

Author and Contributors

Amy Leibensberger, PT, MS, Sr. Dir. Outcomes Integrity
Jennifer Terrell, MD, Executive Medical Director

Angela Gaetano, BA, MS, Manager, Data Science
Alice Townsend, BS, MS, Sr. Analyst, Data Science

Executive Summary:

When therapy and nursing services are delivered to Bundled Payments for Care Improvement (BPCI) and Medicare Advantage (MA) patients by the same Skilled Nursing Facility (SNF) medical teams, MA patients demonstrate similar quality outcomes (readmissions, functional recovery and community discharge) with statistically better efficiencies when severity-adjusted therapy hour/day target guidelines are followed.

On October 1, 2019 the new CMS payment reform, Patient Driven Payment Model (PDPM), took effect for all SNFs serving Medicare patient populations. Along with the payment reform, changes in SNF practice will result in an effort to provide efficient care delivery and quality outcomes. It is anticipated that, due to the payment incentives, lower rehabilitation (therapy) services will result.

PDPM payment will be based not on therapy volume, but on the needs, characteristics and conditions of the patient upon admission to the SNF. Maximization of therapy utilization, both in minutes per week and length of stay (LOS), incentivized in the current RUGS-IV (Rehabilitation Utilization Groups) system will no longer be present.

In SNF facilities across the country, two payment systems with differing incentives, RUGS-IV and Medicare Advantage (MA), are utilized simultaneously. While one incentivizes therapy volume (RUGS), the other (MA) promotes high efficiencies.

Similarly, naviHealth manages over 2.7 million lives in the post-acute care (PAC) setting for ACO and MA plans in addition to over 108,000 annual bundled payment episodes in the CMS BPCI program. Many of these beneficiaries are managed in the same SNF with identical therapy providers and nursing staff.

naviHealth Care Managers utilize a tool, the **nH Predict | Outcome**, the output of which is based upon a severity-adjusted algorithm derived from a Best Practice national dataset. Similar to the PDPM algorithms, the **nH Predict | Outcome** output uses patient conditions and characteristics, including admission function of mobility, ADL and cognition, primary diagnosis and relevant comorbidities. This high-tech tool provides clinicians and SNF Interdisciplinary Teams (IDT) with risk-adjusted projections of functional gain, LOS and therapy minutes/week which they use in setting goals and outcome expectations.

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The high-tech **nH Predict | Outcome** component is augmented with the high-touch practices of the naviHealth Care Manager, where patients are closely monitored throughout the SNF episode working alongside the SNF care team. This high-tech, high-touch model has resulted in value-based care where both quality and efficient outcomes are achieved.

In the MA model, the naviHealth Care Coordinators, along with naviHealth Medical Directors, authorize skilled days for the MA Health Plans. This is not true for the BPCI population; in the BPCI population, naviHealth care management is limited to providing SNF teams only with guidance, but without authorization, for skilled stays. Both models are provided with severity -adjusted minimum therapy intensity (minutes per week or hours per day) targets.

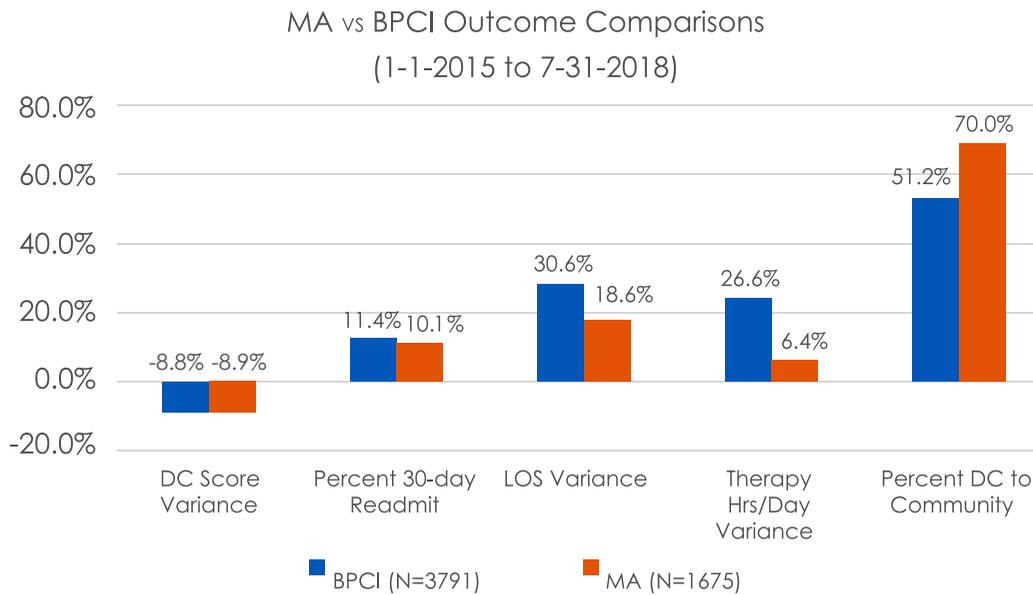
This unique situation provides an opportunity to study outcomes of different care delivery models within the same SNFs, utilizing the same therapy and nursing staff. Assuming efficient and effective practices similar to MA are needed to succeed with PDP, can comparable quality outcomes be achieved with similar or better efficiencies in the MA population when compared with BPCI?

This retrospective study included 5,470 SNF skilled episodes discharged from 19 SNFs between January 1, 2015 to July 31, 2018. Only SNFs where BPCI and MA records were managed concurrently were included; at least 20 episodes from both payers must have been managed with naviHealth care management.

For each outcome variable, the average variance of the actual values and the predicted values (from the **nH Predict | Outcome** report) were calculated. (Percent Variance = [(Actual-Predicted)/Predicted]*100)

Statistical analyses of these severity-adjusted variances (at significance level $\alpha = 0.05$) indicated the following:

- Quality indicators
 - **The discharge functional scores** between MA and BPCI were **not statistically different**.
 - **Readmission** directly from the SNF within 30 days of admission was also **not statistically different**.
 - The percent of patients **discharged to community was statistically higher for the MA population** as compared to BPCI (by ~19% in this sample).
- Efficiency indicators
 - **LOS** was **statistically lower for the MA population** as compared to BPCI (by ~12% in this sample).
 - **Therapy hours per day** were **statistically lower for the MA population** as compared to BPCI (by ~20% in this sample).



Success in the PDPM payment model requires cost-efficient and effective care delivery. The value-based model will need to be similar to that currently being practiced with mature, well-managed MA plans.

In SNFs with multiple payers, where incentives for volume and value can be diverse, similar or higher quality outcomes (readmissions, functional recovery and community discharge) **can** be achieved with lower LOS and therapy minutes per week.

This would indicate that success with efficient care and quality outcomes under PDPM, where incentives for lower therapy utilization and LOS are present, can be achieved, given a high-touch, high-tech Clinical Model.