Patient Driven Payment Model (PDPM) and the MDS:

A Total Evolution of the SNF Payment Model

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Centers for Medicare & Medicaid Services (CMS) has been focused on developing payment models that deliver high quality person-centered care with supporting data that is trackable and reflects appropriate outcomes for all individuals, while reducing regulatory burden and healthcare costs. Transparency and communication across all healthcare systems has also been an area of concentration for CMS, as it continues to re-construct payment models throughout the healthcare spectrum. Current attention for CMS has been on evolving the Skilled Nursing Facilities (SNF) Prospective Payment System (PPS) that has included research and review of SNF historical reimbursement data, Office of Inspector General (OIG) reports, Medicare Payment Advisory Commission's (MEDPAC's) reports, current systemic and administrative regulatory burdens, and the "resident's actual care needs."

On October 1, 2010, CMS implemented a 66-group Version 4 of the RUGs (RUG-IV), as well as an updated resident assessment tool, Version 3.0 of the Minimum Data Set (MDS 3.0). This is the SNF PPS payment model in place through CMS FY2018. In the beginning phases of determining of researching a replacement for RUG-IV, CMS issued an advance notice of proposed rulemaking (ANPRM) on April 27, 2017 with a new model titled Resident Classification System, Version 1 (RCS-1). After further research and consideration of comments regarding the RCS-1 model, CMS released an alternative proposal on April 27, 2018 titled the Patient-Driven Payment Model (PDPM) to replace the existing SNF PPS classification system. PDPM promotes the utilization of "resident characteristics and care needs while reducing systematic and administrative complexity." PDPM removes service based metrics utilized in the current RUG-IV SNF PPS and derives payment

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from supportable resident characteristics. If the proposal is finalized, the proposed PDPM would replace the current SNF PPS classification system on October 1, 2019.

PDPM significantly alters the use of Resource Utilization Groups (RUGs) for therapy and modifies the RUGs for Nursing. Part of the reasoning behind the proposed PDPM is due to data that provides a strong correlation between residents receiving just enough therapy to surpass the Ultra-High and Very-High therapy thresholds for financial incentives (often referred to as "RUG-hugging"), rather than providing services based on the resident's needs. PDPM is focused on utilizing specific resident characteristics that are clinically relevant to establish a per diem rate, rather than reimbursing based upon the volume of services provided.

The objectives of this white paper are to review critical components of the proposed PDPM to determine how the new SNF payment model will impact the role of the MDS Coordinator, including effective strategies for best practices and tactics for accurate capturing of resident-specific characteristics on the MDS. This will empower the MDS coordinator to ensure that the resident is provided with all appropriate services from Day 1 and the SNF will be reimbursed accordingly for services provided.

The focus of PDPM is on the resident's condition and resulting care needs rather than on the amount of care provided. These new resident characteristics then determine the payment received by the SNF. The reimagined structure of this proposed model would move Medicare towards a more value-based, post-acute care payment system putting care needs of the patient first while significantly reducing the administrative burden currently associated with SNF PPS. One of the biggest critiques of the RCS-1 system was that it did not correlate with the Quality Measure of the IMPACT Act, and PDPM was revised to address this valid concern. PDPM emphasis will placed be on clinically relevant, patient driven factors, rather than volume-based delivery of services, for determining Medicare payment. PDPM adjusts Medicare payments based on each aspect of a resident's care, most notably for Nursing and for Non-Therapy Ancillaries (NTAs), which are items and services not related to the provision of therapy such as drugs and medical supplies. This redistribution of reimbursement more accurately aligns with the actual costs associated with the care provided, especially for medically complex patients.

The current SNF payment model (RUG IV) has complex assessment rules and almost constant scheduled assessments that require a large volume of paperwork and labor investment to complete. The proposed PDPM is resident driven and designed to improve incentives to treat the needs of the

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resident's verses concentrating on the volume of services the resident receives. PDPM will reduce the amount of MDS-related paperwork and number of assessments to complete for the MDS Coordinators and the additional members of the interdisciplinary team. CMS estimates that "PDPM would simplify complicated paperwork requirements for performing patient assessments by significantly reducing reporting burden (approximately $2.0 billion over 10 years), helping to create greater contact between health care professionals and their patients."

One method by which the proposed PDPM will significantly decrease the amount of assessments required is by having the 5-day SNF PPS scheduled assessment classify a resident for the entirety of the resident's SNF stay. In the current RUG-IV model, the 5-day assessment window with days 1 – 5 with allowable grace days from day 6-8. CMS is proposing the removal of the "grace days" from the 5-day assessment window. The scheduled assessment window proposed in PDPM for the 5-day assessment will be identified as days 1-8 of the resident's PPS stay.

Due to residents often experiencing significant clinical changes which may require reassessment to accurately capture these changes, PDPM includes a new assessment called an Interim Payment Assessment (IPA). The IPA would be comprised of the 5-day SNF PPS MDS Item Set (Item Set NP) and would be required to be completed when a reassessment is indicated. Providers would be required to complete an IPA in cases where the following two criteria are met:

(1) There is a change in the resident's classification in at least one of the first-tier classification criteria for any of the components under the proposed PDPM such that the resident would be classified into a classification group for that component that differs from that provided by the 5-day scheduled PPS assessment, and the change in classification group results in a change in payment either in one particular payment component or in the overall payment for the resident.

(2) The change(s) are such that the resident would not be expected to return to his or her original clinical status within a 14-day period.

The Assessment Reference Date (ARD) for the IPA would be no later than 14 days after a change in a resident's first tier classification criteria is identified. The IPA is not meant to capture every day or frequent changes, rather it is to be performed when there are substantial changes to a resident's clinical condition. In cases where the IPA is required and a facility fails to complete one, the facility would follow the guidelines for late and missed unscheduled MDS assessments which are explained in Chapters 2.13 and 6.8 of the MDS RAI Manual and would receive the default rate for those days.

A Discharge Assessment will continue to be required at the time of facility discharge for Part A residents. The combination of the 5-day Scheduled PPS assessment, the IPA Assessment, and PPS Discharge Assessment would provide flexibility for providers to capture and accurately the report the

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resident's condition, as well as correctly reflect resource utilization associated with that resident. The decrease in assessments required under the proposed PDPM will minimize the administrative burden on the SNFs.

CMS put forward an interrupted stay policy, which would require completion of a new MDS if there is a readmission to the hospital that is longer than three days and/or admission to a different SNF during the episode. This new policy would not trigger a reset of the variable per diem adjustment clock noted above, meaning that those overall length of stay incentives remain intact regardless of the presence of an interrupted stay.

PDPM is projected to be a simplified and more accurate version of RCS-1 consisting of several changes. PDPM has five CMI (case-mix index) components as compared to RCS-1 which had four. The five separate CMIs for PDPM are: Nursing Groups, Physical Therapy (PT) groups, Occupational Therapy (OT) groups, Speech-Language Pathology (SLP) groups, and Non-Therapy Ancillary (NTA). One adjustment to the CMI groups when compared to RCS-1 is that PT and OT are categorized into their own groups, where in RCS-1 PT and OT were grouped together. The PT and OT groups are separate in PDPM, but scored using the same elements as defined in RCS-1. Payment would be calculated by multiplying the case-mix index for the resident's group with each component, first by a base payment rate and then by the days of service received. The payment calculations for each component would then be added together to create a resident's total per diem rate. A significant reduction in classification groups was achieved with PDPM by combining data elements under each case-mix classification group (refer to Table 1 for number of case-mix classification groups for each of the 5 CMI components for PDPM).

Table 1

Case-Mix Index Groups	Number of Case-Mix Classification Groups
Nursing	25
Physical Therapy (PT)	16
Occupational Therapy (OT)	16
Speech-Language Pathology (SLP)	12
Non-Therapy Ancillary (NTA)	6

Another change from the previously proposed RCS-1 model to the PDPM, is the per diem payment adjustment for PT and OT components changed to a twenty- day base rate with a 2% reduction every seven days for PDPM verses a fourteen day base rate for RCS-1. PDPM also approves a combined 25% of group and concurrent mode of treatment for each therapy discipline during the

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entire stay. Therapists must provide at least 75% of the treatment at a 1:1 individualized ratio for each resident. This is a change from the current SNF PPS payment model for which all group and concurrent services are financially disincentivized and rarely occur.

In the proposed PDPM, data from the MDS, starting with the ICD-10 code and category that supports the SNF Part A stay, are used to classify a resident and serve as the foundation for all the individual group CMIs. PT case-mix and payment will be determined by the ICD-10 code category for SNF admission and the functional score based on Section GG MDS questions. OT case-mix and payment are determined exactly like PT. While PT and OT will always have the same RUG score, the payment will differ for each category between the disciplines. SLP case mix and payment is determined by the ICD-10 code category for SNF admission, as well as factors including swallowing disorders, mechanically altered diets, speech co-morbidities and cognition, all derived based on MDS data. The daily SLP rate does not decrease over time like the PT and OT rates. Additional MDS data including other clinical diagnoses also contribute to the case-mix classifications. Unlike the RUG-IV classification, where each resident is only classified into one combined therapy and nursing RUG group based on the MDS, PDPM breaks apart therapy and nursing to allow for a separate classification for each category. Each resident will fall into a PT, OT and SLP category regardless of the provision of therapy services and the case mix will not be impacted by the presence or absence of therapy services in the proposed rule. Resident advocates have expressed concern that the PDPM could potentially reimburse providers for therapy services that are never delivered to the resident or at a significantly reduced amount. In response to some of these concerns, CMS included in PDPM that the facility reports the therapy minutes on the discharge assessment to allow for oversight. CMS has further stated that it expects providers to continue with no changes in practice, especially in regard to the provision of therapy services under PDPM. However, it remains unclear how, when or who would address instances where this occurs, especially on a large scale.

Under the current SNF PPS model (RUG-IV), payments for NTA costs are incorporated in the nursing component. MedPAC wrote in the March 2016 Report to Congress, "Almost since its inception, the SNF PPS has been criticized for encouraging the provision of unnecessary rehabilitation therapy services and not accurately targeting payments for nontherapy ancillary (NTA) services such as drugs (Government Accountability Office 2002, Government Accountability Office 1999, White et al. 2002)." Due to data findings supporting the misutilization of the NTA under the current SNF PPS, the proposed PDPM addressed this issue by

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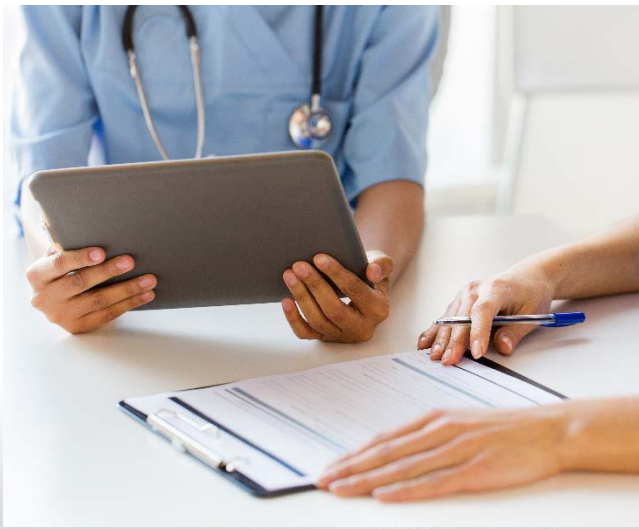
eliminating the use of therapy utilization (RUG) and instead provides for a more accurate reflection of payments for NTA services. In the PDPM, the NTA category is an adjusted per diem payment that is 3% over baseline for the first three days and then returns to the baseline rate by day four.

PDPM will replace Section G with Section GG as the foundation for establishing ADL scores and the data will be used for scoring the functional components related to the PT, OT and Nursing Case Mixes. Unlike Section G under the current SNF PPS, Section GG will measure some functional areas with an average of several items. The Section GG scores which will be averaged are the two bed mobility items, the three transfer items, and the two walking items. The proposed scoring would include the individual items added to the average scores and resulting in a range from 0 – 24 (refer to Table 2 for proposed Section GG items for PT and OT for functional measure).

Table 2

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	



PDPM nursing RUGs are similar to the current non-therapy nursing RUGs under RUG-IV. RCS-1 had the total number of RUGS decreased from 66 to 43, and now the proposed PDPM decreased it to a total of 25 by combining existing groups. PDPM accomplishes this by collapsing the ADL Scores for some categories for the 4 middle ADL groups into just 2 ADL groups for these nursing RUGS. Under PDPM, all residents would be classified into only one of the 25 nursing case-mix groups and all residents would always receive a nursing RUG. The proposed PDPM nursing classification model consists of 7 categories: extensive services, clinical conditions, depression, number of restorative nursing services, GG-based function score, PDPM nursing case-mix group, and nursing case-mix index.

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To accurately provide each resident with the appropriate services and capture the appropriate reimbursement for services provided, it will be vitally important for your SNF to perform all assessments and provide all services starting on the first day of the resident's admission. This includes accurate documentation of the signs and symptoms of depression and identification, and if clinically indicated, the implementation of restorative nursing services on Day 1 of the resident's SNF stay. If documentation doesn't accurately reflect the services provided or indicated, then this will impact the overall reimbursement throughout the resident's entire stay. As previous stated, a 5-day SNF PPS scheduled assessment will classify a resident under the proposed PDPM for the entirety of the resident's SNF stay, unless a resident experiences significant clinical changes which may require reassessment called an IPA to capture the changes.

There are many components to consider with PDPM, including the Skilled Nursing Facility Quality Reporting Program (SNF QRP) component. SNFs are already familiar with the QRP and have experience gathering data and submission, along with having the Quality Improvement and Evaluation System (QIES) and Assessment Submission and Processing (ASAP) system notifications. The listing is found in the proposed rule (see page 202, Table 39: Quality Measures Currently Adopted for the FY 2020 SNF QRP). There are nine Resident Assessment Instrument Minimum Data Set (RAI/MDS) measures and three claims-based measures already adopted for the fiscal year 2020 SNF QRP. These are as listed:

RAI/MDS Measures

1. Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)
2. Wording changes only for (1. Percent of Residents or Patients with Pressure Ulcers Above) in Skin Integrity Post-Acute Care (PAC): Pressure Ulcer/Injury Measure Effective 10/1/2018.
3. Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)
4. Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)
5. Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
6. Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636)
7. Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF # 2633)
8. Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
9. Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC SNF QRP

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SNFs are to begin submitting data for quality measures 2633, 2634, 2635 and 2636 by October 1, 2018. The CMS will publicly display these measures from January 1 to December 31, 2019, for SNFs that meet the minimum number of cases on Nursing Home Compare. CMS explains that "publicly sharing this data with the consumer will help the patient make a more informed choice when selecting care service providers for their individual needs." CMS also supports the Patients over Paperwork Initiative, incentivizing person-centered care and continuing the movement away from paying for volume.

Submission of this data through the MDS must meet the submission requirements through the QIES. Failure to submit all data may result to a two percent reduction to of the annual payment update for the applicable payment year

SNF QRP MDS 3.0 Item Set Updates as of October 1, 2018 will include:

- New/modified/deleted GG items to reflect data needs for new functional outcome measures
- New MDS Item set I0020 (primary medical condition), J2000 (major surgery during 100 days prior to admission) items for risk adjustment for functional outcome measure
- Modified MDS Item set M0300 for clarity/accuracy

CMS has contributed numerous resources and and conducted research as the foundation for the development of the proposed PDPM. Healthcare entities and payment systems are continuing to evolve with a focus on providing person-centered care that has supporting documentation reflective of the services required to support the needs and care of every person. Healthcare fraud and overutilization are other factors that contribute to the need to reassess and alter the reimbursement structure for healthcare systems. PDPM is a payment system that incorporates person-centered care that is individualized to accurately reflect all services provided, while endeavorging to protect government funds from fraud and overutilization.

With the proposed PDPM, providers will have to be diligent with performing comprehensive assessments, documenting accurately, and providing appropriate services starting on Day 1 of the resident's admission. One of the key shifts that every provider will need to make is providing comprehensive care and and ensuring that supportive documentation is in place starting on the day of admission. Because a key omission during the 5-day assessment will impact payment for the entire stay, it is vital that healthcare leaders coordinate the efforts of their teams to be proactive and thorough from the Day 1. This will aid providers in the goal of providing all residents with high quality care that is reflective of an individualized plan of care focused on appropriate length of stay and optimal outcomes. The reimbursement provided by CMS via the proposed PDPM would utilize data captured on the 5-day assessment to provide payment for services provided by the SNF throughout the resident's entire stay. Interdisciplinary team communication and documentation are integral components in determining whether a SNF will successfully transition to PDPM. It is yet to be

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determined if PDPM will be the finalized rule to evolve the SNF payment model, but providers should be proactive and prepared to transition when the time arrives.

Could your community benefit from additional PDPM resources or onsite training? Gravity Healthcare Consulting offers informative onsite training to educate your interdisciplinary team on changes proposed by CMS to occur in the SNF. Gravity Healthcare Consulting also offers interim staffing, including RNAC/MDS Coordinators and Administrators, mock surveys, restorative nursing training, CMI audits, and an array of webinars. Our contact information is listed below. We look forward to assisting your community any way we can.

References

1. Centers for Medicare and Medicaid Services. Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for CY 2019, SNF Value-Based Purchasing Program, SNF Quality Reporting Program. Available April 27, 2018, at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-09015.pdf

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