Preparing for Medicare Payment Reform: The Skilled Nursing Facility Patient-Driven Payment Model (PDPM)

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Speaker:
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Session Outline
• Course Introduction and Resources*
• Overview of Volume to Value Concept
• History of SNF PPS and Basic Concepts
• Review of PDPM
• Overarching CMS Initiatives
• Skilled Nursing Facility Initiatives and Systems
• Promoting OT’s Role and Value
• Wrap-up

Presentation Abstract
As health care reform has evolved in recent years, the focus has been on movement toward a system that supports value-based care and improved quality of care and away from a system driven by volume and payment rules. As part of this focus, the Centers for Medicare and Medicaid Services (CMS) have put forth efforts to reform the payment system for Skilled Nursing Facilities to a system that is driven by patient characteristics, factors, and care needs. As a result of these efforts, a new Medicare Skilled Nursing Facility (SNF) payment system, the Patient-Driven Payment Model (PDPM), is slated to take effect on October 1, 2019. The PDPM payment structure is based on a combination of components, including components related to nursing services, physical therapy services, occupational therapy services, speech-language pathology services, and non-therapy ancillary services, as well as an element referred to as a non-case-mix component. Certain patient characteristics and factors are specified as determinants of payment for each of the service components. For occupational therapy, these determinants include the primary reason for SNF care and the functional status of the patient. These payment reform efforts are also linked to the post-acute care reform provisions of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, quality programs, and outcome reporting, updates to the SNF Medicare Conditions of Participation, and the CMS Patients Over Paperwork Initiative. This presentation will provide an overview of the PDPM, as well as the connection with other related CMS initiatives. This session will also provide an opportunity for participants to consider and explore the potential impact of the PDPM on occupational therapy service delivery and to consider and explore ways in which to facilitate transition to the new model.

Learning Objectives
Participants will be able to:
• Describe the structure of the Patient-Driven Payment Model
• Discuss the potential impact of the Patient-Driven Payment Model on occupational therapy service delivery and ways in which to facilitate transition to the new model
• Explain the connection between the Patient-Driven Payment Model and other Medicare Skilled Nursing Facility initiatives and updates
• Identify resources to support transition to the new payment model

*Notepad graphic throughout from https://upload.wikimedia.org/wikipedia/commons/thumb/7/71/Notepad_icon.svg/600px-Notepad_icon.svg.png
### Course Level and Intent

**Intermediate Level Course:** Expect participants to have at least a basic understanding of skilled nursing home service delivery and related Medicare rules prior to participation in this course.

**Intent:** Review of the topic aimed at familiarizing participants with the changing skilled nursing facility prospective payment system, as well as at provoking thought about clinical practice and operational issues in preparation for the pending changes.

### Audience Survey

- OT, OTA, Student, Other?
- Setting(s)?
- Job role(s)?
- Level of knowledge re: PDGM?
- Any subtopics of particular interest?

### Resources

- Course Handouts
- Slides
- Resources and References
- Embedded links
- Primary Resources:
  - CMS: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html)
  - AOTA: [https://www.aota.org/Practice/Manage/value.aspx?promo_name=payment-quality&promo_creative=Practice&promo_position=hero](https://www.aota.org/Practice/Manage/value.aspx?promo_name=payment-quality&promo_creative=Practice&promo_position=hero)

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How Did We Get To this Point?

- Triple Aim - Populations, Quality & Cost
- Affordable Care Act
- IMPACT Act
- Specific to skilled nursing facilities (SNFs): Concerns about appropriate utilization of therapy services and system-driven financial incentives

Focus on Quality

- Quality as a Cycle
- Transparency
- Data Follows the Person

- HOW DO YOU DEFINE QUALITY?

Triple Aim

- Patient/Population Safety
- Reduce Harm
- Patient & Family Engagement
- Effective Communication
- Coordinated Care
- Disease & Health Management
- Evidenced Based Care
- Affordable Value Based Care

Affordable Care Act

- Expand access to insurance coverage (e.g. Medicaid expansion)
- Increase consumer insurance protections
- Focus on prevention and wellness
- Optimize health quality and health systems performance
- Reduce rising health costs

https://www.hhs.gov/healthcare/about-the-aca/index.html
Prospective Payment Systems

- Used for Medicare Part A services
- Per diem rates using a case-mix methodology, adjusted for geographic labor/wage costs
- Payment rates and rules set through federal rule-making process
- An important concept: Resource Utilization
  - The care needed by a patient
    - Persons (Skilled, non-skilled, operational, etc.)
    - Supplies (Medical, Drugs, Equipment, etc.)
    - Time/Length of stay
    - Overhead costs

History of SNF Medicare Part A

- Before SNF PPS reimbursement for SNF Medicare Part A services was retrospective and cost-based
- SNF PPS was implemented in 1998 per the Balanced Budget Act of 1997
  - Originally 44 Resource Utilization Groups (RUGs); refined to 53 RUGs in 2006; and to 66 RUGs in 2010; includes therapy, nursing and non-case-mix components
  - Some RUGs focused on level of Rehab Services (Low, Medium, High, Very High, Ultra High)
  - Currently Resource Utilization Group, Version IV
- Use Minimum Data Set (MDS) for Assessments
  - Currently MDS 3.0 v1.16.1
- Multiple schedule and unscheduled assessments, refined and changed over the years
- Require reporting of therapy days, minutes, and modes
History of SNF Medicare Part A

- Changed focus to patient characteristics and factors
  - 2013: Under contract with CMS, Acumen, LLC explores alternatives for therapy reimbursement under SNF PPS
  - May 2017: CMS posted an Advanced Notice of Proposed Rulemaking (ANPRM) to put forth and solicit stakeholder input on a potential new model for SNF PPS, called the Resident Classification System, Version 1 (RCS-1)
  - April 2018 FY 2019 SNF Proposed Rule: CMS puts forth revised plan for SNF payment reform, renamed the Patient-Driven Patient Model for implementation FY 2020
  - August 2018; FY 2019 SNF Final Rule: CMS finalizes PDPM plan for implementation Oct. 1, 2019

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What is Changing?

- New case-mix methodology and adjustments
- Therapy days and minutes no longer driving RUGs
- Patient characteristics and factors driving reimbursement
- SNF PPS assessment schedule
- Some MDS items (e.g., Sections I, J, and O; See MDS Changes Fact Sheet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_MDS-Changes-V7_508.pdf)
- Rules about the amount of concurrent and group therapy
- Addition of an Interrupted Stay policy

What is not changing?

- 3-Day Hospital Stay (expect for BPCI and ACO waivers)
- Need for daily skilled, reasonable, and medically necessary services of Nursing and/or Rehab
- Several MDS items
- OBRA assessment schedule
- Need for accurate and timely coding
- Need for comprehensive, outcome measure-based therapy evaluations
- Requirement that services be in accordance with accepted standards of practice and supported in the professional literature (i.e., evidence-based)
- Documentation requirements and the need for accurate, thorough, and timely documentation
- Need for interdisciplinary communication and collaboration


Effect of PDPM

By introducing such individual patient's unique needs independently, PDPM improves payment accuracy and encourages a more patient-centric care model.

Assessment Schedule

<table>
<thead>
<tr>
<th>Current</th>
<th>Unscheduled</th>
<th>PDPM</th>
<th>OBRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF PPS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduled</td>
<td>Unscheduled</td>
<td>PDPM</td>
<td>OBRA</td>
</tr>
<tr>
<td>5-Day</td>
<td>5-Day OMRA</td>
<td>Admission</td>
<td>Initial Comprehensive</td>
</tr>
<tr>
<td>14-Day</td>
<td>14-Day OMRA</td>
<td>Interim Payment Adjustment (IPA)</td>
<td>14-Day</td>
</tr>
<tr>
<td>30-Day</td>
<td>EOT OMRA</td>
<td>Discharge</td>
<td>Quarterly</td>
</tr>
<tr>
<td>60-Day</td>
<td>EOT-R OMRA</td>
<td>Significant Correction</td>
<td>Annual</td>
</tr>
<tr>
<td>90-day</td>
<td>Short Stay</td>
<td>Interrupted Stay</td>
<td>Discharge</td>
</tr>
<tr>
<td></td>
<td>COT OMRA</td>
<td></td>
<td>Reentry</td>
</tr>
<tr>
<td></td>
<td>Discharge</td>
<td></td>
<td>Significant Change</td>
</tr>
<tr>
<td></td>
<td>Significant Change</td>
<td></td>
<td>Significant Corrections</td>
</tr>
<tr>
<td></td>
<td>Significant Correction</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Also AIDS adjustment noted on previous slide

Based on mapped ICD-10s for Primary Diagnosis (MDS Section I), Surgical History (MDS Section J); "Return-to-Provider" (RTP) claim function applied when submitted ICD-10 is not mapped

Based on mapped ICD-10s for Primary Diagnosis (MDS Section I), Surgical History (MDS Section J); "Return-to-Provider" (RTP) claim function applied when submitted ICD-10 is not mapped

- Acute Neurological Condition as noted in primary reason for admission list
- Mechanically Altered Diet or Swallowing Disorder from MDS Section K items


Based on mapped ICD-10s for Comorbidities Diagnosis; “Return-to-Provider” (RTP) claim function applied when submitted ICD-10 is not mapped


Cognitive Score

Under PDPM, just as under RUG-IV, a patient’s cognitive status is assessed using either the Brief Interview for Mental Status (BIMS). In cases where the BIMS cannot be completed, a Staff Assessment for Mental Status is completed. The Cognitive Performance Scale (CPS) is then used to score the patient based on the responses to the Staff Assessment.

Under RUG-IV, the BIMS and the CPS produced separate scores, with no single measure of cognitive status that allowed comparison across all patients. The new PDPM Cognitive Score is based on the Cognitive Function Scale (CFS), which combines scores from the BIMS and CPS into one scale that can be used to compare cognitive function across all patients.

In order to receive a PDPM identification, all required items must be completed. Either a BIMS score or CPS score is necessary to classify the patient under the SLP component.

PDPM Cognitive Score Classification Methodology

<table>
<thead>
<tr>
<th>Cognitive Level</th>
<th>BIMS Score</th>
<th>CPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Level 15+</td>
<td>0</td>
<td>0-1</td>
</tr>
<tr>
<td>Mildly Impaired</td>
<td>0-9</td>
<td>2-12</td>
</tr>
<tr>
<td>Moderately Impaired</td>
<td>0-9</td>
<td>13-25</td>
</tr>
<tr>
<td>Severely Impaired</td>
<td>0-9</td>
<td>26-50</td>
</tr>
</tbody>
</table>

 Modes of Therapy

- Definitions of modes unchanged
- Continue to be recorded in MDS Section O
- Focus on Individual
- Group and Concurrent as clinically appropriate
  - < 25% of total stay
  - CMS tracking patterns of utilization via entry of total days and minutes (MDS Section O) on discharge evaluation
  - Non-fatal error message if exceed 25%
- Co-treatment may still be provided when clinically appropriate

Additional note: Therapy days and minutes will also be entered in Section O for admission assessment 7-day lookback
Nursing Component

- Clinical Information from SNF Stay
- Functional Status
- Extensive Services Received
- Presence of Depression
- Restorative Nursing Services Received

(AIDS adjustment may also be applied)

Nursing Component

- Uses same basic nursing classification structure as RUG-IV with some modification
  - Nursing RUG collapsed from 43 to 25
    - Extensive services
    - Special Care High
    - Special Care Low
    - Clinically Complex
    - Behavioral Symptoms and Cognitive Performance
    - Reduced Physical Function

Examples of Nursing Classification

From p. 5 of PDPM Functional and Cognitive Scoring Fact Sheet

PDPM Cognitive Score Classification Methodology

<table>
<thead>
<tr>
<th>Cognitive Level</th>
<th>BMS Score</th>
<th>CPS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitively Unrecent</td>
<td>13-15</td>
<td>0</td>
</tr>
<tr>
<td>Mildly Impaired</td>
<td>8-12</td>
<td>1-2</td>
</tr>
<tr>
<td>Moderately Impaired</td>
<td>6-7</td>
<td>3-4</td>
</tr>
<tr>
<td>Severely Impaired</td>
<td>-</td>
<td>-56</td>
</tr>
</tbody>
</table>

Non-Therapy Ancillary (NTA) Component

- Under RUG IV NTA was combined with nursing as one component, but under PDPM is a separate component
- Based on the presence of certain comorbidities or use of certain extensive services
  - Primarily driven by medication/drug costs
- Points assigned and tiered
- Examples:
  - HIV/AIDS = 8 points
  - Parenteral IV feeding: Level Low = 3 points
  - Diabetes Mellitus Code = 2 points

NTA Component: Payment Groups

<table>
<thead>
<tr>
<th>NTA Score Range</th>
<th>NTA Case Mix Group</th>
<th>NTA Case Mix Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>12+</td>
<td>NA</td>
<td>1.25</td>
</tr>
<tr>
<td>0 – 11</td>
<td>NB</td>
<td>2.53</td>
</tr>
<tr>
<td>6 – 9</td>
<td>NC</td>
<td>1.85</td>
</tr>
<tr>
<td>3 – 5</td>
<td>ND</td>
<td>1.34</td>
</tr>
<tr>
<td>1 – 2</td>
<td>NE</td>
<td>0.96</td>
</tr>
<tr>
<td>0</td>
<td>NF</td>
<td>0.72</td>
</tr>
</tbody>
</table>

Variable Per-diem Adjustment Factors and Schedule – NTA Component

<table>
<thead>
<tr>
<th>Medicare Payment Days</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>3.0</td>
</tr>
<tr>
<td>4-100</td>
<td>1.0</td>
</tr>
</tbody>
</table>


Interrupted Stay Policy

- If a patient is discharged from a SNF and readmitted to the same SNF no more than 3 consecutive calendar days after discharge, then the subsequent stay is considered a continuation of the previous stay:
  - Assessment schedule continues from the point just prior to discharge
  - Variable per diem schedule continues from the point just prior to discharge
- If patient is discharged from SNF and readmitted more than 3 consecutive calendar days after discharge, or admitted to a different SNF, then the subsequent stay is considered a new stay:
  - Assessment schedule and variable per diem schedule reset to day 1

- Meant to decrease an unintended incentive for providers to discharge and readmit patients for the purpose of resetting the variable per diem adjustment schedule
- Reduction of preventable hospital readmission is still a quality of care priority
- Applies to in-facility discharge from/re-admission to Part A stay

Meant to reflect historical changes in resource utilization

From p. 2 of Variable Per Diem Adjustment Fact Sheet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_VPD_v3_508.pdf
HIPPS Code Format

- Character 1: PT/OT Payment Group
- Character 2: SLP Payment Group
- Character 3: Nursing Payment Group
- Character 4: NTA Payment Group
- Character 5: Assessment Indicator (0=IPA; 1=5-day; 6=non-PPS coded OBRA)

Example:

PT/OT Payment Group: TN
SLP Payment Group: SH
Nursing Payment Group: CBC2
NTA Payment Group: NC
Assessment Type: 5-day PPS
HIPPS Code: NHNC1


Base Rates

<table>
<thead>
<tr>
<th>Rate component</th>
<th>Nursing</th>
<th>NTA</th>
<th>PT</th>
<th>OT</th>
<th>SLP</th>
<th>Non-case-mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Diem Amount</td>
<td>$103.49</td>
<td>$78.95</td>
<td>$59.33</td>
<td>$55.23</td>
<td>$93.15</td>
<td>$92.53</td>
</tr>
</tbody>
</table>

*The rates shown in Tables 12 and 13 illustrate what the adjusted federal per diem rates would be for each of the case-mix adjusted components if we were to apply the proposed PDPM to the proposed FY 2019 base rates given in Tables 4 and 5.

Changeover from RUG IV to PDPM

- No transition period between RUG-IV and PDPM
- RUG-IV through 09/30/2019
- PDPM begins 10/01/2019
- For patients crossing from September to October under Medicare Part A benefits, an IPA assessment will need to be completed with and assessment reference date no later than 10/07/2019
- For those patients, 10/01/2019 will be considered Day 1 of the Variable Per Diem Adjustment Schedule
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Overarching CMS Initiatives

- Quality programs
- Innovation
- Transparency
- Patients over Paperwork Initiative
- Effective transition/discharge planning
- Hospital readmission reduction

Skilled Nursing Facility Updates and Changes

- Updated Conditions of Participation
  - 3 Phases - Nov. 2016, 2017, 2019
    - Among areas of focus are resident rights, discharge planning, person-centered care, infection control, quality assurance and performance improvement, staff training
    - Details in Final Rule posted 10/04/2016
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- MDS and RAI Manual Updates (Oct. 1, 2018)
  - Expanded Section GG
    - To full set of self-care and mobility items
    - Includes Prior Level of Function and Prior Device Use items
Quality Initiatives

• Increased accountability and transparency
  • Consumer awareness, engagement, and choice
  • Provider reputation
  • May have financial incentives or penalties

Overlying Quality Initiatives

• Post-Acute Care reform (IMPACT Act) (required for four PAC provider types - HHA, SNF, IRF, LTCH)
• Quality Reporting Program (QRP)
• Value-Based Purchasing Measure (VBP)
• SNF Quality Assurance and Performance Improvement (QAPI)
• 5-Star Rating Program and Nursing Home Compare Website
• Payroll-Based Journal (PBJ)
• Special Focus Facility (SFF) Initiative [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/SFFList.pdf]
• Emergency Preparedness (required for HHAs and 16 other provider types)

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Overarching themes

• OT and other rehab disciplines must move from being drivers of reimbursement to drivers of quality and outcomes
• Empowerment
  • Putting clinical decision-making in the hands of the clinicians together with focus on patient characteristics, factors, and engagement
  • Opportunities to show value and support parallel initiatives

A note about a reality that cannot be overlooked: Health care entities are businesses that cannot ignore financial and operational concerns, but the evolving changes look to promote best practices and to assure the right factors and incentives are driving patient care.
Through OT Practice

• Occupation/Function
  • Mitigating Risks (Re-admissions)
  • Supporting quality and outcomes
• Evidence-based Practice
• Billing and Clinical Documentation
  • Accurate, Appropriate, Complete, Thorough
• Team Collaboration

For PDPM

• Identifying, collaborating, documenting to support:
  • Clinical Category
  • Functional scoring

For Overlay of Other Initiatives

Clinical and Operational Level

• To promote quality
• To facilitate outcomes
• To support provider reputation
• To provide data that supports OT’s role and value
• Etc.

Think About a Case Scenario

• From and OT perspective....
  • What occupations might you address?
  • What risks might OT intervention mitigate at the SNF and in regard the client’s discharge/transition plan?
  • How might you collaborate to support the components of PDPM?
  • How might you contribute to quality initiatives?
  • How might you document to support to support PDPM, quality of care, and outcomes?
Example - A Case Scenario

An 82 year old female, with a history of COPD and macular degeneration, admitted after open reduction, internal fixation for a right hip fracture sustained when she fell while reaching to put some groceries away in a lower cupboard. She uses a portable oxygen tank that she transports via a basket in a wheeled walker. She plans to return to her assisted living facility (ALF) unit, where she was previously performing basic self-care activities independently, other than showering, for which she had a personal aide 3 x/week. The aide also helped with laundry once a week. She took her main meal in the facility dining room at noontime, but independently prepared light meals and snacks. She took the facility van to the store every other week to purchase groceries and a couple of times a month for social activities. She also independently ambulated with the walker to and from various recreational and social activities within the ALF. Her daughter assists her with management of her finances because her mother was complaining of memory difficulties and being overwhelmed by the paperwork. Her daughter takes her to church every week and to family outings once or twice a month, using a car for transportation.

Sharing Thoughts About CMS Case Scenario #2

• From and OT perspective....
  • What occupations might you address?
  • What risks might OT intervention mitigate at the SNF and in regard the client’s discharge/transition plan?
  • How might you collaborate to support the components of PDPM?
  • How might you contribute to quality initiatives?
  • How might you document to support to support PDPM, quality of care, and outcomes?

Factors to Consider and Think About as You Prepare for the Changes Ahead

• Facilitators
• Barriers/Challenges
• Knowledge level and gaps
• Opportunities
• Protecting yourself from burnout (4th aim)
• Operational issues

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Where To Go From Here

- Access Information and Stay informed
  - Course handout
  - CMS
  - AOTA
  - Other Education resources (Employers, courses, etc.)
- Show your value
  - AOTA Advocacy (comorbidities, interventions for cognition and swallowing)
  - Occupations
  - Evidence-based Practice
  - Billing and clinical documentation (also provides data)
  - Interdisciplinary Team Collaboration

A few more minutes...

- How can ConnOTA help?
  - What/Where/When?
  - What other type of info do you feel you need?
  - Make a note on your course assessment so there is follow up

Parting Words....

- Approach with confidence
- Be engaged in the process and showing your value
- Learn and think about and prepare for the impact of the changes
- Embrace the opportunities and empower yourself, your clients, and your co-workers

Special Thanks....

- For shared content and collaboration from:
  - Morgan Rachel Villano, MPA, MSPS, OTR/L
  - Cindy Kuziak, PT, MBA, RAC-CT
  - Christine Kroll, OTD, MS, OTR, FAOTA
  - Nancy Richman, OTR/L, FAOTA