Improving Home Health Revenue Cycle

HCAF HomeCareCon 2022

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Melinda A. Gaboury, with more than 30 years in home care, has over 20 years of executive speaking and educating experience, including extensive day to day interaction with home care and hospice professionals. She routinely conducts Home Care and Hospice Reimbursement Workshops and speaks at state association meetings throughout the country. Melinda has profound experience in Medicare PDGM training, billing, collections, case-mix calculations, chart reviews and due diligence. UPIC, RA, ADR & TPE appeals with all Medicare MACs have become the forefront of Melinda's current impact on the industry. She is currently serving on the NAHC/HHFMA Advisory Board and Work Group and is Treasurer on the Home Care Association of Florida Board of Directors & the newest member of the Tennessee Association for Home Care Board of Directors. Melinda is also the author of the Home Health OASIS Guide to OASIS-D1 and Home Health Billing Answers, 2022.

Speaker

Melinda A. Gaboury, CEO
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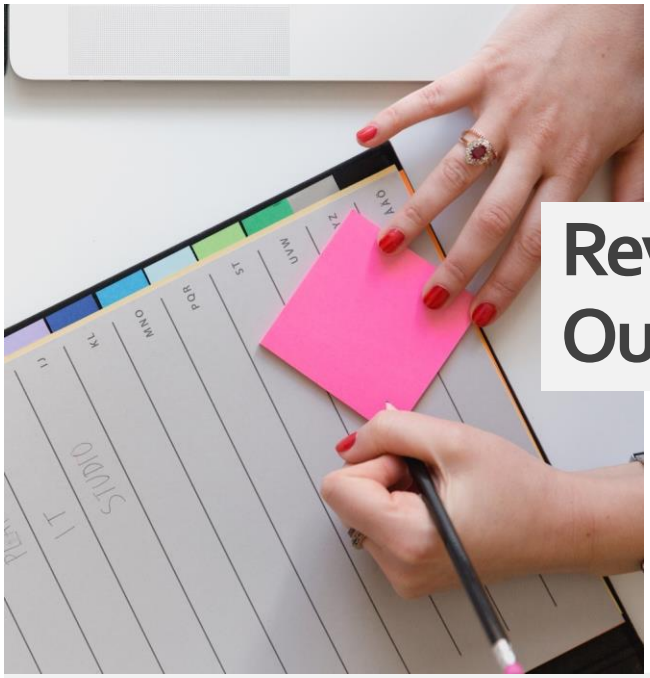

Revenue Cycle Outlined

- Intake
- Clinical Assessment
- Orders Management
- Billing & Collections
- Payment - Reconciliation

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Tips to Remember - NOA

- An NOA was required for any period of care that started on or after 01.01.22
- HHAs must submit the NOA when they have received the appropriate physician's written or verbal order that contains the services required for an initial visit, and the HHA has conducted the initial visit at the start of care
- NOA must be submitted within five calendar days from the start of care. A payment reduction applies if an HHA does not submit the NOA within this time frame.
- Reduction in payment amount would be equal to a 1/30th reduction to the wage-adjusted 30-day period payment amount for each day from the home health start of care date until the date the HHA submitted the NOA
    - Reduction would include any outlier payment
    - Reduction amount will be displayed with value code "QF" on claim

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Notice of Admission

- For all patients receiving HH services in 2021 whose services will continue in 2022, you should submit an NOA with a one-time, artificial "admission" date corresponding to the "From" date of the first period of continuing care in 2022.
- Example: Start of Care 12/15/2021
  - First 30-day Period 12/15/21 – 01/14/22 (NO PAY RAP)
  - Second 30-day Period 01/15/22 – 02/17/22 (NOA)

In the example above the "artificial admission date" would be 1/15/22 and would need to be used on all final claims going forward until the patient is discharged.

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NOA 2022 - EXAMPLE

Start of Care 60-DAY Episode with 30-day PAYMENT PERIODS

01/03/22 – 02/01/22 & 02/02/22 – 03/04/22

- NOA filed and accepted at MAC on 02/20/22
- HIPPS Code value $2,800 for 1st Period and $1,800 for 2nd Period

When 1st final is paid the agency will receive the following payment:

- $0 due to NOA be accepted after the first 30-day period is over.

When 2nd final is paid the agency will receive the following payment:

- $1,800 divided by 30 = $60 per day
- $60 X 18 days (2/2 – 2/19) = $1,080
- $1,800 - $1,080 = **$720**

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Example
Low Utilization Payment Adjustments (LUPA)

- If the claim reflects visit counts that are below the LUPA threshold the NOA is filed, but is accepted LATE – the agency will not be paid per visit for the visits that are in the penalty window.
- Patient admitted January 15, 2022 (1/15 – 02/13)
- HIPPS code calculated reflects a 5 visit LUPA threshold – visits were provided on 1/15, 1/22, 1/29 & 2/10
- Agency does file a NOA, but it is not received until 1/23.
- Due to the Final Claim payment resulting in a LUPA, the agency will be penalized for the visits in the non-covered days range. So, NON-covered is 1/15 & 1/22.

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Final Claims – Billing Requirements

All payment periods

- OASIS assessment(s) transmitted to & accepted at database
  - SOC, recertification, ROC or other follow-up, *if applicable*
- Compliant F2F encounter documentation obtained
- All physician orders signed & dated
  - POC & all other interim orders applicable to payment period
- All billable visit & NRS documentation completed
- Compliant therapy reassessment documentation completed

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Payment Pricing

Claim payments subject to pricing

- OASIS Validation is the first step – the Claim will RTP if the OASIS data and the claim do not match.
- Payment period timing
  - Claim payments to be automatically repriced for early or late status based on paid claims history on Medicare CWF (Start of Care ONLY)
- Admission source
  - **Occurrence codes 61 & 62** will now be used to trigger payment calculation for Institutional vs. Community. Claims data will be utilized to reconcile periodically with the Institutional credit given.

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Payment Pricing

Claim payments subject to pricing

- Clinical Grouping & Comorbidities
  - The primary & all secondary diagnoses are taken from the CLAIM to determine the Clinical Grouping and Comorbidity level.
- Functional Scores
  - OASIS Responses will be extracted from the OASIS-D1 and used to calculate the HIPPS code
- The final HIPPS code calculated by the Medicare MAC is the one that your final claim payment will be based on regardless of the HIPPS code that you sent in on the claim.

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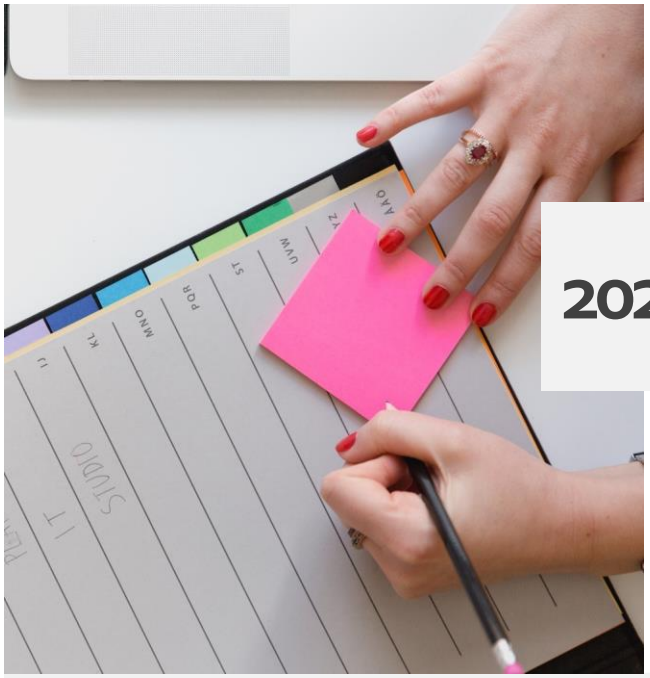

2023 Proposed Rule

- Rate Changes
- Case Mix Weight Changes
- OASIS Completion Changes
- Telehealth
- Value-Based Purchasing

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2023 PROPOSED Rule – Rate Update

- This rule proposes routine, statutorily required updates to the home health payment rates for CY 2023. CMS estimates that Medicare payments to HHAs in CY 2023 would decrease in the aggregate by -4.2% based on the proposed policies.
  - This decrease reflects the effects of the proposed 2.9% home health payment update percentage ($560 million increase),
  - An estimated 6.9% decrease that reflects the effects of the proposed prospective, permanent behavioral assumption adjustment of -7.69% ($1.33 billion decrease),
    - An estimated 0.2% decrease that reflects the effects of a proposed update to the fixed-dollar loss ratio (FDL) used in determining outlier payments ($40 million decrease).

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2023 Proposed Rule – base rate

TABLE B27: CY 2023 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2022 National Standardized 30-Day Period Payment	Permanent BA Adjustment Factor	Case-Mix Weights Budget Neutrality Factor	Wage Index Budget Neutrality Factor	CY 2023 HH Payment Update	CY 2023 National, Standardized 30-Day Period Payment
$2,031.64	0.9231	0.9895	0.9975	1.029	$1,904.76

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2023 Proposed Rule – per visit rate

TABLE B29: CY 2023 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2022 Per-Visit Payment Amount	Wage Index Budget Neutrality Factor	CY 2023 HH Payment Update	CY 2023 Per-Visit Payment Amount
Home Health Aide	$71.04	0.9992	1.029	$73.04
Medical Social Services	$251.48	0.9992	1.029	$258.57
Occupational Therapy	$172.67	0.9992	1.029	$177.54
Physical Therapy	$171.49	0.9992	1.029	$176.32
Skilled Nursing	$156.90	0.9992	1.029	$161.32
Speech-Language Pathology	$186.41	0.9992	1.029	$191.66

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Case-Mix Weight Changes Proposed 2023

- Each of the 432 payment groups under the PDGM has an associated case-mix weight and Low Utilization Payment Adjustment (LUPA) threshold. CMS' policy is to annually recalibrate the case-mix weights and LUPA thresholds using the most complete utilization data available at the time of rulemaking.
- In this proposed rule, CMS is proposing to recalibrate the case-mix weights (including the functional levels and comorbidity adjustment subgroups) and LUPA thresholds using CY 2021 data to more accurately pay for the types of patients HHAs are serving.

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Case-Mix Weight Changes Proposed 2023

- 238 groups: -5% - 0% change in weights
- 183 groups: 0% - +5% change in weights
- 10 groups: +5% - +10% change in weights
- 1 group: 10% - 12% increase in weights
- Changes to the PDGM case-mix weights are implemented in a budget neutral manner

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Proposed Wage Index Changes

- Proposed to apply a permanent 5% cap on any decrease to a wage index from its wage index in the prior year, regardless of the circumstances causing the decline.
- Proposed that a wage index for CY 2023 would not be less than 95 percent of its final wage index for CY 2022, regardless of whether the geographic area is part of an updated CBSA
- Subsequent years, a wage index would not be less than 95% of its wage index calculated in the prior CY – also proposed, that if a prior CY wage index is calculated based on the 5% cap, then the following year's wage index would not be less than 95% of capped wage index

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LUPA Threshold Proposed Changes 2023

- Original based on the 10th percentile of visits - based on 2021 the following is proposed in updating the LUPA Thresholds for 2023:
  - 120 case mix groups will have a reduction of 1 visit in the LUPA Threshold
  - 18 case mix groups will have an increase of 1 visit in the LUPA Threshold
  - 12 case mix groups will have a reduction of 2 visits in the LUPA Threshold
  - 2 case mix groups will have a reduction of 3 visits in the LUPA Threshold
  - 280 case mix groups will have NO CHANGE in the LUPA Threshold

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LUPA Add-On Update – no change 2023

LUPA Add-On

- SN1.8451
- PT 1.6700
- SLP 1.6266
- OT1.6700 (2023 – will be updated after data is gathered from OT actually doing initial visits)

- To calculate the payment, multiply the per-visit payment amount for the first SN, PT, or SLP visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes by the appropriate factor to determine the LUPA add-on payment amount.
- For example, using the proposed CY 2022 per-visit payment rates for those HHAs that submit the required quality data, for LUPA periods that occur as the only period or an initial period in a sequence of adjacent periods, if the first skilled visit is SN, the payment for that visit would be $297.65 (1.8451 multiplied by $161.32), subject to area wage adjustment.

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Outlier

- ✓ The FDL ratio and the loss-sharing ratio are selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by section 1895(b)(5)(A) of the Act).
- ✓ Historically, we have used a value of 0.80 for the loss-sharing ratio, which, we believe, preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs that exceed the outlier threshold amount.
- ✓ **Using CY 2021 claims data (as of March 21, 2022) and given the statutory requirement that total outlier payments do not exceed 2.5 percent of the total payments estimated to be made under the HH PPS, we are proposing an FDL ratio of 0.44 for CY 2023. CMS will update the FDL, if needed, once we have more complete CY 2021 claims data. (2022 = 0.40)**

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Telehealth Data Collection 2023

To collect more complete data on the use of telecommunications technology in the provision of home health services, we are soliciting comments on the collection of such data on home health claims, which we aim to begin collecting by January 1, 2023 on a voluntary basis by HHAs, and will begin to require this information be reported on claims by July of 2023.

Three New G-Codes:

1. identifying when home health services are furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system;
2. synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system;
3. and the collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency, that is, remote patient monitoring. We would capture the utilization of remote patient monitoring through the inclusion of the start date of the remote patient monitoring and the number of units indicated on the claim.

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Home Health OASIS Proposed Changes

- In addition to OASIS-E Implementation effective January 1, 2023 – there are proposed changes, INCLUDING the proposal to require OASIS be completed on ALL payers and ALL OASIS be transmitted to the database and ALL OASIS be used in risk adjusted outcome calculations!
    - 2025 HH QRP – January 1, 2024-June 30, 2024
    - 2026 HH QRP –July 1, 2024-June 30, 2025
    - Recognizes potential burden for HHAs
    - Provide CMS with robust quality of care information

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Home Health Value-Based Purchasing Model

Home Health Value-Based Purchasing is set to begin January 1, 2023

- Proposed Rule for 2023 proposing changing the HHA Baseline and Model Baseline Years to 2022 INSTEAD of 2019 – assuming your agency was certified PRIOR to January 1, 2022

Performance Year 5

- CMS ended the program early and not applying any adjustments from the PY 5 due to uncertainties from the pandemic and the exempted quarters – 2020 is not being used in any reporting or payment adjustments

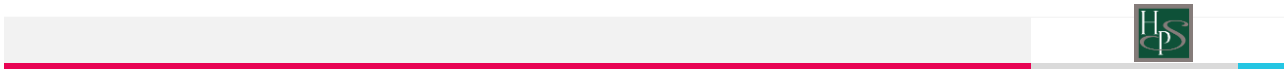
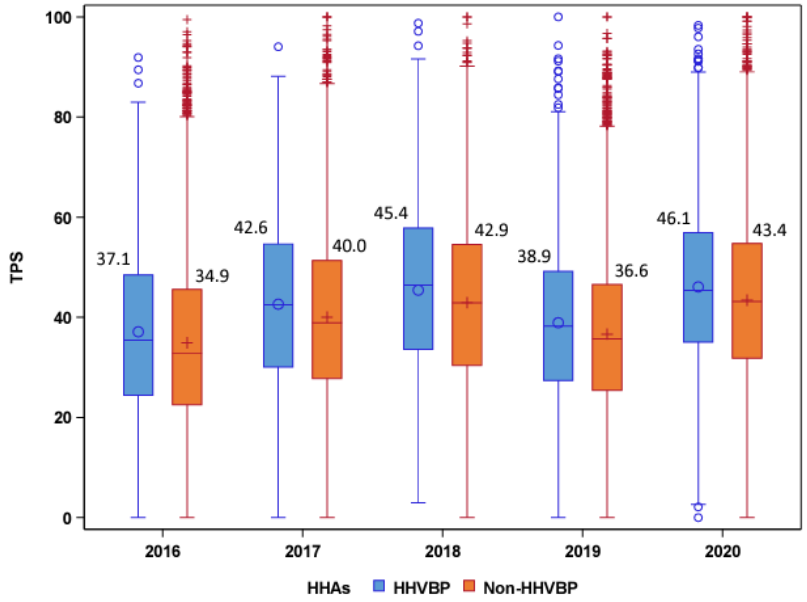
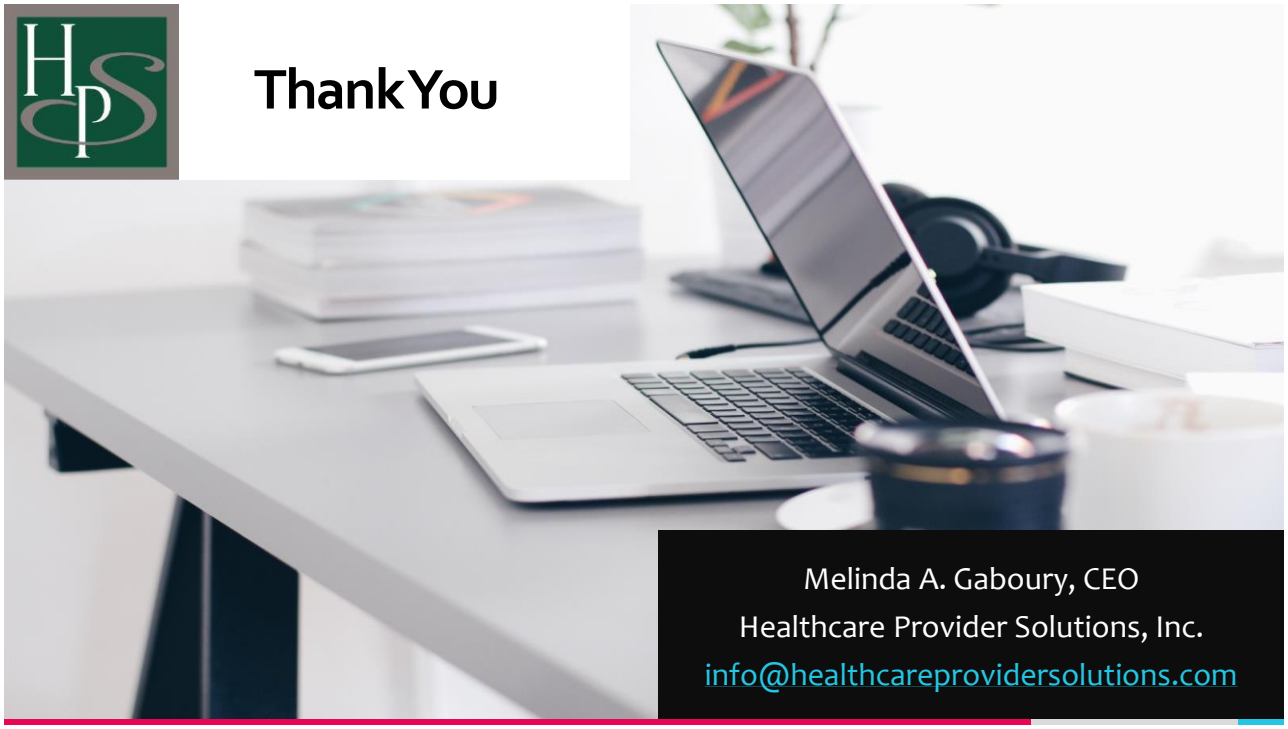


Exhibit 48. Higher Agency TPS Values in HHVBP versus Non-HHVBP States, 2016 – 2020



Thank You



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