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Strengthen your revenue health

Patient-Driven Groupings Model (PDGM): Ready, Set, Go!

Melinda A. Gaboury, COS-C

pdgmimpact.com

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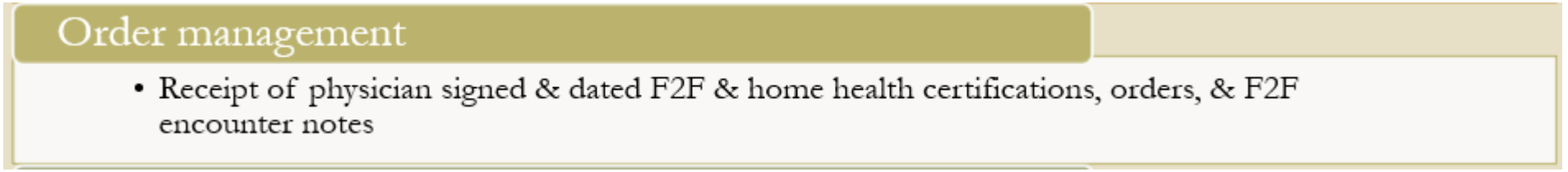
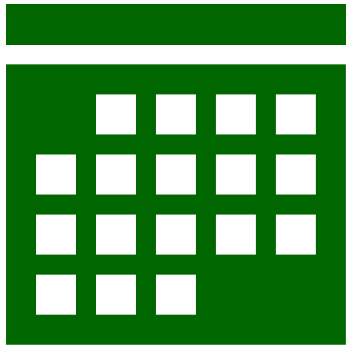
Orders Management



- Timely signed orders will be critical to cash flow
- Order management must be treated with urgency, as if it were a new thing and we are forced to make it happen
- Assign someone the specific task in their job description and ensure that timelines established for follow-up and resending of orders is followed.
- Use the tools you have to the fullest – MOST EMRs have a physician order tracking mechanism that many don't realized exists

Orders Management

- Not all physicians are the same…understand what each requires in order to get orders back timely.
- Know who is responsible in each office and hold them accountable
- Example timeline:
  - Day 7 ⇨ resend orders
  - Day 12 ⇨ call to physician office
  - Day 15 ⇨ escalate to clinical or manager
  - Day 20 ⇨ liaison visit to office



Billing/Collections

- RAP beginning of every 30 day payment period
- Final end of every 30 day payment period
- Remittance Advise Issued – Cash Posting Occurs
- Reconciliation between what you are paid and what EMR calculated that you would get paid

Request for Anticipated Payment (RAP)

- Required for each 30-day payment period
  - **Proposed 07/2019 & now FINAL to be Paid at 20% INSTEAD of**
    - ~~Paid 60/40 split payment for SOC periods~~
    - ~~Paid 50/50 split payment for all other periods~~
  - No payment for HHAs Medicare certified in 2019 or thereafter
    - 2019 certified HHAs required to submit "no-pay" RAPs
- RAPs to potentially be phased out – RAPs with NO PAY for all in 2021
  - RAPs PROPOSED July 2019 to be replaced by a Notice of Admission effective January 1, ~~2021~~ 2022

Request for Anticipated Payment (RAP)

- Prior to billing the 1st 30-day RAP – first billable visit must be completed, OASIS locked and POC completed and sent to physician.
- 2nd 30-day RAP – first billable visit must be completed. (POC is already done & OASIS unless there is an Other Follow-up or Resumption to use.)
- The percentage payment for the RAP is based on the HIPPS code **as submitted**. Upon receipt of the corresponding claim, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems.
- Subject to auto-cancellation & payment recoupment by MAC when corresponding claim is not successfully received timely
  - 60 days from end date of 30-day payment period, or
  - 60 days from date RAP is paid, whichever date is greater
- Must be in "paid" status before final claim can be billed & paid

Final Claims

- Required for each 30-day payment period
  - No sequential billing (being tested for future implementation)
    - Required to have corresponding RAP in “paid” status
  - Paid full claim amount - Less recoupment of RAP payment (80%)
    - Subject to payment pricing & adjustments, *if applicable*

Final Claims

Billing Requirements

- All payment periods
  - OASIS assessment(s) transmitted to & accepted at ASAP
    - SOC, recertification, ROC or other follow-up, *if applicable*
  - Compliant F2F encounter documentation obtained
  - All physician orders signed & dated
    - POC & all other interim orders applicable to payment period
  - All billable visit & NRS documentation completed
  - Compliant therapy reassessment documentation completed

Some data required on a PPS Final claims will be tweaked for PDGM:

- 18-digit Treatment Authorization Code/OASIS Matching Key will **NO Longer exist** under PDGM
- **Occurrence Code 50** will be entered on the Final claims with the Occurrence Date equal to the date the assessment is completed from M0090 of the OASIS that your system used to create the HIPPS
- **Occurrence Codes 61 & 62** will be utilized on 1st (initial) 30-day payment period Finals to signify that the patient is an Institutional patient status:
  - **Occurrence Code 61** – with the date of the ACUTE HOSPITAL discharge date that was within 14 days prior to the HHA start date
  - **Occurrence Code 62** – with the date of the SNF, IRF, LTCH or IPF discharge date that was within 14 days prior to the HHA start date

Final Claims

- **Occurrence Code 61** will be used on 2nd 30-day payment period Finals to signify that the patient is an Institutional patient status:
  - **Occurrence Code 61** – with the date of the ACUTE HOSPITAL discharge date that was within 14 days prior to the HHA begin date of the current 30-day period

Examples:

- Patient admitted to home health on 02/01/20. Patient discharged from Acute Hospital on 01/31/20. Patient readmitted to the Acute Hospital on 02/20/20, discharged home on 2/27/20 and was resumed to home health on 02/28/20.
  - 1st 30-day Final - - Occurrence Code 61 - - Occurrence Date 01/31/20
  - 2nd 30-day Final - - Occurrence Code 61 - - Occurrence Date 02/27/20

Final Claims

Examples:

- Patient admitted to home health on 02/01/20. Patient discharged from Acute Hospital on 01/31/20. Patient readmitted to SNF on 02/20/20 and was discharged 02/27/20 and returned to home health on 02/28/20.
    - 1st 30-day Final - - Occurrence Code 61 - - Occurrence Date 01/31/20
    - 2nd 30-day Final - - there is NOT one as patient would be discharged from home health when admitted to a SNF
    - 1st 30-day Final UPON READMISSION TO HOME HEALTH - - Occurrence Code 62 - - Occurrence Date 02/27/20

If more than one inpatient discharge occurs during the 14 day period, the HHA reports only the most recent discharge date. Claims reporting more than one of any combination of occurrence codes 61 and 62 will be returned to the provider (RTP) for correction.

Payment Pricing

Claim payments subject to pricing

- OASIS Validation is the first step – the Claim will RTP if the OASIS data and the claim do not match.
- Payment period timing
  - Claim payments to be automatically repriced for early or late status based on paid claims history on Medicare CWF (Start of Care ONLY)
- Admission source
    - **Occurrence codes 61 & 62** will now be used to trigger payment calculation for Institutional vs. Community. Claims data will be utilized to reconcile periodically with the Institutional credit given.

Payment Pricing

Claim payments subject to pricing

- Clinical Grouping & Comorbidities
  - The primary & all secondary diagnoses are taken from the CLAIM to determine the Clinical Grouping and Comorbidity level.
- Functional Scores
  - OASIS Responses will be extracted from the OASIS-D1 and used to calculate the HIPPS code

- The final HIPPS code calculated by the Medicare MAC is the one that your final claim payment will be based on regardless of the HIPPS code that you sent in on the claim.

RAP #1

- Patient admitted to HH 1/2/20 with expected payment for period of $1,800
- RAP for payment period 1/2/20 billed on 1/10/20
- Expected payment for period 2/1/20 is $1,500 & RAP billed on 2/5/20

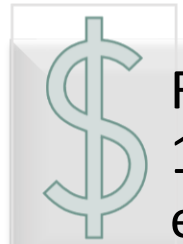
RAPs pay 20% of expected payment period amount based on ***proposed*** rule

RAP for payment period 1/2/20 paid $360 approx. 1/20/20

RAP for payment period 1/31/20 paid $300 approx. 2/14/20

RAP #2

- HH became Medicare certified 6/2/2019
- Patient admitted to HH 11/17/19
- Patient discharged 2/20/20



RAP for PPS episode 11/17/19 pays 60% of expected episode amount

RAP for PDGM payment period 1/16/20 pays $0

RAP for PDGM payment period 2/15/20 pays $0

CLAIMS

- Patient admitted to HH 1/1/20 with expected payment for period of $1,800
- Payment period 1/1/20 ended 1/30/20 & claim billed on 2/10/20
- Payment period 1/31/20 ended 2/29/20 with expected payment of $1,500 & claim billed on 3/10/20

Claims pay final amount after any adjustments, less amount paid on RAP

Claim for payment period 1/01/20 paid $1,440 approx. 2/26/20

Claim for payment period 1/31/20 paid $1,200 approx. 3/26/20

Payment Adjustments

Partial Episode Payment Adjustment (PEP)

- Applies to three intervening events occurring during a 30-day payment period: Beneficiary elected transfer to another agency - Discharge from your agency & subsequent readmission to your agency or another HH - Change from traditional Medicare to Medicare Advantage plan
- Claim payment prorated based on first & last billable visit dates during 30-day payment period

Outliers

- Applies to high cost 30-day payment periods based on time spent in home during visits – units reported on the claim
- Calculation unchanged from PPS except that the FDL ratio will be 0.63 - applied to 30-day period

Partial Episode Payment Adjustment (PEP)

Patient is admitted to the home health agency on 1/15/20, having no home health episodes in previous 6 months. The patient was discharged from an Acute Hospital from an official admission on 1/13/20. The patient is admitted with a primary focus of care of Hypertensive Heart Disease with Heart Failure and comorbidities of an allowable Dementia and a Stage 2 pressure ulcer. The OASIS responses reflect a Medium functional status.

First 30-day Payment Period

- Timing – Early
- Admission Source – Institutional
- Clinical Grouping – MMTA - Cardiac
- Functional Status - Medium
- Comorbidity – High
- HIPPS code – 2HB31 – ~~1.4976~~ 1.4453
- **$2,563.07**

Second 30-day Payment Period

- Timing – Late
- Admission Source – Community
- Clinical Grouping – MMTA - Cardiac
- Functional Status - Medium
- Comorbidity – High
- HIPPS code – 3HB31 – 0~~.9109~~ 0.8592
- **$1,523.69**

Partial Episode Payment Adjustment (PEP)

- 2nd 30-days the patient has had no changes in condition in the first 30-days and goes to another home health on day 45 of the current episode. The agency provided the first billable visit at on day 32 and last visit prior to transfer was day 44. The agency will receive the following payments:
  - **1st 30-days - - $2,563.07**
  - **2nd 30-days - - $1,523.69 – divided by 30 = $50.79 per day**
    - **13 days of treatment – days 32-44**
    - **$50.79 x 13 = $660.27**

Notice of Admission

- RAPs PROPOSED July 2019 to be replaced by a Notice of Admission (NOA) effective ~~**January 1, 2021**~~ **2022**
  - NOA would be filed upon admission of the patient to home health…it must be filed and ACCEPTED at the MAC within 5 days of the SOC date.
  - If it is not accepted within 5 days the agency will be penalized for every day up until it is accepted at the MAC
    - Estimated HIPPS amount divided by 30 for a daily amount and the daily amount multiplied by the number of allowable days based on the accepted date.

LUPA Thresholds

Variable thresholds based on Case Mix Grouping

- Different level for each of the 432 Case Mix Groupings – ranges between 2 - 6 visits.
- Based on 30 day payment periods – NOT 60 day episodes
- Utilize 10th percentile value of visits for each threshold
- LUPA reimbursement is per visit (as prior PPS)

LUPA add-on

- Applies only to SOC 30-day payment periods with total visits at or below LUPA visit threshold

Case Mix Weights - LUPA

1FC11	Behavioral Health – High	Early - Community	0	4	1.1798
1FC21	Behavioral Health – High	Early - Community	1	4	1.2305
1FC31	Behavioral Health – High	Early - Community	2	4	1.3271
2FC11	Behavioral Health – High	Early - Institutional	0	4	1.3599
2FC21	Behavioral Health – High	Early - Institutional	1	4	1.4106
2FC31	Behavioral Health – High	Early - Institutional	2	4	1.5072
3FC11	Behavioral Health – High	Late - Community	0	2	0.7737
3FC21	Behavioral Health – High	Late - Community	1	2	0.8244
3FC31	Behavioral Health – High	Late - Community	2	3	0.9211
4FC11	Behavioral Health – High	Late - Institutional	0	3	1.2212
4FC21	Behavioral Health - High	Late - Institutional	1	3	1.2719
4FC31	Behavioral Health - High	Late - Institutional	2	3	1.3685
1FA11	Behavioral Health - Low	Early - Community	0	3	0.9284
1FA21	Behavioral Health - Low	Early - Community	1	4	0.9791
1FA31	Behavioral Health - Low	Early - Community	2	3	1.0757

LUPA Rates – Final Rule 2020

TABLE 25: CY 2020 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2019 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2020 HH Payment Update	CY 2020 Per-Visit Payment
Home Health Aide	$66.34	X 1.0066	X 1.015	$ 67.78
Medical Social Services	$234.82	X 1.0066	X 1.015	$239.92
Occupational Therapy	$161.24	X 1.0066	X 1.015	$164.74
Physical Therapy	$160.14	X 1.0066	X 1.015	$163.61
Skilled Nursing	$146.50	X 1.0066	X 1.015	$149.68
Speech-Language Pathology	$174.06	X 1.0066	X 1.015	$177.84

Financial Impact - Rates

- FINAL RULE Base Rate for 2020 - $1,864.03
  - While this rate is higher than the original proposed amount it is less 4.36% Due to Behavioral Adjustment

TABLE 23: CY 2020 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2019 30-day Budget Neutral (BN) Standard Amount	Wage Index Budget Neutrality Factor	CY 2020 HH Payment Update	CY 2020 National, Standardized 30-Day Period Payment
$1,824.99	X 1.0063	X 1.015	$1,864.03

Rural Add-On – Final Rule 2020

TABLE 27: HH PPS RURAL ADD-ON PERCENTAGES, CYs 2020-2022

Category	CY 2020	CY 2021	CY 2022
High utilization	0.5%	None	None
Low population density	3.0%	2.0%	1.0%
All other	2.0%	1.0%	None

Cash Flow

Current PPS Episode – SOC - $4,000

RAP billed around Day 10 - $2,400

Final billed around Day 75 and by day 90 - $1,600

By Day 90 total of $4,000

PDGM 30-day Payment Periods - $2,000 each

RAP billed around Day 10 - $400

RAP for 2nd 30-day Day 35 - $400

Final billed around Day 45 and by day 60 - $1,600

Final billed around Day 75 and by day 90 - $1,600

Don’t let PDGM Slow You Down

eSolutions has PDGM covered:

- Advanced Medicare eligibility verification
- OASIS submission and tracking
- Special reporting and real-time Medicare claim insights
- Tracking of episodes, RAPs, RTPs, and HIPPS code changes
- Automated Medicare revenue cycle from start to finish

Thank You for Attending!

Melinda A. Gaboury, COS-C

Chief Executive Officer

Healthcare Provider Solutions, Inc.

pdgmimpact.com

info@healthcareprovidersolutions.com

615-399-7499

Contact Information

Follow us!

eSolutions

866.633.4726

info@esolutionsinc.com

8215 W. 108th Terrace
Overland Park, KS 66210