



Payments and Payment Adjustments under the Patient-Driven Groupings Model

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PROVIDER TYPES AFFECTED

This special edition MLN Matters® article is intended for Medicare-certified home health agencies, and physicians that order home health services.

PROVIDER ACTION NEEDED

This article provides information on the implementation of the new Home Health Prospective Payment System (HH PPS) case-mix adjustment methodology named the Patient-Driven Groupings Model (PDGM). The PDGM will be implemented for home health periods of care starting on and after January 1, 2020.

BACKGROUND

Since October 2000, Home Health Agencies (HHAs) have been paid under a Prospective Payment System (PPS) for a 60-day episode of care that includes all covered home health services. Covered home health services include:

- Skilled Nursing (SN) care (other than solely venipuncture for the purposes of obtaining a blood sample) on part-time or intermittent basis;
- Home health aides on a part-time or intermittent basis;
- Physical Therapy (PT);
- Occupational Therapy (OT);
- Speech-Language Pathology (SLP);
- Medical social services;
- Routine & non-routine medical supplies (for example, catheters, catheter care supplies, ostomy bags, and ostomy care supplies);
- Durable Medical Equipment (paid separately from the home health prospective payment);
- Injectable osteoporosis drug, calcitonin (reimbursed on a reasonable cost basis and the patient must meet certain criteria).

The 60-day payment amount is adjusted for case-mix and area wage differences. The case-mix adjustment under this system included a clinical dimension, a functional dimension, and a

service dimension, in which payment would increase if certain thresholds of therapy visits were met.

Section 51001 of the Bipartisan Budget Act of 2018 (BBA of 2018) includes several requirements for home health payment reform, effective January 1, 2020. These requirements include the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of payment to a 30-day unit of payment. The mandated home health payment reform resulted in the Patient-Driven Groupings Model, or PDGM. The PDGM removes the current incentive to overprovide therapy, and instead, is designed to focus more heavily on clinical characteristics and other patient information to better align Medicare with patients' care needs.

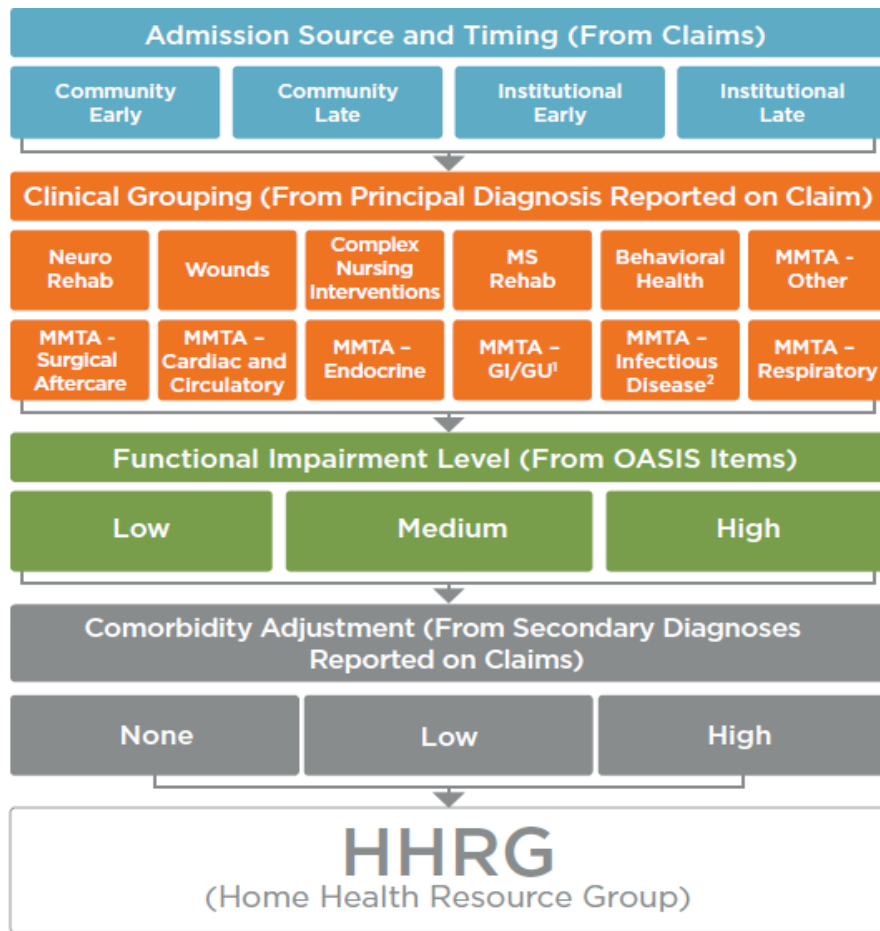
Overview of the Patient-Driven Groupings Model:

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 case-mix groups for the purposes of adjusting payment under 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; complex nursing interventions; behavioral health; 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;
- **Functional impairment level** (three subgroups): low, medium, or high
- **Comorbidity adjustment** (three subgroups): none, low, or high based on secondary diagnoses.

In total, there are $2 \times 2 \times 12 \times 3 \times 3 = 432$ possible case-mix adjusted payment groups. The remainder of this article provides more detail on each PDGM grouping category and additional adjustments to payment that are made within the PDGM.

Figure 1: Structure of the Patient-Driven Groupings Model



Under the Patient-Driven Groupings Model, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period's combination of subcategories places the 30-day period into one of 432 different payment groups.

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

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 inpatient hospital stay 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 a post-acute stay.

The Medicare claims processing system will check for the presence of an acute/post-acute Medicare claim for an institutional stay occurring within 14 days of the home health admission on an ongoing basis. However, if the HHA is aware that a beneficiary had a preceding acute/post-acute care stay, HHAs have the option to submit occurrence code 61 (hospital discharge date) or occurrence code 62 (other institutional discharge date) indicating a preceding institutional stay in order to categorize the home health admission as “institutional”.

Timing of the 30-Day Period:

Under the PDGM, the first 30-day period is classified as early. All subsequent 30-day periods (second or later) in a sequence of 30-day periods 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).

HHAs will not have to determine whether a 30-day period is early (the first 30-day period) or late (all adjacent 30-day periods beyond the first 30-day period). CMS will use Medicare claims data and not the Outcome and Assessment Information Set (OASIS) in order to determine if a 30-day period is considered early or late. Information from the Medicare claims system will be used during claims processing to automatically assign the appropriate timing category.

While the unit of payment for home health services will be a 30-day period, all other requirements (that is, certification, recertification, updates to the comprehensive assessment and plan of care) will remain on a 60-day basis. 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 with injury; a follow-up assessment would be submitted at the start of a second 30-day period to 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.

Clinical Groups:

Under the PDGM, each 30-day period is grouped into one of twelve clinical groups based on the patient’s principal diagnosis as reported on home health claims. 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 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 non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions, including substance use disorder
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)-- <ul style="list-style-type: none"> • MMTA –Surgical Aftercare • MMTA – Cardiac/Circulatory • MMTA – Endocrine • MMTA – GI/GU • MMTA – ID/Neoplasms/ Blood 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.

While there are clinical groups where the primary reason for home health services is for therapy (for example, Musculoskeletal Rehabilitation) and other clinical groups where the primary reason for home health services is for nursing (for example, Complex Nursing Interventions), these groups represent the primary reason for home health services during a 30-day period of care, but not the only reason for home health care. Home health remains a multidisciplinary benefit and payment is bundled to cover all necessary services identified on the individualized home health plan of care.

Functional Impairment Level:

The PDGM designates a functional impairment level for each 30-day period based on responses to the OASIS items in Table 2 below:

Table 2: OASIS Items Used for Functional Impairment Level in the PDGM

Item #	Description
M1033	Risk for Hospitalization
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

Responses that indicate higher functional impairment and a higher risk of hospitalization are associated with higher resource use and are therefore assigned higher points. These 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 associated with increased resource use. 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.
- **No comorbidity adjustment:** A 30-day period would receive no comorbidity adjustment if no secondary diagnoses exist or none meet the criteria for a low or high comorbidity adjustment.

A 30-day period can have a low comorbidity adjustment or a high comorbidity adjustment, but not both. A 30-day period of care can receive only one low comorbidity adjustment regardless of the number of secondary diagnoses reported on the home health claim that fell into one of the individual comorbidity subgroups or one high comorbidity adjustment regardless of the number of comorbidity group interactions, as applicable. The low comorbidity adjustment amount would be the same across the subgroups and the high comorbidity adjustment would be the same across the subgroup interactions.

HIPPS Code:

The home health PPS Grouper will automatically draw the information from the claims and submitted OASIS assessment needed to group the 30-day period and assign the Health Insurance Prospective Payment System (HIPPS) code which corresponds to the Home Health Resource Group (HHRG) for the 30-day period of care. Each character of the HIPPS code is associated with a PDGM case-mix variable as described above. Under the PDGM, the HIPPS code is no longer required with OASIS submission. The official CMS Grouper will be updated annually along with rulemaking. Table 3 details the HIPPS code structure and the PDGM case-mix variables associated with each character position.

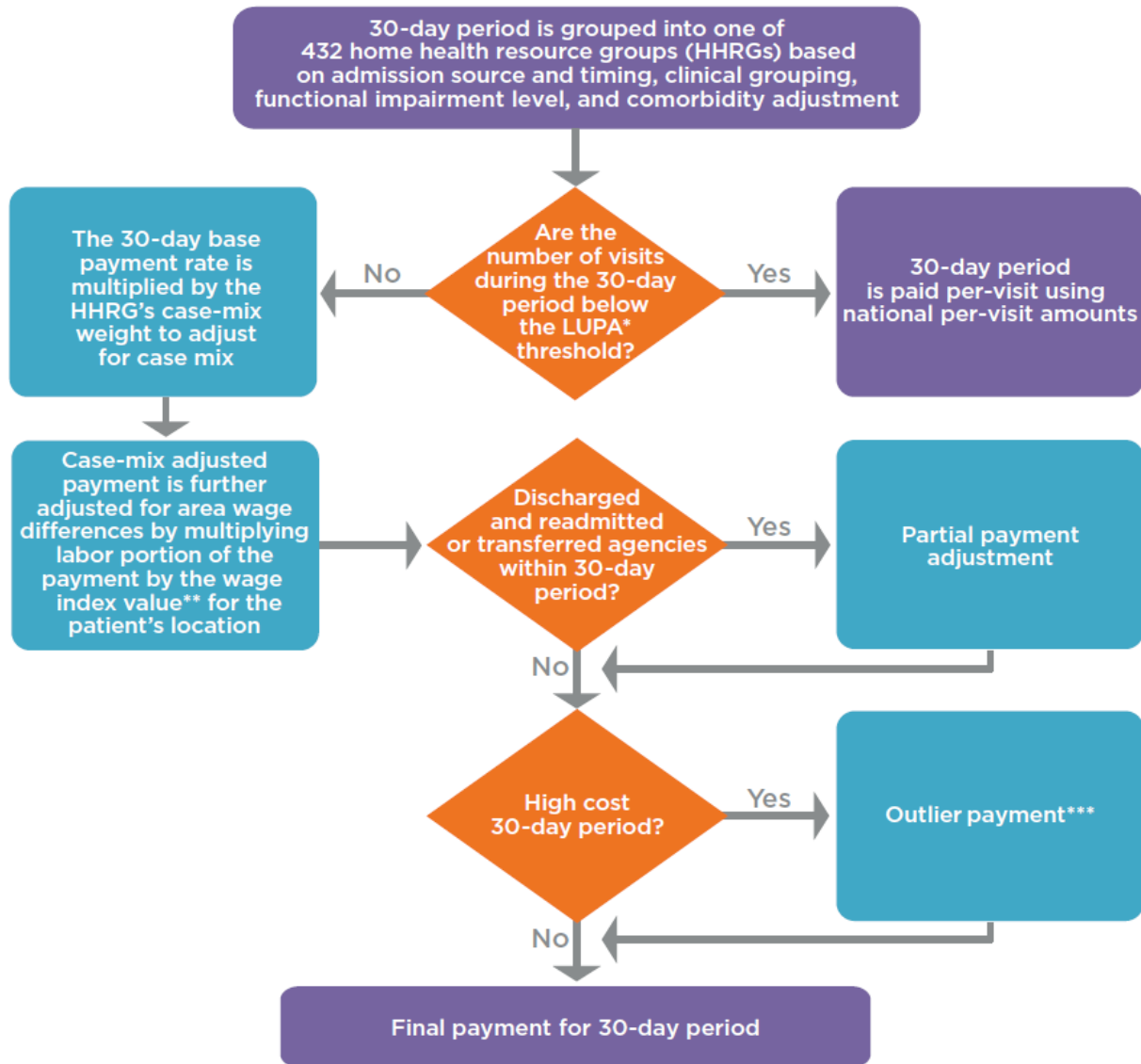
Table 3: Home Health HIPPS Code Structure

Position #1 Admission Source & Timing	Position #2 Clinical Group	Position #3 Functional Impairment Level	Position #4 Comorbidity	Position #5 Placeholder
1 Community-Early	A MMTA-Other	A Low	1 No	1
2 Institutional-Early	B Neuro Rehab	B Medium	2 Low	
3 Community-Late	C Wounds	C High	3 High	
4 Institutional-Late	D Complex Nursing			
	E MS Rehab			
	F Behavioral Health			
	G MMTA-Surgical Aftercare			
	H MMTA-Cardiac			
	I MMTA-Endocrine			
	J MMTA-GI/GU			
	K MMTA-Infectious			
	L MMTA-Respiratory			

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. Figure 2 describes how 30-day periods are paid and when payment adjustments are made.

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

Additional Payment Adjustments for the Patient-Driven Groupings Model:

Low Utilization Payment Adjustment (LUPA)

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.

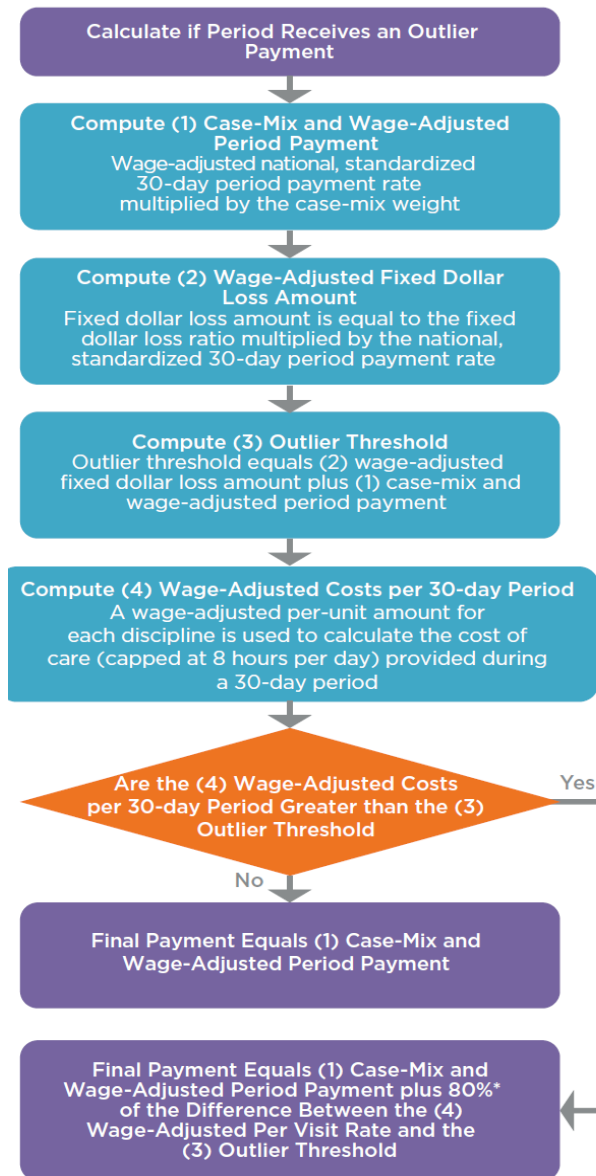
Partial Payment Adjustments

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 payment adjustment.

Outlier Payments

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.

Figure 3: Calculation of Outlier Payment



*80% is referred to as the loss sharing ratio

RESOURCES

HHA Center Webpage which has an [interactive grouper tool](#) for HHAs to use to see how their case-mix weights would be established with their patient populations. The HHA Center webpage also has the PDGM case mix weights, LUPA thresholds, and agency-level impacts available for download at <https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html>

MLN Article MM11081: Home Health Patient-Driven Groupings Model (PDGM) - Split Implementation at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11081.pdf>

MLN Article MM11527: Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11527.pdf>

PDGM webpage at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html>

DOCUMENT HISTORY

Date of Change	Description
November 22, 2019	Initial article released.

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