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Patient Driven Payment Model (PDPM) Implementation and Calculation

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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Georgia Acuity Background

- The Resource Utilization Group (RUG) – III 34 group resident classification system is currently utilized by Georgia to incorporate acuity adjustment for nursing facility reimbursement.
- Rug-IV is utilized by Medicare.

CMS Guidance for Continuing Rug-Based Systems

- On October 1, 2019, the Medicare program replaced their RUG-based resident classification system with the Patient Driven Payment Model (PDPM).
- Due to this, the Centers for Medicare & Medicaid Services (CMS) have indicated to states their desire to remove elements from the Minimum Data Set (MDS) resident assessment that are not necessary for resident classification under PDPM.

CMS Guidance for Continuing Rug-Based Systems

- CMS formalized this plan through the release of their prospective MDS item set version 1.18.11, set to be effective October 1, 2023.
- CMS further cemented their plans through guidance provided in the State Medicaid Director's Letter (SMD #22-005), specifying that CMS would no longer support RUG classification after October 1, 2023.

CMS Guidance for Continuing Rug-Based Systems

- At their discretion, States can choose to implement and mandate the completion of an Optional State Assessment (OSA), which would allow for the continued collection of the items necessary for RUG classification.
- CMS has stated that they will only allow for OSAs to be submitted and validated through the current CMS MDS submission system through September 30, 2025.

OSA Overview

- The OSA is an MDS item set version that collects only the items necessary for classification under a RUG-III or RUG-IV-based resident classification system.
- Implementing an OSA would require nursing facilities to complete and submit a separate OSA form every time they complete and submit federally required MDS assessment.

OSA Overview

- This would cause additional administrative burden for nursing facility personnel to complete the additional assessment, and to the State in their assessment processing and case-mix index (CMI) calculations.
- The current recommendation from the State is to **not** implement an OSA and instead transition directly to a PDPM resident classification system.

PDPM Background

- Beginning in the late 1990s, the Medicare program implemented the RUG resident classification system for reimbursement, which utilized resident conditions, functional status, and actual minutes of therapy provision to determine reimbursement rates.
- On October 1, 2019, the Medicare program introduced the PDPM resident classification system, which was a paradigm shift in reimbursement philosophy.

PDPM Background

- PDPM increased the number of components with acuity adjustment from two to five, and based therapy payments on the expected needs of residents as opposed to the actual minutes of therapy provided.
- CMS indicated the significant increase in residents classifying into the higher paying rehabilitation (therapy) payment categories when underlying resident conditions may not warrant such treatment as a main reason for developing and transitioning to PDPM.
- State Medicaid agencies across the country have seen these same trends in increased rehabilitation (therapy) group classification.

PDPM Use for Medicaid Programs

- Of the five PDPM acuity components, the State is implementing only one, the nursing component. The nursing component measures the estimated nursing (registered nurse [RN]/licensed practical nurse [LPN]/certified nursing assistant [CNA]) resource needs a resident may have based on their presenting conditions and functional status.
- This component very closely aligns with the costs in the current nursing facility reimbursement methodology that are adjusted by acuity.
- The state is not considering the other four acuity adjusted components, Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), and Non-Therapy Ancillary (NTA), for the reasons laid out on the following slides.

Therapies (PT/OT/SLP)

- The reason for excluding the three therapies centers on their reimbursement being predominantly the responsibility of payers outside of the Medicaid program.
- The majority of nursing home Medicaid residents (typically 70 percent to 80 percent) are dually-eligible for both Medicare and Medicaid. The PT/OT/SLP needs of dual-eligible Medicaid residents are covered and paid for by the Medicare part B program and are not the responsibility of the Medicaid program.
- As such, Medicaid therapy costs included in the rate calculation are very low (a few dollars a day), and would not warrant a case-mix/acuity adjustment.

NTA Component

- The reason for exclusion of the NTA component also relates to the fact that the majority of those costs are being reimbursed outside of the Medicaid nursing facility inpatient per diem.
- In Georgia, expenses related to Drugs Charged to Patients (prescription drugs), laboratory, and radiology costs account for around 80 percent of NTA expenses. These expenditures are covered and paid by Medicare part D (Drugs), the Medicaid pharmacy benefit, or reimbursement separately through the Medicaid fee schedule (laboratory/radiology services).
- As such, there is generally not a strong correlation between the NTA acuity adjustment and the remaining Medicaid NTA costs (mainly medical supplies), and secondly, the remaining Medicaid NTA costs are typically small in nature and would not warrant case-mix/acuity adjustment.

PDPM Snapshot

Nursing Component

- Nursing Base Rate X Nursing PDPM.
- Nursing using same characteristics as under RUG-IV (Georgia is continuing to use RUGs III).
- If the PDPM assessments do undergo an audit process, providers should be able to support the data elements listed in those assessments.

PDPM Snapshot

Nursing Component Continued

Section GG items included in the Nursing Functional Score:

Section GG Item	Functional Score Range
GG0130A1 – Self-Care: Eating	0-4
GG0130C1 – Self-Care: Toileting Hygiene	0-4
GG0170B1 – Mobility: Sit to Lying (average of two items)	0-4
GG0170C1 – Mobility: Lying to Sitting on Side of Bed (average of two items)	0-4
GG0170D1 – Mobility: Sit to Stand (average of three items)	0-4
GG0170E1 – Mobility: Chair/Bed-to-Chair Transfer (average of three items)	0-4
GG0170F1 – Mobility: Toilet Transfer (average of three items)	0-4

PDPM Cognitive Scoring

- Under RUG-IV, a patient's cognitive status is assessed using the Brief Interview for Mental Status (BIMS):
  - In cases where the BIMS cannot be completed, providers are required to perform a staff assessment for mental status.
  - The Cognitive Performance Scale (CPS) is then used to score the patient's cognitive status based on the results of the staff assessment.
- Under PDPM, a patient's cognitive status is assessed in exactly the same way as under RUG-IV (i.e., via the BIMS or staff assessment):
  - Scoring the patient's cognitive status, for purposes of classification, is based on the Cognitive Function Scale (CFS), which is able to provide consistent scoring across the BIMS and staff assessment.

PDPM Cognitive Scoring: Methodology

CPS is used by staff to assess a resident's cognitive performance when BIMS cannot be completed.

Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13-15	0
Mildly Impaired	8-12	1-2
Moderately Impaired	0-7	3-4
Severely Impaired		5-6

Nursing Component

- RUG-IV classifies patients into a therapy RUG based on how much therapy the patient receives, and a non-therapy RUG based on certain patient characteristics:
  - Only one of these RUGs is used for payment purposes.
  - Therapy RUGs are used to bill for over 90 percent of Part A days.
- PDPM utilizes the same basic nursing classification structure as RUG-IV, with certain modifications:
  - Function score based on Section GG of the MDS 3.0.
  - Collapsed functional groups, reducing the number of nursing groups from 43 to 25.
- Takeaway:
  - Under PDPM, the nursing component has done away with therapy as the driver of reimbursement.

MDS Changes

- Both RUG-IV and PDPM utilize the MDS 3.0 as the basis for patient assessment and classification.
- The assessment schedule for RUG-IV includes both scheduled and unscheduled assessments with a variety of rules governing timing, interaction among assessments, combining assessments, etc.:
  - Frequent assessments are necessary, due to the focus of RUG-IV on such highly variable characteristics as service utilization.
- The assessment schedule under PDPM is significantly more streamlined and simple to understand than the assessment schedule under RUG-IV.
- The changes to the assessment schedule under PDPM have no effect on any Omnibus Budget Reconciliation Act of 1987 (OBRA)-related assessment requirements.

MDS Changes

- Skilled Nursing Facility (SNF) Primary Diagnosis:
  - Item I0020B (New Item).
  - This item is for providers to report, using an ICD-10-CM code, the patient's primary SNF diagnosis.
  - "What is the main reason this person is being admitted to the SNF?"
  - Coded when I0020 is coded as any response 1 – 13.

PDPM HIPPS Coding

- Based on responses on the MDS, patients are classified into payment groups, which are billed using a 5-character Health Insurance Prospective Payment System (HIPPS) code.
- The current RUG-IV HIPPS code follows a prescribed algorithm:
  - Character 1-3: RUG Code
  - Character 4-5: Assessment Indicator
- In order to accommodate the new payment groups, the PDPM HIPPS algorithm is revised as follows:
  - Character 1: PT/OT Payment Group
  - Character 2: SLP Payment Group
  - Character 3: Nursing Payment Group
  - Character 4: NTA Payment Group
  - Character 5: Assessment Indicator

Medicaid-Related Issues

- PDPM may have a number of effects on Medicaid programs:
  - Upper Payment Limit (UPL) Calculation
  - Case-Mix Determinations
- UPL represents a limit on certain reimbursements for Medicaid providers:
  - Specifically, the UPL is the maximum a given State Medicaid program may pay a type of provider, in the aggregate, statewide in Medicaid fee-for-service.
  - State Medicaid programs cannot claim federal matching dollars for provider payments in excess of the applicable UPL.

Medicaid-Related Issues

- While budget neutral in the aggregate, PDPM changes how payment is made for SNF services, which can have an impact on UPL calculations:
  - States will need to evaluate this effect to understand revisions in their UPL calculations.

Timeline for PDPM Implementation

Timeline for PDPM implementation

The Department will transition to PDPM on July 1, 2024. Providers will receive a "Shadow" Rate Sheet for demonstration purposes only beginning July 1, 2023.

Please see the chart below detailing the quarterly data utilized for each reimbursement calculation.

Rates Effective	CMI Data	PDPM Data	Comments
7/1/2023	3/31/2023	N/A	
10/1/2023	6/30/2023	N/A	
1/1/2024	9/30/2023	N/A	CMS will no longer support RUG data effective 10/01/2023.
4/1/2024	N/A	N/A	Continue to reimburse at the 1/1/2024 Rate.
7/1/2024	N/A	3/31/2024	State reimbursing using PDPM.

Shadow Rates – Demonstrative Only

- A shadow rate will be calculated using the available PDPM data – the rate is **not** an official rate or effective rate, it is to demonstrate the impact on the rates using PDPM data in comparison to the CMI data.
- Shadow rates will be provided for the following periods:
  - July 1, 2023
  - October 1, 2023
  - January 1, 2024
  - April 1, 2024

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Georgia Resident Listings

- Resident Listings will now include the PDPM Nursing Component Value (PDPM Code) and the Nursing Component CMI Values (PDPM CMI and CMI Add-On).
- The Calculation will not change, the PDPM values will be used in place of the RUG-III values.
- The PDPM Calculation is not performed by Myers and Stauffer; the PDPM value is extracted from the MDS Daily Extract files received from CMS.
- Providers can validate their PDPM value from the MDS Software with the PDPM value provided on the Resident Listings.
- The following slide shows an example of the changes to the Resident Listing Report.
- Frequently Asked Questions provided by the Georgia Department of Community Health (DCH) will provide links to the CMS website with documentation that can assist in how the PDPM values are calculated by CMS.

Georgia Department of Community Health - Case Mix Evaluation
Listing of Residents
Most Recent Assessment with Effective Date up to XX/XX/XXXX
Assessments Received as of XX/XX/XXXX

Print Date: XX/XX/XXXX

Page: 1 of 1

Provider Number: LTCXXXXXX
Provider Name: Provider One
GA ID: GAXXX

A0310a,b	Resident Name	Completion Date (Z0500b)	PDPM Code	PDM CMI	PDPM CMi Add-On	Resident ID	Medicaid Cognitive Add-On	Payment Source
01, 01	Resident, One BIMS = 15	XX/XX/XXXX	A	3.95		00000001		Medicare
01, 01	Resident, Two BIMS = 12	XX/XX/XXXX	C	2.85		00000002		Medicare
03, 99	Resident, Three BIMS = 99 CPS = 3 B0100 = 0 B0700 = 2 C0700 = 1 C1000 = 1 G0110H1 = 1	XX/XX/XXXX	I	1.68	1.71	00000003	Not Included	Medicaid

Number of Residents, Overall CMI Averages and Medicaid CMI Average

Medicaid Residents:	1	1.68
Medicare Residents:	2	3.40
Other Residents:	0	0.00
Total Residents:	3	2.83

CMI for Medicaid Payment Rate: 1.71

Impairment Count:
Number of the following:
- C1000 - Decision Making: Not Independent = 1 or 2
- B0700 - Understood: Not Independent = 1, 2 or 3
- C0700 - Short-Term Memory: Not OK = 1

Severe Impairment Count:
Number of the following:
- C1000 - Decision Making: Mod. Impairred = 2
- B0700 - Understood: Sometimes/Never = 2 or 3

* Number and % of Residents Included in Cognitive Add-On

Medicaid Residents:	0	0.00%

IF B0100 = 0 AND C1000 = 0 AND B0700 = 0 AND C0700 = 0 THEN CPS = 0
IF B0100 = 0 AND C1000 < 3 AND Impairment Count = 1 THEN CPS = 1
IF B0100 = 0 AND C1000 < 3 AND Impairment Count > 1 AND Severe Impairment Count = 0 THEN CPS = 2
IF B0100 = 0 AND C1000 < 3 AND Impairment Count > 1 AND Severe Impairment Count = 1 THEN CPS = 3
IF B0100 = 0 AND C1000 < 3 AND Impairment Count > 1 AND Severe Impairment Count = 2 THEN CPS = 4
IF B0100 = 0 AND C1000 = 3 AND GG0130A > 1 THEN CPS = 5
IF B0100 = 0 AND C1000 = 3 AND GG0130A = 1 THEN CPS = 6
IF B0100 = 1 THEN CPS = 6

Appendix D Update

- Appendix D will be updated for PDPM to continue to pay extra funds for Medicaid-only patients.

	RUG-IV Component Value	PDPM Nursing Component	PDPM Nursing Component CMI	PDPM Nursing Component CMI – 2%
Extensive Services	ES3	A	3.95	4.03
	ES2	B	2.99	3.05
	ES1	C	2.85	2.91
Special Care High/Low	HDE2	D	2.33	2.38
	HDE1	E	1.94	1.98
	HBC2	F	2.18	2.22
	HBC1	G	1.81	1.85
	LDE2	H	2.02	2.06
	LDE1	I	1.68	1.71
	LBC2	J	1.67	1.70
	LBC1	K	1.39	1.42
Cognitive Impairment	CDE2	L	1.82	1.86
	CDE1	M	1.58	1.61
	CBC2	N	1.51	1.54
	CA2	O	1.06	1.08
	CBC1	P	1.3	1.33
	CA1	Q	0.91	0.93
Behavior Issues	BAB2	R	1.01	1.03
	BAB1	S	0.96	0.98
Physical Functioning	PDE2	T	1.53	1.56
	PDE1	U	1.43	1.46
	PBC2	V	1.19	1.21
	PA2	W	0.69	0.70
	PBC1	X	1.1	1.12
	PA1	Y	0.64	0.65

Questions and Answers

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Resources

DCH link:

https://dch.georgia.gov/providers/provider-types/nursing-home-providers/pdpm

CMS link:

https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model

https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf

(This is the Resident Assessment Instrument (RAI) manual, and Chapter 6, pages 6 – 11 of this manual provides information on the calculation for the PDPM [HIPPS] value; it also provides a PDPM Calculation Worksheet.)

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