Introduction to PDGM

The Patient Driven Grouping Model

And Its

Implications for Home Health Therapist

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What is PDGM and how will it impact Therapy?

- PDGM (Patient Driven Grouping Model) is the new way that Home Health agencies will be reimbursed by CMS, effective January 1st 2020.
- PDGM radically changes the method of payment, ELIMINATING payment per visit for THERAPY.
- PDGM was driven by the Affordable Care Act and certain perceptions of CMS; their desire to shift more payment toward more medically complex patients.

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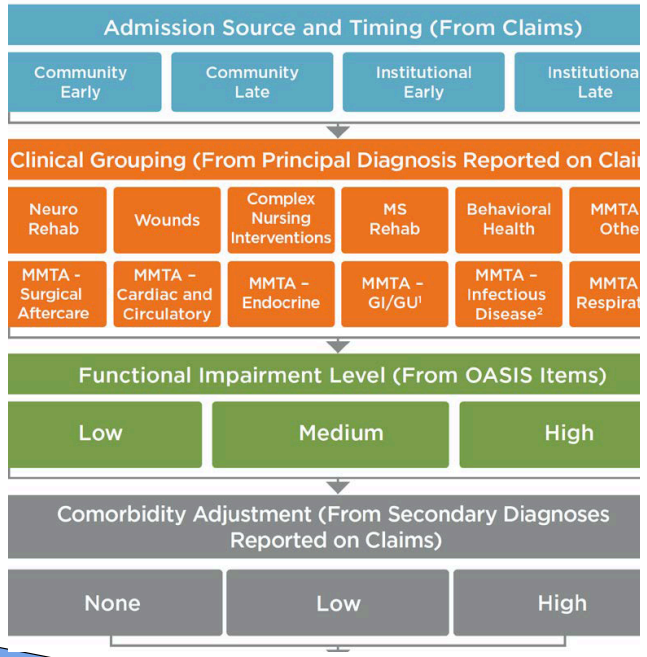
PDGM Overview

- Under the old model, payment was influenced by 3 clinical levels and 3 functional levels, but was heavily driven by number of therapy visits.
- PDGM pays agencies based on factors which are independent of the actual number of visits*. The PDGM model includes:
    1. The Source and Timing of the Referral
    2. A Clinical Grouping
    3. Level of Functional Impairment
    4. Co-morbidities

* Except in LUPA situations



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Related Big Changes

- Payment is now based on a 30 day claim cycle, which is separate from the 60 day Episode.
- The number of visits in a LUPA varies by Clinical Grouping (anywhere from 2 to 7)
- OASIS based Functionality Scores are expanded and more directly influence payment
- The number of case mix Groupings increases from 153 to 432

Source of Referrals and Timing

- Patients discharged from institutions (i.e. Acute Care Hospitals, SNFs, etc.) result in a higher level of pay than community (any other) referral, particularly for the first claim period.

- A claim for the 1st 30 day cycle for the first episode is paid more than claims for a 2nd or later 30 day cycles.

- There are two distinct payment cycles in each 60 day episode, but episode based processes (i.e. POC, OASIS) remain the same at 60 days.

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Clinical Groupings

- The diagnosis (ICD-10) puts each episode in one of 12 Clinical Groupings

- The Groupings have assumptions about the amount and type of resources needed, and have a major effect on payment amount

1 Musculoskeletal Rehabilitation	7. MMTA Cardiac/Circulatory
2 Neuro/Stroke Rehabilitation	8. MMTA-Endocrine
3 Wounds-Post Op Would Aftercare, Skin/Non Surgical Wound Care	9. MMTA-GI/GU
4. Complex Nursing Intervention	10. MMTA- Infectious Diseases/Neoplasms/Blood Forming diseases
5. Behavioral Health Care	11. MMTA-Respiratory
6. MMTA Surgical Aftercare	12. MMTA-Other

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Level of Functional Impairment

- Functional Impairment is categorized as ***low, medium or high***
- Determined by items on the SOC OASIS; points are assigned but the level of impairment varies by Clinical Groupings.

Functional OASIS Items	Current System	PDGM
M1800: Grooming	No	Yes
M1810: Current ability to dress upper body safely	Yes	Yes
M1820: Current ability to dress lower body safely	Yes	Yes
M1830: Bathing	Yes	Yes
M1840: Toilet Transferring	Yes	Yes
M1850: Transferring	Yes	Yes
M1860: Ambulation/Locomotion	Yes	Yes
M1033: Risk for hospitalization	No	Yes

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Co-Morbidities

- Either None, Low (1 comorbidity) or High (2 or more comorbidities)
- 10 Specific Low groups and 34 High Groups defined, all driven by secondary ICD-10s.
- Comorbidities add complexity and therefore result in greater payment

The case mix weight

- The HHA submits the input for each of the four factors, but does NOT make a determination as to the claim amount.
- The factors are put into a “calculator” by CMS which spits out the payment amount, which is a ratio which is applied to a national average for 30 day claims
- Agencies can get a rough idea of payment in advance via an estimator, but ultimately the CMS claims administrator determines the amount.

Implications for Agencies

- Therapy shifts from a driver of revenue to a cost; less therapy may mean more profit. *Expect a reduction in referrals and approved visits.*

- To guard against agencies eliminating visits when they are appropriate, each agency will be measured against a base line of therapy usage levels for 2018/2019, and against expectations for the grouping; too much deviation will be a red flag for audit.

- Agencies will have less ability to understand their revenue until after each claim period. Some agencies are significantly impacted when PDGM is compared to their payments under the current model.

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Implications for Therapists

- This system removes any financial incentive for more therapy visits; in fact, many agencies are likely to discourage visits if they are at all questionable.
- Therapy POCs will need to even more clearly articulate health related goals and the relevant benefits to justify their need.
- PT doing SOC needs a clear assessment of the functionality items and goal oriented improvements; rate at the lowest level of capacity, not the average level as appropriate.

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Implications for Therapists

- It is important to limit care to what is medically necessary and appropriate. Keep your Frequencies tight. Document progress using objective measures and focusing on the potential benefits of therapy.

- In some cases, we will need to be advocates for our patients – fight for the right level of care. Don't hesitate to invoke your professional judgment based on your personal observation and assessment of the patient. You uniquely have the expertise and personal observations to define an appropriate plan.

- Some agencies may push to include more activities in each visit. Be practical and realistic about what can be accomplished.

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Implications for Therapists

- Ensure that you have clear communication with other team members. Does the case manager know why you are in there, what you are accomplishing, and how you add value for the agency?

- Timeliness of notes is even more important. In IL, because of RCD the RAP (Request for Anticipated Payment) must be submitted within 5 days of the SOC, which means the need the therapy eval and POC to complete the submission.

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Implications for Therapists

- The transition is likely to be very challenging for Agencies and Therapists alike. Understand that everyone is going through a learning curve.

- If an agency seeks to limit your visits, be prepared to have a clear statement as to your plan and why it benefits the patient. Anything that prevents rehospitalizations, falls, or that improves patient ADLs is relevant and important.

- Expect a dip in visits; you may need more patients to have the same number of visits. Don't hesitate to contact the referral coordinators with your concerns and issues.

Additional Resources

- The official CMS page
  https://www.govinfo.gov/content/pkg/FR-2018-11-13/pdf/2018-24145.pdf

- The actual text of the regulations
  https://www.govinfo.gov/content/pkg/FR-2018-11-13/pdf/2018-24145.pdf

- Tables and information from the Aptiva Website

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