The Patient Driven Payment Model
An Industry Game Changer

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Today’s Presenters

Colleen O’Rourke, PT, MBA
SVP, Clinical and Network Solutions
naviHealth

Amy Leibensberger, PT, MS
Senior Director, Outcomes Integrity
naviHealth
Our Goals for Today

1. Highlight the basic components of the Patient Driven Payment Model
2. Discuss the effect PDPM will have on key SNF operations and delivery of care
3. Detail imperative strategies for SNFs to ensure both quality outcomes and cost-efficient care are achieved simultaneously
4. Explore how developing robust high-quality networks with health plans, health systems and other PAC providers will be crucial for PDPM success
A bit about naviHealth

19 Years
Experience in discharge management

Manage care transitions for

- 875+ Acute hospitals
- 12K+ PAC facilities

25% of all nationwide acute discharges move across our networks

$350 MILLION in unnecessary costs removed from the healthcare system annually

20% generated in savings and reduced medical expenses for health plan partners

Providing services for the BPCI Advanced initiative in
22 STATES

>150 HOSPITALS across 12 health systems

~ 3.5 MILLION Medicare Advantage and ACO member lives under PAC management

>100K BPCI Advanced episodes of care managed annually

CLINICAL IMPACT
8% average BPCI savings per episode vs. historical baseline

*Figures based on Monthly CMS Claims, Q1/Q2 2016 results for 2017 Phase II (a1-aa) episodes annualized. Financials based on experience, and results in managing episodes in partnership with health systems as an Awardee Convener in the inaugural Bundled Payments for Care Improvement Initiative.

Disclaimer: The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document.
What type of organization are you from?
How familiar are you with PDPM?
An Overview of PDPM
In July 2018, CMS announced a new case-mix classification model called the Patient Driven Payment Model (PDPM) set to launch on October 1, 2019.

PDPM is a welcome change from the therapy-minute driven payment system of the Resource Utilization Group, Version IV (RUG-IV), where quantity versus quality of service drove care decisions and profitability.

The model represents the single largest change to the SNF Prospective Payment System since its inception, with impacts on patient classification, assessment burden, care planning and care design.

Are you ready?
Why the Shift from RUG-IV to PDPM?

RUG-IV

- Issues with the current case-mix model, RUG-IV, have been identified by CMS, OIG, MedPAC, the media, among others
- Under RUG-IV, most patient days (90%*) are classified into a therapy payment group
- SNF patients who may have major differences in terms of nursing needs and costs often receive same payment for nursing services

Source: John Kane, Technical Advisor/SNF Payment Team Lead, CMS: NASL Conference, Feb 2019
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**PDPM**
- Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided
- Intends to reduce administrative burden on providers
- Reallocates SNF payments to currently underserved beneficiaries without increasing total Medicare payments

Source: John Kane, Technical Advisor/SNF Payment Team Lead, CMS: NASL Conference, Feb 2019
### Why the Shift from RUG-IV to PDPM?

<table>
<thead>
<tr>
<th>RUG-IV</th>
<th>PDPM</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Issues with the current case-mix model, RUG-IV, have been identified by CMS, OIG, MedPAC, the media, among others</td>
<td>• Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided</td>
<td>• Underscores commitment to true value-based care</td>
</tr>
<tr>
<td>• Under RUG-IV, most patient days (90%*) are classified into a therapy payment group</td>
<td>• Intends to reduce administrative burden on providers</td>
<td>• Places equal stock in efficiency and quality</td>
</tr>
<tr>
<td>• SNF patients who may have major differences in terms of nursing needs and costs often receive same payment for nursing services</td>
<td>• Reallocates SNF payments to currently underserved beneficiaries without increasing total Medicare payments</td>
<td>• Supports comprehensive patient-centered clinical care driven by outcomes, not incentives</td>
</tr>
</tbody>
</table>

*Source: John Kane, Technical Advisor/SNF Payment Team Lead, CMS: NASL Conference, Feb 2019*
RUGs vs. PDPM

While RUG-IV (left) reduces everything about a patient to a single, typically volume-driven, case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics, and goals of each patient.

Source: CMS
Patient-Driven Care Under PDPM

Five case-mix-adjusted payment components:

1. Physical Therapy with variable per diem
2. Occupational Therapy with variable per diem
3. Speech-Language Pathology
4. Nursing
5. Non-Therapy Ancillary with variable per diem

One non-case-mix component to cover non-variable SNF resources (room, board, utilities, capital costs, etc.)

Source: Skilled Nursing Facilities Patient-Driven Payment Model Technical Report, Acumen, April 2018
Individualization Under PDPM

By addressing each individual patient’s unique needs independently, PDPM improves payment accuracy and encourages a more patient-driven care model.

While Patient A has more underlying medical conditions and a strong need for Speech Therapy, Patient B has a high need for Physical Therapy and Nursing Care.

Source: CMS
## A Snapshot of PDPM

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Base Rate</th>
<th>CMI</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>PT Base Rate</td>
<td>×</td>
<td>PT CMI</td>
</tr>
<tr>
<td>QT</td>
<td>QT Base Rate</td>
<td>×</td>
<td>QT CMI</td>
</tr>
<tr>
<td>SLP</td>
<td>SLP Base Rate</td>
<td>×</td>
<td>SLP CMI</td>
</tr>
<tr>
<td>NTA</td>
<td>NTA Base Rate</td>
<td>×</td>
<td>NTA CMI</td>
</tr>
<tr>
<td>Nursing</td>
<td>Nursing Base Rate</td>
<td>×</td>
<td>Nursing CMI</td>
</tr>
<tr>
<td>Non-Case-Mix</td>
<td>Non-Case-Mix Base Rate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CMS
## Determinants Base Rate Payment in PDPM

<table>
<thead>
<tr>
<th>PT (16 groups)</th>
<th>OT (16 groups)</th>
<th>SLP (12 groups)</th>
<th>Nursing (25 group)</th>
<th>NTA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary reason for SNF care</td>
<td>• Primary reason for SNF care</td>
<td>• Primary reason for SNF care</td>
<td>• Clinical information from SNF stay</td>
<td>• Comorbidities present</td>
</tr>
<tr>
<td>• Functional status</td>
<td>• Functional status</td>
<td>• Cognitive status</td>
<td>• Functional status</td>
<td>• Extensive services received (from a list of 50 conditions)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Presence of swallowing disorder or mechanically altered diet</td>
<td>• Extensive services received</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Other SLP-related comorbidities</td>
<td>• Presence of depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Restorative nursing services received</td>
<td></td>
</tr>
<tr>
<td>Variable per diem</td>
<td>Variable per diem</td>
<td>Variable per diem</td>
<td>Variable per diem</td>
<td></td>
</tr>
<tr>
<td>• 2% reduction every 7 days after day 20</td>
<td>• 2% reduction every 7 days after day 20</td>
<td>• 300% day 1-3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 100% thereafter</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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PDPM | What Changes, What Does Not?
# Model Changes

## RUG-IV

<table>
<thead>
<tr>
<th>Case-Mix Components</th>
<th>1. Two case-mix components: Therapy and Nursing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Determination</td>
<td>2. The highest of 66 RUGs level is used to determine payment; hierarchical.</td>
</tr>
<tr>
<td>Group and Concurrent</td>
<td>3. Group and Concurrent therapy delivery modes are financially discouraged.</td>
</tr>
<tr>
<td>Assessment Frequency</td>
<td>4. Five mandated, scheduled assessments during a 90-day episode of care. Five unscheduled assessments.</td>
</tr>
</tbody>
</table>

## PDPM

| 1. Five case-mix components: OT, PT, ST, Nursing, Non-Therapy Ancillary (NTA); one non-case mix. |
| 2. Combination of six components used to determine payment; over 28,000 possible combinations. |
| 3. Group and Concurrent therapy delivery modes are incentivized to max of 25% per discipline. |
| 4. 5-day, Discharge and Interim Payment Assessment (IPA) scheduled during episode of care. |
Model Changes, Cont’d.

**RUG-IV**

1. **Payment Rates**
   - Constant rates (100%) for the assigned RUGs level over the LOS.

2. **Rehab Therapy**
   - Maximum therapy incentivized; rates constant within RUGs group.

3. **Functional Assessment**
   - Functional measurement based on four functional tasks; Section G.

4. **Therapy Mins/Visits**
   - Therapy minutes/days recorded on the MDS for only the last seven days of every assessment.

**PDPM**

1. **Declining rates** over LOS for OT, PT and NTA.

2. Incentivizes lower therapy utilization; PT/OT rates decline after Day 20.

3. Function measured using ten functional tasks utilizing Section GG.

4. Therapy minutes (total, concurrent, group), start/stop dates and # of days recorded on discharge MDS.
Value-driven care is, by definition, a balance between care quality and care cost.

CMS measures the quality of care provided to SNFs in a variety of ways.

PDPM redefines the relationship between payment and quality measures, realigning payment incentives and quality incentives.

- High-value, efficient providers are those who are able to deliver high-quality care at a low cost.
- SNF Quality Reporting Program
- SNF Value-Based Purchasing
- Nursing Home Compare Star Ratings

- Given the more holistic style of care emphasized under PDPM, program integrity and data monitoring efforts will also be more comprehensive and broad.

Source: John Kane, Technical Advisor/SNF Payment Team Lead, CMS: NASL Conference, Feb 2019
What is Not Changing Under PDPM

- CMS Chapter 8 Regulations
  Qualifications for Skilled Level of Care
    - Patient must require the skill of a Nurse or Therapist on a daily basis
    - Must be reasonable and necessary for the treatment of a patient’s particular illness or injury based on medical needs
    - Patient’s skilled need must be related to, or a direct result from, the patient’s acute hospitalization
    - Patient’s needs cannot be met in a lower (less restrictive) level of care

- Documentation requirements
- The risk for audits from CMS
- Participation in the Department of Public Health Survey Process
- Requirements to report Quality Measures
How are SNFs Preparing for October 1?

**Analyze**
- Analysis of the financial impact of payment reform

**Enhance Processes**
- Improving capture of NTA and Nursing codes on MDS
- Enhancing nursing documentation for justification of skilled need
- Enhancing nursing skillset if considering increasing medical complex admissions
- Working to enhance communication within IDT and with referring hospitals
- Integrating more frequent IDT meetings during assessment period

**Assess Rehab Delivery of Care**
- Alterations in Therapy Staffing ratios
- Consideration for appropriate use of concurrent/group therapy
- Conduct follow-up calls with patients who had identified needs (and relevant providers and community resources) after discharge home
- Developing practice guidelines; functional-based rehabilitation for efficient and effective care
- Use of rehabilitation in traditionally non-revenue-generating services
naviHealth Preparation

Utilization Management

• Development of PDPM UM Authorization tool
• Parallels methodology of CMS

Product Enhancements

• **nH Predict | Outcome** report
  • Predictive tool for care management based on patient characteristics
  • Enhanced algorithms for improved accuracy and preciseness

• **nH Predict | Pulse** dashboard
  • Severity adjusted aggregate report
  • SNF performance and network report

Training & Education

• Engagements with SNF/IDT re: PDPM
Strategies for Success to Thrive in PDPM

- Internal look at Network adequacy and overall performance
- The use quality and efficiency data to make Participating Provider determinations
- Partnering and collaborating to drive value while preserving or improving the patient experience
- Proficiency in care transitions – who is responsible?
- A patient-centric model – using data and information to make more informed decisions
- The importance of high-quality highly valued care partners for patients as they journey through their recovery

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Questions?

Thank You

PDPM@naviHealth.com