CMS has a new case-mix classification model, the Patient-Driven Groupings Model (PDGM), effective beginning January 1, 2020. Check out the information below to find out how this new model compares with the Home Health Prospective Payment System (HH PPS).

### HH PPS

- Home health agency (HHA) providers submit one RAP and one final claim for each 60-day episode.

- Split Percentage Payment:
  - First 60-day episode of care is 60/40
  - Subsequent episodes are 50/50

- If the claim is not received 120 days after the start date of the episode or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by FISS and will be recouped.

### PDGM

- HHA providers submit one RAP and one final claim for each 30 day period.

- *Split Percentage Payment:*
  - First 30-day period of care is 60/40
  - Subsequent periods are 50/50

- HHA providers newly enrolled in Medicare on or after January 1, 2019, submit a no-pay RAP and one final claim for each 30 day period.

- *2020 proposed rule may change split payment amounts*

- FISS will be modified to auto-cancel RAP payments on or after January 1, 2019, when the final claim is not received within 90 days of the statement “From” date of the RAP, or 60 days from the “Paid” date of the RAP.

### Episode of Care/Timing

- **Early Episode of Care**
  - First two 60-day episodes in a sequence of adjacent-covered episodes.

- **Late Episode of Care**
  - Third episode and beyond in a sequence of adjacent-covered episodes.

- **Early Period of Care**
  - First 30 days.

- **Late Period of Care**
  - Second or later 30-day period.

### Admission Source

- Two admission source categories used for grouping a 30-day period of care.

- **Institutional**
  - Any acute or post-acute care in the 14 days prior to the HH admission.

- **Community**
  - No acute or post-acute care in the 14 days prior to the HH admission.

- Optional reporting of new occurrence codes 61 and 62 identifies the admission source.
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### HH PPS

**Number of therapy visits:**
- 0–13 visits
- 14–19 visits
- 20+ visits

**Case-mix adjusted payment for 60-day episode** is made using one of 153 HHRGs based on severity levels:
- Clinical
- Functional
- Service Utilization

### PDGM

**Therapy thresholds eliminated.**

**Case-mix adjusted payment for a 30-day episode** is made using 432 possible groups:
- Admission Source
- Institutional/Community
- Timing
- Early/Late
- Clinical Grouping
- Principal claim diagnosis
- Functional Impairment Level
- OASIS items
- Comorbidity Adjustment
- Secondary claim diagnoses

**Position 1,** Timing/Admission Source  
**Position 2,** Clinical Group  
**Position 3,** Functional Level  
**Position 4,** Comorbidity  
**Position 5,** Placeholder

HHAs may submit the HIPPS code they expect will be used for payment if they run grouping software. If not, they may submit any valid HIPPS code. Grouping to determine the HIPPS code used for payment will occur in Medicare systems and the submitted HIPPS code on the claim will be replaced with the system-calculated code.

**Low Utilization Payment Adjustment (LUPA)**

Each of the 432 case-mix groups has a threshold to determine if the period of care would receive a LUPA. This threshold is determined by the tenth percentile of visits in each payment group with a minimum threshold of two.

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**HH PPS vs PDGM**