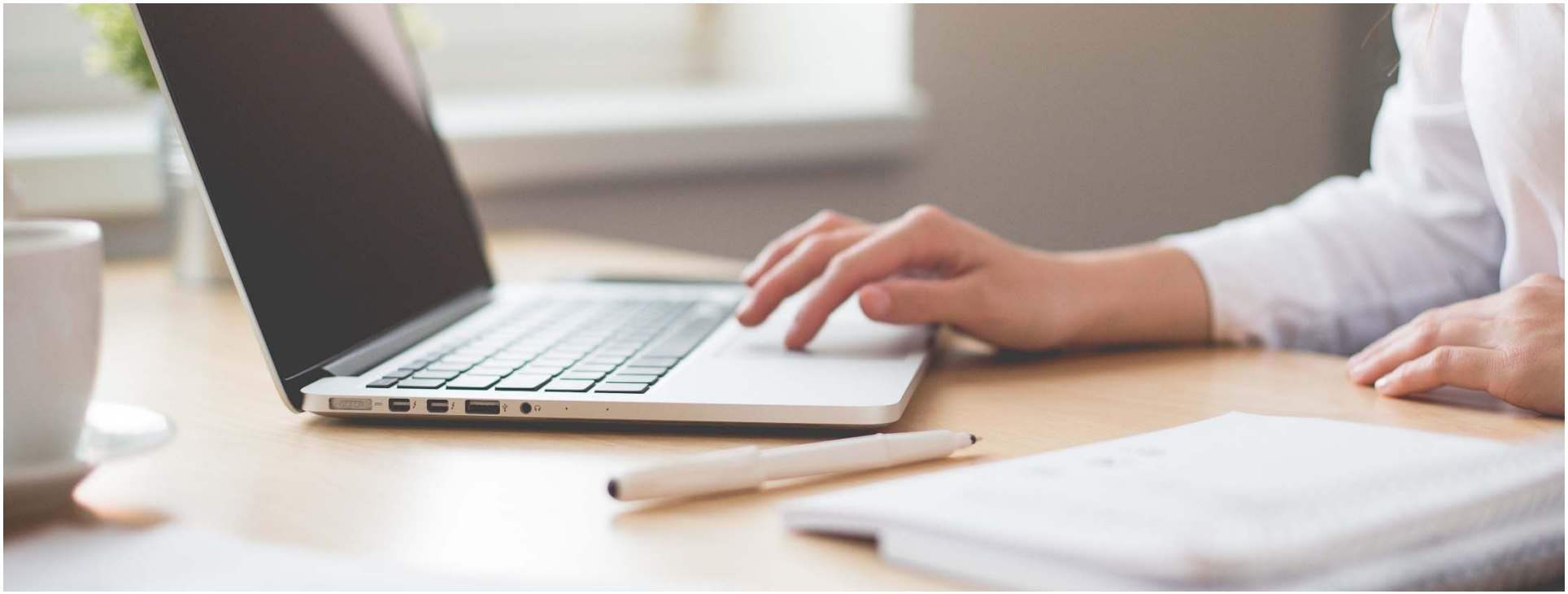
HEALTH DIMENSIONS GROUP

LeadingAge Minnesota

Patient-Driven Payment Model for SNFs Is Set to Go: Now What?

August 22, 2018



Housekeeping

Your Participation

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Audio:

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- Choose **Phone Call** and dial using the information provided

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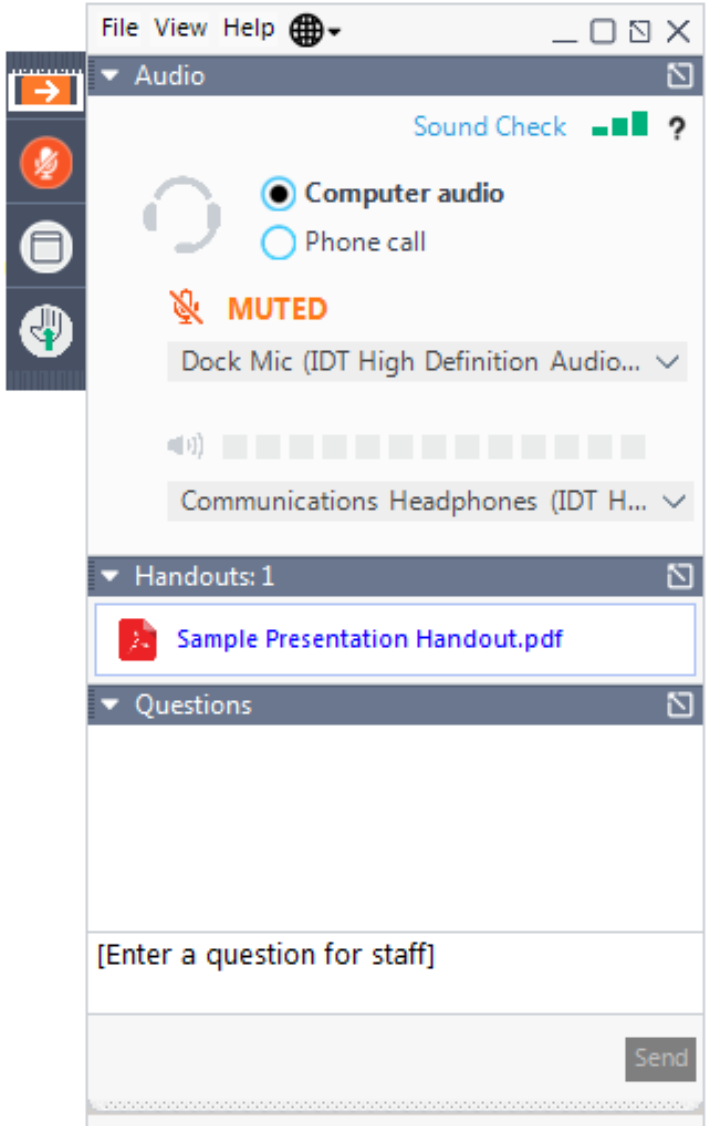
Submit questions and comments via the Questions panel

Note: Today's presentation is being recorded and all attendees are on mute



About Health Dimensions Group

HDG is a leading consulting and management firm, providing services to post-acute, long-term care, and senior living providers, as well as hospitals and health systems across the nation

HDG Solutions

- Management
- Strategy
- Operational performance
- Revenue cycle management
- Financial advisory
- Value-based transformation
- Workforce solutions

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Presentation Topics

- Basics of the finalized payment model
  - What changed in the final rule
  - What did not change and why
- Strategic and operational imperatives moving forward

Brian Ellsworth, MA

As **Vice President, Public Policy and Payment Transformation**, Mr. Ellsworth has more than 30 years of experience in Medicare & Medicaid policy, payment, and care delivery transformation, with an emphasis on care integration for the chronically ill and value-based transformation.

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Collin Higgins

As **Director of Analytics and Research,** Mr. Higgins has over 15 years of health care consulting experience and specializes in conducting market research, demand analysis, competitive assessment, and other data analysis for post-acute and long-term care providers across the continuum of care.

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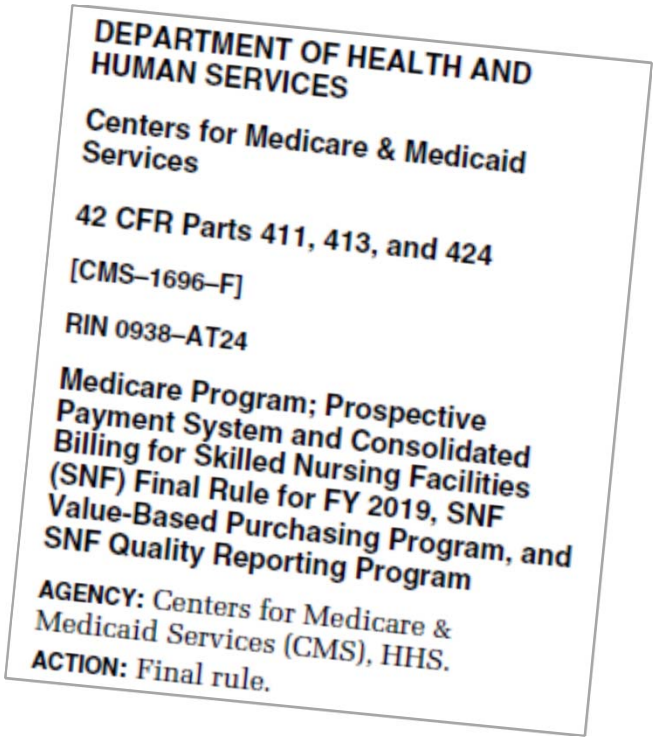
Basics of Patient-Driven Payment Model (PDPM)

Patient Characteristics Instead of Service Utilization

Ready, Set, Go!

- PDPM finalized for October 1, 2019, implementation
- CMS chose to send unequivocal message to providers and vendors
- Intended to provide lead time for retooling of operations, software, contracts, service lines, as well as staff training



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 411, 413, and 424

[CMS–1696–F]

RIN 0938–AT24

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

Federal Register / Vol. 83, No. 153 / Wednesday, August 8, 2018 / Rules and Regulations

https://www.gpo.gov/fdsys/pkg/FR-2018-08-08/pdf/2018-16570.pdf

Major Components of PDPM

Component	Primary Split	Secondary Split	LOS Adjustment	No. Payment Groups
Physical Therapy	Clinical category: ICD-10 code from MDS item I8000; augmented by surgical code from checklist on MDS item J2000	Section GG functional impairment (includes early loss ADLs)	2% decline per week after day 20 of length of stay (LOS)	16
Occupational Therapy				
Speech	Acute neuro, SLP comorbidity, cognitive impairment	Mechanically altered diet or swallowing disorder		12
Nursing	Collapsed non-rehab RUGs	Section GG functional impairment		25
Non-therapy Ancillary	Comorbidity list (Table 27 in final rule)		3X higher first 3 days, then same	6
Non-case-mix				1

Six Components Add Up to a Total Rate

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Technical_Report_508.pdf

Other Key Payment Features

- **Variable Per Diem Adjustment (VPDA)**
  - Changes per diem payment based on LOS
  - Affects PT, OT & NTA rate components only
- **Reduced MDS assessment schedule**
  - 5-day assessment
  - Interim payment assessment (*at SNF option*)
  - Discharge assessment
- **Interrupted stay policy**
  - Absent > 3 days or discharged to new SNF
  - New 5-day assessment
- **Section O of MDS**
  - Therapy reporting requirements for CMS tracking
- **Wage index**
  - Similar to current system

Key Changes in Final Rule

- MDS coding for preceding hospitalization surgical procedures for PT/OT group classification now will be in checklist format
- Interim Payment Assessment (IPA) now optional
- Section GG of MDS coding tweaks (see Appendix)
- Administrative presumption for Medicare coverage – added 6 classifiers for PT, OT & SLP

CMS stuck with prior proposals in many instances, indicating that implementation will be closely monitored and policies revisited as necessary

MDS Coding for PT/OT Groups: Change for Surgical Procedure Coding

- CMS finalized proposed PT and OT components under PDPM, with one important modification:
  - Instead of using ICD-10 code, providers will select, as necessary, a surgical procedure category in a sub-item within MDS Item J2000; this category will identify the relevant surgical procedure that occurred during the patient's preceding hospital stay and will augment the patient's PDPM clinical category
- Will help reduce administrative burden for coding the preceding surgical procedures, but SNFs still need to up their game on ICD-10 coding on the MDS as it determines the primary reason for the SNF stay

Interim Payment Assessment (IPA): Now Optional for Providers

- **Proposed:** would have been required assessment if:
  1) a payment group would change, and
  2) patient not expected to return to original status within 14 days
- **Final:** "*Rather than making the Interim Payment Assessment (IPA) a required assessment as proposed, it will be optional, and providers may determine whether and when an IPA is completed.*"
- Additionally, providers will set their own criteria for IPAs (guidelines to be developed with input)
- Important: IPA does **not** reset VPDA clock

What Did Not Change in Final Rule

- Federal base payment rates or wage index policy
- Speech Language Pathology, Nursing, and Non-therapy Ancillary (NTA) components
- Variable Per Diem Adjustment policy
- Interrupted stay policy
- Permanent adjustment in case mix that accounts for increased costs of patients with AIDS
- Swing Bed PPS Assessment additions (Table 34 of FR)
- PPS Discharge Assessment additions (Table 35 of FR)
- Consolidated billing exclusions
- Group and concurrent therapy limits

Group and Concurrent Therapy Limits: Having Your Cake and Eating It, Too

- CMS mounted a vigorous defense of retaining group and concurrent therapy limits
  - Citing data that 99% of current Medicare Part A therapy in SNFs is performed on individual basis
  - Evidence that CMS cites is a byproduct of current RUGs system that they are replacing!
- A non-fatal warning edit will be triggered on a provider's validation report when the amount of group and concurrent therapy exceeds 25% within a given therapy discipline
  - CMS states that increased scrutiny or future policy changes are possible if abused

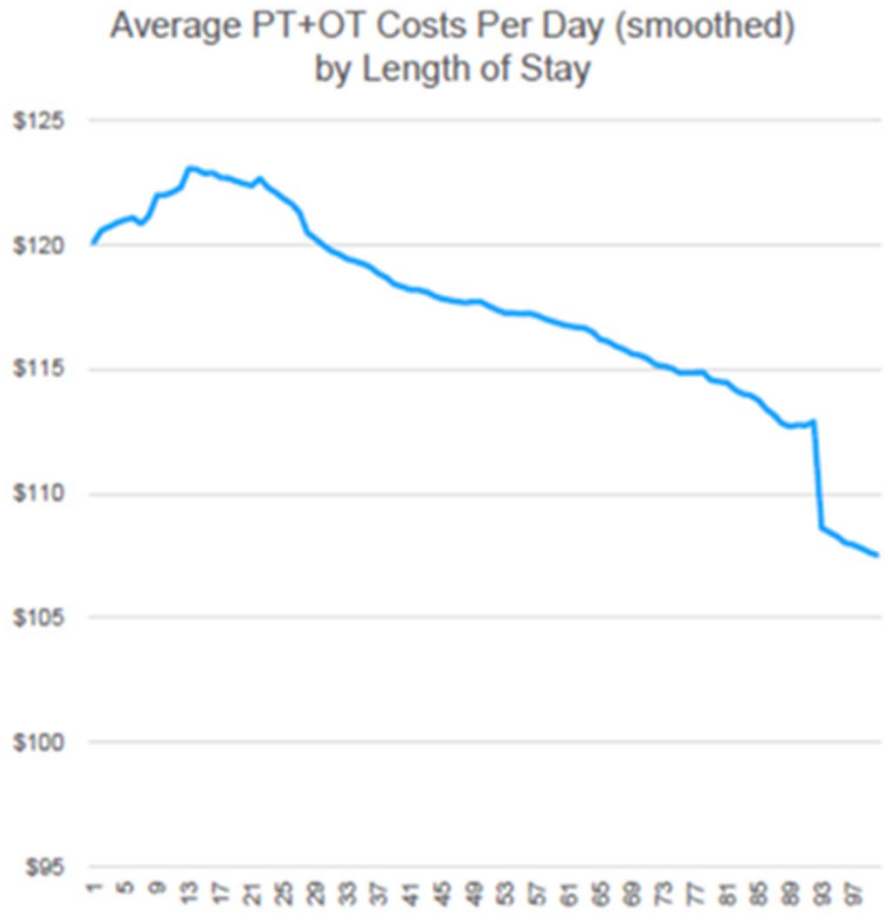
Strategic Imperatives of PDPM

Standing Pat Not an Option

Align with Value-Based Payors

- Payment model changes likely to incentivize better access for medically complex patients, of interest to population health managers
  - Non-therapy ancillary payments are improved for high-comorbidity and short-stay patients
  - More transparent nursing payments for clinically complex patients
- LOS adjustment rewards shorter stays for therapy patients, which is of interest to bundlers and ACOs
- Medicare Advantage plans may take a close look at this system and adopt in whole or in part, or with changes

Understand Relationship of Revenues to Costs Over LOS: PT/OT



Source: Acumen, SNF Technical Expert Panel, October 2016

Payment Adjustment

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

Source: Proposed Rule, Federal Register, April 27, 2018

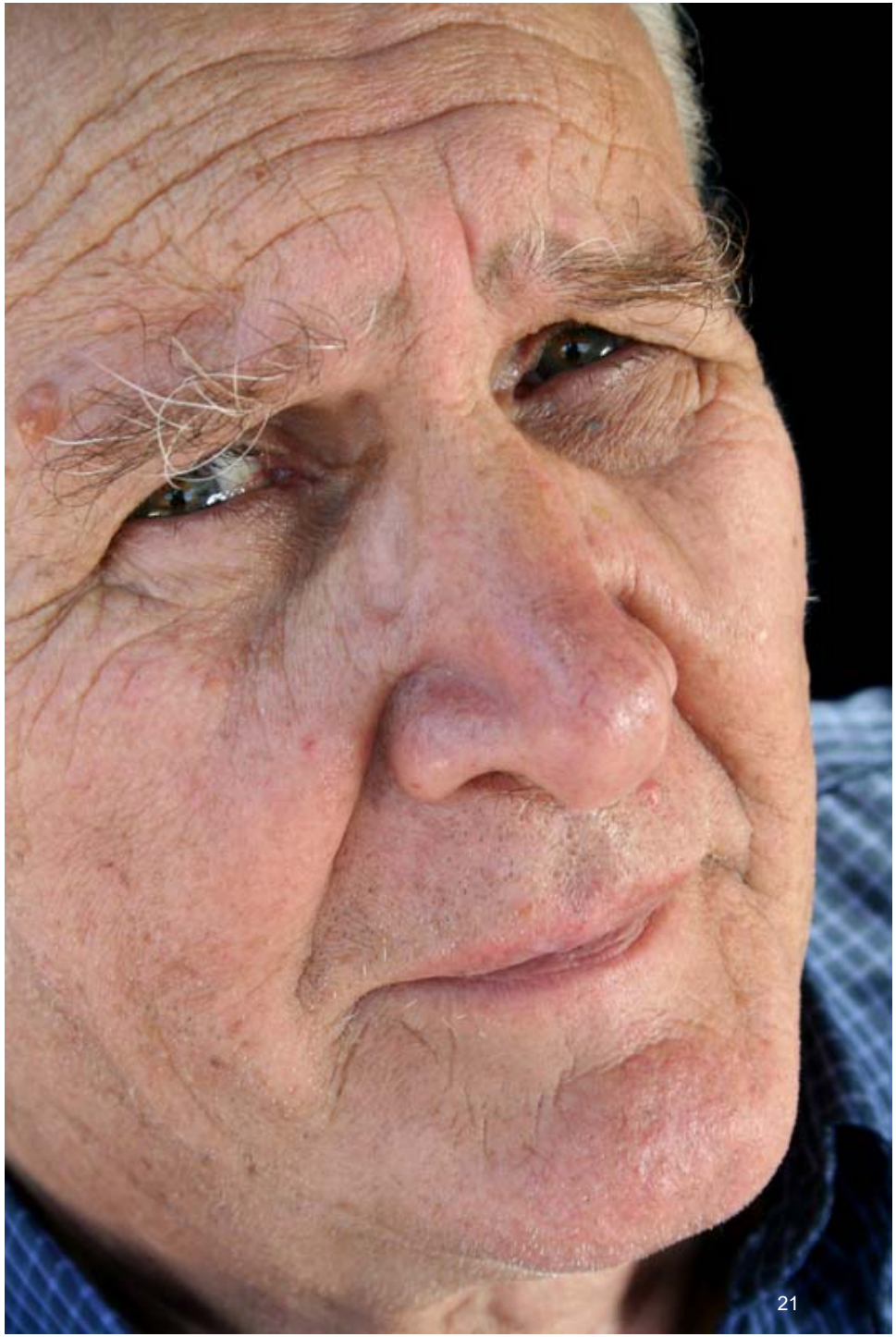
Length of Stay Not the Only Consideration

Nursing Case Study With Long LOS

- **60-day** length of stay
- 75-year-old male
- Stage 4 pressure ulcer, wound is infected
- Oral antibiotics
- Diabetic, daily insulin
- Obese
- Colostomy

RUGs: <$20,000

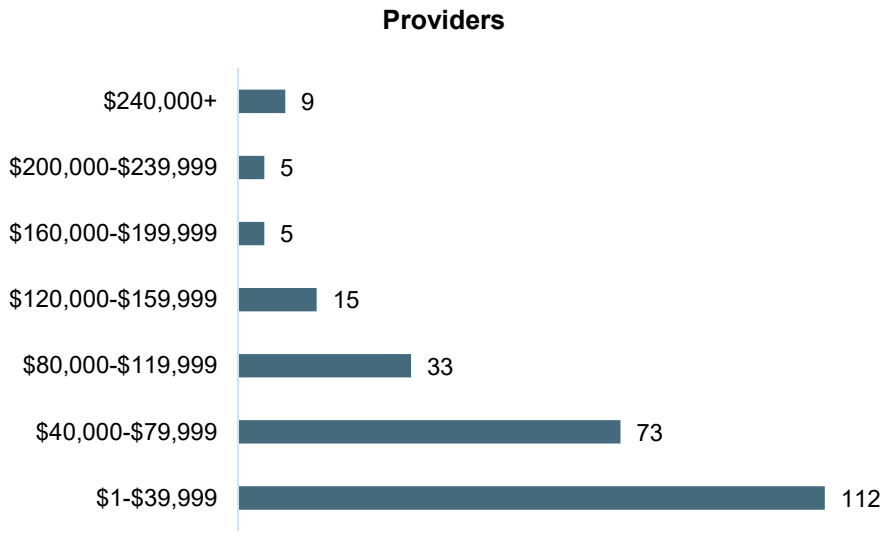
PDPM: >$30,000

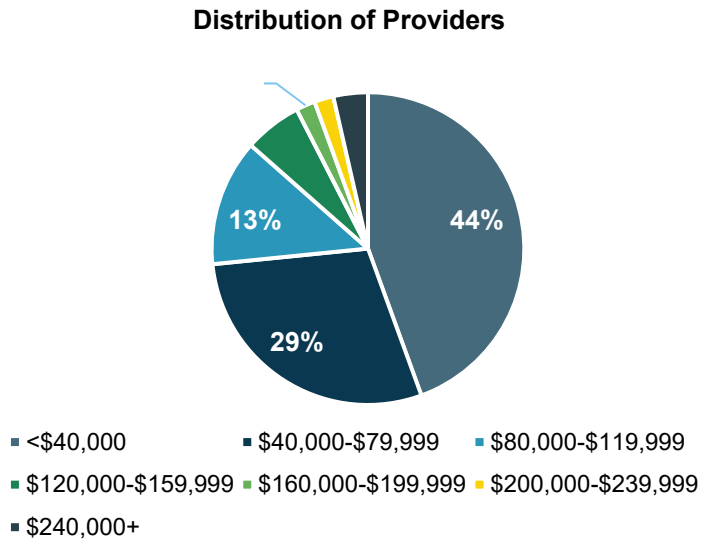


Understand What's Rewarded and Penalized Under PDPM

Domain	Metric	% of Stays	% Change
Utilization Days	1–15 day LOS	35.4%	13.7%
	16–30 day LOS	33.8%	0.0%
	31+ day LOS	30.9%	-2.5%
Therapy	Rehab Ultra	58.4%	-8.4%
	Rehab Very High	22.4%	11.4%
	Rehab High	6.8%	27.4%
	Rehab Medium	3.3%	41.1%
	Rehab Low	0.1%	67.5%
	Non-Rehab	9.1%	50.5%
Facility Type	Urban/Freestanding	70.6%	-1.0%
	Urban/HB/Swing	2.2%	15.3%
	Rural/Freestanding	25.6%	3.2%
	Rural/HB/Swing	1.6%	21.1%

PDPM - Projected Revenue Gain
(Absent Behavior Change) for MN SNFs only

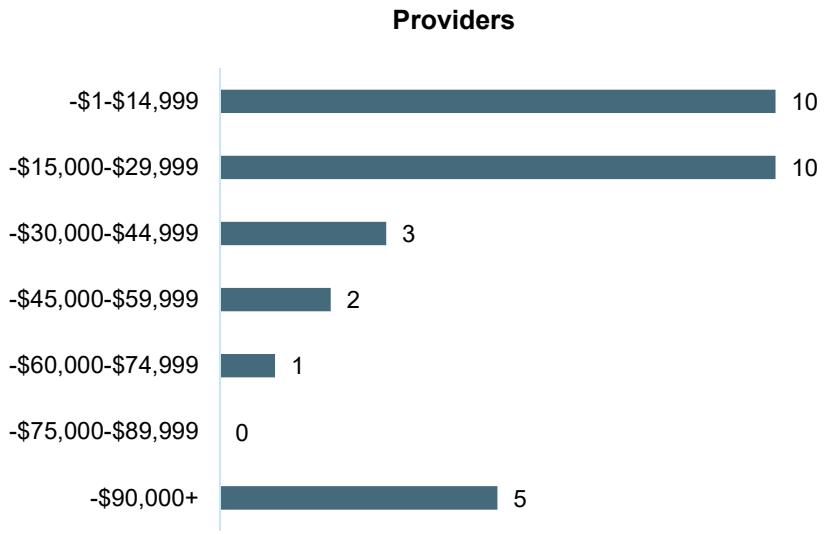


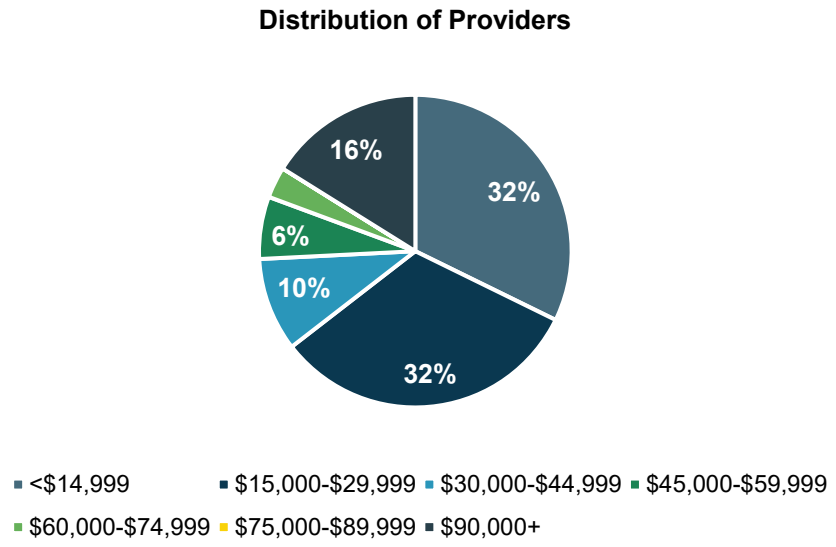


Source: Centers for Medicare & Medicaid Services

- The median revenue gain in Minnesota is $62,545
- Nationally, the median revenue gain is $64,469
- Although budget neutral at the national level, MN will have a net gain of $15 million in the conversion

PDPM - Projected Revenue Loss
(Absent Behavior Change) for MN SNFs only





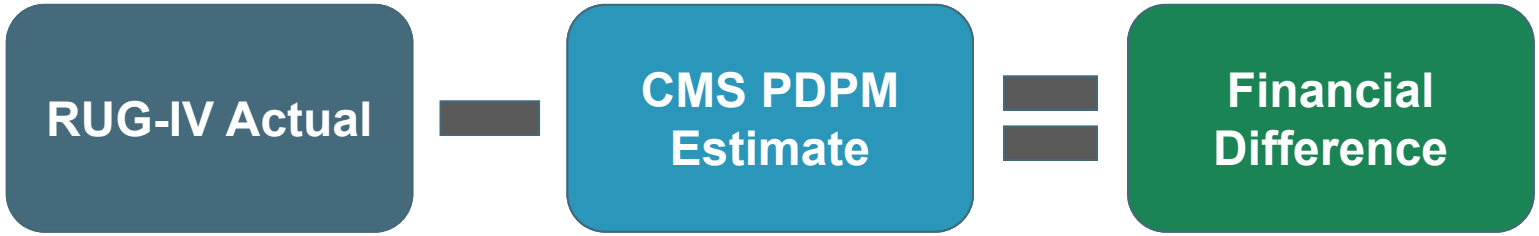
Source: Centers for Medicare & Medicaid Services

- The median revenue loss in Minnesota is $44,966
- Nationally, the median revenue loss is $74,786
- Overall, 41% of SNFs nationally will have a loss in the conversion; only 11% of MN SNFs will have a loss

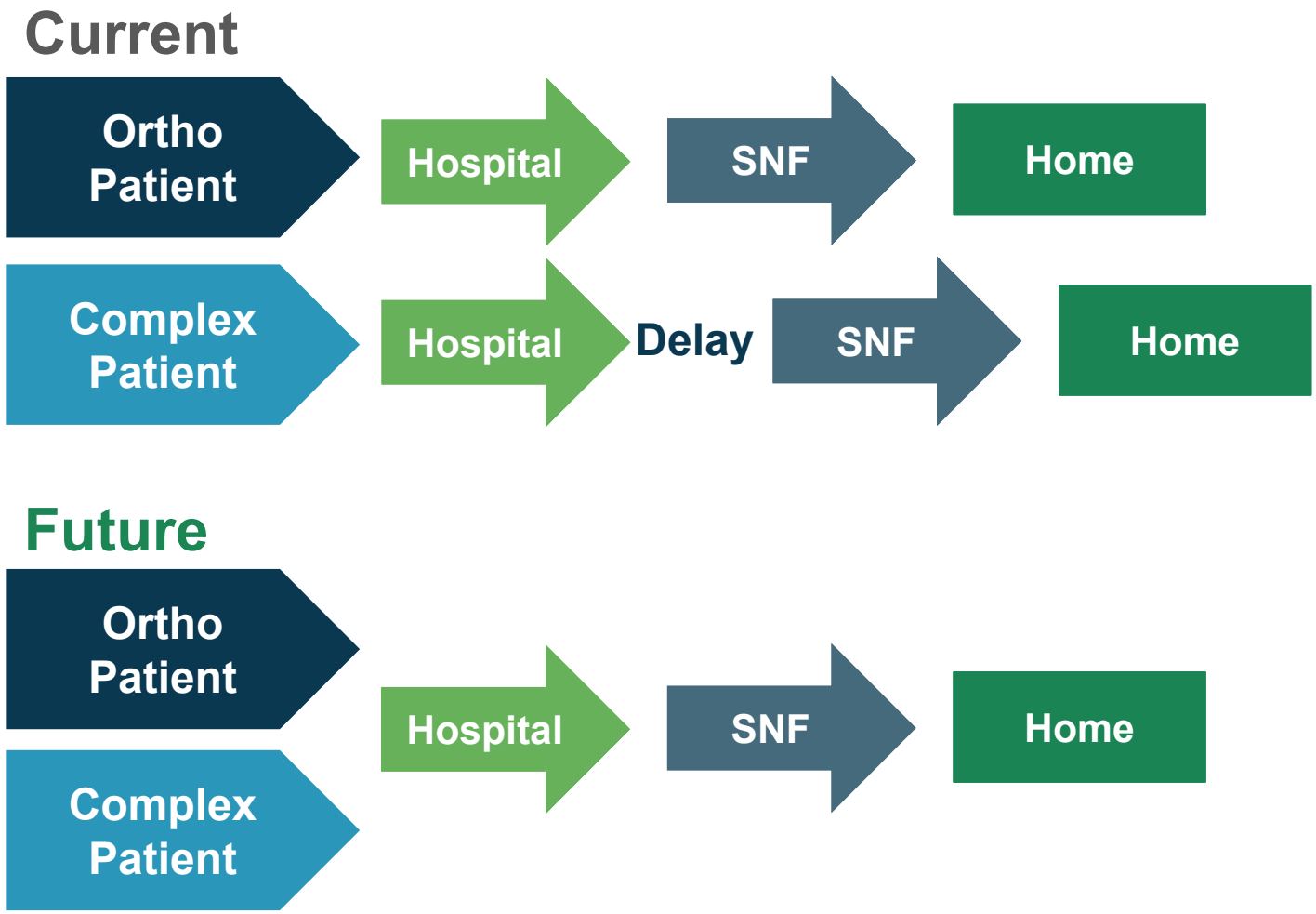
Access to Impact Data

- Request your anticipated financial change from RUG IV to PDPM according to CMS
- Complete the online form at …

  https://healthdimensionsgroup.com/pdpm-impact/



One Reason Why You Cannot Stand Pat: Markets Will Evolve Under PDPM



More Reasons Not to Stand Pat: Coding Creep and Recalibration

- CMS is permitted by law to adjust rates for changes in coding not related to actual changes in patient characteristics (BBA of 1997)
- Recalibration refers to the process of changing the relative payment weights (aka CMIs) in response to changes in relative costs of care
- Coding practices and actual delivery of care are both likely to change under PDPM

Bottom line: if your coding is poor to begin with and/or does not improve sufficiently over time, or relative care costs do not evolve consistent with market trends, even a positive initial impact could turn negative

Operational Imperatives of PDPM

Operational Imperatives Under PDPM

- Triple check process more important than ever
- Manage case proactively, prioritizing return to function in most efficient manner possible
- Drive occupancy by making the pivot to more medically complex care
- Reduce silos between therapy and nursing
- Understand each patient's expected reimbursement on the front end
- Accurate and complete coding of the MDS is critical
- Consider new modes of care and technology

Clinical Program Development

- Identify referring hospitals' challenging placements
- Know niche of each of your competitors
- Broaden clinical capabilities
- Identify areas for therapy and nursing to collaborate, such as:
  - Bladder training
  - CHF
  - Stroke

Therapy Considerations

- Focus on obtaining functional outcome in most efficient manner
- If therapy practices are going to be modified, carefully establish evidence-base on outcomes well before October 1, 2019

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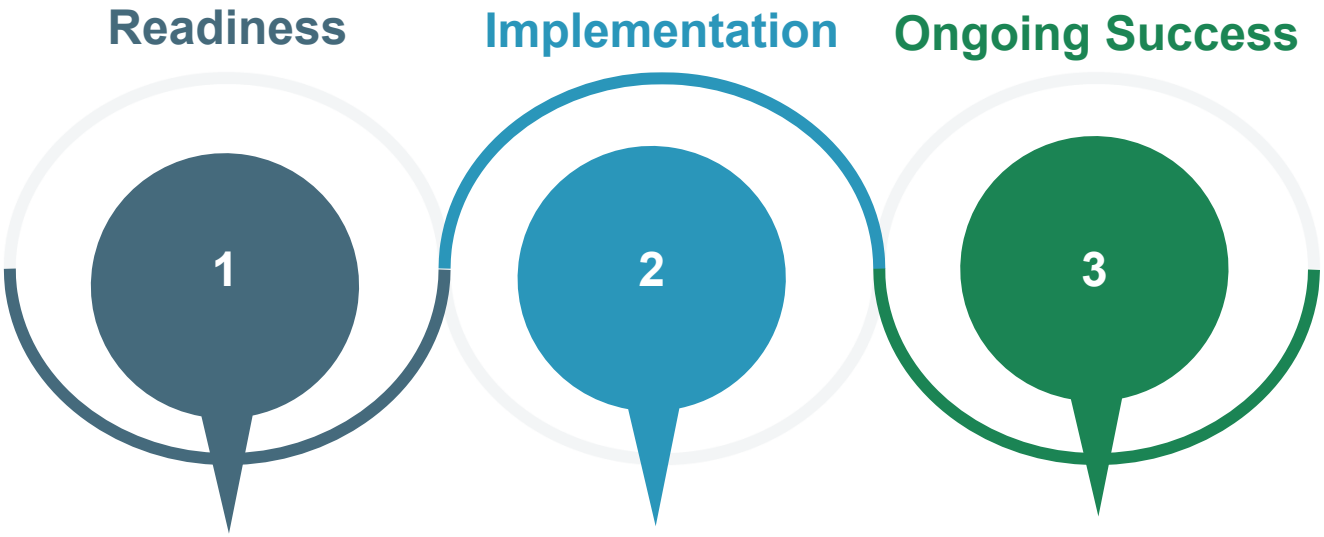
Start Preparing Now!

1. Understand the financial impact
2. Ensure that MDS coding is complete and accurate
3. Evaluate the provision of therapy and move from a focus on therapy minutes to a focus on functional outcomes
4. Assess and validate how markets will likely evolve
5. Enhance clinical capabilities and consider making the pivot to a more medically complex caseload

Our PDPM Consulting Solutions



- Impact assessment
- Financial analysis
- Operational readiness assessment

- Training & education
- Process development
- Acute alignment

- Ongoing success
- Process & operational efficiency
- Revenue optimization

Questions

For More Information

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Thank you for attending!

Appendix

Brief Index of Key PDPM Components

PDPM Item	Final Rule Table #	August 8, 2018 Federal Register Page #
PT and OT Groups	21	39209
SLP Groups	23	39212
Nursing Groups	26	39217
Non-Therapy Ancillary Points List	27	39222
Non-Therapy Ancillary Groups	28	39223
Variable Per Diem Factors PT/OT	30	39228
Variable Per Diem Factors NTA	31	39221
PDPM PPS Assessment Schedule	33	39231

Four Major PT/OT Clinical Categories Based on Primary Reason for SNF Care

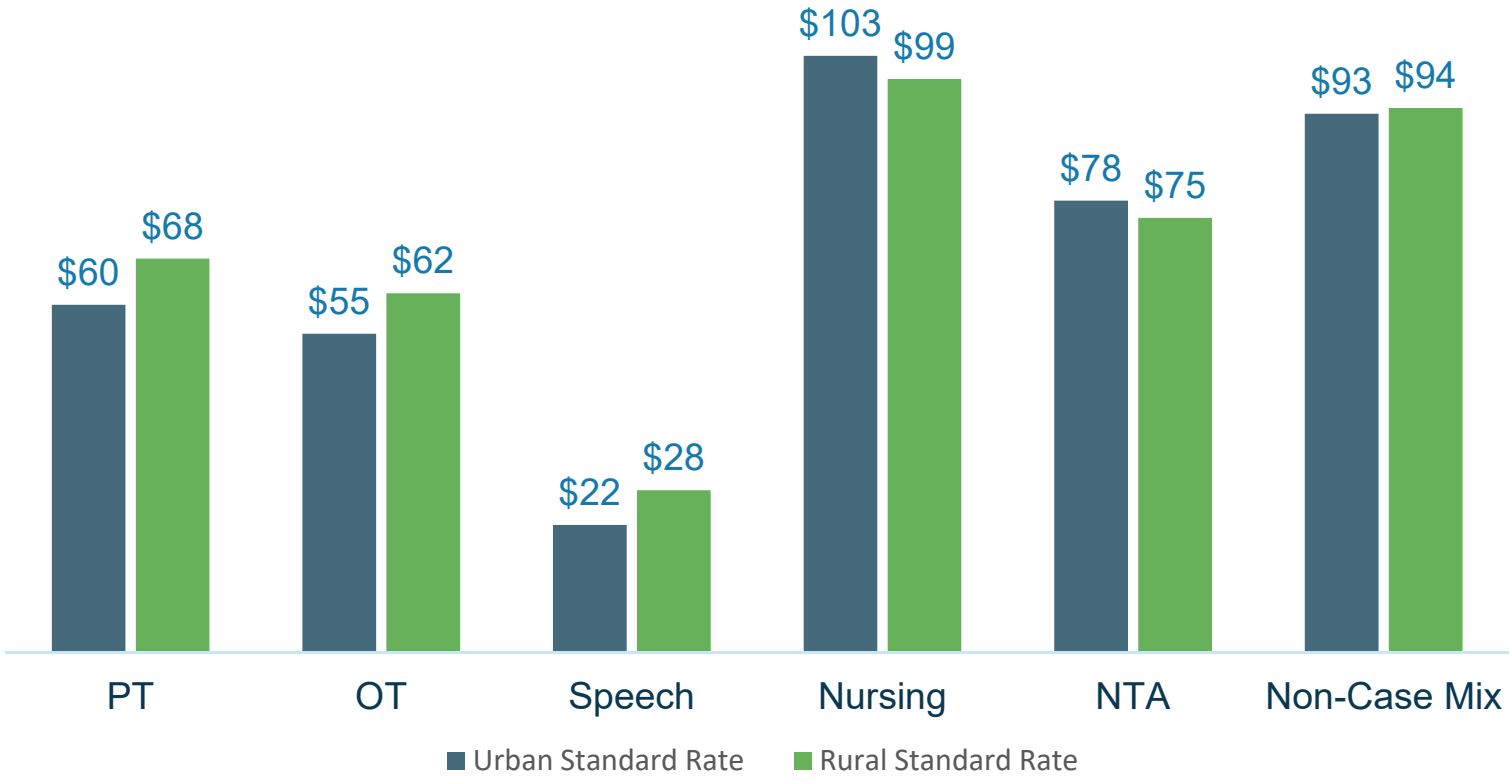
PDPM Clinical Category	Collapsed PT and OT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Non-Orthopedic Surgery	Non-Orthopedic Surgery and Acute Neurologic
Acute Neurologic	
Non-Surgical Orthopedic / Musculoskeletal	Other Orthopedic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	
Medical Management	Medical Management
Acute Infections	
Cancer	
Pulmonary	
Cardiovascular and Coagulations	

Section GG of the MDS is Basis for Secondary Splits for PT, OT, and Nursing Components

Section GG Item		Score
GG0130A1	Self-care: Eating	0-4
GG0130B1	Self-care: Oral Hygiene	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to Lying	0-4 (average of 2 items)
GG0170C1	Mobility: Lying to Sitting on Side of Bed	
GG0170D1	Mobility: Sit to Stand	0-4 (average of 3 items
GG0170E1	Mobility: Chair/Bed-to-Chair Transfer	
GG0170F1	Mobility: Toilet Transfer	
GG0170J1	Mobility: Walk 50 Feet with 2 Turns	0-4 (average of 2 items)
GG0170K1	Mobility: Walk 150 Feet	

- Section GG aligns with the IMPACT Act
- Incorporates early-loss ADLs

Standard Rates for Each Component Are Adjusted by CMI and Wage Index



Section GG Coding Tweaks in Final Rule

- For purposes of calculating the function score, all missing values for section GG assessment items will receive zero points. Similarly, the function score will incorporate a new response “10. Not attempted due to environmental limitations” and CMS will assign it a point value of zero.
- The final rule further states:
  - Furthermore, consistent with a commenter’s suggestion, we will adopt MDS item GG0170I1 (Walk 10 feet) as a substitute for retired item GG0170H1 (Does the resident walk), and we will use responses 07: “resident refused,” 09: “not applicable,” 10: “not attempted due to environmental limitations,” or “not attempted due to medical condition or safety concerns” from MDS item GG0170I1 to identify residents who cannot walk