



Patient Driven Payment Model (PDPM)

New Reimbursement, New Challenges for SNF Providers

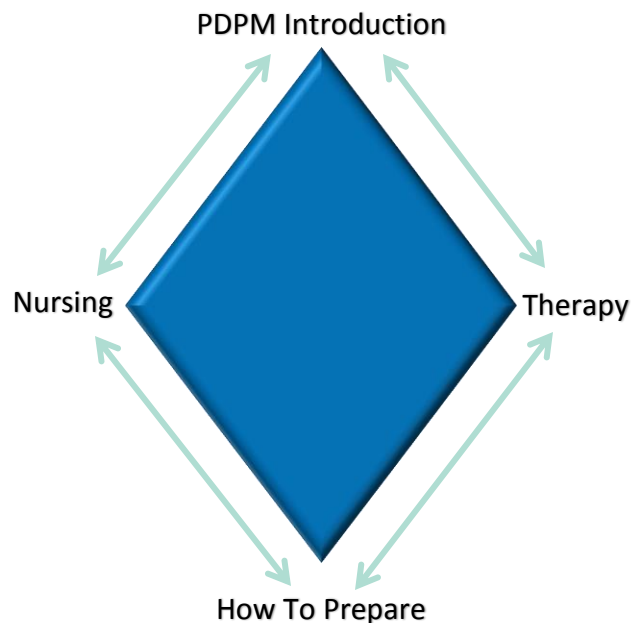
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This article will address 4 components of PDPM: 1- A brief overview of the PDPM payment model; **2-** New challenges impacting nursing, **3-** Therapy: Debunking myths and therapy's role in PDPM; and finally **4-** What we can do now to begin preparing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

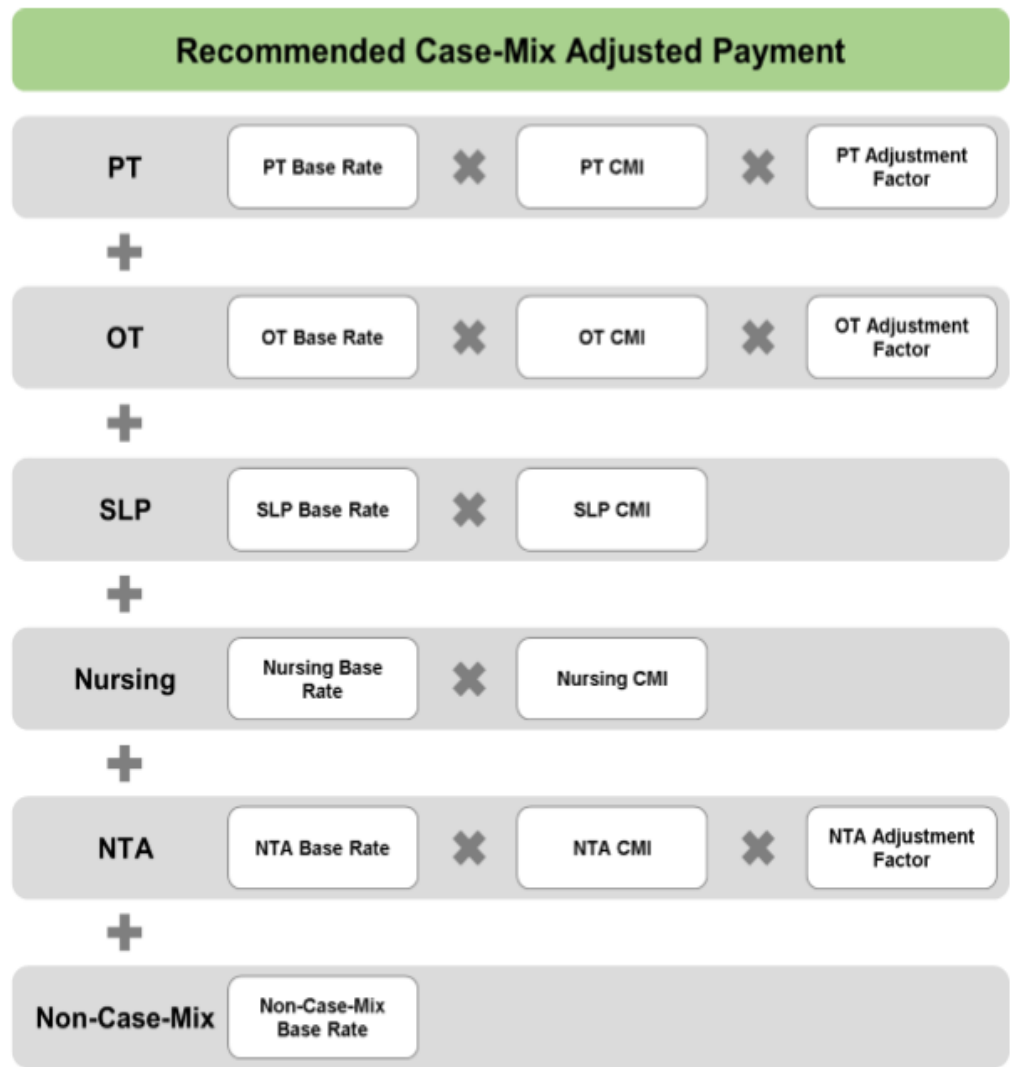


The introduction of PDPM as the new SNF payment model for Part A patients will impact Providers greatly. This is by far the biggest change that SNF Providers will experience since the introduction of PPS in 1999. Under PDPM, each patient is assigned a case mix classification that drives daily reimbursement. 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.

This concludes Part 1 of the PDPM article.

Stay tuned for Part 2: New Challenges Impacting Nursing

Follow up articles on PDPM can be found by visiting <https://www.therapyctr.com/PDPM2018/>.