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Home Health Patient-Driven Groupings Model (PDGM) - Split Implementation

MLN Matters Number: MM11081 Revised

Related CR Release Date: February 15, 2019

Related CR Transmittal Number: R4244CP

Related Change Request (CR) Number: 11081

Effective Date: January 1, 2020 Claim "From" dates on or after this date.

Implementation Date: January 6, 2020

Note: We revised this article on February 19, 2019, to reflect the revised CR 11081 that CMS issued on February 15. The changes to the CR had no impact on the article. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for home health (HH) services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11081 effectuates the policies of the Patient-Driven Groupings Model (PDGM) as described in the November 2018 HH final rule. Please make sure your billing staff is aware of these changes.

BACKGROUND

Since October 2000, HH agencies (HHAs) are paid under a prospective payment system (HH PPS) for a 60-day episode of care that includes all covered HH services. The 60-day payment amount is adjusted for case-mix and area wage differences. Additionally, HH episodes of care can receive higher payments if certain therapy thresholds are met. As part of the HH PPS payment structure, HHAs receive approximately half of the expected final payment amount up front, after performing the first visit in a 60-day episode of care, with the remaining amount received at the end of the 60-day episode of care upon final claim submission.

In early February of 2018, Section 51001 of the Bipartisan Budget Act of 2018 (BBA of 2018) became law and included several requirements for HH payment reform, effective January 1, 2020. These reform measures include the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of service to a 30-day unit of service. In the CY 2019 final HH PPS Rate Update final rule, CMS finalized an alternative case-mix method called the PDGM, which includes the payment reform requirements as set forth in the BBA of 2018 and will be implemented in CY 2020.

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CR 11081 Key points

CR 11081 effectuates the policies of the PDGM, as described in the CY 2019 HH final rule available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1689-FC.html and as required by Section 51001 of the BBA of 2018.

These policies include a change to the unit of payment from 60-day episodes of care to 30-day periods of care and the elimination of therapy thresholds for use in determining HH payment. The PDGM will assign 30-day periods of care into one of 432 case-mix groups based on the following variables:

- Timing: The first 30-day period of care is an early period of care. The second or later 30-day period of care is a late period of care;
- Admission Source: If the patient was referred to HH from the community or an acute or post-acute care referral source;
- Clinical Group: The primary reason the patient requires home care, represented by distinct clinical groups as determined by the principal diagnosis reported on the HH claim;
- Functional Impairment Level: The patient's functional impairment level is based on OASIS items for activities of daily living; and
- Comorbidity Adjustment: If the patient has certain comorbid conditions reported on the HH claim, the 30-day period of care can receive a no, low, or high comorbidity adjustment.

In conjunction with the PDGM, this final rule implements a change to the Low-Utilization Payment Adjustment (LUPA) threshold from the current four or fewer visits per 60-day episode of care to thresholds that vary based on the 10th percentile of visits in a 30-day period of care for each case-mix group in the PDGM.

Beginning in CY 2020, HHAs that are certified for participation in Medicare on or after January 1, 2019, will no longer receive split-percentage payments. HHAs that are certified for participation in Medicare effective on or after January 1, 2019, would still be required to submit a "no pay" Request for Anticipated Payment (RAP) at the beginning of care to establish the HH period of care, as well as, every 30 days thereafter upon implementation of the PDGM in CY 2020.

Existing HHAs, meaning those HHAs certified for participation in Medicare prior to January 1, 2019, will continue to receive RAP payments upon implementation of the PDGM in CY 2020. For split percentage payments to be made, existing HHAs would have to submit a RAP at the beginning of each 30-day period of care. For the first 30-day period of care, the split percentage payment would be 60/40 and all subsequent 30-day periods of care would be a split percentage payment of 50/50. **Please note that a final claim must be submitted at the end of each 30-day period of care.**

ADDITIONAL INFORMATION

The official instruction, CR11081, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4244CP.pdf

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
February 19, 2019	We revised the article to reflect the revised CR 11081 that CMS issued on February 15. The changes to the CR had no impact on the article. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.
February 1, 2019	Initial article released.