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1. Introductions
2. **Background****
3. Overview of the Model
4. Resource Use
5. 30 Day Periods
6. Clinical Groups
7. Functional Levels
8. Other Variables Used to Group Periods
9. Comorbidity Group
10. Case-Mix Weights
11. Impact Analyses

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Home Health Prospective Payment System (HH PPS)

- Implemented in October 2000
  - Bundled payment for all covered HH services provided in a 60 day episode

- Level of payment determined by results of a patient assessment – case-mix adjustment
 - Allows different payment for patients with different needs.

HH PPS: Current Case-Mix System

- Home Health Agencies (HHAs) complete the Outcomes and Assessment Information Set (OASIS) for each patient

- Result of the assessment groups episode into one of 153 Home Health Resource Groups (HHRGs)
    - Timing (early/late episodes; exception 20+ therapy group)
    - 3 clinical levels
    - 3 functional levels
    - 9 service use categories (number of therapy visits)

- HHRG is the starting point for payment calculation

HH PPS: Current Case-Mix System

- **Clinical Domain** – whether the patient has one or more clinical conditions such as incontinence; intravenous infusion (IV), enteral, or parenteral therapies; the presence of wounds or pressure ulcers, etc.

- **Functional Domain** – whether the patient has problems with activities of daily living such as dressing, bathing, transferring, walking (locomotion), and toileting.

- **Service Use Domain** – based on the number of therapy visits during the episode.

HH PPS: Current Case-Mix System
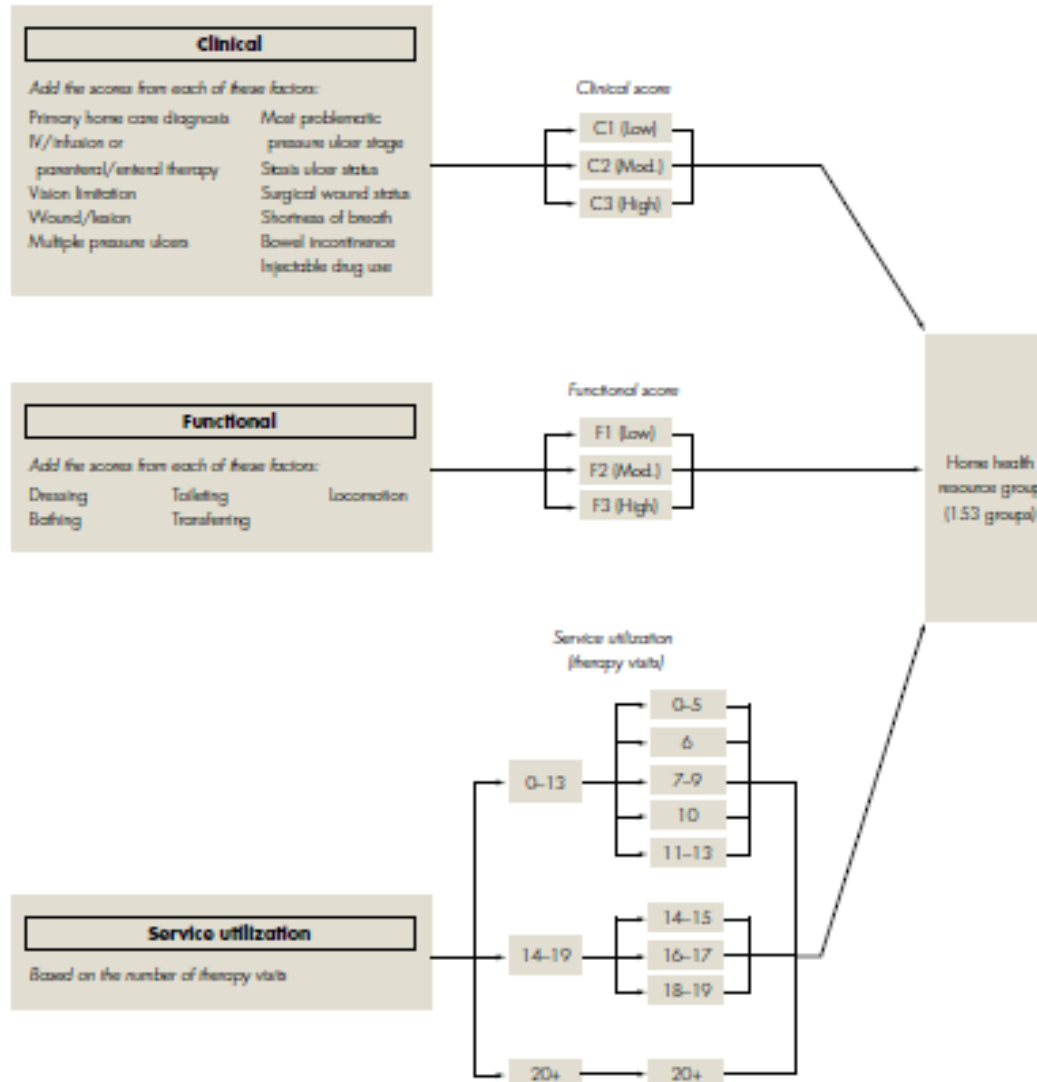
Motivation – Section 3131(d) Report to Congress

- Examined costs associated with beneficiaries who were: low-income, lived in underserved areas, had high severity of illness

- Report found current payment system produced lower margins for those
  - needing parenteral nutrition
  - with traumatic wounds or ulcers
  - who required substantial assistance in bathing
  - admitted to HH following an acute or post-acute stay
  - who have a high Hierarchical Condition Category score
  - who had certain poorly controlled clinical conditions
  - who were dual eligible

Motivation – MedPAC Annual Reports (2011, 2015)

- The Medicare HH Benefit is ill-defined

- HH payment should not be based on the number of therapy visits
  - Current system incentivizes more therapy visits and fewer non-therapy visits

- HH payment should be determined by patient characteristics

Motivation

- Payment Reform Principles
  - Improve payment accuracy for HH services
  - Promote fair compensation to HHAs
  - Increase the quality of care for beneficiaries

- Initial Work
  - Assessing utilization of current payment system
  - Considered alternative approaches to construct case-mix weights (CY 2016 Rule)
    - Diagnosis on Top
    - Predicted Therapy
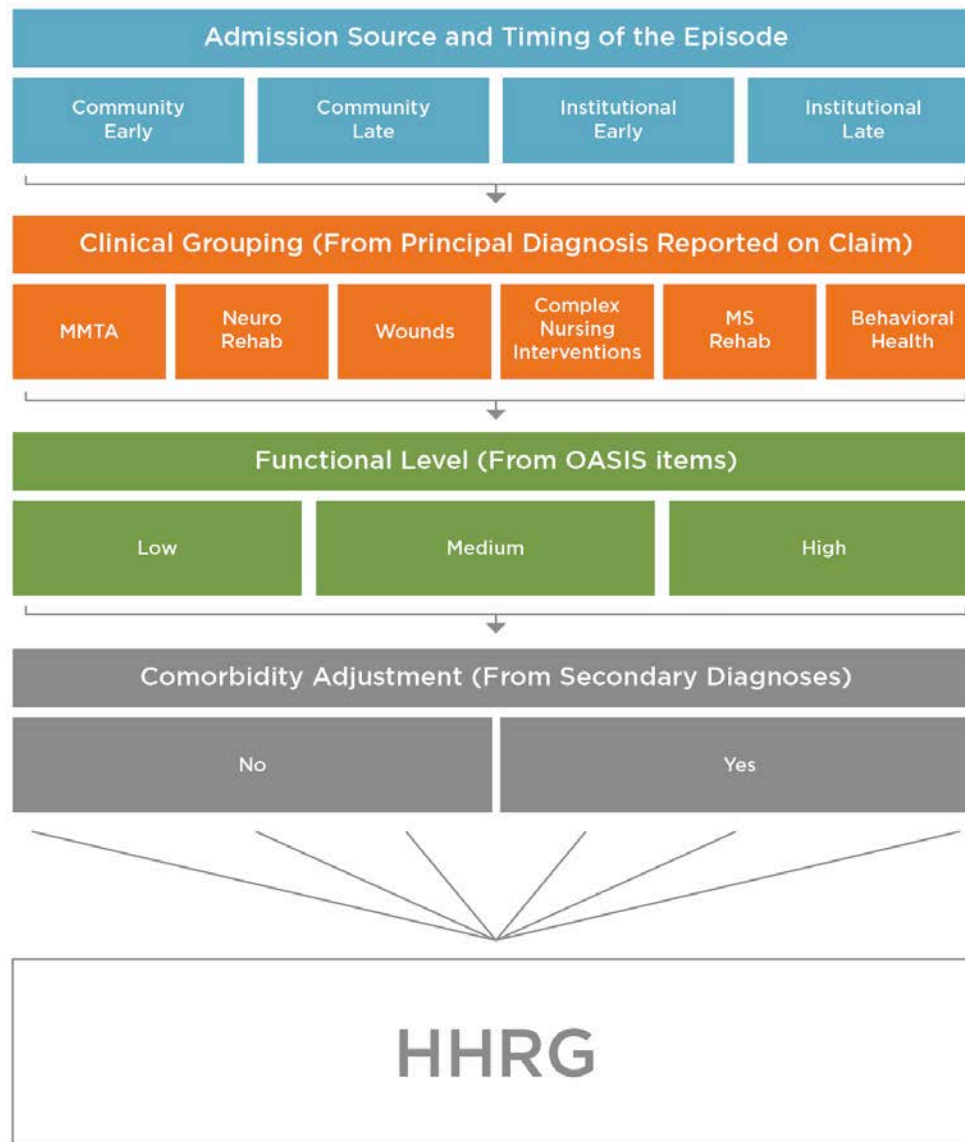   - Home Health Groupings Model

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Overview of HHGM

- Each HH period is categorized into different sub-groups within each of the five categories below:
  - Timing (early or late; period is placed into 1 of 2 groups)
  - Referral source (community or institutional source; period is placed into 1 of 2 groups)
  - Clinical grouping (musculoskeletal (MS) rehab, neuro/stroke rehab, wounds, Medication Management Teaching and Assessment (MMTA), behavioral, or complex nursing care; period is placed into 1 of 6 groups)
  - Functional level (low or high; low, medium, or high; period is placed into 1 of 2 groups (MS Rehab and Behavioral Health) or 1 of 3 groups for the other clinical groups)
  - Comorbidity adjustment (no or yes; based on secondary diagnoses; period is placed into 1 of 2 groups)

- In total, HHGM produces $2*2*(2*2+4*3)*2 = 128$ different payment groups

Under the Home Health Groupings Model, an episode is grouped into one (and only one) subcategory under each larger colored category. An episode's combination of subcategories groups the episode into one of 128 different payment groups.

Episodes in the MS Rehab and Behavioral Health clinical groups can only be grouped in the low or high functional level.

The Complex Nursing Interventions clinical group uses a mix of principal diagnoses and OASIS items to group episodes.

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Measuring Period Costs

- Need to measure period costs to design a payment system

- Resource use is an estimate of period costs

- Multiple approaches considered; two main candidates:
  - Wage Weighted Minutes of Care (WWMC) [payment system currently uses this method]
  - Cost per Minute plus Non-Routine Supplies (CPM + NRS)

Comparison of Approaches

	Wage Weighted Minutes of Care (WWMC)	Cost per Minute plus Non-Routine Supplies (CPM + NRS)
Data Sources	Bureau of Labor Statistics (BLS) wage estimates, HH Medicare claims	Cost Reports, HH Medicare claims
General Approach	Wages multiplied by amount of care provided for each discipline	Total costs multiplied by amount of care provided for each discipline
Costs Represented	Wages and fringe benefits directly related to patient visit	Wages, fringe benefits, overhead costs, transportation costs, other non-visiting services labor costs
Non-Routine Supply	Determined through separate model	Use NRS cost-to-charge ratio to obtain NRS costs per period

Selecting a Resource Use Approach

- High correlation between methods (0.82 correlation coefficient)

WWMC advantages	**CPM+NRS advantages**
▪ Incorporates labor categories (e.g., LPN versus RN) ▪ BLS data are available more quickly ▪ No imputation needed	▪ NRS is incorporated into one payment system, rather than a separate model ▪ Incorporation of more than just visit costs ▪ Lower ratio of Skilled Nursing to Therapy costs

- HHGM findings use the CPM+NRS method

- Exploration of differences and their implications continues

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30 Day Periods: Overview and Motivation

- In the HH PPS, HHAs are paid for each (up to) 60 day episode of care provided

- However, we found significant resource usage differences across 60 day episodes' first and second halves
  - Separately paying each half in accordance with differential resource use better aligns payments with cost

- For the HHGM analysis, we simulate 30 day periods for which Medicare would pay for HH services

Distribution of Resource Use Across Current Episode Configuration

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

Benefits of Transition to 30 Day Periods

1. HHGM fit statistics (e.g., R2) improve from reduced variation arising from a more constrained time window; in turn this creates more accurate case-mix weights

2. 30 day periods would reduce/eliminate a need for preemptive partial payments (i.e., Request for Anticipated Payment); HHAs would bill monthly (as hospices and skilled nursing facilities do now) and receive final payment sooner

Methodology

- Simulated 30 day periods were constructed using segments of current 60 day episodes
    1. A 30 day period comprised of days 1 up to 30
    2. Where applicable (depending on episode length), a second period comprised of days 31 and above

    Example: a 58 day episode yields two new segments: a initial 30 day period (days 1-30) and a second 28 day period (days 31-28)

- Any 60 day episode 30 days or fewer will not yield a second period

Results

- Overall, there were 5,585,396 60-day episodes

  - Of these, 1,389,492 episodes are 30 days or less
    - No additional 30 day periods were produced

  - The remaining 4,195,904 episodes exceed 30 days
    - Each produces an additional period with remaining days after generating an initial period from the first 30 days
    - However, after generating an additional 4,195,904 periods, we excluded 469,673 periods without visits or that would be considered a LUPA under the HHGM

- In sum, 1,389,492+(2)(4,195,904)-469,673 = 9,311,627 30 day periods

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Periods are Grouped by Primary Reason for Home Health under the HHGM
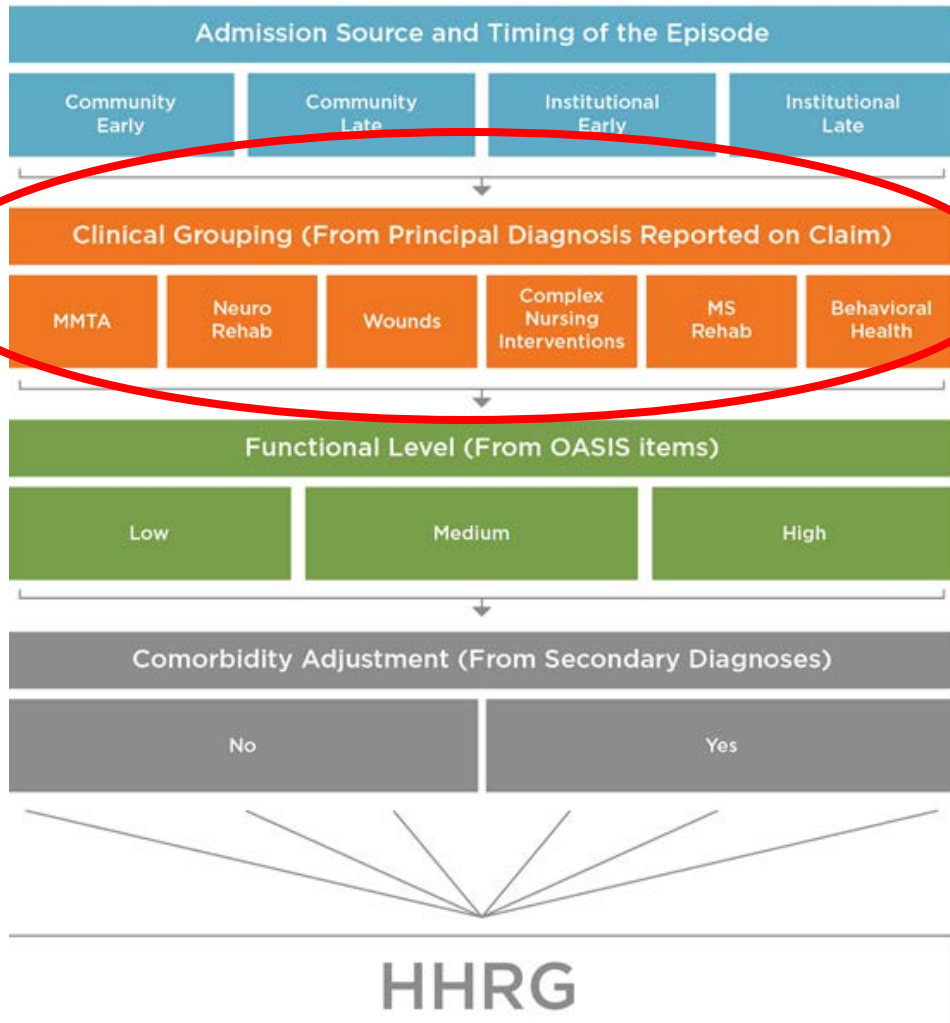
- Clinical groups are intended to reflect the primary reason for HH services

- Defined by diagnosis on HH claim
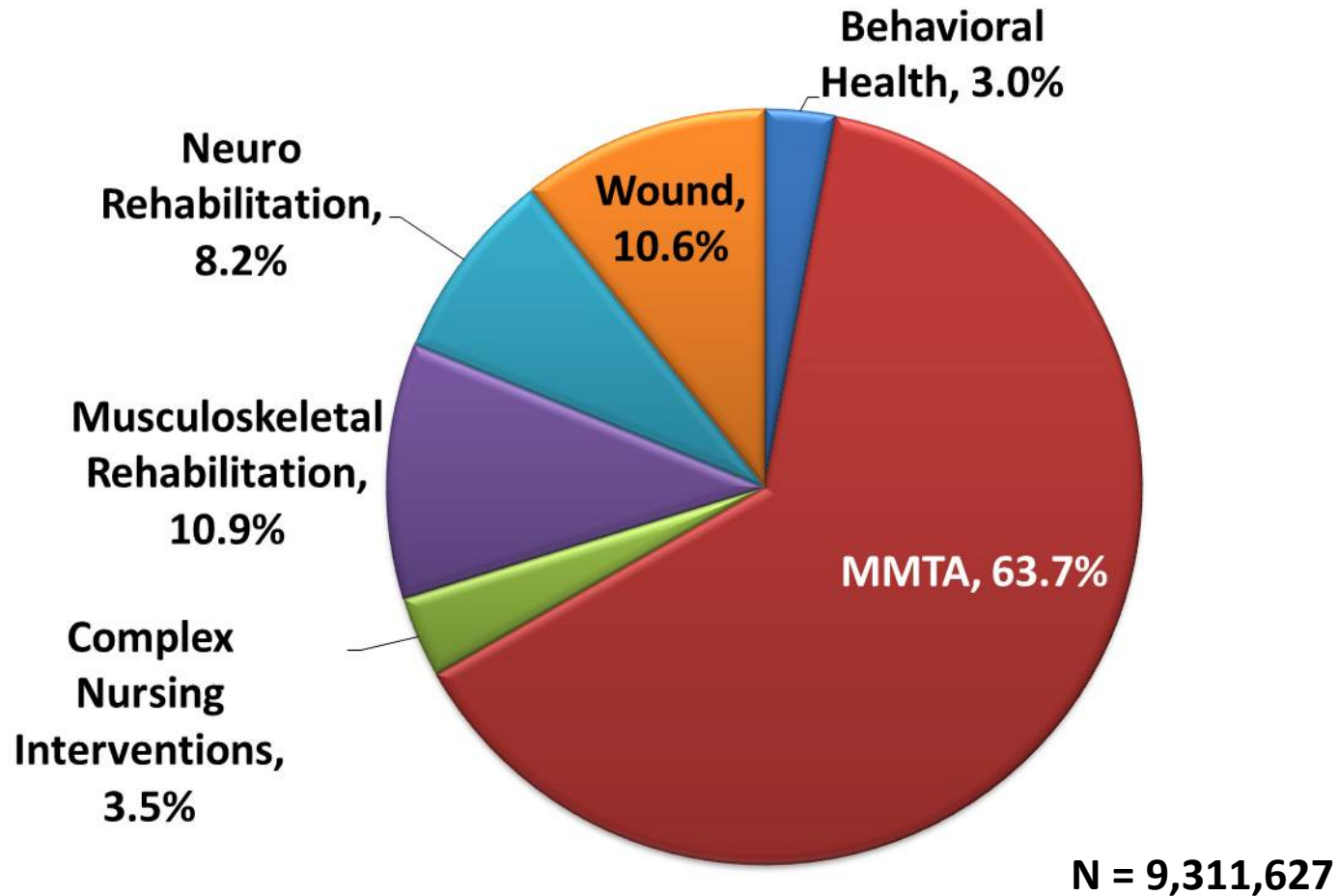
- Six total groups used in the HHGM

Description of the Six Clinical Groups

Clinical Group	Main reason for HH encounter is to provide:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds 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
Complex Nursing Interventions	Assessment, treatment, and evaluation of complex medical and surgical conditions including IV, total parenteral nutrition, enteral nutrition, ventilator, and ostomies, as well as the presence of certain V-codes as primary diagnosis
Behavioral Health Care	Assessment, treatment, and evaluation of psychiatric and substance abuse conditions
Medication Management, Teaching and Assessment (MMTA)	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above groups

Using ICD-9/10 Codes to Define Groups

- Extensive review of all ICD-9/10 codes

- Period assigned to clinical group based on principal diagnosis

- Secondary diagnosis codes were used if necessary (e.g., principal diagnosis was too vague, unlikely to require HH, etc.)
  - Affected approximately 20% of periods
  - After using secondary diagnoses, 0.4% of periods still could not be categorized and were dropped for analyses
  - In practice, may require agency to resubmit valid principal diagnosis

- Additional adjustments (discussed later) for other health conditions

Percentage of Periods by Clinical Group

Behavioral Health, 3.0%

Neuro Rehabilitation, 8.2%

Wound, 10.6%

Musculoskeletal Rehabilitation, 10.9%

MMTA, 63.7%

Complex Nursing Interventions, 3.5%

N = 9,311,627

Average Resource Use by Clinical Group
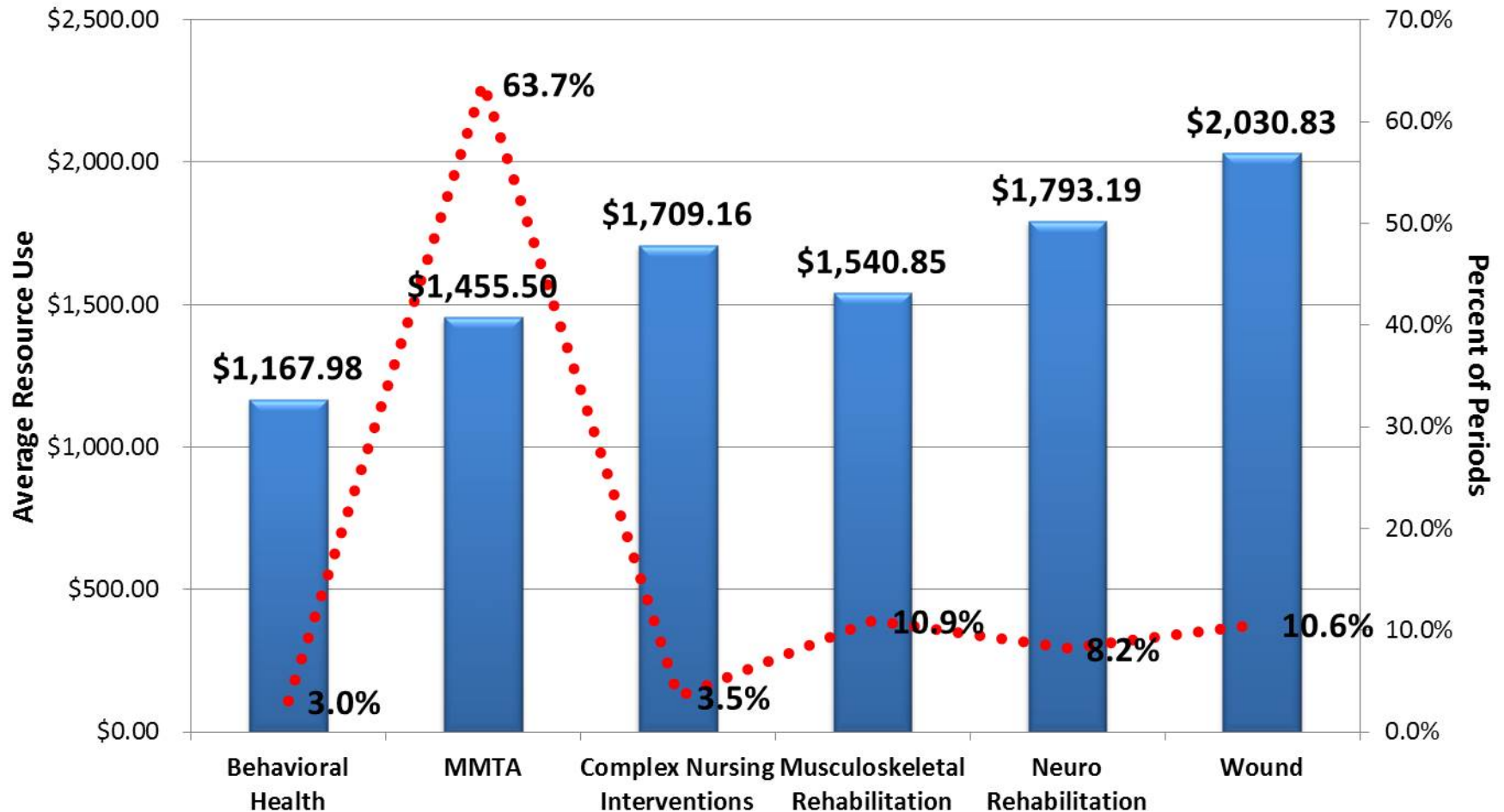
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Periods are Grouped by Functional Level under the HHGM
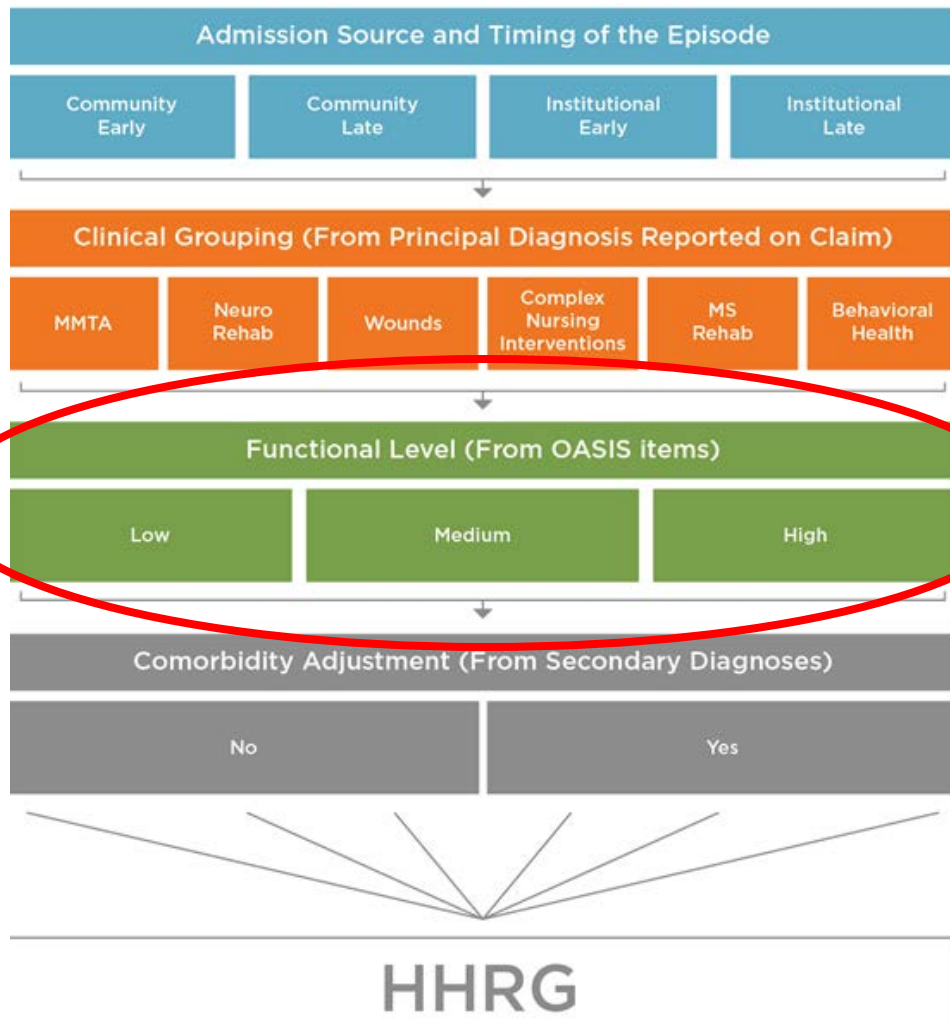
- Under the HHGM, periods are categorized into levels based on the relationship between functional status and period cost

- A selection of OASIS items are used to create these levels

Functional OASIS Items

Functional OASIS Items	Current Payment System	HHGM
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
M1845: Toileting Hygiene	No	No
M1850: Transferring	Yes	Yes
M1860: Ambulation/Locomotion	Yes	Yes
M1870: Feeding or Eating	No	No
M1880: Current ability to plan and prepare light meals	No	No
M1890: Ability to use telephone	No	No

Functional OASIS Items

(M1800) **Grooming:** Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.

☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.

☐ 2 - Someone must assist the patient to groom self.

☐ 3 - Patient depends entirely upon someone else for grooming needs.

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.

☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.

☐ 2 - Someone must help the patient put on upper body clothing.

☐ 3 - Patient depends entirely upon another person to dress the upper body.

Average Resource Use for Periods by Response to OASIS Functional Items
(M1800 – M1820) After Combining Categories

Item	Response	Mean	N	%
M1800: Grooming	0	$1,448.21	5,513,380	58.5%
	1	$1,646.20	3,905,106	41.5%
M1810: Current Ability to Dress Upper Body	0	$1,390.64	5,026,560	53.4%
	1	$1,690.15	4,391,926	46.6%
M1820: Current Ability to Dress Lower Body	0	$1,288.13	2,972,718	31.6%
	1	$1,576.01	4,905,575	52.1%
	2	$1,852.11	1,540,193	16.4%

Creating the Functional Level

- The level is based on seven functional items
  - Additionally, we use M1032 (Risk of Hospitalization)

- Regressed resource use on selected items (with HHGM diagnosis groups as additional covariates)

- Regression coefficients used to create Functional scores
  - Each period receives a total score using those point values for each item

- Periods within each HHGM diagnosis grouping split into thirds (low/medium/high) based on total score

Functional Variable Points

Variable	Response Category	Points
M1800: Grooming	1	3
M1810: Current Ability to Dress Upper Body	1	4
M1820: Current Ability to Dress Lower Body	1	7
	2	10
M1830: Bathing	1	6
	2	17
	3	25
M1840: Toilet Transferring	1	4
M1850: Transferring	1	7
	2	13
M1860: Ambulation/Locomotion	1	13
	2	17
	3	27
M1032: Risk of Hospitalization	4 or more items checked	12

Summary Statistics for Functional Levels

Clinical Group	Level	Points	Average Resource Use	N	% Within Clinical Group
MMTA	Low	0-36	$1,177.34	1,987,235	33.2%
	Medium	37-55	$1,467.31	2,138,844	35.7%
	High	56+	$1,668.97	1,867,502	31.2%
Behavioral Health	Low	0-44	$961.73	140,456	50.6%
	High	45+	$1,378.51	137,114	49.4%
Complex	Low	0-33	$1,430.58	106,673	33.8%
	Medium	34-60	$1,795.29	102,305	32.4%
	High	61+	$1,960.16	106,570	33.8%
Musculoskeletal Rehabilitation	Low	0-48	$1,396.39	573,591	55.1%
	High	49+	$1,639.45	468,173	44.9%
Neuro Rehabilitation	Low	0-48	$1,512.02	262,566	33.8%
	Medium	49-67	$1,793.74	252,592	32.5%
	High	68+	$1,986.97	261,104	33.6%
Wound	Low	0-41	$1,759.76	346,257	34.2%
	Medium	42-65	$1,993.35	332,204	32.8%
	High	66+	$2,207.39	335,300	33.1%

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Periods are Grouped by Admission Source and Timing
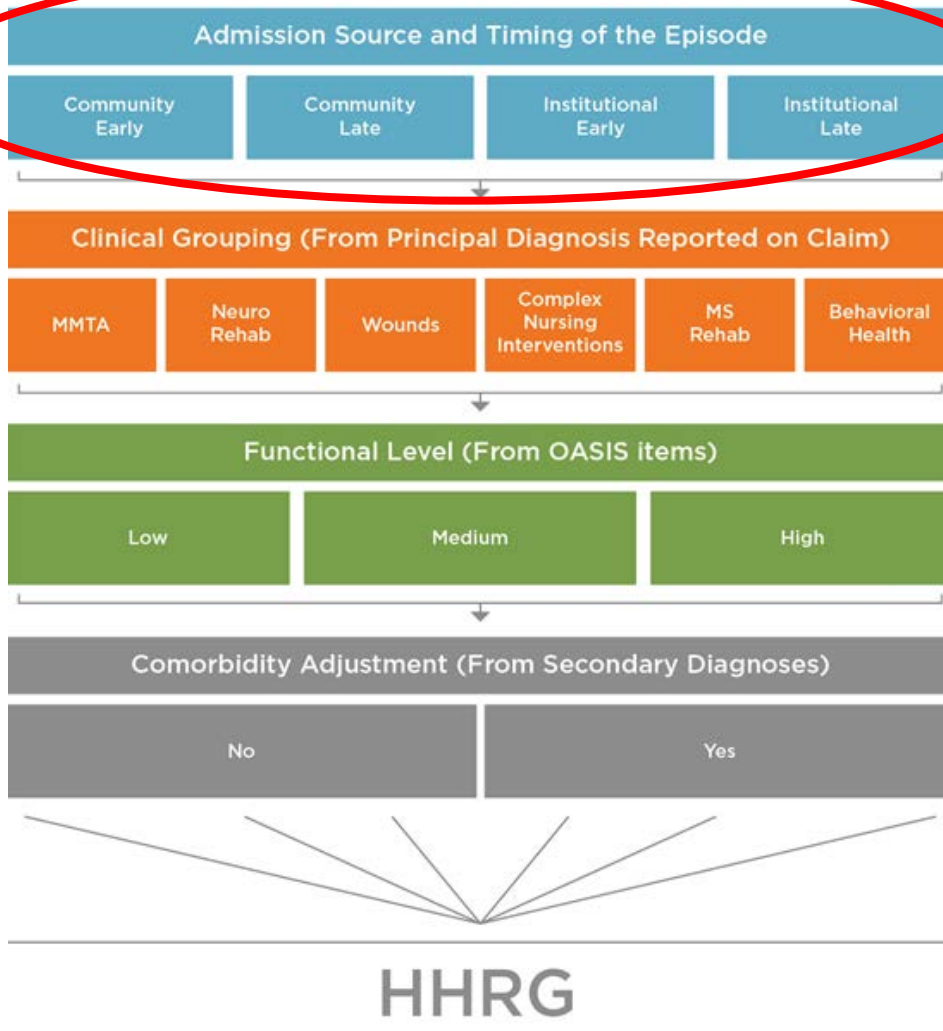
- Explored options for incorporating meaningful patient groups

- Two currently used:
  - Admission source
  - Period timing

Period Admission Source

- **Institutional:** Acute or post-acute (skilled nursing facility, inpatient rehabilitation facility, long term care hospital) care in the 14 days prior to the HH admission

- **Community:** No acute or post-cute care in the 14 days prior to the HH admission
  - 30 day periods: second 30 days of a 60 day episode is assigned community

Admission Source	Average Resource Use	Number of Periods	Percent	SD	25th Percentile	Median	75th Percentile
Institutional	$2,114.39	2,339,944	25.1%	$1,340.60	$1,161.28	$1,850.11	$2,729.50
Community	$1,365.55	6,971,683	74.9%	$1,194.51	$557.96	$1,004.14	$1,811.20
Total	$1,553.73	9,311,627	100.0%	$1,274.92	$647.67	$1,207.50	$2,096.43

Period Timing

- **Early periods:** the first 30 day period in a sequence of HH periods

- **Late periods:** second and later 30 day periods in a sequence of HH periods
  - Sequence of HH periods are those with no more than 60 days between the end of one period and the start of the next period (no change from current definition)

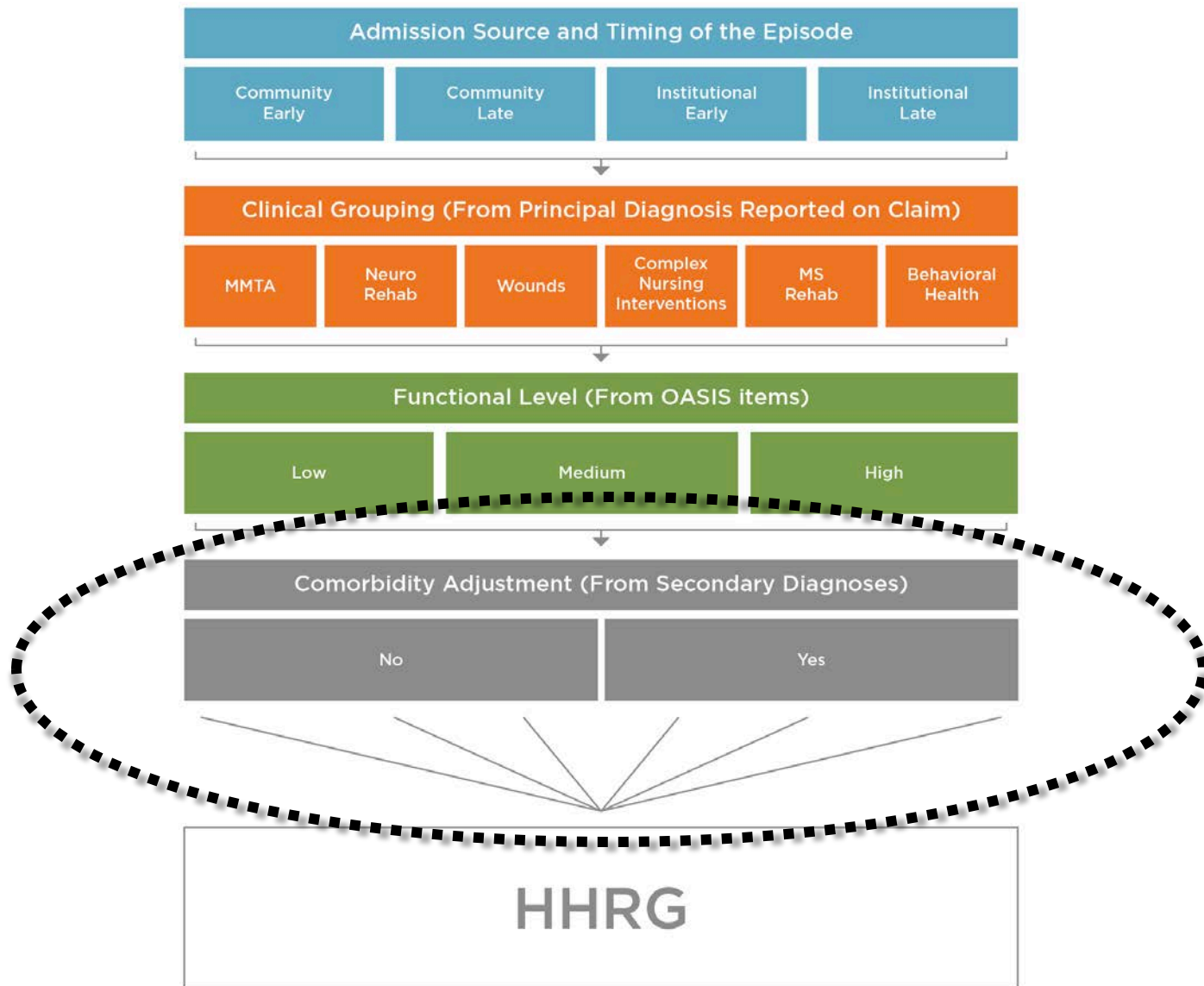| Timing	Average Resource Use	Number of Periods	Percent of Periods	SD	25th Percentile	Median	75th Percentile
Early Periods	$2,054.92	2,881,389	30.9%	$1,255.20	$1,152.50	$1,808.09	$2,646.46
Late Periods	$1,329.14	6,430,238	69.1%	$1,218.51	$531.52	$943.75	$1,738.65
Total	$1,553.73	9,311,627	100.0%	$1,274.92	$647.67	$1,207.50	$2,096.43

Resource Use by Timing and Admission Source

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Admission Source and Timing of the Episode

Community Early	Community Late	Institutional Early	Institutional Late

Clinical Grouping (From Principal Diagnosis Reported on Claim)

MMTA	Neuro Rehab	Wounds	Complex Nursing Interventions	MS Rehab	Behavioral Health

Functional Level (From OASIS items)

Low	Medium	High

Comorbidity Adjustment (From Secondary Diagnoses)

No	Yes

HHRG

Under the Home Health Groupings Model, an episode is grouped into one (and only one) subcategory under each larger colored category. An episode's combination of subcategories groups the episode into one of 128 different payment groups.

Episodes in the MS Rehab and Behavioral Health clinical groups can only be grouped in the low or high functional level.

The Complex Nursing Interventions clinical group uses a mix of principal diagnoses and OASIS items to group episodes.

Comorbidity Adjustment: Motivation

- The primary HH diagnosis determines the HHGM clinical group

- However, secondary diagnoses also contain relevant information indicating patient need for case-mix adjustment, even after accounting for other aspects of the HHGM

- A **comorbidity** is defined as a medical condition coexisting in addition to a primary diagnosis
  - Comorbidity is tied to worse health outcomes, more complex medical need and management, and higher care costs

Comorbidities Specific to Home Health

- A HH specific comorbidity list was developed with broad clinical categories used to group comorbidities within the HHGM:
  - heart disease
  - respiratory disease
  - circulatory disease
  - cerebrovascular disease
  - gastrointestinal disease
  - neurological conditions
  - endocrine disease
  - neoplasms
  - genitourinary/renal disease
  - skin disease
  - musculoskeletal disease
  - behavioral health
  - infectious diseases

Comorbidities Specific to Home Health

- When evaluating comorbidities for HHGM inclusion, we assigned those with at least 0.1% of periods to subcategories

- For remaining comorbidities, we determined each subcategory's associated average resource use and flagged those with increased costs for a **comorbidity adjustment group**

- Periods having at least one comorbidity included with the adjustment group will receive an adjustment

Frequency of Periods and Resource Use Estimates by Comorbidity Presence

Comorbidity Group	# Periods (30 Day Periods)	% Periods (30 Day Periods)	Mean Resource Use	Median Resource Use
No Comorbidity Adjustment	7,231,600	77.7%	$1,507.19	$1,180.26
Comorbidity Adjustment	2,080,027	22.3%	$1,715.54	$1,307.01
Total	9,311,627	100.0%	$1,553.73	$1,207.50

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Home Health Groupings Model: Case-Mix Weights

- The HHGM assigns separate payment weights to periods for patients with similar characteristics and needs

  – Separate periods into one of 128 case-mix groups

  – Calculate each group's **case-mix weight** as the group's predicted mean cost relative to the overall average

  – Use the new case-mix weights to adjust the HH base payment amount; higher resource need periods are assigned higher case-mix weights and thereby receive more payment

Calculating Case-Mix Weights for the 128 Payment Groups

- Regression estimates the relationship between period cost and the broad categories on the HHGM process diagram

- Estimate fixed effects regression at the level of each HH agency
  - Dependent variable is resource use
  - Independent variables
    - Timing
    - Referral source
    - Clinical group
    - Functional level
    - Comorbidity adjustment

- Case-mix weights equal predicted period cost divided by average period cost

Table of Select Case-Mix Weights

Number of Episodes	Comorbidity Adjustment?	Clinical Group and Level	Admission Source and Timing	% of Episodes	Average Resource Use	Standard Deviation of Resource Use	Coefficient of Variation Resource Use	Weight
672	Yes	Behavioral Health - Low	Institutional - Late	0.01%	$1,366.15	$1,126.92	0.825	1.0804
890	Yes	Behavioral Health - Low	Institutional - Early	0.01%	$1,682.08	$1,048.21	0.623	1.2057
1299	Yes	Behavioral Health - High	Institutional - Late	0.01%	$1,999.15	$1,311.69	0.656	1.3206
1,504	Yes	Behavioral Health - Low	Community - Early	0.02%	$1,549.13	$1,014.89	0.655	1.0289
1,685	Yes	Neuro - Low	Institutional - Late	0.02%	$2,047.48	$1,331.05	0.650	1.3515
1,755	Yes	Behavioral Health - High	Institutional - Early	0.02%	$2,335.92	$1,356.50	0.581	1.4459
1,947	Yes	Complex - Medium	Community - Early	0.02%	$1,932.54	$1,460.84	0.756	1.4119
2,337	Yes	Complex - High	Community - Early	0.03%	$2,230.44	$1,909.36	0.856	1.5246
2,449	Yes	Neuro - Medium	Institutional - Late	0.03%	$2,534.44	$1,461.58	0.577	1.5605
2,527	Yes	Complex - Low	Community - Early	0.03%	$1,591.80	$1,351.28	0.849	1.157
2,568	Yes	Behavioral Health - High	Community - Early	0.03%	$2,067.90	$1,147.75	0.555	1.2691
2,678	Yes	Complex - Low	Institutional - Late	0.03%	$1,839.10	$1,618.53	0.880	1.2085
2,882	Yes	MS Rehab - Low	Institutional - Late	0.03%	$1,977.88	$1,328.48	0.672	1.2588
3,986	Yes	Neuro - Low	Community - Early	0.04%	$2,059.28	$1,140.43	0.554	1.3
4,067	No	Complex - High	Community - Early	0.04%	$2,026.06	$1,529.43	0.755	1.3904

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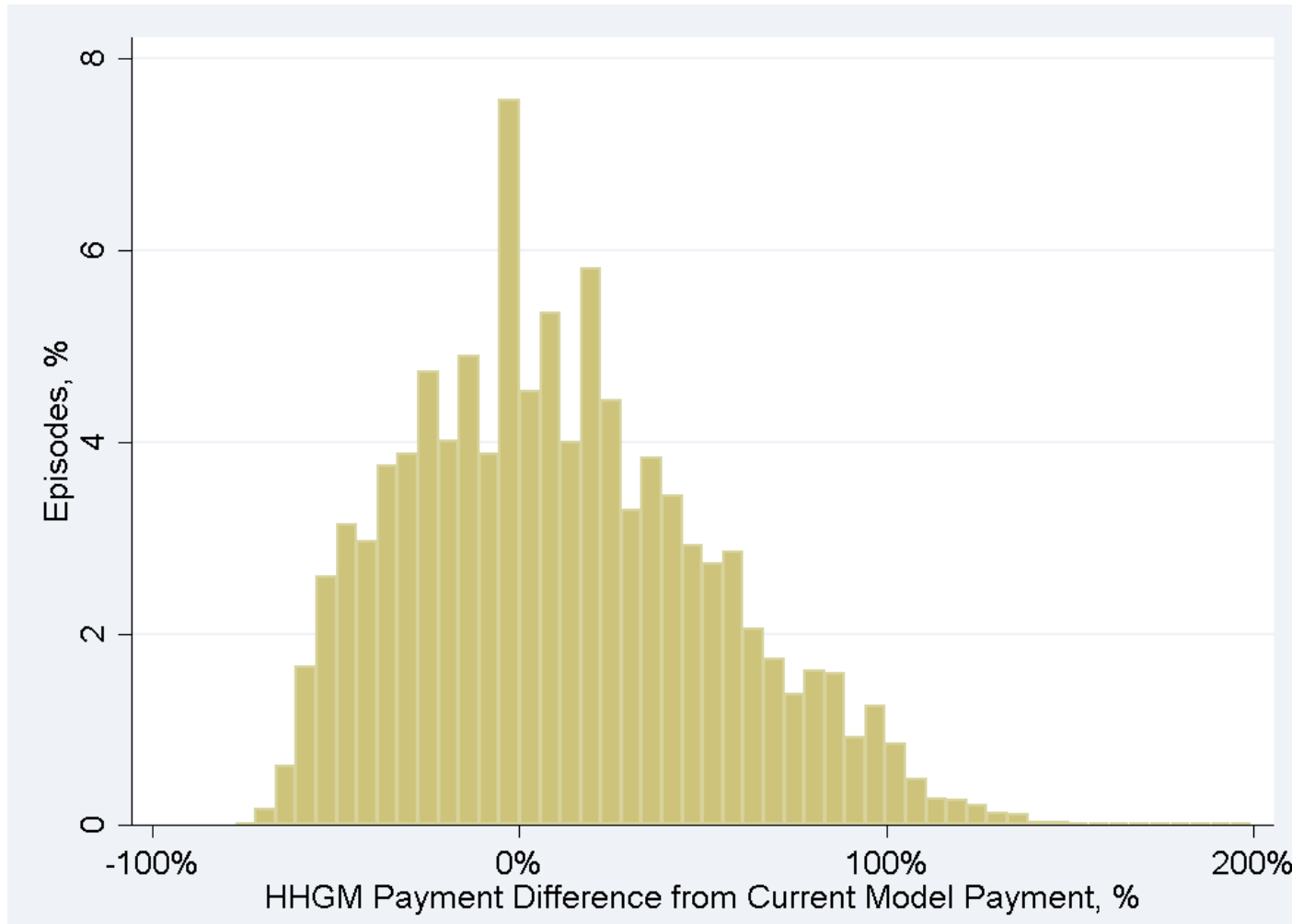
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Impacts Overview:
Actual vs. Simulated HHGM Payments

- Per design, overall HHGM mean payments are equal to those under the current payment system
  - $1,519 (HHGM) vs. $1,519 (Actual)
  - Calculated as ratio of period payments in the HHGM vs. current payment systems; a value above (below) "1.0" indicates greater (fewer) payment under the HHGM
  - **"Impact Ratio"** = 1.00 (= $1,519/$1,519)

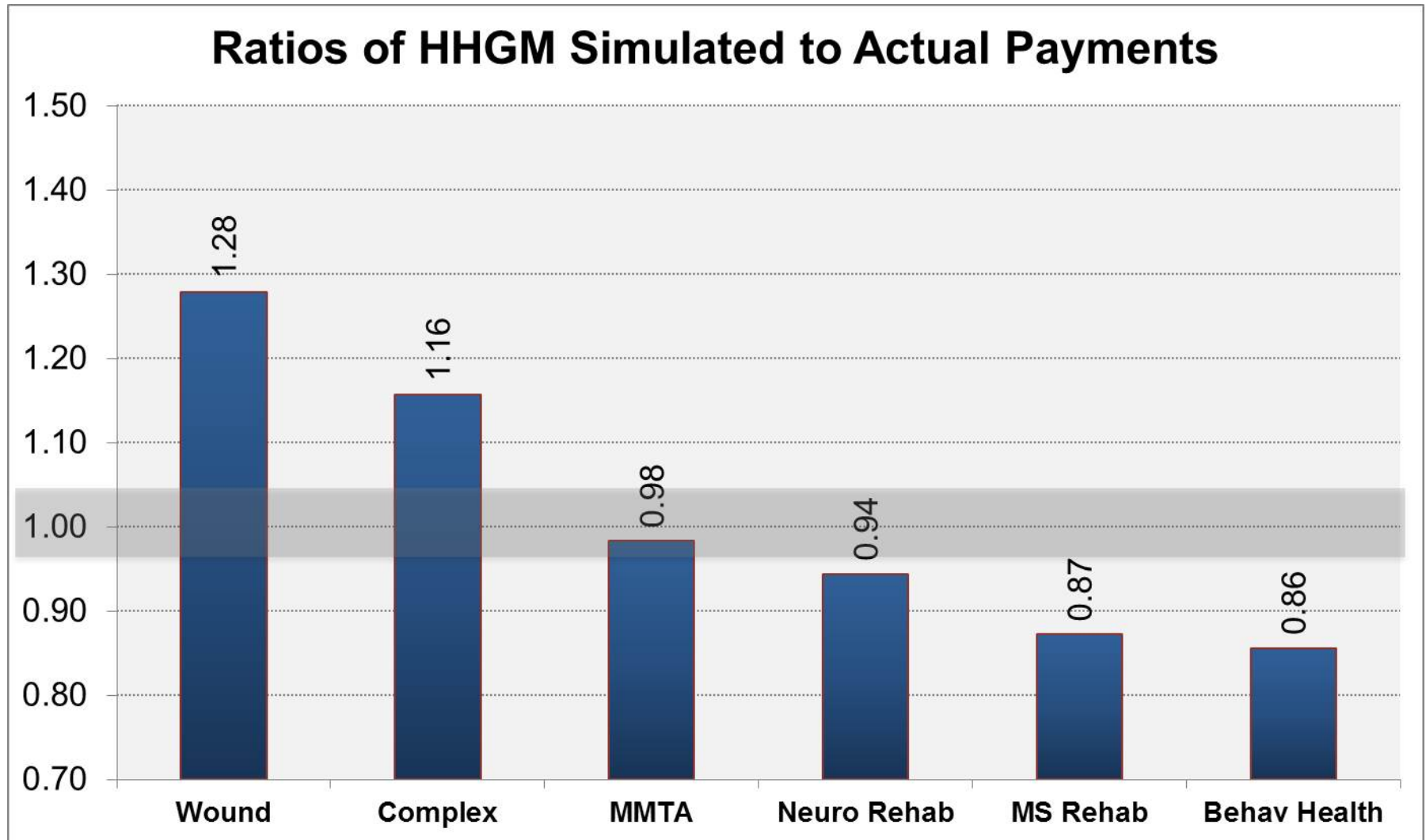- However, individual periods' payments vary at different points in the distribution…

Distributions of Payments under Actual Paid Weights and HHGM Simulated Weights
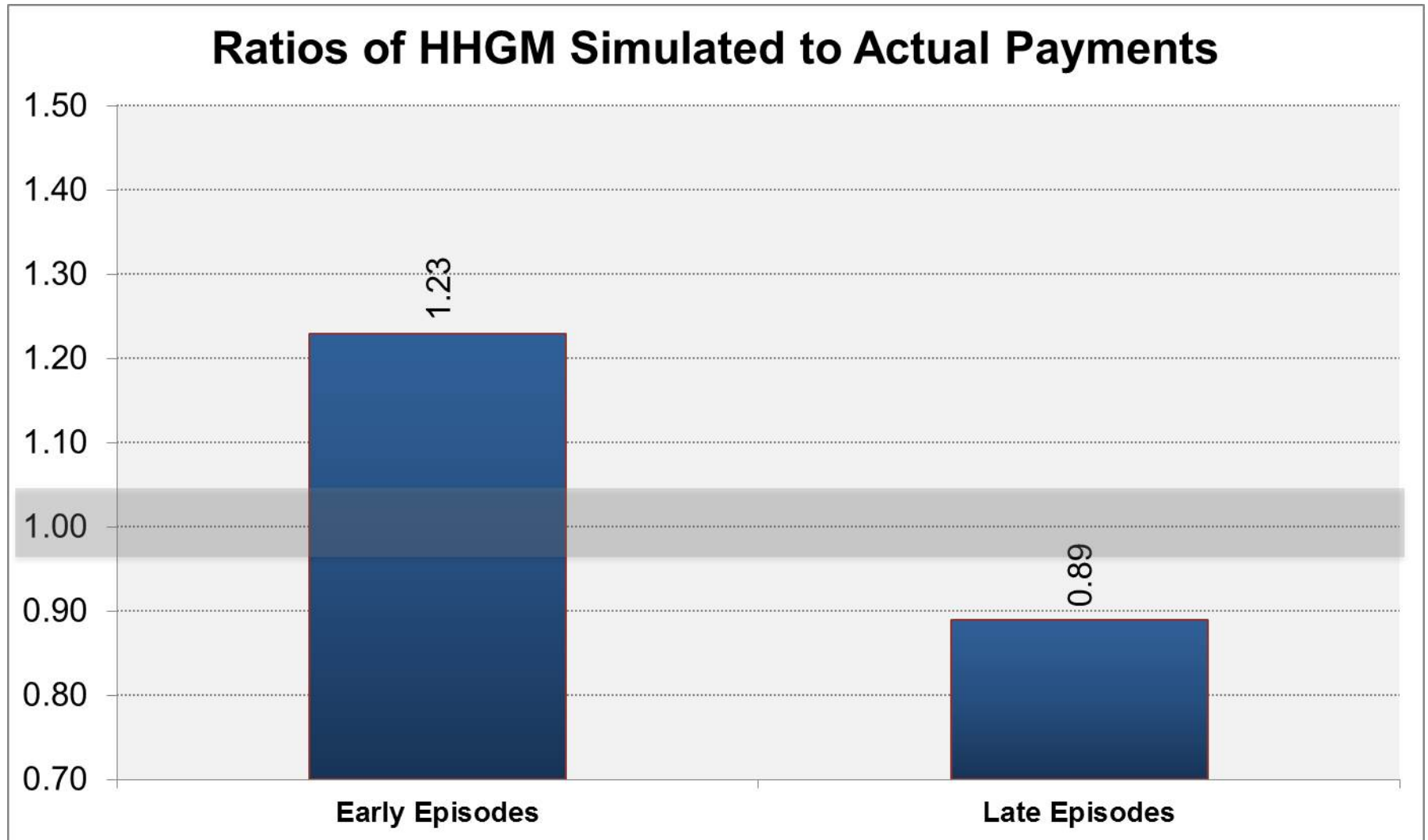

Distributions of HH PPS Payments ($)

Current Model   HHGM Simulated
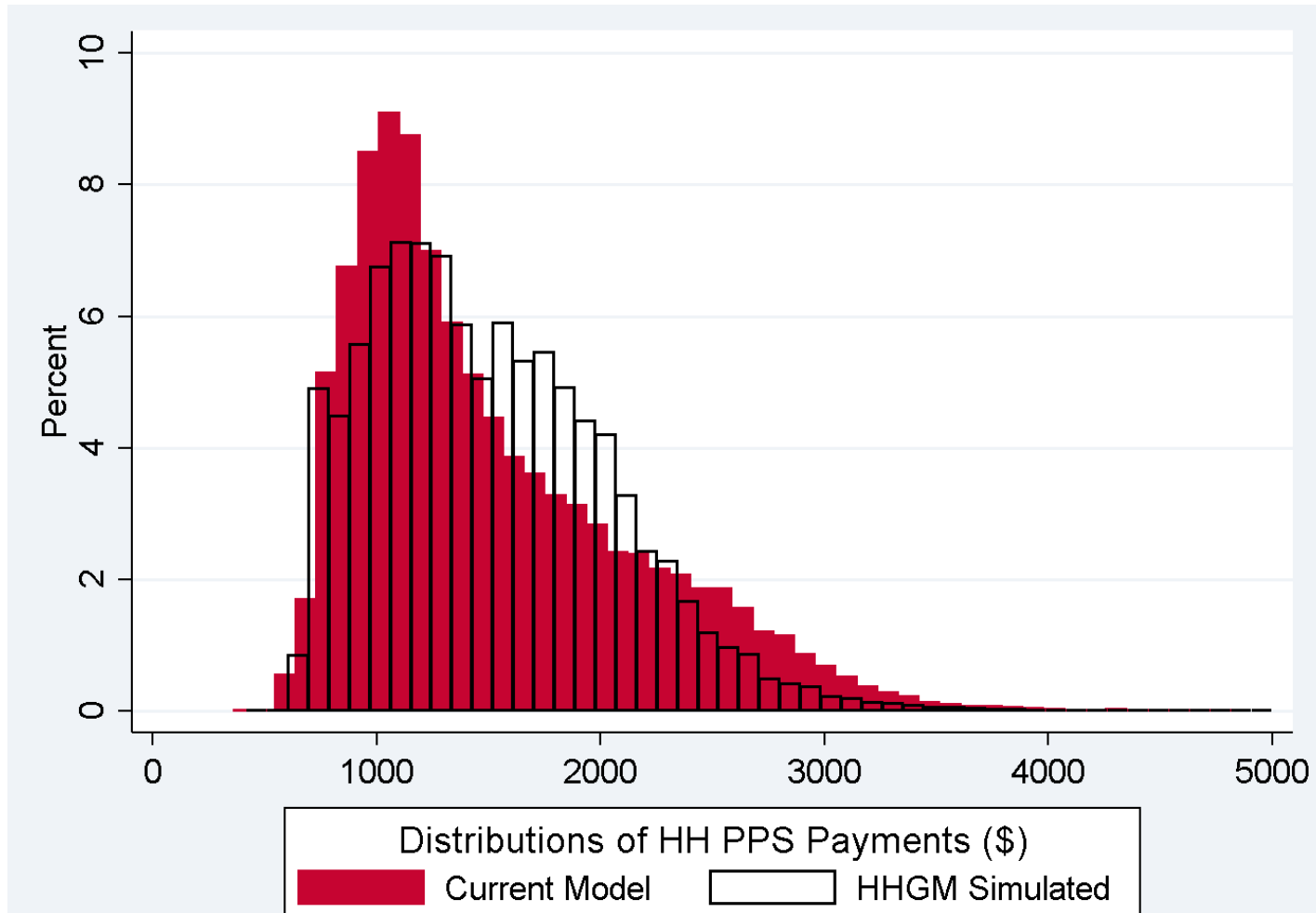
Payment Difference (in %) Distribution between the HHGM and Current Payment System Amounts

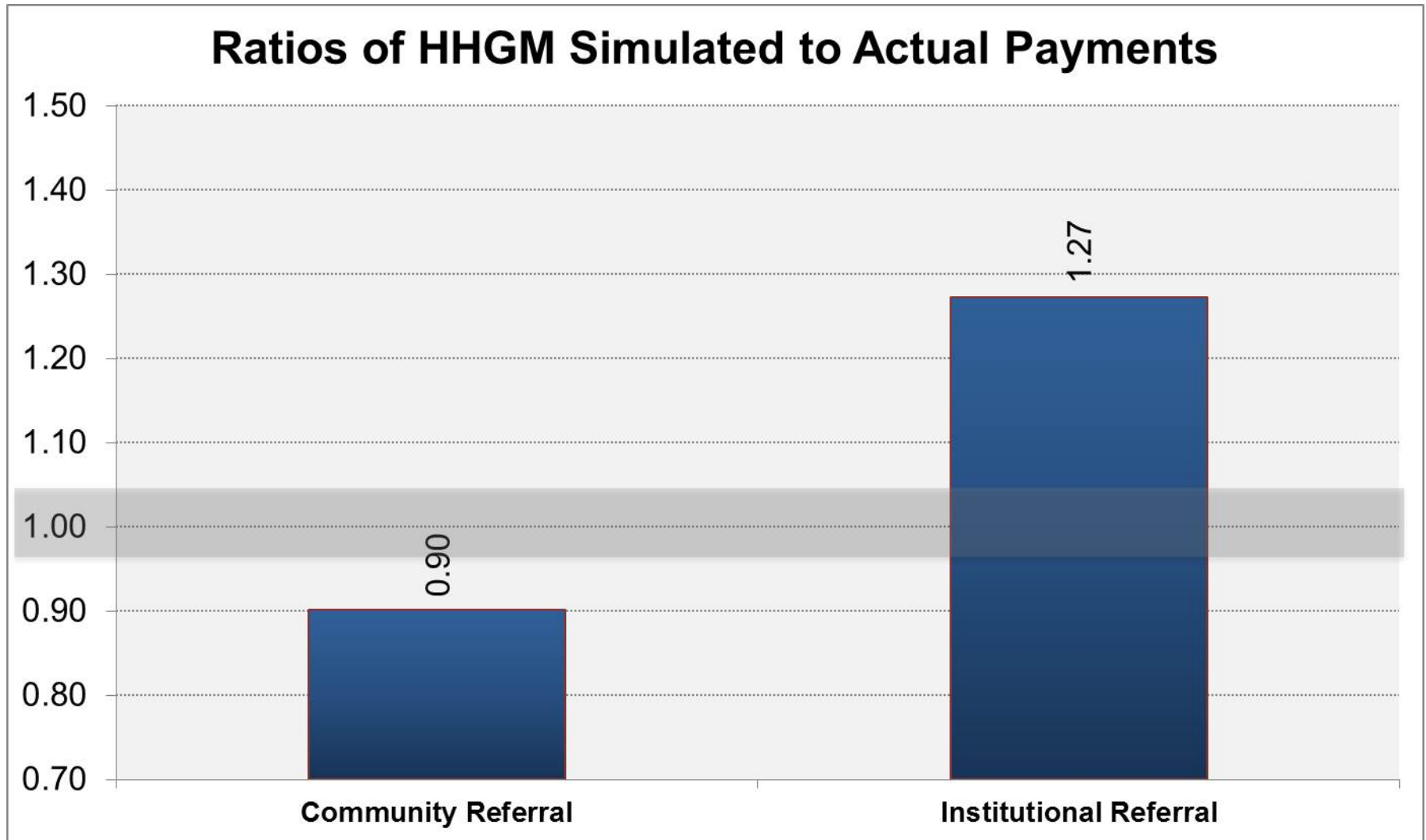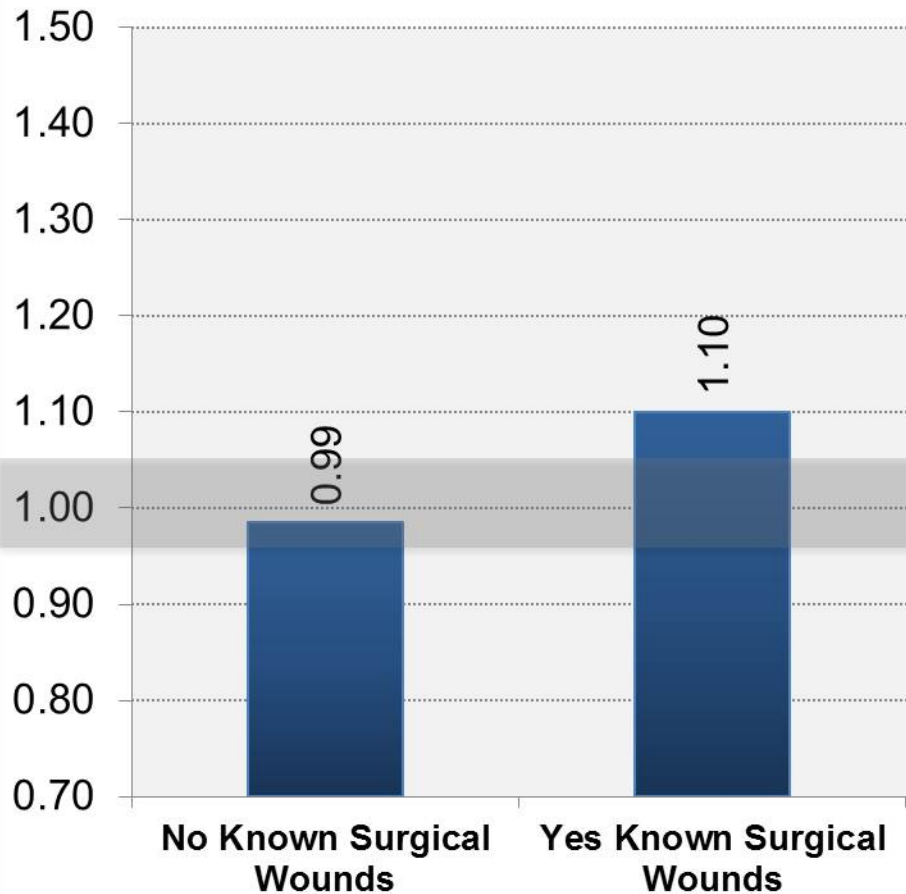# HHGM Impacts, by Clinical Grouping

Ratios of HHGM Simulated to Actual Payments

Clinical Grouping	Ratio
Wound	1.28
Complex	1.16
MMTA	0.98
Neuro Rehab	0.94
MS Rehab	0.87
Behav Health	0.86

HHGM Impacts, by Period Timing

HHGM Impacts, by Referral Source

Ratios of HHGM Simulated to Actual Payments

Community Referral: 0.90
Institutional Referral: 1.27

HHGM Impacts, 3131(d) Categories
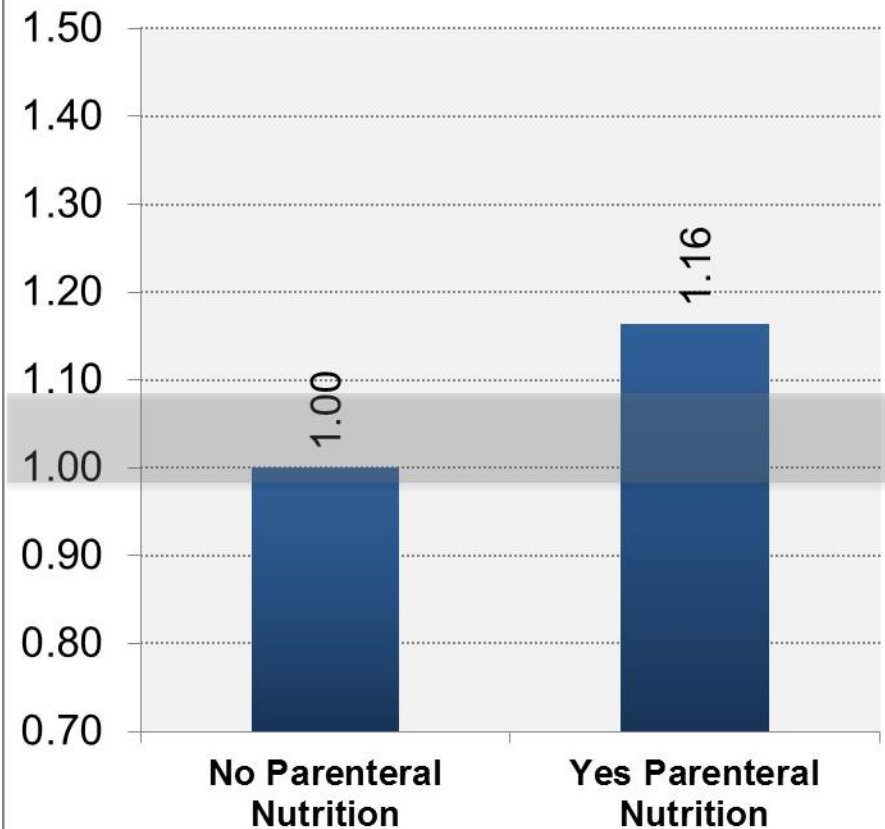
Strengths of the HHGM

- Similar to the current payment system in design and setup
  - But uses different variables to case-mix adjust payments

- Addresses criticisms of the current payment system

- Easier to identify the reason for the HH period

Question & Answer Session

Questions?

- Please contact Abt Associates (HomeHealth@abtassoc.com) for questions or comments on today's presentation
  - Please be as specific as possible with your questions.
  - Thank you!

Acronyms in this Presentation

- BLS: Bureau of Labor Statistics
- CPM + NRS: Cost per Minute + Non-Routine Supplies
- CY: Calendar Year
- HH PPS: Home Health Prospective Payment System
- HH: Home Health
- HHAs: Home Health Agencies
- HHGM: Home Health Groupings Model
- HHRGs: Home Health Resource Groups
- ICD: International Classification of Diseases
- IV: Intravenous
- LUPA: Low Utilization Payment Adjustment
- MMTA: Medication Management, Teaching, and Assessment
- MS: Musculoskeletal
- MSS: Medical Social Services
- OASIS: Outcomes and Assessment Information Set
- OT: Occupational Therapy
- PT: Physical Therapy
- SLP: Speech Language Pathology
- SN: Skilled Nursing
- WWMC: Wage Weighted Minutes of Care

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