The single largest change to the Skilled Nursing Facility (SNF) Prospective Payment System in over 20 years was implemented on October 1, 2019 with the introduction of the Patient-Driven Payment Model (PDPM).

CMS launched PDPM as an integral step toward value-based care. This change is significant — and SNFs, health systems, health plans and other post-acute care (PAC) providers need to understand its potential impact on their businesses.

What PDPM means for SNF care

PDPM has replaced the existing Resource Utilization Group (RUG) payment methodology which CMS established to be budget neutral.

Most significantly, PDPM will transform how SNF payments work: rather than driven primarily by rehabilitation volume, payments will be determined by identified patient needs and conditions.

PDPM helps to better align payment incentives and quality measures. Currently, under RUG, patients with major differences, in terms of skilled nursing needs and costs, often receive the same payment. This is because patients are typically consolidated into a single, volume-driven, case-mix group primarily based upon therapy services and needs, despite their varying nursing complexities. In fact, 90% of patient days are classified into one of the therapy payment groups.

“Cost and quality outcomes must be of equal consideration in determining the value of patient care. Both are equally important,” said naviHealth Senior Director of Outcomes Integrity Amy Leibensberger.

PDPM, however, tailors payments based upon the unique, individualized needs, characteristics and goals of each patient. Specifically, payments are driven by five case-mix-adjusted components:

- Physical Therapy, with a variable per diem
- Occupational Therapy, with variable per diem
- Speech-Language Pathology
- Nursing
- Non-Therapy Ancillary, with variable per diem

There is an additional component that covers non-variable SNF resources like room and board, utilities, and capital costs.

“With PDPM the payments are based on five components, therefore, the medically complex patients will be more appropriately reimbursed, in contrast to the RUG payment system. PDPM insures that payment is driven by the needs of these patients, not how much therapy is delivered,” according to Leibensberger.

CMS will also begin monitoring a number of SNF elements under PDPM to ensure adherence to the new guidelines as well as the appropriate and quality care delivery. SNFs are now required to provide CMS with documentation to support, not only the skilled need for SNF care, but also to verify coding of medical conditions — ensuring that any care delivered is appropriate for the unique needs of the patient.

The agency is monitoring a number of elements under PDPM, and CMS is closely monitoring SNF changes in practices:

- Patients with depression, IV medications, modified diet consistencies and respiratory therapy needs will result in higher reimbursements, so physician-directed supporting documentation will be mandated for many coded items.
- Therapy service minimums are not established with the new payment reform, so reduction in therapy services may occur;
- Concurrent and group therapy are incentivized up to 25% of total minutes delivered, so significantly higher use of these therapy modes may occur.

How providers can be successful with PDPM

For health systems, health plans and PAC providers, there are a number of strategies that can help ensure success under PDPM.

1. Ensure patients are receiving appropriate, high-level care.

Across the PAC continuum, providers need to ensure that patients are achieving the most appropriate clinical outcomes in the most efficient period of time. This means not only coding appropriately in the MDS and supplying supporting documentation, but insuring that patients are receiving the appropriate level of nursing care and therapy mode — from individual to concurrent to group —for their unique needs. Moreover, providers will need to ensure that SNF staff competencies, skillsets and ratios are appropriate for patient needs, especially if providers are considering increasing medically complex admissions.

Many providers, in general, will be working on care maps and practice guidelines to help

bring uniformity to patient care. Vital to developing these plans — as well as selecting the right plans for patients — will be the ability to both confidently assess the unique needs of patients at admission, while also determining whether the patient's eventual outcomes and costs align with expectations.

2. Continue to evaluate and build high-quality networks.

Enlisting the support of high-quality, high-value provider partners will be critical for success under PDPM. It's important to recognize that, when PDPM arrives, payors will be evaluating network adequacy and overall performance. To build stronger networks, providers will need to analyze both quality and efficiency performance across the PAC continuum, to identify high-value providers.

There are a number of reasons why high-performing partners are essential. For instance, PAC providers will need to be highly proficient at care transitions, in order to guide patients through appropriate and efficient paths of care. Providers will also need to actively communicate with both upstream and downstream providers to ensure that patients' clinical information is not only accurate, but active and relevant to the needs of patients in skilled facilities. Likewise, providers will need to enhance communication within their interdisciplinary team (IDT) and with referring hospitals very early on, ensuring that patient needs are met when they first arrive at skilled facilities.

In other words, with stronger PAC networks, providers can maintain better communication, achieve more streamlined care, improve the patient experience, and more confidently meet their quality and efficiency goals.

3. Use data to drive a patient-centric care model

CMS is expecting SNFs to improve functional outcomes — measured over the course of care, via Section GG on the SNF MDS — and lower PAC costs, while maintaining or improving the patient experience. To reliably achieve those aims, health systems, health plans, and PAC providers will need to leverage robust, data-driven tools to ensure they're maximizing quality and efficiency. With the aid of real-time or near-time data, providers can make better decisions about when and where patients need to transition and the level of therapy they will require as they recover.

PDPM is a true game changer for post-acute care. By realigning SNF payments with quality initiatives, PDPM incentivizes PAC providers to eschew volume-driven strategies and adopt a patient-central model of care. To achieve success under PDPM, providers should leverage

data-based strategies to ensure they hit their key quality and efficiency targets.