WHITE PAPER

Patient-Driven Payment Model Preparation Guide

The Long-Term Care Provider's Preparation Guide to Transitioning to the Patient-Driven Payment Model (PDPM)

In this guide, we'll walk you through the changes being proposed as part of PDPM and what it means for your operations. We'll also provide you with steps you can take now to prepare for this transition.

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The reduction in administrative tasks related to PDPM should save Medicare $2 billion dollars over the next 10 years.

Introduction

What is the Patient-Driven Payment Model (PDPM)?

PDPM is the next iteration of payment reform following the Resident Classification System Version 1 (RCS-1) advance notice of rule-making released in 2017, which was set to replace the RUGs IV system of reimbursement. PDPM follows suit from RCS-1 in moving away from a therapy minutes driven reimbursement system to one more focused on the clinical characteristics of the resident.

With PDPM, reimbursement will be decided on fewer MDS assessments as well. There will be a reduction in scheduled PPS assessments from five to one required assessment and only two unscheduled assessments: the IPA and the Discharge PPS assessments. This reduction in administrative tasks should save Medicare $2 billion dollars over the next 10 years.

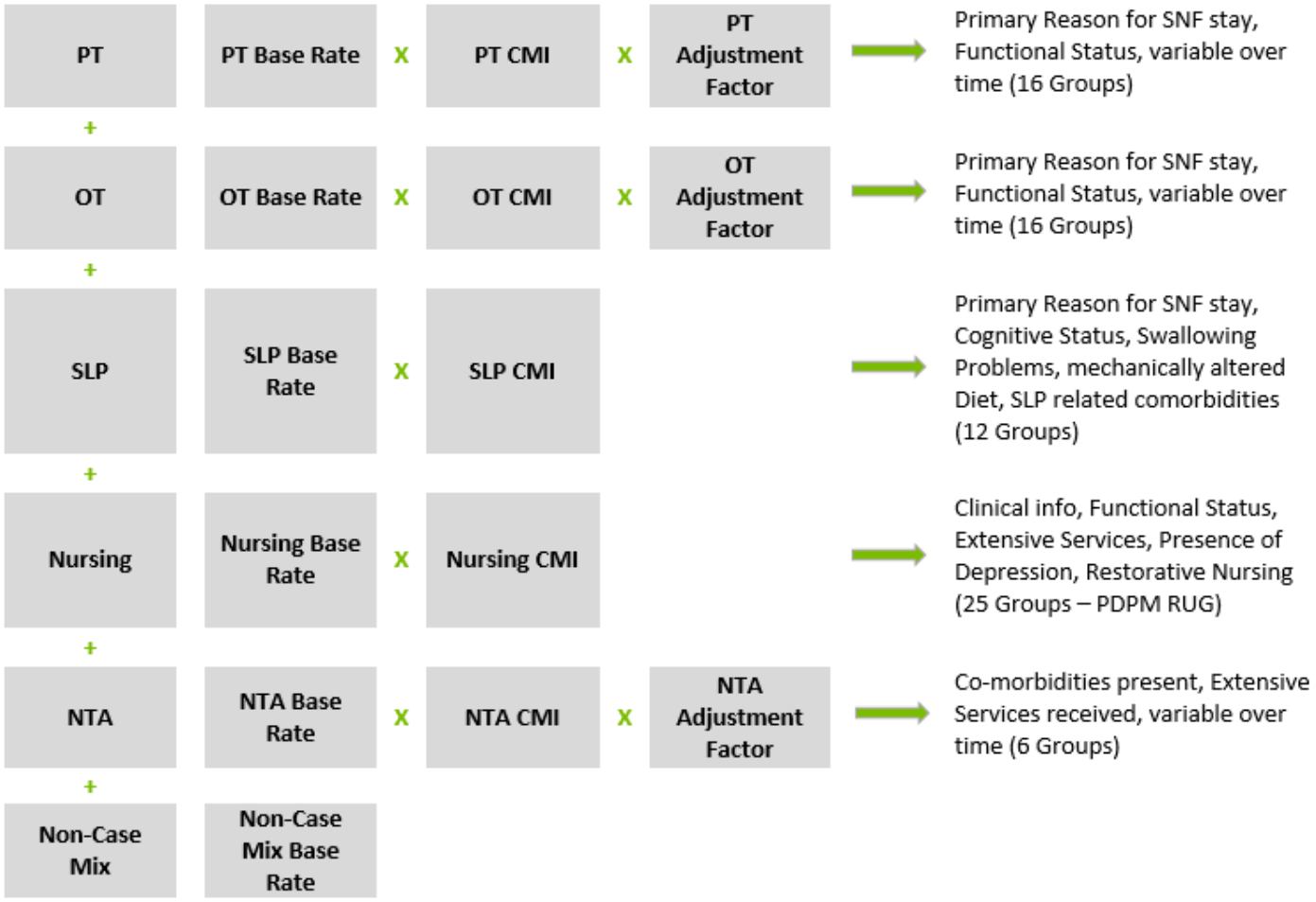
Case-Mix Overview

Resident characteristics, which will determine the clinical category for care, will use I0020B from MDS 3.0. There are 10 clinical categories for care: acute infection, acute neurological, cancer, cardiovascular and coagulations, major-joint replacement or spinal surgery, medical management, non-orthopedic surgery, non-surgical orthopedic/musculoskeletal, orthopedic surgery and pulmonary. These are further grouped into four categories for OT and PT calculations: major joint replacement or spinal surgery, other orthopedic, non-orthopedic and acute neurologic and medical management.

PDPM uses five case-mix components and a non-case-mix component to determine the rate of reimbursement for the residents stay. The previous RUGs IV calculation only used therapy and nursing components and was weighted by therapy minutes in the higher categories. Therapy minutes will not be used in the new case-mix calculation for therapies although they will be required as part of the discharge assessment process. The five case mix components are PT, OT, SLP, Nursing and Non-therapy Ancillaries. These will be combined with a non-case mix amount to calculate daily reimbursement. SLP will use the presence of comorbidities (aphasia, CVA/TIA/stroke, hemiplegia/paralysis, traumatic brain injury, tracheostomy care, presence of a ventilator or respirator, laryngeal cancer, apraxia, dysphagia, ALS, oral cancers and speech and language deficits), cognitive impairment and the presence of swallowing disorders or the need for a mechanically altered diet to determine case mix. The NTA case mix is determined by the need for extensive service covered through the MDS and the part-c risk adjusted model. Points are associated with the services and a total determined, which would place the resident in a case-mix group for NTA.

The table on the following page shows how the daily rate for PDPM is calculated by case-mix component for each resident.

PDPM reimbursement will be calculated using five Case-Mix Components.



PDPM does not completely do away with the RUGS IV methodology. The Nursing Component uses a modified non-therapy RUG calculation that places residents into one of 25 categories instead of the previous 43 nursing categories under the 66 Grouper. The 25 PDPM RUGs reduces the number of end-splits determined by ADL calculations.

The ADL Score previously used in RUG IV has also been updated to include Section GG items.

Inclusion of Section GG Items

The ADL Score previously used in RUG IV has also been updated to include section GG items. Items in section GG are used to calculate LTPAC cross-setting measures as required by the IMPACT Act of 2014.

In PDPM, the four late loss ADLs used in the calculation for RUGs IV would be replaced with items from section GG; an eating and toileting item, three transfer items and two bed mobility items.

GG0130A1	Self-care: Eating
GG0130B1	Self-care: Oral Hygiene
GG0130C1	Self-care: Toileting Hygiene
GG0170B1	Mobility: Sit to lying
GG0170C1	Mobility: Lying to sitting on side of bed
GG0170D1	Mobility: Sit to stand
GG0170E1	Mobility: Chair/bed-to-chair transfer
GG0170F1	Mobility: Toilet Transfer
GG0170J1	Mobility: Walk 50 feet with 2 turns
GG0170K1	Mobility: Walk 150 feet

Other Inclusions

There is also a proposal that the Nursing CMIs will use staffing data to reflect nursing utilization during care. Additionally, PDPM adds an 18% increase for the nursing component when the resident has HIV/AIDS.

Payments for Nursing and Speech Language Pathology will remain constant through the resident's stay but PT, OT, and Non-therapy Ancillaries will see variable rates over the length of stay. PT and OT will see downward adjustments of 2% at 20 days and then a further 2% decrease for every seven days after the 20-day mark. NTA will decrease by two-thirds starting on day four.

Impact on Skilled Nursing Organizations

PDPM will push SNFs to take on more-clinically complex residents. Homes will need to start evaluating current care and staff resources to determine if they are prepared for this shift or will need to implement systems and training for staff in order to weather the shift.

Therapy, previously incentivized in the previous payment model is not included in the case mix calculations but the need for therapy based on care requirements is predicted to be the same. PDPM requires 75% of all therapy delivered be individually provided: Concurrent and group therapies are capped at 25% of total minutes provided (down from 50% in RCS-1) (even though therapists see merit to these modalities for residents and they are a more cost-effective approach to therapy delivery).

CMS predicts that non-profit organizations should see an increase of 1.9% and government providers should see increases of about 4.2%. Smaller SNF providers should see modest increases, while those running homes over 100 certified beds may see declines in revenue.

CMS has provided a worksheet that will assist facilities to determine what their case mix may look like post implementation of PDPM. This crosswalk will help form decisions on care provision, therapy utilization, and the impact of NTA on overall reimbursement and revenue.

Below is a high level summary of how PDPM compares to RUGs IV.

Item	RUGs IV	PDPM
Definition	Residents are classified into a RUG grouper based on the care provided for the period covered. Residents can fall into more than one RUG score in this methodology, but the one with the highest associated case-mix index is used for reimbursement.	Residents are classified into one of 10 clinical categories based on primary diagnosis. The category determines the case-mix index OT and PT. Nursing uses PDPM RUG. SLP and Non-therapy Ancillaries are determined by co-morbidities present. The indexes are added together and combined with a non-case mix component for the total daily rate reimbursed.
Case Mix Components	Nursing Therapy (PT, OT, SLP)	Physio Therapy (PT) Occupation Therapy (OT) Speech Language Pathology (SLP) Non-therapy Ancillary (NTA) Nursing
ADL/Function Scoring	MDS Section G	MDS Section GG
Total Number of groups	66	28, 800 PT/OT – 16 groups SLP – 12 Groups NTA – 6 Groups Nursing – 25 Groups
Reimbursement	1. # of minutes of therapy 2. Nursing Service delivered - Payment is uniform through the period covered by the MDS assessment	1. Clinical Category/Nursing PDPM RUG 2. Function Score (Therapy minutes not counted toward reimbursement) - Nursing and SLP rates remain constant - OT/PT rates decline over LOS – 2% for every 7 days after day 20 - NTA rates decline after day 3 by 2/3rd
MDS Assessments	5 Scheduled MDS Assessments: - 5-day - 14-day - 30-day - 60-day - 90-day Additional Unscheduled Assessments: - Other Medicare Required Assessment - Start of Therapy - Change of Therapy - End of Therapy - Significant Changes in Condition - Discharge Assessment	1 Scheduled MDS Assessment - 5-day Additional Unscheduled Assessments: - Discharge Assessment - Interim Payment Assessment (IPA)* * An IPA will be rare and will be required in the following circumstances: 1. For all Part A residents on transition to PDPM 2. When these criteria are met: there is a change in first tier classification AND the resident would not be expected to return to original status in 14 days.

Preparing for PDPM

To adequately prepare for PDPM, there are a number of activities you can do now to be ready for the change. Below are key recommendations to prepare:

Review Current Workflows – Reviewing your processes from end-to-end will help determine what processes will need to change once PDPM is in effect.

Educate Staff – Training staff on the shift in data capture is critical. For example, staff will need to ensure that all diagnoses and conditions are collected as soon as possible to ensure accurate coding of the MDS. They will also need identify Primary Diagnosis that maps to a clinical category where possible. Additionally, providing information on PDPM as a whole to staff is important to give them the big picture as to why they need to adopt the changes stemming from PDPM.

Inform Physicians – Communicating to physicians about the upcoming changes and educating them on the new categories and importance of correct DX is critical for successful adoption of PDPM.

Review Therapy Contracts – Investigating the business impact from the therapy perspective is crucial to avoiding any surprises.

Conclusion

PDPM is more than just a new name attached to payment reform. The shift from RCS-1 moves the skilled nursing reimbursement model away from therapy provision as the main driver and focuses payments on the provision of nursing care with higher rates being attached to the more clinically complex individual and decreasing reimbursement for longer lengths of stay inline with the shift from volume to value. When this payment model takes effect, currently targeted for October 1, 2019, your organization needs to be ready. By reviewing your processes and educating staff and physicians alike, your organization will be prepared to maintain a consistent revenue stream through the transition to the new payment model.

Questions? Click here to connect with us.

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