HH PPS vs PDGM

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

PDGM

Request for Anticipated Payment (RAP)

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

All HHA providers submit one RAP and one final claim for each 30-day period (excluding low utilization payment adjustments (LUPAs)).

Split Percentage Payment:
- 20 percent on RAP and 80 percent on final claim

HHA providers newly enrolled in Medicare on or after January 1, 2019, will not receive a split payment. The entire payment will be received with the final claim.

Auto Canceled RAPs

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.

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.

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

Early Period of Care
First 30 days.

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

Low Utilization Payment Adjustment (LUPA)

Four or fewer visits per episode.

Each of the 432 case-mix groups has a threshold to determine if the period of care would receive a LUPA. This threshold is specific to each case-mix weight and ranges between two and six visits.

HH PPS vs PDGM

HH PPS

PDGM

Admission Source

Not used in HH PPS.

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

Institutional
Hospital discharge 14 days prior to HH start of care is reported on admission and continuing claims. Other institutional discharge 14 days prior to HH start of care is reported only on admission claims.

Community
Any HH payment period that does not have a qualifying institutional stay.

Optional reporting of new occurrence codes 61 (hospital) and 62 (other institutional) identifies the institutional admission source. Do not report on RAPs.

Home Health Resource Groups (HHRGs)

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

- Clinical
- Functional
- Service Utilization

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

Health Insurance Prospective Payment System (HIPPS) Code

Position 1, Timing (early/late) Threshold
Position 2, Clinical Domain
Position 3, Functional Domain
Position 4, Therapy Utilization
Position 5, Non-routine Supplies

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.

Therapy

Number of therapy visits:

- 0–13 visits
- 14–19 visits
- 20+ visits

Therapy thresholds eliminated.