Webinar: Home Health

Getting a headstart on the Patient Driven Groupings Model (PDGM):

an overview for all home health leaders and staff

with **Gina Mazza, BSN, RN, CPHQ** of Fazzi Associates


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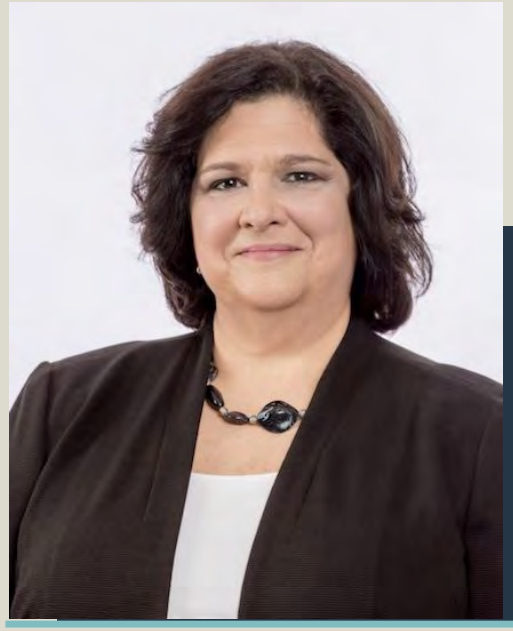

About the presenter

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Senior Vice President Regulations and Compliance

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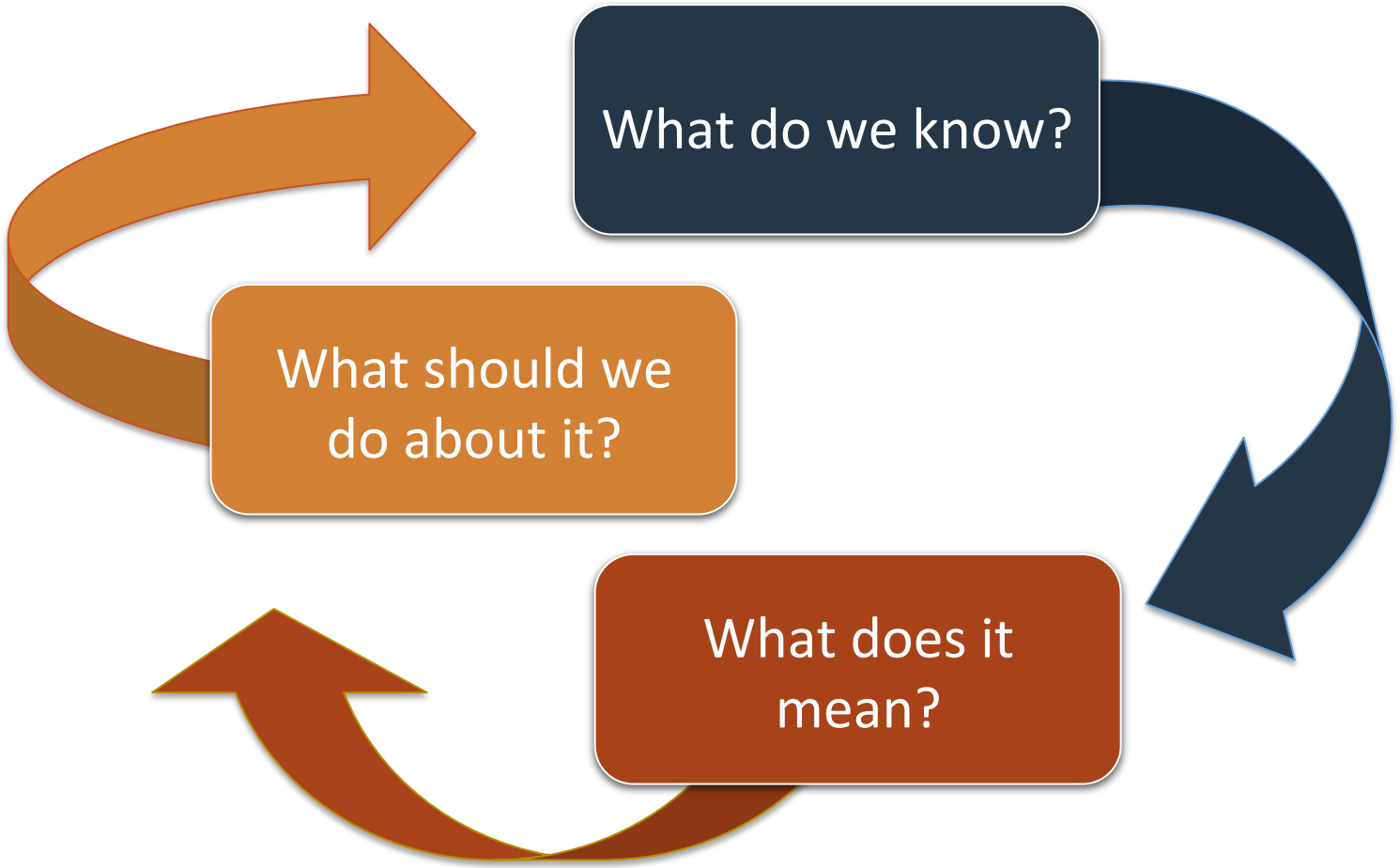
Today’s objectives

- Discuss the concepts behind PDGM and contrast with the current HHPPS methodology.
- Identify the case mix factors used in the PDGM.
- Discuss initial recommendations for successful transition to the new reimbursement model.

Strategic Management Model



https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

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Home Health Agency (HHA) Center

Spotlights

- CMS-1689-F
  - The Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1689-FC) that updates the Medicare Home Health Prospective Payment System (HH PPS) rates and wage index for calendar year (CY) 2019. The final rule results in a 2.2 percent increase ($420 million) in payments to HHAs in CY 2019 and finalizes the methodology used to determine the rural add-on payment for CYs 2019 through 2022 as well as regulations text changes regarding certifying and recertifying patient eligibility for Medicare home health services and remote patient monitoring. This rule also finalizes the removal of seven measures from the Home Health Quality Reporting Program, a regulatory text change regarding OASIS data, and refinements the Home Health Value-Based Purchasing model. For CY 2020, this rule finalizes the implementation of an alternative case-mix adjustment methodology, the Patient Driven Groupings Model (PDGM). The PDGM will be implemented in a budget neutral manner on January 1, 2020. A Home Health Claims-OASIS Limited Data Set (LDS) file will be made available, upon request, to accompany the CY 2019 HH PPS final rule (click here). Lastly, this rule finalizes the definition of a "infusion drug administration calendar day" for the implementation of temporary transitional payments for home infusion therapy services for CYs 2019 and 2020, finalizes health and safety standards for home infusion therapy, and finalizes an accreditation and oversight process for home infusion therapy suppliers.
    - CY 2019 HH PPS Wage Index [ZIP, 104KB]
    - CY 2019 HH PPS Case Mix Weights [ZIP, 13KB]
    - CY 2019-CY 2022-Rural-Add-On-Payment Designations [ZIP, 134KB]
    - Overview of the Patient-Driven Groupings Model [PDF, 449KB]
    - Analysis Comparing BLS vs. Cost Report Case-Mix Weights [ZIP, 122KB]
    - PDGM Case Mix Weights and LUPA Thresholds [ZIP, 45KB]
    - PDGM Grouper Tool CY 2019 (Updated 11/06/2018) [ZIP, 1MB]
    - PDGM Agency Level Impacts [ZIP, 938KB]

Patient Driven Groupings Model (PDGM)

- Better align payment with costs
- Increase access to vulnerable patients associated with lower margins
- Address payment incentives in current system, i.e. eliminate impact of therapy volume on payment
- Place patients into clinically meaningful payment categories
- Effective January 1, 2020

Used with Permission: Abt Associates, Medicare Home Health Prospective Payment System: Case Mix Methodology Refinements. Overview of Home Health Grouping Model. November 18, 2016

HHS. CMS. Medicare and Medicaid Programs: CY 2019 Home Health Prospective Payment System Rate Update and Proposed CY 2020 Case-Mix Adjustment Methodology Refinements; Home health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements. Final Rule.

Payment impact - 2020

- Budget Neutral Approach
- Cost-per-Minute + Non-routine Supplies
- RAPs continue – *with exceptions*
- LUPA category remains – *with significant changes*
- Partial Episode Payment Maintained
- Outlier Policy Maintained

Request for Anticipated Payment: RAPs

- Agencies certified on/after January 1, 2019 submit a “No Pay” RAP at beginning of care and every 30 days in PDGM.

- Agencies certified before January 1, 2019, continue to submit RAP and receive split payment.

- Agencies certified before January 1, 2019: First 30 day period 60/40 split then, 50/50 split.

PDGM and Quality Episode

- Two 30-day payment periods within a 60-day certification period
- 60-day timing for certification periods remains unchanged
- Assessment within 5 days of SOC and, no less than last 5 days of every 60 days unchanged
- Plan of Care corresponds with 60-day certification
- OASIS time points remain unchanged

30-Day Unit of Payment

- 30-day period = days 1-30 of a current 60-day episode where “day 1” is the current 60-day episode’s *From Date*. Second period is days 31 and above.

- CMS will calculate a proposed, national, standardized 30-day payment amount. Would propose the actual 30-day payment amount in the CY 2020 HH PPS proposed rule.

- Going forward will calculate payment amount by updating the preceding year by the HH payment update percentage.

Case-Mix Weight Structure

- Admission Source and Timing
- Clinical Grouping
- Comorbidity Adjustment
- OASIS Items-Functional Level

- An episode is grouped into one (and only one) subcategory under each category. An episode's combination of subcategories groups the episode into one of 432 different payment groups.

Patient Driven Groupings Model

1 Admission Source and Timing

- Community Early
- Community Late
- Institutional Early
- Institutional Late

2 Clinical Group

- Neuro Rehab
- Wounds
- Complex Nursing Interventions
- MS Rehab
- Behavioral Health
- MMTA - Surgical Aftercare
- MMTA - Cardiac/Circulatory
- MMTA - Endocrine
- MMTA - GI/GU
- MMTA - Infectious Disease/ Neoplasms/Blood-Forming Disease
- MMTA – Respiratory
- MMTA - Other

3 Functional Level

- Low
- Medium
- High

4 Comorbidity

- None
- Low
- High

= HHRG 432

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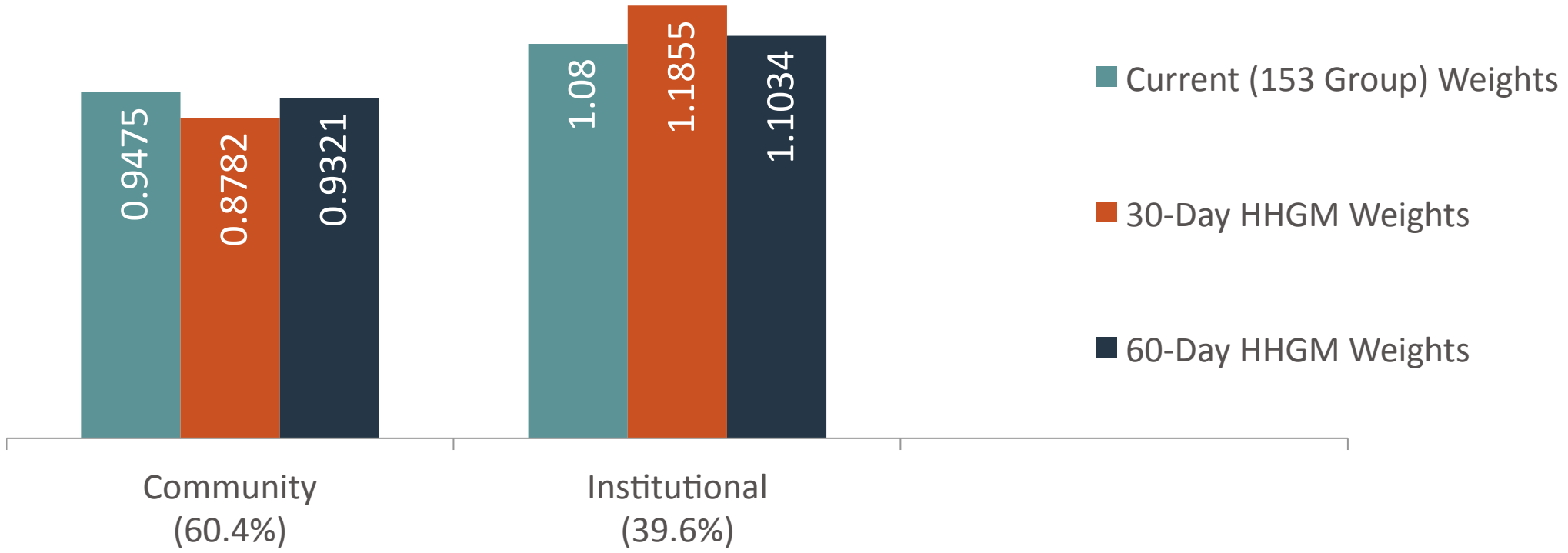
Admission Source

- Uses a 14-day “look-back” period to each 30-day period
- **Community**: no acute or post-acute care in the 14 days prior to the HH admission (30-day periods; second 30 days of a 60-day episode is assigned community)
- **Institutional**: acute care or post-acute, inpatient psychiatric facility, Skilled nursing facility, inpatient rehab facility, long term care hospital in the 14 days prior to the HH admission
- Medicare claims processing system would check for presence of an acute/post-acute Medicare claim occurring within 14 days of the HH admission on an ongoing basis
- Manual Occurrence Codes will be allowed

Average Case-Mix Weights by Admission Source



Used with Permission: Abt Associates, HHGM Technical Expert Panel, February 1, 2018.

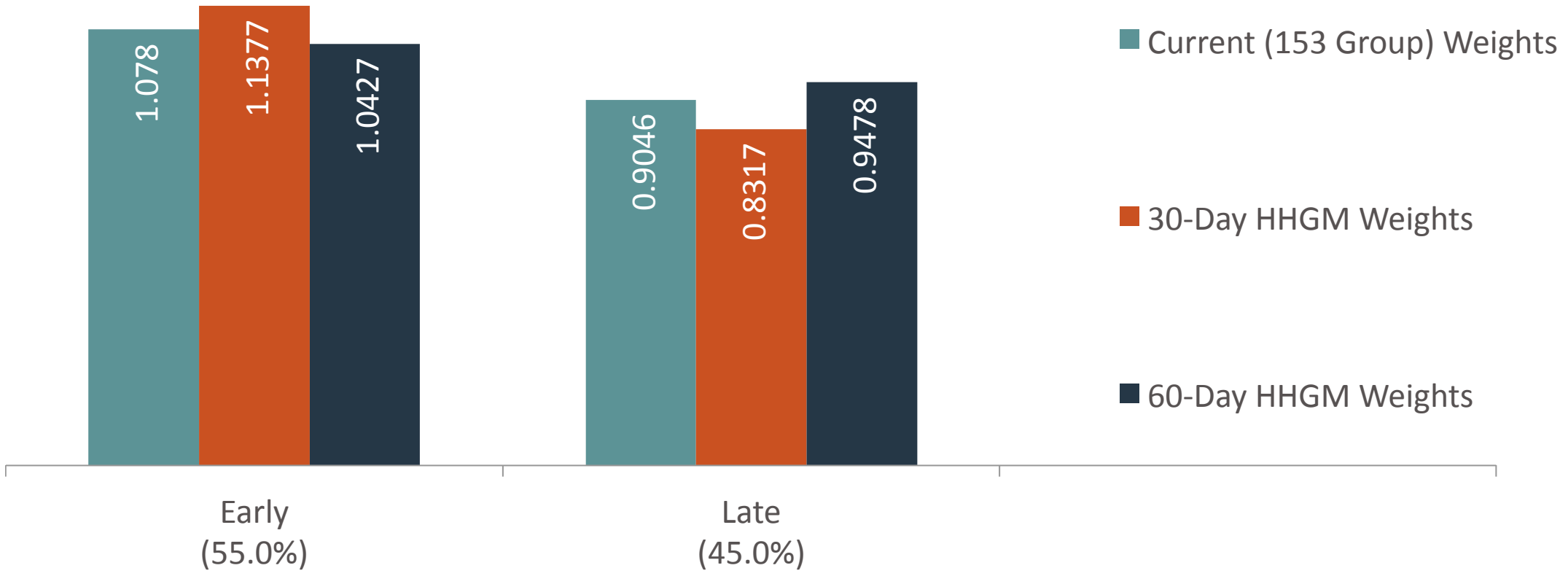
Timing

- Only the first 30-day period in a sequence of periods defined as **early** and all other subsequent 30-day periods would be considered **late**.

- First episodes are those where the beneficiary has not had home health in the 60 days prior to the start of the first episode.

- To identify the first 30-day period in a sequence, Medicare claims processing system would verify that the claims “From date” and “Admission date” match.

Average Case-Mix Weights, by Timing



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Clinical Groupings

- Each 30-day period of care will be assigned to one of twelve groups based on the reported principal diagnosis.
- Diagnosis code must support the need for HH services.
- Secondary diagnosis codes would then be used to case-mix adjust the period further through additional elements of the model, such as the comorbidity adjustment.

PDGM Clinical Groups

Clinical Group	Primary Reason for HH Encounter:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers, burns and other lesions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies

PDGM Clinical Groups, *continued*

Clinical Group	Primary Reason for HH Encounter:
MMTA – Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/ Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA – Respiratory	Assessment, evaluation, teaching and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

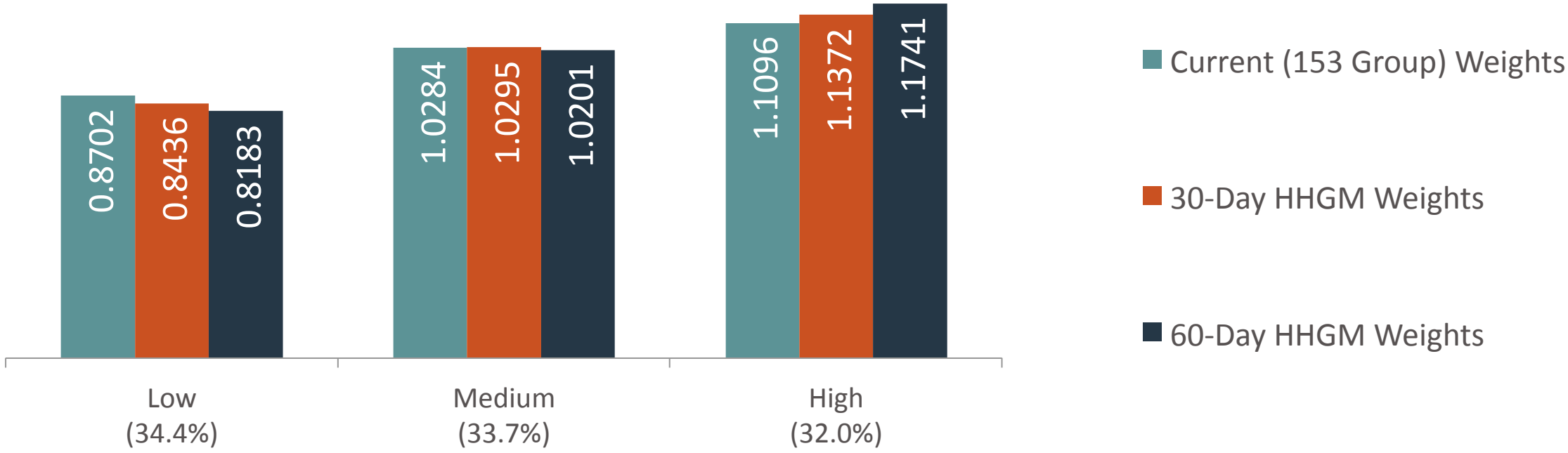
Functional Impairment

- Functional status allows for higher payment for higher service needs
- Functional scores result in 3 levels: low, medium, high
- Functional levels per clinical group
- Functional scores and levels will be updated for 2020

Functional Items

Current HH PPS	PDGM
	M1800: Grooming
M1810: Dressing upper body	M1810: Dressing upper body
M1820: Dressing lower body	M1820: Dressing lower body
M1830: Bathing	M1830: Bathing
M1840: Toileting	M1840: Toileting
M1850: Transferring	M1850: Transferring
M1860: Ambulation & locomotion	M1860: Ambulation & locomotion
	M1033: Risk of Hospitalization

Average Case-Mix Weights by Level of Functional Limitations



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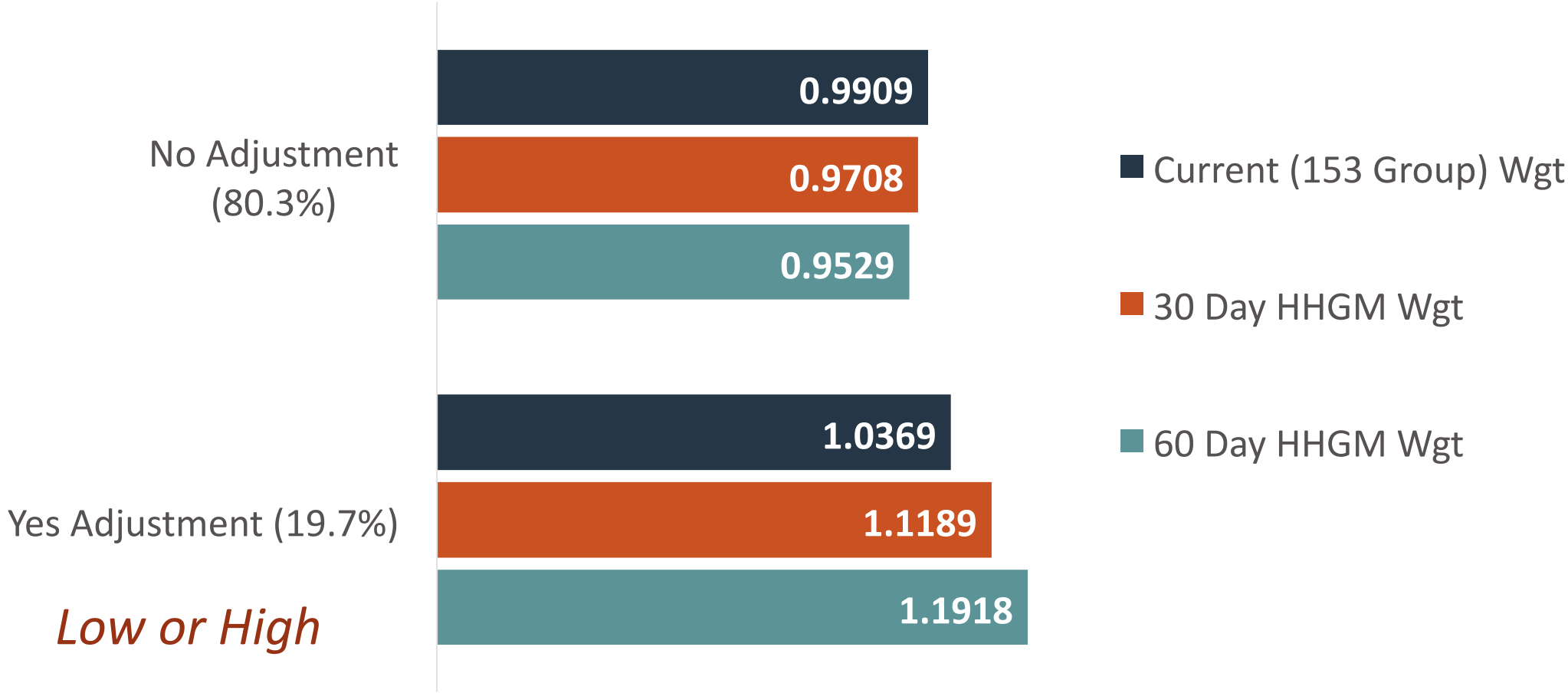
Comorbidities

- **No Adjustment:** No comorbidity diagnosis that falls into a comorbidity adjustment subgroup.

- **Low Comorbidity Adjustment:** A comorbidity diagnosis that falls into one comorbidity adjustment subgroup.

- **High Comorbidity Adjustment:** Two or more diagnosis that fall within the same comorbidity subgroup interaction.

Average Case-Mix Weights, by Comorbidity Adjustment



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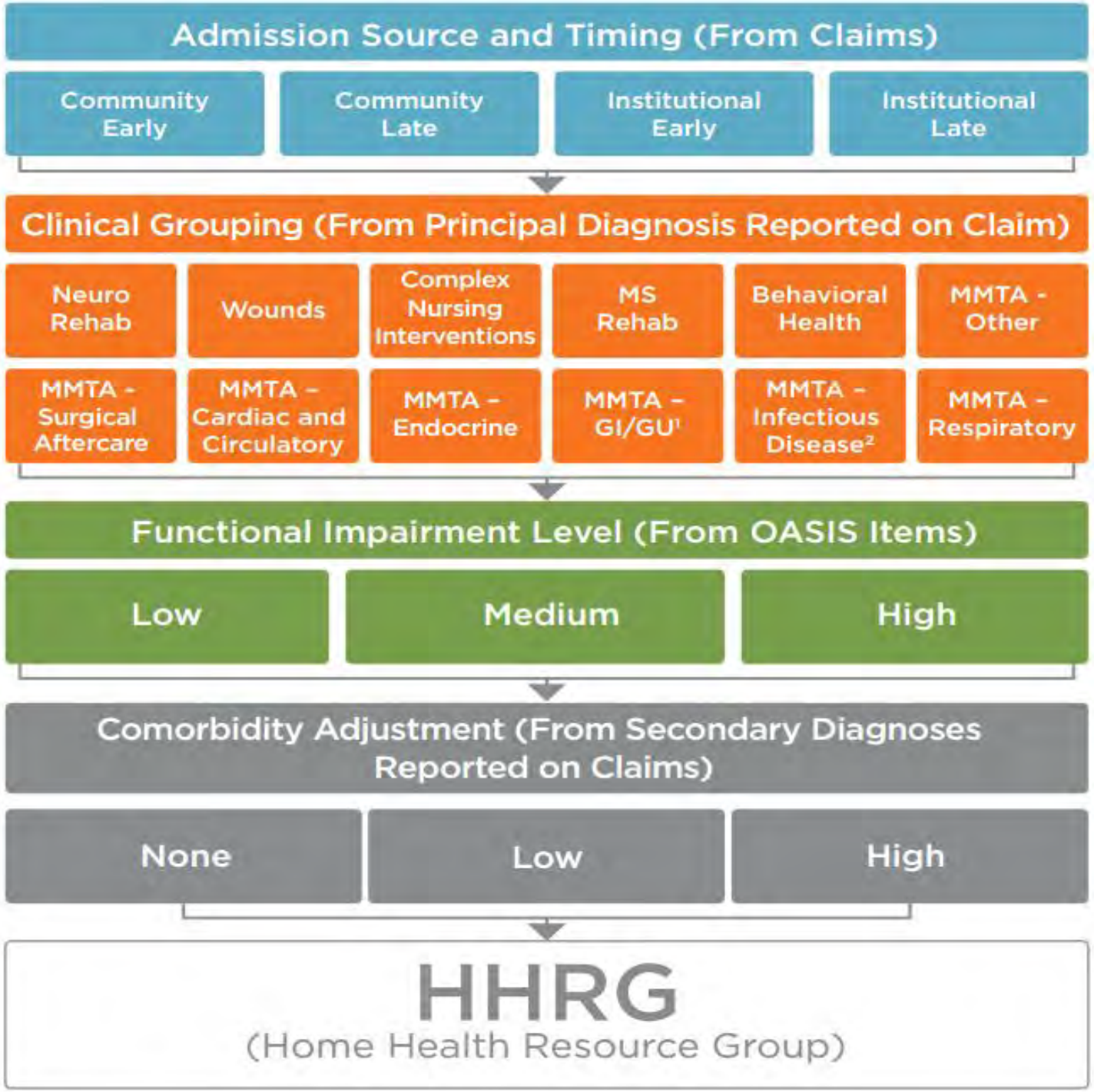
Comorbidities

Subgroup	Description
Neuro	Includes diabetic retinopathy and other blindness
Neuro	Includes diabetic neuropathies
Circulatory	Includes acute and chronic embolisms and thrombosis
Heart	Includes heart failure
Cerebral	Includes sequelae of cerebrovascular diseases

Comorbidities

SubGroup	Description
Neuro	Includes Parkinson’s Disease
Skin	Includes cutaneous abscess, cellulitis, and lymphangitis
Neuro	Includes hemiplegia, paraplegia, and quadriplegia
Circulatory	Includes varicose veins with ulceration
Skin	Include diseases of arteries, arterioles and capillaries with ulceration and non- pressure chronic ulcers
Skin	Includes stages Two-Four and unstageable pressure ulcers by site



DHHS. CMS. Medicare and Medicaid Programs: CY 2019 Home Health Prospective Payment System Rate Update and Proposed CY 2020 Case-Mix Adjustment Methodology Refinements; Home health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements. Proposed Rule.

LUPAs

- LUPA thresholds will vary for a 30 day period depending on the payment group to which it is assigned.
- LUPA thresholds range from 2-6 visits.
- LUPA add-on factors will remain the same as current system.
- LUPA thresholds for each PDGM payment group would be reevaluated every year.

HIPPS	Clinical Group and Functional Level	Timing and Admission Source	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Visit Threshold (10th percentile or 2 - whichever is higher)
2GC11	MMTA - Surgical Aftercare - High	Early - Institutional	0	4
2GC21	MMTA - Surgical Aftercare - High	Early - Institutional	1	5
2GC31	MMTA - Surgical Aftercare - High	Early - Institutional	2	5
3GC11	MMTA - Surgical Aftercare - High	Late - Community	0	2
3GC21	MMTA - Surgical Aftercare - High	Late - Community	1	2
3GC31	MMTA - Surgical Aftercare - High	Late - Community	2	2
4GC11	MMTA - Surgical Aftercare - High	Late - Institutional	0	3
4GC21	MMTA - Surgical Aftercare - High	Late - Institutional	1	4
4GC31	MMTA - Surgical Aftercare - High	Late - Institutional	2	4
1GA11	MMTA - Surgical Aftercare - Low	Early - Community	0	3
1GA21	MMTA - Surgical Aftercare - Low	Early - Community	1	3
1GA31	MMTA - Surgical Aftercare - Low	Early - Community	2	3
2GA11	MMTA - Surgical Aftercare - Low	Early - Institutional	0	3
2GA21	MMTA - Surgical Aftercare - Low	Early - Institutional	1	4
2GA31	MMTA - Surgical Aftercare - Low	Early - Institutional	2	4
3GA11	MMTA - Surgical Aftercare - Low	Late - Community	0	2
3GA21	MMTA - Surgical Aftercare - Low	Late - Community	1	2
3GA31	MMTA - Surgical Aftercare - Low	Late - Community	2	2
4GA11	MMTA - Surgical Aftercare - Low	Late - Institutional	0	3
4GA21	MMTA - Surgical Aftercare - Low	Late - Institutional	1	3
4GA31	MMTA - Surgical Aftercare - Low	Late - Institutional	2	3
1GB11	MMTA - Surgical Aftercare - Medium	Early - Community	0	4
1GB21	MMTA - Surgical Aftercare - Medium	Early - Community	1	4
1GB31	MMTA - Surgical Aftercare - Medium	Early - Community	2	5
2GB11	MMTA - Surgical Aftercare - Medium	Early - Institutional	0	4
2GB21	MMTA - Surgical Aftercare - Medium	Early - Institutional	1	5
2GB31	MMTA - Surgical Aftercare - Medium	Early - Institutional	2	5
3GB11	MMTA - Surgical Aftercare - Medium	Late - Community	0	2
3GB21	MMTA - Surgical Aftercare - Medium	Late - Community	1	2

Federal Register, Vol. 82. No. 144. DHHS. CMS. Medicare and Medicaid Programs: CY 2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements. Proposed Rule.

LUPAs

"Current data suggest that what would be about 1/3 of the LUPA episodes with visits near the LUPA threshold move up to be become non-LUPA episodes. We assume this experience will continue under the PDGM, with about 1/3 of those episodes 1 or 2 visits below the thresholds moving up to become non-LUPA episodes."

Federal Register, Vol. 82. No. 144. DHHS. CMS. Medicare and Medicaid Programs: CY 2018 Home Health Prospective Payment System Rate Update and Proposed CY 2019 Case-Mix Adjustment Methodology Refinements; Home health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements. Proposed Rule.

Agency Behavior Assumptions

1. Clinical Group Coding: Coding to maximize payments.

2. Comorbidity Coding: More 30 day periods will receive comorbidity adjustment.

3. LUPA Threshold: 1-2 extra visits will be made to receive the full 30 day payment.

Payment Impact of Behavior Assumptions

Example: 30 Day BN Standard Payment: $1873.91

Percent Decrease: 6.42%

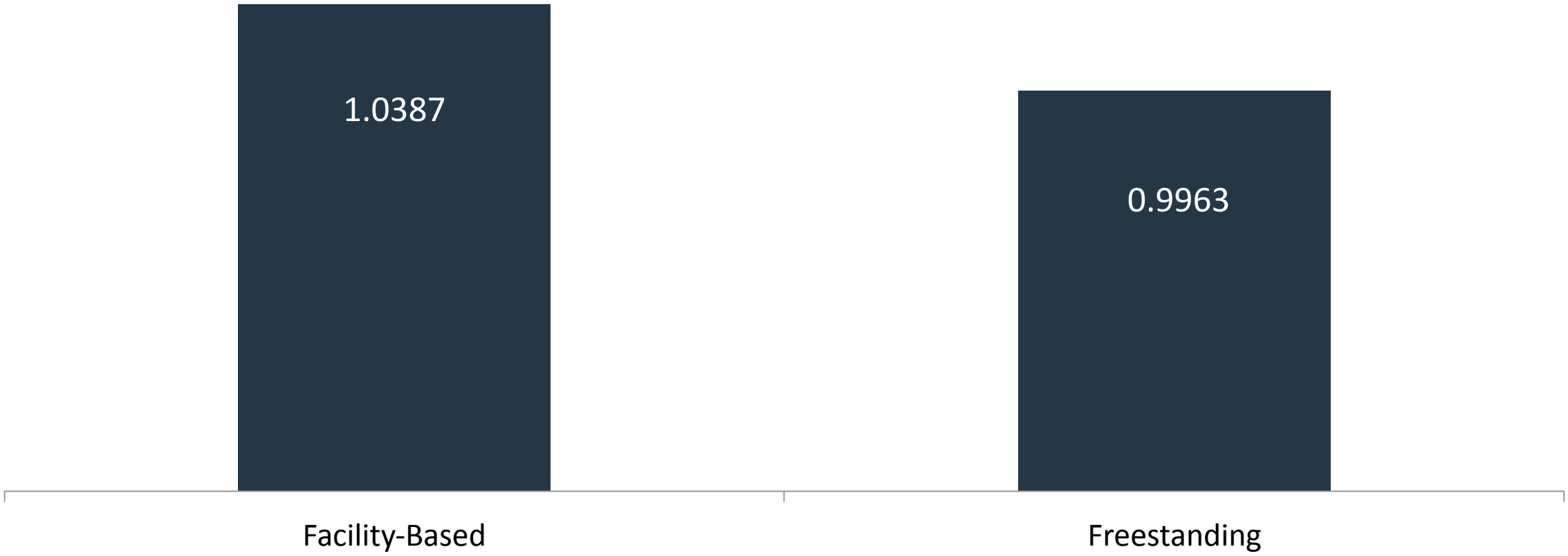
Revised 30 Day Standard Payment: $1753.68

Nursing Therapy Ratio Revenue Impact

Nursing Therapy Ratio	Average Payment 60-day Episode	Average Payment per 60-day, PDGM	Payment Change	Percent Change
1st Quartile (Lowest 25% Nursing)	$3,240.26	$2,919.00	-$321.26	-9.91%
2nd Quartile	**$2,952.24**	**$2,928.58**	**-$23.67**	**-0.80%**
3rd Quartile	$2,819.50	$3,001.58	$182.07	6.46%
4th Quartile (Top 25% Nursing)	$2,605.20	$3,048.29	$443.08	17.01%

Fazzi's BI Analysis

Impact Ratio by Facility Type



Impact Ratio by Ownership

	Average period $, 153-group current system	Average period $, PDGM	Average episode $, 153-group current system	Average episode $, PDGM	Impact Ratio
For-Profit	$1,703	$1,683	$2,997	$2,962	0.9885
Gov't-Owned	$1,606	$1,652	$2,582	$2,657	1.0291
Non-Profit	**$1,848**	**$1,902**	**$2,883**	**$2,967**	**1.0288**

Impact Ratio by Census Division

	Average period $, 153-group current system	Average period $, PDGM	Average episode $, 153-group current system	Average episode $, PDGM	Impact Ratio
East North Central	$1,723	$1,704	$2,904	$2,873	0.9891
East South Central	$1,426	$1,439	$2,553	$2,577	1.0092
Mid Atlantic	$1,955	$2,015	$3,034	$3,128	1.0309
Mountain	$1,881	$1,783	$3,122	$2,961	0.9484
Northeast	$1,969	$2,018	$3,250	$3,331	1.0248
Outlying	$1,012	$1,124	$1,746	$1,938	1.1100
Pacific	$2,123	$2,203	$3,620	$3,758	1.0380
South Atlantic	$1,781	$1,686	$2,955	$2,798	0.9468
West North Central	$1,817	$1,746	$2,882	$2,770	0.9611
West South Central	$1,418	$1,476	$2,635	$2,743	1.0408

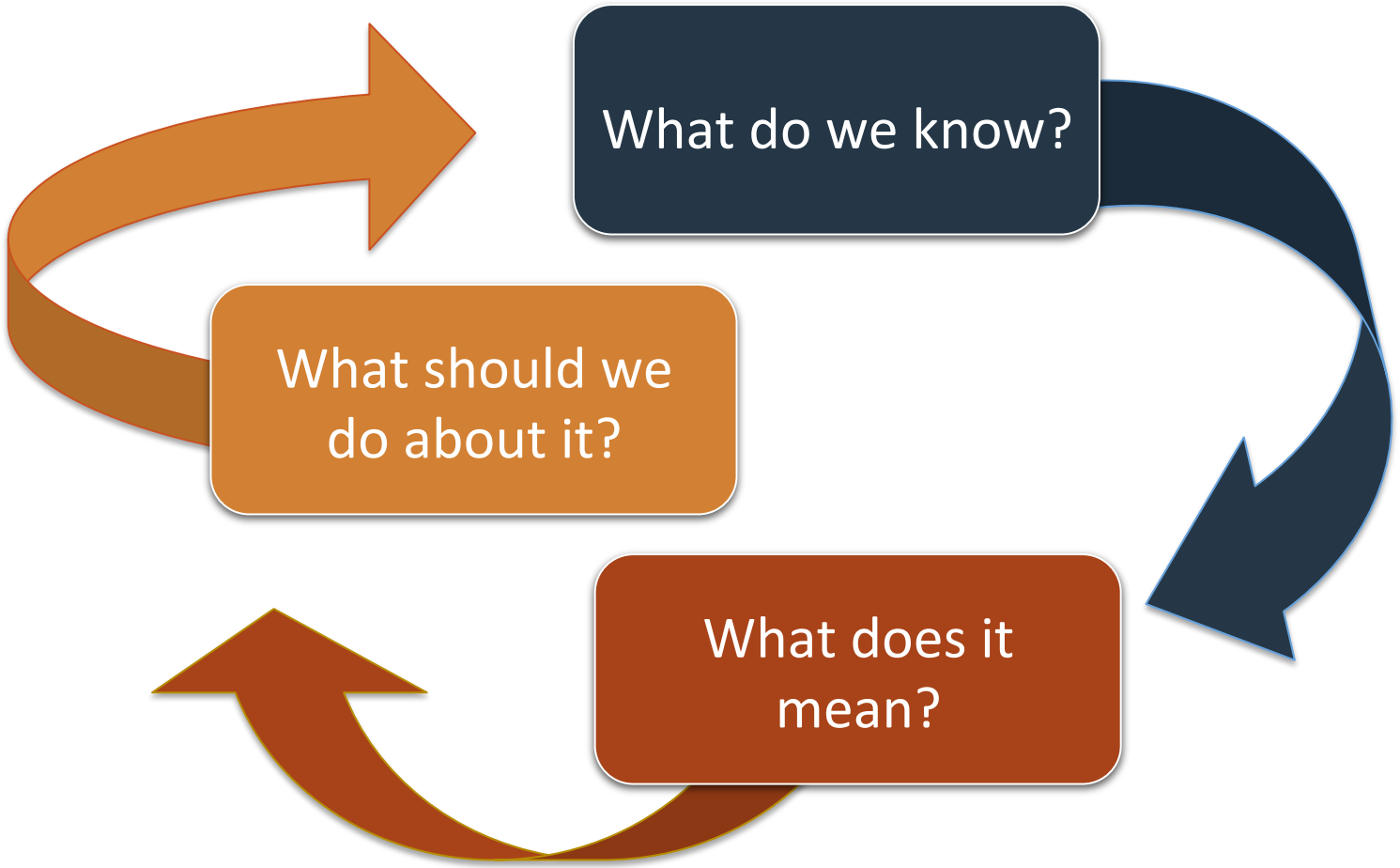
Summary of Findings

- Wound and complex episodes have higher payment weight, behavioral health, some MMTA have lower; higher weights with other indicators or higher severity

- Episodes treated by non-profits and those in the Northeast are simulated to have higher weights, agencies with a higher ratio of nursing will also have an average higher weight

- *Each agency will be impacted individually.*

Strategic Management Model



“Making systems work is the great task of my generation of physicians and scientists. But I would go further and say that making systems work — whether in healthcare, education, climate change, making a pathway out of poverty — is the great task of our generation as a whole.”

- Atul Gawande

Leadership’s Checklist

- ✓ Prepare Using the Strategic Management Model
- ✓ Collect and Analyze Your Organization’s 2018 Performance
- ✓ Create an Agency-wide Committee to Champion PDGM
- ✓ Generate Buy-In: Plan the education for leaders and staff

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