Home Health Care News

With just five full months to go before the Patient-Driven Groupings Model (PDGM) becomes a reality, home health providers have reached crunch time.

As it has been all along, the assumption-based behavioral adjustment baked into PDGM remains the home health industry's No. 1 issue. Originally, the behavioral adjustment was estimated to create a 6.42% payment cut to providers in 2020; it's now closer to 8%, thanks to the July 11 proposed payment rule from the Centers for Medicare & Medicaid Services (CMS).

Refining revenue cycle management will be a priority for many providers throughout the remainder of 2019, as will strengthening intake processes and coding capabilities.

Home Health Care News checked in with five providers — Elara Caring, Bayada Home Health Care, Visiting Nurse Service of New York (VNSNY), Cornerstone VNA and LifeCare Home Health & In-Home Services — to learn more about their PDGM preparation progress.

Their PDGM status, concerns and overall outlook is provided below.

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PDGM will impact each home health agency differently. At Elara Caring, we're working hard to ensure we're prepared as we can be for when it takes effect next year. Preparations are underway for our care teams, as well as for operations support teams. We're also in the process of preparing our billing and electronic medical records teams to ensure they're

equipped, adjusted and have processes in place to manage the new requirements, reimbursement environment and all that follows.

Having built a company designed to meet the exact demands CMS has been messaging for several years, we feel good about our preparations thus far. We are constantly reassessing the impact PDGM will have on our business, and we are constantly refining our preparation strategies with every meeting, new data point or new piece of information. We have a strong team that is working across all business areas to ensure we're well-equipped to manage the new model.

Throughout the rest of 2019, Elara will continue to focus on several areas, including care planning and therapy adjustments; clinical groupings and coding; and revenue cycle management that comes with the shift from 60-day payments to 30-day billing cycles. We are focused on making sure that none of our patients feels the impacts of this new model.

Providing the right care, at the right time, in the right place remains mission-critical.

— G. Scott Herman, CEO of Elara Caring

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At BAYADA, we feel confident in our planning activities for PDGM. We are choosing to look at PDGM as a driver toward improving the care that we deliver through streamlining our internal communication and care planning processes.

However, across the industry, we are observing a high degree of variation. There's a slight sense of the "Wild West" occurring right now, with a wide range of planning activities that are taking place across different agencies. For example, some providers are directing resources toward coding, while others are focused on referral sources and expanding their institutional mix. The majority appear to be planning for the reduced revenue cycle, moving to 30-day periods. On the other side of the spectrum, we have spoken with a few agencies that have yet to initiate any new processes at all.

While BAYADA is focusing on internal preparation, we also have been actively engaging with other providers, both large and small, to share information and investigate alternative strategies. Interestingly, we have seen a high degree of openness and willingness to work in partnership among perceived "competitors." We are all in this together and can only benefit from working collaboratively.

When the first iteration of PDGM was proposed in 2018 (then known as HHGM), we began to analyze our historical practice patterns and how they would translate to this new payment methodology. We mapped out the potential impact on our existing processes and identified ways that we could proactively improve and streamline our approach to team-based care planning. Also in 2018, we entered into a value-based contract with a Medicare Advantage plan that shared some similarities with PDGM. We chose to classify those patients into the PDGM groupings, internally, so that we could practice a new care planning approach in a smaller sample size, then make adjustments based on performance and employee feedback.

We observed some excellent clinical outcomes and a positive response from our teams, so we felt confident in expanding this to other states earlier this year. We are now continuing to roll out this approach across the country in preparation for 2020, classifying our clients into the PDGM methodology and utilizing team-based care planning strategies.

We have a number of workstreams currently underway, many of which are focused on back-office activities, such as the billing process. We are working closely with our EHR vendor to understand their system enhancements and how best to prepare for changes to the billing cycle, mapping out where we may need to focus resources.

We are also working on external messaging — simplifying what our referral sources need to understand about PDGM, and how this would impact them. Some of this messaging relates to coding and the information we receive at the time of referral. We have already seen a significant reduction in our use of "unacceptable" codes, and expect to continue that downward trend through the remainder of the year.

The key is staying nimble; we believe in fostering a certain degree of flexibility with new processes, since some aspects of PDGM are still subject to change. That said, we are closely reviewing the proposed rule, and will make adjustments based on the final rule when it arrives in October, if needed.

— Anthony D'Alonzo PT, DPT, MBA, director of clinical strategy and innovation at Bayada Home Health Care

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I don't think we know [PDGM's impact] yet. One reason is that the industry is very dependent on the third-party administrators that Medicare uses to process its claims. This is a very different system with a very complex way of adjudicating claims, and we hope that the third-party administrators are ready for the PDGM implementation. So far, we don't have information one way or the other about this, so there's some anxiety around that.

Also, regarding the IT systems that support all of the various home care agencies' intake, coding and billing, there are a number of new PDGM-related products from IT vendors that haven't been released yet. The industry is cautiously optimistic, but we're still waiting to see these products and learn more about them.

I think that the industry as a whole is working very hard to understand what they need to do to execute and implement this new system. There are lots of pilots going on to make sure that when the time comes, everyone can execute on the new system. Overall, I think the shift to PDGM is a very reasonable approach, because it's designed to ensure that home care agencies get reimbursed more for their patients who are sicker and require more intensive services. It makes sense — it's just a complex system. Each patient gets reimbursed differently based on many different factors, and you have to capture all this information up front and get it right.

We feel good about [VNSNY's readiness]. We're spending an enormous amount of time planning for PDGM, with multiple teams of people focused on making sure that we're moving

forward and implementing it correctly. The major things we're working on are making sure we get the right information up front that we need to code and adjudicate a claim; understanding how utilization is going to impact our reimbursements; and then understanding how are we going to adjust as an organization to these new billing cycle rules. We're very dependent on our IT vendors to help us with this, so we're working closely with them as well.

I think there's a number of things that will take priority industry-wide throughout the rest of 2019. Certainly, there will be major changes in the revenue cycle because of the new rules of PDGM, so we're focused on that. And because different and new information will be needed when admitting patients, intake and coding are also going to be a big focus. And since we'll now have two different cycles of possible LUPAs — the first 30 days, and then the next 30 days — another big challenge for us is to understand how that's going to impact our reimbursements. The other thing we're focused on, like every home care agency, is what the overall financial impact of this new reimbursement system will be. Although it's designed to be budget neutral in the broadest sense, some agencies will do better and some will do worse under PDGM.

On this note, I should add that we were very disappointed to see that the behavioral adjustment under PDGM was increased to a shade over 8% in the just-released CMS rule for home health. We also see the decision to eliminate RAP payment by 2021 as an issue that will impact cash flow for many organizations.

— Marki Flannery, president and CEO of the Visiting Nurse Service of New York (VNSNY)

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The industry certainly seems to be trying to get agencies prepared. There are multiple educational opportunities offered using a multitude of modalities from newsletters to webinars and live conferences. Electronic health record (EHR) vendors and consultants have been in high gear. The EHR used by Cornerstone Visiting Nurse Association has been preparing their agencies for months with several development teams working exclusively on PDGM, and quarterly releases and webinars. That being said, there remains a high number of agencies with a too-high utilization of therapies, which will not serve them well come PDGM. Cornerstone VNA is in excellent shape for the future. We are fortunate to have a leadership team that stays abreast of changes and is forward-looking. Cornerstone VNA has always been driven by clinical best practice with patient-driven goals; our therapy utilization has never been higher than our use of any other discipline unless clinically indicated by patient need. Additionally, we pride ourselves in the number of specialty services we offer including wound care, psychiatric nursing, diabetic education, disease management programs, and our nationally recognized telehealth program.

The leadership team has availed ourselves of any and all educational offerings from a variety of national and regional sources. We make excellent use of analytics and other data sources to study both clinical and financial indicators of business health. We are an organization that believes strongly in staying informed of industry trends and opportunities for growth and improvement.

PDGM preparation is likely to continue its focus on financial management including claims and order management and clinically on diagnosis groupings and coding. Agencies need to be

prepared in regards to maximizing the use of their EHR, leveraging analytics to track claims and orders life cycles, and escalating their use of key clinical metrics.

— (Jointly with Cornerstone VNA) Kerrie Landry, MBA, CFO; and Barbara Boulton, RN, MSN, clinical informatics manager

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What I see is that top-run agencies with a focus on the long-term success are taking their time to really understand the whole effect of PDGM on their operations and have started making sound adjustments. However, I see a lot of agencies — primarily independently run, small- to mid-size agencies — that are not taking the upcoming changes seriously.

The key to staying sustainable is to have a really good understanding of your current agency operations, your referral sources, patient demographics — and make appropriate adjustments in internal processes and patient populations.

But this is easier said then done. Many independent and non-hospital-affiliated agencies have spent years developing their business models catering to a particular type of referral sources and patient population. Whether its post-ortho care, partnerships with community physicians and assisted living operators, these models will not help them meet their financial bottom lines in 2020.

Unlike, hospital- or SNF-owned agencies, the majority of independent agencies do not have a luxury of cherry-picking referrals, and struggle daily to stay sustainable. With that said, I see a number of agencies not being able to adjust and may exit the home health market. I feel that hospital-affiliated agencies are in better position to adjust in terms of type of patients served, billing and coding practices, but may struggle to meet their financial bottom lines due to the cumbersome and not effective internal processes.

We have a long-term sustainability vision and, thus, take any changes that come our way very seriously. We identified key impacts of PDGM on our agency as: reimbursement shift from community to institutional, the change from 60 to 30 day episode billing, and the elimination of the therapy component. We assessed that in order to stay sustainable in 2020, we needed to make necessary changes. Over the last year, we have been working on strengthening our business partnerships with skilled facilities and hospital systems to adjust our referral sources and patient population. We put more focus on strengthening and marketing our complex clinical interventions programs, infusions, wound care and post stroke [services].

Recent re-implementation of the [Review Choice Demonstratoin] has also actually served as a great time to start tightening our internal processes from intake to documentation submission and review, coding, RAPs and finals billings. There is no room for delays or inaccuracies anymore.

— Jane Shekman, CEO of LifeCare Home Health & In-Home Services

Companies featured in this article:

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