Please Don't Punish Me!

(Another) Rational Discussion on Payment Reform

ZIMMET HEALTHCARE SERVICES GROUP, LLC

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The Patient Driven Payment Model is scheduled to take effect October 1, 2019. There is ample time to prepare, but little time to waste.

This is not "PDPM-101" – another "primer" is the last thing our industry needs at this point. Stakeholders are well-aware that CMS will replace the decades old SNF RUG system with a payment methodology predicated on resident condition, rather than the arbitrary volume of therapy delivered (if you don't recognize the preceding initialisms or acronym, there is no need to continue reading).

To provide context, the SNF PPS Demonstration Project (started in 1993 when CMS was still HCFA) was my first experience with a fundamental SNF payment system change (during which I met my longtime partner Sheryl Rosenfield). "The Demo" began a 25-year journey wherein ZHSG assembled among the most diverse and accomplished team of SNF reimbursement-compliance professionals in the industry. We have since participated in, advised on, or helped implement dozens of rate-setting initiatives. **This one is different.** PDPM is not a one-time "PTP" situation (parlance in my office for "Plane-Train-Plane" – engagements in which a consultant flies in and out the same day to conduct a single in-service); deliberate transition planning takes time. So enjoy Thanksgiving, then get down to business.

ZHSG has prepared for PDPM like no other event in our history – conducting literally tens of thousands of modeling scenarios and simulations that have revealed the essence of the new system:

PDPM is not a singular payment system change – it is, in fact, comprised of three distinct complex new rate setting methodologies, in addition to the latest iteration of the familiar "nursing" RUG model (coupled with elimination of the traditional MDS schedule), plus a fifth static overhead payment. We must treat each "Component" as an independent payment driver, then combine them to compute a patient-specific PDPM "Composite" rate. Complicating matters, length of stay is a diluting rate variable (heavily weighted during the first three days). Meanwhile, daily monitoring of clinical changes specific to "eligibility" is both mundane and novel – adding compliance concerns and Composite enhancement opportunities to the mix. ***Successful preparation requires an accretive, multidisciplinary approach that is meticulously structured, effectuated, measured and continually refined.***

This document addresses the realities and operational challenges facilities will endure through the PDPM transition, and highlights certain subtleties that should not be overlooked. It is not promotional fodder, but a response to how we have seen the market react.

CMS promotes PDPM as a system designed to "reduce the administrative burden on providers," yet the new model is far more complex than its predecessor.

The intricacies of the new payment system, and the resources needed to properly prepare, will challenge even the most competent providers and support firms. While our PDPM Transition & Support Program is fully developed and active, we are carefully managing our calendar to ensure availability to properly assist our longstanding clients – so consider this post as more musing than marketing.

RUG-IV could be mastered with a competent therapy director and accurate ADL coding. PDPM is a multi-faceted system requiring diverse skill sets and at least modest technological functionality to optimize reimbursement and maintain compliance. I despise this hackneyed saying, but a "true *team* approach" is essential. Do not expect an individual "PDPM Guru" to emerge as the authority on system or strategy – there are simply too many compounding variables to consider.

The PDPM "Composite" rate is the sum of five Component parts (PT/OT should not be considered distinct elements), and every case must be analyzed to avoid counter-productive financial outcomes. Certain PDPM Component optimization strategies may "offset" gains with payment reductions in the others. For example, compliant Functional Coding that enhances the PT/OT rate often decreases the Nursing RUG Component by an even greater amount. In other words, PDPM management does not lend itself to the "reimbursement arbitrage" we've seen in previous systems.

These "moving parts" include reimbursement-sensitive elements that are financially irrelevant under RUG-IV, but may impact revenue by hundreds of dollars per day come next October. Food for thought: "When was the last time you sought reimbursement input from your facility's dietician, otolaryngologist, or psychologist?" You'll want to get to know them – they may factor into every one of your resident's Composite score. Ancillary services (contracts and pricing) must be considered far in advance of implementation as well.

Possible Deliberately Pilfered Millions?

Unlike the original "Generational Transition" from cost-based reimbursement to PPS in 1999, PDPM is intended to be Budget Neutral – just a revised "Revenue Delivery System" designed to shift dollars away from therapy as a "resource" to more appropriately reimburse for overall patient-specific needs. Per CMS' Impact Analysis, annual SNF spending is projected to total $26.66 billion under PDPM, with only a $1 rounding error away from the budget if RUG-IV were to continue unabated. **Spoiler Alert:** Changes in "provider behavior" will drive up the aggregate Medicare spend and be followed by a corrective recalibration (sound familiar?), it's only a question of how long CMS needs to compute the overage.

The pattern described above should surprise no one. However, PDPM is geographically redistributive as well. All things being equal, New York providers lose $88 million annually (almost $29 per day), while my home state of New Jersey generously sacrifices $36 million (over $16 per day) to other locales. We isolated the factors driving this redistributive array (no political conspiracy theories, please), but this is just one of the unintended "ancillary" effects of PDPM we must consider.

Warning: this is where things start getting weird:

Many of our clients are struggling to measure, quantify and promote their "value" to referral sources under the healthcare reform movement. *(Where is this lunatic going with this – we were talking about PDPM… we are, just give me a chance).*

Despite its national application, PDPM does not change the fact that healthcare is a "local" business. Accountable Care Organizations, BPCI participants or any other entity "at risk" for a patient's fee-for-service Medicare spend may not understand the complex array of metrics that make each resident's score unique – but I promise they will notice the aggressive variations in PDPM per diem rates relative to currently comparative market averages, and they'll expect answers.

Assuming clinical outcomes are similar among competitors, "Episodic SNF Cost" (the amount we bill Medicare per stay) is the ultimate "value measure" used to benchmark performance against competing SNFs. The cost is calculated using an equation consisting primarily of three variables: re-hospitalization rate, length of stay and average per-diem rate (we could add other expense drivers generally outside the SNFs' control such as physician utilization – but maybe some other time).

PDPM maintains the same equation, with one significant difference: SNFs today in any given region generally maintain similar RUG distributions (the concentration of Ultra High Rehab days creates minimal variation in competitors' average per diem rate). These same facilities may realize rates that vary by hundreds of dollars per day under PDPM; our "upstream partners" will question whether you treat such a disproportionately acute population that the higher episodic spend supports your facility's value proposition – or is your team simply more astute at managing the four variable PDPM rate Components to enhance "Composite" scores? They will figure out quickly if they are, in reality, paying more for the same product, and their conclusions have the potential to alter the flow of patients through the local provider ecosystem for years to come.

This overlooked (and unintended) scenario may have the most sobering impact on SNFs lucky enough to qualify as "preferred providers" in ever-tightening "narrow networks."

The good news is there is no cause for concern. As we walked the exhibit hall at the AHCA annual convention in San Diego recently, we learned the industry is densely packed with PDPM Polymaths – overnight experts who will lead you through every challenge – like Reimbursement Sherpas safely guiding SNFs ascending Mount Medicare (if I were granted one wish, it would be for a font that conveys sarcasm).

As I wrote last year specific to RCS, I fully expected the consulting field to grow crowded, with new offerings primarily emerging from the industry's sector most impacted by a system wherein therapy utilization is untethered to payment. That paper is outdated now of course, but I keep it posted to quell any suggestion that our narrative is a visceral reaction to a new competitive threat. Quite the opposite.

Competent consulting services cannot be commoditized – every facility/market is unique and requires special consideration – we have had to carefully budget our consulting "inventory" to ensure availability for current clients. That said, I have already seen enough new PDPM "consultants" offering ill-conceived therapy-centric "solutions" destined for failure that I feel compelled to offer this advice: be wary of those with little to lose, when so much is at stake.

ZHSG's Position and Plan

The AHCA conference marked the unofficial start of PDPM-mania. The rash of education, new products, services and one-dimensional promotional rhetoric was near deafening and, in my opinion, often borderline irresponsible. ZHSG has no "agenda." We are committed to remaining independent and objective – which is why we have refrained from "carnival barker" styled exaggeration and irresponsible fear mongering. We do not prey on client fears; we would not advise until we had conducted every conceivable modeling exercise and developed logic tests to quantify how many of the nearly 29,000 theoretical Composite combinations were mutually exclusive (the actual number may surprise you).

ZHSG is confident that most well-managed, properly prepared SNFs have the capacity to benefit from the new system – very few should be "Punished." Our goal is to provide the scalable resources SNFs require to realize their "PDPM Potential" – the enhanced, compliant revenue and efficiency that PDPM affords most providers.

Twenty-five years of reimbursement-consulting has taught us valuable lessons, which have come to define ZHSG's "Rules of Payment System Engagement." PDPM will touch all facets of SNF operations – reimbursement, regulatory and market issues – and require a multidimensional team that includes nurses, therapists, coders, cost reporting, billing/finance professionals and local analysts. All of whom factor into the PDPM equation.

Operators need the depth and breadth of insight to anticipate how PDPM will impact not just SNF Medicare revenue, but how the system will resonate with local healthcare stakeholders obsessed with measuring "value," but lacking the skills required to neutralize outcomes for comparative integrity.

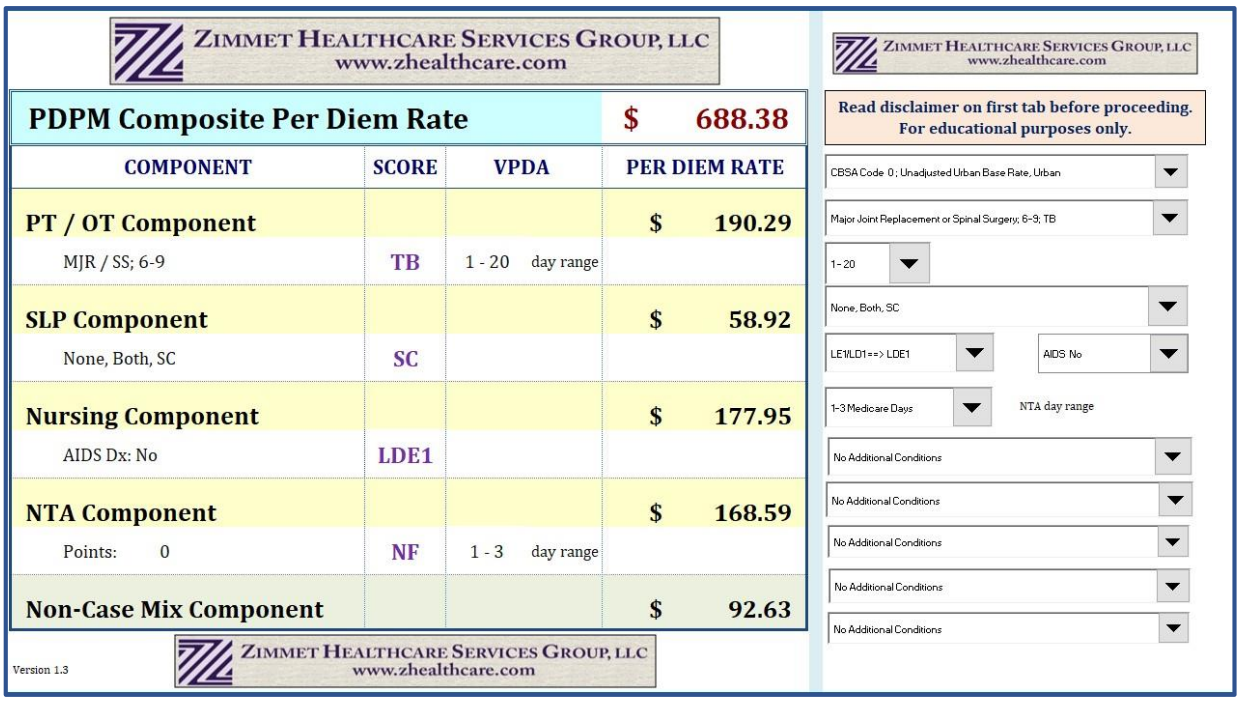
In addition to subject matter expert support, the complexity of PDPM, with thousands of "Composite" rate combinations and need for daily monitoring to capture enhancement opportunities (Interim Payment Assessments will be discussed in a future post), will also require technology solutions to augment traditional reimbursement management.

ZHSG now offers highly-specialized, integrated reimbursement-compliance technology applications and advisory solutions that are essential in today's market. I know, the field is already saturated with software… but we are not a technology company, we are simply extending our support through explicitly designed "Consulting Delivery Systems." We invite you to experience what this distinction really means – enhanced utility without the technology fatigue plaguing our industry (and personal lives, for that matter).

Contact us anytime to discuss our approach to PDPM; and for our current clients, how we can most efficiently incorporate PDPM support within the context of our active consulting service agreements.

My next PDPM post will address common myths and misconceptions about the new system. Feel free to share your thoughts, but **Please Don't Plagiarize Me**!

Test your understanding of PDPM. Take the "Reimbursement-Rhetoric" quiz on the next page. I will post my answers and explanations before Thanksgiving.



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PDPM Composite Per Diem Rate			$ 688.38
COMPONENT	SCORE	VPDA	PER DIEM RATE
PT / OT Component			$ 190.29
MJR / SS; 6-9	TB	1 - 20 day range	
SLP Component			$ 58.92
None, Both, SC	SC		
Nursing Component			$ 177.95
AIDS Dx: No	LDE1		
NTA Component			$ 168.59
Points: 0	NF	1 - 3 day range	
Non-Case Mix Component			$ 92.63

Version 1.3

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Read disclaimer on first tab before proceeding.
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CBSA Code 0 ; Unadjusted Urban Base Rate, Urban
Major Joint Replacement or Spinal Surgery; 6-9; TB
1 - 20
None, Both, SC
LE1/LD1==> LDE1
AIDS No
1-3 Medicare Days
NTA day range
No Additional Conditions
No Additional Conditions
No Additional Conditions
No Additional Conditions
No Additional Conditions

Check out www.zhealthcare.com and model your outlook on our PDPM Rate Simulator. Call (877) SNF-2001 for a complimentary access code.

PDPM Reimbursement v. Rhetoric Quiz

Rank in order of Reimbursement-Sensitivity:

_____Primary Dx for PT/OT & SLP Classification

_____Secondary / Tertiary Diagnoses

_____Section GG Function Score

_____Length of Stay

_____Restorative Nursing

_____IV Therapy

_____CBSA / AWI Adjustment

_____Clinical Eligibility

_____Quality & Outcomes (e.g. Re-Hospitalization rate)

_____New Reimbursement "Influencers" (e.g. Dieticians, Psychologist, Coders, etc.)

_____Impact on Alternative Payment Models (ACOs, BPCI, ISNP, MA)

_____SLP Variables

_____Monitoring for Clinical Changes

_____Restorative Nursing

_____MDS Reference Date Planning

_____Patient-Specific Therapy Programs

_____Respiratory Therapy

_____PHQ Score

_____Other Non-Therapy Ancillaries

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Use our PDPM Rate Simulator to calculate the impact on Composite scores. Visit us at www.zhealthcare.com. Call (877) SNF-2001 for a complimentary access code.

_____BONUS QUESTION: Which of the following will provide source data for the most useful PDPM analytics: