PDPM Financial Analysis: Therapy Armageddon or Therapy Freedom?

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As providers we breathed a sigh of relief when CMS informed us on April 27, 2018 that RCS-1 was being tabled in favor of a new, remodeled edition titled the Patient Driven Payment Model, or PDPM. And while PDPM shows many improvements over what was believed to be "Therapy Armageddon" in RCS-1, there are still many concerns in the therapy and skilled nursing world about what PDPM means for the future. With a significantly altered reimbursement structure for therapy services, many providers have considered drastic cuts in the amount of therapy services they intend to provide under PDPM. Furthermore, with CMS focused on a "value over volume" agenda, PDPM encompasses a paradigm shift because skilled nursing and long-term care reimbursement is no longer powered by the amount (i.e. minutes) of therapy services provided. And, in fact, providers could theoretically increase their margins further by not providing therapy services because the community will continue to receive therapy reimbursement even if therapy services are not provided, though that is not recommended and would place the community at great liability. It is critical for every provider to become fully informed and prepared for PDPM by understanding that PDPM is

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essentially a redistribution of reimbursement, how PDPM impacts in-house and contract rehab margins, the new risks for audits, denials and recoupments under PDPM and the imperative to partner with the right therapy services under PDPM.

PDPM is essentially a redistribution of the reimbursement provided under RUGs-IV (See Table 1). Overall, CMS has stated that the impact of PDPM should be budget neutral, though it will not impact individual providers in the same way. The key to understanding PDPM reimbursement is that approximately $500 million reduction in therapy reimbursement was shifted over to increase nursing reimbursement by $520 million. In the first draft of the proposed rule, there was a -$18 million reduction due to a missing therapy non-case mix component. While advocates have requested that CMS correct this "error" CMS has clarified that this therapy non-case mix was already distributed throughout the existing payment groups and will not be added to PDPM. And at the worst, it should be a sum-zero game even if providers do not change any of their behaviors. However, advocates have requested that CMS correct this error and if it is corrected, it will result in a potential increase by $20 million in revenue for the industry. And at the worst, it should be a sum-zero game even if providers do not change any of their behaviors. However, history has proven that when CMS changes the targets, initiatives and reimbursement structure, providers have adjusted behaviors to accommodate these changes. And organizations with thought leaders who implement a proactive strategy can leverage these regulatory changes to positively impact overall revenue while continuing to strive for clinical excellence and outcomes.

Table 1: Overall financial analysis of PDPM for all providers based upon NASL analysis.

However, PDPM is not intended to have the same impact on all providers. As would be expected with a completely new platform for reimbursement, some providers will come out ahead and some behind if they do not change any practices. From the CMS analysis shown in Table 2, we note that for-profit entities are expected to see a loss of -0.7% while non-profit providers should see a gain of 1.9%. Facilities with less than 100 beds are likely to see an increase in revenue up to 3.5%, though larger facilities may see a modest reduction in reimbursement. Communities with more than 200 beds stand to see the greatest loss of just under 2% with PDPM. Urban locations will see a reduction in reimbursement by 0.7% while rural locations stand to see an increase of 3.7%. This analysis is based upon MDS data that was submitted to CMS for several years and is based upon the associated case mix and resident characteristics of those historical MDSs.

In analyses conducted by Gravity Healthcare Consulting on behalf of multiple clients, it has been noted that multiple errors in documentation or scoring on MDSs that didn't impact reimbursement under RUGs-IV would have a powerful impact under PDPM. For example, one resident who did not have a Section GG score that was consistent with what was in the documentation would receive an additional $8.39 in reimbursement per day under PDPM for an accurate Section GG score. Two other residents who had the incorrect ICD-10 active diagnosis selected on the MDS would see an increase of $99.21 or $29.01 per diem if the correct ICD-10 code had been selected. In approximately 75% of the MDSs audited by Gravity in June 2018, it was noted that coding or documentation errors would result in reduced and inaccurate per diem rates under PDPM. Providers need to be proactive now and implement PDPM-focused MDS audits, ICD-10 coding training for MDS coordinators, and robust nursing documentation auditing and training to prepare for PDPM. Also, Section GG ADL coding training for the nursing team, especially CNAs or GNAs, will be critical to successfully transition to PDPM as Section GG will now be the foundation for ADL coding (instead of Section G).

Provider Characteristics	% of Providers	Percent Change
All Stays	100.0%	0.0%
Ownership		
For profit	72.0%	-0.7%
Non-profit	22.6%	1.9%
Government	5.4%	4.2%
Number of Certified SNF Beds		
0-49	10.0%	3.5%
50-99	38.2%	0.6%
100-149	34.7%	-0.2%
150-199	11.1%	-0.3%
200+	5.9%	-1.8%
Location		
Urban	72.7%	-0.7%
Rural	27.3%	3.8%
Facility Type		

Table 2: CMS projected effects of PDPM versus RUGS-IV: Facility Characteristics from the Technical Expert Panel Report by Acumen.

A financial analysis comparing the per diem rates of PDPM versus the reimbursement under RUGs-IV is enlightening. The bottom line is that there are no direct or exact correlations. It is like trying to compare checkers and chess games – they are both played on a checkered board, but the playing pieces, rules and strategies for success are so vastly different that there are few parallels other than the playing board. In many of our analyses, residents that currently achieve RUs (Rehab Ultra High categories) can see a slight decrease under PDPM. However, this is not always the case, especially for residents who are medically complex, who might instead have an increased reimbursement under PDPM. And residents in the non-RU groups (i.e. RV, RH, RM) often see a significantly higher reimbursement with PDPM as compared to RUGs-IV. For the first example in Table 3, the RUGs for PDPM and RUGs-IV along with reimbursements are shown for a resident with a hip replacement and a diabetic foot ulcer with no other major complications or issues. Under PDPM, if this resident had achieved an RU, it would result in a loss of $65.33 per day. By contrast, if that resident had only received an RV with RUGs-IV, the provider would see an increase in reimbursement by $105.74 per day, or just over $2,000 in a typical 20-day stay.

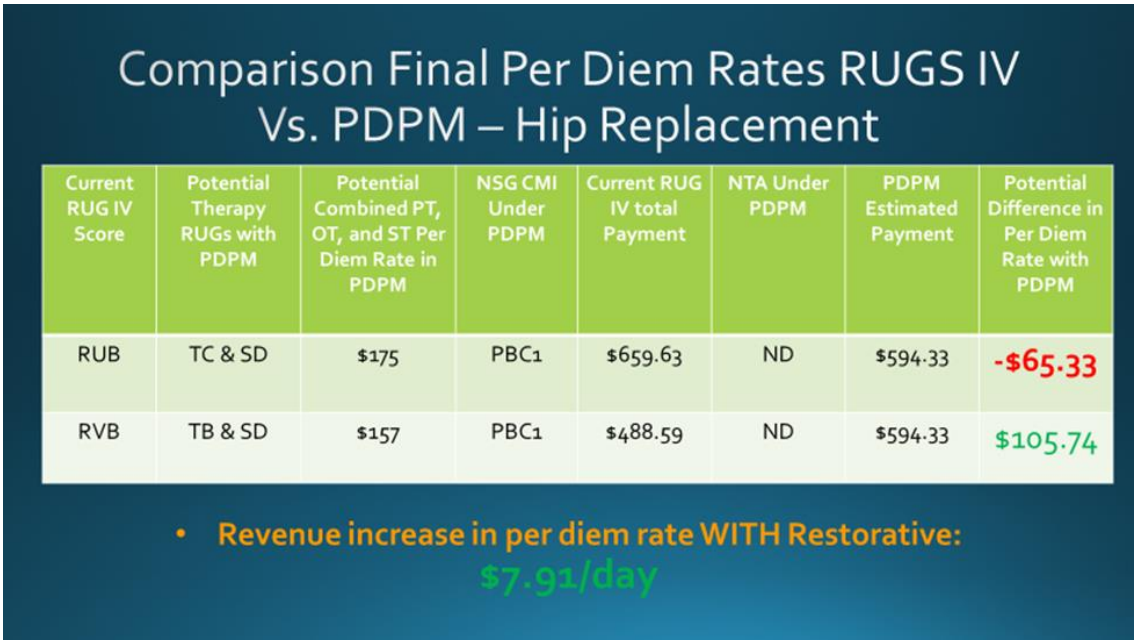

Table 3: Comparison of per diem rates of RUGs-IV vs. PDPM for a resident with a hip replacement.

In another example, a resident would fall into the Medical Management Rehab Category for PDPM due to an acute exacerbation of COPD, with a chronic diabetic foot ulcer and chronic dysphagia on a mechanically soft altered diet. For this resident, providers would see a significant jump in reimbursement with PDPM as compared to RUGs-IV. And, the reimbursement for an RV (Rehab Very High) resident who received 500+ minutes per week of therapy services would see an even greater increased reimbursement of $241.79 per day. This increased per diem revenue equates to almost $5,000 of additional revenue in a typical 20-day length of stay.

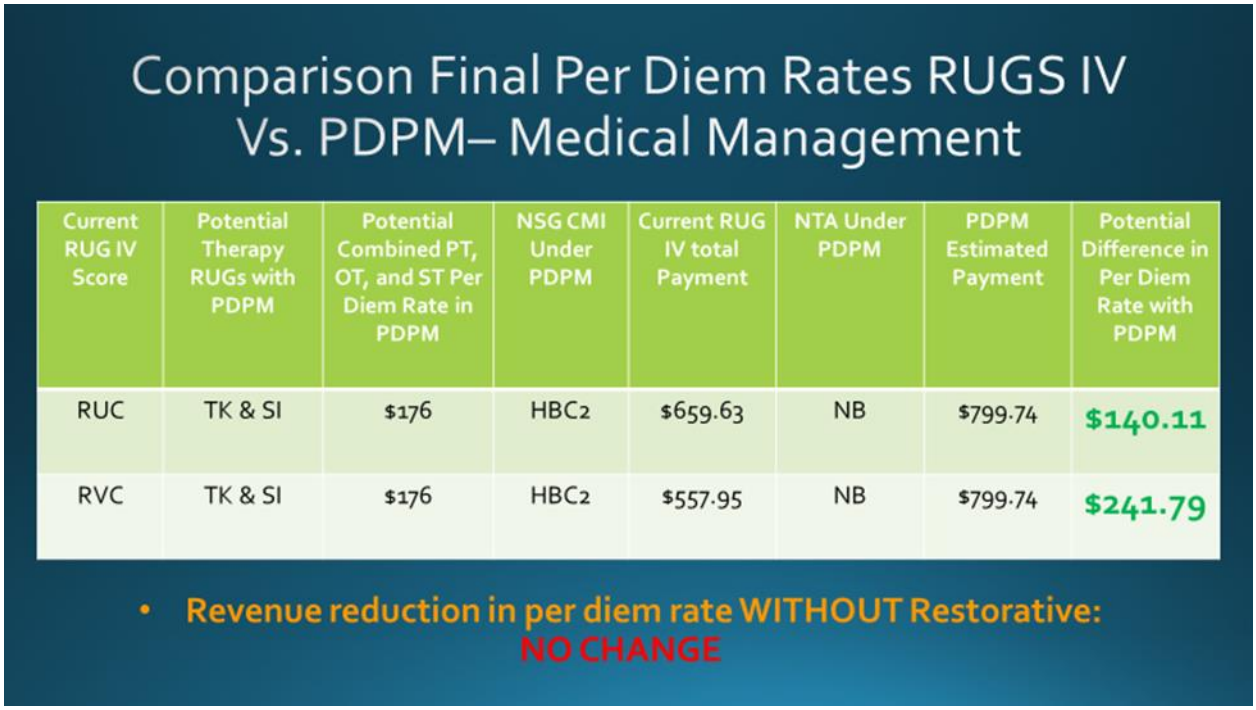

Table 4: Comparison of final per diem rates for RUGs-IV versus PDPM for a resident with COPD, chronic diabetic foot ulcer and chronic dysphagia.

Stroke residents are another key outlier for consideration of the financial analysis of PDPM versus RUGs-IV. Residents with CVAs (cerebrovascular accidents) tend to be an outlier because they are likely to use most or all 100 days of skilled services, either from the ongoing provision of therapy and/or because of the likelihood of requiring enteral (tube) feedings. Additionally, CVA residents almost always require speech therapy services and often achieve an RU for a significant portion of the skilled stay. Table 5 shows the reimbursement for a resident who suffered from a right middle cerebral artery CVA who is totally hemiplegic on the left side of her body upon admission. She is unable to speak and unable to manage food or liquid and is receiving enteral feedings and is totally dependent for all care. In this analysis, the CVA resident would receive an increased reimbursement of $104.55 per day as compared to an RU under RUGs-IV and an increase of $205.23 per day for an RV.

Comparison Final Per Diem Rates RUGS IV Vs. PDPM– Acute Neurologic

Current RUG IV Score	Potential Therapy RUGs with PDPM	Potential Combined PT, OT, and ST Per Diem Rate in PDPM	NSG CMI Under PDPM	Current RUG IV total Payment	NTA Under PDPM	PDPM Estimated Payment	Potential Difference in Per Diem Rate with PDPM
RUC	TM & SL	$159	HDE1	$659.63	NB	$763.18	$104.55
RVC	TM & SL	$159	HDE1	$557.95	NB	$763.18	$205.23

- Revenue reduction in per diem rate WITHOUT Restorative: NO CHANGE

Table 5: Comparison final per diem rates RUGs-IV versus PDPM for a resident with a stroke and left hemiplegia, dysphagia and a tube feeding.

However, with a CVA resident or other residents who require more than 20 days of skilled care, PDPM presents a new challenge. Under PDPM, starting on day 21, the PT and OT reimbursement decreases by 2% every 7 days. Upon admission, this resident would qualify for a combined PT, OT and ST per diem rate of $283.02. This means that at day 21 the combined therapy per diem rates for PT, OT and ST would drop to $279.70. By days 98-100, the skilled reimbursement would drop to the lowest rate of $205.15, or 76% of the per diem rate established upon admission.

Another dramatic difference between PDPM and RUGs-IV is that under RUGs-IV, residents are always in an assessment due to the potential need for a COT at any assessment check point in between the established 5-day, 14-day, 30-day, 60-day and 90-day assessments. Under PDPM, the administrative burden is significantly reduced because the only two assessments that will need to be completed for the majority of residents are the admission/5-day assessment and the discharge assessment. The only time that another assessment would be indicated is if there is a change in a first-tier classification for the resident in which case an Interim Payment Assessment, or IPA, should need to be completed within 14 days of the noted change. Because it is possible for resident who is skilled for 100 days to see changes in their first-tier categories during the 100 days, they are likely to require one or more IPAs and thus could see the actual payments increase or change over the stay despite the percent reduction due to length of stay.

For a final per diem comparison, Table 6 shows a resident who has completed a surgical removal of a kidney tumor who has few functional limitations upon admission and requires little physical assistance to complete self-care and mobility tasks. Under RUGs-IV, if this resident was appropriate for an RUA, the reimbursement would actually drop by $15.19 per day with PDPM. However, if the resident had only achieved an RVA under RUGs-IV, the reimbursement would instead increase by $58.25 per day.

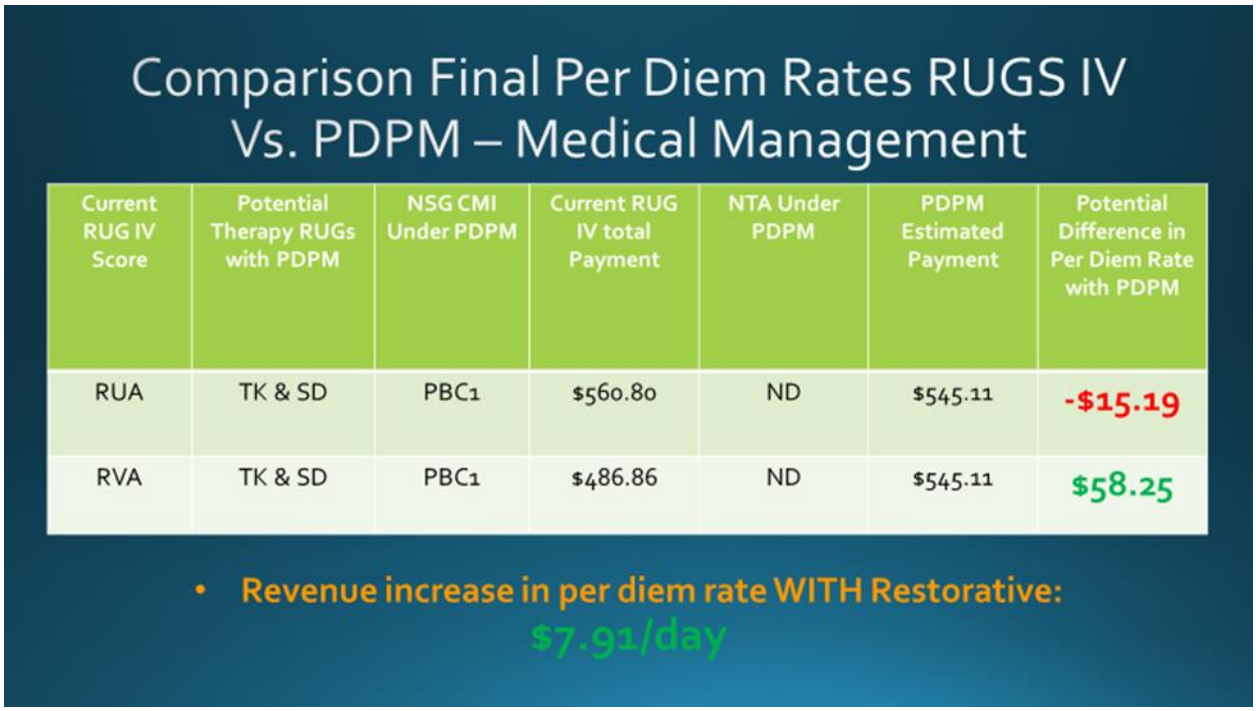

Table 6: Comparison of per diem rates of RUGs-IV versus PDPM for a resident with kidney tumor, s/p surgical removal who required little assistance with self-care and mobility upon admission.

During the transition to PDPM, every provider and contract rehab company will need to carefully consider how to ethically provide treatment within the confines of the new payment system. While it may be tempting to cut back therapy minutes or days of therapy provided because the facility will continue to receive reimbursement regardless of whether therapy services are given, providers should take caution. During an open forum call in May 2o18, CMS stated clearly that they expect that provider behavior will not change, ESPECIALLY IN THE PROVISION OF THERAPY SERVICES. The key to reduce the risk to providers and therapists from anticipated audits, denials and recoupments by the Office of Inspector General (OIG) or the MACs is to maintain approximately the same levels of service provision as were delivered under RUGs-IV. Any provider or therapy company who presents with outliers would especially be a target. Some outliers that could be viewed as potentially inappropriate would include:

Target Area	Reason for Targeting
Low provision of therapy minutes per skilled resident	Could be perceived as not providing adequate therapy services commensurate with the individual clinical needs of the resident
High provision of therapy minutes per skilled resident	In a values-based environment, over utilization of therapy to achieve good outcomes does not fit into the CMS goal of the best value for amount of services provided.
Poor outcomes based on Section GG data at admission versus discharge, regardless of the therapy minutes provided	Again, because of the values-based initiatives of CMS and regardless of the number of therapy minutes provided, CMS wants to see progress and outcomes, so providers with poor outcomes can expect to be targeted.
Exceptionally high outcomes based upon Section GG data at admission versus discharge, especially if the therapy minutes are below the national average	This could be interpreted as either inaccurate Section GG data to drive reimbursement and/or inaccurate reporting of therapy minutes provided
Similar amounts of therapy provided to all residents regardless of case mix/RUG	Might indicate that therapy service levels were being dictated to the therapist rather than being driven by resident need
Providing the same number of minutes for specific RUG levels	Similar to "RUG hugging" under RUGs-IV, providing exact pre-set "prescriptions" for therapy could be interpreted as being provided based upon the reimbursement rather than the individual resident clinical needs and response to intervention on each day

Table 7: Therapy potential target areas and justification under PDPM.

Organizations utilizing contract therapy services under PDPM will need to exercise caution and provide regular oversight of the therapy department to avoid these pitfalls. Communities should require that their contract rehab provider supply them with a weekly and/or monthly report of average therapy minutes per resident, average therapy minutes per RUG, and number of skilled residents not receiving therapy services along with clinical justification. Poor Section GG outcomes or Section GG outcomes that are trending downward, especially if accompanied by reduced therapy minutes, or increased length of stay should be red flags to any organizations that the contract rehab provider may not be providing adequate or quality-driven services under PDPM.

Many providers have begun to consider going to an in-house therapy model with the PPS changes. Under RCS-1, many analysts predicted that this may be the only way for organizations to move forward without major losses. On a positive note, PDPM does offer more breathing room with more appropriate reimbursements for therapy. But, because of the need to actively oversee and monitor the provision of services regardless of the PDPM reimbursement, providers may find it best to consider transitioning to an in-house program prior to the implementation of PDPM. Historically, the transition to an in-house program has been fraught with challenges including staffing, clinical oversight, compliance and regulatory updates and implementation, etc. While some organizations choose to use a short-term management model for the initial transition, what occurs most often is that as soon as the management agreement ends, the therapy department quickly departs from industry standards, best practice and regulatory compliance. An effective alternative is a Hybrid Therapy Consulting Model to provide at least two consultants to oversee the in-house therapy program for the long term. One consultant should be the Operational Oversight Consultant and the second consultant should be a Compliance Consultant. Due to potential conflicts of interest, organizations should insist that these be two separate and distinct consultants with separated roles, rather than allowing consultants to fill both roles simultaneously. One Gravity customer went from -$33,000 operational loss per month and an initial compliance score of 25% to $40,000-50,000 monthly margins and 90%+ compliance score in less than a year utilizing the Hybrid Therapy Consulting Model.

For providers that move forward with contract rehabilitation services, the next important decision to make is how to structure the payment model under PDPM. Because the structure is so different, few if any contracts with therapy providers under RUGs-IV will remain valid and workable under PDPM. The primary recommendation is to consider splitting a percentage of the per diem therapy rates with the rehab agency and allowing the therapists to set the amount and frequencies of therapy services as clinically indicated. And because the actual reimbursement for several tiers of rehabilitation services is not necessarily commensurate with the amount of therapy minutes each individual resident will require, contracts should be arranged to provide the per diem rate every day of the skilled stay regardless of the actual provision of therapy services. This allows the provider to supply the contract rehab agency with adequate aggregate resources to supply an adequate amount of therapy minutes under PDPM. Thus, by splitting the per diem rate with the contract rehab group, the provider can expect the rehab agency to keep the organization out of the target areas. The first example in Table 8 shows the rehab and facility margins for a resident who had a hip fracture and received a total hip replacement. If the PDPM therapy reimbursement is split 50/50 with the contract rehab provider, then the therapy margins increase slightly as compared to an RU and the facility margins also increase for the rehab component by $19.79. The margins increase further for both if comparing an RVB and RHC as well. And, beyond the therapy component, providers will also see a rise in the nursing and NTA components of PDPM reimbursement so total margins for the facility could be even higher.

Comparison of Contract Therapy Scenarios Under PDPM – Hip Replacement

Current RUG IV Score	Current Per Diem Therapy Component of RUG IV	Potential RUG with PDPM	Potential Combined PT, OT, and ST Per Diem Rate	Current Payment to Contract Rehab	Current Facility Margin After Contract Rehab	Proposed Payment to Contract Rehab Under PDPM	Potential Margins for Facility with Contract Rehab Under PDPM	Potential Change To Provider Therapy Margins Under PDPM
RUC	$240.98	TC & SD	$236.67	$102.86	$138.12	(50% of per diem) $118.33	$118.33*	-$19.79
RVB	$164.93	TB & SD	$222.63	$71.43	$93.50	$111.31	$111.32*	$17.82
RHC	$109.52	TC & SD	$236.67	$46.43	$63.09	$118.33	$118.33*	$55.24

* Will be offset by increased per diem rates for Nursing and Non-Therapy Ancillary

Table 8: Comparison of contract therapy scenarios under PDPM for a resident with a hip replacement.

On table 9 another example is displayed of the potential margins and reimbursements for the provider and rehab agency for a resident who falls in the medical management category. CMS reports that 39% of all residents fell into this Medical Management grouping, which could represent a variety of diagnoses such as infection, pneumonia, COPD or a UTI. In this example, for RUC, RVC and RHC both the therapy provider and the facility would receive the same reimbursement of $148.19 under PDPM. Again, because PDPM is based upon resident characteristics and not the amount of services provided, the reimbursement is the same for all 3 levels with PDPM. Unlike the hip fracture example above, which often requires RU levels of therapy, many medical management residents only receive RV or RH under RUGs-IV because of the different clinical needs and tolerance for therapy. Under PDPM, the facility would expect to receive an additional margin of $32.99 for RV and $82.54 for RH, if the therapy provider received 50% of the per diem.

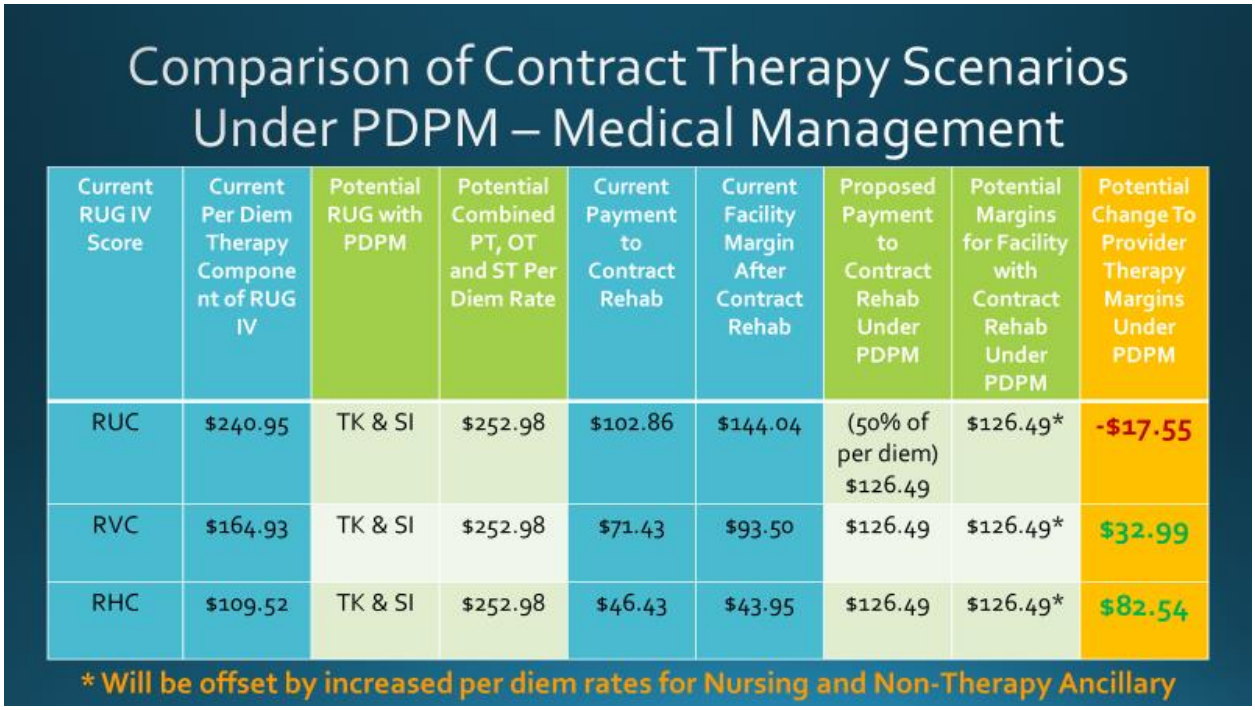

Table 9: Comparison of contract therapy scenarios under PDPM for a resident in the Medical Management Category.

In the final contract rehab analysis, Table 10 features a resident who has suffered a new stroke, is completely hemiplegic, requires total assistance upon admission and is unable to speak or swallow. This is one of the highest reimbursement categories for all residents that is possible under PDPM. In this scenario, the total therapy reimbursement is $262.92, which is appropriate considering stroke survivors often require the most intense, frequent and lengthy services. If the provider splits the therapy component of the per diem rate with the contract rehab agency, their margins will decrease slightly by $6.63 per day for a RU-level resident, which is the most commonly appropriate clinical level for residents with CVAs. Margins increase further for residents at the RV and RH level. In addition, PDPM allows for significantly increased reimbursement to the therapy provider in the amount of $28.60 per day. This is welcome news for the therapy industry because the RU level of approximately 720 minutes was often restrictive for therapists and many therapists provided significantly more services to CVA residents, more than 850 minutes per week. The reimbursement structure under PDPM facilitates more appropriate reimbursement to therapists and therapy providers to be able to supply these additional services to this population as clinically indicated.

Comparison of Contract Therapy Scenarios Under PDPM – Acute Neurologic

Current RUG IV Score	Current Per Diem Therapy Component of RUG IV	Potential RUG with PDPM	Potential Combined PT, OT and ST Per Diem Rate	Current Payment to Contract Rehab	Current Facility Margin After Contract Rehab	Proposed Payment to Contract Rehab Under PDPM	Potential Margins for Facility with Contract Rehab Under PDPM	Potential Change To Provider Therapy Margins Under PDPM
RUC	$240.95	TN & SL	$262.92	$102.86	$138.09	(50% of per diem) $131.46	$131.46*	-$6.63
RVC	$164.93	TN & SL	$262.92	$71.43	$93.50	$131.46	$131.46*	$37.96
RHC	$109.52	TN & SL	$262.92	$46.43	$63.09	$131.46	$131.46*	$68.37

* Will be offset by increased per diem rates for Nursing and Non-Therapy Ancillary

Table 10: Comparison of contract therapy scenarios under PDPM for a resident in the Acute Neurologic category.

The bottom line is that organizations need to partner with the right therapy providers and/or consulting groups as it will be critical to have oversight, direction, accountability and clinical guidance over rehabilitation within the structure of PDPM. With the new redistribution of reimbursement under PDPM, providers need to consider alternative payment models if using contract rehabilitation providers and add new levels of accountability to the oversight of therapy services. Gravity Healthcare Consulting offers a wide array of services and products to help you and your team transition to PDPM with success, including:

- Hybrid Therapy Consulting Model
- Section GG ADL Coding training
- Customized PDPM analysis and strategy report
- PDPM-focused MDS auditing and training
- Restorative Program including manual, video modules, and onsite training with competencies

Providers can also check their predicted RUGs by following this link to CMS SNF PDPM Provider Specific Impact file here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/SNFPPS/therapyresearch.html

Using a CCN (CMS Certification Number), providers can locate a facility and accompanying information, which is based upon FY 2017 data. Gravity Healthcare Consulting can also complete a comprehensive analysis to identify where individual organizations stand and what opportunities exist to further improve accuracy of reimbursement under PDPM.