PEPPER Sessions Chapter 3 Target Areas
Home Health Agencies

In this session, I'll review the target areas for the PEPPER for Home health agencies. The home health agencies are reimbursed through the Home Health Agency, or HHA, Prospective Payment System (PPS) which was recently revised.

CMS estimates that approximately 3.4 million beneficiaries receive home health services from approximately 12,400 agencies costing Medicare approximately $17.9 billion.

The previous home health PPS had been identified as at risk for improper Medicare payments over the past few years, prompting CMS to evaluate and eventually implement a new payment system, which went into effect Jan. 1, 2020. In addition, the comprehensive error rate testing, or CERT, contractor's most recent estimate for 2019 was that 12.1% of home health claims were found to be in error resulting in a projected improper payment of over $2.3 billion.

The current home health agencies target areas in the PEPPER were developed based on a review of the previous home health PPS benefit and focusing on areas that could be at risk for improper Medicare payments. The PEPPER team also reviewed studies related to improper Medicare payments, and analyzed national home health agency claims data. Lastly, we coordinated with CMS subject matter experts to obtain guidance and input on the home health target areas. The target areas are evaluated each year, so there may be changes over time in response to changing vulnerabilities within the Medicare program. In a moment I'll be reviewing the changes that are currently planned to the HHA PEPPER target areas following the implementation of the new payment model.

Our goal is to provide statistics that can help identify a higher risk of improper Medicare payment, while understanding and taking into account the services that home health agencies provide.

Let's go into more detail regarding the new HHA payment model. The previous HHA prospective payment system or PPS was based on a case-mix model known as Home Health Resource Groups or HHRGs. CMS, the Office of Inspector General, the Medicare Payment Advisory Commission, the media, and others all identified issues with the HHRG system. Overall, these issues were identified because payments under this model were based on the number of therapy visits provided to patients, regardless of each patient's unique characteristics, needs, or goals, which incentivized the provision of therapy.

The Patient Driven Groupings Model (PDGM), which came into effect on Jan. 1, 2020, is designed to improve payment accuracy and appropriateness by focusing on the patient, rather than the volume of therapy visits provided. For more information about the PDGM, visit the CMS web site, and also take advantage of resources and education available through your Medicare Administrative Contractor. The *Home Health Agency PEPPER* target areas are planned to be revised starting with the first report that reflects statistics for calendar year 2020. At this time we are planning for the following changes:

- Eliminate *High Therapy Utilization Episodes* target area
- Revise *Episodes with 5 or 6 Visits* to reflect when the HHA hits the minimum or minimum+1 number of visits for the respective payment group

- Clinical groupings (there are 12) are assigned based on the PDX. We currently have the top diagnoses report which uses CCS, and we may continue this or Maybe add a report on the 12 clinical groups
- We plan to add two new target areas related to comorbidities
- And add a new target area focused on admission source (these new target areas will be reviewed shortly)

There will also be changes to the supplemental "top" reports; the "Top Therapy Episodes" report will be deleted. In addition, current references to an "episode" will be revised to "period" except for the situation where multiple periods are billed for the same beneficiary within 60 days. More details about these changes will be included in the PEPPER user's guide that will be available in the summer of 2021.

In the PEPPER we refer to a target area as those areas that have been identified as potentially at risk for improper Medicare payment. So basically, a target area is a provision of services or an episode of service that's been identified as prone to improper Medicare payments or abuse. In the PEPPER we generally construct these target areas as ratios, where the numerator is the count of episodes or services that may be problematic and the denominator is a larger reference group.

In the home health PEPPER, we report the statistics as either a percent, as in the majority of the PEPPERs that we produce, or as a rate. We will calculate a rate when the numerator and denominator are measured using different units. Two of our target areas are reported as rate in the home health PEPPER.

So let's review the target areas in the home health report. You'll notice that each of the target areas has a specifically defined numerator and denominator. And we use these numerator and denominator definitions to determine the numerator count or value as well as the denominator. And that allows us to calculate the percent or the rate. The *Average Case Mix* target area calculates the average case mix for episodes ending during the report period. Here we are comparing the sum of the case mix weight for all episodes ending in the report period, excluding the LUPAs and the PEPs, to the number of episodes.

Here we're focused on the risk of over-coding on the OASIS, which can lead to higher payments for the home health agency. Since the numerator and denominator here are a different unit, we are calculating this target area as a rate, not as a percent. If a home health agency has a high average case mix, it could be a potential indication of over-coding. On the other hand, if you know that your patient population tends to have a higher case mix, then that might be something that you would expect to see when you look at your PEPPER.

The next target area, also reported as a rate, focuses on the average number of episodes. Here the concern is that the home health agency is continuing those services beyond the point where they're medically necessary. This is one of those risk areas that was identified in an older OIG report, released in 2012. Here we're calculating the average number of episodes that each beneficiary received and we're dividing the total number of episodes paid to the home health agency by the number of unique, or individual beneficiaries, served by the home health agency. And again, this one is also reported as a rate, not as a percent.

The next target area, also reported as a rate, focuses on the average number of episodes. Here the concern is that the home health agency is continuing those services beyond the point where they're medically necessary. This is one of those risk areas that was identified in an older OIG report, released in 2012. Here we're calculating the average number of episodes that each beneficiary received and we're dividing the total number of episodes paid to the home health agency by the number of unique, or individual beneficiaries, served by the home health agency. And again, this one is also reported as a rate, not as a percent.

The next target area looks at episodes that have five or six visits. To qualify for an HHRG, the beneficiary must have received at least five visits during the 60 day period. If the beneficiary receives less than five visits, then the home health agency received what's called a LUPA, or a Low Utilization Payment Adjustment payment. This LUPA payment is much less than the HHRG payment. So there is obviously a financial incentive for the agency to provide enough visits to qualify for that HHRG payment. If an agency has a high percentage of episodes that have five or six visits, the question would be, did the beneficiary need those additional visits or could they have been served with fewer visits. This target area will be modified for the calendar year 20 reports to identify periods that just exceed the LUPA threshold for the respective payment group, likely by one visit.

The *Non-LUPA Payment* target area, which is the next target area, looks at this same concern, but from another angle. Most home health agencies should have some number of LUPA payments. On average, nationally, that's about 8.5%. So if there are no or very few LUPA payments, then that could also be an indication of that incentive to receive the higher HHRG payment. We expect to retain this target area.

The use of therapy within home health had also been widely known as a risk area; there was an incentive to provide more therapy so that the agency received higher reimbursement. This target area looks at the number of episodes where there were 20 or more therapy visits paid to the home health agency, as a proportion of all the episodes paid to the home health agency. This target area will be retired in the CY 20 report.

The last target area in the home health report is focused on outlier payments which is a concern also identified by the OIG in the older report from 2012. Excessive amount of outlier payments could be an indication of improper Medicare payments, again, to enhance reimbursement. So here we're looking at the total dollar amount of outlier payments for those episodes as compared to the total dollar amount of all episodes paid. And excessive outlier payments, again, may be related to over utilization and necessity of services.

On this slide are the three new target areas that we are planning to add to the calendar year 20 report, planned for release in July, 2021.

To provide some background for these new target areas, some of the factors considered in the PDGM include the following:

- Comorbidity adjustments:
    - The HHA receives a “High comorbidity adjustment” if there are two or more secondary diagnoses that are associated with higher resource use when both are reported

together compared to if they were reported separately. That is, the two diagnoses may interact with one another, resulting in higher resource use.

  - The Home health agency receives a "Low comorbidity adjustment" if there is one reported secondary diagnosis that is associated with higher resource use.
  - The Home health agency receives no comorbidity adjustment if there are no reported secondary diagnoses that could be considered either a low or high comorbidity adjustment.

- Admission source is also now a factor. If the beneficiary was treated in an institutional setting (for example, short-term acute care hospital, long-term acute care hospital, inpatient rehabilitation facility or IRF, inpatient psychiatric facility, IPF, or a skilled nursing facility, SNF within 14 days prior to the HHA admission, the HHA receives a higher adjustment than if the beneficiary was admitted to the Home health agency directly from the community setting. So that represents a financial incentive.

CMS evaluated and approved three new target areas designed to assess the potential for circumventing these new payment adjustments:

- <u>High Comorbidity</u> where the numerator is the count of periods with two or more secondary diagnoses that interact with one another and, therefore, qualify for a high comorbidity adjustment, and the denominator is the count of all periods

- <u>Low Comorbidity</u>
  - Where the numerator is the Count of periods with one or more secondary diagnoses that are associated with higher resource use and, therefore, qualify for a low comorbidity adjustment (excluding periods that also qualify for a high comorbidity adjustment)
  - And the Denominator is the Count of all periods

- <u>Admission Source</u>
  - Where the numerator is the count of periods with discharge from short-term acute care hospitals, long-term acute care hospitals, critical access hospitals, IRFs, IPFs, or SNFs in the 14 days prior to the home health admission and the denominator is the count of all periods

The *Home Health Agency PEPPER* will include these new target areas after one year of PDGM claims are available for inclusion; meaning that the quarter 4 calendar year 20 release of this PEPPER (scheduled for distribution in July 2021) will reflect these changes.