Executive Update:

Patient Driven Groupings Model
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Presented by:
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Cindy Campbell BSN, RN

Handouts and Questions

Download handouts here:
Type your questions here:

Objectives

• Discuss the concepts behind PDGM
• Show the financial impact of each PDGM reimbursement factor – early/late, institutional/community, primary diagnosis set, co-morbidity or not, functional level
• Discuss operational recommendations for a successful transition to the new payment model
STRATEGIC MANAGEMENT MODEL

What do we know?

What should we do about it?

What does it mean?

- Better align payment with patient needs
- Increase access to home health care to vulnerable patients associated with lower margins
- Address payment incentives in current system, i.e. impact of therapy volume on payment
- Allow patient characteristics to better determine payment

PROPOSED PAYMENT IMPACT, 2020

- Budget Neutral Approach
- Effective January 1, 2020
- Comment period ends August 31, 2018

PDGM PAYMENT OVERVIEW

• Two 30-day periods within a 60-day episode
• 60-day certification period remains unchanged
• Plan of Care corresponds with 60-day certification
• OASIS time points remain unchanged

PDGM PAYMENT OVERVIEW, CONT.

• RAPs continue - except for new Agencies
• LUPA category remains - with significant changes
• Case Mix Weight is calculated per 30 day period
• Partial Episode Payment Maintained
• Outlier Policy Maintained

Patient Driven Groupings Model

1. Admission Source and Timing
   - Community Early
   - Community Late
   - Institutional Early
   - Institutional Late

2. Clinical Group
   - MMTA
   - Neuro Rehab
   - Bruises
   - Complex Nursing Care
   - MI Revascularization
   - Behavioral Health

3. Functional Level
   - Low
   - Medium
   - High

4. Comorbidity
   - None
   - Low
   - High

= HHRG (216)
**MAJOR CHANGES**

<table>
<thead>
<tr>
<th>HH PPS</th>
<th>PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Score: low, medium, high</td>
<td>Assigned to 1 of 6 Clinical Groups</td>
</tr>
<tr>
<td>Functional Scores</td>
<td>Combine OASIS responses. Low, medium and high</td>
</tr>
<tr>
<td>Therapy Visits</td>
<td>Number of therapy visits/thresholds will have no impact on case mix weight</td>
</tr>
<tr>
<td>153 payment HHRGs</td>
<td>216 payment HHRGs</td>
</tr>
<tr>
<td>NRS</td>
<td>Non-Routine Supply utilization cost already determined in CMW</td>
</tr>
<tr>
<td>LUPAs</td>
<td>LUPA thresholds will vary depending upon assigned payment group</td>
</tr>
</tbody>
</table>

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**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.

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

• Uses a 14 day “look-back” 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 or post-acute (SNF, inpatient rehab facility, long term care hospital) care in the 14 days prior to the HH admission

ADMISSION SOURCE, CONT.

• 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

- **Community** (60.4%)
  - Current (153 Group) Weights: 0.7222
  - 30-Day HHGM Weights: 1.081
  - 60-Day HHGM Weights: 1.385

- **Institutional** (39.6%)
  - Current (153 Group) Weights: 0.9321
  - 30-Day HHGM Weights: 1.1034
  - 60-Day HHGM Weights: 1.1855

TIMING

- Only the first 30-day period in a sequence of periods be 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

![Graph showing average case-mix weights by timing]

CLINICAL GROUPINGS

- Each 30-day period of care will be assigned to one of six 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

<table>
<thead>
<tr>
<th>Clinical Group</th>
<th>Primary Reason for HH Encounter:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal Rehabilitation</td>
<td>Therapy (PT/OT/SLP) for a musculoskeletal condition</td>
</tr>
<tr>
<td>Neuro/Stroke Rehabilitation</td>
<td>Therapy (PT/OT/SLP) for a neurological condition or stroke</td>
</tr>
<tr>
<td>Wounds - Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care</td>
<td>Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers, burns and other lesions</td>
</tr>
</tbody>
</table>

### PDGM Clinical Groups, Cont.

<table>
<thead>
<tr>
<th>Clinical Group</th>
<th>Primary Reason for HH Encounter:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Nursing Interventions</td>
<td>Assessment, treatment and evaluation of complex medical and surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies</td>
</tr>
</tbody>
</table>

### PDGM Clinical Groups, Cont.

<table>
<thead>
<tr>
<th>Clinical Group</th>
<th>Primary Reason for HH Encounter:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Care</td>
<td>Assessment, treatment and evaluation of psychiatric and substance abuse conditions</td>
</tr>
<tr>
<td>Medication Management, Teaching and Assessment (MMTA)</td>
<td>Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups.</td>
</tr>
</tbody>
</table>
**PERCENTAGE OF PERIODS BY CLINICAL GROUP**

- Wound, 8.9%
- Neuro Rehab, 10.1%
- Complex Nursing, 3.5%
- Musculoskeletal Rehab, 17.9%
- Behavioral Health, 3.6%


**FUNCTIONAL LEVELS**

- Current HH PPS
- PDGM

<table>
<thead>
<tr>
<th>Functional Level</th>
<th>Current HH PPS</th>
<th>PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1800: Grooming</td>
<td>M1810: Dressing upper body</td>
<td></td>
</tr>
<tr>
<td>M1810: Dressing upper body</td>
<td>M1820: Dressing lower body</td>
<td></td>
</tr>
<tr>
<td>M1820: Dressing lower body</td>
<td>M1830: Bathing</td>
<td></td>
</tr>
<tr>
<td>M1830: Bathing</td>
<td>M1840: Toileting</td>
<td></td>
</tr>
<tr>
<td>M1840: Toileting</td>
<td>M1850: Transferring</td>
<td></td>
</tr>
<tr>
<td>M1850: Transferring</td>
<td>M1860: Ambulation &amp; locomotion</td>
<td></td>
</tr>
<tr>
<td>M1860: Ambulation &amp; locomotion</td>
<td>M1032: (M1033 in OASIS-C1): Risk of Hospitalization</td>
<td></td>
</tr>
</tbody>
</table>

**AVERAGE CASE-MIX WEIGHTS, BY LEVEL OF FUNCTIONAL LIMITATIONS**

- Current [153 Group] Weights
- 30-Day HHGM Weights
- 60-Day HHGM Weights

<table>
<thead>
<tr>
<th>Functional Level</th>
<th>Low (34.4%)</th>
<th>Medium (33.7%)</th>
<th>High (32.0%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.8732</td>
<td>1.0284</td>
<td>1.1096</td>
</tr>
<tr>
<td></td>
<td>0.8183</td>
<td>1.0295</td>
<td>1.1372</td>
</tr>
<tr>
<td></td>
<td>0.8183</td>
<td>1.0295</td>
<td>1.1372</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Comorbidity Adjustment</th>
<th>30 Day HWGM Wgt</th>
<th>60 Day HWGM Wgt</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Adjustment (80.3%)</td>
<td>0.9909</td>
<td>0.9708</td>
</tr>
<tr>
<td></td>
<td>0.9523</td>
<td></td>
</tr>
<tr>
<td>Yes Adjustment (19.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low or High</td>
<td>1.0369</td>
<td>1.1189</td>
</tr>
<tr>
<td></td>
<td>1.1918</td>
<td></td>
</tr>
</tbody>
</table>

LUPAs

- PDGM proposes that the approach to calculating thresholds change. LUPA thresholds will vary depending upon 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.
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.

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.
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.

**IMPACT RATIO BY FACILITY TYPE**

- Facility-Based: 1.0387
- Freestanding: 0.9963

**AVERAGE CASE-MIX WEIGHTS, BY OWNERSHIP TYPE**

- Non-Profit (26.8%)
  - Current (153 Group) Wgt: 0.9659
  - 30 Day HHGM Wgt: 1.0143
  - 60 Day HHGM Wgt: 0.9484

- For-Profit (71.2%)
  - Current (153 Group) Wgt: 1.0939
  - 30 Day HHGM Wgt: 0.9336
  - 60 Day HHGM Wgt: 1.0405

- Gov’t-Owned (2.0%)
  - Current (153 Group) Wgt: 1.0353
  - 30 Day HHGM Wgt: 0.9868
  - 60 Day HHGM Wgt: 0.9997
**Impact Ratio by Census Division**

<table>
<thead>
<tr>
<th>Division</th>
<th>Average Period $</th>
<th>Average Period $</th>
<th>Average Episode $</th>
<th>Average Episode $</th>
<th>Impact Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>East North Central</td>
<td>$1,723</td>
<td>$1,704</td>
<td>$2,304</td>
<td>$2,873</td>
<td>0.9891</td>
</tr>
<tr>
<td>East South Central</td>
<td>$1,426</td>
<td>$1,439</td>
<td>$2,553</td>
<td>$2,577</td>
<td>1.0092</td>
</tr>
<tr>
<td>Mid-Atlantic</td>
<td>$1,955</td>
<td>$2,013</td>
<td>$3,094</td>
<td>$3,128</td>
<td>1.0909</td>
</tr>
<tr>
<td>Mountain</td>
<td>$1,881</td>
<td>$1,783</td>
<td>$3,122</td>
<td>$2,961</td>
<td>0.9484</td>
</tr>
<tr>
<td>Northeast</td>
<td>$1,969</td>
<td>$2,018</td>
<td>$3,250</td>
<td>$3,351</td>
<td>1.0248</td>
</tr>
<tr>
<td>Outlying</td>
<td>$1,012</td>
<td>$1,124</td>
<td>$1,746</td>
<td>$1,998</td>
<td>1.1300</td>
</tr>
<tr>
<td>Pacific</td>
<td>$2,123</td>
<td>$2,203</td>
<td>$3,620</td>
<td>$3,758</td>
<td>1.0380</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>$1,781</td>
<td>$1,686</td>
<td>$2,955</td>
<td>$2,798</td>
<td>0.9468</td>
</tr>
<tr>
<td>West North Central</td>
<td>$1,817</td>
<td>$1,746</td>
<td>$2,882</td>
<td>$2,770</td>
<td>0.9611</td>
</tr>
<tr>
<td>West South Central</td>
<td>$1,418</td>
<td>$1,476</td>
<td>$2,635</td>
<td>$2,743</td>
<td>1.0408</td>
</tr>
</tbody>
</table>

**Strategic Management Model**

- What do we know?
- What should we do about it?
- What does it mean?

**Know Your Data**

- Model impact for your organization
- "PDGM Grouper Tool" at [https://go.cms.gov/1RoGVo](https://go.cms.gov/1RoGVo)
- "PDGM agency-level financial impact estimate CY 2019 at [https://go.cms.gov/1RoGVo](https://go.cms.gov/1RoGVo)
Know Your Data Cont.

• Know your data and then ask, what does it mean? For example, look at LUPAs.
  • Frequently observed causes for LUPAs:
    • erroneous acuity capture with reflected care planning, due, often, to less than competent OASIS assessment and data capture. (Revenue impact high)
    • Stressed staffing levels
    • Stressed staff who don’t know how to meet productivity, are failing and cannot achieve all the visits
    • Etc…

Operational Must Haves PDGM and Payment Reform

• Effective leadership of change – most often a learned behavior
• ICD-10 coding – best practice
• OASIS competence, including risk stratification, laying the foundation for capture of acuity, revenue and laying the pathway to effective care planning
• Ask yourself: How much are you paying for less than competent assessments?

Look in an Organizational Mirror

Compare your reality:
• Coding – Reliably competent, timely and cost effective
• OASIS – Reliably competent in assessment process, acuity capture conveyed with data integrity – timely
• Care planning and Case Management – using accurate acuity capture to drive and execute evidence-based, interdisciplinary best practice care plans?
**KEEP LOOKING**

- Processes – LEAN with optimal IS platform integration
- Supervision – focused, field-based measure and support of KP Bs
- Engagement – High with reflective high retention
- Clinical Model – Best-practice, multi-disciplinary, innovative utilization management
- Structure – optimally aligned, lean and scalable. Adapted to PDGM

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**DO NOT LOSE SIGHT OF VALUE!**

- Strengthen market positioning, leveraging outcomes which count
- Drive EPISODE PRODUCTIVITY
- Care Management -CoP compliant, ongoing, best-practice care planning education
- Clinical model with intent to turn growing knowledge into ACTION
- Integrate advancing models of care through innovation, increase RPM opportunities
- Support all through optimal organizational design

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**PAYMENT POLICY CHANGE - REMOTE PATIENT MONITORING**

CMS is proposing to define remote patient monitoring in regulation for the Medicare home health benefit and to include the cost of remote patient monitoring as an allowable cost on the HHA cost report.

### IMPACT FROM TELEHEALTH PROGRAM (SOI)

<table>
<thead>
<tr>
<th></th>
<th>Decrease</th>
<th>No Change</th>
<th>Increase</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall quality</td>
<td>0.7%</td>
<td>13.8%</td>
<td>74.9%</td>
<td>30.6%</td>
</tr>
<tr>
<td>Referrals</td>
<td>0.0%</td>
<td>51.5%</td>
<td>38.9%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Visits per episode</td>
<td>36.4%</td>
<td>46.8%</td>
<td>7.7%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Unplanned hospitalizations</td>
<td>62.6%</td>
<td>17.9%</td>
<td>8.0%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Emergent care</td>
<td>50.9%</td>
<td>29.5%</td>
<td>7.3%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Patient self care</td>
<td>2.4%</td>
<td>28.4%</td>
<td>59.5%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>3.5%</td>
<td>22.4%</td>
<td>63.4%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Agency costs</td>
<td>18.0%</td>
<td>35.9%</td>
<td>30.1%</td>
<td>16.0%</td>
</tr>
</tbody>
</table>

*Fazzi’s State of the Industry Report 2017*

### QUAD AIM, PILLARS OF NEW MODEL

**Empower patients:**

- Patient-centered shifts care planning
- Leverage meaningful outcomes

### QUAD AIM, PILLARS OF NEW MODEL CONT.

**Increase Innovation:**

- Integrate technology along revenue cycle and into clinical model. Data driving clinical and operating decisions!

**Increase Competition:**

- Compete on quality and cost
- Leverage relationships and continuum
REMEMBER - SKEPTICS ARE GOOD!

“Bull markets are born on pessimism, grow on skepticism, mature on optimism and die on euphoria.”

-Sir John Templeton

COMPETENCE WILL DRIVE SUSTAINABILITY WITH INTEGRITY

CMS will be evaluating industry “behavioral adjustments” to the rule:

- Upcoding
- Visit patterns over new LUPA thresholds, by category
- Increasing numbers of episodes, etc.

COMPETENCE WILL DRIVE SUSTAINABILITY WITH INTEGRITY CONT.

- Reinforces the concepts of solidifying agency core competencies of Coding, OASIS assessment at bedside, capture of acuity in timely/quality documentation, use of evidence based, best practice care planning and effective, multi-disciplinary case management.
- We can, with integrity, tell the story of how home health meets complex health and illness needs effectively at a low cost, with high satisfaction AND integrity!
What is Your OASIS-D Transition Plan?

Fact: OASIS accuracy is mission-critical with its impact on patient care, publicly reported outcomes, Star ratings, value-based purchasing (VBP) measures and reimbursement.

Fact: OASIS-D changes effective January 1, 2019 will be extensive and could negatively impact accuracy, productivity and risk adjustment.

Fact: OASIS accuracy will become even more important with the Patient-Driven Groupings Model (PDGM) payment reform signed into law by the Bipartisan Budget Act of 2018 and slated for 2020.

Fazzi has you covered with a complete menu of education offerings to help your agency successfully transition to OASIS-D. We’ll work with you to integrate and tailor these solutions for your needs and budget...

1. Sign up for the Fazzi Learning Center which includes our industry’s gold standard of OASIS competency. Application-based training, The OASIS Walk®, the OASIS Tool Kit, customized learning plans for every level, proficiency testing, reporting that shows clinicians’ competency by impact on outcomes, financials, VBP measures, and much more. Our OASIS-D Readiness Package is included in the Fazzi Learning Center! Customers receive free “crosswalk” training and automatic OASIS-D updates just in time to make the transition to OASIS-D.

2. Kick off or supplement your transition plan with a focused in person training at your agency. Led by nationally esteemed OASIS expert and enthusiast Anita Werner, our trainers will provide engaging and effective OASIS-D crosswalk training at your location. By combining in person training with the Fazzi Learning Center, you’ll accommodate the individual learning styles of your staff and still get the in-depth, ongoing, on demand and affordable online university of our Learning Center.

3. Register for our three-part OASIS-D Readiness Webinar Series, “Out With the Old; In With the New”, covering everything you need to know to become OASIS-D ready. In the first session, we begin to build a foundation for OASIS-D. In session two, we cover the new OASIS-D items. Lastly, in session three we review the new OASIS-D mobility items.

4. Take advantage of the ultimate in application-based learning and coaching by purchasing our “Ride Along” OASIS Assessments. One of our expert trainers will “ride along” with your clinicians to observe their OASIS assessments in the home. Using the OASIS Toolkit, your clinicians receive immediate feedback delivered in a way that boosts their skills and their confidence at the same time. Your clinical management team also receives a comprehensive report to help them facilitate continuous learning and improvement. Use our “Ride Along” Assessments now to ensure proficiency on the OASIS C-2 items that will continue to be crucial under OASIS-D – or bring us in early next year to ensure OASIS-D competence – or both!

What they say about our OASIS education...

“Loved the way this was presented. It makes understanding the OASIS so much easier because of the way you have broken it down. Would definitely suggest this program to other nurses!”

“I’ve been involved with OASIS since its inception in the 90’s. I have been certified twice and this was by far the best presentation.”

“This was a great course with a highly knowledgeable presenter making this course easy to follow. Thank you!”

“Really enjoyed all the content and the presentation! Very well thought out!”

If you’d like information on how Fazzi can help your agency with the transition to OASIS-D, please contact us at OASISD@fazzi.com or call 800-379-0361 and simply ask for “Help with OASIS-D”. 