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Executive Update:

Patient Driven Groupings Model

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Executive Update:
Patient Driven Groupings Model

Presented by:
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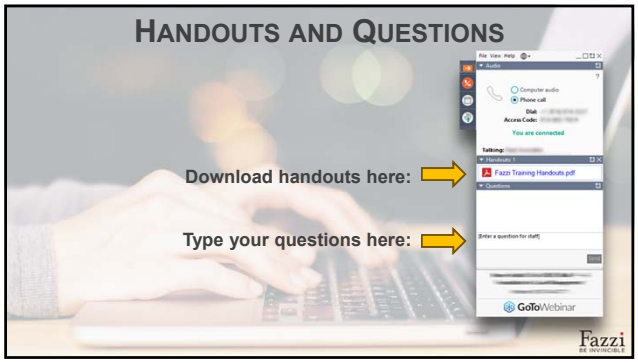
HANDOUTS AND QUESTIONS



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

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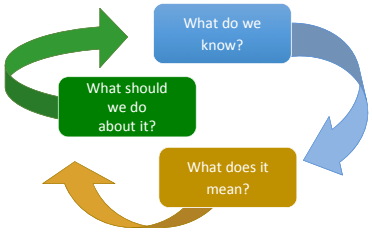
Strategic Management Model



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Proposed Patient Driven Groupings Model (PDGM)

- 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

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

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Proposed Payment Impact, 2020

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

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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

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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

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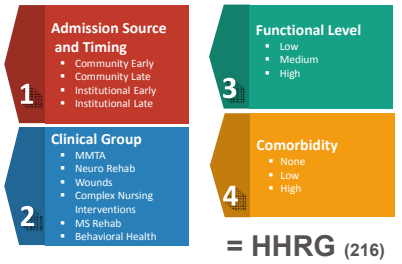
Patient Driven Groupings Model



= HHRG (216)

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MAJOR CHANGES

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

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

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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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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

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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

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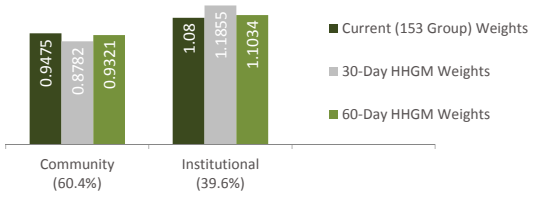
Average Case-Mix Weights, by Admission Source



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

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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.

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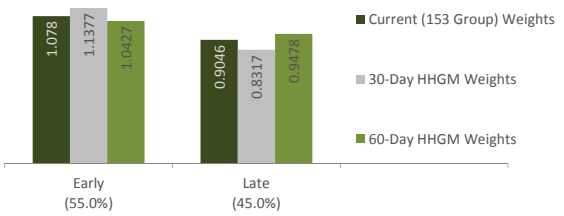
AVERAGE CASE-MIX WEIGHTS, BY TIMING



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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.

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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

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PDGM Clinical Groups, cont.

Clinical Group	Primary Reason for HH Encounter:
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies

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PDGM Clinical Groups, cont.

Clinical Group	Primary Reason for HH Encounter:
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and substance abuse conditions
Medication Management, Teaching and Assessment (MMTA)	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups.

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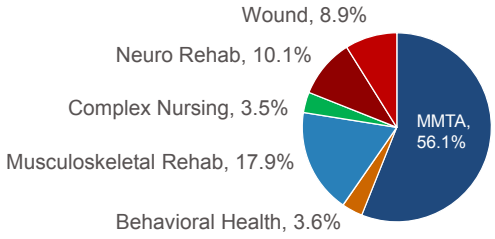
Percentage of Periods by Clinical Group



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Functional Levels

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
	M1032: (M1033 in OASIS-C1): Risk of Hospitalization

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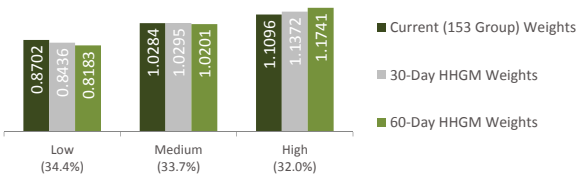
Average Case-Mix Weights, by Level of Functional Limitations



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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.

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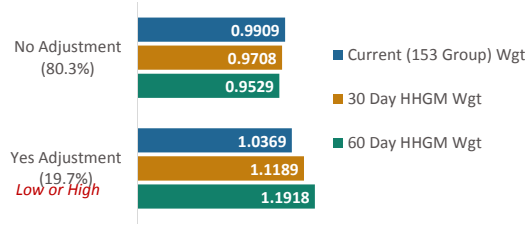
AVERAGE CASE-MIX WEIGHTS, BY COMORBIDITY ADJUSTMENT



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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.

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TABLE 40—PROPOSED LUPA THRESHOLDS FOR THE PROPOSED HHGM PAYMENT GROUPS BASED ON CY 2016 UTILIZATION DATA

HIPPS	Clinical group and functional level	Timing and admission source	Comorbidity adjustment	Threshold (10th percentile or 2—whichever is higher)
1AAN	MMTA—Low	Early—Community	No	4
1AAY	MMTA—Low	Early—Community	Yes	4
1ABN	MMTA—Medium	Early—Community	No	4
1ABY	MMTA—Medium	Early—Community	Yes	4
1ACN	MMTA—High	Early—Community	No	4
1ACY	MMTA—High	Early—Community	Yes	4
1BAN	Neuro—Low	Early—Community	No	4
1BAY	Neuro—Low	Early—Community	Yes	5
1BBN	Neuro—Medium	Early—Community	No	5
1BBY	Neuro—Medium	Early—Community	Yes	5
1BCN	Neuro—High	Early—Community	No	5
1BCY	Neuro—High	Early—Community	Yes	5
1CAN	Wound—Low	Early—Community	No	5
1CAY	Wound—Low	Early—Community	Yes	4
1CBN	Wound—Medium	Early—Community	No	5
1CBY	Wound—Medium	Early—Community	Yes	5
1CCN	Wound—High	Early—Community	No	5
1CCY	Wound—High	Early—Community	Yes	5
1DAN	Complex—Low	Early—Community	No	3
1DAY	Complex—Low	Early—Community	Yes	3
1DBN	Complex—Medium	Early—Community	No	3
1DBY	Complex—Medium	Early—Community	Yes	3
1DCN	Complex—High	Early—Community	No	3
1DCY	Complex—High	Early—Community	Yes	3
1EAN	MS Rehab—Low	Early—Community	No	5

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.

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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.

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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.

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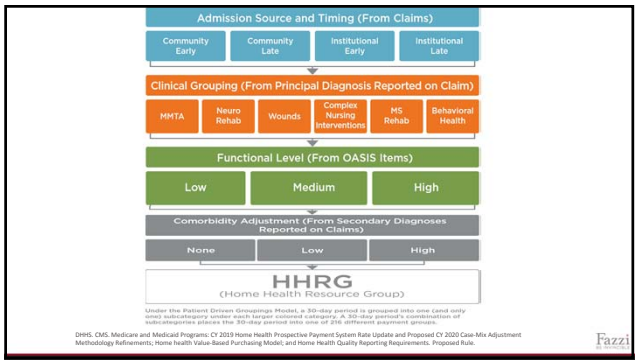
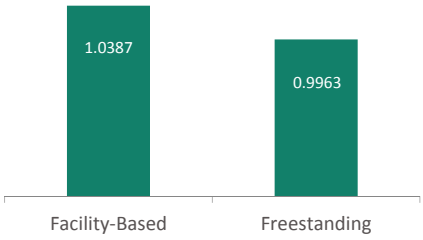


Impact Ratio by Facility Type



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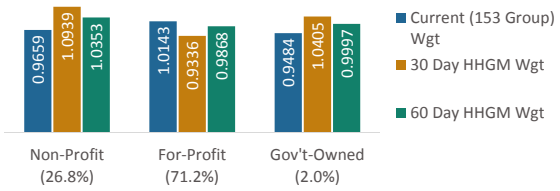
Average Case-Mix Weights, by Ownership Type



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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

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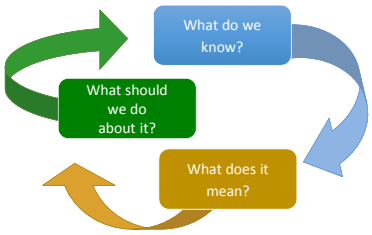
Strategic Management Model



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Know Your Data

- Model impact for your organization
  - "PDGM Grouper Tool" at https://go.cms.gov/1RoGVoi
  - "PDGM agency-level financial impact estimate CY 2019 at https://go.cms.gov/1RoGVoi

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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…

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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?

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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?

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KEEP LOOKING

- Processes – LEAN with optimal IS platform integration
- Supervision – focused, field-based measure and support of KPBs
- 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.

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-02.html

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Impact from Telehealth Program (SOI)

	Decrease	No Change	Increase	Not Sure
Overall quality	0.7%	13.8%	74.9%	10.6%
Referrals	0.0%	51.5%	38.9%	9.6%
Visits per episode	36.4%	46.8%	7.7%	9.1%
Unplanned hospitalizations	62.6%	17.9%	8.0%	11.5%
Emergent care	50.9%	29.5%	7.3%	12.3%
Patient self care	2.4%	28.4%	59.5%	9.6%
Patient satisfaction	3.5%	22.4%	63.4%	10.8%
Agency costs	18.0%	35.9%	30.1%	16.0%

Fazzi's State of the Industry Report 2017

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Quad Aim, Pillars of New Model

Empower patients:

- Patient-centered shifts care planning
- Leverage meaningful outcomes

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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

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Remember - Skeptics are Good!

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

-Sir John Templeton

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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.

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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!

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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".

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