TO: **MSSNY's Officers, Councilors and Trustees**

FROM: **MSSNY Long-Term Care Subcommittee**

DATE: **November 7, 2019**

RE: **Resolution on Patient-Driven Groupings Model (PDGM)**

At the September 26 meeting of MSSNY's Long-Term Care subcommittee, the committee heard a presentation from Al Cardillo, President of the Home Care Association of New York (HCA) and Patrick Conole, Vice President for Finance and Management for HCA, regarding the new PDGM methodology for paying for home care under the Medicare program.

The PDGM is a new payment methodology for home care that relies more heavily on clinical characteristics and other patient data to classify home health services into more meaningful payment categories. It is part of CMS' effort to shift Medicare payment away from volume-based payment towards value-based payment. According to CMS Administrator Seema Verma, "the rule overhauls how Medicare pays for home health, refocusing on the needs of patients, promoting innovation, and reducing burdens for physicians and home health providers According to one summary, when the PDGM rules go into effect January 1, 2020, what will change is:

- ***New payment episode timings:*** PDGM will break up the standard 60-day episode of care into one of two 30-day periods. That means 30-day periods will be implemented as a basis for payment vs. the 60-day periods used now. Each 30-day period is grouped into one of 12 clinical categories based on the patient's main diagnosis.
- ***Payment groupings:*** PDGM will increase the number of payment groupings and unique case-mix potential from 153 to 432. The current system allowed for 153 combinations, but with PDGM each 30-day period can be categorized into one of 432 case-mix groups.
- ***Elimination of therapy thresholds:*** PDGM will eliminate therapy thresholds as a primary determinant of reimbursement, so therapy visits will no longer determine reimbursement. The number of therapy visits will no longer impact the case-mix weight.
- ***OASIS assessments:*** The Outcome and Assessment Information Set (OASIS) will remain on a 60-day cycle, but there will be two payment periods within that cycle instead of one. Based on an OASIS assessment, new 30-day periods will be categorized according to five subgroups:
    - Only the first 30-day episode would qualify as "early," with all subsequent episodes qualifying as "late." Currently, the first two 60-day periods are considered early.
    - Admission source (community or institutional referral): The 30-day period would be classified as "institutional" if the patient had an acute or post-acute stay within 14 days of the start of care.
    - Clinical grouping: Patients would be assigned to 1 of 6 major clinical groups. Each 30-day period is grouped into one of 12 clinical categories based on the patient's main diagnosis.
    - Functional impairment level (low, medium or high): OASIS codes would help designate a patient's level as "low impairment," "medium impairment," or "high impairment."
    - *Comorbidity adjustment (none, low or high, based on secondary diagnoses)*
- ***Increased claims:*** The number of claims and the Requests for Anticipated Payments (RAPs) submissions are expected to significantly increase.
- ***Low Utilization Payment Adjustments (LUPAs):*** LUPAs will undergo a major change, as each Home Health Resource Group (HHRG) will have its own LUPA visit threshold (2-6 visits) and the LUPA count will reset every 30-day payment period.

- ***Diagnoses:*** According to one summary, about 40% of the diagnoses allowed for under the current system will not be accepted as primary diagnoses under PDGM. Also, if the diagnosis codes are not correct, the claims will be denied.

Al Cardillo, HCA President, noted the potential of new administrative responsibilities for physicians ordering home health care services. He also spoke about the challenges of the face to face encounters, and the expense of therapy services. He expressed concerns about facilities not being able to finance therapy services. Following discussion by committee members it was agreed that this matter should go to the MSSNY Council on November 7th for further action.

Following the meeting, when staff asked the AMA Division of Regulatory Affairs about this issue, they indicated that they "haven't heard about this" and "will have to look into it".

Recognizing the possibility for additional administrative burden on physician and potential impact on their patients in need of home care services, the Committee recommended the following action by MSSNY, to be approved by the MSSNY Council.

RESOLVED, that the Medical Society of the State of New York work with the American Medical Association to monitor implementation of the Patient Driven Groupings Model (PDGM) methodology to determine whether this new program will impose additional administrative burdens on physicians certifying home care services for their patients, and/or whether it will impede patients from receiving needed home care services; and be it further

RESOLVED, that should it be determined that this new program is creating new administrative burdens or patient access issues, that these concerns be conveyed to CMS and Congress for remediation.