Patient Care and Financial Success in the PDGM Payment World

June 17th, 2020

- SHP Wednesday Winning Webinars

SHP STRATEGIC HEALTHCARE PROGRAMS | Corridor

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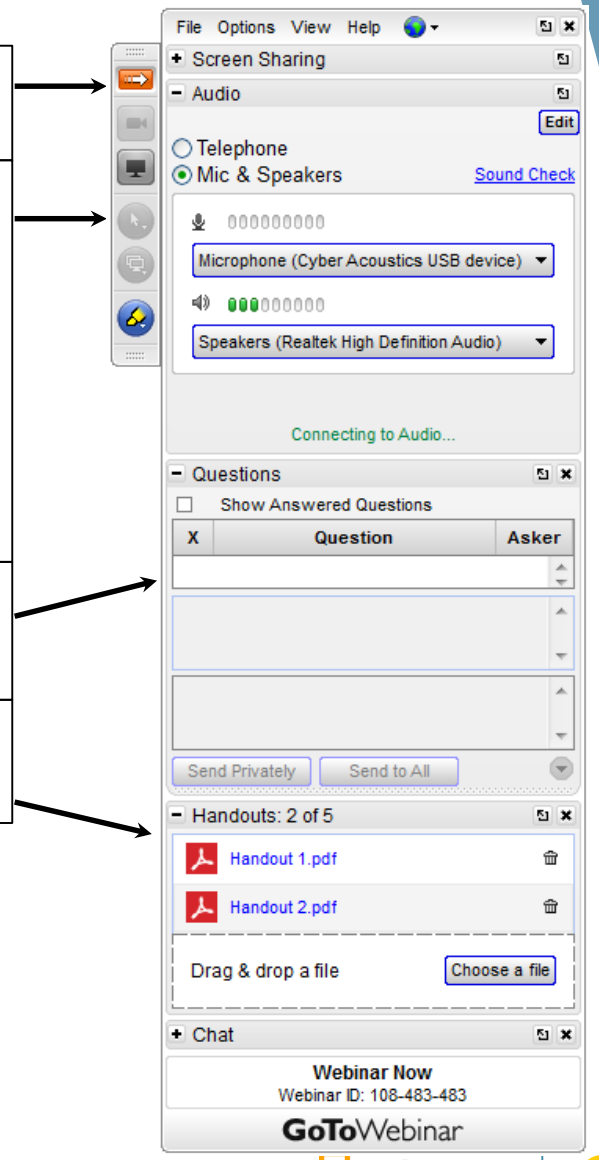

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Objectives

- Interpret PDGM benchmarks using data from the first 5 months of 2020
- Understand the Initial results in the new PDGM World
- Identify innovative patient centered approaches for managing visit utilization and clinical groupings choices

Interpret PDGM benchmarks

Early Benchmarking Data

- Based on PDGM 30-Day Periods (as of June 9th)
- Compares SHP National Database with CY'20 Periods Starts to CMS '20 Final Rule projections which were based on CY 2018 Claims data (paid through July 31, 2019)
- Based on later of either Final Claims or OASIS
- QE's are not included
- Claims (LUPA rates and Visits) data is for Jan – April '20 only
- COVID-19 will impact the data into Q2

PDGM is New – Be Aware of Implications

- PDGM only applies to 30-day Payment Periods that begin in CY 2020
- Total Periods and the sequence of periods can be impacted
  - January will have very limited 2nd period counts – Jan 31st starts only!
- Source and Timing will reflect higher Early and Institutional Periods initially
  - A higher proportion of 1st Period HHRGs will come from a hospital or other institution
- Understand the reports and what parameters were used
- LUPA rates may be higher in the short term if billed sooner than other non-LUPA periods

PDGM Components - National

Clinical Group	SHP	CMS	Period Sequence		
			1st Only	Any 1st	2nd +
MMTA - Other	2.9%	3.0%	3.1%	3.2%	2.7%
Neuro / Stroke Rehab	10.3%	10.2%	9.4%	10.9%	9.8%
Wounds	14.4%	11.9%	8.0%	10.4%	17.8%
Complex Nursing	3.9%	4.4%	1.3%	1.6%	5.9%
Musculoskeletal Rehab	18.4%	18.8%	31.1%	24.3%	13.4%
Behavioral Health	2.7%	3.1%	1.5%	1.9%	3.4%
MMTA - Surgical Aftercare	4.2%	3.4%	7.1%	5.8%	2.7%
MMTA - Cardiac / Circulatory	18.0%	21.9%	14.0%	16.4%	19.4%
MMTA - Endocrine	5.4%	7.1%	3.1%	4.1%	6.4%
MMTA - GI / GU	5.1%	4.1%	5.5%	5.6%	4.7%
MMTA - Infectious Disease	5.4%	3.8%	5.8%	5.5%	5.2%
MMTA - Respiratory	9.3%	8.3%	10.0%	10.3%	8.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

PDGM Components - National

Comorbidity	SHP	CMS	Period Sequence		
			1st Only	Any 1st	2nd +
None	47.5%	56.4%	58.1%	52.9%	42.9%
Low	38.4%	35.5%	33.5%	36.4%	40.2%
High	14.1%	8.1%	8.4%	10.7%	17.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Functional Impairment	SHP	CMS	1st Only	Any 1st	2nd +
Low	24.0%	35.1%	21.9%	19.0%	28.2%
Med	32.2%	33.4%	35.2%	33.6%	31.1%
High	43.8%	31.5%	42.9%	47.4%	40.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source & Timing	SHP	CMS	1st Only	Any 1st	2nd +
Community – Early	13.4%	13.3%	23.8%	29.0%	0.0%
Institutional – Early	27.4%	18.5%	67.2%	59.2%	0.0%
Community – Late	54.4%	61.4%	3.3%	5.0%	97.0%
Institutional – Late	4.8%	6.8%	5.7%	6.8%	3.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

CMS on Case-Mix Weights (CMW)

- Using Claims Data for CY 2018 paid through 7/31/19, CMS calculated the resources or “cost of care” consumed using a Regression Analysis for each of the 432 HHRGs to determine a corresponding case-mix weight
- Used a Cost per minute + Non-Routine Supplies (NRS) approach to determine resource use
- Set the Functional Impairment point thresholds to achieve approximately 1/3 for each level – low, medium and high
- CMS is using national rate adjustments to account for expected behavioral adjustments (LUPA, Clinical Grouping and Comorbidity)

CMS Regression Analysis – CMW

- Case-mix weight for HHRG - 3A2B
- Adjustment factor of Late Community is significant

Constant	1.0124

Admission Source	Admission Timing: Early	Admission Timing: Late
Community	0	-0.4061
Institutional	0.1801	0.0414

Clinical Group	Functional Impairment Level: Low – Pt. Range	Low – Case Mix	Medium – Pt. Range	Medium – Case Mix	High – Pt. Range	High – Case Mix
Wound	0-41	0.2345	42-59	0.3787	60+	0.5032
Neuro	0-45	0.1804	46-60	0.3401	61+	0.4424
MMTA- Endocrine	0-34	0.0856	35-52	0.2588	53+	0.375
Musculoskeletal Rehab	0-38	0.069	39-52	0.1791	53+	0.3341
MMTA- Other	0-36	0	37-52	0.1331	53+	0.2312
MMTA- Cardiac and Circulatory	0-36	-0.0455	37-52	0.1055	53+	0.2173
MMTA- Inf. Disease, Neoplasms, and Blood Diseases	0-36	-0.0235	37-52	0.1024	53+	0.2159
MMTA-Surgical Aftercare	0-37	-0.1006	38-50	0.0524	51+	0.2103
MMTA-Respiratory	0-37	-0.049	38-52	0.0887	53+	0.1966
Complex Nursing Interventions	0-38	-0.0593	39-58	0.1341	59+	0.1963
MMTA -GI and GU System	0-41	-0.0565	42-54	0.0983	55+	0.1851
Behavioral Health	0-36	-0.084	37-52	0.0784	53+	0.1674

Comorbidity Adjustment	
No Comorbidity Adjustment	0
Low Comorbidity Adjustment	0.0507
High Comorbidity Adjustment	0.1474
Total Case Weight	0.7901

Source: Amended from CY 2020 CMS Final Rule

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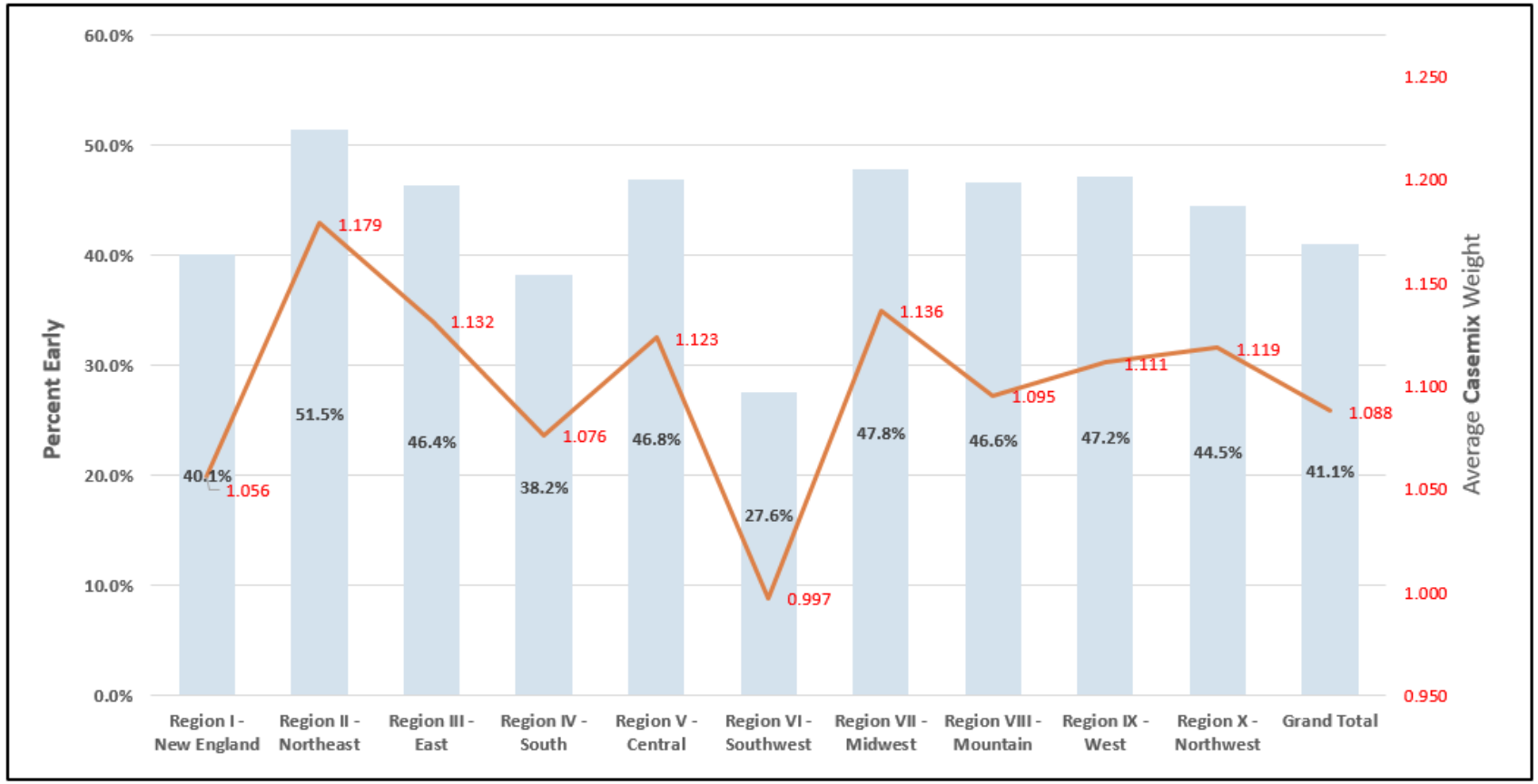
Case-Mix Weight – CMS Regions (non-LUPA)

- Early Periods CMW reflect the higher resources utilized

Clinical Group	All Periods	Period 1	Period 2	Period 3	Period 4	Period 5+
MMTA - Other	1.030	1.262	0.819	0.773	0.779	0.762
Neuro / Stroke Rehab	1.209	1.454	0.996	0.954	0.956	0.969
Wounds	1.212	1.497	1.085	1.055	1.059	1.071
Complex Nursing	0.867	1.217	0.783	0.760	0.769	0.786
Musculoskeletal Rehab	1.178	1.377	0.894	0.828	0.841	0.845
Behavioral Health	0.810	1.134	0.721	0.678	0.673	0.608
MMTA - Surgical Aftercare	1.094	1.278	0.763	0.715	0.728	0.741
MMTA - Cardiac / Circulatory	0.989	1.280	0.816	0.766	0.766	0.758
MMTA - Endocrine	1.079	1.385	0.956	0.905	0.907	0.887
MMTA - GI / GU	1.021	1.260	0.787	0.756	0.758	0.759
MMTA - Infectious Disease	1.022	1.282	0.815	0.765	0.763	0.749
MMTA - Respiratory	1.039	1.290	0.797	0.760	0.760	0.757
Overall	**1.088**	**1.345**	**0.881**	**0.855**	**0.858**	**0.858**

Casemix vs % Early Periods

- Reflects strong correlation to Early Periods on Non-LUPA CMW



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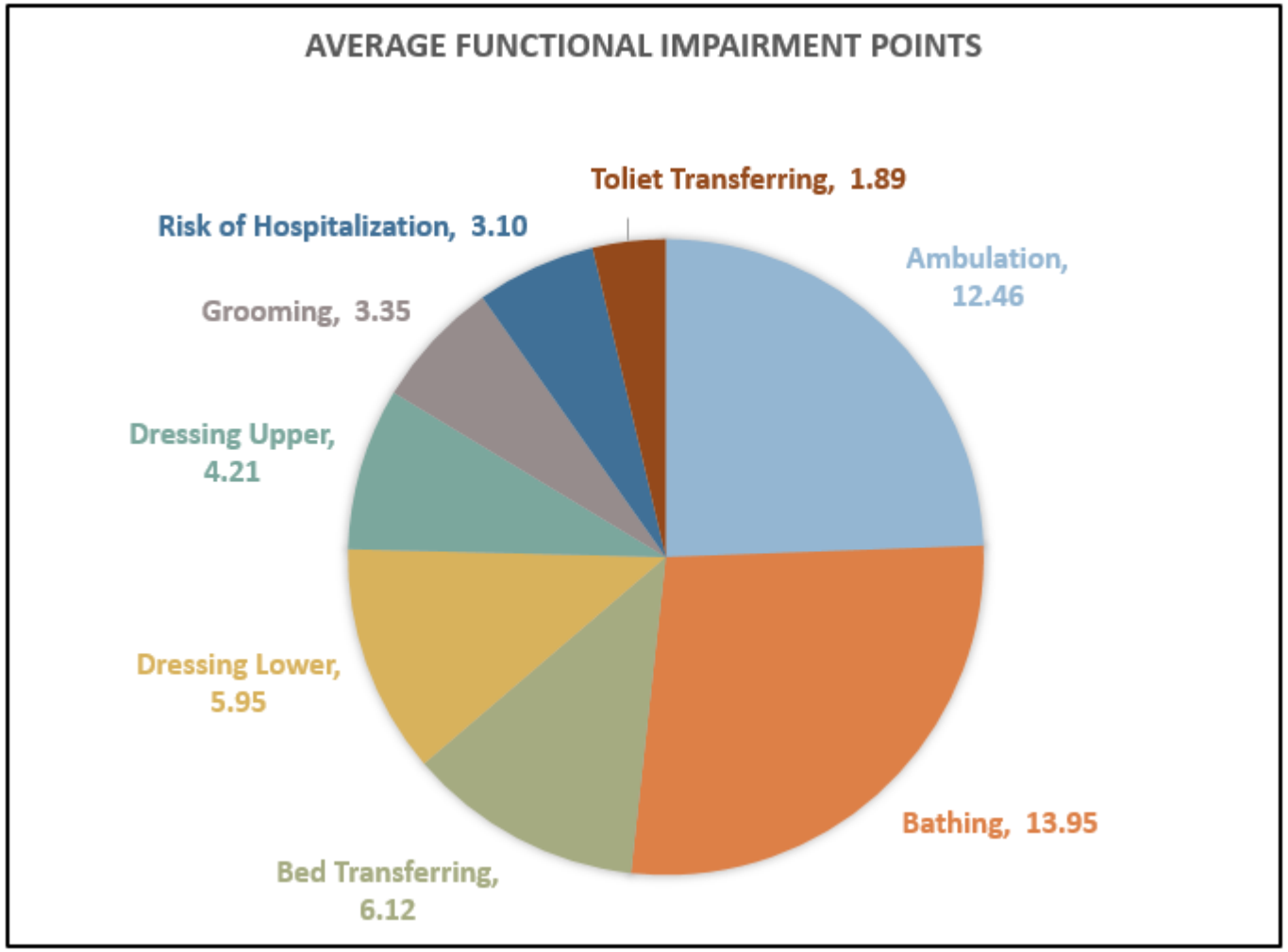
Functional Impairment

- Points Distribution By OASIS Item
- Total Points Avg = 51.03
- Higher than CMS base-line points



Understand the Initial results in the new PDGM World

LUPA Rates

- Rates based on Period Sequence
- Nuances of First Period LUPA rates if continued to a 2nd Period

Clinical Group	Period 1	Period 2	Period 3	Period 4	Period 5 +
Behavioral Health	9.4%	11.4%	4.4%	8.3%	9.3%
Complex Nursing	12.6%	13.2%	21.0%	14.1%	25.7%
MMTA - Cardiac	9.6%	10.9%	3.7%	7.9%	4.1%
MMTA - Endocrine	9.6%	16.8%	6.4%	11.7%	5.9%
MMTA - GI / GU	9.2%	11.2%	6.1%	8.7%	11.4%
MMTA - Infectious	8.9%	11.5%	6.4%	9.5%	15.1%
MMTA - Other	9.9%	11.6%	3.9%	6.8%	6.8%
MMTA - Respiratory	9.1%	11.4%	3.6%	7.8%	4.1%
MMTA - Surg Aftcr	10.5%	14.4%	4.1%	9.8%	3.8%
MS Rehab	10.5%	11.1%	2.7%	8.3%	3.8%
Neuro Rehab	10.9%	11.5%	4.0%	8.5%	6.5%
Wounds	9.1%	13.5%	5.5%	9.6%	5.1%
Overall	**9.9%**	**11.9%**	**4.9%**	**8.9%**	**8.3%**

Source: SHP 30-Day Period Claims Billed Jan ‘20 – April ‘20

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LUPA Rates

- Comparison based on Clinical Group & LUPA Thresholds

	Visit Threshold				
Clinical Group	**2**	**3**	**4**	**5**	**6**
MMTA - Other	8.2%	8.3%	10.1%	13.4%	
Neuro / Stroke Rehab	7.1%	12.4%	9.1%	11.5%	11.7%
Wounds	4.9%	7.8%	8.3%	10.4%	
Complex Nursing	22.5%	14.8%	10.6%		
Musculoskeletal Rehab	7.6%	10.5%	7.0%	10.7%	11.3%
Behavioral Health	8.7%	10.2%	9.9%		
MMTA - Surgical Aftercare	11.1%	8.0%	10.1%	12.2%	
MMTA - Cardiac / Circulatory	6.0%	9.4%	9.1%	12.1%	
MMTA - Endocrine	5.4%	10.2%	8.7%	12.1%	
MMTA - GI / GU	10.1%	8.4%	10.0%		
MMTA - Infectious Disease	11.7%	9.1%	9.8%		
MMTA - Respiratory	7.4%	8.4%	9.5%	12.3%	
Overall	**8.9%**	**8.9%**	**9.3%**	**11.2%**	**11.4%**

Percent of HIPPS Codes	21.8%	29.6%	31.7%	14.6%	2.3%
Percent of LUPA Period Count	36.1%	19.8%	15.7%	21.7%	6.7%

Source: SHP 30-Day Period Claims Billed Jan ‘20 – April ‘20

Visit Utilization

- Breakout by Discipline and Clinical Group (Standard Payment)

Clinical Group	Nursing	PT	OT	ST	MSW	HHA	Total
MMTA - Other	3.46	3.30	0.92	0.15	0.09	0.36	8.28
Neuro / Stroke Rehabilitation	2.62	4.04	1.55	0.75	0.10	0.48	9.55
Wounds - Post-Op Wound Aftercare	7.39	1.29	0.43	0.05	0.05	0.40	9.61
Complex Nursing Interventions	4.05	0.74	0.23	0.08	0.03	0.84	5.97
Musculoskeletal Rehabilitation	2.43	5.31	1.32	0.07	0.06	0.37	9.56
Behavioral Health	3.17	2.32	0.79	0.36	0.11	0.30	7.05
MMTA - Surgical Aftercare	5.10	2.64	0.78	0.11	0.06	0.24	8.93
MMTA - Cardiac / Circulatory	4.19	2.67	0.82	0.11	0.08	0.41	8.27
MMTA - Endocrine	4.74	2.45	0.75	0.12	0.10	0.42	8.57
MMTA - GI / GU	4.25	2.57	0.82	0.11	0.08	0.46	8.29
MMTA - Infectious Disease	4.30	2.29	0.68	0.11	0.08	0.42	7.88
MMTA - Respiratory	4.22	2.87	0.93	0.17	0.09	0.37	8.65
Overall	**4.19**	**3.04**	**0.91**	**0.17**	**0.07**	**0.41**	**8.80**

Source: SHP 30-Day Period Claims Billed Jan ‘20 – April ‘20

Visit Utilization

- Breakout by Payment Type and Clinical Group

Clinical Group	Overall	Standard	LUPA	PEP	Outlier
MMTA - Other	8.31	8.28	1.61	6.31	21.69
Neuro / Stroke Rehabilitation	9.83	9.55	2.03	7.70	24.32
Wounds - Post-Op Wound Aftercare	9.74	9.61	1.92	7.37	24.77
Complex Nursing Interventions	5.48	5.97	1.09	5.51	22.20
Musculoskeletal Rehabilitation	9.47	9.56	2.43	8.43	22.63
Behavioral Health	7.09	7.05	1.40	4.18	20.36
MMTA - Surgical Aftercare	8.93	8.93	1.95	8.23	22.51
MMTA - Cardiac / Circulatory	8.35	8.27	1.74	7.20	21.94
MMTA - Endocrine	10.02	8.57	1.81	9.15	38.97
MMTA - GI / GU	8.32	8.29	1.46	6.16	22.21
MMTA - Infectious Disease	7.85	7.88	1.26	6.91	22.00
MMTA - Respiratory	8.69	8.65	1.63	7.67	22.23
Overall	**8.90**	**8.80**	**1.82**	**7.46**	**24.08**
Percent of Jan-Apr '20 Period Claims	100.0%	85.4%	9.5%	0.1%	5.0%

Source: SHP 30-Day Period Claims Billed Jan ‘20 – April ‘20

Visit Utilization

- Breakout by Period Sequence (Standard Payment)

Clinical Group	Period 1	Period 2	Period 3	Period 4	Period 5 +
MMTA - Other	10.30	6.06	6.97	6.08	6.40
Neuro / Stroke Rehabilitation	12.20	6.92	7.95	6.62	7.39
Wounds - Post-Op Wound Aftercare	11.50	8.27	8.88	8.36	8.92
Complex Nursing Interventions	8.50	5.64	5.77	5.24	5.27
Musculoskeletal Rehabilitation	11.31	6.48	7.84	6.51	7.24
Behavioral Health	9.71	5.60	6.07	5.37	5.13
MMTA - Surgical Aftercare	10.35	5.86	7.18	6.33	7.43
MMTA - Cardiac / Circulatory	11.15	6.41	6.76	5.83	6.14
MMTA - Endocrine	11.02	7.00	7.24	6.51	7.41
MMTA - GI / GU	10.36	6.22	6.71	5.95	6.17
MMTA - Infectious Disease	9.77	6.23	6.58	5.79	5.98
MMTA - Respiratory	10.91	6.26	6.90	5.94	6.28
Overall	**11.05**	**6.62**	**7.45**	**6.53**	**6.99**

Source: SHP 30-Day Period Claims Billed Jan ‘20 – April ‘20

New PDGM World

- Profitability will be impacted by resources utilized compared to the revenue for each period and sequence
- Managing LUPA's became a lot more complicated
- Need to consider the entire Stay (multiple 30-day payment periods)
- Need to manage utilization while improving on Outcomes (60-day Hospitalizations, HHCAHPS, Star Ratings)
- Diagnosis coding (primary and secondary) along with OASIS accuracy are an important focus

Patient centered approaches for managing visit utilization and clinical groupings choices

Focus of Care and Acceptable Primary Diagnoses

- Reminder: Primary diagnosis must be related to the focus of care that the plan of care is addressing
- When there are two or more diagnoses with equal foci of care, any of them can be moved to the primary diagnosis position
- If the diagnoses come from different Clinical Groupings and they are equally valid foci of care, you can choose the primary diagnosis that is higher revenue
- **Note**: while clinical grouping could be higher reimbursement, overall reimbursement could be affected by comorbidity diagnosis changes

Primary Diagnosis Choice Considerations

- What is the clinician documenting for the Focus of Care?
- What does the Face to Face Encounter say is the reason for home health?
- Are there other disciplines involved?
- Are there interventions for multiple diagnoses included in POC?
- How many visits are projected?

Patient Comorbidities

….a condition coexisting with the primary diagnosis that can affect the Home Health Plan of Care in terms of services provided and time spent with patients….

Primary Diagnosis Trends

- Foley Cath Changes-check visit frequency
- Hypertension with therapy services ordered
- Chronic Obstructive Pulmonary Disease with therapy services ordered
- MMTA Cardiac—commonly selected-20% of time

Frequency of Changes to Primary Diagnosis

	% of Diagnosis Changes
1st Period	.6%
2nd Period	14%

Source: SHP Q1 Data

What is your agency process for changing the Primary Diagnosis?

- **CMS Guidance**

When diagnosis codes change between one 30-day claim and the next, there is no requirement for the HHA to complete an RFA 5-Other follow-up assessment to ensure that diagnosis coding on the claim matches to the OASIS assessment.

- Should you have an agency process?

Did responses to functional assessment change along with the change in focus of care?

If so, be sure to capture the information by doing an other follow-up assessment

M1033 Risk for Hospitalization

PATIENT HISTORY AND DIAGNOSES, continued

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

- ☐ 1 - History of falls (2 or more falls – or any fall with an injury – in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8
- ☐ 10 - None of the above

Impact of M1033 Risk for Hospitalization

- One of the OASIS items that impacts the functional level scoring
- At least 4 items chosen are required (excluding response 8,9, and 10) to receive 11 points towards functional score
- Items that can impact functional scoring include:
  - Hx of falls
  - Unintentional weight loss
  - Multiple hospitalizations
  - Multiple emergency department visits
  - Decline in mental, emotional or behavioral status
  - Reported or observed history of difficulty complying with medical instructions
  - Currently taking 5 or more medications

M1033 Tips for Accurate Response

- **History of Falls:**
  - Witnessed and un-witnessed
  - Has to be 2 or more falls OR
  - Any fall with injury
- **Decline in mental/emotional/behavioral status:**
  - Use clinical judgement since no OASIS guidance re: decline
  - Important items that can be included in documentation that may affect response: forgetfulness, stress, moodiness
- **Unintentional weight loss**
  - Difficult to determine what is intentional vs unintentional
  - Consistent place to document weight tracking most helpful
- **Observed history of compliance**
  - Can be reported or observed by clinician
  - Important items that can be included in documentation that may affect response: compliance with diet, exercise, treatments

M1033 Tips related to: Multiple Hospitalizations/ED visit responses

- Inpatient Psych and LTC facilities not included in count for hospitalizations
- Observation Stays are excluded
- If patient discharged and readmitted to hospital in same day, it is counted as two
- Urgent care and walk in clinics are excluded for ED count

Hospitalizations Readmission/Resumption after Inpatient Stay under PDGM

- **Per CMS:**

If patient enters hospital during a 30 day/60 day episode of care, the HH agency may choose to discharge the patient since they expect the patient will not return to them in the same episode. If this occurs, the discharge is not recognized for Medicare payment purposes so the same episode continues.

If the patient does discharge from the facility and return to the same agency, the agency will need to bill one claim for all of their HH services that occurred prior to hospital admission and post hospital admission within that 30 day/60 day episode.

https://www.cms.gov/files/document/r4489cp.pdf 10.1.14

Readmit vs Resume?

- When in the 30 day period is the hospitalization occurring?
- Why did the patient go back into the hospital?
- Is patient going to SNF or inpatient rehab?
- Are you able to predict whether the patient will be coming back in the same episode?
- What is the cost of admission vs. resumption?

Visit Utilization begins with: What is our goal in caring for patient?

- Patient Goal and Discipline Goals
- Improving functional status so can continue to remain at home
- Preventing Hospitalization or ED visits
- Appropriate reimbursement for services provided (includes preventing avoidable LUPAs)
- Improving quality outcomes
- Managing cost of care

What are best practices for determining visit utilization?

- **Patient Goal -** all disciplines working towards the patient's goal
- **Software logic -** can assist in pointing you in a general direction
- **Clinician Assessment-**clinical picture of the patient based on discipline assessments
- **Disciplines at top of license-** clinicians working at the top of their license further enhances how each can be utilized

Options to manage visit utilization operationally

- **Population Health/Utilization Review Manager**
  - **Pros** - larger and consistent view across organization, centralized, standardization, uses software or evidence-based information
  - **Cons** - may not be individualized based on clinician assessment
- **Clinical Manager oversight** (starting at admission)
  - **Pros**-includes clinician at bedside or in driveway
  - **Cons-**may differ by team, less standardization
- **Hybrid approach**
  - Utilize software or evidence-based practice guidance to determine standardized visit frequencies by diagnosis
  - Utilize clinician input at admission to individualize the standard utilization recommendations
  - Provide consistent view across organization for managing utilization

PRACTICE SCENARIOS

Primary Diagnosis Choice for: Hubert Jahnke

- ***Clinician Focus of Care:*** *Foley Catheter Changes every 3 weeks*
- **HH Order states:** *Provide catheter care 16 FR with 10cc balloon to be changed every 3 weeks; PT and OT evaluation;*
- **H&P Assessment includes:**
  - *Type 2 DM diet controlled*
  - *Diabetic peripheral neuropathy- takes Neurontin*
  - *Essential HTN*
  - *Neurogenic Bladder*

- Given the HH order, should the primary diagnosis be foley catheter care?
- Are the therapy evaluations available at the time of coding?
- What are the therapists focused on doing for the patient?
- Is there enough information to choose primary diagnosis for this patient?

Visit Utilization Patient Scenario: Jay Johnson

- Hospitalized for breathing problems and is now on oxygen therapy and a new medication for COPD
- History of rheumatoid arthritis, hypertension, and falls
- Functional Status include challenges with bathing, dressing, and grooming due to dyspnea. Challenges with ambulation due to dyspnea and RA. Home safety an issue.
- M1033 boxes checked: falls, ED visits, >5 meds, hospitalizations
- HH Orders include SN, PT, and OT
- Husband is involved caregiver

Patient Scenario: Jay Johnson

- **First 30-day period:**
  - 2LC11
  - Institutional Early
  - MMTA Respiratory
  - High Functional
  - No Comorbidity Adjustment
- **Second 30-day period:**
  - 3LC11
  - Community Late
  - MMTA Respiratory
  - High Functional
  - No Comorbidity Adjustment

Actual Visit Utilization Choices: Jay Johnson

- **First 30-day period**: 23 visits

  Actual Visits Performed:
  - 11 SN visits
  - 8 PT visits
  - 4 OT visits

- **Second 30-day period:** LUPA

  Scheduled Visits:
  - 1 SN visit
  - 2 OT visits

  Actual Visits Performed:
  - 1 OT visits (missed SN visit and OT only needed to make 1 visit to meet goals)

Is this Alternative Visit Utilization pattern better for Jay Johnson and for the agency?

VISIT UTILIZATION PLAN-Jay Johnson										
Dates	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Total
SN	3	2	2	1, TPV	1	TPV	1	TPV	TPV	10
PT	1	3	1	1	1					7
OT	1		2	1	1	1				6
TOTAL	5	5	5	3	3	1	1	0		23

Revenue/Expense Analysis: Jay Johnson

- Impact of the LUPA is significant compared to Scheduled and the Alternative
- Alternative plan of care provides some relief when visits may be missed
- Losses in first period are offset by gains in the second period

Visits	Period 1	Period 2	Total
Scheduled	23	3	26
Actual	23	1	24
Alternative	18	5	23
Revenue			
Scheduled	$ 2,589	$ 1,497	$ 4,086
Actual	$ 2,589	$ 165	$ 2,754
Alternative	$ 2,589	$ 1,497	$ 4,086
Expense			
Scheduled	$ 3,591	$ 472	$ 4,063
Actual	$ 3,591	$ 164	$ 3,754
Alternative *	$ 2,857	$ 894	$ 3,751
Net			
Scheduled	$ (1,002)	$ 1,024	$ 23
Actual	$ (1,002)	$ 1	$ (1,000)
Alternative	$ (267)	$ 603	$ 335

Using CMS National Standarized Rate and Costs for CY 20

* Includes four telehealth visits (.25 nursing cost/visit)

Questions?

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