Preparing for Medicare Payment Reform: The Home Health Agency Patient-Driven Groupings Model (PDGM)

1

2019 ConnOTA Annual Spring Conference
Saturday, March 2, 2019

Speakers:
Elaine Craddy Adams, MPPA, OTR/L, FAOTA
Morgan Rachel Villano, MPA, MSPS, OTR/L

Session Outline

2

- Course Introduction and Resources*
- Overview of Volume to Value Concept
- History of HHA PPS and Basic Concepts
- Review of PDGM
- Overarching CMS Initiatives
- Home Health Initiatives and Systems
- Promoting OT's Role and Value
- Wrap-up

Presentation Abstract

3

As health care reform has evolved in recent years, the focus has been on movement toward a system that supports value-based care and improved quality of care and away from a system driven by volume and payment rules. As part of this focus, the Centers for Medicare and Medicaid Services (CMS) have put forth efforts to reform the payment system for Home Health to a system that is driven by patient characteristics, factors, and care needs. Further, the Bipartisan Budget Act of 2018 mandated a change from 60-day to 30-day Home Health episodes of care and mandated removal of therapy visit thresholds from the Home Health payment system. As a result of this legislation and CMS' efforts, a new Medicare Home Health payment system, the Patient-Driven Groupings Model (PDGM) is slated to take effect on January 1, 2020. The PDGM payment structure is based on a combination of components, including the home health admission source and admission timing, where the patient falls in terms of clinical/diagnostic groupings, the functional level of the patient, and a comorbidity adjustment. These payment reform efforts are also linked to the post-acute care reform provisions of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, quality programs, and outcome reporting, updates to the Home Health Medicare Conditions of Participation, and the CMS Patients Over Paperwork initiative. This presentation will provide an overview of the PDGM, as well as the connection with other related CMS initiatives. This session will also provide an opportunity for participants to consider and explore the potential impact of the PDGM on occupational therapy service delivery and to consider and explore ways in to facilitate transition to the new PDGM model.

Notepad graphic throughout from https://upload.wikimedia.org/wikipedia/commons/thumb/7/71/Notepad_icon.svg/600px-Notepad_icon.svg.png

Learning Objectives

4

Participants will be able to:

- Describe the structure of the Patient-Driven Groupings Model
- Discuss the potential impact of the Patient-Driven Groupings Model on occupational therapy service delivery and ways in which to facilitate transition to the new model
- Explain the connection between the Patient-Driven Groupings Model and other Medicare Home Health initiatives and updates
- Identify resources to support transition to the new payment model

Course Level and Intent

5

Intermediate Level Course: Expect participants to have at least a basic understanding of Home Health service delivery and related Medicare rules prior to participation in this course.

Intent: Review of the topic aimed at familiarizing participants with the changing home health prospective payment system, as well as at provoking thought about clinical practice and operational issues in preparation for the pending changes

Audience Survey

6

- OT, OTA, Student, Other?
- Setting(s)?
- Job role(s)?
- Level of knowledge re: PDGM?
- Any subtopics of particular interest?

Resources

7

- Course Handouts
  - Slides
  - Resources and References
- Embedded links
- Primary Resources:
  - CMS:
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf
  - AOTA: https://www.aota.org/Practice/Manage/value.aspx?promo_name=payment-quality&promo_creative=Practice&promo_position=hero

Session Outline

8

- Course Introduction and Resources
- Overview of Volume to Value Concept*
- History of HHA PPS and Basic Concepts
- Review of PDGM
- Overarching CMS Initiatives
- Home Health Initiatives and Systems
- Promoting OT's Role and Value
- Wrap-up

How Did We Get To this Point?

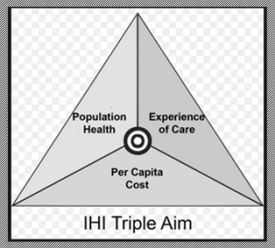
9

- Triple Aim - Populations, Quality & Cost
- Payment Models-Bundled Payment Care Incentive & Hospital Readmission Reduction Program
- Affordable Care Act
- Impact Act

Triple Aim

10

- Patient/Population Safety
- Reduce Harm
- Patient & Family Engagement
- Effective Communication
- Coordinated Care
- Disease & Health Management
- Evidenced Based Care
- Affordable Value Based Care

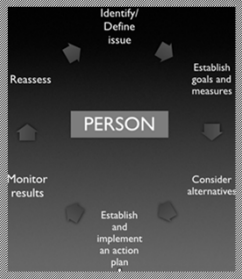


The IHI Triple Aim, retrieved from HealthPopuli.com

Focus on Quality

11

- Quality as a Cycle
- Transparency
- Data Follows the Person
- HOW DO YOU DEFINE QUALITY?



Adams and Villano, 2018, slide 14

CMS New *Value* Based Bundled Payment Model "BPCI Advanced"

12

- BPCI purpose - improve quality of care and patient outcomes while reducing costs to Medicare, Medicaid and CHIP
- October 1, 2018 - December 31, 2023 Voluntary basis
- Focus remains on TJR of LEs, CHF and Sepsis (32 total clinical episodes)
- Single Retrospective Bundled Payment
- Acute Care Hospitals and Physician Group Practices
  - Participants can receive increased monies *IF* the total cost for the beneficiaries is less than a pre-determined targeted cost; conversely if the participants spend more than pre-determined targeted cost then they must repay Medicare
  - BPCI Advanced process includes quality components in the pre-determined targeted cost

Lewin Group, 2018. https://downloads.cms.gov/files/cmmi/bpci-models2-4-yr5evalrpt.pdf
&
https://innovation.cms.gov/

Affordable Care Act

13

- Home Care one of the 10 mandated essential benefits to reduce the cost for elderly services within SNF, LTC and acute care
- Expand access to insurance coverage (e.g. Medicaid expansion)
- Increase consumer insurance protections
- Focus on prevention and wellness
- Optimize health quality and health systems performance
- Reduce rising health costs

https://www.hhs.gov/healthcare/about-the-aca/index.html

Medicare Post-Acute Care Transformation Act
IMPACT Act 2014

14

The IMPACT Act: Standardized Patient Assessment Data Elements

- **Requirements for reporting assessment data:**
  - Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions

  - The data must be submitted with respect to admission and discharge for each patient, or more frequently as required
- **Data categories:**
  - •Functional status •Cognitive function and mental status •Special services, treatments, and interventions •Medical conditions and co-morbidities •Impairments •Other categories required by the Secretary

Center for Medicare and Medicaid Services. (2018). https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-06-21-IMPACT.html

Bipartisan Budget Act of 2018 (BBA of 2018) & Home Health

15

- Section 51001 episode length changes from 60 days to 30 days
- Budget Neutral payment system - previously proposed model in 2017 would have cut approximately $950 million in payment
- Face to Face documentation - MD signing from acute, post acute or community remains viable but also the information in the HHA "chart" may also be used to substantiate homebound status (Healthcare first)
- Chronic Act provisions
- Repeal of therapy caps
- # of therapy visits no longer drives reimbursement

Healthcarefirst, Inc. (2018) https://www.healthcarefirst.com/blog/bipartisan-budget-act-2018/

Session Outline

16

- Course Introduction and Resources
- Overview of Volume to Value Concept
- History of HHA PPS and Basic Concepts*
- Review of PDGM
- Overarching CMS Initiatives
- Home Health Initiatives and Systems
- Promoting OT's Role and Value
- Wrap-up

Prospective Payment Systems

17

- Used for Medicare Part A services
- Payment rates and rules set through federal rule-making process
- An important concept: **Resource Utilization**
  - The care needed by a patient
    - Persons (Skilled, non-skilled, operational, etc.)
    - Supplies (Medical, Drugs, Equipment, etc.)
    - Time/Length of stay
    - Overhead costs

History of Home Health Medicare Part A

18

- HH PPS Implemented in October 2000
- Outcome and Assessment Information Set (OASIS)
  - Currently OASIS-D
- Payment typically provided as split percentage
  - Request for Anticipated Payment (RAP) and then claim at end of episode
  - Adjusted for case-mix and area wage differences
  - Standard episode and resource utilization adjustments
  - Quality program adjustments
- Therapy supervisory and reassessment rules (e.g., 13th and 19th visit requirement in 2013 and 2014)

History of Home Health Medicare Part A

19

- Changed focus to patient characteristics and factors
  - CY 2018 Proposed Rule: Home Health Groupings Model (HHGM) proposed
  - CY 2018 Final Rule: Delayed Implementation announced with plan for CMS to consider stakeholder comments, collaborate further with stakeholders and revise plan
  - Feb. 1, 2018: CMS and Abt Associates convene a Technical Expert Panel for input on Home Health payment reform
  - CY 2019 Proposed Rule: CMS puts forth revised plan for HH payment reform, renamed Patient-Driven Groupings Model for implementation CY 2020; Folds in mandates of BBA of 2018
  - CY 2019 Final Rule: CMS finalizes PDGM plan for implementation January 1, 2020

HHA Moratoria Discontinued

20

- Specific states (IL, FL, MI, TX)
- Many safety nets
  - Review Choice Demonstration
  - Contractor reform and Targeted Medical Review and POE
  - Increased focus on curbing fraud and abuse
  - Revamping of Program Integrity contractors (RACs, ZPIC, UPIC, SMRC, etc.)
  - Bipartisan Budget Act of 2018 provisions
  - IMPACT Act
  - PDGM
  - HH Compare and 5-Star Rating
  - Home Health HHCAHPS (Home Health Care Consumer Assessment of Healthcare Providers and Systems)
  - Health Outcomes Survey (HOS) (Medicare Advantage)
  - Revised Conditions of Participation (CoPs)

https://homehealthcarenews.com/2019/02/cms-lifts-moratoria-on-home-health-after-5-years/

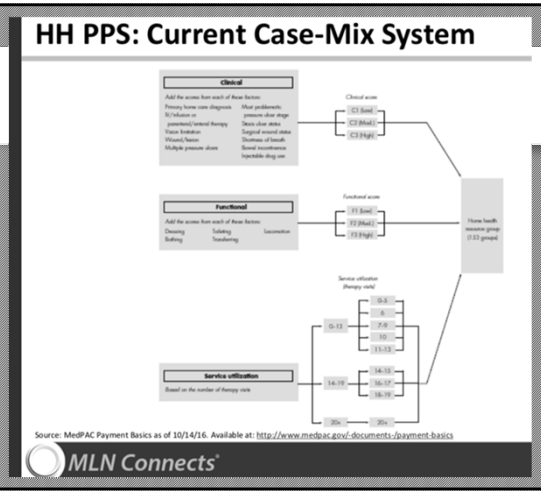
Home Health Resources Groups (HHRG) Current HH PPS

21

- Starting Point for Payment Calculation up to Q60 days per each episode
- Currently 153 HHRGs (i.e., Home Health Resource Group = Case-mix Group)
- Current HHRG process includes:
  - Timing (early/late)
  - 3 Clinical Levels
  - 3 Functional Levels
  - 9 Service Use Categories (# of therapy visits)

HH PPS: Current Case-Mix System

22



Session Outline

23

- Course Introduction and Resources
- Overview of Volume to Value Concept
- History of HHA PPS and Basic Concepts
- Review of PDGM*
- Overarching CMS Initiatives
- Home Health Initiatives and Systems
- Promoting OT's Role and Value
- Wrap-up

PDGM Changes

24

- January 1, 2020
  - PDGM
    - 60-Day to 30 day unit of service/payment period
    - Number of therapy visits no longer driving reimbursement
    - Change to five components to determine HHRG
      - From 153 HHRGs to 432 HHRGs
- Operation Change: Split Implementation of Split Percentage Payment
- OASIS-D began January 1, 2019:
  - Added Section GG items
    - Not a determinant of payment in PDGM (which uses Section M)
    - Only data collection

Split Implementation

25

From CMS MLN Matters Article: Home Health Patient-Driven Groupings Model (PDGM) – Split Implementation, p. 2

Beginning in CY 2020, HHAs that are certified for participation in Medicare on or after January 1, 2019, will no longer receive split-percentage payments. HHAs that are certified for participation in Medicare effective on or after January 1, 2019, would still be required to submit a "no pay" Request for Anticipated Payment (RAP) at the beginning of care to establish the HH period of care, as well as, every 30 days thereafter upon implementation of the PDGM in CY 2020.

Existing HHAs, meaning those HHAs certified for participation in Medicare prior to January 1, 2019, will continue to receive RAP payments upon implementation of the PDGM in CY 2020. For split percentage payments to be made, existing HHAs would have to submit a RAP at the beginning of each 30-day period of care. For the first 30-day period of care, the split percentage payment would be 60/40 and all subsequent 30-day periods of care would be a split percentage payment of 50/50. Please note that a final claim must be submitted at the end of each 30-day period of care.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11081.pdf

Why the Changes to HH PPS Process?

26

- 30 day timeframe improves case mix accuracy
- 30 day timeframe reduces and/or eliminates preemptive partial payments
- Payment for quality services and outcomes is foci of PDGM
- Medicare Home Health benefit not well defined
- Current system encourages higher therapy visits yielding increased reimbursement
- 60 day episodes indicated resource use differential

Discrepancy in Resource Use in Current HH PPS 2013 Data

27

Mean Visits & Resource Use in each 15 Day Segment of a (Full) and First 60-Day Episode among CY 2013 Episodes; n=836,815

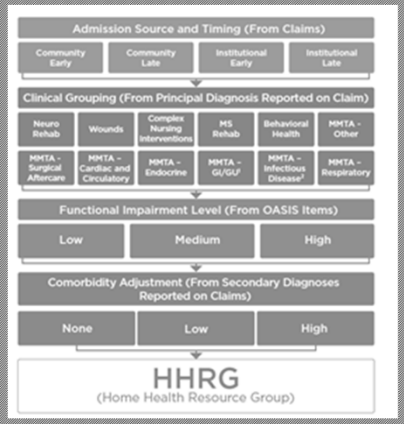
	Days 1-15	Days 16-30	Days 31-45	Days 46-60
Total Visits	**8.1**	**6.3**	**5.0**	**4.5**
SN Visits	4.2	2.6	2.3	2.3
PT Visits	2.4	2.1	1.5	1.2
OT Visits	0.7	0.6	0.4	0.3
SLP Visits	0.1	0.1	0.1	0.1
Aide Visits	0.7	0.7	0.6	0.5
MSS Visits	0.1	0.1	0.0	0.0
Resource Use	**$307.45**	**$210.89**	**$166.23**	**$153.81**

Center for Medicare and Medicaid Services. (2017). Slide 20. Retrieved from https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2017-01-18-Home-Health.html

What has not changed….

28

- Basic coverage rules (e.g., homebound definition, skilled need, reasonable and medically necessary service)
- Assessment schedule and who can do them
  - Initial and subsequent OASIS assessments must be completed by a Nurse, PT or SLP. OT may only completed subsequent assessments.
  - AOTA efforts – Home Health Flexibility Act
- 60-Day certification period
- 60-Day plan of care
- Therapy supervisory visit requirements (at least every 30 days)



From Centers for Medicare & Medicaid Services *Overview of the Patient-Driven Groupings Model Overview* (2018), p. 1 (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf)

29

Slide shared from 2019 AOTA Conference WS308 Presentation- Understanding and Managing Occupational Therapy's Role in Post-Acute Care Reform and Standardization - C. Kroll, N. Richman, & E. Adams

Admission Source

30

Based on claim data

Early (First 30 days)

Late (Subsequent 30-day periods)

Rules related to interrupted stays, resumption of care and readmissions; and timing of such

Slide shared from 2019 AOTA Conference WS308 Presentation- Understanding and Managing Occupational Therapy's Role in Post-Acute Care Reform and Standardization - C. Kroll, N. Richman, & E. Adams

Admission Timing

31

Based on claim data

Institutional (Historically higher resource utilization)

Community

Slide shared from 2019 AOTA Conference WS308 Presentation- Understanding and Managing Occupational Therapy's Role in Post-Acute Care Reform and Standardization - C. Kroll, N. Richman, & E. Adams

Clinical Grouping

32

- Based on Primary Diagnosis reported on claim
- Main reason for HH encounter
- 12 clinical groups
  - Five basic clinical categories, of which two are for therapy
  - Seven categories for Medication Management, Teaching and Assessment (MMTA)

Slide shared from 2019 AOTA Conference WS308 Presentation- Understanding and Managing Occupational Therapy's Role in Post-Acute Care Reform and Standardization - C. Kroll, N. Richman, & E. Adams

33

Description of the 12 Clinical Groups

Clinical Group	Description	Main reason for HH encounter is to provide:
1	Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
2	Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
3	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
4	Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions (e.g., ostomies, TPN)
5	Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and substance abuse conditions

26

From CMS Overview of the Patient-Driven Groupings Model (PDGM) Webinar, Feb. 12, 2019; https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Presentation.pdf; slide 26

Slide shared from 2019 AOTA Conference WS308 Presentation-Understanding and Managing Occupational Therapy's Role in Post-Acute Care Reform and Standardization - C. Kroll, N. Richman, & E. Adams

34

Description of the 12 Clinical Groups, continued

Clinical Group	Description	Main reason for HH encounter is to provide:
6-12	**Medication Management, Teaching and Assessment (MMTA)** 6. MMTA-Surgical Aftercare 7. MMTA-Cardiac/Circulatory 8. MMTA-Endocrine 9. MMTA-GI/GU 10. MMTA-Infectious Disease/Neoplasms/ Blood-forming Diseases 11. MMTA-Respiratory 12. MMTA-Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previous groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching and assessment.

27

From CMS Overview of the Patient-Driven Groupings Model (PDGM) Webinar, Feb. 12, 2019; https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Presentation.pdf; slide 27

Slide shared from 2019 AOTA Conference WS308 Presentation-Understanding and Managing Occupational Therapy's Role in Post-Acute Care Reform and Standardization - C. Kroll, N. Richman, & E. Adams

35

Functional Impairment Level

Based on OASIS-D Section M

PDGM Functional Impairment Level Based on Responses to Seven OASIS Items

Functional OASIS Items	Current Payment System	PDGM
M1800: Grooming	No	Yes
M1810: Current ability to dress upper body safely	Yes	Yes
M1820: Current ability to dress lower body safely	Yes	Yes
M1830: Bathing	Yes	Yes
M1840: Toilet Transferring	Yes	Yes
M1850: Transferring	Yes	Yes
M1860: Ambulation/Locomotion	Yes	Yes
M1033: Risk for hospitalization	No	Yes

31

Two new determinants for payment

From CMS Overview of the Patient-Driven Groupings Model (PDGM) Webinar, Feb. 12, 2019; https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Presentation.pdf; slide 31

Slide shared from 2019 AOTA Conference WS308 Presentation-Understanding and Managing Occupational Therapy's Role in Post-Acute Care Reform and Standardization - C. Kroll, N. Richman, & E. Adams

36

Functional Impairment Levels and Associated Points

Thresholds for Functional Levels by Clinical Group, CY 2017

Clinical Group	Level of Impairment	Points (2017 Data)
Behavioral Health	Low	0-36
	Medium	37-52
	High	53+
Complex Nursing Interventions	Low	0-38
	Medium	39-58
	High	59+
Musculoskeletal Rehabilitation	Low	0-38
	Medium	39-52*
	High	53+
Neuro Rehabilitation	Low	0-44
	Medium	45-60
	High	61+
Wound	Low	0-42
	Medium	43-61
	High	62+
MMTA - Surgical Aftercare	Low	0-24
	Medium	25-37
	High	38+

33

From CMS Overview of the Patient-Driven Groupings Model (PDGM) Webinar, Feb. 12, 2019; https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Presentation.pdf; slide 33

Slide shared from 2019 AOTA Conference WS308 Presentation-Understanding and Managing Occupational Therapy's Role in Post-Acute Care Reform and Standardization - C. Kroll, N. Richman, & E. Adams

Comorbidities

37

- Based on secondary diagnoses reported on claim
- Includes broad clinical categories used to group comorbidities specific to home health (per historical data) within the PDGM
- A 30-day period may receive
  - No comorbidity adjustment,
  - A low comorbidity adjustment, or
  - A high comorbidity adjustment
- *"Comorbidity is tied to poorer health outcomes, more complex medical need and management, and higher care costs."* (Feb. 12, 2019; Slide 37)

Slide shared from 2019 AOTA Conference WS308 Presentation- Understanding and Managing Occupational Therapy's Role in Post-Acute Care Reform and Standardization - C. Kroll, N. Richman, & E. Adams

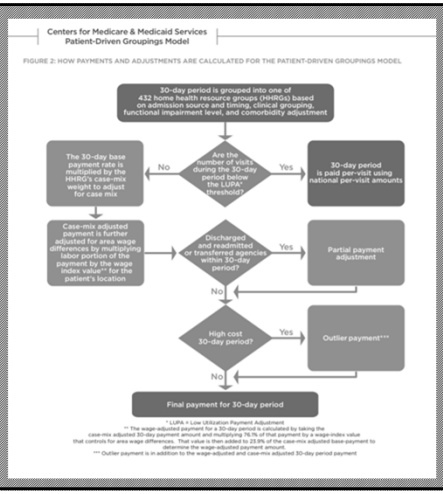
The HHRG system above will be recorded on claims as HIPPS codes, using the following code structure:

Position #1	Position #2	Position #3	Position #4	Position #5
Source & Timing	Clinical Group	Functional Level	Co-Morbidity	Placeholder
1 - Community Early	**A** - MMTA Other	**A** - Low	**1** - None	**1**
2 - Institutional Early	**B** - Neuro Rehab	**B** - Medium	**2** - Low	
3 - Community Late	**C** - Wounds	**C** - High	**3** - High	
4 - Institutional Late	**D** - Complex Nursing Interv.			
	E - MS Rehab			
	F – Behavioral Health			
	G – MMTA Surgical Aftercare			
	H – MMTA Cardiac & Circulatory			
	I – MMTA Endrocine			
	J – MMTA GI/GU			
	K – MMTA Infectious Disease			
	L – MMTA Respiratory			

Home Health (HH) Patient-Driven Groupings Model (PDGM) - Split Implementation p. 19, https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4228CP.pdf

38

Type to enter a caption



From CMS Patient-Driven Groupings Model Overview, p. 5, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf

Note: Additional graphic about outlier adjustment on p. 6 of the Overview

39

Session Outline

40

- Course Introduction and Resources
- Overview of Volume to Value Concept
- History of HHA PPS and Basic Concepts
- Review of PDGM
- Overarching CMS Initiatives*
- Home Health Initiatives and Systems
- Promoting OT's Role and Value
- Wrap-up

Overarching CMS Initiatives

41

- Quality programs
- Innovation
- Patients over Paperwork Initiative
- Transparency
- Effective transition/discharge planning
- Hospital readmission reduction

Session Outline

42

- Course Introduction and Resources
- Overview of Volume to Value Concept
- History of HHA PPS and Basic Concepts
- Review of PDGM
- Overarching CMS Initiatives
- Home Health Initiatives and Systems*
- Promoting OT's Role and Value
- Wrap-up

Home Health Updates and Changes

43

- OASIS-D (January 1, 2019)
  - Purpose to improve standardization across Post Acute Care settings - collect quality measures as defined by the Impact Act provisions
  - Section GG "Functional Abilities and Goals" NEW guidance from CMS for OASIS data collection
  - Section J "Health Conditions" added to OASIS to track falls with or without injury
- HHA Conditions of Participation (CoPs). (September 28, 2018)
  - Updated interpretive guidance for HHA surveys
    - CMS Pub. 100-07, State Operations Manual, Chapter 2 and Appendix B
    - Assigned new and revised tag numbers
    - Updates to General Provisions, Patient Care and Organizational Subparts
      - Includes sections with focus on patient rights, comprehensive assessment, care planning, quality, and skilled professional services

Home Health Updates and Changes

44

- Re-initiated the Pre-claim Review Demonstration Project (Slated for December 2018 but still pending)
  - Renamed *Review Choice Demonstration for Home Health*
  - To combat Medicare fraud related to insufficient evidence of medical necessity for HHA care
  - Starting in high risk states (IL, OH, NC, FL, TX)
- Quality Initiatives
  - Increased accountability and transparency
    - Consumer awareness, engagement, and choice
    - Provider reputation
  - May have financial incentives or penalties

Overlying Quality Initiatives

45

- Post-Acute Care reform (IMPACT Act) (required for four PAC provider types – HHA, SNF, IRF, LTCH)
- Quality Reporting Program (QRP)
- Value-Based Purchasing Measure (VBP)
- 5-Star Rating Program and Home Health Compare Website
- Home Health HHCAHPS (Home Health Care Consumer Assessment of Healthcare Providers and Systems)
- Health Outcomes Survey (HOS) (Medicare Advantage)
- Emergency Preparedness (required for HHAs and 16 other provider types)

Session Outline

46

- Course Introduction and Resources
- Overview of Volume to Value Concept
- History of HHA PPS and Basic Concepts
- Review of PDGM
- Overarching CMS Initiatives
- Home Health Initiatives and Systems
- Promoting OT's Role and Value*
- Wrap-up

Overarching themes

47

- OT and other rehab disciplines must move from being drivers of reimbursement to drivers of quality and outcomes
- Empowerment
  - Putting clinical decision-making in the hands of the clinicians together with focus on patient characteristics, factors, and engagement
  - Opportunities to show value and support parallel initiatives

A note about a reality that cannot be overlooked: Health care entities are businesses that cannot ignore financial and operational concerns, but the evolving changes look to promote best practices and to assure the right factors and incentives are driving patient care.

Through OT Practice

48

- Occupation/Function
  - Mitigating Risks (Re-admissions)
  - Supporting quality and outcomes
- Evidence-based Practice
- Billing and Clinical Documentation
  - Accurate, Appropriate, Complete, Thorough
- Team Collaboration

For PDGM

49

- Identifying, collaborating, documenting to support:
  - Clinical category
  - Functional assessment and scoring
  - Comorbidity adjustment

For Overlay of Other Initiatives Clinical and Operational Level

50

- To promote quality
- To facilitate outcomes
- To support provider reputation
- To provide data that supports OT's role and value
- Etc.

Think About CMS Case Scenario #2

51

- From and OT perspective…..
  - What occupations might you address?
  - What risks might OT intervention mitigate?
  - How might you collaborate to support the components of PDGM?
  - How might you contribute to quality initiatives?
  - How might you document this?

Example - CMS Webinar Case Scenario 2

52

- Mrs. Jones was discharged from the hospital status post colectomy with colostomy placement for colon cancer.
- She has documented post-mastectomy lymphedema syndrome (I97.2) from a previous episode of breast cancer with surgery and lymph node removal 10 years ago for which she wears a compression sleeve that limits the use of her affected arm. She has residual weakness (M62.81) from a prolonged hospital stay. She also has a diagnosis of Type 1 diabetes without complications (E10.9).
- Mrs. Jones's surgeon has referred her to home health for colostomy teaching and management (Z43.3) and physical therapy to assist with post-op strengthening.

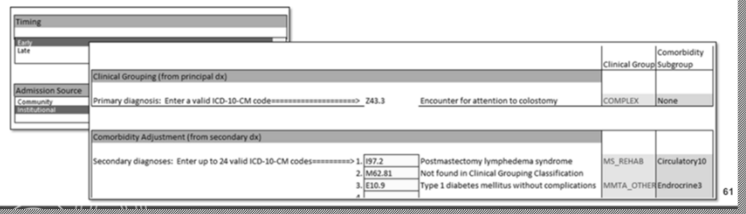
Disclaimer: All scenarios are for illustrative purposes and assumption is that these beneficiaries meet all criteria for home health services. 60

Center for Medicare and Medicaid Services. (2019). Slide 60. https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2019-02-12-PDGM.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Example – CMS Webinar Case Scenario 2

53

- Early period
- Institutional admission source
- Add primary and secondary diagnosis codes



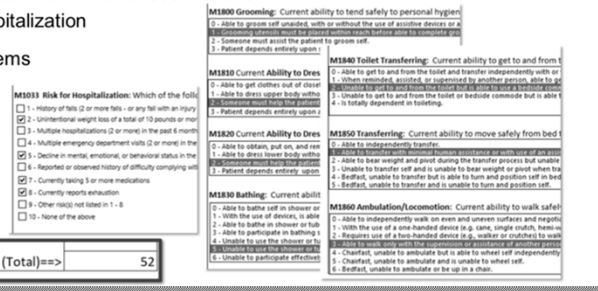
Center for Medicare and Medicaid Services. (2019). Slide 61. https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2019-02-12-PDGM.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Example - CMS Webinar Case Scenario 2

54

OASIS responses from initial assessment for:

- Risk for Hospitalization
- Functional items



Center for Medicare and Medicaid Services. (2019). Slide 62. https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2019-02-12-PDGM.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Example – CMS Webinar Case Scenario 2

55

- HHRG payment group = Early-Institutional-Complex Nursing Intervention: Medium Functional Impairment-High Comorbidity (2DB31)
- Case-mix weight = 1.5255

HIPPS Code	
1st position (Source & Timing)	2
2nd position (Clinical Group)	D
3rd position (Functional Level)	B
4th position (Comorbidity)	3
5th position (Placeholder)	1
HIPPS Code	2DB31
Case-mix weight	1.5255

- Does not include LUPA, partial payments and outlier adjustments
- Official CMS grouper tool will be updated along with rulemaking

Center for Medicare and Medicaid Services. (2019). Slide 63. https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2019-02-12-PDGM.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Example – CMS Webinar Case Scenario 2

56

Example Scenario #2: 30-day Payment Plus Case-Mix Adjustment and Geographic Wage Index

CY 2019 Illustrative Payment Example	Value	Operation	Adjuster	Equals	Output
National, Standardized 30-day Period Payment Rate	$1,753.68				
Case-Mix Adjustment for HIPPS 2DB31	1.5255				
Case-Mix Adjusted Period Payment Amount	$1,753.68	*	1.5255	=	$2,675.24
Labor Portion of the Case-Mix Adjusted Period Payment Amount	$2,675.24	*	0.761	=	$2,035.86
Non-Labor Portion of the Case-Mix Adjusted Period Payment Amount	$2,675.24	*	0.239	=	$639.38
Wage Index Value (Beneficiary lives in 20524, Duchess County-Putnam County, NY))	1.2263				
Wage-Adjusted Labor Portion of the Case-Mix Adjusted Period Payment Amount	1.2263	*	$2,035.86	=	$2,496.58
Total Case-Mix and Wage-Adjusted Period Payment Amount (Wage-Adjusted Labor Portion plus Non-Labor Portion)	$639.38	+	$2,496.58	=	$3,135.96

Center for Medicare and Medicaid Services. (2019). Slide 64. https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2019-02-12-PDGM.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Sharing Thoughts About CMS Case Scenario #2

57

- From and OT perspective…..
  - What occupations might you address?
  - What risks might OT intervention mitigate?
  - How might you collaborate to support the components of PDGM?
  - How might you contribute to quality initiatives?
  - How might you document this?

Factors to Consider and Think About as You Prepare for the Changes Ahead

58

- Facilitators
- Barriers/Challenges
- Knowledge level and gaps
- Opportunities
- Protecting yourself from burnout (4th aim)
- Impact of the structure of HH – not 24/7 and staff not always in the same space
- Possible shift HH customer service, *referral patterns* and reimbursement allowances (e.g., Medicare Part B)

Session Outline

59

- Course Introduction and Resources
- Overview of Volume to Value Concept
- History of HHA PPS and Basic Concepts
- Review of PDGM
- Overarching CMS Initiatives
- Home Health Initiatives and Systems
- Promoting OT's Role and Value
- Wrap-up*

Where To Go From Here

60

- Access Information and Stay informed
  - Course handout
    - CMS
    - AOTA
    - Other Education resources (Employers, courses, etc.)
- Show your value
  - AOTA Advocacy
  - Occupations
  - Evidence-based Practice
  - Billing and clinical documentation (also provides data)
  - Interdisciplinary Team Collaboration

A few more minutes…

61

- How can ConnOTA help?
  - What/Where/When?;
  - What other type of info do you feel you need?
  - Make a note on your course assessment so there is follow up

Parting Words….

62

- **A**pproach with confidence
- **B**e engaged in the process and showing your value
- **L**earn and think about and prepare for the impact of the changes
- **E**mbrace the opportunities and empower yourself, your clients, and your co-workers

Special Thanks….

63

- For shared content from:
  - Christine Kroll, OTD, MS, OTR, FAOTA
  - Nancy Richman, OTR/L, FAOTA