Leadership for PDGM and Beyond: The Big Picture of the Next Wave of Industry Change, Challenge and Opportunity
Leadership for PDGM and Beyond: The Big Picture of the Next Wave of Industry Change, Challenge and Opportunity

Presented by: Tim Ashe RN, MS, MBA
Chief Clinical Officer WellSky
President Fazzi Associates

Hospice and Home Health Compare

- Risk contracting
- HH CoPs
- Star Ratings Patient Care
- Star Ratings Satisfaction Surveys
- HEART Tool

**Patient-Driven Groupings Model**

- Bundled Payments for Care Initiative
- IMPACT Act
- Value-Based Care
- PEPPER Reporting
- Review Choice Demonstration
PwC: The Five Forces Shaping the US $5 Trillion Health Ecosystem

- **Rise of consumerism** (Consumer access and ownership of health data; consumer cost-sharing; price transparency and shopping)
- **Shift from volume to value** (Federal drive toward value-based purchasing; insurer push for value-based contracts; pharmaceutical and life sciences company push toward value-based contracts)
- **March of technological advances and digitalization** (Use of electronic medical records and other health data; 3D printing; emergence of blockchain technology; development of –omics; spread of machine learning and artificial intelligence)
- **Decentralization** (Spread of virtual care and remote patient monitoring; embrace of alternate venues and resources for care; increased use of extenders; seamless sharing of data among stakeholders)
- **Surge in interest in wellness** (Consumer interest in wellness; insurer incentives for wellness; employer interest in wellness)

Source: PwC Health Research Institute

PDGM

The Patient Driven Groupings Model (PDGM) will dramatically change Home Health reimbursement in 2020. To succeed under PDGM, agencies will need to examine every corner of their operations from intake to care management to coding and billing.
Patient Driven Groupings Model (PDGM)

- Better align payment with costs
- Increase access to vulnerable patients associated with lower margins
- Address payment incentives in current system, i.e. eliminate impact of therapy volume on payment
- Place patients into clinically meaningful payment categories
- Effective January 1, 2020

PDGM and Quality Episode

- Two 30-day payment periods within one 60-day certification period.
- 60-day timing for certification periods remains unchanged.
- Assessment within 5 days of SOC and, no less than last 5 days of every 60 days unchanged.
- Plan of Care corresponds with 60-day certification.
- OASIS time points remain unchanged.
- Significant Change in Condition is required.
PDGM Revenue Cycle: 30-Day Payment Periods

60-Day Episode

Front-loaded visits

<table>
<thead>
<tr>
<th></th>
<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>M</td>
<td>T</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>15</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>22</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>29</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

Tapered visits

Order management

Case Mix Weight Structure

An episode is grouped into one (and only one) subcategory under each category. An episode’s combination of subcategories groups the episode into one of 432 different payment groups.

- Admission Source and Timing
- Clinical Grouping
- Comorbidity Adjustment
- OASIS Items-Functional Level
Patient Driven Groupings Model

Admission Source and Timing
- Community Early
- Community Late
- Institutional Early
- Institutional Late

Functional Level
- Low
- Medium
- High

Clinical Group
- Neuro Rehab
- Wounds
- Complex Nursing Interventions
- MS Rehab
- Behavioral Health

Comorbidity
- None
- Low
- High

= HHRG 432

Intake Tips

- Educate the entire intake/sales team. Buy-in!
- Use tools or scripts to help communicate with referral sources.
- Ensure staff have sales skill with knowledge of agency.
- Identify the top diagnoses used now that won’t work in PDGM.
Timing

- Only the first 30-day period in a sequence of periods defined as early and all other subsequent 30-day periods would be considered late.
- First episodes are those where the beneficiary has not had home health in the 60-days prior to the start of the first episode.
- To identify the first 30-day period in a sequence, Medicare claims processing system would verify that the claims “From Date” and “Admission Date” match.

Average Revenue Admission Source and Timing

<table>
<thead>
<tr>
<th></th>
<th>Percent of 30-Day Periods</th>
<th>PDGM Payment/Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Early</td>
<td>13.38%</td>
<td>$2,135</td>
</tr>
<tr>
<td>Community Late</td>
<td>60.60%</td>
<td>$1,400</td>
</tr>
<tr>
<td>Institutional Early</td>
<td>19.31%</td>
<td>$2,419</td>
</tr>
<tr>
<td>Institutional Late</td>
<td>6.72%</td>
<td>$2,221</td>
</tr>
</tbody>
</table>

Source: Fazzi Business Intelligence Analysis
Clinical Groupings

- Each 30-day period of care will be assigned to one of twelve groups based on the reported principal diagnosis.
- Diagnosis code must support the need for HH services.

Revenue By Clinical Group

<table>
<thead>
<tr>
<th>Clinical Group</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex</td>
<td>$1,394</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>$1,398</td>
</tr>
<tr>
<td>MMTA Other</td>
<td>$1,563</td>
</tr>
<tr>
<td>MMTA Infectious</td>
<td>$1,605</td>
</tr>
<tr>
<td>MMTA Endocrine</td>
<td>$1,621</td>
</tr>
<tr>
<td>MMTA Cardiac</td>
<td>$1,634</td>
</tr>
<tr>
<td>MMTA GI/GU</td>
<td>$1,684</td>
</tr>
<tr>
<td>MMTA Resp.</td>
<td>$1,695</td>
</tr>
<tr>
<td>MMTA Aftercare</td>
<td>$1,863</td>
</tr>
<tr>
<td>MS Rehab</td>
<td>$1,902</td>
</tr>
<tr>
<td>Neuro Rehab</td>
<td>$1,990</td>
</tr>
<tr>
<td>Wound</td>
<td>$2,023</td>
</tr>
</tbody>
</table>

Source: Fazzi Business Intelligence Analysis
Impact Ratio by Clinical Group

<table>
<thead>
<tr>
<th>Clinical Group</th>
<th>Impact Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH</td>
<td>0.85</td>
</tr>
<tr>
<td>Complex</td>
<td>1.06</td>
</tr>
<tr>
<td>MMTA Cardiac</td>
<td>0.99</td>
</tr>
<tr>
<td>MMTA AC</td>
<td>1.09</td>
</tr>
<tr>
<td>MMTA Endo</td>
<td>1.09</td>
</tr>
<tr>
<td>MMTA GIGU</td>
<td>0.98</td>
</tr>
<tr>
<td>MMTA Infec</td>
<td>1.01</td>
</tr>
<tr>
<td>MMTA Resp</td>
<td>0.97</td>
</tr>
<tr>
<td>MMTA Other</td>
<td>0.96</td>
</tr>
<tr>
<td>MS Rehab</td>
<td>0.97</td>
</tr>
<tr>
<td>Neuro Rehab</td>
<td>0.93</td>
</tr>
<tr>
<td>Wound</td>
<td>1.25</td>
</tr>
</tbody>
</table>

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Federal Register, Vol. 83, No. 219, November 13, 2018

Functional Impairment

- Functional status allows for higher payment for higher service needs.
- Functional scores result in 3 levels: low, medium, high.
- Functional levels per clinical group.
- Functional scores and levels will be updated for 2020.
### Functional Items

<table>
<thead>
<tr>
<th>Current HH PPS</th>
<th>PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1810: Dressing upper body</td>
<td>M1800: Grooming</td>
</tr>
<tr>
<td>M1820: Dressing lower body</td>
<td>M1810: Dressing upper body</td>
</tr>
<tr>
<td>M1830: Bathing</td>
<td>M1820: Dressing lower body</td>
</tr>
<tr>
<td>M1840: Toileting</td>
<td>M1830: Bathing</td>
</tr>
<tr>
<td>850: Transferring</td>
<td>M1840: Toileting</td>
</tr>
<tr>
<td>M1860: Ambulation &amp; locomotion</td>
<td>850: Transferring</td>
</tr>
<tr>
<td></td>
<td>M1860: Ambulation &amp; locomotion</td>
</tr>
<tr>
<td></td>
<td>M1033: Risk of Hospitalization</td>
</tr>
</tbody>
</table>

### Impact Ratio for Functional Levels

- **Low**: 0.95
- **Medium**: 0.99
- **High**: 1.06

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Federal Register, Vol. 83, No. 219, November 13, 2018
New! OASIS D1

- Addition of two existing items to the Follow-Up assessment.
- Optional data collection at specific time points for 23 items.
- Effective for M0090 Date Assessment Completed as of January 1, 2020 or later and, recertifications on or after December 27, 2019.
- Recerts on or after December 27, 2019: enter the M0090 date of January 1, 2020 and submit on January 1, 2020.

Source: CMS OASIS–D1 OASIS Updates for CY 2020

Comorbidities

- Secondary diagnosis codes used to case-mix adjust the period further through the comorbidity adjustment.
- **No Adjustment**: No comorbidity diagnosis that falls into a comorbidity adjustment subgroup.
- **Low Comorbidity Adjustment**: A comorbidity diagnosis that falls into one comorbidity adjustment subgroup.
- **High Comorbidity Adjustment**: Two or more diagnosis that fall within the same comorbidity subgroup interaction.
Impact Ratio for Comorbidity Adjustment

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Federal Register, Vol. 83, No. 219, November 13, 2018

LUPAs

- LUPA thresholds will vary for a 30 day period depending on the payment group to which it is assigned.
- LUPA thresholds range from 2-6 visits.
- LUPA add-on factors will remain the same as current system.
- LUPA thresholds for each PDGM payment group would be reevaluated every year.
# LUPA/Utilization Recommendations

| ✓ | Audit now to assess accuracy of service utilization. |
| ✓ | Use case management to help ensure effective service. |
| ✓ | Discharge planning starts with admission goals. |
| ✓ | Clinical managers must have case management skills. |
| ✓ | Empower clinical teams via education and planning. |

# Agency Behavior Assumptions

1. **Clinical Group Coding:** Coding to maximize payments.
2. **Comorbidity Coding:** More 30 day periods will receive comorbidity adjustment.
3. **LUPA Threshold:** 1-2 extra visits will be made to receive the full 30 day payment.
Payment Impact of Behavior Assumptions

Example: 30 Day BN Standard Payment: $1873.91

Percent Decrease: 8.01%

Revised 30 Day Standard Payment: $1724

Average Number of Days to Complete SOC and send 485/POC Certifying Order

<table>
<thead>
<tr>
<th>Time</th>
<th>Percentage of Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 0-5 days</td>
<td>52%</td>
</tr>
<tr>
<td>Within 6-10 days</td>
<td>31%</td>
</tr>
<tr>
<td>Within 11-20 days</td>
<td>16%</td>
</tr>
<tr>
<td>Within 21-30 days</td>
<td>1%</td>
</tr>
</tbody>
</table>
Orders Management Tips

- Timely entry of Plan of Care and Interim Orders.
- Assign responsibility to track and monitor order workflow.
- Set aggressive timeline and corresponding actions.
- Identify your current status in order to improve gaps.

RAP and Final Claim Process

- Billing occurs for every 30 day period of care
- Sequential billing is not required
- Final Claim paid less recoupment of RAP
- OASIS validation requirements have not changed
## Financial Leaders Tips

| ✔  | Evaluate current volume and workflow for gaps. |
|    | Understand how your EMR will function ahead of PDGM. |
| ✔  | Collaborate with clinical leaders on efficiencies. |
| ✔  | Ensure finance team is prepared via education & planning. |

## Strategic Management Model

1. **What do we know?**
2. **What should we do about it?**
3. **What does it mean?**
“Making systems work is the great task of my generation of physicians and scientists. But I would go further and say that making systems work — whether in healthcare, education, climate change, making a pathway out of poverty — is the great task of our generation as a whole.”

Atul Gawande

---

### Leadership’s Checklist

- [✓] Prepare using Strategic Management Model.
- [✓] Analyze using your organization’s 2018 performance data.
- [✓] Generate Buy-In: Educate each team of leaders and staff.
- [✓] Work out each key workflow. Set up standard work often.
You Are at a Strategic Inflection Point

“A strategic inflection point is the time in the life of a business when its fundamentals are about to change; that change can mean an opportunity to rise to new heights. But, it may just as likely signal the beginning of the end.”

Andrew S. Grove
Co Founder, Intel
- Author: Only the Paranoid Survive

Time Person of the Year: 1997
Strategic Management Model

- What do we know?
- What should we do about it?
- What does it mean?

Why now
Industry Challenges: Massive Shift in Population Demographics

36 M
new seniors

65%
have at least two chronic conditions

1 M
nursing deficit

Medicare spends nearly $60 billion per year on post-acute services, or 12 percent of its annual expenditure.

Industry Challenge: Increasing Emphasis on Efficiency and Quality

36 million new seniors
In the next 10 years, the 65+ population will grow by 36 million people, putting large strains on existing care resources.

65% have at least two chronic conditions
Prevalence of conditions like heart disease and diabetes greatly increase medical complexity and double or triple overall care cost.

Deficit of nursing staff
By 2022, there will be a projected deficit of 1,000,000 nurses in the United States.
Industry Challenge: Historic Transition to Risk-Based Payment Models

Managed Medicare & Medicaid
35% of Medicare recipients and 65% of Medicaid recipients are now being managed by private insurers in capitated risk models.

Value-based & bundled payments
By 2020, 90% of all FFS Medicare payments will be tied to outcomes through programs like value-based purchasing and bundled payments.

Site-neutral payments
Universal reimbursement based off of patient acuity instead of care settings, incentivizing a move to less expensive sites of service.

Post-Acute Care
12%
of total health system spending

Post-Acute Care
73%
of total variation in cost & quality

Industry Challenges: Historic Transition to Value-Based Payment Models
Simple Fact....

The number of people needing health care services will grow dramatically for the next 35 years.

Simple Fact....

We cannot accept mediocre quality because voters won’t accept it and poor quality requires more services and increased cost of health care.
Simple Fact....

The US cannot afford to provide health services using a health system model and infrastructure that is not financially sustainable.

The Future

_Quadruple Aim_

Triple Aim plus a focus on staff engagement
Value-Based Payment Will Accelerate Across PAC

**Past**
Fee For Service
Provider Requirements
Provide and bill for care services delivered, with limited reporting of value-based performance metrics.

**Present**
Some Risk Exposure
Provider Requirements
Participate in some value-based arrangements through CMS & MA, but still with limited downside risk.

**Future**
Full Risk Sharing
Provider Requirements
Participate in fully capitated arrangements with payers, taking on both upside and downside patient care risk.

Market Pressure & Competition Will Drive Innovators Towards Full Risk Exposure

---

Care Goal- Successful Journey to Home
Our Customers' Challenge

LTAC
IRF
PAC VENUE
DECISION
Very little Science In Decision
SNF
HH
PROVIDER
PLACEMENT
Very little Science In Decision
CARE PLAN
Very little science in decision
SNF1
SNF2
SNF3

Hospitalization

Readmissions- 20%, 1.6M patients, $17 Billion+ In Costs

Lack of Clinical Best Practices
No Science To Key Care Decisions
Patient & Family Not Engaged
Poor Outcomes For Patients & Payers

Reality: Current State of Care Landscape

Connecting the Continuum to Improve Health and Wellness

Transitions of Care

Intelligent Care Management
Rehabilitation Facility
Long-Term Care Facility
Human Services
Community Services
Home IV & SPRx
HME
Home Health
Hospice

Interoperability
Analytics
Outsourced Services
Thought Leadership, Consulting, Education
Leadership to Drive Success!

1. Top 10% Profit Margin
2. Top 10% HHCAHPS
3. Top 10% HHC
4. Lowest 10% Hospitalization
5. Lowest 10% Cost

- Quadruple Aim Ready
- Value-Based Partnering
- Evolved Care Management
  - Standardized Best Practice – Risk stratified – data analytics
- Scalable and Standardized Platform
  - Structure, workflows, technology enabled, Core Competencies including Management – Performance

Simplify, Simplify, Simplify!
We Believe this Change Will Necessitate a Software Reinvention

**Past**
Record Keeping

Capabilities
For Meaningful Use, a *software* system engineered to satisfy care data capture and storage requirements

**Present**
Efficiency & Reporting

Capabilities
For lower reimbursement paradigm, a *web-based* system optimized for staff efficiency & data reporting

**Future**
Insights & Impact

Capabilities:
For risk-based future, an intelligent system built with ML/AI for informing better care and strategy decisions

Great Caregivers + Machine Learning Will Enable Providers To Bend Cost Curve

---

Historic View: Experts vs. AI

**Clinical expertise**  vs.  **Analytic insights**
Our Belief: Experts + AI Key to Future Success

Clinical expertise → Intelligent Care Management ← Analytic insights

Intelligent Care Management *in Action*
Predictive Analytics – Focused Intelligent Care Management

- Clinical Best Practice
- Identify and manage risk
- Risk for rehospitalization
- Right level of care – hospice, palliative care
- Algorithms for high quality outcomes – episode visit profile
- Fuel perfect plans of care

Insights Into Growth and Success

- Use data and technology to reduce variability and efficiency
- Use technology that simplifies regulatory compliance
- Leverage analytics tools that put your clinical data to work
- Invest in staff education and development
- Performance evaluation and reward
Through it all you need to lead change!

As You Initiate Strategic Change Efforts, Remember the J Curve of Change

- Whenever you initiate change, it never goes exactly how you expect.
- There is often resistance and the belief by some that the change won’t work.
- Like the letter J, the path may go down but it will go up.
- Having a clear vision and an unwavering commitment to your mission and core values will absolutely lead to success.
Leaders Know What To Do In The Future

“It’s not what you know that matters, it’s what you do with what you know.”

- Fazzi

Fazzi
Home Care | Hospice

11 Village Hill Road, Suite 101
Northampton, MA 01060
413.584.5300
fazzi.com