WHAT TO EXPECT AS PDPM IMPLEMENTATION RAMPS UP

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WHAT TO EXPECT AS PDPM IMPLEMENTATION RAMPS UP

By Brad Granger, Vice President and Daniel Cafarella, Associate

Providers across the country are gearing up for the October 1st implementation of the new Patient Driven Payment Model (PDPM) for their Medicare reimbursement. They are diving into the weeds on how to accurately code the minimum data set (MDS) in order to capture reimbursement based on the clinical characteristics of the patient. Consultants are focusing SNF nursing administrators on key areas such as the 5-day MDS assessment, ICD 10 diagnosis coding, capturing patient Mood & Depression observations and proper coding of other areas of the MDS. This new system will be a fundamental change in the reimbursement system but is being optimistically embraced as a better model to accurately reimburse for clinical complexities where SNFs traditionally excel.

The Inception of PDPM

In April of 2018, the Centers for Medicare & Medicaid Services (CMS) released its Skilled Nursing Facilities (SNF) PDPM report, which focused on reimbursing skilled nursing facilities (SNFs) for typical nursing services and complex medical care, as opposed to previous models which tilted reimbursement toward increased therapy delivery. The proposal is in tune with CMS's overarching goal of rewarding value over volume and reducing administrative burdens.

As an attempt to redefine the current resident classification model, also referred to as case-mix adjustment, the report introduced the PDPM as an efficient and improved payment system for SNFs that emphasizes patient need instead of volume of services.

The PDPM was designed to replace the Resource Utilization Group (RUG IV) model currently utilized by CMS for Medicare Part-A stays. In its announcement, CMS touted several potential benefits of the new model, such as a reduced number of payment group combinations, simplified payment calculations and reduced paperwork. In fact, the number of payment group combinations is expected to be reduced by 80% as compared to its proposed predecessor, the Resident Classification System, Version 1 (RCS-1). Further, CMS estimates the new model will generate $2 billion in system-wide savings over the next decade. Below, we take a look at what led to this new model being created and what providers and industry leaders are saying about its proposed implementation.

History & Background

The RCS-1 was announced in 2017 as a means to replace the RUG IV system.

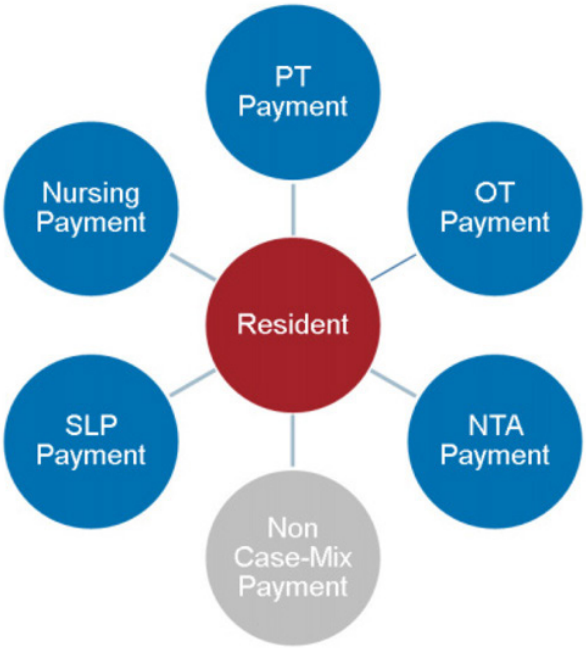
After announcing the RCS-1 plan last year, CMS received industry feedback which resulted in substantial changes to the model. As such, the PDPM was born. In its announcement of the new plan, CMS stated that: "The proposed new model is designed to improve the incentives to treat the needs of the whole patient, instead of focusing on the volume of services the patient receives, which requires substantial paperwork to track over time."

After thorough examinations of the relationship between resident characteristics and the use of SNF resources, Acumen, working with CMS, developed the PDPM and the following five case-mix adjustment payment components:

- PT: covers utilization of physical therapy (PT)
- OT: covers utilization of occupational therapy (OT)
- SLP: covers utilization of speech-language pathology (SLP) services
- Nursing: covers utilization of nursing services and social services
- NTA: covers utilization of non-therapy ancillary (NTA) services

The proposal also maintains an existing sixth option, referred to as the "non-case-mix component" (Figure 1).

Figure 1:

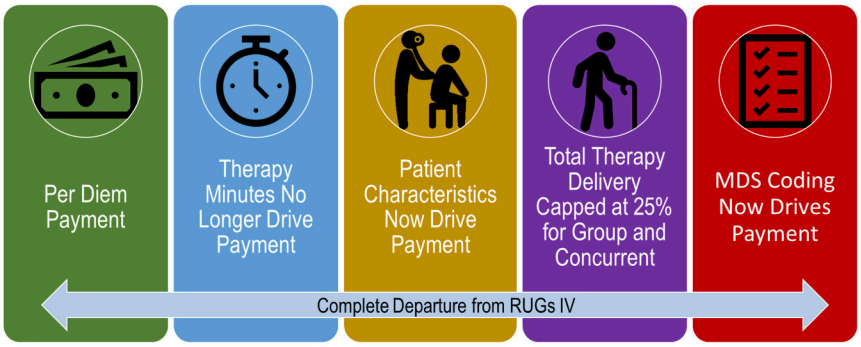


Source: Acumen, Skilled Nursing Facilities Patient-Driven Payment Model Technical Report, April 2018.

The chief advantages of the PDPM, as described by Acumen, are the fact that it eliminates therapy minutes as the basis for therapy payments and it "establishes a separate case-mix-adjusted component for NTA services, thereby mitigating financial incentives to provide excessive therapy and improving allocation of system resources to medically complex beneficiaries."

PDPM Transition and Implementation

As the PDPM implementation date is approaching quickly, there are several tactical changes SNF operators should be knowledgeable about in order to be prepared by October 1. One major change is in regards to the SNF PPS assessment schedule. Under PDPM, the PPS five-day assessment and PPS discharge assessments are the only assessments required to be completed. CMS added two additional optional assessments called the interim payment assessment (IPA) and the optional state assessment (OSA), as an effort to allow operators to make clinical changes that will drive per-diem adjustments. Also, the PDPM program will remove the SNF PPS 14-day, 30-day, 60-day, and 90-day assessments, in addition to other Medicare assessments used for therapy per-diem adjustments.



The IPA assessment should be completed when it is determined a resident has undergone a medical change requiring an update to the PPS assessment. The data included in the IPA assessment is not fixed and can be updated upon a triggering event of the resident's condition.

The OSA is not a PDPM assessment, as it was created to assist states that utilize RUG IV assessments as a basis for Medicaid reimbursement. The intent of this assessment is to enable providers to gather enough data for Medicaid case-mix states, as most of the SNF PPS assessments are eliminated with PDPM. The OSA is optional and may only be required by SNFs that reside in Medicaid case-mix states.

In addition, the transition to PDPM brings additional changes to the SNF PPS MDS coding items required for reimbursement. CMS issued a draft version of the updated Minimum Data Set – Resident Assessment Instrument (MDS-RAI) form, which will add, remove or modify approximately 80 MDS codes in order to implement the new PDPM components.

In addition to the reduction of MDS items, there are approximately 40 new MDS codes that will affect the classification of residents and per diem rates. One of the most important MDS code items that will be added is one that determines the main diagnosis for admission. Other significant codes that are being added include new surgical history items as well as MDS items impacting non-therapy ancillary and swing bed assessments.

PDPM Effect on Operators' Profitability

The effect PDPM will have on SNF operators' profitability remains to be seen. Some industry observers estimate that it could negatively affect reimbursement, as SNFs will not be reimbursed for services provided beyond the resident's classification under PDPM.

Kim Saylor, vice president of Concept Rehab, a rehab services provider in Toledo, Ohio, noted that there inevitably will be winners and losers once the program is implemented.

"PDPM is initially designed to be budget neutral for CMS but not necessarily for individual providers," she said. "It is important to realize there will be winners and losers predicated on historical referral and practice patterns. The types of patient acuities, care protocols, and therapy/nursing utilization are primary determinates for an individual facility's PDPM financial impact. Assuring you have systems in place to identify, capture and code items that previously didn't impact reimbursement will be key."

Understanding the financial implications of PDPM prior to October 1 is essential, noted Saylor.

"There are tools available currently to crosswalk historical service delivery from a RUG IV rate to a projected PDPM rate to assess and analyze your specific financial implications," she said. "However, caution should be applied, as assumptions of input data are used to pivot from one reimbursement system to another."

Operational strategies likely will need to shift, Saylor added.

"Of particular importance will be accurately capturing reimbursement for the services we are providing," she said. "The amount of therapy services, quality of rehab care, state-of-the-art techniques and rehab equipment will remain primary census drivers for patients, families, physicians and case managers. Therapy is a key success component for assuring quality outcomes and guaranteeing patient satisfaction which significantly impact a SNF's census and therefore margins. As a therapy provider, we and others in the industry look forward to being part of this change and evolving towards value and away from volume."

Optima Healthcare Solutions, a senior living software provider, is optimistic on the financial impact of PDMP. According to Optima, "PDPM is designed to be budget neutral. Within SNFs, this is expected to be true. With some therapy dollars reallocated to nursing, SNFs will be able to offset the loss in therapy reimbursement with higher reimbursement for the nursing care that's already being provided. From a revenue perspective, contract therapy providers will see a reduction in revenues. However, because of the provisions that have been made under PDPM, it's very possible to achieve neutral to positive profit margins, while increasing patient outcomes."

As implementation approaches, operators should be cognizant of the financial implications of PDPM and adjust their policies and procedures to adapt to the new environment.

"Navigating the transition to and implementation of PDPM will be dependent upon excellent interdisciplinary collaboration," said Saylor. "Begin discussions with your therapy provider now to assure a successful transition."

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