PDPM Transition Compliance: A Necessary Focus to Mitigate Risk

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Learning Objectives

- Why a payment model change?
- RUGS vs. PDPM: Road to change
- PDPM: 5 component overview
- CMS Monitoring under PDPM
- Compliance and program integrity initiatives under PDPM

Increased Flexibility = Increased Risk

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CMS Framework in Developing PDPM

- Existing statutory authority must remain unchanged
- Must remain budget neutral
- Must be implementable by October 1, 2019 (FY 2020)
- Must use existing data: CMS hired Acumen to complete the research
- Shifts away from metric based therapy payments

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Why Replace RUGS?

- Over 90% of Part A covered SNF stays are paid using rehab RUGs (86% Ultra High or Very High) – they believe that choice of service is based on maximizing indexing categorizations
- Value based care over volume
- OIG and MedPAC have repeatedly expressed concerns with incentives in current RUG model
- CMS believes a greater number of case-mix components are necessary to develop a patient-centered approach to align payment of actual care needs

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RUGs vs. PDPM

RUGs	PDPM
2 case-mix components	5 case-mix components
Index Maximizing	Index Combining
Group/Concurrent deterrents	Group/Concurrent: ???
5 scheduled PPS assessments	1 scheduled PPS assessment
Constant rates for LOS	Declining rates over LOS
Maximum therapy incentivized	Minimum therapy incentivized

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What doesn't change…

- SNF Coverage Criteria
- Documentation Requirements
- Physician Certifications
- Basic administrative process
- Payment rate adjustment
- Requirement of Participation
- Denial Notices
- Payment and policy associated with therapy evaluations
- Student supervision policy

WHAT THE PATIENT NEEDS!!!

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PDPM Assessments

- **5-Day**
  - Resident Classification codes based on MDS & ICD-10 codes
  - Surgery information from hospital is new & critical
- **Interim Payment Assessment** (Optional) – *Compliance Alert!*
- **Discharge Assessment**
  - MDS with Therapy Codes
- **Interrupted Stay Policy** – *Compliance Alert!*
  - New stay: new admission; Variable Per Diem Adjustment begins day 1 for PT/OT/NTAS
    - If away >3 midnights and returns to the same facility
    - Regardless of the number of midnights out of the facility , patient transfers to a new facility
  - Less than 3 days following discharge and readmit is treated as continuation of prior stay

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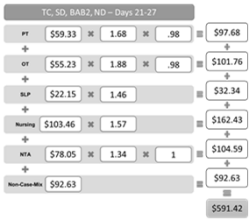
Application of Case Mix Adjustments and Total Per Diem Payment



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PDPM Case-Mix Components

- PT
- OT
- SLP
- Nursing
- NTAS
- Non-Case Mix

A case mix group is determined for each of the first five components based on their drivers. The case mix group's associated case mix index is then multiplied by the adjusted Federal Base Rate.
The summation of the 5 component CMG per diems plus the non case mix rate determine the per diem reimbursement.
The variable per diem adjustment schedule does apply to PT, OT and NTAs.

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PT/OT Components

- Each resident is assigned to 1 of 16 payment groups, each with its own CMI based on the following:
  - Primary Diagnosis grouping
    - MDS Section I
  - Functional Status
    - MDS Section GG *Compliance Alert!*

Note: The Variable Per Diem Adjustment Schedule does apply to PT and OT case mix groups. Beginning Day 21 and every 7th day thereafter the rate decreases by 2%.

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Therapy Services
Compliance Alert!

- Therapy services are to be reported on SNF PPS discharge MDS – Section O
- Access and Intensity: CMS has stated that a variance in therapy services is expected, although will be highly scrutinized is a decrease is associated with a decline in the Quality Measures
- Mode: There is a 25% limit on the total amount of concurrent and or group therapy permitted per stay within each discipline
  - Currently there is not a penalty for claims exceeding the limit – although a non-fatal edit will be sent to the facility
  - CMS will monitor and flag providers for audits and revise policy if abused – could result in recoupments

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SLP Components

- Each resident is assigned to 1 of 12 payment groups, each with its own CMI based on the following:
  - Group #1 Determinant Driver
    - Acute Neurologic Dx: MDS - Section I
    - Cognitive Status: MDS – Section C - BIMS & CPS *Compliance Alert!*
    - SLP related comorbidities: MDS – Sections I, O, K *Compliance Alert!*
  - Group #2 Determinant Drivers
    - Swallowing disorder: MDS – Section K *Compliance Alert!*
    - Mechanically altered diet: MDS – Section K *Compliance Alert!*

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Non-Therapy Ancillary Component

- Front loads cost of equipment, medication and other ancillary expenses
- 50 Item list of Extensive Services and Conditions: with an additional 1500 ICD-10 codes identified on the CMS NTA Crosswalk that might qualify for points on the 50 item list *Compliance Alert!*
- Higher point value associated with the following
  - HIV/AIDS
  - Parenternal IV feeding
  - IV medication
  - Ventilatory or Respirator
  - Lung Transplant

Note: The Variable Per Diem Adjustment Schedule does apply to the NTA case mix group. Beginning Day 4 the multiplier decreases from 3 to 1 for the remainder of the stay.

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Nursing Component

- Each resident is assigned to 1 of 25 payment groups with its own CMI based on:
  - Primary Diagnosis grouping – MDS Section I
  - Function Status: MDS – Section GG
  - Presence of Depression: MDS – Section D (PHQ-9)
  - Extensive Services: MDS – Section O, K, M & I
  - Restorative nursing services: MDS – Section O

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Nursing Component

- 25 Nursing RUGs defined as follows:
  - Extensive Services
    - Tracheostomy Care, Ventilator, or Isolation
  - Special Care High, Special Care Low and Clinically Complex
    - Depression – *Compliance Alert!*
  - Behavioral and Reduced Physical
    - Restorative Nursing

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CMS Monitoring Under PDPM

- ICD-10 coding and admission assessments
- Section GG of the MDS for functional scoring
- Mechanically altered diet for SNF residents with regard to SLP case mix group
- Depression coding influencing the nursing case mix group
- Interim Payment Assessments (IPA) - even absent an IPA requirement, CMS expects SNFs to constantly evaluate, capture, document and treat clinical and functional changes that occur in patients throughout an SNF stay
- Therapy: Mode, access, intensity
- Interrupted stay policy – CMS believes frequent SNF readmissions may be indicative of poor quality care being provided by the SNF. CMS will monitor facility use of this policy closely for facilities whose residents experience frequent readmission.

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Possible Payment Implications

- Therapy
  - Payment system redesign goal is to reduce therapy component margins
  - Likely would see decreases in payments for traditional RU and possibly RV patients by reallocating nursing and NTA dollars
- Nursing
  - Re-weighted to favor nursing for complex patients
  - Nursing payments are intended to be higher
- Non-Therapy Ancillaries (NTA)
  - Part D drug data as a proxy in its NTA component design
  - Intended to more accurately reimburse for these costs but as yet unclear

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Primary PDPM Compliance Issues

- PDPM will "carryover" some compliance issues from the RUGs system and produce new challenges
- Changes in therapy utilization will be contrasted from practices under the RUGs system
- Claims of over-utilization may shift to under-utilization

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Increased Compliance and Program Integrity Legal Risk

- While PDPM might address excess therapy utilization, it is likely to create new, serious challenges for beneficiaries, providers and Medicare;
- Existing regulations such as the Requirements of Participation and the 60-Day Overpayment Rule have not been addressed in the design of the payment system;
- Conflict of interest issues (clinical staff who work for the SNF making assessment and coding assignments);
- Upcoding, Compliance and Program Integrity issues (same reasons as above); and
- Need for enhanced collaboration between SNF clinicians and MDS coordinator

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Operational Considerations and Issues

- **Requires CMS to significantly update…**
  - The MDS 3.0 assessment instrument
  - RAI manual
  - Provider training materials
- **Requires CMS to update policy guidance and educational materials…**
  - CMS Claims Processing Manual guidance
  - CMS Benefit Policy Manual
  - CMS Medicare Learning Network (MLN) and other educational materials related to SNF PPS
- **Requires significant changes to Fiscal Intermediary (MAC) operations**

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Other Operational Considerations

- **Shift in reimbursement:**
  - More during early portion of stays, less as time passes.
  - More for dual eligible, complex, receiving extensive services, or longer prior inpatient stay
  - From therapy to nursing.
  - Away from residents with fewer comorbidities
  - More for high-cost diagnosis categories
    - Vent
    - ESRD
    - Wound care
- **Requires providers to strategize a compliance plan to monitor, audit, track changes in service delivery**
- **Requires software vendors to completely rewrite, test, and install products for SNFs to submit necessary patient assessment and claims information**

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Changed Incentives = New Practices?

- **How might providers react?**
  - Shorter lengths of stay
  - Increase efficiency of rehab/therapy services
  - Specialty units for high-cost residents
- **Financial:**
  - SNF: potentially positive
  - Therapy Service Providers: potentially mixed
    - Revenue: negative
    - Margin: neutral to positive (based on ability to manage costs and outcomes)
- **Compliance**
  - Facility Practices
  - Operational Issues
  - Run-out of RUGs cases

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PDPM Per Diem Payment Over LOS

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A New Premium on Clinical Proficiency and Documentation

Compliance Alert!

- Adapting to PDPM billing will require highly accurate documentation and coding of each resident's medical condition, ADL status, and co-morbidities in order to receive compensation which most accurately reflects the resident's condition and the services provided to each resident.
- This will require medical and administrative teams to enhance their medical coding knowledge and skill in order to most accurately capture the data required to sufficiently document each resident's condition and avoid coding errors that can result in lower reimbursements to the facility – or recoupment where documentation does not support designated reimbursement.

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The Future of PDPM?

- Will PDPM really support the ultimate development of a Unified Post-Acute Care (UPAC) system as a volume-based system?
- What legislative/regulatory challenges exist for PDPM or an episodic payment system?
- What must be done at an operational level to ensure facility readiness?
- What does a transition plan from RUG-IV to PDPM look like?
- What methodological elements need to be altered for the system to be viable and serve the care needs of beneficiaries?
- What data needs to be collected to support the changes as a result of the transition to PDPM?

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Thank You

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