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Your PDGM Resource

PDGM PRIMER

CONDENSED FY 2019 HH FINAL RULE

The Balanced Budget Act of 2018, which mandated CMS to eliminate therapy threshold as a part of the reimbursement, combined with CMS' desire to move from volume to value in a patient-centered model has resulted in a final payment reform methodology. This model is called the Patient-Driven Groupings Model (PDGM) and is defined on https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html.

CMS states the payment reform principles are threefold:

- Improve payment accuracy for HH services
- Promote fair compensation for home health agencies
- Increase the quality of care for beneficiaries

PDGM

Under the new PDGM model the HHRG is calculated differently using various patient characteristics to determine a case-mix score. There are five components to the new model:

- Admission Source
- Episode Timing
- Clinical Grouping
- Functional Level
- Comorbidity Adjustment

These five components make up the four groupings utilized to calculate the new case-mix index.

Admission Source and Episode Timing

CMS has designated two admission source categories – community or institutional – depending on what healthcare setting was utilized in the 14 days prior to home health. CMS is moving to a 30-day payment unit inside the 60-day episode of care. Each 30-day period the patient receives care will create a new HHRG payment rather than a HHRG payment for the entire 60-day episode. The 30-day unit of payment would be categorized as institutional if an acute or post-acute stay occurred in the 14 days prior to the start of the 30-day period of care. The 30-day period of care would be classified as community if there was no acute or post-acute stay in the preceding 14 days. Similar to the current payment system, 30-day periods under the PDGM would be classified as "early" or "late" depending on when they occur within a sequence of 30-day periods. The first 30-day period is classified as early. All subsequent 30-day periods in the sequence (second or later) are classified as late. OASIS timepoint assessments are not affected by the transition to 30-day payment periods.

The admission source and timing categories are:

- Community Early
- Community Late
- Institutional Early
- Institutional Late

Clinical Grouping

The PDGM would group these 30-day periods into clinical categories based on a variety of patient characteristics.

The Clinical Grouping consists of 12 clinical groups:

- Musculoskeletal Rehabilitation
- Neuro/Stroke Rehabilitation
- Wounds-Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care
- Complex Nursing Interventions
- Behavioral Health Care (including Substance Abuse Disorders)
- Medication Management, Teaching and Assessment (MMTA) containing seven subgroups
  - MMTA -Surgical Aftercare
  - MMTA – Cardiac/Circulatory
  - MMTA – Endocrine
  - MMTA - GI/GU
  - MMTA – Infectious Disease/Neoplasms/Blood-forming Disease
  - MMTA – Respiratory
  - MMTA - Other

Table 27 describes the Clinical Grouping patient characteristics

CLINICAL GROUPS	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds- Post-Op Wound Aftercare and Skin/Non-surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of nonsurgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions, including substance use disorders
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA – Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA –Respiratory	Assessment, evaluation, teaching, and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

A full list of the ICD-10 codes and their assigned clinical grouping is available here:
https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html

Functional Impairment Level

Under PDGM for each 30-day period, the patient is categorized into one of three functional impairment levels. The functional level would be assigned based on responses to certain functional OASIS items. Criteria for assignment into the three functional impairment levels may differ across each clinical group. The three functional impairment levels are:

- Low
- Medium
- High

The OASIS items to be included as part of the functional impairment level adjustment under this case-mix methodology are shown below. Points are assigned based on the OASIS response of each item. The points are then totaled to determine functional category as noted in Table 29 below:

- M1800 Grooming
- M1810 Current Ability to Dress Upper Body
- M1820 Current Ability to Dress Lower Body
- M1830 Bathing
- M1840 Toilet Transferring
- M1850 Transferring
- M1860 Ambulation
- M1033 Risk of Hospitalization (at least four responses checked, excluding responses #8, #9, and #10.)

Home health periods in the high impairment level have responses for the final functional OASIS items that are associated with the highest resource use on average. This means the higher the score, the higher the impairment. CMS proposes the functional impairment level point thresholds will vary between the clinical groups to account for the patient characteristics within each clinical group associated with increased resource costs affected by functional impairment.

Comorbidity Adjustment

Finally, the PDGM includes a comorbidity adjustment category that takes into consideration the presence of secondary diagnosis codes. The three comorbidity adjustment levels are:

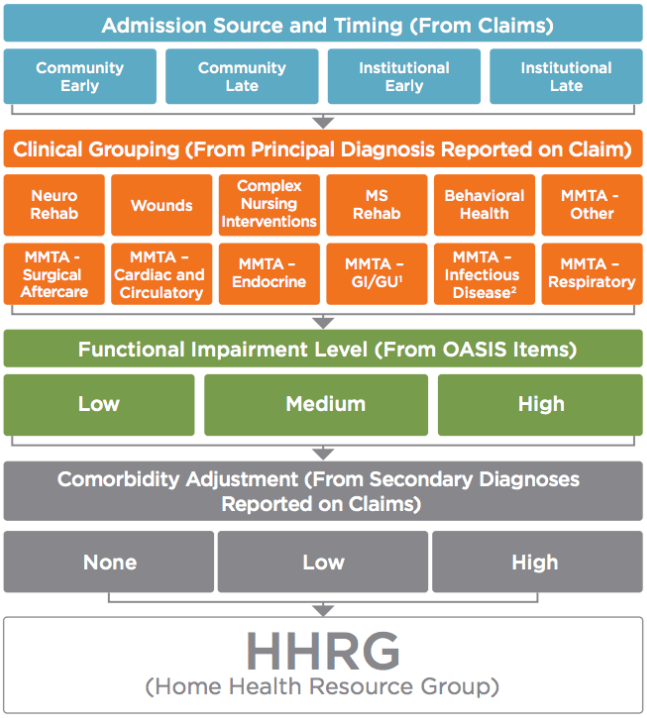
- None
- Low
- High

The broad, body system-based categories CMS proposes to use to group comorbidities within PDGM include the following:

Heart Disease (11 subcategories)	Circulatory Disease and Blood Disorders (12 subcategories)
Respiratory Disease (9 subcategories)	Neurological Disease and Associated Conditions (11 subcategories)
Cerebral Vascular Disease (4 categories)	Genitourinary and Renal Disease (5 subcategories)
Gastrointestinal Disease (9 subcategories)	Skin Disease (5 subcategories)
Endocrine Disease (6 subcategories)	Musculoskeletal Disease or Injury (5 subcategories)

Neoplasms (24 subcategories)	Infectious Disease (4 subcategories)
Behavioral Health (including Substance Use Disorders) (11 subcategories)	

To qualify for a low comorbidity adjustment there is a reported secondary diagnosis that falls within one of the home health specific comorbidity sub-groups associated with higher resource use. To qualify for a high comorbidity adjustment there are two or more secondary diagnoses reported that fall within the same comorbidity subgroup interaction that are associated with higher resource use.



Under PDGM, a patient can qualify for only one comorbidity adjustment (low, medium or high) for each 30-day period of care dependent on the secondary diagnoses reported on the home health claim. This figure demonstrates how each 30-day period of care would be placed into one of the 432 Home Health Resource Groups (HHRGs) under PDGM for CY 2020.

Low Utilization Payment Adjustment (LUPA) in PDGM

LUPAs are a part of the PDGM model. However, the process to calculate LUPAs will change due to the introduction of the 30-day unit of payments. Under PDGM, the 30-day periods of care CMS estimates LUPAs will account for 8% of all episodes. To create LUPA thresholds in each 30-day period of care, CMS has set the LUPA threshold at the tenth percentile value of visits or two, whichever is higher for each payment group. For example, for episodes in the payment group corresponding to MMTA–Respiratory-Functional Level Low – Early Timing – Institutional Admission – No Comorbidity (HIPPS 2LA11), the threshold is three visits for a 30-day unit of payment.

Behavioral Assumptions

CMS is making assumptions about behavior changes that could occur as a result of the implementation of the 30-day unit of payment and case mix factors to be implemented in CY2020. Those assumptions fall into three categories.

Clinical grouping code: CMS states in the rule that they will assume "HHAs will change their documentation and coding practices in order to have a 30-day period be placed in a higher-paying clinical group." CMS does not condone this practice but acknowledges this may be a factor.

Comorbidity coding: CMS states in the rule "that by taking into consideration the additional ICD-10 codes allowed in the claim for secondary diagnosis coding, more 30-day periods of care will receive a comorbidity adjustment than if it only used OASIS diagnosis codes for payment."

LUPA threshold: Because LUPA thresholds will vary from 2-6 visits depending on the case-mix group assigned, CMS is assuming agencies will provide 1-2 extra visits to receive a full 30-day payment and avoid the LUPA payment.

Summary

Aegis Therapies believes that PDGM is clear evidence that CMS is taking concrete steps to move from volume to value for the services provided to a Medicare beneficiary. Key considerations include:

- 30-day unit of payment
- Elimination of therapy visits for reimbursement
- Case-mix + NRS in episode payment
- Reimbursement tied to clinical characteristics and designation into 432 possible payment groupings
- Variable LUPA thresholds for each payment group
- Implementation in a budget neutral manner
- Set to begin 1/1/2020

This report is based on our initial review of what is a complex revision to case-mix classification and payment methodology for HH PPS. Aegis Therapies believes that all care should be patient-centered to meet the unique needs of each patient and will continue to work with our agency partners to meet the patient's needs, regardless of the payment methodology. Aegis Therapies will also continue to study the rule.

Questions about this information? Contact AskAtHome@AegisTherapies.com or visit our Resource Center for more information at AegisTherapies.com/Resources.