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Home Health Grouping Model

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The impacts of the Home Health PPS payment rate update

The current case-mix adjusted payments under the Home Health Prospective Payment System (HH PPS) are therapy driven, and beneficiaries with low-income, living in under-served areas have a high severity of illness. Ideally, Home Health (HH) payment should be determined by the patient characteristics and should equally weigh a non-therapy service.

In the CY 2018 HH PPS rule (82 FR 35270), CMS finalized a new payment system called the Home Health Groupings Model (HHGM) which overhauls the current Medicare Home Health reimbursement system by eliminating the use of therapy service thresholds and concentrating on the clinical characteristics and other patient information. Another major change is refining the unit of payment from a 60-day episode of care to a 30-day episode of care.

While HHGM reflects a change in the case-mix adjustment methodology, the conditions for payment would remain the same for Medicare HH services i.e. there will not be any changes in the Home Health Conditions of Participation (CoPs).

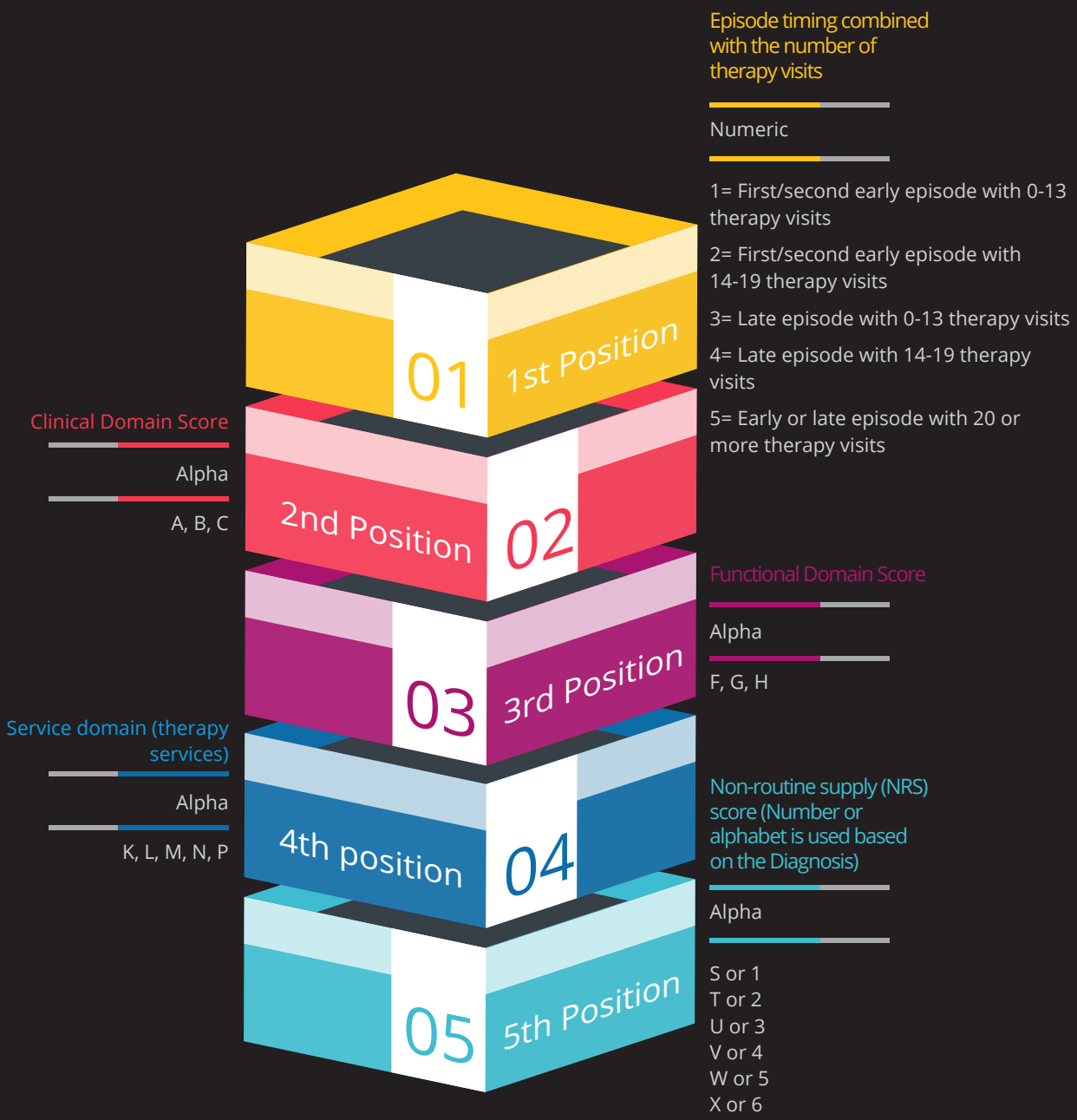
The drastic impact of the proposed HH PPS case-mix adjustment methodology refinements, including the change in the unit of payment to a 30-day period of care, is an estimated cut of $950 million (~ $1 billion) in payments to HHAs in the CY 2019. This is applicable only if the refinements are implemented in a non-budget neutral manner for a 30-day period of care.

The commercial impact of the Home Health PPS payment rate update is an estimated $80 million in payment for the CY 2018.

The newly proposed rule is targeted to take effect from January 1, 2019

Current case-mix adjustment payment:

Currently, the Medicare HH services are billed for 60-day episodes, thereby causing costly over-utilization. OASIS C2 is used for clinical assessment at the time of admission based on the diagnosis by the physician. Every question on the OASIS is evaluated, and the assessment completion yields the case mix weight to get the Home Health Resource Group (HHRG) score. This is combined with the episode timing and the total number of therapy visits to calculate a five-digit HIPSS code.



HIPPS Code Breakdown

Highlights of HHGM:

The HHGM has proposed to implement case-mix methodology refinements with Medicare payments and the highlights include:

NEW ADDITIONS

01 New Admission source category

02 Six clinical groups to categorize patients based on the primary reason for Home Health care

03 Comorbidity adjustment for secondary diagnosis

MODIFICATIONS

01 Unit of payment from a 60-day episode of care to a 30-day period of care

02 In the episode timing categories – early and late for community and institutional

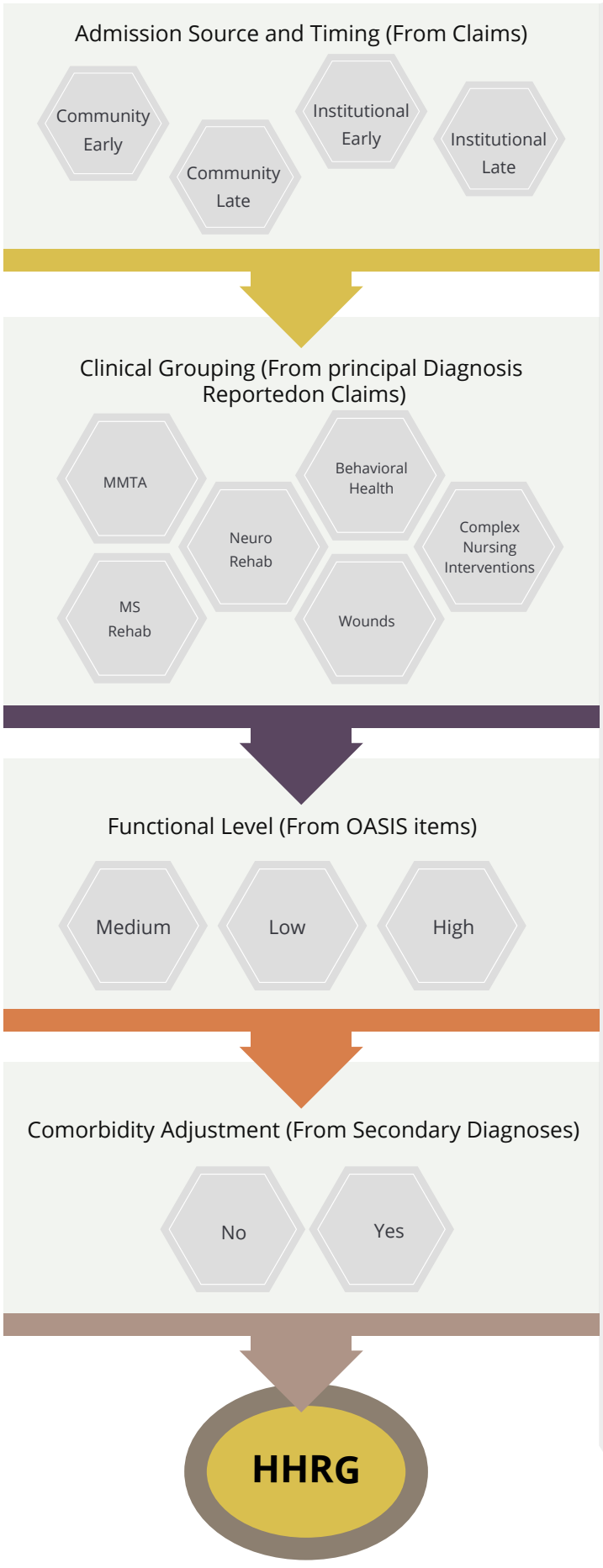
03 Revised functional levels and corresponding OASIS items

04 In the Low-Utilization Payment Adjustment (LUPA) threshold

Outline of the Home Health Grouping Model:

In total, the HHGM produces 144 different payment groups and each HH period is categorized into different sub-groups within each of the five categories below:

Category I	Timing	Early or late; the period is placed into 1 of the 2 groups
Category II	Admission source	Community or institutional source; the period is placed into 1 of the 2 groups
Category III	Clinical grouping	Musculoskeletal (MS) rehab, neuro/stroke rehab, wounds, Medication Management Teaching and Assessment (MMTA), Behavioral, or complex nursing care; the period is placed into 1 of the 6 groups
Category IV	Functional level	Low, medium, or high; the period is placed into 1 of the 3 groups
Category V	Comorbidity adjustment	No or yes; based on the secondary diagnosis; the period is placed into 1 of the 2 groups



Structure of the Proposed HHGM:

4 Admission Source and Timing categories x 6 Clinical Groupings x 3 Functional levels x 2 Comorbidity Adjustments = 144 groups

Timing

- Early: First 30 days period; will receive more payment
- Late: Subsequent periods

Admission source

- 14-day admission source will determine the grouping
- Institutional will receive a higher payment

Clinical Grouping

- Determined using OASIS, based on the principal diagnosis code

Functional level

- Determined using OASIS items to predict if the period will have higher cost or lower cost

Comorbidity Adjustment

- Secondary diagnosis used to adjust one of the 15 comorbidities covering the following domains:
  - Heart Disease
  - Cerebral Vascular Disease
  - Circulatory Disease and Blood Disorders
  - Endocrine Disease
  - Neoplasm
  - Neurological Disease and Associated Conditions
  - Respiratory Disease
  - Skin Disease

Other Important Changes:

Low Utilization Payment Adjustment (LUPA) thresholds

In the current payment model, for each payment group, one threshold (5 visits) applies to all the episodes. Therefore, any patient visits less than 5 times within 60-days window will be paid using LUPA rates for individual visits.

Example: For the MMTA – Functional level: Medium – Early timing – Institutional Admission, the threshold is four visits. If the episodes assigned to that particular payment group had four or fewer visits those would be national per-visit rates.

Under HHGM, for a standardized per visit payment adjustment, it is proposed to be higher than 10th percentile value of visits or two visits by a payment group for a 30-day period (instead of 60 days).

Non-Routine Supply (NRS) Bundling

In the current HH PPS, all episodes without LUPA receive payments for NRS, regardless of whether or not the HHA has provided NRS during that episode. NRS payment is determined by using the presence of clinical factors from the OASIS that are associated with NRS provision. Analyses have documented that two-thirds of the episodes do not indicate whether NRS is provided, yet the episodes still receive some NRS payment with the current payment design.

Hence, under HHGM, the NRS will be included with the base payment rate i.e. cost per visit + NRS, to avoid fraud payments.

High-cost Outliers, LUPA Add-On Payments, and Partial Payment Adjustments will remain the same as the current payment system.

Impacts on the Home Health Software

The drastic change in calculating the episode brings an impact on the application. Though the structure of HHGM is very flexible and adaptable, the system needs to add additional payment categories without affecting the current model. Following are the features within the EHR:

Interoperability

When a patient is referred to a home health agency, complete clinical information is required for calculating episode cost in the HHGM. A patient is categorized based on the primary reason for admission and grouped into one of the six clinical groups. This information needs to be part of a clinically structured document like C-CDA using DIRECT messaging or by incorporating within a Home Health software using standards like FHIR or through APIs from the source EHR.

Billing dashboard

The changes in the unit of payment enable quick analysis of accounting and claim categorization based on the referral information and OASIS assessment. Availing this dashboard, patient data is used to determine the case-mix weight, remittances received from the payer as well as for RAP submission for 033 TOB, LUPA, outliers or for a non-RAP LUPA. By keeping a track of all the TOB, patient status (FL 17), claim adjustments, and billing errors by the RC, a possible resolution can be alerted, immediate fixes can be done and RAP/claim can be re-submitted.

Decision Support

While clinical decision support system forms the basis for collecting the right OASIS information, an equal importance should be given to alert the aides to ensure that every information is filled periodically. Based on the visit, the HHRG will get automatically calculated post visit and all the missing information can be shown as an intervention. Intervention triggered after every visit will allow aides to address the issues immediately, rather than waiting for 30-days. With the inclusion of NRS in the base calculation, proper tracking of NRS or any DME is required for each visit.

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Methodology Used to calculate the Cost of Episodic Care

Currently the Wage Weighted Minutes of Care (WWMC) approach is used to determine resource use for each episode by multiplying utilization (in terms of the number of minutes of direct patient care provided by the discipline) with the corresponding opportunity cost of that care (represented by wage and fringe benefit rates from the BLS).

The HHGM proposes to use a Cost Per Minute plus Non-Routine Supplies (CPM + NRS) approach. In this approach, the episodes will be grouped into their case-mix groups as mentioned in table 2 and the average resource use for each case-mix group dictates the group's case-mix weight. Here, the resource use will be the estimated cost of visits recorded on the home health claim + the cost of NRS recorded on the claim. This is then converted into the cost using an NRS cost to charge ratio that is specific to each HHA.

If there is a high amount of NRS cost for all the episodes in a particular group (holding all else equal), the resource use will be higher relative to the average, and the case-mix weight will correspondingly be higher.

While this approach evenly weighs skilled nursing and therapy services, it also includes direct and indirect costs (eg: transportation) associated with the care.

Home Health Groupings Model
Episode Payment Determination
(Episode Base Payment Amount)
X
(Case-Mix Weight)
X
(Wage Index)
+
Outlier Payment Amount
=
Home Health Episode Total Episode Payment

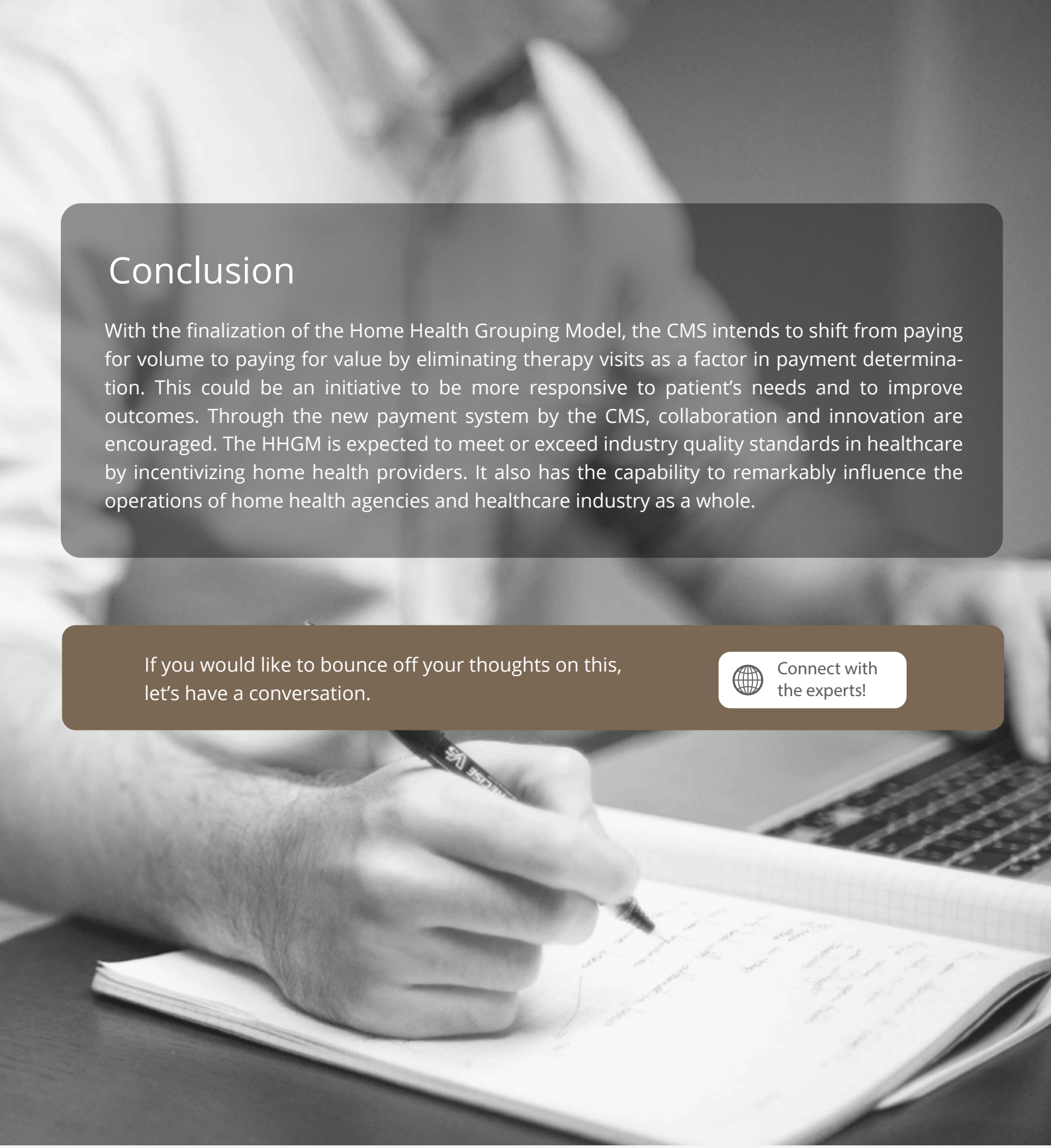
Strengths of HHGM

Similar to the current payment system, but uses different variables for case mix adjusted payments focusing on the patient rather than therapy services

Addresses the criticism of calculating the cost for every episode including non-routine supply along with base payment

Easier to identify the reason for the HH period from the HIPSS code in the claims and easily aligns with OASIS submission

30-day reimbursement window cycle will balance out the risk effectively across home care agency



Conclusion

With the finalization of the Home Health Grouping Model, the CMS intends to shift from paying for volume to paying for value by eliminating therapy visits as a factor in payment determination. This could be an initiative to be more responsive to patient's needs and to improve outcomes. Through the new payment system by the CMS, collaboration and innovation are encouraged. The HHGM is expected to meet or exceed industry quality standards in healthcare by incentivizing home health providers. It also has the capability to remarkably influence the operations of home health agencies and healthcare industry as a whole.

If you would like to bounce off your thoughts on this, let's have a conversation.

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About Us

At Nalashaa, we partner with healthcare organizations of all stages, from startups to established firms, and work with them to build engaging user experiences that reduce organziational cost and risk. Our healthcare and technology expertise, along with our flexible engagement models, make us a great fit for developing the quality technology while reducing time to market and engineering costs.

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