HHGM is Alive and Kicking:

How Can You Prepare for

What's Next?

Presented by:

SHP
STRATEGIC HEALTHCARE PROGRAMS

Chris Attaya
VP of Product Strategy, SHP

Winning Webinar Series

Corridor

Sue Payne
VP & Chief Clinical Officer, Corridor

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Objectives

- Understand the latest updates for CMS and the components of the proposed HHGM model
- Identify the winners and losers and other insights based on data from SHP
- Identify clinical operations changes necessary with implementation of a HHGM-like model
- Have strategies to manage both the patient and the financials under HHGM

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Understand the latest updates for CMS and the components of the proposed HHGM model

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CY 2018 Proposed Rule – July 2017

- CMS contracted with Abt Associates to reassess the current HHPPS model and develop an alternative payment model that better aligns patients needs and payments
- Uses 30-day periods rather than 60-day episodes for payment
- Eliminates the use of the number of therapy visits in payment determination
- Relies on clinical characteristics and other patient information in the model
- Includes Non-Routine Supplies (NRS) in the base rate
- Proposed to begin January 1, 2019 in a non-budget neutral manner ($950M reduction in payments)

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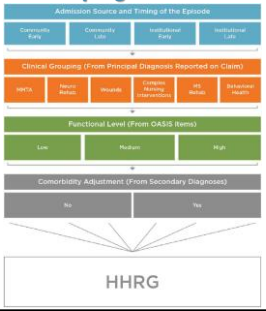
Home Health Grouping Model



4 x 6 x 3 x 2 = 144 Groups

Source: CMS CY 2018 HH Proposed Rule

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Timing of 30-Day Periods

- The first 30 days would be defined as early and all other subsequent period would be classified as late
- A 30-day period could not be considered early unless there was a gap of more than 60 days between the end of one period and the start of another

TABLE 31: Average Resource Use by Timing (30 Day Periods)

Timing	Average Resource Use	Number of Episodes	Percent of Episodes	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Early Episodes	$2,102.29	2,719,495	31.47%	$1,265.68	$1,213.51	$1,848.12	$2,681.90
Late Episodes	$1,348.18	5,922,612	68.53%	$1,229.14	$537.85	$987.54	$1,760.20
Total	$1,585.48	8,642,107	100.00%	$1,289.23	$671.96	$1,262.65	$2,119.49

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Source: CMS CY 2018 HH Proposed Rule

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Admission Source

- Patients discharged from an institutional setting (acute or post-acute) in the prior 14 days will be defined as institutional and all others as community
- Second periods with a institutional discharge within 14 days of the SOC would be considered community

TABLE 32: Average Resource Use by Admission Source (14 day look-back) Admission Source

	Average Resource Use	Number of 30-day Periods	Percent of 30-day Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Institutional	$2,165.06	2,153,712	24.92%	$1,350.43	$1,224.83	$1,899.41	$2,772.04
Community	$1,393.10	6,488,395	75.08%	$1,208.29	$571.97	$1,060.51	$1,838.39
Total	$1,585.48	8,642,107	100.00%	$1,289.23	$671.96	$1,262.65	$2,119.49

Source: CY 2016 Medicare Home Health Claims Data (as of March 17, 2017).

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Source: CMS CY 2018 HH Proposed Rule

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Clinical Groups

- Based on the Principle Diagnosis on the Home Health Claim
- Would be the primary reason patient is receiving services under the Medicare home health benefit

TABLE 34: Clinical Groups Used in the Home Health Groupings Model

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
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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Source: CMS CY 2018 HH Proposed Rule

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Clinical Groups

- Nineteen percent (19%) of the 30-day periods were considered Questionable Encounters (QE)
- If a 30-day period of care could not be grouped based on the home health reported principal diagnosis, the claim would be returned to the provider for more accurate or definitive coding.

TABLE 35: Frequency and Associated Resource Use of Clinical Groups

Clinical Group	Average Resource Use	N	Percent	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Musculoskeletal Rehabilitation	$1,713.10	1,430,813	16.56%	$1,149.61	$1,495.09	$878.95	$2,276.98
Neuro/Stroke Rehabilitation	$1,811.74	772,579	8.94%	$1,319.45	$1,511.06	$851.12	$2,434.60
Wound	$2,055.47	906,782	10.49%	$1,666.59	$1,609.16	$955.17	$2,623.31
Behavioral Health	$1,252.08	289,513	3.35%	$1,019.25	$954.32	$505.15	$1,704.72
Complex Nursing Interventions	$1,703.24	336,249	3.89%	$1,573.15	$1,240.74	$675.88	$2,206.54
MMTA	$1,437.37	4,906,171	56.77%	$1,200.35	$1,105.63	$589.92	$1,936.81
Total	$1,585.48	8,642,107	100.00%	$1,289.23	$1,262.65	$671.96	$2,119.49

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Source: CMS CY 2018 HH Proposed Rule

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Functional Level

- Like with the current HHPPS model, HHGM patients would be classified into 1 of 3 functional level based on the following OASIS items:

M1800 – Grooming	M1840 – Toilet Transferring
M1810 – Dress Upper Body	M1850 – Transferring
M1820 – Dress Lower Body	M1860 - Ambulation
M1830 - Bathing	M1032 – Risk of Hospitalization

- Functional Levels based on Points
  - Low, Medium, High

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Functional Level

- CMS designed to have 1/3 as low, medium and high in each of the Clinical Groups

TABLE 37: Thresholds for Functional Levels by Clinical Group, CY 2013 and CY 2016

Clinical Group	Level	Points (2013 Data)	Points (2016 Data)
MMTA	Low	0-36	**0-36**
	Medium	37-55	**37-54**
	High	56+	**55+**
Behavioral Health	Low	0-30	**0-38**
	Medium	31-55	**39-57**
	High	56+	**58+**
Complex Nursing Interventions	Low	0-33	**0-36**
	Medium	34-60	**37-59**
	High	61+	**60+**
Musculoskeletal Rehabilitation	Low	0-37	**0-39**
	Medium	38-55	**40-55**
	High	56+	**56+**
Neuro Rehabilitation	Low	0-48	**0-49**
	Medium	49-67	**50-66**
	High	68+	**67+**
Wound	Low	0-41	**0-42**
	Medium	42-65	**43-65**
	High	66+	**66+**

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Source: CMS CY 2018 HH Proposed Rule

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Co-morbidity Adjustment

- CMS analyzed the presence of comorbidities as another factor that could impact resource utilization and costs
- Excluded QEs that used secondary diagnoses for coding, 2nd Dx with the same three character ICD-10 as primary to assign the clinical group, unspecified site or side, or used to explain the primary diagnosis

TABLE 39: Frequency of Comorbidity Groups and Distribution of Average Resource Use

Comorbidity Group	Mean Resource Use	Frequency of Periods	Percent of Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
No Comorbidity Adjustment	$1,534.17	7,365,806	85.23%	$1,228.43	$1,227.35	$653.57	$2,061.88
Comorbidity Adjustment	$1,881.60	1,276,301	14.77%	$1,562.89	$1,484.39	$803.15	$2,475.20
Total	$1,585.48	8,642,107	100.00%	$1,289.23	$1,262.65	$671.96	$2,119.49

Source: CMS CY 2018 HH Proposed Rule

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Other Key Elements

- RAPs (Request for Anticipated Payments) and Final Claims billed the same way, but for 30-day Periods
  - CMS to evaluate if RAPs are still necessary
- PEPs (Partial Episode Payments) and Outliers have the same methodology
- LUPAs have variable thresholds based on HIPPS code – Each HHGM payment group threshold based on 10th percentile of visits or 2 visits which ever is higher
  - LUPA visits are one less than the threshold listed
  - Thresholds ranges from 2 visits – 7 visits

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Behavioral Adjustments

- LUPAs one visit under the HHGM thresholds
  - FY 2001 – 16% of episodes were LUPA
  - 7% of current 60-day episodes receive a LUPA
  - 4.9% of 30-day periods of care are just one visit below thresholds
  - Agencies would provide one additional visit to avoid a LUPA
- Highest paying Dx code would be listed as Primary Dx
  - Compared changes from DRGs to MS-DRGs
  - IRF PPS first year transition
  - Experience in HH nominal case mix growth
- No Explicit comment on increasing number of Periods

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HHGM Rescue Proposal

- Proposal - October 26, 2017
  - Allow 30 day payment period but maintain 60 day certifications
  - Start January 1, 2020 with rate of $1,772
  - Extend HH-VBP to all remaining states
  - Rates change by current statute but no lower than .5%
  - Budget Neutrality for all future regulatory proceedings
  - Technical Expert Panel Requirements
  - Other Key Provisions: Extension of Rural Add-on; ALJ Settlements: Home Health documentation to support Medicare Eligibility; F2F Home Record; APN and NP to order Home Care
- HHGM was pulled from the CY 2018 Final Rule

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Negotiations with CMS

- Letter to CMS – December 12, 2017
  - Principles – Budget Neutral; Limit Behavioral change adjustment; Reasonable Reimbursement; Payment on Patient Characteristics and Clinical Needs; Operating Consistently with other aspects of service delivery; Enough Time to implement; and Fully Tested and Validated.
  - Timeline with Pilot by Q4 2018 and Implementation >9 months after issuance of final rule.
  - Form a TEP
  - Re-weight certain payment groups with higher hospitalization rates
  - Retain 60-day Payment Periods
  - Retain current method for Non-Routine Supplies (NRS)

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Proposals to Consider

- Almost Family Proposal
  - Model focuses on patient “goals” rather than “characteristics”
  - Risk Based Grouper Model
    - Keep patients out of hospital
    - Improve their level of function
- Technical Expert Panel (TEP) – February 1, 2018
  - Complex and many questions need to be followed-up on
  - Tie payments to outcomes? 1) CMS is supposed to tie payments to costs; 2) CMS will not know outcomes until well after the episode
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/HH-PPS-HHGM-TEP-materials.pdf

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Congressional Continuing Resolution (CR)

- SEC. 51001. HOME HEALTH PAYMENT REFORM
  - **Budget Neutral** Transition To A 30-Day Unit Of Payment For Home Health Services
  - 30-DAY UNIT OF SERVICE.—For purposes of implementing the prospective payment system with respect to home health units of service furnished during a year beginning with 2020, the Secretary shall apply a **30-day unit of service** as the unit of service applied under this paragraph.
  - TREATMENT OF THERAPY THRESHOLDS.—For 2020 and subsequent years, the Secretary shall **eliminate the use of therapy thresholds** (established by the Secretary) in case mix adjustment factors established under clause (i) for calculating payments under the prospective payment system under this subsection
  - IN GENERAL.—The Secretary shall **annually determine** the impact of differences between **assumed behavior changes** (as described in paragraph (3)(A)(iv)) and actual behavior changes on estimated aggregate expenditures under this subsection with respect to years beginning with 2020 and ending with 2026

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Identify the winners and losers and other insights based on data from SHP

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SHP Data Analysis – CY 2017

- SHP National Database
- All Medicare Traditional Episodes ending in CY 2017 with a corresponding Medicare claim
- Grouper model was used with a correction
- Total Episode Count – 2,908,644
  - 554,011 Questionable Diagnoses (19.0%)
  - 3,173 Unknown Diagnoses (.1%)
- HHGM Period #1 – 2,351,460
- HHGM Period #2 – 1,714,129
- Revenue assumptions based on CY 2017 National Rates for HHPPS HHRGs (inc. Non-Routine Supplies) compared to the CY2018 Proposed Rule HHGM Group Model with estimated budget neutral rate of $1,772 (no Area Wage assumptions)

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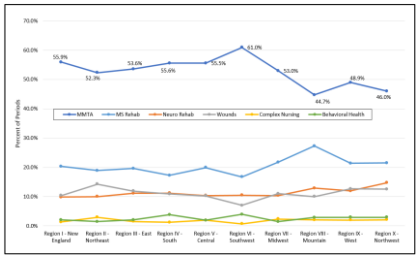
HHGM Components by CMS region

- Clinical Group



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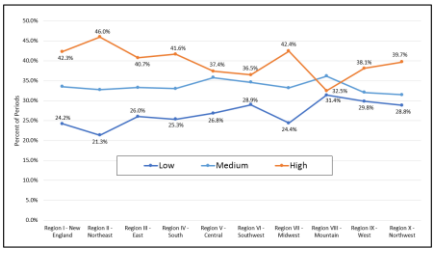
HHGM Components by CMS region

- Functional Level



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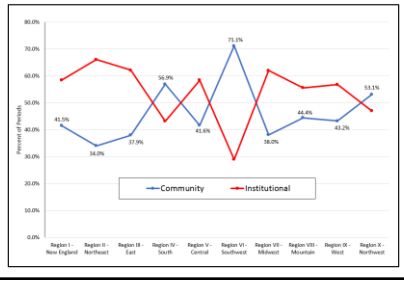
HHGM Components by CMS region

- Admission Source (Period 1)



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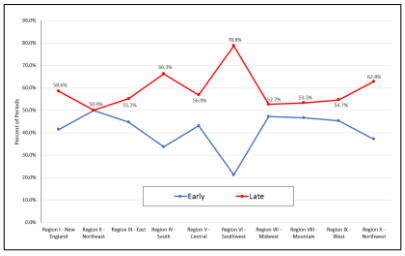
HHGM Components by CMS region

- Timing of the Episode



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LUPA data across CMS Regions

- LUPA Percent of Periods highest in the Northeast

Medicare Region	HHGM Period 1 LUPA	HHGM Period 2 LUPA
Region I - New England	8.3%	11.3%
Region II - Northeast	10.0%	13.6%
Region III - East	8.3%	11.0%
Region IV - South	6.9%	8.0%
Region V - Central	8.7%	11.3%
Region VI - Southwest	4.9%	5.1%
Region VII - Midwest	9.4%	12.2%
Region VIII - Mountain	7.9%	10.0%
Region IX - West	9.1%	11.8%
Region X - Northwest	8.7%	8.8%
Grand Total	**7.6%**	**9.1%**

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LUPA data across HHGM Clinical Categories

- LUPA averaged 8.2% across all periods

HHGM Clinical Category	HHGM Period 1 LUPA	HHGM Period 2 LUPA
MMTA	6.8%	8.6%
Neuro Rehab	7.1%	7.9%
Wounds	7.2%	10.5%
Complex Nursing	19.2%	13.9%
MS Rehab	9.3%	10.3%
Behavioral Health	7.5%	7.9%
Grand Total	**7.6%**	**9.1%**

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HHGM Revenue Compared to HHRG

- Based on Standard PPS Episodes (excluding LUPA, PEP, Outliers)

CMS Region	HHRG Revenue ($ millions)	HHGM Revenue ($ millions)	Percent Variance
Region I - New England	$ 469.66	$ 482.04	2.6%
Region II - Northeast	$ 407.70	$ 425.78	4.4%
Region III - East	$ 708.73	$ 704.31	-0.6%
Region IV - South	$ 2,059.16	$ 2,053.24	-0.3%
Region V - Central	$ 850.05	$ 844.34	-0.7%
Region VI - Southwest	$ 1,041.23	$ 1,074.19	3.2%
Region VII - Midwest	$ 205.01	$ 202.38	-1.3%
Region VIII - Mountain	$ 119.55	$ 107.98	-9.7%
Region IX - West	$ 424.22	$ 434.21	2.4%
Region X - Northwest	$ 212.08	$ 209.49	-1.2%
Grand Total	**$ 6,497.42**	**$ 6,539.89**	**0.7%**

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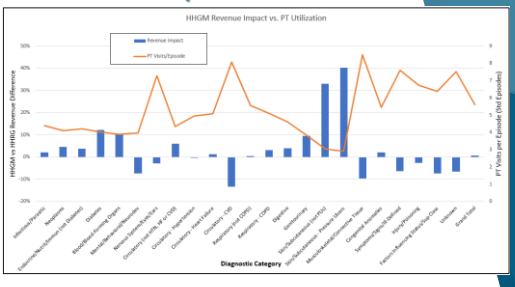
HHGM Revenue Compared to HHRG



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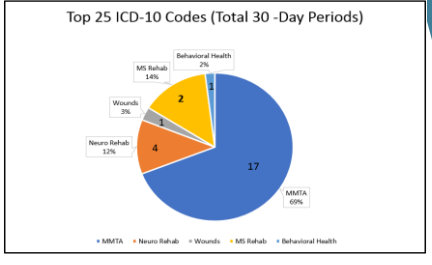
Top 25 ICD-10 Primary Dx Codes



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Top 25 ICD-10 Primary Dx Codes

ICD Code	ICD Description	Clinical Group	# of Periods
Z47.1	Aftercare following joint replacement surgery	MS Rehab	202,893
I11.0	Hypertensive heart disease with heart failure	MMTA	167,012
I10.	Essential (primary) hypertension	MMTA	140,866
I13.0	Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny	MMTA	124,604
J44.1	Chronic obstructive pulmonary disease w (acute) exacerbation	MMTA	122,905
J44.9	Chronic obstructive pulmonary disease, unspecified	MMTA	114,861
Z48.812	Encntr for surgical aftcr following surgery on the circ sys	MMTA	88,877
G20.	Parkinson's disease	Neuro Rehab	79,023
E11.9	Type 2 diabetes mellitus without complications	MMTA	68,437
I87.2	Venous insufficiency (chronic) (peripheral)	MMTA	66,654
Z47.89	Encounter for other orthopedic aftercare	MS Rehab	59,749
E11.621	Type 2 diabetes mellitus with foot ulcer	Wounds	54,198
Z48.3	Aftercare following surgery for neoplasm	MMTA	53,908
I69.354	Hemiplga following cerebral infrc affecting left nondom side	Neuro Rehab	53,866
I69.351	Hemiplga following cerebral infrc aff right dominant side	Neuro Rehab	52,088
Z48.815	Encntr for surgical aftcr following surgery on the dgstv sys	MMTA	49,713
E11.22	Type 2 diabetes mellitus w diabetic chronic kidney disease	MMTA	49,661
I48.91	Unspecified atrial fibrillation	MMTA	48,722
I12.9	Hypertensive chronic kidney disease w stg 1-4/unsp chr kdny	MMTA	43,366
J18.9	Pneumonia, unspecified organism	MMTA	42,496
E11.65	Type 2 diabetes mellitus with hyperglycemia	MMTA	39,117
F03.90	Unspecified dementia without behavioral disturbance	Behavioral Health	36,894
G30.9	Alzheimer's disease, unspecified	Neuro Rehab	36,698
J44.0	Chronic obstructive pulmon disease w acute lower resp infct	MMTA	34,472
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	MMTA	31,311
Total			1,862,391

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Comparison of Top Diagnosis Codes

- Top Diagnosis codes in each HHGM Clinical Group
- HHGM Revenue is lower in 3 of the 6 Groups
- Variance is significant compared to national PPS rates are reimbursed today

ICD Code	ICD Description	Clinical Group	Avg. HHRG $	Avg. HHGM $	% Change
Z47.1	Aftercare following joint replacement surgery	MS Rehab	$ 3,304	$ 2,724	-17.6%
I11.0	Hypertensive heart disease with heart failure	MMTA	$ 3,053	$ 3,054	0.0%
G20.	Parkinson's disease	Neuro Rehab	$ 4,057	$ 3,669	-9.6%
E11.621	Type 2 diabetes mellitus with foot ulcer	Wounds	$ 2,802	$ 4,366	55.8%
F03.90	Unspecified dementia without behavioral disturbance	Behavioral Health	$ 3,041	$ 2,803	-7.8%
Z43.5	Encounter for attention to cystostomy	Complex Nursing	$ 2,562	$ 3,570	39.3%

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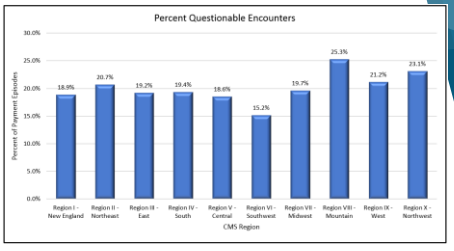
Questionable Encounters (QE)

- SHP National Average was 19.0%



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Top 20 QEs by ICD-10 Code

- Begin to address codes that would be questionable

ICD Code	ICD Description	Primary Diagnosis Category	QE's	% of Total
M62.81	Muscle weakness (generalized)	Musculoskeletal/Connective Tissue	95,153	17.2%
N39.0	Urinary tract infection, site not specified	Genitourinary	43,502	7.9%
Z46.6	Encounter for fitting and adjustment of urinary device	Factors Influencing Status/Sup Class	38,567	7.0%
R26.89	Other abnormalities of gait and mobility	Symptoms/Signs/Ill-Defined	22,956	4.1%
R26.81	Unsteadiness on feet	Symptoms/Signs/Ill-Defined	14,095	2.5%
R53.1	Weakness	Symptoms/Signs/Ill-Defined	12,951	2.3%
R29.6	Repeated falls	Symptoms/Signs/Ill-Defined	12,600	2.3%
R26.9	Unspecified abnormalities of gait and mobility	Symptoms/Signs/Ill-Defined	11,760	2.1%
S72.001D	Fx unsp part of nk of r femr, subs for clos fx w routn heal	Injury/Poisoning	10,554	1.9%
S72.002D	Fx unsp part of nk of l femr, subs for clos fx w routn heal	Injury/Poisoning	10,413	1.9%
I13.2	Hyp hrt & chr kdny dis w hrt fail and w stg 5 chr kdny/ESRD	Circulatory - Hypertension	10,162	1.8%
R26.2	Difficulty in walking, not elsewhere classified	Symptoms/Signs/Ill-Defined	8,079	1.5%
I12.0	Hyp chr kidney disease w stage 5 chr kidney disease or ESRD	Circulatory - Hypertension	6,128	1.1%
M19.90	Unspecified osteoarthritis, unspecified site	Musculoskeletal/Connective Tissue	5,701	1.0%
M19.91	Primary osteoarthritis, unspecified site	Musculoskeletal/Connective Tissue	5,641	1.0%
M06.9	Rheumatoid arthritis, unspecified	Musculoskeletal/Connective Tissue	5,228	0.9%
S81.801D	Unspecified open wound, right lower leg, subs encntr	Injury/Poisoning	5,010	0.9%
S81.802D	Unspecified open wound, left lower leg, subsequent encounter	Injury/Poisoning	4,943	0.9%
C34.90	Malignant neoplasm of unsp part of unsp bronchus or lung	Neoplasms	4,881	0.9%
Z91.81	History of falling	Factors Influencing Status/Sup Class	4,712	0.9%
Top 20 Codes			333,036	60.1%
Grand Total			554,011	100.0%

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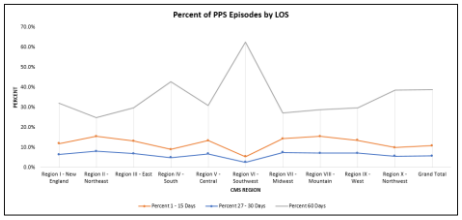
Lengths of Stay (LOS) by Region

- Shows Percent of Episodes across 1- 15 days, 27 – 30 days and at 60 days



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Identify Clinical Operation Changes Necessary with HHGM Like Model

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HHGM CLUES……

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30 day periods of care

- **Fact**: Home health frontloads patient visits and we utilize the greatest amount of resources in the first 30 days
- **Fact**: Only 25% of home health episodes end in 30 days
- **Fact**: Average Medicare patient LOS=46 days
- **Fact**: 45% of patients LOS is 60 days
- **Fact**: Average # of visits for 30 day periods=10.5
- **Fact**: 5% RAPS not submitted till final; Average Days to RAP=12; Auto cancellations

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CMS/MedPAC Data Episodes Ending in 2014-2016

Challenges - 30 day periods of care

OPERATIONS

- Avoid confusion between Payment Model vs Care Model
- Review patient status prior to end of 30 days to determine next step
- Avoid discharging too early
- Continue with frontloading as necessary
- Will need to continue to determine plan of care and interventions over 60 days
- Still responsible for 60 day episode related to specific measures:
  - Rehospitalization
  - Emergency Department Visits
  - Discharge to community
  - MCR Spending per Beneficiary

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Challenges - 30 day periods of care

BILLING

- Potential impact on RAP (request for anticipated payment)
- Impact on Medicare billing staff resource given a 60 day episode in this model would require billing in two increments
- Watch Out: Late Episode or Second 30 day period will be reimbursed less than early episode or first 30 day period
- Days to RAP may increase due to need to confirm diagnoses to specificity as needed for coding
- With reimbursement lower after first 30 day period, need to stay focused on cost management

Corridor

Clinical Characteristics is the Driver

MMTA, MS Rehab, Neuro Rehab, Wounds, Behavioral, Complex

- **Fact**: Has been lack of reimbursement for clinically complex patients
- **Fact**: Therapy Utilization will not drive reimbursement under HHGM
- **Fact**: 20% of home health primary diagnoses weren't mapped to 6 clinical groupings

Corridor

Operational Challenges with Clinical Groupings

- Questionable Encounters—who will care for these patients?
- Questionable Encounters—need to build in additional time to query physicians for specific information needed to code
- Improving functional status of patients while managing therapy costs
- Improving functional status enough that they can stay at home
- Orthopedic/behavioral diagnoses shortchanged in reimbursement
- Chronic Disease diagnoses shortchanged in reimbursement as it relates to therapy?

Corridor

Questionable Encounters

- Examples of codes that fall in QE:
  - Injury, Unspecified
  - UTI unspecified
  - Sepsis, unspecified organism
  - Muscle Weakness
  - Other general symptoms
  - Manifestation Codes where coding guidelines require an etiology code to be reported as primary diagnosis
  - Diagnoses with lack of specificity
  - Most of these codes were too vague to support need for home health

Corridor

Operational Challenges with QE's

- Patients with QE will return to provider
- Will need to touch record twice
- Need time to discuss patient with clinician/quality staff to determine if patient is appropriate for HH and/or just needs to be coded differently
- Must have coding specificity
- Must have enough referral and physician documentation to be specific in coding

Corridor

Managing LUPAs in HHGM

- LUPAS are defined as between 2 & 7 visits in new proposed model
- A '4 visit LUPA' means reimbursement by the visit vs by HHRG, if below threshold (3 and below visits)
- Clinical Groupings with highest LUPA %: complex nursing and MS Rehab; Wounds in 2nd 30 day period;
- LUPA Examples:
  - MMTA Low Functional, Late Community: <2 visits is LUPA
  - MS Rehab High Functional Late Community : < 7 visits LUPA

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Admission Source Matters

- **Fact:** 25% of the 30 day periods of care are classified institution and remaining 75% are classified community
- **Fact:** Patients who have had institutional stay within past 14 days required higher average resource than those from the community
- **Fact:** Patients discharged from institutional require more time to get back to functional level after being in a facility.

Corridor

Operational Challenges with Admission Source Changes

- Competition for patients from institution may increase
- Agencies with large % of patients admitted from community, may see changes to their reimbursement/revenue
- LEAN look at your costs/efficiencies

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Functional Assessment -Accuracy Is Still Critical

Determining Low/Med/High Functional Levels:

- M1800 Grooming
- M1810 Current Ability to Dress Upper Body
- M1820 Current Ability to Dress Lower Body
- M1830 Bathing
- M1840 Toilet Transferring
- M1850 Transferring
- M1860 Ambulation/Locomotion
- M1032 Risk of Hospitalization

Research shows relationship between functional status and costs of health care (including readmissions)

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Comorbidity Adjustment

- **Fact:** Comorbidity tied to worse health outcomes, more complexity, and higher care costs
- **Fact**: Based on historical data, the percentage of 30 day periods with co-morbidity adjustment was 15%

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Operational Challenges with Comorbidity Adjustment

- Getting the right amount of information to code accurately
- Requests for right amount of information may affect referral source view of 'user friendly'
- Accurate coding to include co-morbid conditions as appropriate

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Strategies to Manage Both the Patient and the Financials Under HHGM Like Model

Corridor

Clinical groupings and functional levels approaches

- Review your agency's interventions related to complex nursing patients
- OASIS Accuracy is crucial for:
  - Functional Levels that impact resource use
  - Quality Outcomes
- Coding Accuracy is crucial for:
  - Determining correct primary dx
  - Determining co-morbidity adjustment
  - Identifying primary focus of care
  - Avoiding Questionable Encounters and time needed to determine appropriate HH code

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Improving Functional Status of Patients

- What is right amount of therapy to produce results?
- Use of therapy assistants
- Use of rehab aides
- Use of tele rehab
- Alexa/Siri-move reminders
- What is right amount of therapy to produce results?
- Need for initial therapy evaluation
- Focus on transition to outpatient therapy, as appropriate

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Improving Functional Status of Patients

- Utilize centralized therapist to make recommendations
- Observation of functional status via webcam 
- Therapist can cover many more patients without travel
- Therapist can case conference with rehab aides/therapy assistants

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Managing Dementia Patients

- Impacts co-morbidity adjustment so must capture it
- As primary dx, will have less revenue for dementia under HHGM
- Dementia/Behavioral Diagnoses impact many home health patients
- How can you manage dementia patients differently?
  - Train HHAs to work with dementia patients
  - Utilize SLP or OT to assist with educating dementia patients and then pair them with home health aides
  - Utilize Social Workers/Community Resources

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How Will Structure and Resource Use Change?

- Therapy staff—not driver—hybrid approach 
- Clinical Management oversight prior to end of 30 days
- May see more nursing in clinical groupings
- More billers—RAP/Final Claim for each 30 days

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Data Needed to test run impact on your agency

- Primary Diagnoses of Medicare Patients for past 12 months
- Stratify Medicare patients by admission source for past 12 months
- Determine your readmission trend for MCR patients over past 12 months in days and by diagnosis

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Data Needed to test run impact on your agency

- Stratify Medicare patients by primary diagnoses and length of stay
- Identify discipline utilization for Medicare patients
- Identify when Medicare patients came to you in past 12 months (timing)
- Utilize the CMS HHGM Modeling Tool (see link at end of presentation)

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Analysis and Respond to Data

- Map primary diagnoses to the HHGM clinical groupings
- Take a look at who your patients are and how you cared for them?
- What is their admission source?
- When do your patients re-hospitalize?
- Can you lower your care costs if you receive more patients from the community since reimbursement is lower?

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Analyze and Respond to Data

- Overlay your Medicare patients from past year to HHGM model
- Are there patients who don't map to the six clinical groupings?
- Do they meet criteria for HH or are they coded incorrectly?
- Are you confident in the specificity of your coding/OASIS review?
- Are the visits performed in the 2nd 30 days giving you positive results?

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How are you a voice in payment model changes?

- Stay up to date on any future payment model proposals and send in your comments
- Participate in proposed payment model pilots or TEPs

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Questions?

SHP 63

Addendum: Link to HHGM Grouping Tool

Look for HHGM Grouping Tool at:

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

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Addendum: Comorbidity Diagnoses Highlights

- Heart Disease 1: includes hypertensive heart disease.
- Cerebral Vascular Disease 4: includes sequelae of cerebrovascular disease.
- Circulatory Disease and Blood Disorders 9: includes venous embolisms and thrombosis.
- Circulatory Disease and Blood Disorders 10: includes varicose veins of lower extremities with ulcers and inflammation, and esophageal varices.
- Circulatory Disease and Blood Disorders 11: includes lymphedema.
- Endocrine Disease 2: includes diabetes with complications due to an underlying condition.
- Neoplasm 18: includes secondary malignant neoplasms.
- Neurological Disease and Associated Conditions 5: includes secondary parkinsonism.
- Neurological Disease and Associated Conditions 7: includes encephalitis, myelitis, encephalomyelitis, and hemiplegia, paraplegia, and quadriplegia.
- Neurological Disease and Associated Conditions 10: includes diabetes with neurological complications.
- Respiratory Disease 7: includes pneumonia, pneumonitis, and pulmonary edema.
- Skin Disease 1: includes cutaneous abscesses, and cellulitis.
- Skin Disease 2: includes stage one pressure ulcers.
- Skin Disease 3: includes atherosclerosis with gangrene.
- Skin Disease 4: includes unstageable and stages two through four pressure ulcers.

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Thank You for Attending!

Presented by:

SHP
STRATEGIC HEALTHCARE PROGRAMS

Chris Attaya
VP of Product Strategy, SHP

Corridor

Sue Payne
VP & Chief Clinical Officer, Corridor
spayne@corridor.com