Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

57th Annual Meeting

Thursday, September 3, 2026
Republic ABC Room
1:30pm-2:30pm

5a. Rewiring Rehab for VBP Success

Presented by:

Arnie Cisneros PT, HHSM - Home Health Strategic Management

Thank you to our Partners:

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United Healthcare Community Plan
AXXESS

Rewiring Rehab for VBP Success

TAHCH 57th Annual Meeting

hhsm

1

Home Health Strategic Management

- HH Post-Acute Consulting Firm –Post-Acute Outcomes
- Arnie Cisneros PT – President, SURCH Developer
- UR Mgmnt Model for HH PDGM & VBP Reforms – SURCH
- CMS BPCI Pilot Programs – Comp Joint Replacement
- CMS CMMI - Bundled Post-Acute Bundle Pilot Programs
- Deliver VBP-Level HH Outcomes in Value Era
- HH Management model replicates Medicare Part A success
- Objective, real-time care production & delivery management
- Rehab Management for success in the Value Era

2

Impact Act Reforms Introduce V2V Changes for Medicare Programming

3

Volume to Value Home Health Changes

- PDGM - VBP – connects payment to Value
- Subsequent IMPACT ACT reforms pending for HH
- Introduces Value model w improvement of expectation
- Establishes new clinical baselines for Outcomes
- VBP Model seeks rapid care programs and outcomes
- UR management focuses on best practice delivery

4

Medicare Success w Utilization Review (UR) Care Management

5

Medicare Success w UR Care Management

- Utilization Review – used across care continuum
- Care Management via “Documentation for Coverage
- Acute Care, LTACH, IRF, Sub-Acute Rehab (SNF)
- Requires realtime care management & timely notes
- IDENTICAL to SNF Rehab Minimal Data Set (MDS)
- MDS nurse managed all care , including rehab

6

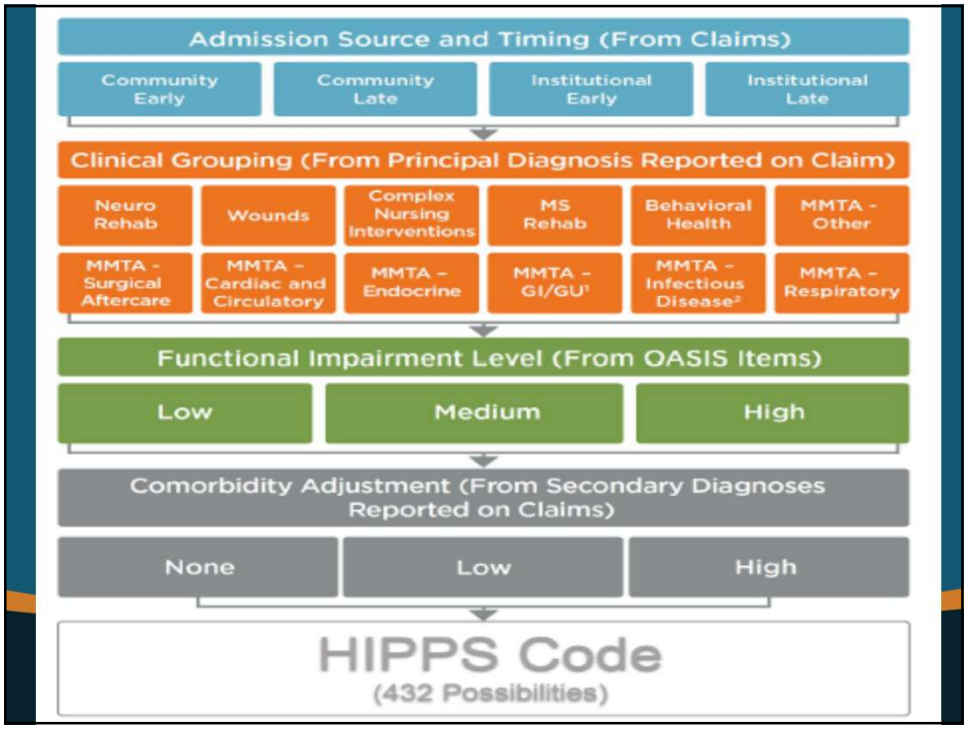
Medicare Success w UR Care Management

- All elements of HH program managed by HH agency
- All care decisions made on objective documentation
- Value HH focuses on best practices and visit content
- Required documentation review & implementation
- Therapist to manage patient program thru Assistant
- Freq/Dur, MVs, Non-compliance, Safety, Falls, CGVR

7

PDGM Outlines Structural Model based on Clinical Groupings and SOC Acuity

8



9

PDGM
Functional ADL Scores for Rehab Utilization

10

Functional Scoring by Clinical Group

FUNCTIONAL LEVELS BY CLINICAL GROUP (BASED ON 2017 DATA)					
Group	Impairment Level	Points (2017)	Group	Impairment Level	Points (2017
Behavioral Health	Low	0-36	MMTA – Cardiac and Circulatory	Low	0-36
	Medium	37-52		Medium	37-52
	High	53+		High	53+
Complex Nursing Interventions	Low	0-38	MMTA – Endocrine	Low	0-51
	Medium	39-58		Medium	52-67
	High	59+		High	68+
Musculoskeletal Rehabilitation	Low	0-38	MMTA Gastrointestinal and Genitourinary Systems	Low	0-27
	Medium	39-52		Medium	28-44
	High	53+		High	45+
Neuro/Stroke Rehabilitation	Low	0-44	MMTA – Infection Disease, Neoplasms, and Blood-Forming Diseases	Low	0-32
	Medium	45-60		Medium	33-49
	High	61+		High	50+
Wounds	Low	0-42	MMTA – Respiratory	Low	0-29
	Medium	43-61		Medium	30-43
	High	62+		High	44+
MMTA – Surgical Aftercare	Low	0-24	MMTA - Other	Low	0-32
	Medium	25-37		Medium	33-48
	High	38+		High	49+

11

PDGM – Real-time Protocol for Rehab POC

- Accurate ADLs for SOC OASIS admission (Walk/Manual)
- ADL score delineates FIL Severity level for visit range
- Low Severity – (0-6), Medium – (7-13), High – (14-20)
- How do we increase OASIS accuracy vs PPS era?
- OASIS - a discipline-neutral document x 25 years
- OASIS accuracy assure acuity integrity – and rehab LOS
- In addition, care content per visit should change V2V
- Establish Value-based HH delivery path for PDGM & beyond

12

Specific Rehab changes for Success in Home Health's Value Era

13

Rehab Changes in the HH Value Model

- Initial Changes will be felt by all Therapists and Assistants
- Timeliness – required for PDGM – VBP success
  - SOC – 24 hours
  - Eval – 48 hours
  - Missed Visits – dilute care – reduced via schedule mgmnt, MD appt not reason for MV
- Freq/Duration maintenance – prospective based on documentation for patient response to treatment
  - 3xwk for unsafe ambulators, avoid 1xwk frequency
  - Examples of 1xwk allowed

14

Rehab Changes in the HH Value Model

- Evaluation – Objective Testing – MMT – by Joint or movement – R hip flx – R hip ext - R Knee flx – R knee ext – R sh flex – R sh ext – etc – required for skilled PREs basd on patient strength
- Weakness related to functional decline will be strengthened via skilled PREs
- Progressive Resistive Exercises –the only skilled therex recognized by Medicare
- Plan of Care – based on FIL guidelines & OASIS ADL declines
- POC – managed by Agency Supervisor (as per MDS)

15

Rehab Changes in the HH Value Model

- Any change to SOC POC must be approved by agency (Sup)
- POC Changes – Frequency changes, DC, Extension, Eval only
- Change requests will be based on documentation to date
- 5-element documentation allows for agency change review
- Gait Training - 150' top limit for distance – feet vs minutes
- Fall prevention essential based on Assistive Device use
- IND w single point cane – NOT Homebound in today's HH
- Safety issues related to patient non-compliance w AD

16

Rehab Changes in the HH Value Model

- Any change to SOC POC must be approved by agency (Sup)
- OT – placed in home for ADL declines – Groom, Bath, Toileting, Equipment, etc.
- Some shallow OT declines may be referred to PT
- Equipment must be ordered initially – won't extend for DME
- HHA may be assigned for initial assist – will leave w OT
- Therapeutics Exercise – PREs – Accurate & performed during visit – Must relate to MMT findings and functional performance during visit

17

Rehab Changes in the HH Value Model

- Any change to SOC POC must be approved by agency (Sup)
- 3 (FAIR) MMT Eval grade – gravity neutralized to start
- Progress per visit after re-performance - compliance demo
- Significant change from current exercises – Reps, Sets?
- Miscellaneous items - No Copy and Paste – federal law
- Therapists to manage case – concerns must involve supervising therapist
- Therapist communicates w agency supervisor if necessary

18

Speech Services in Home Health's Value Era

19

Thoughts on MSB-PAC Spending Initiative & the effects on Rehab

20

Impact Act Era
HH Rehab Denials

21

Impact ACT HH Rehab Denial

- HH Episode s/p Acute care Admission
  - SOC Dx – DM, HTN, UTI
  - SOC Subjective – Pt reports “Still sick and weak”
  - OASIS M1400 – 3 – dyspnea with minimal exertion
  - OASIS M1600 – Incontinent
  - OASIS M1800/M1810 – 2 Assist in UE and LE dressing

22

Impact ACT HH Rehab Denial

- M1860 – 3 - Unsafe – home cluttered with Fall Risk
- PT Eval – ambulates SBA x 25 feet w/o LOB
- Denial followed – PT Eval – OT Eval – 10 SN Visits
- Upon audit, patient declared "NOT HOMEBOUND"
- In addition, Ind dressing based on M1810/1820 – 2
- Audit Review – Did this patient need Home Health?

23

Impact ACT HH Rehab Denials

- Medicare employs OASIS/Discipline note for denials
- How do we demo skilled care for coverage?
- Are we documenting to validate/complete care?
- Exam – Min asst Dressing interpreted as "handing clothes to patient" OT denied (OASIS Dress – 2)
- Audit may affect entire program denial w rehab

24

Medicare Required Home Health Documentation Nursing - Rehab

25

HHSM SURCH Medicare Required Documentation

- CMS-required documentation required for value coverage
- SOC/Evaluation *Accuracy* – rehab objective baselines
- *STG/LTG* – for all disciplines – all goals
- *Compliance/Caregiver* Involvement – SOC/Evals & visits
- *Home Program* Development – for *ALL* disciplines
- Discharge Statement – each visit, related to DC plans
- Documentation for Coverage (DFC) assures Value success
- HH Clinical staff experience with DFC from inpatient jobs

26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27