Preparing for the Patient-Driven Payment Model

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Presented by:

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Kathy is a visionary thought leader and innovator with three decades of state, federal, and international executive experience. She is a nationally recognized leader in aging and long-term care. From 2009 to 2016, Kathy served as the Assistant Secretary for Aging at the U.S. Department of Health & Human Services (HHS). Simultaneously, Kathy created the Administration for Community Living and was its first Administrator.

Through legislative and administrative management, Kathy has supported significant growth in various organizations. Kathy also has served as the Kansas Secretary for Aging, Chief of Staff, and Chief of Operations for then-Governor Kathleen Sebelius, and general counsel for the Kansas Insurance Department. Since returning from Washington in 2016, Kathy has been a Senior Health Policy Advisor for the Kansas-City-based Center for Practical Bioethics and an adjunct faculty member at the University of Missouri-Kansas City School of Law.

Kathy received her Bachelor of Science Administration from the University of Kansas School of Business and Juris Doctor from the University of Kansas School of Law. She is involved in professional organizations that include the National Academy of Social Insurance, the National Council on Aging, the American Bar Association, National Academies of Medicine, and Center for Practical Bioethics, among others.

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Amy provides consulting services in support of post-acute care facilities and has many years of experience in the healthcare industry. As a licensed nursing home administrator with a strong financial background, she specializes in third-party payer reimbursement, especially Medicare and Medicaid cost reporting. She combines this experience with her operational background to advise clients on financial performance, operational efficiencies, and reimbursement issues.

Amy also assists clients and accountable care organizations with evaluating new payment models—including bundled payment analysis—and provides managed care cost analysis. Recently, Amy has focused on Medicare innovation models and interpreting industry benchmarks to help providers navigate the ever-changing post-acute and long-term care industry.

A graduate of Ohio University, Amy holds Bachelor of Science degrees in Long-Term Health Care Administration and Health Services Administration. Amy is also an active member of the American College of Healthcare Administrators.

Objectives

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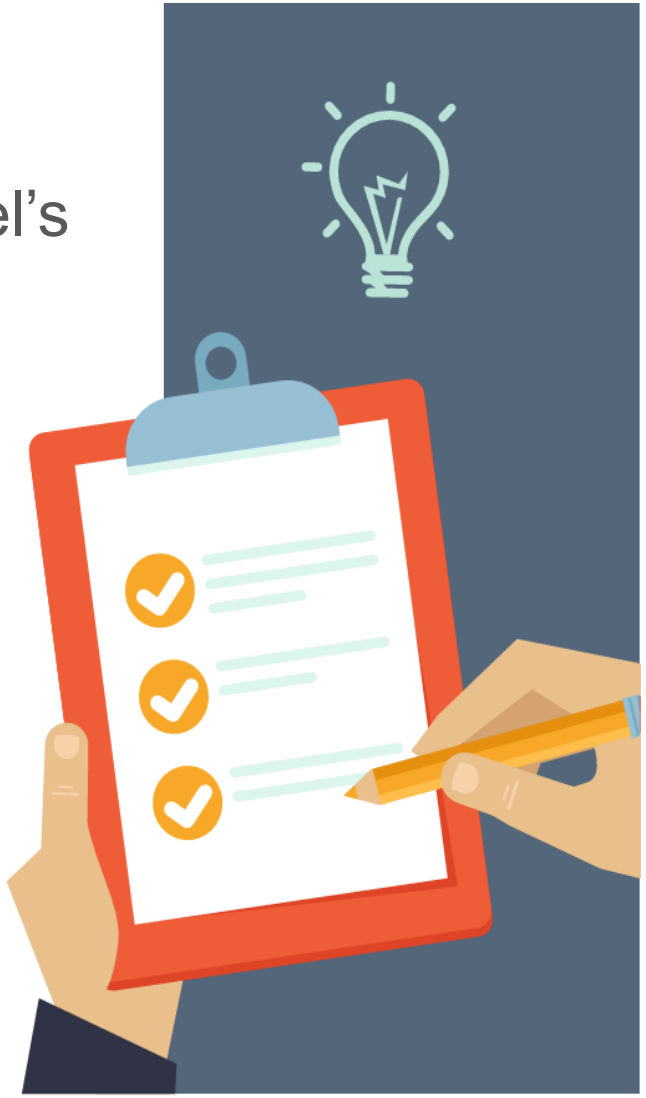
- Defining Patient Driven Payment Model (PDPM)
- Explaining the reimbursement model's transition from therapy-based payment to payment for complex care
- Identifying the driving forces of reimbursement under PDPM
- Outlining steps to prepare for and thrive under PDPM
- Understanding of how PDPM fits into the larger context of the healthcare continuum



How did we get here?

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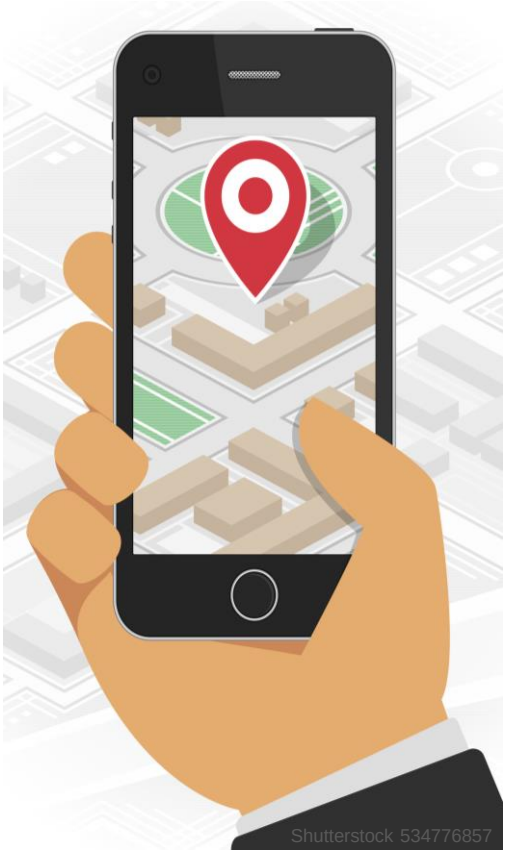

- Resource Utilization Group IV (RUGs) system for which SNF providers were reimbursed for the resources utilized
- Criticism of RUGs system for the very strong reliance on therapy minutes for driving reimbursement
- Incentivizes therapy delivery
- CMS recognized that RUGs payment was primarily based upon therapy without regard for patient's unique characteristics, needs, and goals which sparked the upcoming payment overhaul.

RUGs IV Components

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- Payments are based primarily on the amount of therapy minutes provided to a resident.
- Index Maximizing – this model reduces everything about a resident into one of the 66 RUGs levels; a volume-driven, single case-mix (CM) group.
- A large percentage of Medicare A residents receive therapy services.

“Well, sir, it’s this rug I have. It really tied the room together.”

– Jeffrey ‘The Dude’ Lebowski

Image Source: Karen Arnold for Pixabay, pixabay.com

Fundamental Shift in Payment Method

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- Therapy Driven → Resident Characteristics
- Improves appropriate reimbursement

RUGs IV	PDPM
Resource Utilization Group	Patient Driven Payment Model
▪ Per diem rate based on a single RUG	▪ Payment is directly related to resident characteristics
▪ RUGs has two CM adjusted components: 1. Therapy 2. Nursing 3. Non-Case-Mix Base Rate	▪ Per diem rate based on the sum of six components: 1. Physical Therapy* 2. Occupational Therapy* 3. Speech Therapy 4. Non-Therapy Ancillary* 5. Nursing 6. Non-Case Mix Component **Includes a variable per diem (VPD) adjustment that adjusts the daily rate over the course of the resident's stay*

- The Medicare resident receives a CM score in five of the categories in addition to a non-case mix component

Patient Driven Payment Model

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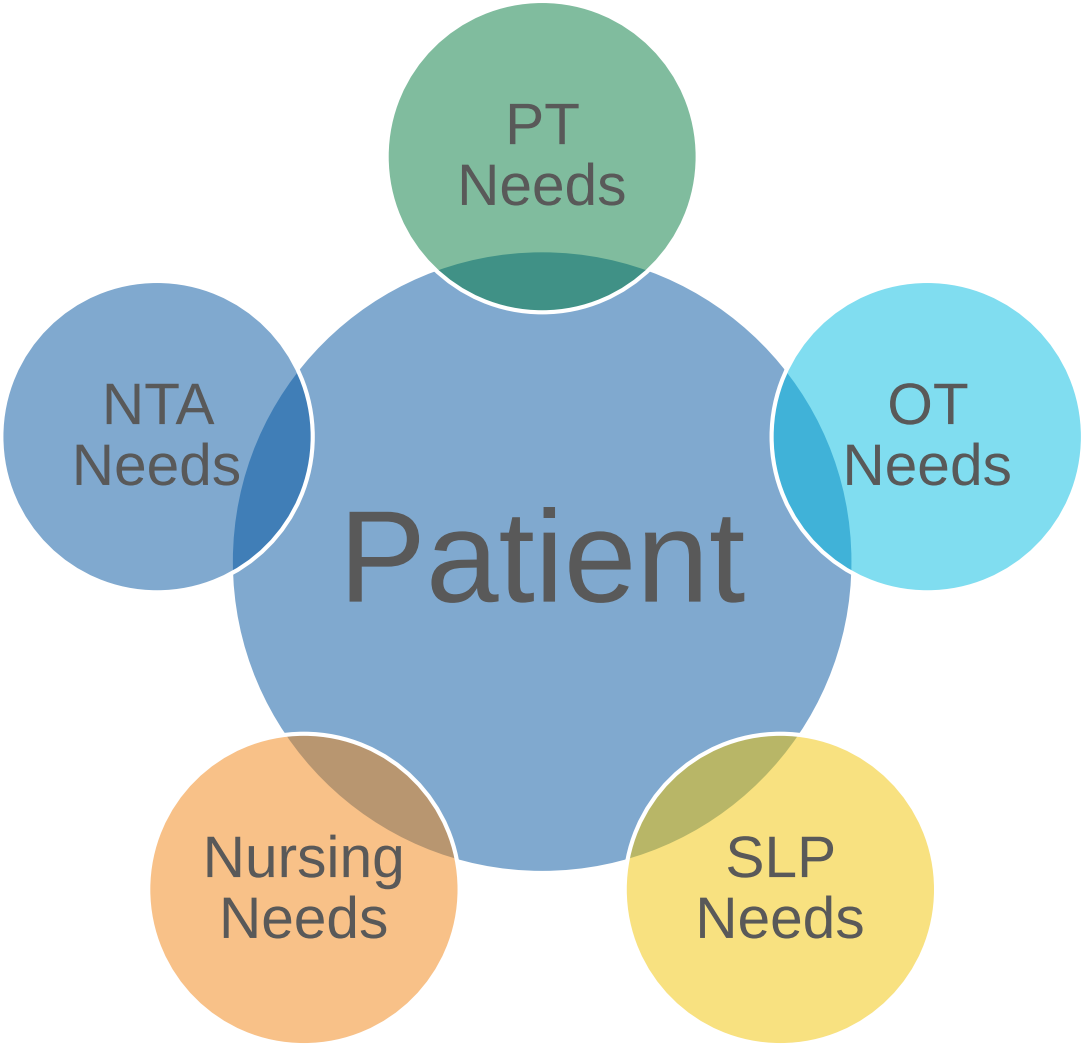

PDPM Components

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- PDPM components address resident needs more independently with a focus on unique characteristics.
  - **PT** – Clinical Category, Functional Score in Section GG, subject to VPD
  - **OT** – Clinical Category, Functional Score in Section GG, subject to VPD
  - **ST** – Acute Neurological Condition, ST- related comorbidity or cognitive impairment, mechanically altered-diet, swallowing disorder
  - **NTA** – Comorbidity score, subject to VPD
  - **Nursing** – Same characteristics as under RUGs-IV
  - **Non-Case Mix** - covers SNF resources that do not vary according to patient characteristics

Key Characteristics of PDPM

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- Remains a per diem payment equal to the sum of component rates
- PDPM is patient characteristic-based
- There is a variable payment schedule over the course of the resident's stay
- ICD-10 Coding on the MDS becomes the basis for payment
- Ability to have group and concurrent therapy

Clinical Category

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- The resident is first classified into a clinical category based on the primary diagnosis for the SNF stay
- ICD-10 Code → MDS Section J

PDPM Clinical Categories

1. Acute Infections
2. Acute Neurologic
3. Cancer
4. Cardiovascular and Coagulations
5. Medical Management
6. Major Joint Replacement or Spinal Surgery
7. Non-Surgical Orthopedic/Musculoskeletal
8. Non-Orthopedic Surgery
9. Orthopedic – Surgical Extremities, Not Major Joint
10. Pulmonary

Physical and Occupational Therapy (PT/OT)

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- Based on the captured clinical category, the PT and OT component uses four clinical categories for patient classification.

Clinical Categories	PT & OT Clinical Categories
▪ Major Joint Replacement or Spinal Surgery	▪ Major Joint Replacement or Spinal Surgery
▪ Acute Neurologic ▪ Non-Orthopedic Surgery	▪ Acute Neurologic ▪ Non-Orthopedic Surgery
▪ Non-Surgical Orthopedic/Musculoskeletal ▪ Orthopedic – Surgical Extremities, Not Major Joint	▪ Other Orthopedic
▪ Medical Management ▪ Cancer ▪ Pulmonary ▪ Cardiovascular and Coagulations ▪ Acute Infections	▪ Medical Management

PT and OT Function Score

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- Resident functional assessment which is the sum of the scores of MDS section GG

Scoring Response	Functional Score
Independent, Set-up Assist	4
Supervision or CGA	3
Partial/Mod A	2
Substantial/Max A	1
Dependent, refused, N/A	0

Section GG	Score
Self-Care: Eating	0 – 4
Self-Care: Oral hygiene	0 – 4
Self-Care: Toileting hygiene	0 – 4
Mobility: Sit to lying Mobility: Lying to sitting on side of bed	0 – 4 (average of 2 bed mobility)
Mobility: Sit to stand Mobility: Chair/bed-to-chair transfers Mobility: Toilet transfer	0 – 4 (average of 3 transfer)
Mobility: Walk 50 ft w/2 turns Mobility: Walk 150 ft	0 – 4 (average of 2 walking)

PT/OT Case-Mix Groups

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Clinical Category	Therapy Function Score	PT/OT CM Group	PT CM Index	OT CM Index
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.59
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.17
Medical Management	6-9	TJ	1.42	1.44
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

Source: Centers for Medicare & Medicaid Services [CMS-1696-F], available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16570.pdf

Speech Therapy (ST)

- Elements
  - Clinical category – Acute Neurologic
  - 12 ST-Related Comorbidities
  - Cognitive Impairment
  - Mechanically Altered Diet
  - Swallowing Disorder

ST Related Co-Morbidities

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Aphasia	CVA, TIA, or Stroke	Hemiplegia or Hemiparesis
TBI	Tracheostomy Care	Ventilator or Respirator
Laryngeal Cancer	Apraxia	Dysphagia
ALS	Oral Cancer	Speech and Language Deficits

Cognitive Function Score

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- MDS Section C
- A blend of the BIMs and CPS to get the Cognitive Function Score
  - In cases where the BIMS cannot be completed, the CPS score derived from pieces of the Staff Assessment for Mental Status as well as Comatose, and Makes Self Understood
- PDPM Cognitive Levels - cognitively intact, mildly impaired, moderately impaired, or severely impaired
- Who is going to perform the BIMS?

ST Case-Mix Group

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Presence of Acute Neurologic Condition, ST-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	ST CM Group	ST CM Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any One	Neither	SD	1.46
Any One	Either	SE	2.33
Any One	Both	SF	2.97
Any Two	Neither	SG	2.04
Any Two	Either	SH	2.85
Any Two	Both	SI	3.51
All Three	Neither	SJ	2.98
All Three	Either	SK	3.69
All Three	Both	SL	4.19

Source: Centers for Medicare & Medicaid Services [CMS-1696-F], available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16570.pdf

Therapy Delivery

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- RUGs
  - Minimum required minutes to meet the RUG level
- PDPM
  - Specific number of minutes are not required
  - Allows 25% in Group and Concurrent Therapy (combined)
  - Minutes are reported on MDS by type of service
  - All residents will be classified into a PT, OT, ST category regardless of whether they are receiving services

Therapy Considerations

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- Therapy utilization and demand for services and therapists may decrease
- There's no urgency if a resident misses or refuses treatment
- Must still follow physician orders
- Contract vs. in-house models
- Choosing the right pricing model
- Service delivery – is it still appropriate to provide services five, six, or seven days per week?

Nursing

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- Nursing component will use Section GG of the MDS to capture the Nursing Function Score
- Increasing Score → Increasing Independence

Section GG item	Score
Self-Care: Eating	0-4
Self-Care: Toileting Hygiene	0-4
Mobility: Sit to Lying Mobility: Lying to Sitting, side of bed	0-4 (average of 2 items)
Mobility: Site to Stand Mobility: Chair/bed-to-chair transfer Mobility: Toilet Transfer	0-4 (average of 3 items)

- Non-linear relationship to reimbursement

Nursing Case-Mix Group

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RUG-IV Group	PDPM Nursing CM Group	Nursing CM Index
ES1	ES3	4.04
ES2	ES2	3.06
ES3	ES1	2.91
HE2 / HD2	HDE2	2.39
HE1 / HD1	HDE1	1.99
HC2 / HB2	HBC2	2.23
HC1 / HB1	HBC1	1.85
LE2 / LD2	HBC1	2.07
LE1 / LD1	LDE1	1.72
LC2 / LB2	LBC2	1.71
LC1 / LB1	LBC1	1.43
CE2 / CD2	CDE2	1.86
CE1 / CD1	CDE1	1.62
CC2 / CB2	CBC2	1.54
CA2	CA2	1.08
CC1 / CB1	CBC1	1.34
CA1	CA1	0.94
BB2 / BA2	BAB2	1.04
BB1 / BA1	BAB1	0.99
PE2 / PD2	PDE2	1.57
PE1 / PD1	PDE1	1.47
PC2 / PB2	PBC2	1.21
PA2	PA2	0.70
PC1 / PB1	PBC1	1.13
PA1	PA1	0.66

Source: Centers for Medicare & Medicaid Services [CMS-1696-F], available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16570.pdf

Non-Therapy Ancillary (NTA)

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- Nursing component doesn't address the variations on NTA costs
- The co-morbidities and extensive services that are provided
- Derived mostly from MDS but some ICD-10 codes
- There are 50 conditions in the CMS table for NTA

Co-Morbidities/Extensive Services	Points
HIV/AIDS	8
IV feeding (Level High)	7
Special treatments ▪ IV medication post-admit code	5
Special treatments ▪ Ventilator or respirator post-admit code	4
IV feeding (Level Low)	3
Transfusion MS COPD Wound infection, etc.	2
Chronic pancreatitis Intractable epilepsy Cirrhosis of liver, etc.	1

NTA Case-Mix Group

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NTA Comorbidity Score	NTA Case-Mix Group	NTA Case-Mix Index
12+	NA	3.25
9-11	NB	2.53
6-8	MC	1.85
3-5	ND	1.34
1-2	ME	0.96
0	NF	0.72

Source: Centers for Medicare & Medicaid Services [CMS-1696-F], available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16570.pdf

Variable Per Diem Adjustment (VPD)

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- Due to historical variances in cost of care tracked over the length of the resident's stay, adjustment factors will be applied under PDPM and will change the per diem rate over the course of the resident's stay.
- For PT, OT, and NTA only

VPD Schedule for PT and OT			
Medicare Days	Adjustment Factor	Medicare Days	Adjustment Factor
1 – 20	1.00	56 – 62	0.88
21 – 27	0.98	63 – 69	0.86
28 – 34	0.96	70 – 76	0.84
35 – 41	0.94	77 – 83	0.82
42 – 48	0.92	84 – 90	0.80
49 – 55	0.90	91 – 97	0.78
		98 – 100	0.76

VPD Schedule for NTA	
Medicare Days	Adjustment Factor
1 – 3	3.0
4 – 100	1.0

Change in MDS Assessment Schedule

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Assessment Schedule	
RUGs IV	**PDPM**
▪ **Five-Day** ▪ **14-Day** ▪ **30-Day** ▪ **60-Day** ▪ **90-Day** ▪ **Additional Unscheduled:** 1. Other Medicare Required Assessment 2. Start of Therapy 3. Change of Therapy 4. End of Therapy 5. Significant Changes in Condition 6. Discharge Assessment	▪ **Five-Day** ▪ **Two Additional Unscheduled:** 1. Discharge Assessment 2. Interim Payment Assessment (IPA) ▪ **IPA Required:** 1. For All Part A Residents On Transition to PDPM, Adds Tracking of Therapy

IPA

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- Optional assessment where providers may determine whether and when an IPA is completed
- The assessment reference date (ARD) for the IPA will be the date the facility chooses to complete the assessment based on a triggering event that causes the facility to choose the IPA
- Payment for the IPA will begin on the same day as the ARD
- The IPA is placed into the payment system as a way to recognize changes in the patient condition over the course of the stay
- VPD rate is not impacted

FY 2020 Proposed Rule – Payment Rates

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- Defined Group Therapy
  - Exactly four patients in current SNF PPS, proposed to adopt is two to six residents doing the same or similar activity
- The proposed SNF payment update is 2.5%, or an increase of $887 million from FY 2019.
- The proposed base rates for the urban and rural PDPM components

FY 2020 Unadjusted Base Rates

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- FY 2020 Unadjusted Federal Rate Per Diem – Urban

Rate Component	PT	OT	ST	Nursing	NTA	Non-Case Mix
Per Diem Amount	$61.16	$56.93	$22.83	$106.64	$80.45	$95.48

- FY 2020 Unadjusted Federal Rate Per Diem – Rural

Rate Component	PT	OT	ST	Nursing	NTA	Non-Case Mix
Per Diem Amount	$69.72	$64.03	$28.76	$101.88	$76.86	$97.25

Estimating the Impact

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- Step 1: Case-Mix Adjusted Rate, Days 1-3, Urban

Component	Component Group	CMI	Rate Base	Component Rate	VPD Adjustment	VPD Adjusted Rate
PT	TB	1.69	$61.16	$103.36	1.00	$103.36
OT	TB	1.63	$56.93	$92.80	1.00	$92.80
ST	SH	2.85	$22.83	$65.07	-	$65.07
Nursing	CBC2	1.54	$106.64	$164.23	-	$164.23
NTA	ND	1.34	$80.45	$107.80	3.00	$323.40
Non-Case-Mix	-	-	$95.48	$95.48	-	$95.48
					TOTAL:	**$844.34**

Estimating the Impact

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- Step 2: Wage Index Adjusted Rate

PDPM Case-Mix Adjusted Per Diem, Days 1 – 3	Labor Portion (70.8%)	Wage Index (Tampa, FL)	Wage Index Adjusted Rate	Non-Labor Portion	Total Case Mix and Wage Index Adjusted Rate
$844.34	$597.79	0.8794	$525.70	$246.55	$772.24

- Step 3: Adjusted VPD Rate for Resident LOS (30 Days)

Days of Stay	NTA VPD Adj.	PT/OT VPD Adj.	Adjusted Rate
1 – 3	3	1.00	$ 772.24
4 – 20	1	1.00	$575.05
21 – 27	1	0.98	$ 571.46
28 – 30	1	0.96	$ 567.87
Total Reimbursement For 30-Day Stay:			**$17,796.41**

Compliance Risks

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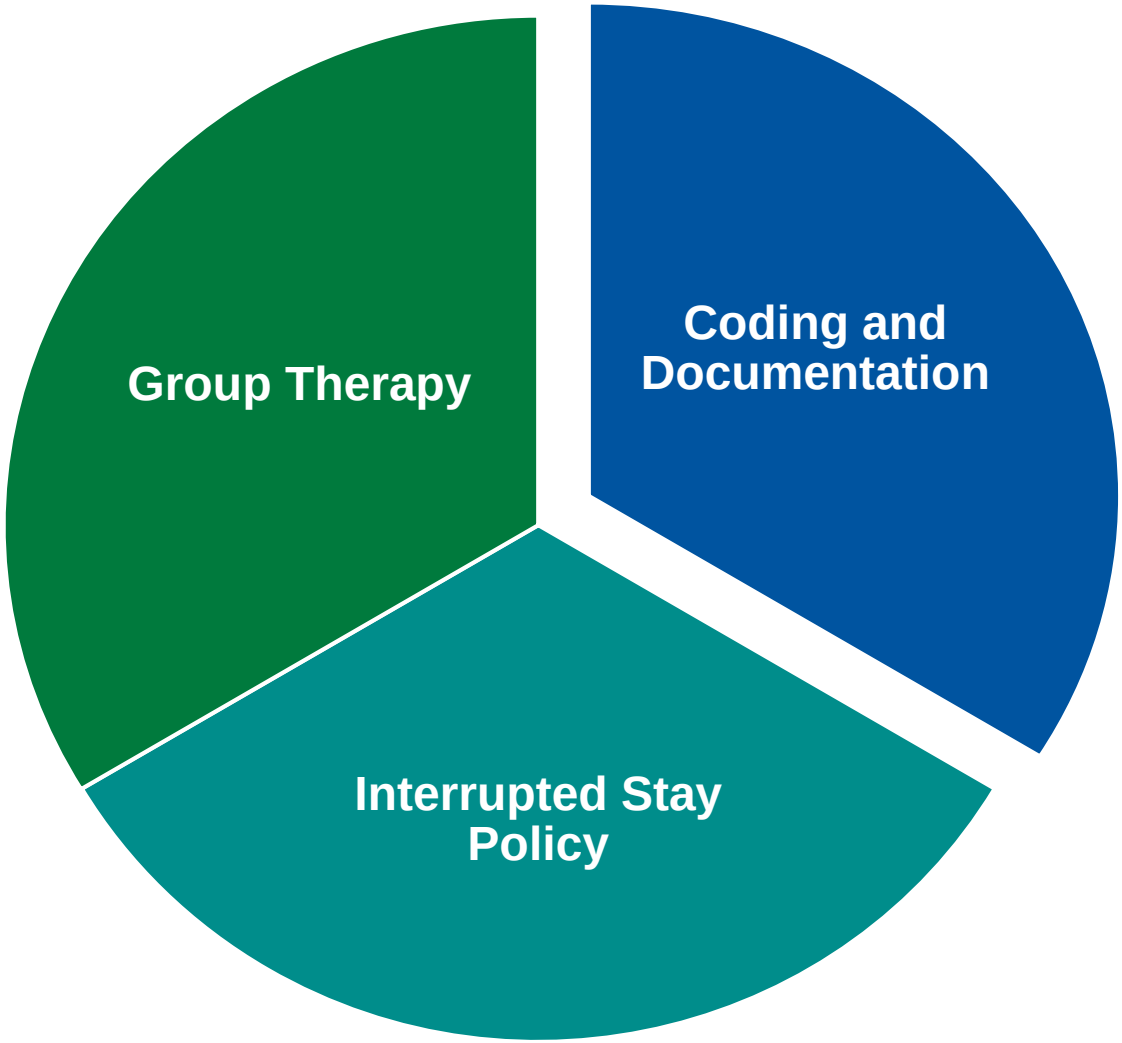

How Does PDPM Fit in The Healthcare Continuum?

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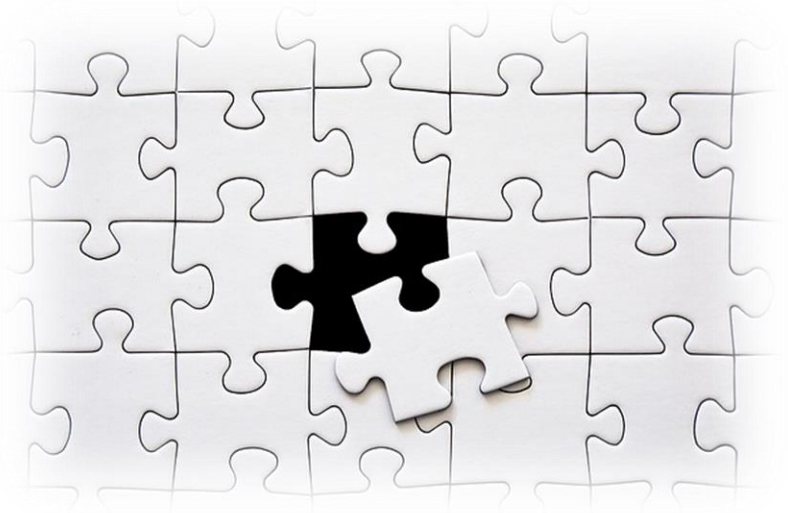
- CMS efforts to increase transparency
- CMS believes aligning the group therapy definition serves to improve the agency's consistency in payment policies across PAC settings, and creates opportunities for site neutral payments.
- PDGM for Home Health providers – similar goal to align reimbursement with patient needs to balance volume of therapy, January 1, 2020
- ***Value*** over ***Volume***
- IMPACT Act



The PYA Crystal Ball

- Successful transition will require highly accurate documentation and coding of the resident's condition, ADLs, and co-morbidities to ensure accurate reimbursement
- Steep learning curve
- Heavy swing from over-providing to under-providing
- Opportunities to care for more complex patients

- Audits with a focus on documentation
- Strategies to partner with acute providers
- Chain reaction challenges with other payors

What does PDPM Mean for Hospitals?

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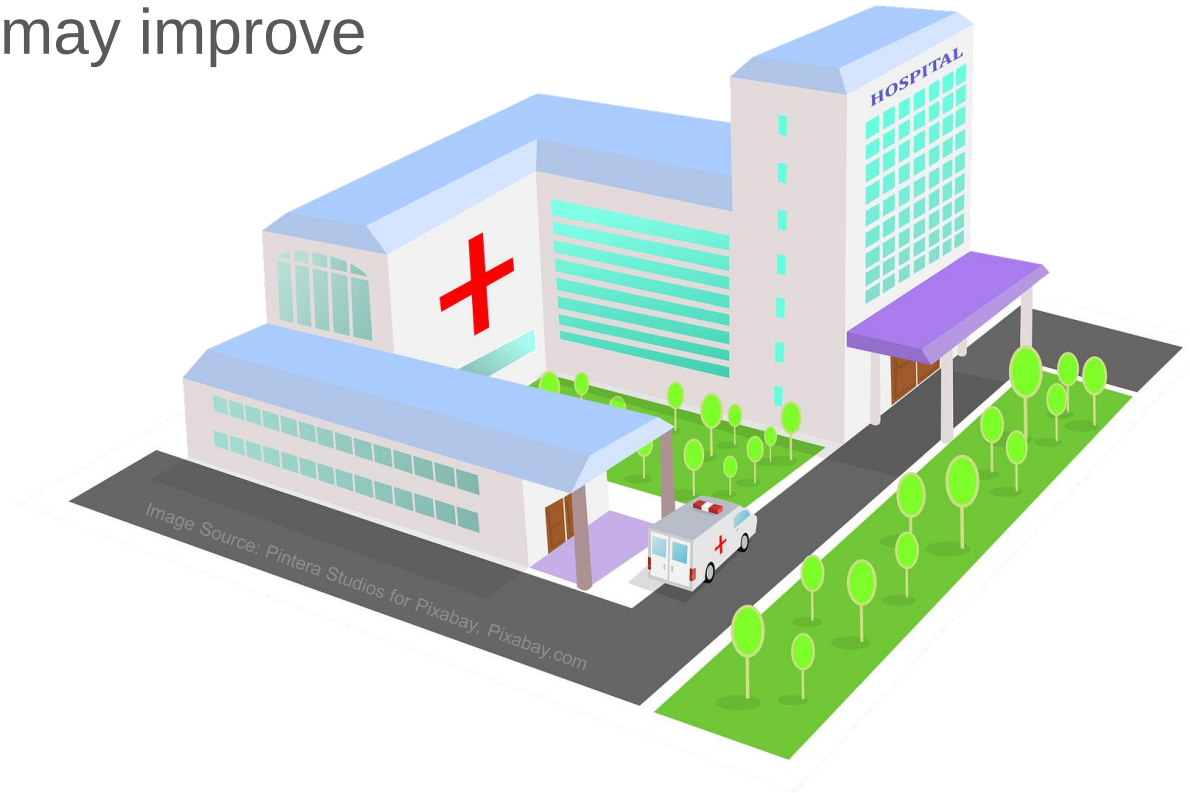
- Patients with more comorbidities will move up in the referral preference
- The early assessment period will create a greater sense of urgency
- Care transitions may improve
- Readmissions



Questions?

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Thank you!

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