



Countdown to PPS Refinement: The Final Rule & its Impact

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Medicare: PPS Revisions in Development

- First revision since original implementation in October 2000
- Proposed Rule issued April 26
- 60 day comment period (closed June 26)
- Final rule released August 22, 2007
- Implementation January 1, 2008





PPS Reform Rule

- Financial impact CY 2008
 - 3.0% inflation update (+\$430 million)
 - Minus 2.75% coding creep adjustment (-\$410 million)



Proposed vs. Final Rule

- **Base Episode Payment Rates**

	<u>Proposed</u>	<u>Final</u>	<u>Variance</u>
Episodes beginning in 2007 and ending in 2008	\$ 2,355.96	\$ 2,337.06	-0.8%
Episodes beginning and ending in 2008	\$ 2,300.60	\$ 2,270.32	-1.3%





Proposed vs. Final Rule

- **LUPA Add-On**
 - For the first episode in a sequence of adjacent episodes or the only episode

<u>Proposed</u>	<u>Final</u>	<u>Variance</u>
\$ 92.63	\$ 87.93	-5.1%



Proposed vs. Final Rule

- **Outlier**
 - A higher fixed dollar loss (FDL) means fewer cases are eligible for outlier payments

	<u>Proposed</u>	<u>Final</u>
FDL	0.67	0.89





Proposed vs. Final Rule

– Market Basket Index (Inflation Update)

- Update at risk through Congressional action.

Proposed

2.9%

Final

3.0%



Proposed vs. Final Rule

– Case Mix Creep

- Change due to CMS updating their data analysis to include 2005 information

	<u>Proposed</u>	<u>Final</u>
Rate Reduction:		
Year One	2.75%	2.75%
Year Two	2.75%	2.75%
Year Three	2.75%	2.75%
Year Four	<u>0.00%</u>	<u>2.71%</u>
Total	<u>8.25%</u>	<u>10.96%</u>





Proposed vs. Final Rule

- Therapy Threshold (same as proposed)

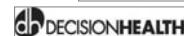
	1 st & 2 nd Episodes		3 rd & 4 th Episodes		All Episodes
	0 – 13 Therapy Visits	14 – 19 Therapy Visits	0 – 13 Therapy Visits	14 – 19 Therapy Visits	20 + Therapy Visits
S 1	0 to 5	14 to 15	0 to 5	14 to 15	20 +
S 2	6	16 to 17	6	16 to 17	
S 3	7 to 9	18 to 19	7 to 9	18 to 19	
S 4	10		10		
S 5	11 to 13		11 to 13		



Proposed vs. Final Rule

– Medical Supplies

	<u>Proposed</u>	<u>Final</u>
Number of Severity Levels	5	6
Add-on for LUPA episodes	No	No
Add-on to reflect changes after SOC	No	No





Proposed vs. Final Rule

– Medical Supplies Continued

<u>Severity Level</u>	<u>Payment Amount</u>	
	<u>Proposed</u>	<u>Final</u>
1	\$ 12.96	\$ 14.12
2	\$ 54.69	\$ 51.00
3	\$ 109.48	\$ 139.84
4	\$ 215.17	\$ 207.76
5	\$ 367.34	\$ 320.37
6	N/A	\$ 551.00



Proposed vs. Final Rule

– Other Provisions

	<u>Proposed</u>	<u>Final</u>
SCICs	Eliminated	Unchanged
MO175	Eliminated from Payment Calculation	Unchanged
Case Mix Adjuster	153 Case Mix Categories	Unchanged





Early vs. Late Episodes

- Definition
 - “Early” = First or second *adjacent* episode
 - “Late” = 3rd or more adjacent episodes



Early vs. Late Episodes

- Challenge – How do you know if it is an Early or Late episode?
 - Addition of a new OASIS item M0110
 - If unknown select “Early”
 - Automatic Default
 - CMS comments state “CWF will automatically adjust claims up or down to correct episode timing”
 - “**No** canceling and resubmission on the part of HHAs will be required”





Early vs. Late Episodes

- Adjacent Episodes
 - “Episodes are considered to be adjacent if they are contiguous, meaning that they are not separated by more than a 60-day period ”
 - Episodes from other agencies will be considered adjacent if they are within the 60-day period



Early vs. Late Episodes

- Challenge – How do you know if it is an adjacent episode?
 - Adjacent episodes for most episodes will be based on the calculated 60-day period regardless if the patient had an earlier discharge
 - Exception PEP episodes – 60-day begins after the last billable visit





Early vs. Late Episodes

- Challenge – How do you know if it's an adjacent episode?
 - CMS will automatically adjust claims to reflect the proper sequence upon payment
 - CMS has stated in the comments that they will initiate adjustments to previously paid episodes



Four-Equation Model

- Establishment of four separate regression Models
- Four different types of episodes
- Therapy dictates the type of episode AND impacts case weight/payment

1 st & 2 nd Episodes “Early”		3 rd or Later Episodes “Later”		All Episodes (Early/ Late)
1	2	3	4	5
0 – 13 Therapy Visits	14 – 19 Therapy Visits	0 – 13 Therapy Visits	14 – 19 Therapy Visits	20 + Therapy Visits





Four-Equation Model

- Establishment of four separate regression Models
- Example of Different payment rates – C1F1S1

1 st & 2 nd Episodes “Early”		3 rd or Later Episodes “Later”		All Episodes (Early/ Late)
1	2	3	4	1,2,3,4+
\$1,322.92	\$3,659.30	\$1,485.47	\$3,979.87	\$5,788.18



Four-Equation Model

- Result
 - Increase the number of case-mix groups from 80 to 153
 - Greatly increases the complexity
 - 20+ Therapy visits is not a 5th Regression Equation
 - Need to identify Early/Late





GOOD NEWS

- CMS will automatically Up/Down code for therapy thresholds



Payment Rate at Dec 31, 2007

- Episodes beginning in 2007 and ending 2008
 - Current Case-mix methodology
 - Base Rate \$2,337.06
- Episodes Starting in 2008 and ending 2008
 - New Case-mix Methodology
 - Base Rate \$2,270.32





Financial Management Under the Final Regulations



Establish a PPS Refinement Team

- Members
 - Clinical
 - Finance
 - Business Operations
 - Information Systems
 - Administration





PPS Refinement Team

- Responsibilities
 - Evaluation & Assessment
 - Planning & Implementation
 - Tracking & Monitoring



Role and Functions Finance

- First Step “Where do we Stand”
- Quantify Changes
 - We recommend using 100% of your database
 - Using current Information System
 - If reports are able to be created
 - Health Analytics Company





Role and Functions Finance

- Important to know if analysis is based on billed claims or final paid claims
 - May need to add an additional factor for final claim adjustments (i.e., Therapy Up/down codes)
- Otherwise, we recommend the use of a random statistical sample that can be extrapolated to the universe



Role and Functions Finance

- 2nd Step
- Educate Members on Financial Ramifications
 - Why and Where there were changes to the overall reimbursement
 - Begin the process of “Drill Down”





Role and Functions Finance

- 3rd Step “Drill Down into the detail”
 - What are your agency’s true gross margins
 - Include all Direct Care Cost
 - What should be included in the calculation of direct costs
 - Direct Care
 - Wages
 - Benefits
 - Transportation
 - Contracted Services
 - Medical Supplies



Role and Functions Finance

- 3rd Step “Drill Down into the detail”
 - Build the Final Regulations into your next year budget
 - June 30
 - 6 Months
 - September 30
 - 9 Months





Role and Functions Finance

- 3rd Step “Drill Down into the detail”
 - Areas to Review
 - Look closely at your agencies resources
 - Do we need or have a Coder?
 - How are we reviewing Therapy up/Down codes
 - » Final rules state Medicare will automatically adjust for therapy thresholds
 - Identify Areas for Improvement
 - Where are our current backlogs
 - Goal is to free up resources to assist in other areas



Role and Functions Finance

- 3rd Step “Drill Down into the detail”
 - Analyze Current Vendor Contracts
 - Medical Supplies
 - Look at your current model
 - Are we getting the best price and service?





PPS Final Rule Financial Ramifications

- Revenue Recognition
 - Methods used for timing of revenue:
 - Straight Line (IT system driven)
 - Earlier of 60 days or date of discharge
 - Average length of stay
 - NO CHANGE REQUIRED
 - Payment Method (IT system driven)
 - Initial episode 60/40
 - Subsequent episodes 50/50
 - NO CHANGE REQUIRED



PPS Final Rule Financial Ramifications

- Revenue Recognition (con't):
 - Other Methodologies (Outside IT system)
 - Visits weighted by medical supplies
 - MORE COMPLEX REVENUE BASE INCREASES FROM 80 TO 612 HHRG (4X153) SINCE OUTSIDE SYSTEM





PPS Final Rule Financial Ramifications

- ❖ Cash Flow Complications Beginning of Calendar Year 2008
 - ❖ Final Bills submitted under both systems
 - ❖ Capturing early/late episode
 - ❖ Hiccup in implementation
 - ❖ Managed Care (if use PPS payment methodology)



PPS Final Rule Financial Ramifications

- ❖ Cost of Implementation
 - ❖ Training caregivers to new OASIS requirements
 - ❖ Printing of forms (if POC is not used)
 - ❖ Hiring a coder with homecare experience
 - ❖ Education of all departments on overall changes & those that specifically affect their function
 - ❖ Possible updates of IT system to newer versions to accommodate new billing requirements





Data



Data Agenda

- Impact at the industry level
 - National Averages
 - By Agency Characteristics
- Impact at the agency level
 - Range of impact
 - Change between the proposed and final rule
- Data on specific components of the rule
 - Therapy
 - Early/Late
 - NRS
 - By Diagnosis





A Word About the Data

- Source is OCS
- Representative of more than
 - 1.25 million cases of care
 - 2,000 provider locations



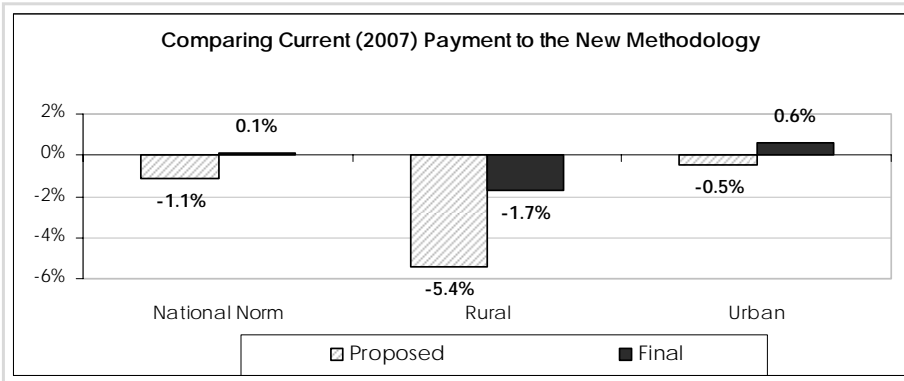
A Word About the Data

- Analyses on next few slides are:
 - Based on non-LUPA episodes ended in 2006
 - Using today's PPS methodology and the methodology outlined for 2008 as defined in the final rule
 - Comparing 2007 reimbursement with reimbursement expected in 2008
 - *2008 base payment rate includes all of the changes in the final rule, including the 3% market basket increase and 2.75% "case mix creep" decrease*

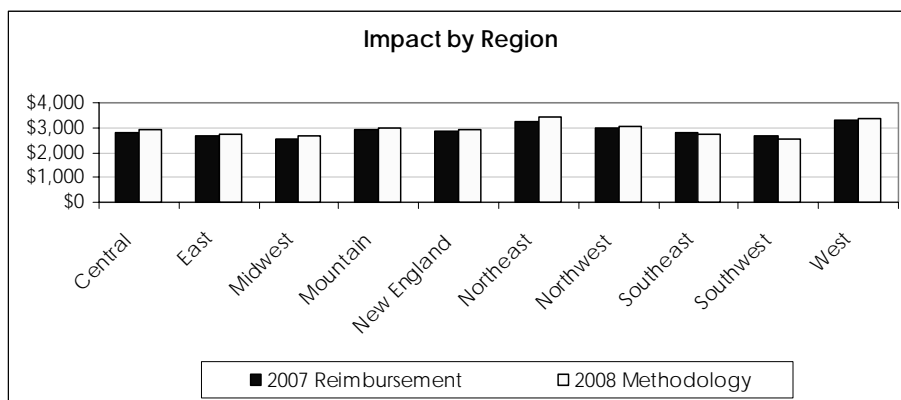




Industry-Level Impact

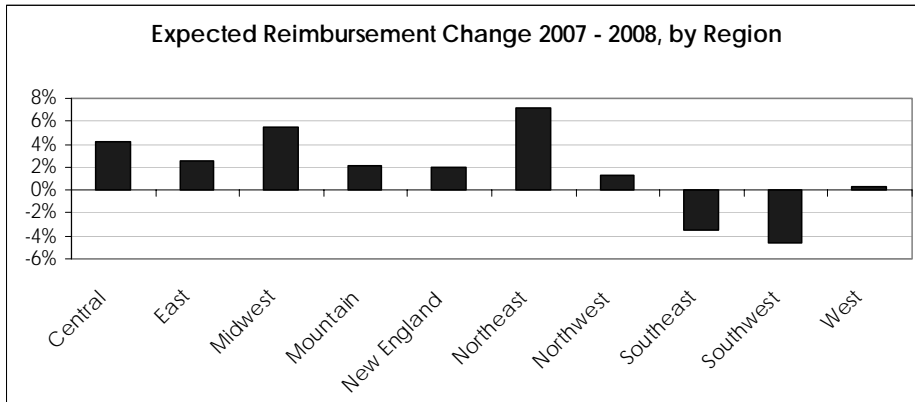


Industry-Level Impact

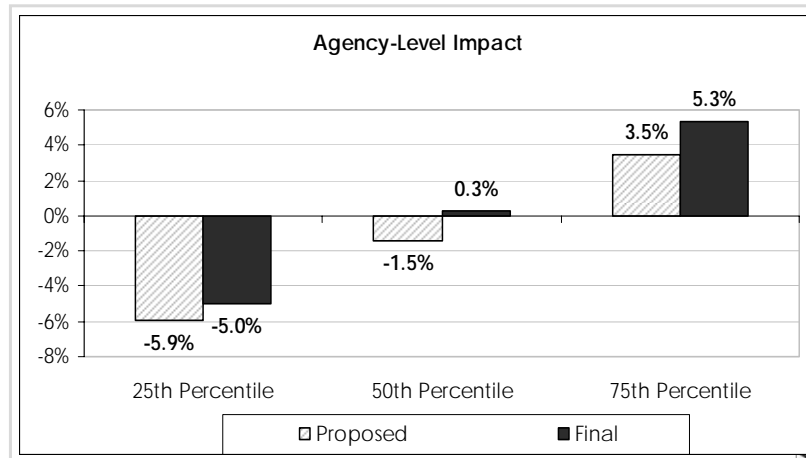




Industry-Level Impact



Agency-Level Impact



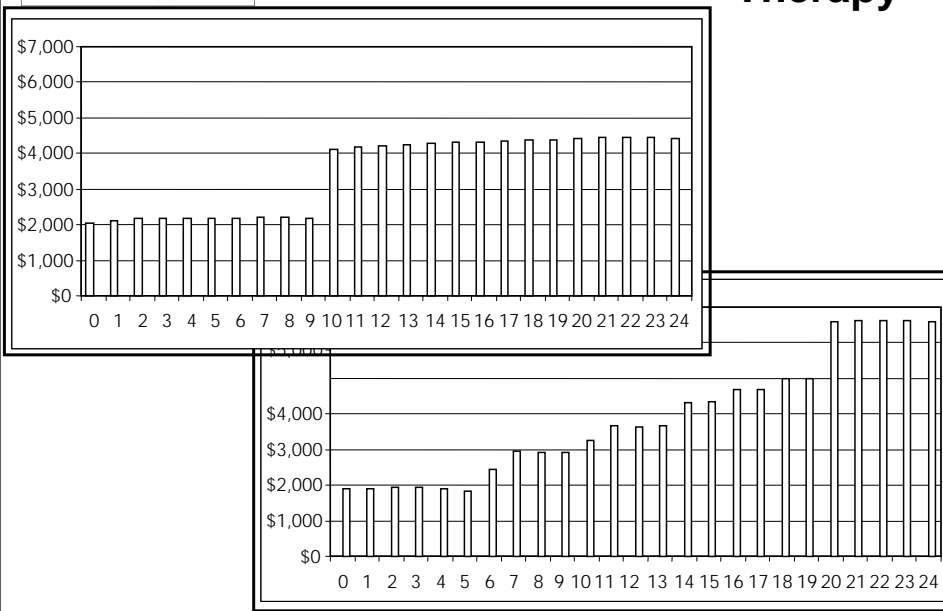


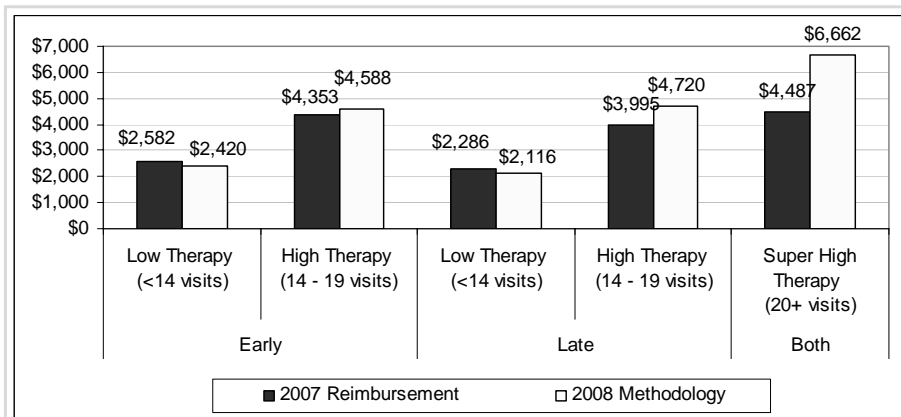
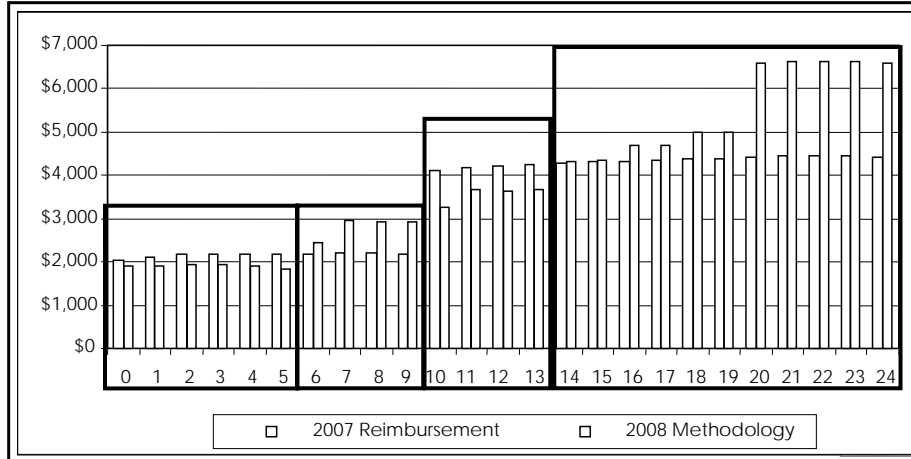
Snappy Fact

Almost 75% of agencies can expect the same or a higher reimbursement under the final rule, as compared to the proposed rule.



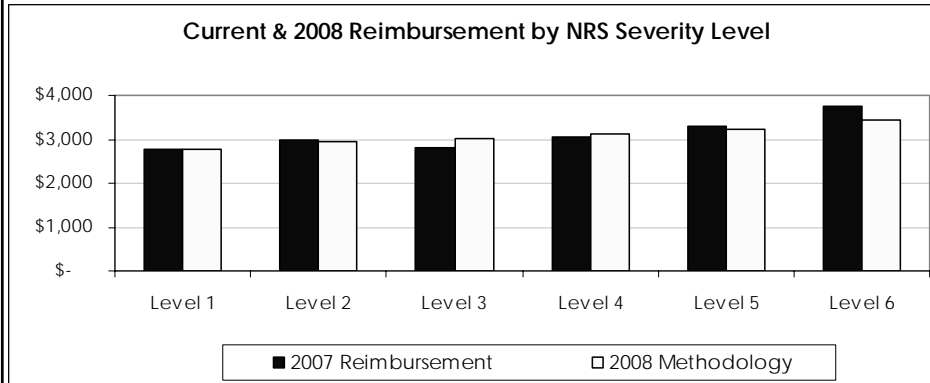
Therapy



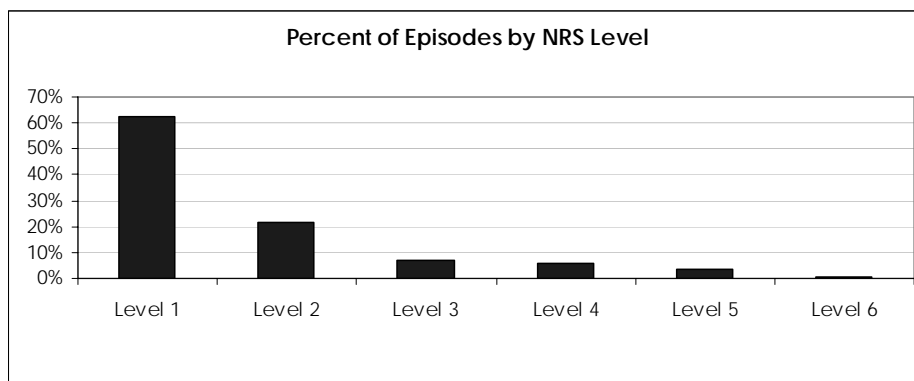




Non-Routine Supplies



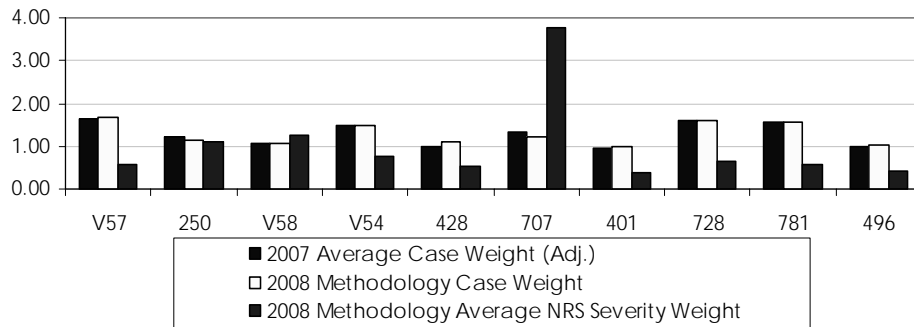
Non-Routine Supplies





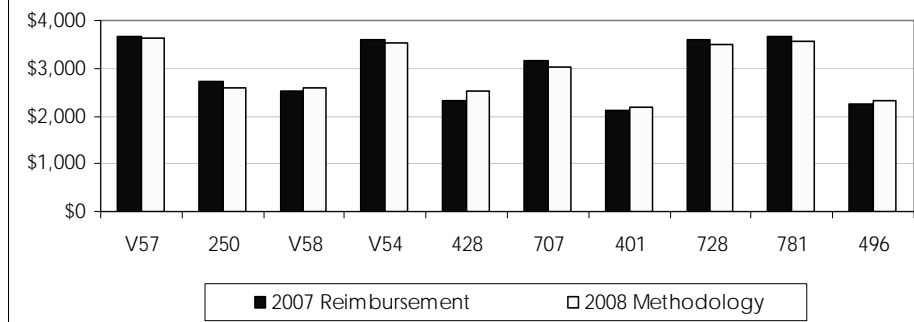
Non-Routine Supplies

Impact by Diagnosis



By Diagnosis

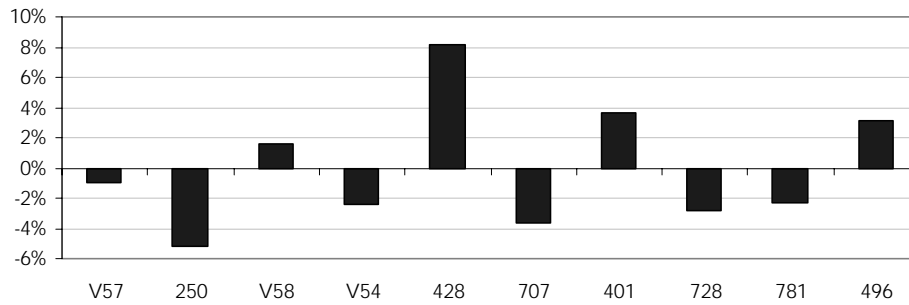
Impact by Primary Diagnosis





By Diagnosis

Expected Reimbursement Change 2007 - 2008, by Diagnosis

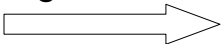
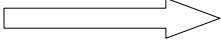


Operations Considerations





OASIS Changes

- M0175 – Eliminated from Service Utilization domain – still a required M0 item
- M0610 – Eliminated from Clinical domain
- M0800 – added to Clinical domain
- M0110: Episode timing
 - Identification of early or late episode
- Format of Diagnosis items
 - M0245  M0246
 - M0825  M0826
 - Specific number of anticipated therapy visits



New M0 Item Included in Clinical Domain

(M0800) Management of Injectable Medications: Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

- 0 - Able to independently take the correct medication and proper dosage at the correct times.
- 1 - Able to take injectable medication at correct times if:
 - (a) individual syringes are prepared in advance by another person, OR
 - (b) given daily reminders.
- 2- - Unable to take injectable medications unless administered by someone else.
- NA - No injectable medications prescribed.
- UK - Unknown





New M0 Item: M0110

- Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?

- | | | |
|----|---|--|
| 1 | - | Early |
| 2 | - | Later |
| UK | - | Unknown |
| NA | - | Not Applicable: No Medicare case mix group to be defined by this assessment. |

CMS Fallback: Early with less reimbursement

CMS plans to automatically adjust payments when claims are submitted which would change the episode timing



Episodes in Sequence

- First or Second Episodes
- 3rd or subsequent episodes
- Strategies
 - Interview patient
 - Referral source
 - CWF
- Possible increased scrutiny if increase in long lengths of stay
 - Case conferences
 - Documentation
- Impact of:
 - Hospitalizations
 - Medicare Advantage





Comment and Response

- Comments
 - Concerned that paying more for later episodes would lead to gaming, with patients on service longer than is appropriate.
 - Concerned that case-mix refinements create incentives for less efficient and less effective care if agencies provide unneeded care to extend length of stay.
- Response
 - CMS concerned also
 - Plan to monitor visits and share concerns with RHHIs



New M0 Item: M0230/M0240/M0246

- Eliminate M0245
 - Replace with M0246 for first and secondary diagnoses
- New table/format





New M0 Item: M0826

- **THERAPY NEED**
- **(M0826) Therapy Need:** In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**
- (___ __) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).
- NA - Not Applicable: No case mix group defined by this assessment.

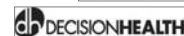
Person completing OASIS must have the number of combined therapy visits on the Plan of Care

Enter "000" if there will be no therapy services



Diagnosis Considerations

- Addition of some V-Codes
 - 414 series for Chronic Ischemic Heart Disease
 - Except 414.9- unspecified
 - Dementia – (see following slide)
 - Abnormal Gait 781.2 now linked to pressure ulcer (see following slide)
 - Stroke – (see following slide)
 - Acute stroke codes not included
 - Incontinence
 - In the 2005 data, a cost-increasing effect from urinary incontinence was not observed, so it was deleted from the four-equation model





Comments and Responses

- Comment
 - The proposed rule designates the dementia codes 290.0 series as manifestation codes in the Psych 2 diagnosis group, but the proposed rule offers points when Psych 2 conditions are primary only
- Response
 - The Manifestation designation was removed for these codes and they are point bearing regardless of whether the codes are primary or secondary diagnoses.



Comments and Responses

- Comment
 - The Neuro 3 code list included ICD-9 436 which is an outdated code. They asked that it be replaced with 434.91
- Response
 - In order to comply with the “ICD-9 Official Guidelines for Coding and Reporting”... we have deleted codes in categories 430-437 listed in the Neuro 3-Stroke diagnostic category. The conditions in these categories identify the cause of the initial onset of an acute stroke and must not be assigned in the home health setting. Agencies should use category 438 late effect of cerebrovascular disease, for conditions occurring at any time after the onset of an acute stroke.





Comments and Responses

- **Comment**
 - Asked for the reason for linking the case-mix adjustment for 781.2 with pressure ulcers as persons receiving therapy services for abnormal gait are not usually bed or chair bound. Additionally, points are not allocated for the 781.2 in the 14 plus therapy visit equations.
- **Response**
 - The models indicate that patients with pressure ulcers are overall more clinically compromised if they also have a diagnosis of 781.2. Because we are adopting a graduated payment for therapy in the 14 plus visit category, the gait disorder does not add any additional power to the model



Functional Domain - Unchanged

- M0650 Dressing upper body
- M0660 Dressing lower body
- M0670 Bathing
- M0680 Toileting
- M0690 Transferring
- M0700 Ambulation

M0 Items are unchanged but the scoring is different and dependent on therapy utilization and episode timing





Non-Routine Supplies Case Mix Variables - Diagnoses

- Wounds
- Burns
- Surgical complications
- Skin conditions
- Added 3 V-Codes for ostomies
 - V55.5 – Cystostomy care
 - V55.0 – Tracheostomy care
 - V55.6 – Opening to Urinary System



Comments and Response

- Comments
 - Concerned that agencies have not been accurately billing for supplies and therefore the calculation for the NRS are not based on complete information
- Response
 - To ensure that NRS costs are being reported, claims that do not report supply costs will be returned to the provider (RTP)
 - Will need to resubmit with supplies reported on claim
 - If no supplies used, claim must explicitly note that fact





Non-Routine Supplies Operations Considerations

- Ensure orders for supplies
 - Still need to be on 485 or interim orders
- Track supplies by patient
- Include on bill
- Process
 - Internal
 - Vendor reports



Operations Considerations

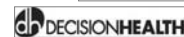
- OASIS Considerations
 - Accuracy
 - Consistency
 - Review process
 - Training
- Coding expertise
 - Training
 - Certification
 - Experience





SCIC Adjustment

- Eliminated SCIC adjustments
 - No billing component
- CoP still require – looking for clarification
 - 484.55(d) Update of the comprehensive assessment (includes OASIS)
 - As frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status,
 - Not less frequently than...within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests



Quality Data

- Reporting of Quality Data
 - Effective CY 2008
 - 2.9% Reduction
 - Pay attention to:
 - Discharges OASIS
 - Transfer OASIS
- Home Health Compare
 - Emergent care for wound infections
 - Improvement in status of surgical wounds

