Patient-Driven Groupings Model

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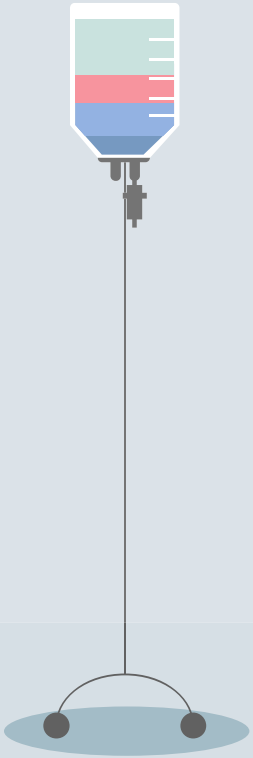
TABLE OF CONTENTS



What is PDGM?

- Patient-Driven Groupings Model
- To be implemented January 1, 2020
- Largest payment changes since PPS in 2008
- Only impacts Medicare Part A
- Mandated by BBA of 2015

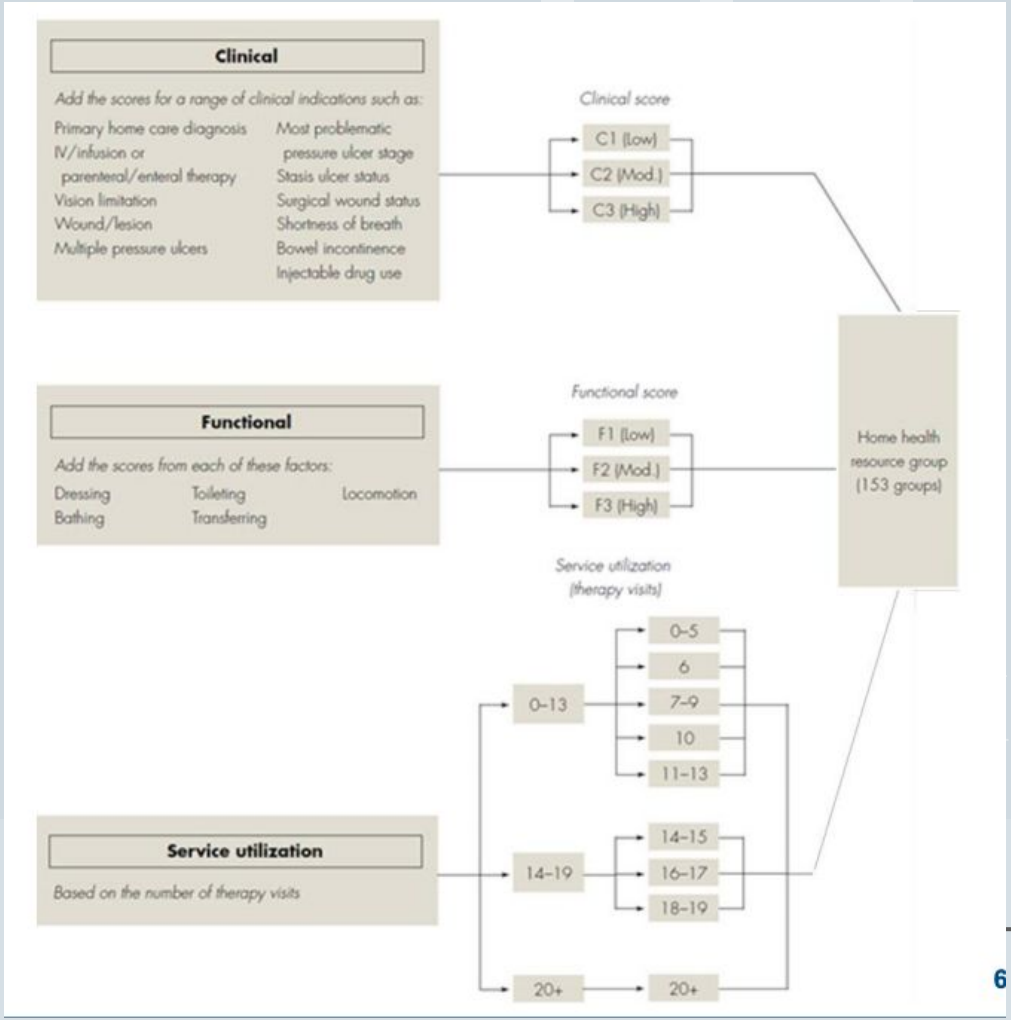
Overview

- PDGM is budget-neutral
- PDGM is about value over volume
- Data and outcome driven
- Emphasis on evidence based practice and appropriate documentation of medical necessity
- Bundled payments

- PDGM does not place any restrictions on the frequency, type, or duration of services provided for any discipline.
- A patient's need for therapy will not change under PDGM!
- Still the responsibility of the evaluating clinician to determine what services are medically necessary

Current PPS

- **Clinical**: One or more clinical conditions
- **Functional**: Level of ADL impairment
- **Service Utilization**: Number of therapy visits per 60-day episode



(CMS, 2019)

Payment

- 60-day to 30-day payment periods
- Expand HHRGs to 432 options
- Elimination of therapy thresholds
- Based on client factors and predicted resource utilization
- Value over volume

Unusual Payments

LUPA

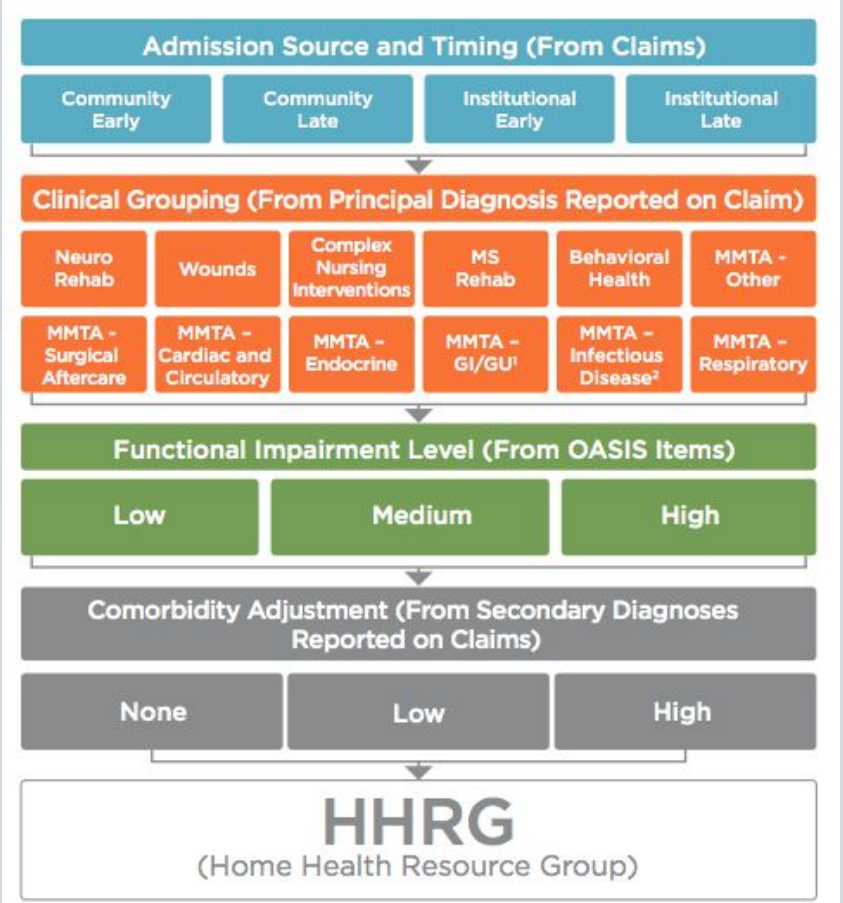
- Low-Utilization Payment Adjustment (LUPA)
- Varies on payment group
- 10th percentile value of visits used to create payment group specific LUPA threshold
- Paid per-visit
- If at or above total # of visits for threshold, paid with case mix rate

Outlier

- Unusually large number or costly mix of visits
- Payment equal to 80% of the difference between imputed costs and the threshold amount

(CMS, 2019)

HHRGs



Under the Patient-Driven Groupings Model, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period's combination of subcategories places the 30-day period into one of 432 different payment groups.

1 Gastrointestinal tract/Genitourinary system
2 The infectious disease category also includes diagnoses related to neoplasms and blood-forming diseases

(CMS, 2019)

Home Health Resource Group

Admission Source

Where a patient discharged from in the last 14 days

Early = first 30 days Late = last 30 days

Institutional Early

Institutional Late

Community* Late

Community* Early

*Observation stay at hospital is a community admission

Clinical Grouping

Determined by primary diagnosis indicating need for home health

Neuro Rehab

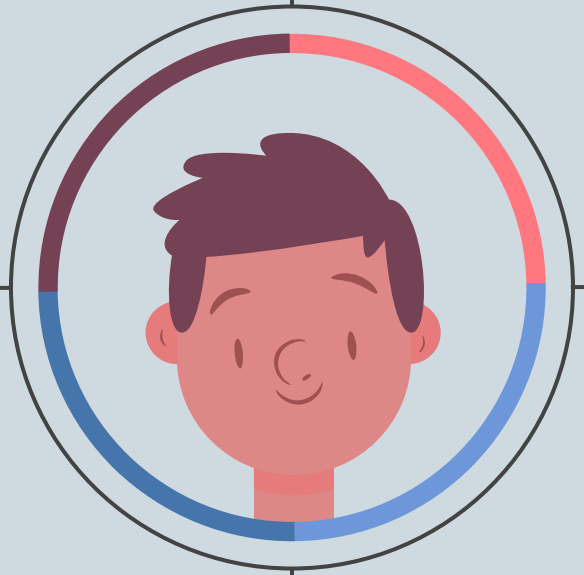
Wounds

Complex Nursing Interventions

MS Rehab

Behavioral Health

Medication Management, Teaching, Assessment (MMTA)



None Low High

Have to impact the plan of care

Comorbidity Adjustment

Low Medium High

Higher functional impairment = higher reimbursement

Functional level calculation varies by clinical group

Functional Impairment Level

(CMS, 2019)

Clinical Grouping

CMS stated in the final rule that "it is the responsibility of the patient's treating physician to determine if and what type of therapy (that is, maintenance or otherwise) the patient needs regardless of clinical grouping".

TABLE 27: FINAL CLINICAL GROUPS USED IN THE PDGM

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA –Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA –Respiratory	Assessment, evaluation, teaching, and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

Clinical Group Frequency

Must find a way to emphasize our value for MMTA groups!

Clinical Group	Frequency of Use %
MS Rehab	17.9
Neuro Rehab	10.1
Wound	8.9
Behavioral Health	3.6
Complex Nursing	3.5
MMTA	56.1

MMTA -	
Aftercare	6.1
Cardiac	31.7
Endocrine	8.5
GI/GU	8.0
Infectious	6.9
Respiratory	14.4
Other	24.4

Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Federal Register, Vol. 83, No. 219, November 13, 2018 and Federal Register, Vol. 82, No. 144, July 28, 2017.

Comorbidities

- "a medical condition coexisting in addition to a principal diagnosis"
  - Leads to poorer outcomes, more complex needs, higher cost
- Specific tables identifying how comorbidities should be classified on final rule (83 FR 56487)

- Heart disease
- Respiratory disease
- Circulatory disease
- Cerebral vascular disease
- Gastrointestinal disease
- Neurological conditions
- Endocrine disease
- Neoplasms
- Genitourinary/Renal disease
- Skin disease
- Musculoskeletal disease
- Behavioral health issues (including substance use disorders)
- Infectious diseases

(CMS, 2019)

Comorbidities

Secondary diagnosis codes used to case-mix adjust the payment period

None:
no comorbidity diagnosis in adjustment subgroup

Low: 1 diagnosis associated with higher resources use

High: 2 or more diagnoses associated with higher resource use when reported together

Code as accurately as possible. Not just “fracture”
use “left humeral fracture”

(CMS, 2019)

Clinical Group Functional:	Low	Medium	High
MMTA - Surgical Aftercare	0-24	25-37	38+
MMTA - Cardiac & Circulatory	0-36	37-52	53+
MMTA - Endocrine	0-51	52-67	68+
MMTA - Gastrointestinal & Genitourinary system	0-27	28-44	45+
MMTA - Neoplasms, Infections & Blood-Forming Disease	0-32	33-49	50+
MMTA - Respiratory	0-29	30-43	44+
MMTA - Other	0-32	33-48	49+
Behavioral Health	0-36	37-52	53+
Complex Nursing Interventions	0-38	39-58	59+
Musculoskeletal Rehabilitation	0-38	39-52	53+
Neuro Rehabilitation	0-44	45-60	61+
Wound	0-41	42-61	62+

Stages of Plan of Care

Beginning of Episode

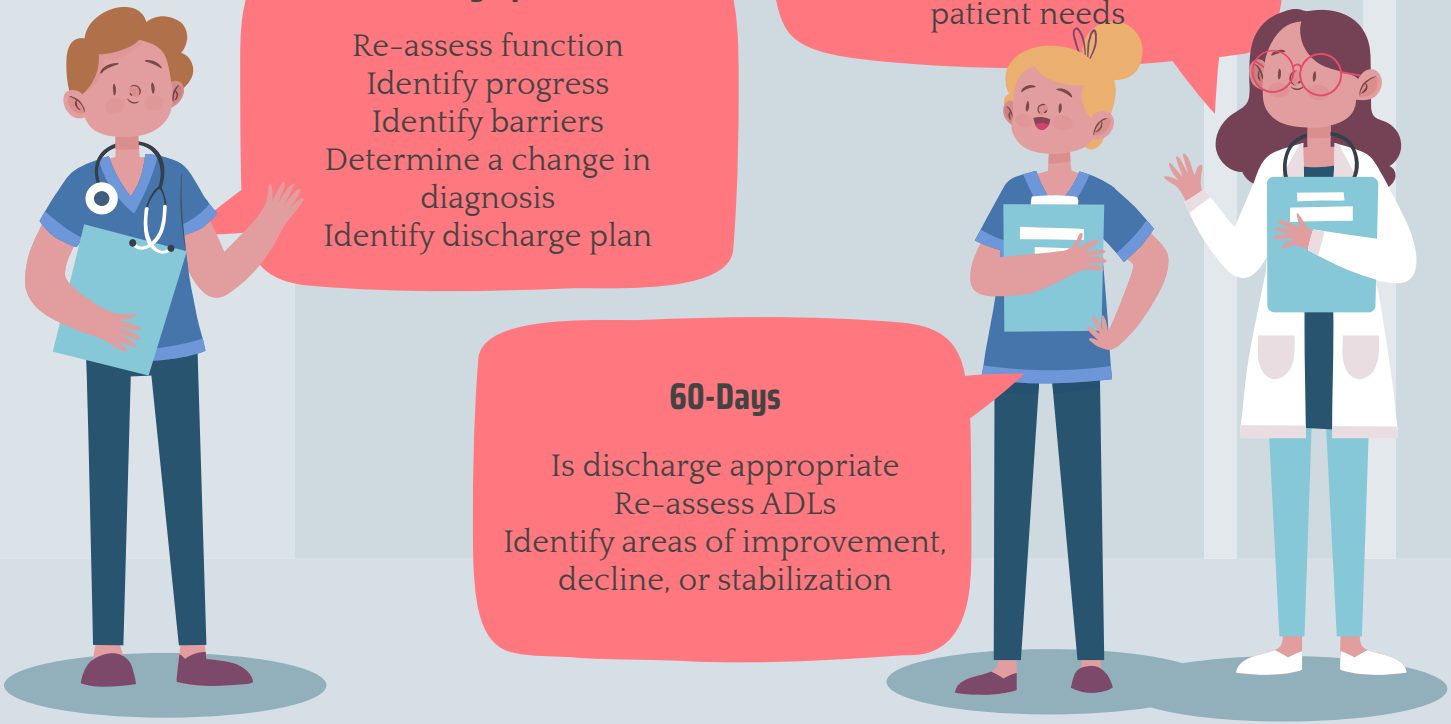
Score ADL items
Identify primary diagnosis
Identify comorbidities
Coordinate plan of cares to fit patient needs

30-Day Update

Re-assess function
Identify progress
Identify barriers
Determine a change in diagnosis
Identify discharge plan

60-Days

Is discharge appropriate
Re-assess ADLs
Identify areas of improvement, decline, or stabilization



Therapy Visits

Myths

1. Telehealth visits can be billed the same as a regular visit and is covered by Medicare.

2. Patients do not need as much therapy under PDGM.

3. Medicare capped the number of therapy visits for each episode.

4. The more visits provided, the better the patient outcomes.

Facts

1. Home health visits must be furnished in the beneficiary's home and must include personal contact with the beneficiary by staff.

2. PDGM does **not** change the medical needs of a patient.

3. Medicare has **not** placed any restrictions on the number of therapy visits.

4. A higher number of visits does not necessarily indicate improved outcomes or higher quality of care.

The OASIS-D

Outcomes and
Assessment
Information Set

OASIS M1800's

	PDGM	PPS
M1800: Grooming	✓	✗
M1810: Current ability to dress upper body safely	✓	✓
M1820: Current ability to dress lower body safely	✓	✓
M1830: Bathing	✓	✓
M1840: Toilet Transferring	✓	✓
M1860: Ambulation/Locomotion	✓	✓
M1033: Risk for Hospitalization	✓	✗

OASIS Completion

- Observation is the **only** method for accuracy
  - Consider best and worst daily function
  - Is it SAFE not was it completed
  - Include patient report and other influencing factors (time of day, cues, need for supervision)
- Occupational therapists can contribute to data collection within 5 days of initiating OASIS Start of Care.
  - Coordinate with team
- Section M1800 is used to determine the Functional Impairment Level
- Section GG is used to track patient progress across post-acute care settings

(Vance & Page-Greifinger, 2019)

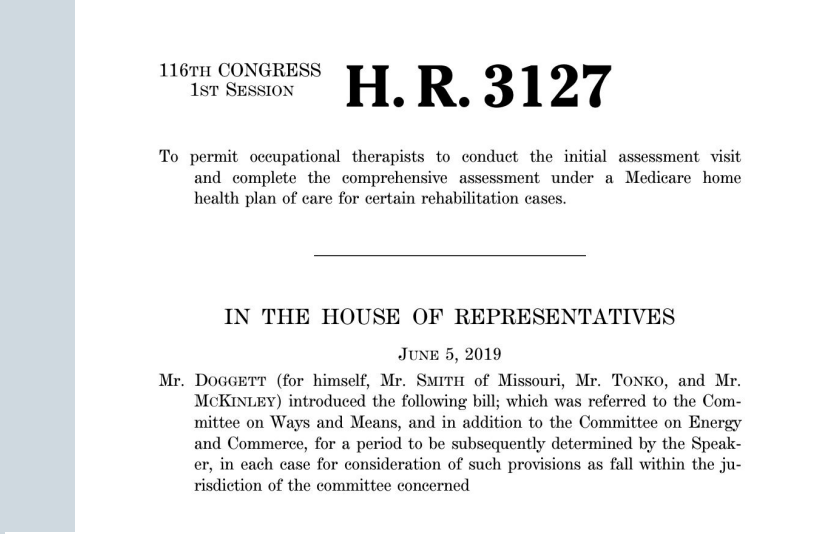
OASIS Considerations

- Captures resources needed by agency and families.
- Develop comprehensive education that is developed by therapists for RNs.
- Avoid scoring the best case scenario. Acknowledge patient at their best and worst.
- Cannot guess. Read the guide.

Medicare Home Health Flexibility Act

- Permit OTs to complete OASIS Start of Care Therapy-only cases
- Budget Neutral
- Introduced in House and Senate
- www.aota.org/takeaction

Sponsored by:
Senators Todd Young (R-IN), Ben Cardin (D-MD), Reps. Lloyd DOgett (D-TX), Jason Smith (R-MO), Paul Tonko (D-NY), and David McKinley (R-WV)



116TH CONGRESS
1ST SESSION

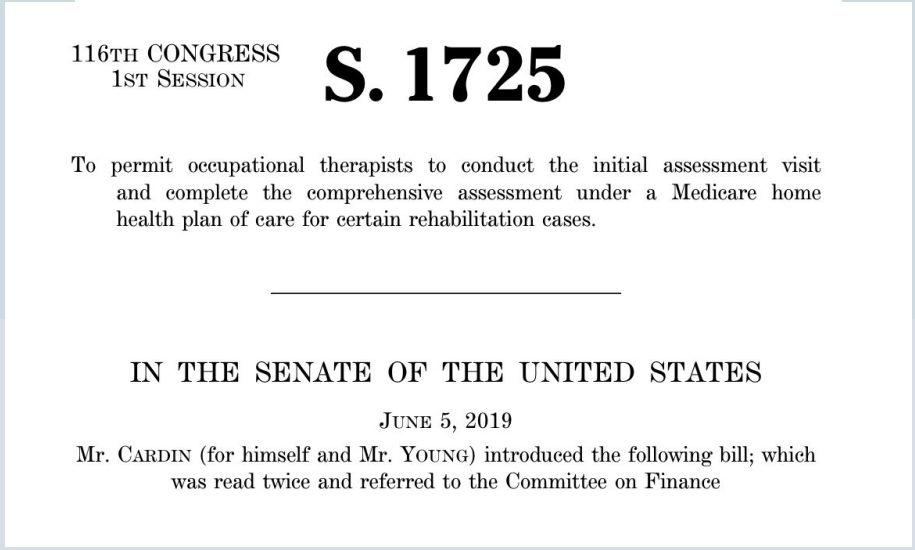
H. R. 3127

To permit occupational therapists to conduct the initial assessment visit and complete the comprehensive assessment under a Medicare home health plan of care for certain rehabilitation cases.

IN THE HOUSE OF REPRESENTATIVES

JUNE 5, 2019

Mr. DOGGETT (for himself, Mr. SMITH of Missouri, Mr. TONKO, and Mr. MCKINLEY) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned



116TH CONGRESS
1ST SESSION

S. 1725

To permit occupational therapists to conduct the initial assessment visit and complete the comprehensive assessment under a Medicare home health plan of care for certain rehabilitation cases.

IN THE SENATE OF THE UNITED STATES

JUNE 5, 2019

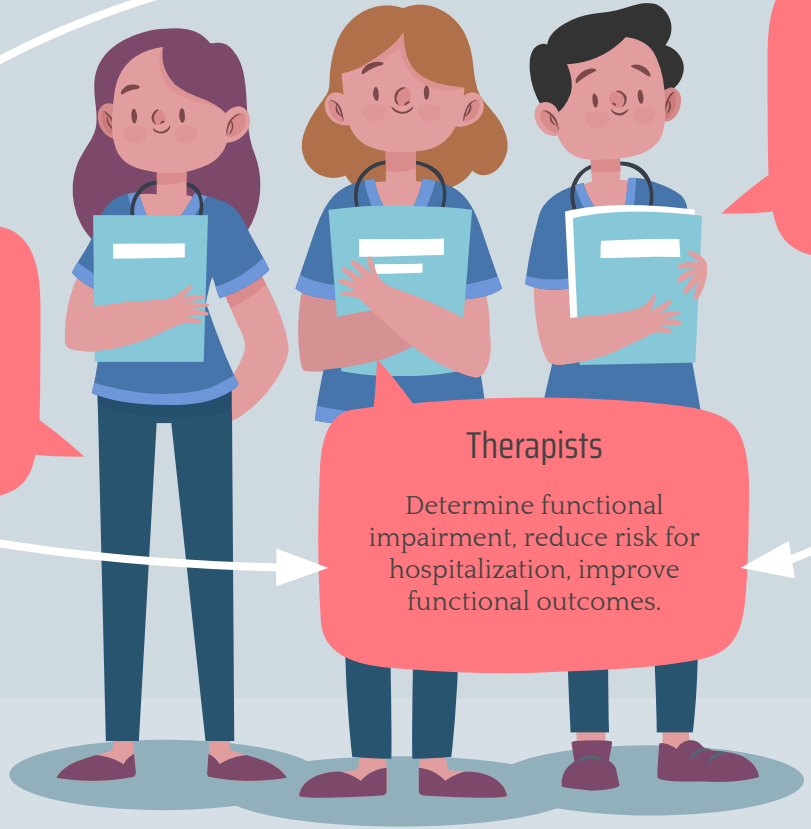
Mr. CARDIN (for himself and Mr. YOUNG) introduced the following bill; which was read twice and referred to the Committee on Finance

Role of Occupational Therapy

OT under PDGM

- Remain unable to complete the OASIS Start of Care
- Are not a qualifying service
- Discuss agency goals and quality metrics openly and frequently
- Identify specific opportunities to positively affect agency outcomes
- Identify YOUR specific value and role
- Take an active role in case management and care coordination

The TEAM



Physicians

Approves plan of care, orders disciplines for plan of care, prescribes medications, overall case management

Nursing

Medication management, wound care, comorbidity adjustments, chronic disease management.

Therapists

Determine functional impairment, reduce risk for hospitalization, improve functional outcomes.

Care Coordination

- Active listening to reflect patient/family goals
- Timely communication of patient goals
  - Facilitate realistic goal development
- All clinicians operate at top of their license
- Schedule visits and service utilization based on patient needs
- Team meetings are a must
- Continuity of care
- All disciplines reinforce activity, therapy recommendations, and medication adherence
- Identify objective progress, not frequency of visits

Plan of Care

- What services are you providing that are skilled?
  - Why should you be paid?
- How does your plan of care match your patient's goals and needs?

- Initiate discharge planning from the evaluation
- Eliminate a one size fits all way of prescribing care
- More effective with fewer visits
- Give the patient agency in their recovery
- Involve caregivers and other staff as needed

Who Really Needs an HEP?

- Ensure plan of care is appropriate to the chronic conditions not just “muscle weakness”
  - Energy conservation for all Cardiac and Respiratory Diseases
  - Pursed lip breathing and bathing for COPD patients
  - Lifestyle Redesign
- Promote general activity into daily routines
  - Ditch the HEPs
- Engage in simple home modifications and DME/AE training

OASIS Evaluation

Cognition

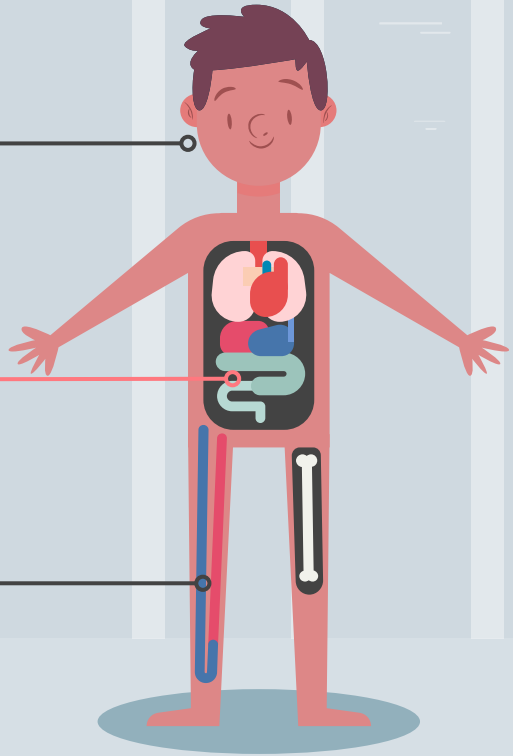
Can still treat cognition.
Emphasize if an activity is SAFE

Comorbidities

Acknowledge the impact.
Treat the patient, not the condition

Functional Limitation

Accurate scoring of the OASIS.
Objective **FUNCTIONAL** outcomes



IADLs are not coded on an OASIS, but can be documented on the OASIS

Occupational Profile:

Download the template at **www.aota.org/profile.**

- ☐ Client's Concerns
- ☐ Successful occupations
- ☐ Interests & Values
- ☐ Occupational History

Performance Patterns

☐ Habits ☐ Routines ☐ Roles ☐ Rituals

- ☐ Environment: Supports & Barriers (Physical, Social)
- ☐ Context: Supports & Barriers (Cultural, Personal, Temporal, Virtual)
- ☐ Client's Priorities and Desired Outcomes

www.aota.org/value
www.aota.org/profile

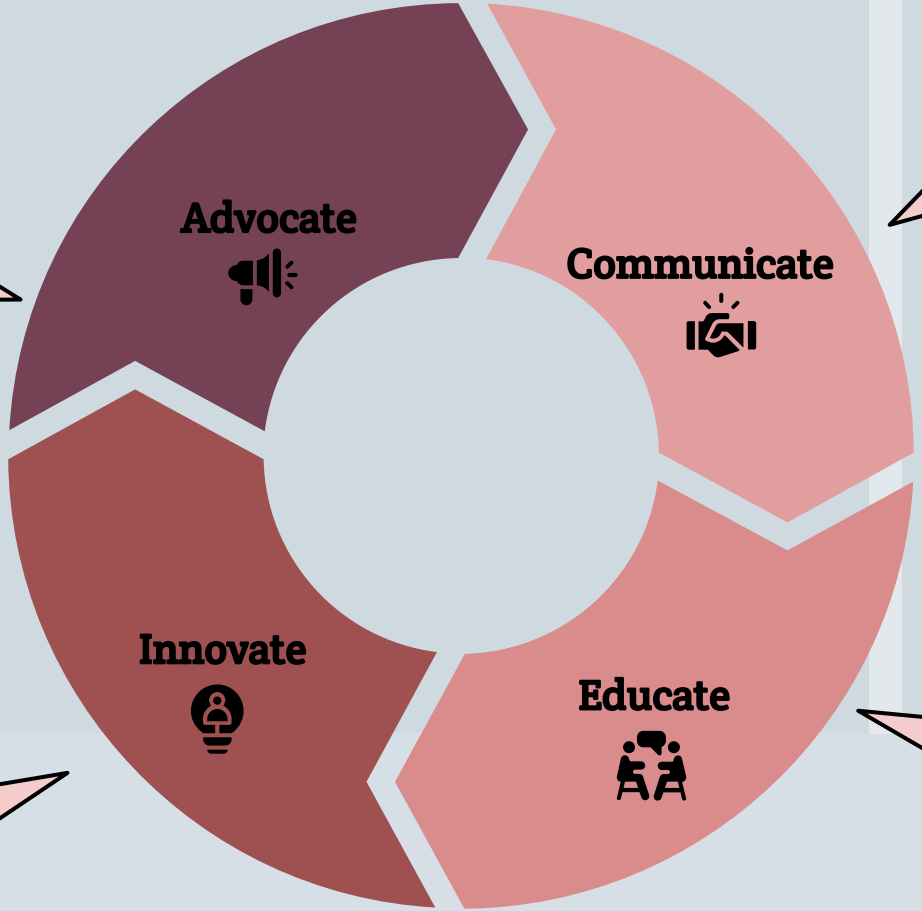
Analysis of Occupational Performance

Click on the Quality Toolkit at **www.aota.org/value** for links to standardized assessments and screeners used in each of the areas below.

	Addressed	Is this area a Priority		Addressed	Is this area a Priority
Occupations					
ADLs	☐	☐	IADLs	☐	☐
Performance Skills					
Psychosocial/Behavior Skills	☐	☐	Fall Prevention/Fear of Falling	☐	☐
Client Factors—In addition to areas identified while addressing ADLs and IADLs (e.g., motor, sensation, pain)					
Vision	☐	☐	Functional Cognition	☐	☐
Performance Patterns					
Habits, Routines, Roles	☐	☐			
Contexts & Environments	☐	☐			
Include Safety Screen					

How to Optimize Your Skills

Advocate for your value in home health and what you specifically can offer the team.



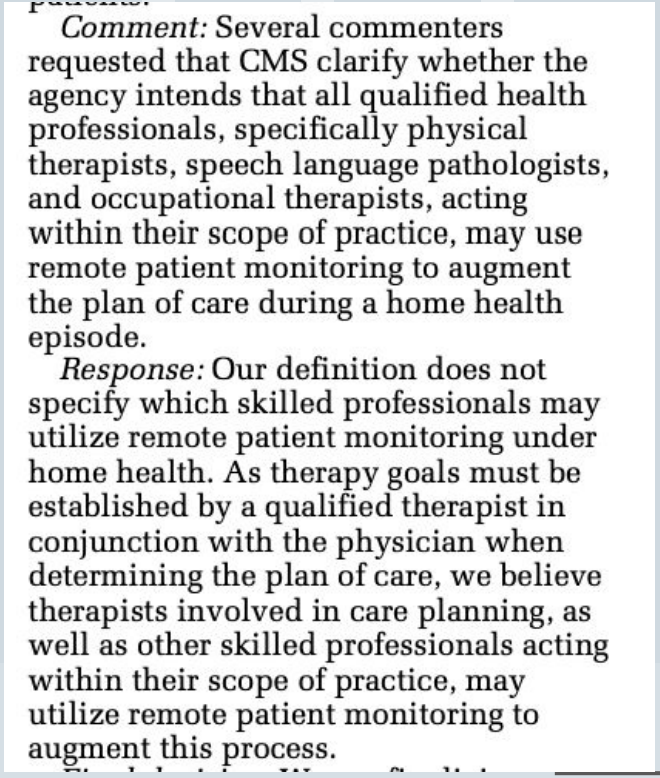
Communicate with other clinicians to ensure the patient is receiving the right amount of services at the right time.

Refresh your interventions and plan of care with EBP and add value to the agency outside of direct patient care.

Educate the team and agency on the OT scope of practice and provide training for other clinicians.

Remote Patient Monitoring

"the collection of physiological data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency.'



Comment: Several commenters requested that CMS clarify whether the agency intends that all qualified health professionals, specifically physical therapists, speech language pathologists, and occupational therapists, acting within their scope of practice, may use remote patient monitoring to augment the plan of care during a home health episode.

Response: Our definition does not specify which skilled professionals may utilize remote patient monitoring under home health. As therapy goals must be established by a qualified therapist in conjunction with the physician when determining the plan of care, we believe therapists involved in care planning, as well as other skilled professionals acting within their scope of practice, may utilize remote patient monitoring to augment this process.

What else Can We Do?

- Train clinicians on accurate scoring of ADL items
- Engage in case management
- Facilitate discharge planning and caregiver meetings
- Discuss pay for indirect patient care (hourly vs per visit)

Opportunities for Advocacy

Federal Advocacy

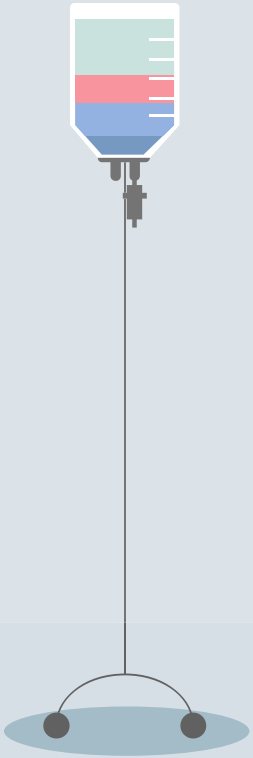
Support home health legislation, follow regulatory and policy updates from AOTA, submit comments to CMS.

Everyday Advocacy

Tell other clinicians why we are seeing a patient not just how often.

Local Advocacy

Actively engage in policy development with your agency. If you wait, it may be too late.



Reduce Spending

Improve Outcomes

"We are so busy empowering others, we forget how to empower ourselves."

~ Christina Metzler

Knowledge is power and advocacy is not an option. Not only can your advocacy protect patient access, but could protect your job.

CONCLUSION

1. Therapy no longer directly drives reimbursement, but we still drive reimbursement through quality outcomes and patient safety.
2. Occupational therapy practitioners must advocate for themselves and not wait until implementation.
3. Educate yourself about the rules and discuss policies that you feel are not accurate or are fraud.
4. Consider how you can modernize your practice to better serve the patient and the agency.

THANKS!

Any questions?

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REFERENCES

- American Occupational Therapy Association, American Physical Therapy Association, American Speech-Hearing-Language Association, and the Centers for Medicare & Medicaid Services. (2019). *Demonstrate value of therapy services before home health payment changes begin* [Recorded webinar]. Retrieved from https://goto.webcasts.com/viewer/event.jsp?ei=1252583&tp_key=fb2be41070
- Centers for Medicare & Medicaid Services. (2018a). *Centers for Medicare & Medicaid Services Patient-Driven Groupings Model*. Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf
- Centers for Medicare & Medicaid Services (2018b). *Outcome and Assessment Information Set OASIS-D guidance manual effective January 1, 2019*. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/draft-OASIS-D-Guidance-Manual-7-2-2018.pdf
- Centers for Medicare & Medicaid Services. (2019). *Overview of the Patient-Driven Groupings Model (PDGM)*. Retrieved from https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Presentation.pdf
- Vance, K. (2019). *Occupational therapy and data collection in home health*. Retrieved from https://hhqi.wordpress.com/2019/04/19/occupational-therapy-and-data-collection-in-home-health/
- Vance, K., Page-Greifinger, L., (2019) PDGM National Summit: A Revolution in Medicare Home Health Payment. *Clinical Aspects of PDGM*. Retrieved from https://homecaremissouri.org/mahc/documents/PDGMhandouts-2slidesperpage.pdf


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