Read Between the Lines of CMS' PPS Refinements…Put Yourself in the Winner's Circle!

The Home Health Prospective Payment System Proposed Rule is thought provoking. CMS has made some startling but difficult to contest assumptions. There were many credible statisticians involved in the thorough analysis comparing 2003 claims data against Pre-IPS and Pre-PPS claims data. The overriding opinion is that only 13.4 percent of the 23.3 percent increase in the home health case-mix index is due to actual case mix changes; 8.7% of the case mix increase is due to "provider behavioral changes", p. 112 CMS-1541-P. NAHC and the Industry believe that some behavioral changes undoubtedly took place but to assume that 8.7% of the "coding creep" is behavior change is just not an accurate or fair assumption. Throughout the analysis CMS frequently refers to "negative incentives" in the current system that have caused providers to distort patient severity, to change clinical practice in such a way that some types of patients may not have received adequate or any care. CMS believes that negative incentives in the current PPS model have caused providers to focus on artificial payment thresholds for monetary gain. CMS 2003 comparative data clearly indicates that there has been;

- An increase in case mix index…**BUT**… there was
  - A decrease in visits per episode AND…
  - A decrease in need for personal care
  - A decrease in chronic long term care provided
  - A decrease in wound care patients
- A significant increase in rehabilitation services

1999 - 2001	**2003**
Average visits = 36	Average visits = 20
Therapy visits = 3	Therapy visits = 4.4
Functional scores = F0 ↑ F1 ↑	Functional scores =F 2 ↑ F0 ↓ F1 ↓
Case Mix Index = 1.08	Case Mix Index = 1.22
Resources = $477.06	Resources = $462.59
	• 2% rate admission for "No Able & Willing Caregiver" • 44% decrease in personal care (HHA) utilization

CMS also has recognized that the current Outcome and Assessment Information Set (OASIS) does not accurately reflect severity of illness related to resource consumption sufficiently to equitably pay providers for the high cost of initial episodes, for medical supplies and for caring for more chronically ill patients. Higher payments tended to be inaccurately weighted and distributed rather than blended appropriately across the universe of patients. No surprise, the consequence, just as with cost reimbursement in the 90's, provider practice…followed the money. The therapy threshold is a good example; prior to IPS, the therapy visit average across the universe of patients was 3 visits per episode of care; post PPS the therapy visit average increased to 4.4 as providers focused on achieving the 10 visit threshold. Pre PPS, the highest concentration of therapy visits fell in the 5 to 7 category– below the 10 visit therapy threshold put into place by CMS. Post PPS there were two visit peaks, one peak below the therapy threshold and the second peak of therapy visits was between 6 and 13. It's hard to argue with facts.

Much of this behavior change is most certainly due to increased provider education with OASIS completion. Many providers did not initially understand how critical the need for accuracy with the initial assessment really was and that the patient scoring at discharge would ultimately become the information sent to CMS describing how well the organization managed patient care.

OASIS completion was not a meaningful process until the fall of 2003. Public reporting of patient outcomes in 2003 suddenly increased the "value" of outcomes improvement. The refinements of PPS appear to be right on target with eventual implementation of the proposed Home Health P4P (Pay for Performance). This first step of "smoothing" payment based on diagnosis coding and patient severity is possibly the initial foray into a more disease (management) and outcome driven model of payment.

There are some important steps to take right now to prepare for these changes. The first is to educate ourselves as much as possible about the changes that will take place as a result of the PPS refinement proposal. The second step is to do an analysis of operations to determine what financial and clinical operations impact these changes may have. The third is to better prepare our organization's financial and clinical processes for the enactment of the proposed rule. Below is a checklist with some of the important areas to address.

Prepare For PPS 2008

Episode Timing

1. Implement a process for ongoing tracking of episode timing and designate responsibility for CWF checking
2. Review process for checking common working file to Incorporate time points for subsequent checking
3. Develop a process for communication of CWF information to appropriate staff
4. Designate responsibility for management of financial adjustments that may necessary related to episode timing (to keep internal data current)
5. Include an episode adjustment monitor on weekly or monthly dashboard or management report

Information System

1. Talk with your software vendor to discuss timelines for system upgrades 2. Volunteer for beta site participation 3. Suggest provider involvement in the planning process 4. Review episode timing & therapy threshold alerts with vendor 5. Ensure that an interoperable medical supply billing interface will be available 6. Request reports to facilitate NAHC recommended revenue recognition models
Clinical Model 1. Analyze current clinical model for adequacy of patient care management process 2. Focus on primary clinician model and eliminate hand-offs as much as possible to facilitate communication and coordination 3. Invest in tele-monitoring to increase efficiencies and improve outcomes 4. Align incentives-compensate for the management of patients-not just visits
Education 1. Make education a priority-insure that ALL clinicians are adequately oriented and that ongoing education is required and efficiently provided. 2. Consider initiating remote education models to ensure standardized message and to increase staff time and travel.
Assessment & Diagnosis Coding 1. OASIS certification for more than one person 2. Consider hiring a certified coder-someone who understands home care PPS 3. Investigate outside benchmarking assistance & compare with internal software capabilities 4. Check adequacy of current process for OASIS review
Rehabilitation Services 1. Require physical therapy only admissions to be completed by physical therapists where state regulations permit. 2. Require physical therapists to complete the therapy assessment and M0 826 for all therapy patients 3. Consider creating a position for rehab management to include review of therapy OASIS
Medical Supply Management 1. Review your entire medical supply process; renegotiate vendor contracts if appropriate 2. Use an electronic interface for ordering to eliminate duplicity and error 3. Capture supply cost and revenue by diagnosis

Careful management of therapy visit projection adjustments and episode timing issues will be extremely important. Revenue projections could easily be off by thousands of dollars if processes are not in place to check the common working file at specified time points to pick up discrepancies with episode timing. Adjustments that CMS will make with the End of Episode claim due to a change in the episode will directly affect your revenue. For example; A patient has been on service with another agency for 2 episodes (no break in service) without your knowledge and you admit them as episode 1 (early) when it is really episode 3 (late). CMS will adjust accordingly. Add in a few therapy adjustments and you can have thousands of dollars at risk without your knowledge. It is also very important to validate any adjustment made by CMS. If you do not have a detailed process in your internal operations for identifying the change in therapy visits and to capture a change in the episode from early to late, you will have no way to know whether the adjustments made are correct. To illustrate the impact of only a few undetected adjustments;

A patient is admitted for the first time to your agency.
HHRG = C2F2S3 1st episode 6 Physical Therapy and 3 Occupational Therapy visits were projected

Revenue = $2,800.30

You discover the patient was actually under the care of another agency previously and they are in their 3rd episode (6 Therapy Visits) = C2F2S3

Revenue = $3,113.43

Adjustment = $ 313.13
If you had only 3 like adjustments = $939.39

Whoops! The patient actually received 16 Therapy visits
New HHRG = C2F2S2

Revenue = $4,799.54

Adjustment = **$1,686.11 !!!**
Just 3 (like) adjustments would = **$5058.33**

Another patient is in their 2nd Episode
14 Therapy visits were projected and the HHRG is C2F2S**1**

Revenue projected = $4,239.80 **But…**
Only **12 PT** visits were actually performed = New HHRG **C2F2S5**

Revenue = $3,621.20

Adjustment = **($618.60)** 3 (like) adjustments = **($1,855.80)**

A negative adjustment of $1, 855.80 could be very important to know about especially since it is very likely that more than 3 adjustments will be made in a month.

Weekly and monthly management reports are used by most businesses to assist with management of business and clinical operations. Some items to monitor are included in the following sample management reports;

Weekly Management Reports

Episode Timing	Total # New Episodes	Total # Ended Episodes	Revenue	Adjusted Revenue Amount	Total Visits	Average # Visits	Total Therapy Visits	Ave. Therapy Visits
EARLY 1								
2								
LATE 3								
4								

Episode Timing	Skilled Nursing Visits	Tele-monitors In Use	Average LOS	Average Case Weight	Medical Supply Revenue	Medical Supply Costs
EARLY **1**						
2						
LATE 3						
4						

Monthly Clinical Management Reports

Clinician	New Admits	Total Episodes	Tele-monitors Placed	Average Daily Census	Average Case Weight	Average Episode Revenue
S. Jones RN						
A. Smith RN						
J. Allen RPT						
M. Anders RN						

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In our efforts to prepare for major changes, we must not lose sight of the reason we are in home care. The fourth step is to continue focus on patient outcome improvement. With the proposed changes, patient diagnosis and severity should begin to more closely correlate with resource consumption and revenue will hopefully be more equitably distributed. With the next CMS analysis we will likely see more chronically ill patients cared for in home care, more wound care provided using national best practices, a completely new distribution of therapy visits and I believe we will continue to see case mix scores increase as a result of the upward shift in actual patient severity. Those organizations that choose to better their performance both clinically AND financially will be prepared for success with whatever challenges and Pay for Performance indicators that CMS chooses to send their way!