



PointClickCare®

Patient-Driven Grouping Model (PDGM)

Ultimate Survival Guide

The Ultimate Survival Guide to Transitioning to the Patient-Driven Groupings Model (PDGM)

The Centers for Medicare & Medicaid Services (CMS) is overhauling the home health prospective payment system as they continue the shift toward value-based care.

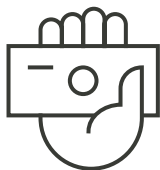
Proposed changes are projected to increase Medicare payments to home health agencies by 2.1%, or \$400 million, in calendar year 2019. However, more than 44 percent of home health providers will see a decrease in reimbursement under PDGM.

DON'T BE ONE OF THEM!

INTRODUCTION

What is the Patient-Driven Groupings Model?

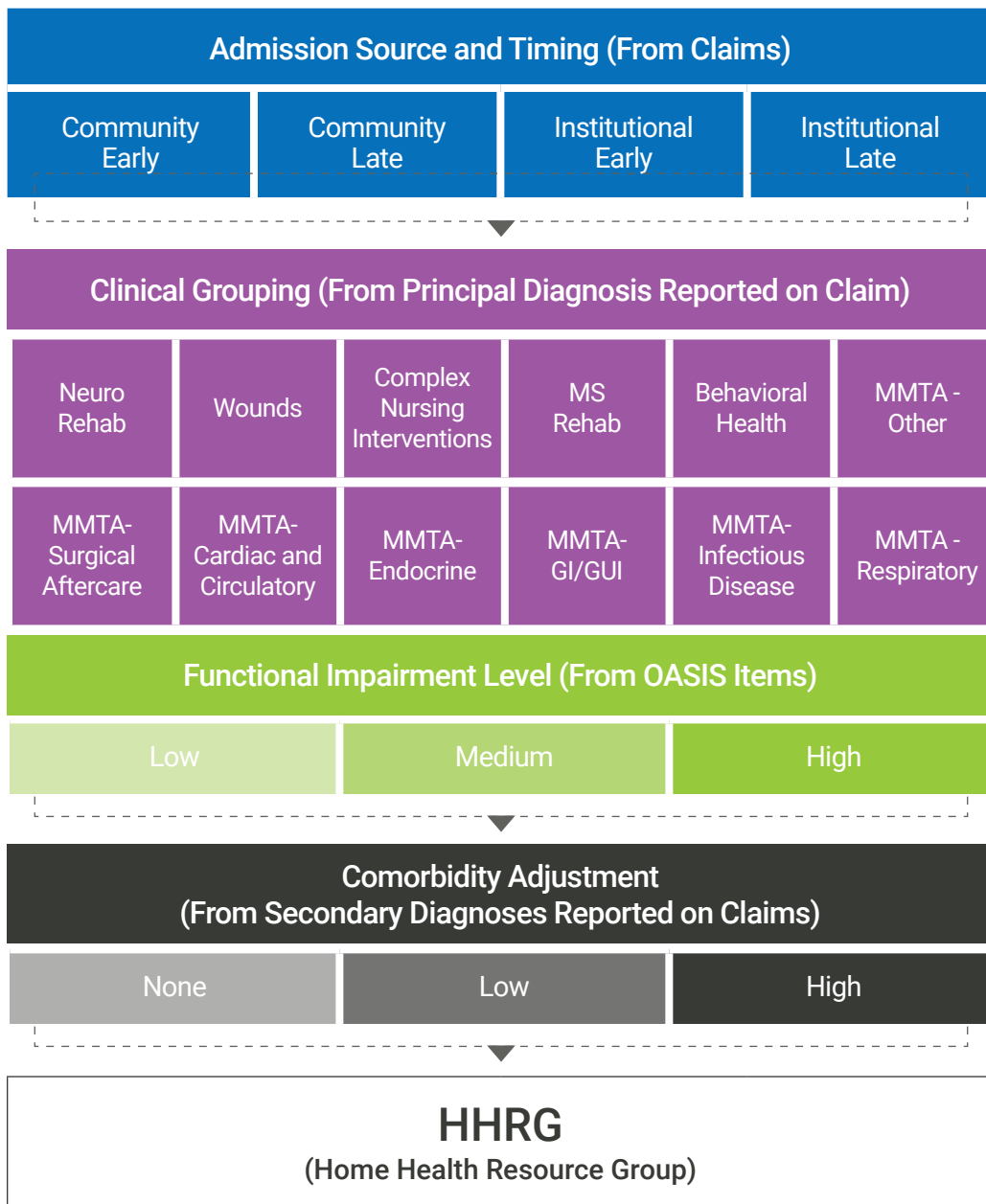
The Patient-Driven Groupings Model (PDGM) uses 30-day periods as a basis for payment. Each 30-day period can be categorized into one of 432 case-mix groups. 30-day periods are placed into different subgroups for each of the following broad categories:



- **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.

The number of therapy visits will no longer impact the case-mix weight and non-routine supplies will be included in the payment amount. LUPAs are also undergoing a major change in this new model and will be something that agencies will need to be cognizant about.

See Figure 1 below for an overview of how 30-day periods are categorized into the 432 case-mix groups for the purposes of adjusting payment in the PDGM.



Under the Patient-Driven Grouping 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.

Figure 1

KEY CHANGES

The devil will be in details, so it is important to understand how some of these updates can have significant impact to reimbursement.

For example, the changes to Timing and Admission Source can swing the reimbursement amount by nearly 42% for the same patient between two 30-day episodes.



1 Timing

In the current PPS model, the first 2 60-day episodes are classified as early. However, in PDGM, timing defines an early episode as the first 30-days. All subsequent 30-day periods in the sequence are classified as late and will have a lower reimbursement amount.

Today, about 25% of episodes are less than 30 days and approximately 73% are completed in less than 60 days.

Timing	Average Reimbursement
Early	\$2,323.63
Late	\$1,847.26
Difference	(\$476.37)
% difference	-19.6%

First 30 days

defines an Early Episode in PDGM



2 Admission Source:

Where the patient is coming from can also dramatically impact your payment. Under 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. Patients coming from the community will have a lower reimbursement amount for the payment period than a patient coming from an institutional setting.

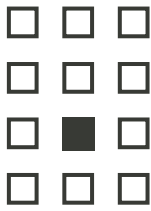
Admission Source	Average Reimbursement
Institutional	\$2,361.16
Community	\$1,809.73
Difference	(\$551.43)
% difference	-23.4%



3 Timing + Admission Source:

Combining these two factors for the same patient across the two different 30-day payment periods can be eye-popping. 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. So, for the same patient, the second 30-day period could look something like this:

Source and Timing	Average Reimbursement
Institutional Early	\$2,483.18
Community Late	\$1,455.39
Difference	(\$1,028.79)
% difference	-41.40%



4 Clinical Groupings:

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. The primary diagnosis must still support the need for skilled Home Health services.

CMS has mapped specific ICD-10 codes to each clinical grouping. Selecting the right ICD-10 code will become especially important since in the current PPS model, 19% of the 30-day periods would be considered Questionable Encounters (QE) in the new PDGM. Reasons why episodes can't be assigned to a clinical group are either because the primary diagnosis code was **(a) Non-specific, (b) Unlikely to have required skilled home health care, or (c) Indicative of a diagnosis that was too acute for home health care.** Under the rule, QE's will be rejected and returned to provider.

Based on feedback during the proposed ruling timeframe, CMS updated the ICD-10 diagnosis tables adding ~5,000 diagnosis codes that previously were considered QE as valid codes (38,409 to 43,287). Knowing and selecting the most appropriate code has never been more important to making sure you get properly reimbursed based on the patient's true characteristics.

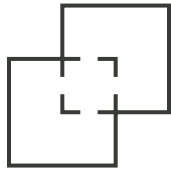
Table 1 shows the breakout of the Clinical groupings. (provided by Abt and CMS)

19%

of the 30-day periods would be considered Questionable Encounters (QE)

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 a non-surgical wounds, ulcers, burns, and other lesions.
Complex Nursing interventions	Assessment, treatment, and evaluation of a complex medical and surgical conditions.
Behavioral Health Care	Assessment, treatment, and evaluation of psychiatric and substance abuse conditions.
Medication Management, Teaching, and Assessment (MMTA) <ul style="list-style-type: none"> • 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.

Table 1 PDGM Clinical groupings



5 Comorbidity Adjustment:

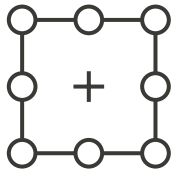
The PDGM includes a comorbidity adjustment category based on the presence of secondary diagnoses. Depending on a patient's secondary diagnoses, a 30-day period may receive no comorbidity adjustment, a low comorbidity adjustment, or a high comorbidity adjustment. The comorbidity adjustment in PDGM can increase payment by up to 20%, according to CMS.

CMS will be pulling the principal and secondary diagnoses off the claim vs the OASIS in the PDGM. In contrast to the OASIS, which allows agencies to designate one primary diagnosis and only five secondary diagnoses, the claim can support up to 24 secondary diagnoses.

Again, understanding how the comorbidities interact with each other and the principal diagnoses code is going to be very important during the Start of Care Q/A process.

Comorbidity adjustment
in PDGM can increase
payment by

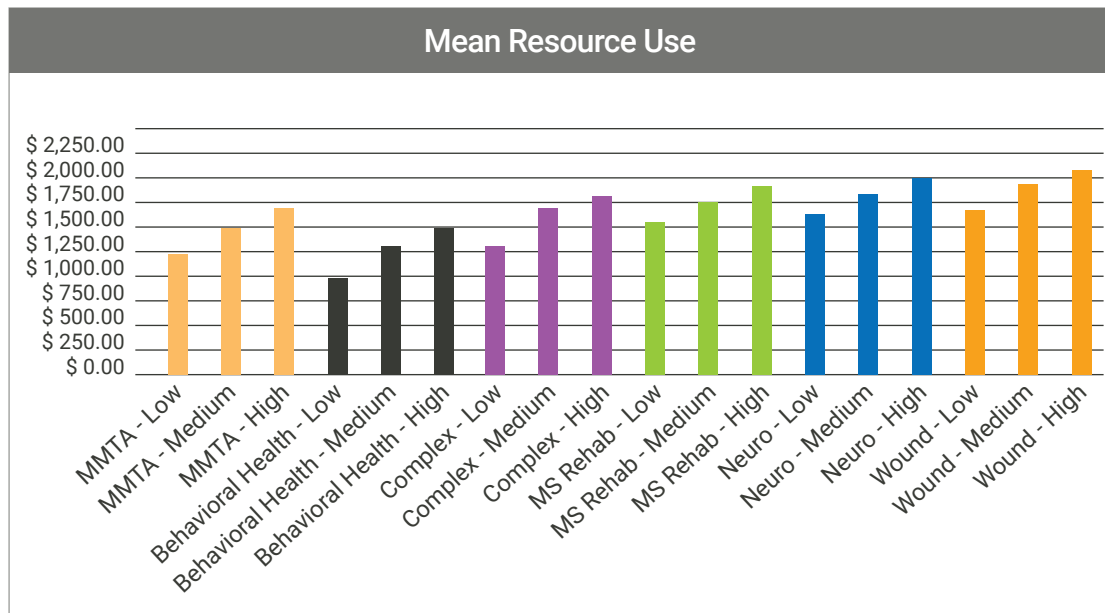
20%



6 Functional Level:

Eight OASIS Responses are combined to determine resource use by clinical group and are categorized as low, medium, or high cultivation. Responses that indicate higher functional impairment and a higher risk of hospitalization are assigned higher points. Each clinical grouping has a separate set of thresholds for low, medium, and high payments.

See table below to understand how the clinical grouping and the functional impairment rating interact with each other.



Data from Table 43 of the Proposed 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements.

REVENUE CYCLE MANAGEMENT CHANGES AND IMPACTS

From a revenue cycle management perspective, while the 60-day episode of care remains intact, there will now be 2 units of 30-day payments – with 2 RAPs and 2 Finals, each with their own case-mix weight. For those agencies who received a CCN on or after to 1/1/2019, CMS will not be giving a RAP payment.



One of the most significant changes are aimed at LUPAs. Currently, home health providers are hit with a Low Utilization Payment Adjustment (LUPA) claim if they provide four or fewer visits during a 60-day care episode. Regardless of the reason, providers only receive a “per-visit” payment, instead of getting the full-episode payment. While the concept of the LUPA won’t disappear, the thresholds change significantly. PDGM takes that four-or-fewer rule and breaks it down into a 2-6 visit threshold depending on the payment group to which it’s assigned.

This shift from each episode having one RAP and one final claim, to having two RAPs and two finals may negatively affect cash flow at the beginning of the episode. Not to mention what might have been previously a full payment under the 60-day episode may now result in a full 30-day period payment with a LUPA on the second 30-day period. Agencies will also be feeling an increased urgency in obtaining required documentation to bill finals more expeditiously, which could be devastating for providers that struggle to obtain documentation today.

Under PDGM, agencies will be required to update their revenue recognition, accrual methodology, and episodic key performance indicators.

Finally, there is uncertainty around how or whether the Medicare Advantage Plans will adopt PDGM which may lead to errors or delay in payment and claims processing.



Preparing for PDGM

The future of your agency is dependent on the capabilities and actions of your leadership, management, and employees to meet the challenges of adapting to changes in the industry. Failing to prepare, as well as failing to make the choices and decisions needed to adapt, will result in severe negative consequences to your organization, your employees, and your community.

Now is the time to prepare as well as act!



Review Current Workflows

Reviewing your processes from end-to-end will help determine what will need to change once PDGM is in effect. **Start with:**

- Intake personnel determining the correct Admission Source and communicating it downstream to billing and your coder
- Clinical Q/A process around reviewing and coding the OASIS and plan of care
- Scheduling the right level of staff at what point in the 60-day episode
- Closely managing and tracking physician orders
- Billing the RAP and Finals as expeditiously as possible
- Preparing for more payment postings and possible adjustments as CMS will be validating payment based on claims data

In this new model, you will experience a greater impact of a lack of accountability by any member of your team. This increases the need for effective communication and collaboration across the organization as a top priority. Be prepared to remediate or remove under-performing team members.



Staff

Training staff on the shift is critical. Expect productivity decreases during the education and training phase. You will need to invest in education and training to coordinate the transition.

Strengthen the following with education and training:

- Clinical competency
- Effective patient influence and engagement
- Clinical documentation practices to support patient complexity, homebound, and skilled need

- Insure the accuracy of your OASIS completion and ICD-10 coding to improve outcomes and obtain proper reimbursement

Effective Staffing Models:

Investigating the business impact from the therapy perspective is crucial to avoiding any surprises. You should be developing strategies to obtain patient outcomes utilizing a broader array of disciplines.

Evaluate the implementation of a clinician scorecard based on outcomes.

Consider compensation programs that reward clinicians that exceed in patient outcome results with efficient visit utilization.



Physicians

Your agency will need to work with referring physicians to educate them as to the greater importance of returning required documentation on a timely basis. Your agency may have to prepare to reduce referrals from physicians who will not complete and return required documentation.



The future of your agency is dependent on the capabilities and actions of your leadership, management, and employees.



Conclusion

The Payment-Driven Groupings Model is more than just a new name attached to payment reform. The shift from PPS to PDGM moves the home care reimbursement model away from therapy provision as the main driver and focuses payments on the provision of skilled care with higher rates being attached to the more clinically complex individual. When this payment model takes effect, currently targeted for **January, 1, 2020**, your organization needs to be ready.

By reviewing your processes and educating staff, your organization will be prepared to maintain a consistent revenue stream through the transition to the new payment model.

