

Quality Reporting Program Provider Training



**SKILLED
NURSING
FACILITY**

**QUALITY REPORTING
PROGRAM**

Patient Driven Payment Model: What is Changing (and What is Not)

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May 8, 2019

Objectives

- Describe key aspects of the Patient Driven Payment Model (PDPM).
- Name four things that are changing due to the PDPM.
- Identify three things that are not changing due to PDPM.
- Explain the Resource Utilization Group (RUG)-IV – PDPM Transition.
- Name the two main areas of Medicaid payment affected by PDPM.



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Acronyms in This Presentation

- ABN – Advance Beneficiary Notice
- AI – Assessment Indicator
- ARD – Assessment Reference Date
- CMS – Centers for Medicare & Medicaid Services
- HIPPS – Health Insurance Prospective Payment System
- HIV/AIDS - Human Immunodeficiency Virus/Aquired Immunodeficiency Syndrome
- ICD-10 CM – International Statistical Classification of Diseases and Related Health Problems-10 Clinical Modification



Acronyms in This Presentation (cont. 1)

- IPA – Interim Payment Assessment
- MedPAC – Medicare Payment Advisory Commission
- MDS – Minimum Data Set
- NF – Nursing Facility
- NOMNC – Notice of Medicare Non-Coverage
- NTA – Non-Therapy Ancillary (NTA)
- OIG – Office of the Inspector General
- OT – Occupational Therapy



Acronyms in This Presentation (cont. 2)

- PDPM – Patient Driven Patient Model
- PPS – Prospective Payment System
- PT – Physical Therapy
- RUG – Resource Utilization Group
- SLP – Speech Language Pathology
- SNF – Skilled Nursing Facility
- UPL – Upper Payment Limit
- VPD – Variable Per Diem



Patient Driven Payment Model (PDPM) Overview

PDPM Overview

- Issues with the current case-mix model, the RUG-IV, have been identified by CMS, Office of the Inspector General (OIG), Medicare Payment Advisory Commission (MedPAC), the media, among others.
 - Therapy payments under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) are based primarily on the amount of therapy provided to a patient/resident, regardless of the patient's/resident's unique characteristics, needs or goals.
 - SNF patients/residents who may have significant differences in terms of nursing needs and costs often receive the same payment for nursing services.

PDPM Overview (cont. 1)

- The PDPM represents a marked improvement over RUG-IV for the following reasons:
 - Improves payment accuracy and appropriateness by focusing on the patient/resident, 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 (cont. 2)

- 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 (cont. 3)

Therapy

Therapy Base Rate



Therapy CMI

or

Non-Case-Mix Therapy Base Rate



Nursing

Nursing Base Rate



Nursing CMI



Non-Case-Mix

Non-Case-Mix Base Rate

PDPM Overview (cont. 4)

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

PDPM Overview (cont. 5)

- 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/resident’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 (cont. 6)

PT

PT Base Rate



PT CMI



VPD Adjustment Factor



OT

OT Base Rate



OT CMI



VPD Adjustment Factor



SLP

SLP Base Rate



SLP CMI



NTA

NTA Base Rate



NTA CMI



VPD Adjustment Factor



Nursing

Nursing Base Rate



Nursing CMI



18% Nursing Adjustment Factor
(Only for Patients with AIDS)

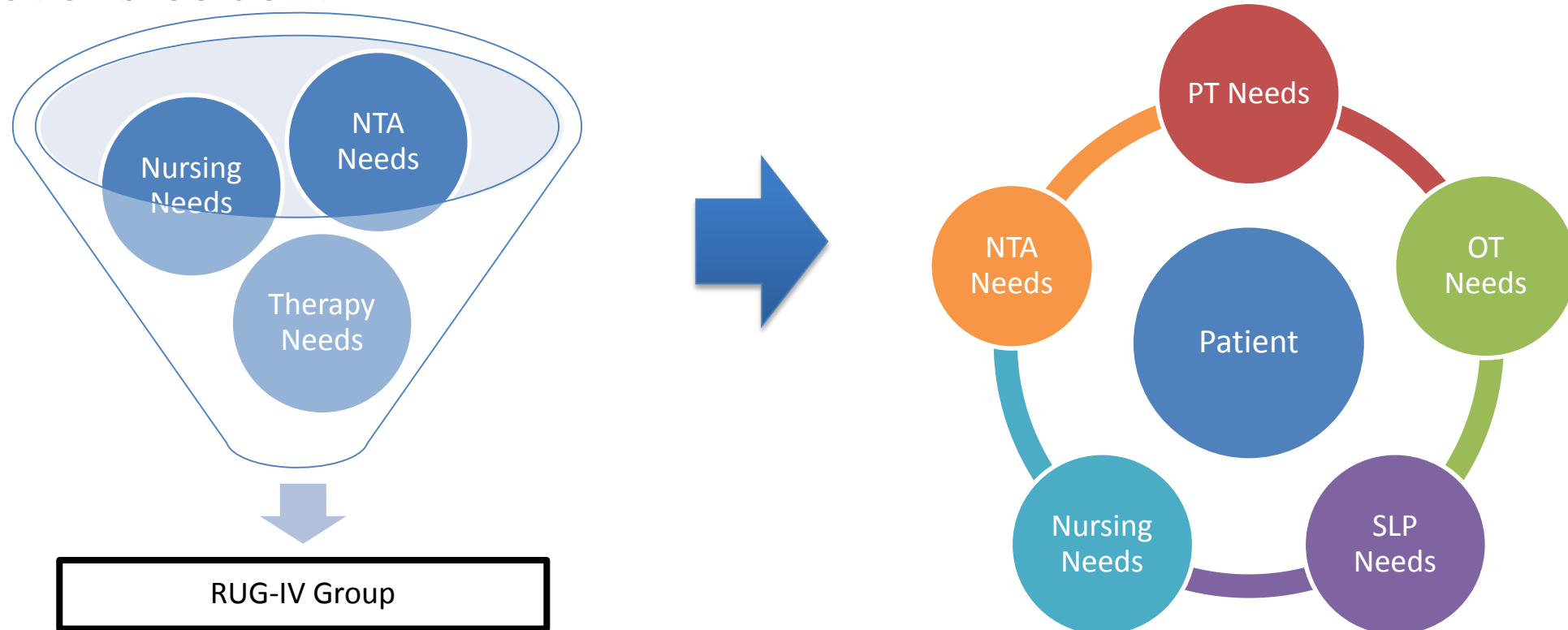


Non-Case-Mix

Non-Case-Mix Base Rate

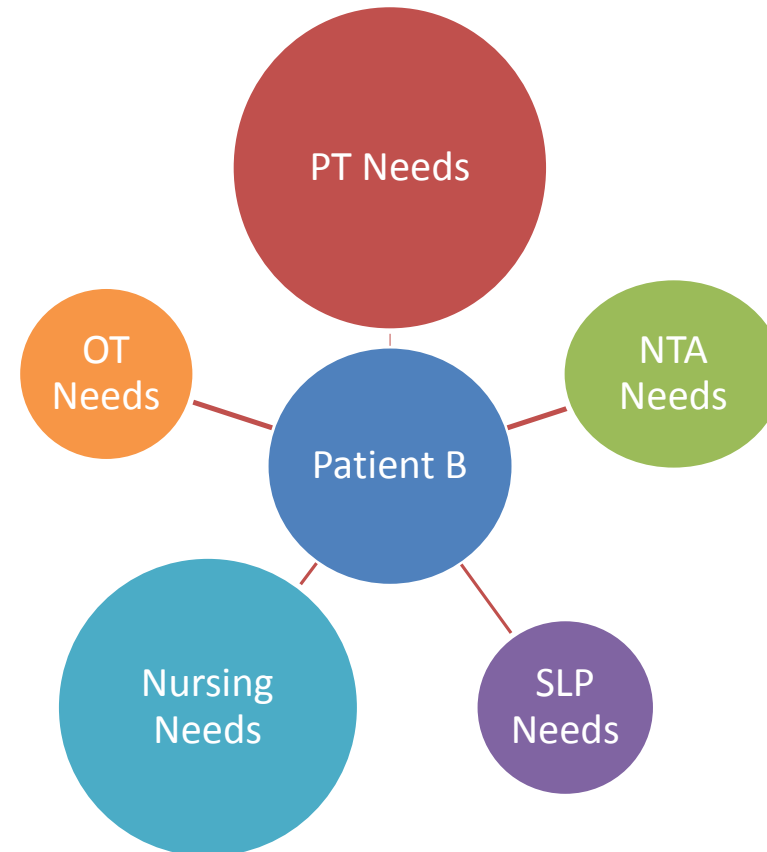
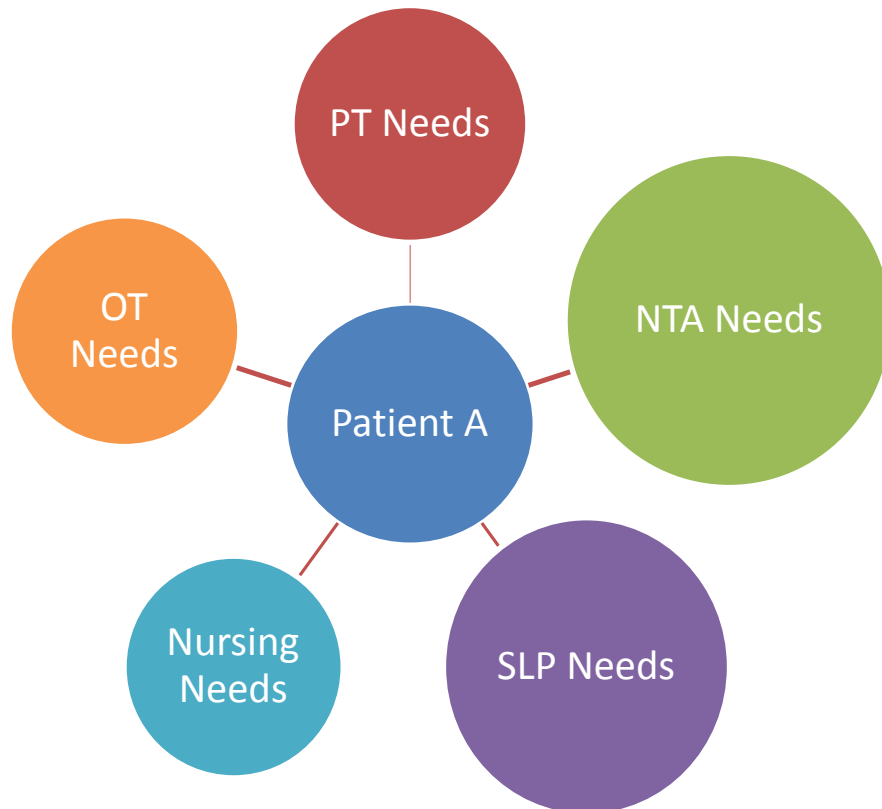
PDPM Overview: Model Snapshot

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



PDPM Overview: Model Snapshot (cont.)

- By addressing each of a patient's unique needs independently, PDPM improves payment accuracy and encourages a more patient-/resident-driven and holistic care model.



Patient/Resident Classification Examples Under RUG-IV and Patient Driven Payment Model (PDPM)

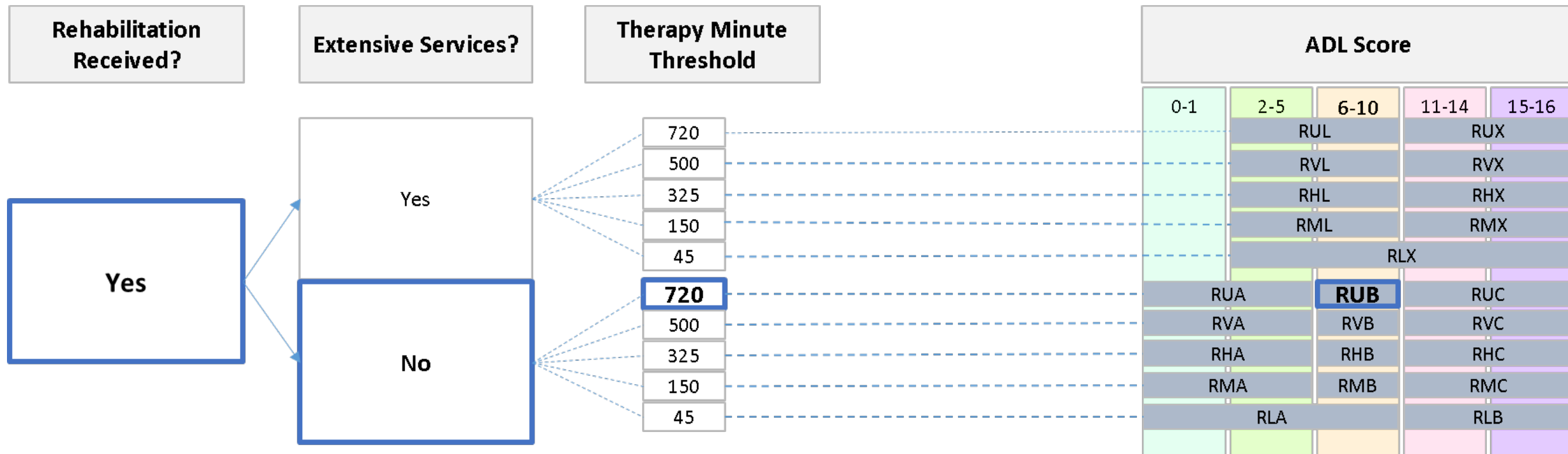
Patient/Resident Classification Example

- Consider two patients/residents with the following characteristics:

Patient Characteristics	Patient A	Patient B
Rehabilitation Received?	Yes	Yes
Therapy Minutes	730	730
Extensive Services	No	No
ADL Score	9	9
Clinical Category	Acute Neurologic	Major Joint Replacement
PT and OT Functional Score	10	10
Nursing Function Score	7	7
Cognitive Impairment	Moderate	Intact
Swallowing Disorder?	No	No
Mechanically Altered Diet?	Yes	No
SLP Comorbidity?	No	No
Comorbidity Score	7 (IV Medication and Diabetes)	1 (Chronic Pancreatitis)
Other Conditions	Dialysis	Septicemia
Depression?	No	Yes

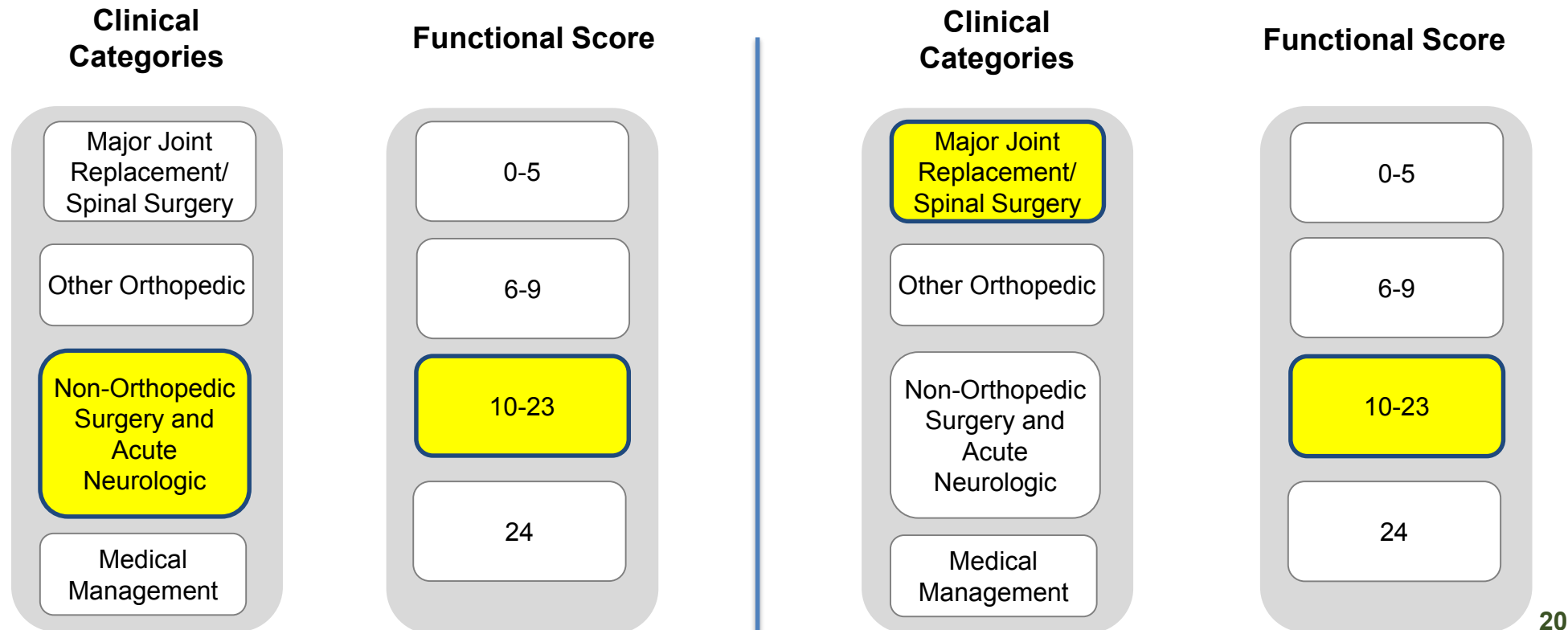
RUG-IV Classification

- Under the RUG-IV model, both patients/residents would be classified into the same RUG-IV group because they received the same number of therapy minutes and received no extensive services, despite significant differences between them.



PDPM Classification: PT and OT Components

- Patient/Resident A (left) is classified into Acute Neurologic with a functional score of 10. Resident B (right) is classified into Major Joint Replacement/Spinal Surgery with a functional score of 10.



PDPM Classification: SLP Component

- Patient/Resident A (left) is classified into Acute Neurologic, has moderate cognitive impairment and is on a mechanically-altered diet. Patient/Resident B (right) is classified into non-neurologic with no SLP-classification related issue.

Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment

None

Any One

Any Two

All Three

Mechanically-Altered Diet or Swallowing Disorder

Neither

Either

Both

Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment

None

Any One

Any Two

All Three

Mechanically-Altered Diet or Swallowing Disorder

Neither

Either

Both

PDPM Classification: NTA Component

- Patient/Resident A (left) has a comorbidity score of 7 from IV medication (5 points) and diabetes mellitus (2 points). Patient/Resident B (right) has a comorbidity score of 1 from chronic pancreatitis (1 point).

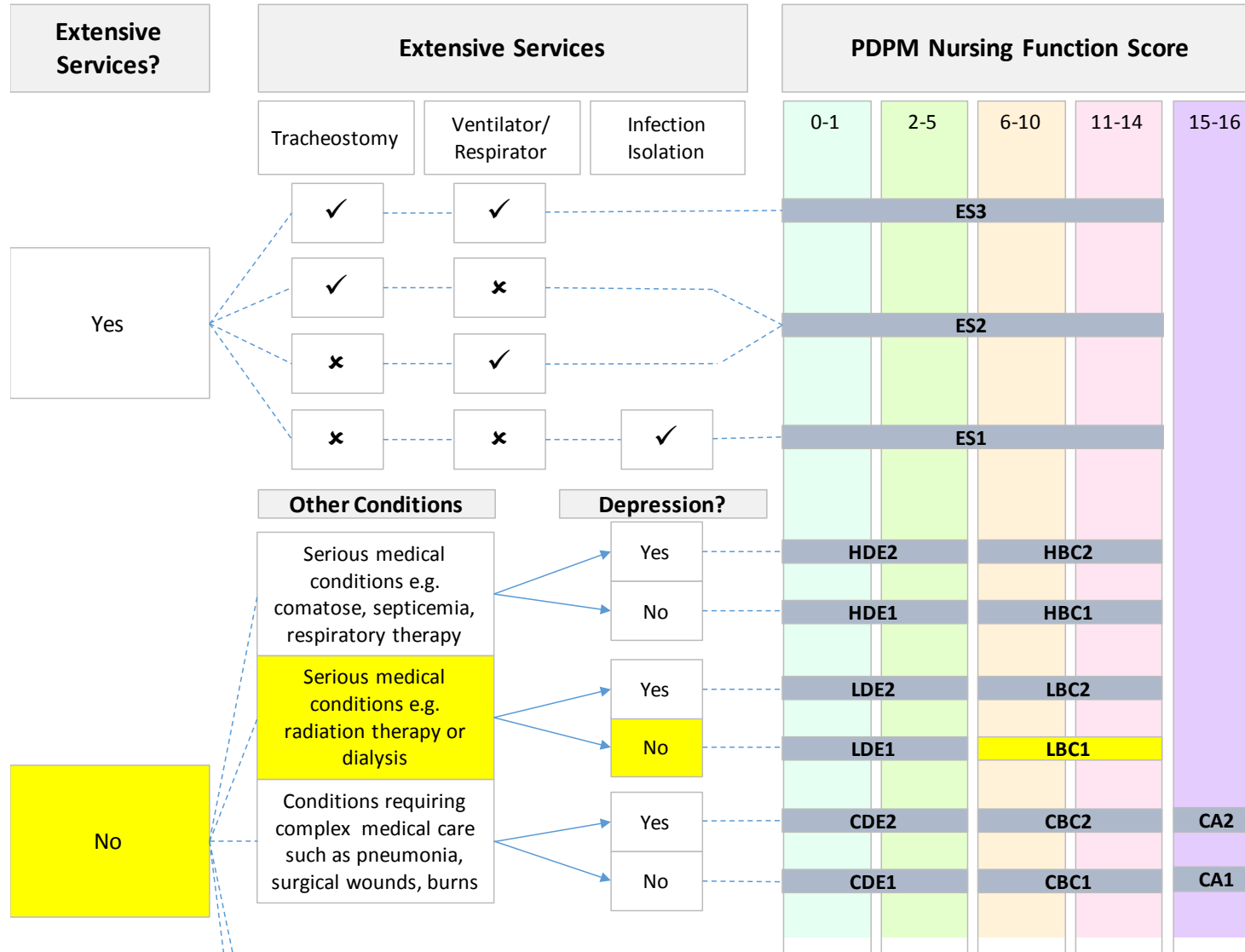
NTA Comorbidity Score

0	6-8
1-2	9-11
3-5	12+

NTA Comorbidity Score

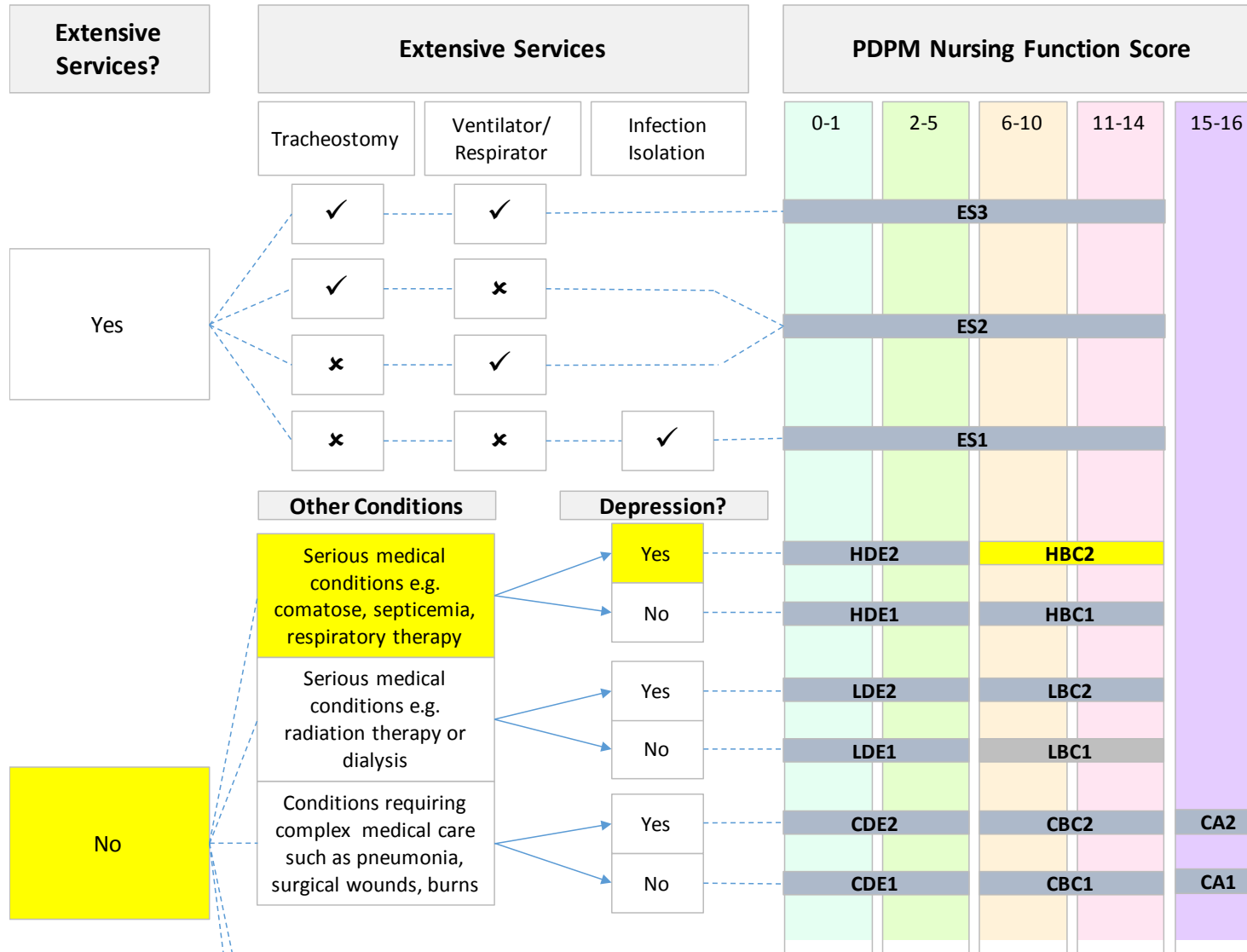
0	6-8
1-2	9-11
3-5	12+

PDPM Classification: Nursing Component



- Patient/Resident A is receiving dialysis services with a nursing function score of 7. Patient/Resident A is classified into LBC1.

PDPM Classification: Nursing Component (cont.)



- Patient/Resident B has septicemia, a nursing function score of 7 and exhibits signs of depression. Patient/Resident B is classified into HBC2.

What the Patient Driven Payment Model (PDPM) Does Change

What PDPM Does Change

- PDPM represents the single largest change to the SNF PPS since its inception, with impacts on patient/resident 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.



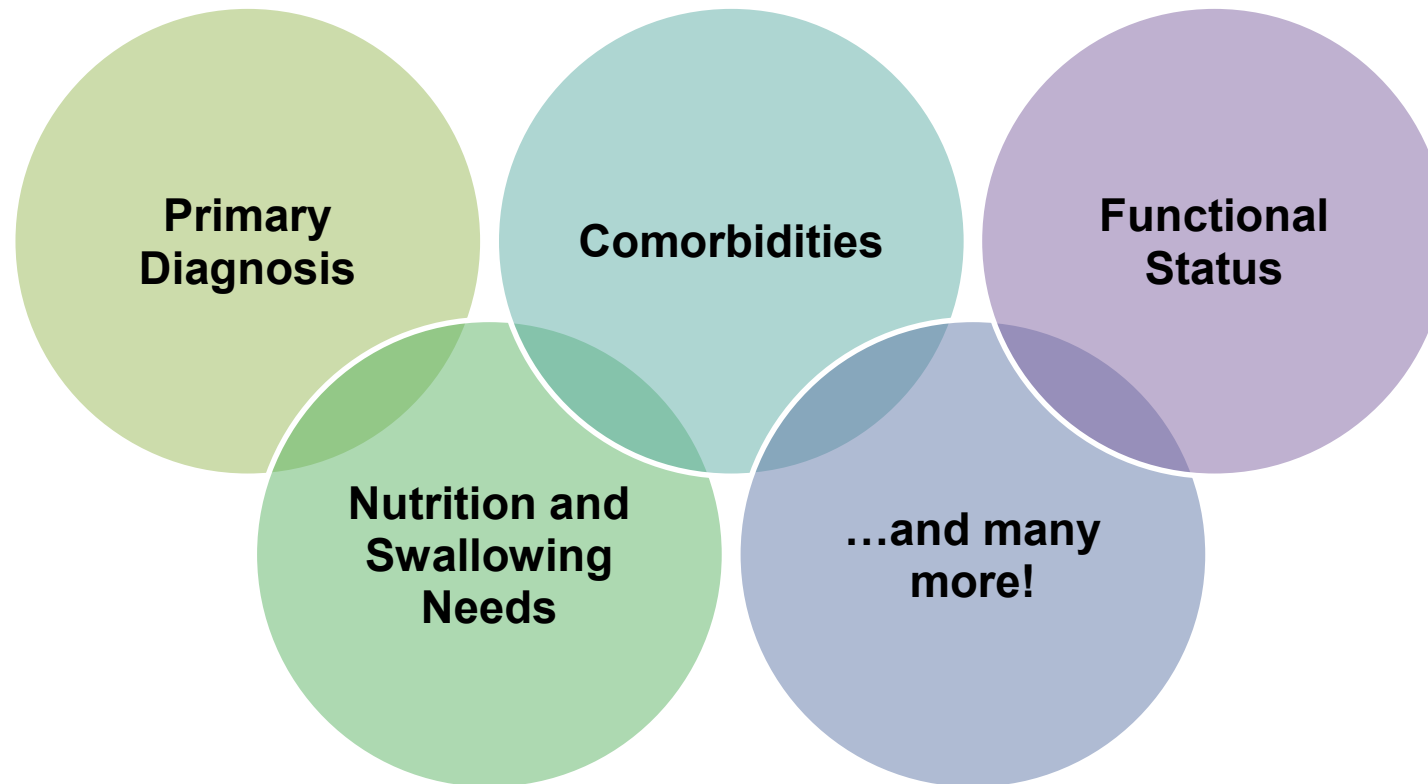
Payment Classification Data

Payment Classification Data

- While both RUG-IV and PDPM utilize the MDS as the basis for patient/resident classification, the data elements used are quite different.
- For over 90 percent of the days billed under RUG-IV, the only two patient/resident characteristics relevant for payment purposes are the patient's/resident's functional status and how much therapy the patient/resident received.
 - These elements tell us very little about the actual patient/resident and more about the services the facility furnished to the patient/resident.

Payment Classification Data (cont. 1)

- For every day billed under PDPM, the patient/resident characteristics relevant for payment purposes are also those relevant for care planning purposes:



Variable Per Diem (VPD) Adjustment

VPD Adjustment

- The Social Security Act requires that the SNF PPS pay on a per-diem basis.
- Constant per diem rates do not accurately reflect changes in resource utilization throughout the stay and may allocate too few resources for providers at beginning of stay.
- To more accurately account for the variability in patient/resident costs over the course of a stay, under PDPM, an adjustment factor is applied (for certain components) that changes the per diem rate over the course of the stay.
 - Similar to what exists under the Inpatient Psychiatric Facility PPS.

VPD Adjustment (cont.)

- PT and OT Components

Day in Stay	Adjustment Factor	Day in Stay	Adjustment Factor
1-20	1.00	63-69	0.86
21-27	0.98	70-76	0.84
28-34	0.96	77-83	0.82
35-41	0.94	84-90	0.80
42-48	0.92	91-97	0.78
49-55	0.90	98-100	0.76
56-62	0.88		

- NTA Component

Day in Stay	Adjustment Factor
1-3	3.00
4-100	1.00

Emphasis of Care

Emphasis of Care

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

Payment for SNF Patients/Residents with HIV/AIDS

PDPM Payment for SNF Patients/Residents with HIV/AIDS

- As PDPM was developed, the rate components were specifically designed to account accurately and appropriately for the increased cost of AIDS-related care, as determined through our research.
- Accordingly, the PDPM addresses costs for this subpopulation in two ways:
 - Assigns those patients/residents with AIDS the highest point value (8 points) of any condition or service for purposes of classification under its NTA component.
 - An 18% add-on to the PDPM nursing component. As under the previous RUG-IV model

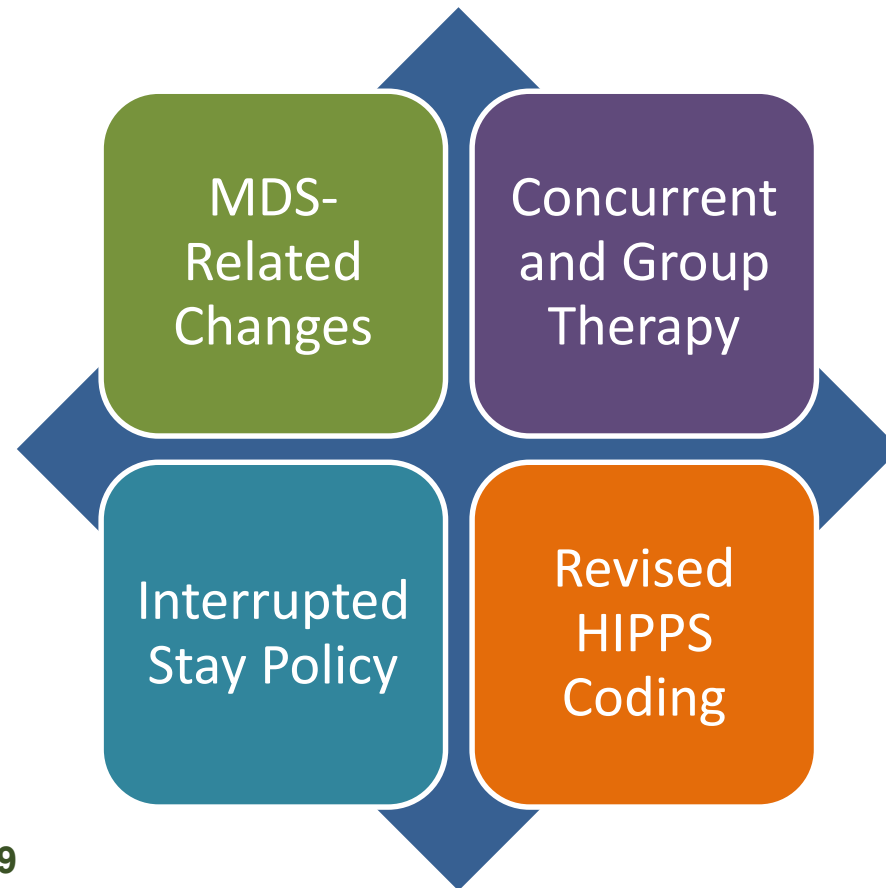
PDPM Payment for SNF Patients/Residents with HIV/AIDS

- As under the previous RUG-IV mode, the presence of an AIDS diagnosis continues to be identified through the SNF's entry of International Statistical Classification of Diseases and Related Health Problems-10 Clinical Modification (ICD-10-CM) code B20 on the SNF claim.
 - Providers may report AIDS diagnoses on the MDS, as permitted by their state laws, but only the presence of this diagnosis on the claim is sufficient for the patient's/resident's per diem rate to be adjusted accordingly.

Additional Patient Driven Payment Model (PDPM) - Related Changes

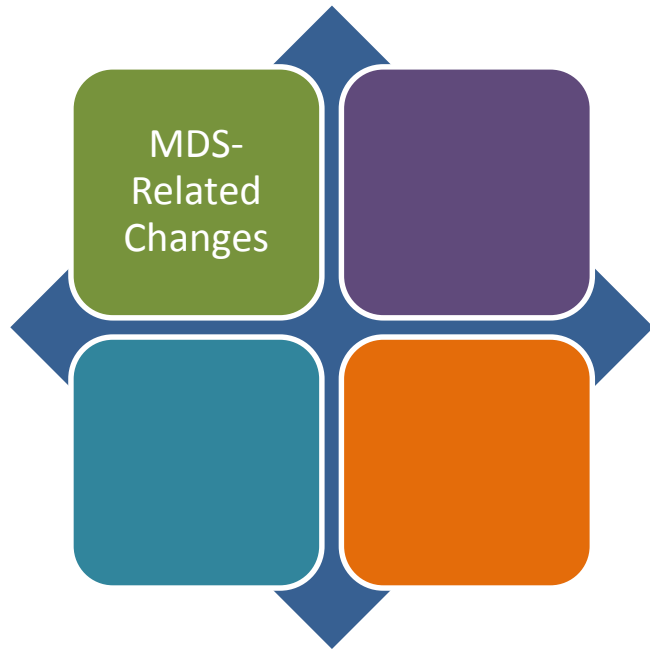
Additional PDPM-Related Policies

- In addition to the case-mix refinements, PDPM also includes additional policy changes to the SNF PPS to be effective concurrent with implementation of PDPM.



MDS-Related Changes

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/resident care and more on meeting administrative requirements.

PPS Assessments (cont. 1)

- 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/residents 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.



Assessment Schedule Under RUG-IV

Scheduled PPS assessments			
Medicare MDS assessment schedule type	Assessment reference date	Assessment reference date grace days	Applicable standard Medicare payment days
5-day	Days 1-5	6-8	1 through 14
14-day	Days 13-14	15-18	15 through 30
30-day	Days 27-29	30-33	31 through 60
60-day	Days 57-59	60-63	61 through 90
90-day	Days 87-89	90-93	91 through 100
Unscheduled PPS assessments			
Start of Therapy OMRA	5-7 days after the start of therapy	Date of the first day of therapy through the end of the standard payment period.	
End of Therapy OMRA	1-3 days after all therapy has ended	First non-therapy day through the end of the standard payment period.	
Change of Therapy OMRA	Day 7 (last day) of the COT observation period	The first day of the COT observation period until end of standard payment period, or until interrupted by the next COT-OMRA assessment or scheduled or unscheduled PPS Assessment.	
Significant Change in Status Assessment	No later than 14 days after significant change identified	ARD of Assessment through the end of the standard payment period.	

Assessment Schedule Under PDPM

Medicare MDS assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
5-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed).
Interim Payment Assessment (IPA)	Optional Assessment	ARD of the assessment through Part A discharge (unless another IPA assessment is completed).
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A.

New Item Sets: Interim Payment Assessment (IPA)

- Optional Assessment: May be completed by providers in order to report a change in the patient's PDPM classification.
 - Does not impact the variable per diem schedule.
 - ARD determined by the provider.
 - Payment Impact: Changes payment beginning on the ARD and continues until the end of the Part A stay or until another IPA is completed.

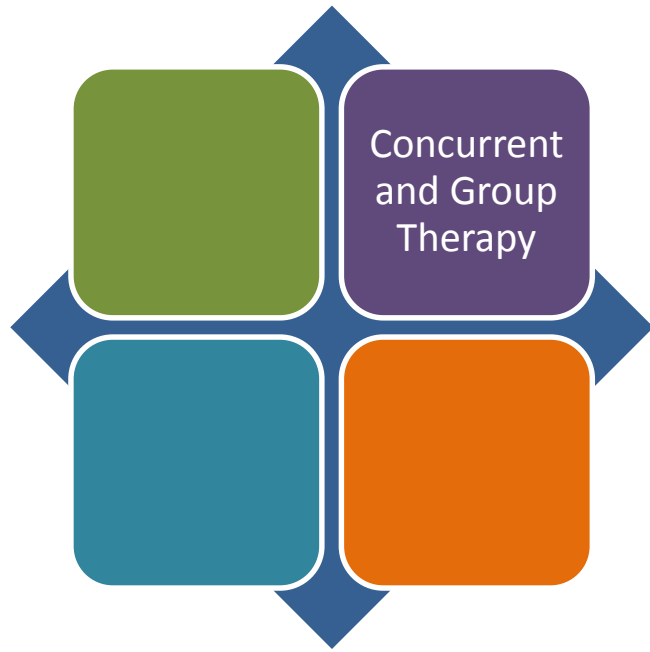
New Item Sets: Optional State Assessment (OSA)

- Solely to be used by providers to report on Medicaid-covered stays, per requirements set forth by the state.
- Allows providers in states that use either the RUG-III or RUG-IV models as the basis for Medicaid payment to continue to do so.



Concurrent and Group Therapy Limits

Concurrent and Group Therapy Limits



- Under RUG-IV, no more than 25 percent of the therapy services delivered to SNF patients/residents, for each discipline, may be provided in a group therapy setting, while there is no limit on concurrent therapy.
- Definitions:
 - Concurrent therapy: One therapist with two patients/residents doing different activities.
 - Group therapy: One therapist with four patients/residents doing the same or similar activities.

Concurrent and Group Therapy Limits (cont. 1)

- Under PDPM, we use a combined limit *both* concurrent and group therapy to be no more than 25 percent of the therapy received by SNF patients/residents, for each therapy discipline.
- Compliance with the concurrent/group therapy limit will be monitored by new items on the PPS Discharge Assessment:
 - Providers will report the number of minutes, per mode and per discipline, for the entirety of the PPS stay.
 - If the total number of concurrent and group minutes, combined, comprises more than 25 percent of the total therapy minutes provided to the patient/resident, for any therapy discipline, then the provider will receive a warning message on their final validation report.

Concurrent and Group Therapy Limits (cont. 1)

- How to calculate compliance with the concurrent/group therapy limit:
 - Step 1: Total Therapy Minutes, by discipline,
(O0425X1 + O0425X2 + O0425X3).
 - Step 2: Total Concurrent and Group Therapy Minutes, by discipline,
(O0425X2 + O0425X3).
 - Step 3: C/G Ratio (Step 2 result/Step 1 result).
 - Step 4: If Step 3 result is greater than 0.25, then non-compliant.

Concurrent and Group Therapy Limits Examples

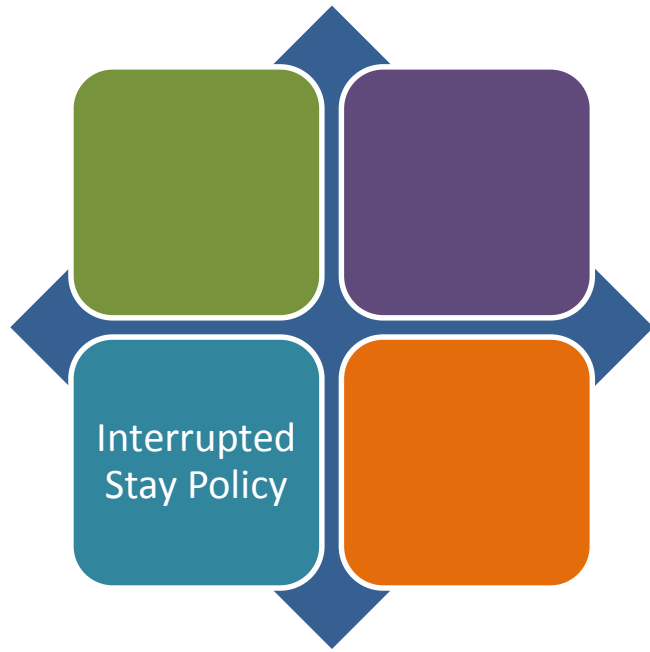
- Example 1:
 - Total PT Individual Minutes (O0425C1): 2,000.
 - Total PT Concurrent Minutes (O0425C2): 600.
 - Total PT Group Minutes (O0425C3): 1,000.
- Does this comply with the concurrent/group therapy limit?
 - Step 1: Total PT Minutes (O0425C1 + O0425C2 + O0425C3): 3,600.
 - Step 2: Total PT Concurrent and Group Therapy Minutes (O0425C2 + O0425C3): 1,600.
 - Step 3: C/G Ratio (Step 2 result/Step 1 result): 0.44
 - Step 4: 0.44 is greater than 0.25, therefore this is non-compliant.

Concurrent and Group Therapy Limits Examples (cont.)

- Example 2:
 - Total SLP Individual Minutes (O0425C1): 1,200.
 - Total SLP Concurrent Minutes (O0425C2): 100.
 - Total SLP Group Minutes (O0425C3): 200.
- Does this comply with the concurrent/group therapy limit?
 - Step 1: Total SLP Minutes (O0425C1 + O0425C2 + O0425C3): 1,500.
 - Step 2: Total PT Concurrent and Group Therapy Minutes (O0425C2 + O0425C3): 300.
 - Step 3: C/G Ratio (Step 2 result/Step 1 result): 0.20.
 - Step 4: 0.20 is not greater than 0.25, therefore this is compliant.

Interrupted Stay

Interrupted Stay



- Under RUG-IV, each time a SNF patient/resident is discharged from a Part A-covered stay (leaves the facility, drops below skilled coverage, etc.), and returns to a Part A-covered stay, the provider must treat each admission as a new SNF admission.
- Due to the incentives created as a result of the variable per diem, PDPM introduces to the SNF PPS an “Interrupted Stay” policy.

Interrupted Stay (cont. 1)

- If a patient/resident is discharged from a SNF and readmitted to the same SNF no later than 11:59 p.m. of the third consecutive calendar day after having left Part A coverage, then the subsequent stay is considered a continuation of the previous stay:
 - Three-day window referred to as the “interruption window.”
- An interrupted stay has an effect on the patient’s/resident’s assessment schedule and variable per diem schedule.
 - Assessment schedule continues from the point just prior to discharge.
 - Variable per diem schedule continues from the point just prior to discharge.

Interrupted Stay (cont. 2)

- If a patient/resident is discharged from SNF and readmitted outside the interruption window, or admitted to a different SNF, then the subsequent stay is considered a new stay:
 - Assessment schedule and variable per diem schedule resets to day 1.
 - This policy applies not only in instances when a patient/resident physically leaves the facility, but also in cases when the patient/resident remains in the facility but is discharged from a Medicare Part-A covered stay.
 - Example: If a patient/resident in a SNF-stay remains in the facility under a Medicaid-covered stay, but returns to skilled care within the interruption window.

Interrupted Stay: Examples

- Example 1: Patient/Resident A is admitted to the SNF on 11/07/19, admitted to the hospital on 11/20/19 and returns to the same SNF on 11/25/19.
 - New stay.
 - Assessment schedule: Reset; stay begins with a new 5-day assessment.
 - Variable Per Diem: Reset: stay begins on Day 1 of the VPD schedule.
- Example 2: Patient/Resident B is admitted to the SNF on 11/07/19, admitted to the hospital on 11/20/19 and admitted to a different SNF on 11/22/19.
 - New stay.
 - Assessment schedule: Reset; stay begins with a new 5-day assessment.
 - Variable Per Diem: Reset; stay begins on Day 1 of the VPD schedule.

Interrupted Stay: Examples (cont. 1)

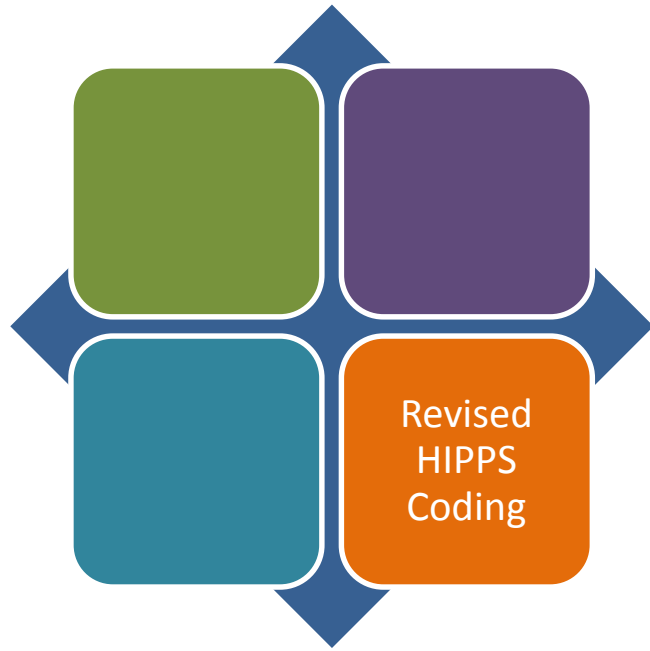
- Example 3: Patient/Resident C is admitted to the SNF on 11/07/19, admitted to a hospital on 11/20/19 and returns to the same SNF on 11/22/19.
 - Continuation of previous stay.
 - Assessment schedule: No PPS assessments required, IPA optional.
 - Variable Per Diem: Continues from Day 14 (Day of Discharge).

Interrupted Stay: Examples (cont. 2)

- Example 4: Patient/Resident D is admitted to SNF on 11/07/2019. The patient/resident remains in the facility, but is discharged from Part A on 11/20/19. The patient/resident returns to a Part-A covered stay on 11/22/19.
 - Continuation of previous stay.
 - Assessment Schedule: No PPS assessments required, IPA optional.
 - Variable Per Diem: Continues from Day 14 (Day of Part A Discharge).

Health Insurance Prospective Payment System (HIPPS) Coding

PDPM HIPPS Coding



- The current RUG-IV HIPPS code follows a prescribed algorithm:
 - Character 1-3: RUG code.
 - Character 4-5: Assessment Indicator (AI) Code.
- In order to accommodate the new payment groups, the PDPM HIPPS algorithm is revised as follows:
 - Character 1: PT/OT Payment Group.
 - Character 2: SLP Payment Group.
 - Character 3: Nursing Payment Group.
 - Character 4: NTA Payment Group.
 - Character 5: AI Code.

HIPPS Coding – Default Billing

- PDPM HIPPS – Default Billing:
 - As under RUG-IV, there may be instances in which providers may bill the “default” rate on a SNF claim (e.g., when an MDS assessment is considered late).
 - The default rate refers to the lowest possible per diem rate.
- The default code under PDPM is ZZZZZ, as compared to the default code under RUG-IV of AAA00.

Medical Review and Data Monitoring

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/resident is reasonable, necessary and individualized based on the patient's/resident's unique condition.



Medical Review and Data Monitoring (cont. 1)

- 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/resident's primary diagnosis is a major joint replacement, then the reviewer should be able to verify that the patient/resident received a major joint replacement.

Medical Review and Data Monitoring (cont. 2)

- 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/residents under PDPM, as compared to RUG-IV, or the manner in which it is delivered, may trigger additional program reviews and potential policy changes.

Payment/Quality Alignment

Payment/Quality Alignment

- CMS measures the quality of care provided to SNF patients/residents 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.



Payment/Quality Alignment (cont.)

- 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/resident 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 the Patient Driven Payment Model (PDPM) Does Not Change

What PDPM Does Not Change

- Despite the significant changes occurring under PDPM SNF PPS policies remain unchanged under PDPM:
 - Basic administrative processes under SNF PPS.
 - Wage index calculations.
 - Payment and policy associated with therapy evaluations.
 - Denial notice policies, Advance Beneficiary Notices (ABNs), Notices of Medicare Non-Coverage (NOMNCs).
 - Student supervision policies.
- There are three particular areas that remain unchanged under PDPM that are of particular note.



What is Covered

What is 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 service, required on a daily basis, and be reasonable and necessary for the treatment of a patient's/resident's particular illness or injury, based on the individual's particular medical needs, and accepted standards of medical practice.

What You Should Document

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/resident's illness or injury, i.e., consistent with...the individual's particular medical needs.



What You Should Document (cont.)

- 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.
- PDPM does not change these documentation requirements, but rather strengthens the importance of documenting all aspects of a patient's/resident'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 Your Patient/Resident Needs

What Your Patient/Resident Needs

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

What Your Patient/Resident Needs (cont.)

- 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 – Patient Driven Payment Model (PDPM) Transition

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 (cont. 1)

- 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/resident 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 (cont. 2)

- For patients/residents 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 /resident 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/resident's stay begins on or after October 1, 2019, then the provider would begin with the 5-day assessment, as usual.

Patient Driven Payment Model (PDPM) and Medicaid

PDPM and 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 and Medicaid (cont. 1)

- 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.

PDPM and Medicaid (cont. 2)

- 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/resident status, consistent with their case-mix rules.

PDPM and Medicaid (cont. 3)

- With PDPM implementation, CMS will continue to provide technical support for legacy payment models, such as RUG-III and RUG-IV, through continued support of the OSA.
- 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.

Patient Driven Payment Model (PDPM) Resources

PDPM Resources

- PDPM website: <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



Summary



- In this lesson you learned:
 - Key aspects of the PDPM.
 - Things that are changing and not changing due to the PDPM.
 - That there is no transition period between RUG-IV and PDPM.
 - That there are two main areas of Medicaid payment affected by PDPM.

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Questions?



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