Skilled Nursing Facility Prospective Payment System

Patient Driven Payment Model: What is changing (and what is not)

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Agenda

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PDPM Overview
PDPM Overview

• Issues with the current case-mix model, the Resource Utilization Group, Version IV (RUG-IV), have been identified by CMS, OIG, MedPAC, the media, among others.
  – Therapy payments under the SNF PPS are based primarily on the amount of therapy provided to a patient, regardless of the patient’s unique characteristics, needs or goals.
  – SNF patients who may have significant differences in terms of nursing needs and costs often receive the same payment for nursing services.
The Patient Driven Payment Model (PDPM) represents a marked improvement over RUG-IV for the following reasons:

- Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided.
- Significantly reduces administrative burden on providers.
- Re-allocates SNF payments to currently underserved beneficiaries without increasing total Medicare payments.
PDPM Overview

• RUG-IV consists of two case-mix adjusted components:
  – Therapy: Based on volume of services provided
  – Nursing: The nursing case-mix index does not currently reflect specific variations in non-therapy ancillary utilization.

• RUG-IV uses a constant per diem rate, meaning that the payment rate for a given RUG is the same on Day 1 and Day 100 of a patient’s stay.
  – This results in too few resources at the outset of a SNF stay when costs are higher.
PDPM Overview

- PDPM consists of five case-mix adjusted components, all based on data-driven, stakeholder-vetted patient characteristics:
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech Language Pathology (SLP)
  - Non-Therapy Ancillary (NTA)
  - Nursing
PDPM Overview

• PDPM also includes a “variable per diem adjustment” that adjusts the per diem rate over the course of the stay.
  – This better targets payments under the SNF PPS to reflect cost trends.

• For the PT, OT, and NTA components, the case-mix adjusted per diem rate is multiplied against the variable per diem adjustment factor, following a schedule of adjustments for each day of the patient’s stay.
  – The adjustment factors used for the PT/OT components are different from those used under the NTA component, due to the differences in cost trajectory between the PT/OT components and the NTA component.
# PDPM Overview

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Model Snapshot

- While the RUG-IV model (left) reduces everything about a patient to a single, typically volume-driven case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics and goals of each patient.
Model Snapshot

• By addressing each of a patient’s unique needs independently, PDPM improves payment accuracy and encourages a more patient-driven and holistic care model.
What PDPM Does Change
What PDPM Does Change

- PDPM represents the single largest change to the SNF PPS since its inception, with impacts on patient classification, assessment burden, care planning and care design.

- Understanding the differences between RUG-IV and PDPM and the impact of these differences under the SNF PPS is essential to the success of the PDPM.
What PDPM Does Change: Payment Classification Data

• While both RUG-IV and PDPM utilize the MDS as the basis for patient classification, the data elements used are quite different.

• For over 90 percent of the days billed under RUG-IV, the only two patient characteristics relevant for payment purposes are the patient’s functional status and how much therapy the patient received.
  
  – These elements tell us very little about the actual patient and more about the services the facility furnished to the patient.
What PDPM Does Change: Payment Classification Data

• For every day billed under PDPM, the patient characteristics relevant for payment purposes are also those relevant for care planning purposes:
  – Primary diagnosis
  – Comorbidities
  – Functional Status
  – Cognitive Status
  – Nutrition and Swallowing Needs
  – And many more.
What PDPM Does Change: Emphasis of Care

- Under RUG-IV, SNF patients are classified as being either “therapy” patients or “non-therapy” patients.
  - This dichotomy, coupled with the payment incentives that exist under RUG-IV, has caused a significant increase in SNF patients skilled only for a single aspect of care and facilities admitting fewer medically complex patients.

- Under PDPM, all SNF patients are classified under each component of care, highlighting the importance, complexity, and unique qualities of SNF care and SNF patients.
What PDPM Does Change: Payment/Quality Alignment

• CMS measures the quality of care provided to SNF patients in a variety of ways.
  – SNF Quality Reporting Program
  – SNF Value Based Purchasing
  – Nursing Home Compare Star Ratings

• Value driven care is, by definition, a balance between care quality and care cost.
  – High-value, efficient providers are those who are able to deliver high quality care for low cost.
What PDPM Does Change: Payment/Quality Alignment

• Under RUG-IV, existing quality metrics are aligned, in many ways, with perverse payment incentives.
  – Example: By trying to achieve the highest possible therapy classification, a patient will receive a significant amount of therapy, thereby reducing the chance of the patient developing a worsening pressure ulcer.

• PDPM redefines the relationship between payment and quality measures, realigning payment incentives and quality incentives.
What PDPM Does Change: PPS Assessments

• The most often criticized aspect of the SNF PPS is the array of assessments that providers are required to complete.
  – Scheduled assessments, unscheduled assessments, combining assessments, assessments, assessments, assessments.

• The complexity of the RUG-IV assessment schedule represents a significant potential financial risk for providers (i.e., default billing and provider liability), and means clinicians focusing less on direct patient care and more on meeting administrative requirements.
What PDPM Does Change: PPS Assessments

- The PDPM assessment schedule is much more streamlined and simple, reducing the financial risk on providers and allowing clinicians to focus more time on patients and less time on paperwork.

- Assessments under PDPM also make use of more standardized data elements, such as section GG functional status items, allowing us to further reduce burden by retiring legacy data elements and improving coordination of care and communication among different provider types.
What PDPM Does Change: Medical Review and Data Monitoring

• Regardless of the payment model used, ensuring appropriate safeguards for program integrity is always essential.
  – Ensuring program integrity can also represent an administrative burden and potential financial risk for providers.

• Under RUG-IV, given the high percentage of billed days in therapy groups, program integrity and monitoring efforts tend to focus on documentation and billing for therapy services, ensuring that the therapy furnished to a SNF patient is reasonable, necessary and individualized based on the patient’s unique condition.
What PDPM Does Change: Medical Review and Data Monitoring

• Given the more holistic style of care emphasized under PDPM, program integrity and data monitoring efforts will also be more comprehensive and broad.

• For program integrity, we expect provider risk will be more easily mitigated to the extent that reviews focus on more clearly defined aspects of payment, such as documentation supporting patient diagnoses and assessment coding.

  – If the provider codes that the patient’s primary diagnosis is a major joint replacement, then the reviewer should be able to verify that the patient received a major joint replacement.
What PDPM Does Change: Medical Review and Data Monitoring

• Therapy services will still represent an important and significant part of data monitoring and program integrity efforts.
  – New items are being added to the MDS to allow CMS to track therapy service delivery, both in terms of intensity and the manner of delivery

• CMS will be monitoring therapy service provision under PDPM, as compared to RUG-IV, at the national, regional, state, and facility level.
  – Significant changes in the amount of therapy provided to SNF patients under PDPM, as compared to RUG-IV, or the manner in which it is delivered, may trigger additional program reviews and potential policy changes.
What PDPM Does Not Change
What PDPM Does Not Change: Actually, a lot!

• Despite the significant changes occurring under PDPM, many SNF PPS policies remain unchanged under PDPM.
  – Denial notice policies, ABNs, NOMNCs
  – Payment and policy associated with therapy evaluations
  – Student supervision policies
  – Basic administrative processes under SNF PPS

• There are three particular areas that remain unchanged under PDPM that are of particular note.
What PDPM Does Not Change: What’s Covered

• The SNF PPS covers skilled nursing care, skilled rehabilitation services and other goods and services.

• PDPM does not change what is covered under the SNF Part A benefit, or what is not covered.

• Whether under RUG-IV or PDPM, in order to be covered, SNF services must be skilled services, required on a daily basis, and be reasonable and necessary for the treatment of a patient’s particular illness or injury, based on the individual’s particular medical needs, and accepted standards of medical practice.
What PDPM Does Not Change: What You Should Document

• Section 30.2.2.1 of Chapter 8 of the Medicare Benefit Policy Manual states that SNF claims must include sufficient documentation that would allow a reviewer to determine:
  – Skilled involvement is required in order for services to be furnished safely and effectively,
  – The services are reasonable and necessary for the treatment of a patient’s illness or injury, i.e., consistent with…the individual’s particular medical needs.
  – The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.
What PDPM Does Not Change: What You Should Document

• PDPM does not change these documentation requirements, but rather strengthens the importance of documenting all aspects of a patient’s care, consistent with PDPM’s focus on a more holistic care model.

• Given the increased relevance of a greater set of data elements supporting payment under PDPM, providers should ensure that there is strong documentation and support for the care associated with each PDPM component.
What PDPM Does Not Change: What Your Patient Needs

• While PDPM changes how patients are classified into payment groups, PDPM does not change what SNF patients need, their goals, or the unique characteristics of each patient that should drive care planning.
  – If a patient needs 720 minutes of therapy per week as of September 30, 2019, and nothing changes clinically about the patient, then the patient needs 720 minutes of therapy per week as of October 1, 2019.
  – If group therapy is not clinically indicated for the patient as of September 30, 2019, and nothing changes clinically about the patient, then it is not clinically indicated for the patient as of October 1, 2019.
What PDPM Does Not Change: What Your Patient Needs

• A major component of CMS’ PDPM monitoring strategy is monitoring for consistency in care provision between RUG-IV and PDPM.
  – Therapy intensity, duration, and manner of delivery
  – Increased utilization of mechanically altered diets
  – Anomalies in comorbidity coding

• Any significant shifts in care provision between RUG-IV and PDPM could draw significant scrutiny from CMS review entities.
RUG-IV – PDPM Transition
As discussed in the FY 2019 SNF PPS Final Rule, there is no transition period between RUG-IV and PDPM, given that running both systems at the same time would be administratively infeasible for providers and CMS:

- RUG-IV ends September 30, 2019
- PDPM begins October 1, 2019
RUG-IV – PDPM Transition

• In order to receive a RUG-IV HIPPS code that can be billed for services furnished prior to October 1, 2019, providers must use an assessment with an ARD set for on or prior to September 30, 2019.

• For instance, if a patient is admitted to the facility in the last few days of September 2019, providers must have an assessment with an ARD set for on or prior to September 30, 2019, in order to receive a RUG-IV HIPPS code.
  – Providers still have the usual 14-day completion period and 14-day submission period, regardless of the assessment ARD.
RUG-IV – PDPM Transition

• For patients admitted prior to October 1, 2019, but whose stays continue past this date, in order to receive a PDPM HIPPS code that can be used to bill for services furnished on or after October 1, 2019, providers must complete an IPA with an ARD no later than October 7, 2019:
  – October 1, 2019, will be considered Day 1 of the VPD schedule under PDPM, even if the patient began their stay prior to October 1, 2019.
  – Any “transitional IPAs” with an ARD after October 7, 2019, will be considered late and relevant penalty for late assessments would apply.

• If the patient’s stay begins on or after October 1, 2019, then the provider would begin with the 5-day assessment, as usual.
PDPM & Medicaid
PDPM & Medicaid

• While PDPM was created to replace the case-mix classification system used under Medicare, it also has effects on Medicaid payment programs.

• There are two main areas of Medicaid payment affected by PDPM:
  – Upper Payment Limit (UPL) Calculation
  – Case-mix Determinations
PDPM & Medicaid

• UPL represents a limit on certain reimbursements for Medicaid providers:
  – Specifically, the UPL is the maximum a given State Medicaid program may pay a type of provider, in the aggregate, statewide in Medicaid fee-for-service.

• While budget neutral in the aggregate, PDPM changes how payment is made for SNF services, which can have an impact on UPL calculations:
  – States will need to evaluate this effect to understand revisions in their UPL calculations.
For purposes of Medicaid reimbursement, states utilize a myriad of different payment methodologies to determine payment for Nursing Facility (NF) patients, including versions of RUG-III and RUG-IV.

Case-mix states also may rely on PPS assessments to capture changes in patient case-mix, including scheduled and unscheduled assessments:

- As of October 1, 2019, all scheduled PPS assessments (except the 5-day) and all current unscheduled PPS assessments will be retired.
- To fill this gap in assessments, CMS created the OSA, which may be required by states for NFs to report changes in patient status, consistent with their case-mix rules.
PDPM & Medicaid

• With PDPM implementation, CMS will continue to provide technical support for legacy payment models, such as RUG-III and RUG-IV, until at least 10/01/2020.

• We are aware that states require Section GG and the PDPM related payment items in order to consider a transition to PDPM for their Medicaid payment systems.
  – We are working to continue our technical support for legacy payment models for a period that will allow states to collect and analyze the data necessary for a transition to PDPM.
PDPM Resources

- PDPM website: [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)

- For questions related to PDPM implementation and policy: PDPM@cms.hhs.gov

- For questions related to the OSA: OSAMedicaidinfo@cms.hhs.gov
Questions and Answer Session
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