Webinar: Home Health

PDGM Readiness: What about **therapy?**

presented by **Gina Mazza, BSN, RN, CPHQ**
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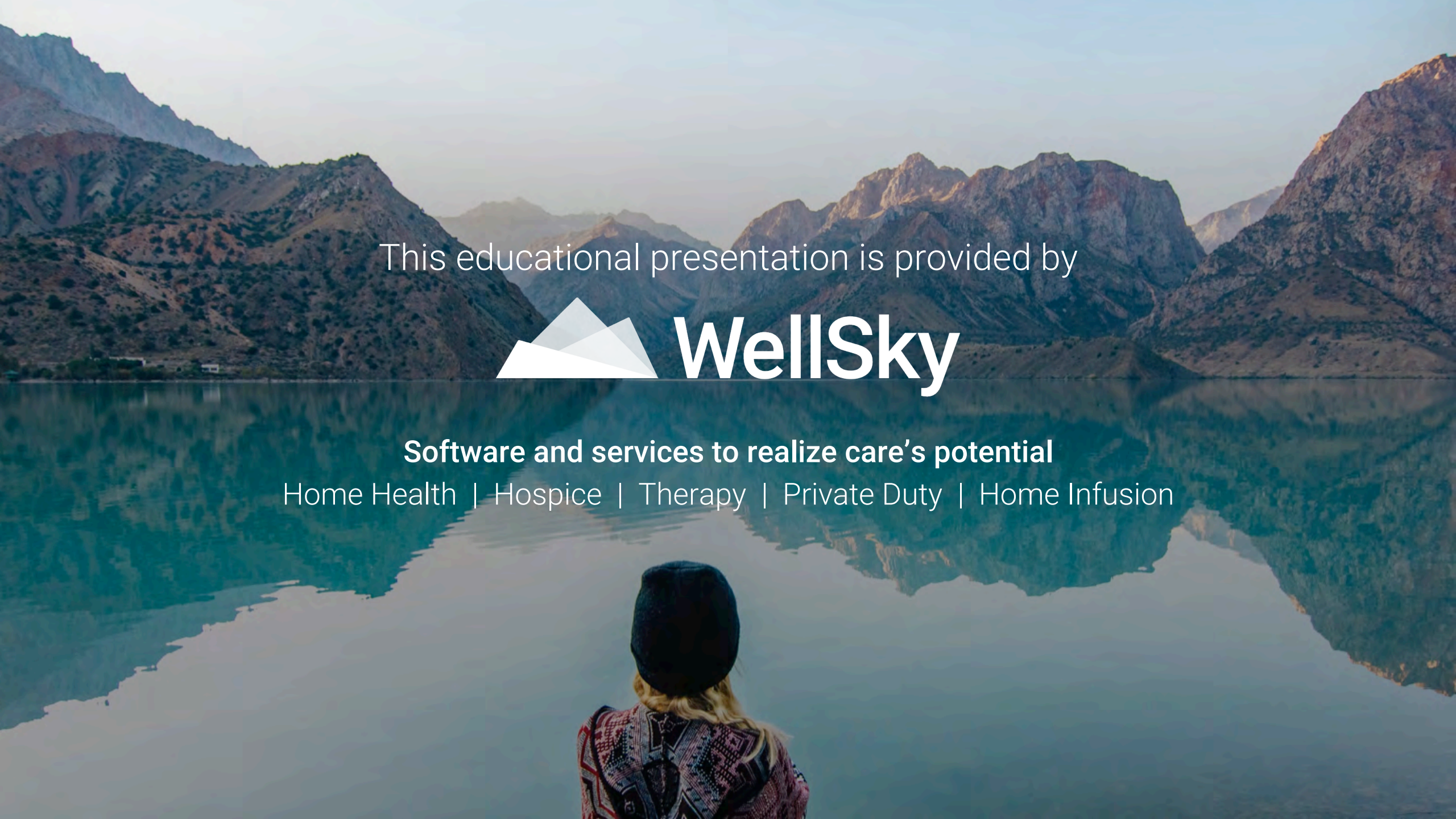
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Meet the presenters

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Meet the presenters

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Today's objectives

- Identify the case mix factors used in the PDGM related to therapy services.
- Discuss best practice recommendations for ensuring quality of care by including therapy services under PDGM.

Patient Driven Groupings Model (PDGM) **goals**

- 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.

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

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.

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 if unchanged
- Plan of Care corresponds with 60-day certification
- OASIS time points remain unchanged

What about VBP and the CoPs?

"...The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training..."

Plan of care requirements

i. Pertinent diagnosis
ii. Mental, psychosocial and cognitive status
iii. Services, supplies and equipment required
iv. Frequency and duration of visits
v. Prognosis
vi. Rehabilitation potential
vii. Functional limitations
viii. Activities permitted
ix. Nutritional requirements
x. All medications and treatments
xi. Safety measures to protect against injury
xii. A description of the risk for ER visits and hospitalization re-admission, and all interventions that address underlying risks
xiii. Patient/caregiver education and training to facilitate discharge
xiv. Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and patient
xv. Information related to advanced directives
xvi. Any additional items the physician or HHA may choose

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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Clinical groupings include therapy

- 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.

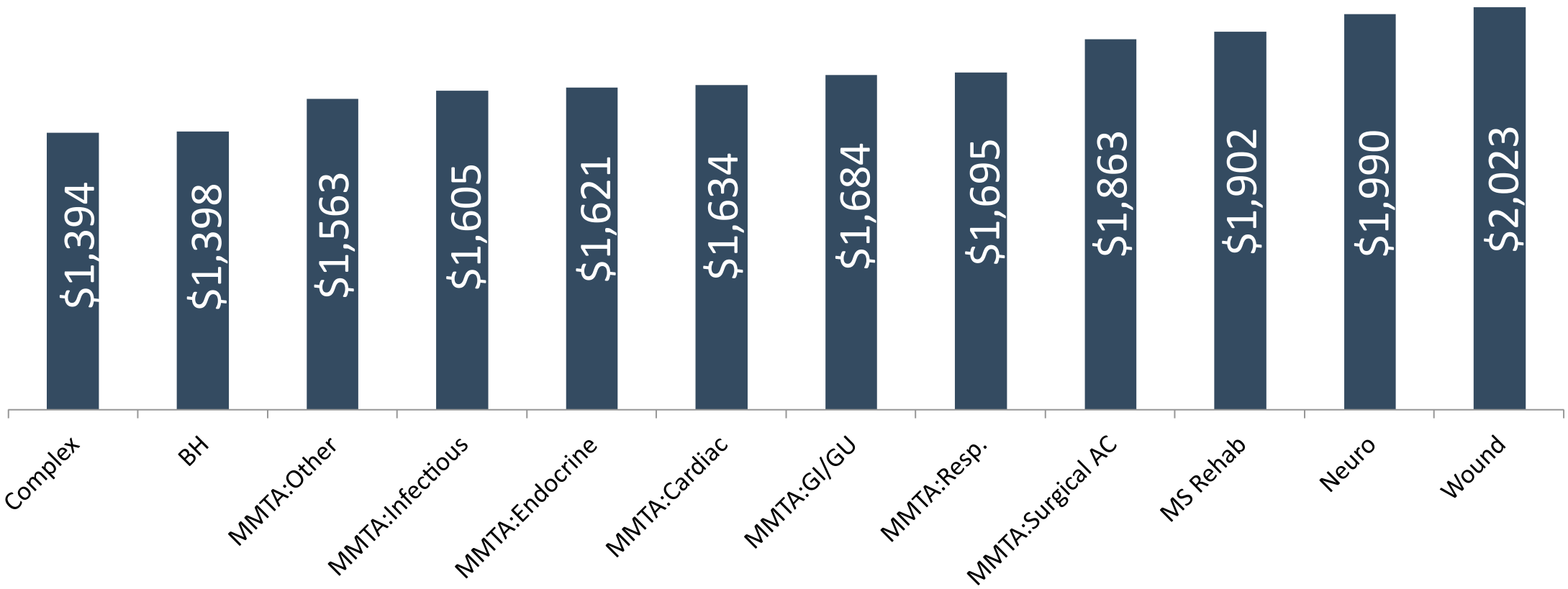
PDGM clinical groups

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

Revenue by clinical group



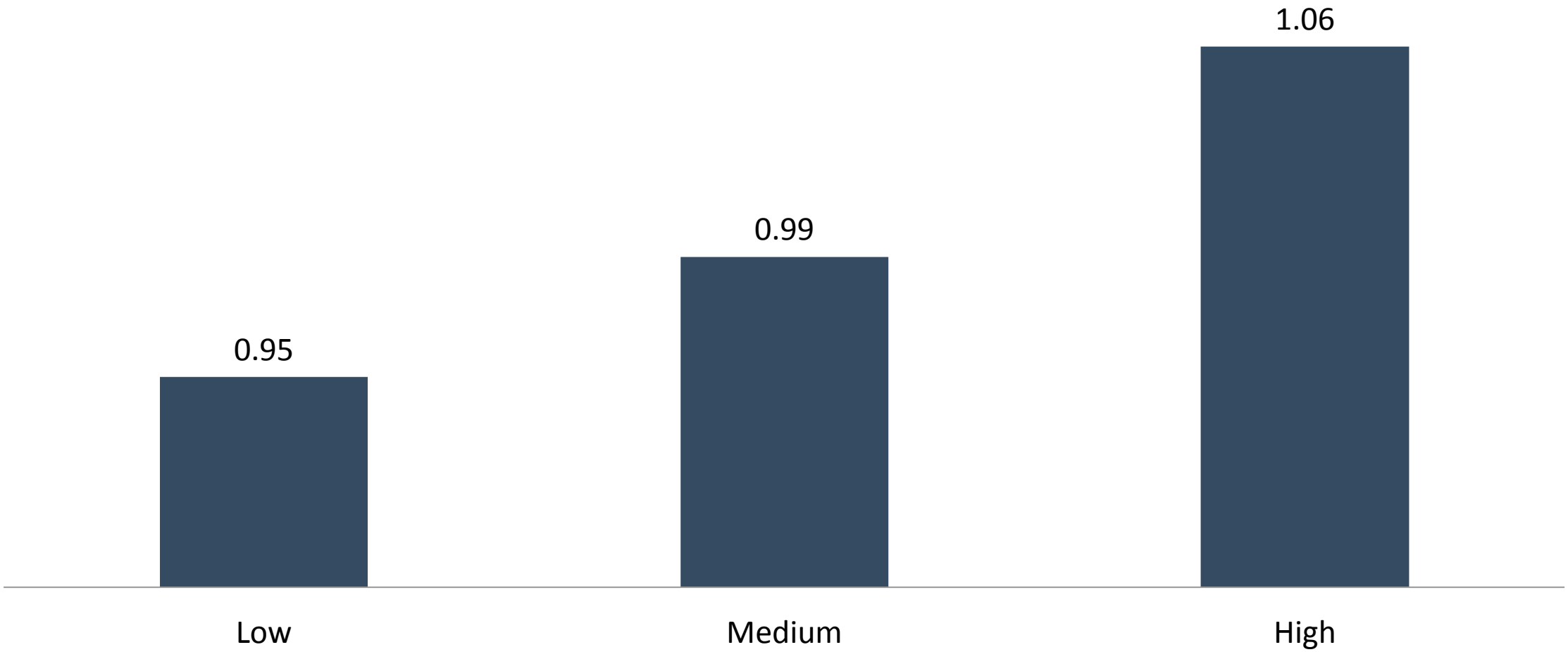
Source: Fazzi Business Intelligence Division

Clinical Group	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Home Health Aide	Medical Social Services
MMTA Other	4.599	2.889	0.771	0.151	0.774	0.074
Neuro Rehab	3.129	4.350	1.721	0.817	1.016	0.105
Wounds	7.718	1.700	0.584	0.077	0.815	0.063
Complex Nursing	4.187	1.060	0.356	0.122	1.099	0.043
MS Rehab	3.140	5.181	1.258	0.084	0.706	0.063
Behavioral Health	3.317	2.914	0.976	0.403	0.649	0.108
MMTA - Surgical Aftercare	5.472	2.647	0.809	0.127	0.449	0.072
MMTA - Cardiac	4.734	2.719	0.807	0.112	0.809	0.077
MMTA - Endocrine	6.695	2.523	0.675	0.091	0.800	0.082
MMTA - GI/GU	4.535	2.734	0.857	0.139	0.820	0.087
MMTA - Infectious	4.763	2.309	0.687	0.116	0.779	0.086
MMTA - Respiratory	4.407	2.932	0.919	0.181	0.762	0.097

Functional impairment

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

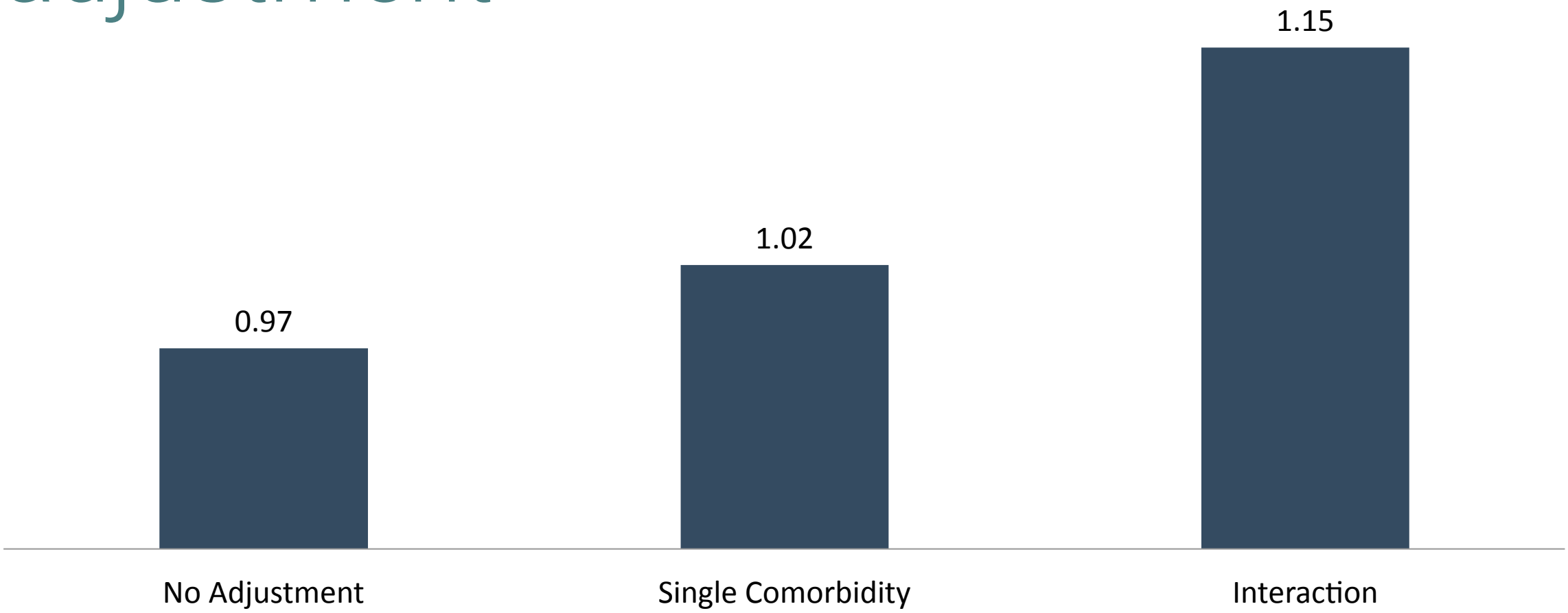
Impact ratio for functional levels



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

Impact ratio for comorbidity adjustment



OASIS best practices

- Assessment should include observation of functional activities.
- Encourage clinicians to consider the most dependent score first and work towards the more independent scores.
- Reinforce with clinicians:
    - Functional OASIS scores should be selected based on the patient's ABILITY to SAFELY perform the task.
    - Functional OASIS scores should not be scored on the availability of a caregiver.

Key elements of care delivery

1. OASIS assessment

- OASIS D training
- OASIS/Coding competency process
- Plan for more changes

2. Coding expertise

- Essential competency
- Maintain experts and/or outsource

3. Effective case management

- Implement/maintain case management processes
- IDT approach helps identify risks, goals and the plan
- Use case manager/s role
- Bridges care delivery with QAPI

Keys to quality

- Under Value Based Purchasing, agencies will still be measured on the quality of care provided.
    - Therapy services may be necessary to manage outcomes related to improvement of patient self-care and mobility during a quality episode.
- HHCAHPS performance measures will still involve patient's/caregiver's evaluation of safety needs being addressed
- Conditions of Participation require agencies to provide comprehensive care to address all of the patient's needs

Competency assessment strategies

1. Joint visits
   - Clinical manager or coworker
   - Standardized feedback forms
2. IDT meetings
   - SBAR-G
3. Audit of clinician documentation
   - Are OASIS scores supported?
   - Is the source of patient problem's tied to specific diagnoses?

Best practice recommendations

- Ensure OASIS assessment competency
- Create a culture of treating the whole patient
- Develop strategies for supporting therapy services
- Ensure effective care management practices

Controlling your future

"The best way to predict the future is to create it."

- Peter Drucker

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