Patient Driven Payment Model – Critical Checklist Items

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Count Down to PDPM Implementation from Today

152 Calendar Days

Transition Work
Executive Summary

1. Conceptual PDPM Differences Relative to RUGs
2. PDPM Admissions Process
3. Care Delivery
4. Discharge Planning
5. AHCA Resources

PDPM is Not RUGs V – Fundamentally Different Approach to Operations and Payment

- Patient Driven Payment Model
  - Therapy minutes do not equal payment
  - Payment based on differing patient characteristics
  - Intent is to redistribute resources among all four direct care related components and the non-therapy ancillary component

- Top 3 Capabilities for Success
  1. Diagnose, code full clinical picture
  2. Be capable of handling more complex patients
  3. Accurately report codes with consistent / supporting documentation

Changes in Core Strengths Moving from RUGs to PDPM

- Clinical
  - Deliver Therapy Minutes
  - Diagnose Patients

- Administrative
  - Form Completion
  - Coordinate Patient Care
## Patients Over Paperwork – CMS Balance

<table>
<thead>
<tr>
<th>Framework Element</th>
<th>PDPM SNF Impact</th>
<th>CMS Expectations &amp; Actions</th>
</tr>
</thead>
</table>
| Flexibility       | • Assessment Schedule Elimination  
                    • Case Mix Group Assignment Flexibility  
                    • Interim Payment Assessment Design  | • Initial Patient Assessment in 8 Days  
                                               • Case Mix Group Appropriate  
                                               • Infrequent and Medical Documentation |
| Accountability    | • SNF Primary Diagnosis Expectation  
                    • Section GG -- Nursing & Therapy  
                    • Coding & Documentation  | • Admission & Discharge Should Match  
                                               • Expected Functional Score Relationship  
                                               • Medical Information Supports Coding |
| Transparency      | • Enough data to monitor  
                    • Quality Reporting Program  
                    • Value-Based Purchasing Program  | • Will monitor provider behavior, patient condition, and billing  
                                               • Patient Outcomes |

**PDPM Admissions**
PDPM Offers New Flexibility but Also Offers New CMS Oversight Resources

<table>
<thead>
<tr>
<th>High Risk Behavior Examples</th>
<th>Motivation</th>
<th>Implications</th>
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</thead>
<tbody>
<tr>
<td>Upcoding</td>
<td>Revenue Maximization</td>
<td>CMS will have a direct line of sight via ICD-10 and other MDS document</td>
</tr>
<tr>
<td>Downsizing Therapy</td>
<td>Overhead Reduction</td>
<td>CMS is clear the SNF benefit and coverage requirements remain the same and will be monitoring for outcomes (e.g., QRPs)</td>
</tr>
<tr>
<td>Over-Use of Interrupted Stay</td>
<td>Restart Variable Per Diem</td>
<td>Risk of being placed under “heighten scrutiny”</td>
</tr>
<tr>
<td>Vague IPA Trigger Definition</td>
<td>Room to Argue +/- in CMGs and Rates</td>
<td>Any changes in CMGs using and IPA should be supported by ample clinical documentation</td>
</tr>
</tbody>
</table>

Download AHCA PDPM Compliance Assessment Tool Available on March 26

How will You Communicate with Your Hospitals?

- What is your SNF ICD-10 Diagnosis Coding Capacity and Ability to Assess Diagnostic Information for Case Mix Group Assignment?
- What is Your Return to Provider Rate and Plan to Reduce that Rate?
- What is Your Strategy to Strengthen Physician and MDS Coordinator Communication to Secure ICD-10 Diagnosis for High Impact Item Coding?

Optimal Initial Patient Assessment Strategy and Team Planning

- New IDT Structure
- 8 Days
- Days 9 and Later
- Default to Lowest Case Mix Groups and Related Rates

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Overall Shift in Care Plan Design Expectations

Resource Utilization Group IV  +  PDPM

Volume of Minutes

Patient-Centered Care Based on Clinical Characteristics Assessed with VBP and QRPs

… Which is Another Way of Saying Moving from Volume to Value

“To better ensure that resident care decisions appropriately reflect each resident’s actual care needs, we believe it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from verifiable resident characteristics.” (83 FR 39185)
Assessing Your Organizations Admissions Process Today

- How accurate is MDS and ICD-10 coding today?
- Are MDS coordinators getting detailed enough information from physicians and SNF clinicians to accurately code?
- How likely is it that ICD-10 codes will be accurate for PDPM mapping and do not generate RTP errors?
- Do your Medical Director & physicians understand that information needs to be more complete prior to completion of the initial patient assessment?
- Does your team need to improve accuracy of MDS Section GG (days 1-3), depression, and restorative nursing items (min 6 days) and for selecting appropriate ARDs? Does your staff need training on these?
- Does the new accuracy and needed supporting documentation require the same/more/less time as the prior MDS schedule understanding the 8 day window?

Care Delivery & Payment
Care Delivery Process Transformation

1. Assess Patient In-Person Before Admission
   - SNF nurse accesses patient record to obtain clinical information
   - SNF nurse conducts assessment while patient still in hospital

2. Strategy for Regular Care Plan Reviews and Updates
   - Convene interdisciplinary team to review diagnostic info
   - Determine missing clinical information; MDS coordinator secures info from NPs/physicians

3. Use of Interim Payment Assessment
   - Team Assesses and Identifies Trigger
   - Discuss need for expedited physician visits and clearer information with Medical Director

Optional Interim Payment Assessment – Adjusting for Changes in Care Needs

- CMS assumes “stable patient characteristics”
- IPA is optional and will be completed when providers determine that the patient has undergone a significant clinical change
- Expected to be infrequent

“...to provide excellent skilled nursing and rehabilitative care and continually monitor and document patient status”

“...makes clear that the SNF’s responsibility in this context would include recognizing those situations that warrant a decision to complete an IPA in order to account appropriately for a change in patient status”
Interrupted Stay Policy Use & Tracking

- Strategy to Avoid CMS “Heighten Scrutiny”
- Training on completion of Discharge MDS
- Assure SNF care delivery practices and care decision-making processes are based on medical necessity and appropriate business relationships
- Develop and implement monitoring strategy and procedures to assure adherence to policy

How Does Your Care Delivery Need to Change?

- How are therapists involved in care plan development and follow-through?
- Does your nursing and therapy team convene to discuss admission details?
- How will your team ensure “holistic care planning?”
- How will your Interim Payment Assessment policy be designed and monitored?
  - Develop policy for setting the ARD date and Lookback Period
  - Define payment dates – IPA ARD through Part A Discharge in policy
  - Define Criteria for Triggering Event (Example: Results in a payment change in either one component or overall payment and the change(s) are such that the resident would not be expected to return to his or her original clinical status within a 14 day-period)
  - Assessment approach – daily?; What is assessed?; Documentation?
- What will your interrupted stay policy procedure and monitoring entail?
  - Completion of MDS
  - Rehospitalization Impacts
### PDPM Daily Rate Calculation Major Joint Replacement Patient - Days 1-3

<table>
<thead>
<tr>
<th>Component</th>
<th>Unadj Fed Rate</th>
<th>Case-Mix Index</th>
<th>Special Adjustors</th>
<th>Variable per diem</th>
<th>Payment (per diem)</th>
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<tbody>
<tr>
<td>PT</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$781.70*</td>
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</table>
Importance of Accurate Nursing and NTAS Coding

**Days 1-3**

- Non-CM: $277.89; 12%
- PT: $334.62; 14%
- OT: $278.37; 12%
- SLP: $97.02; 4%
- Nursing: $415.92; 18%
- NTA: $941.28; 40%
- Non-CM: $277.89; 12%

**Days 21-27**

- Non-CM: $648.41; 16%
- PT: $765.17; 20%
- OT: $636.51; 16%
- SLP: $226.38; 6%
- Nursing: $970.48; 24%
- NTA: $732.11; 18%
## PDPM Daily Rate Calculation - Days 1-3

<table>
<thead>
<tr>
<th>Component</th>
<th>Unadj Fed Rate</th>
<th>Case-Mix Index</th>
<th>Special Adjustors</th>
<th>Variable per diem</th>
<th>Payment (per diem)</th>
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<tbody>
<tr>
<td>PT</td>
<td>$99.08</td>
<td>1.13</td>
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<td>1.00</td>
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<td>OT</td>
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<tr>
<td>Component</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>$2,084.48</strong></td>
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</table>
Importance of Accurate Nursing and NTAS Coding

Days 1-3

PT: $335.88, 5%
OT: $317.94, 5%
SLP: $65.97, 1%
NTA: $3,838.80, 61%
Nursing: $1,416.96, 23%
Non-CM: $277.89, 5%

Importance of Accurate Nursing and NTAS Coding

Days 21-27

PT: $768.05, 9%
OT: $727.02, 8%
SLP: $153.93, 2%
NTA: $2,985.71, 35%
Nursing: $3,306.24, 38%
Non-CM: $648.41, 8%
What Happens When Something is Missed?

**MDS IV Medication Item is Not Entered**

<table>
<thead>
<tr>
<th>Condition/extensive service</th>
<th>Source</th>
<th>Points</th>
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<tbody>
<tr>
<td>HIV/AIDS</td>
<td>SNF Claim</td>
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<tr>
<td>Parenteral IV Feeding: Level High</td>
<td>MDS Item K0510A2, K0710A2</td>
<td>7</td>
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<tr>
<td><strong>Special Treatments/Programs: Intravenous Medication Post-admit Code</strong></td>
<td>MDS Item 00100H2</td>
<td>5</td>
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<tr>
<td>Special Treatments/Programs: Ventilator or Respirator Post-admit Code</td>
<td>MDS Item 00100F2</td>
<td>4</td>
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<tr>
<td>Parenteral IV feeding: Level Low</td>
<td>MDS Item K0510A2, K0710A2</td>
<td>3</td>
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</table>

<table>
<thead>
<tr>
<th>NTA score range</th>
<th>NTA case-mix group</th>
<th>NTA case-mix index</th>
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<tbody>
<tr>
<td>12+</td>
<td>NA</td>
<td>3.25</td>
</tr>
<tr>
<td>9–11</td>
<td>NB</td>
<td>2.53</td>
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<tr>
<td>6–8</td>
<td>NC</td>
<td>1.65</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>
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</tbody>
</table>

Failing to identify or incorrectly coding just one PDPM payment driver MDS item can have a significant impact on CMI.

*resident has 2 NTA points for diabetes*
### 30 Day Revenue Impact

<table>
<thead>
<tr>
<th>Days</th>
<th>RUG-IV</th>
<th>PDPM With Accurate MDS</th>
<th>PDPM With Missing MDS IV Meds Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>$631.25</td>
<td>$914.60</td>
<td>$706.06</td>
</tr>
<tr>
<td>4-20</td>
<td>$631.25</td>
<td>$625.81</td>
<td>$556.20</td>
</tr>
<tr>
<td>21-27</td>
<td>$631.25</td>
<td>$622.26</td>
<td>$554.36</td>
</tr>
<tr>
<td>28-30</td>
<td>$631.25</td>
<td>$618.71</td>
<td>$552.52</td>
</tr>
<tr>
<td><strong>30 Day Total</strong></td>
<td><strong>$18,937.50</strong></td>
<td><strong>$19,594.54</strong></td>
<td><strong>$17,111.70</strong></td>
</tr>
</tbody>
</table>

### Impact Over a Full 100-Day Stay

- **RUG-IV = $63,125**
- **PDPM Correct MDS = $62,517**
- **PDPM Missing IV Meds = $55,154**
Some Final Thoughts

Redefine Upstream and Downstream Relationships

- CMS is Not Educating Other Medicare Providers
- Be Prepared to Use a Data Driven Approach to Define Your PDPM Position
Break Out of the RUG’s Mindset

- Blend Clinical Cultures – Nursing and Therapy
- Revisit Communication Methods Using LTC TeamSTEPPs®
- Innovate
- Interview IT Vendors and Compare Capacity
- Revisit Communication Methods Using LTC TeamSTEPPs®
- Keep it Simple – Find PDPM Overlaps with Other Work
- Co-Creat Opportunities and Solutions with Upstream and Downstream Partners
- Create Road Maps That Align with PDPM Mile Markers (i.e., HIPPS Codes, NPRM, etc.)
- Drive messaging on PDPM with Partners Find New Ways to Collaborate

Transition Check List – List Not Exhaustive

- Interim Payment Assessment (IPA) policies and procedures
- Plan to assess all patients using an IPA by October 7
- Built in a cushion for the inability to use the short stay policy for RUGs
- Admissions team and processes have been re-organized
- Care planning process is aligned with CMS' “holistic” plan vision
- Discharge processes account for ISP, Section O, MDS & claims link
- ICD-10 Return to Provider rate has been tested and minimized
- QRP and VBP is being Monitored for Post-Transition Performance
PDPM Suggested Resources

PDPM ACADEMY – Business Solutions for Better Patient Care
More Resources Will Be Available – Workshop is Just the Start

- Monthly Webinars
  - Q&As
  - Updates on CMS Activities
  - FAQs from Each

AHCA Email
- PDPM@ahca.org
- Responses drafted by AHCA staff or fielded with CMS as needed
- Answers synthesized into FAQs Weekly

Additional Tools
- Regular Release of Additional Tools
- Updates to Existing Tools as CMS Releases Information

PDPM Academy Focused on Supporting Members for Transition – Reboot in Fall 2019 for Operations

AHCA Tools and Resources Offer a Deep Dive on PDPM Transition – Compliance

High Risk Topics
- ICD-10 Coding
- Resident Interviews
- Diagnosis- Admission and Subsequent Changes
- Daily Skilled Coverage
- Resource Underutilization
- Interrupted Stay Policy
- Interim Payment Assessment
- Upcoding Risks
- Section GG
- Therapy Access
- Shorten Lengths of Stay
Therapy Delivery Under PDPM Guide

Key Topic Areas

- Overview of PDPM Impact on Therapy Services
  - What is Changing? – What is Staying the Same?
  - High-Risk Therapy-Related Compliance Areas
  - SNF Quality Areas Influenced by Therapy Team

- Applying the AHCA Four Core Competencies for Success Under PDPM to Therapy Services

- Therapy Staffing and Contracting Considerations under PDPM

Measures to watch in LTC Trend Tracker:

- Discharge to Community (AHCA)
- Length of Stay (AHCA)
- SS Improvement in Function, Risk Adjusted (Five Star)
- LS ADL Decline (Five Star)
- LS Worsening Mobility (Five Star)
- Medicare Spending per Beneficiary (QRP)
- Discharge to Community (QRP)
- SS Improvement in Self-Care (AHCA – coming soon!)
- SS Improvement in Mobility (AHCA – coming soon!)
- SS Discharge to Community (Five Star)
- Change in self-care (QRP – coming next year)
- Change in mobility (QRP – coming next year)
- Discharge self-care score (QRP – coming next year)
- Discharge mobility score (QRP – coming next year)
Questions about the contents of this program may be directed to pdpm@ahca.org.

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