GAPS Health: Helping Skilled Nursing Facilities Succeed Under the Patient-Driven Payment Model

The Patient-Driven Payment Model (PDPM) is soon to change the reimbursement protocol for Skilled Nursing Facilities (SNFs) across the United States. Finalized in July 2018 by the Center for Medicare & Medicaid Services (CMS), the PDPM's official launch date is October 1, 2019. This new Medicare payment rule uses a different set of reimbursement calculations to classify SNF patients in a covered Part A stay, effectively replacing the Resource Utilization Group, Version IV (RUG-IV) for the SNF Prospective Payment System (PPS).

PDPM Adjusts Payment Process Throughout Patient Care Continuum

PDPM addresses concerns that the current payment system, which revolves around service volume (total therapy minutes), creates potentially biased financial incentives. PDPM guidelines effectively shift focus away from accumulated billable therapy hours/minutes, focusing instead on each patient's individual clinical characteristics and overall health profiles to develop a complete "episode of care" approach. Under these new directives, a patient's initial assessment leverages a carefully-weighted case mix to establish a treatment and therapy regime that optimizes positive outcomes based on each resident's individualized care needs. Medicare views this as a better way to achieve payment accuracy.

Basic Medicare Part A: Understanding the Definition of Skilled Care

As they are with any reimbursement reform, SNFs across the country are under mounting pressure to make several regulatory, operational, and procedural adjustments when transitioning to the new payment model. However, there are some core Medicare Part A concepts and care strategies that will remain the same under PDPM. Much like RUG-IV, the PDPM program requires skilled patient care to be provided daily by a nurse and/or therapist. Skilled care is defined as:

- Five times/week for therapy
- Seven days/week for nursing

And should meet definitions for both therapy and nursing.

Medicare Part A: Understanding the Patient Spell of Illness

Understanding the Medicare Part A legislation for the PDPM program will also prove crucial for SNFs across the country. Immediately following a qualifying three-day hospital stay, Medicare Part A covers a maximum of 100 days of SNF service during a patient's skilled "benefit period," also known as the spell of illness. The first 20 days of the benefit period are fully paid for by Medicare. However, day 21 through day 100 has a Part A co-insurance requirement that is the patient's responsibility, using Medicaid, insurance backup, or other payment methods.

Key factors to consider when calculating Part A reimbursement include:

- The 100-day spell of illness is broken when a patient no longer requires daily skilled nursing and/or therapy and 30 consecutive days lapse without the patient receiving these skilled services.
- If the spell of illness is interrupted, but the patient demonstrates a change in health condition within 30 days, they can be placed back on Medicare Part A in the SNF to access the remaining days in the benefits period, regardless of whether the patient has remained in the SNF or has returned home.
- If the spell of illness is interrupted and the skilled services break exceeds 60 days, the benefits period resets. The next time a patient has a 3-day qualifying hospital stay and transitions to a SNF, they initiate a new 100-day benefits period.

It's important to note that if the interruption in the provision of daily skilled care is greater than 30 days but less than 60 days, the patient must have a three-day hospital stay in order to access the remaining benefit period, up to a maximum of 100 days.

Basic Medicare Part B Therapy Is Unchanged Under PDPM

Part B therapy remains primarily the same under the new payment model. Along with restorative treatment, Part B therapy can play a significant role in quality measurements for five-star rankings, the state case mix index program, and positive survey outcomes, all of which help SNFs remain competitive in the turbulent and ever-changing world of healthcare. Additionally, Part B therapy can also be a principal driver of overall quality of life for the patient as they learn critical skills for autonomy and self-sufficiency. The basic therapy covered in Medicare Part B under PDPM states:

- To qualify for Part B care, a patient must demonstrate a decline in function, or have an adverse event (change in condition) noticed by the nurse, therapist, and/or a physician.
- An order must be written along with timely certifications/re-certifications for patients to receive available services up to 5 times weekly.
- Long-term patients in a SNF may be placed into a Part B therapy program, secondary to a change of condition that would merit an intervention.
- There is no limit on treatments or time with respect to a Part B program. However, the treatment regime can be subject to a fiscal intermediary audit at any time, with access to an appeals process as needed.

PDPM Shifts Therapist and Nursing MDS Responsibilities

The current RUGs legislation mandates the completion of multiple, time-sensitive Minimum Data Sets (MDS) to maintain patient care compliance and procure service reimbursements. Failure to submit a required MDS could result in a Medicare intermediary technical denial. When completing Minimum Data Sets, multiple nursing conditions and services must be identified and addressed in the final care plan. However, under RUGs, the nursing staff, services and procedures, while contributing to the overall care of the patient, generally are not the principal drivers of a facility reimbursement. Instead, the payment model focuses primarily on therapists to qualify patients for skilled care and relies on total billable therapy hours/minutes during the patient's stay to generate facility revenue.

The PDPM system effectively changes the skilled care qualification and reimbursement landscape between therapists and nurses. Under the new payment model, therapy maintains its role as a revenue initiator, albeit in a minimized capacity when compared to current RUGs requirements. However, for the first time, nursing services will establish itself as the principle revenue generator for SNFs. As the main drivers of the new reimbursement system, nursing personnel must become highly proficient at comprehensively evaluating, charting, and treating the total patient episode.

The First Eight Days: Managing A Patient's MDS Requirements Under PDPM

The PDPM program significantly reduces the required Minimum Data Sets mandated under RUG-IV. Still, the PDPM prescribes that every SNF patient must have a comprehensive and completed MDS within the first five days of admission, with an allowed grace period of three days, for a total of eight days. During these eight critical assessment days, the facility's interdisciplinary team must thoroughly examine and evaluate the total patient health profile.

The new payment model includes five case-mix adjusted components and one non-case mix adjusted component associated with the appropriate scoring of each patient (all Part A patients in the facility on September 30th to Oct 30th must be re-evaluated and scored under this new system). Unlike RUG-IV, which uses a

single group classification to determine case-mix indexes and per-diem rates, the PDPM requires every SNF to classify residents into a separate group for each individual case mix-adjusted component. Every resident must be assigned to a specific SLP group, PT group, OT group, NTA group, and a nursing group, which all carry their own individual case-mix indexes and per-diem rates.

The six total categories include:
- ***Physical Therapy***: 16 case-mix adjusted possible scores
- ***Occupational Therapy***: 16 case-mix adjusted possible scores
- ***Speech-Language Pathology***: 12 case-mix adjusted possible scores
- ***Nurse***: 25 case-mix adjusted possible scores
- ***Non-Therapy Ancillaries (NTA)***: six case mix-adjusted possible scores
- ***Non-Case mix***, geographically adjusted base rate

Under the PDPM program, PT and OT rates (after the 20th day) will decrease 2% every seven days. However, speech-language therapy maintains its daily rate, making it a significant player in the new payment model. It's also important to note that, under PDPM, the Non-Therapy Ancillary (NTA) portion of the rate is three times the standard reimbursement for the first three days, based on the understanding that patient care is more expensive at the onset of a SNF admission.

Approaching PDPM Deadline Has Many SNFs Scrambling to Align Resources for Successful Transition

With the October 1st deadline rapidly approaching, SNFs on a national scale are racing to transition from the rigid billable hours/minutes approach outlined in RUG-IV to PDPM's more agile, patient-centric, episode of care payment model. For healthcare executives, administrators, and practitioners, a successful conversion requires far more than just reevaluating current standard operating procedures and internal practices to drive better patient outcomes and avoid potentially significant financial penalties for failing to comply with PDPM legislation. To execute a seamless payment program adaptation that does not disrupt the patient care experience, SNFs across the U.S. can now look to GAPS Health and their enhanced clinical care model as a potential solution.

With the October 1st deadline rapidly approaching, SNFs on a national scale are racing to transition from the rigid billable hours/minutes approach outlined in RUG-IV to PDPM's more agile, patient-centric, episode of care payment model.

What Is GAPS Health?

GAPS Health is an integrated care model consisting of the following four pillars:

- Medical directorships
- Pharmacy management
- Chronic Care Management (CCM)
- Post-SNF discharge program (AfterCare)

GAPS Health's integrated care model positions SNFs for success in an increasingly complex financial, regulatory, and compliance environment. Services include:

- Onsite clinical pods consisting of a Medical Director, Pharmacist, NP/PA & RNs that support 10-20 SNFs/pod
- PDPM optimization through comprehensive & consistent documentation for patient acuity
- Medication management and optimization with direct MD/PharmD onsite oversight
- CCM for custodial patients that supports Quality Measures and partnerships with community physicians
- 30-day AfterCare program that leverages an RN-led remote contact center model to provide ER diversion and census management via a direct admission program for declining patients

It's important to note that the RN-led AfterCare program improves the patient experience and contributes to Value Based Purchasing (VBP) & Census Management via reduced ED transports and direct admissions back to SNF for declining patients.

By providing a robust combination of integrated services, GAPS Health substantially improves quality & financial outcomes for SNFs compared to legacy medical director and "SNF-ist" models.

The Benefits Of The GAPS Health Model

GAPS Health can help SNFs of every size and scope effectively migrate towards an operating model that will succeed under PDPM, allowing GAPS Health to become a significant and essential partner. Partnering with GAPS Health delivers several mission-critical PDPM transition benefits, including the following:

Establish Benefits Period Reimbursement Team

The GAPS process begins by convening an interdisciplinary team to determine the appropriate patient classification across PDPM's five case-mix and one non-case mix adjusted components. This designated group must meet a minimum of two times with all stakeholders in attendance, ideally conducting the first meeting within three days of admission to complete section GG of the patients' Minimum Data Sets within the required five to eight days.

All members of the assigned team must conduct an in-depth, comprehensive review of the chart and all other pertinent information available from the referral sources. Additionally, the group will discuss and compare their observations and assessments of the patient to complete the Minimum Data Set process. Completion of the MDS can set both billing and reimbursement for the patient's length of stay (LOS) during the assigned 100-day spell of illness.

The cross-functional stakeholders will include:

- Physical, Occupational, and Speech-Language Therapists
- Director of Nurses
- Facility Administrators
- Minimum Data Set (MDS) Nurse
- Social Services
- Interdisciplinary Team

The interdisciplinary team will also include a Case Manager; the PDPM program will require a converted MDS Nurse to serve in this new essential capacity. Finally, a competent, knowledgeable GAPS-trained physician will always participate in these group meetings to oversee each resident evaluation and establish all relevant and appropriate reimbursement terms.

Additionally, if the patient's health declines and additional services or procedures are required after the initial evaluation, the GAPS physician can determine if an Interim Patient Assessment (IPA) should be completed to rescore the resident. While not required, an IPA can positively impact reimbursement and patient care. The GAPS medical director plays a critical role when identifying the need for a resident's IPA as well as ensuring proper documentation completion. Having GAPS Health as a integral part of the team reduces the risk of poor audit results.

Oversee Accurate Nursing and Therapy Services Scoring

As the PDPM program shifts the focus of revenue generation away from therapists and billable therapy minutes, skilled nursing personnel will find themselves under increasing pressure to effectively score each admitted patient and complete lengthy and complex Minimum Data Sets within the first five (up to eight) days of admission. Getting existing nursing staff trained on new charting and evaluating protocol can help with the payment model transition. However, no matter how much staff training is conducted, scoring consistency often proves challenging at best.

The traditionally high RN turnover at nursing homes (often ranging from 40-60%) means that trained resources often leave the facility, instantly creating imminent and potentially costly performance gaps as remaining resources and new employees work to eliminate the patient scoring void. A GAPS medical director resolves the issues of both untrained nursing staff and the high industry RN turnover rate. Additionally, the GAPS resource serves as the de facto evaluator/scorer for all nursing and therapy services, systematically working through each resident's individual health profile and care needs along with the designated cross-functional group as needed to establish a thorough and accurate case mix index.

Medicare Part A & B Transitions

The onsite medical director also oversees the benefits period for every resident, including spell of illness interruptions for optimized and appropriate facility reimbursement and positive patient outcomes. If a patient presents physical or mental deterioration in any way, a decline in function, or a change in condition related to the original spell of illness within 30 days of being taken off their Medicare Part A stay, the patient can be readmitted to the skilled nursing facility and placed back on Medicare Part A, continuing the 100-day count on their original benefit period.

GAPS Health plays an essential role in Medicare Part A interruptions. The spell of illness can be reinstated regardless of whether the patient suffered a health setback at home or in the SNF. GAPS physicians are trained to promptly recognize a change in condition that requires patient placement back on Medicare Part A.

Similarly, GAPS Health's post-discharge AfterCare program leverages nurse-led clinical teams to provide consistent communication with discharged patients, conducting real-time phone assessments to gauge health levels and proactively

prevent a wellness lapse that may require readmission. By tracking and monitoring a patient's post-discharge progression, GAPS AfterCare nurses can identify a health shift and alert all relevant clinicians immediately, promoting a positive patient outcome. Additionally, the team can facilitate a direct admission to the SNF as needed, ensuring patients receive the care they require while simultaneously helping hospitals and SNFs avoid rehospitalization penalties.

It's important to note that GAPS Health supports a seamless transition back into an initial spell of illness for both residents and outpatients. Upon a direct admission, the GAPS team not only reestablishes care and reimbursement parameters but also coordinates appropriate non-therapy ancillary rates for the SNF.

The GAPS medical director can play an integral role in Part B therapy services programs as well. Typically, approximately 30-40% of the long-term population could be on Part B therapy, making this a significant opportunity for both patients and SNFs. GAPS practitioners identify eligible patients who have suffered an adverse health event or demonstrated a functional decline, completing required orders and certifications to keep the resident in the program as long as deemed necessary.

GAPS Health's AfterCare Program Is Powered by Lacuna Health

GAPS AfterCare serves as a major differentiator for SNFs, both with patients and within the entire medical community. For this program, GAPS Health has partnered with Louisville-based Lacuna Health, a subsidiary of Kindred Healthcare that specializes in bridging the communication and intelligence gap between patients and SNFs, both immediately after discharge as well as throughout the 30-day post-SNF period.

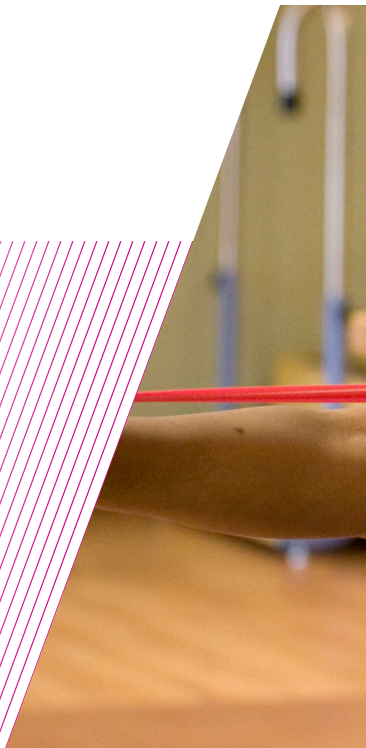
Lacuna Health is white-labeled and powers GAPS AfterCare by providing RN-led remote care teams that serve as a direct extension of the GAPS medical director and offer a multitude of recovery-critical services such as:

- Reinforcing and educating on GAPS Health treatment plans
- Providing medication education and pharmacy attainment
- Facilitating timely primary care and specialty appointments
- Screening for depression and falls risk
- Performing patient post-discharge surveys on behalf of SNFs
- Assessing for early signs of declining condition and facilitating services as an alternative to the hospital such as Home Health Care (HHC), Assisted Living Facilities (ALFs) or back to the SNF as a direct admission

Ultimately, GAPS Health provides four areas of differentiated value compared to existing medical directorship models:

- Improve patient/family outcomes and experience
- Optimize PDPM payment accuracy, and regulatory/compliance oversight
- Drive quality measures, VBP performance and census management
- Enable SNF positioning for narrow networks and value arrangements with payers and ACOs

To learn more about how GAPS Health can help support your skilled nursing facility as it successfully navigates the legislation transition by the October 2019 deadline and beyond, visit http://www.gapshealth.com.



Sources

CMS.gov, Patient Driven Payment Model
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

CMS.gov, Skilled Nursing Facility PPS
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html

CMS.gov, Medicare General Information, Eligibility, and Entitlement Chapter 3 - Deductibles, Coinsurance Amounts, and Payment Limitations
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf

Medicare Interactive, Outpatient Therapy Costs
https://www.medicareinteractive.org/get-answers/medicare-covered-services/rehabilitation-therapy-services/outpatient-therapy-costs

Health and Hospital Commission, Definition of Case Mix For Hospitals
http://www.healthandhospitalcommission.com/docs/May26Meeting/CasemixIndex-Defintion.pdf

CMS.gov, PDPM Calculation Worksheet for SNFs
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/MDS_Manual_Ch_6_PDPM_508.pdf

The Costs of Turnover in Nursing Homes. Med Care. 2009 Oct; 47(10): 1039–1045. Dana B. Mukamel, Ph.D., Professor and Senior Fellow, William D. Spector, Ph.D, Senior Social Scientist, Rhona Limcangco, Ph.D., Ying Wang, M.S., Zhanlian Feng, Ph.D., Assistant Professor, and Vincent Mor, Ph.D., Professor & Chair
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2761533/

gapshealth.com