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Budget 2020: Prepare your bottom line for PDGM

A strategic budgeting approach to PDGM *from* Simione™ HEALTHCARE CONSULTANTS

If there's one word that encompasses PDGM success, it's balance.

IIn order to be successful in PDGM, all of the pieces must come together. This means balanced clinical outcomes, patient needs, patient experiences, staff experiences, compliance and financial outcomes. When every part of your organization has a seat at the table and their input is included, your preparedness for PDGM will solidify.

The answer is not to focus on any one asset, but instead to rely on your organization as a whole in order to generate quality outcomes. *Balance is key.*

Using the Simione PDGM Analysis Toolkit, this e-book explores both benchmark and budget data – including national and state information to compare to individual provider numbers – to demonstrate how every component of your organization can gather data, make assumptions based on that data and **ultimately understand the impact of PDGM on your bottom line.**

A brief overview of PDGM

No home health agency is immune to the coming implementation of PDGM. And while everyone in the industry is likely already familiar with the final rule, here's a brief overview of the impending changes.

The who, what, when & why

THE WHO: No agency is immune to PDGM. The coming changes will affect all home health agencies.

THE WHAT: PDGM will bring the biggest changes since the implementation of PPS in 2000. The two biggest changes are:

- Payments will go from 60-day episodes (with one 60-day payment) to 30-day period payments for each 60-day episode.
- The treatment of therapy thresholds will be eliminated.

THE WHEN: PDGM will be implemented for episodes beginning on or after January 1, 2020.

THE WHY: Simply put, the PDGM model better aligns with patient needs and ensures that clinically complex and ill beneficiaries will have adequate access to home health care.

The architecture of PDGM

ADMISSION SOURCE AND TIMING: Patients can come from any of these four combinations – community early, community late, institutional early, or institutional late. Some quick definitions:

- **Early:** The first 30-day period in a sequence of periods.
- **Late:** Any other subsequent 30-day period.
- **Institutional:** Any inpatient stay within 14 days, prior to home health admission.
- **Community:** Everything else, including emergency room observation stays.

CLINICAL GROUPING: The primary diagnosis reported on the claim will fit into one of 12 clinical groupings – neuro rehab, wounds, complex nursing, MS rehab, behavioral health, and medication management teaching and assistance is broken into seven subcategories of surgical aftercare, cardiac/circulatory, endocrine, GI/GU, infectious disease, respiratory and other.

FUNCTIONAL IMPAIRMENT LEVEL: Similar to the F1, F2 and F3 levels in PPS, the functional impairment levels in PDGM are low, medium or high. These are based on the eight OASIS items, and the thresholds for low, medium and high are dependent on the clinical grouping from the primary diagnosis.

COMORBIDITY ADJUSTMENT: This is based on the secondary diagnoses recorded on the claim, and agencies can report up to 24 secondary diagnoses. If there are no secondary diagnoses that are classified in a comorbidity subgroup that qualifies for a comorbidity adjustment, then the period will have no comorbidity adjustment. The presence of one or more secondary diagnosis that is classified into a comorbidity subgroup that qualifies for a comorbidity adjustment will result in the period having a low comorbidity adjustment, as long as the comorbidity subgroup is different from the comorbidity subgroup of the primary diagnosis. The presence of two secondary diagnoses that fall into one of the comorbidity subgroup interaction pairings will result in a high comorbidity adjustment as along as both comorbidity subgroups are different from the comorbidity subgroup of the primary diagnosis.

The national benchmarks

COMPARE TOTAL NUMBER OF PPS EPISODES TO THE TOTAL NUMBER OF PDGM PERIODS: Since you're going from a 60-day episode to two 30-day periods of payments, you need to evaluate how many episodes had 30 days of care (as these only qualify for one period payment). **The national average for episodes lasting 30 days or less is 30.1%.**

PPS DOLLARS VS. PDGM DOLLARS: With no behavioral adjustment (budget neutral), the dollars look very similar between PPS and PDGM from a national perspective – the net change is zero. But when looking at it state by state (not shown), the numbers begin to change both positively and negatively.

National PPS vs PDGM Reimbursement Distribution by Clinical Grouping

Clinical grouping	PPS Episodes	PDGM Periods	Change in Reimbursement	% Change
Behavioral Health Care	$266,442,450	$260,859,032	$(5,583,418)	-2.1%
Complex Nursing Interventions	$203,480,730	$251,689,310	$48,208,581	23.7%
MMTA- Surgical Aftercare	$641,980,742	$631,207,988	$(10,772,754)	-1.7%
MMTA- Cardiac/Circulator	$2,311,675,677	$2,426,761,779	$115,086,102	5.0%
MMTA- Endocrine	$696,469,209	$794,761,702	$98,292,493	14.1%
MMTA- GI/GU	$606,147,056	$619,594,114	$13,447,058	2.2%
MMTA- Infectious Disease	$598,650,797	$637,201,077	$38,550,281	6.4%
MMTA- Respiratory	$1,102,512,689	$1,155,695,582	$53,452,893	4.8%
MMTA- Other	$1,189,122,721	$1,204,137,449	$15,014,728	1.3%
Musculoskeletal Rehabilitation	$3,407,038,603	$3,052,556,654	$(354,481,946)	-10.4%
Neuro/Stroke Rehabilitation	$1,665,594,421	$1,591,637,822	$(73,956,599)	-4.4%
Wound	$1,463,888,255	$1,810,550,336	$346,662,081	23.7%
Questionable Encounters	$2,644,852,974	$2,351,890,434	$(292,962,540)	-11.1%
Total	**$16,798,068,861**	**$16,789,040,485**	$(9,028,376)	-0.1%

SOURCE AND TIMING BY CLINICAL GROUP: Referencing the period distribution chart, you can see the timing and source by clinical group. A majority of patients arrived as late community – meaning they were on non-inpatient service beyond the first 30-day period. This is because all recertifications and subsequent 30-day periods (as long as there is no inpatient stay) are classified as late community.

Surgical aftercare and musculoskeletal rehab are higher in early institutional due to patients being admitted post-surgery.

National PDGM Period Distribution by Timing & Source by Clinical Grouping				
Clinical grouping	**Early Institutional**	**Late Institutional**	**Early Community**	**Late Community**
Behavioral Health Care	7.3%	4.5%	15.3%	73.0%
Complex Nursing Interventions	7.2%	6.1%	5.5%	81.2%
MMTA- Surgical Aftercare	46.6%	8.2%	8.5%	36.7%
MMTA- Cardiac/Circulator	17.2%	8.6%	8.6%	65.6%
MMTA- Endocrine	8.6%	5.8%	11.7%	73.8%
MMTA- GI/GU	25.1%	11.1%	9.5%	54.2%
MMTA- Infectious Disease	21.6%	10.3%	10.0%	58.2%
MMTA- Respiratory	9.4%	4.4%	14.1%	72.1%
MMTA- Other	25.8%	10.9%	8.0%	55.3%
Musculoskeletal Rehabilitation	33.4%	4.7%	14.7%	72.1%
Neuro/Stroke Rehabilitation	17.0%	5.5%	15.9%	61.7%
Wound	9.4%	7.0%	13.6%	70.0%
Questionable Encounters	13.3%	4.9%	22.6%	59.2%
Total	**19.5%**	**6.8%**	**13.4%**	**60.4%**

ACTUAL CASE MIX WEIGHT BY SOURCE AND TIMING COMBINATIONS: Now looking at case mix weight by admission timing and source, you'll notice the case mix weight is higher for early institutional, which makes up 20% of episodes. Late community actually makes up 60% of episodes but has the lowest case mix weight. Why is that?

The majority of PDGM periods are late community because most of them are subsequent periods *after* the initial 30 days. **This results in a higher volume of periods, but a lower case mix weight. The lower case mix weight is due to the lower average resource use after the first 30 days of care.**

National PDGM Periods & Case Mix Weight by Admission Timing & Source			
Admission Source	**PDGM Periods**	**% of Periods**	**Average Case Mix Weight**
Early - Institutional	1,862,142	20%	1.3730
Late - Institutional	647,828	7%	1.2750
Early - Community	1,280,766	13%	1.2070
Late - Community	5,778,215	60%	0.8050
Total	**9,568,951**	**100%**	**1.0000**

NATIONAL BENCHMARKS

CLINICAL GROUPINGS: PPS EPISODES VS. PDGM PERIODS: Each 30-day period will be assigned to one of the 12 clinical groupings, based on the primary diagnosis reported on the claim. **While the diagnosis will likely be the same over a 60-day period of care, a significant change in the patient's condition can create a need for a follow-up assessment, thus making it possible for a diagnosis change between the first and second periods.**

National PDGM Period Distribution by Timing & Source by Clinical Grouping				
Clinical grouping	**Early Institutional**	**Late Institutional**	**Early Community**	**Late Community**
Behavioral Health Care	109,256	197,189	21,323	19.5%
Complex Nursing Interventions	98,506	182,712	14,300	14.5%
MMTA- Surgical Aftercare	236,550	357,604	**115,496**	**48.8%**
MMTA- Cardiac/Circulator	841,631	1,486,023	197,239	23.4%
MMTA- Endocrine	233,510	428,073	38,947	16.7%
MMTA- GI/GU	227,486	380,701	**74,271**	**32.6%**
MMTA- Infectious Disease	237,570	398,962	**76,178**	**32.1%**
MMTA- Respiratory	411,073	740,375	81,771	19.9%
MMTA- Other	433,441	739,092	127,790	29.5%
Musculoskeletal Rehabilitation	1,024,118	1,591,107	**457,129**	**44.6%**
Neuro/Stroke Rehabilitation	457,165	794,824	119,506	26.1%
Wound	504,676	888,776	120,576	23.9%
Questionable Encounters	818,640	1,383,372	**253,908**	**31.0%**
Total	**5,633,702**	**9,568,951**	**1,698,453**	**30.1%**

In the third column above, you'll notice the number of 60-day episodes with only one 30-day period. Surgical aftercare patients, GI/GU, infectious disease, MS rehab, and questionable encounters (in orange) have between 30% and 50% of patients who are on service for one period or less. **This is because they have a higher percentage of stays less than 30 days.**

Keeping that in mind with the chart below, notice the percentage change in reimbursement based on the clinical groupings. Higher therapy patients like MS rehab and neuro stroke receive less in reimbursement, whereas wound care sees an increase. **This is because in PDGM, there is higher reimbursement and case mix for higher acuity patients – due to higher resource use.**

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Wound	$1,463,888,255	$1,810,550,336	$346,662,081	23.7%
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VISITS BY DISCIPLINE: For a brief look at visits by discipline, you can see on the chart below that wound care patients make up an average 10.9 visits per 30-day period. Behavioral healthcare patients have an average of 7.7 visits per 30-day period. **Thus, there would be higher resource use for wound care as compared to behavioral healthcare.**

National PPS vs PDGM Reimbursement Distribution by Clinical Grouping							
Clinical grouping	**SN**	**PT**	**OT**	**ST**	**MSW**	**HHA**	**Total**
Behavioral Health Care	3.8	2.0	0.8	0.4	0.1	0.7	**7.7**
Complex Nursing Interventions	3.9	1.0	0.3	0.1	-	1.2	**6.6**
MMTA- Surgical Aftercare	5.5	2.6	0.8	0.1	0.1	0.4	**9.6**
MMTA- Cardiac/Circulator	4.9	2.5	0.8	0.1	0.1	0.8	**9.2**
MMTA- Endocrine	7.3	2.2	0.6	0.1	0.1	0.8	**11.1**
MMTA- GI/GU	4.7	2.6	0.8	0.1	0.1	0.8	**9.1**
MMTA- Infectious Disease	4.9	2.1	0.6	0.1	0.1	0.8	**8.6**
MMTA- Respiratory	5.3	2.2	0.6	0.1	0.1	0.8	**9.1**
MMTA- Other	4.5	2.8	0.9	0.2	0.1	0.8	**9.3**
Musculoskeletal Rehabilitation	3.2	5.2	1.3	0.1	0.1	0.7	**10.5**
Neuro/Stroke Rehabilitation	3.2	4.3	1.8	0.9	0.1	1.1	**11.3**
Wound	7.8	1.6	0.6	0.1	0.1	0.8	**10.9**
Questionable Encounters	3.2	4.4	1.1	0.2	0.1	0.7	**9.8**
Total	**4.6**	**3.2**	**1.0**	**0.2**	**0.1**	**0.8**	**9.8**

Side note on questionable encounters

Questionable encounters are the primary diagnoses codes that do not fit into one of the 12 clinical groupings, and in order for agencies to adapt to PDGM, they must eliminate their use of these diagnoses codes. This is because, in PDGM, questionable encounters will not be billable. For example, muscle weakness is the most common questionable encounter and CMS has designated it as inappropriate for home health – because it's a symptom code, not a diagnosis code. It's important that, as an agency, you work on determining the root cause of these non-applicable diagnoses codes.

In that same reimbursement chart above, you can see the financial effects caused by questionable encounters. If agencies made zero changes to their coding, $2.3 billion would not be billable under PDGM.

5 MOST COMMON QUESTIONABLE ENCOUNTERS: These top five questionable encounters make up significant portions of all diagnoses – *each no longer billable under PDGM*.

1. **M62.81** - *Muscle weakness*
2. **R26.89** - *Abnormalities/gait*
3. **M54.5** - *Low back pain*
4. **R26.81** - *Unsteadiness on feet*
5. **R53.1** - *Weakness*

The impacts of PDGM

Now that we have a solid understanding of the technical changes coming with PDGM, we can look at how those changes will impact your agency. More specifically, how it will impact each department.

Sales and marketing

Just like your agency will have to change its approach to coding, you will also find it beneficial to change your strategic marketing.

- Identify your margin within each clinical group and within specific diagnoses to focus on where your agency is seeing higher volume. *Just because some clinical groups have a decrease in reimbursement, doesn't mean they still don't have higher margin patients. Margins are also dependent on visit utilization and supply resource use for these patients.*
- Ask where your patients are being referred from and work on leveraging relationships with those referral sources. *Focus on getting more patients that have higher margins.*
- Consider a strategy that utilizes lower resource use with quality outcomes. *These cases can still have the highest gross and net margins for those in neuro/stroke and musculoskeletal rehab.*
- It's not enough to just know the reimbursement, but also to be able to drill down into your margins and assign a cost based on utilization by discipline and resource use. *Medical supplies are a good example of this.*
- Target new referral sources. Specializing in specific services and diagnoses can allow you to create care pathways around diagnoses where you know you have positive margins, as well as quality outcomes. *Leverage the data of your referral sources to obtain more of these patients.*
- For high therapy agencies, consider more interdisciplinary approaches and daily living improvements for patients.

Intake and referral management

Looking at each phase of the patient (from referral to intake to admission to service delivery and through billing) will give you a thorough understanding of the impacts of PDGM – which go from intake all the way through to billing.

1 IT ALL STARTS WITH SALES AND MARKETING

Before patients even enter your service, your marketers should be educating referral sources on PDGM, which should provide you an appropriate diagnosis code(s) from the physician. This approach to marketing saves time in revenue cycle because you avoid requesting information after the fact, and instead addresses it as early as possible.

2 INTAKE AND REFERRAL MANAGEMENT HAS A CONTINUOUS IMPACT THROUGH BILLING

Gathering as much patient information from facilities will lead to more accurate and timely coding. Since we no longer have to drop a final claim after 60 days (now 30 days), it's vital to get specific information from referral sources. All the same billing regulations apply, but our timing is now shortened.

3 PROCESSING YOUR REFERRALS IS JUST AS IMPORTANT AS YOUR RELATIONSHIPS WITH THEM

Capturing source and timing, observation status verification, electronic referrals from healthcare systems, tracking transfers and hospitalizations, and monitoring outcomes. **EMR capabilities are more important than ever and understanding what your platform can (and cannot) deliver is vital to PDGM existence.**

Information technology

Now that you know what your EMR is capable of, here's a list of must-have features for navigating PDGM and moving your organization forward:

- PDGM compliance (which version will provide this?)
- Telemonitoring
- Document management
- Supply management solutions
- Interface utilization (eliminate all workarounds)

Have an IT taskforce that understands your organization's needs from your EMR and stay in communication with them for the next several months to ensure an easy transition into PDGM. They will help you adjust and facilitate any needed changes to your system.

Perhaps most important of all, make sure everyone in your organization is trained and knows how to use the technology completely. If everybody's working within the system, then it's able to communicate from marketing all the way through billing – **making the PDGM transition much smoother.**

Data gathering: How to budget for Medical PDGM patients

Looking at Medicare revenue, here are the steps to take to budget for Medicare PDGM patients from a gross margin perspective.

1 SET UP A BUDGET TEAM

Your budget team should be a balanced representation of your organization – not just accounting, but also clinicians because they will be impacted the most by PDGM. Finance will need input from clinicians so that everyone understands what's coming and you have 100% buy-in across your organization.

2 RECOGNIZE PDGM BUDGETING AS AN ORGANIC TOOL

Budgets should evolve as your organization evolves, especially for PDGM. Recognize that some PDGM strategies may not work, and you may have to re-evaluate and reforecast.

3 LOOK AT MEDICARE ADMISSIONS

How many Medicare admissions are you seeing per month and how long are those patients staying on service? Evaluate how many periods by clinical group you're seeing per patient to get an accurate idea of admissions.

4 LOOK AT REIMBURSEMENTS

Evaluate the first 30-day period vs. all subsequent 30-day periods. If you have a longer length of stay, you can break this down even further by showing the first four periods vs. just the first period and all subsequent periods.

5 LOOK AT VISITS BY DISCIPLINE, BY PERIOD, BY CLINICAL GROUP

The next step of breaking that information out is to then look at the sequence of periods through the full year, noticing what clinical groups have more sequences of periods and how utilization changes in each subsequent period.

THERE ARE TWO REASONS FOR THIS APPROACH:

1 First 30-day period: highest utilizations are seen in the first 30 days

2 Highest acuity patients are those who stay on service

How your data can create value

You've gathered a range of data on your organization's admissions, length of stays, and reimbursements – now it's time to use that data to create a useful budget that will prepare your bottom line for PDGM.

WHAT ASSUMPTIONS CAN YOU MAKE? In order to project any change in your Medicare admissions, you need to know what percentage of questionable encounters will be able to be classified into an acceptable clinical group, based on the primary diagnosis. **This would allow those encounters to be billable.**

Having a 100% realization percentage means that you would get your questionable encounter volume down to zero – which is ideal. But in reality, you may not be able to educate all of your referral sources. Instead you can focus on targeting your primary referral sources, which means you'll have to continue accepting some patients with unacceptable primary diagnoses. It is more realistic to aim for 100% beyond year one of PDGM. The key to reclassifying the questionable encounters is to identify the most common primary diagnosis that is applicable in PDGM and redistribute these patients into that clinical group. **This means drilling down into your questionable encounters and revealing as much information as possible that could match them with the appropriate primary diagnosis**.

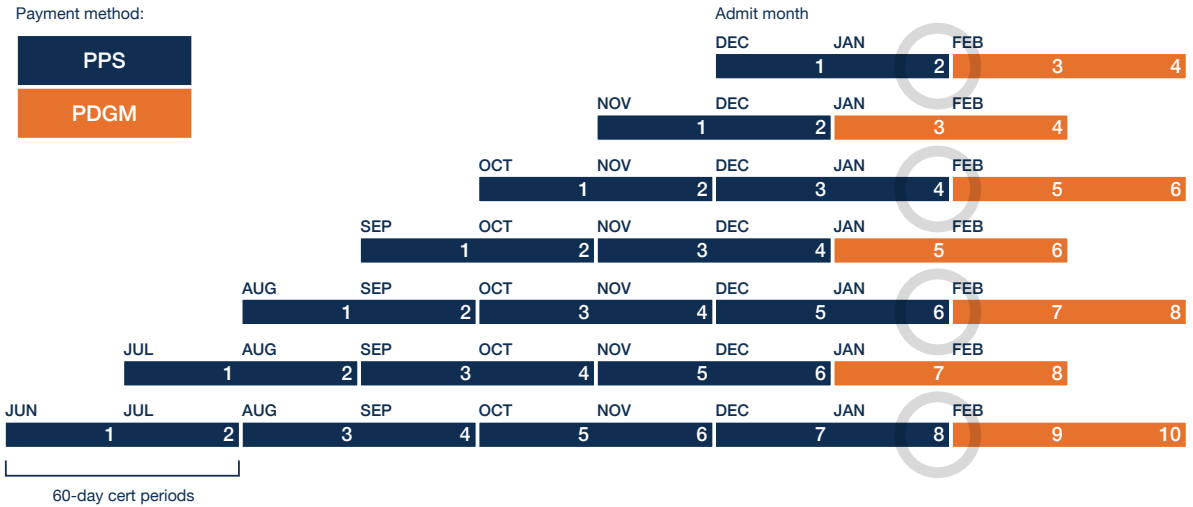
WHAT CHANGES CAN YOU MAKE TO ADMISSION AND DISTRIBUTION BY CLINICAL GROUP? You can project change in referrals by clinical group, as well as redistribute patients within each clinical group as a result of the development of care pathways or specialized service programs based on specific diagnoses.

WHAT ADJUSTMENTS CAN YOU MAKE BASED ON CARE PATHWAYS TO LENGTH OF STAY, NUMBER OF PERIODS PER ADMISSION OR UTILIZATION BY CLINICAL GROUP? As you evaluate your care delivery processes, it may produce better quality outcomes and re-hospitalizations if you change length of stay and/or utilization.

2020 projections: How PDGM will affect your bottom line

As you budget for 2020's PDGM implementation, remember that you need to account for PPS patients within the first two months. PPS patients on service from November and December of 2019, will continue to get paid under PPS in January and February 2020. That's why PPS needs consideration in this budget.

TIPS ON BUILDING PROJECTIONS FOR YOUR BUDGET: Transition patient volume from PPS discharges to PDGM – see the chart below for an example of PDGM carry-over of patients admitted prior to January 1, 2020.



CALCULATE THE FOLLOWING FOR YOUR ORGANIZATION:

- Projected PPS revenue and PDGM revenue
- Visits per period by discipline
- Staffing data (hours worked, paid-time-off, overtime rates, salaries, per diem rates, etc.)
- Mileage costs (cost per visit)
- Medical supplies (cost per visit)

Knowing your gross and net margins is important, because it allows you to know if certain clinical groups are impacting your bottom line. The Simione budget model goes beyond giving you the tools to plan adjustments and assumptions – **they allow you to see how exactly your bottom line is impacted.**

Like any budget, balance is crucial.

And for PDGM, having a firm grasp on where your organization is seeing shifts in margin – and how to navigate clinical groups and questionable encounters – **is the answer to being prepared.**

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For more information or to request a demo, please visit **www.brightree.com/demo** or call us at **1.888.598.7797.**

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