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White paper

What every home health agency should know about the Patient Driven Groupings Model: A three-part series

Part III - Developing a PDGM action plan

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About the author

Sharon S. Harder has over three decades of executive management experience in the healthcare industry. She has served in financial and operational leadership roles in a variety of healthcare organizations ranging from a major healthcare professional association to large post-acute healthcare providers. As President of C3 Advisors, LLC, Sharon engages with clients to develop and implement the strategic vision required to improve their profitability and competitive position in the rapidly transforming health care marketplace.

Being proactive has its virtues. Being proactive early on is even better.

With PDGM there is a significant amount of information to assimilate and it is clear that an effective action plan and approach to preparedness will not be the same for every agency. Like everything else, it will require an understanding of the agency's strengths as they relate to the changes imposed by PDGM and its weaknesses in the form of procedural gaps that could create difficulty later on.

As we think about payment reform in general, it is important to remember that CMS has designed PDGM to be budget neutral and, in that vein, it has projected that some agencies will be likely to realize revenue gains under PDGM and others will not, all things being equal and unchanged from 2017. The program is certain to be tweaked between now and 2020; however, it is unlikely to go away. And, as we saw in the first installment of this series when we looked back at the incubation of PPS, there are perils in ignoring the inevitability of change.

PDGM is destined to affect each agency in different ways. Those that have relied heavily in the past on therapy volume for patients without a directly preceding inpatient stay could have a significant amount of work to do to transform their operations and approaches to patient care and case management. Those that have focused more on skilled nursing for complex patients may have different challenges along the lines of managing utilization and avoiding LUPAs as visit frontloading practices are reversed.

Whatever your agency's circumstances, **there will be work to be done.**

Your PDGM action plan

Here are **ten things** your agency needs to do to start preparing for success under payment reform. Don't be fooled. This will take some concentrated effort.

1. **Analyze the Agency Level Impacts File** that has been offered by CMS to find out how your agency is most likely to fare under PDGM. It can be found here: https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html. If your agency is among those that could see a revenue increase, good for you; but, don't rest on your laurels! As you can see from the following table, every State will have agencies that are expected to gain and those that will decline.

AGENCY IMPACTS BY STATE – EST GAINS AND LOSSES

ST	# HHA Est Losses	$ Effect	# HHA Est Gains	$ Effect	Total Est Effect	ST	# HHA Est Losses	$ Effect	# HHA Est Gains	$ Effect	Total Est Effect
AK	4	($287,819)	10	$708,528	420,709	MT	18	($932,585)	9	$204,641	-727,944
AL	55	($8,743,784)	94	$12,336,267	3,592,483	NC	94	($20,730,073)	72	$8,828,894	-11,901,179
AR	27	($3,804,969)	80	$8,300,183	4,495,214	ND	10	($663,082)	7	$350,061	-313,021
AZ	73	($11,232,627)	68	$3,853,001	-7,379,626	NE	39	($6,400,944)	30	$891,403	-5,509,541
CA	373	($37,695,873)	882	$125,687,582	87,991,709	NH	10	($1,796,992)	18	$3,074,120	1,277,128
CO	105	($18,766,702)	40	$802,383	-17,964,319	NJ	9	($4,692,603)	33	$16,827,962	12,135,359
CT	37	($6,053,972)	51	$10,706,620	4,652,648	NM	32	($3,038,600)	40	$3,286,570	247,970
DC	15	($381,972)	4	$529,879	147,907	NV	49	($5,338,426)	79	$9,324,857	3,986,431
DE	8	($840,276)	11	$1,746,137	905,861	NY	30	($6,163,174)	97	$46,902,596	40,739,422
FL	739	($149,620,173)	187	$8,917,439	-140,702,734	OH	258	($28,433,220)	274	$12,241,418	-16,191,802
GA	55	($9,459,605)	47	$7,989,335	-1,470,270	OK	59	($6,856,009)	189	$31,115,536	24,259,527
HI	8	($858,104)	6	$177,243	-680,861	OR	21	($1,891,363)	36	$6,586,237	4,694,874
IA	61	($2,791,810)	94	$4,831,508	2,039,698	PA	128	($20,743,989)	182	$19,082,519	-1,661,470
ID	39	($9,368,622)	8	$314,900	-9,053,722	RI	14	($1,781,990)	9	$1,214,111	-567,879
IL	218	($27,844,316)	451	$49,295,059	21,450,743	SC	37	($7,995,460)	32	$5,169,155	-2,826,305
IN	119	($15,107,889)	83	$6,860,954	-8,246,935	SD	28	($1,827,433)	4	$81,891	-1,745,542
KS	67	($9,389,788)	47	$3,975,928	-5,413,860	TN	85	($20,065,669)	41	$8,906,159	-11,159,510
KY	55	($9,101,715)	47	$6,985,202	-2,116,513	TX	601	($66,653,072)	1606	$124,685,995	58,032,923
LA	36	($3,836,445)	152	$25,014,901	21,178,456	UT	77	($10,200,682)	12	$338,698	-9,861,984
MA	48	($9,074,216)	134	$27,904,377	18,830,161	VA	135	($24,638,394)	94	$7,376,477	-17,261,917
MD	38	($14,092,116)	14	$1,525,623	-12,566,493	VT	1	($63,579)	10	$2,721,251	2,657,672
ME	12	($2,477,981)	10	$2,345,804	-132,177	WA	38	($12,139,630)	22	$3,632,147	-8,507,483
MI	380	($35,422,100)	127	$13,113,495	-22,308,605	WI	51	($5,244,157)	51	$5,692,586	448,429
MN	100	($11,986,342)	53	$1,961,630	-10,024,712	WV	29	($4,778,600)	32	$2,655,524	-2,123,076
MO	101	($11,772,484)	62	$4,856,431	-6,916,053	WY	19	($1,420,252)	7	$458,428	-961,824
MS	12	($4,039,858)	34	$24,887,885	20,848,027	**Total**	**4661**	**($678,561,615)**	**5819**	**$678,511,409**	**-50,206**

2. **Take the time to fully understand the case-mix weights in the context of the services your agency most often provides.** Take a look at the top and bottom echelons of the case-mix list by assigned weight. Use the grouper tool provided by CMS to calculate your own agency's case-mixes based on historical patient characteristics. It may take some work. It will be worth the effort. Remember the following:

   Of the **top 50 PDGM case-mixes**:

   - 41 are associated with Early Payment Periods
   - 42 are associated with Institutional Admissions

- 43 are associated with at least one comorbidity that is counted toward the case mix weight and 32 are predicated on comorbidity interactions
- 48 are associated with at least a Medium Functional Deficit
- 27 are found in the Neuro/Stroke or Wound Clinical Groups

If these characteristics are reflective of your agency's patient population, PDGM will be a very good thing for you. On the other hand, if your agency's patient population more closely resembles the bottom 50 PDGM case mixes, there is work to do and to be forewarned is to be forearmed .

Of the **bottom 50 PDGM case mixes**:

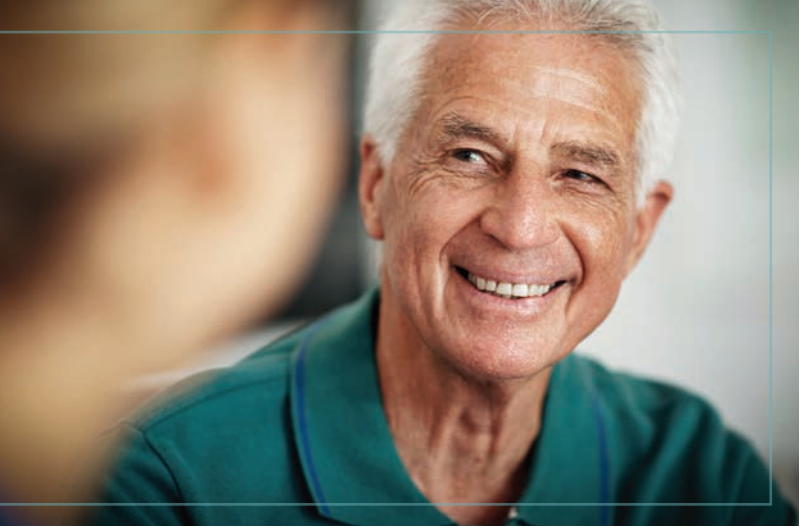
- All 50 are associated with Late Payment Periods
- All 50 are associated with Community Admissions
- Half rely on no applicable comorbidities
- 29 are associated with Low Functional Impairment
- 35 are in one of the seven MMTA categories

The takeaway is that agencies with a disproportionate share of community admissions, longer lengths of stay and a diagnosis found in one of the MMTA categories could have more difficulty maintaining margins on services.

3. **Review your agency's coding practices by comparing 2017 and 2018 episode primary diagnoses against the CMS list for PDGM.** The worksheet with the acceptable home health diagnoses and corresponding Clinical Groups can be found at the URL above – look for the PDGM Grouper Tool and download the file.

   Remember that, on average, one in five claims in 2017 featured a primary diagnosis that could not be assigned to a PDGM Clinical Group. These were generally claims with non-specific, symptomatic coding. CMS has warned us for two years running about these codes and their relationship to "questionable encounters."

   If your agency performed better than average, congratulate the team. But, unless your agency turns in a zero percent result for claims and codes that cannot be matched to the PDGM code list, there is still work to do. Start now. This is something that should be addressed even if PDGM were never to materialize. Work with the coding team to identify sources of information that would yield more specific coding; for example, patient History & Physical information (H&Ps) as a key component of the referral information packet in each medical record. If your agency is not routinely acquiring that type of information prior to admitting new patients, now would be a good time to start changing the Intake Process.



Remember and emphasize the following in educating the coding team:

- There are no "R" Codes on the list of PDGM diagnoses. Thus, primary diagnosis like "abnormality of gait" or "difficulty walking" are not acceptable coding choices. CMS recognizes that coding guidelines allow for selection of these types of codes as primary diagnoses; however, CMS also has indicated that these codes are not specific enough to establish an effective and individualized Plan of Care. Be forewarned.

- Avoid unspecified coding that has, historically, been common to home health but that does not establish a clear rationale for skilled services (a finding that CMS has been reiterating for several years). The most common example is M62.81, Muscle Weakness General which is also a code missing from the list of permitted codes that will lead to assignment of a Clinical Group.

- Be aware of the 5,000 or so codes that have been added and be proactive – if your team finds more that should be added, be prepared to make a recommendation at the next opportunity.

4. **Review your agency's Admission Sources in the context of the PDGM rules.** Even though CMS may not use OASIS data, that doesn't prevent you from doing so to identify the percentage of patients served in 2018 who would have been classified as Community admissions versus those who could be classified using the Institutional source criteria. Over 80% of the top 50 PDGM case-mixes are associated with Institutional Admissions while 100% of the bottom 50 are linked to Community Admissions.

   If your admissions are too concentrated in the Community Admission category, which could signify revenue losses under PDGM, start working to develop partnerships with hospitals and post-acute care facilities in your service area as a means of levelling out this category of performance. These relationships take time to cement, so don't wait to focus on this aspect of PDGM strategy! And, don't fall into the 'donut delivery' marketing trap. Work with your team to develop compelling evidence around your agency's quality and outcomes as a means of portraying your agency as a worthwhile community partner. What hospitals and SNFs care most about right now is how your agency can keep their discharged patients from making an avoidable return trip to the facility.

5. **Review your agency's Clinical Groups to determine concentration levels, utilization patterns and outcomes.** Using average utilization levels by discipline, measure your potential performance under PDGM by Clinical Grouping and also measure outcomes. Is there room for improvement or is there a story here that can be used to market your agency's specialization in certain clinical areas, such as wound care or neuro/stroke rehabilitation? (Keeping in mind that over half of the top 50 case mixes are in one of these two Clinical Groups.)

   Consider establishing clinically reasonable utilization parameters by Clinical Group and case-mix. Care planning should follow, as closely as possible, the established parameters and they should be monitored to help keep as much control on cost as possible. Be aware that this is not a suggestion to cut back on needed patient services, but a suggestion to monitor and control direct costs of care as much as possible while still focusing on quality and desirable patient outcomes. Work with the clinical team to be more efficient.

6. **Review your agency's PPS episodes by breaking them into PDGM Payment Periods and do the same for the visits that were performed during each period.** Then, identify the areas or types of episodes where there are gaps or problems that need to be addressed.

   Here are some examples of what to look for.

   - Do the effects of frontloading visits at the beginning of an episode with fewer visits at the end put your agency into jeopardy for a potentially high percentage of LUPAs under PDGM? For more fragile patients, would the use of remote patient monitoring allow the agency to more evenly space visit frequencies to maintain quality outcomes and still reduce LUPA exposure?
   - Do you have a significant number of episodes that rely on relatively low nursing utilization and high levels of non-skilled services such as Aide visits (for example, monthly Foley catheter changes or monthly B12 injections with more regular Aide services)? Is there a need to review how visit frequencies are set to ensure that there is at least one skilled visit in each Payment Period with no dependent services after the last skilled event?

   For certain types of episodes, the Payment Period change will make things a bit more complicated. Start working now to analyze how your agency handles unusual episodes and to change how visits and frequencies are planned, if necessary, to avoid unwelcome future reimbursement surprises.

7. **Review current episodes and OASIS ADL responses for accuracy to ensure that your agency will be able to get maximum benefit from completely accurate OASIS responses related to Activities of Daily Living and Rehospitalization Risk.** Clearly, responses must be accurate, but educate your staff on the scoring nuances of the Functional Impairment component of each case mix. Over 95% of the top case mixes rely on at least a medium level of impairment and this is an area that, for some

clinicians, has become so routine that responses are more habitual than thoughtfully considered. Some follow-up education with a new focus could be in order for the clinical team members who are performing patient assessments.

8. **Review Final Claims for current episodes to ensure that all of the relevant diagnoses are being listed on your Final Claims.** Why? Because if diagnoses are missing from the claim the agency may, in the future under PDGM, not get the credit it deserves for single or interactive comorbid patient conditions. Remember that this information will not come from your OASIS, it will come from the claim and CMS will assign comorbidity levels based on the information it gets from the agency. Another thing to focus on is making sure that the coding team is including all of the relevant diagnoses for this purpose.

9. **Make sure the agency's Medicare Cost Report is accurate and reflective of true costs especially costs by discipline.** Remember that, for 2020, the 2018 Cost Report data will likely be used to calculate costs that contribute to case-mix values. It is true that many agencies have taken the position that the Cost Report doesn't matter very much because it has not been used to establish reimbursement for many years; however, that is now about to change in a very material way. Cost Report accuracy has never been more important.

10. **Address major processes and potential opportunities for redesign/refinement to ensure that key processes are updated for maximum compliance and efficiency.** And, educate all staff members early and often as 2020 approaches to avoid unnecessary procedural hiccups that could cost the agency money.

    The Intake Team should be acquiring H&Ps to facilitate accurate coding not only of the primary diagnosis but all comorbidities. They should also be compiling information about the patient's prior institutional stay(s) that will enable the agency to code an Institutional Admission. Remember, if the stay is not attributable to Medicare, acquiring documentary proof of the stay should be a part

of the intake process as a prelude to coding and submitting the claim.

The agency team at large should be clearly focused in 2019 on improving document flow and timeliness of signed Plans of Care, certifications, orders and other required documentation. The Conditions of Payment have not changed, but the timelines are going to get shorter and the volume of claim submissions is going to essentially double. Greater revenue cycle efficiency will be critical in 2020.

The clinical team should be focused on ways to contain costs by managing visit frequencies, using remote patient monitoring where it can help and maximizing interventions and patient time during the visits that are done. If your agency pays clinical staff members by the visit, start thinking about ways in which utilization parameters can be set and controlled to reduce costs without reducing quality.

These are only a few of the things that each agency should be considering in 2019. I'm sure there are many more. Your teams are in the best position, once they understand the framework of PDGM, to know where the strengths and weaknesses reside – and where your agency's key performance indicators will hold up or suffer. Involve everyone in the review and strategy formation process. The key point is that we must be cognizant of the magnitude of the changes that are coming, and it is critical that agencies be sufficiently prepared to meet the challenge. If your agency needs help, find it any way that you can but do not make the mistake of underestimating the time or effort that will be needed to ensure success under payment reform.

Good luck, and may the force be with you!

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