

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

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

REQUEST FOR ANTICIPATED PAYMENT (RAP)

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.

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.

AUTO CANCELED RAPS

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.

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.

EPISODE OF CARE/TIMING

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.

Four or fewer visits per episode.

LOW UTILIZATION PAYMENT ADJUSTMENT (LUPA)

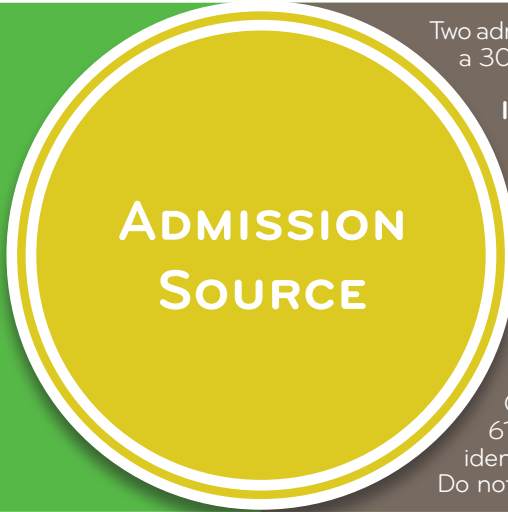
Each of the 432 case-mix groups has a threshold to determine if the period of care would receive a LUPA. This threshold is specific to each case-mix weight and ranges between two and six visits.

HH PPS vs PDGM

HH PPS

PDGM

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.

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

- 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.

Number of therapy visits:

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



Therapy thresholds eliminated.