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COVID-19 Scrambles PDPM Math, Particularly Around Therapy Minutes: 'This Will Be a Complete Rebuild'

As the nation prepares for life after the threat of COVID-19, the spotlight will be on CMS to figure out any changes that will need to be made to the PDPM structure. The SNF sector will also need to adapt through this heavily volatile time with new rules and regulations.

Written by: Maggie Flynn

6/21/2020

In the lead-up to the implementation of the Patient-Driven Payment Model (PDPM) on October 1, 2019, consultants, therapists, and the federal government warned operators over and over that therapy minutes would come under intense scrutiny in the months following the start of the new Medicare reimbursement system.

The model allowed for patients to receive up to 25% of their total therapy minutes in a group and concurrent setting, but prior to PDPM, the proportion of those minutes was very low.

As a result, the Centers for Medicare & Medicaid Services (CMS) indicated that it would be watching shifts in therapy quite closely both during and after the transition to PDPM.

"We do plan on monitoring that and seeing how much of a change occurs, along with changes in the patient population," a spokesman for CMS said during a December 11, 2018 presentation on PDPM. "Because if we don't observe changes in the patient population … that would suggest that payment incentives are continuing to have an impact on care decisions, as opposed to the needs of the patients. Then we'll have to consider the scope of those levels, whether it's at the facility level or the national level, and then consider what's appropriate [to address that]."

Shortly after PDPM took effect, the chairman and CEO of Sabra Health Care REIT, Inc. (Nasdaq: SBRA), a real estate investment trust with skilled nursing properties, argued that good operators wouldn't immediately spike their group and concurrent services — and echoed the idea that those who did would be caught.

"You're not going to see the good operators go from 0% concurrent and group therapy to 25%, which is the max," Rick Matros said during an earnings call on October 31, 2019. "You may see some guys do that out there, and I think they'll get in trouble if they do that."

Then came COVID-19, and whatever calculations might have gone into the 25% cap on group and concurrent therapy were shredded overnight.

Therapy is still a major focus under PDPM, even during the time of COVID-19, Hilary Forman, chief clinical strategies officer at the consulting firm HealthPRO Heritage — which also offers therapy services — said in a webinar held June 16.

But the pandemic has drastically altered therapy utilization.

"We were all worried in the fall about going over the cap," she said. "And now we're down to zero. So this will be a complete rebuild for us moving forward — again."

Admission practices under COVID-19 have varied from place to place, with some SNFs forced to take in admissions while others were closed to them altogether, Forman noted. Isolation mandates meant the therapy gyms were probably closed, with therapy likely conducted in patient rooms, she said. But when it came to PDPM, that might have been a chance, in coding the Minimum Data Set (MDS), to meet the "isolation" criteria for nursing, she added.

In terms of other opportunities that COVID might have opened, SNFs that had been struggling to deal with the new normal under PDPM might now have a chance to redesign their workflows, Forman said on the webinar.

Of course, COVID might have exacerbated the challenges they were facing, Forman noted, but some opportunities for SNFs to look at care redesign do exist.

These opportunities for improvement might include, according to the presentation:

- Early patient identification of IVs in the hospital
- Breaking down existing silos in patient profiling and care planning
- Making sure to determine nursing skilled services and rehabilitation
- Providing a thorough review of the non-therapy ancillary component of PDPM

Clinical outcomes also remain the name of the game for therapy, and some of consulting firm CLA's early findings were encouraging. Its data from on the functional outcomes from Section GG, taken from the MDS from before and after PDPM and COVID-19, highlight this — even if the amount of minutes provided aren't exactly the same, Forman said. There are all kinds of reasons for the changes, ranging from telehealth to limited disciplines that could be provided.

But the emphasis on a holistic view of the patient is important.

"With all of the focus on whether or not we would deliver the right amount of minutes, if that minute would change, if the minutes would be delivered in group or concurrent, it's fantastic to see at least in this subset of roughly about 400 sites, you can see that the outcomes over time improved," Forman said.

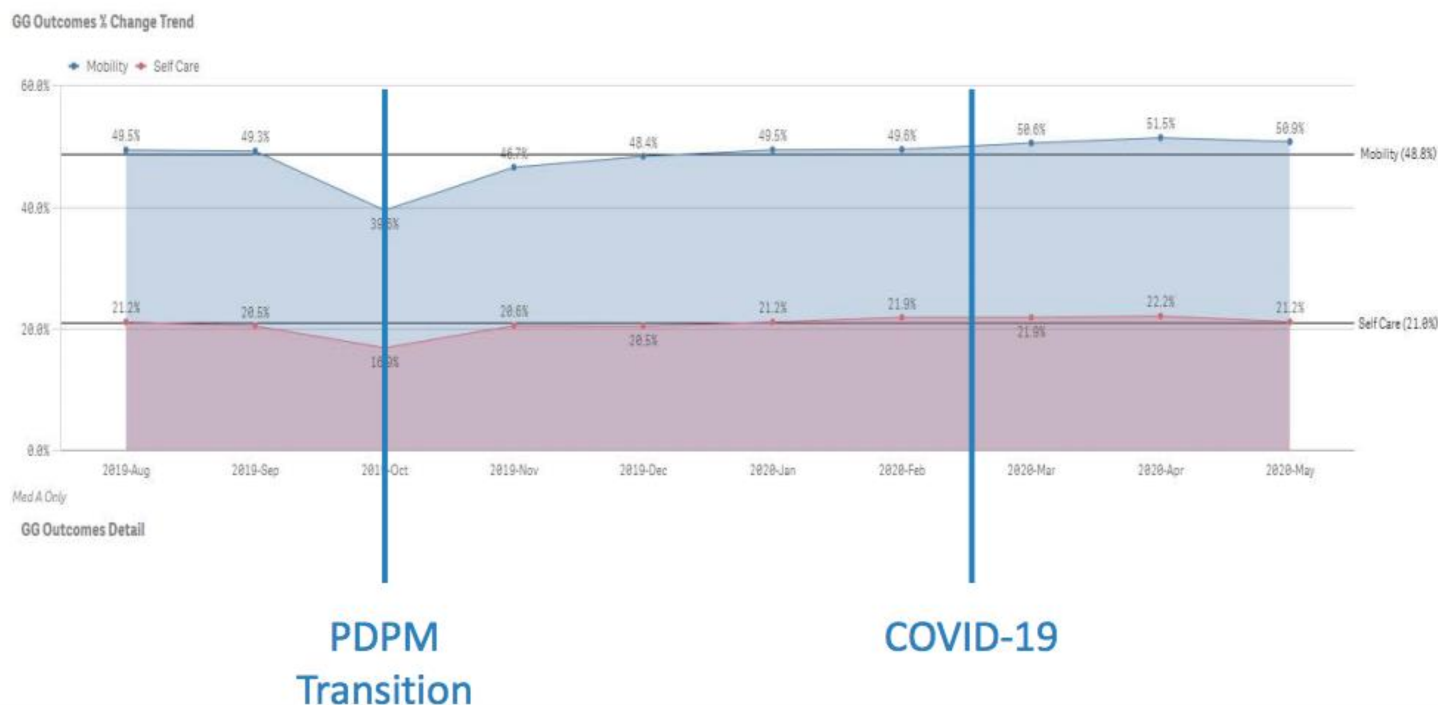

Chart showing Section GG outcomes before and after PDPM and COVID-19. Source: CLA

Infection control measures, which had a significant cost for facilities in terms of staffing, obtaining personal protective equipment (PPE), and meeting testing requirements, also affected therapy, according to Forman.

"It did create some silver linings for the therapy community, and one was the ability for us to really redesign therapy delivery," she said. "We were able to introduce telehealth into multiple sectors, not only in the skilled setting, but in our senior living."

Skilled Nursing News

Bottom Line: How a Turnaround Consultant Finds Nursing Home Upside Amid COVID-19

The following is an interview with Derek Pierce, the managing director at the turnaround and consulting firm Healthcare Management Partners. Pierce answers some timely questions around the operations of SNF facilities like his own as they cope with the rising costs of COVID-19.

Written by: Maggie Flynn

6/18/2020

Skilled nursing facilities have seen spikes in operating costs with the onset of the COVID-19 pandemic, putting increased pressure on already-tight budgets.

But the increased aid to SNFs from the federal government might help keep some of them afloat, as long as they can survive the broader trends that were playing out even before COVID-19.

Derek Pierce, managing director at the turnaround and consulting firm Healthcare Management Partners, has seen struggling nursing homes of an array of shapes and sizes. For him, the COVID-19 pandemic has in some ways put more resources in his path to help them — while making the day-to-day work of receivership much more of a challenge.

Healthcare Management Partners at the end of May entered into a joint venture with the investment banking and advisory firm SC&H Capital and the consulting firm I3 Healthcare Consulting, to help health care organizations — both acute and post-acute entities — weather the storm.

SNN caught up with Pierce to talk about financial considerations for SNFs both before COVID and during- and what's going to come.

This interview was recorded on June 3 and has been condensed and edited for clarity.

Let's start by going over your work with SNFs — going back before COVID-19, if we can remember that far back.

Yeah, it seems like a lifetime ago. I cut my teeth in the business as a Medicare auditor for a Blue Cross plan in the South 30 years ago. A lot of the auditing we did was a cost-based reimbursement methodology for hospitals and nursing homes, and hospitals were being phased out, nursing homes phased out a little further down the timeline.

From there, I started really getting into nursing homes about 15 years ago as a restructuring officer, worked in the CFO role of a large faith-based nursing home in Syracuse — 670 beds — and then did a 31-facility CFO role, a turnaround also in Tennessee, kind of closer to home for me. Since that CFO turnaround assignment, I've been doing a lot of receiverships in the nursing home space, nursing homes and a lot of assisted living care.

I've seen a large, almost institutional type setting in the Syracuse market, down to smaller rural, 60-bed or maybe up to 120-bed nursing home facilities in Tennessee and had several assignments between all of that.

But that's a high level of what I've done in the space. It's usually in financial, reimbursement, operations, and now these receiverships — which is akin to a bankruptcy although it's a little less complex. I've been appointed receiver over a lot of these facilities in a fiduciary-type capacity, where I'm over not just financials but over the overall building itself.

Can you talk about some of the financial issues in the SNF space that you saw in this work – even pre-COVID-19?

What comes back in my mind a lot of times when I think through the timeline of payment methodologies is: You hear people talk about businesses, saying, "Just tell me what the rules are, and I'll play by those rules, and I'll learn to live within my means."

But when the program changes — back in, I guess it was the Clinton administration, what happened is they they basically changed the rules. You know, the government has such a presence, as far as payers go, in the buildings that you're living by the whims of a regulation that could take them up or down — or out of business, in some extreme cases. If you imagine that — "just tell us what the rules are, and we live by them" — and then

suddenly those rules keep changing, that's kind of what I've seen in nursing homes, more than probably any other [setting]. Hospitals, it's been pretty steady, but [not] in nursing homes.

A really good example, in just the last 10 to six years, it's become more prevalent: managed care, long-term care programs where states are actually kind of pushing the fee-for-service concept, a per-diem payment, to the managed care organizations (MCOs) and saying, "Okay, we want you to manage, and we want it to be multiple payers, not just one, like in the old days."

It's now multiple MCOs saying: We're going to divide up the Medicaid population, and we're all going to pay you our own way on our own claim form. And we're going to limit services.

As an example, Virginia went through this about two years ago, and I had a building that I was responsible for. It was really difficult. You went to the state and cried: "We're not getting paid by these MCOs!"

It was this transition period; slowly they worked through the transition, but what you have is now a ratcheting down of utilization. So, these MCOs do what they do, which is manage cases, manage the patient, find alternatives for them, like home care, age-in-place. They find these alternatives that are less costly, and now suddenly facilities that are essentially a fixed-cost business are struggling with occupancy rates, declining occupancy rates.

That's probably one of the big examples, is the managed care coming into play for these for these Medicaid populations. [With] Medicare, it has has been in place for a while, but that's relatively new for Medicaid.

So how has COVID-19 shaken up the landscape? Has any of what you talked about been made worse by it, and if not, why not?

With the payment structure? My sense — and I have just recently taken on four buildings in Texas, so I have a little insight into it; I'm still getting my arms around the buildings and what's going on — but there's a lot of press and a lot of money being thrown at the buildings.

Obviously, it's being given with caveats, and making sure that people are following the rules, but the CARES Act, hospitals trying to be helpful to making sure that the nursing homes have access — for a restructuring officer, it's kind of been a chance to breathe. A lot of times I go into buildings where they don't have days of cash — with minutes of cash, not days of cash on hand. And here, because of some of the funding, it's been very helpful until I can sort out what needs to be changing.

To your real question, for the business and industry as a whole, not just specific to my struggling nursing homes, I think it's kind of steady-as-you-go for payments, the [revenue] cycle and whatnot. If anything, it's acceleration: How can the MCOs help get you paid quicker. I haven't seen much of a disruption on that side of it. It's the admission side of it, that's really the challenge. You can't take admissions, so your occupancies are declining just as we sit here.

You said: If not, why not? I think there's just so many people trying to join hands to make sure we're going to get through this. I guess that's my sense. I'm not a payer expert, but my sense would be that, that they would be: What can we do? And: We'll figure it out later. Even with CMS, when they went through this accelerated payment concept a couple of months ago for hospitals, it was a it was an effort of: Let's get you some money, and then we'll worry about how we would get back from you after we get through this crisis.

Is there anything about being a receiver that's harder in the pandemic situation? Are there any upsides?

Access to the buildings, obviously. We're non-essential, is how we're defining ourselves, and being able to keep the staff safe, making sure there's adequate PPE in the buildings. It's all about compliance in that regard, the clinical aspect, and you feeling the responsibility of it, keeping these people safe and the residents and patients safe in the building.

I think that's the one that weighs on probably me the most. I was on calls until about 9 p.m. last night from [certified nursing assistants] that were expressing concerns about issues in the building, some as basic as payroll issues.

What really troubles us in this, I think it's with a third of all COVID-19 cases or deaths coming from nursing homes — you knew it was serious beforehand, but now you're seeing it in the data. The data is now coming back and saying: This is the most vulnerable group in our country. And you're responsible for them. And so then trying to motivate the staff who were burned out and feeling overwhelmed and under-appreciated.

Shifting gears a bit, can you talk about what SNFs might expect in terms of issues of litigation?

In receiverships, you often have some immunity from that because it's a court appointment from a government agent. The building itself, we always cover ourselves with workers' comp and malpractice, and we do make sure that the coverages are in place.

I do think it'll become litigious. I think that's why hospitals got around the elective side of this so quickly; it was not worth the risk of infecting somebody. We don't have that option in the nursing home space, as a hospital would, so we have to do what we can.

[Families] can't see their loved ones in the building; they can't go in, and then they find out something has happened, and I just can't imagine how grief-stricken they would be. This is nothing profound here, but I just can't imagine it's not going to be an issue in a year or two, when we get things kind of settled down.

As the joint venture among SC&H Capital, Healthcare Management Partners, and I3 Healthcare Consulting gets under way, what are some of the issues you've been hearing from SNF clients?

In most of my cases, I am dealing with the struggling facilities, but it's trying to get economies of scale with services. So if there's something that's being done in one building, and it's being done by a different vendor or done in a completely different way in a second building, let's try to come up with a list of initiatives to do the same thing at both buildings and create some savings. That could be with the EMR. It could be with vendors, pharmacy vendors or food service vendors, but trying to come up with some commonality.

That's not necessarily new in post-COVID or within COVID. I do think some of the nursing homes that are struggling — and occupancy rates are continuing to decline — there is going to be at some point, I believe, mergers or divestitures.

A lot of these REITs [real estate investment trusts] that own the real estate have responsibilities to their shareholders. I just think there's going to be more changes. People are going to be trimming these facilities from their portfolio. We were seeing it, obviously, prior, but I just think it's going to accelerate something that was already in process.

Obviously technology: I think the increase in telehealth in the buildings is a must for the physician rounds. I think it's just going to continue in the ways of pushing acuity up in the buildings.

Technology takes center stage in senior living in 2020

The technological advances that we are seeing in the senior living space are outpacing the advancements that we have relied on in the past. They have become a necessity in the current state of affairs with COVID more than ever.

Written by: Lois A. Bowers

6/22/2020

Someday, when we look back on 2020, we might well say it was the year of technology in senior living.

Even before the COVID-19 pandemic took hold, of course, all types of technology ranging in price, size and scope helped providers keep residents safe and healthy and helped them keep track of their efforts toward these ends. Since coronavirus became a part of our everyday vocabulary, however, operators have found new and creative ways to integrate technology into their workplaces and into the lives of staff members and residents — whether it's using desktops, laptops or tablets to help residents connect with their loved ones; commissioning robots to keep residents engaged and connected; embracing telehealth to ensure that residents get the care they need; or something else.

We've shared some of these stories via our award-winning Daily Briefing e-newsletter, website, and print magazine, in our photo-centric In Focus online feature, and in our recent technology supplement, and we know there are more stories to share as well.

We want you and your staff to get the recognition you deserve for your efforts, and the McKnight's Excellence in Technology Awards is one way we can help. The entry deadline for the awards is July 24, and there is no charge to enter.

Take a look at these six categories in the senior living track and think about what initiatives your organization has undertaken — before or during the COVID-19 pandemic — that include technology and fit into one or more of them:

- Quality. Winning entries will describe the technology involved and how it was applied, describe and document how care quality improved, and address the overall effect of the change.
- High-Tech/High-Touch. Winning entries will describe the technology involved and how it was applied, describe and document how this change improved interaction between residents and staff, and address the overall effect of the change.
- Innovator of the Year. Winning entries will describe how innovation was key, and how it made a difference in caregiving and/or the bottom line.

- Keep It Super Simple. Winning entries will describe a simple but effective technology-related application that improved care and/or operations.
- Safety. Winning entries will describe the technology involved and how it was applied, describe and document how this change improved safety for residents and/or staff, and address the overall effect of the change.
- Activities. Winning entries will describe the technology involved and how it was applied, describe and document how this change improved activities, and address the overall effect of the change.

The awards have a skilled nursing track with six categories as well; the Transitions category takes the place of Activities, but all other categories are the same.

For more information, visit mcknightstechawards.com. You can submit entries here. Please note that entries must be submitted by provider organizations, not vendors.

Stanley Healthcare is the Platinum sponsor of the program this year. MatrixCare is the Gold sponsor for the senior living track.

Compartmentalization in Post-COVID Design of Older Adult Communities

The senior living model has already begun to shift as a result of COVID-19 and many communities are rethinking the way in which living spaces are designed. We take a look at a few ideas and examples that can be implemented by future sites and current spaces alike.

Written by: Jami Mohlenkamp

6/22/2020

Of all the populations affected by the spread of COVID-19, older adults have been among the hardest-hit. In recent years, senior living communities have shifted away from the healthcare-oriented designs of skilled nursing and hospitals in lieu of spaces that feel more like home and foster a sense of community. New design challenges, however, have arrived with the spread of a pandemic, which has shown that the older adult population can be highly susceptible to disease and infection spread in common living communities.

Owners, operators, architects and designers would be remiss to revert to designs more appropriate for medical settings, which often stifle a feeling of community and negatively affect emotional wellbeing among older adults. Instead, the future of design in older adult communities should seek to evoke feelings of home and foster connection while also adding functionality to limit the spread of disease to keep residents and staff members healthier.

Compartmentalization is key

The ability to compartmentalize – to design spaces that allow for both community and containment – will be a key factor in the design of older adult communities post-COVID. The goal of compartmentalization is to reduce the number of interactions residents and staff members may have with potential germ sources during an emergency. It can foster the ability to quarantine residents from central common areas, such as the dining room; limit visitor travel within the community; reduce the spread of germs through heating, ventilation and air conditioning (HVAC) systems and mechanical, electrical and plumbing engineering (MEP) systems; and more.

Designing in small house capabilities

Aging-adult communities of all types and sizes can be designed to reduce the number of interactions residents may have with potential germ sources such as staff members, family members, visitors – and even other residents – during an emergency. By thinking of the overall community as individual spaces that can be broken into compartments that don't co-mingle, you can foster connection in some circumstances and containment in others.

For example, localized common spaces in each resident wing can be made intentionally large enough to support a common living and eating area for residents of that wing. This way, residents have smaller eating areas closer to their individual living spaces and can avoid large dining areas during times of quarantine or social distancing.

Large communities could be designed as a cluster of smaller household models, with a central, common amenity area. This connectability can allow for staff and resource flexibility in an emergency situation while maintaining the benefit of fewer individuals in contact with separate households. Creating outdoor spaces for visitor interaction can limit visitor travel farther into the community.

Improving safety through MEP systems

Reducing the transmission of germs through HVAC and MEP systems is another challenge that can be aided through design. Using zonal isolation for heating and cooling systems, for example, can ensure that residents and employees are not only isolated from contact spreading and physical cross contamination, but also through droplet and particulate exposure through air. In addition, filtration and purification systems can help reduce the risk of contamination inside each zone.

Electrical and plumbing fixtures also are hot spots for viruses and bacteria. To help combat this reality, plumbing fixtures should have anti-bacteria surfaces, smart controls and touchless operations. Light switches and control devices in public areas can be touchless or motion-sensored to help reduce the spread of germs through shared light switches that are used by multiple people throughout the day.

Small house models

The small house model is one that may gain popularity in the post-COVID area. Typically with 10 to 12 residents and two staff members, these units generally feel very much like home while also limiting exposure to large groups and the spread of germs.

The small house model also can be designed vertically to accommodate more residents on a smaller footprint while keeping each floor to a maximum of 12 residents depending on acuity level and suite size. This option is particularly appealing in more densely populated urban areas, where it's easier to find the space to build up rather than out.

The way forward

Knowing what we know now, it's clear that the design of aging adult communities will be different in the future than it was in the past. But this understanding opens up opportunities to look at new ways of designing spaces that strike the balance between fostering relationships and emotional well-being and keeping residents, visitors and staff members safe and healthy. Compartmentalization of spaces, systems and resources will be key to finding that balance.