Patient Driven Payment Model: A Guide to Delivering Value

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• Co-founder of Patient Pattern, a clinical decision support software to help manage clinical outcomes and optimize practitioner decision support for PDPM.

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- National Director of Consultant Services for Remedi SeniorCare Pharmacy. She has been a clinical consultant pharmacist for Remedi for seven years, but has been in long-term care for twelve years.
- She graduated from the University of Toledo College of Pharmacy in 2007 with her Doctorate of Pharmacy degree.
- She is an active member of ASCP, and is on the board of directors for Ohio ASCP. She has been a board certified geriatric pharmacist since 2012.
Disclosure

The speaker discloses no relevant financial conflicts of interest with regard to this activity.
Learning Objectives

• Describe the new PDPM reimbursement model for skilled nursing facilities (SNFs).

• Identify programs, protocols and cases that demonstrate value to the SNF from an interprofessional perspective.

• Compare examples of interprofessional teams can influence SNFs to improve medication management, reduced poor patient outcomes and maximized reimbursement.
Self-Assessment Question #1

What does PDPM stand for?

A. Prescription Drug Payment Model
B. Prescription Driven Pharmacy Model
C. Patient Driven Payment Model
D. Patient Deciding Prescription Model
Self-Assessment Question #1

What does PDPM stand for?

A. Prescription Drug Payment Model
B. Prescription Driven Pharmacy Model
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AGENDA

1. PDPM Overview
2. Do’s & Don’ts for PDPM
3. Measuring Clinical Complexity
4. Facilitating Collaboration
It Is Not the Strongest of the Species that Survives But the One Most Adaptable To Change

- Charles Darwin
Payment Models Are Changing

Driven by Centers for Medicare and Medicaid (CMS)

- Value-Based Purchasing
- Accountable Care Organizations (ACOs)
- iSNPs/dSNPs/cSNPs
- Patient Driven Payment Model (October 1st, 2019)
- Patient Driven Grouping Model (January 1st, 2020)

SNP = Special needs plan
PDPM: WHY NOW?

Office of Inspector General Audits 2010-2020

12/2010: Questionable billing practices in SNFs: $500 million in overpayments

02/2013: SNFs fail to meet discharge planning: $5.1 billion in overpayments

06/2015: Billing Changes in Therapy: Improvements needed $143 million in overpayments

02/2019: 3-Day Qualifying Stay: $84 million in improper payments

06/2019: Incidents of Potential Abuse / Neglect not reported at SNFs

Due 2020: Involuntary DC from SNFs for dual eligible beneficiaries in SNFs

Moving Forward:
• CMS will monitor therapy provisions under PDPM to identify facilities that have significant billing changes.
• CMS will be monitoring changes in MDS/therapy/diagnoses
• What strategies do you have in place in case of an audit?

SNF = Skilled Nursing

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WHAT DO YOU KNOW ABOUT PDPM?

- Therapy no longer drives reimbursement
- ICD-10 Coding now drives reimbursement
- Clinical Complexity must be captured
- PT/OT/NTA rate decreases over length of stay (LOS)
- There is no: ‘1 perfect diagnosis’ ‘720 min of therapy’

Moving Forward:

- How do we measure clinical complexity?
- How will you assure that the MDS and EHR has captured patient complexity?
- How do medications factor into PDPM?
- Facility EHR is not going to make PDPM easier.
- If a code is missed, it will not be considered a change of condition.
Self-Assessment Question #2

Which of the following is NOT a case-mixed adjusted components of PDPM?

A. Physical Therapy (PT)
B. Occupational Therapy (OT)
C. Speech-Language Pathology (SLP)
D. Non-Therapy Ancillary (NTA)
E. Nursing
F. Wound Care
Self-Assessment Question #2

Which of the following is NOT a case-mixed adjusted components of PDPM?

A. Physical Therapy (PT)
B. Occupational Therapy (OT)
C. Speech-Language Pathology (SLP)
D. Non-Therapy Ancillary (NTA)
E. Nursing
F. Wound Care
The Need to Know

• Skilled nursing facilities will be accepting more medically complex resident under PDPM. Physicians and APP will need a way to predict the degree of risk for adverse outcomes and stay alert to changes in condition such as the Fraility Risk Score.

• Pharmacist - be prepared to receive many requests for additional and/or clarification of ICD-10 codes to best describe each resident upon admission. It is important to understand the need for such requests and the value of responding to them in as timely a manner as possible.

• Remember that this is the biggest change in reimbursement for SNF in 20 years. There will be a learning curve in the beginning for both the facility and the practitioners.
Interdisciplinary Team Effort

- Admissions Staff: 10.0%
- PT/OT: 20.0%
- Medical Staff: 10.0%
- Dietary: 3.0%
- Pharmacist: 4.0%
- Social Work: 5.0%
- SLP: 8.0%
- Nursing: 40.0%

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SNF FINANCIAL IMPACT

FINANCIAL IMPACT

Social
1.0%

Medical
90.0%

Nursing
3.0%
PDPM IMPLEMENTATION

+ Educate all staff, including physicians
+ Pre-Admission Assessments
+ Assess MDS Integrity
+ Consider Measuring Risk
+ Start Collaborating today.
PDPM STRATEGY
DON’T’S

INCREASE CLINICAL COMPLEXITY

- Costs $$$ in staff development and training.
- Failure to develop the right programs could result in decreased census, deficiencies & lawsuits.
- RUG-IV ~ 20 MDS items affect reimbursement
- PDPM = 161 MDS item fields for MDS coordinators to track for reimbursement

HIRE ICD-10 CODERS

- 68,000 ICD-10 Codes
- Software & Training costs
- Can MDS coordinators or Therapists become coding specialists by Oct 1?
- ICD-10 software not constructed to assist with increasing revenue
- ICD-10 coding is important to determine primary diagnosis
- There are many downstream components in determining PDPM score

ELIMINATE MDS COORDINATORS

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INVEST IN ICD-10 SOFTWARE
CUT THERAPY (PT & OT)
- MDS will still document therapy minutes
- Therapy will always be needed for rehabilitation & discharge planning
- SNF post-acute market has been based upon the need for therapy.

DON'T'S

DECREASE LENGTH OF STAY
PDPM incentivizes shorter lengths of stay, however shorter LOS may negatively impact
- Patient satisfaction
- Census
- Claims-based quality measures
- Value-based purchasing

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PDPM STRATEGY DO’S

COMPREHENSIVE DOCUMENTATION!

- Analyze your facilities’ recent admissions to determine the impact of PDPM
- Understand your staffing/admission review levels
- Ensure your medication indications/diagnoses are accurate
- Five-Star Quality Measures
- Hospital ED admissions/30-day Readmissions

All disciplines must: CONTRIBUTE, COLLABORATE & be aware of the TIMELINE
Importance of Primary Diagnosis

“I hear there’s a new ICD-10 code for carpal tunnel syndrome caused by clicking too many times in an EMR system.”
CLINICAL CATEGORIES

• SNF patients are first classified into a clinical category based on the “Primary Diagnosis” for the SNF stay
• ICD-10-CM codes, coded on the MDS in Item I0020B, are mapped to 1 of 10 PDPM clinical categories:

  Major Joint Replacement or Spinal Surgery
  Non-Surgical Orthopedic/Musculoskeletal
  Orthopedic Surgery
  Acute Infections
  Medical Management
  Cancer
  Pulmonary
  Cardiovascular and Coagulations
  Acute Neurologic
  Non-Orthopedic Surgery
THE IMPORTANCE OF CLINICAL DIAGNOSIS

CLINICAL CATEGORY

ICD-10 DIAGNOSIS

SPECIFICITY IN CODING

 Populate a Clinical Category

Refinement of the Diagnosis promotes better documentation

Practitioner Diagnosis helps drive PDPM Payment

Patient’s Primary Diagnosis into the Skilled Nursing Facility
What is the most accurate source for primary diagnosis?
Cases: What is the Primary Diagnosis?

80 y.o. F w/ a hx of right MCA embolic stroke, left hemiplegia, aphasia, homonymous hemianopsia resulting in gait instability and a fall and fracture?

95 y.o. M w/ a UTI, develops sepsis and HCAP, and delirium. Now is deconditioned, unable to transfer and has uncontrolled hypertension?
Interim Payment Assessment (IPA)

- Only additional opportunity to change payment.
- When is it appropriate to perform an IPA?
- What defines a significant change in condition?
- Requires new diagnoses that are relevant for PDPM.
Facility EHR is not going to make PDPM easier for us.

Opportunity to collaborate, design new care pathways, and maximize outcomes.

ICD-10 Problem…
I DIDN'T CHOOSE PDPM

PDPM CHOSE ME
Building Tools to Assist Engagement

- CCDA (Hospital)
- PDPM Coach (SNF)
- Medical Practitioner Verification
- PDPM Rate Optimizer
- Payment $$$

Workflow Optimization

PDPM Coach
Verify Diagnoses
(active within the last 7 days)

Active
- Essential (primary)
  hypertension (ICD-10: I10)
  NOT PDPM RELEVANT
  $153.47

- Malignant neoplasm of
  larynx, unspecified (ICD-10:
  C329)
  NOT PDPM RELEVANT

+ Add Active Diagnosis

Click to Verify
Per Diem (Day 1): $797.46
$153.47

I, Dr. John Williams, verify the above information regarding the patient Jane Doe.

Notes (optional):
Updated Jane's primary DX to a PDPM-relevant alternative

Confirm Verification
Risk Stratification and Outcomes Management

The Hidden Key to Success for Post-Acute Care
### What’s the Difference?

<table>
<thead>
<tr>
<th>Patient A</th>
<th>Patient B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male, 74 years</td>
<td>Male, 74 years</td>
</tr>
<tr>
<td>Health-care associated pneumonia</td>
<td>Health-care associated pneumonia</td>
</tr>
<tr>
<td>Triple antibiotic therapy &amp; fluids</td>
<td>Triple antibiotic therapy &amp; fluids</td>
</tr>
<tr>
<td>• Becomes temporarily debilitated</td>
<td>• Becomes debilitated quickly with cognitive decline, delirium.</td>
</tr>
<tr>
<td>• Quick recovery</td>
<td>• Falls, fractures hip and develops GI bleeding from drug - drug interactions.</td>
</tr>
<tr>
<td>• Discharged Home</td>
<td>• Requires Hospitalization</td>
</tr>
</tbody>
</table>

**Mildly Frail**

**Severely Frail**
Disorders Leading to Death

Frailty is the #1 Cause of Death Among Older Adults

1. Frailty 30%
2. Organ Failure 23%
3. Cancer 20%
4. Dementia 15%
5. Other causes 13%

Indexing Enables Clinicians to Focus Their Care and Not be Overwhelmed by Data Overload

Statistically Significant

vs.

Clinically Significant

Moves healthcare from single-organ focus to multisystem, multi-organ care

= patient centered care
Frailty affects a patient’s response to stressors

- Mildly Frail
- Moderately Frail
- Severely Frail

Severely Frail patients may never get back to baseline function after a stressor
Collaboration Is Key

Facility Challenges
Diagnosis, surgical, comorbidity or other coding issues
Timelines of practitioner visits/documentation
Improper IPA assessments
Collaboration with MDS coordinator/administrators
Diagnoses discordance

Role of Consultant Pharmacist
Admission medication review - critical
Medication indication accuracy
Review opportunities to optimize medications
Review documentation of diagnoses in practitioner encounter notes and work on cadence
Ensure alignment between facility MARs and practitioner documentation
PDPM and Medications

Rate Your Anxiety Level

10 - Panicked
9 - Somewhat Panicked
8 - Fearful
7 - Somewhat Fearful
6 - Very Worried
5 - Worried
4 - Anxious
3 - Apprehensive
2 - Nervous
1 - Slightly Nervous
Consultant Pharmacists and PDPM

The most useful tool to an MDS nurse?
Consultant Pharmacists and PDPM
Medication Management and PDPM

- Replaces RUG IV
  - Removes therapy minutes as basis for payment
  - PDPM focus is on specific resident needs not volume of therapy
- Five Patient Mix Classifications versus Two
  - Physical Therapy
  - Occupational Therapy
  - Speech Language Pathology
  - Nursing
  - Non-Therapy Ancillary Comorbidity Score
Medication Management and PDPM

Source: CMS.gov
Medication Management and PDPM

- Hospital Outlook
- Strategy
  - Over vs Underutilization
  - Team effort approach starting with the hospital to the SNF care team
- Conditions/Extensive service points system
- Get it right the first time
- Right drug right now
Conditions and Extensive Service Classification

NTA Classification

- 50 NTA conditions/extensive services
- Points range from 1 to 8
- 15 have >1 point
- 35 have 1 point
NTA Scoring

- 6 NTA groupings
  - Highest case-mix group requires NTA score of 12+
- Payment calculated by multiplying the NTA base rate by the case mix index

<table>
<thead>
<tr>
<th>NTA score range</th>
<th>NTA case-mix group</th>
<th>NTA case-mix index</th>
</tr>
</thead>
<tbody>
<tr>
<td>12+</td>
<td>NA</td>
<td>3.25</td>
</tr>
<tr>
<td>9-11</td>
<td>NB</td>
<td>2.53</td>
</tr>
<tr>
<td>6-8</td>
<td>NC</td>
<td>1.85</td>
</tr>
<tr>
<td>3-5</td>
<td>ND</td>
<td>1.34</td>
</tr>
<tr>
<td>1-2</td>
<td>NE</td>
<td>0.96</td>
</tr>
<tr>
<td>0</td>
<td>NF</td>
<td>0.72</td>
</tr>
</tbody>
</table>
NTA Classification/Disease States

• What is NTA
• Highest scores
  • HIV/AIDS
  • TPN
  • IV therapy
  • Respirator/Ventilator
• SNF’s to take more complex, acute residents
• Variable Per Diem Adjustment
• Generic vs Brand
Pharmacy Collaboration

• Areas of focus-ties to the Mega Rule/IMPACT Act
  1. Formulary/Therapeutic Interchange
  2. Limited supply
  3. IV → PO
  4. Antibiotic Stewardship Program
  5. Deprescribing
  6. Medication Reconciliation
  7. Other Areas?
IV-PO Antibiotic Therapy

• Benefits
  • Reducing the risk of intravascular catheter or line infection
  • Improved patient comfort and mobility
  • Decreased length of stay
  • Reduced nursing preparation and administration time
  • Reduced medication and supply costs

• Consultant Pharmacist involvement
Antibiotic Stewardship

• F-881
  • Establish Program
  • Use Protocols
  • System to Monitor

• Pharmacist Assistance
  • Appropriate
  • Black Box Warnings
  • Dosing
  • Allergy
  • Duration
Deprescribing

• Deprescribing is good prescribing
  • Challenges
  • Benefits
• Reduction of unnecessary medications
• Not just *prescription* medications
• Tools to use
  • Beers Criteria; START/STOEP Criteria; CMS Adverse Event Trigger Control
Deprescribing

- Polypharmacy consequences:
  - Increased healthcare costs
  - Adverse drug events
  - Drug Interactions
  - Medication non-adherence
  - Functional status
  - Cognitive impairment
  - Falls
  - Urinary Incontinence
  - Nutrition
  - Regulatory Risk
Diagnosis Reconciliation

• Is a medication ordered without a corresponding diagnosis code
  • Looking at the overall picture of the resident is a consultant pharmacist responsibility
  • Tying in the diagnostic categories CMS has isolated
  • Time window critical for coding
  • EHR hurdles
Medication Reconciliation

• IMPACT Act
  • Clinically significant medication related issues
  • Admission Drug Regimen Review

• Transitions in Care
  • Problems most often cited
    • New medications started
    • Home medications missed
    • Not on institution’s formulary
    • Old medications re-started
    • Doses changed
Other Areas of Focus

• Interim Payment Assessment (IPA)
  • Change in condition
    • Weight loss/gain
    • Bowel/Bladder dysfunction
    • Dysphagia
    • Falls
    • Mood Disturbance
    • Respiratory Changes
    • Mental Status Change
  • New diagnosis added
  • Change in plan of care
Other Areas of Focus

- Quality Measures
  - Psychotropics
  - Fall Reviews
  - Antibiotic Stewardship (UTI)
  - Bowel/Bladder
  - Weight Loss

- October 8, 2019: Moderate-Severe Pain has been removed
  - This change reflects the support of the federal initiative to reduce opiate utilization
Survey Implications
Survey Implications

• F 636: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident’s functional capacity

• F 639: A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan

• F 641: The assessment must accurately reflect the resident’s status.
Survey Landscape

- **F 636**
  - B = 20
  - C = 3
  - D = 397
  - E = 102
  - F = 4
  - G = 1*

- **F 639**
  - C = 1
  - D = 5
  - E = 1
  - F = 1

- **F 641**
  - B = 92
  - C = 4
  - D = 1690
  - E = 379
  - F = 2
  - G = 1*
  - J = 1*
  - K = 1*
  - L = 1*
F 641: The assessment must accurately reflect the resident’s status: Actual Harm

- The facility failed to accurately assess the resident’s corneal transplant
- Facility D/C’d antibiotic and steroid ophthalmic drops when entering physician orders
- Resident missed 32 doses of antibiotic and 19 doses of steroid
- This failure has the potential to put other residents at risk of eye infection, complete transplant failure, or loss of vision, and places all residents at risk for improper assessment.
Consultant Pharmacist Collaboration

• High Cost Drivers
  • Type of resident admitted
  • High cost individual medications
  • Specialty Medications/IVs
  • Overutilization of medications
  • Lack of formulary program
Consultant Pharmacist Collaboration

- Interdisciplinary team involvement
- Be the medication expert resource for:
  - DON
  - MDS
  - Dietary
  - Prescribers
Consultant Pharmacist Collaboration

**Clinical**
- Indication for use
- Dose/Duration appropriate
- Drug interactions, allergies
- Efficacy
- Adverse Effects
- Monitoring
- Change in Condition

**Nursing**
- Administration times
- Frequency
- Stop dates
- Manufacturer’s guidelines

**Administrative**
- Medication selection
- Formulary
- Therapeutic Interchange
- Policy/Procedures
- Regulatory guidance
- Non-pharmacological Interventions
Self-Assessment Question #3

How can pharmacists play a role in PDPM?

A. Perform admission medication regimen reviews
B. Assist in medication management services through the case-mixed adjusted components
C. Collaborate on the interdisciplinary team
D. All of the above
Self-Assessment Question #3

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Social Q&A