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White paper

What every home health agency should know about the Patient Driven Groupings Model: A three-part series

Part I - Getting ready for PDGM: preparation will not be optional

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About the author

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At the very end of October 2018, the Centers for Medicare and Medicaid Services (CMS) released the 2019 Home Health Final Rule with much anticipated news about home health payment reform in the form of the Patient Driven Groupings Model (PDGM). The announcement came as no great surprise, but it cemented the realization that a wave of change is beginning – and the timeline has been set. At the time of this writing – January 2019 – agencies have just one year to get ready. With that in mind, home health professionals must accept the inevitability of payment reform and acknowledge that preparing for it will seem like a full-time job.

What predated PDGM and essentially sealed its fate was the Bipartisan Budget Act (BBA) passed by Congress early in 2018. The BBA mandated not only 30-day payment periods, but also elimination of home health reimbursement thresholds based on volume of therapy services. In mid-2018, CMS also finalized the Patient Driven Payment Model (PDPM) for skilled nursing facilities (SNFs), which focused on many of the same principles as PDGM including the elimination of the SNF therapy maximizing reimbursement formulas. PDPM will be implemented for skilled nursing facilities in October 2019. Thus, at the same time home health agencies will be considering how best to provide the right mix of services to home health patients, our friends at another major stop along the post-acute care continuum will be dealing with very similar challenges.

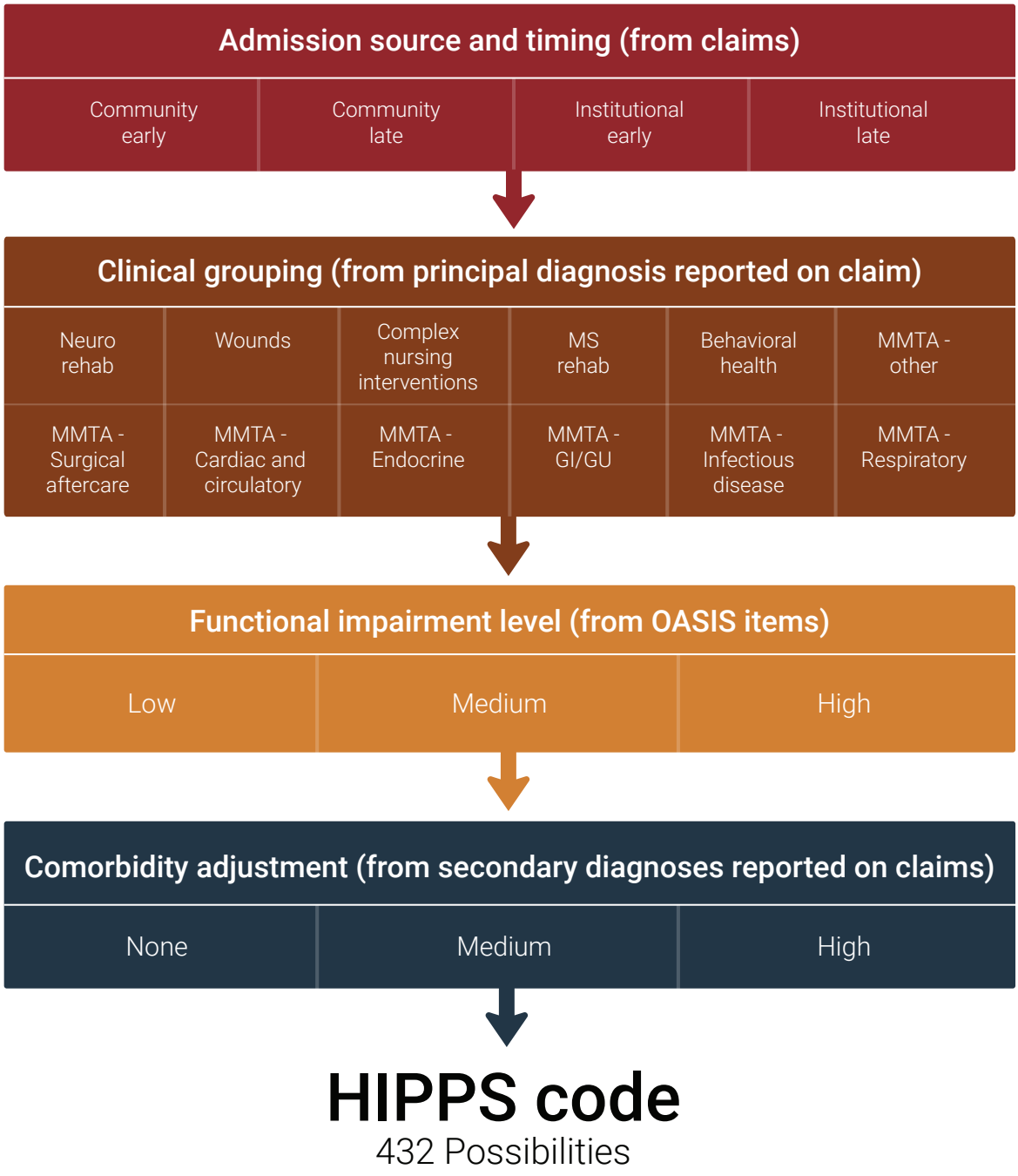
As we think of PDGM and future changes toward site-neutral payments that will move us closer to a unified post-acute reimbursement model, there are five overarching concepts that agency management teams should keep in mind as they strategize in early 2019.

- **First, adapting to PDGM will take work.** And that work should begin right now. Failing to plan for the changes that will be imposed by PDGM equates to planning to fail in 2020.
- **Second, we must become smarter about care planning and service delivery.** CMS has made it clear that patient characteristics, skilled need, and an effective balance of services must be our primary areas of focus. Visit volume will no longer drive payments. Agencies that are unable to assimilate this concept and transform their operations will suffer – and possibly cease to exist – as PDGM gathers momentum.
- **Third, home health is a very competitive segment of post-acute care.** To stand out from the competition, home health agencies must focus on quality and patient outcomes. And they must be able to make a compelling case for why provider networks and payers should select them over their competitors for partnering or specialization opportunities.
- **Fourth, home health isn't the only segment of the post-acute industry that is undergoing change.** The effects of payment reform on other sectors (such as inpatient skilled nursing) will present revenue growth opportunities – but only for those agencies with the financial strength and market position to pursue them.
- **Fifth, a patient's home is the least expensive venue of care.** Those who receive timely and effective home health services are less likely to be hospitalized or readmitted following an inpatient discharge. Because of the constraints being placed on SNFs (value-based purchasing incentives) and hospitals (readmission penalties), home health referrals will continue to add intrinsic value to these types of providers. Home health will remain a key element of the continuum of Medicare coverage, even as post-acute care changes.

For all these reasons and more, home health professionals should approach 2019 as a year of transformation – to a new way of thinking about patient care. There are very few things we can be absolutely sure about, but of one thing we can be certain: **procrastination in preparing for PDGM will not pay dividends.**

The big picture – program highlights and case-mix construction

PDGM is designed as a multi-factor grouping model that will drive case-mix calculations. These case-mix calculations will form the basis for reimbursement before wage index adjustments. CMS's illustration of the model is shown below. Under PDGM there will be a total of 432 case-mix codes depicting a combination of factors that will drive reimbursement.



PDGM highlights

1. PDGM is designed to be budget neutral. This means the changes in the case-mix weights and reimbursement rates are not intended to alter overall Medicare expenditures if the changes were not implemented.

2. PDGM is designed to "better align payments with patient needs" and to ensure that clinically complex patients have adequate access to care. Under PDGM, therapy visit volume will no longer influence case-mix calculations and reimbursement for services.

3. PDGM imposes 30-day payment periods, which are separate and distinct from traditional Medicare episodes. Each payment period within an episode must have at least one skilled visit to be eligible for reimbursement. Even though payments will be predicated on 30-day payment periods, the timelines for completing an episodic OASIS and the periods covered by plans of care will not be altered under PDGM.

4. The Wage Weighted Minutes of Care approach to calculating costs will be replaced with a Cost per Minute plus Non-Routine Supply (CPM+NRS) methodology using data from home health Medicare cost reports.

5. Home Care Resource Group (HHRG) calculations that emanate from the SOC or recertification OASIS will pertain to all 30-day payment periods within each 60-day episode. CMS has not yet published specifics, but it appears that a follow up OASIS would be required to establish the change in primary diagnosis and payment case-mix applicable to a second payment period within a single episode.

6. PDGM is intended to be complementary to other CMS initiatives such as the Value-Based Purchasing Program and the Review Choice Demonstration. It will not replace either one, but "could assist" in meeting requirements of the IMPACT Act related to development of a unified post-acute payment system.

7. Low Utilization Payment Adjustment (LUPA) thresholds will be variable, applied to 30-day payment periods, and will range from two to six visits based on the case-mix. In essence, there will be 432 different ways to calculate a low-utilization payment period.

8. Medicare Advantage Plans will be under no obligation to adopt a payment methodology that is synonymous with or similar to PDGM. However, CMS acknowledges that some Medicare Advantage Plans will likely adjust their reimbursement structures to mimic PDGM. Agencies should make sure they are well informed about how contracted payers intend to structure their payment formulas after 2020.

9. Behavioral assumptions that operate as base-rate reductions are built into PDGM as the model currently stands. The behavioral adjustment has been set at 6.42% and has been created to mitigate potential improper changes in coding practices, including coded comorbidities designed to raise payments and agency management of low-utilization periods to avoid LUPA payment reductions. The home health industry objects to these behavioral assumption reductions and is attempting to eliminate them. At present, however, they are a feature of PDGM.
10. Split-percentage payments, or RAPs, will continue (at least for a time) under PDGM, but only for agencies that are Medicare-certified on or before January 1, 2019. Agencies certified later will submit no-pay RAPs and will be paid only at the time of submission of the final claim. CMS is considering a discontinuation of advance, split-percentage payments at some point in the future.

Case-mix: admission sources

There are two admission source categories: institutional and community. Each patient's whereabouts during the 14-days before each home health 30-day payment period will determine the admission source designation that applies to the payment period. This designation influences the case-mix weight with "institutional" admissions generally yielding higher case-mixes than "community" admissions.

Case-mix: timing

There are two timing classifications: early and late. Under PPS, an "early" episode is defined as the first and second 60-day episodes, with contiguous episodes three and beyond defined as "late" episodes. Under PDGM, the first 30-day payment period is considered "early." Every concurrent payment period after the first is considered "late." Early payment periods will be reimbursed at a higher rate than will late payment periods.

Case-mix: clinical groups

Under PDGM, patients will be assigned to one of six clinical groups based on principal diagnosis:

1. Musculoskeletal Rehab
2. Neuro/Stroke Rehab
3. Wounds – Post-Op Aftercare and Skin/Non-Surgical Wound Care
4. Complex Nursing Interventions
5. Behavioral Health
6. Medication Management, Teaching and Assessment Groups:
    - MMTA - Surgical Aftercare
    - MMTA - Cardiac/Circulatory
    - MMTA - Endocrine
    - MMTA - Gastrointestinal/Genitourinary
    - MMTA - Infectious Disease (including Neoplasms, Blood Forming Diseases)
    - MMTA – Respiratory
    - MMTA - Other

A clinical group assignment could change from one payment period to the next based on a change in condition commemorated by the submission of a follow-up assessment. However, the clinical group cannot be changed within a single payment period.

Case-mix: functional impairment levels

Functional impairment will be determined based on OASIS responses to M1800 (grooming), M1810 (ability to dress upper body), M1820 (ability to dress lower body), M1830 (bathing), M1840 (toilet transferring), M1850 (transferring), M1860 (ambulation/locomotion), and M1032 (hospitalization risk).

Scoring will vary by clinical group and will be divided into low, medium, and high impairment levels.

Case-mix: comorbidity adjustments

There will be an opportunity for payment adjustments based on the presence of certain comorbid conditions or combinations of comorbidities. The adjustments will be available for low or interactive comorbidity calculations. If there are no eligible comorbidities or comorbidity combinations, the comorbidity adjustment will be set at none.

There are 13 low comorbidity adjustment subgroups and 34 high comorbidity adjustment interaction groups that will influence payments.

Case-mix: HIPPS codes

As with the Prospective Payment System (PPS), the formula will yield a Health Insurance Prospective Payment System (HIPPS) code that will be associated with a case-mix weight. The table below shows the construct of HIPPS codes under PDGM.

Position 1	Position 2	Position 3	Position 4	Position 5
Timing/admission	Clinical group	Functional level	Comorbidity adjustment	Static placeholder
1 - Early/community 2 - Early/institutional 3 - Late/community 4 - Late/institutional	A - MMTA other B - Neuro/stroke C - Wound D - Complex nursing E - MS rehab F - Behavioral health G - MMTA - surgical H - MMTA - cardiac I - MMTA - endocrine J - MMTA - GI/GU K - MMTA - infectious L - MMTA - respiratory	A - Low B - Medium C - high	1 - None 2 - Low 3 - High	1

Defining case-mix weights – calculating costs

Cost calculations are based on the concept of resource use. Under PDGM, case-mixes are defined based on admission source, timing, clinical group, functional impairment level, and comorbidity(ies). The average resource use for each case-mix dictates the assigned case-mix weight where resource use is the estimated cost of visits recorded on the claim together with non-routine supply (NRS) costs. Under PDGM, the additional NRS adjustment is eliminated.

Under the PPS system, costs are calculated using the Wage Weighted Minutes of Care (WWMC) calculation which relies on data from the Bureau of Labor Statistics. Under PDGM, the cost calculation will shift to a Cost Per Minute + NRS formula (CPM+NRS) using home health Medicare Cost Reporting and claims data.

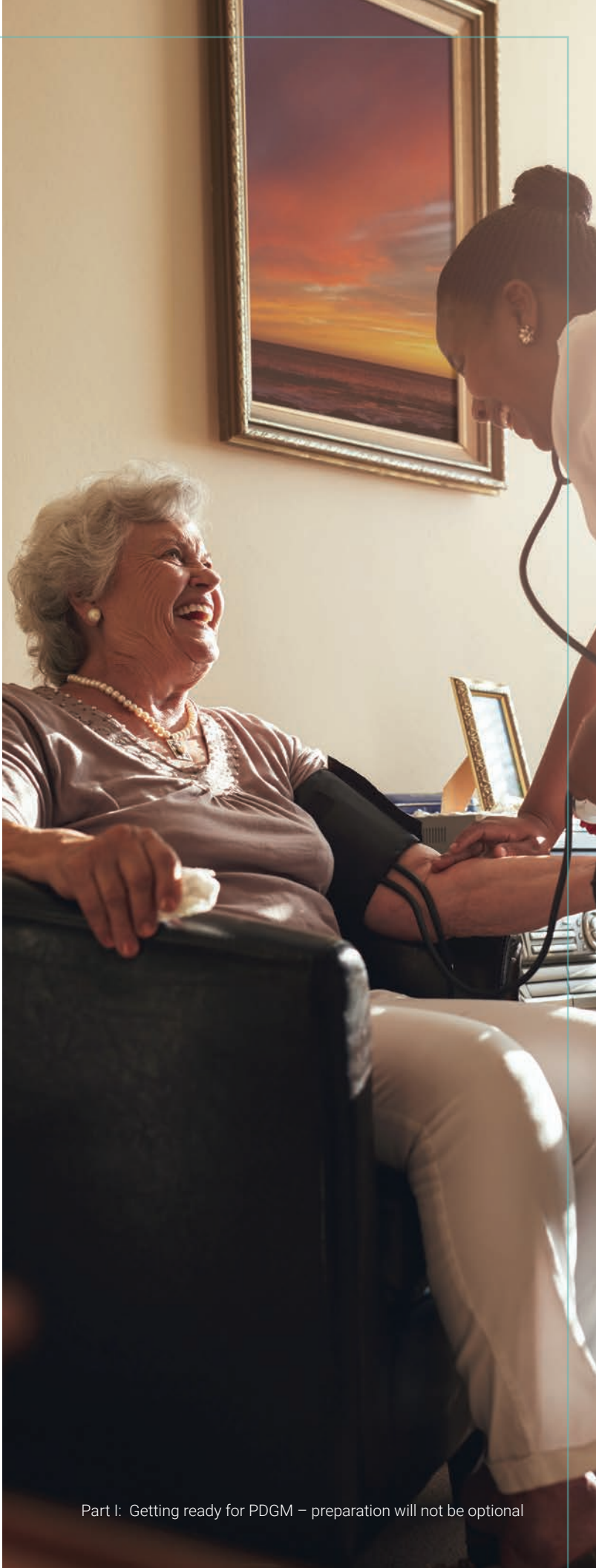
The key takeaway: PDGM will require work

PDGM represents the most sweeping change in reimbursement for home health providers in more than two decades – since the implementation of the Interim Payment System. Sometimes it can be useful to look backward to apply lessons learned to the current situation. PDGM provides that opportunity. Here is why:

PDGM is not the first program created, at least in part, as the result of a "balanced budget act." In fact, the Balanced Budget Act of 1997 had a major impact on home health as it set limits on Medicare spending for the home health, refocused home health as a intermittent post-acute benefit, established the homebound status requirement, introduced the concept of episodic care, and created the requirement for outcome reporting using OASIS. The Interim Payment System (IPS) was the prelude to the Prospective Payment System, which was officially implemented on October 1, 2000. IPS was the first, drastic step away from cost-based reimbursement for home health services. In the two years that followed IPS, more than 10% of home health agencies closed. Many of those that closed were located in rural areas where access to care was limited.

As PPS was implemented, very few agencies were ready for a change to episodic, case-mix based reimbursement. It soon became clear that the Health Care Financing Administration (HCFA, as the predecessor of CMS) wasn't entirely ready either, as regulations and payment formulas were still being modified weeks after official implementation of the program.

Within about a year following PPS, more than a third of home health agencies had closed. The predominant reason was that they were simply not ready or operationally equipped to handle a completely new approach to reimbursement for services that did not equally reward length of stay and service volume. As I confess to some "seniority" in the industry, my recollection is that many providers simply believed that it would all go away. They believed that preparing for PPS wasn't



necessary. But of course, PPS didn't go away. Those who failed to prepare… failed more often than not.

Within three years of the introduction of PPS (after the initial round of agency failures), agencies began to build momentum again as new providers entered the market largely unencumbered by the travails of the past. Between 2004 and 2015, the number of home health agencies grew by 60%. This suggests that the changes imposed by PPS were less of the problem than agencies' inability to adapt. (Although even I will admit that things haven't been all that easy for home health agencies in recent years.)

So, as we think back to the good old days of PPS, fondly reminiscing about a mere 80 case-mixes rather than the 432 we may have in a little more than a year, let's not lose sight of a few important facts:

First, there is unabated demand for home health services. Some of that demand will come as other post-acute providers face their own challenges and need to refer fragile patients to skilled care at home as a means of preventing unnecessary and avoidable hospitalizations.

Second, PDGM is not the death knell to the industry that some fear, but it is a definite and clear call to refocus our approach to providing care.

Third, major change always requires work. PDGM will be no exception. The learning curve will be steep at first, but it is worth tackling. To that end, the next two installments in our series will go beyond the basics to cover some of the complexities and nuances of PDGM and provide some initial guidance for what you doing now to prepare.

Stay tuned!