The Quest for Success Under PDGM

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Panel Introductions and the “Buzz”

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Leadership under PDGM

Being an effective leader requires attention to detail, strong planning and evaluation skills, action initiation, and providing direction for your agency’s future (a little bit of everything!). Transitioning to PDGM is no different.

We would like to provide a framework for “leading” under PDGM and identified 4 leadership perspectives for the important changes your agency needs to address. We call them the 4 Leadership “A”s:

- **Assessment** - What are we seeing in the first few weeks under PDGM across the country and in your agencies?
- **Analysis** - How is this impacting/ disrupting your ‘status quo’? What is your data telling you?
- **Action** - How are you implementing change to adjust to what you’re learning from your assessment and analysis?
- **Advocacy** - What actions in the broader policy/regulatory realm are necessary to bring changes to improve sustainability, quality, innovation, etc.
Leadership under PDGM

Challenges we plan to address using the Four Leadership “A”s:

- Questionable Encounters (QE’s)
- OASIS and Diagnosis Coding
- LUPA Utilization
- KPI’s and Benchmarking
- Billing/Cash Flow
- Staffing

Reserving Time for Questions to the Panel as part of the Presentation
# Questionable Encounters

## Assessment:

- **Initial Unacceptable Diagnoses**

<table>
<thead>
<tr>
<th>Periods</th>
<th>Code</th>
<th>Description</th>
<th>Compared CY 2018 Top 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>907</td>
<td>M62.81</td>
<td>Muscle weakness (generalized)</td>
<td>1</td>
</tr>
<tr>
<td>441</td>
<td>R53.1</td>
<td>Weakness</td>
<td>6</td>
</tr>
<tr>
<td>402</td>
<td>R68.89</td>
<td>Other general symptoms and signs</td>
<td>New</td>
</tr>
<tr>
<td>223</td>
<td>R55.</td>
<td>Syncope and collapse</td>
<td>New</td>
</tr>
<tr>
<td>205</td>
<td>M54.5</td>
<td>Low back pain</td>
<td>3</td>
</tr>
<tr>
<td>203</td>
<td>R69.</td>
<td>Illness, unspecified</td>
<td>New</td>
</tr>
<tr>
<td>195</td>
<td>R26.9</td>
<td>Unspecified abnormalities of gait and mobility</td>
<td>7</td>
</tr>
<tr>
<td>174</td>
<td>R26.89</td>
<td>Other abnormalities of gait and mobility</td>
<td>2</td>
</tr>
<tr>
<td>167</td>
<td>R29.6</td>
<td>Repeated falls</td>
<td>4</td>
</tr>
<tr>
<td>156</td>
<td>Z51.89</td>
<td>Encounter for other specified aftercare</td>
<td>New</td>
</tr>
<tr>
<td>3,073</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SHP National Data Base of PDGM Unacceptable Dx’s run as of January 8, 2020
Questionable Encounters

Analysis:

- M68.2-Muscle Weakness
  - Old problem-New Education
  - Can be coded as a secondary diagnosis if not integral to the primary diagnosis
  - Congestive Heart Failure, COPD are commonly occurring co-morbidities is the muscle weakness the actual reason for care?
- R-Codes are signs and symptoms
  - R53.1-Weakness
  - R68.89-Other General Signs and Symptoms
  - R69-Illness Unspecified
  - CMS expects specific reasons for care
- Z51.89-Other Specified Aftercare
  - The Why-
Questionable Episodes

Analysis:

R26.89 Questionable Episode
- Patient is having pain
- Patient was a therapy referral
- Patient had abnormality of gait

Correct Diagnosis to C79.49
- Patient has cancer of the nervous system

C79.49
- Secondary Malignant Neoplasm of other parts of the nervous system
- MMTA-Infectious

G89.3
- Neoplasm Related Pain (acute) (chronic)
- MMTA-Other
Questionable Encounters

**Analysis:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Drug</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>M62.81</td>
<td>ATORVASTATIN ORAL</td>
<td>6047</td>
</tr>
<tr>
<td></td>
<td>FUROSEMIDE ORAL</td>
<td>5801</td>
</tr>
<tr>
<td></td>
<td>GABAPENTIN ORAL</td>
<td>5221</td>
</tr>
<tr>
<td></td>
<td>HYDROCODONE-ACETAMINOPHEN ORAL</td>
<td>4362</td>
</tr>
<tr>
<td></td>
<td>LEVOTHYROXINE ORAL</td>
<td>4159</td>
</tr>
<tr>
<td></td>
<td>ASPIRIN ORAL</td>
<td>4038</td>
</tr>
<tr>
<td></td>
<td>POTASSIUM CHLORIDE ORAL</td>
<td>4025</td>
</tr>
<tr>
<td></td>
<td>AMLODIPINE ORAL</td>
<td>3868</td>
</tr>
<tr>
<td></td>
<td>LISINOPRIL ORAL</td>
<td>3787</td>
</tr>
<tr>
<td></td>
<td>OMEPRAZOLE ORAL</td>
<td>3428</td>
</tr>
</tbody>
</table>
Questionable Encounters

**Action:**
- Education
  - Purist Coders vs Extremist Coders
    - Purist
      - Appropriate and Payable
    - Extremist
      - Not on a list; it’s not coded
      - Superficial Rules
- Workflow
  - Pre-assessment Coding
  - Intake

**Advocacy:**
- Payment model updated based on statistical analysis each year.
- Collect the data and clinical rationales
- NAHC: PDGM Diagnosis Workgroup
OASIS and Diagnosis Coding

**Assessment:**
- Timeliness
  - 5 day window for assessment
  - RAP Turn Around
- Completeness
  - Corrections to a minimum
  - Inconsistency in clinical record

**Analysis:**
- Timeliness
  - Turnaround Time
  - Commonalities-specific disciplines
- Completeness
  - Clinical Understanding of the OASIS
  - Inconsistency and Congruency
OASIS and Diagnosis Coding

**Action:**
- Case Conference
  - When
  - What
  - Why
- Clinician Education
  - Always Ongoing
  - Evaluate Understanding
  - Ride Along

**Advocacy:**
- OASIS Quality Measure and Maintenance Project
- OASIS E-Most Significant and Expansive Change in 20 Year History
LUPA Utilization

Assessment:

It is a little early to get a read on LUPA rates. A couple of perspectives can be made looking at data from prior periods.

<table>
<thead>
<tr>
<th>Clinical Group</th>
<th>All</th>
<th>Period 1</th>
<th>Period 2</th>
<th>Period 3</th>
<th>Period 4</th>
<th>Period 5+</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMTA - Other</td>
<td>7.8%</td>
<td>9.2%</td>
<td>12.0%</td>
<td>3.1%</td>
<td>7.8%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Neuro Rehab</td>
<td>7.6%</td>
<td>8.5%</td>
<td>10.0%</td>
<td>2.4%</td>
<td>7.1%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Wounds</td>
<td>8.3%</td>
<td>8.4%</td>
<td>14.3%</td>
<td>4.8%</td>
<td>10.2%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Complex Nursing</td>
<td>20.0%</td>
<td>9.5%</td>
<td>14.1%</td>
<td>18.1%</td>
<td>14.6%</td>
<td>23.1%</td>
</tr>
<tr>
<td>MS Rehab</td>
<td>9.3%</td>
<td>9.7%</td>
<td>12.2%</td>
<td>2.2%</td>
<td>7.8%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>7.8%</td>
<td>8.5%</td>
<td>10.2%</td>
<td>3.8%</td>
<td>7.4%</td>
<td>7.1%</td>
</tr>
<tr>
<td>MMTA - Surgical Aftercare</td>
<td>11.2%</td>
<td>9.3%</td>
<td>17.5%</td>
<td>3.6%</td>
<td>9.8%</td>
<td>4.1%</td>
</tr>
<tr>
<td>MMTA - Cardiac</td>
<td>7.4%</td>
<td>8.1%</td>
<td>11.9%</td>
<td>3.3%</td>
<td>7.8%</td>
<td>3.7%</td>
</tr>
<tr>
<td>MMTA - Endocrine</td>
<td>7.0%</td>
<td>8.0%</td>
<td>12.1%</td>
<td>3.2%</td>
<td>7.3%</td>
<td>3.8%</td>
</tr>
<tr>
<td>MMTA - GI/GU</td>
<td>9.9%</td>
<td>9.3%</td>
<td>12.8%</td>
<td>5.6%</td>
<td>8.9%</td>
<td>9.3%</td>
</tr>
<tr>
<td>MMTA - Infectious</td>
<td>10.8%</td>
<td>8.1%</td>
<td>12.4%</td>
<td>6.1%</td>
<td>8.9%</td>
<td>16.0%</td>
</tr>
<tr>
<td>MMTA - Respiratory</td>
<td>7.8%</td>
<td>8.0%</td>
<td>11.8%</td>
<td>3.0%</td>
<td>7.4%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Overall Average</td>
<td>8.9%</td>
<td>8.8%</td>
<td>12.4%</td>
<td>3.9%</td>
<td>8.3%</td>
<td>7.3%</td>
</tr>
</tbody>
</table>

Source: SHP National Data Base CY 17,18; CY2019 Final Rule
LUPA Utilization

Assessment:

Top Ten by PDGM HHRG and by Period Sequence

<table>
<thead>
<tr>
<th>Period 1</th>
<th>Clinical Group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1FB3</td>
<td>Behavioral Health</td>
<td>17.1%</td>
</tr>
<tr>
<td>1DA1</td>
<td>Complex Nursing</td>
<td>15.5%</td>
</tr>
<tr>
<td>3DA2</td>
<td>Complex Nursing</td>
<td>14.7%</td>
</tr>
<tr>
<td>1DB2</td>
<td>Complex Nursing</td>
<td>14.4%</td>
</tr>
<tr>
<td>1DC1</td>
<td>Complex Nursing</td>
<td>14.4%</td>
</tr>
<tr>
<td>1DA2</td>
<td>Complex Nursing</td>
<td>14.4%</td>
</tr>
<tr>
<td>1DEB1</td>
<td>Complex Nursing</td>
<td>14.0%</td>
</tr>
<tr>
<td>2AB3</td>
<td>MMTA-Other</td>
<td>12.2%</td>
</tr>
<tr>
<td>4AB3</td>
<td>MMTA-Other</td>
<td>12.2%</td>
</tr>
<tr>
<td>2IB3</td>
<td>MMTA-Endocrine</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Period 2</th>
<th>Clinical Group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>4EA1</td>
<td>MS Rehab</td>
<td>50.8%</td>
</tr>
<tr>
<td>4FB3</td>
<td>Behavioral Health</td>
<td>50.0%</td>
</tr>
<tr>
<td>4GB2</td>
<td>MMTA-Surg Aftercare</td>
<td>45.9%</td>
</tr>
<tr>
<td>4EB1</td>
<td>MS Rehab</td>
<td>45.0%</td>
</tr>
<tr>
<td>4GA1</td>
<td>MMTA-Surg Aftercare</td>
<td>44.6%</td>
</tr>
<tr>
<td>4GC1</td>
<td>MMTA-Surg Aftercare</td>
<td>41.6%</td>
</tr>
<tr>
<td>4IA1</td>
<td>MMTA-Endocrine</td>
<td>40.6%</td>
</tr>
<tr>
<td>4BA2</td>
<td>Neuro Rehab</td>
<td>40.4%</td>
</tr>
<tr>
<td>4BA3</td>
<td>Neuro Rehab</td>
<td>40.2%</td>
</tr>
<tr>
<td>4GB1</td>
<td>MMTA-Surg Aftercare</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Period 3</th>
<th>Clinical Group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>4DC3</td>
<td>Complex Nursing</td>
<td>26.7%</td>
</tr>
<tr>
<td>4DB3</td>
<td>Complex Nursing</td>
<td>25.0%</td>
</tr>
<tr>
<td>4BB3</td>
<td>Neuro Rehab</td>
<td>25.0%</td>
</tr>
<tr>
<td>3DA2</td>
<td>Complex Nursing</td>
<td>23.0%</td>
</tr>
<tr>
<td>3DC1</td>
<td>Complex Nursing</td>
<td>22.0%</td>
</tr>
<tr>
<td>3DB2</td>
<td>Complex Nursing</td>
<td>21.6%</td>
</tr>
<tr>
<td>3DC2</td>
<td>Complex Nursing</td>
<td>20.8%</td>
</tr>
<tr>
<td>4IB3</td>
<td>MMTA-Endocrine</td>
<td>19.2%</td>
</tr>
<tr>
<td>3DB1</td>
<td>Complex Nursing</td>
<td>19.0%</td>
</tr>
<tr>
<td>3DA1</td>
<td>Complex Nursing</td>
<td>18.4%</td>
</tr>
</tbody>
</table>

Source: SHP National Data Base - Preview Report (CY19); CY2020 Final Rule
LUPA Utilization

Analysis:
- In many cases the LUPA rates are lower than it had been under PPS on average. Review where your rates may be higher than the benchmarks. Keep in mind the $ impact depends on the case-mix adjusted PDGM rate and the LUPA rate. Comparing one visit less than the threshold can be a swing of $800 – $2,500. First period financial impacts will be higher.

Action:
- Randomly review about 25 episodes with LUPAs monthly for next 2 months
- Root cause analysis – review cases that may have been preventable
  - Does patient’s clinical picture match visit utilization provided?
  - Was LUPA a result of missed visits, staffing issues, not homebound, patient refusal?
  - Did patient require more visits to meet goals/improve outcomes?
- Build workflows around these inappropriate LUPA cases – i.e. late institution, 2nd period, surgical aftercare. Track patients in high rate, high volume periods prior to starting the subsequent 30-day period (24th – 27th day).
LUPA Utilization

Advocacy:

- In the CY 20 Final Rule, CMS noted an expected LUPA rate of 7.1% with a behavioral adjustment of 1.88% of revenue. Represents ~$35.87 per 30-day payment.

- Need to track this closely – CMS calculated that 1/3rd of LUPA 1-2 visits from threshold will get extra visits.

- Using National Rates and 2.5 as a LUPA visit average, the rate would need to drop to 4.6% to approximate the behavior change CMS is predicting. With the CY 20 rule where the behavioral adjustment was cut in half, the rate would be 5.9% for CY 2020.
KPI’s and Benchmarking

Assessment:
PDGM introduced new payment components and 30-day periods
But…OASIS assessments did not change
New PDGM terminology requires a facelift to your KPIs and Dashboards
Early metrics to consider:
   Claims and $ at MAC in queue to be paid
   Days to RAP and Final by early/late periods
   “Unacceptable” primary Dx’s
   Cash Days on Hand

Metrics that cross the fiscal year may not be easily blended i.e. Case-mix weight
Consider size and scope of your operations
Track and trend against expectations (budget)
Identify and report on metrics that addresses the priorities of your organization

“Measure only what you’re going to manage; manage only what matters”
KPI’s and Benchmarking

Analysis:
Compare to national and state benchmarks for variances:

- Payment Periods by:
  - Clinical Group
  - Early/Late
  - Community/Institution
  - Functional Impairment level
  - Comorbidity Adjustment
- LUPA Rates by Clinical Group
- LUPA Rates by Periods and Stays
- Length of Stay and Periods
- Periods per Stay
- Case-mix weight by Period and Stay
- Single period stays
- Functional Impairment Scoring

- Visits per Period Sequence
- Visits by Discipline per Stay
- Therapy visit ratios
- Visit Intensity (Front loading/Per week)
- Efficiency Metrics (Best Practice)
- Period and Stay costs/margin
- Outcomes by Clinical Group
- Revenue by:
  - PDGM HHRG
  - Period Sequence
  - Stay (Episode of Care)
  - LUPA/PEP/Outlier
- Diagnoses per patient and Δ RAP to Final
KPI’s and Benchmarking

**Action:**
- Update or create reporting based on the right level of detail for your audience – Board, Execs, Directors, Staff.
- Identify unexpected variances or trends heading in the wrong direction. Plan for midcourse corrections where necessary.
- Update your Forecasts with up-to-date information. Will help to inform next year’s budget process.

**Advocacy:**
- Support NAHC on real-time tracking in responding the behavioral adjustments. Share your data as appropriate.
- Respond with comments to the CY 2021 Proposed Rule on Behavioral Adjustments
Billing/Cash Flow

**Assessment:**

- Billing (general)
  - Some initial issues with:
    - iQIES
    - Some clearinghouses
    - Some EMRs

- Medicare
  - Confirmed that RAPs and claims have successfully been billed
  - RAP payments have been issued
  - Final claim payments going to holding status

- Medicare Advantage
  - Some payors having issues with claim submissions
  - Lack of clarity regarding PDGM approach
Billing/Cash Flow

Analysis:

- Cash Flow – how are you/will you be impacted?
- Variables
  - Days to RAP
  - Days to Final Claim
  - Cash Mix Change
  - Volume (census/periods per patient)
- Building a model
  - Assumptions
    - RAPs pay 7 days after submission
    - Final Claims pay 14 days after submission
    - Daily billing of RAPs and Finals
  - Need to determine variables listed above
Billing/Cash Flow

**Analysis:**
- Cash Flow example – $5,000,000 annual Medicare revenue

### Days to RAP – 7 days

### Days to FC – 14 days

### Case Mix Impact - Unchanged

### Periods Per Patient – 1.7

<table>
<thead>
<tr>
<th></th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>2020 Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW Monthly Cash</td>
<td>$416,667</td>
<td>$324,137</td>
<td>$262,027</td>
<td>$465,246</td>
<td>$405,090</td>
<td>$418,593</td>
<td>$405,090</td>
<td>$4,764,733</td>
</tr>
<tr>
<td>Monthly Cash Difference from 2019</td>
<td>$(92,529)</td>
<td>$(154,640)</td>
<td>$48,579</td>
<td>$(11,577)</td>
<td>$1,926</td>
<td>$(11,577)</td>
<td>$(235,267)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-22%</td>
<td>-37%</td>
<td>12%</td>
<td>-3%</td>
<td>0%</td>
<td>-3%</td>
<td>-4.7%</td>
<td></td>
</tr>
<tr>
<td>Average Daily Cash</td>
<td>$13,441</td>
<td>$10,456</td>
<td>$9,035</td>
<td>$15,008</td>
<td>$13,503</td>
<td>$13,503</td>
<td>$13,503</td>
<td>$13,053</td>
</tr>
</tbody>
</table>
Billing/Cash Flow

**Action:**
- Maintain a cash flow budget
- Manage unbilled
- Closely monitor MA billing
- Focus on non-traditional Medicare A/R

**Advocacy:**
- Push Medicare Advantage payors for PDGM payment
- Push non-Medicare for better rates
- Telehealth reimbursement
- Value based reimbursement
- Notice of Admission penalty
Staffing

**Assessment:**
- Therapy – not the same reaction as PDPM

**Analysis:**
- Therapy
  - Adjustments to therapy staffing model
  - PTAs/COTAs?
  - Per diem vs. full-time
- Revenue Cycle
  - Intake
  - Document Management
  - QA
  - Billing
- Clinical Staffing
  - Management
  - Home health aides
Staffing

**Action:**
- Determine if staffing needs to be updated based on early results of PDGM
  - Potential “warning signs”
    - Increase in:
      - Days to RAP
      - Days to Final Claim
      - LUPA Percentage
      - Missed Visits
    - Decrease in Census
- For the changes you did make, analyze the results

**Advocacy:**
- What direct or indirect effect on staffing occur at your agency that CMS didn’t consider? Share this information to promote advocacy efforts
Questions?
Thank You!

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