The **new Patient-Driven** Payment Model:

An overview for nursing homes

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There's no topic garnering more buzz in SNF circles than the fast-approaching PDPM reimbursement system. What do SNFs need to know and do to be prepared? And among all the swirling news, which items are truths you can trust and which are myths that need to be busted? This article breaks down the issues and aims to provide guidance.

On October 1, 2019, the Centers for Medicare & Medicaid Services (CMS) will implement the most fundamentally different reimbursement system in more than 20 years.

The Patient-Driven Payment Model (PDPM) replaces the long-standing prospective payment and resource utilization group (RUG IV) system with a new per diem system that emphasizes patient-centered care metrics.

Observers have said CMS was motivated to change its reimbursement methodology after years of overutilization of services like therapy that the RUG system encouraged. According to the American Health Care Association (AHCA), while therapy minutes and related thresholds will no longer drive payment, CMS will still require providers to report them on the Discharge Minimum Data Set, or MDS. The MDS is the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes.

Expectations are that PDPM will revolutionize the manner in which nursing homes assess, document and bill for services, and lower the overall administrative burden required to obtain reimbursement for care.

While some observers agree PDPM will result in better care and lower costs, some believe providers will continue to legally (and arguably, rightly) look for undiscovered funding streams to capture much-needed revenue to continue to be viable.

Current literature is rife about PDPM's expected impact, and some say it has led to some misinformation. Tad Druart, chief marketing officer for Cantata Health, an information technology services and solutions company, dispelled some of those myths recently for McKnight's Long-Term Care News.

Among those myths are:

Myth: PDPM is the same as value-based care.
Fact: PDPM applies only to nursing homes, while value-based care is a global concept describing the delivery of holistic, personalized care across the healthcare spectrum. And while outcomes generally drive reimbursement in value-based care, they influence, but by no means drive it, under PDPM.
Myth: PDPM will automatically cause most SNFs to lose money.
Fact: Most SNFs, according to Druart, have potentially been providing - but not always recording - many kinds of clinically complex care. Many facilities may begin doing so under PDPM.
Myth: PDPM deprioritizes therapy.
Fact: Appropriate utilization of therapy is a goal of PDPM; therapy of all kinds will continue to be encouraged and acceptable.
Myth: The MDS coordinator role will lose importance.
Fact: While a lower administrative burden is promised, coordinators will continue to have an important, if not enhanced, role in assessments and documentation.

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Key things providers need to know about PDPM

According to Jennifer Leatherbarrow, RN, BSN, RAC-CT-QCP, CIC, a senior clinical consultant at Richter Healthcare Consultants, the SNF community came close to working under a different system than PDPM in 2018 when CMS introduced RCS-1, or the "resident classification system."

According to the Center for Medicare Advocacy, RCS-1 was a system that would have rewarded facilities with higher reimbursement if they provided 15 or fewer days of Medicare coverage and only one form of therapy. Leatherbarrow says PDPM has made a number of notable changes to improve payment accuracy.

In her company blog, Leatherbarrow makes note of some things every provider should know about PDPM. Many of these concern how things like clinical conditions and functional and cognitive scores affect "component case-mix groups" (CMGs) in determining reimbursement rates.

All told, Leatherbarrow has a positive view of PDPM and its impact. "Factoring all of the changes together, I truly believe this could be a positive change for our industry," she says. "While we will get paid less for therapy-intensive residents, we will get paid substantially more for clinically complex residents. This payment shift will cause us to provide therapy services based on resident need and not reimbursement."

SNF provider impacts

Virtually no department within a nursing home will be unaffected under PDPM. Here's a peek at how various McKnight's experts view the coming impact.

Resident care. Documenting nursing care will be more important than ever before, according to Sherrie Dornberger, executive director, immediate past president of the National Association of Directors of Nursing Administration in Long Term Care (NADONA). She advises SNF nurses to review and revise, as needed, any tools they use to ensure that they are observing and then reporting what they see.

Legal issues. According to John Durso, litigation risks will increase under PDPM because caregivers will be serving more medically complex people. He also reminds staff that "many [plaintiffs'] lawyers will monitor the documented care prior to and after PDPM participation" in an effort to establish that appropriate care may not have been provided.

Payment impact. Providers will have the ability to directly impact five of the six areas comprising reimbursement, according to Caryn Adams, director of Wipfli, a top 20 accounting and business consulting firm. She advises providers to ready their facility by assessing "where they are today" in terms of ICD-10, MDS coding, and reviewing documentation to support diagnoses as well as skill. She also advises SNF providers to do a thorough review of their existing therapy contracts, as well as Medicare and resident assessment policies and procedures, and revise as needed.

Treatment impact. Providers would do well to pay close attention to wound care, according to Jeri Lundgren, a certified wound care nurse/specialist and president and owner of Senior Providers Resource, LLC. Lundgren believes ensuring proper diagnoses, staging and assessments of wounds is key and can directly impact reimbursement under the nursing and non-therapy ancillary components. Proper diagnosis and coding for diabetics will be particularly crucial because of the myriad complications of the disease.

PDPM has the potential to improve payment accuracy, but SNFs must be vigilant about following new regulations and documentation standards. A consultant pharmacist can help in part by reviewing documentation regarding patient response to medication, checking for order omissions or duplications, and assessing appropriate use of medications for a certain diagnosis.