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MDS Alert

Reimbursement: CMS Releases FY 2019 Prospective Payment System Update

RUG-IV and RCS-1 are out, and the 'SNF Patient-Driven Payment Model' is in.

On Friday, April 27, the Centers for Medicare and Medicaid (CMS) released the Fiscal Year 2019 Proposed Rule. Though the biggest changes won't go into effect until Oct. 1, 2019, your facility needs to start preparing and strategizing now, as some restructuring may be required.

Multiple items are addressed in the Proposed Rule, including the Medicare rate increasing to 2.4 percent, value-based purchasing (VBP) adjustments including the hospital readmission metric facing a 2 percent reduction or possible 1 percent increase, and the quality reporting program (QRP) extension of an additional year to calculate the Medicare Spending Per Beneficiary (MSPB) and discharge to community measures.

But the biggest change is the news that the Patient-Driven Payment Model (PDPM) will replace the Resident Classification System 1 (RCS-1), says **Kris Mastrangelo,** president and CEO of **Harmony Healthcare international** in Topsfield, Massachusetts.

Know these details

Here are the top things you and your facility need to know about PDPM, so you can start figuring out how you'll prepare.

Implementation of the PDPM is delayed until Oct. 1, 2019.

The PDPM focuses on "patient characteristics" instead of "caregiver resources," Mastrangelo says, and therapy minutes are no longer the major basis for reimbursement. In the PDPM, therapy minutes will be counted at discharge instead.

The PDPM system is a per diem system - so no more bundling, like RUG-IV or the proposed RCS-1. Additionally, the PDPM will begin reimbursing less per day after day 20.

"The intent is that the reimbursement will exceed the cost during the first 20 days and decrease the cost thereafter, with an overarching theme to decrease the length of stay. This might not be a game changer if the provider navigates innovative, cost-effective, and innovative modes of therapy," Mastrangelo says.

The PDPM cuts down on the number of necessary assessments, requiring only:

- 5-Day MDS Assessment
- Discharge MDS Assessment
- Interim Payment Assessment, which is a voluntary assessment to change payment (with specific criteria outlined)

Instead of the groups initially proposed for RCS-1, the PDPM will have five groups, all with per diem rates:

- Physical Therapy (PT) Component
- Occupational Therapy (OT) Component
- Speech Pathology (SLP) Component
- Non-Therapy Ancillary (NTA) Component
- Nursing Component

Note that physical therapy and occupational therapy are no longer combined.

The PDPM allows up to 25 percent groups and concurrent therapy. "While this seems to be a win, it is not. The calculation is 25 percent of total time for groups and therapy. This parameter continues to negatively impact patient care and the usage of necessary modes for effective service delivery. More advocacy and education are needed on the social, emotional, and physical benefits resulting from patient to patient interactions," Mastrangelo says. "This is alsoinconsistent with the philosophy to allow the providers latitude, flexibility, and control over the service delivery."

PDPM could mean patient-centered care

The PDPM is designed to "shift care from therapy to other forms of care as other categories are underutilized," according to CMS, which is why therapy minutes won't be counted until discharge. This change is not meant to minimize the significance of therapy, but to make sure facilities are providing residents with comprehensive care.

With the sea of changes toward patient-centered care, PDPM is ostensibly a major adjustment to reimbursement made in the hopes that facilities will prioritize the delivery of individualized, high-quality care for residents, instead of making decisions based on reimbursement. Obviously, facilities should be putting residents' well-being first, but with reimbursement currently dispersed mostly on the amount of therapy residents receive, some facilities may be disregarding other important activities and services.

Will PDPM change the culture of the delivery of care in the long-term care industry? That remains to be seen. "One of the things that one has to contemplate in payment reform is does the tail wag the dog? Do we change service delivery based on reimbursement?" Mastrangelo asks.

PDPM could be the push needed to make patient-centered care the reality in every facility, but we don't yet know whether the methods for reimbursement truly align with the ideal delivery of care. "It doesn't necessarily align; we won't know if it aligns until the factors that impede service delivery, like groups, are lifted. The clinician has to have clinical judgment, but the judgment should not be influenced by reimbursement, though that's happening," Mastrangelo says.

"The overarching theme is that a patient shouldn't go to a nursing home and sit in a bed and decline with minimal activity, they need restorative therapy and nursing," she adds.

Start preparing now

"Providers need time to think and strategize," Mastrangelo says.

The length of stay and tapered payment inherent to the PDPM model, which is replacing the bundling system that is the current standard. Theoretically, this means less money coming in to the facility, but it's also a chance to make adjustments that can benefit everyone - residents, staff, and the general culture of long-term care. If a facility can master a lower mode of therapy or care and still meet the responsibility to not discharge residents too soon, the forced change to PDPM could bea boon.

As for steps forward: Define your patient population through facility assessment. Figure out how and whether this payment model matches your current operating model. Is your business still viable with this payment structure? Start running the numbers now and so you're prepared to make any necessary adjustments before next October. For example, if your facility currently has an outside company providing therapy services to residents, this could be the moment to look at bringing therapy totally in-house.

Resource: You can read the FY 2019 Proposed Rule here: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-09015.pdf. The Proposed Ruleis open for public comment on the Federal Register through June 26 and you can access it here: https://www.federalregister.gov/documents/2018/05/08/2018-09015/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities (or by downloading it from the Federal Register: https://www.federalregister.gov/public-inspection.)

Additional resources for facilities to use when looking at their own data were pointed out on the call and include a SNF PDPM Classification Walkthrough, SNF PDPM Grouper Tool and a SNF PDPM NTA Comorbidity Mapping tool, all available via: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html

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