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Communications in the PDGM Evolution

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The care continuum is increasingly essential to ACOs, Population Health, and decreased 30-day re-admission while the Patient-Driven Groupings Model (PDGM) is overshadowing the rapid evolution of the industry's largest home health providers. Hospital and home health communications coordination is more essential than ever and often overlooked. In the current environment, the priority is on internal communications for operational and coding changes, including employee morale, rather than on marketing services in a highly competitive environment to build growth.

With the long-awaited PDGM upon us, we are marking the biggest home health reimbursement overhaul in two decades. PDGM officially launched on Jan. 1 after originally being proposed by the Centers for Medicare & Medicaid Services (CMS) in July 2018. With changes to billing periods, therapy reimbursement, and LUPAs, it's the most significant shift since the Prospective Payment System (PPS) was implemented on Oct. 1, 2000.

DeTora Consulting has identified the following issues, challenges, and keys to success that will determine the success of home health industry clients in the first month.

Hospital-based and private home health organizations have committed much to early preparation for PDGM. The greatest concern of the moment is whether CMS and its contractors are equally prepared. The skilled nursing facilities' experience in October with PDGM is instructive as there were a number of operational problems. Additionally, the phaseout of the RAPs will create some cash flow difficulties for some home health agencies (HHAs).

There is significant confusion around the PDGM policy that will trigger claim rejections in the form of "Return to Provider" when the claim does not have an acceptable diagnosis code. There are a number of codes that had been routinely used for many years that are now no longer acceptable under PDGM. We hope that CMS is willing to quickly revisit its position on the so-called "Questionable Encounters."

It is not easy to identify just a handful of actions that will lead success. Still, there are some core elements in the transformation to PDGM that are needed to optimize for chances of success:

1. Gain control of revenue cycle management. This means taking all necessary steps to speed up securing acceptable physician documentation, including the plan of care, primary diagnosis coding and comorbidities support, along with the HHAs timely completion of OASIS. The sooner RAPs and final claims can be submitted, the more stable the HHA will be.
2. Engage in comprehensive, interdisciplinary clinical management. This will ensure that the level of care provided fits the individual patient. It is the best way to control LUPAs, outliers, and efficient overall visit utilization.
3. Referral management. Internally, the HHA referral team needs to understand and appreciate the changes brought on by PDGM. Externally, referral sources need to understand the impact of PDGM on them relative to documentation challenges, etc.
4. Securing PDGM-related benchmarking data on a near real-time basis. This includes both financial and clinical data that explain the changes within an HHA.

With the success of advocacy around the PDGM base payment rate –namely, the significant reduction in the behavioral adjustment and the elimination of the HHGM's 4.3% rate cut — the anxiety levels in transitioning to PDGM have been notably reduced in HHAs across the country.

For cash flow to be properly managed, agencies must manage their unbilled claims to keep that list as small as possible. It is inevitable that Medicare cash flow is going to take a dip early in 2020; agencies should remember to focus billing and collections efforts on non-Medicare payers to maximize incoming cash flow.

Communication and collaboration become paramount for patient care management under PDGM. Case conferencing, as well as a rapid response team that is dealing with any issues that may come up, plays a huge role in that. The issues we've had so far are very minor and have been quickly addressed. Case conferencing under PDGM includes LUPA management and monitoring the new LUPA thresholds. It also includes evaluating patients coming up on the end of their 30-day payment period to determine if they will be continuing care into a subsequent period. It's also important to have proper

communication channels in place in instances where a patient's primary diagnosis code changes mid-period.

During the first month, home health providers must focus on getting their clinical and operational processes up-to-date and in place quickly. They must make sure to communicate with clinicians, referral sources, and the physicians signing orders. The intake staff needs to be collecting a billable primary diagnosis. Clinicians need to be completing thorough and accurate OASIS assessments quickly. Quality assurance reviews should be performed quickly to ensure accurate information is included in all documentation and any process breakdowns are identified. Be sure to communicate with physicians to ensure orders are signed in a timely manner. All of these things must be in place now so that the final claim can be billed at the end of the month.

It's still very early in the implementation, and we are waiting to see exactly how CMS will handle this transition and whether their systems will work properly to process OASIS data, RAPs, and claims. We encourage all home health providers to check daily for updates from CMS, especially during the first 90 days.

I have been tracking and observing several home health Facebook groups, which is where I stay in the loop with my colleagues. We have already begun to witness the turmoil caused by PDGM on social media and morale is being affected. Home health organizations and clinicians need communications support to endure these seismic shifts caused by PDGM. We are embedded in a tech-driven world and if home health agencies don't adapt to help their operational inefficiencies, they won't survive.

Marketing departments must be working closely with operations, finance, and human resources to effectively communicate and educate employees on the PDGM changes and reassure them of the administrative support provided by the organization. Keen strategic marketers may already be conducting the appropriate market research required to identify, prioritize, and calculate ROI from purging clients from flailing competitors and acquisitions of financially frail rivals.

For questions on PDGM, home health marketing plans, or to request a proposal, please call us at 908-447-9231 or email Gabrielle@DeToraConsulting.com.

About Gabrielle DeTora

Gabrielle is a healthcare marketing strategist with nearly two decades of executive experience and a proven track record of driving ROI. Gabrielle has worked with the CEOs and leadership teams of nearly 50 health systems, representing over 100 hospitals nationwide. She has served as the strategic leader for health systems, brand marketing agencies, and consultancies.

Earlier in her career, Gabrielle served as the Vice President of Health Strategy for a major advertising agency. There, she oversaw all strategic business planning, branding, marketing, and execution for more than a dozen large healthcare systems, healthcare organizations, and insurance companies.

Her past experience also includes top executive strategic planning and marketing roles at St. Joseph's Healthcare System, Hunterdon Healthcare System, the Cure for Lymphoma Foundation, and the Leukemia & Lymphoma Society. This deep experience gives her a keen understanding of the healthcare industry, which she uses to deliver highly effective strategic marketing plans for her clients.

Beyond the work Gabrielle conducts for her clients, she is also called upon regularly to speak at national healthcare conferences, and is a regular contributor to a variety of healthcare publications. Gabrielle has an MBA from Kennedy-Western University and a BBA from the Zicklin School of Business (CUNY).

To ask questions or inquire about consultant services for effective and efficient strategic planning execution, please contact Gabrielle DeTora at gabrielle@detoraconsulting.com or 908-447-9231.

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