Approaching Therapy in A New Era

LeadingAge New Jersey and New Jersey Hospital Association
Navigating Your Path to Success Under the SNF PDPM
June 27, 2019
Presentation Topics

- Overview of Therapy Under PDPM
- Therapy Components: Deeper Dive
- Therapy Changes Ahead
- Departmental Structure Considerations: In-house or Contract
Biggest Change: PDPM No Longer Ties Payment to Therapy Minutes
Why the Changes to Therapy Under PDPM

- Over 90% of covered stays in SNF setting billed using one of the 23 rehabilitation RUG categories
- Over 60% of those days billed in one of the 3 ultra-high rehab RUGS

CMS, MedPAC, and OIG repeatedly noted that therapy minutes tend to cluster around payment thresholds, indicating delivery focused on reimbursement instead of patient needs.
Skilled Criteria Does Not Change

Skilled requirements:
3 overnights, Medicare days available, 60-day wellness break, 30-day return, practical matter

Covered skilled stay needs 7 days/week for nursing or 5 days/week for therapy services

Skilled care requires skills, knowledge, and judgment of licensed therapist

No treatment minimums defined, but PDPM expects “reasonable and necessary” care
(Chapter 8, Medicare Benefit Policy Manual)

Management of plan of care and teaching & training

CMS states individual therapy generally best for patient
Moving Forward…

- Requirements for safe and appropriate discharge have not changed
- MDS still documents therapy minutes—only at discharge
- SNF post-acute market has been based upon need for therapy
- Acute market will continue to not provide enough therapy in their setting, so will need to be done at SNF level
Therapy Components: Deeper Dive

Physical and Occupational Therapy (PT/OT)
Speech-Language Pathology (SLP)
PT/OT Components

- For PT & OT components, two classifications used:
  - Clinical category
  - Functional status (section GG)

- Generally higher payment in PT/OT component for more independent patients

- 2% reduction to this portion of the payment starting day 21 (Variable Per Diem Adjustment)

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_Template_Payment-Overview_v4_508.pdf
# PT/OT Components: Clinical Categories

<table>
<thead>
<tr>
<th>PT/OT Clinical Categories</th>
<th>Collapsed PT and OT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Major Joint Replacement or Spinal Surgery</td>
<td>1  Major Joint Replacement or Spinal Surgery</td>
</tr>
<tr>
<td>2  Non-Orthopedic Surgery</td>
<td>2  Non-Orthopedic Surgery and Acute Neurologic</td>
</tr>
<tr>
<td>3  Acute Neurologic Groups</td>
<td></td>
</tr>
<tr>
<td>4  Non-Surgical Orthopedic/Musculoskeletal</td>
<td>3  Other Orthopedic</td>
</tr>
<tr>
<td>5  Orthopedic Surgery (except Major Joint Replacement or Spinal Surgery)</td>
<td></td>
</tr>
<tr>
<td>6  Medical Management</td>
<td>4  Medical Management</td>
</tr>
<tr>
<td>7  Acute Infections</td>
<td></td>
</tr>
<tr>
<td>8  Cancer</td>
<td></td>
</tr>
<tr>
<td>9  Pulmonary</td>
<td></td>
</tr>
<tr>
<td>10 Cardiovascular and Coagulations</td>
<td></td>
</tr>
</tbody>
</table>

41,000 eligible ICD-10 codes map into 10 clinical categories, which then map into 4 PT/OT payment groups

Source: Centers for Medicare and Medicaid Services
# PT/OT Functional Impairment Groups

<table>
<thead>
<tr>
<th>Section GG Items</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care: Eating</td>
<td>0–4</td>
</tr>
<tr>
<td>Self-care: Oral Hygiene</td>
<td>0–4</td>
</tr>
<tr>
<td>Self-care: Toileting Hygiene</td>
<td>0–4</td>
</tr>
<tr>
<td>Mobility: Sit to Lying</td>
<td>0–4 (Average of 2 items)</td>
</tr>
<tr>
<td>Mobility: Lying to Sitting on Side of Bed</td>
<td></td>
</tr>
<tr>
<td>Mobility: Sit to Stand</td>
<td>0–4 (Average of 3 items)</td>
</tr>
<tr>
<td>Mobility: Chair/Bed-to-Chair Transfer</td>
<td></td>
</tr>
<tr>
<td>Mobility: Toilet Transfer</td>
<td></td>
</tr>
<tr>
<td>Mobility: Walk 50 Feet with 2 Turns</td>
<td>0–4 (Average of 2 items)</td>
</tr>
<tr>
<td>Mobility: Walk 150 Feet</td>
<td></td>
</tr>
</tbody>
</table>

**Maximum Score** (highest functioning/most independent patient) 24

*Source: Centers for Medicare and Medicaid Services*
# PT/OT Components: Payment Groups

*Lowest Function Score Not Always Highest Payment Result*

<table>
<thead>
<tr>
<th>Clinical Category</th>
<th>PT/OT Function Score</th>
<th>PT</th>
<th>OT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>0–5</td>
<td>1.53</td>
<td>1.49</td>
</tr>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>6–9</td>
<td>1.69</td>
<td>1.63</td>
</tr>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>10–23</td>
<td>1.88</td>
<td>1.68</td>
</tr>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>24</td>
<td>1.92</td>
<td>1.53</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>0–5</td>
<td>1.42</td>
<td>1.41</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>6–9</td>
<td>1.61</td>
<td>1.59</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>10–23</td>
<td>1.67</td>
<td>1.64</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>24</td>
<td>1.16</td>
<td>1.15</td>
</tr>
<tr>
<td>Medical Management</td>
<td>0–5</td>
<td>1.13</td>
<td>1.17</td>
</tr>
<tr>
<td>Medical Management</td>
<td>6–9</td>
<td>1.42</td>
<td>1.44</td>
</tr>
<tr>
<td>Medical Management</td>
<td>10–23</td>
<td>1.52</td>
<td>1.54</td>
</tr>
<tr>
<td>Medical Management</td>
<td>24</td>
<td>1.09</td>
<td>1.11</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
<td>0–5</td>
<td>1.27</td>
<td>1.30</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
<td>6–9</td>
<td>1.48</td>
<td>1.49</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
<td>10–23</td>
<td>1.55</td>
<td>1.55</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
<td>24</td>
<td>1.08</td>
<td>1.09</td>
</tr>
</tbody>
</table>

**NOTE:** Green shading indicates functional category that pays highest case mix.

Source: Centers for Medicare and Medicaid Services
SLP Component

For SLP component, PDPM uses multiple different patient characteristics that were predictive of increased SLP costs:

- Acute neurologic clinical classification
- Certain SLP-related comorbidities
- Impaired cognition
- Use of mechanically altered diet
- Presence of swallowing disorder and supporting diagnosis

Source: Centers for Medicare and Medicaid Services
## SLP-Related Comorbidities

- 12 SLP comorbidities identified as predictive of higher SLP costs:

<table>
<thead>
<tr>
<th>1. ALS</th>
<th>7. Laryngeal Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Aphasia</td>
<td>8. Oral Cancers</td>
</tr>
<tr>
<td>4. CVA, TIA, or Stroke</td>
<td>10. Tracheostomy (while resident)</td>
</tr>
<tr>
<td>5. Dysphagia</td>
<td>11. Traumatic Brain Injury</td>
</tr>
<tr>
<td>6. Hemiplegia or Hemiparesis</td>
<td>12. Ventilator (while resident)</td>
</tr>
</tbody>
</table>

- Conditions and services combined into single SLP-related comorbidity flag
- Patient qualifies if any of the conditions/services is present
- Mapping between ICD-10 codes and SLP comorbidities available at CMS.gov/PDPM

*Source: Centers for Medicare and Medicaid Services*
# SLP Component: Payment Groups

<table>
<thead>
<tr>
<th>Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment</th>
<th>Mechanically Altered Diet or Swallowing Disorder</th>
<th>CMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Neither</td>
<td>0.68</td>
</tr>
<tr>
<td>None</td>
<td>Either</td>
<td>1.82</td>
</tr>
<tr>
<td>None</td>
<td>Both</td>
<td>2.66</td>
</tr>
<tr>
<td>One</td>
<td>Neither</td>
<td>1.46</td>
</tr>
<tr>
<td>One</td>
<td>Either</td>
<td>2.33</td>
</tr>
<tr>
<td>One</td>
<td>Both</td>
<td>2.97</td>
</tr>
<tr>
<td>Two</td>
<td>Neither</td>
<td>2.04</td>
</tr>
<tr>
<td>Two</td>
<td>Either</td>
<td>2.85</td>
</tr>
<tr>
<td>Two</td>
<td>Both</td>
<td>3.51</td>
</tr>
<tr>
<td>Three</td>
<td>Neither</td>
<td>2.98</td>
</tr>
<tr>
<td>Three</td>
<td>Either</td>
<td>3.69</td>
</tr>
<tr>
<td>Three</td>
<td>Both</td>
<td>4.19</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare and Medicaid Services
Payment System Builds in Expectation of Tapering of Therapy Over Length of Stay

Variable Per Diem Payment Adjustment

<table>
<thead>
<tr>
<th>Medicare Payment Days</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–20</td>
<td>1.00</td>
</tr>
<tr>
<td>21–27</td>
<td>0.98</td>
</tr>
<tr>
<td>28–34</td>
<td>0.96</td>
</tr>
<tr>
<td>35–41</td>
<td>0.94</td>
</tr>
<tr>
<td>42–48</td>
<td>0.92</td>
</tr>
<tr>
<td>49–55</td>
<td>0.90</td>
</tr>
<tr>
<td>56–62</td>
<td>0.88</td>
</tr>
<tr>
<td>63–69</td>
<td>0.86</td>
</tr>
<tr>
<td>70–76</td>
<td>0.84</td>
</tr>
<tr>
<td>77–83</td>
<td>0.82</td>
</tr>
<tr>
<td>84–90</td>
<td>0.80</td>
</tr>
<tr>
<td>91–97</td>
<td>0.78</td>
</tr>
<tr>
<td>98–100</td>
<td>0.76</td>
</tr>
</tbody>
</table>

Source: Proposed Rule, Federal Register, April 27, 2018

Average PT + OT Costs Per Day (smoothed) by LOS

Source: Acumen, SNF Technical Expert Panel, October 2016
Length of Stay Conundrum

• PDPM sensitizes payment for PT/OT to LOS, but only a financial concern if those costs don’t fall as rapidly as payment

• Meanwhile, shorter LOS can negatively impact:
  – Patient satisfaction
  – Outcomes under QRP and star ratings
  – Census
  – Rehospitalization rates (including SNF Value-Based Purchasing Adjustment)

• However, shorter LOS will be of interest to bundlers and ACOs

Develop clear understanding of the relationship of LOS to PT & OT costs and outcomes by clinical category
Changes Ahead
Therapy System Assessment Keys

- Therapist involved in GG?
- Amount of speech? Diagnosis?
- Information populates MDS?
- Cognition?
- Evaluation timing?
- Is GG “Usual”?
Nursing and Therapy Moving to Next Step

**Daily Review**

- Implement daily huddle or utilization review as clinical picture must be closely monitored

**Case Management**

- Have Nursing lead case management meetings for patients

**Know Payment Pre-admission**

- Understand clearly what you will be paid for patient at/before admission to know how to proceed with care delivery model

**Earlier Handoffs**

- Ensure Therapy to Nursing handoffs occur earlier for follow-up on care levels for restorative and direct care nursing staff
Opportunities and Challenges to Therapy Reform

• Balancing efficiencies (intensity and LOS) with quality outcomes
• Guidance/pathway for care from time of admission to discharge
• Effective diagnoses coding and sequencing
• Understanding your costs in relation to revenue:
  – Tapering PT/OT in relation to payment adjustments
  – Understanding outcomes in relation to full costs of care
Roadblocks for Shift from Therapy Model of Services to Patient Clinical Picture

• Who will lead the charge?
  – Meeting structure will need to change
• Who will participate in your 72-hour meeting/post admission meeting?
  – Therapy should be part of the meeting
• Who will monitor outcomes?
• Concurrent and group minute monitoring?
• How to align length of stay with Variable Per Diem Payment Adjustment (VPDA)?

If therapy practices are going to be modified, carefully establish evidence-base on outcomes
HDG Philosophy on the Future

• Therapy practice likely to evolve; one need only look at the past under RUGs or Medicare Advantage

• Technologies, training, enhanced collaboration, modality changes, and outcomes focus will all positively contribute to obtaining optimal outcomes

• All changes in practice must be tied to clinical needs and patient outcomes
From 2010 to 2013, Rehab Ultra Grew by 30+% What Grew This Fast Can Ungrow!

Group and Concurrent Therapy Definition and Policy: Current

- **Concurrent therapy**: treatment of 2 patients at same time, when patients are not performing same or similar activities, both of whom must be in line of sight of therapist.

- **Group therapy**: treatment of 4 patients who are performing same or similar activities and supervised by therapist not supervising any other individuals.

- Use of group or concurrent must be justified in plan of care:
  - Benefits, amount patient should receive of these therapy modes
  - How services will meet patient’s needs

- Must clearly require skills of a therapist to perform

- *Entire generation of therapists did not live with group or concurrent*
Group Therapy Definition and Policy: Proposed

• “Qualified rehabilitation therapist or therapy assistant treating 2–6 patients at the same time who are performing the same or similar activities.”

• New SNF policy mirrors inpatient rehabilitation facility policy to set uniform standard across post-acute care

• CMS stated:
  – “more clinical flexibility when determining the appropriate number for a group, without compromising the therapist’s ability to manage the group and the patient’s ability to interact effectively and benefit from group therapy.”
  – Therapists have ability to make clinical determinations as to what works for the patient; mentioned clinical appropriateness as well as benefits to patients
Group and Concurrent Therapy Limits Will Be Monitored on Section O of MDS

Under PDPM, CMS will use combined limit on both concurrent and group therapy to be no > 25% of therapy received by SNF patients, for each therapy discipline

- Compliance with concurrent/group therapy limit monitored on PPS discharge assessment
- If limits exceeded for any therapy discipline, provider receives warning message on final validation report
What CMS Has Actually Said About the Future of Therapy

• “Therefore, we want a way to track the therapy utilization before and after PDPM is put into effect, so we can make adjustments accordingly in the future. Second, we want to track the amount of concurrent and group therapy being provided to patients to make sure that the therapies these patients receive continues to be as individualized as possible.”

• “Some stakeholders asked questions regarding the minimum amount of therapy that is necessary to provide under PDPM. The answer to this question, regardless of case-mix classification system, is the amount that is necessary to maintain or restore function for the patient consistent with that patient’s needs and goals. We are aware of the possibility of some providers potentially stinting on therapy under PDPM and will be monitoring closely in case of such issues.”

If therapy practices suddenly change and outcomes worsen, litigation risk may also increase

Source: Transcript of CMS PDPM training webinar December 11, 2018
What Your Patient Needs

Major component of CMS’ PDPM monitoring strategy is monitoring for consistency in care provision between RUG-IV and PDPM:

- Therapy intensity, duration, and manner of delivery
- Increased utilization of mechanically altered diets
- Anomalies in comorbidities coding

Any significant shifts in care provision between now and PDPM could draw scrutiny from CMS review entities
Important to Have Solid Clinical Foundation and Evidence Base for Therapy

HDG completed analysis that compares a given SNF (or group of SNFs) to a cohort of SNFs meeting minimum quality thresholds on risk-adjusted basis:

• Inferred therapy minutes per day from Medicare claims for 2016 to 2018 for all U.S. SNFs

• Defined “national quality cohort” of approximately 5,000 SNFs with sufficient star ratings and metrics above the 50th percentile in patients improving in function (from Nursing Home Compare)

• Segmented claims by 10 clinical categories that comprise PT/OT component, plus: elective joint replacements and “no prior acute stay”
### National Quality Cohort Therapy Minutes Per Day (Risk Adjusted)

<table>
<thead>
<tr>
<th>Example Clinical Category</th>
<th>NJ Average Therapy Minutes Per Day</th>
<th>25th Percentile</th>
<th>Median</th>
<th>Mean</th>
<th>75th Percentile</th>
<th>NJ Average Compared to Quality Cohort Mean</th>
<th>NJ Average Compared to Quality Cohort 25th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Infections</td>
<td>79</td>
<td>65</td>
<td>76</td>
<td>73</td>
<td>84</td>
<td>8%</td>
<td>21%</td>
</tr>
<tr>
<td>Other Orthopedic - Non Surgery</td>
<td>91</td>
<td>76</td>
<td>86</td>
<td>83</td>
<td>94</td>
<td>9%</td>
<td>20%</td>
</tr>
<tr>
<td>All Clinical Categories</td>
<td>84</td>
<td>71</td>
<td>80</td>
<td>77</td>
<td>86</td>
<td>9%</td>
<td>18%</td>
</tr>
</tbody>
</table>

- Average therapy minutes per day for patients with Acute Infections are substantially lower than for patients in the Other Orthopedic – Non Surgery category
- As a state, NJ SNFs operate close to the 75th percentile of the national quality cohort across all clinical groups
- If NJ operated between the mean and 25th percentile, substantial savings would result
- Since almost all minutes currently provided as individual therapy, use of group and concurrent therapy would further drive savings

Source: HDG analysis of 2016–2018 Medicare claims data
Departmental Structure Considerations

In-house or Contract?
Therapy Considerations: In-House

**Pros**
- Keep costs contained
- Flexibility: “experimentation” as this system goes into effect
- Options for therapy roles and responsibilities
- Overall control
- Customer satisfaction

**Cons**
- Knowledge of staffing par levels
- Determination of compensation for rehab staff
- System training for staff
- Industry knowledge of therapy best practices or changes
- Solely responsible for any denials—full dollar amount
- Expertise to oversee
- Recruitment
Therapy Considerations: Contract

Pros

• Less oversight
• Some practice in other settings with fixed therapy payments, e.g., hospitals
• Possible multiple service lines, so are able to facilitate transitions in care
• Shared indemnification for audits
• Care paths backed by internal research

Cons

• Conflict of interest
• Delivering on value-adds
• Unknown if delivered in the past on promises
• Silos may still exist between SNF and therapy partner
Best Contract Terms

- Are win-win
- Obtain and verify outcomes on MDS
- Support areas that drive revenue: MDS section GG; ICD-10 coding
- Assure appropriate reimbursement and compliance attained
- Drive towards value (outcome ÷ cost to get there)
Imperative That You Choose the Right Therapy Provider

- Prepared for change
- Partner for outcomes and quality measures
- Uses solid clinical pathways
- Optimizes group and concurrent therapy opportunities
- Incentivized to align clinical category with therapy costs
Areas to Check Before Signing on the Dotted Line…

- Review current contract for all payor types
- Therapist participation in meetings
- Mix of rehab/non-rehab days
- ALOS—overall and by diagnosis
- Therapy payment for each component
- Outcomes at discharge
# Therapy Provider Contract Options

<table>
<thead>
<tr>
<th>Option 1: Cost Per Minute</th>
<th>Option 2: Pass-through Rehab Costs/On-site Time</th>
<th>Option 3: One Flat Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy to calculate</td>
<td>Simple to calculate</td>
<td>Simple approach</td>
</tr>
<tr>
<td>Who decides the minutes?</td>
<td>Could build in productivity requirements</td>
<td>Dependent upon acuity and patient case mix</td>
</tr>
<tr>
<td>What is appropriate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who drives process for intensity?</td>
<td>Who decides amount of time?</td>
<td>Types of patients may change and profitability will change</td>
</tr>
<tr>
<td>Clinical category not tied to costs</td>
<td>Clinical category not tied to costs</td>
<td>May be “behind” the environmental changes</td>
</tr>
<tr>
<td><strong>Option 4:</strong> Tiered Per Diem Rate</td>
<td><strong>Option 5:</strong> Portion of Rehab Component</td>
<td><strong>Option 6:</strong> Other Options</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Potentially aligns the clinical picture of patients</td>
<td>Similar to most contracts currently with RUGs</td>
<td>Value-based/outcome option</td>
</tr>
<tr>
<td>May be more appropriate in future as industry “figures it out”</td>
<td>Amount of therapy delivered is discretion of the company</td>
<td>Management contract-hybrid of in-house and contract</td>
</tr>
<tr>
<td>Susceptible to being on downside</td>
<td>“Guaranteed” profit for community</td>
<td>Other options?</td>
</tr>
<tr>
<td>Like managed care/level of care approach</td>
<td>Smaller numbers of areas to track—only 16 for PT/OT and 12 for SLP</td>
<td></td>
</tr>
<tr>
<td>Community absorbs VPDA</td>
<td>Both sides share risk</td>
<td></td>
</tr>
<tr>
<td>Minutes may be less or more than clinically appropriate</td>
<td>No outcome incentives/penalties</td>
<td></td>
</tr>
</tbody>
</table>
Therapy Provider Contract Key Considerations

- Clause to renegotiate at any point-rate changes
- Consider six-month “wait and see” clause
- Timing: Talking in July? Decision by September
- Patient outcomes incentives
- Payment for concurrent or group
Questions?
Resources

- CMS Medicare Learning Network (MLN) December 11, 2018, webinar: SNF PPS: Patient-Driven Payment Model
- CMS Fact Sheet: PDPM Patient Classification
- Therapy Provider Contract Action Steps
For More Information

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Disclosure

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