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National Provider Call Transcript



**Centers for Medicare & Medicaid Services
Home Health Groupings Model Technical Report Call
MLN Connects National Provider Call
Moderator: Hazeline Roulac
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Contents

Announcements and Introduction	2
Presentation	3
Model Overview.....	3
Resource Use.....	7
30-Day Periods	9
Clinical Groups	11
Functional Levels.....	13
Other Variables Used to Group Periods.....	16
Keypad Polling	22
Question and Answer Session	23
Additional Information	34

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Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call.

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 and Introduction

Hazeline Roulac: Thank you, Holley.

Hello, everyone. Thank you for joining us today. I am Hazeline Roulac from the Provider Communications Group here at CMS. Welcome to this MLN Connects National Provider Call on the Home Health Groupings Model Technical Report. MLN Connects Calls are part of the Medicare Learning Network®.

In December 2016, CMS published the Medicare Home Health Prospective Payment System Case-Mix Methodology Refinements Technical Report, including an overview of the Home Health Groupings Model. This technical report describes efforts to reassess the current Home Health PPS and develop large-scale payment methodology changes. During today's call, CMS introduces the Home Health Groupings Model.

A question-and-answer session will follow the presentation. We want to thank everyone who submitted questions during the registration process. Many of your questions will be addressed during the presentation, and others will be address at the start of the Q&A session.

Before we begin, I have two announcements.

There is a slide presentation for this call. You should have received a link to the presentation in your registration emails. If you have not already done so, please view or download the presentation from the CMS website at go.cms.gov/npc. That's go.cms.gov/npc. Select today's date from the list and click on Slide Presentation under Call Materials.

This call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website under Call Materials. We will put an announcement in the MLN Connects Provider eNews when these materials are available. At this time, it is my pleasure to turn the call over to Michael Plotzke.

Michael?

Presentation

Michael Plotzke: Thank you very much. My name is Michael Plotzke. I am an economist with Abt Associates, and I am the principal investigator on a contract with CMS to help reform the current Medicare Home Health Prospective Payment System. CMS has contracted with Abt Associates to reassess the current Home Health Prospective Payment System and develop changes to the payment system that address three broad areas. Those are: one, better-aligned payment with patient needs; two, address payment incentives and vulnerabilities in the current payment system; and, three, respond to criticisms to the current payment system.

So, I am planning to spend the next 45 minutes or so giving a high-level overview of the model we've developed, which is called the Home Health Groupings Model or HHGM. And please note, during the presentation, I'll go back and forth between calling the model the Home Health Groupings Model or the HHGM. This model is also described in more detail in a report that's on the CMS website.

As we go through the slides, I'll try to say which slide I'm on. So right now I'm on slide 3. So, this slide shows –these are items which we are going to cover today. These topics closely follow the structure of the report, and this agenda is repeated throughout the slide deck as a roadmap for what I'll discuss.

Model Overview

So, I'll begin with the second item on the agenda, which is a general overview of the model and, also, I'll discuss how the current payment system is set up. This overview should, hopefully, provide a foundation. So, as I describe specific details of the model in the subsequent sections, it should hopefully be easy to understand how everything fits together.

All right. Slide 4. Under the current Home Health Prospective Payment System, which was first implemented in October 2000, home health agencies are paid a national

standardized 60-day episode payment for all covered home health services, and the payment's adjusted for case mix in and areas wage differences. Episodes of care with four or fewer visits are paid a national per-visit amount for the type of visits that are provided. For episodes of care requiring five or more visits, payments are based on expected resource use. Expected resource use is an estimate of episode cost based on the length, number, and types of visit that occur during an episode.

If the same payment was provided to all episodes—regardless of the differences and characteristics used to control for case mix—home health agencies would have a financial incentive to treat only patients that require the fewest resources and avoid patients who are costly. The case mix system, however, allows for different payments for different expected patient needs.

All right. Slide 5. So, to determine expected resource use for payment purposes. In the current payment system, patients are categorized into 1 of 153 different home health resource groups or HHRGs. This information – or these HHRGs are based on information from the OASIS and from home health claims. Each HHRG has a unique associated case mix weight, which allows differential payments for episodes of care that cover patients with differing needs. Each of the HHRG combines a clinical severity level, a functional severity level, and a service use severity level. The HHRGs also take into account episode timing information.

All right. So, slide 6. Let me provide some additional explanation on the structure of the current payment system. In the current payment system, the clinical domain measures things like whether the patient has one or more clinical conditions such as, but not limited to, incontinence or IV therapy. The functional domain measures things like whether the patient has problems with activities of daily living such as dressing, bathing, transferring, walking, and toileting. And, finally, the service use domain is based on the number of therapy visits provided during the episode.

All right. Slide 7. So this slide shows how each of the different components previously discussed are combined to form one of the 153 different payment groups that make up the current payment system. As we progress with the presentation, I'm going to show a counterpart to this figure that describes how the Home Health Groupings Model is set up.

All right. Slide 8. So, now I've reviewed the current payment system. Let me quickly describe some background on why the Home Health Groupings Model was developed. Abt's work was preceded by Section 3131(d) of the Affordable Care Act, which required a study on home health agency cost related to providing access to the home health benefits for three different groups of beneficiaries. Those three groups are: one, low-income beneficiaries; two, those in medically underserved areas; and, three, those with high severity of illness. That study from 3131(d) examined whether there are financial incentives in the current payment system to select certain patients over others.

The study found that home health agency margins were lower for a number of different types of patients. The study made a number of suggestions regarding how the payment system should be improved. Some of these included: one, increasing payment to agencies with a disproportionate share of low-income patients; and, two, ensuring the payment system controls for admission source, the HCC risk score for the patients and for the presence of comorbidities. As Abt and CMS explored the construction of the current payment system and thought about constructing a reformed payment system, we took these findings and suggestions under advisement.

All right. Slide 9. So, this next slide further motivates the development of the Home Health Groupings Model. MedPAC has repeatedly called for home health payment reform. MedPAC has stated that the Medicare home health benefit is ill-defined and that it allows for a broad range of services leading to potential misuse. Also, MedPAC has consistently recommended removing the number of therapy visits that occur during an episode from the payment system and using only patient characteristics when setting payment.

All right. Slide 10. So, after reviewing the prior work described in the last few slides, Abt and CMS developed a set of guiding principles that describe the key aspects of how the Home Health Prospective Payment System should be constructed. Then, Abt conducted several analyses related to findings from the CMS and MedPAC reports as well as other areas identified jointly by Abt and CMS. Additionally, we held several clinical expert and technical expert panels that also helped us identify areas for analysis.

Based on that work, we created three alternative approaches to constructing case mix weights for the Home Health Payment System. These approaches were described in the

proposed rule for calendar year 2016. The Home Health Groupings Model that I'll describe today was one of the options described in calendar year 2016.

All right. Slide 11. So, the next few slides will give an overview of how the Home Health Groupings Model is set up. Then, later parts of the presentation will provide more detail on each characteristic of the model.

All right. Slide 12. So, the Home Health Groupings Model groups home health episodes prospectively into a number of different payment groups. Within the HHGM, the unit of time covered by a home health payment is actually called a 30-day period, instead of a 60-day episode, as it's called in the current payment system. Therefore, when you hear me talk about periods or 30-day periods, those are very similar to the episodes or 60-day episodes in the current payment system. The major difference is just that the 30-day periods cover a shorter period of time.

Payment groups in the HHGM are defined based on how a specific 30-day period fits into five large categories. Those categories are: one, timing; two, referral source; three, the clinical grouping; four, the functional level; and, five, a comorbidity adjustment. In total, there are 128 possible different payment groups a 30-day period could be grouped into under the current setup of the HHGM. This is a reduction in the number of payment groups compared to the current home health payment system, which has 153 groups. Unlike the current payment model, the HHGM does not rely on the number of therapy visits performed to influence payment and, therefore, being placed in a payment group does not depend on the number of therapy visits provided. So, just to say it again, all else equal, the HHGM does not reimburse 30-day periods differently if more or less therapy is provided during that 30-day period.

The 128 groups described in this presentation is a reduction from the 324 groups discussed in the calendar year 2017 Home Health PPS proposed rule. This reduction was achieved by reducing the number of referral source categories, functional levels, and groups that would receive a comorbidity adjustment.

All right. Slide 13. So, this slide uses a graphic to essentially repeat the same information that was on the previous slide. So, for each colored row that you see in the figure, a 30-day period will be placed into a single box. A 30-day period's combination of boxes produces the final payment group that the period is placed into. There are 128 different

possible combinations of boxes the 30-day period can be grouped into when you group each period into a single box for each row. Later in the presentation, I will describe how we construct the case mix weights for each of the 128 possible payment groups in the model.

For the next several slides, I'll provide more information about how the Home Health Grouping Model is set up, information on each of the boxes listed here, and we'll also discuss methodologies for assigning 30-day periods into the boxes. As we review that information, we'll flash this diagram up again in several places. But, definitely refer back to this slide as needed so you can better understand how each group or variable fits into the overall structure of the Home Health Groupings Model.

All right. Slide 14. So, now that I have provided an overview of the Home Health Groupings Model, I wanted to next start discussing components of the model in more detail. So, next, I'm going to discuss resource use, which is a proxy that we use to measure the relative cost of 30-day periods.

Resource Use

Slide 15. So, in designing a payment system, we need a measure of the cost of providing care so that home health periods can be compared to each other. The relative resource intensity of one home health period to another is how payment weights are developed. And payment weights are needed so that more resource-intensive 30-day periods are reimbursed a higher rate than less resource-intensive 30-day periods. Thus, an accurate measure of cost is critical to determining the correct relative payment rates.

We proxied home health period costs with measures of resource use. Multiple approaches were considered, and two main candidates emerged. One is what's currently used in the payment system, wage-weighted minutes of care, and the second is based upon information extracted from the Medicare cost reports and is referred to in the report as cost per minute plus non-routine supplies or cost per minutes plus NRS. Both of these approaches are proxies for 30-day period costs and, as such, they are not meant to and do not describe the total costs incurred by agencies during a 30-day period of care. However, resource use would be correlated with total cost. And as we're interested in the relative cost across a 30-day periods and not the absolute cost for each 30-day period, it's not necessary to measure total costs.

All right. Slide 16. So this table provides an overview of the two approaches that I just described—the wage-weighted minutes of care and the CPM plus NRS. One major difference between the approaches is the data source that’s used for each approach. The wage-weighted minutes of care method relies upon wages reported by the Bureau of Labor Statistics to determine an hourly wage for a home health care provider. Wages and fringe benefits are available for each of the six home health disciplines and are, in fact, actually available at a more granular level than just those six disciplines. For example, wages for registered nurses and licensed and practical vocational nurses are provided separately.

Moving down to the General Approach part of the table, these wages are then multiplied by the amount of care provided by discipline, where the amount of care is determined from the time spent during home visits as reported on Medicare home health claims data. This multiplication yields a resource use estimate for each 30-day period of care. In contrast, under the cost per minute plus NRS approach, we extract information from agencies’ cost reports. We extract total costs and visits from the cost report data and combine them with the minutes of care from the Medicare home health claims to generate an estimate of 30-day period costs.

The costs represented, as described in the third row of the table, differ for each method. The wage-weighted minutes of care method represents wages and fringe benefits directly related to visiting patients. Costs from the Medicare cost reports, on the other hand, represent additional costs, not only wage with fringe benefits but also overhead cost, transportation costs, and other costs not directly related to labor for visiting patients.

Lastly, non-routine supplies are treated differently under each method. Non-routine supplies are those needed to treat a patient-specific illness or injury in accordance with the physician’s plan of care to be contrasted with routine supplies that are already bundled into the cost of providing the home health care visits. Examples include those related to wound care, ostomy, and neurological supplies.

The current payment system determines NRS payment using the presence of clinical factors associated with episodes using NRS through a separate payment model. Under the cost per minute plus NRS approach, though, NRS costs would be created using the NRS cost-to-charge ratio obtained from each agency’s cost report. The cost-to-charge

ratio is combined with the charges from the home health claims to obtain costs of NRS provisions. And those costs are included when we estimate the cost of each 30-day period. So, the NRS cost would be rolled into the overall episode costs under the cost per minute plus NRS approach.

Okay. Slide 17. So, for the most part, the analyses shown in the report are similar in the fact that it doesn't matter much if the wage-weighted minutes of care or the cost per minutes plus NRS approach is used. For the most part, though, the technical report and what I'll describe for the rest of this presentation will rely on the cost per minute plus NRS approach.

As I described a moment ago, the two methods are highly correlated with each other and each has its advantages and disadvantages. The wage-weighted minutes of care method's advantages include the use of labor categories that are fairly granular and are nationally representative. Also, the BLS data are available rather quickly with only a 1-year lag. On the other hand, the cost per minute plus NRS approach combines NRS rather than using a separate model, and it also incorporates more costs than those directly affiliated with patient visits.

30-Day Periods

All right. Slide 18. So, now I'm going to walk you through the section of the report dealing with the creation of the 30-day periods. We simulated 30-day periods instead of the usual 60-day episodes for the Home Health Groupings Model. So, first, I'll talk a little bit about why it is we're doing this and how we're doing it and, then, a little bit about what it does to our results.

Slide 19. All right. So, just a little background and motivation. So, in the current payment system, agencies are paid at 60-day episodes. However, episodes need not necessarily literally last 60 days. Roughly three-quarters of episodes actually do last 60 days, but the other quarter of episodes don't, and many are quite a bit shorter—30 days or less. Our motivation for considering shorter periods is that we found across a 60-day episode, there was not uniform resource use. That is, costs are not constant across the length of an episode. By separating episodes in half, we'd be better able to target differences in costs with payments. And a better alignment of payment and costs will improve payment accuracy, which is a primary objective of the payment system and payment reform. So for the HHGM, we're simulating 30-day periods and not 60-day episodes.

All right. Slide 20. The estimates on this table will, hopefully, better motivate some of the cost variation within a 60-day episode. Essentially, this table just shows a number of staff visits at 15-day increments and, at the bottom, resource use as a dollar valuation of these visits, its average resource use for those particular days for the episodes being examined. Quite simply, we find that costs are much higher earlier in the episode and lesser later on. So, in the first 30 days, costs average about \$250 to \$260 using our definition of resource use compared to \$150 in the later half. So the idea is to pay a higher amount in the first 30 days and a lower amount to the last 30 days, reflecting this cost differential. And this is what one of the things the Home Health Groupings Model attempts to do.

Slide 21. So, doing this will let us construct a more accurate payment system, that is, our payment models will produce better statistics, which will lead to more accurate episode case mix weights and better-aligned payments. Shorter episodes may also promote home health providers to more frequently review patients' conditions and statuses, respond more diligently to patient needs and, thereby, care quality would be improved. And, lastly, 30-day period would reduce, if not eliminate, a need for pre-emptive partial payments through the RAP, reducing complexity and streamlining payments. HHAs could bill monthly in the same manner as SNFs and hospices and receive their final payment sooner.

All right. Slide 22. So, how do we create the 30-day periods when we're simulating data for the models that we're putting together? It's simple. We basically just split 60-day episodes into two 30-day halves. So, the details arise with figuring out what to do with episodes that aren't quite 60 days long. So, what if an episode lasts 49 days or what if a 60-day episode only lasts 29 days? So, here's what we do. We generate an initial period of the first up-to-30 days. And for those episodes where there are more than 30 days, we generate a second period of days 31 and above up to the last day of the original 60-day episode.

So an example. Take a 58-day episode. It would produce two 30-day periods, an initial period based on days 1 through 30 of the 58 days and then a second not-quite-30-day period of 28 days based on days 31 through 58. Naturally, if a 60-day episode is 30 days or less—let us say it is just 25 days—then it would only generate one initial period and no second since there would be no days 31 and above.

All right. Slide 23. So, when creating the Home Health Groupings Model and when we're presenting the results later on in the presentation, our analysis started with roughly 5.5, 5.6 million 60-day episodes that occurred in 2013. So, all the analyses are based on this initial sample. Of those 60-day episodes, there are 1.3, 1.4 million that are 30 days or less and would have no second 30-day periods attached to them. The remaining 4.1 to 4.2 million episodes exceeded 30 days. So, they will produce a first 30-day period and a second period of some length. What we found in actuality, though, is that some number, a little over 10 percent of those, were days or 30-day periods – second 30-day periods totally without any visits or that would be considered a LUPA under the Home Health Groupings Model, which we're excluding now. So we dropped those.

So, in sum, we've got 1,389,492 60-day episodes that are 30 days or less and don't generate a second 30-day period. We have 4.1 million 60-day episodes that do produce a first and second 30-day period, less periods which are not usable for the analysis and, therefore, we are left with a sample of 9.3 million 30-day periods for our analytic sample. And, again, these are the periods that the results for the remainder of the report and presentation are based on.

Clinical Groups

All right. Slide 24. So, that's all I want to say about 30-day periods for now. In the next section of the slides, I'm going to talk about the clinical groupings, which is one of the ways we sort 30-day period into different payment groups.

Slide 25. So, this chart shows that under the Home Health Groupings Model, patients that enter home health will be categorized into one of the boxes in each of the color levels. We discuss clinical groupings first because, in some ways, categorizing 30-day periods by clinical characteristics is the heart of the Home Health Groupings Model. The clinical groups are intended to reflect the primary reason for home health services as defined by a patient's diagnosis. Six total groups were developed.

Slide 26. So the six clinical groups are shown on slide 26. All home health periods will be classified into one of these six groups. They include rehabilitation for musculoskeletal and rehabilitation for neuro and stroke. Then we have a group for assessment, treatment and evaluation of wounds, both surgical and non-surgical. The next group is assessment, treatment, and evaluation requiring complex nursing interventions such as IV therapies, TPN, internal nutrition, and ventilators. For just this group, we actually

checked for the presence of these interventions using OASIS items. Then, there are the clinical group for assessment, treatment, and evaluation of behavioral health conditions. And the last and largest home health clinical grouping is the assessment, evaluation, teaching, and medication management for medical and surgical conditions not classified in the previous five groups. Some of the top diagnoses in this category are those for diabetes, heart failure, COPD, and hypertension.

All right. Slide 27. So, to develop and define these clinical groupings, the team conducted a comprehensive review of all ICD-9 codes. For modeling purposes, we assigned each 30-day period to a clinical group based on the principal diagnosis on the OASIS assessment that was associated with that 30-day period. And this initial sorting of 30-day period secondary diagnosis codes were used, if necessary, if the principal diagnosis code was too vague or unlikely to require home health. Twenty percent of 30-day periods were affected in that the secondary diagnosis codes were used. In practice, though, if implemented, the agency would be asked to resubmit the claim if the principal diagnosis could not be used. In a later section of this presentation, we'll talk more about how the Home Health Groupings Model accounts for the interaction between multiple clinical conditions.

Slide 28. So the distribution of 30-day periods in 2013 is shown here. Medication management, teaching, and assessment comprises the majority of 30-day periods at 63.7 percent. MMTA covers all 30-day periods related to assessment, evaluation, and teaching that are not covered by other groups. Thus, MMTA, in some ways, serves as the default clinical group. The next largest groups are musculoskeletal rehab and wound care at around 10 to 11 percent each. The neuro and stroke rehab comprised 8.2 percent of the 30-day periods. Complex nursing interventions – that group had 3.5 percent of 30-day periods, and behavioral health had 3 percent of 30-day periods.

All right. Slide 29. So this graph shows the average resource use using the cost per minute plus NRS methodology for episodes by each clinical grouping. The red bars represent average resource use and the dotted lines represent the proportion of 30-day periods by clinical group. Absolutely, the wound care group have the highest average resource use with values at over \$2,000 on average. Thirty-day periods in the behavioral health group have the lowest average resource use at around \$1,100. And the – and that group also accounts for the smallest number of patients. MMTA, the largest category – those 30-day periods have an average resource use of \$1,455.

Functional Levels

All right. So, moving on to slide 30. So, the previous slides were a brief overview of how the clinical groups are constructed. And the next part of the Home Health Groupings Model that I'll discuss is the creation of the functional levels.

Slide 31. So, under the Home Health Groupings Model, each 30-day period is then placed into what is called a functional level. The level indicates if, on average, a period, given its responses on certain functional OASIS items, is predicted to have high costs or low costs, as measured by resource use. Musculoskeletal rehab and behavioral health periods can be categorized in a lower high level with roughly 50 percent of periods in each functional level. For the other clinical groups, periods -- 30-day periods can be classified into one of three different functional levels with roughly 33 percent of periods in each functional level. The creation of this functional level is very similar to how the functional levels and clinical levels are created in the current payment system.

All right. Slide 32. So there are a number of OASIS items we considered to use to construct the functional level. You can see from this table which functional items are used in the current system and which ones are used in the Home Health Groupings model. As you can see, there is lot of overlap in which items we use. Using both a univariate and multivariate analysis, we looked at each item from the above list, and the item's responses determine which items and response had a strong relationship with resource use. We decided not to use those OASIS items that appeared to have a weak or counterintuitive relationship with resource use.

Just to be clear, we considered many different OASIS items in this process and not just the seven functional items we've listed on the slide. If you go to Chapter 7 of the report and, in particular, look at Exhibit 7-1, you can see the entire list of OASIS items that we considered, which included most of the functional items, many cognitive items, and a few other OASIS items. Again, we performed a univariate and multivariate analysis to determine which items had a weak or counterintuitive relationship with resource use and decided not to include those items in our calculation of the functional level.

Slide 33. So, I want to provide a slightly more -- some slight -- increased description on how the process of measuring a relationship between an item and resource use works. So as you know, for the OASIS items, there are a number of different responses associated with each item. I'm showing items M1800 and M1810 and the responses

here. We did a lot of work to try to condense responses so we could have – measure a better relationship between the item and resource use. You can see for item M1800 we have a highlighted box around response 2 and 3. For our model response of 2, it would be treated the same as a response of 3 for item M1800. We've combined them. So, when you see that kind of darkened box, that's all that that means. We've just combined the responses.

We decided which responses to combine based on whether the average resource use for the two or more responses were similar and whether or not a particular response was frequently used. Some responses for particular items are rarely chosen, and we combined those with other responses. You can also get a good sense for which responses had similar resource use compared to other responses and which ones – which responses were infrequently picked by looking at the results in Exhibit 7-1 from the report.

All right. Moving on to slide 34. So, the report in Chapter 7 describes the process of combining the responses in more detail, and it also shows the average resource use for each OASIS item before and after the responses were grouped. This is portion of Exhibit 7-3 from the report, and it shows the average resource use associated with each item and the responses after the responses were combined. Combining the responses makes the relationship between the responses and resource use clear. This table shows that as functional status for each of these items gets worse, that is, a higher response is picked, there is an increase in average resource use.

Slide 35. So if you review the previous slides, the seven functional items we had listed on the first table from this section are what we are going to use to determine each 30-day period's functional level. We also used the OASIS item M1032, Risk of Hospitalization, to help determine the functional level. So we have a number of items, as I said, that are going to determine the functional level. The question is how exactly is that level calculated? So, let me explain.

What we do is regress resource use, which is our approach to estimating 30-day period costs on the selected functional items plus the risk of hospitalization item that I just mentioned. So we use the sample of 30-day periods that I described a moment ago when I was talking about the 30-day periods and regressed their resource use on their functional items – the responses for those functional items in item M1032.

The items and their responses are all represented as binary variables. And like I indicated before, some of the responses for some of the functional items have been combined if the responses for a particular item were infrequently used or had similar average resource use compared to another response from that item.

Slide 36. After estimating the regression, we then take the results of the regression and use the coefficients to calculate a score for each 30-day period. Coefficients are transported into something we call points by taking the coefficient, dividing by 10, and rounding to the nearest integer. This approach is very similar to how the functional and clinical scores are calculated in the current payment system. So after we do this, we calculate a score for each period. We compute thresholds for the low, medium, and high functional levels, which I'll show on an upcoming slide. These thresholds are computed separately for each clinical grouping.

The points associated with each OASIS item for the functional level is shown here, which is Exhibit 7-5 from the report. So these are the results that come from the regression I mentioned a moment ago. As I mentioned in the report, if the Home Health Groupings Model were implemented, we would use updated data to revisit the relationship between these OASIS items and other OASIS items we've considered with resource use to see if the relationship has changed and if we need to update the points values. Again, this process would be very similar to how the Four Equation Model is updated under the current payment system.

Just so you understand the table, let me explain how it works. So a beneficiary would receive zero point for any of the items listed here if they had a response of zero for any of those items. You can see by looking at that – at the table, that as functional status gets worse – so, a higher response is checked – or there is a higher risk of hospitalization, resource use increases and, therefore, the beneficiary is assigned more points. For example, having a response of 1 for M1860 is worth 13 points. Having a response of 3 is worth 27 points.

All right. Slide 37. So we use the points from the table on the previous slide to assign 30-day periods to different functional levels. You can see that this table divides periods into different levels by how many points they have and what clinical group they're in. By design, we've constructed the thresholds for each category. So roughly a third of periods are placed into each category, that is, the low functional level, the medium

functional level, and the high functional level. We do this for MMTA, complex, neuro rehab, and the wound clinical groups. The other two clinical groups—behavioral health and musculoskeletal rehab—only have two levels, low and high, because there wasn't as much variation of resource use for periods in those groups as compared to the other clinical groups. That is, we could have fewer groups, which would simplify the payment system.

Other Variables Used to Group Periods

All right. Slide 38. So, the previous slides were a description of how the functional level is created. And now I'm going to discuss other variables related to admission and timing source, which are also going to be used to group patients under the Home Health Groupings Model.

Slide 39. So, under the Home Health Groupings Model, patients would be categorized into one of the boxes in each of the color levels. So now we're at the top blue row of the figure. From the previous work that I described earlier, admission source and timing of the 30-day periods were identified as important components to the payment system. And these next few slides describe how they're added to the Home Health Groupings Model.

Slide 40. So the admission source for a 30-day period can either be institutional or community. If it's institutional, the patient is coming from an acute or post-acute care visit which occurred 14 days prior to the home health admission. Post-acute care includes visits with skilled nursing facilities, inpatient rehab facilities, or long-term care hospitals. The 30-day period is categorized as community if there are no acute or post-acute care visits in the – or stays in the 14 days prior to admission. Note the second 30 days of a 60-day episode would be categorized as a community admission source unless there was an intervening hospitalization in the last 14 days of the first 30-day period.

The purple table shows that the average resource use is higher for institutional 30-day periods: \$2,000 on average vs. \$1,300 on average for 30-days periods which are admitted from the community. Seventy-five percent of 30-day periods are considered community, while 25 percent are considered institutional in the data that we examined.

All right. Slide 41. So I'll move on to discuss timing next. Thirty-day periods are considered early if they are first in a sequence of home health periods. Thirty-day periods are considered late if they are not first—instead if they are instead second or later in a sequence of 30-day periods. Sequences are defined the same as they are currently defined in the current payment system. So 30-day periods are on the same sequence if there are no more than 60 days between the end of one period and the start of another. The purple table shows that the average resource use for early 30-day periods is \$2,000, and for late 30-day periods, it is \$1,300. Most 30-day periods that we see in our data are considered late, roughly 70 percent vs. 30 percent of episodes which are early.

All right. Slide 42. So this graph shows average resource use for 30-day periods stratified by timing and admission source. The red bars represent average resource use and the dotted line shows the proportion of 30-day periods in each category. Early institutional 30-day periods comprise 18.2 percent of all 30-day periods and have the highest average resource use at \$2,100. Late community 30-day periods have the lowest average resource use at \$1,200. And most—62 percent—of 30-day periods are late coming from the community.

Slide 43. So those previous slides were a description of how admission and timing are incorporated into the Home Health Groupings Model. Next, I'll move on to discuss the comorbidity adjustment.

Slide 44. So far we've discussed several characteristics that will group – or will be used to group 30-day periods into payment groups for payment determination. The comorbidity adjustment is the last of these adjustments, and I'll quickly review how that's put together.

Slide 45. So first, let me describe the motivation behind using a comorbidity adjustment. So we already have a clinical grouping in the Home Health Groupings Model that's based on the primary home health diagnosis, as we already discussed. However, patients rarely have a single condition. The presence of secondary diagnoses also determines the course of care and, therefore, the secondary diagnoses contain relevant information indicating patient need that could be used for further case mix adjustment, that is, after controlling for the clinical group. I have been using secondary diagnoses on this slide loosely to convey the sense of comorbidity, that is, medical conditions coexisting in

addition to the primary diagnosis. Comorbidities are tied to poor health outcomes, more complex medical needs and management, and also higher costs.

All right. Slide 46. So, to determine the comorbidity adjustment for the Home Health Groupings Model, first we analyze the reported secondary diagnoses in our data, the data from calendar year – or from 2013 that I mentioned earlier that have roughly 9.3 million 30-day periods. The issues we encountered, though, were often just further descriptions of the primary diagnosis, that is, they were not distinct conditions. Negating those, we identified a number of different categories, each containing multiple diagnosis codes as listed on this slide. These different categories were commonly associated with higher resource use.

Slide 47. Specifically, we identified the comorbidities that occurred in at least 0.1 percent of 30-day periods and only those that were associated with increased average resource use. After doing that identification, any 30-day period having at least one comorbidity from those that met the above criteria received the comorbidity adjustment.

Slide 48. So, this table shows some information about the comorbidity adjustment. About 22 percent of 30-day periods had a comorbidity which triggers being in the adjustment group, which means resource use for episodes with the comorbidity adjustment is about \$1,700 on average, relative to \$1,500 on average for the 30-day periods without the comorbidity adjustment. That represents a roughly 14-percent difference between episodes from those two groups: the comorbidity adjustment group and no comorbidity adjustment group.

So the prior slides indicated which characteristics – I'm sorry. I'm on slide 49. The prior slides indicated what characteristics would be used to group 30-day periods in the Home Health Groupings Model. After all the 30-day periods are grouped, we can construct the case mix weights, which I will describe in the next few slides.

Slide 50. So, as I discussed previously, there are 128 different payment groups a 30-day period can be grouped into under the Home Health Groupings Model. For each of those 128 different payment groups, we determine a unique case mix weight for the group by first estimating a regression between the resource use of each 30-day period and binary variables controlling for the five dimensions described in the prior slide. That – or prior

slides. That is, we're controlling for timing, admission source, clinical group, functional level, and comorbidities.

After estimating that model on simulated home health 30-day periods, we then use the results of the model to predict the expected resource use for periods in each payment group based on those five characteristics I mentioned a moment ago. We divide the predicted resource use for each of the 128 payment groups by the overall average resource use to calculate the average case mix of all 30-day periods within a particular payment group. Just like in the current system, that case mix weight is then used to adjust the base payment rate to then determine each 30-day period's payment.

All right. Slide 51. So, there are a few other things I want to mention about the regression. The dependent variable in the regression is resource use using the cost per minute plus NRS method. However, we also tested the model using resource use calculated using the wage-weighted minutes of care method. The results between the models weren't too different, as described in the report.

Another thing to note is that we estimated the model using fixed effects at the level of each home health agency. The inclusion of the fixed effects term controls for agency characteristics that don't vary across the 30-day periods that the agency provides, which may be correlated with the variables that determine a 30-day period's payment group. For example, if the age of the agency was correlated with admission source, not including the fixed effects when estimating the model, it would cause the coefficients in the model to be biased. It turns out that including or not including the fixed effects term, though, does not dramatically impact the results of the model. The results of the model with and without fixed effects is shown in the report.

All right. Slide 52. So, those results from the regressions are then used to create the case-mix weight. Again, you can calculate the case-mix weights for each of the 128 groups by taking the coefficients that apply to a 30-day period from the regression, adding them together, and then dividing by the average resource use across all 30-day periods. That produces the weight. And the weight indicates whether the 30-day period has higher resource use compared to the average 30-day period or lower resource use. This slide shows a selection of the weights from the regression. The report shows all the weights.

It's important to note that the weights are created based on the relationships we see in the existing home health data. We did not do anything to try to increase or decrease the weight for a particular payment group. It just describes the relationships that we see between episodes in a particular payment group and the resource use of those episodes.

Slide 53. So, now that I've discussed how the case-mix weights are calculated, I can now show some of the impacts discussed in the report that discuss differences in case-mix weights across the Home Health Groupings Models and the current payment system.

Slide 54. So, as I just reviewed the Home Health Groupings Model – so, as I just reviewed, the Home Health Groupings Model assigns different payment weights and, therefore, different payments to groups of 30-day periods with common characteristics. The current payment system also does the same thing only episodes are grouped to different payment groups, as explained at the start of this presentation. On average, the Home Health Groupings Model produces identical payments to the current system. This was done by design. However, when looking at individual episodes, payments can differ between the Home Health Groupings Model and the current system.

Slide 55. Here, we have histograms of the mass of payments under the current payment system and the Home Health Groupings Model. Red are the payments in the current model and the clear bars represent payments for 30-day periods under the Home Health Groupings Model. The distribution does not perfectly overlap. But you can see the similarities. The Home Health Groupings Model has a little more mass in the center. Another way to look at this graphically is to plot the distribution of the difference of the current home – of the current and Home Health Groupings Model payments by each 30-day period.

Slide 56 shows that type of histogram. It shows the differences by 30-day periods between the two payment systems. While the difference is centered around zero percent, there can be significant variations in the tails of the distribution, indicating that some 30-day periods are paid differently under the HHGM compared to the current payment system.

Slide 57. Okay. So, now, I am going to go through a few figures depicting impact graphically across different characteristics. This figure and the ones that follow will

show, across characteristics of the 30-day periods, the simulated payment impacts were the Home Health Groupings Model adopted. This figure shows the impact by clinical grouping. The bar heights represent the impact ratios. These ratios are the payment under the Home Health Groupings Model over the payment under the current system. If the ratio is one, this indicates a one-to-one payment match, no change at all across the systems. Being less than one or under the line means that the 30-day periods with these characteristics would receive less payment on average under this reform. And 30-day periods over the line would receive more payment.

Case in point. So the 30-day periods under the wound category would receive, on average, more, specifically a ratio of 1.28 times more payment under the Home Health Groupings Model than they currently receive. They would receive more payment under the Home Health Groupings Model according to this impact ratio. Thirty-day periods in the complex groups, which is above the line at one, would also receive more payment in the Home Health Groupings Model compared to the current payment system on average. In contrast, 30-day periods in the musculoskeletal rehab and behavioral health group would receive, on average, less in the Home Health Groupings Model compared to the current payment system.

Slide 58. All right. So these impacts – this table shows the impacts by timing. Under this Home Health Groupings Model, 30-day periods which are early would receive higher payment, about 22 percent more, than under the current system, and late 30-day periods would receive less payment on average.

Slide 59. This slide shows impacts by admission source. The 30-day periods coming from community would receive lower payment in the HHGM compared to the current system, and 30-day periods coming from the institutional admission would receive higher payment under the Home Health Groupings Model.

Slide 60. The Home Health Groupings Model tends to give higher payments to 30-day periods associated with the categories in the 3131(d) report. Remember from my description at the beginning of the presentation that 3131(d) report in part motivated some of the work done in creating the Home Health Groupings Model. The impacts show that 30-day periods with known surgical wounds have higher payment under the HHGM compared to the current system. Thirty-day periods with parenteral nutrition also do better under the HHGM compared to the current system. These are just the

selected group of characteristics mentioned by that report. The other characteristics mentioned in the 3131(d) report also show similar findings in that they typically receive higher average payment under the Home Health Groupings Model.

All right. So, slide 61. So, all the previous slides that I've gone over today were a very brief high-level overview of the Home Health Groupings Model and the work that was done in the report. So, please review the report if you want to learn more about how the Home Health Groupings Model was developed. As I explained at the start of the presentation, this work was motivated by some of the criticisms of the current payment system that I indicated earlier. For example, within the Home Health Groupings Model, payment is not impacted by the level of therapy provided during a 30-day period.

Also, the Home Health Groupings Model addresses findings from the 3131(d) study to Congress that I described at the start of the presentation. That report found that margins differed across beneficiary characteristics such as parenteral nutrition, traumatic wounds, whether bathing assistance is needed, and also admission source. As a result, the HHGM considers those characteristics when grouping 30-day periods into 128 different payment groups. We find that strength to the model is its clarity. From the groupings, clinicians can easily identify the type of patients that they see in home health. Compared to the current payment system, the Home Health Groupings Model should help CMS better understand the reasons behind each home health 30-day period.

So, that completes the presentation, and I will now hand it back to Hazeline.

Keypad Polling

Hazeline Roulac: Thank you, Michael.

In just a moment, we will move on to the question-and-answer portion of our call. But, before we do, we will pause to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. There will be a few moments of silence while we tabulate the results.

Holley, we are ready to start polling.

Operator: CMS appreciates that you minimize the Government’s teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine. Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling. Please continue to hold while we complete the polling. Again, please hold while we complete the polling.

Thank you for your participation. I’d now like to turn the call back over to Hazeline Roulac.

Question and Answer Session

Hazeline Roulac: Thank you, Holley.

So we will now move on to the Q&A portion of our call. Michael will begin to respond to some of the questions that were received during the registration process. And then we’ll move on to taking participant questions. Michael?

Michael Plotzke: Thank you.

So, before I talk about the questions that were received prior to the call, I do want to point out on slide 63 we have listed an email address for you to send questions and comments to. So, if, you know, you’re not able to say something that you’d like to say during this call, please write to the email address listed on the slide. And please be as specific as possible with your questions so we’re best able to answer them.

All right. So we received roughly 13 questions prior to this call, and I’m going to run through what those questions were and our answers to those questions.

So question 1 was, “Are you planning to release OASIS data in LDS format so that the impact of the new reimbursement system can be analyzed?”

So, at this time, there's no change being proposed for what data files are made available. The data files that were made available in the past will continue to be made available.

Question 2, "Can you please walk us through how an episode will be calculated?"

So, the presentation covered this question, and more information is available in the report. Additionally, please send an email if you have other questions about this topic.

Question 3, "How does this apply – how does this, the Home Health Groupings Model, apply to a small home health agency with less than 10 patients per month?"

So, if implemented, this system, Home Health Groupings Model would apply to all Fee-for-Service patients regardless of agency size.

Question 4, "How will the treatment authorization code calculation change to accommodate the new grouping model as auditors are now using the treatment authorization code to retroactively calculate HIPPS codes for appropriate payment determinations? Will there – also, will the RAP payment actually turn into the first of the 30-day sequential bills? Also, will submission of OASIS into CMS depository be required by the 30-day sequential claim as it aligns with OASIS submission requirements?"

So the answers to those questions are: The treatment authorization code would still need to be used for the purpose mentioned if the agency submitted something that was incorrect such as an episode being reported late, however the – or an episode actually being late but the home health agency thought the 30-day period was early.

In terms of the RAP, the Home Health Groupings Model is supposed to accelerate payment compared to what the current payment system offers. So RAPs may no longer be applicable. The Home Health Groupings Model would not change the timing of the OASIS submission. A single OASIS submission would cover two 30-day periods of care.

Question 5, "How will this proposed change to the 30-day model impact agencies financially? It seems that this will put additional burdens on agencies for increased assessment and administrative oversight. How will patients be impacted? Will it be 30-day – will 30-day – will it be 30-day episodes after the initial episode or will it change

to be 60-day episodes? Most often, patients are not stable in the first 30 days and still requires considerable resources to continue to work towards getting back their previous level of function.”

So, the answer is the impacts were detailed in the presentation, and I encourage people to read through the report to understand more about those impacts. The HHGM is not meant to place additional burdens on agencies. As mentioned before, the timeline for submitting the OASIS would not change under the HHGM. After the initial 30-day period, home health agencies would still go for additional 30-day periods, if needed. There would no longer be a 60-day episode. However, if a patient is not stable within their first 30 days and require additional resources to get back to their previous level of function, additional 30-day periods could be provided. As stated in the presentation, in the current payment system, there is, on average, less resources spent on patients in the second part of a 60-day episode, which was one of the motivations for switching to 30-day periods.

Question 6, “If you change the 60-day episodes to 30-day episodes, do we need to recert patients every 30 days?”

So, the answer is: No additional OASIS would need to be submitted for the second 30-day period. No additionally recertification would need to be completed. A claim covering the second 30-day period would need to be submitted.

Question 7, “Please clarify the definition and timeframe for the comprehensive assessment as a condition of participation and confirm if it is a component of physician certification.”

So the answer is: The HHGM would not impact the definition and timeframe of the comprehensive assessment as a condition of participation.

Question 8, “Provide information on the risk adjustment facts and considerations on which approaches to consider as we move forward with home care expectations, documentation, and measurement such as the HHVBP and Star Ratings.”

So, the answer is: The HHGM does not include any measures from the HHVBP and/or the Star Ratings. Case-mix weights are risk-adjusted in the Home Health Groupings

Model through the five broad categories – that is, timing, admission source, functional level, clinical group, and comorbidity – that I mentioned throughout the presentation today.

Question 9, “What are the expectations and implications to Senior Advantage that is not Fee-for-Service plans?”

So, the answer is: The Home Health Groupings Model would be an update to the prospective payment system for Fee-for-Service patients. It is not intended to impact non-Fee-for-Service plans.

Question 10, “What are the new CMS billing guidelines for 2017?”

The answer is: The information in this presentation does not impact anything for calendar year 2017. Please review the final rule for calendar year 2017 Home Health Prospective Payment System Rate Update for more information about the PPS as it stands in calendar year 2017.

Question 11, “What is the consideration given to patients’ age in risk adjustment? The average age for a patient is almost 10 years older than the national average, which impacts their ability to achieve outcome improvements. Is there any consideration given to patients that are transferred to hospice care?”

So, the answer is: In the report, we indicate in our preliminary model for the functional level we controlled for patient age but found that after controlling for other variables in the model that the impact of age was very close to zero. Therefore, age was dropped from the model. The Home Health Groupings Model does not give any consideration to patients that are transferred to hospice care.

Question 12, “When would this be targeted for implementation?”

The answer is: As of now, the HHGM has no target date for implementation.

And question 13, “Will CGS or the MACs provide educational worksheets?”

And the answer is: If implemented, it is reasonable to assume the CGS or the MACs would provide educational worksheets.

All right. So, now, I will turn the call back to Hazeline.

Hazeline Roulac: Michael, thank you very much for responding to those questions that were received during the registration process.

So we will now begin to take questions from our participants that are on the line with us today. I want to remind everyone that this call is being recorded and transcribed. Before asking your question, please give your name and the name of your organization. In an effort to get to as many questions as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star one to get back into the queue, and we'll address additional questions as time permits. All right, Holley, we are ready to take our first question.

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

Our first question comes from the line of Luke James.

Luke James: Yes. Thank you for your time today and explanation on the slides. Our question is primarily centered around the statement about comparing institutional late to community late referrals or episodes rather – 30-day episodes. Can you let us know how the model took into account patients who readmitted, for example, on day 14 of a first 30-day episode versus those that readmitted on day 17 of their first 30-day episode and how one would be paid roughly \$800 less for their second day or their second 30-day period because they are considered community late if they readmitted on day 14 of their first episode versus those receiving \$800 more who readmitted—on average—who readmitted on day 17 of their first 30-day episode and would be considered an institutional late episode for their second 30-day, if needed? Thank you.

Michael Plotzke: Thank you for the question. So, as described in the part of the report that talks about the construction of case-mix weights, the payment regression and the coefficients of the payment model which feed into the case mix weights are all dependent on the relationships we see in the data between episodes in each payment group and their resource use. So, for episodes that are in community late vs. institutional late, we did notice a difference in average resource use between 30-day periods within those groups and, therefore, that is why you saw the relationships that you saw. Does that answer your question?

Luke James: How can it be that big of a difference in resource use using the definition outlined on the call today between patients that both readmit just 3 days apart and, as such, are considered or categorized differently in their second 30-day period if both need that second 30-day period of care between institutional late and community late, meaning they both readmitted on their first 30 days and only 2 or 3 days apart but receive meaningfully different amounts in their second 30-day period?

Michael Plotzke: Right. So, the – all the episodes within those two different payment groups don't fall into the specific examples that you provided. There are a lot of episodes within community late that would not have had any sort of readmissions. There might be a small portion that can just fall under the threshold, I guess, of being considered an institutional admission. And that's kind of where the difference between the two payments groups lies. And, you know, there's a threshold that was picked to try to classify what we saw is the majority of episodes in terms of our look back period within those two groups. And that was what was decided upon for the analysis in the report.

Hazeline Roulac: Thank you for your question. Next question.

Operator: Our next question comes from the line of Shari Vanderdonck.

Shari Vanderdonck: Hi. We were wondering how it's going – a partial episode payment is going to be adjusted from a 60-day to a 30-day, and is there going to be – is it going to be based on a 30-day rather than a 60-day readmission rate?

Hazeline Roulac: I'm sorry, Shari. Can you repeat your question? We could hardly hear you.

Shari Vanderdonck: Yes. A partial episode payment is based on a 60-day readmission rate. Now that it is 30 days, is it going to be a partial episode payment within 30 days of discharge? Or is it still going to be a PEP 60 days after discharge and then they're readmitted?

Hillary Loeffler: Yes. Hi. This is Hillary Loeffler. I'm the director of the Division of Home Health and Hospice here at CMS. So, we haven't really outlined any policy changes, if any, that would occur with the PEP adjustment if we were to go forward with this model. At this time, there's no, you know, set plans for the agency to propose moving forward with this at this time. But if there is something that does go out for public comment, we would address any PEP policy changes that would be required. Off the top of my head, I'm going to say – I mean, the PEP policy would probably work similar to what it does now in the 60-day period. If your discharge earlier than 30 days, the 30-day portion of your payment would be prorated down based on the number of days on service.

Shari Vanderdonck: Okay. Thank you.

Hillary Loeffler: Yes.

Operator: Again, if you would like to ask a question, press star, then one on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

And our next question comes from the line of Deborah Barry.

Deborah Barry: Hi. Thank you for taking my question. I have a question about the 30-day payment portion of it. Currently, we can submit a RAP after we receive the OASIS data and, you know – the first OASIS data. But, under the 30-day payment, you said we could get a full payment at the end of the 30 days. So, does that mean that we have to have all of our orders signed as if we were submitting a final payment before we get paid for that first 30 days? Because it seems like under the new system, our payments would actually be delayed, not given to us sooner.

Hillary Loeffler: So, hi. Again, this is Hillary Loeffler. I'm the director of the Division of Home Health and Hospice. So, we're not proposing this model at this time. This is just

conceptual. So, we're absolutely interested in feedback and questions and concerns from you guys on the burdens. With regards to the RAP, I mean, I do think the regulations require that orders are put immediately into a plan of care and submitted to the physician immediately upon submitting the RAP for reimbursement.

Deborah Barry: Right.

Hillary Loeffler: So, you know, off the top of my head, I am not sure it would be an increase in burden per se for you to get the order signed within 30 days because they are required to be submitted to the physician for signature immediately upon a billing that RAP.

Deborah Barry: Right. But, right now, you can bill a RAP before you get the order signed and returned. So, say, for instance, you get your OASIS completed within 5 days – your 485 completed within 5 days and submitted for signature, you can theoretically bill your RAP on day 5 – day 6, right? But if we are required to have all the orders back and signed before we bill for that first 30-day episode or payment period, it would be probably at the end of the 30-days before we could bill. So it would be delaying payments significantly to home health agencies.

Hillary Loeffler: Yes. If we switched to a 30-day billing increment, you would have to wait until all the services are provided in that 30-day period until you bill for services.

Deborah Barry: Okay.

Operator: And our next question will come from the line of Chris Attaya.

Chris Attaya: Thank you, Michael, nice presentation. You noted that – when you were defining the different groups, you had used ICD-9 codes, although I think the slide might have suggested maybe you looked at the ICD-10. Are you expecting any additional complications by going from the ICD-9 to the ICD-10? And do you have a timeframe for when maybe you would release which codes will be in the ICD-9 or 10 clinical groupings?

Michael Plotzke: We're in the process of doing the same sort of analysis for ICD-10 codes using updated data that reports ICD-10 codes instead of ICD-9 codes. I don't have

an exact timeline for when that information would be reported. But it is something that we're definitely looking at.

Chris Attaya: Thank you.

Operator: Again, to ask a question, press star followed by one on your telephone keypad. To withdraw a question or if your questions has been answered, you may remove yourself from the queue by pressing the pound key.

Our next question comes from the line of Jane.

Jane: Hi. We have two questions. One is the plan of care – is that going to have to be 30 days or 60 days? And, then, the next question is the PCR – how is that related to – we're in Illinois and we're required to do PCR right now.

Michael Plotzke: So, similar to the desire to not increase burden for submission of OASIS and other paperwork that would need to be done, you know, at this time, I think, our intention would not be to change anything in terms of the timeline for the plan of care or the requirements regarding that. But as Hillary had mentioned, everything is still kind of in process in terms of how this model would be finalized if it would be finalized.

And, then, could you repeat the second question again?

Jane: For the pre-claim review – right now, we're in Illinois and we're required to do a pre-claim review for every single episode. Would that be changed to every 30 days, or how's that going to work?

Michael Plotzke: Hillary can comment to that, I think, since, you know, again, this model is not necessarily something with a timeline for being implemented or possibly might not be implemented. I think those kind of considerations haven't been fully finalized yet.

Jane: Okay. Thank you.

Operator: And our next question will come from the line of David Kerns.

David Kerns: Considering the cost per visit for therapy is the highest usually as far as different disciplines from agencies, what precautionary measures have you considered to prevent the underutilization of therapy within this model, especially in cases such as a patient recovering from a stroke?

Michael Plotzke: I think it's something that we will have to continue to monitor as time goes on. Obviously, the analysis that we've done has been conducted on data that is from the current payment system and the incentives of the payment system feed into the results that we get. So, you know, we look at the differences – we'll – we would certainly, if this model was implemented, look at the differences between therapy that we see in current data vs. older data and try to understand if there was a reduction in therapy after the implementation of the model.

Hazeline Roulac: Thanks for your question.

And before we take the next question, I would just like to ask if you could speak just a little louder because we are really having a hard time hearing your questions. Thank you.

Go ahead, Holley.

Operator: And our next question will come from the line of Carrie Harrison.

Carrie Harrison: Yes. I wanted to clarify the – for episodes that exceed 30 days – so, in the second 30-day period, if the visits in that timeframe meet LUPA requirements or, you know, would be a LUPA payment, do we get a LUPA payment in that second 30 days?

Michael Plotzke: Yes. So, this isn't something that I focused on the overview. But, if you do read the report, it goes into a little bit of detail on how the LUPA rates would change under the Home Health Groupings Model. And, certainly, you could have a 60-day episode – we had 60-day episodes in the data that we used where the first 30 days would be billed using the case-mix weight and then the second 30 days would be paid under the LUPA rates. So, that is a possibility.

Operator: And our final question will come from the line of Luke James.

Budd Langham: Hi. Thank you. This is actually Budd Langham. I had a question on slide 16 about the non-visiting labor costs. If you could explain what all would be included under the CPM plus NRS column there and how those resources or how that would be weighted in terms of measuring the resources provided.

Michael Plotzke: Sure. So, if you look at the report, it will detail specific parts of the cost report that were used to get that cost information. I will say to contrast with the wage-weighted minutes of care method, which is what is used currently, the wage-weighted minutes of care method only kind of costs out the visits by the average hourly wage and average hourly fringe rates.

And the cost per minute plus NRS approach uses the cost report to understand all the costs that are associated with the cost centers that are associated with each of the six disciplines of care – so skilled nursing, the therapy, medical social services, and the aids. And that – those costs incorporate a lot of different categories like the column indicates, so including overhead costs of the home health agency, transportation costs, and other related costs, including the wage and the fringe benefits.

I unfortunately don't have the cost – Medicare Home Health Cost Report right in front of me. So, I can't discuss the particular details of what is in the – or what are included in the columns that represents the non-visiting service costs. If you do email, the email address that is listed on the slide, I can provide more information if you are not able to find that information in the report.

Budd Langham: Thank you. Are the non-visit costs weighted the same in the model as the visiting-related costs? And does Abt have a model to distribute to allow agencies to understand the impact, a spreadsheet form or a simple tool for us to be able to understand how that might impact us?

Michael Plotzke: So the costs are allocated – definitely, the costs from the cost center – the overhead costs are kind of allocated down to the different disciplines using a standard formula that has already worked its way into the cost report data that we receive. So, we don't do anything special or different to the data beyond what is recorded in the cost reports and what is publicly available on the CMS website.

Hazeline Roulac: Okay, thank you for your questions.

Budd Langham: You're welcome. And any information about the model or tool for agencies to be able to see how we would fare in this model?

Michael Plotzke: So, you can certainly look at the report and see what the case mix weights are for each of the 128 different payment groups. So, using the information on how the payment groups are constructed in the report, you should be able to understand the differences in case mix weights for your episodes vs. what it might be under the Home Health Groupings Model if that were implemented.

And if there's any specific questions about how certain things were implemented for the Home Health Groupings Model or methodological decisions that were made or how to group your data, again, feel free to email the Abt Associates email address that's listed at the end of the slide deck.

Operator: At this time, there are no further questions. Hazeline, I'll turn it over to you.

Additional Information

Hazeline Roulac: Thank you, Holley.

Okay. So, we want to thank you for your participation in this call today. If we did not get to your question, you can email it to the address listed on slide 63 of the presentation.

If you missed any information presented today or would like to review again, an audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will place an announcement in the MLN Connects newsletter, and you will receive an email when these resources are available.

On slide 65 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your call experience.

Again, my name is Hazeline Roulac. I would like to thank our presenter and thank you, our participants, for joining us today for this presentation on the Home Health Groupings Model Technical Report. Have a great day, everyone.

Operator: This concludes today's conference call. Presenters, please hold.

-END-

