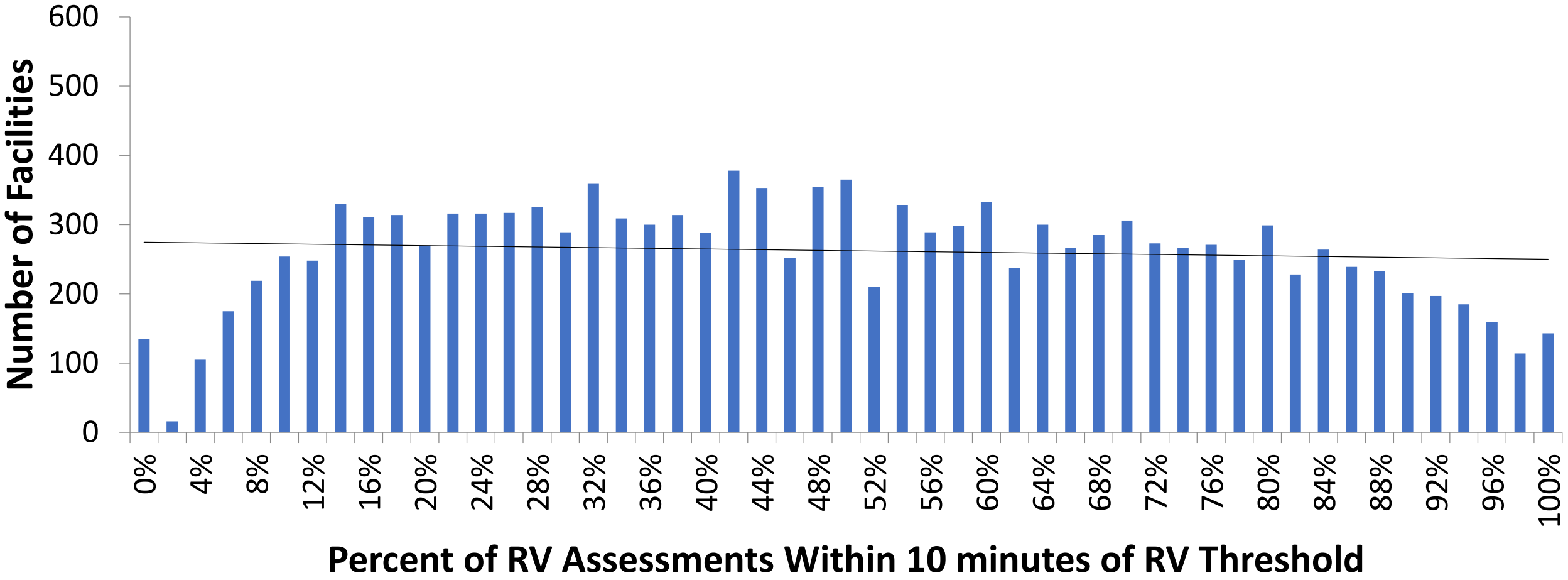
Therapy Services After Payment Changes in SNFs: How to Show Your Value within PDPM

Jointly presented by CMS and AOTA, APTA, and ASHA

Where are we now?

- Issues with the current case-mix model, the Resource Utilization Group, Version IV (RUG-IV), have been identified by CMS, OIG, MedPAC, the media, among others.
    - Therapy payments under the SNF PPS are based primarily on the amount of therapy provided to a patient, regardless of the patient's unique characteristics, needs or goals.
    - SNF patients who may have significant differences in terms of nursing needs and costs often receive the same payment for nursing services.

Where are we now?



Source: SNF Public Use File (2016): https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/SNF2016.html

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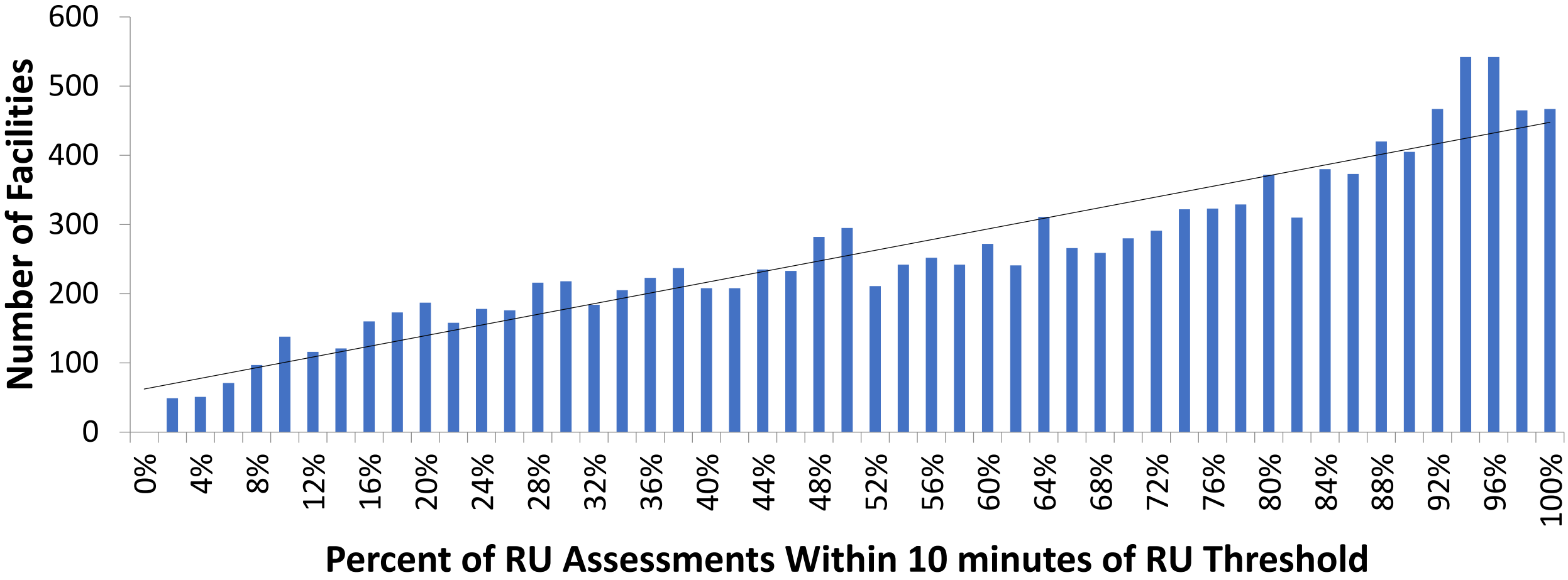


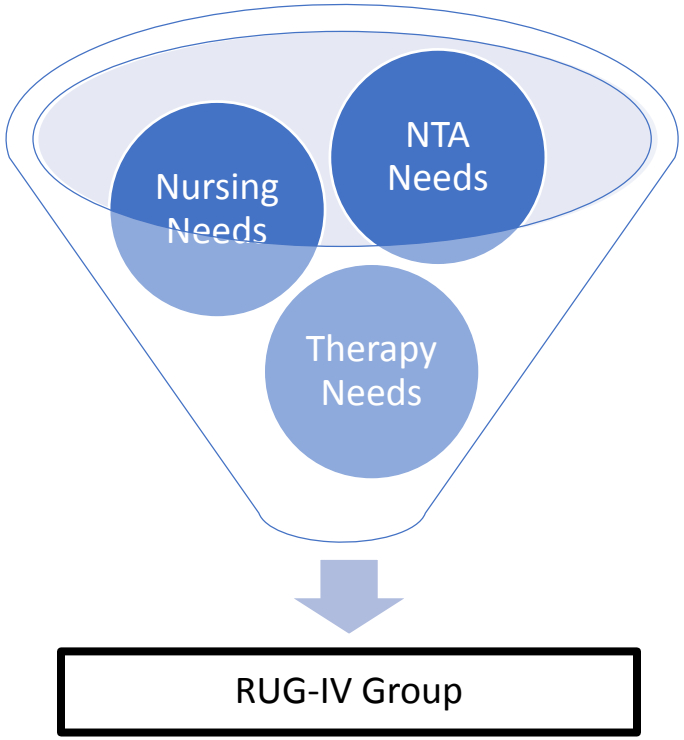
Source: SNF Public Use File (2016): https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/SNF2016.html

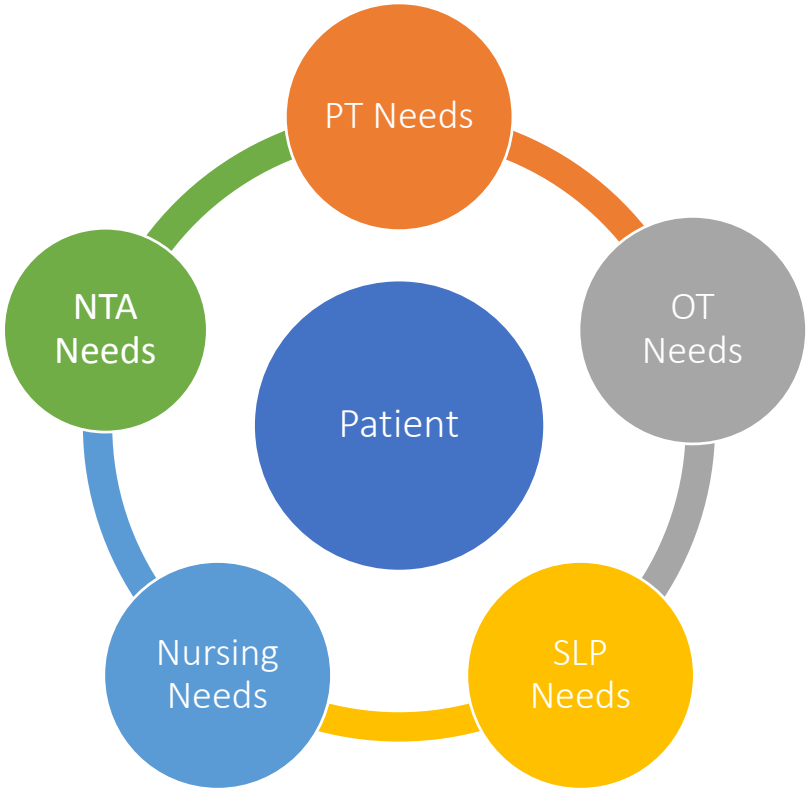
Where are we going?

- The Patient Driven Payment Model (PDPM) represents a marked improvement over RUG-IV for the following reasons:
  - Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided.
  - Significantly reduces administrative burden on providers.
  - Re-allocates SNF payments to currently underserved beneficiaries without increasing total Medicare payments.

Where are we going?

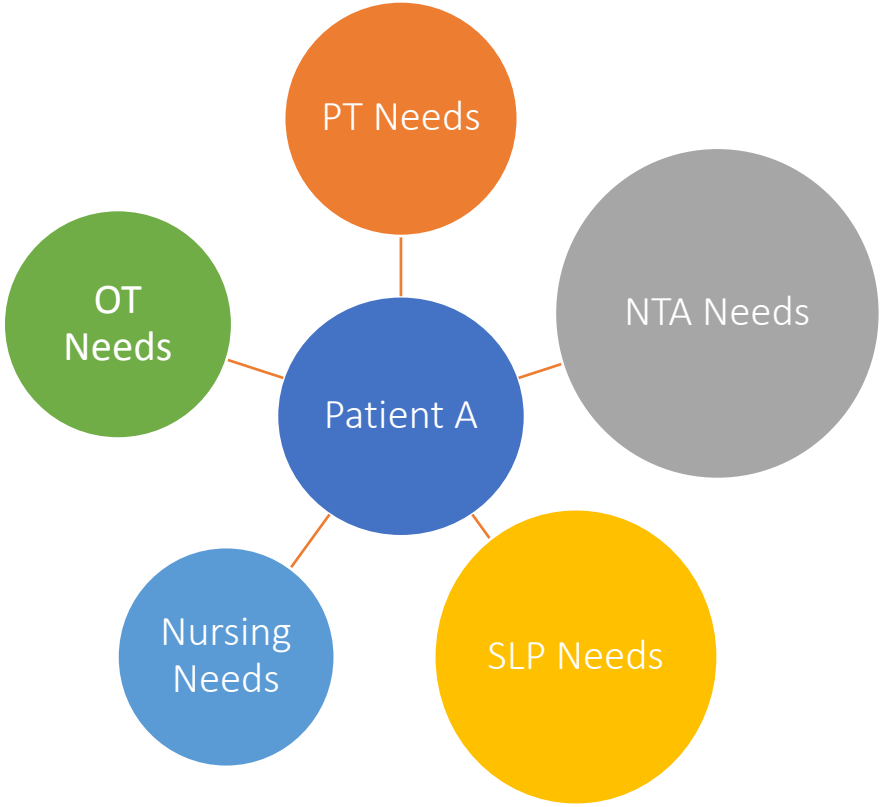
- While the RUG-IV model (left) reduces everything about a patient to a single, typically volume-driven case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics and goals of each patient.

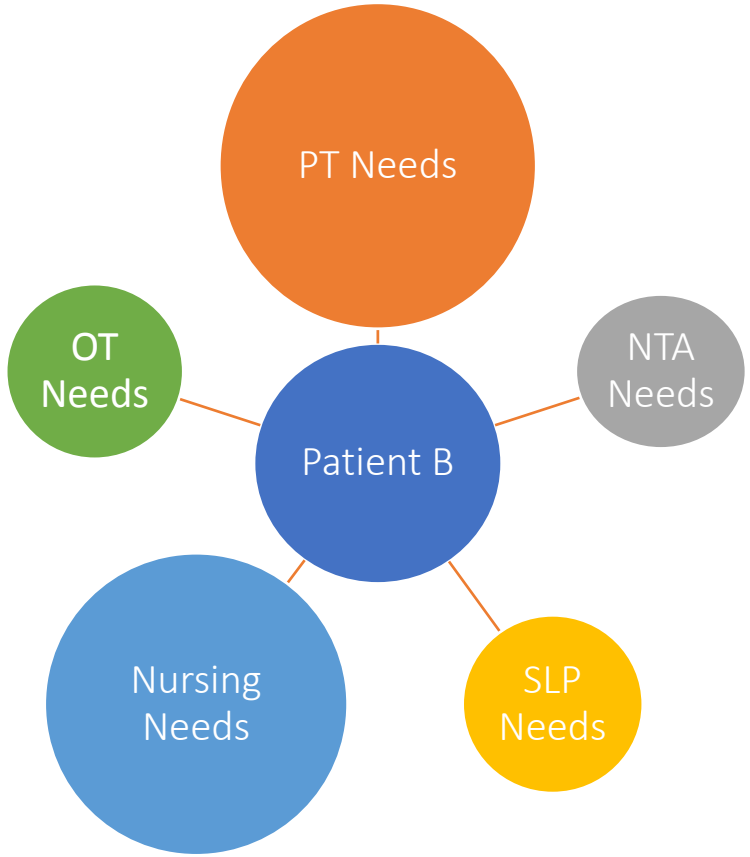




Where are we going?

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





Medical Review and Data Monitoring

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

- For program integrity, we expect provider risk will be more easily mitigated to the extent that reviews focus on more clearly defined aspects of payment, such as documentation supporting patient diagnoses and assessment coding.
  - If the provider codes that the patient's primary diagnosis is a major joint replacement, then the reviewer should be able to verify that the patient received a major joint replacement.

Medical Review and Data Monitoring

- Therapy services will still represent an important and significant part of data monitoring and program integrity efforts.
  - New items are being added to the MDS to allow CMS to track therapy service delivery, both in terms of intensity and the manner of delivery

- CMS will be monitoring therapy service provision under PDPM, as compared to RUG-IV, at the national, regional, state, and facility level.
  - Significant changes in the amount of therapy provided to SNF patients under PDPM, as compared to RUG-IV, or the manner in which it is delivered, may trigger additional program reviews and potential policy changes.

Myths Versus Reality

Myth #1

- There will be a significant reduction in the amount of therapy services SNF residents need.

WRONG. Patient need for therapy will not change from September 30, 2019 to October 1, 2019, and SNFs must meet SNF quality program requirements. Therapy practitioners must continue to use their clinical judgment to provide medically necessary, skilled therapy based on individual patient needs and goals, with a focus on patient outcomes.

Myth #2

- CMS is changing the coverage requirements of OT, PT, and SLP services furnished in a SNF.

WRONG. Although the payment methodology for SNFs will change effective 10/1/2019, the criteria for skilled therapy coverage is not changing. Patients must receive the skilled therapy services they need.

Myth #3

- The variable per diem rate reduction for PT/OT services after Day 20 reflects CMS's intention that SNFs should deliver less PT/OT starting on Day 21 of the SNF stay.

WRONG. Therapy services should be provided based on patient presentation and clinical need. The slight rate decrease starting on Day 21 reflects current PT/OT cost data. The Medicare benefit and practice standards require that a SNF patient receives the reasonable and medically necessary skilled care that they need.

SLP services are not subject to the variable per diem rate.

Myth #4

- To maximize profit, SNFs should require therapists and assistants to deliver the maximum amount of concurrent and group therapy (25%) for each discipline for each patient.

WRONG. Although PDPM includes a combined limit on group and concurrent therapy of 25%, therapists and assistants should deliver the mode(s) of therapy that is best attuned to individual patient needs and goals. The provision of group and concurrent therapy should be incorporated into the plan of care of the patient. Group therapy documentation requirements remain the same: you must plan for a group in advance and document how group therapy will help each patient achieve their goals.

Myth #5

- Two patients treated separately by a therapy student and their instructor at the same time will quickly exceed the 25% threshold because these minutes are always counted as concurrent. The limit will make it inefficient for the therapist or assistant and could deter SNFs from training students.

WRONG. CMS does not require that student therapy be labeled as concurrent. Current utilization data indicates that a 25% combined cap on group and concurrent therapy should not deter facilities from training therapy students in the future.

Myth #6

- CMS has no mechanisms in place to hold providers accountable to ensure they deliver the appropriate amount of therapy services to SNF residents.

WRONG. CMS intends to monitor numerous data sources for changes in therapy utilization, including quality metrics and claims. Examples include Nursing Home Compare, the SNF Value-Based Purchasing Program, and Payroll-Based Journal data, which may reflect poor quality care or reductions in therapy services that compromise patient condition. Section O of the MDS includes a section to record the minutes of therapy provided and the mode of treatment (group, concurrent, individual) for each patient. Also keep in mind that the 3 therapy organizations have a direct line of communication with CMS and can share real-time, ongoing feedback with the agency.

Myth #7

- PDPM will require the “primary reason” for SNF care diagnosis code to be the same as the primary reason for the prior inpatient stay diagnosis code.

WRONG. PDPM requires facilities to code the diagnosis that corresponds most closely to the primary reason for SNF care. It’s possible that the patient was in the hospital for X diagnosis, but developed Y, and the purpose of the SNF stay is to treat Y. Accordingly, in this case, the SNF would code the secondary condition that arose during the hospital stay, rather than the primary reason for the prior hospitalization.

Myth #8

- Medicare has established productivity requirements with which therapy practitioners must comply.

WRONG. Productivity requirements are an industry-developed mechanism to maintain profitability and manage staff. Medicare uses the Payroll-Based Journal data submitted by SNFs to monitor staffing adequacy.

Myth #9

- If the condition is not on the list of clinical conditions or comorbidities that link to a SNF PDPM therapy payment category, the services cannot be provided.

WRONG. SNF covered services should be provided when medically necessary, regardless of the diagnosis code and reimbursement model.

Myth #10

- The PDPM is final and no change is possible.

WRONG. Continued evolution of this payment system is absolutely possible. CMS staff has indicated that they will monitor patient access to medically necessary care, including therapy services. CMS may make changes as needed to ensure appropriate payment for medically necessary, skilled care.

Myth #11

- PDPM dictates which therapy disciplines provide care based on payment categories/components.

WRONG. Qualified practitioners should provide medically necessary, skilled care based on state scope of practice, training, and education, as well as the Long-Term Care Facility Requirements of Participation. For example, both an OT and SLP practitioner may provide discipline-specific cognitive interventions to treat a patient's cognitive impairment when warranted by the patient's condition.

Preparing for Change

Strategies to Prepare for PDPM Implementation

- Conduct workflow analysis
- Identify opportunities for regular interprofessional collaboration
- Proactively document and address changes in plans of care
- Determine what discipline specific data is being gathered and how that relates to quality reporting
- Understand the link between care and data being captured by therapists/assistants and how that relates to performance under the quality measures
- Follow clinical practice guidelines and develop a common clinical language for your teams
- Therapy practitioners should assess their knowledge of regulatory requirements and understanding of Medicare Part A, Medicare Part B, Medicare Advantage, and 3rd party payer rules

Demonstrating Your Value

Practical Strategies to Demonstrate Value

- Therapists and assistants should examine their facilities' quality metrics and performance and identify and communicate to others how they impact various metrics, including falls, pain, pressure ulcers, and discharge to community
- Identify opportunities to collaborate with other care disciplines, improve communication, and bring ongoing value to the entire care team
- Therapists and assistants should consider how they can contribute to their patients' quality of life and overall outcomes; strategies may vary by facility, depending on patient population and characteristics
- Therapists and assistants should use the settings they work in as living laboratories, to better understand dosing and the relationship between outcomes and quality measures

Focus on the Metrics

- SNF Quality Reporting Program
  - 11 measures, incl. falls, readmissions, pressure ulcers, self-care, and mobility
- Nursing Home Compare
  - Health inspections, staffing, and quality measures
- Long-Term Care Facilities Conditions of Participation
  - Appendix PP – Guidance to surveyors for LTC facilities
- SNF Value-based Purchasing Program
  - This program rewards SNFs with incentive payments based on the quality of care they provide to Medicare beneficiaries, as measured by a hospital readmissions measure.

Conclusion

What You Can Do

- Stay informed and engaged
- Talk to your colleagues and share the facts - bust the myths about PDPM!
- Think about the value YOU bring to the table from a clinical effectiveness standpoint
- Use clinical judgment, not administrative mandates, to make clinical decisions
- Work with your facilities to develop creative interdisciplinary solutions to deliver quality outcomes for patients
- Use resources from your therapy professional organization to help ensure you are using best practices and appropriately documenting your services
- Consider a self-assessment of your skills, and consider how you can support your facility(ies) in meeting the challenges that lay ahead

QUESTIONS

Resources

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html
- https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending
- https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/mds30raimanual.html
- AOTA: http://www.aota.org/Practice/Manage/value/Skilled-Nursing-Facilities-Patient-Driven-Payment.aspx
- APTA: http://www.apta.org/Payment/Medicare/NewPaymentModels/
- ASHA: https://www.asha.org/practice/reimbursement/medicare/medicare-patient-driven-payment-model/
- https://integrity.apta.org/ConsensusStatement/