104. PDGM – Data/Preparation
PDGM – Data/Preparation
David Merk and Michael McGowan

Continuing Education

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Using Data to Drive Success Under PDGM

PDGM is a significant change in how CMS pays for home health services. With the right data you can:

- Understand how PDGM will impact your agency
- Create metrics that will best enable you to manage within the new framework
- Learn where there are opportunities to better serve the patients targeted by CMS

Understand why you must BEGIN NOW to get ready!

How does PDGM Compare to PPS

- The concepts of HHRGs, HIPPS, Outliers, and LUPAs are retained.
- Payment is for 30-day periods, not 60, but based partly on data from 60-day assessments.
- HHRGs are based on 5 factors, only one of which is from the OASIS.
- As many as 24 secondary diagnoses can be included on a claim and figure in calculation of a comorbidity score.
- Functional deficits contribute, but a count of therapy visits does not.
- There are 432 HHRGs, rather than 153.
- Each of the HHRGs has its own LUPA threshold, ranging from 2-6 visits.
- The first payment period nearly always has a higher threshold.
Under prior payment systems, as well as PPS, the volume of services provided has played a key role in determining payment.

Under PDGM, the focus is on the characteristics of the patient.

The schedule for OASIS assessments remains the same. A SOC or Recert applies across both 30 day payment periods.

This yields 432 combinations, compared with 153 for PPS. Each determinant contributes a bit toward the case-mix for each HHRG.
Calculation of the 30-day Fee is Familiar

- For a given 30-day period, a patient is assigned to one of the HHRGs
- Each HHRG has an assigned case-mix
- CMS has determined a 30-day episode standardized fee (expected to be $1,883.34 for 2020, excluding the proposed Behavioral Adjustment)
- Using the processes in place under PPS:
  - The standardized fee is divided into a labor and non-labor portion
  - The labor portion is multiplied by a labor factor based on where the patient resides
  - The weighted labor portion is added to the non-labor portion and the sum is multiplied by the case-mix
  - The case-mix is important. If a case-mix is raised by a certain amount, the episode payment will be raised by a proportional amount.

The All-Important Primary Diagnosis!!

- PDGM introduces new jargon: “Questionable Encounter Code”, “QECs”.
- The PPS Grouper lists 72,476 diagnostic codes.
- For PDGM, only 43,287 are accepted as “groupable”.
- Rationale: Vague codes don’t reveal the costs an agency will incur in providing care.
  - R-Codes such as “Other Malaise”, “Muscle Weakness”.
  - Majority (75%) of the codes flagged as “unspecified” are QECs.

Note: The Questionable Encounter Codes can be included as secondary codes but won’t affect payment.
To Avoid Questionable Encounter Codes

- Be specific
- Only PDGM diagnoses
- Avoid symptom codes
- Coding partnerships
- Train referral sources – Begin NOW!
- Certified documentation specialist

The Base 30-Day Payment if the Primary Diagnosis is Accepted

- The base, or minimum, payment is found when:
  - Source of Referral = "Community",
  - Timing = "Late",
  - Functional = "Low",
  - Comorbidity = “None”, and when the Clinical Grouping is **MMTA Surgical Aftercare**.

$901

Assumption:
- The labor rate for the patient's CBSA is 1.0
- CMS uses the calculated standard 30-day rate of $1,883.34 NOT implement the proposed 6.42% “Behavioral Adjustment”
Add-On for Each Clinical Grouping

<table>
<thead>
<tr>
<th>Clinical Grouping</th>
<th>Neuro Rehab</th>
<th>Wounds</th>
<th>Complex Nursing</th>
<th>Musculoskeletal Rehab</th>
<th>Behavioral Health</th>
<th>MMTA Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-DAY PAYMENT</td>
<td>$572</td>
<td>$635</td>
<td>$131</td>
<td>$363</td>
<td>$43</td>
<td>$210</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MMTA Surgical Aftercare</th>
<th>MMTA Cardiac and Circ.</th>
<th>MMTA Endocrine</th>
<th>MMTA GI/GU</th>
<th>MMTA Infectious</th>
<th>MMTA Respiratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$169</td>
<td>$393</td>
<td>$93</td>
<td>$154</td>
<td>$125</td>
</tr>
</tbody>
</table>

Average Payment for 30-day Period: $1,142

Add-On for Institutional and/or Early Timing

<table>
<thead>
<tr>
<th>Late/Community to Late/Institution</th>
<th>Late/Community to Early/Community</th>
<th>Late/Community to Early/Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>$842</td>
<td>$761</td>
<td>$1,104</td>
</tr>
</tbody>
</table>

- Ultimately drawn from Claims data but can be estimated based on the patient’s known treatment history and on M1001 on the OASIS.
- For any payment period, a ROC in the last 14 days of the preceding period can convert it to an Institutional referral.
Add-On for Increase in Functional Score

### Functional Impairment Level
(from OASIS Items)

<table>
<thead>
<tr>
<th>30-DAY PAYMENT</th>
<th>Neuro Rehab</th>
<th>Wounds</th>
<th>Complex Nursing</th>
<th>Musculoskeletal Rehab</th>
<th>Behavioral Health</th>
<th>MMTA Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-Med</td>
<td>$322</td>
<td>$287</td>
<td>$389</td>
<td>$240</td>
<td>$334</td>
<td>$264</td>
</tr>
<tr>
<td>Low-High</td>
<td>$508</td>
<td>$512</td>
<td>$461</td>
<td>$509</td>
<td>$501</td>
<td>$500</td>
</tr>
<tr>
<td><strong>MMTA Surgical Aftercare</strong></td>
<td>$310</td>
<td>$389</td>
<td>$311</td>
<td>$308</td>
<td>$308</td>
<td>$271</td>
</tr>
<tr>
<td>Low-Med</td>
<td>$603</td>
<td>$505</td>
<td>$541</td>
<td>$485</td>
<td>$485</td>
<td>$476</td>
</tr>
<tr>
<td>Low-High</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average Shift in Payment for 30-day Period:
- LOW to MEDIUM is $363
- LOW to HIGH is $507

### About the Functional Add-On
- This is the only determinant taken directly from the OASIS.
- Based on seven items.
- All have been on the SOC and ROC, but two, M1800 and M1033, have not been on Recerts.
- They will be added under OASIS-D1 to accommodate PDGM.
- Long history of under-assessing functional status.
- Difficult to relate the items to PDGM scoring of functional status.
- Each Clinical Grouping has its own thresholds for Low, Medium, and High.
- Monitor staff performance, comparing across staff, time, and items.
Functional Scoring

<table>
<thead>
<tr>
<th>OASIS Item</th>
<th>TIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1800 Grooming &lt;br&gt;New to functional scoring with PDGM</td>
<td>Consider ability, rather than willingness or actual performance, to safely perform grooming tasks</td>
</tr>
<tr>
<td>M1810/M1820 Dressing Upper/Lower Body</td>
<td>Consider ability, rather than willingness or actual performance, to safely obtain, put on, and take off clothing that is regularly worn</td>
</tr>
<tr>
<td>M1830 Bathing</td>
<td>Consider ability, rather than willingness or actual performance, to safely wash entire body</td>
</tr>
<tr>
<td>M1840 Toilet Transfers</td>
<td>Consider ability, rather than willingness or actual performance, to safely get to and from the toilet or commode and transfer on and off</td>
</tr>
<tr>
<td>M1850 Transferring</td>
<td>Consider ability, rather than willingness or actual performance, to safely transfer between bed and chair in both directions or turn and position self if bedbound</td>
</tr>
<tr>
<td>M1860 Ambulation</td>
<td>Consider ability, rather than willingness or actual performance, to safely ambulate or wheel self</td>
</tr>
<tr>
<td>M1033 Risk for Hospitalization &lt;br&gt;New to functional scoring with PDGM</td>
<td>It is important to mark all that apply in order to accurately determine the functional impairment</td>
</tr>
</tbody>
</table>

Add-On for Increase in Comorbidity Score

| Comorbidity Adjustment (From Secondary Diagnoses Reported on Claims) |
|---|---|
| NONE to LOW | Payment will increase by about $113* |
| NONE to HIGH | Payment will increase by about $339* |

* the comorbidity add-ons have a tiny bit of variation from Clinical Grouping to Clinical Grouping.

- Compared to other factors, the impact of the comorbidity score is uniform and light.
- Expect that about 10% of your payment periods will be scored as High and about 35% will be scored as Low.
Comorbidity Score Facts

- There are approximately 1,100 diagnoses that can figure into the scoring if used as a Secondary Diagnosis.
- Any of them would be acceptable as the Primary Diagnosis.
- Any one of them would generate a score of Low.
- CMS has organized these diagnoses into 20 “sub-groups”.
- A score of High can be assigned if Secondary Diagnoses from two of these sub-groups are included on the claim.
- Sub-groups have “sub-chapters”. If a Secondary code is from the same sub-chapter as the Primary Diagnosis, it is ignored.

High Comorbidity – Examples of Pairings

<table>
<thead>
<tr>
<th>Sample Pairing</th>
<th>Pairing 1</th>
<th>Pairing 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerebral 4</td>
<td>167.82</td>
<td>Heart 10</td>
</tr>
<tr>
<td>166.151 Hemiplegia affecting right side</td>
<td>148.3 Typical Atrial Fibrillation</td>
<td></td>
</tr>
<tr>
<td>149.9 Cardiac Arrhythmia unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral 2 - bipolar, mania, depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F32.9 Major depressive disorder, recurrent, mild</td>
<td>Skin 3 - Arterial disease with ulcer of foot</td>
<td></td>
</tr>
<tr>
<td>F31.9 Bipolar disorder, unspecified</td>
<td>L97.233 Atherosclerosis of native arteries of right leg with ulceration of ankle</td>
<td></td>
</tr>
<tr>
<td>Endocrine 3 - diabetes type 1, 2, and other type</td>
<td>L97.421 Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin</td>
<td></td>
</tr>
<tr>
<td>E10.9 Type 1 diabetes mellitus without complications</td>
<td>Neuro 5 - Parkinson’s disease</td>
<td></td>
</tr>
<tr>
<td>E11.621 Type 2 diabetes mellitus with foot ulcer</td>
<td>G20 Multiple artherosclerosis</td>
<td></td>
</tr>
<tr>
<td>Neuro 3 - physiological mental disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance</td>
<td>G98.322 Pressure ulcer of left heel, stage 2</td>
<td></td>
</tr>
<tr>
<td>F03.91 Unspecified dementia with behavioral disturbance</td>
<td>I99.014 Pressure ulcer of right foot, stage 4</td>
<td></td>
</tr>
<tr>
<td>Renal 3 - urinary tract disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N90.0 Urinary tract infection, site not specified</td>
<td>Skin 4 - stage two through four and unstageable pressure ulcers by site</td>
<td></td>
</tr>
<tr>
<td>N40.1 Benign prostatic hyperplasia with lower urinary tract symptoms</td>
<td>L99.232 Pressure ulcer of left foot, stage 2</td>
<td></td>
</tr>
<tr>
<td>Respiratory 5 - COPD, asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J44.1 Chronic obstructive pulmonary disease with acute exacerbation</td>
<td>I99.153 Pressure ulcer of sacral region, stage 3</td>
<td></td>
</tr>
<tr>
<td>J45.0 Severe persistent asthma, uncomplicated</td>
<td>L99.154 Pressure ulcer of right heel, stage 4</td>
<td></td>
</tr>
<tr>
<td>J47.0 Bronchitis with acute lower respiratory infection</td>
<td>Skin 3 - diseases of arteries, arterioles, and capillaries with ulceration and non-pressure chronic ulcers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>L10.233 Atherosclerosis of native arteries of right leg with ulceration of ankle</td>
<td></td>
</tr>
<tr>
<td></td>
<td>L97.212 Non-pressure chronic ulcer of right calf with fist layer exposed</td>
<td></td>
</tr>
</tbody>
</table>
Putting it Together

<table>
<thead>
<tr>
<th>Determinant</th>
<th>“Score”</th>
<th>30-day $$</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Groupable” Diagnosis</td>
<td>Any one of 43,287 Listed Codes</td>
<td>$901</td>
</tr>
<tr>
<td>Clinical Grouping</td>
<td>Wound</td>
<td>$635</td>
</tr>
<tr>
<td>Timing</td>
<td>Early/Institutional</td>
<td>$1,104</td>
</tr>
<tr>
<td>Functional Score</td>
<td>Medium</td>
<td>$287</td>
</tr>
<tr>
<td>Co-morbidity</td>
<td>High</td>
<td>$339</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$3,266</td>
</tr>
</tbody>
</table>

- $3,266 for the first 30 days.
- The second period (Late/Community) would be eligible for a payment of $2,162 if the patient remained in care.
- A total of $5,428 for the 60 days.
- LUPA Thresholds = 5 and 3

Major Implications of PDGM Payment Model

- Make sure you have a groupable primary diagnosis.
- Monitor timely initiation of care. It may come into play in determining whether a payment period is found to be “Institutional” or “Community” based.
- Monitor your visits to avoid LUPAs
- Functional items are often under-assessed. Accurate completion of these questions on the OASIS can be monitored. Compare staff as to PDGM Functional score performance.
- Consider tools which afford you flexibility in staffing.
Looking Beyond Individual Payment Periods

• CMS has asserted that PDGM will:
  • Be revenue neutral with winners and losers but it will balance out.
  • Not necessitate additional billing effort
  • Reduce the number of LUPAs

All these assertions are questionable.

The Four Payment Outcomes

1. Some episodes would be paid nothing under PDGM – usually 12% to 15%
2. About 25% would yield payment for just the first payment period.
   The patients would have been discharged during the first period.
3. Either one or both payment periods would result in a LUPA – roughly 10% to 16% of the payment periods
4. The remainder, 45% to 55%, would receive full payment for both periods
Scenario 1: Enough Gain to Overcome QECs

<table>
<thead>
<tr>
<th>PDGM Impact Summary</th>
<th># of Affected Episodes</th>
<th>% of PPS Episodes</th>
<th>PDGM Projected Revenue</th>
<th>Gain or Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionable Encounter Code (Non-Reimbursable)</td>
<td>17</td>
<td>7.30%</td>
<td>$0</td>
<td>($45,229)</td>
</tr>
<tr>
<td>Full Episode Pay for 1st Period Only; DC in 1st 30 Days</td>
<td>11</td>
<td>4.70%</td>
<td>$22,057</td>
<td>($306)</td>
</tr>
<tr>
<td>Episode Includes 1 or More LUPA Periods</td>
<td>7</td>
<td>3.00%</td>
<td>$9,959</td>
<td>$1,078</td>
</tr>
<tr>
<td>Full Pay for Both Periods</td>
<td>197</td>
<td>84.90%</td>
<td>$644,353</td>
<td>$89,454</td>
</tr>
<tr>
<td>TOTAL</td>
<td>232</td>
<td>100%</td>
<td>$676,369</td>
<td>$45,007</td>
</tr>
</tbody>
</table>

- Low number of QECs
- Low visit utilization, “long” length of stay yield gain for nearly every Clinical Grouping

Scenario 2: Gains Do Not Offset QECs

<table>
<thead>
<tr>
<th>PDGM Impact Summary</th>
<th># of Affected Episodes</th>
<th>% of PPS Episodes</th>
<th>PDGM Projected Revenue</th>
<th>Gain or Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionable Encounter Code (Non-Reimbursable)</td>
<td>141</td>
<td>8.8%</td>
<td>$0</td>
<td>($529,719)</td>
</tr>
<tr>
<td>Full Episode Pay for 1st Period Only; DC in 1st 30 Days</td>
<td>151</td>
<td>10.1%</td>
<td>$408,674</td>
<td>($20,588)</td>
</tr>
<tr>
<td>Episode Includes 1 or more LUPA Periods</td>
<td>74</td>
<td>4.6%</td>
<td>$96,012</td>
<td>($8,113)</td>
</tr>
<tr>
<td>Full Pay for Both Periods</td>
<td>1,221</td>
<td>76.4%</td>
<td>$5,038,597</td>
<td>$138,370</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,597</td>
<td>100%</td>
<td>$5,543,284</td>
<td>($420,050)</td>
</tr>
</tbody>
</table>

Without QECs, there would be an overall gain
Scenario 3:

Payment under PPS is unusually high due to high therapy levels.

<table>
<thead>
<tr>
<th>Description</th>
<th># of Affected Episodes</th>
<th>% of PPS Episodes</th>
<th>PDGM Projected Revenue</th>
<th>Gain or Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionable Encounter Code (Non-Reimbursable)</td>
<td>100</td>
<td>18.7%</td>
<td>$0</td>
<td>($365,145)</td>
</tr>
<tr>
<td>Full Episode Pay for 1st Period Only; DC in 1st 30 Days</td>
<td>101</td>
<td>18.9%</td>
<td>$198,455</td>
<td>($78,097)</td>
</tr>
<tr>
<td>Episode Includes 1 or more LUPA Periods</td>
<td>28</td>
<td>5.2%</td>
<td>$41,536</td>
<td>($11,814)</td>
</tr>
<tr>
<td>Full Pay for Both Periods</td>
<td>306</td>
<td>57.2%</td>
<td>$939,895</td>
<td>($189,316)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>35</td>
<td>100%</td>
<td>$1,179,886</td>
<td>($644,373)</td>
</tr>
</tbody>
</table>

Loss for pay-for-both episodes.
Payment under PPS is unusually high due to high therapy levels.

A Further Look:
Variations for Clinical Groupings

<table>
<thead>
<tr>
<th>Description</th>
<th># of Affected Episodes</th>
<th>% of PPS Episodes</th>
<th>PDGM Projected Revenue</th>
<th>Gain or Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro</td>
<td>61</td>
<td>14.3%</td>
<td>$156,110</td>
<td>($104,857)</td>
</tr>
<tr>
<td>Rehab</td>
<td>84</td>
<td>17.0%</td>
<td>$213,387</td>
<td>($96,929)</td>
</tr>
<tr>
<td>Wounds</td>
<td>66</td>
<td>10.8%</td>
<td>$209,705</td>
<td>$11,898</td>
</tr>
<tr>
<td>Complex</td>
<td>1</td>
<td>0.1%</td>
<td>$2,716</td>
<td>$576</td>
</tr>
<tr>
<td>Behavioral</td>
<td>8</td>
<td>1.6%</td>
<td>$18,642</td>
<td>($10,914)</td>
</tr>
<tr>
<td>MMTA-Cardiac</td>
<td>62</td>
<td>9.9%</td>
<td>$155,608</td>
<td>($24,246)</td>
</tr>
<tr>
<td>MMTA-Endocrine</td>
<td>25</td>
<td>4.3%</td>
<td>$68,573</td>
<td>($10,325)</td>
</tr>
<tr>
<td>MMTA-GI/GU</td>
<td>21</td>
<td>3.7%</td>
<td>$58,506</td>
<td>($9,807)</td>
</tr>
<tr>
<td>MMTA-Infectious</td>
<td>22</td>
<td>3.7%</td>
<td>$56,130</td>
<td>($12,187)</td>
</tr>
<tr>
<td>MMTA-Respiratory</td>
<td>32</td>
<td>5.9%</td>
<td>$82,119</td>
<td>($29,995)</td>
</tr>
<tr>
<td>MMTA-Surgical</td>
<td>2</td>
<td>0.2%</td>
<td>$5,763</td>
<td>$1,463</td>
</tr>
<tr>
<td>MMTA-Other</td>
<td>51</td>
<td>8.3%</td>
<td>$126,550</td>
<td>($25,020)</td>
</tr>
</tbody>
</table>
Turn your Data into Action

- Data gets meaning through comparisons
- Compare across teams, assessors, case managers, and time
- Compare performance with industry benchmarks

Need for tools to identify areas needing attention
PDGM Poses Many Challenges

- The data in your EMR can help you to identify obstacles and opportunities.
- We’ve hinted at some of the strategies being explored within the home health industry.
- Now we will discuss potential solutions in more detail.

It’s a Competition

IT'S NO LONGER THE BIG BEATING THE SMALL,
BUT THE FAST BEATING THE SLOW...
The Problem

Agencies are trying to preserve “The Familiar” processes that have produced high cost low value care.

What do Agencies want?

- Provide the best patient care
- Sustain Current Profit Margins
- Predictable Regulatory compliance
- Meet CMS expectations
AND...

CMS has changed their expectations and goals...

- Have great “data proven” outcomes
- Reduce the cost of good outcomes
- Decrease cost of care
- Lower service utilization
- Shorter LOS
- Keep patients out of the hospital

Regardless of …

- Nursing Shortage
- RCD
- HHVBP
- Referral Sources / F2F
- COP’s & COP’s
- Decreasing Margins
- UPIC/ MAC’s/ ADR’s
Data Black Out ... 7-9 months into transition

Fast vs Slow

- Legacy practices
- New Practices
- Micromanaging data
- QA DURING the assessment

BEST PRACTICES
Why?

Asses & Treat
Diagnosis-based
Outcome driven vs Financial Driven
Legacy practices Retroactive
PDGM Best practice Pro-Active

Path / Slow to Fast

Current Processes Retroactive.

Benchmarking
LUPA Rates
Recert rates
# Therapy Visits
Case-mix development
Clinician Alerts – babysitting vs teamwork
Service Utilization
Retroactive Monitoring of clinicians
New Processes Proactive:

Standardized Systematized Operations achieving “Systemness”.

- Becker's
- McKnight's
- New England Patriots

Path / Slow to Fast

How do we produce these results?

- Increase Productivity to FOUR Billable OASIS assessments
- Reduces cost of care
- Increases profit margins due to reduced costs
- ELIMINATE 95% of after-hours documentation
- Recruitment Retention
Path / Slow to Fast

Data Creation vs Data Review

- Errors are “fixed” while the nurse is with the patient
- Eliminate 100% of the Corrections Cycles
- Intra Episode monitoring of STARS and OASIS

DURING THE VISIT
Care Planning
Service utilization
Profit margins Established

Path / Slow to Fast

Managing vs Monitoring Clinicians

- Changing our QA processes Reactive to Live Interactive
- Analytics interactive part of the OASIS Assessment
- Asses and treat to Diagnosis-Based care
- Transition to hyper accurate rapid cycle interactive processes
Next Steps…

Does PDGM Eliminate late episodes?

Reactive Analytics

Failed Attempts

Inadequate Profit Margins
Continued Staff turnover
Audit Risk Data Profiles
ADR’s / UPIC
Proactive Analytics

Successful results

Grow vs Sustain
Above average margins
Clinician R & R
Reduced Risk of Audits

QUESTIONS