Improving Home Health Margins under PDGM

A Cisneros PT K McCormick RN BSN May 9, 2024

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Home Health Strategic Management - HHSM

- Home Health Consultants (30+ years HH experience)
- Developed from PAC Clinical Practice – Acute, SNF,HH
- Arnie Cisneros PT – President, SURCH Developer
- Kimberly McCormick RN BSN – Exec Clinical Dir
- Utilization Review Model for Home Health
- CMS Bundled Payment Pilot for CJR reforms
- Post-Acute PPS Trial for Episodic Models
- Operational Solutions for PDGM, VBP Success

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Comparing Home Health PDGM and PPS in terms of Positive Outcomes

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Comparing HH PDGM & PPS

The HH Volume-based PPS era was based primarily on therapy visit totals and episode LOS. Most of our employees & clinicians see the HH benefit through the PPS model. PDGM was developed in response to PPS programming concerns, and it inverts the PPS model. By capitating HH payments & focusing HH Value at the Star of Care, PDGM rewards accuracy & efficiency with improved fiscal margins. Most HH Providers & their employees are unfamiliar with this programming change, PDGM outcomes (clinical & fiscal) suffer. Finally, HH VBP Expansion installs a Pay-4-Performance (P4P) element to our care production & management with a focus on clinical efficiency.

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Addressing Home Health PDGM Outcomes Clinical vs. Fiscal

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Addressing PDGM Outcomes Clinical vs. Fiscal

- PDGM is a Value-era model that changes care production & delivery
- By inverting the Volume-based PPS model, PDGM challenges HH
- Questionable PDGM education may have left operations unaddressed
- As a result, many HH Providers unable to produce desired outcomes
- Traditional HH Operations (based on PPS) fail in PDGM terms
- PDGM programming specifics must be addressed w operations
- Failure to do so results in compromised outcomes
- In addition, Value-based HH aligns clinical and fiscal outcomes
- Internalize – Better care produces better fiscal margins

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Addressing PDGM Outcomes Clinical vs. Fiscal

- PDGM Value points present throughout the episode for success
- Culture change difficult in Home Health – particularly for Value
- Multiple reasons for unique HH Value Model – address for success
- HH Clinician-led industry resistant to change – Operations can't help
- HH Retro-active Operational Model in terms of care management
- HH Volume legacy difficult to overcome – clinician-led approach
- PPS Volume-era allowed for extended LOS and Margins
- PDGM requires efficient care content – a managed-care model

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Addressing PDGM Outcomes Clinical vs. Fiscal

- Increased performance required by PDGM stresses HH agencies
- Care elements required that exceed outstanding PPS-level care
- PDGM clinical and cultural changes present struggle at all levels
- Administration – integration of PDGM changes w/o insight into Value
- Management – Supervisory – change from retroactive to real-time
- Management – Supervisory – assume care responsibility w/o insight
- Front-line clinical staff – used to clinical independence – retro model
- Front-line staff – Confident about care delivery based on PPS

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Drivers of Home Health PDGM Margins

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Drivers of Home Health PDGM Margins

- Multiple drivers in PDGM affect eventual Fiscal (& Clinical) margins
- PDGM drivers are related directly to outcomes – verified by VBP
- Direct, Indirect, and VBP Drivers present throughout PDGM
- PDGM drivers reinforce lack of PPS-based care programming
- PPS POC approach – IT MIGHT TAKE US THIS LONG TO REACH GOALS
- PDGM POC approach – MAYBE WE CAN GET THEM BETTER THIS FAST
- PDGM drivers must be managed for success in terms of Outcomes
- This IS NOT Home Health as we all know it

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Direct Fiscal Drivers of Home Health PDGM Margins

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Direct Fiscal Drivers of HH PDGM Margins

- HH clinicians unable to self-manage PDGM/VBP culture change
- Drivers must be managed on an in-agency basis (Acute Care?)
- PDGM Direct Drivers include:
  - OASIS Accuracy
  - Primary Diagnosis
  - Co-morbidities
  - Coding
  - POC Development – Clinical Utilization

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Direct Fiscal Drivers of HH PDGM Margins

- OASIS Accuracy – Primary PDGM payment factor
- Elevated level of OASIS accuracy - > 95%
- Scrubbers don't do it after the SOC visit completed
- What has your agency done to address since PDGM?
- Primary diagnosis – has value but OASIS acuity essential
- Co-morbidities support clinical acuity profile & payment
- Coding – significantly decreased vs PPS in terms of value
- Level of Coding present at SOC

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Direct Fiscal Drivers of HH PDGM Margins

- POC Development – Clinical Utilization essential for PDGM
- PDGM programming can support Value if managed in-agency
- Clinical staff unable to manage PDGM for outcomes
- OASIS Accuracy, FIL guides LOS (30/60 day) and rehab visits
- Value POC required – SN visit avg – 5 per episode
- Assure Value program via in-episode management
- Non-compliance, value visit totals, CGVR, DC mgmnt

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Indirect Fiscal Drivers of Home Health PDGM Margins

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Indirect Fiscal Drivers of HH PDGM Margins

- HH clinicians unable to self-manage PDGM/VBP culture change
- Drivers must be managed on an in-agency basis (Acute Care?)
- PDGM Indirect Drivers include:
  - Timeliness – 24 - 48 hrs? 5 days? Post-Acute Providers?
  - Productivity of Clinical Staff?
  - Scheduling
  - Communication
  - In-Episode – DC Management – best practice control

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Indirect Fiscal Drivers of PDGM Margins

- Timeliness establishes efficient programming w 24-hr SOC
- Timeliness relates to all other Post-Acute Providers – 24 hrs
- 24-hr SOC requires efficiency at Intake to complete referral
- Also require scheduling coordination for 24 hr admit (IRF-SNF)
- Difficult to create optimal outcomes w/o 24-hr admits
- Scheduling integrity requires full productivity – Hosp, IRF, SNF
- This is the care efficiency we are focusing on
- Clinical staff CANNOT self-manage in this area

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Indirect Fiscal Drivers of PDGM Margins

- HH Communication managed by in-agency personnel
- WHY? PDGM requires elevated level of clinical management
- Example – Change of Condition real-time notifications
- Compliant patients - efficient clinical outcomes w/o volume
- Visit mgmnt is margin mgmnt – are we good after PPS here?
- Case Conference – does this drill down? Assure timely goals?
- In-Episode Clinical Rounds most effective for PGDM
- Drills down on the outcomes, waste, & clinical concerns

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The Role of VBP in Home Health PDGM Margins

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How does VBP affect PDGM Margins

- VBP Bonus 5% of payment total for VBP-qualified Providers
- Top 10% of PDGM performers – 5% Bonus – increase planned
- Ultimate measure of efficient care = PDGM margins
- VBP baselines demo – PPS clinical staff wont produce VBP
- VBP IS THE CARE EXPECTATION FOR THE FUTURE
- Difficult to optimize outcomes without VBP success
- Why wouldn't we be excited about improved care/outcomes?

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How does VBP affect PDGM Margins

- VBP tells us - can't be successful in HH w/o Culture Change
- Who leads in HH? Everyone needs it – Managers/Sup – Staff
- Medicare is aligning HH with other Post-Acute Providers
- Can you match other Post-Acute Providers in Value control?
- Value-based HH Providers must manage HH for PDGM patient
- Must break the PPS mold for success – concern re clinicians?

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Closing Thoughts on Improving your PDGM Margins
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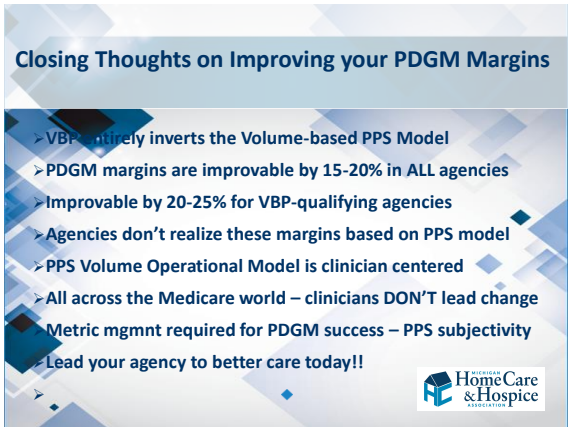
Closing Thoughts on Improving your PDGM Margins
VBP entirely inverts the Volume-based PPS Model
PDGM margins are improvable by 15-20% in ALL agencies
Improvable by 20-25% for VBP-qualifying agencies
Agencies don't realize these margins based on PPS model
PPS Volume Operational Model is clinician centered
All across the Medicare world – clinicians DON'T lead change
Metric mgmnt required for PDGM success – PPS subjectivity
Lead your agency to better care today!!
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