PDPM & Elder Justice Act

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Stefanie Corbett, DHA, has served in various senior leadership roles in healthcare organizations. In 2014 she founded Corbett Healthcare Solutions, based out of Charlotte, North Carolina, to assist post-acute care organizations with regulatory compliance and operations management. Prior to consulting, she served as the deputy director of health regulation for the South Carolina Department of Health and Environmental Control, where she was responsible for overseeing the promulgation and enforcement of healthcare regulations at all licensed healthcare facilities/agencies across the state. In addition to working as an entrepreneur and in the public sector, Corbett has led post-acute care organizations and taught as an assistant professor in healthcare administration programs at local universities.

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Learning Objectives

At the completion of this educational activity, the learner will be able to:

- Determine the purpose and goals of PDPM
- Identify the differences between PDPM and RUG-IV
- Determine how therapy utilization and MDS assessments will be impacted
- Determine how the new reimbursement rates will be assigned
- Implement strategies to prepare for the transition to PDPM from RUG-IV
- Understand the requirements of the Elder Justice Act
- Establish training priorities for compliance with the Elder Justice Act

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PDPM Purpose & Goals

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PDPM Purpose & Goals

- The Patient Driven Payment Model was developed in response to OIG and MedPAC recommendations for a new payment model to achieve:
  - Greater account for resident characteristics and care needs
  - Better alignment between SNF PPS payments and resource use
  - Elimination of therapy provision-related incentives
- PDPM is effective on October 1, 2018 with an implementation date of October 1, 2019

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Differences Between PDPM & RUG-IV

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Differences Between RUG-IV and PDPM: Base Rates

- RUG-IV includes PT/OT/SLP/nursing in **one** base rate
- Under PDPM, there are **six** separate base rates that impact reimbursement:
  – PT groups
  – OT groups
  – SLP groups
  – Nursing groups
  – Non-Therapy Ancillary (NTA) groups
  – Non-case mix groups

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Differences Between RUG-IV and PDPM: Reimbursement Rate Adjustments

- Under RUG-IV, per diem reimbursement rates are adjusted with scheduled and unscheduled MDS assessments
- Under PDPM:
  – PT/OT rates will remain constant for days 1-20
    • Then decrease 2% every 7 days after day 20 (i.e., days 21-27, 28-34, 35-41, …)
  – NTA rates will remain constant days 1-3 (300%)
    • Then decrease by 2/3 for days 4-100

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Differences Between RUG-IV and PDPM: Therapy Utilization

- Under RUG-IV, therapy utilization was based on a predetermined category (RUG level)
- Under PDPM, the sole denominator of how much/little therapy a resident receives is determined by the assessment process and by the clinical judgment of the care team
  - Focus on goals, outcomes, and efficiency

Differences Between RUG-IV and PDPM: Therapy Utilization

RUG-IV Reimbursable Minutes

- 100% of individual minutes
- 100% of co-treatment minutes
  - More than 1 discipline at a time
- 50% of concurrent minutes
  - No more than 2 patients at the same time
- 25% of group minutes
  - Working on the same goal/functions

PDPM Reimbursable Minutes

- Therapy utilization may include group and/or concurrent treatment sessions provided no more than 25% of the total therapy utilization (by minutes) is classified as group or concurrent

Differences Between RUG-IV and PDPM: Diagnoses Codes

- Under RUG-IV, active diagnoses are captured in the MDS with ICD-10 codes
- Under PDPM, ICD-10 diagnoses and procedural codes must be identified upon admission to appropriately classify residents into reimbursement categories
  - Also, the NTA component allows facilities to capture additional acuity elements and thus payment, for additional existing comorbidities (e.g., pressure ulcers, COPD, morbid obesity, etc.), plus a modifier for parenteral/IV feeding

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Differences Between RUG-IV and PDPM: MDS Assessments

- Under RUG-IV, there are several scheduled and unscheduled assessments:
  - 5-day, 14-day, 30-day, 60-day, 90-day
  - SOT, EOT, and COT
- Under PDPM, only 2 MDS assessments (MDS) will be required:
  - Admission
  - Discharge
  - A new Interim Payment Assessment (IPA) is optional to capture significant changes in a resident's condition and care needs

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How Rates Are Assigned Under PDPM

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SNF PPS Federal Base Payment Rate Components

- PDPM separately identifies and adjusts 5 different case-mix components:
    - PT – adjusted based on Function Score
    - OT – adjusted based on Function Score
    - SLP – adjusted based on cognitive level, SLP-related comorbidities, presence of an acute neurological condition, and/or presence of a swallowing disorder/mechanically-altered diet
    - Nursing – adjusted based on Function Score, depression, and/or # of restorative services
    - Non-therapy ancillary (NTA) – adjusted based on comorbidity count
- These 5 case-mix components are then combined with the non-case-mix component to form the full SNF PPS per diem rate for each resident

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SNF PPS Federal Base Payment Rate Components

- Based on the MDS assessment, every resident will fall into a group within the 5 case-mix components of PT, OT, SLP, non-therapy ancillary (NTA) and nursing
  - 16 PT groups
  - 16 OT groups
  - 12 SLP groups
  - 6 NTA groups
  - 25 nursing groups

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FY 2019 Federal Base Rate Per Diem

TABLE 12: FY 2019 PDPM Unadjusted Federal Rate Per Diem--Urban[3]

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$103.46	$78.05	$59.33	$55.23	$22.15	$92.63

TABLE 13: FY 2019 PDPM Unadjusted Federal Rate Per Diem–Rural

Rate Component	Nursing	NTA	PT	OT	SLP	Non-Case-Mix
Per Diem Amount	$98.83	$74.56	$67.63	$62.11	$27.90	$94.34

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10 Clinical Categories

- Under PDPM, the resident would first be categorized into 1/10 PDPM clinical categories using the first line in MDS item I8000 (item I0020, as needed) to report the ICD-10-CM code that represents the primary reason for the resident's Part A SNF stay

- Mapping between ICD-10-CM codes and the ten clinical categories is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html

TABLE 14: PDPM Clinical Categories

Major Joint Replacement or Spinal Surgery	Cancer
Non-Surgical Orthopedic/Musculoskeletal	Pulmonary
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Cardiovascular and Coagulations
Acute Infections	Acute Neurologic
Medical Management	Non-Orthopedic Surgery

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Collapsed Clinical Categories for PT/OT

- 10 PPDM clinical categories are collapsed into 4 PT/OT clinical categories:
  - Major joint replacement or spinal surgery
  - Non-orthopedic surgery and acute neurologic
  - Other Ortho
  - Medical Management

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New Function Score Methodology

- New function score for PT and OT payment based on section GG functional items used to case-mix adjust PT/OT rate component
  - Measures a resident's average function using two bed mobility items, three transfer items, one eating item, one toileting item, one oral hygiene item, and two walking items

TABLE 18: Section GG Items Included in PT and OT Functional Measure

Section GG Item		Score
GG0130A1	Self-care: Eating	0-4
GG0130B1	Self-care: Oral Hygiene	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4 (average of 2 items)
GG0170C1	Mobility: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0-4 (average of 3 items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0-4 (average of 2 items)
GG0170K1	Mobility: Walk 150 feet	

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SLP Categories

- Payment category will be assigned based on any combination/none of the following:
  - Cognitive impairment (based on BIMS/CPS)
  - Presence of acute neurologic condition
  - SLP-related comorbidity
- Then any combination/none of the following:
  - Mechanically-altered diet
  - Swallowing disorder

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Cognitive Function Scale Scoring

TABLE 20: PDPM Cognitive Measure Classification Methodology

| Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13-15	0
Mildly Impaired	8-12	1-2
Moderately Impaired	0-7	3-4
Severely Impaired	-	5-6

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NTA Category

- Based on a comorbidity score – a weighted, count methodology to account for 50 high acuity conditions that have a significant impact on costs, including, but not limited to:
  - HIV/AIDs
  - Feeding tubes
  - Certain cancers
  - MS
  - Bone/joint necrosis
  - Morbid obesity
  - Unhealed Stage 4 wounds

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Nursing Category

- Based on 25 RUG-IV Nursing RUGs:
  - Extensive Services
  - Special Care High
  - Special Care Low
  - Clinically Complex
  - Behavioral Symptoms & Cognitive Performance
  - Reduced Physical Function
- Adjusted by:
  - Depression
  - # Restorative Services
  - New Function Score (MDS Section GG)

Calculation of Total PDPM Case-Mix Adjusted Per Diem Rate

- The total case-mix adjusted PDPM per diem rate equals the sum of each of the **five case-mix adjusted components** and the **one non-case-mix adjusted rate component**…
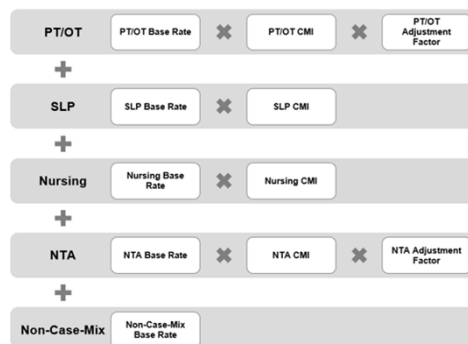
Implications of PDPM

PDPM Implications

Volume- ⟹ Value-Based Care

PDPM Implications

- Clinical complexity is the focus of increased payment opportunity
- Facilities will receive greater reimbursement for more acute (sicker) patients, such as those with certain cancers, HIV/AIDS, multiple pressure ulcers, morbid obesity, and etc.

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PDPM Implications

- Thorough preadmission screening
  - Insurance verification
  - Level of care determination
  - Revenue projection
  - Expense projection (consolidated billing)
  - Clinical competencies
  - Length of stay (short- vs. long-term)
  - Psychosocial issues

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PDPM Implications

- Effective goal setting and achievement
  - Goals
  - Outcomes
  - Efficiency
  - Interdisciplinary team and resident/family involvement

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PDPM Implications

- Mitigating survey risks
  - Resident outcomes (i.e., QM performance, QAPI, and etc.)
  - Utilization
  - Care planning
    - Individualized, resident-centered care
  - MDS accuracy
  - Adequate staffing
  - Clinical competence
- Mitigating claims audit risks
  - Under- vs. overutilization
  - Length of stay
  - ICD-10 coding accuracy

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How to Prepare for PDPM Today

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PDPM Preparation Strategies

- Technology updates (i.e., EMR/EHR software)
- Education and training of interdisciplinary team
  - Clinical competency, quality outcomes, and efficiency
- Update preadmission screening tools/checklists
  - Clinical competency
  - Revenue and expense projections
- MDS changes
  - MDS assessment accuracy, competency and sound judgment
  - Sections I and GG
  - ICD-10-CM and ICD-10-PCS coding training and education
    - Active diagnoses and comorbidities
    - Primary diagnosis
  - RAI Manual update

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PDPM Preparation Strategies

- Focus on facility assessments (F726 & F838)
  - Evaluate facility and needs of resident population
  - Evaluate staffing models
  - Assess and develop clinical competence
  - Evaluate policies and procedures
- Survey preparation
  - Conditions of Participation
  - Critical Element Pathways

PDPM Preparation Strategies

- Therapy management culture change
  - Utilization will not involve minutes
  - Focus on goals, outcomes, and efficiency
  - "Practical matter"

Elder Justice Act

Elder Justice Act

- First comprehensive legislation to address elder abuse
- Elder abuse prevention law introduced in 2002 and enacted into law in 2010 as part of the Patient Protection and Affordable Care Act on March 23, 2010
- "Elder justice" is defined as efforts to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect and exploitation and protect elders with diminished capacity while maximizing their autonomy

Elder Justice Act

- Provides federal resources that prevent, detect, treat, understand, intervene and, where appropriate, prosecute elder abuse, neglect, and exploitation
  - Federal funding provided for state and local Adult Protective Services Programs
  - Additional support for the LTC Ombudsman Program
  - Authorized an Elder Abuse Coordinating Council for federal agencies
  - Authorized an Advisory Board on Elder Abuse, Neglect and Exploitation

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Elder Justice Act

- Nursing home owners, operators, employees, managers, agents and contractors are required to report any reasonable suspicion of a crime against a resident or anyone receiving care from the facility
  - Must report any reasonable suspicion of a crime to law enforcement and DHHS within 24 hours after a reasonable suspicion if there is no serious bodily harm
  - If the suspicion resulted in serious bodily harm to the resident, the suspicion must be reported within 2 hours

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Elder Justice Act

- If a covered individual fails to comply with the reporting requirement, that individual can be subject to a civil monetary penalty of up to $200,000
- That penalty increases to $300,000 if the failure to report increased the harm to the victim or resulted in harm to another victim
- Owners of long-term care facilities are required to notify covered individuals annually of their reporting obligations under the EJA, as well as post related notices at their facilities
- If a facility retaliates against an individual for filing a report, it can be subject to a civil monetary penalty of up to $200,000 and can be excluded from participation in any federal health care program for a period of two years

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Compliance with Elder Justice Act

- Annually notify each covered individual of their reporting obligations
- Post notice in an accessible and appropriate location (i.e. poster)
  - Notice for employees specifying their rights, including the right to file a complaint under the statue with the state survey agency
- Refrain from retaliation
- Providers may not employ or contract with an individual that has violated the Elder Justice Act reporting requirements

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Conditions of Participation - Phase 3 :
§483.95 Training Requirements

- Must develop, implement and maintain an effective training program for all new and existing employees, contractors, and volunteers on abuse, neglect, and exploitation:
  - Activities that constitute abuse, neglect, exploitation and misappropriation of resident property
  - Procedures for reporting incidents
  - Dementia management and abuse prevention

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This concludes today's session.

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