PDGM SERIES

What Home Health Providers Need to Know About PDGM

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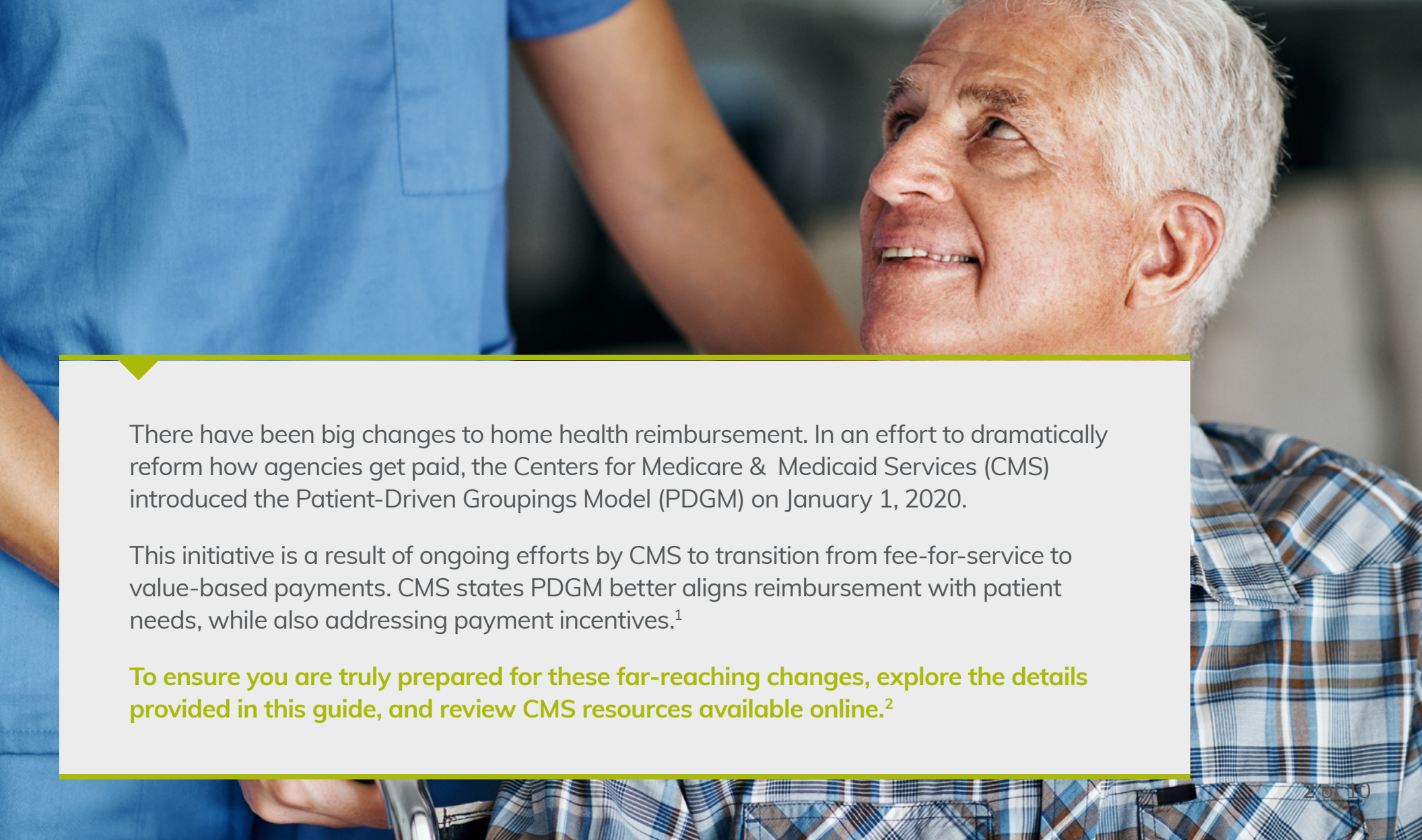
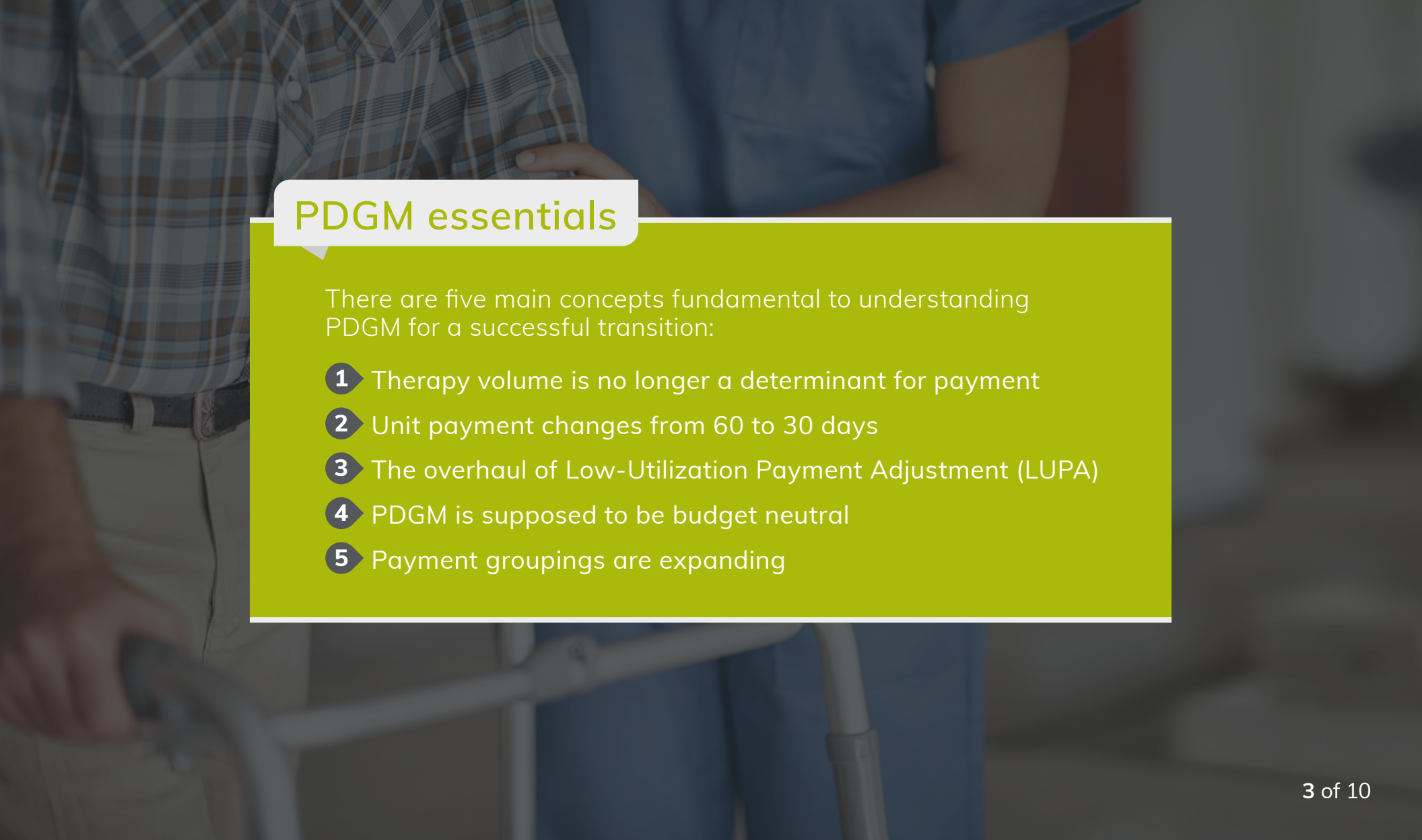


There have been big changes to home health reimbursement. In an effort to dramatically reform how agencies get paid, the Centers for Medicare & Medicaid Services (CMS) introduced the Patient-Driven Groupings Model (PDGM) on January 1, 2020.

This initiative is a result of ongoing efforts by CMS to transition from fee-for-service to value-based payments. CMS states PDGM better aligns reimbursement with patient needs, while also addressing payment incentives.[1]

To ensure you are truly prepared for these far-reaching changes, explore the details provided in this guide, and review CMS resources available online.[2]



PDGM essentials

There are five main concepts fundamental to understanding PDGM for a successful transition:

1. Therapy volume is no longer a determinant for payment
2. Unit payment changes from 60 to 30 days
3. The overhaul of Low-Utilization Payment Adjustment (LUPA)
4. PDGM is supposed to be budget neutral
5. Payment groupings are expanding

PDGM eliminates therapy volume as a payment rate determinant

Under the new payment model, therapy volume no longer determines payment rates. The new model aligns payment with a broader range of clinical characteristics and patient needs. The goal is to eliminate incentives with therapy overutilization and emphasize value over volume.

This new payment calculation is based on patient group designations. Patient groups factor in a combination of clinical group, functional level, admission timing, source and comorbidity adjustments. The timing aspect (early or late) looks at whether patients are in their first 30 days or a later period.

Agencies need to adjust to these changes strategically and validate that the volume of therapy they are recommending is actually required for each patient. It is important for agencies not to abandon – or radically cut – therapy services. They should still be an integral part of the business model. PDGM may change revenue streams, but it doesn't change the conditions of patients and their need for therapy. And cutting therapy services could raise a red flag to CMS and trigger oversight alarms.

One mechanism that can help all home health agencies navigate through PDGM is CMS's interactive grouper tool[3], which calculates agencies' expected payments under the new model.

Unit payment changes

60 ▸ 30 DAYS

Among the more significant adjustments home health agencies need to make is shifting from 60-day episodes of care for payment to 30-day periods.

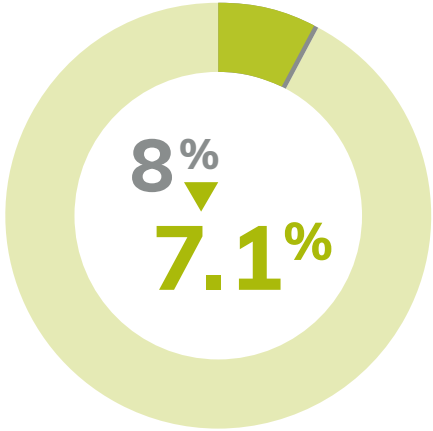
What this means for providers is you have to plan, deliver, document and bill for care twice as often. The first 24-to-48 hours from the start of care (SOC) is crucial to optimize reimbursements. Thus, providers must assess patient needs and create a Plan of Care (POC) as quickly as possible.

LUPAs hit with big changes

Under the previous system, home health providers were levied with a Low Utilization Payment Adjustment (LUPA) claim if they delivered four or fewer visits during a 60-day care episode to any category of patient. They received only a standardized per-visit payment versus a full-episode payment, with no exceptions.

Under PDGM, the four-or-fewer rule is broken down into 216 different scenarios. The concept of LUPA still exists, but the thresholds are varied based upon the patient group. The new LUPA thresholds range from two-to-six visits for every 30-day pay period. In some cases, agencies will need to expand visits from four visits in a 60-day period to as many as 12, depending upon the patient groups.

According to CMS, the average LUPA rate was 8 percent under the previous payment model. With PDGM, the rate is projected to decrease to 7.1 percent.



AVERAGE LUPA RATE

PDGM budget neutrality: Know the assumptions

Congress mandated that PDGM be budget neutral, according to the Bipartisan Budget Act of 2018.[4] CMS asserts budget neutrality; however, they've made three major assumptions to get there. It is important for agencies to understand these assumptions when trying to anticipate the impact of PDGM on their bottom lines.

ASSUMPTION 1

Home health providers will change coding practices to always list the highest-paying diagnosis code as the principal diagnosis. This will place the patient into a higher paying clinical group.

ASSUMPTION 2

More 30-day periods of care will receive a comorbidity adjustmentthan they do currently. PDGM allows agencies to designate up to 24 secondary diagnoses, as opposed to the current limit of five under OASIS. CMS estimates that this change alone can increase payment by up to 20 percent.[5]

ASSUMPTION 3

Agencies will actively seek to avoid LUPAs by adding visits.

If the three assumptions do not hold true, CMS estimates that payment could dip by as much as $110 for the 30-day period.

Payment groupings increase substantially

PDGM also increases the number of payment groupings and unique case-mix potential. The previous 153 groupings have expanded to 432. Each 30-day period is now categorized into one of those 432 Home Health Resource Groups (HHRGs).

The HHRGs consist of a combination of subgroups based on the following categories:

- Admission source (community or institutional)
- Timing of the 30-day period (early or late)
- Clinical grouping (12 subgroups based on principal diagnosis)
- Functional impairment level (low, medium or high)
- Comorbidity adjustment (none, low or high)

This level of complexity represents a major change that will require significant staff education and planning to assure cases are assessed, coded and billed correctly.

Tips for navigating through PDGM

Now that PDGM is underway, make sure you have the right practices in place to be successful. Here are six operational areas to focus on:

- Streamlining and increasing billing efficiency
- Increasing understanding and use of ICD-10 coding
- Assembling complete health histories with a recording of comorbidities
- Developing a sense of urgency in devising care and discharge plans
- Collaborating between cross-functional teams for coordinated care
- Improving the understanding of OASIS requirements by clinicians and coders

PDGM promises significant change to a home health agency's operation. While the move away from therapy volume is a major shift, it opens up opportunities for agencies to be more fully compensated for delivering all the care patients need to achieve their health goals. A smooth transition requires a comprehensive plan to ensure that PDGM requirements are met and that your organization avoids taking a financial hit.

To find out how ABILITY can help you successfully prepare for PDGM

Contact us today ›

[1] CY 2019 "Home Health Prospective Payment System Rate Update; Value-Based Purchasing Model; Quality Reporting Requirements and Home Infusion Therapy," accessed July 25, 2019 (CMS-1689-P) 83 FR 32340 2018 https://www.federalregister.gov/documents/2018/07/12/2018-14443/medicare-and-medicaid-programs-cy-2019-home-health-prospective-payment-system-rate-update-and-cy

[2] "Home Health Patient-Driven Grouping Models," Centers for Medicare and Medicaid, accessed July 25, 2019; https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html

[3] "CY 2019 Home Health Prospective Payment System Rate Update; Value-Based Purchasing Model; Quality Reporting Requirements and Home Infusion Therapy," accessed July 25, 2019 (CMS-1689-P) 83 FR 32340 2018 https://www.federalregister.gov/documents/2018/07/12/2018-14443/medicare-and-medicaid-programs-cy-2019-home-health-prospective-payment-system-rate-update-and-cy

[4] Tim Mullaney, "Encompass Health Flags Top PDGM Concerns," Home Healthcare News, accessed July 25, 2019, https://homehealthcarenews.com/2018/07/beyond-the-basics-3-things-home-health-providers-should-know-about-pdgm/

[5] Robert Holly, "Beyond the Basics: 3 Things Home Health Providers Should Know About PDGM," Home Healthcare News, accessed July 25, 2019, https://homehealthcarenews.com/2018/07/beyond-the-basics-3-things-home-health providers-should-know-about-pdgm/