AXXESS

PDGM BASICS

SPEAKER

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Introduction to PDGM

- Patient-Driven Groupings Model to begin January 1, 2020
- Replaces Health Prospective Payment System (HHPPS)
- Mandated by Bipartisan Budget Act of 2018
- Finalized in CY 2019 HHPPS Final Rule

Provisions of PDGM

- Alignment of payment with costs
- Fair compensation for home health agencies
- Access to care for more acutely ill patients
- Elimination of therapy-driven payment and incentives
- Grouping of patients into clinically meaningful payment categories
- Improved quality

Current HHPPS System

- Produces lower margins for patients:
  - Needing non-oral nutrition
  - With traumatic wounds or ulcers
  - Who required substantial assistance in bathing
  - Admitted to home health following an acute or post-acute stay
  - Who have a high hierarchical condition category score
  - Who had certain poorly controlled clinical conditions
  - Who were dually eligible

PDGM Impact on Payment

- Budget-neutral approach
- RAPs will continue (with exceptions)
- LUPAs remain (with changes)
- PEPs maintained
- Outlier policy maintained

Distribution of Resource Use Across Current Episode Configuration

Mean Visits & Resource Use in each 15 Day Segment of a (Full) and First 60-Day Episode among CY 2013 Episodes; n=836,815

	Days 1-15	Days 16-30	Days 31-45	Days 46-60
Total Visits	**8.1**	**6.3**	**5.0**	**4.5**
SN Visits	4.2	2.6	2.3	2.3
PT Visits	2.4	2.1	1.5	1.2
OT Visits	0.7	0.6	0.4	0.3
SLP Visits	0.1	0.1	0.1	0.1
Aide Visits	0.7	0.7	0.6	0.5
MSS Visits	0.1	0.1	0.0	0.0
Resource Use	**$307.45**	**$210.89**	**$166.23**	**$153.81**

Documentation and Payment Periods

Home Health Prospective Payment System

- Documentation Period:
  60-day episodes
- Comprehensive Assessment Timeline: 60 days per §484.55
- Unit of Payment: 60 days

Patient-Driven Groupings Model

- Documentation Period:
  60-day episodes
- Comprehensive Assessment Timeline: 60 days per §484.55
- Unit of Payment: 30 days

Standard Payment Rates

Home Health Prospective Payment System

- $3,154 national standard 60-day episode payment rate
- $15-$570 Non-Routine Supplies (NRS) payment add-on per 60-day episode
  - Based on OASIS responses

Patient-Driven Groupings Model

- $1,874 estimated proposed national 30-day period payment rate (needed for budget neutrality)
  - Before 6.425% decrease for behavioral adjustments
  - NRS is built in to payment rate
- Actual rate will be set in 2020 payment final rule

How Cost is Calculated

Home Health Prospective Payment System

- During 60-day episode:
  - Wage Weighted Minutes of Care from Bureau of Labor Statistics
  - Hospital-based wage information and estimated costs
  - No consideration of overall costs such as transportation
  - Costs are aggregated for the home health service industry

Patient-Driven Groupings Model

- During care episode:
  - Cost-Per-Minute plus NRS
  - Incorporates a wider variety of costs (such as transportation)
  - Costs are available for individual HHA providers

Comparison of Approaches

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

Advantages of Cost Types

Wage Weighted Minutes of Care	Cost-Per-Minute plus Non-Routine Supplies
Incorporates labor categories (RN vs LPN/LVN)	Integrated into one payment system, rather than a separate model
Bureau of Labor Statistics data are available more quickly	Incorporation of more than just visit costs
No imputation of resource use versus cost is needed	Lower ratio of SN to Therapy costs

Case Mix Structure

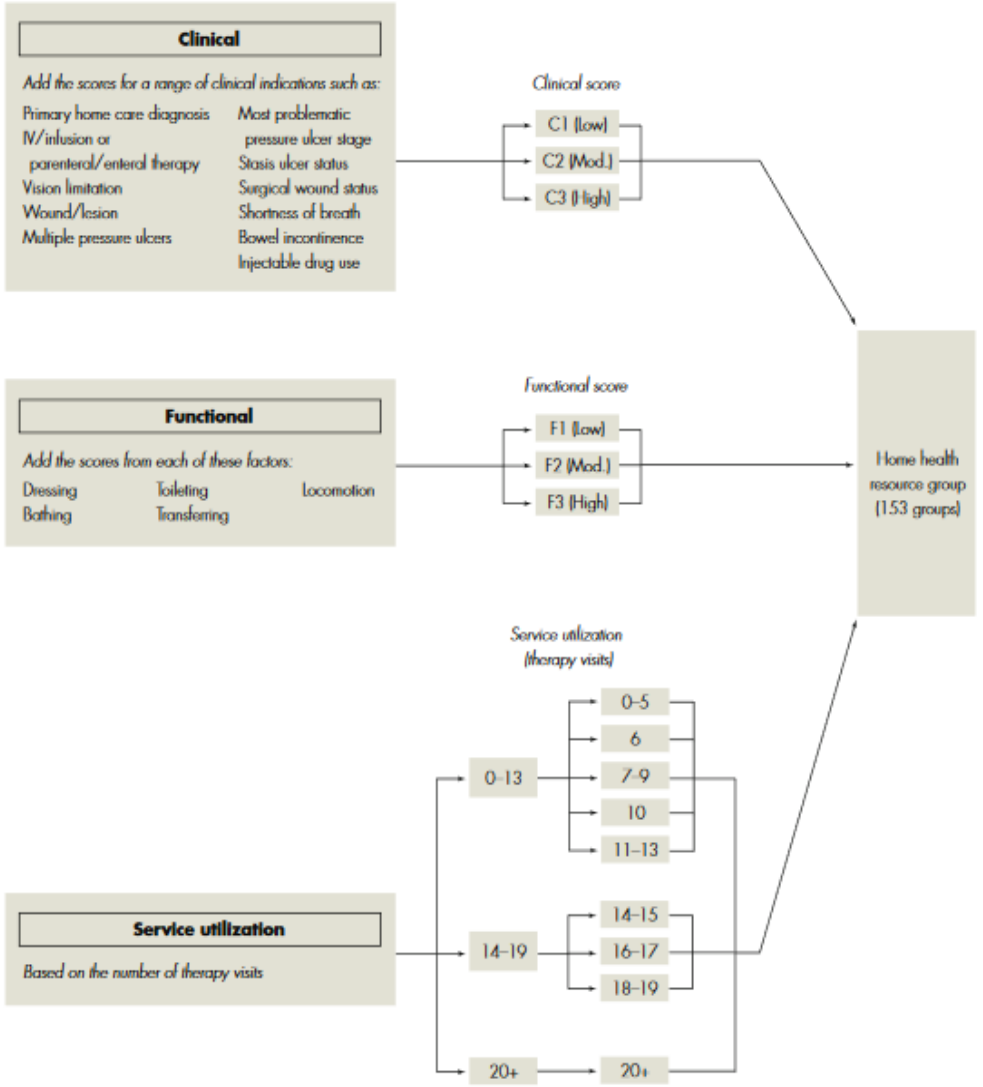
Home Health Prospective Payment System

- Admission source and timing (from OASIS)
- Clinical Domain (from OASIS)
- Functional Domain (from OASIS)
- Service Utilization Domain (from OASIS)
- NRS adjustment calculation (from OASIS)
- **153** Home Health Resource Groups

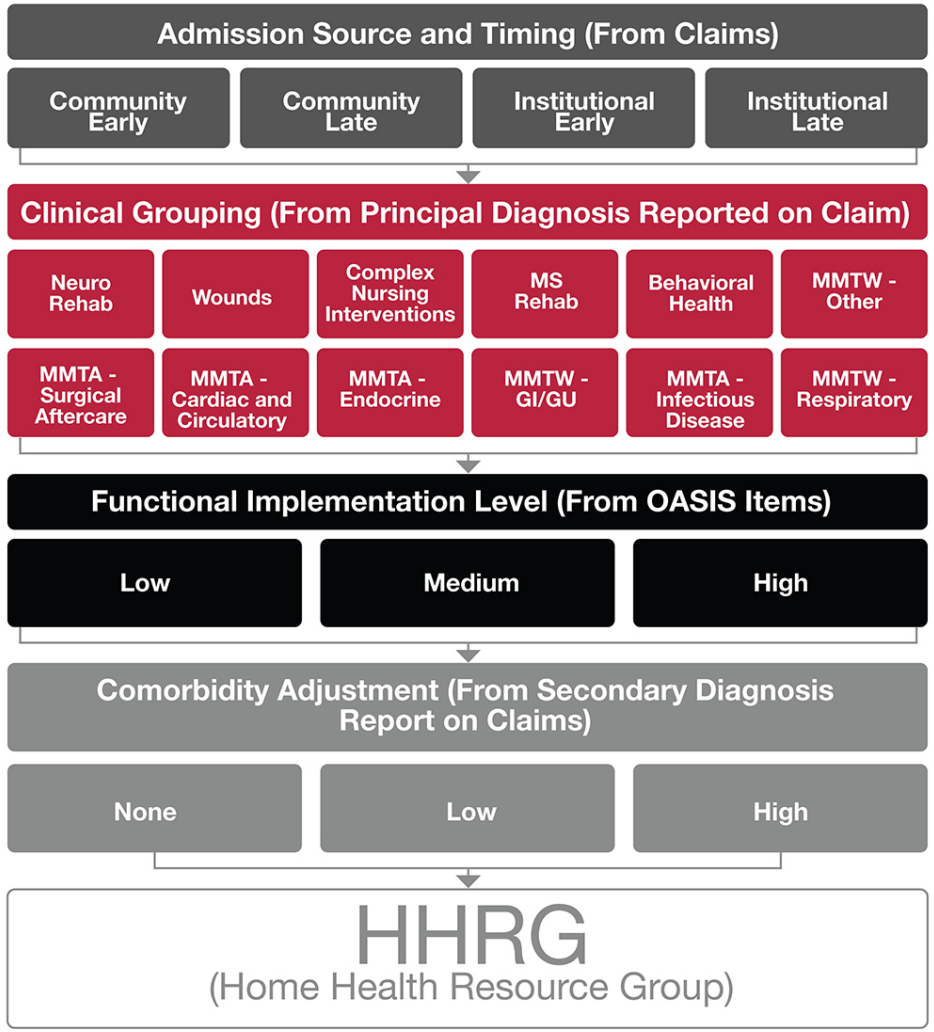
Patient-Driven Groupings Model

- Admission source and timing (from claims data)
- Clinical severity (primary diagnosis on claim)
- Functional severity (from OASIS)
- Possible comorbidity adjustment (from secondary diagnoses on claim)
- **432** Home Health Resource Groups

Overview of HHPPS



Overview of PDGM



Comparison of Timing

HHPPS Groupers: Timing

- **Based on OASIS items**
- M0110: Episode Timing (Early/Late)
- M2200: Therapy Need
- Four Groupers
- **Early** = first (2) 60-day episodes
- **Late** = all subsequent 60-day episodes
- Resets with >60 day gap between episodes

PDGM Groupers: Timing

- **Based on Claims data**
- Timing: Early/Late
- Admission source: Community/Institutional
- Four Groupers
- **Early** = first 30 days only
- **Late** = all other 30-day periods of care
- Resets with >60 day gap between periods of care

HHPPS Episode Timing Groupers

		1st and 2nd Episodes		3rd+ Episodes		All Episodes
		0 to 13 therapy visits	14 to 19 therapy visits	0 to 13 therapy visits	14 to 19 therapy visits	20+ therapy visits
Grouping Step		1	2	3	4	5

PDGM Episode Timing Groupers

Clinical Grouping

HHPPS Groupers: Clinical

- **Based on combination of OASIS item responses**
- Three clinical severity levels
- Assignment is based on points range for each severity:
  - C1: Low
  - C2: Medium
  - C3: High

PDGM Groupers: Clinical

- **Based on Claims data**
- Primary diagnosis only
  - 43,287 diagnoses of 94,444
- 12 clinical groups
- Each clinical group has its own severity threshold:
  - Low
  - Medium
  - High

Clinical Grouping

HHPPS Groupers: Clinical

- M1021 Primary Diagnosis
- M1023 Secondary Diagnosis
- M1030 Therapy at home
- M1200 Vision
- M1242 Pain
- M1311 & M1324 Pressure Ulcer Stages
- M1334 Stasis Ulcer Stages
- M1342 Surgical wound status
- M1400 Dyspnea
- M1620 Bowel Incontinence
- M1630 Ostomy
- M2030 Injectable drug use

PDGM Groupers: Clinical

- Primary Diagnosis
  - Behavioral health
  - Complex nursing
  - Musculoskeletal rehabilitation
  - Neuro/Stroke rehabilitation
  - Wounds
  - Medication Management/Teaching/Training (MMTA)
    - Seven subcategories of MMTA

Clinical Grouping

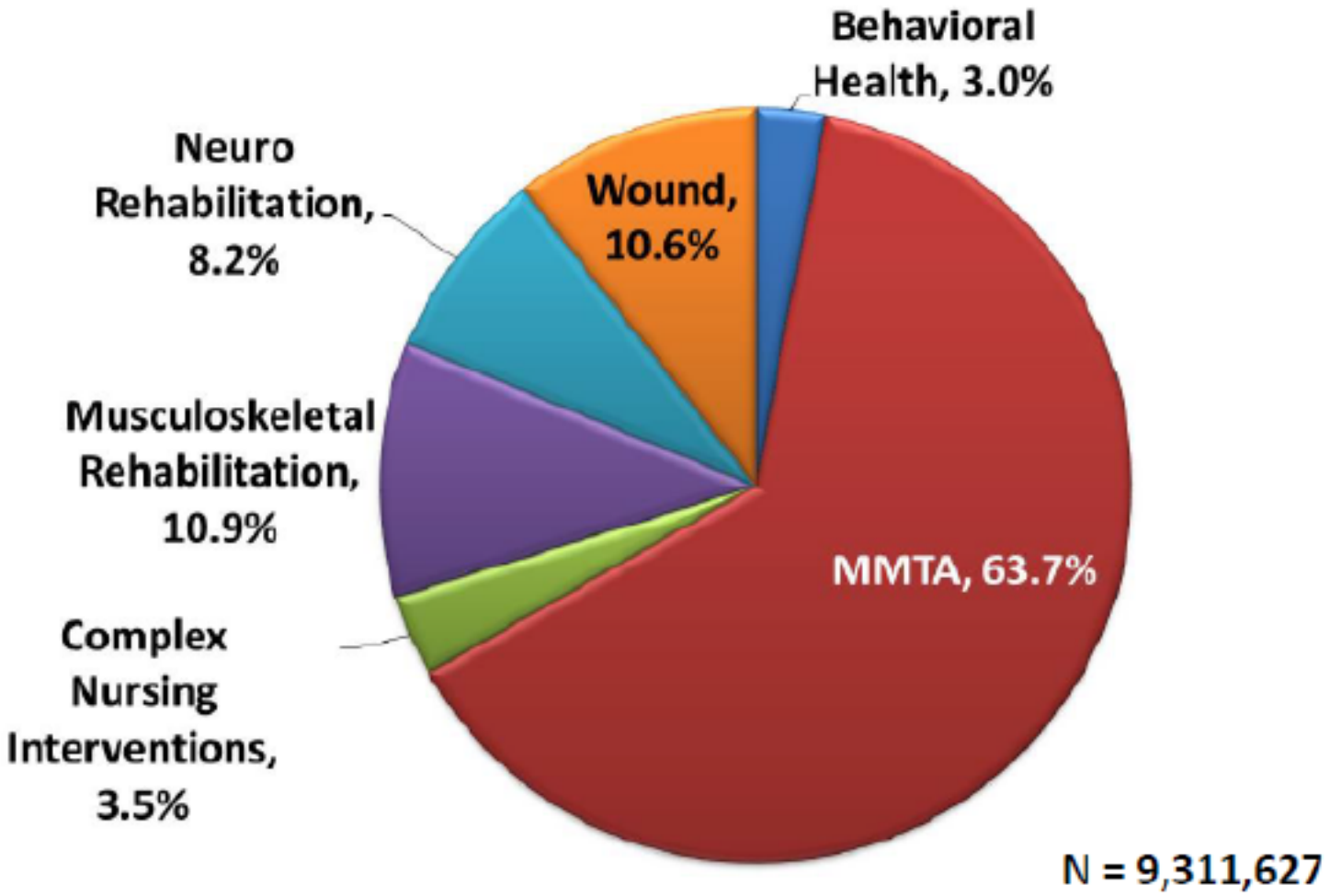
PDGM Groupers: Clinical

- MMTA Subcategories
  - Cardiac/Circulatory
  - Endocrine
  - Gastrointestinal/Genitourinary related conditions
  - Infectious disease/neoplasms/blood forming diseases
  - Respiratory
  - Surgical aftercare
  - Other

PDGM Clinical Grouping

CLINICAL GROUP	PRIMARY REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/ Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers burns and other lesions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and sub-stance abuse conditions
Medication Management, Teaching and Assessment (MMTA) • MMTA –Surgical Aftercare • MMTA – Cardiac/Circulatory • MMTA – Endocrine • MMTA – GI/GU • MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases • MMTA –Respiratory • MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.

Percentage of Periods by Clinical Group



Functional Groupings

HHPPS Groupers: Functional

- **Based on OASIS items**
- Three functional impairment levels from six OASIS items
  - F1
  - F2
  - F3
- Each grouper has its own points threshold

PDGM Groupers: Functional

- **Based on OASIS items**
- Three functional impairment levels:
  - Low
  - Medium
  - High

Functional Groupings

HHPPS Groupers: Functional

- **Based on OASIS items**
- M1810 or M1820 Dressing upper or lower body (1, 2 or 3)
- M1830 Bathing (2 or >)
- M1840 Toilet Transferring (2 or >)
- M1850 Transferring (2 or >)
- M1860 Ambulation (1, 2, or 3)
- M1860 Ambulation (4 or more)

PDGM Groupers: Functional

- **Based on OASIS items**
- M1800 Grooming
- M1810 Dressing Upper Body
- M1820 Dressing Lower Body
- M1830 Bathing
- M1840 Toilet TF
- M1850 Transferring
- M1860 Ambulation/Locomotion
- M1033 Risk for Hospitalization

Comorbidity Adjustment

HHPPS

- No comorbidity adjustment

PDGM

- Secondary diagnoses may contribute to a comorbidity adjustment category
  - No comorbidity adjustment
  - Low comorbidity adjustment
  - High comorbidity adjustment

Comorbidity Adjustment

HHPPS

- No comorbidity adjustment

PDGM

- No adjustment
- Low adjustment
  - There is a reported secondary diagnosis that is associated with higher resource use
- High adjustment
  - There are two or more secondary diagnoses that are associated with higher resource use when reported together compared to if they were reported separately

Comorbidity Subcategories

- Heart disease (11)
- Respiratory disease (9)
- Circulatory disease and blood disorders (12)
- Cerebral vascular diseases (4)
- Gastrointestinal disease (9)
- Neurological and associated conditions (11)
- Endocrine (6)
- Neoplasms (24)

Comorbidity Subcategories

- Genitourinary and renal (5)
- Skin (5)
- Musculoskeletal disease or injury (5)
- Behavioral (11)
- Infectious diseases (4)

Non-Routine Supplies in HHPPS

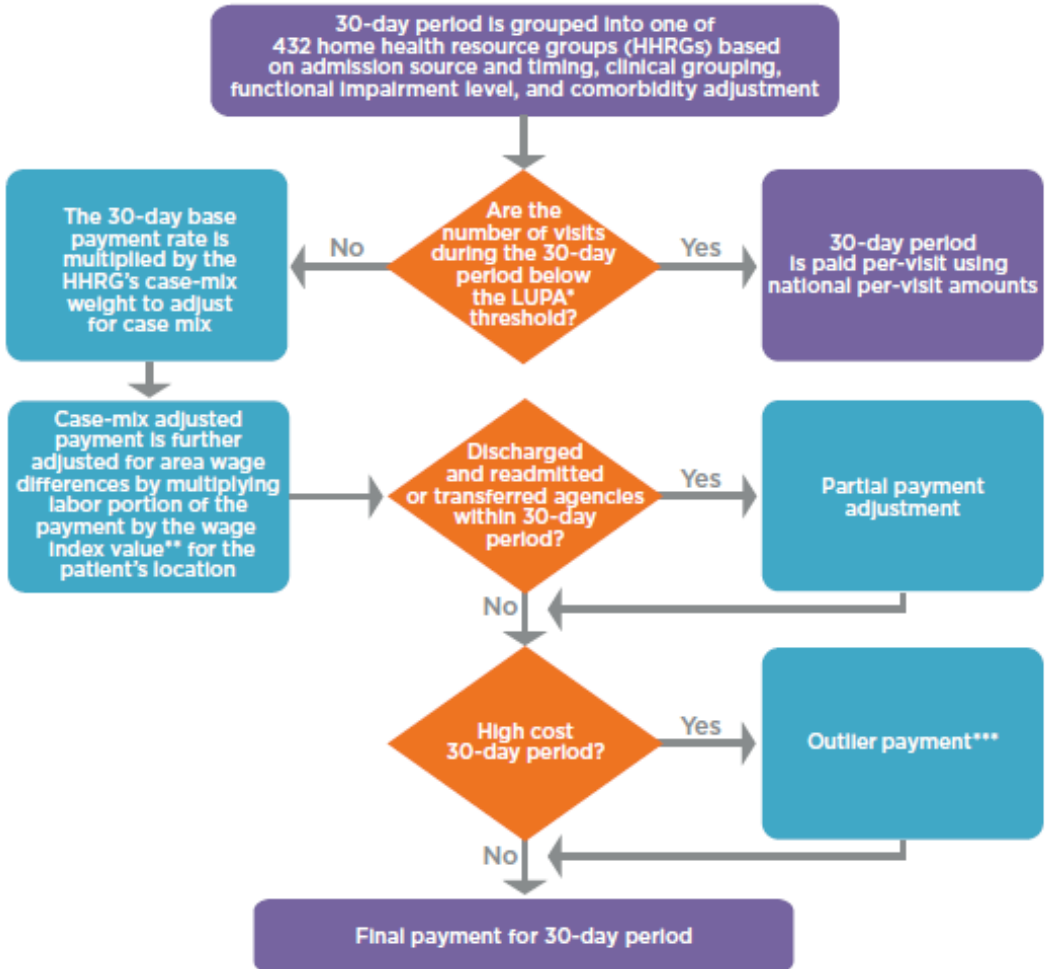
- In HHPPS, NRS cost is calculated by an algorithm using diagnoses and OASIS items
- The payments range from $14.62 to $570.48

Non-Routine Supplies in PDGM

- Resource use based on the estimated cost of visits plus the cost of NRS recorded on claims
- Cost of NRS is generated by taking NRS charges on claims and converting them to costs using an NRS cost to charge ratio that is specific to each HHA
- When NRS is factored into the average resource use, that establishes the case-mix weights
- In PDGM, NRS would still be paid prospectively
- No separate case-mix adjustment model is needed such as in HHPPS currently

PDGM: Payment and Adjustments

FIGURE 2: HOW PAYMENTS AND ADJUSTMENTS ARE CALCULATED FOR THE PATIENT-DRIVEN GROUPINGS MODEL



Payment Adjustments: LUPA

HHPPS

- Low-utilization payment adjustment (LUPA) for fewer than five visits made in 60-day episode

PDGM

- LUPA threshold varies for each payment group
- Per 30-day payment period
- Ranges from two to six visits

Payment Adjustments

HHPPS

- Outlier payments
- Partial Episode Payment (PEP)
- Per 60-day episode

PDGM

- Outlier payments
- Partial period payment
- Per 30-day payment period

PDGM and RAPs

- Agencies certified on or after January 1, 2019 will submit no-payment RAPs every 30 days
- Agencies certified before January 1, 2019 will continue to submit RAPs for split payment
- Agencies certified before January 1, 2019 will receive 60/40 split payment first 30 days, 50/50 split on subsequent 30 day periods

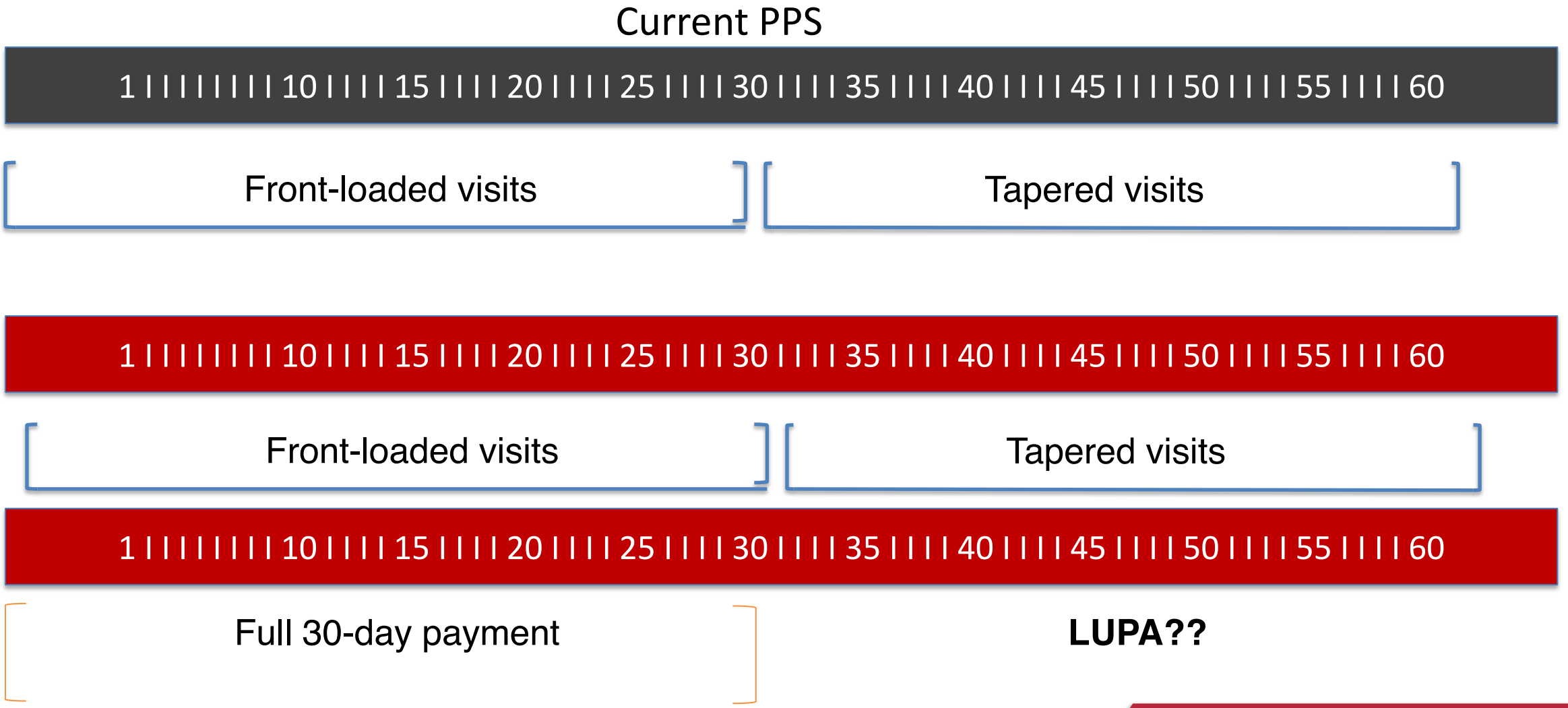
PDGM Payment Appeals

- Because the assignment of the payment classification will be performed by the claims system based on data reported by the HHA on the claim or the corresponding patient assessment:
  - The provider could correct this information to change the assignment of patient classification and resulting payment
  - The agency could submit a correction OASIS assessment and subsequently adjust their claim after the corrected assessment is accepted or
  - Correct the payment-related items on the claim (occurrence code, diagnosis code, etc.) and submit the adjusted claim.

Other Notes

- Medicare Advantage (MA) are private plans and may choose to change their payment models to mirror PDGM
- Agencies will need to contact each private MA plan to find out details of coverage prior to 2020
- PDGM will have no impact on Medicare secondary payer process

Strategy Thoughts



Preparation

WHY	HOW
PDGM will impact all operations of agency	Educate all personnel on changes
Relies heavily on accurate ICD-10-CM coding	Assess current coding processes and accuracy
Increases number of billing transactions due to shorter payment periods	Assess current billing processes and timelines
Therapy utilization no longer a payment characteristic	Assess current orders management and documentation practices
Relies heavily on admission source and timing	Assess resource utilization to assure patient-centered care
Exposes poor assessment and case management	Ensure clinical competency of assessment and case management and utilization of technology to assist

CMS' Education Plans

- Update Home Health Agency Billing chapter of the Medicare Claims Processing Manual
- Educational publications: MLN matters, YouTube, announcements, MAC website articles
- Individuals can email: HomehealthPolicy@cms.hhs.gov

Resources For This Presentation

- MLN Connects “Home Health Payment Reform – The Home Health Groupings Model”, January 18, 2017, National Provider Call
- “Home Health Care Services Payment System”, Revised October 2018. www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_hha_final_sec.pdf?sfvrsn=0
- MLN booklet “Home Health Prospective Payment System”, March 2018. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Health-PPS-Fact-Sheet-ICN006816.pdf

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