Home Health Patient-Driven Groupings Model Call

Moderated by: Hazeline Roulac
February 12, 2019— 1:30pm

Table of Contents

Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Hazeline Roulac.

Thank you, you may begin.

Announcements & Introduction

Hazeline Roulac: Thank you Dorothy. I am Hazeline Roulac from the Provider Communications Group here at CMS, and I'm your moderator today. I would like to welcome you to this Medicare Learning Network call on the Home Health Patient-Driven Groupings Model.

During this call, our Subject Matter Experts will provide an overview of the Patient-Driven Groupings Model that will be implemented on January the 1st, 2020. CMS will use the PDGM to reimburse Home Health Agencies for providing Home Health Services under Medicare Fee-for-Service. The presentation includes a walkthrough of payment adjustments, including low utilization payment adjustments, partial payment adjustments, and outlier payments. A question and answer session follows the presentation.

Before we get started; you received a link to the presentation in your confirmation email. The presentation is available at the following URL: go.cms.gov/npc. That is go.cms.gov/npc.

Today's event is not intended for the press, and the remarks are not considered on the record. If you are a member of the press you may listen in, but please refrain from asking questions during the question and answer session. If you have inquiries, please contact press@cms.hhs.gov.

Our speakers today Kelly Vontran, Technical Advisor with the Division of Home, Health, and Hospice; and Wil Gehne, Technical Advisor in the Division of Institutional Claims Processing. At this time, it is my pleasure to turn the call over to Kelly Vontran. Kelly?

Presentation

Kelly Vontran: Thanks Hazeline. Good afternoon everyone, and good morning to our participants on the West Coast. As Hazeline introduced, my name is Kelly Vontran, and I'm a Technical Advisor in the Division of Home, Health, and Hospice, and the Chronic Care Policy group here at CMS. I am also a Nurse, and I have spent the majority of my clinical career in the Home Health and Hospice setting.

I am joined by my colleague Wil Gehne from the Division of Institutional Claims Processing in the Provider Billing Group. We appreciate your interest in this National Provider Call on the overview of the Patient Driven Groupings Model, or in short, the PDGM. This call is to provide you information on the PDGM, which is to implement on January 1, 2020.

The PDGM is a new case-mix adjustment methodology that adjusts Home Health Care payments based on patient characteristics for 30-day periods of care under Medicare fee-for-service. These changes represent the

largest overhaul of the payment methodology since the implementation of the Home Health Perspective Payment System on October 1, 2000.

At the end of this session you should have a better understanding of the PDGM, including the variables that are used to adjust payment for a Home Health period of care, how the case-mix weights are established, and what operational changes to expect with implementation of the PDGM. And as Hazeline said, we will have a question and answer session at the end of this call.

So, I'm on slide 2, and this slide provides a list of many of the acronyms found in this presentation, and I'm sure many of these are quite familiar to you. On slide 3 is our agenda for today's presentation, and this includes a short overview of the current Home Health Perspective Payment System, including how payments are currently adjusted for case-mix variation, an overview of the development of the PDGM, discussion about Home Health Resource use, the transition to a 30-day unit of payment, a review of the variables in the PDGM including admission, source, and timing; clinical group, functional impairment levels, and the comorbidity group.

We will have a discussion about the PDGM case-mix weight, and other Home Health payment adjustments. I will also walk you through the PDGM interactive Grouper Tool, available for you to use as you prepare for the PDGM; including example clinical scenarios and payments.

And finally, Wil Gehne will walk you through some of the operational changes you can expect with the implementation of the PDGM.

Current Home Health Prospective Payment System (HH PPS)

Slide 4. So, just to provide some history and context, the current Home Health Perspective Payment System was implemented almost 20 years ago. Medicare currently makes payment under the Home Health PPS on the basis of a national standardized 60-day episode payment rate that is adjusted for the applicable case-mix weight and wage index. This is a bundled payment for all covered Home Health services provided during a 60-day episode of care.

The case-mix adjustment is to account for patients with different care needs. Under the current Home Health PPS, differences in resource use intensity are measured by using wage-weighted minutes of care, which is the amount of time multiplied by the average wages from the Bureau of Labor Statistics by Home Health discipline. And this will be a little important for some discussion we'll have later on in this presentation.

On slide 5, information to adjust for case-mix under the current payment system is obtained from the Outcome and Assessment Information Set, or what we all commonly known as OASIS that Home Health Agencies complete for each patient at admission and every 60 days thereafter. To adjust for case-mix, the Home Health PPS uses a 153-category case-mix classification system to assign patients to a Home Health Resource Group.

Responses to selected elements in the OASIS assessment instrument are used to determine the clinical severity level, the functional severity level, and service utilization. Timing is also a variable in the case-mix adjustment, depending on whether the 60-day episode of care is early — meaning the first two 60-day episodes were late— meaning the third or later 60-day episode of care in a sequence of episodes.
All of these variables ultimately result in the Home Health Resource Group or HHRG, used for payment.

Slide 6. This diagram illustrates how the current payment groups are established based on severity level. The clinical domain account for whether a patient has one or more critical conditions such as pressure ulcers or requires more complex therapies such as parenteral nutrition. The functional domain accounts for the level of functional impairment with activities of daily living such as bathing and dressing. And the service utilization accounts for the number of therapy visits during the 60-day episode. The service utilization adjustment varies based on whether certain thresholds of therapy visits are met.

Slide 7. That brings us to the motivations for developing a new case-mix system for the Home Health PPS. This actually was multi-faceted. One of the first motivations came as a result of the Affordable Care Act, which required CMS to examine vulnerable patient populations receiving Home Health services.

A report to Congress resulted from this examination, and we found that patients with more complex and chronic care needs were more costly for Home Health Agencies and the current payment system resulted in lower provider margins for Home Health agencies caring for patients with these characteristics you see on this slide.

Slide 8. Another motivation for Home Health payment reform were findings presented in the reports by the Medicare Payment Advisory Commission, or MedPAC for short. MedPAC has criticized the Medicare Home Health benefits for being ill defined, in that it is not abundantly clear the type and nature of services being provided, and that therapy thresholds have created a financial incentive to provide more therapy services whether or not patient needs dictate those services.

Over the past several years, MedPAC has recommended that Home Health payments should be determined by patient characteristics and not through the use of therapy thresholds.

Slide 9. As a result of a report to Congress and MedPAC recommendations, CMS considered important principles of payment reform, including improved payment accuracy for services, fair compensation to Home Health Agency, and an increased quality of care for Medicare Home Health beneficiaries. We conducted initial analysis that examined Home Health utilization under the current payment systems, and we considered alternate approaches to construct the case-mix weight.

We shared these findings and potential alternatives to the current case-mix systems through rule making, technical expert panels, and a published technical report. Ultimately, Home Health payment reform was made into law by the Bipartisan Budget Act of 2018, which includes provisions that Home Health payment reform would include a change in the unit of payment to 30-day periods instead of 60-day episodes, and the elimination of therapy thresholds for payment adjustments.

All these motivations that I just described led us to the development of the Patient Driven Groupings Model, our alternative case-mix methodology to adjust Home Health payment.

Overview of the PDGM

Slide 10. So Next I will start with a broad overview before going into more detail on the various components of the PDGM.

Slide 11. As we've been mentioning, the PDGM is a new payment model that relies more heavily on patient characteristics and other patient information to place Home Health series of care into meaningful payment categories that more accurately define the Medicare Home Health benefits. Additionally, the PDGM eliminates the use of therapy thresholds for adjusting Home Health payments.

CMS finalized the PDGM in the calendar year 2019 Home Health final rule with the implementation date of January 1, 2020. Along with the implementation of the PDGM, the unit of Home Health payment will change to a 30-day period of care instead of the 60-day episode of care.

Slide 12. This diagram is a depiction of how the PDGM Home Health Resource Groups are constructed using five main case-mix variables. First, there's the Admissions Source. This accounts for whether the patient is admitted to Home Health from an Institutional or Community source. This information will be collected from Medicare claim.

Second, there's Timing. And this accounts for whether the period of care is early or late. This information will also be collected for Medicare claims.

Third is the Clinical Grouping, and this reflects the primary reason the patient is receiving Home Health services. This information will come from the reported principal diagnosis on Home Health claims.

Fourth is the Functional Impairment Level. This reflects the level of functional impairment as identified through responses to certain OASIS items.

Fifth and finally, is the Comorbidity Adjustment, and this accounts for whether there are certain comorbid conditions present that affects resource use. This information will come from reported secondary diagnoses on Home Health claims.

A 30 day period of care will be grouped into one sub category of these five variables. This model results in 432 possible case-mix groups used to adjust payment. While this is more than the current 153 groups in the current case-mix system, public comments supported more case-mix groups if it meant more accurately aligning payment with patient characteristics. The PDGM leverages many of the same components of the current case-mix system, but in a more clinically relevant way.

Measuring Period Costs

Slide 13. Next, I will discuss how CMS Measure the 30-day period costs when developing the PDGM.

Slide 14. In order to construct the case-mix weights under the PDGM, the cost of providing care needed to be determined as the average cost for each case-mix group. It takes the group's case-mix weight. And since the

law requires a change to 30-day periods, we needed to calculate the cost of the 30-day periods to help determine the appropriate case-mix weight.

As I mentioned in an earlier side, we currently use a wage-weighted minutes of care approach using wage data from the BLS to determine the cost of providing care. However, under the PDGM, we are adopting a cost per minute plus Non-Routine Supply approach to calculate the cost of care. Using this approach, we use Medicare cost reports and Medicare claims. Using Medicare cost reports more accurately represents total Home Health agency costs, meaning not only direct patient care labor costs, but overhead costs as well.

This approach also incorporates Non-Routine Supplies into the base payment rate, instead of requiring a separate case-mix model as is done under the current case-mix system.

Slide 15. This table illustrates the cost per minute plus NRS approach we use for the PDGM. It shows you the data sources we use, our general approach to determining period costs, what the costs represents, and how [NRS] also wrapped into these costs. A more comprehensive explanation to this approach in calculating Home Health 30-day period costs can be found in the calendar year 2019 Home Health proposed and final rule.

30-Day Periods

Slide 16. So, I just provided a high-level explanation on how we calculated the 30-day period cost. The reason this is important is because the Bipartisan Budget Act of 2018 requires a change to the Home Health unit of payment to a 30-day period effective January 1, 2020.

Slide 17. While Home Health services are currently paid for each 60-day episode of care, our analysis has shown that more visits tend to occur in the first 30-day period of care compared to the last 30-day period of care in a 60-day episode. Our analysis also showed that approximately 25% of 60 episodes were 30 days or less in length.

Costs are much higher in the first 30-day period of care compared to the second 30-day period in a 60-day episode, so dividing a single 60-day episode into two 30-day periods more accurately apportions payment. The Bipartisan Budget Act of 2018 requires that payment is made for each 30-day period of care beginning in calendar year 2020.

However, this 30-day period refers only to the unit of payment that is a 30-day billing cycle. So, this means that Home Health agencies will be paid for each 30-day period of care. And note that this change in the in the unit of payment does not change any of the requirements for certification or recertification, completion of the OASIS assessment, or updates to the Home Health plan of care. All of which continue to be done on a 60-day basis.

Slide 18. While the PDGM will not be implemented until calendar year 2020, we wanted to provide Home Health agencies with a sense of the national standardized 30-day period payment amount if the PDGM was implemented in calendar year 2019. So, the national standardized 30-day payment in calendar year 19 would be $1,753.68; and does not include any of the PDGM case-mix or geographic wage adjustment.

We will update this base payment rate for calendar year 2020.

Admission Source and Timing

Slide 19. So now I will move on to describe each of the case-mix variables in the PDGM, starting with Admission Source and Timing.

Slide 20. Looking at the PDGM diagram, you can see that 30-day periods are grouped by Admission Source and Timing. There are two admission source categories for grouping a 30-day period of care: Institutional and Community, as determined by the health care setting utilized in the 14 days prior to the Home Health admissions.

And there are two period timing categories: early versus late, depending on whether they occur within a sequence of 30-day periods.

Slide 21. We found that there was higher resource use for 30-day periods when the patient was admitted to Home Health from an Institutional admission source. So, under the PDGM, 30-day periods for beneficiaries with any inpatient acute care hospitalizations or any inpatient psychiatric facility, skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital stays within 14 days prior to a Home Health admission will be designated as Institutional admission. All other 30-day periods will be designated as Community admission.

Slide 22. Under the PDGM, we will classify the first 30-day period as early, and all subsequent 30-day period in a sequence of periods - meaning the second or later 30-day periods - as late. A sequence of periods means that there are no more than 60 days between the end of one period and the start of the next period. This is the same as how we defined a sequence of episodes under the current system. So, this means that 30-day periods of care cannot be considered early unless there is a gap of more than 60 days between the end of one period and the start of another.

Slide 23. Late 30-day periods are always classified as a Community admission, unless there is an acute hospital stay in the 14 days prior to the late 30-day period. However, we will not categorize post-acute care stays - that is, SNF, IRF, LTCH, IPF stays that occurred during a previous 30-day period, and within 14 days of a subsequent contiguous 30-day period as Institutional. As we would expect Home Health agencies to discharge the patient if the patient required post-acute care in another setting.

Home Health agencies will have the option to include an occurrence code on the claim to identify an Institutional admission source, but the information will be obtained from the Medicare claims processing system to automatically assign admission source and timing categories. Wil Gehne will explain more on these occurrence codes later in this presentation.

Clinical Groups

Slide 24. So, the next case-mix variable we will discuss is the Clinical Groups.

Slide 25. You can see here that the next step in the PDGM case-mix adjustment is the assignment of the clinical group. These clinical groups represent the primary reason for Home Health services as defined by the principal diagnosis reported on Home Health claims. And you can see in this diagram that a 30-day period of care can be grouped into 1 of 12 Clinical Groups. These Clinical Groups characterize most common reasons for Home Health Care services.

Slide 26. So, a 30-day period can be grouped into one of the following: First there's Musculoskeletal Rehab, where the primary reason for the Home Health encounter is to provide therapy – PT, OT, or Speech for a musculoskeletal condition.

Next there is Neuro/Stroke Rehab, where the primary reason for the Home Health encounter is to provide therapy for a neurological condition or stroke.

Next is the Wounds Group, where the primary reason for the Home Health encounter is for the assessment, treatment, and management of surgical or non-surgical wounds.

Next, we have Complex Nursing Intervention, where the primary reason for the Home Health encounter is for assessment, treatment, and evaluation of complex medical and surgical conditions. For example, if a patient has an ostomy, or a patient is receiving total parenteral nutrition.

Next there's Behavioral Health Care, where the primary reason for the Home Health encounter is for the assessment, treatment, and evaluation of psychiatric and substance abuse conditions.

Slide 27. The next Clinical Groups represents Medication Management, Teaching, and Assessment. What we fondly call MMTA; where the primary reason for the Home Health encounter is for assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified into 1 of the other 5 clinical groups.

This group is further divided into 7 subgroups which represent common clinical conditions that require Home Health services for Medication Management, Teaching, and Assessment. Some examples of principle diagnoses that would group into one of the MMTA subgroups include heart failure, pneumonia, and encounter for aftercare following cancer surgery.

While there are Clinical Groups where the primary reason for Home Health services is for therapy and mass rehab for example, and others where the primary reason for Home Health is for nursing, complex, for example, these groups reflect the primary reason for Home Health services during the period of care - but not the only reason.

Home Health remains a multi-disciplinary benefit, and payment is bundled to cover all necessary services identified on the individualized Home Health plan of care. So, for example, if a period of care is grouped under the complex nursing interventions group because the primary reason the patient needs Home Health services is for nursing care, therapy services could also be provided if those therapy services are reasonable and necessary and ordered on a Home Health plan of care.

Slide 28. A 30-day period of care is assigned to a clinical group based on the principle diagnosis code reported on the Home Health claims. Resource use varies across the clinical groups and payment reflects those differences. Every single ICD-10 code was examined to determine the clinical group assignment under the PDGM.
These groups mirror how clinicians differentiate between patient characteristics and the most common types of care that's Home Health agencies provide. If a diagnosis code is reported on a Home Health claim that does not fall into one of the twelve clinical groups - for example, if it is a diagnostic code that cannot be reported as a

principal diagnosis according to ICD-10 coding guidelines, such as a manifestation code - the claim is not denied, rather it is returned to the Home Health agency for more definitive coding.

Under the PDGM, there are additional payment adjustments associated with other reported diagnoses to capture higher resource use for a patient, regardless of whether the services are skilled nursing or therapy based. And I will discuss those adjustments shortly.

Functional Impairment Level

Slide 29. The next case-mix variable under the PDGM is the Functional Impairment Level.

Slide 30. And you can see on the PDGM diagram that the next step in the establishment of the PDGM payment group is the functional impairment level. 30-day periods of care are grouped into 1 of 3 levels of functional impairment: Low, Medium, or High, based on certain OASIS items.

Slide 31. The PDGM uses responses to 7 OASIS items associated with functions, including those items associated with dressing and walking. This is similar to the current payment system which also uses certain OASIS items for the functional domains of the case-mix adjustments.

And you can see in this table those OASIS items the PDGM uses to establish the functional impairment level for case-mix adjustments; which includes two additional OASIS items to measure functional impairment: grooming and risk for hospitalization.

Slide 32. In order to establish the functional impairment levels, we had to go through several steps. Now, without getting too detailed on this call, we looked at the resource use associated with each OASIS item and combined some of the OASIS responses with some of the resource use to establish response categories to better capture the relationship between worsening functional status and resource use.

Each OASIS response category has associated points. The sum of the response category points results in a functional impairment score, which is used to group Home Health periods into a functional level with similar resource use. As I said earlier, there are 3 functional impairment levels under the PDGM: low, medium, and high. The points associated with the functional impairment levels vary between each of the clinical groups, as I will demonstrate on subsequent slides.

Slide 33. This table and the next show each of the clinical groups along with a functional impairment level and the points associated with each level, within each group. Now remember, the points or sum are the sum of all the functional OASIS item response categories. You can see in this red highlighted example that for the musculoskeletal rehab clinical group, the points to meet the level of medium functional impairment range from 39 to 52 points.

Slide 34. And you can see in this highlighted example that for the MMTA respiratory clinical group, the points to meet that same level of medium functional impairment range from 30 to 43 points.
This approach is reflective of the unique patient characteristics within each clinical group, and more accurately adjusts payment to reflect the differences in resource use. For calendar year 2020 implementation, we will update

the functional points and the threshold using the most current data available to reflect any changes in resource use associated with these functional impairment variables.

Comorbidity Group

Slide 35. Finally, the last step in the PDGM case-mix adjustment is the Comorbidity Group.

Slide 36. And Here's our diagram again; you can see this last step in the establishment of the PDGM case-mix weight, where the presence of certain secondary diagnoses can adjust the payment for each 30-day period of care. Under the PDGM, a 30-day period may have no, low, or a high comorbidity adjustment.

Slide 37. The principal diagnosis reported on Home Health claims determines the clinical group under the PDGM. But we know that secondary diagnoses can also impact Home Health resource use and should be taken into account for case-mix adjustment purposes. A comorbidity is a condition coexisting with the principal diagnosis that can affect the Home Health plan of care in terms of services provided and time spent with patients.

Including comorbidities as part of the PDGM case-mix adjustment is essential because comorbidities are tied to poor outcomes or complex care needs, and increased care management that can result in higher health care costs.

Slide 38. To capture unique patient characteristics as part of the PDGM case-mix adjustments, we developed a Home Health specific list of comorbidities. This Home Health conspecific comorbidity list is categorized by body system that you see on this slide and include the associated diseases, illnesses and injuries associated with these body systems. These broad clinical categories include diagnoses with clinically relevant relationships associated with increased resource use.

Slide 39. So, under the PDGM, 30-day period of care can receive a comorbidity adjustment depending on the reporting of certain secondary diagnoses on this Home Health specific list. To receive the low comorbidity adjustment, there is a reported secondary diagnosis associated with higher resource use. To receive high comorbidity adjustments there are two or more reported secondary diagnoses associated with higher resource use when both are reported together compared to if they were reported separately. That is the 2 diagnoses interact, resulting in higher resource use.

A 30-day period of care would receive no comorbidity adjustment if there was no recorded secondary diagnoses that falls into either a low with the high comorbidity adjustment groups. A Home Health period of care can receive payment for a low comorbidity adjustment or a high comorbidity adjustment but not both.

Slide 40. Similar to how we group the functional responses associated with similar resource use, we did the same with the Home Health specific list of diagnoses and the broad clinical categories. So, we defined these broader clinical comorbidity categories into comorbidity subgroups to more accurately capture differences in resource use. This table shows the comorbidity subgroups that will receive a low comorbidity adjustment under PDGM.
So, if there is a reported diagnosis that falls within one of the individual comorbidity subgroups listed in this table, it would receive the low comorbidity adjustment. Looking at the red highlighted example on this slide if there is a

reported secondary diagnosis of heart failure which falls under the Heart 11 subgroup the 30-day period of care would receive a low comorbidity adjustment.

Slide 41. Also using the comorbidity subgroups, we identified clinically, and statistically significant comorbidity interactions associated with higher resource use. This means that there is a secondary diagnosis reported from the subgroups within a comorbidity subgroup interaction listed in this table. The 30-day period care would receive a high comorbidity adjustment.

This slide and the next few slides shows the various comorbidity subgroup interactions that would receive a high comorbidity adjustment if reported secondary diagnoses fall into these interaction combinations. Slide 42. In the calendar year 2019, Home Health final rule, we identify 34 comorbidity subgroup interactions that would receive the high comorbidity adjustment.

Slide 43. I've highlighted this example to illustrate that if there was imported secondary dementia diagnosis that falls under the Neuro 5 comorbidity subgroup and there was also a reported secondary diagnosis of a stage two pressure ulcer which falls under the Skin 4 comorbidity subgroup. The period care would receive the high comorbidity adjustment.

Slide 44. And you can see in this list that there are multiple conditions that interact and impact resource use during a Home Health period of care. This approach recognizes the presence of multiple comorbidities and the interactions between certain conditions that impact the Home Health plan of care.

Case-Mix Weights

Slide 45. So, all the variables I just reviewed are used to establish the case-mix weight under the PDGM.

Slide 46. The purpose of using case-mix weights to switch up payment for a Home Health period of care based on patient characteristics which affect resource use. That is the higher the resource needs, the higher the case-mix weight and the higher the payment adjustment. The PDGM assigned separate case-mix weights to periods, for patients with similar characteristics in care needs.

Similar to the current system, there will be annual recalibration of the PDGM case-mix weight to reflect the most recent utilization available at the time of rulemaking. This means that the case-mix weights we have in calendar year 2019 Home Health final rule and posted on HHA center webpage will be updated for PDGM implementation in calendar year 2020.

Other Adjustments

Slide 47. In addition to the case-mix adjustments, there are Other Payment Adjustments under the PDGM similar to those in the current Home Health process the payment system.

Slide 48. Under the PDGM, there will continue to be a low-utilization payment adjustment or what we call LUPA for those thirty-day periods of care with a low number of visits.
A LUPA period of care is paid on a per visit basis using the national per visit rate. Rather than the current threshold of 4 visits or less to receive a LUPA under the PDGM, each of the 432 case-mix group has a threshold

to determine if the period of care would receive a LUPA. This threshold is determined by the tenth percentile of visits in each payment group with a minimum threshold of 2.

So, under the PDGM, currently the LUPA threshold range between 2 and 6 visits. The table of PDGM LUPA threshold can be found in the calendar year 2019 Home Health final rule and they also posted on the HHA center webpage.

Slide 49. There will also be a partial payment adjustment if a beneficiary transfer from one Home Health agency to another or is discharged and readmitted to the same Home Health agency within 30 days of the original 30-day period start date.

The case-mix adjustment payment for 30-day period it's pro-rated based on the length of the 30-day period ending in transfer or discharge and readmission.

Slide 50. Under the PDGM, 30-day periods that have estimated wage adjusted cost of care that exceed the specifics outlier threshold receive an outlier payment to cover a portion of the high costs associated with that 30-day period.

The approach to calculating outlier payment is the same as the approach used in the current system but is done on a 30-day basis instead of 60 days. The statutory requirements states that total amount of outlier payment cannot exceed 2.5% of total Home Health payments as well as a ten percent cap on outlier payments at the Home Health agency level remain unchanged.

This diagram shows how the outlier payments is calculated for the 30-day period under the PDGM.

Grouper Tool and Example Scenarios

Slide 51. So now that I have explained each of the case-mix variables in the PDGM. The next part of this presentation will demonstrate how to use the interactive grouper tool that is posted on the HHA center webpage. Using example clinical scenarios, you'll be able to see how the case-mix weight is established for a 30-day period of care.

In each of these clinical scenarios, we will go through each step of the PDGM which will result in the case-mix group and its associated case-mix weight. I will also show you how that can translate to the 30-day case-mix adjustment - adjusted payment.

Slide 52. I really do recommend that you download this interactive grouper tool to see what the case-mix weights under the PDGM would be for your respective patient population.

The purpose of this tool is informational and illustrative only. These clinical scenarios are hypothetical, so we are making the assumption that these patients are eligible for the Medicare Home Health benefit. And similar to how Home Health agencies can download the grouper software for the current Home Health PPS, there will be final grouper software available for 2020.
So, in order to establish a case-mix weight for a 30-day period of care in this interactive grouper tool, make sure you input the number of visits to exceed LUPA thresholds. So, I would recommend putting more than 6 visits in

this particular field that you see here on the screen. If you do put less than the LUPA threshold for a particular case-mix group, the grouper tool will not establish the case-mix weight and the tool will have a message that the period of care is subject to a LUPA. And you can see on this slide, in this field we have selected 8 visits for this thirty-day period.

Slide 53. Starting with our first clinical scenario, Mr. Smith was newly diagnosed by his primary care physician with type 2 diabetes with hyperglycemia. Mr. Smith's doctor made a Home Health referral for diabetic management teaching, medication review and evaluation of compliance and response to new medication. Mr. Smith also has a documented history of congestive heart failure, cerebral atherosclerosis and benign prostatic hypertrophy.

So, the first step in the PDGM in the grouper tool is to select timing and admission source. In this scenario, this is Mr. Smith first 30-day period of Home Health care so you would select the timing as early. As Mr. Smith was referred to Home Health services by his primary care physician and there was no Institutional admission 14 days prior to the start of some health, you would select Community at the admission source.

Slide 54. In this scenario, Mr. Smith it's been diagnosed with type 2 diabetes and his physician has referred him to Home Health for diabetic management teaching, medication review and evaluation of compliance in response to his new medication. So, for this example, the Home Health agency selects the diagnosis code for type 2 with diabetes with hyperglycemia as a principal diagnosis. When this code is entered into the primary diagnosis field, the interactive grouper tool will auto populate with 1 of the 12 clinical groups. But this clinical scenario, the clinical group is MMTA Endocrine.

Slide 55. Mr. Smith also have secondary diagnoses of congestive heart failure, cerebral atherosclerosis and benign prostatic hypertrophy. In this scenario the Home Health agency reports all these secondary diagnoses as they impact Mr. Smith plan of care. When these codes are entered into the secondary diagnoses field, the interactive grouper tool auto populates the comorbidity subgroup if applicable. And you will see in this scenario that congestive heart failure and cerebral atherosclerosis are diagnoses that fall into one of the PDGM comorbidity subgroups. However, the benign prostatic hypertrophy does not, meaning it is not on the Home Health specific list associated with higher resource use.

Slide 56. The Home Health agency completes the initial OASIS and identified responses 4 through 7 for the OASIS items M1033 risk for hospital or for hospitalization. When these responses are checked off in the interactive grouper tool you will see that the associated functional points for this item auto populate.

Slide 57. The Home Health agency completes the remaining OASIS functional items for grooming, dressing, bathing, toilet transferring, transferring and walking. These items are checked off in the interactive grouper tool and the sum of the functional point for M1033 and the M1800 auto populates the total functional score.

Slide 58. Now that all the PDGM case-mix variables have been entered into the interactive grouper tool, the Home Health Resource Group and its corresponding case-mix weight are established. So, in this first clinical scenario, the case-mix payment loop is Early, Community, MMTA Endocrine, Low Functional Impairment, High Comorbidity with a Health Insurance Prospective Payment Code or what is commonly called the HIPPS code of 1IA31 with a case-mix weight of 1.2759. This case-mix weight is used to adjust the national standardized 30-day payment amount.

Slide 59. So, you can see how this particular case-mix weight can translate into a 30-day payment amount. We would take the national standardized 30-day period payment rate of one $1,753.68 which is the calendar year 2019 rate and multiply that by the case-mix weight of 1.2759.

Because Home Health payment is also adjusted by the geographic wage index for the location where the patient is receiving Home Health services. We must apply the geographic wage index to the labor portion of the case-mix adjusted payment amount. In this scenario, Mr. Smith lives in Glendale, California so we multiply the labor portion amount by the geographic wage index for Glendale, California. And you can see that this result in a 30-day period payment amount of $2,757.71.

Slide 60. So now for scenario number two. Mrs. Jones was discharged from the hospital status post colectomy with colostomy placement for colon cancer. She has documented post-mastectomy lymphedema syndrome 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 from a prolonged hospital stay. She also has a diagnosis of type 1 diabetes without complications. Mrs. Jones's surgeon has referred her to Home Health for colostomy teaching and management and physical therapy to assist with post-op strengthening.

Slide 61. This is Mrs. Jones's first 30-day period of Home Health care, so the Home Health agency would select early at the timing variable. Mrs. Jones was referred to Home Health immediately following in an acute inpatient hospitalization so the admission source would be Institutional. Mrs. Jones's surgeon referred her to Home Health for colostomy management and teaching as well as for physical therapy for post-op strengthening.

The Home Health agency selects encounter for attention to colostomy as the principal diagnosis and the interactive grouper tool auto populates the clinical group as complex. The Home Health agency enters Mrs. Jones's secondary diagnosis that affects the Home Health of plan of care. The grouper tool auto populates the comorbidity subgroup that's applicable and you can see in this scenario that 2 of the 3 secondary diagnoses fall under a comorbidity subgroup.

Slide 62. The Home Health agency enters the OASIS responses from the initial assessment for the OASIS item M1033 risk for hospitalization and the other OASIS functional items to establish a total functional score for the 30-day period of care.

Slide 63. The payment group for this 30-day period of care as Early, Institutional, Complex Nursing Interventions, Medium Functional Impairment, High Comorbidity with a HIPPS code of 2DB31 and the case-mix weight of 1.5255. And again, this case-mix weight is used to adjust the national standardized 30-day period payment amount.

Slide 64. And again to show you how this particular case-mix weight can translate to a 30-day payment amount, we would take the national standardized 30-day period payments of $1,753.68 and multiply that by the case-mix weight of 1.5255. Since Mrs. Jones lives in Duchess County, New York, we apply the appropriate geographic wage index, the labor portion of the case-mix adjusted payment amount and this results in a 30-day period payment amount of $3,135.96.

Slide 65. And now one last clinical scenario. Mr. Gray has been receiving Home Health services for 60 days (2 continuous 30-day periods of Home Health care) with a diagnosis of Parkinson's disease. He continues with decreased endurance requiring continued skill therapy services twice a week. Mr. Gray requires a Home Health aide 3 times a week to assist with bathing and dressing. He has a documented history of chronic atrial fibrillation, primary osteoarthritis of the right shoulder, right hand and left hand.

Slide 66. Mr. Gray has been receiving Home Health services for the last 60 days and he is being recertified for continued Home Health services. Because this is not Mr. Gray's first 30-day period of care, the Home Health agency would select late as the timing variable. Because Mr. Gray did not have an Institutional say in the 14 days prior to the next 30-day period of health care, the Home Health agency would select Community at the admission source.

The Home Health agency selects Parkinson's disease as the principal diagnosis and the interactive grouper tool auto populates neuro rehab as the clinical group. You will note that Parkinson's disease also falls under a comorbidity subgroup but because it is the reported principal diagnosis, it would not be considered a comorbidity for payment adjustment purposes. The Home Health agency enters Mr. Gray's secondary diagnoses and the grouper tool auto populates the comorbidity subgroups as applicable. You will notice that chronic A-fib is under one of the comorbidity subgroups.

Slide 67. The Home Health agency inters the OASIS responses for risk of hospitalization and the functional items from the recertification assessment and the total functional score is calculated.

Slide 68. The payment for this 30-day period of care is Late, Community, Neuro Rehab, High Functional Impairment, Low Comorbidity with the HIPPS code of 3BC21 and a case-mix weight of 1.1117.

Slide 69. Finally, to show you how this particular case-mix weight can translate to a 30-day payment amount we would again take the national standardized 30 day period payment rate of $1,753.68 and multiply that by the case-mix weight of 1.1117. Since Mr. Gray lives in Columbus, Indiana, we apply the appropriate geographic wage index to the labor portion of the case-mix adjusted payment amount and this results in a 30-day period payment amount of $1,960.85.

All of these are just a few illustrative examples we really do encourage you to take advantage of this interactive grouper tool posted on our Home Health agency center webpage so you can anticipate the case-mix weight and of course finding payment for your patients. And as I previously mentioned, the case-mix weight and the official CMS grouper will be updated for calendar year 2020.

I'm now going to pass the presentation over to Wil Gehne from the Provider Billing Group who will present the last section of this presentation and he will discuss the expected operational changes under the PDGM.

Operational Changes Under PDGM

Wil Gehne: Thanks Kelly. A couple weeks ago we issued the implementation change request for this project. It's 80 pages long with flow charts and record layouts and screen mock ups and much of that information describes operational changes for Medicare contractors. Today I'm just going to highlight some changes affecting Home Health agencies.

On slide 71, one significant operational change under PDGM effect split percentage payments on RAPs. Home Health agencies newly enrolled in Medicare on or after January 1, 2019 will not receive split percentage payments beginning in calendar year 2020 but they will still need to submit a no-pay RAP at the beginning of each 30-day period to establish the Home Health period of care and submit a final claim after the end of each 30-day period.

Note that the HHA doesn't need to submit the RAP with any special coding. Medicare systems will identify the newly enrolled providers and process the RAP at zero payment. Home Health agencies certified prior to January 1, 2019 will continue to receive split percentage payments in 2020 and will also need to submit a RAP at the beginning of each 30-day period and a final claim at the end. Like today, for the first 30-day period of care, the split percentage payment will be 60/40 and all subsequent periods will be a split percentage payment of 50/50.

On slide 72, regarding the admission source adjustment the Kelly talked about, CMS will only adjust the Home Health final claim to account for it. That is if a RAP is submitted and paid with Community admission source and then an acute or post-acute Medicare claim was submitted for the patient before the final Home Health claim is received, the RAP would not be adjusted. Only the final Home Health claim would be adjusted to reflect the Institutional admission. For this reason, Home Health agencies will only indicate admission source occurrence codes which I'll describe later on the final claim and not on RAPs. This is similar with current processing where the majority of payment adjustments are only made on the claim.

On slide 73, since we're implementing a new grouping system the HIPPS codes that represent a payment groups will be completely replaced. Like today each character of the HIPPS codes is associated with the payment variable, but those variables are changing. Today, position 1 reports episode timing and a therapy threshold. Under PDGM we'll report period timing and an admission source.

Today, position 2 reports a clinical severity level. Under PDGM it would be the clinical grouping for the patient. The content of position number 3 is not changing, it remains a functional impairment level but there is a significant change in position 4. Today it reports a service level under PDGM it will carry the comorbidity adjustment.

The 5th position is a place holder; the field that carries the HIPPS code simply requires 5 positions. You probably noticed in all of Kelly's examples that that 5th position was always a 1. So, to apply this to another example, say the HIPPS code is 2DC21, "2" represents an early Institutional period of care, "D" means the patient is in the complex nursing group, "C" means the functional impairment level is high and another "2" in the 4th position represents a low comorbidity adjustment plus the placeholder.

One simplification resulting from the PDGM is that the HIPPS code is no longer required with OASIS submission. The claim system will automatically draw information from claims and the submitted assessment in order to group the 30-day period. This means the payment information remains in the payment system.

The Home Health Agency doesn't need to send the HIPPS code to the ASAP system, and that system will no longer recalculate it and send the HIPPS code on the validation report. HIPPS code must still be submitted on both RAPs and claims, but only the system-generated code will be used for payment on that claim.

Turning to slide 74, another key change is regarding the OASIS that will be used for payment.

The OASIS assessment used to determine the HIPPS code is the most recent time point. So typically, the start of care assessment will be used for determining the functional impairment level for both the first and second 30-day periods of a new Home Health admission. Then the follow-up assessment will be used for the third and fourth 30-day periods and so forth following the regular 60-day recertification schedule.

However, resumption of care assessments may be used for the second or later period if the patient was transferred and admitted to the hospital for 24 hours or more. The system will look for the most recent OASIS assessment based on the claims from date. Using that from date, we'll look back at the assessment completion dates if the most recent date is for resumption of care, that will be selected. If resumption is not found, then the preceding follow-up or started care will be used.

Slide 75. Another simplification under PDGM is that a treatment authorization code is no longer required on every Home Health claim. This field will only be used when required by the pre-claim review process when it actually represents an authorization number.

But one element from the current treatment authorization code is still needed and that is the OASIS assessment completion date, OASIS item MO90. The HHA will use occurrence code 50 to report the OASIS item MO90 date on their claim. To facilitate accurate assignment of the claim into Institutional versus Community payment groups, HHAs will have the option of reporting inpatient discharge dates on the claims using two newly created occurrence codes.

You can report occurrence code 61 to indicate an acute care hospital discharge within 14 days prior to the from date of any Home Health claim or report occurrence code 62 to indicate a skilled-nursing facility, inpatient rehab facility, long-term care hospital, or inpatient psychiatric facility discharge within 14 days prior to the admission date of first Home Health claim.

Note that this is an option if those codes are not present, Medicare systems will use inpatient claims history to assign Institutional payment groups based on the most current information we have.

On slide 76 one crucial question for any implementation is the transition. How will the cut over work? In this, case for 60-day episodes that began on or before December 31st, 2019 and span January 1st, 2020, the payment will be the calendar year 2020 national standardized 60-day episode payment amount.

For Home Health periods of care that begin on or after January 1st, 2020 the unit of payment will be the calendar year 2020 national standardized 30-day payment amount. The key date as well as the from date is January 1st or later. Just a reminder, even though we're shifting from 60-day episodes to 30-day period under PDGM, recertification for Home Health services updates to the comprehensive assessment, and the Home Health plan of care will continue on a 60-day basis.

Resources

Finally, I want to point you to some resources that are available, looking at slide 78. On our website, we have a PDGM overview document that nicely summarizes a lot of the information that Kelly presented earlier. There is also the interactive grouper tool that she demonstrated. We have some download files available, including case-mix weights, LUPA thresholds, and agency level impact information.

And if you want all of the detailed rationale behind the system, our 2019 Home Health final rule published in the Federal Register is also there. All of those resources are linked in the spotlight section on our Home Health agency center webpage. And the change request I mentioned is CR11081, and it is available on our transmittal's website. Thank you. Hazeline?

Question & Answer Session

Hazeline Roulac: Thank you so much Will and Kelly, a lot of good information. We appreciate you going over it with us. We will now take your questions. As a reminder, this event is being recorded and transcribed. In an effort to get to as many questions as possible each caller is limited to one question.

To allow more participants the opportunity to ask questions during this call, please email questions specific to your particular organization to the Home Health policy email box located on slide 80 so our staff can do more research. Preference on this call will be given to general questions applicable to a larger audience, and we will be mindful of the time spent on each question.

Hazeline Roulac: All right Dorothy we are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity.

Once your line is open, state your name and organization. Please note, your line will remain open during the time you are asking your question, so anything you say, or any background noise will be heard in the conference. If you have more than one question, press star one to get back into the queue, and we will address additional questions as time permits.

Please hold while we compile the Q&A roster. Please hold while we compile the Q&A.

Your first question comes from the line of Cody Reber.

Cody Reber: Hi, thank you for taking my question will an '05 follow assessment always be required to document a significant change in condition under PDGM?

Wil Gehne: The PDGM doesn't do anything to change assessment instructions or assessment requirements like that, so the current practice remains in place.

Operator: Your next question comes from the line of Robin Teel.

Robin Teel: Hi, yes, I was just wondering, are there any changes whenever you're providing dual services, so you have a patient on Home Health and hospice?

Kelly Vontran: No, there's no changes to that.

Robin Teel: Okay, thank you.

Operator: Your next question comes from the line of Catherine McBay.

Catherine McBay: Hi, I'm wondering if the new 30-day episode will affect ADRs. When we get ADR requests, will they be for 30 days or 60 days?

Wil Gehne: We don't have anyone for a medical review area, here but I Imagine that they'll correspond to the statement coverage period for the claim.

Hazeline Roulac: And if you can submit that question to the mailbox for further research.

Catherine McBay: Okay, I'll do that thank you.

Hazeline Roulac: Thank you for your question

Operator: Your next question comes from the line of Kim Walden.

Kim Walden: Yes, the question I have is in regards to the resumption 14 days prior to the late 30-day period. If a patient does go into the hospital within 14 days prior to the next--or the late 30-day period, would it be best to go ahead and discharge and admit or do a resumption?

Kelly Vontran: That is really the discretion of the Home Health agency whether or not they should discharge the patient when they go into an acute care hospital.

Operator: Your next question comes from the line of Janet Conzeela.

Janet Conzeela: Hi, slide 74 it's says follow-up assessment used for third and fourth 30-day periods, but we're still doing a recert assessment every 60 days. I'm just confused. Are we adding an extra follow-up assessment?

Wil Gehne: No, it's referring to the recertification assessment, not changing the requirement at all.

Operator: Your next question comes from the line of Cinderella Ko.

Cinderella Ko: Hi, my question is where do we get the wage index information to find out what is the rate for our area? Is this based on zip code?

Kelly Vontran: It is based on the O&B designations for CBSA, and we do have that posted on the Home Health agencies center webpage.

Cinderella Ko: Okay.

Operator: Your next question comes from the line of Josh Limpkin.

Female: Hello, we're wondering if the Institutional adjustment that is reported after the fact will be reported to the agency on the 835, and if so, is there going to be a specific remittance reason code associated with that?

Wil Gehne: Yes, it will be reported to the agency. They will see if the adjustments claim reported on their 835 electronic remittance advice. The remittance advice message--there was a remittance advice message, the number is not coming right to my mind that we used when we regroup a claim now the same remittance advice remark code that's used for regrouping in the current environment will be used on those claims--or those adjustments I should say.

Operator: Your next question comes from the line of Mercedes Hudgins.

Mercedes Hudgins: Yes, hello thank you for taking my question. My question is regarding the Home Health pricer, PC pricer. Will that have any changes, any data elements that'll be changing can you give me any information on that?

Wil Gehne: Yes, there will be a brand-new Home Health PC pricer that will come out later this year. The interface will look different. It'll be simplified because there's a number of pieces of information that are currently on the entry screen like the severity level characters from the treatment authorization code things like that that no longer apply to the payment system. So, they will have a very similar look and feel, but it will have somewhat fewer items that you need to enter to get a pin.

Mercedes Hudgins: Well, that's good, that's good because that really was one of my questions with the treatment authorization code severity point thank you.

Operator: Your next question comes from the line of Ellen Strunk.

Ellen Strunk: Hello and thank you for taking my call. I was wondering about the adjustments on the--for the Community versus Institutional claim. You indicated that was going to come from [inaudible] on the final RAP. But what if the post-acute setting has not submitted their claim before the Home Health submits the final claim.

Wil Gehne: Yeah, we can only adjust to reflect the Institutional payments because if we have the in-patient claim in the system at the time when the Home Health agency submits their claim. But we will have a process that this is what the earlier caller that was asking about the 835 adjustments was talking about.

We'll have the process in our system that when the inpatient claim is received later, it will trigger an automatic adjustment to the Home Health agency claim to put that into an Institutional payment group and pay the difference.

So as long as the final claims--at any point when the final claim--sorry at any point when the claims from the inpatient facility comes in during the timely filing period, they can trigger an adjustment to the Home Health final claims to regroup the period of care.

Ellen Strunk: Okay, thank you.

Operator: Our next question comes from the line of Tamera Schultz; Tamera your line is open.

Tamera Schultz: Sorry, I was on mute. You said that the claim was going to use the most recent OASIS for scoring the HIPPS and that the HIPPS wouldn't be reported on the RAP only on the claim that was receiving payment. So, is that OASIS that would be used would be the most recent OASIS prior to the start of the 30-day period or prior to the end of the 30-day period?

Wil Gehne: Prior to the start of a 30-day period, prior to the claim from date.

Tamera Schultz: Oaky, thank you.

Wil Gehne: And I wanted to clarify, you said there didn't need to be HIPPS code on the RAP. That is not true; there will always need to be a HIPPS code on the RAP. There's no longer a need to submit a HIPPS code on an OASIS assessment to the quality system.

Tamera Schultz: Okay, all right thank you.

Operator: Your next question comes from the line of Katie Burgan.

Katie Burgan: Hi, I've heard that there are situations in which a PT or an OT can prepare an OASIS--

Hazeline Roulac: I'm sorry Katie, could you speak up just a little louder? We can barely hear you.

Katie Burgan: Sure.

Hazeline Roulac: Yeah, please go head.

Katie Burgan: Okay, I've heard that there are situations in which a PT or an OT can prepare an OASIS rather than it being completed by a skilled nurse, and that reimbursement can still be received even if there's no skilled-nursing services provided in the 30-day period. Can you please clarify when this is appropriate?

Kelly Vontran: This would be a situation where therapy is ordered but nursing is not.

Katie Burgan: Yes, well there could be a skilled nursing visit in the first 30 days, but typically, in the second 30-day period, there isn't a skilled-nursing visit only therapy.
Kelly Vontran: and that's fine because remember the OASIS does cover 60 days.

Operator: Your next question comes from the line of John Reisinger.

John Risinger: Hello, thank you for the presentation it's been helpful. I had a question in regards to the admission source and timings, particularly as it pertains to later episodes. Is it correct, from my perspective, that for those Institutional admissions that have the occurrence code 62 which means a SNF, an IRF, an LTCH, etcetera that when it gets to a later episode that they convert over to a Community admission?

Because on page 23 of the hand out it says, late 30-day periods are always classified as Community admissions unless there is an acute hospitalization in the 14 days prior to the late Home Health 30-day period.

So, does that means that only occurrence code 61, which is only applicable to acute-care hospital discharges would continue to be Institutional in nature and everybody else would be Community when you get into the late episodes?

Wil Gehne: Yes, that is correct. The occurrence code 62 will only trigger an Institutional grouping when the from and admission date on the Home Health claim match and only later episodes when from and admission date do not match that only the occurrence code 61 will result in an Institutional payment group.

John Risinger: Okay.

Operator: Your next question comes from the line of Greg Von Arx.

Greg Von Arx: Continuing on that theme is what if the skilled-nursing facility stay was private pay and there's no Medicare claim to adjust with. Will the occurrence code—we'll log the occurrence code and that'll just assume to be correct until an audit or something?

Wil Gehne: That is correct.

Operator: Your next question comes from the line of Leslie Mitchell.

Leslie Mitchell: Yes, is there a place where we can see a listing of the exact diagnosis codes that belong to the 12 clinical groups and the diagnosis that belong to the various comorbidity groups?

Kelly Vontran: Yes, that interactive grouper tool is actually an excel spreadsheet and has multiple tabs and tabs are clearly marked, the ICD-10 diagnoses as well as the comorbidities.

Leslie Mitchell: Great, thank you so much.

Operator: Your next question comes from the line of Karen Calhoun.

Karen Calhoun: Hello, I'm just wondering about the Home Health agency's responsibility for filing their Medicare cost report. And specifically, there are some worksheets like worksheet C's that calculate their costs and visits and to get an average cost per visit on the Medicare cost report. Is there going to be any changes and requirements for that piece?

Hillary Loeffler: So, hi, this is Hillary Loeffler. I'm the Director of The Division of Home Health and Hospice. We don't have anybody from our cost reporting division, but we do work closely with them. There's not going to be

necessarily any changes to the cost report as a result of PDGM, but that's not to say that there might not be cost report changes that comes out in the future that might be unrelated.

There's nothing going to be specific as to implement for this, but they could decide to do some enhancements or overall that cost report in the near future.

Karen Calhoun: Okay, that's great thank you very much.

Operator: Your next question comes from the line of Lisa Woolery.

Lisa Woolery: Hi, Mike thank you for taking my question. This is about that PDGM calculator for recert. So, for that we do the recert OASIS. However, there is no grooming item so the M1800 and the M1033 for hospitalization risk. Those are items on the recert. So, is the direction to just carry over whatever response was in the last SOC-ROC or what is it direction in regard to those 2 items?

Kelly Vontran: Those 2 items will be added to the follow up OASIS. So, you will be able to capture that information.

Lisa Woolery: So, in 2020, there will be able to see it. Okay.

Kelly Vontran: Yes.

Lisa Woolery: Thank you.

Operator: Your next question comes from the line of the Kelsey Fluger.

Kelsey Fluger: Hi, yes, I just have a question with the second 30 days being late. I know the first 30 days are done through the OASIS at the start of care, but then how is that second 30 days documented? Is that through the RAP that's being sent in every 30 days?

Hillary Loeffler: Hi this is Hillary Loeffler again. So, what's going to happen is you're going to put all the diagnosis code on the claim of the claims processing system to determine whether it's early, or late, or Institutional, as Will and Kelly outlined. And then the OASIS that you due, at say start of care, that's going to be accessed through the claims processes.

So, this can use the same OASIS for two different 30-day periods, so that's kind of how it's going to work. We get all the diagnoses from the claim from each 30 day claim independently, system will access the claim's history, determine whether it's early or late, Institutional or Community. And then if you've only done say the start of a care assessment and there was no follow-up or resumption part of the second 30-day period, it'll use that same start of care OASIS to populate the functional items.
Wil Gehne: And that's why the supplement admission date being on the claim is important because it helps the system to look back and find that matching assessment.

Kelsey Fluger: Okay, perfect. Thank you very much.

Operator: Your next question comes from the line of Kristen Rybeck.

Kristen Rybeck: Hi, in some of these scenarios that you gave with the grouper tool, I don't see where the Home Health Value-Based Purchasing is figured in. Where would that figure in in these calculations?

Wil Gehne: They would apply base after the final payment that you see in those examples. So, it would the amount that you say in the example would then be multiplied by your agency specific multiplier.

Kristen Rybeck: Okay, so I'm looking at scenario 2 for example the final payment amount is that $3135.96 the negative or positive adjustment for Value-Based Purchasing would apply to that whole amount.

Wil Gehne: That's correct.

Kristen Rybeck: Okay thank you.

Operator: Your next question comes from the line of Stacy Ashworth.

Stacy Ashworth: Hi, thank you for answering my question. I wanted to provide a specific scenario just to illustrate the question that I'm asking better. So, the clinical groupings from the way I understand how the model was constructed placed patients that were statistically alike into a certain category in terms of reimbursement, and that category was turned into clinical grouping.

So, if on admission I admit patient that has diabetes at 11.9 and they fall into an MMTA other and they don't go back into the hospital, but in the middle of that episode prior to the second 30-day period, this patient falls. They go into the emergency department, and they have a fractured leg. No operation is needed.

They follow-up with ortho, their orthopedist, and he orders therapy. So now I have a patient that I admitted for with the intent to care for their diabetes who now has therapy needs and the fracture would fall in a different category, such as a musculoskeletal, which has the appropriate therapy reimbursement associated with that.

How would I capture that patient's change in conditions so I would receive the reimbursement that I need to take care of the additional resources that my patient now needs under the 60-day plan of care?

Kelly Vontran: So, for the second 30-day period you would have a different principal diagnosis code listed on the claims. So that would then regroup that second 30-day period into a different clinical group.

Stacy Ashworth: Okay, then we should be required to because the claim in the OASIS have to match at least from what I understand. So, would you be required to submit a SCIC?

Hillary Loeffler: So, this is Hillary I mean you can consider this similar to like a significant change in conditions adjustment that we used to do probably going on, what, 10 years ago now and we got rid of. You can do another follow-up OASIS to reassess the functional abilities of that patient.

And then the system would ping that other follow-up assessment as well prior to that 30-day period. We would use that for functional. And as Kelly mentioned, you would put a different primary diagnosis code as the principal on the claim considering that the patient's focused care has now shifted to something other than diabetes.

Wil Gehne: No assessment change that's needed to make the diagnosis code for be reflected in your payment.

Hillary Loeffler: Yes, you can only change the diagnosis code.

Wil Gehne: You made me realize there's probably some language we need to adjust in the manual instructions that just went out to kind of unlink claims and assessments in that circumstance. I think we need to do a little clarification in the manual instruction to speak to that.

Hazeline Roulac: Thanks, for your question.

Operator: Your next question comes from the line of Serena Checkfor. Serena? Serena, your line is open.

Serena Checkfor: Right, now it is. Hi my question is regarding the LUPA threshold. It sounds quite complicated, and I wonder if somebody can elaborate on that? And then the other question is, is there a LUPA add-on? I mean does it still exist with the new system, thank you.

Hillary Loeffler: Hi, this is Hillary Loeffler again. There still would be LUPA add on for the first 30-day period with that's a LUPA. And then with regards to the thresholds, so, if any of those folks that are on the line are familiar with say the in-patient prospective payment system, they have something that's called a short-stay adjustment.

And that is based on the medium length or the average length of stay for each DRG and varies by DRG. This is very similar to that. So, for instance, if there's a case-mix group that has an average number of visits of say 24, and another case-mix group that has an average number of visits of 5. The policy was designed to acknowledge that the averages for each case-mix group are different.

And therefore, the LUPA threshold should reflect that. So today if there is a case-mix group that has say 24 visits in the 60-day period, but you only need 5 in order to get the full 60-day period. But then there's another case-mix group where the average number of visits is 6, it just kind of creates this disparity that we were hoping to address with this new policy that we finalized.

Wil Gehne: Mechanically it just functions like a look-up table. For each HIPPS code, there is a LUPA threshold. So, look up code, A, threshold is 2, look up code, B, the threshold is 3, look up code, C, the threshold is 5, so it is a simple correspondence in those. One of the downloads that I mentioned in the resources has those threshold numbers in it.

Serena Checkfor: Thank you.

Operator: Your next question comes from the line of Cindy Kovako.

Cindy Kovako: Thank you for taking my call. My question was for the payments you give your HIPPS score and you get that initial payment. What happens on the next 30 days? Is that payment for the 60 days or is that--you get another payment on that 30 days?

Wil Gehne: You submit another RAP by the second 30-day periods and the same information is used to--unless anything changes, the same information is used to determine if HIPPS code for that second 30-day period.

Cindy Kovako: Thank you.

Operator: Your next question comes from the line of Olga Lohan.

Olga Lohan: Yes, the question is in the next--the second episode, what frequency are we going to follow if we are only going to have 1485?

Kelly Vontran: Could you clarify exactly what you're asking because again the plan of care covers those--only needs to be updated every 60 days. So, I'm trying to understand exactly what you're asking.

Olga Lohan: Correct, we're going to do 1485 that's it, but on the recert, what frequency are we going to follow if we're only going to have 1485 on the second episode?

Kelly Vontran: If a patient is receiving Home Health for two 30-day periods then that means they are bumping up against the next 60 days in which the recert would have to occur then there's subsequent 30-day period would the research and the Home Health plan of care would cover 60 days. The 30 days is basically the billing cycle.

Olga Lohan: Correct. Okay then, thank you.

Kelly Vontran: All other requirements remain at 60.

Olga Lohan: Thank you.

Operator: Your next question comes from the line of Maria Avers. Maria your line is open.

Maria Avers: Hi, yes, I would like for you to clarify the difference of patient management. If the patient has a SNF stay on day 16 through 30 of the first period what happens with the second period as far as Institutional versus Community? If the patient is transferred and readmitted verses is the patient is then discharged and final billed and then readmitted, so in one scenario you discharge. And then do a start of care, and in another scenario, you do the transfer and do a resumption of care. How does that differ with patient status?
Hillary Loeffler: So, if there's a SNF stay in the last 14 days of the first 30-day period so far prior to your second 30-day period. We outlined in the rule that it would be strange for you to hold on to that patient, and not discharge and readmit. So, you would not get late Institutional if you transferred and then did the resumption of care, but you would get late Institutional if you discharge and readmit.

Maria Avers: Okay, so just to clarify, if you're anticipating that patient coming back to you after a 2- or 3-week period to shore them up, and you held on to them, you really shoot yourself in the foot because you get not

considered Institutional at that point. If you discharge them, and then readmit them and do a whole day start of care, you get the Institutional payment.

Hillary Loeffler: Yes…

Kelly Vontran: Yes, because this is a 30-day period so having them in an open 30-day period of care for 2 to 3 weeks of the 30-day period just doesn't--we outline that that just doesn't seem right for the Medicare program, and the patient should be discharged and re admitted.

Maria Avers: Okay, but that's not how the rule is written so this will change that program right.

Hillary Loeffler: We did describe that in our final rule that Kelly referenced in one of the resource slides, so we did put that in rule making.

Maria Avers: Okay, thank you so very much

Hillary Loeffler: No problem

Hazeline Roulac: Dorothy, we have time for one final question.

Operator: The final question comes from the line of Kristy Buyer.

Kristy Buyer: Hello, I'm basically going to ask the same question that was just asked; that was my question, but I wanted to clarify she indicated a SNF, and I was thinking an acute-care hospitalization in the last 14 days of the 30-day period. Would you have to discharge and re admit to get that late Institutional correct?

Hillary Loeffler: So, for acute just because the length of stay can be highly variable somebody could go into a plan 2, 3 day or it replace the hospitalization. Or they could be in there for 10 to 12 days. Because of the variability and the length of the hospital stay, we do still give difference to the HHA on whether they should discharge and re admit or whether they should transfer and do resumption.

Either way, you're going to get late Institutional. So, for the acute, you can do either or and you would still get a late Institutional for acute-care hospital stays only. Does that answer your question?

Kristy Buyer: Yes, thank you.

Additional Information

Hazeline Roulac: Thanks for your questions and thank you everyone for all of your wonderful questions. We really appreciate you taking the time to ask the questions. Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can email it to the address that's on slide 80.

And also, we hope you will take a few moments to evaluate your experience with today's call. Please see slide 81 for more information on how you can evaluate.

My name is Hazeline Roulac. I would like to thank our presenters, and also thank you for participating in today's Medicare Learning Network event on the Home Health Patient-Driven Groupings Model.

Thank you and have a great day.

Operator: Thank you for participating in today's conference call. You may now disconnect; presenters please hold.