Shifting Gears from PPS to PDGM

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• Facts
• Impact
• Strategy
Admission Source & Timing
(from claims)
<table>
<thead>
<tr>
<th>Current PPS</th>
<th>PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ No comparative payment element</td>
<td>❑ Institutional</td>
</tr>
<tr>
<td></td>
<td>❑ Initial payment periods</td>
</tr>
<tr>
<td></td>
<td>❑ Acute or post-acute inpatient stay 14 days prior to</td>
</tr>
<tr>
<td></td>
<td>❑ Subsequent payment periods</td>
</tr>
<tr>
<td></td>
<td>❑ Acute stay 14 days prior to</td>
</tr>
<tr>
<td></td>
<td>❑ Post-acute stay 14 days prior to</td>
</tr>
<tr>
<td></td>
<td>❑ Only if discharged from &amp; readmitted to home health</td>
</tr>
<tr>
<td></td>
<td>❑ Community</td>
</tr>
<tr>
<td></td>
<td>❑ Any payment period not qualifying as institutional</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PPS</th>
<th>PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Early</td>
<td></td>
</tr>
<tr>
<td>❑ 60-day episodes one &amp; two</td>
<td></td>
</tr>
<tr>
<td>❑ Late</td>
<td></td>
</tr>
<tr>
<td>❑ All third &amp; later 60-day episodes</td>
<td>❑ Early</td>
</tr>
<tr>
<td>❑ Initial admission 30-day payment period</td>
<td></td>
</tr>
<tr>
<td>❑ Late</td>
<td></td>
</tr>
<tr>
<td>❑ All subsequent 30-day payment periods</td>
<td></td>
</tr>
</tbody>
</table>
Clinical Grouping
(from claims)

<table>
<thead>
<tr>
<th>PPS</th>
<th>PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>One of three clinical severity levels based on 13 OASIS assessment items</td>
<td>One of 12 clinical groupings based on diagnostic category of principal diagnosis billed on claim</td>
</tr>
</tbody>
</table>

4.28% Behavioral adjustment
# Functional Impairment Level

*(from OASIS)*

<table>
<thead>
<tr>
<th>PPS</th>
<th>PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>One of three functional severity levels based on six OASIS assessment items</td>
<td>One of three functional impairment levels based on eight OASIS assessment items &amp; diagnostic category of principal diagnosis billed on claim</td>
</tr>
<tr>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate</td>
<td>Medium</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>
Comorbidity Adjustment
(from claims)

<table>
<thead>
<tr>
<th>PPS</th>
<th>PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>No comparative payment element</td>
<td>Application of a comorbidity adjustment based on qualifying other diagnoses billed on claim</td>
</tr>
<tr>
<td></td>
<td>No adjustment</td>
</tr>
<tr>
<td></td>
<td>Low adjustment</td>
</tr>
<tr>
<td></td>
<td>High adjustment</td>
</tr>
</tbody>
</table>

0.38% Behavioral adjustment
LUPAs

**PPS**
- Per-visit payment applied to any 60-day episode with less than five total visits

**PDGM**
- Per-visit payment applied to any 30-day period with total visits ranging from less than two to less than six
  - LUPA threshold unique to each case-mix weight

1.75% Behavioral adjustment
Facts

• Impact

State Estimated PDGM Financial Impacta
• Negative impact of 10% or more
  • 33 agencies
• Negative impact of 5% to 10%
  • 38 agencies
• Negative impact less than 5%
  • 54 agencies
• Positive impact
  • 230 agencies

Before consideration of 6.42% behavioral adjustments

aEstimated by CMS using 2017 claims data
National standard payment rate

Case-mix weight

Admission Source and Timing (From Claims)

Community Early  Community Late  Institutional Early  Institutional Late

Clinical Grouping (From Principal Diagnosis Reported on Claim)

Neuropathic  Wounds  Complex Nursing Interventions  MS  Behavioral Health  MMTA - Other

MMTA - Surgical  MMTA - Cardiac and Circulatory  MMTA - Endocrine  MMTA - G/G/I  MMTA - Infectious Disease  MMTA - Respiratory

Functional Impairment Level (From OASIS items)

Low  Medium  High

Comorbidity Adjustment (From Secondary Diagnoses Reported on Claims)

None  Low  High

HHRG (Home Health Resource Group)

Note: Per CMS LDS 2017 data

Admission Source and Timing

Community, early  Institutional, early  Community, late  Institutional, late

CT  ME  MA  NH  RI  VT
Clinical Grouping (From Principal Diagnosis Reported on Claim)

Note: Per CMS LDS 2017 data

Functional Impairment Level (From OASIS Items)

Note: Per CMS LDS 2017 data
Note: Per CMS LDS 2017 data

Comorbidity Adjustment

None (0) vs Low (1) vs High (2)

Top 5 Change in Payment from PPS to PDGM after distribution of QEs

Note: Per CMS LDS 2017 data
Agency A
- Freestanding
- For profit
- Urban
- Indiana
- $4.1 million annual Medicare revenues
- 10% estimated payment increase under PDGM*

Agency B
- Freestanding
- For profit
- Urban
- Indiana
- $4.0 million annual Medicare revenues
- 12% estimated payment decrease under PDGM*

Note: Estimated by CMS using 2017 data
Clinical Grouping

**Agency A**
- MMTA_GL_GU: 3%
- MMTA_AFTER: 1%
- MMTA_INFECTION: 5%
- MMTA_BENZO: 3%
- BEHAVIOR: 1%
- MMTA_OUGH: 13%
- MS_REHAB: 15%
- MS_UNKN: 1%
- MMTA_OHER: 8%
- WOUND: 6%
- NEURO_REHAB: 9%
- QE'S: 6%
- MMTA_CARD: 26%
- MMTA_ENDO: 2%

**Agency B**
- MMTA_GL_GU: 2%
- MMTA_AFTER: 1%
- MMTA_INFECTION: 2%
- MMTA_BENZO: 2%
- BEHAVIOR: 1%
- MMTA_RESP: 5%
- MMTA_OHER: 2%
- WOUND: 13%
- COMPLEX: 4%
- MS_REHAB: 38%
- MMTA_CARD: 14%
- QE'S: 20%

Note: Clinical groupings based on primary diagnosis code before reassignment of questionable encounters (QE's)

Note: Estimated by CMS using 2017 data

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**Functional Impairment Level - Agency A**

*Non-LUPA*

<table>
<thead>
<tr>
<th>Level</th>
<th>Agency A</th>
<th>Indiana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (1)</td>
<td>27.7%</td>
<td>40.7%</td>
</tr>
<tr>
<td>Medium (2)</td>
<td>42.0%</td>
<td>31.9%</td>
</tr>
<tr>
<td>High (3)</td>
<td>30.3%</td>
<td>27.4%</td>
</tr>
</tbody>
</table>

**Functional Impairment Level - Agency B**

*Non-LUPA*

<table>
<thead>
<tr>
<th>Level</th>
<th>Agency B</th>
<th>Indiana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (1)</td>
<td>43.4%</td>
<td>40.7%</td>
</tr>
<tr>
<td>Medium (2)</td>
<td>35.4%</td>
<td>31.9%</td>
</tr>
<tr>
<td>High (3)</td>
<td>21.2%</td>
<td>27.4%</td>
</tr>
</tbody>
</table>
**Comorbidity Adjustment - Agency A**

Non-LUPA

- Agency A: 45.0% (None), 45.8% (Low), 9.2% (High)
- Indiana: 52.1% (None), 38.3% (Low), 9.6% (High)

**Comorbidity Adjustment - Agency B**

Non-LUPA

- Agency B: 52.5% (None), 39.2% (Low), 8.3% (High)
- Indiana: 52.1% (None), 38.3% (Low), 9.6% (High)

**Volume - Agency A**

MS Rehab (No. 2)

- 16% (Agency A), 19% (Agency B) for All periods
- 7% (Agency A), 8% (Agency B) for LUPA periods

**Volume - Agency B**

MS Rehab (No. 1)

- 22% (Agency B), 29% (Agency B) for All periods
- 5% (Agency B), 5% (Agency B) for LUPA periods

**Est. Margin Analysis - Agency A**

Non-LUPA

- $1,285 average payment
- $1,645 average cost
- 3.0% average case mix weight
- 2% functional improvement
- 4.3% change in PPS payment

**Est. Margin Analysis - Agency B**

Non-LUPA

- $1,044 average payment
- $1,079 average cost
- 2% average case mix weight
- 1.7 functional improvement
- 4.8% change in PPS payment

10 therapy visits per PPS episode

15 therapy visits per PPS episode
**Why Prepare?**
- PDGM impacts all aspects of operations
- PDGM relies heavily on admission source & timing
- PDGM increases number of billing transactions due to shorter payment periods
- PDGM relies heavily on claim diagnosis coding & sequencing for payment accuracy
- PDGM will no longer use therapy utilization as a payment characteristic

**How to Prepare?**
- Identify and train on processes that need changed
- Assess current referral sources and existing patient populations
- Assess current documentation & order management processes
- Assess current coding accuracy and timeliness
- Assess resource utilization to assure patient-centered care

**IDENTIFY AND TRAIN ON PROCESSES THAT NEED CHANGED**
### Business Operations under PDGM

#### Intake Management
- Diagnoses capture protocol
- Admission source and timing determination
- Intake checklist “must haves”
- Education for referral sources

#### RCM Management
- Managing shorter payment periods
- Documentation management
- Dedicate proper resources
- Understand cash flow challenges

#### LUPA Management
- Proper utilization of technology
- Dashboard evaluation
- Education for those with influence
- Develop a performance improvement project

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### ADMISSION SOURCE & TIMING

**Analyze data**

**Assess referral sources**
- Diversify referral sources?
- Foster relations for preferred sources

**Patient population trends**
- Is there influence of control?
- How do you plan to influence trends?
ADMISSION SOURCE & TIMING

- Correctly identify location
- Clear & timely handoff of info

Admission
- Confirm location
- Document accurately
- Confirm timing
- Code accurately on claim

Intake
- Confirm location
- Document accurately

Billing
- Confirm timing
- Code accurately on claim

MANAGING SHORTER PAYMENT PERIODS

Current PPS
- Front-loaded visits
- Tapered visits

PDGM
- Front-loaded visits
- Tapered visits

Full 30-day payment  Managed utilization or a LUPA??
MANAGING SHORTER REVENUE CYCLES

Comprehensive assessments
- Agency deadlines for submission may need to be tighter
- Front end review of admission/OASIS/POC more focused
- OASIS & diagnosis coding accuracy is critical to billing accuracy

Document & order management
- Optimize automation of document management
- Monitor signature/date on orders & follow up regularly
- Use checklist to ensure all document elements (particularly FTF) are confirmed

Billing, collecting & payment posting
- Adhere to process flow for RAP & claim filing
- Include handoff from clinical team to confirm possible change in diagnosis for 2nd payment period
- Process to confirm documentation that supports change in diagnosis

MANAGING CODING ACCURACY

ICD10 accuracy
- Know clinical groups
- Confirm support in documents
- Avoid questionable encounters
- Collaborate on primary & co-morbidities
- Agency policy for follow up assessment
- Assess for change in 2nd payment period

37

38
Collaborate on data accuracy for all new episodes

Consensus discussion on discrepancies (observation or interview?)

Assessing functional tasks in isolation limits the picture of the patient’s routine

Consider how time of day effects performance

Patients living alone are not necessarily performing ADLs safely just because they have no assistance

Be VERY aware of the response item in which assistive devices are introduced

Practice among therapists and nurses to be very familiar with how “25%” physical assistance really feels

Remember dressing items include getting things out of closets and drawers (and letting go of the walker?)

Some ADL items are best scored starting from the bottom up to capture the most accurate response item

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**Assessment**
Collaboration on accurate picture of patient

**Goals**
Patient goal drives plan of care

**Plan of Care**
Individualized to patient

**Taper Frequency**
Allows greater patient engagement in managing condition

**Best Skill Mix**
Assure right discipline is doing the right thing – COORDINATE CARE
BYPRODUCT OF INTERDISCIPLINARY CARE MANAGEMENT

- Coding Collaboration: Accurate data → Accurate payment → Accurate outcomes
- Patient Engagement: In-between visit progress → Fewer visits with good outcomes → Less cost to episode
- Care Coordination: Best skill mix, best value to outcome → More appropriate therapy utilization → Better utilization, less cost to episode
- Tapered Frequency: Reduced hospitalization risk → Outcomes monitored over time → Visits spread over time, reduce LUPA risk

Facts

- Know the facts
- Assess the impact
- Develop a strategy
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