# PDPM Post Implementation – What is Working, What is Not

WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING





Create Opportunities

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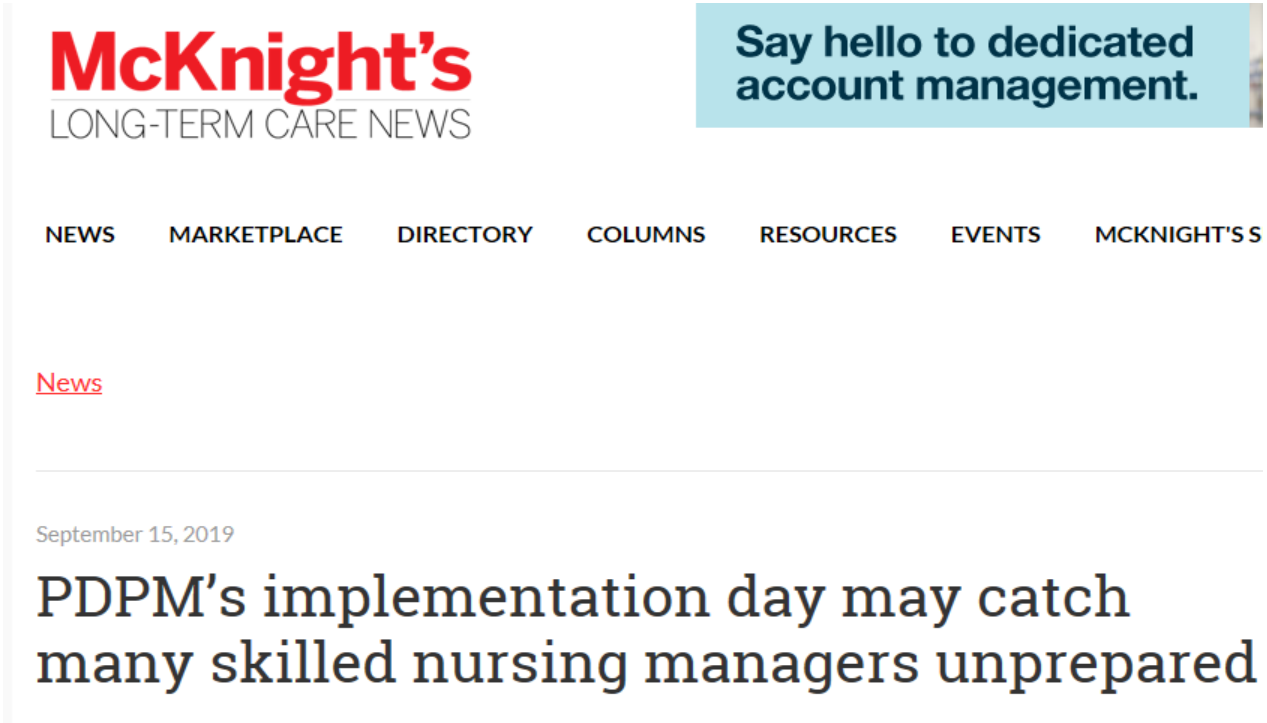
# Learning Objectives

- Understand from a therapy perspective, the change in minutes and the outcomes both pre and post PDPM.
- Understand the impact on cost: the margins on therapy contracts and whether providers are paying more or less per minute than before implementation.
- Understand the clinical documentation: the increase in documentation issues, and the misconceptions causing documentation/coding errors.
- Understand the impact on revenue and how providers are tracking revenue to verify appropriate payments.
- Understand how reimbursement structure, COVID, and revenue/cash flow are creating new challenges for operators to be successful.

# The Good and the Bad after Implementation



McKnight's
LONG-TERM CARE NEWS



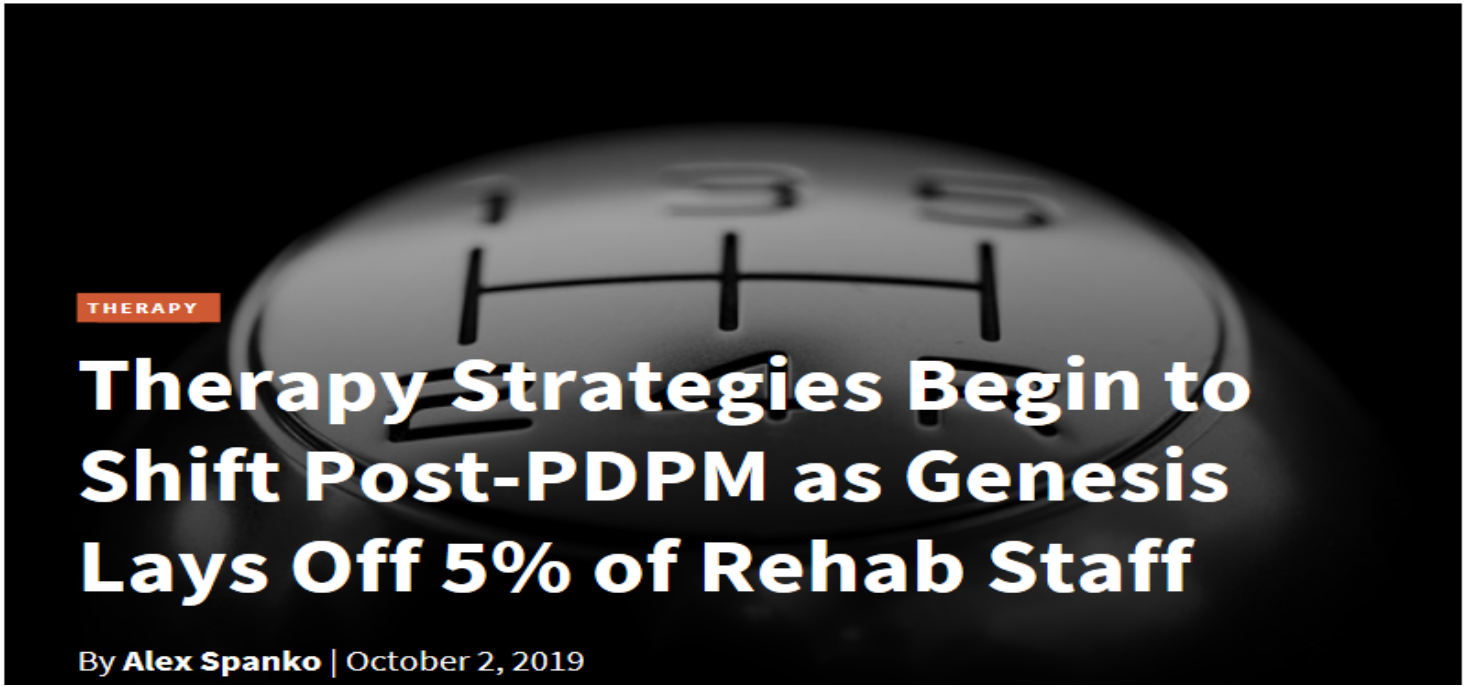
NEWS MARKETPLACE DIRECTORY COLUMNS RESOURCES EVENTS MCKNIGHT'S S

News

September 15, 2019

# PDPM's implementation day may catch many skilled nursing managers unprepared

Skilled Nursing News



# CAUTION!!!!

- CMS is looking for significant shifts in care that appear driven by financial results rather than patient need
  - Dysphasia, altered diets
  - Dementia
  - Depression
  - Group and/or concurrent therapy

# CMS Clarifications and Updates

- CMS grouping logic had errors and had to be reissued on 10/7/19.
- CMS FAQs still clarifying the SNF primary diagnosis does NOT have to be the same as the hospital diagnosis
- Clarification on classification if BIMS or staff assessment for cognitive impairment
- No specific number of days for therapy for therapy component classification

# PDPM Claims Processing

- October 24th was the target date for MACs to begin processing PDPM claims
  - Original target date of October 17th, however claims updates made
- As of October 24th, some MACs were holding claims and others were accepting but producing confusing results
- February CMS identified issues with timing of processing and the variable components in the rate.

# Macro Financial Considerations

**Budget neutral**

- Behavior changes

**More winners than losers**

- 8,101 of 13,769 providers analyzed by CMS are expected to gain

**Therapy cost and utilization**

- Varying provider perspectives

# Financial Optimism???

- Behavior changes may result in preliminary higher rates
- Carefully consider financial decisions based on initial results
- CMS may adjust base rates and/or CMIs to manage budget neutrality – no significant changes noted in FY21 SNF Proposed Rule

# Additional Financial Considerations

- Impact of LOS overall – adjusting to the variability of the rates
- Focus on more clinically complex residents
- Ability to budget with a level of confidence and accuracy?
- Are contracted therapy payments within anticipated parameters.

# Medicare Advantage Plans

- Most Medicare Advantage (MA) plans are switching to PDPM
- Late notices coming from the MA plans leading to duplication of assessments
- Understand the requirements from each individual MA plan.

# Interim Payment Assessments at 10/1

# Numerous Questions During Transition

- What do I do for MDS if a Medicare resident is admitted on 9/30
- What happens if I forget to complete an IPA at the beginning of October?
- How do we account for therapy since we won't have 5 days of therapy for the assessment?
- If a Med A resident ends therapy what assessment should be completed?

# Numerous Questions During Transition

- How are diagnosis being ranked?
- Numerous questions around the use of the electronic health records. Make sure to talk to your vendor.
- If a Med A resident ends therapy what assessment should be completed?

# Interim Payment Assessment (IPA)

- Required for ALL Medicare Part A residents in the facility October 1st.
- Optional assessment (except for 10/1 transition)
- Limited guidelines from CMS on when IPA should be performed – compliance issue
- Will reset payment but not the variable portion
- Still not seeing this used much although would be appropriate and beneficial

# IPA additional information

- No limit on the number of IPA's that can be done
- Should be done when the payment will increase
  - No requirement to do when payment decreases
  - Most likely areas of increase
    - ◊ Nursing
    - ◊ Non-therapy ancillary (NTA)

# Interim Payment Assessment (IPA)

- Section GG items will be derived from a new column which will capture the self performance of the patient
- The look-back for this new column will be the three-day window leading up to and including the ARD of the IPA (ARD and the two calendar days prior to the ARD)

# Interrupted Stay Policy

# Interrupted Stay Policy

- If a patient is discharged and returns to *same* SNF in 3 or fewer calendar days, stay is considered same stay.
  - Variable per diem continues from time of discharge
- If patient is discharged and readmitted more than 3 days, considered new stay
  - Variable rate is reset to day 1

# MDS guidelines for Interrupted Stay Policy

- Must follow both OBRA and Medicare guidelines
- OBRA requirements
  - Discharge return anticipated
- PPS guidelines
  - PPS or Medicare end

# Medicare Compliance Issues

# What to do about restorative nursing

- Program in place
  - Keep going nothing is changing
- Considering implementing a program
  - Determine cost effectiveness
- Medicare rules and guidelines around restorative nursing have not changed

# Other Clinical Specific Items to Address

- Capturing shortness of breath while lying flat with a diagnosis of COPD
- Capturing use of oxygen as appropriate
- Obtaining appropriate cardioresp diagnosis – some of the cardioresp diagnosis quality for an NTA co-morbidity

# What to do about therapy

- Payment structure changes, not dependent on therapy
  - Should evaluate and treat the same
- Monitor group and concurrent
  - CMS watching this closely
- What to do with minutes over the Medicare stay
  - Only get entered on PPS Discharge MDS

# Deciding on admissions

- Nursing skill
- Non-therapy ancillary
- SLP considerations
- Access to diagnosis codes
- Hospital discharge information
- New COVID-19 implications

# Potential Post-Implementation Issues

- Concerns with “up-coding” diagnosis codes
  - Should be monitoring and auditing use of diagnosis codes
- Overuse of mechanically altered diets or identification of swallowing disorders
- “Return to Provider” diagnosis codes resulting in default payments
- Use a triple check form that can help avoid issues

# Guide to facilities

- Get discharge information from hospitals timely
- Use the ICD-10 mapping tools found on CMS website
- Medicare meeting to discuss different components
- Section GG as a collaborative effort
- Medicare guidelines still apply
- Monitor group and concurrent therapy caps
- Triple check/Billing

# Continued Education

- All disciplines involved in the Medicare MDS process should be educated on the change to PDPM.
- Every team member should be on the same page about expectations with a good grasp of how PDPM will impact facility policies and procedures.

# Medicare Cost Reports

# Expected Cost Report Changes

- Per HFS, 9/17/19
  - "CMS is planning to sunset the S-7 with services on or after 10/1/19 and will not have the PDPM be populated on the cost report as there could be too many possible scenarios. We have not received anything official though."
- PS&Rs no longer provide the level of census detail. Still provide RUGs through 9/30/19 then just summary information.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# 30,000 Foot View on PDPM Today

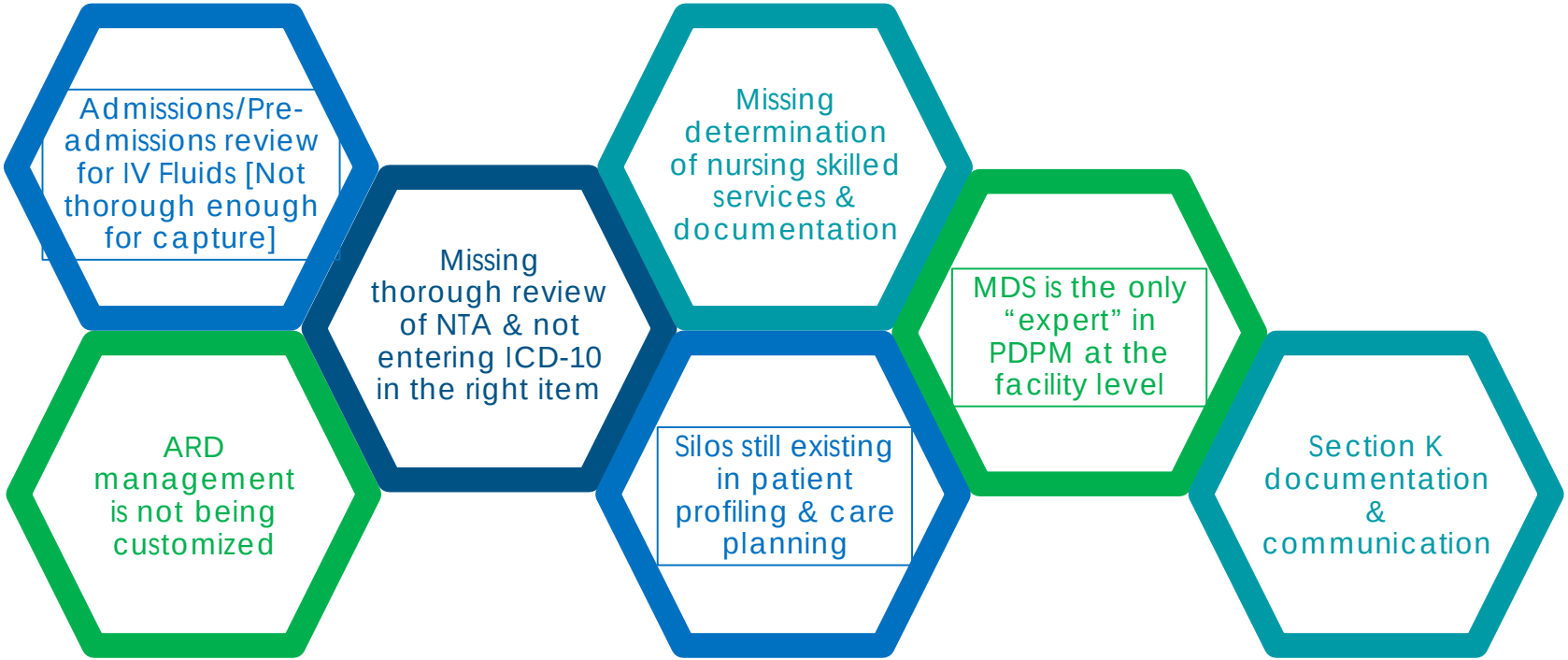
| | | |
|---|---|---|
| Therapy industry layoffs – not all companies | Shift in therapy utilization | Outcomes seen to improve under new pathway models |
| Not a HUGE increase in group and concurrent as expected | Shifts in coding of depression, restorative & Section K | More winners than losers; Not so budget neutral |

# COVID-19 Impact

- Changes in admissions
- Isolation wings & rooms
- Impact of new infection control measures
- ReDesigned therapy delivery
- Introduction to telehealth
- Family & employee relations

# Trends & Opportunities

## Care ReDesign or Attention to Detail?



# CASE STUDY: PDPM Prep Pays Off

Skilled Rehab Facility
New Hampshire

## Goals:

Successful PDPM transition

Bolster Nursing clinical capabilities & documentation

Mitigate predicted financial loss under PDPM

Prepare for 2020 expansion

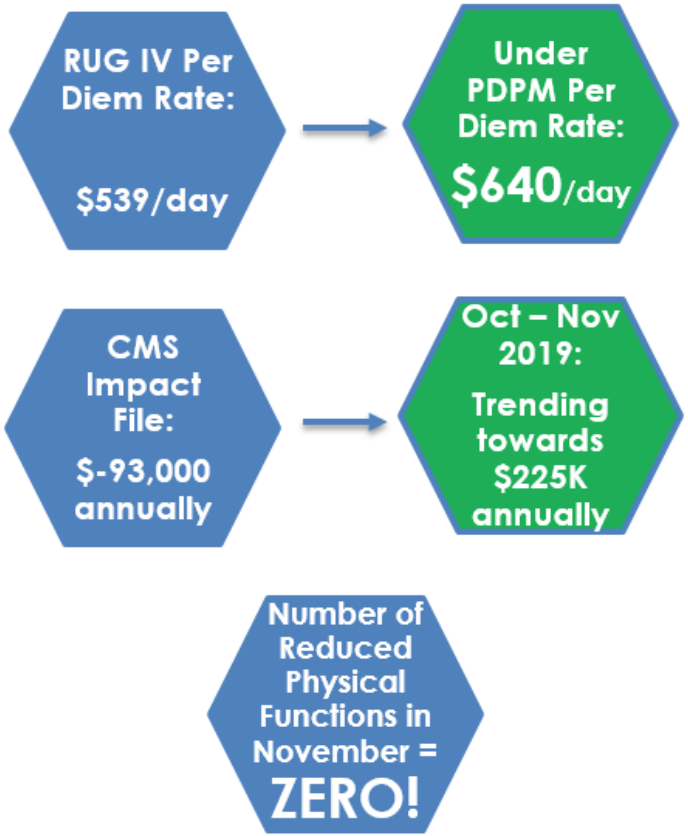
## Successful Initiatives:

Ongoing PDPM consulting, education, training since March 2019

ICD-10 Coding Intensive IDT Training

Implementation of HealthPRO Heritage's Daily Meeting Checklist, New Clinical Meeting Agenda, PDPM Profiler, PTR guide, NTA At a Glance, Triple Check form, Nursing Documentation & RUG guides

Revamped "Admissions Cheat Sheet"



# PDPM Strategic Partner: Pulse Check

Therapy provider elimination of on-site regional support in favor of **virtual models**

Patient, family, or physician complaints about **changes in outcomes & care**

Therapy provider use of **restorative programming to replace skilled therapy**

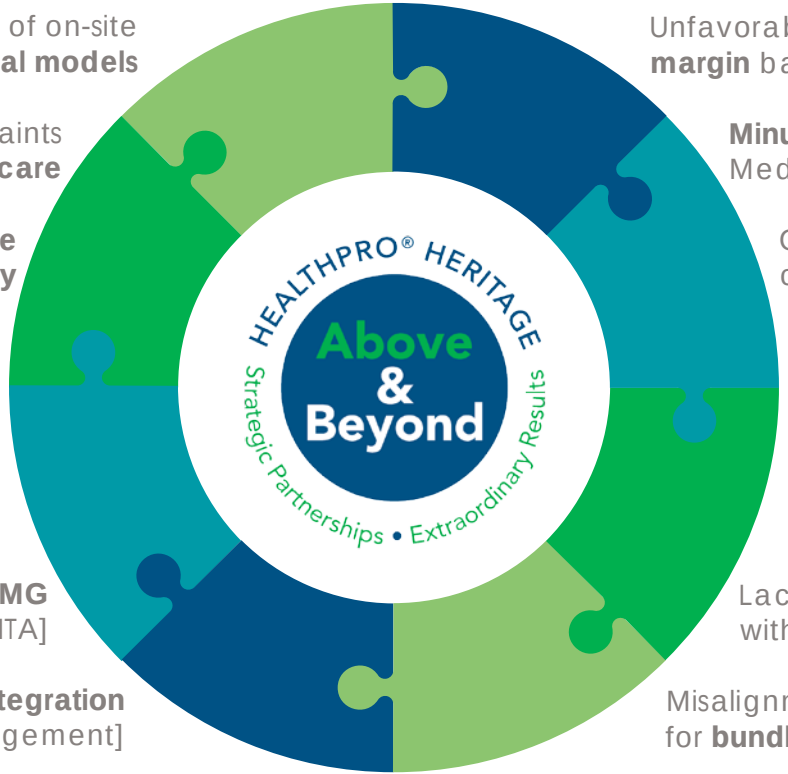
Sub-optimal **Medicaid CMI capture**

Declining **Star Rating and/or QMs**

Reduced therapy provider support for **auditing/denials management**

Lower than expected **PDPM CMG distribution** [nursing, therapy, NTA]

Ineffective **therapy-nursing integration** [programs, workflow, case management]




Unfavorable changes in facility **therapy margin** based on PDPM pricing

**Minute-based therapy contract pricing** for Medicare Part A or total monthly flat fee

Ongoing therapy **billing errors** or challenges

Inability to gauge/access therapy outcomes or **lack of actionable data to inform clinical strategy**

Absence of **evidence-based clinical pathways** to assure outcomes

Lack of coordinated care delivery with **managed payor sources**

Misalignment of reporting & programming for **bundled payors** or ISNPs

# Case Study:

## Operating on all Cylinders: Therapy + Consulting + PDPM Education

### Hospital-Owned Skilled Nursing Centers
**4 Sites**
Virginia

HEALTHPRO® HERITAGE Above & Beyond #beyondordinary

### A PARTNERSHIP APPROACH:

Full Service Rehab for ~16 Years
Regional Operations Oversight
+
Corporate-Level Engagement
Multi-Team Involvement
Monthly Consulting Support
Since January 2019

### SUCCESSFUL INITIATIVES:

Robust Monthly PDPM Education for IDT
(PDPM 1.0 + PDPM 2.0 + PDPM University)

IDT Workflow ReDesign

*PDPM Profiler* in Use by IDT

'The New Clinical Meeting' Process in place

Pre-Transmission Review & Triple Check

TeleMDS Hotline
Unlimited Remote Access to Consultant

ICD-10 Coding Intensive 1-Day Training for IDT

Audit Services Monthly
+ On-Site Review with IDT at each community

Support with Netsmart ReDesign

### SIGNIFICANT IMPACT:

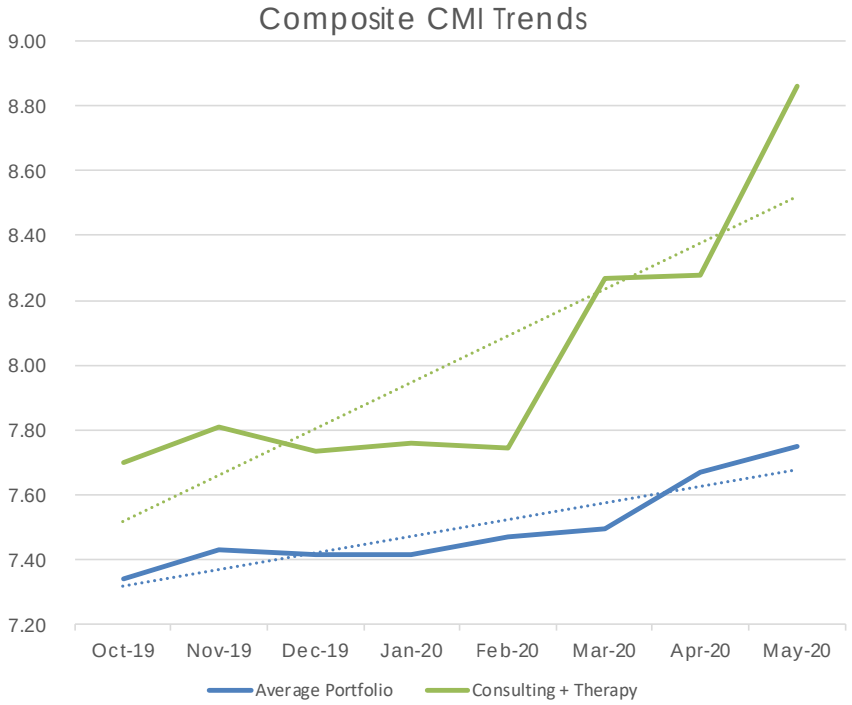
Average Per Diem Rate increased from
$459 to $525 under PDPM
(a $61/day increase)

~7.13k days → $ 430,000

*"Our consultant is extremely knowledgeable; she is a great teacher and has been easy to learn from during our PDPM transition."*
~Partner feedback

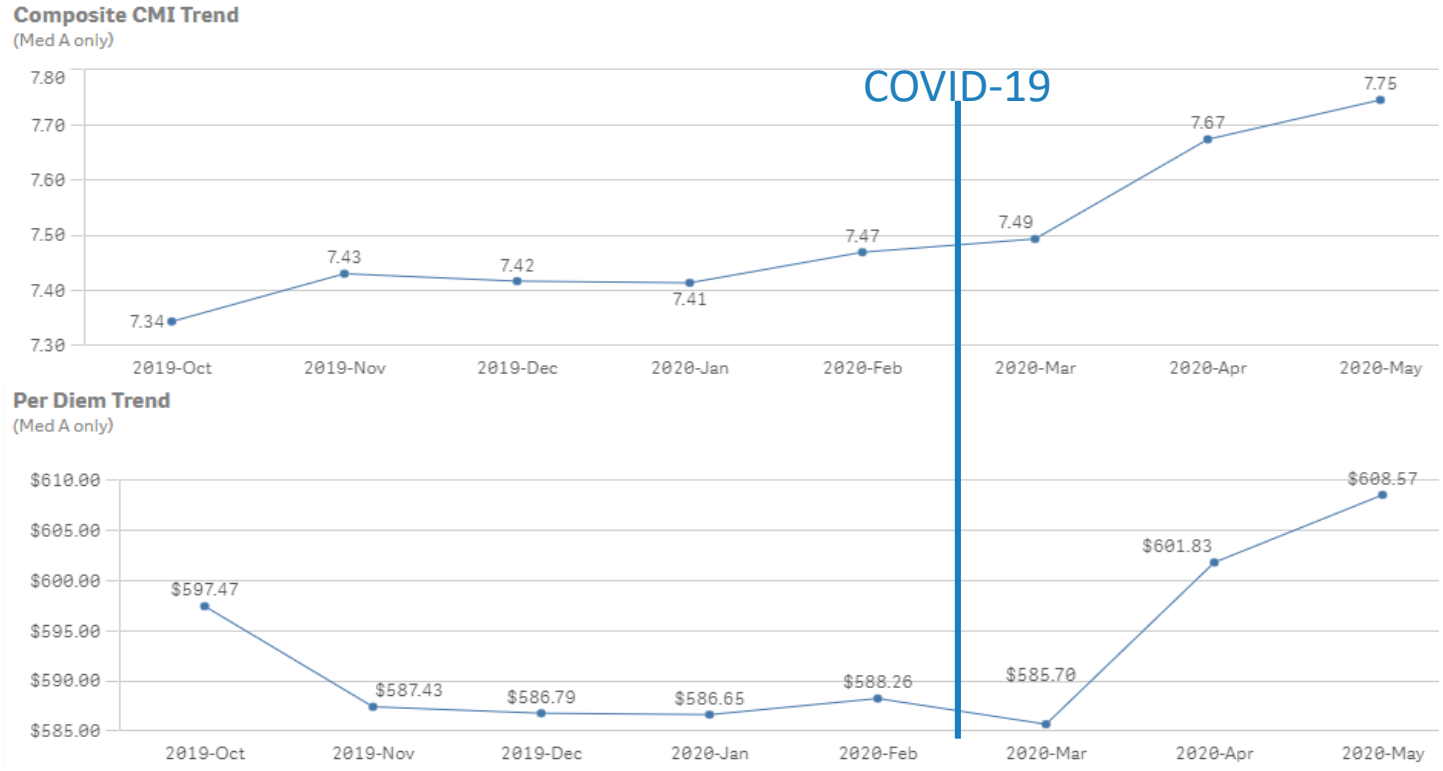
# Case Study:

## Operating on all Cylinders: Therapy + Consulting + PDPM Education




- Immediate and lasting CMI differences
- Fortifies partnership & enhances stakeholder "buy-in"
- Increased clinical and financial ROIs
- Creative economic structures can further align incentives

# Financial Outcomes



# Therapy Contracting: Time to Check-in

Have you reviewed performance with your provider?

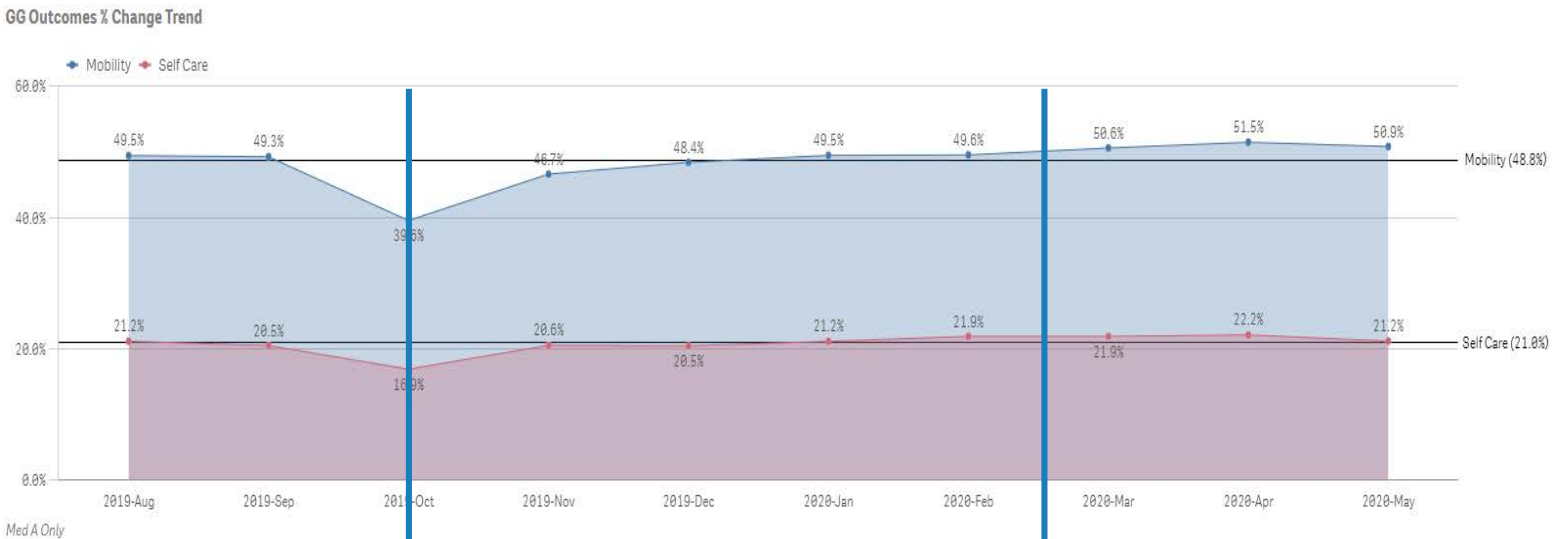
Do you have a strategic partner or a vendor?

How have they adapted with you?

Should you be considering a different methodology?

Fear of change has long-term consequences

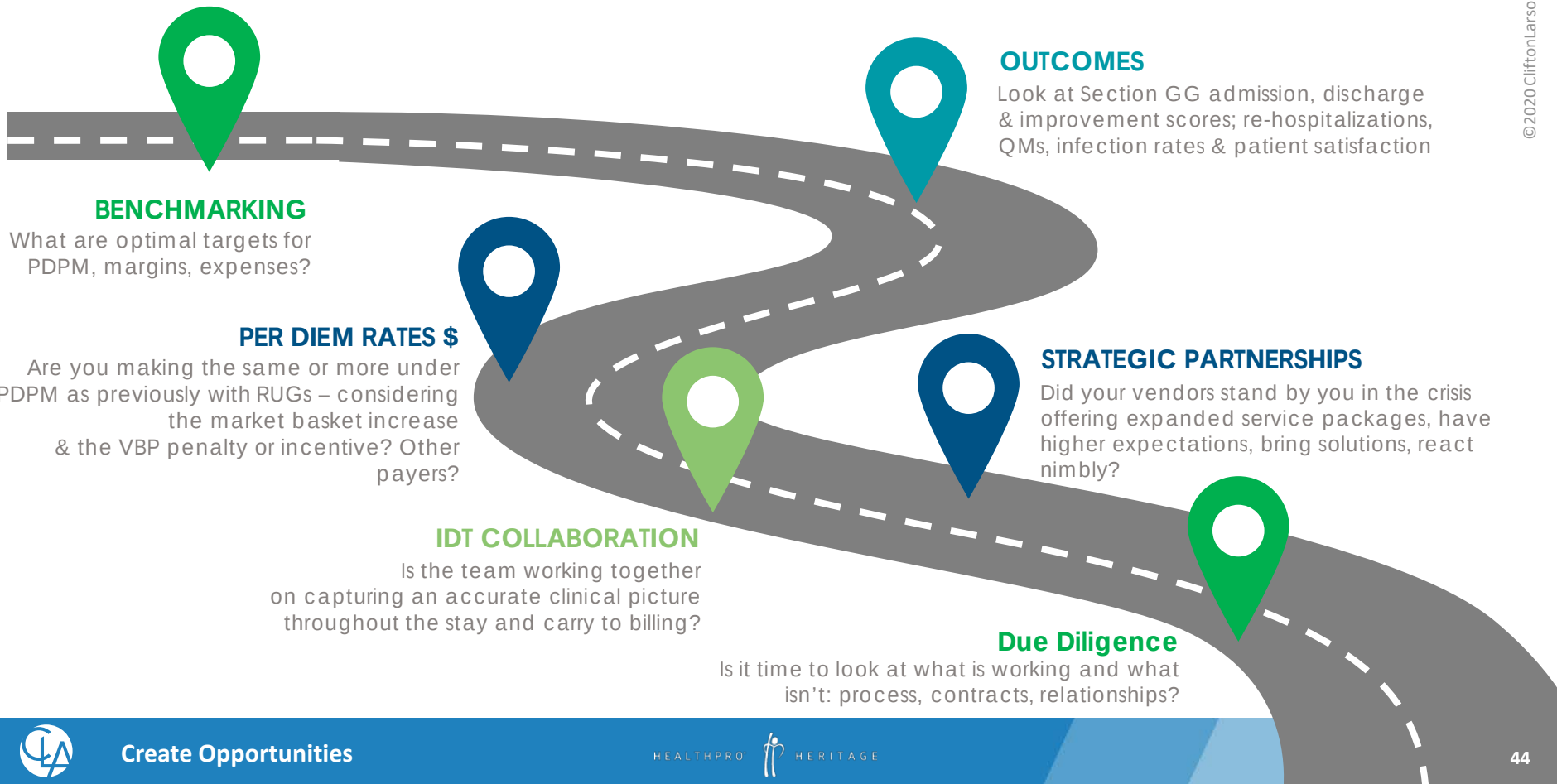
# Clinical Outcomes That Matter




PDPM Transition

COVID-19

# New Roadmap to Success for PDPM & Beyond



### BENCHMARKING
What are optimal targets for PDPM, margins, expenses?

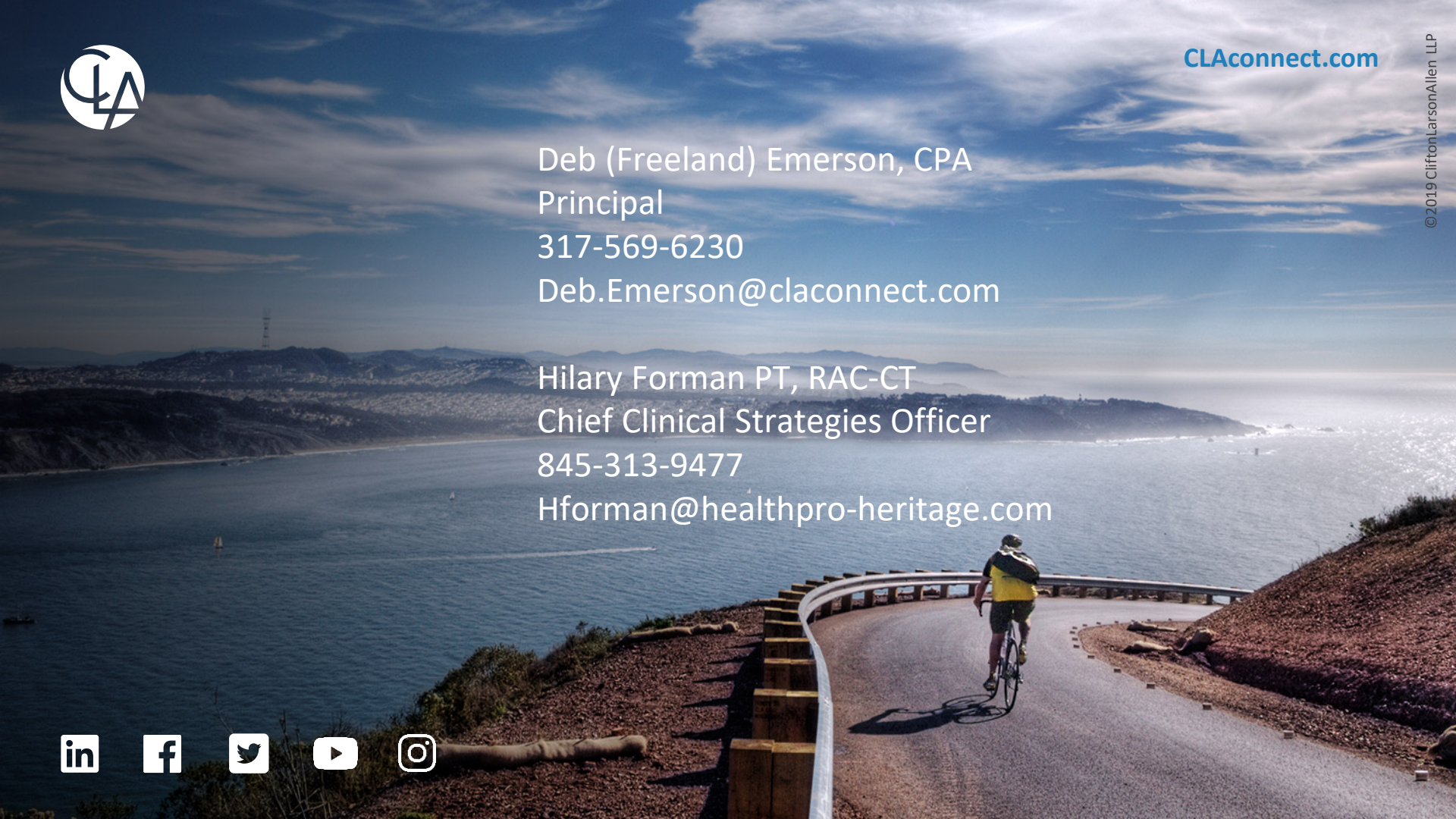
### OUTCOMES
Look at Section GG admission, discharge & improvement scores; re-hospitalizations, QMs, infection rates & patient satisfaction

### PER DIEM RATES $
Are you making the same or more under PDPM as previously with RUGs – considering the market basket increase & the VBP penalty or incentive? Other payers?

### STRATEGIC PARTNERSHIPS
Did your vendors stand by you in the crisis offering expanded service packages, have higher expectations, bring solutions, react nimbly?

### IDT COLLABORATION
Is the team working together on capturing an accurate clinical picture throughout the stay and carry to billing?

### Due Diligence
Is it time to look at what is working and what isn't: process, contracts, relationships?



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