2020 Home Health Patient Driven Grouping Model (PDGM)

On November 8, 2019, CMS issued the Final Rule to update the Medicare Home Health Prospective Payment System (HH PPS) rates and wage index for calendar year (CY) 2020.

In this final rule, CMS finalized the implementation of the 30-day episodic Patient-Driven Groupings Model (PDGM) for **CY 2020** payments, which is takes effect for any episodes BEGINNING on or after January 1, 2020

As compared to the current payment system, which is driven by OASIS, the new PDGM would use **30-day periods**, rather than 60-day episodes, and rely more heavily on clinical characteristics and other patient information (e.g., principal diagnosis, functional level, comorbid conditions, referral source, and timing) to place patients into payment categories. In summary, payments would be determined using a 4-step process, as outline below:

1. Episodes would be classified into four categories based on timing and source of admission.

    1. Community Early
    2. Community Late
    3. Institutional Early
    4. Institutional Late

    Higher reimbursement would go to "institutional" 30-day episodes (those with hospital, skilled nursing facility, and inpatient rehab facility stays within 14 days of home health admission) and those that are "early". Early is defined as the first or only episode in a series of nonadjacent episodes.

2. Episodes are then categorized into 12 clinical groupings or subgroupings based on **Principal Diagnoses** reported on the claim: Musculoskeletal Rehabilitation, Neuro/Stroke Rehabilitation, Wounds — Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care, Behavioral Health Care (including Substance Use Disorder), Complex Nursing Interventions, and seven Medication Management, Teaching and Assessment (MMTA) subgroups.

3. Episodes would then be assigned as Low, Medium, or High **Functional** levels based on OASIS responses from 7 Oasis Functional Groups:

    1. M1800: Grooming
    2. M1810: Current Ability to Dress Upper Body
    3. M1820: Current Ability to Dress Lower Body
    4. M1830: Bathing
    5. M1840: Toilet Transferring
    6. M1850: Transferring and
    7. M1860: Ambulation and Locomotion

4. Adjustments are then made for comorbidities based on up to 24 Secondary Diagnoses. PDGM will give episodes a "no" "low" or "high" comorbidity adjustment.

PDGM's four steps result in one of 432 Home Health Resource Groups, with a 30-day Episodic Federal Standard rate estimated to be $1,864.03. This would also be wage adjusted based on each agency's CBSA. This compares to 153 case mix groups under the current PPS system whose

60-day Episodic Base Rate is $3,220.79**.**

Therapy volume domains as a payment rate determinant has been eliminated under PDGM and is now factored into the case mix weight. In addition, **Non-Routine Supply (NRS)** are also factored into the case mix weight factor and will no longer be an add-on.

Low Utilization Payment Adjustments (LUPA)

Currently, a 60-day episode with four or fewer visits triggers a Low Utilization Payment Adjustment (LUPA), in which the HHA is paid the national per visit amount by discipline, adjusted by the appropriate wage index. Under HHGM, LUPA threshold for each 30-day period of care will vary depending on the PDGM payment group to which it is assigned, ranging from two to six visits, as compared to the 4 visit threshold utilized under the previous PPS methodology. Every payment group will have a different LUPA threshold. The 2 to 6 visit threshold was established using the 10th percentile value of total visits for the specific payment group.

LUPA thresholds for each PDGM payment group will be reevaluated every year based on the most current utilization data available.

The payments for LUPA's will continue to be paid the same methodology as under HHRG's, with the exception that the threshold that will trigger a LUPA computation will be different for every payment group. Below are the current LUPA per visit payment rates, which will be further wage-index adjusted.

	2020
Skilled Nursing	$ 149.68
Physical Therapy	163.61
Occupational Therapy	164.74
Speech Therapy	177.84
Medical Social Worker	239.92
Home Health Aide	67.78
Initial or Only Episode add-on payment:	
Skilled Nursing is first skilled visit	126.49
Physical Therapy is first skilled visit	109.62
Speech Therapy is first skilled visit	111.43

CMS will continue to use three LUPA add-on factors in calculating the LUPA add-on payment amount for LUPA episodes that are the only episode or the first episode in a sequence of adjacent episodes. CMS finalized three LUPA add-on factors to be used in calculating the LUPA add-on payment amount: 1.8451 for skilled nursing, 1.6700 for physical therapy and 1.6266 for speech-language pathology **when that discipline is the first skilled visit in a LUPA episode** that occurs as the only episode or an initial episode in a sequence of adjacent episodes. For example, if the first skilled visit is a Skilled Nurse, the payment for that visit will be $264.59 (1.8451 multiplied by $143.40). Effectively, this translates to an equivalent add-on payment of $121.19, $105.03, and $106.76 for SN, PT, and ST, respectively (as reflected in the above table).

Wage Index

The Standardized **Episodic Rate** and the Standardized **LUPA Rates** stated above are BEFORE applying the CBSA **Wage Index Adjustments**, with a **labor-related** share of **76.1%** for episodic and LUPA rates. The *CBSA Tab* in the attached file list the wage index amounts for all Urban & Rural Counties for 2019.

Outliers

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Under PDGM, outliers will continue to be paid under similar methodology used for the HHRG 60-day episodic reimbursement system. However, the Outlier Fixed Dollar Loss (FDL) factor under PDGM will be **56%** ($1,245.11) of the Episodic Rate. Under HHRG, the FDL factor was 51`%. The Loss Sharing Ratio will remain at **80%.** As implemented in the 2010 final rule, outlier payments will continue to be "capped" at 10% of the AGENCY'S *Total PPS Payments*. The claims processing system would ensure that for each time a claim for a provider was processed, YTD outlier payments for that calendar year could never exceed 10% of YTD total PPS payments for that provider for that calendar year. The 10% payment cap is intended to penalize agencies that are abusing the outlier system and reward those that have not abused the system.

As with HHRG, CMS will continue to use a cost-per-15 minute unit approach, arrived at by dividing the LUPA rate by the average number of minutes per visit and then multiplying by 15 (minutes), as show in the table below:

Visit type	Cy 2020 National Per-visit Payment Rates	Average Minutes-per-visit	Cost-per-unit (1 Unit = 15 Minutes)
Skilled nursing	149.68	44.8	$50.12
Physical therapy	163.61	46.6	$52.66
Occupational therapy	164.74	47.1	$52.46
Speech-language pathology	177.84	48.1	$55.46
Medical social services	177.84	56.5	$47.21
Home health aide	67.78	63.0	$16.14

The table below illustrates how the 15-minute unit will be determined:

Time	Units
<23 minutes	1
23 minutes to <38 minutes	2
38 minutes to <53 minutes	3
53 minutes to <68 minutes	4
68 minutes to <83 minutes	5
83 minutes to <98 minutes	6
98 minutes to <113 minutes	7
113 minutes to <128 minutes	8
128 minutes to <143 minutes	9
143 minutes to <158 minutes	10

Non-Routine Supplies (NRS)

There will NO longer be a Non-Routine Supply add-on. Supplies are now factored into the case mix weight ultimately assigned to the particular 30 day episode.

Rural Add-on

The rural add-on, which expired on January 1, 2018, was reinstated for the years 2019 to 2022, and will continue to apply under PDGM.

Unlike previous rural add-ons, which were applied to all rural areas uniformly, the extension provides varying add-on amounts depending on the rural county FIPS classification by classifying each rural county into one of three distinct categories:

(1) Rural counties and equivalent areas in the highest quartile of all counties and equivalent areas based on the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under part A of Medicare or enrolled for benefits under part B of Medicare only, but not enrolled in a Medicare Advantage plan under part C of Medicare (the "High utilization" category);

(2) Rural counties with a population density of 6 individuals or fewer per square mile of land area and are not included in the "High utilization" category (the "Low Population Density" category); and

(3) Rural counties and equivalent areas not in either the "High utilization" or "Low population density" categories (the "All Other" category).

The rural add-on percentages and duration of rural add-on payments are shown in the table below:

Category	**CY 2019**	**CY 2020**	**CY 2021**	**CY 2022**
High Utilization	1.5%	0.5%		
Low Population Density	4.0%	3.0%	2.0%	1.0%
All Other	3.0%	2.0%	1.0%	

Agencies will now be required to enter the FIPS state and county code on the claim in order to establish the rural add-on amount.

This message does NOT address every aspect of the Final Rule. I strongly encourage you go to the CMS website to read the rule for yourself. The final rule can be found at: *https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp*

Also Attached is an **EXCEL SPREADSHEET** file with the **CMS Grouper Tool** to help you calculate the 30-day PDGM 2020 rates for your individual agency. The Grouper Tool is the same tool provided by CMS on the CMS website. However, I incorporated lookup tables to compute the actual reimbursement based on your CBSA code and FIPS code (used to determine the rural add-on, if any).

Grouping TAB
Steps to navigate the PDGM Grouping Tool**,** enter the following:
1. Number of Visits for the 30 days period
2. Timing of the 30-Day Period: **Early**/**Late**:
   (Only the first 30-days will qualify as "Early". Subsequent episodes will qualify as "Late".
3. Admission Source: **Community** or **Institutional**
4. Clinical Grouping: The **Principle Diagnosis** code expected on the claim
5. Comorbidity Adjustment: Up to **24 Secondary Diagnosis** codes
6. **OASIS** Items-**Functional** Level: Check box for Risk of Hospitalization and select scores from the other seven M-Items

This automatically calculates HIPPS code and case-mix weight.

Enter you **CBSA** code in cell C118 and the **FIPS Code** in cell C119, and the reimbursement for the 30-day episode for your particular CBSA will be computed below on cell **C128**.

The spreadsheet also includes a number of tools I think you may find useful. The file contains the following ***TABS***:

PDGM: The spreadsheet allows you to enter up to Ten CBSA codes in the YELLOW shaded boxes so that you can view the HHRG and LUPA rates for a number of counties in your area. Input your County Code in cells I3 to R3 and the PDGM rates will be generated for each HIPPS code taking into account the wage index for your CBSA. If this is a rural agency you will need to enter the FIPS code in cells I4 to R4. The FIPS code can be obtained from the Rural Add-On Tab.

CBSA: Reflects all the CBSA's in the Country.

Rural Add-On: Contains all of the FIPS codes which are used to determine the rural add-on amount.

LUPA Rates: LUPA per visit rates are also generated based on input in the ***PDGM*** tab.
The table takes into consideration the rural add-on which is based on the combination of the CBSA code 99900 or higher and the FIPS code.

Outlier:: Computes outlier; you need to know the HIPPS code along with the CBSA and number of visits. Enter the HIPPS code in Cell I16). You need to enter the **CBSA** code in cell C3 and the FIPS code in cell C4.

HIPPS Code Structure: This table can be useful in correlating the Grouper to the HIPPS code.

2% Sequestration: All of the rate computations reflect the reimbursement rates before the 2% reduction.