RESEARCH REPORT

Six Insights from the 2019 PDGM Preparedness Survey

How home health agencies are getting ready for the Patient-Driven Groupings Model

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RECOMMENDED FOR

Home health agency leadership

READING TIME

10 min.

The PDGM preparedness survey

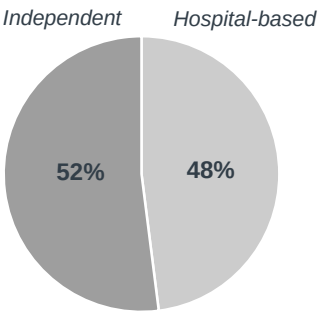
Beginning on January 1, 2020, home health agencies (HHAs) will be reimbursed under a new Medicare payment system, The Patient-Driven Groupings Model (PDGM). In the fall of 2019, we asked 25 agencies from across the country about their priorities and reactions leading up to implementation.

Background on survey respondents

A total of **25 home health agencies** participated in the survey. The respondents represent agencies of varying ownership, size, and therapy utilization.

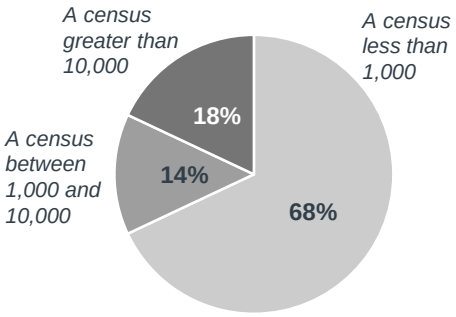
Respondents represent both independent and hospital-based agencies

n=25



Majority of respondents had an average daily census of less than 1,000 patients[1]

n=22



Respondents primarily treat patients falling in lower therapy visit groupings

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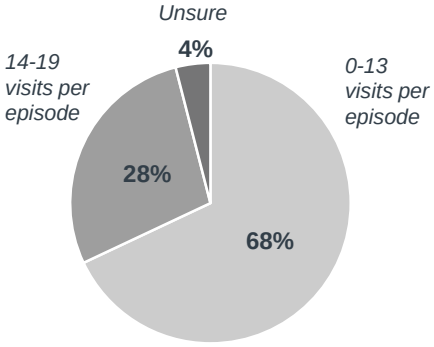


Six lessons on how HHAs are preparing for PDGM

This report outlines six insights about how home health agencies are reacting to the payment change, drawn from survey data analysis and primary research interviews with agencies.

1. Average daily census across entire organization, including multiple agency locations. N is less than 25 due to three agencies failing to reporting census data.

Source: Post-Acute Care Collaborative interviews and analysis.

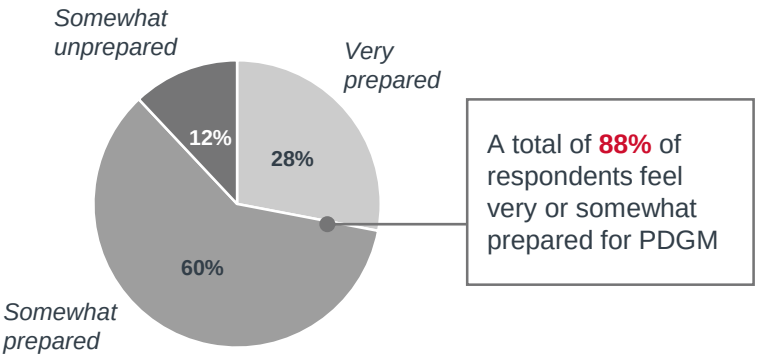
Agencies feel ready, but expect a negative revenue impact

1 Although HHAs feel prepared for PDGM, they expect it to negatively impact their revenue

Across the 25 agencies surveyed, 88% of respondents reported feeling very or somewhat prepared for PDGM, and 72% reported that they expect it to negatively impact their revenue.

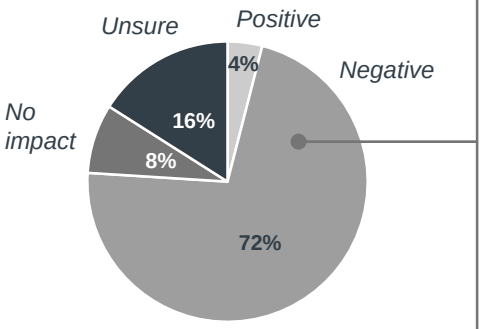
Respondents' level of preparedness for PDGM

n=25



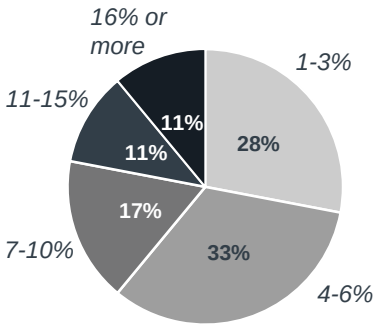
Expected impact of PDGM on agency revenue

n=25



Scale of expected revenue loss

n=18



This contrast between the percentage of agencies feeling prepared, yet still expecting a negative impact is likely due to CMS's behavioral assumptions. CMS has stated in the final payment rule that agencies that do not adjust their behavior by coding the highest-paying diagnosis as primary, selecting all possible comorbidities, and adding visits to avoid LUPAs[1] will receive a downward payment adjustment of 4.36%.[2] This automatic decrease makes the revenue impact of the model much more likely to be negative.

1. Low Utilization Payment Adjustment. Under PDGM, episodes are paid out on a per-visit basis if agencies do not meet a minimum visit threshold. The threshold varies based on the timing and clinical grouping of the episode.
2. In the 2019 proposed rule CMS set the downward adjustment to 8%, but later reduced it to 4.36% in the final rule.

Source: Post-Acute Care Collaborative interviews and analysis.

Agency priorities will shift across the next year

2 Education, financial analysis, and training are top HHA priorities

When we asked agencies to select their top priorities from a pre-populated list, three strategies emerged as the main focus areas of the cohort.

Rank	Priority	Percent selecting as a top three priority	Percent selecting as number one priority
1	Providing general education to staff about what PDGM is and how it works	68%	24%
2	Analyzing the financial impact on our organization	56%	32%
3	Training staff on new coding and assessment practices	56%	12%
4	Improving the efficiency of our billing process	44%	16%
5	Preparing to manage new patient types by modifying our clinical capabilities	32%	4%
6	Identifying and building partnerships with institutional referral sources	28%	8%

This early focus on education, financial analysis, and training reflects the urgency of the payment change. Before HHAs consider broader process and care delivery changes, they are focusing on ensuring staff understand PDGM and are equipped to adapt their daily responsibilities accordingly.

3 HHAs will be more focused on billing in one year, but the implications for investing in new clinical capabilities remains unclear

Respondents were also asked to indicate if each of the listed priorities would be more, less or equally important in one year.

Priority	Percent selecting as more important	Percent selecting as less important	Percent selecting as equally important
Improving the efficiency of our billing process	44%	8%	48%
Preparing to manage new patient types by modifying our clinical capabilities	36%	28%	36%

Overall, 92% of respondents indicated that billing would be more or equally important in one year, reflecting the importance of billing efficiency to their long-term PDGM strategy. Meanwhile, the split between agencies investing more, less, and an equal amount in new clinical capabilities suggests that a shift to different patient types may only occur in the long term, if at all.

Source: Post-Acute Care Collaborative interviews and analysis.

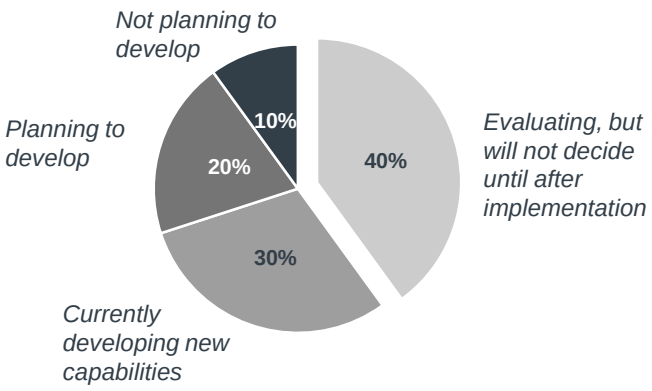
Agencies are undecided on long-term changes

4 HHAs are taking a "wait-and-see" approach to long-term strategy

Although HHAs are heavily focused on training staff, understanding the new model, and analyzing it's impact in the short-term, they are still undecided about how to address the broader changes PDGM could bring about.

Agencies' plans to develop new clinical capabilities

n=25



DATA SPOTLIGHT

36% of respondents are planning to or are currently developing new clinical capabilities. Most commonly, they are doing so to be able to manage **cardiac and wound** patients, both of which have much higher reimbursement potential under the new model.

Agencies' expected need to add visits to avoid LUPA adjustments

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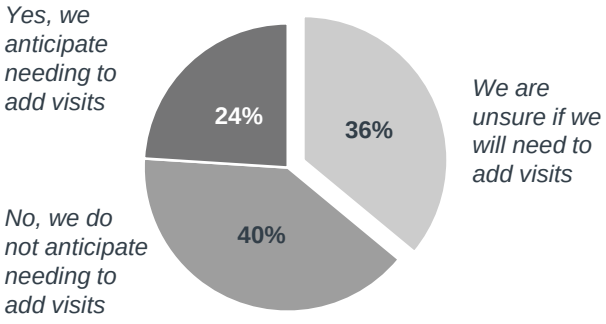
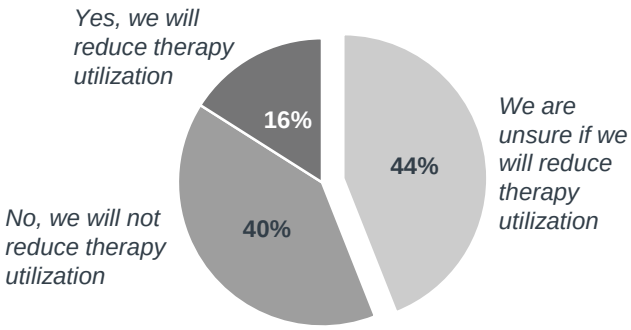


Agencies' plans to reduce therapy utilization

n=25



Agencies' uncertainty about long-term care delivery changes, despite reporting feeling prepared for the model, suggests that many agencies prefer to wait to see what the immediate impact of PDGM will be before investing in further efforts.

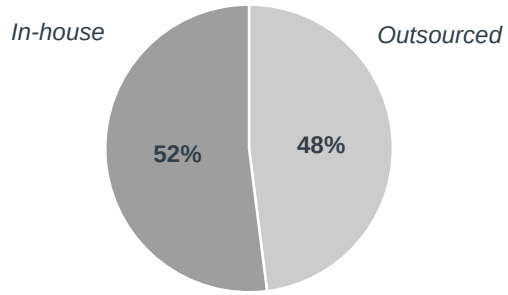
Source: Post-Acute Care Collaborative interviews and analysis.

HHAs are not investing in new coding systems

5 Coding changes are centered on strategies, not system overhaul

Approximately half of the respondents outsource their coding, while the other half do coding in-house. Over 80% of each cohort indicated that they do not plan to change their coding model. This suggests that despite the importance of accurate coding under PDGM, agencies prefer to make changes within their current system rather than to overhaul it.

Respondents' current coding system
n=25



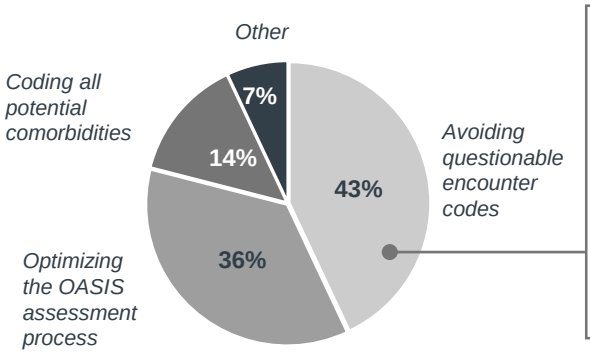
Agencies are not planning to switch their coding ownership

83% Of providers who currently outsource coding plan to continue to do so

85% Of providers doing their coding in house plan to continue to do so

To better understand the adjustments HHAs are making to their coding practices, we also asked each respondent that marked staff training as a top-three priority to indicate which aspect was their main focus. The data showed that HHAs are most focused on avoiding questionable encounter codes, or diagnosis codes that will be rejected under the new system, and optimizing the OASIS[1] process.

Main training priorities
n=14



Additional research

For strategies to help avoid questionable encounter codes, review our research report: **How to Succeed under the Patient-Driven Groupings Model.**

1. Outcome and Assessment Information Set.

Source: Post-Acute Care Collaborative interviews and analysis.

Staffing decisions are mostly in line with PDGM changes

6 Staffing changes reflect the increased importance of billing and nursing

Approximately half of agencies reported plans to add billing staff, and a third indicated they plan to hire more registered nurses in response to PDGM.

Staff member	Percent adding	Percent removing	Percent not changing
Billing	52%	0%	36%
RNs	36%	4%	48%
OTs	0%	12%	84%
PTs	0%	16%	72%

These planned additions are demonstrative of the shorter billing cycle and increased reimbursement of complex nursing patients under PDGM. Interestingly, despite PDGM's move away from therapy-based payment, most agencies do not plan to remove therapy staff, reflecting the continued importance of therapy services in the home setting.

Source: Post-Acute Care Collaborative interviews and analysis

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