Applicable To:
- ☑ Medicare (excluding AZ & KY)
- ☑ Medicaid (excluding KY)
- ☑ CMS Health Plan - CHIP

Claims and Payment Policy: PDGM Implementation for Home Health

Policy Number: CPP-146

Original Effective Date: 1/1/2020
Revised Effective Date(s):

BACKGROUND

Effective January 1, 2020, the Centers for Medicare & Medicaid Services (CMS) will implement a new case-mix classification model, the Patient-Driven Groupings Model (PDGM). PDGM 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. 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.

CMS issued a final rule with comment period (CMS-1711-FC) that updates the Medicare Home Health Prospective Payment System (HH PPS) rates and wage index for calendar year (CY) 2020. The final rule with comment period results in a 1.3 percent increase ($250 million) in payments to HHAs in CY 2020. This rule with comment period also implements the Patient-Driven Groupings Model (PDGM).

This final rule with comment period also implements a change in the unit of payment from 60-day episodes of care to 30-day periods of care, as required by section 51001 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123) and finalizes the 30-day payment amount for CY 2020.

Additionally, this final rule with comment period modifies the payment regulations pertaining to the content of the home health plan of care, allows therapy assistants to furnish maintenance therapy, and changes the split percentage payment approach under the HH PPS. A Home Health Claims-OASIS Limited Data Set (LDS) file will be made available, upon request, to accompany the CY 2020 HH PPS final rule (click here).

View the current HH PPS Grouper Software on the Home Health PPS Software webpage. This final rule with comment period also sets forth routine updates to the home infusion therapy payment rates for CY 2020 and finalizes payment provisions for home infusion therapy services for CY 2021 and subsequent years.

Reasons for 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

POSITION STATEMENT

WellCare's payment reimbursement policies align with the latest final rule from CMS regarding HH PPS rates and wage index.

The Patient-Driven Groupings Model (PDGM) uses 30-day periods as a basis for payment. Figure 1 below provides an overview of how 30-day periods are categorized into 432 case-mix groups for the purposes of adjusting payment in the PDGM. In particular, 30-day periods are placed into different subgroups for each of the following broad categories:

- Admission source (two subgroups): community or institutional admission source
- Timing of the 30-day period (two subgroups): early or late
- Clinical grouping (twelve subgroups): musculoskeletal rehabilitation; neuro/stroke rehabilitation; wounds; medication management, teaching, and assessment (MMTA) - surgical aftercare; MMTA - cardiac and circulatory; MMTA - endocrine; MMTA - gastrointestinal tract and genitourinary system; MMTA - infectious disease, neoplasms, and blood-forming diseases; MMTA - respiratory; MMTA- other; behavioral health; or complex nursing interventions
- Functional impairment level (three subgroups): low, medium, or high
- Comorbidity adjustment (three subgroups): none, low, or high based on secondary diagnoses.

Timing

Under the PDGM, the first 30-day period is classified as early. All subsequent 30-day periods in the sequence (second or later) are classified as late. A sequence of 30-day periods continues until there is a gap of at least 60-days between the end of one 30-day period and the start of the next. When there is a gap of at least 60-days, the subsequent 30-day period is classified as being the first 30-day period of a new sequence (and therefore, is labeled as early).

The comprehensive assessment must be completed within five days of the start of care date and updated no less frequently than during the last five days of every 60 days beginning with the start of care date (as currently required by the Medicare Conditions of Participation at 42 CFR 484.55). As a result, information obtained from the Outcome and Assessment Information Set (OASIS) used in the PDGM may not change over the two 30-day periods the OASIS covers.

However, if a patient experiences a significant change in condition before the start of a subsequent, contiguous 30-day period, for example due to a fall; a follow-up assessment would be submitted at the start of a second 30-day period to

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reflect any changes in the patient's condition, including functional abilities, and the second 30-day claim would be grouped into its appropriate case-mix group accordingly.

Admission Source

Under the PDGM, each 30-day period is classified into one of two admission source categories – community or institutional – depending on what healthcare setting was utilized in the 14 days prior to home health admission. Late 30-day periods are always classified as a community admission unless there was an acute hospitalization in the 14 days prior to the late home health 30-day period. 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.

Clinical Grouping

Under the PDGM, each 30-day period is grouped into one of twelve clinical groups based on the patient's principal diagnosis. The reported principal diagnosis provides information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit.

Table 1 below describes the twelve clinical groups. These groups are designed to capture the most common types of care that home health agencies (HHAs) provide.

TABLE 1: PDGM CLINICAL GROUPS

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 substance 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.

Functional Impairment Level

The PDGM designates a functional impairment level for each 30-day period based on the following OASIS items:

VARIABLE #	DESCRIPTION
M1800	Grooming
M1810	Current ability to dress upper body safely
M1820	Current ability to dress lower body safely
M1830	Bathing
M1840	Toilet transferring
M1850	Transferring
M1860	Ambulation and locomotion
M1033	Risk for hospitalization

CMS estimates a regression model that determines the relationship between the responses for the listed OASIS items and average 30-day period resource use. The coefficients from the regression are used to assign points to a 30-day period. Responses that indicate higher functional impairment and a higher risk of hospitalization are associated with having larger coefficients and are therefore assigned higher points. The points are then summed, and thresholds are applied to determine whether a 30-day period is assigned a low, medium, or high functional impairment level. Each clinical group is assigned a separate set of thresholds. On average, 30-day periods in the low level have responses for the listed OASIS items that are associated with the lowest resource use. On average, 30-day periods in the high level have responses on the above OASIS items that are associated with the highest resource use.

Comorbidity Adjustment

The PDGM includes a comorbidity adjustment category based on the presence of secondary diagnoses. Depending on a patient's secondary diagnoses, a 30-day period may receive no comorbidity adjustment, a low comorbidity adjustment, or a high comorbidity adjustment.

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.

A 30-day period can have a low comorbidity adjustment or a high comorbidity adjustment, but not both. If a 30-day home health period of care does not have reported comorbidities that fall into one of the adjustments described above, there would be no comorbidity adjustment applied.

Determining Case-Mix Weights for the Patient-Driven Groupings Model

The case-mix weight for each of the 432 different payment groups under the PDGM are determined by estimating a regression where the dependent variable is the resource use of a 30-day period and the independent variables are categorical indicators representing the five dimensions of the model described above (timing of a 30-day period, admission source, clinical group, functional impairment level, and comorbidities).

Case-mix weights are produced by dividing the predicted resource use for each PDGM payment group by the overall average resource use of all 30-day periods. The case-mix weights are then used to adjust the 30-day payment rate.

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Additional Payment Adjustments for the Patient-Driven Groupings Model

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.

A 30-day period with a total number of visits below the LUPA threshold are paid per-visit rather than being paid the case-mix adjusted 30-day payment rate. A 30-day period with a total number of visits at or above the LUPA threshold is paid the case-mix adjusted 30-day payment rate rather than being paid per-visit.

When a 30-day period of care involves an unusually large number or a costly mix of visits, the HHA may be eligible for an additional outlier payment (See Figure 3). Once the imputed cost of a 30-day period of care exceeds a threshold amount, the HHA receives a payment equal to 80 percent of the difference between the imputed costs and the threshold amount.

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

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.

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Operational Changes under PDGM: Transition from Current System

For implementation purposes:

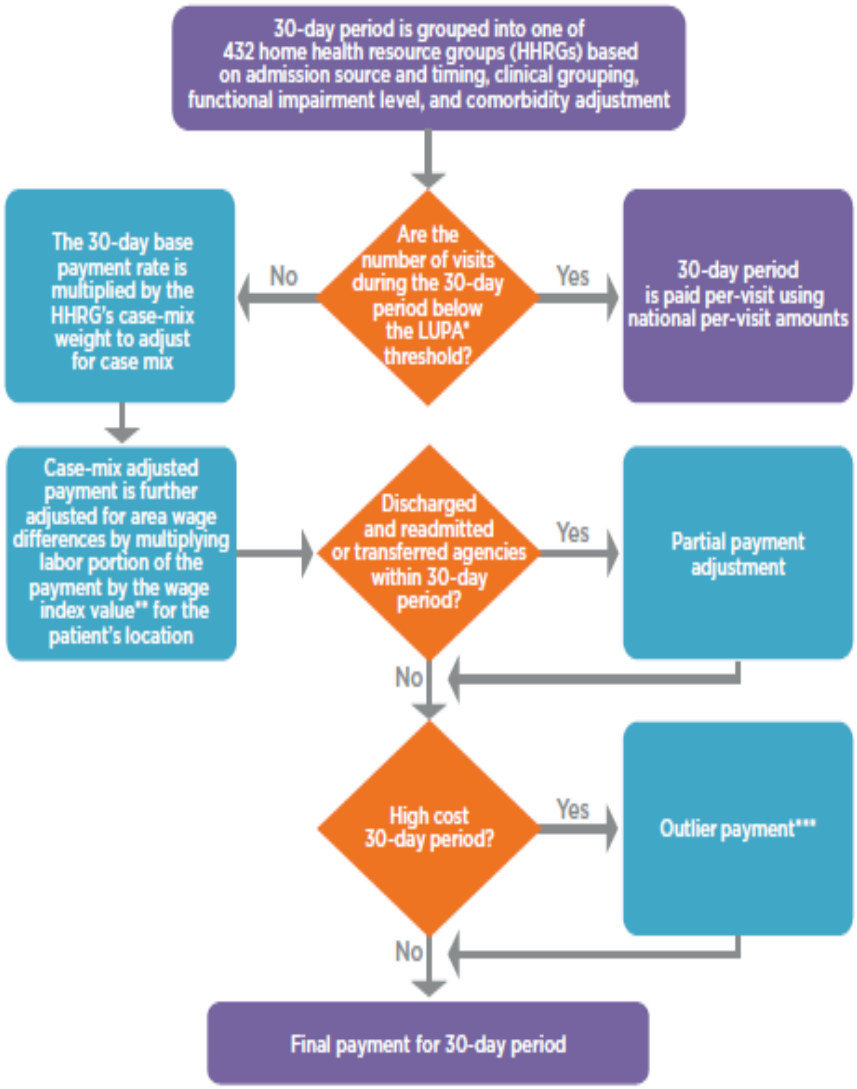
- For 60-day episodes that begin on or before December 31, 2019 and end on or after January 1, 2020 (i.e., episodes that would span the January 1, 2020 implementation date), payment will be the CY 2020 national, standardized 60-day episode payment amount.

- 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.

How Payments and Adjustments are Calculated for the Patient-Driven Groupings Model

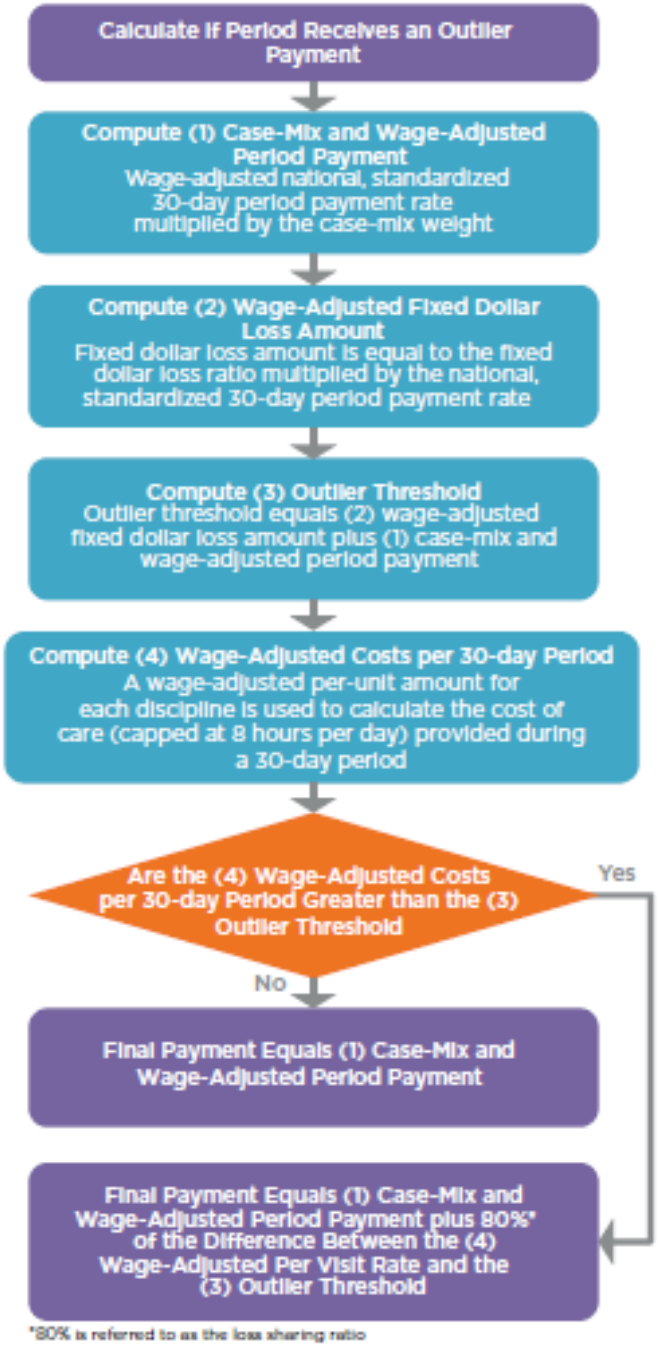
FIGURE 2: HOW PAYMENTS AND ADJUSTMENTS ARE CALCULATED FOR THE PATIENT-DRIVEN GROUPINGS MODEL



* LUPA = Low Utilization Payment Adjustment
** The wage-adjusted payment for a 30-day period is calculated by taking the case-mix adjusted 30-day payment amount and multiplying 76.1% of that payment by a wage-index value that controls for area wage differences. That value is then added to 23.9% of the case-mix adjusted base-payment to determine the wage-adjusted payment amount.
*** Outlier payment is in addition to the wage-adjusted and case-mix adjusted 30-day period payment

Calculation of Outlier Payment

FIGURE 3: CALCULATION OF OUTLIER PAYMENT



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

CODING & BILLING

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

All ICD-10, CPT, HCPCS, and DRG codes are applicable in the context of current official coding guidelines.

DEFINITIONS

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.

REFERENCES

1. Centers for Medicare and Medicaid Services Patient-Driven Groupings Model. Retrieved from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf Accessed December 6, 2019.

2. Home Health Patient-Driven Groupings Model. Retrieved from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM Accessed December 6, 2019.

3. Home Health Agency (HHA) Center. Retrieved from: https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center Accessed December 6, 2019.

4. Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements. Federal Register/Vol. 83, No. 219. Retrieved from: https://www.govinfo.gov/content/pkg/FR-2018-11-13/pdf/2018-24145.pdf Accessed December 6, 2019.

5. MLN Call: A Medicare Learning Network Event: Overview of the Patient-Driven Groupings Model (PDGM). Retrieved from: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Presentation.pdf Accessed December 6, 2019.

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
N/A	• Approved by RGC