How Will PDGM Affect Home Health

Clinical and Billing

Satellite Conference and Live Webcast
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Produced by the Alabama Department of Public Health
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OBJECTIVE

1. Define and explain PDGM.
2. Explain the potential affects on home health reimbursement.
3. Discuss home health clinical and billing relationship shift.
4. Discuss clinical and billing behavior changes.
5. Discuss on-going training needs.

DEFINITION

- **The Centers for Medicare & Medicaid Services (CMS) has finalized the Patient Driven Grouping Model (PDGM), which is planned to start in 2020. The agency has also finalized several other changes to how home health providers are reimbursed for their services starting in 2019, tweaking Remote Patient Monitoring rules and refining the Value-Based Purchasing Model (VBPM). Among its provisions, PDGM is designed to remove current incentives to over-provide therapy services by more strongly weighting clinical characteristics and other patient information, according to CMS. PDGM would also mean that the traditional 60-day unit of payment would be halved to 30 days.**

WHAT WE KNOW – PDGM:

- **Potential billing reduction of 32%**
- **Scripting for intake team to ensure accurate information is received on the front end**
- **Eligibility checks every 28 days**
- **Learn how to adjust on the back end**
- **Concern is Palmetto will not get it right**
- **Verifying adjustments accuracy**
- **Slow claim processing (all new PDGM staff at CMS)**
- **Cash flow concern (expect 60% of $1,500)**

WHAT WE KNOW – UNBILLED:

- **Daily unbilled reports**
- **Goals for unbilled claims**
- **Goals for past due**
- **Evaluating our order tracking process**
- **Centralized reporting of billing delays**
- **Analytic billing review**
- **Unbilled management is essential**
- **Double number of RAPs and Final claims**

WHAT WE DO NOT KNOW

- We will not know the full effect(s) of PDGM until after several billing cycles in 2020

HOW THIS WILL AFFECT HOME HEALTH

Admission source

- **Institutional:**
  - Acute (inpatient acute care hospital)
  - Post-acute institutional referral care in 14 days prior to Home Health Admission
    - Skilled Nursing Facility
    - Long Term Care Hospital
    - In-patient Psychiatric Facility

HOW THIS WILL AFFECT HOME HEALTH

- **Community**
  - No acute or post acute care 14 days prior to Home Health Admission

HOW THIS WILL AFFECT HOME HEALTH

CMS Justification:

- 30 Day periods with an institutional admission source were found to have higher resource cost than 30-day periods with community admission source.

HOW THIS WILL AFFECT HOME HEALTH

- **Early period:**
  - First 30 day period in a sequence of Home Health periods
- **Late period:**
  - Second and later 30 day periods in sequence of Home Health periods
  - Sequence is defined as period with no more than 60 days between the end of one period and the start of the next period

HOW WILL THIS AFFECT HOME HEALTH

- **Payment periods after the initial 30 days are always considered community:**
  - Unless there was an acute care hospitalization within the 14 days prior to the end of the 30 day payment period
  - Post-acute stays occurring in the 14 days prior to the 30 day period would not be classified as institutional unless the HHA discharged the patient from home health services prior to post acute stay

HOW WILL THIS AFFECT HOME HEALTH

- **Admission source will come from Medicare claims processing to automatically assign admission source and timing**
- **Agency has the option of including occurrence code on claim to identify an institutional admission source**

HOW WILL THIS AFFECT HOME HEALTH

Update Claims Requirements

- **Adding M0090 Date from OASIS**
- **Occurrence codes driving admission source**
- **Changes to Diagnoses' source**
- **In HCHB, we need to set up HH admission source in facilities, add qualifying inpatient event, and complete the SOC workflow, HCHB will do the rest**

HOW WILL THIS AFFECT HOME HEALTH

Update Claims Requirements

- **Late periods are always classified as a community admission unless there is an acute hospitalization in the 14 days prior to the late home health 30-day period. In order to capture the institutional stay however, the patient would have to be discharged and readmitted.**

HOW WILL THIS AFFECT HOME HEALTH

Update Claims Requirements

Diagnoses:

- **Diagnoses DO NOT need to match on OASIS , RAP or Final.**
- **Diagnoses used should reflect patient condition at the beginning of the statement period.**

HOW WILL THIS AFFECT HOME HEALTH

Update Claims Requirements

Diagnoses:

- **Case-mix group cannot change within a Period. "If the primary diagnosis changes between the first and second 30-day period, the claim for the 2nd 30-day period would reflect the new diagnosis, you would not change the claim for 1st 30-day period" 2019 HH Final Rule.**

HOW WILL THIS AFFECT HOME HEALTH

Update Claims Requirements

Diagnoses:

- **It is not necessary to complete a F/U OASIS to change diagnoses in Subsequent periods, "Second 30 day claims in a 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30 day claim to the next, there is no absolute requirement to complete another F/U assessment to ensure that diagnosis coding on the claim matches the assessment" CMS transmittal 4294.**

HOW WILL THIS AFFECT HOME HEALTH

Update Claims Requirements

Diagnoses:

- **Diagnoses for claims during the first period come from the POC at SOC/Recert. Diagnoses for claims during subsequent period come from the most recent diagnosis order within the prior period.**

HOW WILL THIS AFFECT MY ROLE

- **Clinical staff will need to be more attentive to physical assessments, OASIS answers, MD orders, and timely MD order f/u.**
- **Clerical, Billing, and Clinical staff will need to strengthen internal communications to close clinical and billing GAPS.**
- **ADPH State Home Health agency has one Parent office with 25 branches; which means an error in one branch affects the entire state.**

WHAT CAN WE DO TO PREPARE

- **Conduct trainings based on the information you are receiving today and additional pending educational opportunities.**
- **Review all emails related to PDGM closely and share with staff.**
- **Incorporate PDGM training into regular scheduled meetings.**
- **Ask questions.**

BILLING

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Overview of the Payment Model

PPS Model	PDGM
• 60-day episode payment (60/40, then 50/50)	• 30-day payment period (60-day episodes of care)
• Diagnosis + OASIS + Projected therapy	• Admission source + Timing + Clinical Grouping + Functional level + Comorbidity adjustment
• Outlier payment	• LUPA (variable)
• LUPAs (4 or fewer visits)	• PEP
• PEP (Partial episode payments)	• Heavy on diagnoses
• Therapy-driven payment model	• 432 case-mix adjustment groups (HHRGs)
• 153 case-mix adjustment groups (HHRGs)	

PDGM REVENUE CYCLE

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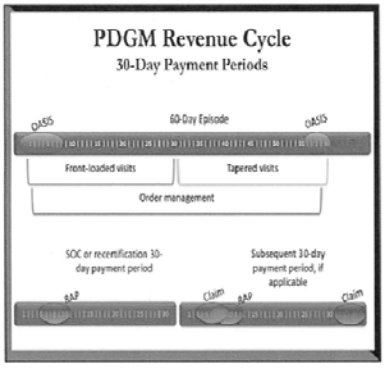

NAHC PDGM Summit 2019

Billing

- For billing purposes, PDGM proposes to keep the RAP/final claim billing methodology
  - CMS estimates the median time to submit a RAP is 12 days so they are soliciting comments on if this makes sense
  - 5% of RAPs not submitted until after day 60
- New agencies as of 1/1/2019 would not receive RAP payments under PDGM but required to submit a "no pay" RAP
  - Potential Notice of Admission in the future

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Billing

- Source of admission indicated by occurrence code on the final claim only (not included on RAPs)
  - Medicare will automatically adjust claim if community is indicated but an institutional source submits Medicare claim
- Clinical Groupings and Comorbidity Adjustment based on diagnoses on the CLAIM, not the OASIS
  - Up to 25 diagnosis codes can go on claim compared to 6 on OASIS

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RAPs

- Required for each 30-day payment period – Goal should be 3-5 days after start of period
- Typically pay in 7-10 days
- Early RAP is paid 60/40 of total claim
- Late RAP is paid 50/50 of total claim
- 2nd period RAP should be billed as soon as possible if you have OASIS/POC documentation
- RAPs assist with cash flow

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FINAL CLAIM

Final claim requirements:

- Successfully transmitted OASIS assessment and in repository
- Compliant F2F certification
- Signed and dated orders
- Signed and dated plan of care

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BILLING STRATEGIES FOR PDGM

Tighten down workflow processes and set higher "bars" for outcomes

- ✓ F2F complete, correct, signed and dated – 98% at SOC
- ✓ Coding and OASIS Review completed – 95% at 2 days
- ✓ Orders completed and sent out and returned signed and dated – 95% received within 30 days
- ✓ OASIS completed and exported to repository – 98% within 7 days

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BILLING STRATEGIES FOR PDGM

- Possible shift to increased e-referrals
- Ensure validation of demographics is completed
- Audits should be done on claims adhering to the plan of care and supported by documentation
- Dashboard should note the percentage of clean claims submitted

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BILLING STRATEGIES FOR PDGM

- Go electronic in billing/cash posting
- See what your pre-bill audits look like and collaborate with clinical to improve outcomes if necessary
- Monthly review of all AR aged > 60 days
- Trend denials by reason

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BILLING STRATEGIES FOR PDGM

- Monitor admissions and re-certifications and notify clinical if you cannot RAP within a specified time period
- Monitor unsigned orders management/F2F management
- Utilize an electronic physicians signature portal

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REVENUE CYCLE KEY PERFORMANCE INDICATORS

- Case-mix weight
- OASIS error percentage
- Outstanding orders by age
- Days to final claim
- AR balance
- Days sales outstanding
- Write-offs
- Rebills

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Partial Episode Payments (PEPs)

- PEP adjustments are made when patient is transferred or discharged and then returns to same or different agency, requiring new OASIS & plan of care within the same 60-day care period.
- Payments calculated as proportion of 30-day period patient was under agency care.

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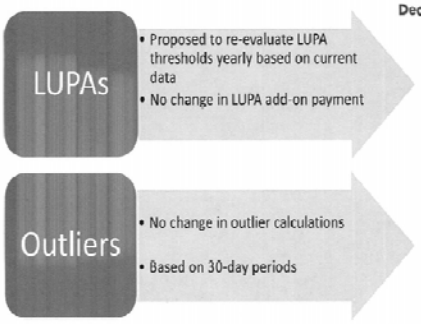

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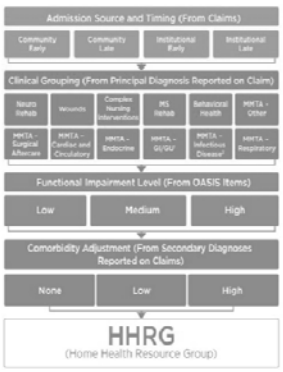
Cash Flow Impact

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

CLINICAL AND BILLING

Patient Driven Groupings Model (PDGM)



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CLINICAL AND BILLING

LUPAs

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

- **PPS:**
  - 60-day episode with four or fewer total visits are paid per visit
- **PDGM:**
  - LUPAs now have variable thresholds based on HHRG
  - Different level for each of the 432 HHRGs
  - 10th percentile value of visits for each threshold
  - LUPA Add-on remains

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CLINICAL AND BILLING

Changes in Claim Management

- CMS will calculate reimbursement based on prior claims in common working file (CWF), diagnoses/visits on submitted claim and OASIS in QIES system, not HIPPS listed on claim
  - Need to investigate all remaining balances on A/R prior to adjusting off in EMR
  - Pricer not implemented until 1/6/2020
- Occurrence Codes for institutional referral sources
  - OC 61 – acute inpatient hospital stay
  - OC 62 – SNF, IRF, LTCH, IPF
- Occurrence Code 50 indicates assessment date
- Treatment authorization code no longer required on claims

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CLINICAL AND BILLING

PDGM

Change requests related to claims processing:

- **CR 11081**
  - **30 day episodes**
  - **LUPA**
  - **No treatment authorization code but will need to include date OASIS completed in OC 50**
  - **OC 61 and 62 added**

CLINICAL AND BILLING

- **CR 11272**
  - **OASIS and claim diagnosis coding does not necessarily have to match.**
    - **Beginning January 1, 2020 the ICD code and principle diagnosis used for payment grouping will be claim coding rather than OASIS item.**
  - **RAP payment is based on HIPPS code as submitted.**
    - **Medicare system will adjust the HIPPS code, as necessary, after receipt of final claim.**

Miscellaneous

- OASIS still completed every 60 days
- PEPs (Partial Episode Payments) have same methodology
- Outliers have same methodology, although fixed dollar loss would need to change
  - Based on current rules, 4.77% of estimated total payments would be outlier dollars
  - CMS requirement that number cannot exceed 2.5%
- Non Routine Supply (NRS) Add-on payments eliminated

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Q & A

SUMMARY

- **We are appreciate your attention this morning. We plan to share information on a regular basis to ensure we are all prepared for PDGM as much as we can be. We know that major changes like this can be challenging, but we intend to be available for our staff to work through all of the hurdles. If you have any concerns after this presentation, please reach out to your supervisor so they can route your concerns to the bureau.**

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