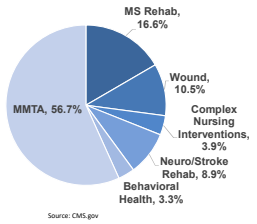
Clinical Grouping

Estimated Periods by Clinical Grouping Provided by CMS



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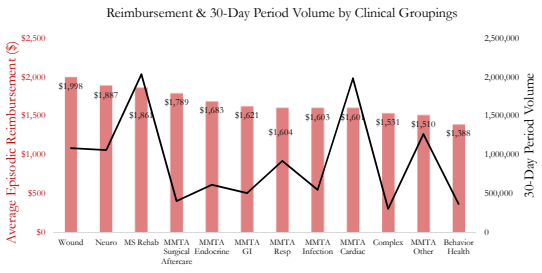
Clinical Grouping Data – National



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PDGM Measure: Functional Level

- 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

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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

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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+

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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+

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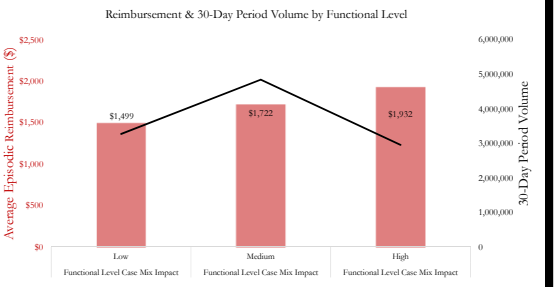
Functional Level Data – National



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PDGM Measure: 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

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PDGM Measure: 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

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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"

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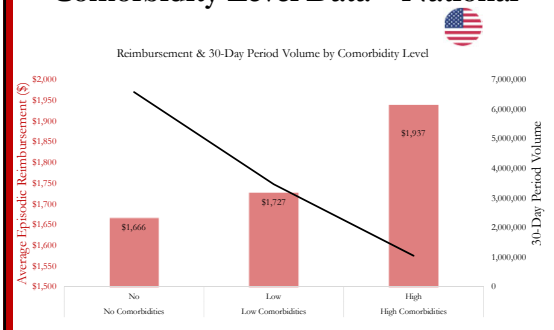
Comorbidity Level Data – National



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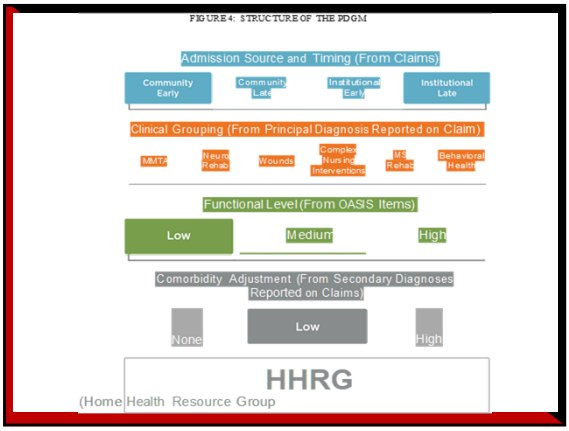

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Non Routine Supply

- 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

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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

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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)

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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

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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%

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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

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PDGM 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"

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CLINICAL OPERATIONS IMPACT

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Clinical Operations Impact

- 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 section 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.

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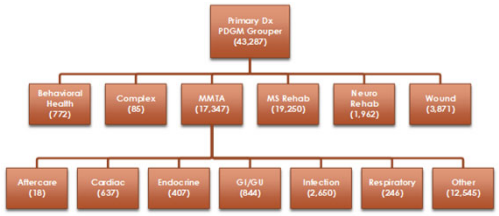
Breakout of Acceptable Primary Diagnosis



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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

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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

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Utilization Management 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

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REVENUE CYCLE OPERATIONS IMPACT

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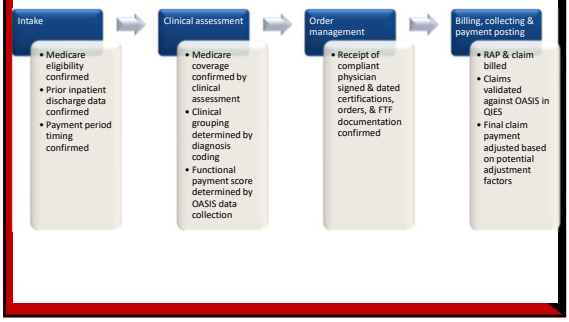
PDGM Revenue Cycle

SOC or Recertification 30-Day Payment Periods



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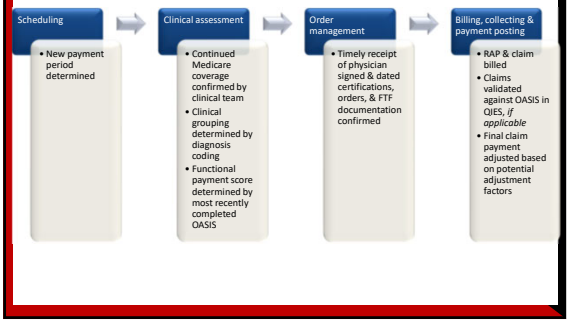
PDGM Revenue Cycle

Subsequent 30-Day Payment Periods



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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

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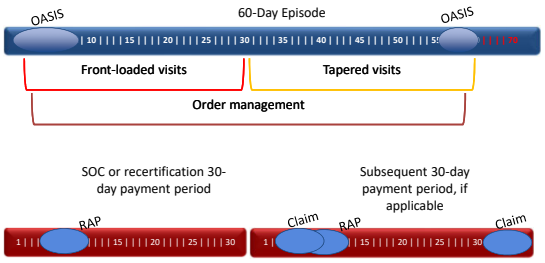
PDGM Revenue Cycle

30-Day Payment Periods



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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?

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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

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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)

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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

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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."

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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

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CASH FLOW IMPACT

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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

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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

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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

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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

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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%

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PDGM Data Analytics

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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

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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

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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)

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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%**

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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%**

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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**

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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%	-2.2%
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%	17.0%

75% to 100% by Skilled Nursing Visits

	PPS Episodes	% of PPS Episodes	% Change in Reimbursement
0 Visits	234,848	19.4%	-20.3%
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%	-15.9%
1-5 Visits	1,638,143	29.1%	-2.9%
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%

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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%	-16.2%
14-19 Visits	258,373	21.4%	-21.4%
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%	-16.2%
21+ Visits	443,886	7.9%	-18.2%

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A REVOLUTION IN MEDICARE HOME HEALTH PAYMENT

SALES/MARKETING IMPACT

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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.

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Referral/Intake

- 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

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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.

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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.

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Sales & Marketing Approach

Dx Groupings Analysis:

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.

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A REVOLUTION IN MEDICARE HOME HEALTH PAYMENT

PREPARING FOR PDGM

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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

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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 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**

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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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		Billie Whitehurst	Netsmart

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