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Tip sheet

The top 5 things

every home health professional needs to know about the **2020 Home Health Final Rule** and the **Patient Driven Groupings Model (PDGM)**

by
Sharon S. Harder
President of C3 Advisors

Introduction

It's official. PDGM will take effect in 2020, and getting ready for it reminds me of getting ready for winter. In autumn, as the weather is changing, everyone knows what is in store in just a few short weeks, but mostly we try to act like the change isn't really going to happen. Then, suddenly, it does -- complete with shorter days, a blizzard or two and my perennial favorite, the polar vortex thrown in for good measure. Winter may be inevitable but that doesn't make planning for it something that most of us look forward to -- and so we procrastinate. We know it's coming. We know it's a fact that will not change. But we also tell ourselves that we have time to deal with reality later. Which brings me to the point of thinking about the changes that we know are coming with the advent of PDGM.

Three years before PDGM was introduced by CMS, I wrote a white paper for Wellsky entitled **The Decision Point: Value vs. Volume in Home Health and Hospice.** In the article, I explored how home-based care would change and what the future might hold. Here is what I wrote at the time: *"Things have changed rather dramatically over the last 20 years in post-acute care delivery, and there are at least two things that everyone can agree on. First, even more significant change is coming. Second, the home-based care models of the future will bear very little resemblance to what we've known in the past."*

Those seem like famous last words as, five years later, we find ourselves on the brink of payment reform that promises to set the industry on its ear. Like winter, PDGM is now inevitable. And, as with winter, we would prefer to ignore it even though common sense tells us we can't. So, for the many who are waking up from long naps where PDGM seemed to be only a bad dream, there is an overwhelming realization that the future has, indeed, arrived and time to prepare is slipping by quickly. Indeed it is.

PDGM will take much from us including the relative simplicity of the PPS payment formula and the financial benefit of soon-to-be-forgotten therapy payment thresholds. Even so, for agencies that can figure out how to effectively

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manage under the new set of rules, there will be much in the way of upside potential.

In fact, although PDGM is intended to be budget neutral, that doesn't mean that all agencies will fare the same. Some will see significant gains and others will witness commensurate financial decline all in the name of patient-centered, low cost care. The agencies that thrive will be those that can manage to be both efficient and effective at the same time and that can hit the ground running in January. Those that don't will be the die-hard procrastinators looking the other way as change bears down. The key question for agencies right now is which side of the great PDGM divide they will land on.

With PDGM, as with other payment reform models, success will require forethought, effort, perseverance and above all, organization. To that end, this paper addresses five basic, high level facts that agency teams must keep in the forefront of their collective thinking – and planning – as PDGM emerges to change the home health landscape for the foreseeable future.

- ***Sharon S. Harder,*** *December 2019*

1 PDGM will shift home health from a volume driven, fee-for-service payment model to a patient-centric model focused on cost, quality and care outcomes.

To be successful under PDGM, providers must shift focus as well. To illustrate the point, the following diagram shows the basic differences that will drive the industry's adjustment to PDGM.

PPS

- Volume driven
- 60-day Episodes
- 153 Case Mixes + NRS add-on with annual recalibration
- Case mix derived based on Clinical, Functional and Service factors
- Nine therapy thresholds that drive payment differentials: 0-5, 6, 7-9, 10, 11-13, 14-15, 16-17, 18-19, 20+
- Static LUPA threshold of 4 visits - 4+1 visits required for full episodic payment
- PEPs and Outliers as other forms of payment adjustment

PDGM

- Value driven
- 30-day Payment Periods
- 432 Case Mixes, NRS bundled in with annual recalibration
- Case mix and Clinical Group derived from the primary diagnosis
- Elimination of therapy thresholds, added Functional Scoring levels designed to influence service levels
- Variable LUPA thresholds – 2 and 6 visits trigger full payment
- PEPS and Outliers remain, but calculated based on 30-day periods

The underlying theory behind PDGM is simple. Rather than focusing on the volume of services provided, we must instead focus on patient characteristics that drive care decisions and influence service delivery results. It seems simple enough in theory, but while we are doing that, we must also learn the ins and outs of a complicated payment methodology with more than a mere handful of variables and moving parts.

The key deliverable for home health providers under PDGM will be better patient outcomes demonstrated by lower rates of avoidable patient hospitalizations. In other words, high quality outcomes that drive lowered Medicare costs. This represents the value proposition that is an inherent part of CMS' march toward universal payment reform. Agencies that can deliver on this premise will be in demand by inpatient providers that are transitioning ever sicker patients out of their facilities to home based care with a clear eye toward avoiding a readmission as they deal with their own versions of payment reform and value-based care initiatives.

When it comes to just about any major operational change, accomplishing an abrupt about face can be challenging even under the best of conditions. Long ingrained habits and ways of thinking usually die hard, especially it seems, in healthcare where change typically takes longer. So, for agencies that have only flirted with policy and process changes in anticipation of PDGM, now is the time to wake up and get serious. For the many more that have given thoughtful consideration to the transition, it is still likely that there is more work to be done.

As much as anything, the concept of PDGM involves adopting a new mindset and your agency's number one goal in the coming weeks will be to embed that mind-set into the fabric of the business at every level.

2 PDGM will demand greater operational efficiency starting with intake and the admission process.

There is a saying that 'timing is everything' and under PDGM that will be the case, especially at intake and the Start of Care (SOC). Quickly obtaining the complete picture of the patient in terms of health history and current skilled need has never been more central to success than it will be under PDGM. Here's why.

- **It will no longer be permissible for agencies to take a 'default' position relative to coding of the primary and secondary diagnoses based on abbreviated referral information or incomplete patient histories.**

  This is a known problem for many agencies that can no longer ignore diagnostic coding gaps as PDGM takes effect. Without valid coding, claims will not be accepted for processing. More to the point, without accurate alignment between the diagnoses on the claim and the content of the POC, the assigned clinical group could be incorrect which, in turn, could contribute to claim errors and possible over or under payment.

  As a result, more definitive patient histories to support diagnostic coding will be an absolute must for agencies to defend Clinical Group assignments and Comorbidities driving payment under PDGM. And, that documentation must be gathered upon intake to facilitate every succeeding step in the admission and care planning process.

- **Differentiating between Institutional and Community Admission Sources will be important for all new admissions.**

  Institutional Admission status, with higher rates of payment, will be assigned to patients coming from a hospital or post-acute inpatient stay in a SNF, IRF, LTCH or inpatient psychiatric unit. It will not be enough to simply assume that a patient is coming from an inpatient stay if he or she was hospitalized prior to the SOC. Similarly, not all nursing facility stays are considered inpatient encounters, so accuracy as to the type of post-acute facility stay that a patient had prior to his/her home health admission will be just as important. Inpatient stays are paid under Medicare Part A or, if paid by another payer, its equivalent. Outpatient services, even when delivered in an inpatient or residential facility, would never yield an Institutional claim designation under PDGM. The intake team will need to know this, will need to assemble documentation to support conclusions regarding PDGM admission status and inform the clinical and revenue cycle teams concerning findings for each newly referred patient. It simply will not be sufficient to wait until it's time to drop the final claim for a payment period to figure out the correct Admission Source.

  For example, some investigation as to the nature of a hospital stay will be required to differentiate between observation stays that are classified under PDGM as Community Admissions versus inpatient stays that would be classified as Institutional. Likewise, a person who has been a long-term resident of

a nursing facility receiving Medicare Part B therapy services with a recent return to his/her home would not be eligible for inclusion under the post-acute Institutional category even though there was a prior facility stay. These are small but important details that the intake team will need to be familiar with as PDGM becomes reality.

- **By 2021 there will be a five-day deadline for RAP submission that will carry a price tag if missed. This will simply accentuate the need for greater intake efficiency.**

  At the SOC, if the intake and admissions group cannot get documentation into the hands of coders and others almost immediately following a referral, the agency's potential for missing this important deadline will increase and with it the potential for payment reductions in the form of proportionate RAP submission penalties will go up.

  In fact, by 2021, all RAPs will be zero-pay submissions. But if the agency fails to submit the RAP on time, even though payment will not be made pursuant to the submission, the payment on the final claim will be proportionately reduced for every day of the period that the RAP was outstanding. After 2021 RAPs will no longer be required and will be replaced by Notices of Admission that will only be required once at the Start of Care. But that still leaves us with a new form of payment jeopardy in the second year of the program.

3 PDGM will alter the traditional approach to care planning and management of service delivery.

PDGM will also force significant change for the clinical team.

- **First and foremost, interventions in the Plan of Care must be aligned with the coding and assessment findings that will drive payment.**

  Many clinical teams will have to rethink how care plans are formulated and adapted as episodes of care progress from one payment period to the next. The requirement related to individualized, patient-specific Plans of Care is not new. Nor is the standard dictating that patients have the right to receive all interventions that are included in an applicable POC. For success under PDGM, initial Plans of Care will need to be specific and relevant to the patient's skilled needs at the time of the assessment. And, if those skilled needs change, the Plan of Care must change, too.

  For some providers, this will mean a shorter, more narrowly defined initial list of interventions that are specific to the patient and not necessarily inclusive of "everything but the kitchen sink." Adding to the benefit of more focused care planning is the fact that when the list of interventions is more tailored and succinct, the agency's clinical team will have a better opportunity to accurately predict service requirements and still be cognizant of the need to preserve payment margins on care.

- **Because each patient's overall functional deficit level will impact reimbursement, it will be important for agencies to demonstrate consistency as well as a high degree of accuracy in OASIS responses related to ADLs.**

  One of the interesting things that can be seen in CMS claims data conformed for PDGM is the way individual agencies respond to the OASIS items between M1800 and M1860. Many agencies show significant fluctuation in functional scores for the same patient, both upward and downward, from one contiguous episode to the next. Many also have a significant percentage of patients at opposite ends of the three-level functional impairment spectrum when PDGM scoring is applied. This suggests that we as an industry have achieved neither consistency nor accuracy in our overall assessment of functional ability. However, as PDGM is introduced there will be a much greater need for not just accuracy in the assessment of the patient but also consistency and alignment with the rest of the

record. For most agencies, this represents both a training need and an opportunity to fare better with higher reimbursement under PDGM when more accurate responses to OASIS functional measures become the norm rather than the exception.

- **Effective management of service delivery will be of paramount importance in 2020. Visit frequencies must be planned with an eye toward available reimbursement, cost and achievable outcomes and, once established, every effort should be made to deliver services as planned.**

  It will be important to look at visit frequencies in terms of expected clinical outcomes. Do we want to continue to front load visits? Or should we adopt a visit planning methodology that takes advantage of *some* front loading for prevention of hospitalization, followed by tapered visit frequencies to ensure that our patient remains stable and achieves his/her treatment goals upon discharge? Common sense suggests a happy medium here.

  Whatever approach the agency takes for planning visit frequencies, the patient's needs must come *first*, followed by reimbursement concerns and then only as clinically appropriate. There is no room under PDGM, just as there is no room under PPS, for medically unnecessary visits for the sheer purpose of maximizing reimbursement.

  When it comes to payment adjustments, carefully planning and fulfilling visit frequencies will be exceptionally important under PDGM to avoid unanticipated LUPAs. Many payment periods will end in the middle of a week and a missed visit early in a week that is postponed and rescheduled for later on, or worse cancelled, could drastically affect payment under PDGM's variable LUPA thresholds, some of which are as high as six visits. As a result, every effort should be taken to avoid missing needed visits and to reschedule them as quickly as possible when missing the encounter is unavoidable. Collaboration in advance with the patient and his/her caregivers concerning the schedule will be a good start for reduction of missed visits. Ensuring that clinicians are making the visits on planned days in accordance with orders will be the next order of business.

  In the end, how visits are arrayed from the first period in the episode to the next will be critical to achieving outcomes and obtaining full reimbursement under PDGM. Providers that fail to pay careful attention to this facet of care management will have hard lessons to learn in 2020 as available reimbursement is foregone due to failure to effectively manage the care plan.

- **The clinical team will need to learn how to evaluate transfers in the context of whether to discharge the patient and potentially accept a partial episode adjustment (PEP) in the first period of an episode that is offset by a readmission and new SOC with an Institutional Admission Source as the patient returns from the hospital.**

Under PPS, there is rarely a good reason to be happy about a PEP. Under PDGM that will change. When patients are transferred back to the hospital during an initial payment period of an episode and unlikely to be resumed prior to the start of the next period, discharging the patient and taking the PEP may make sense. This is because, as the patient is readmitted immediately following a hospital discharge and amid what would have been the second payment period, the new initial period of a succeeding episode would be classified as an Institutional period with a higher case mix.

Every provider should establish clear clinical policies and procedures that spell out the agency's thinking on when and how this approach to case management should be used as a means of providing structure and guidance to the clinicians who must execute the policy.

- **In recent years, most providers have not used follow-up assessments to any great degree. That could change under PDGM.**

  Follow-up assessments, sometimes referred to as SCICs or assessments for Significant Changes in Condition, are not new. In recent years they have been rare; however, under PDGM we will see an uptick in their use.

  Follow-up assessments are designed to memorialize a significant improvement or decline in a patient's condition that influences the Plan of Care. Most often, the change is an unexpected decline but under current PPS payment formulas the change has no bearing on the level of reimbursement. That could change under PDGM. The other thing that could change under PDGM is the agency's ability to change the principal diagnosis on the claim from a first payment period within an episode to the second; sometimes with a follow-up OASIS, but not necessarily always. Thus, the question becomes when and how do we use the follow-up assessment. CMS' responses to date have been less than clearly definitive.

  Here is my best advice. First, the agency should have a clearly defined clinical policy that governs when and how follow-up assessments are used. Second, if the patient's change is material and likely to generate a higher case mix for the second payment period, an assessment may be warranted if for no other reason than to fully document the reasons that contribute to the modification. If the patient's change in condition also involves a significant change in functional deficit, the follow up will always be warranted as that is the only way to influence a change in the patient's functional score under the PDGM rules.

- **As PDGM gains momentum, the content of the Plan of Care (POC) contrasted with clinical documentation in support of care plan interventions and goals will take center stage in medical reviews.**

  This is a dimension of documentation scrutiny that we've not been accustomed to in the past. But because diagnostic coding drives payment under PDGM, it will be fair game for reviewers to compare the focus of care as depicted in the POC to the focal point of care that is actually delivered and documented in the patient's record. In the event of a mismatch, claim denials could be more prevalent. Consequently, the care planning and documentation training and refinements will be important to preserve the relationship between the Plan of Care and the services that are provided.

  The coder and the assessing clinician should collaborate to ensure that the primary diagnosis identified by the coder is in sync with the primary intent of the major interventions that have been identified by the clinician. It is also important to ensure that other coded comorbid conditions are active diagnoses and pertinent to the treatment that is being ordered in the POC because those could also generate additional payment.

  Field staff members who are visiting the patient and documenting their services should be very clear on the focus of care, their visit plans and the intended progress of the patient

toward accomplishment of goals. This will be one of the most basic tenets of clinical success under PDGM.

4 PDGM will increase the revenue cycle workload and change the approach to effectively managing the claim submission process.

PDGM is an all hands on deck proposition. It ends with the revenue cycle and billing team inheriting a significant increase in work load due to the percentage of episodes that will have potentially four claim submissions, rather than two for the next couple of years. It is a fact that efficiency -- or lack of it -- during intake and care planning will distinctly affect the efficiency -- or lack of it -- in the revenue cycle. And, revenue cycle efficiency will have a direct impact on the organization's financial viability as PDGM gets started.

- **The efficiency that is achievable by the revenue cycle team will be directly dependent on the level of efficiency achieved at intake and throughout the care delivery process. Performance gaps that happen earlier in the process pipeline will have a direct impact on cash flow from patient services.**

  RAP payment percentages will drop to 20% in 2020 before they disappear altogether in 2021. For many, this portends a significant decline in cash flow that could start with the RAP payment reduction and be significantly exacerbated by end of period documentation issues that delay submission and payment of the final claim.

  We know that the average episode lasts about 45 days. Current best practice suggests the final claim should be submitted within 10 days of the episode's end but, often agencies are forced to wait for weeks before submitting the final claim due to outstanding documentation that must be in hand prior to billing.

  The cash flow effect of the RAP percentage drop will merely be the initial symptom of a much deeper and more pervasive problem for some providers.

- **In 2021, penalties will be levied for untimely submission of zero-pay RAPs as a prelude to discontinuation of RAPs altogether by 2022 when Notices of Admission will be required.**

  One thing often leads to another; in this case, the reduction of RAP payments will be followed by their elimination. But there is an added dimension to the change because in 2021, agencies will still be required to submit zero-pay RAPs and could encounter a proportionate reduction in reimbursement if and when RAPs are not submitted in the first five days of the payment period to which they apply. While the RAP submission requirements will be relaxed in 2021, they won't be removed. This means that prior to submitting the no-pay RAP, the agency must have the verbal order in hand to support care and must also have completed the first visit of the episode. Thus, assessment and care planning inefficiencies that contribute to documentation delays could have a material and irreversible effect on cash flow in the second year of PDGM.

- **CMS historical data from 2018 suggests that the smaller the agency, the higher the percentage of episodes that will require "double" billing under PDGM.**

  Based on an analysis of 2017 and 2018 claims data, we can determine that smaller agencies have higher percentages of episodes that take up both 30-day payment periods. Thus, the smaller the agency the greater the 'double' billing burden that will result from PDGM's shift to 30-day payment periods. And, by extension, the smaller the agency the greater the staffing burden and barriers to staff expansion to accommodate PDGM.

  For smaller providers, efficiency will be even more important to the billing cycle and timeliness of claim releases than for larger entities. Yet, it is generally thought that smaller agencies have been the ones most

likely to procrastinate with respect to PDGM preparation. They are also the most likely to be without sufficient cash reserves to weather payment gaps that could be caused by staff overload and additional claim submission delays.

5 PDGM will significantly change the compliance focus for all home health providers.

It is a fact that medical review hinges on the conditions of payment which have, as the body of regulation has changed, become more subjective. PDGM will introduce new dimensions of medical review which might come as a surprise for ADRs that relate to 2020 services. There are six areas to watch out for in 2020.

1. **Diagnostic coding must be supported by documentation in the record for codes that will influence payment, especially to confirm the primary diagnosis as the basis for the Clinical Group assignment.**

   Documentation that establishes the rationale for diagnostic coding will need to be retained in the patient record to ensure that if or when questions are asked about coding on the claim, the agency will be able to defend its choices.

2. **Payment review will likely be much more subjective when it comes to alignment of diagnoses that are impacting payment and documentation in the record to support them.**

   A current complaint when it comes to medical review is the subjectivity of the process especially when it comes to determination of medical necessity of services. Our prediction is that in 2020 the problem will become worse as reviewers try to match up documentation with the diagnoses in the record that determine the Clinical Group assignment and drive payment. This will be an ongoing bone of contention between agencies and outside reviewers as PDGM becomes ingrained.

3. **The agency's ability to defend its portrayal of the Admission Source using Occurrence Code 61 or 62 will be important in review, especially in those instances where the underlying claim is not found by the MAC in its initial claim review.**

   Acquiring documentation for the record to establish the basis of a claim that commemorates a hospital or post-acute discharge within 14 days of the start of the episode or payment period will be important especially in the event of a later ADR or post-payment review where, once again, the agency may be called upon to defend the basis for submitting the claim for payment with Occurrence Codes that suggest that the claim is predicated in part on a prior, qualified inpatient stay.

4. **Functional scoring – consistency and predictability will be audit triggers.**

   All agencies should review OASIS trends to ensure that functional scoring is handled in a consistent and accurate way as this, too, will influence payment and will be a focus area for auditors, especially for recertifications where ADL appear to artificially fluctuate.

5. **Beginning in 2020, agencies will be required to include the comprehensive assessment completion date, otherwise known as the M0090 date from the OASIS, on final claims together with Occurrence Code 50.**

   With more collaboration taking place among disciplines relative to patient assessments, the completion date may not be the SOC or Recertification visit date but a later day within the allowed five-day assessment window. This means that, once the initial visit is made, other disciplines needed for a full evaluation of the patient must be able to get in to see the patient within the five-day timeframe if they are to be expected to provide information that would influence the initial assessment findings. Getting the M0090 Date correct

on the assessment and on the claim will be important.

6. **Suspected LUPA avoidance will continue to be an audit trigger but the measurement will be more complicated.**

   Historically, episodes that are just over the four visit LUPA threshold have been frequent targets of medical necessity reviews. But next year, with PDGM, we will see LUPA thresholds that range from two visits to six making the internal review process a little more daunting because there will be 432 variations on the theme – one for every case mix. Nonetheless, agency teams will have to be aware and conscious of LUPA levels to ensure that documentation in the record supports ongoing medical necessity when periods are just over the LUPA thresholds.

All in all, there is much to know and learn from the 2020 Home Health Final Rule and the rulemaking documents from CMS that preceded it.

There will surely be some trial and error – not to mention some adjustments of the rules as we go along if the implementation of PPS 20 years ago is any indicator of what to expect.

So, if your agency hasn't done so already, one thing to consider is identifying your in-house PDGM expert – the person who will be able to answer questions and provide situation-specific, practical, daily guidance around decision making to maximize the effective transition from the current payment model to PDGM. If that person does not exist on your staff, find outside help because it is a certainty that you'll need it. Next, identify your agency's in-house PDGM champion – the staff member designated to monitor operational results considering PDGM requirements, identify areas in need of improvement and work with others in the organization to operationalize changes that will improve performance.

As I keep saying... **we can do it!** Good luck – and be ready to roll on January 1, 2020.

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 large post-acute healthcare providers to a major healthcare professional association. 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 healthcare marketplace. Learn more at C3Advisors.com.