mln call

Overview of the Patient-Driven Groupings Model (PDGM)

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Acronyms in this Presentation

- **BLS:** Bureau of Labor Statistics
- **CPM + NRS:** Cost per Minute + Non-Routine Supplies
- **CY:** Calendar Year
- **HH PPS:** Home Health Prospective Payment System
- **HH:** Home Health
- **HHAs:** Home Health Agencies
- **HHRGs:** Home Health Resource Groups
- **HIPPS:** Health Insurance Prospective Payment System
- **ICD:** International Classification of Diseases
- **IV:** Intravenous
- **LUPA:** Low Utilization Payment Adjustment
- **MedPAC:** Medicare Payment Advisory Commission

- **MMTA:** Medication Management, Teaching, and Assessment
- **MS:** Musculoskeletal
- **MSS:** Medical Social Services
- **OASIS:** Outcome and Assessment Information Set
- **OT:** Occupational Therapy
- **PDGM:** Patient-Driven Groupings Model
- **PT:** Physical Therapy
- **RAP:** Request for Anticipated Payment
- **SLP:** Speech Language Pathology
- **SN:** Skilled Nursing
- **WWMC:** Wage Weighted Minutes of Care

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1. **Current HH PPS****

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4. **30-Day Periods**

5. **Admission Source and Timing**

6. **Clinical Groups**

7. **Functional Impairment Levels**

8. **Comorbidity Group**

9. **Case-Mix Weights**

10. **Other Adjustments**

11. **Grouper Tool and Example Scenarios**

12. **Operational Changes**

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Current Home Health Prospective Payment System (HH PPS)

- Implemented in October 2000
  - Bundled payment for all covered HH services provided in a 60-day episode

- Level of payment determined by case-mix adjustment
  - Allows different payment for patients with different needs

- Differential resource use intensity measured using wage-weighted minutes of care (WWMC)
  - Amount of time multiplied by average wages from the Bureau of Labor Statistics (BLS) by home health discipline

Current Home Health Prospective Payment System, continued

- Home Health Agencies (HHAs) complete the Outcome and Assessment Information Set (OASIS) for each patient

- Result of the assessment groups episode into one of 153 Home Health Resource Groups (HHRGs)
  - Timing (early/late episodes; exception 20+ therapy group)
  - 3 clinical levels
  - 3 functional levels
  - 9 service use categories (number of therapy visits)

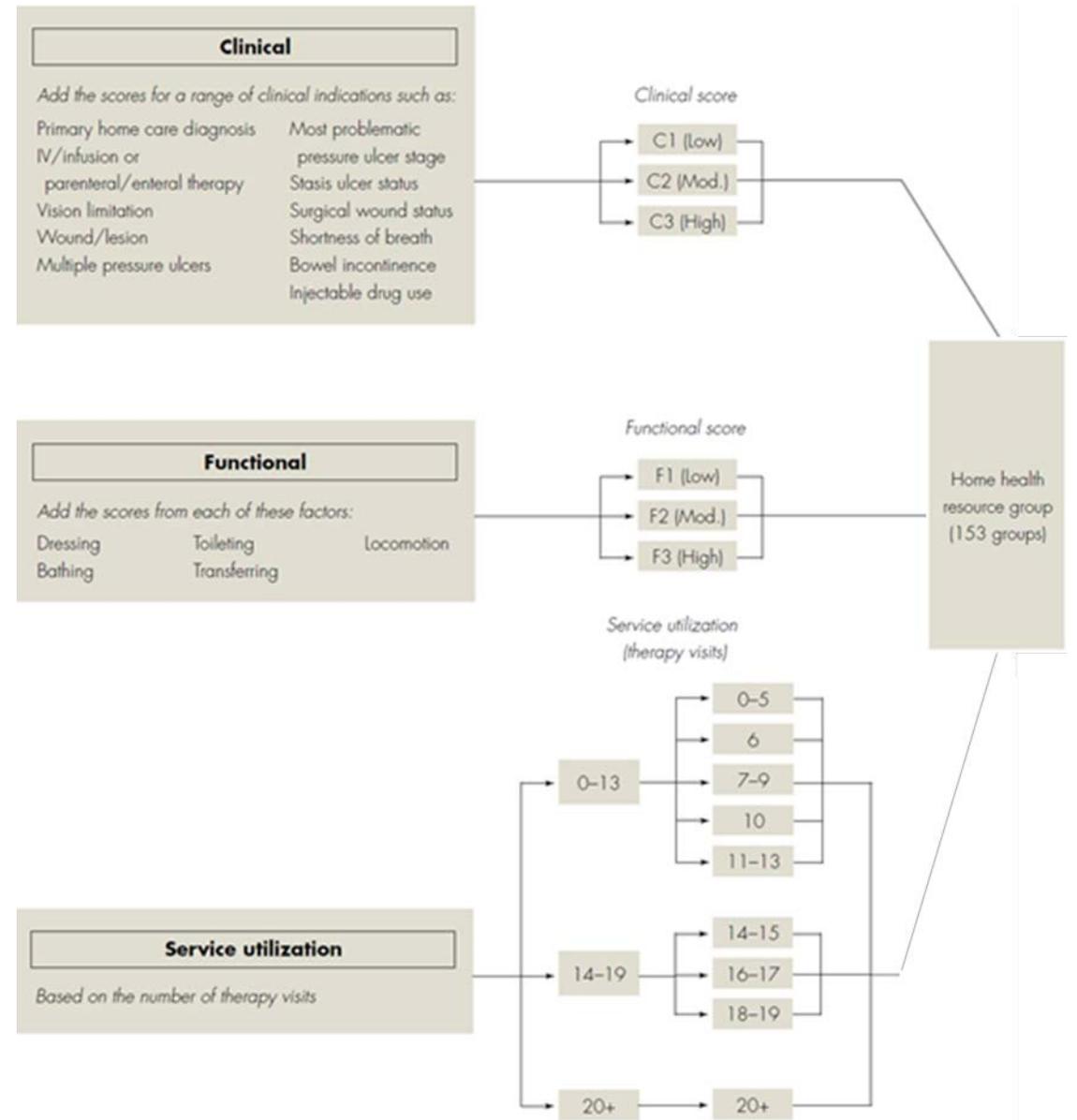- HHRG is the starting point for payment calculation

Current Home Health Prospective Payment System, continued

153 Home Health Resource Groups (HHRGs) based on severity levels:

- **Clinical:** whether the patient has one or more clinical conditions such as incontinence; intravenous infusion (IV), enteral, or parenteral therapies; the presence of wounds or pressure ulcers, etc.

- **Functional:** whether the patient has problems with activities of daily living such as dressing, bathing, transferring, walking (locomotion), and toileting

- **Service utilization:** based on the number of therapy visits during the episode

Clinical

Add the scores for a range of clinical indications such as:

Primary home care diagnosis	Most problematic pressure ulcer stage
IV/infusion or parenteral/enteral therapy	Stasis ulcer status
Vision limitation	Surgical wound status
Wound/lesion	Shortness of breath
Multiple pressure ulcers	Bowel incontinence
	Injectable drug use

Clinical score
- C1 (Low)
- C2 (Mod.)
- C3 (High)

Functional

Add the scores from each of these factors:

Dressing	Toileting	Locomotion
Bathing	Transferring	

Functional score
- F1 (Low)
- F2 (Mod.)
- F3 (High)

Service utilization (therapy visits)

0–13
- 0–5
- 6
- 7–9
- 10
- 11–13

14–19
- 14–15
- 16–17
- 18–19

20+
- 20+

Service utilization

Based on the number of therapy visits

Home health resource group (153 groups)

Motivation for Development of the PDGM – Section 3131(d) Report to Congress

- Section 3131(d) of the Affordable Care Act - Report to Congress found current payment system produced lower margins for those patients:

    - needing parenteral nutrition
    - with traumatic wounds or ulcers
    - who required substantial assistance in bathing
    - admitted to HH following an acute or post-acute stay
    - who have a high Hierarchical Condition Category score
    - who had certain poorly controlled clinical conditions
    - who were dual eligible

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/HH-Report-to-Congress.pdf

Motivation for Development of the PDGM – MedPAC Annual Reports (2011, 2015, 2017)

- The Medicare HH benefit is ill-defined

- HH payment should not be based on the number of therapy visits
  - Payments based on therapy thresholds creates financial incentives that distract agencies from focusing on patient characteristics when setting plans of care.
  - Trend of notable shifts away from non-therapy visits.

- HH payment should be determined by patient characteristics

Development of the PDGM

- Reexamined payment reform principles
  - Improve payment accuracy for HH services
  - Promote fair compensation to HHAs
  - Increase the quality of care for beneficiaries

- Conducted initial analytic work
  - Assessing utilization of current payment system
  - Considered alternative approaches to construct case-mix weights
    - Diagnosis on top
    - Predicted therapy
    - Home Health Groupings Model

- Payment reform solidified by Bipartisan Budget Act of 2018
  - Payment based on 30-day periods (instead of 60-day episodes)
 - Elimination of therapy thresholds

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Patient-Driven Groupings Model (PDGM)

- The PDGM is a new payment model for the Home Health Prospective Payment System (HH PPS) that relies more heavily on clinical characteristics and other patient information to place home health periods of care into meaningful payment categories and eliminates the use of therapy service thresholds.

- PDGM will take effect January 1, 2020.

- In conjunction with the implementation of the PDGM there will be a change in the unit of home health payment from a 60-day episode to a 30-day period.
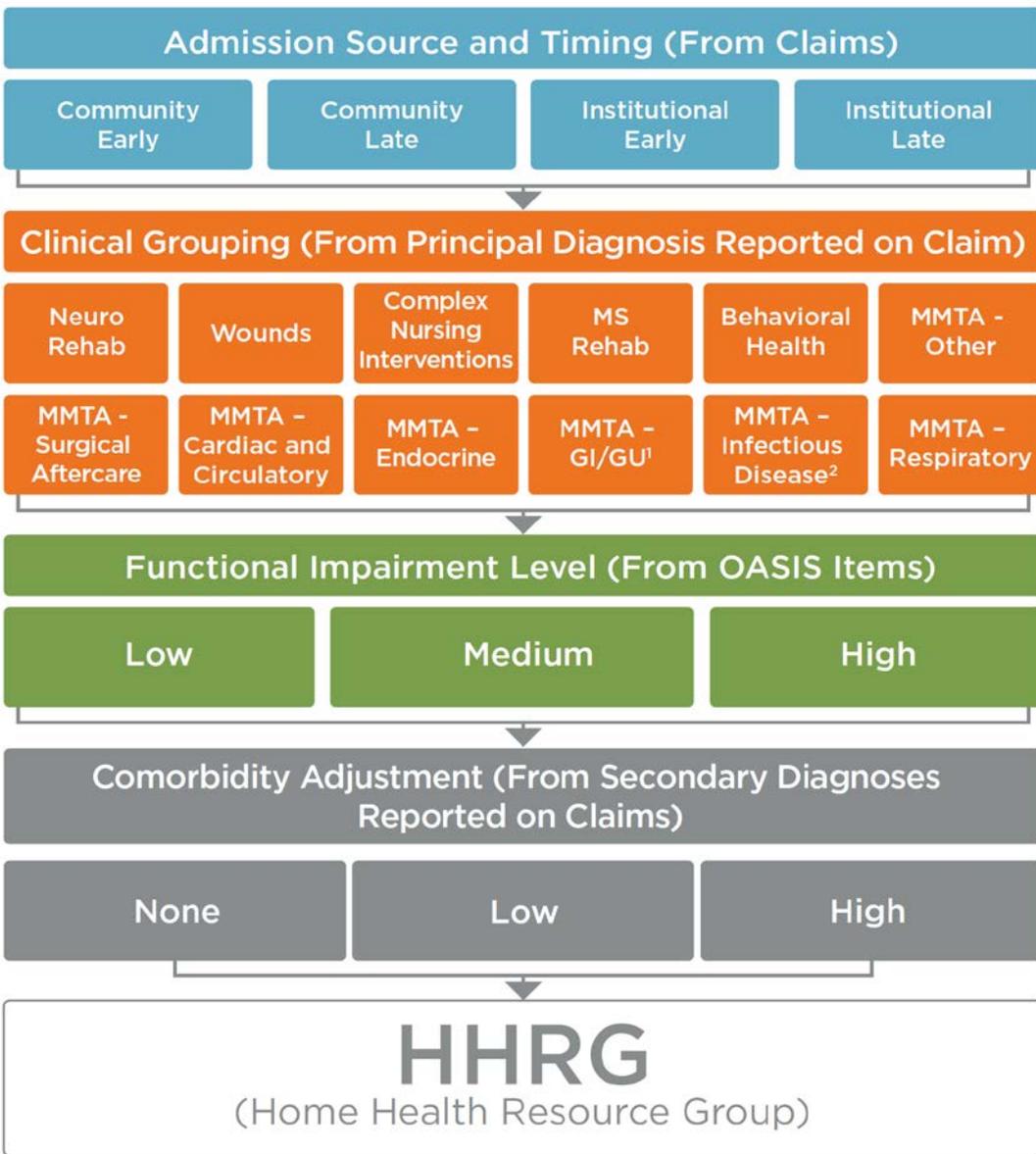
How the Patient-Driven Groupings Model Works

- **Five main case-mix variables—**

  1. **Admission Source**

  2. **Timing**

  3. **Clinical Grouping**

  4. **Functional Impairment Level**

  5. **Comorbidity Adjustment**

- A 30-day period is grouped into **one** subcategory in each color category

- This results in **432 possible case-mix adjusted payment groups** into which a 30-day period can be placed: (2*2*12*3*3 = 432 HHRGs)

[1] Gastrointestinal tract/Genitourinary system
[2] The infectious disease category also includes diagnoses related to neoplasms and blood-forming diseases

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Measuring 30-Day Period Costs Under PDGM

- Need to measure period costs to calculate case-mix adjustment factors that account for variation in costs among different units of services.

- Cost per Minute plus Non-Routine Supplies (CPM + NRS) Approach
  - Uses Medicare cost reports and better reflects total HHA costs
  - Incorporates NRS into the base payment instead of requiring a separate model (as is done under the current payment system)

Cost per Minute plus Non-Routine Supplies (CPM + NRS)

Data Sources	Cost reports, HH Medicare claims
General Approach	Total costs multiplied by amount of care provided for each discipline
Costs Represented	Wages, fringe benefits, overhead costs, transportation costs, other non-visiting services labor costs
Non-Routine Supply	Use NRS cost-to-charge ratio to obtain NRS costs per period

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30-Day Periods

- In the current HH PPS, HHAs are paid for each (up to) 60-day episode of care provided.

- However, more visits tend to occur in the first 30-day period of a 60-day episode of care.

- For the PDGM, payment is made for each 30-day period, as required by the BBA of 2018.

- **Only affects payment**, no changes to the requirements for certification/recertification, completion of OASIS assessments, or updates to the patient's plan of care, all of which continue to be done on a 60-day basis.

National, Standardized 30-day Period Payment Amount

- The PDGM will not be implemented until CY 2020.

- However, to provide HHAs with a sense of the payment amount for a 30-day period of care, we estimated that if the PDGM was implemented in CY 2019, the estimated national, standardized 30-day payment would be:

$1,753.68

- This 30-day payment amount will be updated for CY 2020.

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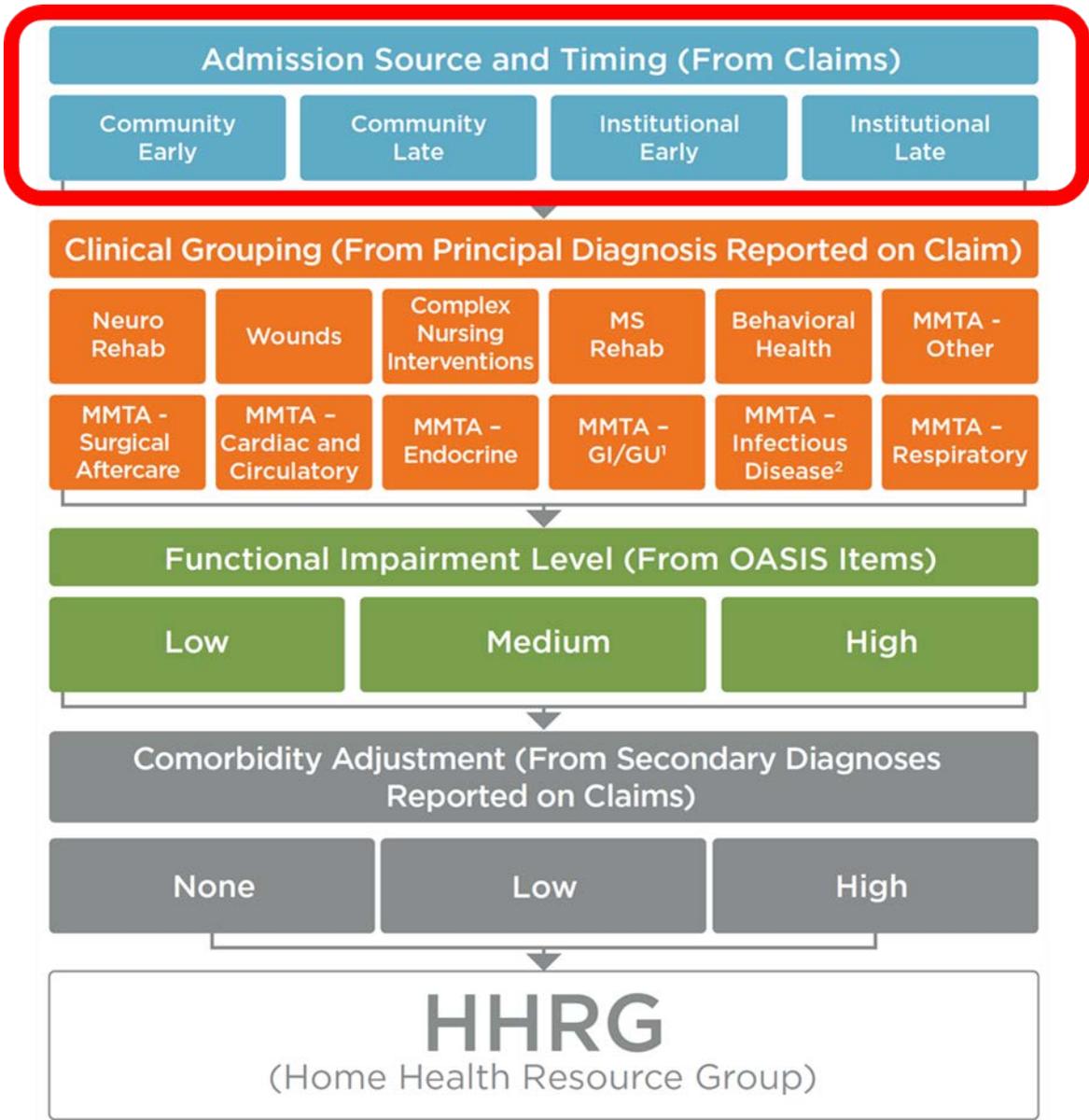
Periods are Grouped by Admission Source and Timing

- Admission source
  - Institutional versus community
- Period timing
  - Early versus late

Admission Source

- **Institutional:**
  - Acute (inpatient acute care hospitals), or;
  - Post-acute (skilled nursing facility, inpatient rehabilitation facility, long term care hospital, or inpatient psychiatric facility) care in the 14 days prior to the HH admission

- **Community:** No acute or post-acute care in the 14 days prior to the HH admission

- 30-day periods with an institutional admission source were found to have higher resource use than periods with a community admission source

Timing

- **Sequence of HH periods:** Periods with no more than 60 days between the end of one period and the start of the next period (no change from current definition)

- **Early periods:** the first 30-day period in a sequence of HH periods

- **Late periods:** second and later 30-day periods in a sequence of HH periods

Additional Notes on Admission Source and Timing

- Late 30-day periods are always classified as a community admission unless there is an acute hospitalization in the 14 days prior to the late home health 30-day period (HHAs have the option whether or not to discharge the patient if the patient is hospitalized for a short period of time).

- A post-acute stay in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to post-acute stay (which is what we would expect to occur).

- Information will come from Medicare systems during claims processing to automatically assign admission source and timing categories.

- HHAs have the option to include an occurrence code on the claim to identify an institutional admission source.
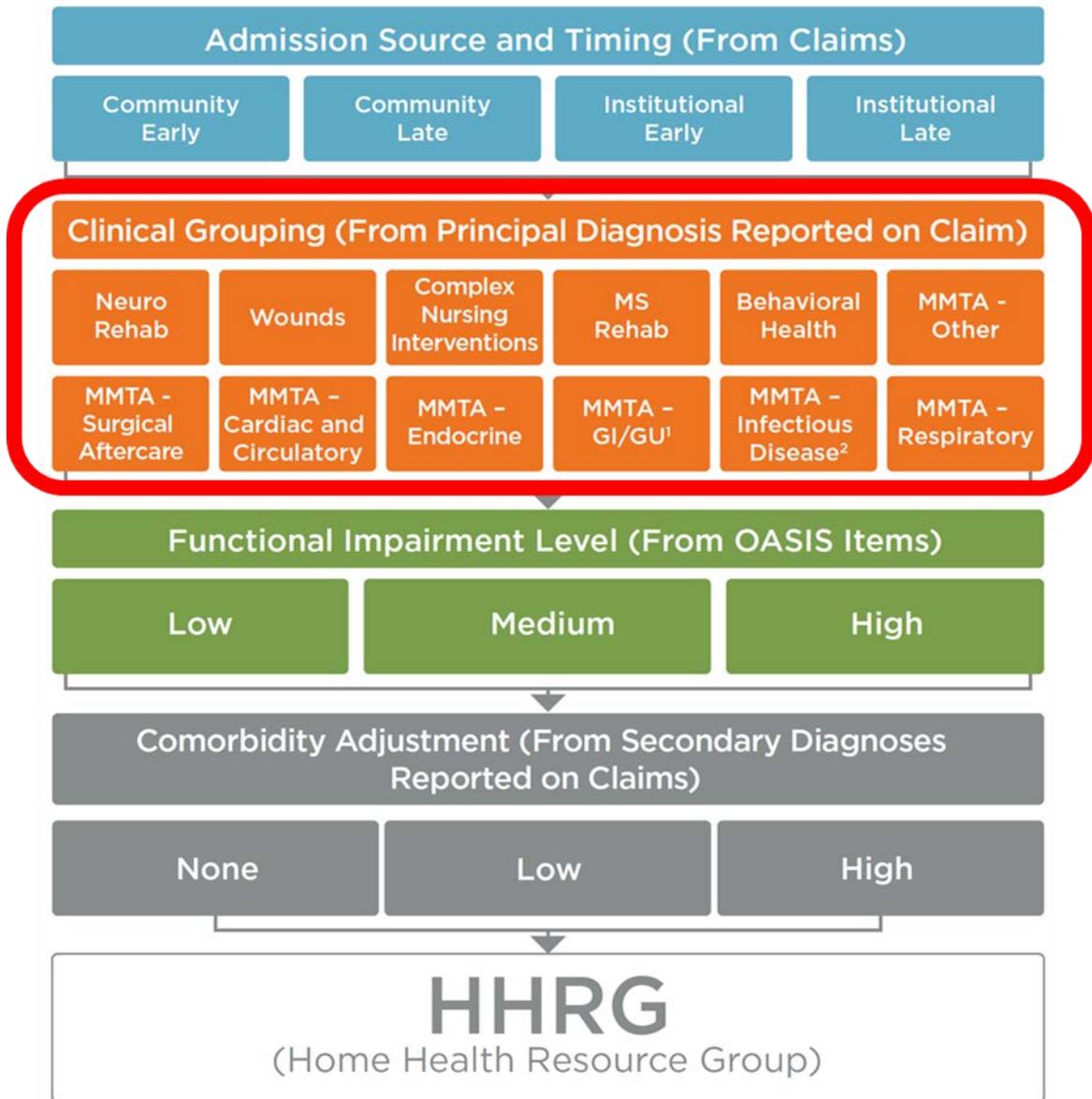
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Periods are Grouped by Primary Reason for Home Health under the PDGM

- Clinical groups are intended to reflect the primary reason for HH services

- Defined by the principal diagnosis reported on HH claim

- Twelve total groups used in the PDGM

Description of the 12 Clinical Groups

Clinical Group	Description	Main reason for HH encounter is to provide:
1	Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
2	Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
3	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
4	Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions (e.g., ostomies, TPN)
5	Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and substance abuse conditions

Description of the 12 Clinical Groups, continued

Clinical Group	Description	Main reason for HH encounter is to provide:
6-12	**Medication Management, Teaching and Assessment (MMTA)** 6. MMTA-Surgical Aftercare 7. MMTA-Cardiac/Circulatory 8. MMTA-Endocrine 9. MMTA-GI/GU 10. MMTA-Infectious Disease/Neoplasms/ Blood-forming Diseases 11. MMTA-Respiratory 12. MMTA-Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previous groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching and assessment.

ICD-10 Codes Used to Determine Clinical Group

- 30-day period assigned to clinical group based on principal diagnosis code on the claim.

- The average resource use of all 30-day periods within a clinical group varies across clinical groups and the payment reflects those differences.

- If a diagnosis code is used that does not fall into a clinical group (e.g., dental codes or other uncovered/invalid codes), claim is returned to the provider for more definitive coding.

- Additional adjustments made for other health conditions (discussed later).

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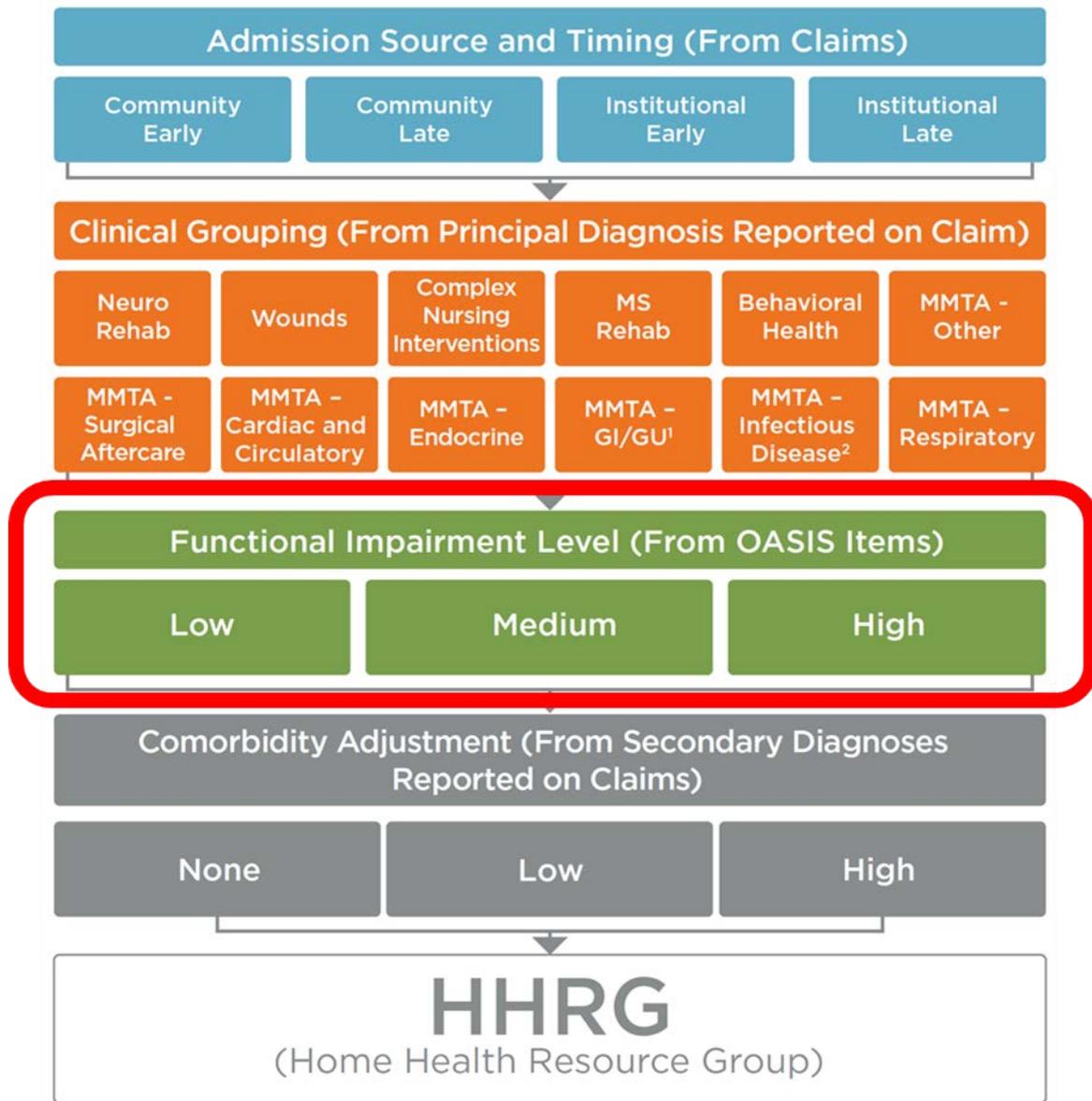
Periods are Grouped by Functional Impairment Level under the PDGM

- 30-day periods are categorized into one of three functional impairment levels

- Certain OASIS items are used to create the levels

PDGM Functional Impairment Level Based on Responses to Seven OASIS Items

Functional OASIS Items	Current Payment System	PDGM
M1800: Grooming	No	Yes
M1810: Current ability to dress upper body safely	Yes	Yes
M1820: Current ability to dress lower body safely	Yes	Yes
M1830: Bathing	Yes	Yes
M1840: Toilet Transferring	Yes	Yes
M1850: Transferring	Yes	Yes
M1860: Ambulation/Locomotion	Yes	Yes
M1033: Risk for hospitalization	No	Yes

Steps for Creating the Functional Impairment Levels

- Determine points for response groups
  - Resource use is regressed on the seven OASIS items (along with other covariates from each of the PDGM groups)
  - Regression coefficients determine the number of points
  - Points reflect relative resource group (high intensity, greater number of points)
- Calculate the functional score
  - For each 30-day period, points are summed to determine an overall functional score
- Assign functional impairment level using score
  - Within each PDGM diagnosis grouping, periods are split into thirds and assigned to a low, medium, or high functional impairment group

Functional Impairment Levels and Associated Points

Thresholds for Functional Levels by Clinical Group, CY 2017

Clinical Group	Level of Impairment	Points (2017 Data)
Behavioral Health	Low	0-36
	Medium	37-52
	High	53+
Complex Nursing Interventions	Low	0-38
	Medium	39-58
	High	59+
Musculoskeletal Rehabilitation	Low	0-38
	Medium	**39-52***
	High	53+
Neuro Rehabilitation	Low	0-44
	Medium	45-60
	High	61+
Wound	Low	0-42
	Medium	43-61
	High	62+
MMTA - Surgical Aftercare	Low	0-24
	Medium	25-37
	High	38+

Functional Impairment Levels and Associated Points, continued

Thresholds for Functional Levels by Clinical Group, CY 2017

| Clinical Group	Level of Impairment	Points (2017 Data)
MMTA - Cardiac and Circulatory	Low	0-36
	Medium	37-52
	High	53+
MMTA - Endocrine	Low	0-51
	Medium	52-67
	High	68+
MMTA - Gastrointestinal tract and Genitourinary system	Low	0-27
	Medium	28-44
	High	45+
MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases	Low	0-32
	Medium	33-49
	High	50+
MMTA - Respiratory	Low	0-29
	Medium	**30-43***
	High	44+
MMTA - Other	Low	0-32
	Medium	33-48
	High	49+

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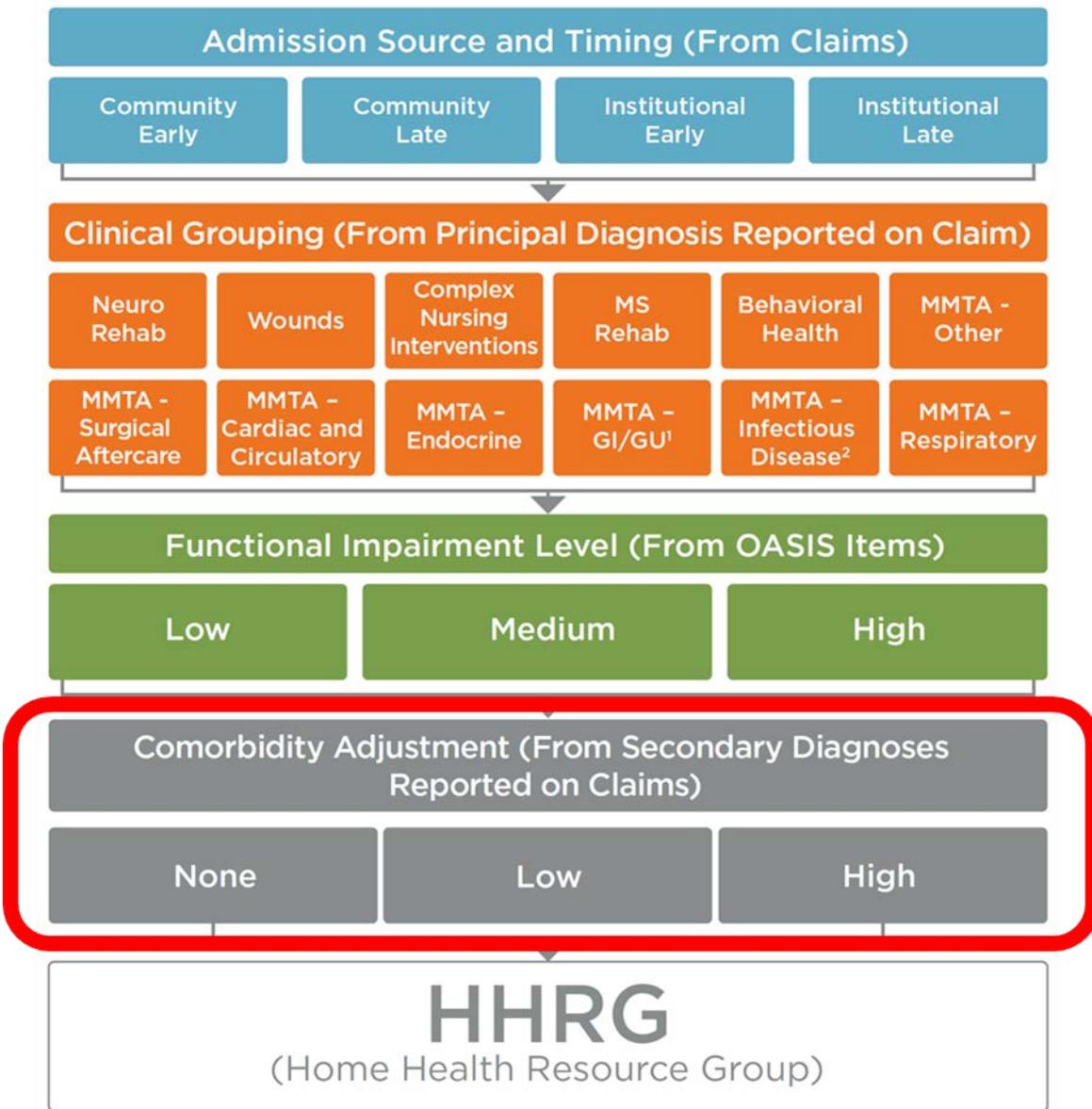
Periods are Grouped by a Comorbidity Adjustment

- The PDGM includes a comorbidity adjustment category based on the presence of secondary diagnoses

- A 30-day period may receive

  – no comorbidity adjustment,

  – a low comorbidity adjustment,

  – or a high comorbidity adjustment

Comorbidity Adjustment

- The principal HHA-reported diagnosis determines the PDGM clinical group.

- However, secondary diagnoses also impact resource use and should be taken into account.

- A **comorbidity** is defined as a medical condition coexisting in addition to a principal diagnosis.
  - Comorbidity is tied to poorer health outcomes, more complex medical need and management, and higher care costs.

Comorbidities Specific to Home Health

A HH specific comorbidity list was developed with broad clinical categories used to group comorbidities within the PDGM:

- – Heart disease
- – Respiratory disease
- – Circulatory disease
- – Cerebral vascular disease
- – Gastrointestinal disease
- – Neurological conditions
- – Endocrine disease

- – Neoplasms
- – Genitourinary/Renal disease
- – Skin disease
- – Musculoskeletal disease
- – Behavioral health issues (including substance use disorders)
- – Infectious diseases

Comorbidities Specific to Home Health

Home health 30-day periods of care can receive a comorbidity adjustment under the following circumstances:

- **Low comorbidity adjustment:** There is a reported secondary diagnosis that is associated with higher resource use, or;

- **High comorbidity adjustment:** 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.

- **No comorbidity adjustment:** there is no reported secondary diagnosis that falls in either the low or high comorbidity adjustment.

Low Comorbidity Adjustment Subgroups

As shown in the CY 2019 HH PPS Final Rule (83 FR 56487)

Comorbidity Subgroup	Description
Cerebral 4	Includes sequelae of cerebral vascular diseases
Circulatory 10	Includes varicose veins with ulceration
Circulatory 9	Includes acute and chronic embolisms and thrombosis
Heart 10	Includes cardiac dysrhythmias
Heart 11	**Includes heart failure**
Neoplasms 1	Includes oral cancers
Neuro 10	Includes peripheral and polyneuropathies
Neuro 11	Includes diabetic retinopathy and other blindness
Neuro 5	Includes Parkinson's disease
Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia
Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers

Source: CY 2017 Medicare claims data for episodes ending on or before December 31, 2017 (as of June 30, 2018).

High Comorbidity Adjustment Interaction Subgroups

As shown in the CY 2019 HH PPS Final Rule (83 FR 56488)

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
1	Behavioral 2	Includes depression and bipolar disorder	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
2	Cerebral 4	Includes sequelae of cerebral vascular diseases	Circulatory 4	Includes hypertensive chronic kidney disease
3	Cerebral 4	Includes sequelae of cerebral vascular diseases	Heart 10	Includes cardiac dysrhythmias
4	Cerebral 4	Includes sequelae of cerebral vascular diseases	Heart 11	Includes heart failure
5	Cerebral 4	Includes sequelae of cerebral vascular diseases	Neuro 10	Includes peripheral and polyneuropathies
6	Circulatory 10	Includes varicose veins with ulceration	Endocrine 3	Includes diabetes with complications
7	Circulatory 10	Includes varicose veins with ulceration	Heart 11	Includes heart failure
8	Circulatory 4	Includes hypertensive chronic kidney disease	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis
9	Circulatory 4	Include hypertensive chronic kidney disease	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
10	Circulatory 4	Include hypertensive chronic kidney disease	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers

Source: CY 2017 Medicare claims data for episodes ending on or before December 31, 2017 (as of June 30, 2018).

High Comorbidity Adjustment Interaction Subgroups, continued

As shown in the CY 2019 HH PPS Final Rule (83 FR 56488)

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
11	Circulatory 7	Includes atherosclerosis	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
12	Endocrine 3	Includes diabetes with complications	Neuro 5	Includes Parkinson's disease
13	Endocrine 3	Includes diabetes with complications	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia
14	Endocrine 3	Includes diabetes with complications	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
15	Endocrine 3	Diabetes with complications	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
16	Heart 10	Includes cardiac dysrhythmias	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
17	Heart 11	Includes heart failure	Neuro 10	Includes peripheral and polyneuropathies
18	Heart 11	Includes heart failure	Neuro 5	Includes Parkinson's disease
19	Heart 11	Includes heart failure	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
20	Heart 11	Includes heart failure	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers

High Comorbidity Adjustment Interaction Subgroups, continued

As shown in the CY 2019 HH PPS Final Rule (83 FR 56488)

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
21	Heart 12	Includes other heart diseases	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
22	Heart 12	Includes other heart diseases	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
23	Neuro 10	Includes peripheral and polyneuropathies	Neuro 5	Includes Parkinson's disease
24	Neuro 3	Includes dementias	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
25	**Neuro 3**	**Includes dementias**	**Skin 4**	**Includes Stages Two through Four and Unstageable pressure ulcers**
26	Neuro 5	Includes Parkinson's disease	Renal 3	Includes nephrogenic diabetes insipidus
27	Neuro 7	Includes hemiplegia, paraplegia, and quadriplegia	Renal 3	Includes nephrogenic diabetes insipidus
28	Renal 1	Includes Chronic kidney disease and ESRD	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
29	Renal 1	Includes Chronic kidney disease and ESRD	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
30	Renal 3	Includes nephrogenic diabetes insipidus	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers

Source: CY 2017 Medicare claims data for episodes ending on or before December 31, 2017 (as of June 30, 2018).

High Comorbidity Adjustment Interaction Subgroups, continued

As shown in the CY 2019 HH PPS Final Rule (83 FR 56488)

Comorbidity Subgroup Interaction	Comorbidity Subgroup	Description	Comorbidity Subgroup	Description
31	Resp 5	Includes COPD and asthma	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
32	Resp 5	Includes COPD and asthma	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers
33	Skin 1	Includes cutaneous abscess, cellulitis, lymphangitis	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers
34	Skin 3	Includes diseases of arteries, arterioles, and capillaries with ulceration and non-pressure, chronic ulcers	Skin 4	Includes Stages Two through Four and Unstageable pressure ulcers

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Home Health Groupings Model: Case-Mix Weights

- The PDGM assigns separate payment weights to periods for patients with similar characteristics and needs:
  - Each 30-day period assigned into one of 432 case-mix groups.
  - Regression using a fixed effects model to measure resource use with the Cost Per Minute (CPM) + NRS approach.
  - Each group's case-mix weight reflects the group's predicted mean cost relative to the overall average.
  - New case-mix weights are used to adjust the HH base payment amount; higher resource need periods are assigned higher case-mix weights and thereby receive more payment.
  - Annual recalibration of the PDGM case-mix weights to reflect the most recent utilization data available at time of rulemaking.

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Low Utilization Payment Adjustment

- Payments for 30-day periods with a low number of visits are not case-mix adjusted, but instead paid on a per-visit basis using the national per-visit rates.

- Each of the 432 different PDGM payment groups has a threshold that determines if the 30-day period receives this Low-Utilization Payment Adjustment (LUPA).
  - For each payment group, the 10th percentile value of visits is used to create a payment group specific LUPA threshold with a minimum threshold of at least two for each group (range is 2-6 visits in a 30-day period).
  - The LUPA thresholds for each of the 432 case-mix groups can be found in Table 32 in the CY 2019 HH PPS Final Rule (83 FR 56493) and on the HHA Center webpage.

Partial Payment Adjustment

- Payments would be adjusted if a beneficiary transfers from one home health agency to another or is discharged and readmitted to the same agency within 30 days of the original 30-day period start date.

- The case-mix adjusted payment for 30-day periods of that type is pro-rated based on the length of the 30-day period ending in transfer or discharge and readmission, resulting in a partial period payment.

Outlier Payment

- Periods that have estimated costs of care (the wage-adjusted costs) that exceed a specific outlier threshold receive an outlier payment to cover a portion of the high costs associated with that 30-day period.

- The approach to calculating the outlier payment is the same as the approach used in the current system.

| Calculate if Period Receives an Outlier Payment | Compute (1) Case-Mix and Wage-Adjusted Period Payment Wage-adjusted national, standardized 30-day period payment rate multiplied by the case-mix weight | Compute (2) Wage-Adjusted Fixed Dollar Loss Amount Fixed dollar loss amount is equal to the fixed dollar loss ratio multiplied by the national, standardized 30-day period payment rate | Compute (3) Outlier Threshold Outlier threshold equals (2) wage-adjusted fixed dollar loss amount plus (1) case-mix and wage-adjusted period payment | Compute (4) Wage-Adjusted Costs per 30-day Period A wage-adjusted per-unit amount for each discipline is used to calculate the cost of care (capped at 8 hours per day) provided during a 30-day period | Are the (4) Wage-Adjusted Costs per 30-day Period Greater than the (3) Outlier Threshold | Final Payment Equals (1) Case-Mix and Wage-Adjusted Period Payment | Final Payment Equals (1) Case-Mix and Wage-Adjusted Period Payment plus 80%* of the Difference Between the (4) Wage-Adjusted Per Visit Rate and the (3) Outlier Threshold |

Yes → (final payment box on right)
No → Final Payment Equals (1) Case-Mix and Wage-Adjusted Period Payment

*80% is referred to as the loss sharing ratio

50

Agenda

1. Current HH PPS

2. Overview of the PDGM

3. Measuring Period Costs

4. 30-Day Periods

5. Admission Source and Timing

6. Clinical Groups

7. Functional Impairment Levels

8. Comorbidity Group

9. Case-Mix Weights

10. Other Adjustments

11. **Grouper Tool and Example Scenarios****

12. Operational Changes

** indicates section to follow

Example Grouper Tool

- [Interactive Grouper tool](#) for learning about the PDGM.

- Obtain the resulting HIPPS code and case mix weight by entering information on a patient's 30-day period for each PDGM category

- Purpose of this tool is informational and illustrative only – final CMS grouper software available in 2020

Download Updated PDGM Grouper Tool CY 2019_11_6_18.xlsx

HH PPS Proposed PDGM

Disclaimer This file was prepared as a service to the public and is not intended to grant rights or impose obligations. The information provided is only intended for use as a learning tool for determining the HIPPS codes assigned to 30-day periods. It does not include information related to partial payments and outliers. It does not contain the edits (such as those related to the guidelines associated with etiology and manifestation codes) included in the official CMS grouper software designed and published by 3M. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Number of visits provided for this 30-day period of care=============> | 8 |

Disclaimer:
All scenarios are for illustrative purposes and assumption is that these beneficiaries meet all criteria for home health services.

Example Scenario 1 – Timing and Admission Source

Mr. Smith was newly diagnosed by his primary care physician with type 2 diabetes with hyperglycemia (E11.65). Mr. Smith's doctor made a home health referral for diabetic management teaching, medication review and evaluation of compliance and response to new medications. Mr. Smith also has a documented history of chronic, systolic (congestive) heart failure (I50.22), cerebral atherosclerosis (I67.2), and benign prostatic hypertrophy (N40.0)

Select **Timing and Admission Source of the 30-period**

Early: first 30-day period in a sequence of periods

Community: No acute or post-acute care in the 14 days prior to the HH admission

Timing
Early
Late

Admission Source
Community
Institutional

Disclaimer:
All scenarios are for illustrative purposes and assumption is that these beneficiaries meet all criteria for home health services.

Example Scenario 1 – Clinical Grouping

Mr. Smith was newly diagnosed by his primary care physician with type 2 diabetes with hyperglycemia (E11.65). Mr. Smith's doctor made a home health referral for diabetic management teaching, medication review and evaluation of compliance and response to new medications. Mr. Smith also has a documented history of chronic, systolic (congestive) heart failure (I50.22), cerebral atherosclerosis (I67.2), and benign prostatic hypertrophy (N40.0)

Input E11.65 for primary diagnosis

Clinical Grouping (from principal dx)			Clinical Group
Primary diagnosis: Enter a valid ICD-10-CM code===================> E11.65	Type 2 diabetes mellitus with hyperglycemia	MMTA_ENDO

One of 12 Clinical Groups will auto-populate

Example Scenario 1 – Comorbidity Adjustment

Mr. Smith was newly diagnosed by his primary care physician with type 2 diabetes with hyperglycemia (E11.65). Mr. Smith's doctor made a home health referral for diabetic management teaching, medication review and evaluation of compliance and response to new medications. Mr. Smith also has a documented history of chronic, systolic (congestive) heart failure (I50.22), cerebral atherosclerosis (I67.2), and benign prostatic hypertrophy (N40.0)

Input I50.22, I67.2, N40.0 for secondary diagnoses

			Clinical Group	Comorbidity Subgroup
Clinical Grouping (from principal dx)				
Primary diagnosis: Enter a valid ICD-10-CM code==================>	E11.65	Type 2 diabetes mellitus with hyperglycemia	MMTA_ENDO	Endrocrine3
Comorbidity Adjustment (from secondary dx)				
Secondary diagnoses: Enter up to 24 valid ICD-10-CM codes========>	1. I50.22	Chronic systolic (congestive) heart failure	MMTA_CARDIAC	Heart11
	2. I67.2	Cerebral atherosclerosis	NEURO_REHAB	Cerebral4
	3. N40.0	Benign prostatic hyperplasia without lower urinry tract symp	MMTA_GI_GU	

Comorbidity Subgroup (if applicable) auto-populates

Example Scenario 1 – Functional Points, Part 1 of 2

The HHA completed the initial OASIS assessment:

- M1033 Risk of Hospitalization: Responses 4-7 (two or more emergency department visits in 6 months; decline in mental, emotional or behavioral status in the past 3 months; reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months; and, currently taking five or more medications)

Select all that apply

OASIS Items contribute to Functional Level	Functional Points
M1033 Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)	11
☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)	
☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months	
☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months	
☑ 4 - Multiple emergency department visits (2 or more) in the past 6 months	
☑ 5 - Decline in mental, emotional, or behavioral status in the past 3 months	
☑ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months	
☑ 7 - Currently taking 5 or more medications	
☐ 8 - Currently reports exhaustion	
☐ 9 - Other risk(s) not listed in 1 - 8	
☐ 10 - None of the above	

Functional Points auto-populates based on responses

Example Scenario 1 – Functional Points, Part 2 of 2

The HHA completed the initial OASIS assessment with the following responses to the OASIS functional items:

- M1800 Grooming
- M1810 Upper body dressing
- M1820 Lower body dressing
- M1830 Bathing
- M1840 Toilet transferring
- M1850 Transferring
- M1860 Ambulation/ locomotion

Select responses for patient

The sum of Functional Points auto-populates Functional Score

Functional Score (Total)==> 18

Example Scenario 1 – HIPPS and Case-Mix Weight

- HHRG payment group = Early-Community-Medication Management, Teaching and Assessment, Endocrine-Low Functional Impairment-High Comorbidity (1IA31)

- Case-mix weight = 1.2759

HIPPS Code	
1st position (Source & Timing)	1
2nd position (Clinical Group)	I
3rd position (Functional Level)	A
4th position (Comorbidity)	3
5th position (Placeholder)	1
HIPPS Code	1IA31
Case-mix weight	1.2759

HIPPS code and case-mix weight auto-populates

- Does not include LUPA, partial payments and outlier adjustments

- Official CMS grouper tool will be updated along with rulemaking

Example Scenario #1: 30-day Payment Plus Case-Mix Adjustment and Geographic Wage Index

CY 2019 Illustrative Payment Example	Value	Operation	Adjuster	Equals	Output
National, Standardized 30-day Period Payment Rate	$1 ,753 .68				
Case-Mix Adjustment for HIPPS 1IA31	1.2759				
Case-Mix Adjusted Period Payment Amount	$1 ,753 .68	*	1.2759	=	$2,237.52
Labor Portion of the Case-Mix Adjusted Period Payment Amount	$2,237.52	*	0.761	=	$1,702.75
Non-Labor Portion of the Case-Mix Adjusted Period Payment Amount	$2,237.52	*	0.239	=	$534.77
Wage Index Value (Beneficiary resides in 31084, Los Angeles-Long Beach-Glendale, CA)	1.3055				
Wage-Adjusted Labor Portion of the Case-Mix Adjusted Period Payment Amount	1.3055	*	$1,702.75	=	$2,222.94
Total Case-Mix and Wage-Adjusted Period Payment Amount (Wage-Adjusted Labor Portion plus Non-Labor Portion)	$534.77	+	$2,222.94	=	**$2,757.71**

Example Scenario 2

- Mrs. Jones was discharged from the hospital status post colectomy with colostomy placement for colon cancer.

- She has documented post-mastectomy lymphedema syndrome (I97.2) from a previous episode of breast cancer with surgery and lymph node removal 10 years ago for which she wears a compression sleeve that limits the use of her affected arm. She has residual weakness (M62.81) from a prolonged hospital stay. She also has a diagnosis of Type 1 diabetes without complications (E10.9).

- Mrs. Jones's surgeon has referred her to home health for colostomy teaching and management (Z43.3) and physical therapy to assist with post-op strengthening.

Example Scenario 2 – Input into PDGM Tool

- Early period

- Institutional admission source

- Add primary and secondary diagnosis codes

Timing	
Early	
Late	

Admission Source	
Community	
Institutional	

		Clinical Group	Comorbidity Subgroup
Clinical Grouping (from principal dx)			
Primary diagnosis: Enter a valid ICD-10-CM code=====================> Z43.3	Encounter for attention to colostomy	COMPLEX	None
Comorbidity Adjustment (from secondary dx)			
Secondary diagnoses: Enter up to 24 valid ICD-10-CM codes=========> 1. I97.2	Postmastectomy lymphedema syndrome	MS_REHAB	Circulatory10
2. M62.81	Not found in Clinical Grouping Classification		
3. E10.9	Type 1 diabetes mellitus without complications	MMTA_OTHER	Endrocrine3
4.			

Example Scenario 2, continued

OASIS responses from initial assessment for:

- Risk for Hospitalization

- Functional items

M1033 Risk for Hospitalization: Which of the follo

- ☐ 1 - History of falls (2 or more falls - or any fall with an injury
- ☑ 2 - Unintentional weight loss of a total of 10 pounds or mor
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 month
- ☐ 4 - Multiple emergency department visits (2 or more) in the
- ☑ 5 - Decline in mental, emotional, or behavioral status in the
- ☐ 6 - Reported or observed history of difficulty complying wit
- ☑ 7 - Currently taking 5 or more medications
- ☑ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8
- ☐ 10 - None of the above

Functional Score (Total)==>	52

M1800 Grooming: Current ability to tend safely to personal hygien

0 - Able to groom self unaided, with or without the use of assistive devices or a
1 - Grooming utensils must be placed within reach before able to complete gro
2 - Someone must assist the patient to groom self.
3 - Patient depends entirely upon s

M1810 Current Ability to Dres

0 - Able to get clothes out of closet
1 - Able to dress upper body witho
2 - Someone must help the patient
3 - Patient depends entirely upon a

M1820 Current Ability to Dres

0 - Able to obtain, put on, and rem
1 - Able to dress lower body witho
2 - Someone must help the patient
3 - Patient depends entirely upon

M1830 Bathing: Current abilit

0 - Able to bathe self in shower or
1 - With the use of devices, is able
2 - Able to bathe in shower or tub
3 - Able to participate in bathing s
4 - Unable to use the shower or tu
5 - Unable to use the shower or tu
6 - Unable to participate effectively

M1840 Toilet Transferring: Current ability to get to and from t

0 - Able to get to and from the toilet and transfer independently with or
1 - When reminded, assisted, or supervised by another person, able to ge
2 - Unable to get to and from the toilet but is able to use a bedside comm
3 - Unable to get to and from the toilet or bedside commode but is able t
4 - Is totally dependent in toileting.

M1850 Transferring: Current ability to move safely from bed t

0 - Able to independently transfer.
1 - Able to transfer with minimal human assistance or with use of an assis
2 - Able to bear weight and pivot during the transfer process but unable
3 - Unable to transfer self and is unable to bear weight or pivot when tra
4 - Bedfast, unable to transfer but is able to turn and position self in bed
5 - Bedfast, unable to transfer and is unable to turn and position self.

M1860 Ambulation/Locomotion: Current ability to walk safely

0 - Able to independently walk on even and uneven surfaces and negotia
1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-w
2 - Requires use of a two-handed device (e.g., walker or crutches) to walk
3 - Able to walk only with the supervision or assistance of another perso
4 - Chairfast, unable to ambulate but is able to wheel self independently
5 - Chairfast, unable to ambulate and is unable to wheel self.
6 - Bedfast, unable to ambulate or be up in a chair.

Example Scenario 2 – HIPPS and Case-Mix Weight

- HHRG payment group = Early-Institutional-Complex Nursing Interventions-Medium Functional Impairment-High Comorbidity (2DB31)

- Case-mix weight = 1.5255

HIPPS Code	
1st position (Source & Timing)	2
2nd position (Clinical Group)	D
3rd position (Functional Level)	B
4th position (Comorbidity)	3
5th position (Placeholder)	1
HIPPS Code	2DB31
Case-mix weight	1.5255

- Does not include LUPA, partial payments and outlier adjustments

- Official CMS grouper tool will be updated along with rulemaking

Example Scenario #2: 30-day Payment Plus Case-Mix Adjustment and Geographic Wage Index

CY 2019 Illustrative Payment Example	Value	Operation	Adjuster	Equals	Output
National, Standardized 30-day Period Payment Rate	$1,753.68				
Case-Mix Adjustment for HIPPS 2DB31	1.5255				
Case-Mix Adjusted Period Payment Amount	$1,753.68	*	1.5255	=	$2,675.24
Labor Portion of the Case-Mix Adjusted Period Payment Amount	$2,675.24	*	0.761	=	$2,035.86
Non-Labor Portion of the Case-Mix Adjusted Period Payment Amount	$2,675.24	*	0.239	=	$639.38
Wage Index Value (Beneficiary lives in 20524, Duchess County-Putnam County, NY))	1.2263				
Wage-Adjusted Labor Portion of the Case-Mix Adjusted Period Payment Amount	1.2263	*	$2,035.86	=	$2,496.58
Total Case-Mix and Wage-Adjusted Period Payment Amount (Wage-Adjusted Labor Portion plus Non-Labor Portion)	$639.38	+	$2,496.58	=	**$3,135.96**

Example Scenario 3

- Mr. Gray has been receiving home health services for 60 days (two contiguous 30-day periods of home health care) with a diagnosis of Parkinson's disease (G20).

- He continues with decreased endurance requiring continued skilled therapy services twice a week. Mr. Gray requires a home health aide three times a week to assist with bathing and dressing.

- He has a documented history of chronic atrial fibrillation (I48.2), primary osteoarthritis of the right shoulder (M19.011), right hand (M19.041), and left hand (M19.042).

Example Scenario 3 – Input into PDGM Tool

- Late period

- Community admission source

- Add primary and secondary diagnosis codes from recertification assessment

Example Scenario 3, continued

- Input OASIS responses from recertification assessment:

- Risk for Hospitalization

- Functional items

M1033 Risk for Hospitalization: Which of the fol
- [x] 1 - History of falls (2 or more falls - or any fall with an inj
- [x] 2 - Unintentional weight loss of a total of 10 pounds or r
- [ ] 3 - Multiple hospitalizations (2 or more) in the past 6 mc
- [x] 4 - Multiple emergency department visits (2 or more) in
- [x] 5 - Decline in mental, emotional, or behavioral status in
- [ ] 6 - Reported or observed history of difficulty complying
- [x] 7 - Currently taking 5 or more medications
- [ ] 8 - Currently reports exhaustion
- [ ] 9 - Other risk(s) not listed in 1 - 8
- [ ] 10 - None of the above

Functional Score (Total)==> | 77

M1800 Grooming: Current ability to tend safely to personal hygien
- 0 - Able to groom self unaided, with or without the use of assistive devices or adap
- 1 - Grooming utensils must be placed within reach before able to complete groom
- **2 - Someone must assist the patient to groom self.**
- 3 - Patient depends entirely upon someone else f

M1810 Current **Ability to Dress Upper** E
- 0 - Able to get clothes out of closets and drawers,
- 1 - Able to dress upper body without assistance if
- **2 - Someone must help the patient put on upper**
- 3 - Patient depends entirely upon another person

M1820 Current **Ability to Dress Lower** E
- 0 - Able to obtain, put on, and remove clothing a
- 1 - Able to dress lower body without assistance if
- 2 - Someone must help the patient put on under
- **3 - Patient depends entirely upon another perso**

M1830 Bathing: Current ability to wash
- 0 - Able to bathe self in shower or tub independe
- 1 - With the use of devices, is able to bathe self ir
- 2 - Able to bathe in shower or tub with the interr
- 3 - Able to participate in bathing self in shower o
- 4 - Unable to use the shower or tub, but able to l
- 5 - Unable to use the shower or tub, but able to p
- **6 - Unable to participate effectively in bathing a**

M1840 Toilet Transferring: Current ability to get to and fro
- 0 - Able to get to and from the toilet and transfer independently with or w
- 1 - When reminded, assisted, or supervised by another person, able to get
- **2 - Unable to get to and from the toilet but is able to use a bedside comm**
- 3 - Unable to get to and from the toilet or bedside commode but is able to
- 4 - Is totally dependent in toileting.

M1850 Transferring: Current ability to move safely from be
- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assist
- **2 - Able to bear weight and pivot during the transfer process but unable to**
- 3 - Unable to transfer self and is unable to bear weight or pivot when trans
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

M1860 Ambulation/Locomotion: Current ability to walk sa
- 0 - Able to independently walk on even and uneven surfaces and negotiat
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-w
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk
- **3 - Able to walk only with the supervision or assistance of another person**
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

Example Scenario 3 – HIPPS and Case-Mix Weight

- HHRG payment group = Late-Community-Neuro Rehab-High Functional Impairment-Low Comorbidity (3BC21)

- Case-mix weight = 1.1117

HIPPS Code	
1st position (Source & Timing)	3
2nd position (Clinical Group)	B
3rd position (Functional Level)	C
4th position (Comorbidity)	2
5th position (Placeholder)	1
HIPPS Code	3BC21
Case-mix weight	1.1117

- Does not include LUPA, partial payments and outlier adjustments

- Official CMS grouper tool will be updated along with rulemaking

Example Scenario #3: 30-day Payment Plus Case-Mix Adjustment and Geographic Wage Index

CY 2019 Illustrative Payment Example	Value	Operation	Adjuster	Equals	Output
National, Standardized 30-day Period Payment Rate	**$1 ,753 .68**				
Case-Mix Adjustment for HIPPS 3BC21	1.1117				
Case-Mix Adjusted Period Payment Amount	$1 ,753 .68	*	1.111.7	=	$1,949.57
Labor Portion of the Case-Mix Adjusted Period Payment Amount	$1,949.57	*	0.761	=	$1,483.62
Non-Labor Portion of the Case-Mix Adjusted Period Payment Amount	$1,949.57	*	0.239	=	$465.95
Wage Index Value (Beneficiary resides in 18020, Columbus, IN)	1.0076				
Wage-Adjusted Labor Portion of the Case-Mix Adjusted Period Payment Amount	1.0076	*	$1,483.62	=	$1,494.90
Total Case-Mix and Wage-Adjusted Period Payment Amount (Wage-Adjusted Labor Portion plus Non-Labor Portion)	$465.95	+	$1,494.90	=	**$1,960.85**

Agenda

1. Current HH PPS

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6. Clinical Groups

7. Functional Levels

8. Comorbidity Group

9. Case-Mix Weights

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11. Grouper Tool and Example Scenarios

12. Operational Changes**

** indicates section to follow

Operational Changes under PDGM: Split Percentage Payments

- HHAs newly enrolled in Medicare on or after January 1, 2019 will not receive split percentage payments beginning CY 2020 but still need to submit a no-pay Request for Anticipated Payment (RAP) at the beginning of each 30-day period to establish the home health period of care. A final claim will be submitted at the end of each 30-day period.

- HHAs certified for participation in Medicare prior to January 1, 2019, will continue to receive split percentage payments in CY 2020. Existing HHAs will need to submit a RAP at the beginning of each 30-day period and a final claim at the end of each 30-day period.

- For the first 30-day period of care, the split percentage payment would be 60/40 and all subsequent 30-day periods of care would be a split percentage payment of 50/50.

Operational Changes under PDGM: RAPs and Admission Source

- For admission source, CMS would only adjust the final home health claim submitted for source of admission.

- If RAP is submitted and paid with community admission and then an acute or post-acute Medicare claims was submitted for that patient before the final home health claim was submitted. The RAP would not be adjusted. Only the final home health claim would be adjusted to reflect the institutional admission.

- HHAs would only indicate admission source occurrence codes on the final claim and not on any RAPs submitted. More details provided on subsequent slide.

Operational Changes under PDGM: HIPPS Code

- Each character of the Health Insurance Prospective Payment System (HIPPS) is associated with the PDGM variables as previously described.

  - **Position #1:** Timing and Admission Source
  - **Position #2:** Clinical Grouping
  - **Position #3:** Functional Impairment Level
  - **Position #4:** Comorbidity Adjustment
  - **Position #5:** Placeholder

- Example HIPPS Code:
  - **2DC21** = Early-Institutional/Complex Nursing/High Functional Impairment/ Low Comorbidity Adjustment

- **HIPPS code is no longer required with OASIS submission** – the system will automatically draw the information from the claims and submitted assessment needed to group the 30-day period.
  - HIPPS code should still be submitted for RAP and claims (but only system-generated code will be used for payment).

Operational Changes under PDGM: OASIS Item Set

OASIS assessment used in determining HIPPS is most recent time point:

- Start of Care (SOC) assessment used for determining the functional impairment level for both the first and second 30-day periods of a new home health admission.

- Follow-up assessment used for third and fourth 30-day periods.

- Resumption of Care (ROC) assessments may be used for determining the functional impairment level for the second (or later) 30-day period if the patient was transferred and admitted to the hospital for 24 hours or more.

- The system will look for the most recent OASIS assessment based on the claim's "From Date".

Operational Changes under PDGM: Other Claims Coding Changes

- A treatment authorization code is no longer required on every HH claim. This field will only be used when required by the Pre-Claim Review project.

- The OASIS assessment completion date will be required on all claims.
  - Report occurrence code 50 and the OASIS item M0090 date

- To facilitate accurate assignment of the claim into institutional vs. community payment groups, HHAs will have the option of reporting inpatient discharge dates on their claims, using newly-created occurrence codes.
  - Report Occurrence code 61 to indicate an acute care hospital discharge within 14 days prior to the From date of any HH claim.
  - Report Occurrence code 62 to indicate a SNF, IRF, LTCH or IPF discharge within 14 days prior to the Admission date of the first HH claim.

Operational Changes under PDGM: Transition from Current System

For implementation purposes:

- For 60-day episodes that begin on or before December 31, 2019 and end on or after January 1, 2020 (i.e., episodes that would span the January 1, 2020 implementation date), payment will be the CY 2020 national, standardized 60-day episode payment amount.

- For HH periods of care that begin on or after January 1, 2020, the unit of payment will be the CY 2020 national, standardized 30-day payment amount.

- Under the PDGM, recertification for home health services, updates to the comprehensive assessment and updates to the HH plan of care will continue on a 60-day basis.

Resources

PDGM Resources

- PDGM overview

- Interactive Grouper tool on HHA Center webpage

- Case mix weights, LUPA thresholds, and agency-level impacts available for download

- CY 2019 Home Health Final Rule on Federal Register

- Home Health Agency Center Spotlights

- Change Request 11081

Question & Answer Session

Questions?

- For questions or comments about today's presentation, please e-mail HomehealthPolicy@cms.hhs.gov

- Please be as specific as possible with your questions

Thank you!

Thank You – Please Evaluate Your Experience

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