+GPM CORP

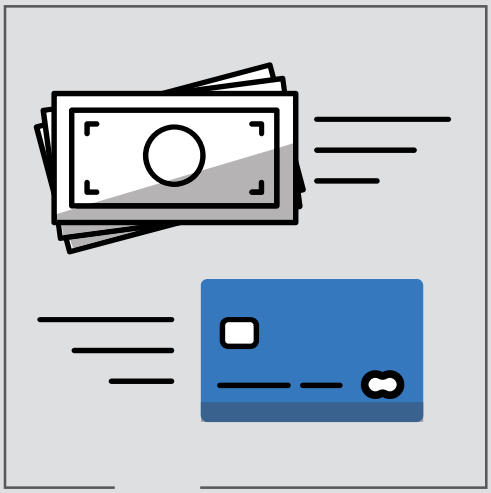
Understanding the Impact of PDPM

Providing Solutions beyond the Free Calculator

PDPM

The Patient Driven Payment Model (PDPM) goes into effect on October 1st, and many providers still aren't fully prepared. At the same time, many practitioners working in skilled nursing facility (SNF) settings don't have it on their radar.

On March 26th, GPM hosted a webinar to bring both audiences up to date on this new model. Read on to learn about this significant change in how facilities are paid for care and services, as well as how they interact with clinicians.



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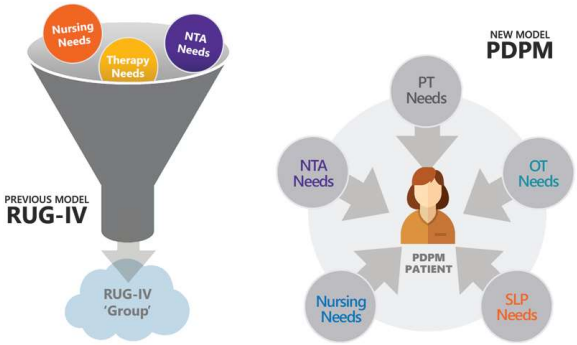
BACKGROUND

The new reimbursement model for Skilled Nursing Facilities

PDPM replaces therapy minutes, as the de facto basis for payment, with resident classifications and expected resource needs. In other words, therapy hours will no longer drive reimbursement (as they do under RUG-IV, the current reimbursement system). The purpose of PDPM is to refocus care on changes to patient complexity while shifting away from volume benchmarks as reimbursement drivers.



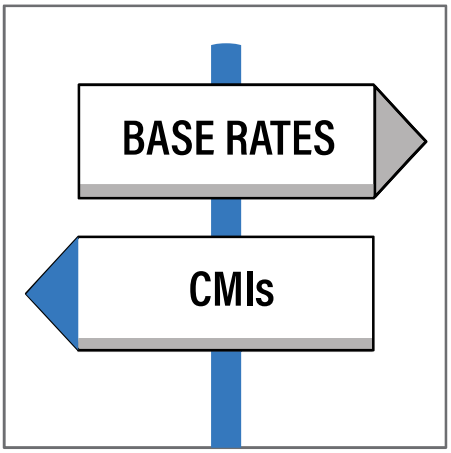
PDPM's five case-mix-adjusted payment components are a utilization of:

1. **Physical Therapy**
2. **Occupational Therapy**
3. **Speech-Language Pathology services**
4. **Nursing and social services**
5. **Non-Therapy Ancillary services**

At the same time, PDPM maintains the existing non-case-mix components to cover utilization of SNF resources that do not vary according to characteristics:

- **Physical Therapy**
- **Nursing**
- **Speech-Language Pathology**
- **Non-Therapy Ancillary services**
- **Occupational Therapy**

Much like the current RUG-IV model, per-diem payment under PDPM will be determined by two primary factors: **Base rates** that correspond to each component of payment and **Case-Mix Indexes** (CMIs) that correspond to each payment group.



Every resident will be classified into a group for each of the five case-mix-adjusted components. The base rate for each component then is multiplied by the CMI corresponding to the assigned resident group.

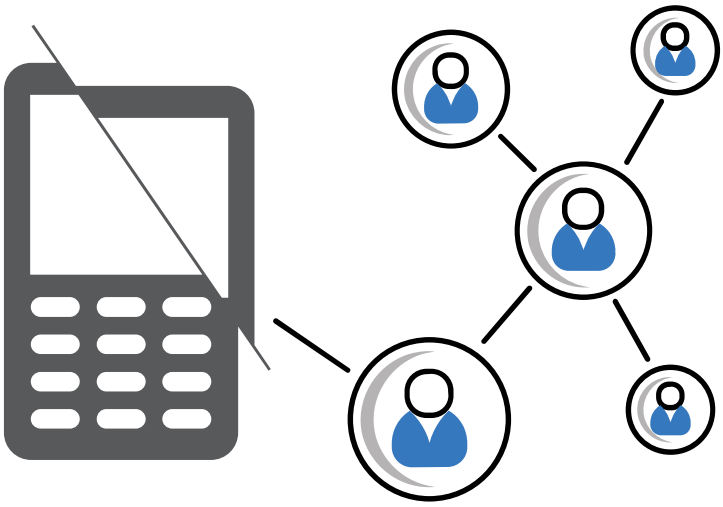
Under RUG-IV, SNFs are required to complete scheduled assessments on or around days 5, 14, 30, 60, and 90 of a patient's Part A SNF stay. Under PDPM, there are three Prospective Payment Systems (PPS) assessments: the 5-day assessment, the interim payment assessment (IPA), and the PPS discharge assessment. The 5-day and discharge assessments are required. The IPA is optional and should be completed when providers determine that the patient has experienced a significant clinical change that would justify a new PPS assessment.

When CMS first introduced the PDPM model, the agency highlighted fraud reduction as a driving factor.

Specifically, CMS suggested that PDPM will eliminate fraud by linking therapy reimbursement to resident needs and not hours. As a result, the agency suggested that more Medicare dollars will go to higher-acuity patients with higher-level health needs, i.e., those "sicker and quicker" patients coming to skilled nursing homes from acute care settings for care and rehabilitation.

This new model will require greater teamwork and communication between clinicians and practitioners.

INTRODUCTION



From 'Broken Phone' to 'Conference Calls'

In many ways, the patient's movement through the care continuum over the years is comparable to the old child's game of "telephone," where the message whispered by the first child in the group is very different from the message the last one heard.

Facilities and practitioners are often working in siloes with different rules, forms, definitions, and technology. As a result, communication is often interrupted, misunderstood, or non-existent.

Under PDPM clinicians and providers will need detailed, complete, and current information from the hospital for accurate diagnoses. Communication within the team must improve fundamentally; all staff, including physicians, will need to be educated about changes in reimbursement. Everyone needs to start considering *now* what they will do on October 1st.

Since diagnostic complexity is the driver for facility reimbursement, it is essential to have clinical programs in place that focus care and treatment for patients in the SNF on these clinically-complex problems and then ensure that at discharge to home (or other setting), there are services in place to keep them stable.

The PDPM Process

An admissions nurse performs the initial MDS assessment and submits the proposed primary diagnoses to an attending physician. As it stands currently, this process is manual; it creates periods of unnecessary waiting.

This presents an opportunity to optimize how your team completes the PDPM process. The facility can use an application such as **Care**Team to perform the MDS assessment. The tools inside of this platform use practioners' ICD-10 documentation and encounter information to mine data and identify triggers that are relevant for the initial assessment, as well as for future IPAs. Once the facility has completed the needed items on their end, the clinician can be notified electronically through CareNote. This an easy to use real time communication and collaboration platform designed specifically for Skilled Nursing Facilities. Once notified, the clinician can then use an EHR platform such as GEHRIMED to admit encounters and finalize diagnostic coding, all of which is sent with the encounter documentation back to the facility - no waiting.

The changes outlined in PDPM are complex and not easy to master. They alter the admissions process, making the MDS coordinator more critical than ever. For facility staff unfamiliar with diagnosing, understanding the vastness and complexity of ICD-10 codes is challenging. At the same time, it is important to capture as much clinical data as possible prior to the 5-day assessment. There is the subsequent need to recognize ongoing clinical changes that may warrant a new diagnosis; trying to devise one based on their observations isn't sufficient for an IPA.

> An IPA requires a change in condition that must be supported by the clinical care for the patient and not just the fact that a particular diagnosis was missed earlier. We believe this must be supported by a practitioner's documentation, using a written order or, preferably, an encounter note.

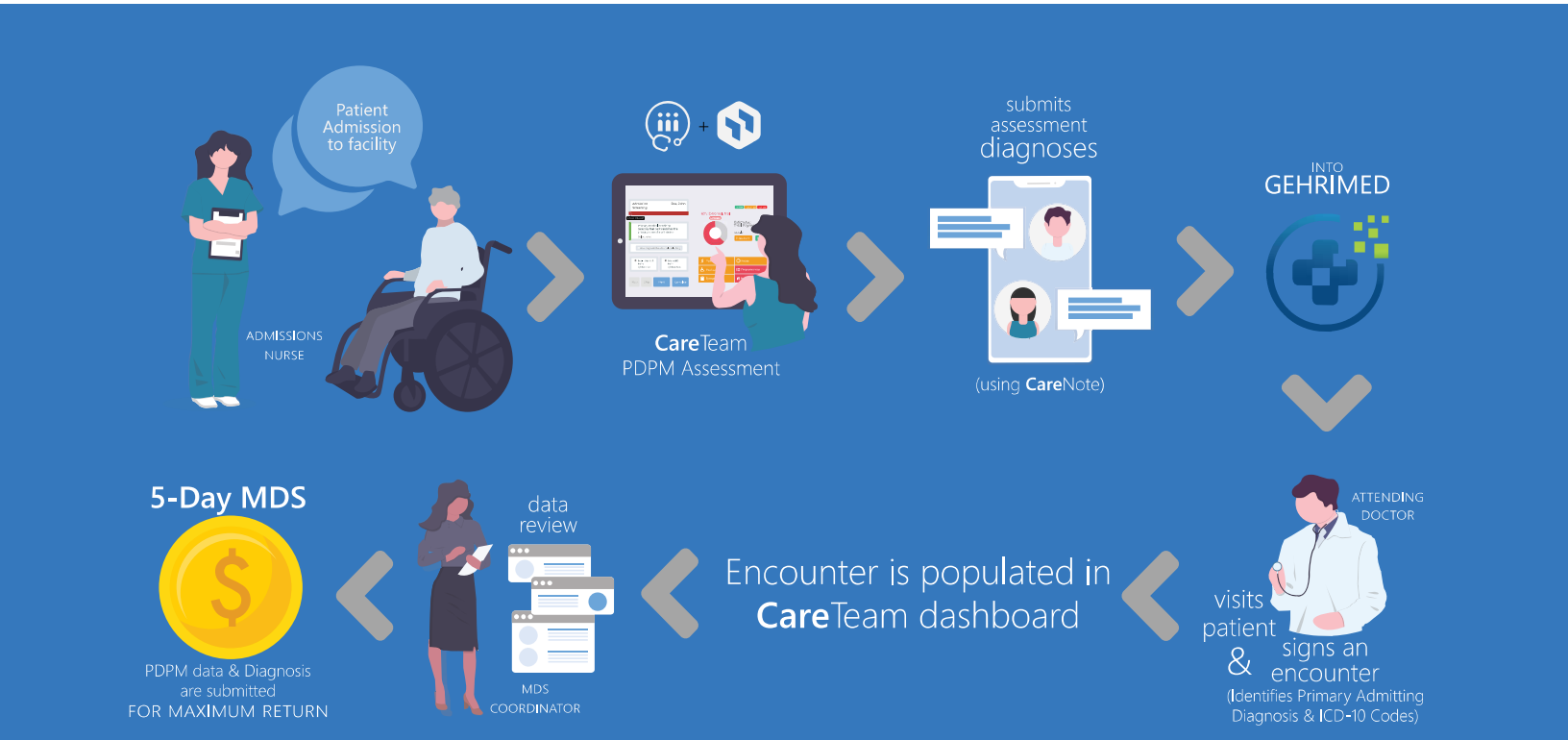
THE DO's & DONT's of PDPM

It is important not to make assumptions or look for shortcuts around the requirements of PDPM. There are 68,000 different ICD-10 codes, making it virtually impossible to train an ICD-10 coder in the next six months. ICD-10 software acts as a reference database; not designed to assist with increasing revenues or identifying which algorithms to use. There are many downstream components in determining PDPM score that neither coders nor software can address adequately. Investing in coders or ICD-10 software is not the path to PDPM success.

Chasing clinical complexity is another ill-advised tactic. Just taking on more clinically complex patients may not necessarily result in higher reimbursements, particularly if this effort isn't supported by increased investment in staff development and training. Failure to do this and to develop effective programs could result in poorer outcomes (such as readmissions, decreases in 5-star ratings, survey citations, and even lawsuits), higher costs, and, ultimately, lower reimbursement. Some facilities may be considering eliminating MDS coordinators. However, as stated earlier, this role will take on greater importance under PDPM, and the integrity of MDS data is key. Facilities must track 161 MDS item fields that affect reimbursement. This is an area where saving a few dollars on salaries could cost the facility tremendously in terms of reimbursement.

While therapy won't be the driver for reimbursement under PDPM, this doesn't mean that facilities can cut their therapy (physical and occupational therapy) staff. A growing number of patients are coming to SNFs for post-acute care, and this means the ongoing need for rehabilitation and therapy services. In fact, facilities may lose admissions if they can't provide adequate therapy services. PDPM simply means that delivering therapy minutes isn't a direct reimbursement rate factor.

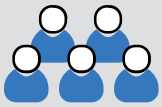
Finally, while a focus on decreasing lengths of stay may seem like a cost-cutting measure, this can create a cascade of negative impacts, including patient complaints and dissatisfaction, census problems (empty beds), lower performance on claims-based quality measures, and poor outcomes such as preventable readmissions.



In preparing for PDPM, the most important component is interdisciplinary team (IDT) collaboration. The entire care team, including attending physicians, their NP/PA colleagues, and the medical director, must be able to analyze the complexity of patients they are bringing into the facility, determine how much reimbursement is tied to them, and measure this against costs (including staffing medical supplies, medications, labs, etc).

It will be essential to focus on the patient complexity coding that will accurately drive reimbursement. Missing codes can lead to incorrectly categorizing the patient and result in lower reimbursement. One major challenge for SNF providers is that information (from the hospital) on admission may not be present in the fullest capacity, and this may impact coding. Therefore, collecting accurate data and making an appropriate clinical diagnosis on admission is essential. To ensure this, all disciplines must contribute, collaborate, and be aware of the timeline for comprehensive assessment and documentation. Team leaders should stay on top of the data:

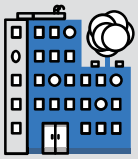
Analyze recent admissions & assess PDPM impact.



Understand staffing levels

Know lengths of stay

Track 5-star quality measures



Know ED admission and 30-day readmission numbers

Filling Technology Gaps

It is not enough to collect data, and EHRs alone are only as effective as the information entered into them. Facilities and practitioners need a process or tool to enable communication across disciplines involved in PDPM to encourage and enable everyone to collaborate and work together. Patient Pattern created an innovative Impact Report that is delivered through CareTeam. This is specifically designed to capture, track, and share data that will promote communication, collaboration, and, ultimately, PDPM success.

The Impact Report uses a facility's MDS data from the past year. Completely automated, it looks at all different components of medical necessity (what the facility is billing for, non-therapy ancillaries, etc.), and identifies for facilities what areas to focus on for change or improvement. It also enables the facility to develop a frailty risk score for patients based on MDS data. This is essential, as frailty is a common clinical syndrome in older adults that carries an increased risk for poor health outcomes including falls, hospitalizations, and mortality. Unfortunately, frailty is not well represented by ICD-10 codes. That is why MDS assessment data is critical to the calculation of frailty. If, based on MDS data, your facility has a higher percentage of patients who are moderately to extremely frail, these individuals will require a higher degree of staff utilization, family discussions, and care planning to prevent negative outcomes; and you can plan accordingly for these additional services and predict the costs for them.

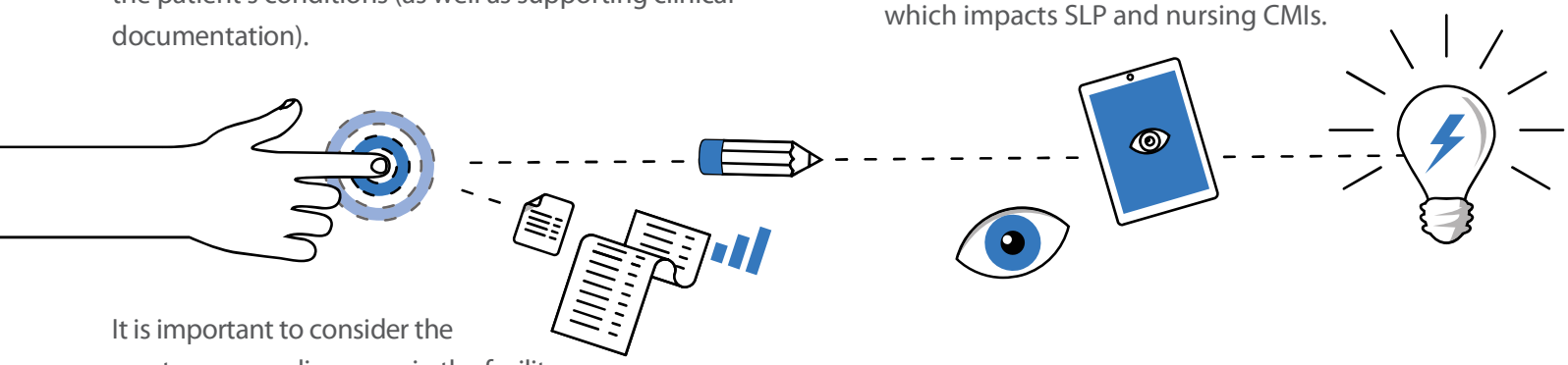
Organizations can use the Impact Report to identify their specific strengths and weaknesses and start changing their processes to prepare for PDPM. Capturing your data accurately can present opportunities for better care and cost efficiencies. The Impact Report should be printed, shared with team leaders, and used as an educational and plan of action tool for everyone in your building.

From Diagnoses to Care to Reimbursement

Each diagnosis under ICD-10 is mapped to one of 10 clinical categories:

- **Major Joint Replacement or Spinal Surgery**
- **Non-Surgical Orthopedic/Musculoskeletal**
- **Orthopedic Surgery**
- **Acute Infections**
- **Medical Management**
- **Cancer**
- **Pulmonary**
- **Cardiovascular and Coagulations**
- **Acute Neurologic**
- **Non-Orthopedic Surgery**

The primary diagnosis medical category is the most important driver for all payment components in PDPM. Both the primary medical condition category and secondary active diagnoses require accurate ICD-10 coding substantiated by comprehensive supporting documentation. It is crucial that it accurately captures the patient's conditions (as well as supporting clinical documentation).



It is important to consider the most common diagnoses in the facility and evaluate these to determine if they are relevant for the purposes of PDPM. The Impact Report will include your facility's top diagnoses and, eventually, your most profitable PDPM diagnoses. You need to look at the caliber of MDS data and practitioner documentation to ensure there is a process to align this to the diagnosis. You also need supportive documentation and an action plan for each active diagnosis. Otherwise, the facility could be open to audits and penalties.

Other important components of the Impact Report:

Physical and occupational therapy (PT/OT). While therapy is no longer driving reimbursement under PDPM, it is essential to track these services; especially as high-intensity rehab patients will have the highest impact on PT/OT components, and Medicare has indicated that it will continue to track therapy minutes. The Impact Report provides information about the rehab population including the percentages of rehab patients in your facility, national averages for each category, and average payment. Similar information is provided for speech language pathology. Evaluate how you will continue to provide similar levels of therapy under PDPM and/or if the facility needs more therapists to accommodate need.

Cognition and mood. The Impact Report provides information including the assessment completion rate, percentage of the facility population that is impaired, the average time to assess after admission, and patients with a change in mood or cognition during their SNF stay. Note that the frailty risk score increases as function and cognition decline. Frailty indicates medical complexity which impacts SLP and nursing CMIs.

Non-therapy ancillary services. NTAs must be assessed as accurately and also as quickly as possible. Reimbursement rates drastically decline on day 3 for this component. Putting a system in place to optimize this section is critical for CMI. If the facility population is less complex, payments are anticipated to decrease. It will be essential to evaluate the integrity of the MDS to ensure diagnoses are properly coded.

Once you gain clinical insight about opportunities for improvement, the PDPM screener lets you focus on individual patient needs. Reimbursement calculations, a dashboard of the entire patient population, identification of patients with a change of condition, as well as an estimate of payment range based on projected lengths of stay allow you to determine if the building is able to care for this patient and, if so, how the care will be managed.

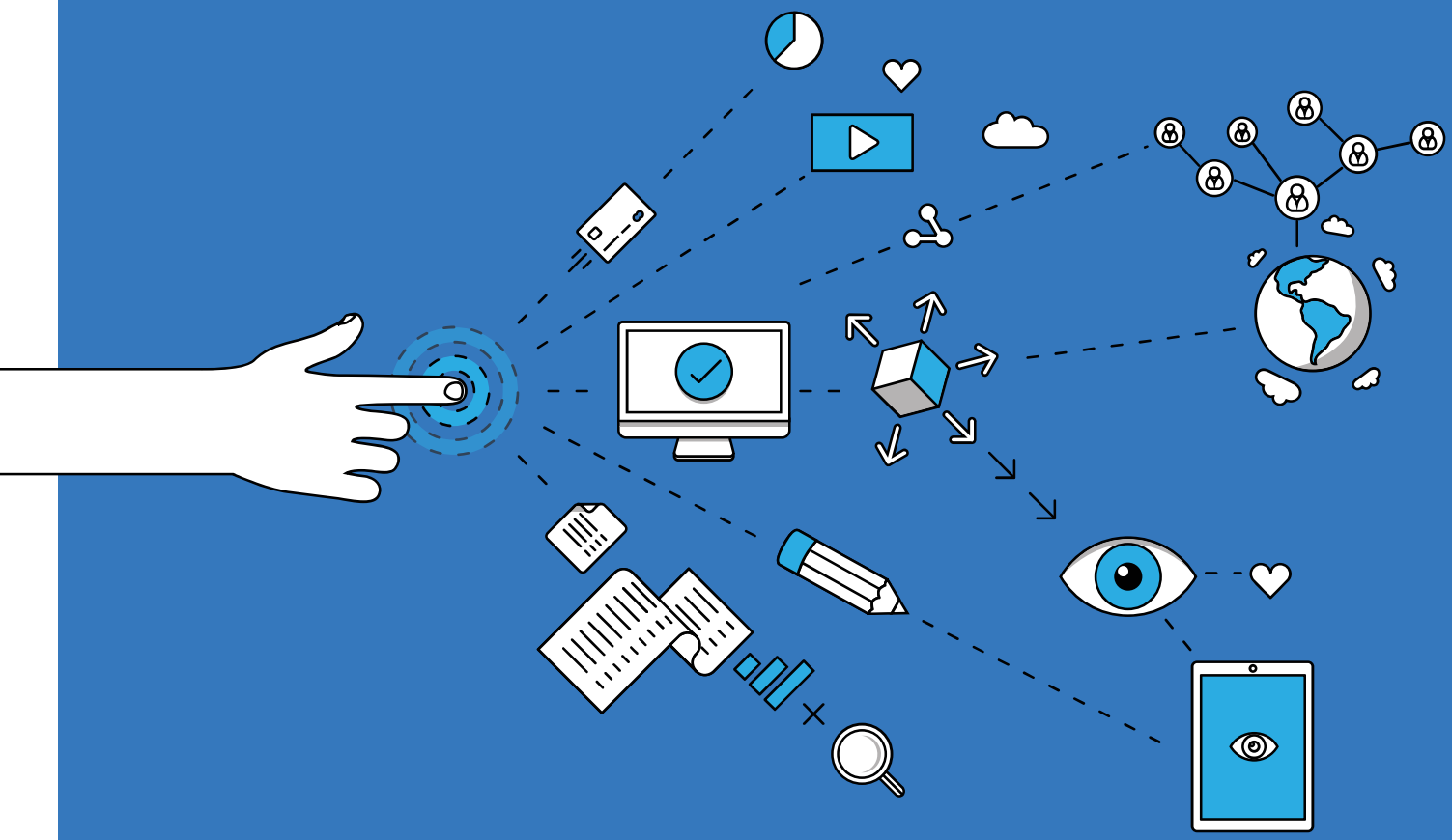
The few minutes required to complete the PDPM screener save time and effort down the road. A completed screener shows the patient's frailty risk, a snapshot of primary and secondary diagnoses, and other key data. The entire Care Team can rely on this accurate and complete information from the start, ensuring correct reimbursements for every patient; Identifying appropriate codes and producing a holistic care plan for every patient.

SUMMARY

PDPM represents a significant shift in how facilities are reimbursed for patient care. It moves the emphasis from therapy hours to the complexity of care each patient requires, i.e., why the person is in the facility. This calls for greater coordination, communication, and collaboration between clinicians and the entire team at the facility; and this requires tools and technology that will enable data to be collected, shared, tracked, and analyzed promptly, accurately, and with ease.

Tools such as the PDPM screener are vital, as PDPM is not just about reimbursement but clinical outcomes as well. The more thorough the assessment and accurate the documentation, the better the team will be able to identify care needs, establish patient-centric goals and care plans, and get each patient home safely and swiftly. The result will bring forth happier patients with better outcomes, facilities that receive adequate, accurate reimbursement and more referrals, and clinicians who are valued and in demand as care partners and team leaders.

Want to take a deeper dive into PDPM? Watch the Webinar.



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