Optima
HEALTHCARE SOLUTIONS

FAQs

Goodbye RCS-1, Hello PDPM!

All of your burning questions, answered.

Optima Healthcare Solutions conducted a webinar in May 2018 about the recently proposed payment reform model – Patient-Driven Payment Model (PDPM), which was announced as the alternative to the previous proposed model, Resident Classification System Version One (RCS-1). The new PDPM model is proposed to go into effect October 1, 2019, and will be replacing the Resource Utilization Group, Version Four (RUG-IV) system. Several questions were posed by the attending audience. Below are the frequently asked questions to provide clarity on what PDPM is, and what Optima is doing to help therapy providers prepare for the change.

Q: Does the skilled nursing facility (SNF) get paid for all three of the therapy case-mix components, regardless whether the patient is being treated by those therapy disciplines?

A: Yes, there is a reimbursement allocation to all three disciplines of therapy for all patients under PDPM. That reimbursement is included regardless of whether each discipline actually treats individual patients.

Q: Would the addition or discharge of a therapy discipline constitute an Interim Payment Assessment (IPA)?

A: No, services being provided to a patient are not a factor in determining a patient's classification under PDPM. The requirement for an IPA to be justified is that the patient's primary classification has changed and is not expected to return to the prior classification within 14 days.

Q: Why does CMS believe that reducing assessments will save a SNF money? Do they expect MDS coordinators will be cut? Do you think MDS coordinators will be cut? If not, you're still paying the same amount regardless of their productivity or activities.

A: The commentary from CMS in the FY-2019 Proposed Rule (p. 21079) is that they project 183 hours of time savings for the average provider per year due to the reduced volume of assessments. They anticipate that the reduction in "administrative burden" will permit providers greater flexibility in interacting with their patients and focusing on their patients' individual care needs. How each provider decides to use those 183 hours of time saved is likely to vary across the industry. Optima is not in a position to speculate beyond the factual data provided by CMS.

Q: Will Medicare Advantage plans be required to follow the PDPM rules?

A: While no specifics are given in the FY-2019 Proposed Rule relative to requirements of Medicare Advantage plans, Optima anticipates that such plans will have similar autonomy under PDPM as they do under RUG-IV.

Q: When are the PDPM tools from Optima (i.e. RUG to PDPM by patient analysis) going to be available?

A: Optima is currently converting the previously developed RCS-1 tools to match PDPM specifications. We anticipate the development and quality assurance related to this conversion to be finished and generally available to customers in July 2018. While this is being completed, we encourage providers to obtain at least one year's worth of MDS submission files to run through the Optima PDPM Processing as soon as the files are available.

Q: Will there be a chart/worksheet that shows the payment structure/reimbursement for each case-mix group, so we know what each case-mix group reimburses?

A: Once CMS publishes the specific information needed for each case-mix group as the rules are finalized, Optima will be able to incorporate this information into the changes we plan to make to support PDPM.

Q: How do ADL scores play a role with PDPM?

A: Functional levels are calculated for self-care and mobility using an item set from Section GG of the MDS to generate a combined score between 0 and 24 for each patient. The functional score is then used as a primary factor in determining the case-mix group and associated reimbursement dollars for both physical and occupational therapy.

Q: What is the ideal amount of therapy with PDPM per case-mix?

A: The ideal amount of therapy varies since it depends on each patient's unique characteristics. While PDPM classification is a factor, there are other characteristics unique to each patient that must be considered to determine an ideal amount of therapy. However, if you are strictly focused on how much therapy does the reimbursement allocation support for each case-mix group, that depends on the labor costs in each unique skilled nursing facility, the mix of modes of treatment (individual, group, concurrent) and the wage-index assigned to the facility. Optima is developing a calculator for individual SNFs to use in order to identify these numbers for their specific circumstances, but the data is not readily available at the present time.

Q: Is there a fee for the additional functionalities being made in Optima Therapy for SNFs to support PDPM?

A: The core functionality updates that Optima will make to support PDPM are included in the Optima Therapy for SNFs product subscription. However, providers may want to take advantage of the additional functionality in our Business Intelligence tool. Please contact Optima Sales for more information at sales@optimahcs.com or call 800-619-4243.

Q: Does the budget neutrality of PDPM include potential cost savings or is it purely revenue-related?

A: The "budget neutrality" of PDPM is strictly based on reimbursement, as it is budget neutral to CMS. The potential cost savings provide an opportunity for enhanced margins for each SNF depending how business decisions are made.

Q: Is it expected that the modifications to Section GG on 10-1-2018 will have an effect on PDPM index for PT/OT?

A: The Section GG items proposed for use with PDPM are existing items in Section GG. However, slight changes to the definitions/instructions of Section GG items will be required after October 1, 2018. While CMS has indicated that those changes are meant to be "clarifications" and not "changes," there is the potential that clinicians will code the same Section GG item differently for some patients based on those clarifications. Therefore, there is the possibility that the Section GG assessment data collected before 10/1/2018 will be slightly different from the data collected on or after that date. However, based on the degree of clarifications being made, the differences are anticipated to be very small. Still, data scientists will need to take it into account in future studies.

Q: In the past you had to document group therapy in advance. Is this still going to be a requirement?

A: This is not specifically addressed in the FY-2019 Proposed Rule, but Optima would anticipate that the same documentation requirements will remain.

Q: How will documentation be impacted? Currently, documentation is our safeguard against ADRs. Will that change?

A: Documentation will carry as much, if not more, weight under PDPM as it has under RUG-IV. It will be critical to have strong documentation to supports the clinical decisions you make for each patient. There will be a shift from supporting why you chose to do so much therapy, to why you chose not to do more therapy.

Q: How do you see PDPM affecting the ability for OT to see SNF patients for cognitive treatment?

A: The FY-2019 Proposed Rule does not comment on which disciplines of therapy would be appropriate for addressing specific patient problem areas. Instead, the focus is on the "whole patient" with an interdisciplinary approach to maximize the functional outcomes for each individual patient.

Q: How do we handle patients that require maintenance therapy?

A: With the transition away from paying for the amount of therapy provided, to paying based on patient characteristics/classification, we would anticipate less scrutiny around decisions made to provide therapy to specific types of patients. Instead, the scrutiny will shift to why therapy was not provided to specific patients when they could have benefited from it.

Q: How can the financial impact of PDPM be quantified now for planning purposes? Can current residents be "cross-walked" to new PDPM rates based on MDS or other clinical data?

A: Yes, in fact Optima had already developed this "cross-walk" based on MDS data for RCS-1, and we are now converting the calculators to match the PDPM specifications. This new functionality will be generally available to Optima customers in July 2018.

Q: Does Optima have plans to better integrate the data collected in Section GG with the assessment items collected in the evaluation to improve efficiency and reduce redundancy.

A: Yes, Optima is currently updating the standard clinical documentation libraries to incorporate the Section GG item set. When this is released, each Optima customer will have the option to opt-in and embed the data in their clinical documents. If collected on the clinical documents and the timing is aligned, the data will then auto-flow to Section GG on the actual MDS and/or MDS Data Report.

Q: Does Optima have ideas of how skilled nursing facilities (SNFs) will be billed for therapy services by contract therapy providers?

A: There had been significant discussion around the possibilities for billing methodologies under RCS-1 (and now PDPM). The three primary methods that have come to the top are:

- Per Diem: In most instances, this method will bill a flat fee per day for every Medicare Part-A patient in a SNF regardless of whether they are receiving therapy. The therapy provider is then responsible for providing an appropriate level of therapy to each Medicare Part-A resident based on their specific needs.
- Percentage of Reimbursement: With this billing method, the therapy company would bill the SNF an agreed upon percentage of the reimbursement allocated for therapy to each resident. The therapy company is then responsible to manage the delivery of therapy services to achieve optimal outcomes within a fixed cost structure.
- Per Minute: With this billing method, the therapy company would bill the SNF on a per minute basis. Since the reimbursement for therapy is fixed for each individual patient, there would presumably be a cap on the number of minutes that the SNF would be billed for based on the patient's PDPM classification and therapy reimbursement.

Q: Do we know what acceptable minute thresholds will be? I keep hearing that Medicare will be tracking these, and that less minutes will be required, less therapists, etc., but no word on what minutes will be acceptable.

A: CMS has indicated in the FY-2019 Proposed Rule that they do not anticipate a significant reduction in the amount of therapy provided to similar patients that were reimbursed under the RUG-IV system. Additionally, CMS has indicated that they anticipate little to no change in the mix in modes of treatment even though they are allowing for 25% of therapy to be in a non-individualized mode. With that acknowledged, providers will be forced to manage the amount of care delivered to patients to align with the reimbursement that CMS is paying for those patients. Without innovative adjustments, therapy providers would not be able to survive financially for the long-term.

Q: CMS has announced an expansion of Section GG to include all of the CARE items (15 mobility and 8 self-care) effective Oct 2018. Would these added items then be included in the PDPM calculation for functional scoring?

A: There is no indication that the additional items will be used in the calculation of functional scores for PDPM classifications. The proposed methodology uses only 10 items from Section GG.

Q: Are the rates that were shown in the webinar actual rates or just used as demonstration?

A: The rates included in the demonstration were base rates for a specific patient classification. The case-mix groups and associated indexes and rates vary widely from patient to patient and facility to facility based upon wage-index differences that are applied to the rates. Therefore, while the rates shown were actual rates, they should not be considered as an approximation of rates for any given facility or patient.

Q: Do you know how those three Section GG items were chosen for OT? Seems very restrictive to the scope of OT.

A: CMS determines the items they choose through consultation with Technical Expert Panels convened for that purpose. On pages 48-50 of the Proposed Rule posted in the Federal Register on May 8th, CMS outlined the reasoning for the selection of the early loss ADLs. Based on their testing and comparisons, results show that the early-loss items are strong predictors of costs.

Q: Do you think PDPM will affect the role of the MDS Coordinator or will it only affect therapy?

A: PDPM will have a significant impact on the way SNFs operate across the board. While our presentation was focused on therapy, the calculations impact nursing as well. MDS coordinators will benefit from a reduced volume of assessments, giving them more time to focus on correct coding, patient care and other valuable contributions to SNF operations.

Q: Where can I get information on NTA and respiratory therapy changes in PDPM?

A: The following resources provide the most in-depth details regarding PDPM:

FY-2019 Proposed Rule for SNFs
Technical Report by Acumen (April 2018)
Calculation Worksheet

Q: I assume the SNF skill criteria for five days a week of therapy will still stand in PDPM?

A: PDPM is a change in the payment methodology. It is not a change to the specific definitions of "skill" that would justify a patient being covered by Medicare Part-A benefits.

Q: How do you anticipate the Care Item Sets and new Section GG coding related to PDPM to align?

A: The PDPM Section GG item set is a subset of the CARE item set. We anticipate that it will remain as a subset and providers may choose to continue to use the full CARE item set for outcomes reporting. However, the PDPM Section GG item set will also have the potential to serve as an outcomes tool on its own. Optima is implementing updates to enable providers to use it for this purpose.

Q: Does CMS reference any research for restricting concurrent and group therapy?

A: CMS generally determines its metrics through a review of literature and consultation with Technical Expert Panels. On pages 48-50 of the Proposed Rule posted in the Federal Register on May 8th, CMS outlined the reasoning for placing a limitation on concurrent and group therapy. Formal research is not the focus of the discussion, but rather, past therapy provider behavior with respect to these modes of treatment and stakeholder response to the ANPRM. CMS believes individual therapy is usually the best mode of therapy, although recognizes that other modes may be more appropriate at times. CMS is soliciting comments to this discussion.

Q: Can we manually import our MDS assessments today or will this be a future upgrade?

A: MDS assessments can be imported today into the Optima Therapy for SNFs product. However, the value of doing so is limited until the modifications to support PDPM calculations have been made generally available in July 2018. If you do import MDS assessments now, you will have a head start to immediately run the scoring process when it is available.

Q: Are there any talks about using rehab techs again?

A: With the allowance for concurrent therapy, it is logical that some therapy providers may employ rehab techs to assist in preparing patients for their treatment. Since treatment minutes don't drive reimbursement in PDPM, it would be ideal to use therapists and assistants for direct treatment while rehab techs support the efficient use of the therapists' and assistants' skills.

Q: Will there still be restorative nursing program payment with PDPM?

A: Restorative nursing programs offer value beyond the PPS RUG-IV level calculations, so it would make sense for them to continue after PDPM. In fact, these programs may become more valuable if therapy programs are reduced as a result of PDPM. CMS proposes to use the existing RUG-IV methodology for classifying residents into non-rehabilitation RUGs to develop a proposed nursing classification that helps ensure nursing payment reflects expected nursing utilization, rather than therapy utilization. As noted in Table 26 of the SNF Proposed Rule, at the current time, the number of restorative nursing services is a consideration that affects the proposed nursing case-mix indexes. (Federal Register version proposed rule, page 35 and 37).

Q: With the SLP case-mix, if a mechanical diet is added later, can it be captured?

A: Depending on the reason for the addition of a mechanical diet, it may or may not be permitted to complete an Interim Payment Assessment (IPA). It would be warranted if the patient's primary classification has changed and is not anticipated to return to the original classification within 14 days.

Q: Do student regulations remain the same?

A: PDPM is a change in the payment methodology, not a change to the specific definitions of types of service provided. Until there are updates to the RAI manual and conditions of participation, we expect the regulations regarding students to remain the same.