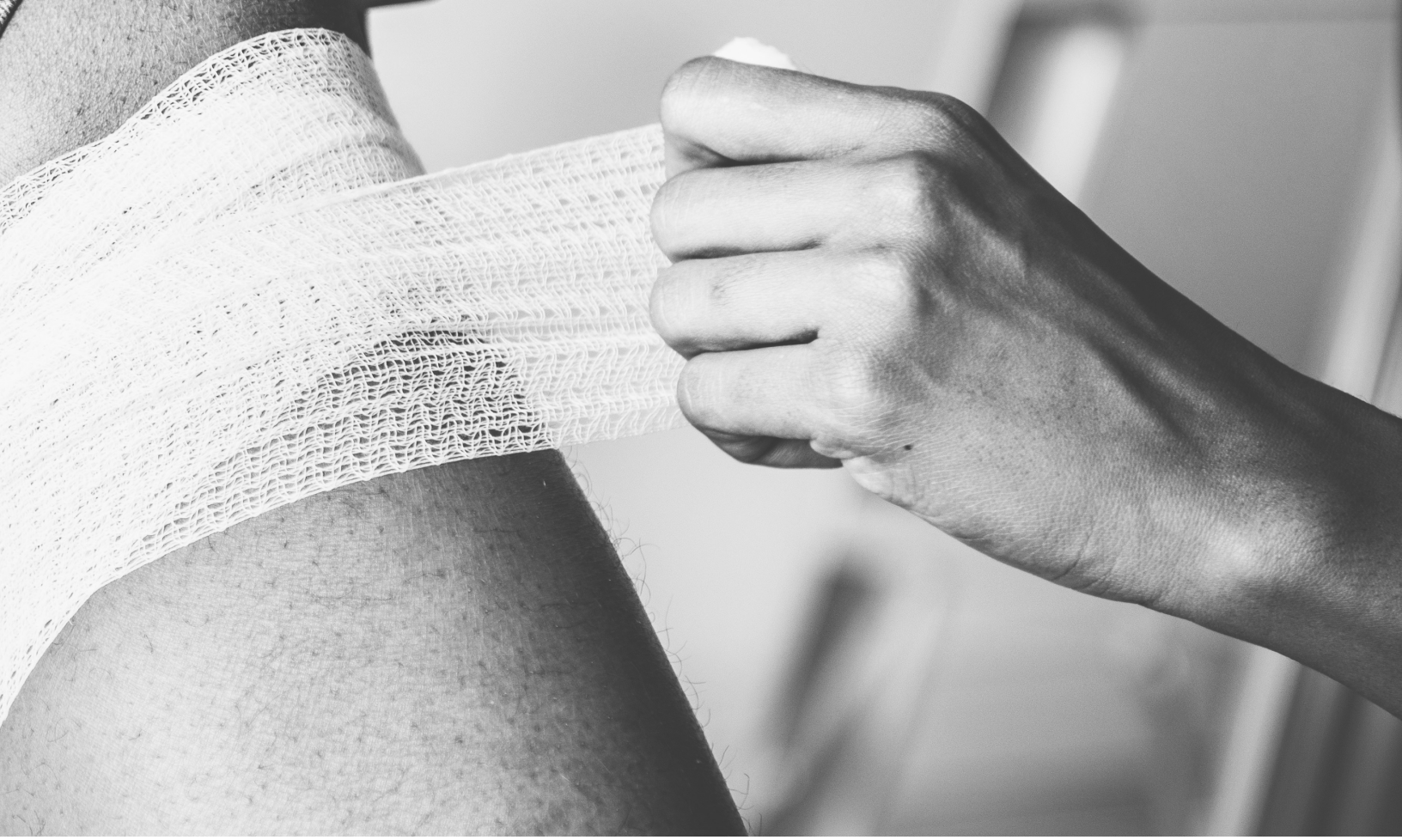

PDGM: IMPACT ON WOUND CARE

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Executive Summary

As in the acute side of healthcare, CMS continues to disincentivize volume and incentivize value. Ultimately, the desire for CMS is to reduce the cost of healthcare and homecare delivery. Other incentives included the improvement of the payment accuracy for HH services, the promotion of fair compensation to HHAs and most importantly to increase the quality of care for beneficiaries.

PDGM is the most significant change to Medicare's payment methodology for home health services since the implementation of the Home Health Prospective Payment System (PPS) almost twenty years ago.

Preliminary projections indicate that PDGM will result in some providers having a positive result from the new payment model while others will experience a negative result. Every provider, regardless of how they are projected to perform, will be required to adapt to the multitude of new competencies, workflows and payment regulations.

Home health agencies have been through significant change before and those required by PDGM, while intense, can be accomplished with positive results with the appropriate planning.

The change from 60 day to 30 day payment periods (50% of respondents), the elimination of therapy thresholds (17% of respondents) and education of staff and management (8% of respondents) are agencies' top concerns about PDGM, according to a recent 161 respondent survey conducted by SUNY Oswego.

The evolution to PDGM will be easier for those with a clear roadmap for the next year and, a commitment to leading the change with inspiration alongside a team of committed change leaders.

Wound care as part of PDGM provides a real opportunity for success. Both for patients, through improved quality of care, and also for providers regarding financial neutrality - both key CMS desires.

Introduction

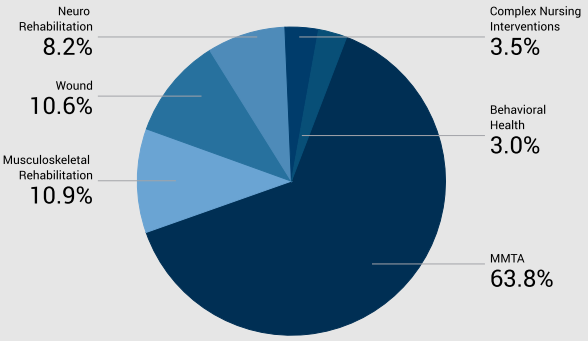
To comply with the requirements outlined in the Bipartisan Budget Act of 2018, the Centers for Medicare and Medicaid Services (CMS) has finalised a new payment model for home health services under Medicare Part A. Required by the Act, The Patient-Driven Groupings Model (PGDM) was developed to improve reimbursement for all types of patients eligible for home health benefits and remove perceived incentives to over-provide therapy services. PDGM will be implemented on January 1, 2020, and is designed to address the following:

- Better align payment with patient needs
- Increase access to home health care for vulnerable patients associated with lower margins
- Address payment incentives in current system, i.e. impact of therapy volume on payment
- Allow patient characteristics to better determine payment

PDGM is essentially a revision of the Home Health Groupings Model (HHGM) proposed by CMS in 2017. The main difference between the two, is that PDGM is designed to be implemented in a budget-neutral manner, whereas HHGM included significant cuts to the home health industry.

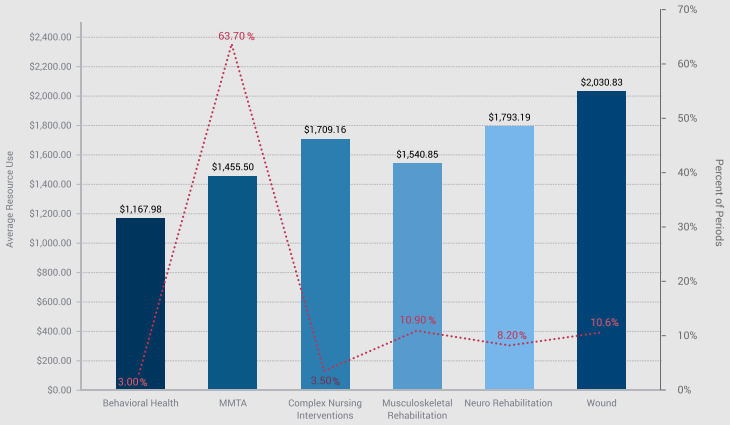
Recent CMS data (Figures 1 and 2) have shown that wound care is one of the most frequent clinical groupings and the one utilizing the most resource.

Figure 1 - Percentage of Periods by Clinical Group



N = 9,311,627

Figure 2 - Average Resource Use By Clinical Group



In the information to follow, we will provide detailed information about the key components of PDGM and demonstrate how they will impact the delivery of care, with an emphasis on the management of persons with wounds.

Wound care is a significant clinical group (10.6%) within home care and has the highest associated reimbursement ($2,090.83)

The Impact of PDGM

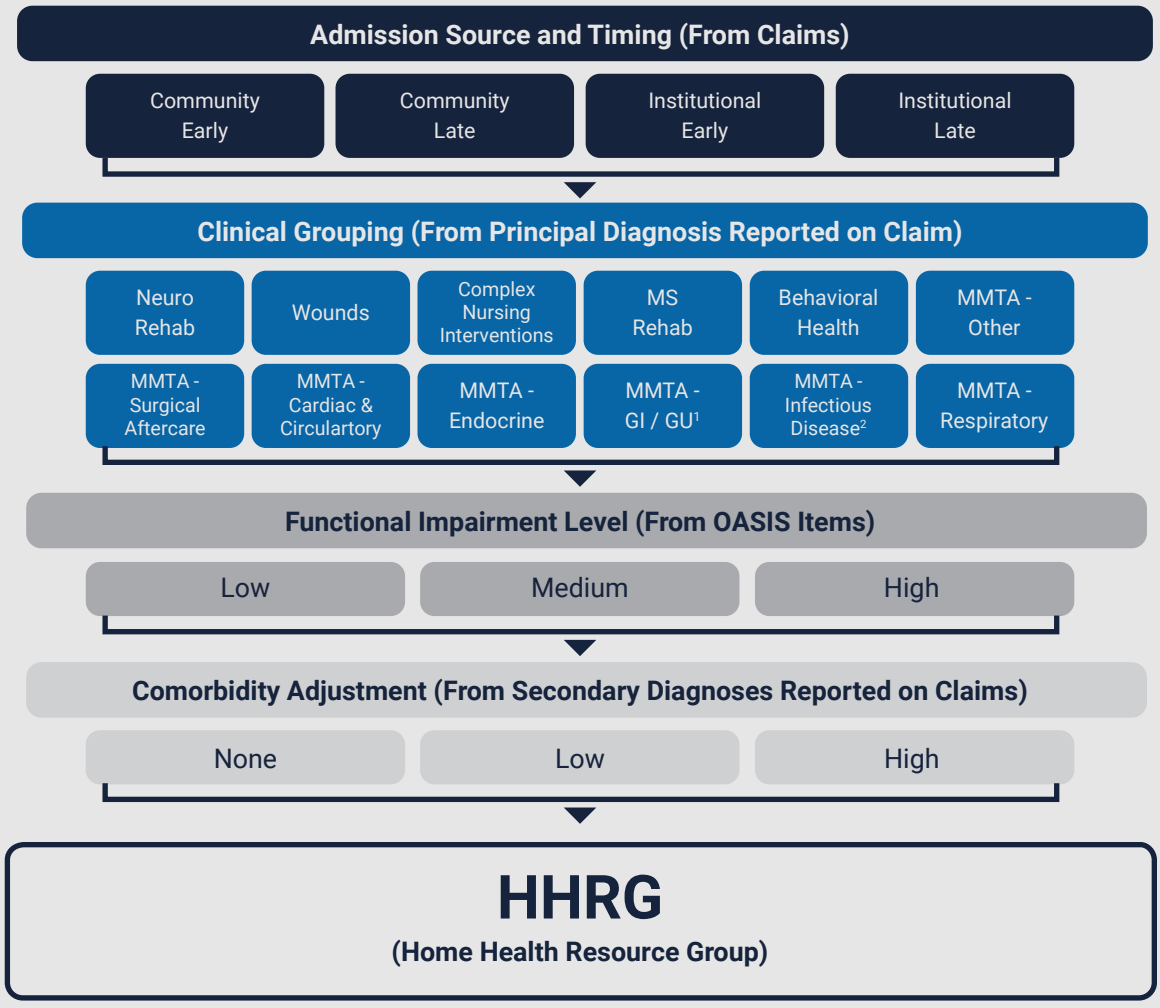
Once implemented, PDGM is expected to revolutionize home health agency operations and double agency's billing efforts. Ironically, one of CMS's objectives beyond budget neutrality is to reduce the administrative burden to focus resources on better care. At first glance, PDGM may seem more onerous, but in the longer term stronger coding against patient needs may actually be less cumbersome, once the new billing processes are integrated into current systems.

As the biggest payment overhaul in years, it's crucial for providers to spend 2019 preparing and adapting to PDGM's significant changes in time for implementation in 2020.

The main areas of impact include:

- Changing to a 30-day payment period from the current 60-day payment period
- Payment based on patient characteristics
- Elimination of the therapy thresholds, for case-mix adjustment, as a component of payment
- 432 possible Home Health Resource Groups (HHRG), a change from the 216 described in the Proposed Rule and the 153 available in the current payment model

Figure 3 - PDGM Process



A recent survey (SUNY Oswego) showed that over 55% of the 161 respondents had not begun to clinically prepare for PDGM. The agencies also stated that they needed help understanding; its impact on quality outcomes (23%); impact on reimbursement (46%) and 12% required help educating staff on the new model.

Among its many changes, PDGM aims to drastically alter how and when therapy services are provided by eliminating the use of therapy volume as a payment rate determinant.

PDGM will affect each agency differently, but, generally, providers can prepare by adjusting their practices and rebalancing their patient populations.

In the first half of 2019, agencies should develop a preparedness plan, educate staff and look for industry partners in coding, telehealth and professional services.

In particular the adoption of technology to better deliver care is encouraged as this will not only benefit patients but also profitability through more appropriate reimbursement capture.

Categories Affecting Your Future Reimbursements Under PDGM

There are five broad categories which determine Home Health Resource Group assignment for each 30-day payment period under the new PDGM process: admission source, timing, clinical grouping, functional impairment level and comorbidity adjustment.

Table 1 - PDGM Categories and their Impact on Wound Care

Category	Proposed Rule	Impact on Wound Care
Admission Source	Each 30-day period will be classified as Institutional or Community, depending whether or not the individual received acute or post-acute services within 14 days of beginning of care under home health. Thirty-day periods classified as Institutional are paid at a higher rate than those classified as community.	Agency may focus on wounds coming from institutions as opposed to primary care, since these tend to be more complex. (HIGHER REVENUE)
Timing	The first 30-day period of any patient's home health stay is considered Early; all subsequent, adjacent 30-day periods are considered Late. The Early period is paid at a higher rate than Late periods.	If you previously saw a wound patient 4 times in one period, that's now 4x in 30 days vs 4 times in 60 days. (INCREASED VISITS)
Clinical Grouping	The patient's principal diagnosis (IDC-10-CM code) that describes the primary reason the person requires home health services will be used to classify the patient into one of the 12 clinical categories or groups. In the Final Rule, CMS subdivided the Medication Management, Teaching and Assessment (MMTA) category into seven different groups.	Agencies will have to pick up more clinical work and diversify their case mix. Wound care is amongst the highest case mix weights. (HIGHER REIMBURSEMENT)

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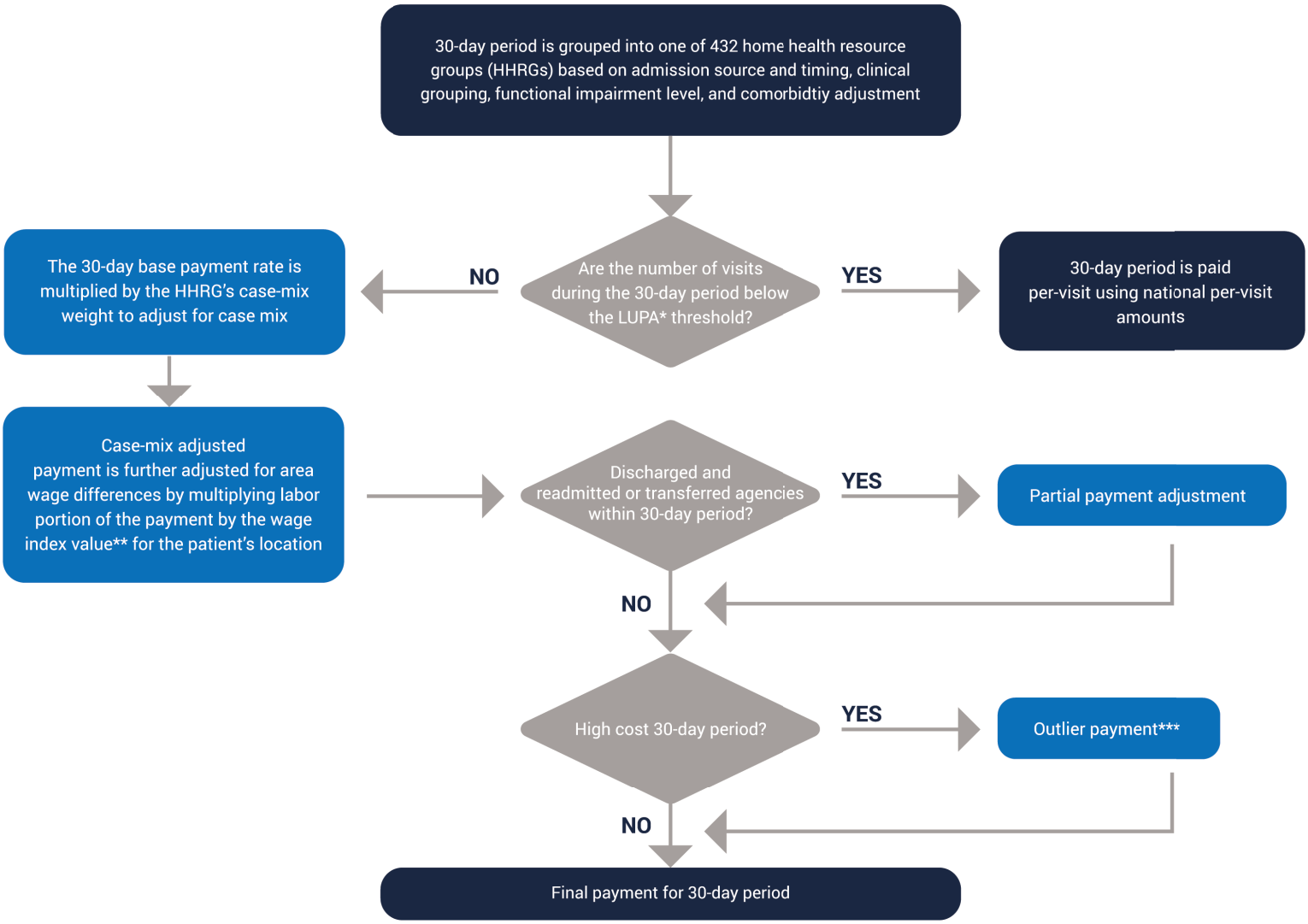
Category	Proposed Rule	Impact on Wound Care
Functional Impairment Level	In PDGM, Functional Impairment Level data (scores) comes from eight items in the OASIS. There are three functional impairments levels – low, medium and high impairment – per clinical group. Each 30-day period of care receives points based in the responses in the OASIS items. The sum of the points results in a functional score. The score thresholds differ for each clinical group. The model is designed to ensure that the patient gets the care and the LUPA and accurate coding and scoring will be the driving force behind its success.	The functional impairment level scoring will be important in the management of persons with wounds ensuring a complete understanding and assessment of the complexity of care. This is especially important with respect to those with multiple comorbidities. It will be key to code and score approritely to ensure effective management both clinically and also financially. (HIGHER CLINICAL EXCELLENCE AND INSTITUTIONAL REVENUE)
Comorbidity Adjustment	The comorbidity adjustment payment (none, low or high) depends on whether individual comorbidities or specific subgroup interactions, or comorbidity combination, are present. Depending on if and which secondary diagnoses are reported, a 30-day period of care may receive no, low or high adjustment. Under PDGM, a 30-day period of care can receive payment for a low or a high comorbidity adjustment, but not both. The low comorbidity adjustment amount would be the same across all 13 individual comorbidity subgroups; similarly, the high adjustment amount would be the same across all 34 comorbidity subgroup interactions.	Wound patients in most cases have multiple comorbidities. A clear understanding and reporting of these can provide more appropriate care with appropriate reimbursement for complex care. Technology may play a part here providing workflow and documentation excellence. (HIGHER CLINICAL EXCELLENCE AND INSTITUTIONAL REVENUE)

Figure 4 - How Payments and Adjustments are Calculated for Patient-Driven Groupings Model



* LUPA = Low Utilization Payment Adjustment

** The wage-adjusted payment for a 30-day period is calculated by taking the case-mix adjusted 30-day payment amount and multiplying 76.1% of that payment by a wage-index value that controls for area wage differences. That value is then added to 23.9% of the case-mix adjusted base-payment to determine the wage-adjusted payment amount.

*** Outlier payment is in addition to the wage-adjusted and case-mix adjusted 30-day period payment

Wound care, if done correctly and efficiently, is an ideal area for higher clinical excellence and greater institutional revenue.

PDGM and LUPA

PDGM changes the approach to calculating visit thresholds. Under PDGM, the Low Utilization Payment Adjustment (LUPA) threshold will vary based on the case-mix assignment for the 30-day period of care, accounting for different resource use patterns based on the beneficiary's clinical characteristics. Key changes to LUPA include:

- thresholds will vary depending upon the payment group to which it is assigned
- thresholds will range from 2-6 visits
- add-on factors will remain the same as current system
- thresholds for each PDGM payment group would be reevaluated every year

CMS finalized the LUPA threshold as of the 10th percentile of visits or two visits, whichever is the higher. This targets roughly the same percentage of LUPA as is currently seen in the industry, or approximately 8%.

LUPA is one of the areas of PDGM where the management of persons with wounds may have little if any impact. This is due to the complexity of care and more intensive visit schedule required in the management of many of these patients. However, the mismanagement of such patients may have significant impact on LUPA.

Case-Mix Weights and Home Health Resource Groups (HHRGs)

Actual PDGM case-mix weights were detailed in the CY 2020 Home Health Prospective Payment System Proposed Rule and will be re-calibrated annually, consistent with the current process.

To calculate the case mix weights and payment rates under PDGM, CMS is shifting to a costing system which they believe better reflects changes in utilization, provider payments and supplies.

There are 432 different HHRGs under PDGM, which is significantly more than existing rules. Each HHRG payment group is defined as the unique combination of the subgroups within the five PDGM categories described above. The case-mix weight for each subgroup adjusts the base or standard payment rate (as defined in the rule) to determine the rate for the 30-day period.

TABLE 2 - PDGM CLINICAL GROUPS

CLINICAL GROUP	PRIMARY REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/ Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers burns and other lesions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and substance abuse conditions
Medication Management, Teaching and Assessment (MMTA): • MMTA –Surgical Aftercare • MMTA – Cardiac/Circulatory • MMTA – Endocrine • MMTA – GI/GU • MMTA – Infectious Disease/ • Neoplasms/Blood-forming Diseases • MMTA –Respiratory • MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.

Payment groups to more than double. Nothing to fear as it more defines the "true" clinical status of the patient better meeting their specific needs, while providing a more appropriate payment structure focused on complexity.

Budget-Neutral Implementation

Although implementation of this new system is required by law to be budget neutral, this does not mean individual home health agencies won't see an impact on their individual financial performance when PDGM is implemented. For example, CMS estimates that free-standing, proprietary (for profit) agencies will see an overall decrease in revenue of 1.2 percent, while facility-based, proprietary agencies will see an increase of 4.4 percent. So there will be winners and losers. Those better prepared, see Table 3, should be the winners.

CMS has released online resources for agencies to test themselves against the new model—a patient-specific one and a business-wide tool. Run your numbers. Along with the final rule, CMS has provided PDGM grouper and agency level impact tools. Use those to model the impact on your agency.

What should you do to prepare for the shift to PDGM?

Organizations that take steps today will find success in PDGM tomorrow. Take time to evaluate the current state of your organization's operations and start by asking if they can support the following:

- Increasing understanding and use of ICD-10 coding
- Collecting complete health histories with a complete recording of comorbidities
- Collaborating between cross-functional teams to provide coordinated care
- Developing a strong understanding of OASIS requirements by clinicians and coders
- Developing a sense of urgency and laser focus on the care to be provided and discharge plan
- Ensure current coding and billing resources and systems are tailored to the needs of PDGM
- Embrace technology to achieve a combination of the above to better manage your organization's financial health under PDGM
- Develop your wound care program to better serve your patient population, help retain staff and deliver financial benefit to your organisation.

Top Ten Key Take-Aways

1	Focus on diagnosis coding. Every agency's plan will look different, based on its individual needs. But providers can count on diagnosis coding being a big feature, thanks to PDGM's focus on the area. In the final rule, CMS affirms the importance of 'precise coding' in the new model, so ensuring that your coding resources are up to the task will be extremely important. Collecting complete health histories with a complete recording of comorbidities will be a must under PDGM, thanks to the payment adjustment for comorbidities.
2	Emphasize OASIS. Accurate OASIS coding will also be paramount under PDGM. Developing a strong understanding of OASIS requirements by clinicians and coders will be key. Accurate OASIS collection lays the foundation for capture of acuity and revenue, while providing the pathway to effective care planning. It also determines risk stratification.
3	Target effective care coordination and discharge planning. Most HHAs will need to focus on these areas in their PDGM transition, experts predict. Providers will need to be collaborating between cross-functional teams to provide coordinated care. Using accurate acuity capture will drive and permit improved execution of evidence-based, interdisciplinary best practice care plans.
4	Evaluate your clinical competencies and opportunities to identify areas of revenue potential and patient benefit (e.g. wound care).
5	Secure buy-in. Drafting a comprehensive PDGM implementation plan isn't enough. You need to get your staff on board. That means rolling out early education to leaders and employees, who need to understand why they are doing things.
6	Achieve optimal productivity. You may want to borrow from Encompass Health's PDGM prep list. The 30-state chain includes "ensure productivity levels are realized for full-time staff" on its to-do list for 2019, according to its Jan. 8 presentation at the J.P. Morgan Healthcare Conference.
7	Using technology to "drive incremental efficiencies" can also ensure a more seamless adoption of PDGM. More importantly, new technological solutions may provide an opportunity to strengthen, manage or develop new clinical competencies.
8	Consider expanding into more complex patient care and develop your administrative workflows to better manage these patients. This will deliver both patient benefits (i.e. improved quality of care) and also institutional benefits (i.e. increased revenues).
9	Don't look at PDGM as a barrier to success, embrace it with insight and opportunity, to better serve your patients growing your business as a leader in home health.
10	Stay tuned. 2019 may see further refinement of the regulation before it goes into effect. The industry is lobbying hard for certain changes, such as elimination of the preemptive behavioral assumption reimbursement cut. Keep on top of new information CMS issues.

Beyond PDGM

In addition to PDGM, CMS's newly proposed changes also include plans to allow the cost of remote patient monitoring to be reported by home health agencies as allowable costs on the Medicare cost report form. The move is expected to promote the adoption of emerging technologies and foster more effective care planning, including the sharing of data throughout the continuum of care, according to CMS.

The proposed rule includes a variety of other potential changes, including updates to the home health quality reporting program and the value-based purchasing program.

For the home health quality reporting program, updates generally focus on removing or replacing certain measures to further align with other CMS policies and reporting programs.

Despite concerns, from a provider perspective, PDGM does have the potential to be a positive change. That's dependent on factors such as patient mix, therapy utilization levels and the amount of referrals coming from institutions versus the community.

A clear understanding and embracement of PDGM, with a desire to expand into more complex patient care and develop your administrative workflows to better manage these patients will deliver both patient benefits (i.e. improved quality of care) and also institutional benefits (i.e. increased revenues).

Wound care, if done correctly and efficiently, presents a key opportunity under PDGM, with both patient and institutional benefits.

Key Resources Used

Vontran K and Gehne W (2019) “Overview of the Patient-Driven Groupings Model (PDGM)”, A Medicare Learning Network (MLN) Event presentation. Feb 12th 2019. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf

Final CMS Ruling: https://www.govinfo.gov/content/pkg/FR-2018-11-13/pdf/2018-24145.pdf

Home Health Patient-Driven Groupings Model National Provider Call - Feb 12, 2019 (https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Presentation.pdf)

Important Home Health Resources from CMS

https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html

PDGM Focused Resources from CMS:

Interactive Grouper tool (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/PDGM-Grouper-Tool-CY-2019.zip)

PDGM Case Mix Weights and LUPA Thresholds (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/PDGM-Case-Mix-Weights-and-LUPA-Thresholds.zip)

PDGM Agency Level Impacts (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/PDGM-Agency-Level-Impacts.zip)

MLN Matters Article MM11081- PDGM - Split Implementation (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11081.pdf)

PDGM - Split Implementation - Change Request 11081 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4228CP.pdf)

For additional assistance, home health agencies may submit questions to the following email address: HomehealthPolicy@cms.hhs.gov.