GRASSI HEALTHCARE ADVISORS, LLC
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Maun-Lemke
Changing the Results of Healthcare

PDPM Webinar

March 7, 2019

MixSolutions

prime care TECHNOLOGIES

Harmony Healthcare

prime care TECHNOLOGIES

PDPM: Key Changes Providers Need to Know

Cheryl Field - Chief Product Officer

Prime Care Technologies

PDPM Key Changes

1	2	3	4	5
• Patient Driven	• Payment Driver	• MDS Impact	• Payment Changes Over Time	• Six Case Mix Components
• Based on patient conditions and diagnosis • Considers function • Considers cognition • Surgical procedures from prior "proximal" hospital stay	• Therapy minutes no longer drive payment • Must still be collected • 25% cap on percent of total provided in group or concurrent	• Less assessment volume for Part A and managed Medicare, which follows Part A assessment pattern • New items – Oct 2019 • MDS coding drives payment	• Length of stay (LOS) drives payment • Payment adjusts automatically over time • Demands providers manage LOS for Medicare Fee for Service	• Physical therapy (PT) • Occupational therapy (OT) • Speech language pathology (SLP) • Nursing • Non-therapy ancillary (NTA) • Non-case mix • AND…endless combinations!

Make PDPM Work For You

Get the data you need…

Starts with referral process

- Problem lists (DRGs) must translate to ICD-10 codes and primary diagnosis for SNF admission
- Use tools that help measure costs of care/services prior to admission
- Plan of care designed to achieve clinical outcomes within revenue driven by PDPM

Real-time analysis from your MDS and EMR data

- Using MDS item response to predict PDPM case mix groups
- Ensuring consistency between EMR data and PDPM case mix groups
- Accurate data to plan and monitor care outcomes

• Check before you do interim payment assessment (IPA)

- Don't assume a higher payment; use technology to verify
- Watch for more guidance from CMS

Getting It Right- Admission MDS

MDS accuracy still matters!

- Hospital discharge summary

- Diagnosis ICD-10 codes from SNF and hospital

- MDS data used for payment classification groups vary by case mix groups

- PT, OT, SLP, nursing and non-NTAS

Compliance

FAQ

- How much therapy should we provide?
- Talk to your interdisciplinary team (IDT) now; contract therapy
- Complete preadmission cost analysis, service needs and plan of care
- Use care maps for outcome management

Caution

- What's reasonable and necessary in September should be reasonable and necessary in October

Key Strategies for Executives

Patient Driven

- Work with vendors to ensure ICD-10 coding accuracy
- Ask hospital to provide DRG and problem lists so staff can get ICD coding right
- MDS item coding beyond diagnosis is essential for NTA portion of rate

Payment Driver

- Therapy becomes cost center to manage like managed care
- Ask vendors for real-time notifications when 25% cap exceeded
- Stay compliant with R/N requirements of therapy services and monitor outcomes/changes

MDS Impact

- New items will require attention and training
- Less volume of assessments
- Don't assume IPA will generate more daily revenue
- Use tools that can predict PDPM

Payment Changes Over Time

- Work with billing staff on payment changes
- Monitor LOS (e.g., admitting higher acuity vs holding on longer lower acuity, which impacts overall LOS)

Six Case Mix Components

- Go beyond ICD-10 coding
- Review accuracy of MDS items that drive SLP, NTA and case mix indexes (CMIs)
- Use technology; too many combinations to audit

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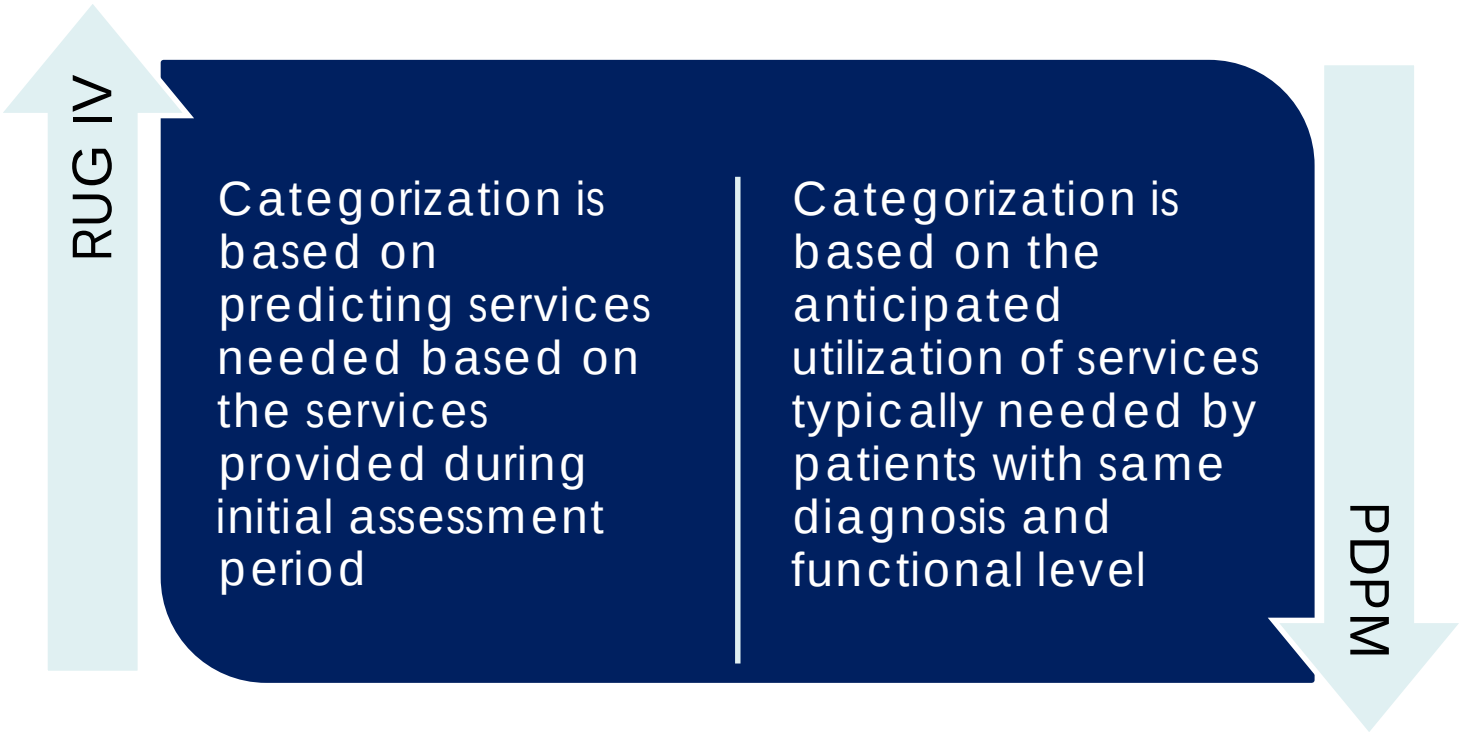
What are the Categories that Give Opportunity?

Joseph Tomaino - Chief Executive Officer

Grassi Healthcare Advisors, LLC

Payment Driven Payment Model



Critical Foundational Elements of PDPM

In summary:

- Your facility will be paid for what your patients need, not what you deliver
  - Based on ICD 10 and MDS coding, functional and cognitive levels, and NTA co-morbidities
- You must deliver the care your patients need
  - Discharge MDS assessment will capture minutes of rehab delivered
- The sicker patients are, the greater the opportunities are for payment
  - AIDS, organ transplants, CML, Multiple Sclerosis, Wound Infections, Diabetes, etc.
- Patients with lower levels of functioning are no longer paid more for rehab
  - Inverse from RUGS IV
- CMS has incorporated more reimbursement for IV medications and advanced care

What Category is the New Rehab Ultra?

Facility leaders are asking what is the best type of patient to seek for admission…which PDPM category is the *New Rehab Ultra???*

- Rehab Ultra under RUGS IV may have paid the most, but it was also one of the most expensive categories and not always the most profitable
- CMS has worked hard using research and stakeholder input to remove opportunities to "game" the system, and to better reimburse high cost care items (such as IV therapy)

Clinical Care Strategies

- Identify patient categories reflective of needs in community & post-acute challenges for your referring hospitals/ ACOs
  - What are the most frequent readmissions to your referring hospitals? CHF, COPD, Diabetics?
- Develop evidence based care paths for these
  - Can you differentiate yourself in your market to provide care for these patients better than your competition?
- Refine care processes to execute care with few variations and no complications
  - Care well provided effectively and at the lowest cost, without complications or readmission, is the key to success under PDPM
- Plan for shortest effective length of stay
  - PDPM lowers the calculation of reimbursement as stay continues past 20 days

Clinical Care Strategies

- Address staffing needs, making sure all work to top of licenses and as efficiently as possible
  - Don't pay a higher level person for something that can be done just as well and appropriately by a lower level program– bring back nursing rehab
- Address facility plan, equipment, and technology needed to provide care as efficiently, effectively and safely as possible
  - Facility improvements, equipment and technology that improve care are capital expenses and non-recurring; examples include walled gases, cardiac monitors, staff communication systems, patient monitoring systems
- Train all staff in these new target populations, care maps, and processes
  - Execute quality with knowledge and passion!

Financial Strategies

- Develop new admission target profiles
  - Clinically complex with NTA co-morbidities are good
  - Keep admitting rehab with co-morbidities
  - Re-analyze expensive med criteria
- Train MDS staff in ICD-10 coding and new MDS data elements and Sect. GG changes
  - ICD-10 coding is now a critical foundation to category assignment, and Sect. GG is tricky
  - Don't overuse Interim Assessments, but don't be afraid to use them when appropriate
- Ensure that functional and cognitive assessments are accurate and comprehensive
  - These are essential for capture of appropriate category and some have significant end splits
- Ensure adequate SLP resources
  - SLP assessments play important role in PDPM

Financial Strategies

- Redefine measures of success for rehab business unit– care based on need, not reimbursement
  - Rehab standards of care need to reflect providing the right amount of therapy to achieve good outcomes– not too much and not too little
- Address right level of rehab staffing and plan for appropriate use of concurrent therapy
  - Concurrent therapy and effective use of nursing rehab program, along with right-leveling amount of therapy will result in fewer therapist FTEs needed
- Re-negotiate contracts with therapy vendors to reflect new measures of success and needed staffing levels
  - Contract for efficiency and effectiveness, not volume or reimbursement

Harmony Healthcare

Leveraging Market Position

Kris Mastrangelo – President & CEO

Harmony Healthcare

PDPM Market Position

- Clinical Capacity
- Competencies
- Systems
- Care Planning
- $ Impact New Model
- MDS Coding
- Staffing
- Document Accuracy
- Quality Measures
- Pre-Admission Data

Successful Contract Relations

- The best predictor of future performance is past behavior
- Toward that end, make sure your evaluation of contract relations includes an assessment of how the contractors have assisted the organization in achieving prior goals
- Achieving goals in PDPM will require a focus on patient outcomes
- What does the service contractor bring to the table to assure that patient outcomes are achieved?

Implementation Strategies

- Key strategies:
  - Do not make abrupt changes in how you provide care
    - Drastic changes in care delivery may trigger questions regarding the appropriateness of prior care decisions
    - Focus on quality is a imperative
  - Do look at efficiency
    - Are there opportunities to reduce expense without impacting quality?
    - Are there possibilities to improve outcomes?
    - What are current quality concerns?

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Financing For Success

Sharon Thole - Director

Love Funding

Why Wait for PDPM to Start to Evaluate Your Balance Sheet?

- A HUD refinance allows for:
  - High Leverage
  - Long Term
  - Low Fixed Interest Rate
  - Non-recourse Debt

Freeing Up Cash

- Train staff
- Develop specialized programming
- Add key positions
- Purchase necessary equipment
- Solidify physician relationships
- Make physical plant improvements or additions
- Maintain market competitiveness

Love Funding

- Love Funding is a top FHA lender with over 30 years of experience. We offer refinance, acquisition, construction, rehabilitation and bridge financing programs for healthcare facilities, including skilled nursing, assisted living, independent living and memory care facilities, as well as hospitals.
- Our proprietary bridge loan platform, through Midland States Bank, provides interim and construction funding for projects seeking long-term, permanent financing using HUD loan programs.

Maun-Lemke

Changing the Results of Healthcare

How to Market

Clint Maun - President & Senior Partner

Maun-Lemke, LLC

PDPM and Your Revenue

- Advance your clinical capability attitude
- Base your clinical advancement on referral source needs
- Organize internally
- Set referral source meetings
- Target your marketing
- Plan your follow-up

Design Your Internal Plan

- Discuss Referral Source Needs
- Get Team Buy In
- Develop Training
- Get Vendor Partner Support
- Obtain Physician Support
- Build Excitement

Referral Source Meetings

- Prepare Assumptions
- Secure Correct People for Meetings
- Talk about their Needs – Not your Capabilities
- Work to get Specialist Involvement
- Discuss Money and Service Upside
- Set Follow-up

Coordinated and Continued Work

- Prepare for First Case
- Develop Targeted- Marketing Plan
- Document all Training and Specialist Work
- Prepare Outcome Results
- Plan for next Referral Source Meetings
- Set up Niche Marketing

Managed Care Going Forward

Susie Mix – CEO & President

Mix Solutions Inc.

Facility Impact

- Review contract Verbiage for RUG based Contracts
- Have conversation with health plans to determine if amendment is needed

Develop Strategic Plan for

Negotiation of Managed Care Contacts

- We must determine what this reimbursement style will do for our facility
- If favorable, present to managed care organizations