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PDPM: Where providers should be now, on Oct. 1, and at 6 and 12 months post implementation

Steven Littlehale
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"Tick, Tick … Boom!," a lesser known musical by composer Jonathan Larson, who won a Pulitzer and three Tony Awards for his musical "Rent," opens with a ticking sound.

"The sound you are hearing is not a technical problem. It is not a musical cue. It is not a joke. It is the sound of one man's mounting anxiety. I … am that man."

Regarding the Patient-Driven Payment Model, we are all that man!

PDPM has dominated our professional awareness since its predecessor, RCS-1, hit the airways over two years ago. The amount of attention it has received is indeed appropriately proportioned to the impact it will have on how we render, and are reimbursed for, care. Care will not change as much as how we document the assessment of care, but no matter how you slice it, this is a significant piece of pie.

In preparation for an exciting PDPM presentation at Senior Care 360 this week, I collaborated with two standout colleagues around key activities that skilled nursing facility providers should accomplish to achieve PDPM success. Tricia Field, Director of Nursing Services at American Senior Communities, and Jonalyn Brown, VP of Operations at Consonus Healthcare, are these standout clinicians, and thinkers, who join me at this event at National Harbor this week.

Here are a few of the highlights of our presentation.

Tricia, Jonalyn, and I collaborated around four questions. Here are our results:

What are the key milestones you should have achieved by now?

- Education and training of all existing and newly hired stakeholders provided
- Use of data analytics/technology to identify missed opportunities
- ICD-10 training for MDS and med records, with emphasis on improved identification of primary diagnosis, provided
- Financial analysis of RUG-IV to PDPM performed

These four essentials, while key milestones, are also fluid and ongoing. The education of PDPM isn't a "one and done." Between the complexity of PDPM and turnover, this is an ongoing process. The financial analysis provided by CMS and others has limited benefit if you're not employing analytics that identify opportunity and ultimately improve assessment skills to better capture and document acuity.

What are the five essential things to do between now and October 1?

1. Finalize rehab contract terms and pricing
2. Provide specific training of MDS department and IDT based on anticipated impacts of RAI manual updates released and anticipated
3. Finalize policies, procedures, and processes to incorporate PDPM practices
4. Implement PDPM MDS scheduling conference calls between September 23 and October 1 with hotline available 24-hours-a-day between September 30 and October 3 (staffed by RAI Team)
5. Review Medicare eligibility requirements and how to write a "skilled note" with nursing.

All Medicare FFS patients who are already in your care prior to October 1 will need to have an Interim Payment Assessment (IPA) — no exceptions — so expect a large volume of questions and support needed from the end of September through the first full week of October.

By April 2020 (six months post implementation), if you are meeting your goals, what must be true?

1. Risk is mitigated (audits and denials) by maintaining quality measures with changes to how rehabilitative care is rendered and improvements to nursing documentation
2. Neutral to positive financial outcome under PDPM occurs when compared to historical data under RUG-IV

3. MDS-based rates of key PDPM financial drivers are aligned with national benchmarks: Depression, SLP CMI, use of IPA, etc.
4. PDPM compliance plan implemented

Although CMS has stated that PDPM will be budget neutral, that is highly unlikely. There will be some "winners" and "losers," but budget neutrality was based upon the assumption that assessment accuracy would remain as precarious as it currently is under RUG-IV. Accuracy on current "non-payment items" will improve, additional acuity will be captured, care that was previously not documented will be, and PDPM reimbursement will be higher than RUG-IV. Careful documentation is paramount to a PDPM compliance plan. There will be "bad actors" who will dominate the headlines and influence policy.

By September 2020 (12 months post implementation), if you are meeting your goals, what must be true?

1. Renegotiated risk-sharing models with outside rehab provider (if using contract therapy) implemented
2. Use of data analytics to ensure consistent and appropriate optimization of revenue and quality improvement
3. Increased market share based upon superior financial and clinical/satisfaction outcome data
4. Anticipation of and ready to respond to CMS revision of the PT/OT/SLP/nursing component rates
5. Reevaluation of the effectiveness of PDPM compliance plan occurring

The musical "Tick, Tick … Boom!" concludes with, "The tick, tick booms are softer now. I can barely hear them, and I think if I play loud enough, I can drown them out completely." Our sincere wish is that our lists provide you with reassurance that you're on the right track, or new insights for success.

Based upon what we're seeing, you are "playing loud enough" and should enter the final rush before PDPM implementation October 1 with a sense of confidence and purpose, never losing sight of what this is ultimately all about: the care of our nation's most frail elders.

Steven Littlehale is a gerontological clinical nurse specialist, chief innovation officer at Zimmet Healthcare Services Group and chief clinical officer-emeritus at PointRight Inc.