Patient Driven Payment Model (PDPM)

New Reimbursement, New Challenges for SNF Providers

Lance Hill, OTR/L, RAC-CT®
Executive Vice President of SNF Operations
Dir. of Regulatory and Clinical Compliance
email: lhill@therapyctr.com

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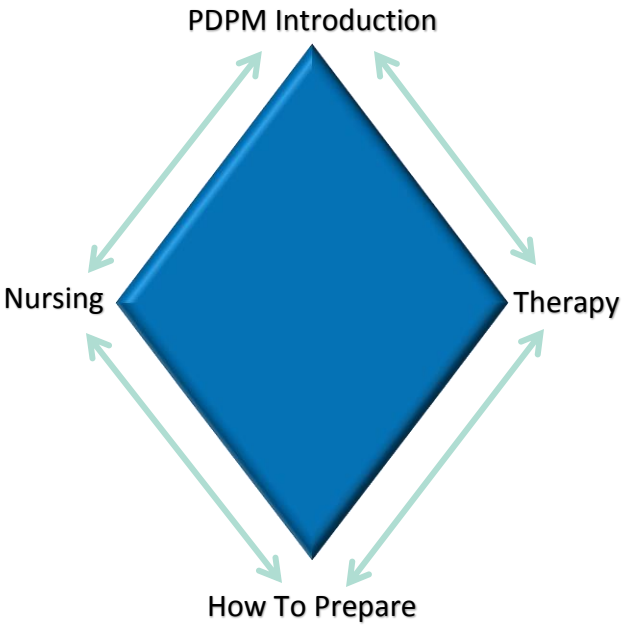
This article will address 4 components of PDPM: 1- A brief overview of the PDPM payment model; **2**- New challenges impacting nursing, **3**- Therapy: Debunking myths and therapy's role in PDPM; and finally **4**- What we can do now to begin preparing for change.

Overview of PDPM

CMS has adopted a new Part A payment model set to replace RUG's IV becoming effective October 1, 2019. The PDPM or Patient Driven Payment Model is expected to create a reimbursement system that is more cost effective with patient outcomes being the central driver of care. The PDPM program is to be budget neutral which means that it should not cost Medicare more than the current PPS reimbursement model. Why change then? CMS believes that PPS was built with inherent flaws that incentivized Providers based on the amount of therapy provided instead of the amount of care the patient truly needed.

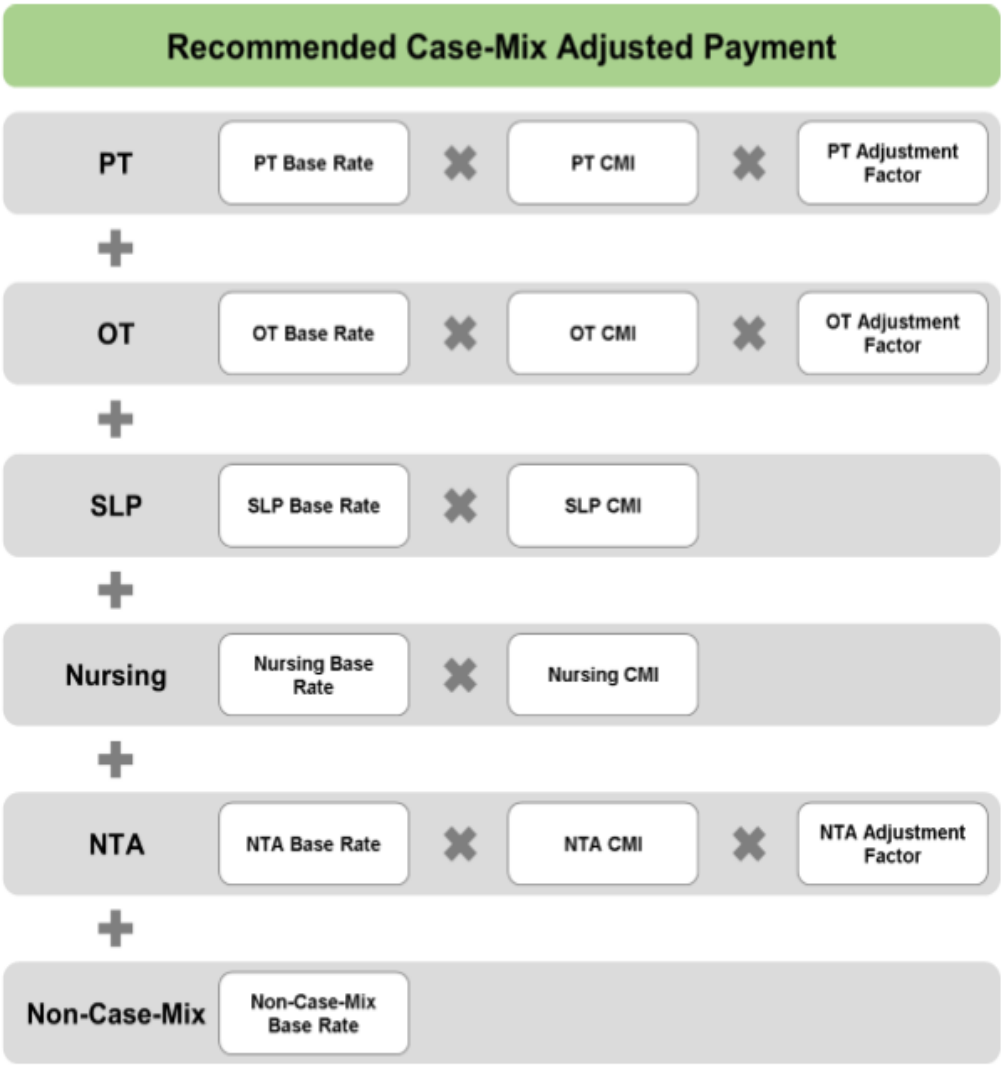


The introduction of PDPM as the new SNF payment model for Part A patients will impact Providers greatly. This is by far the biggest change that SNF Providers will experience since the introduction of PPS in 1999. Under PDPM, each patient is assigned a case mix classification that drives daily reimbursement. The process starts with the patient being assigned into one of 10 clinical categories based on admission ICD 10 medical diagnoses. After the patient is classified medically and comorbidities taken into account, patient classification is further determined based on the calculations of 5 separate case mix scores. Each of the 5 component scores are added together to yield the patient's overall case mix classification that will determine the overall patient reimbursement. These five criteria areas are:

- Nursing
- OT
- PT
- ST
- Non Therapy Ancillary

Final reimbursement will be the combination of:

Clinical Category + Comorbidities serving as the foundation or base for reimbursement, followed by the Case Mix Adjusted per diem for PT + Case Mix Adjusted per diem for OT + Case Mix Adjusted per diem for ST + Case Mix Adjusted per diem for Nursing + Case Mix Adjusted per diem for NTA (non therapy ancillary).



So how will PDPM be different than RUG's IV?

- Under PDPM reimbursement is determined through Index combining vs. Index maximization seen under RUG's IV
- PDPM will see a return of Group and Concurrent therapies vs. RUG IV where use of group and concurrent was discouraged
- 1 required MDS assessment vs. 5 required assessments under RUG's IV
- PDPM does not incentivize for increased therapy. Under RUG's IV payment was determined by the amount of therapy provided whereas PDPM will rely on clinical complexity, medical diagnosis and goals/outcomes of therapy
- PDPM requires that each discipline or classification justify and support the level of services provided independently otherwise overall scoring will be negatively impacted
- PDPM is focused on patient outcomes to a higher degree than RUG's IV
- PDPM reimbursement decreases as length of stay increases
    - Days 1-20 are paid at 100%
    - Days 21-100 will see payment decrease by 2% every 7 days
- Under PDPM ICD-10 diagnosis codes MUST be identified on admission as they drive the clinical category each patient is categorized into
- Comorbidities play an increased role in determining reimbursement under the PDPM model
- Section GG (revised and revamped) will replace Section G on the MDS

As you can see PDPM will require all SNF Providers to take a hard look at systems and processes as well as ensure that key personnel are trained to effectively navigate the PDPM arena.

New Challenges Impacting Nursing

Under PDPM, not everything will be or look new. Carrying over from PPS will be the 25 RUG IV nursing RUG classifications currently in use.

- Extensive Services
- Special Care High and Special Care Low
- Clinically Complex
- Behavioral & Cognitive Performance
- Reduced Physical Function

These categories will be adjusted by 3 factors:

- Level of Restorative services provided
- Depression indicators as defined in the RAI manual
- Section GG!

*** It is important to note here that Section GG has been revised and will replace Section G on MDS's under the PDPM model of care.

MDS accuracy is and continues to be critical under PPS but even more attention to detail will be required under PDPM. To be successful under PDPM, your MDS team needs to be educated to capture the patient's condition and to actively recognize significant changes in patient condition should they arise. Active care is key.

The Good, Bad and Ugly

The Good: Required or Scheduled MDS assessments will decrease from a minimum of 5 in a 100 day stay to 1 (completed at the beginning of care).

The Bad: Unlike PPS where if the patient received and classified in a therapy RUG, the strength of support and justification of skilled nursing services was not as important due to therapy's involvement, under the PDPM this will change. Because PDPM takes into account 5 silos of care, each silo must support and justify the services and care delivered in order to qualify for reimbursement. This means that Nursing will need to support and justify the skilled nursing services being delivered and cannot rely on therapy involvement to support the rate. This is also true of therapy. OT must independently support OT services, PT, PT services and ST, ST services. If any of the silos do not adequately justify the level of services provided, that silo will have a negative impact on patient's overall reimbursement.

The Ugly: Section GG and I8000. As mentioned in the introduction, Section GG will replace Section G on the MDS under PDPM. The definitions surrounding Section GG remain the same but new item sets have been added and one category deleted. Here the care team is looking to capture the patient's "Usual" performance in the first 72 hours of care and in the final 72 hours of care on planned discharges. Although many of the item set questions seem therapy related, do not fall into the trap of thinking that therapy should be the only ones answering these questions. The questions are geared for the entire Care Team and the key to remember here is "Usual". Yes therapy should have input but should not be the sole source of data. How does the patient "Usually" perform each task? Often time's therapy will see the patient in a much better light during the first 72 hours compared to the patient usual, so their data should rarely be used as the data to be input on the MDS. At time of discharge how the patient performs in therapy should be more indicative of what the final MDS data records.

So why is it important to be wary of sole use of therapy data on the initial Section GG MDS? The short answer is **outcomes**. PDPM is geared to reward patient outcomes. CMS has been moving to value based purchasing for the past 15+ years and outcomes is key. If your MDS data reports a more independent patient as the usual, your final outcomes will not reflect the true level of care you have provided. This could result in audit scrutiny from MAC's, RAC's and ZPIC's to name a few.

I8000 Active Diagnosis is a field that under PDPM will require careful attention to detail. Education and training now is critical. As mentioned previously, PDPM begins with the Part A patient being classified into a clinical category based on the diagnosis codes appearing in I8000. Not capturing accurate or detailed medical diagnoses will affect your reimbursement. The impact can be compounded if the patient has a missed diagnosis that would qualify for additional reimbursement based on the approved Comorbidities List established inside the PDPM Framework. It is critical that the entire care teams, including physicians are well versed in proper and accurate coding.

Therapy: Debunking Myths and Therapy's Role in PDPM

Therapy under the PDPM model will likely see a drastic change. While the treatment techniques provided to patients will remain mostly unchanged, how therapy is delivered will. Remember PPS rewarded or incentivized Providers for delivering more therapy services. One of the primary drivers for change to the PDPM model surrounds CMS's worry of possible fraud, waste and abuse. CMS believed that increased financial rewards from higher therapy RUG levels at times took precedence over patient need. To combat this, PDPM is outcomes driven, removes much of the incentive to provide more therapy and instead relies on patient condition and functional scores as the primary drivers of reimbursement.

Does that mean that you will no longer need therapy in your facility? The answer is NO! CMS has explicitly stated that under PDPM the expectation is that the patient will not see significant changes in the delivery of services. The expectation that patient outcomes will either remain at the same level or even improve is central to CMS's decision to switch from PPS. What this means is that if a patient is receiving therapy at a Rehab Very High Level or 500 minimum minutes per week, then the expectation is that under PDPM, a level of therapy care will need to be delivered that will yield the same or better outcomes than under the PPS RV category. Section O of the MDS will also receive modifications and will be the instrument CMS uses to insure that the delivery of therapy care does not suffer under PDPM. The new Section O on the Discharge MDS will track therapy start date, therapy end date, minutes of therapy provided (Individual + Group + Concurrent) by discipline and how many total days by discipline the patient receive each therapy service. CMS has made it clear in the final rule that they will monitor the provision of therapy and expects that there will not be a significant decline in minutes provided.

CMS has stated that if they see a significant decline in provided therapy minutes, they could use this as justification to reduce payments in future years. It is not recommended to have a radical shift in therapy delivery.

One of the areas that CMS has included in the PDPM model is that will impact the delivery of therapy is to make concurrent and group therapy less restrictive than it currently is under PPS. Both group and concurrent therapy are allowed under PPS however, benefits for clinician's to use these treatment categories is either nil or actually increases their risk of denial. With PDPM, group and concurrent therapies will see a comeback to a maximum of 25% of the patient's *overall treatment minutes*. This will need to be monitored carefully by your rehab team; going over the 25% threshold will result in payment denials. RUG levels will go away and will be replaced with 3 case mix silos. One for OT, one for PT and another for ST.

As opposed to the 41 specific rehab RUG's under PPS, there will now be hundreds of possible case mix combinations. Like nursing, coding accuracy will be a critical component to maximizing reimbursement and balancing the level of care that each patient needs.

How We Can Prepare Now

Although PDPM is a year away, there are definite items that we can work on today to prepare for October, 2019. Establishing processes and investment in education today will pay huge dividends when PDPM is implemented. Where to start?

ICD 10 Coding Accuracy: **[Importance- CRITICAL]** Coding accuracy can determine success or failure in PDPM. Unlike PPS where more care equaled more reimbursement, PDPM starts with the patient being categorized into a Medical Classification based on ICD 10 coding. Missing key ICD 10 codes can result in a patient being incorrectly categorized resulting in decreased payment. Certain comorbidities also give financial benefits if present so it is essential that these are captured on ADMISSION. Remember that the number of required assessments will decrease and CMS has stated that IPA's or Interim Patient Assessments should not be used to correct mistakes. Collecting accurate and complete data on admission is essential when managing the bottom line on Part A patients.

One of the major challenges that a SNF Provider faces is information on admission. It is highly recommended that education begins now. Having dialog with hospitals, discharge planners and most importantly physicians and educating on the importance of detailed and accurate coding will not only save countless headaches but will position you to be highly successful under the PDPM payment model.

Physician Education: **[Importance- CRITICAL]** Even though this was just mentioned, physicians will be essential to your success under PDPM and their importance cannot be stated enough. Incomplete, vague, or incorrect coding will cost you valuable reimbursement dollars. Success under PDPM starts with proper classification into one of the 10 Clinical Categories. Having physicians onboard, educated and fully understanding the value of correct coding will position you to best succeed under the new payment model.

Care Team Education: **[Importance- VITAL]** Building systems in preparation of PDPM will ensure a smooth and easy transition. In order for this to happen however, all members of the Care Team must know their new roles and educate themselves to expectations. Your MDS Coordinator as relayed earlier holds a very important role to facilitate accurate information to the MDS. The information transmitted on the MDS will be vital in ensuring that you are paid for the services provided but also ensuring that you stay paid. Communication between Therapists, Nursing, Social Services, Dietary and CNA's needs to be cultivated. Missed information can lead to missed items on the MDS translating into missed revenue. Section GG is another vital area of importance. It is recommended that education be provided on how to properly code GG. The MDS Coordinator will need to be well versed in Section GG as they will be the person to make the final determination as to what is the patient's "Usual". Good communication between all members of the care team will help insure that the MDS is accurate on submission.