Optima
HEALTHCARE SOLUTIONS

WHITE PAPER

Patient-Driven Payment Model (PDPM)

Revised SNF Payment Model and How It Compares to RUG-IV and RCS-1

The proposed rule for FY-2019 has been the most anticipated since the introduction of the Medicare Prospective Payment System in 1998. Following the Advanced Notice of Proposed Rule Making (ANPRM) suggestion of a new payment model, RCS-1, SNF providers and their therapy partners have been eagerly waiting for an indication of whether it would really happen. While the RCS-1 name has been scrapped in favor of PDPM, the essence of the system now in a proposed rule—to become effective in October 2019—is very much the same. The payment model eliminates payment based on services delivered in favor of resident classifications and anticipated resource needs during the course of a patient's stay. PDPM includes some important revisions and clarifications from RCS-1, but it could appropriately be named RCS-1.1.

CLASSIFICATION

RUG-IV

Service-based metrics classify patients into one of 66 possible resource utilization groups based on the calculation of two case-mix indexed components.

1. Therapy
2. Nursing

Patients may fall into multiple case-mix groups, but the one with the highest index wins.

RCS-1

Groups patients into one of 10 primary classifications that are used as a component in calculating four case-mix indexed components:

1. Physical and occupational therapy (PT/OT)
2. Speech-language pathology (SLP)
3. Non-therapy ancillary (NTA)
4. Nursing

The rates assigned to the four indexes are combined with a non-indexed component to derive the daily rate for a patient.

PDPM

Groups patients into one of 10 primary classifications that are used as a component in calculating five case-mix indexed components:

1. PT
2. OT
3. SLP
4. NTA
5. Nursing

The rates assigned to the five indexes are combined with a non-indexed component to derive the daily rate for a patient.

REIMBURSEMENT

RUG-IV

Therapy minutes delivered is the primary determinant of payment.

Incentivizes higher therapy utilization.

Rates are constant throughout a patient's length of stay, as long as the services provided remain constant.

RCS-1

Therapy minutes delivered has no impact on reimbursement.

Incentivizes lower therapy utilization.

PT/OT rates decline 1% every 3rd day after the 14th day of a patient's stay.

NTA rates decline by 2/3rds after the 3rd day of a patient's stay.

PDPM

Therapy minutes delivered has no impact on reimbursement.

Incentivizes lower therapy utilization.

PT/OT rates decline 2% every 7th day after the 20th day of a patient's stay.

NTA rates decline by 2/3rds after the 3rd day of a patient's stay.

MODES OF TREATMENT

RUG-IV	RCS-1	PDPM
Group and concurrent therapy are financially discouraged.	Group and concurrent therapy are financially beneficial with generous limits. • Group therapy is capped at 25% per patient. • Concurrent therapy is capped at 25% per patient. • Based on group and concurrent caps, at least 50% of therapy must be individualized.	Group and concurrent therapy are financially beneficial with greater limitations than RCS-1. • Group and concurrent therapy combined is capped at 25% per patient, per discipline. • Based on group and concurrent caps, at least 75% of therapy must be individualized.

FUNCTIONAL ASSESSMENT

RUG-IV	RCS-1	PDPM
Section G Function is measured based on four basic activities: transfers, toileting, eating, bed mobility.	Section G Function is measured based on three basic activities: transfers, toileting, eating.	Section GG Function is measured based on 10 indicators of function: eating, oral hygiene, toileting hygiene, sit to lying, lying to sitting on side of bed, sit to stand, chair/ bed-to-chair transfer, toilet transfer, walk 50 feet with two turns, walk 150 feet.

ASSESSMENTS

RUG-IV

5 scheduled assessments:

- 5-Day
- 14-Day
- 30-Day
- 60-Day
- 90-Day

5 unscheduled assessments:

- Other Medicare Required Assessment (OMRA)
- Change of Therapy (COT)
- End of Therapy (EOT)
- Significant Change
- PPS Discharge

RCS-1

1 scheduled assessment:

- 5-Day

2 unscheduled assessments:

- Significant Change
- PPS Discharge

PDPM

1 scheduled assessment:

- 5-Day

2 unscheduled assessments:

- PPS Discharge
- New - Interim Payment Assessment (IPA)

*IPAs are expected to be very limited due to criteria specified to trigger such an assessment.

REPORTING THERAPY MINUTES

RUG-IV

Every assessment reports the last 7-days of therapy minutes and treatment days.

RCS-1

Discharge assessments report therapy minutes.

PDPM

Discharge assessments to include a modified "Section O" with greater detail, including the following for each discipline:

- Start Date
- Stop Date
- Individual Minutes
- Concurrent Minutes
- Group Minutes
- Treatment Days

*This data will likely be compiled by CMS along with the Section GG outcomes data and serve as a basis for rate adjustments (up or down) for patient classifications in the future.

HOW THE THERAPY CASE-MIX IS DETERMINED

RUG-IV

Index-Maximizing

A patient is classified into one or more groups with case-mix indexes assigned to each. The highest indexed group that the patient falls into is used for re-imbursement. This leads to over 90% of Medicare patient days being paid based on therapy delivery.

RCS-1

Index-Combining

All patients are assigned to two therapy groups:

PT/OT
- Clinical Category
- Functional Score
  - Section G
- Cognition Level

SLP
- Clinical Category
- SLP Comorbidities
- Cognitive Level
- Swallowing Disorder or Mechanically Altered Diet

PDPM

Index-Combining

All patients are assigned to three therapy groups:

PT
- Clinical Category
  - Major Joint Replacement or Spinal Surgery
  - Non-Orthopedic Surgery and Acute Neurologic
  - Other Orthopedic
  - Medical Management
- Functional Score (0 – 24)
  - Section GG

OT
- Clinical Category
  - Major Joint Replacement or Spinal Surgery
  - Non-Orthopedic Surgery and Acute Neurologic
  - Other Orthopedic
  - Medical Management
- Functional Score (0 – 24)
  - Section GG

NOTE: While RCS-1 made poor cognition detrimental to PT and OT rates, PDPM has eliminated that correlation.

SLP
- Presence of...
  - Acute Neurologic Classification
  - Cognitive Impairment
  - SLP Comorbidity
- Presence of...
  - Mechanically Altered Diet or...
  - Swallowing Disorder

PAYMENT CATEGORIES

RUG-IV	RCS-1	PDPM
66 RUG Groups	139,320 unique combinations based on: PT/OT: 30 classifications SLP: 18 classifications Nursing: 43 classifications NTA: 6 classifications	28,800 unique combinations based on: PT/OT: 16 classifications SLP: 12 classifications Nursing: 25 classifications NTA: 6 classifications NOTE: While PT and OT have unique index values assigned to them, the actual classification is always the same for PT and OT under PDPM.

Managing Care

PDPM is a significant revision of RCS-1. But make no mistake, the fundamental goal of the proposed value-based payment model remains the same—to provide patient-centered care that treats the needs of the whole patient, instead of incentivizing delivery of an ultra-high volume of services to the patient.

With minutes separated from reimbursement, PDPM will likely lead to a reduction in the amount of therapy provided compared to the current RUG model, which incentivizes over-delivery of therapy services. It will no longer be a case of increasing therapy minutes to ultra-high levels to capture the maximum payment. SNFs who over-deliver therapy won't get paid for services provided beyond the reimbursement level for each resident classification. But under-delivering therapy will lead to poor patient outcomes and potential Medicare take-backs. CMS has allocated reimbursement dollars specifically for therapy to each and every resident in a skilled nursing facility and reasonably expects therapy services to be provided accordingly. Under-delivery of therapy may also lead to lower overall rates in future years, as CMS will likely adjust indexes up or down based on the amount of therapy actually delivered as reported on Medicare Discharge Assessments.

Therapy providers will need to carefully manage how they deliver services in order to provide just the right level of care for each resident and achieve the desired functional outcome.

Preparing for PDPM

With a proposed October 1, 2019 implementation date, it's important to start laying the groundwork now for the necessary changes. This includes having the right technology and tools in place to help guide decisions and determine the best approach for each therapy business.

EMR software with advanced business intelligence (BI) and data analysis tools can help therapy providers predict their future needs and manage costs under PDPM. They will also need tools for guiding treatment plans by resident classification. Effective EMR software solutions must be able to suggest customizable treatment protocols that will allow them to deliver the appropriate level of care for each unique resident.

Ask your EMR vendor what capabilities they will have to support your transition.