Surviving and Thriving Within the PDPM Framework

PATIENT PATTERN

WHITE PAPER

Executive Summary

"To survive, and flourish, it is critically important to understand the nature of the changes impacting the (SNF) sector today. Failure to do so, particularly with the major disruption that is now just beginning to take hold, will likely result in some operators going out of business." Kramer, Provider, 2018

Kramer is referring to the Patient Driven Payment Model (PDPM). The model is intended to improve resource allocation and to provide more reimbursement to facilities treating vulnerable populations in the Medicare Part A, Short-Stay population. An additional goal of the new model is to curb the exorbitant costs of care for Medicare Part A and to do so in an approach that establishes per diem rates based on the overall picture of the patients characteristics. Those that drive care provided by all professionals and medical complexity rather than rates set by the amount of therapy minutes provided for the patient.

This model represents the most disruptive change in a reimbursement model seen in decades and relies more heavily on MDS Data obtained from all professionals, and available for submission to CMS by Day 5 of the Part A stay. PDPM is designed to identify all patient characteristics know to contribute to complexity of care and accomplished this by structuring the MDS Items and answers to be more specific about diagnoses, function, cognition, and mood. Each of these areas must be assessed on admission for the first MDS.

Hence there will be significant disruption to the current practices for admission, as done by all professionals. The status quo will not enable survival or success. Every professional assessing the patient for a Medicare Part A Short-Stay - from pre-admission screen, to EHR vendors, medical staff and MDS coordinators' data collection has to change to accomodate PDPM from day #1 - October 1, 2019.

The objective of this white paper is to present an approach to help healthcare professionals Master the Model - the PDPM.

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Background

There are many challenges facing healthcare professionals and organizations caring for the older and chronically ill population in the U.S. today. The PDPM is the most recent challenge and in part was developed after multiple other reimbursement plans failed to curb the costs of care for this population or to recognize the value of caring for the clinically complex patients who may be too ill or cognitively impaired to benefit from extensive rehab. The spectrum of services will now be considered in the PDPM per diem rate. In recent models therapy minutes drove the reimbursement rates and many facilities reported minutes of therapy not always based on clinical judgment but to increase reimbursement.

In 2016 there were 15,263 Skilled Nursing Facilities, providing post-acute care, with an average length of stay (LOS) at 36 days, an average hospital readmission rate of 9.8%, providing intensive rehab therapy to 83% of patients, at an average cost of $19,206 per patient.[1] These costs are not sustainable in the reality of a burgeoning older population, advances in high cost treatments, increases in costly high-tech procedures, and a healthcare system in disarray. For decades there have been many reimbursement models developed for post-acute care in the skilled nursing setting with the same goals but to date none have realized these ambitions.

RUGS-IV was the most recent reimbursement model but came under scrutiny by CMS, as all previous models, and so Interact 2014 envisioned a new reimburse model tied to patient characteristics and clinically complex needs for care not just from therapist but from all disciplines. That model is known as the Patient Driven Payment Model (PDPM) and under PDPM, a per-diem payment would be adjusted based on patient characteristics and care needs. PDPM has the potential to shift payments for individual patients, especially those with clinically complex diagnoses likely to require the highest amounts of nursing care resources.

This white paper is to provide an overview of a new payment model, the Patient Driven Payment Model (PDPM), designed to account for the patient characteristics that increase complexity and nursing care needs in Medicare A Short-Stay patients and to tie reimbursement to those characteristics. We will introduce proprietary software developed to support an understanding of clinical complexity based on a measurement of risk associated with frailty, proven to enhance patient care, improve quality outcomes, manage resource utilization and generate revenue within the new PDPM framework. Our goal is to educate and engage providers of post-acute care in the skilled nursing care setting by sharing an innovative software approach, marrying technology and data, to

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[1] ***MedPAC analysis of data from Provider of Services files from CMS, pg. 14.***

maximize reimbursement while providing high quality care.

Historical Perspective

RUGS-IV preceded PDPM and reimbursement rates where to be based on all patient characteristics identified and captured within a standard approach relying on a Hierarchical Condition Category (HCC) derived from ICD-10 codes. This categorization allowed for a high degree of specificity on diagnoses but is a paradigm ill-suited for managing risk in the Post-Acute Nursing Home population. The HCC framework, based on a disease model, was insensitive to patient changes in condition. PDPM is designed to address this shortcoming by accounting for complexity of care characteristics, calculating in components that have the potential for increasing nursing care needs. PDPM also incorporates an option for submitting an Interim MDS for a significant change in condition.

A complete overhaul of the RUGS IV classification model was undertaken and the Patient Driven Payment Model (PDPM) was developed. PDPM was the result of the statistical analysis of MDS data and cost reporting on 2.2 million Medicare recipients. Population health data was analysed for:

- ***Patient Clinical Characteristics***
- ***Functional Status***
- ***Cognitive Status/Impairment***
- ***Age***
- ***Prior utilization of acute hospital stays, emergency dept, post-acute care***
- ***Services utilized in SNF (PT/OT/SLP)***

From this analysis CMS made assumptions, drew conclusions, and developed the Patient Driven Payment Model (PDPM). It did not meet the CMS goal of simplification but instead is complicated, requiring post-acute care providers to develop and implement a plan, to ensure documentation expertise, to educate and engage all professionals, and to evaluate approaches and tools to assure both accuracy in documenting the Primary Diagnosis ICD-10 Code and predicting the clinical complexity and nursing care needs associated with that primary diagnosis.

CMS had goals of simplifying the payment system, addressing the concerns of MedPAC and OIG, and tailoring payments to fairly compensate facilities providing care for the clinically complex and most costly patients. The goal of simplification was certainly not met and only full implementation October 1, 2019, will tell whether other goals have been met.

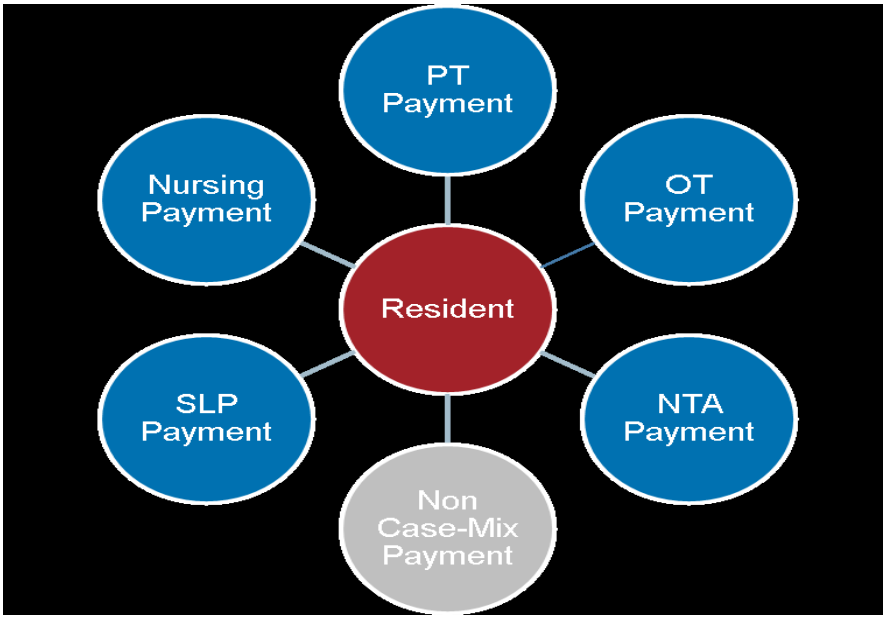
PDPM Overview

The Patient-Driven Payment Model (PDPM) is designed to compensate facilities based on complexity of care rather than on therapy minutes. PDPM establishes a Reimbursement Rate for the patient's entire Medicare A stay. This rate is based on the 5-day MDS and the Assessment Reference Date (ARD) can be any PPS day between Days 1 and 8. <u>The PDPM formula does not apply to long-term care patients.</u>

Under PDPM, a per-diem payment would be determined based on two primary factors:

1. ***Base rates that correspond to each component of payment***
    a. ***clinical characteristics (tracheostomy, ventilator, stroke, wounds)***
    b. ***level of assistance required to perform activities of daily living***
    c. ***skilled services received (rehabilitation, extensive services, or IV medication)***

2. ***Case Mix Index (CMI) that correspond to each payment group.***



The ICD-10 for the patient's primary diagnosis places the resident into a Clinical Category, with further grouping for each of the five case-mix-adjusted components and one non-case-mix adjusted component. The base rate for each component would be multiplied by the CMI corresponding to the assigned resident group.

The rate can be changed during the Medicare A stay if an Interim Payment Assessment (IPA) is completed. An IPA might be appropriate for a change in cognition and/or function. the most significant drivers of reimbursement. An IPA might also be considered if the Admission MDS did not capture the most accurate ICD-10 for the Primary Diagnosis. The Interim Payment Assessment (IPA) replaces the significant change of condition MDS. IPA requires a change in the condition classification in at least one of the 1st tier classifications such as function, cognition, or diagnosis and the condition cannot be reversible within 14 days. An IPA is NOT done for change in therapy minutes.

Aside from the Admission MDS and possible IPA driven MDS the only other MDS for a

Medicare A short stay patient will be completed upon discharge.

A "Final Rule" on PDPM was issued by CMS in July, 2018, with a new MDS being implemented October 1, 2018, and the full roll-out of PDPM scheduled for October 1, 2019.

PDPM Concerns and Pain Points

There are concerns about the PDPM within the industry. Will the pendulum swing from therapy driving reimbursement to limited or inadequate therapy provided, neither offering the best approach to care for the patient? Will there be a decreased demand for therapists? Will facilities chase patients with the highest clinical complexity but not be able to provide needed care?

There are concerns within the medical community. The lack of clinical risk assessment tools available for clinicians managing patients with multiple diagnoses and frailty inhibits their ability to predict clinical complexity and nursing care needs, both drivers of reimbursement. Neither can be accurately predicted from a diagnosis alone yet ICD-10 Coding will drive reimbursement. Will accuracy will be an issue? Therapy and NTA reimbursement decreases over length of stay so perhaps residents will be discharged sooner but a premature discharge often leads to readmissions.

Medical practitioners will be required to assign primary ICD-10 codes for their patients, not based on the way we are trained to assign diagnosis for the type of visit, but rather these diagnoses are going to be critical for accurate part A stay reimbursement for the facility. Ironically, it does not affect practitioner's part B billing or reimbursement; creating an opportunity for confusion and frustration on bridging the gap. The opportunity here for practitioners is to be the leaders in their facilities and help drive appropriate documentation that can help their facilities remain viable. A new partnership and enhanced collaborative opportunity is in the making.

These concerns are legitimate and will be addressed over time by education and engagement of those providing post-acute care across settings. Our focus is on the most frail residents receiving their PAC in the nursing home setting. Obvious cases of frailty are easy to detect, but more subtle functional deficits, especially when dementia is present, require careful digging that includes gathering collateral information and using standardized screening tools.[2] This paper introduces proprietary software developed to calculate a Frailty Risk Score as a measure of clinical complexity and a predictor of nursing needs associated with their frailty. Knowing the degree of frailty of a patient in PAC has been proven to enhance patient care, improve quality outcomes, manage resource utilization under RUGS IV and is expected to generate revenue within the new PDPM framework when implemented on October 1, 2019.

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[2] McGregor M, Krushner-Kow J. Why don't doctors screen more for frailty? Healthy Debate.ca, University of British Columbia, Canada. May 25, 2016

Our Solution

Health information technology (HIT) has the potential to bridge the gap between the challenges in the current RUGS market and the culture change needed to improve the quality, accuracy, and efficiency of providing patient care and capturing reimbursement dollars under PDPM.

PDPM is intended to improve resource allocation and to provide more reimbursement to facilities treating vulnerable populations. PDPM determines payment based primarily on the ICD-10 Code for the primary diagnosis and while having the most accurate ICD-10 code is important it is not always easy to obtain from the hospital discharge papers and it is not the equivalent of clinical complexity. For determining clinical complexity and predicting nursing care needs another measure is beneficial to identify risk for decline and complications. The best measure of risk and vulnerability to poor outcomes is found in measuring frailty.[3]

A frail elderly person represents a complex system at the edge of failure. (Rockwood, 2009)

Frailty is a clinical syndrome of loses across multiple body systems and as frailty increases so does the risk for bad outcomes like falls, weight loss, skin breakdown, etc. The outcomes we all want to avoid are often unavoidable in the very frail resident. Frailty is the result of the natural aging process, the accumulation of chronic illnesses, and the loss of function and/or cognition. So frailty is a good marker for clinical complexity and predicting nursing needs in the PAC patient, those covered by Medicare A, under PDPM. For long stay residents, knowing who is at the highest risk for poor outcomes provides an opportunity for the professionals to develop proactive care plans built on the understanding of the inerrant risk for this patient.

In order to meet these challenges and not only succeed, but exceed, state-of-art technology and innovation are required. Dated software will need to be replaced and new software options thoroughly vetted to assure they are incorporating PDPM - ready guidance, directing users in every discipline on best practices of care, including completeness and accuracy in documentation. Without this there is potential for poor outcomes to increase and reimbursement dollars to be left on the table. From pre-admission screening to MDS completion and to every entry in the patient's record - accuracy and completeness will be required.

Patient Pattern software addresses each requirement and is the first-to-market for calculating your PDPM reimbursement potential and a Frailty Risk Score. The software package, incorporates your MDS data and also provides a Care Map including actionable information for care and documentation. Patient Pattern has a proven record of improving outcomes, increasing satisfaction, reducing litigation claims, and decreasing costs. Adding PDPM management will increase reimbursement potential as well.

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[3] ***Gill TM, et al. Trajectories of disability in the last year of life. NJM Apr 2010; 62(13)***

Our Innovative Software - PDPM Modified

The innovative software we are presenting here is built around the concept of frailty as the best predictor of risk in the chronically ill population. The software relies on functional and cognitive data, along with routine pre-admission screening data to calculate a preadmission PDPM score and a Frailty Risk Score. It then analysis the 5-Day Admission MDS data and the facility MDS data to calculate a preadmission PDPM score and a Frailty Risk Score.

The more comprehensive and complete the data the more accurate and useful will be the calculated scores. The Frailty Risk Score is a reliable estimate of both the current degree of risk and the potential for clinical complexity of care with any new clinical stressor event.

Our software solution has been widely used throughout the USA since 2013 and has demonstrated the ability to lead professionals in a structured approach to PAC care that:

1. ***Reduces Rehospitalization rates***
2. ***Improve short-stay Quality Measures***
3. ***Reduces complaints and litigation***
4. ***Manages polypharmacy, reducing medication costs***
5. ***Lowers utilization of aggressive diagnostics and laboratory testing***
6. ***Supports earlier Palliative Care after unexpected significant change in condition***

Our January 2019 software package includes a Pre-Admission Screen, adapted to start the data collection for the Admission MDS the Patient Driven Payment Model (PDPM). When incorporated into the facility workflow a major step has occurred, the status quo is being interrupted and the facility is on the road to Mastering the Model - the PDPM.

Patient Pattern, Inc., is a Health Information Technology (HIT) Company, part of the NYS Center for Excellence in Bioinformatics, located in Buffalo, New York. The team is comprised of experts in clinical geriatrics, complex patient management, clinician education, health policy and aging research, health economists, data scientists and technologists who have come together to develop innovative solutions to meet the needs of the growing population of complex patients.

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