The best practices are
the ones that work for **you.**[SM]

Home Health Patient-Driven Groupings Model
Understanding Medicare's new home health payment mechanism

In November 2018, CMS announced an overhaul of the way home health agencies will be reimbursed under Medicare. The new model, the Patient-Driven Groupings Model (PDGM), will go into effect on January 1st, 2020.

Qualifications for the Medicare Part A Home Health Benefit

Under PDGM, Medicare will continue to reimburse providers that meet the same qualifications as the current model.

Patient Eligibility Criteria

- Homebound
- Require skilled services
- Be under a physician's plan of care, following an initial face-to-face encounter

Services Furnished

- Part-time or intermittent skilled nursing (<8 hours/day and < 35 hours/week)
- Physical, occupational, speech therapy
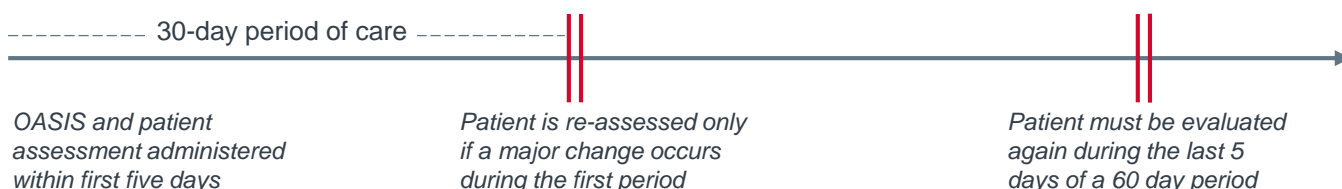- Medical social services
- Home health aide services

> ⚠ Does not cover private duty services, DME[1], or NPWT[2] furnished using a disposable device

The Home Health Prospective Payment System

Beginning in 2020, payment rates for 30-day periods of care will be determined using information gathered from the Outcome and Assessment Information Set (OASIS) and claims data. This information is used to classify periods into one of 432 different case-mix groups, each of which corresponds to a pre-determined payment rate. The shift from 60-day episodes to 30-day periods is a significant change from the current system.

Timeline of patient assessments and provider payments

Even though payments will be made for 30-day periods of care, providers will only need to perform comprehensive patient assessments at the beginning and end of 60 days, unless there is a significant change during the first 30 days.

30-day period of care

OASIS and patient assessment administered within first five days

Patient is re-assessed only if a major change occurs during the first period

Patient must be evaluated again during the last 5 days of a 60 day period

Source: CMS, "Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations," *Federal Registrar* (November, 13, 2018); Post-Acute Care Collaborative interviews and analysis.

1) Durable medical equipment.
2) Negative pressure wound therapy.

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PDGM Payment Categories and Adjustments

Each 30-day period will be assigned to a payment group based on information from OASIS and claims data across four categories. The period will be classified into one subgroup in each category, the combination of which will determine the case-mix rate for that period.
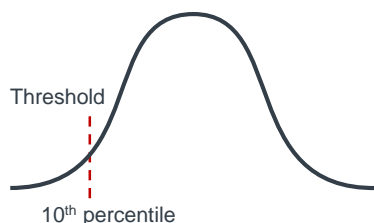
Category	Data source	Calculation details	Subgroups
Admission source and timing	Claims, based on setting utilized in the 14 days prior to home health admission	*First 30-day period is considered early, all subsequent periods are classified as late*	• Community[1] early • Community late • Institutional[2] early • Institutional late
Clinical grouping	Principal diagnosis as reported on claims	*Primary reason for receiving home health care*	• Musculoskeletal rehab • Neuro/stroke rehab • Wounds • Complex nursing • Behavioral health care • MMTA[3] - divided into 7 subgroups[4]
Functional level	OASIS	*Within each clinical group, 1/3 of periods will be assigned to each subgroup, based on CMS thresholds*	• Low • Medium • High
Comorbidity adjustments	Secondary diagnosis as reported on claims	*If there are no, one, or two or more secondary diagnoses associated with higher resource use*	• None • Low • High

Payment adjustments

There are two payment adjusters for periods of care that utilize much fewer or much more resources than average.

Low resource (LUPA)

Number of visits in a payment group

Threshold

10th percentile

If the total number of visits over a 30-day period is below the LUPA threshold for that payment group, the period is paid at a per-visit rate.

Outlier payment

$$\frac{\text{(Wage-adjusted fixed dollar loss amount) + (Case-mix and wage-adjusted period payment)}}{= \text{Outlier threshold}}$$

• For periods with an exceptionally large number or costly mix of visits

• If the cost of the 30-day period exceeds a CMS threshold, the agency receives a payment of 80% of the difference between their imputed costs and the threshold amount

1) Admission from prior home health or a primary care provider.
2) Admission from an acute or post-acute facility.
3) Medication management, teaching, and assessment.
4) Subgroups include: surgical aftercare, cardiac and circulatory, endocrine, gastrointestinal tract and genitourinary system, infectious disease, respiratory, other.

Source: CMS, "Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations," *Federal Registrar* (November, 13, 2018); Post-Acute Care Collaborative interviews and analysis.

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Major Changes and Implications of the New Model

Implications for Budget Neutrality

CMS has designed PDGM to be a budget neutral change for providers—meaning that the new model will have no impact on overall reimbursement. However, this claim is based on three behavioral assumptions about the way home health agencies will respond to these changes. The model assumes providers will:

1 Change coding and documentation practices to put the highest-paying diagnosis as the principal diagnosis

2 Code for comorbidities whenever possible to receive a payment increase of up to twenty percent

3 Actively avoid LUPAs by adding visits until they reach the minimum threshold

6.42%

Potential reduction in payment for agencies that do not make these behavioral adjustments

Home health agencies that do not quickly make these adjustments risk facing reduced reimbursement when the model goes into effect. Providers will need to make two major changes to prepare:

▶ Help staff understand new coding practices and LUPA strategy

▶ Streamline care planning process at admission to ensure optimal assessment

How to Prepare for the Main Program Changes

The changes implemented under PDGM are intended to more accurately reimburse providers for the clinical complexity of the patients they manage and reduce the incentive to over-provide therapy. PDGM, much like the SNF Patient-Driven Payment Model (PDPM), is yet another sign from CMS of a shift from volume to value.

Although there are many differences in this new model, there are two major changes that providers should begin to prepare for now:

	Why the change was made	*How to prepare*
The number of therapy visits is no longer used to determine payment	• To reduce costs by removing the incentive to over-provide therapy • To more appropriately reimburse providers for managing complex patients who do not require therapy	• Closely watch resource use over a period; match the need for high-cost providers with clinical needs • Partner with upstream providers to bolster clinically capabilities
Providers will be reimbursed for 30-day periods of care instead of 60-day episodes	• Costs are higher, on average, during the first 30-days • Shorter payment periods promote more accurate reimbursement as patient needs change over time	• Invest in accurately assessing patient needs at the beginning of a period

Source: CMS, "Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations," *Federal Registrar* (November, 13, 2018); Post-Acute Care Collaborative interviews and analysis.

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