



The National  
**CONSUMER VOICE**  
for Quality Long-Term Care  
formerly NCCNHR

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# PATIENT DRIVEN PAYMENT MODEL: WHAT DOES IT MEAN FOR RESIDENTS?

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January 23, 2020

# **MEDICARE AND SKILLED NURSING FACILITIES**

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## **CONSUMER VOICE**

### **MEDICARE'S NEW PAYMENT-DRIVEN PAYMENT MODEL**

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# TODAY'S WEBINAR

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- Requirements for Medicare Part A coverage of a stay in a skilled nursing facility (SNF).
- New Medicare Part A reimbursement system for SNFs – Patient-Driven Payment Model (PDPM) – in traditional Medicare program (not Medicare Advantage).

# MEDICARE COVERAGE OF SNF CARE

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- Basic Requirements
  - 3-day qualifying hospital stay, 42 C.F.R. §409.30(a)(1).
  - Admission within 30 days of hospital discharge.
  - Physician certification of need for SNF care.
  - Daily skilled nursing or rehabilitation services
    - Nursing 7 days/week, or
    - Rehabilitation 5 days/week, or
    - Combination of nursing and rehabilitation 7 days/week.
  - Practical matter: inpatient care needed, 42 C.F.R. §409.31(b)(3)

# *JIMMO v. SEBELIUS*, Civ. No. 5:11-CV-17 (D. VT. Jan. 2013)

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- Federal class action lawsuit to eliminate use of improvement standard in SNFs, home health, outpatient therapy.
- Filed Jan. 18, 2011 in federal district court in Vermont.
- Settled Oct. 16, 2012; Court approved settlement Jan. 24, 2013.
- Plaintiffs: 5 individuals and 6 organizations
  - Alzheimer's Association
  - National Multiple Sclerosis Society
  - National Committee to Preserve Social Security & Medicare
  - Paralyzed Veterans of America
  - Parkinson's Action Network
  - United Cerebral Palsy

# CORRECTIVE ACTION PLAN

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- Ordered by Court Feb. 2, 2017, including, among 10 required actions:
  - CMS must disavow improvement standard.
  - CMS must create a dedicated webpage.
  - CMS must post one set of Frequently Asked Questions.
  - CMS must post corrective action statement.
  - CMS must clarify summary of national call for contractors and adjudicators (Dec. 16, 2013).
  - CMS must direct Medicare Administrative Contractors to conduct additional training on manual clarifications.
  - CMS must report its compliance to the Court by Sep. 4, 2017.

# CMS'S *JIMMO* WEBPAGE

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**<https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html>**

- Important Message box
- Links to resources
- Frequently Asked Questions (FAQs)
- Our recommendation: Use the Transmittal version of revisions to the Medicare Benefit Policy Manual (new language, in red italics, is a clear visual representation of changes made by *Jimmo*).

# PATIENT-DRIVEN PAYMENT MODEL

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- Effective Oct. 1, 2019, CMS implemented a new “budget-neutral” replacement for Resource Utilization Groups (RUG-IV).
- Patient-Driven Payment Model (PDPM) bases payment on resident characteristics, rather than on services provided. 83 Fed. Reg. 39162, 39183-39265 (Aug. 8, 2018).
  - Final rules are essentially unchanged from proposed rules, 83 Fed. Reg. 21018, 21034-21080 (May 8, 2018).
  - Different from earlier proposal, Resident Classification System, Version I, 82 Fed. Reg. 20980 (May 4, 2017).



# PDPM

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- Enormous change in financial incentives for SNFs from prior system, RUGs.
- Initial primary concern was therapy, but admissions, assessment practices, and transfer/discharge practices are also changing, reflecting PDPM's financial incentives.

# HOW RUGS WORKED

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- Two case-mix adjusted categories
  - Nursing (nurse staffing and non-therapy ancillary services [chiefly, drugs]).
  - Rehabilitation
    - The more minutes of therapy per day, the higher the daily reimbursement rate.

# PROBLEMS WITH RUG-IV

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- Perceived overuse of therapy; definitely over-billing.
  - RUG-IV: more than 90% of residents in a rehabilitation category.
  - In FY2017, for 60% of claims, SNFs billed Medicare for the three top highest of the 66 RUG-IV categories.
  - HHS Inspector General and Medicare Payment Advisory Commission (MedPAC) reported that RUGs-IV encouraged excessive therapy and underpaid non-therapy ancillaries (chiefly drugs).
  - Lot of litigation under False Claims Act, particularly against chains, for overbilling, fraudulent billing.

# PDPM OVERCOMPENSATES FOR CONCERNS ABOUT RUG-IV

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- PDPM will pay less for residents who receive any therapy and more for residents who receive no therapy (according to CMS's Impact Analysis, Resident-Level, 83 Fed. Reg., 39257-39259, Table 37).
  - However, under Medicare statute, beneficiaries qualify for Part A coverage of SNF stay if they need rehabilitation services 5 days/week (or skilled nursing services 7 days/week).

# HOW PDPM WORKS (PART 1)

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- Instead of RUGs' two case-mix adjusted components, PDPM creates six federal base payment rates:
  - Five components are case-mix adjusted (physical therapy, occupational therapy, speech language pathology, nursing, non-therapy ancillaries [primarily drugs]).
  - One component is not case-mix adjusted.

## HOW PDPM WORKS (PART 2)

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- Each of five case-mix adjusted components (PT, OT, ST, nursing, non-therapy ancillaries) has its own case-mix groups.
  - PT: 16 case-mix groups;
  - OT: 16 case-mix groups;
  - ST: 18 case-mix groups;
  - nursing: 25 case-mix groups;
  - non-therapy ancillaries: 6 case mix groups.

## HOW PDPM WORKS (PART 3)

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- CMS separately calculates the case-mix component by multiplying the case-mix index by the component federal base payment rate.

## HOW PDPM WORKS (PART 4)

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- CMS applies **variable per day adjustment** schedule, which automatically reduces the daily payment for three case-mix categories on a sliding scale.
  - PT and OT: decline of 2% every seven days after day 20.
  - Non-therapy ancillaries (drugs): decline of 3% beginning on day four of Part A stay.



# HOW PDPM WORKS (PART 5)

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- CMS adds these five case-mix adjusted components to non case-mix adjustment component to come up with total daily rate. 83 Fed. Reg., 39225.

# MODE OF THERAPY

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- PDPM allows up to 25% of therapy to be provided in group or concurrent settings (instead of as individual therapy, as 99% of therapy under RUG-IV was billed).
  - Group may have 6 residents, 84 Fed. Reg. 38728, 38745-38750 (Aug. 7, 2019).
- But exceeding 25% cap leads only to “a non-fatal warning edit” – no penalty.

# INTERIM PAYMENT ASSESSMENT (IPA)

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- PDPM authorizes reclassification of residents under IPA for substantial change in resident condition, but final rules (in one of few changes from proposed rules) do not include criteria for IPA. 83 Fed. Reg. 39162, 39233 (Aug. 8, 2018).
  - Proposed rules: resident not expected to return to original clinical status within 14 days.

# CMS's ASSESSMENT OF IMPACT OF PDPM

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- Final rules describe financial impact of new reimbursement system and include two tables illustrating impact of PDPM's changes on residents and on facilities. 83 Fed. Reg., 39257-39259, Table 37 (Impact Analysis on Residents), and 83 Fed. Reg., 39160-39161, Table 38 (Impact Analysis on Facilities).

# CMS's ANALYSIS OF IMPACT ON RESIDENTS

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- Higher rates if resident has
  - High non-therapy ancillary costs; receives extensive services; is dually eligible for Medicare and Medicaid; needs IV medication; has ESRD; has diabetes or a wound infection; needs amputation/prosthesis care; had longer prior inpatient stay.

83 Fed. Reg. 39162, 39257 (Aug. 8, 2018).

# CMS's ANALYSIS OF IMPACT ON RESIDENTS

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- CMS writes, “we project that for residents whose most common therapy level is RU (ultra-high therapy) – the highest therapy level, there would be a reduction in associated payments of 8.4% percent, while payments for residents currently classified as non-rehabilitation would increase by 50.5 percent.”

83 Fed. Reg. 39162, 39257 (Aug. 8, 2018).

# IMPACT ANALYSIS ON RESIDENTS (FROM TABLE 37)

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- Higher rate if
  - Male
  - Under age 65
  - Medicare-covered stay in SNF of 1-15 days
  - Long inpatient hospital stay
  - **Not receiving any therapy at SNF**
  - Severely cognitively impaired
  - Needs ventilator

# IMPACT ANALYSIS ON RESIDENTS (FROM TABLE 37)

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- Lower rate if
  - Female
  - Over age 90
  - Medicare-covered SNF stay of 31+ days
  - 3-day prior inpatient hospital stay
  - **Receives all three therapies (PT, OT, and ST)**
  - Cognitively intact or mildly or moderately cognitively impaired
  - Not need ventilator or infection isolation



# CMS's ANALYSIS OF IMPACT ON FACILITIES

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- Higher reimbursement if
  - **“high proportion of non-rehabilitation residents;”** small facilities; non-profit facilities; government-owned facilities; hospital-based and swing bed facilities.  
83 Fed. Reg., 39259.

# IMPACT ANALYSIS ON FACILITIES (FROM TABLE 38)

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- Higher reimbursement if
  - Rural West North Central facility
  - 90-100% of residents are dually eligible for Medicare and Medicaid
  - 0-10% of Medicare-covered stays are 100 days
  - **75-90% of Medicare-covered stays are billed as non-rehabilitation.**

# IMPACT ANALYSIS ON FACILITIES (FROM TABLE 38)

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- Lower rate if
  - Urban Mid-Atlantic facility
  - Fewer than 25% of residents are dually eligible for Medicare and Medicaid
  - 25-100% of Medicare-covered stays are 100 days
  - **0 – 10% of Medicare covered stays are billed as non-rehabilitation.**

# CONCERNS ABOUT THERAPY

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- What would happen to therapy?
  - Would beneficiaries needing therapy be admitted to SNFs?
  - Would residents get the therapy they need?
  - Would residents continue to receive individual therapy?
- What would happen, especially, to maintenance therapy (*Jimmo*)?
  - Dismissive CMS comment in final rules: no special tracking of maintenance therapy is necessary.

# OCT. 1, 2019

## (effective date of PDPM)

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- Impact of PDPM is immediate, with loss of thousands of therapy jobs nationwide and SNF demands that therapists use group and concurrent therapy instead of individual therapy.
  - Genesis Healthcare laid off 585 therapists (almost 6% of rehabilitation employees).
- As much as we were anticipating significant changes, the speed was shocking and the behavior, brazen.

# PDPM DID NOT CHANGE ELIGIBILITY AND COVERAGE RULES

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- Eligibility: daily skilled care (generally, skilled nursing 7 days/week or skilled therapy 5 days/week, or a combination), 42 U.S.C. §1395f(a)(2)(B).
- Therapy should be provided as assessed and ordered in care plan.
- Baseline care plan, 42 C.F.R. §483.21(a), must be developed within 48 hours of admission.
  - Baseline care plan includes therapy, §483.21(a)(1)(ii)(D).
  - Baseline care plan may be especially important because length of stay is reduced under PDPM and comprehensive care plan is not required for 21 days after admission.

# WHAT BENEFICIARIES AND THEIR ADVOCATES CAN DO ABOUT THERAPY

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- Request care planning meeting and say
  - Medicare eligibility and coverage rules have not changed.
  - Therapy should be provided as assessed and ordered in care plan.

# AT CARE PLANNING MEETING

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- Use the preamble to 2018 regulations, 83 Fed. Reg. 39162, 39239 (Aug. 8, 2018)
  - “[W]e believe that individual therapy is usually the best mode of therapy provision as it permits the greatest degree of interaction between the resident and the therapist, and should therefore represent, at a minimum, the majority of therapy provided to the resident.”
  - “group and concurrent therapy should not be utilized to satisfy therapist or resident schedules.”
  - “all group and concurrent therapy should be well documented in a specific way to demonstrate why they are the most appropriate mode for the resident and reasonable and necessary for his or her individual condition.”

CMS made many similar additional points in preamble.



# AT CARE PLANNING MEETING

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- Use preamble to 2019 regulations, 84 Fed. Reg. 38728, 38726 Aug. 7, 2019), which says
  - “SNFs should include in the patient’s plan of care an explicit justification for the use of group rather than individual or concurrent therapy.”
  - Description in care plan should identify “the specific benefits to that particular patient of including the documented type and amount of group therapy.”

CMS made many similar additional points in preamble.

# AT CARE PLANNING MEETING

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- Use CMS's FAQs for PDPM, #12.1 (Aug. 2019)
  - “PDPM does not change the care needs of SNF patients, which should be the primary driver of care decisions, including the type, duration, and intensity of skilled therapies, made on behalf of SNF patients.”

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM/> (click on the FAQ link).

# WHAT ELSE TO DO

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- If not satisfied with facility response, if looking for strength and safety in numbers, if wanting to do more advocacy,
  - Raise concerns about therapy at resident council meeting.
  - File grievance with facility, 42 C.F.R. §483.10(j).
  - File complaint with state survey agency (in health department).
  - Contact Regional Office/Central Office of CMS.
    - Effective Oct. 1, 2019, CMS adds new items to Discharge Assessment to identify minutes of therapy and mode of therapy.
    - Monitoring of decline in therapy is possible, but will CMS do it and act on it?
  - Let Members of Congress know.

# CONCERNS BEYOND THERAPY

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- Cutbacks to therapy services was most obvious immediate problem, but many additional issues are also becoming apparent.

# ADMISSIONS

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- New admissions practices are likely.
- SNFs may “specialize” in new areas, such as ventilator care, dialysis.
  - Residents who had been hard to place (e.g., residents needing ventilators) are easier to place as some SNFs actively recruit them.
    - Special Focus Facility candidate recruiting ventilator patients.

# FINANCIAL ADVANTAGES OF VENTILATOR CARE FOR SNFs

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- Highest case mix group for nursing component (which does not decline with length of stay).
- Greater chance of 100 days of Medicare coverage.
- (Just ((at least) 15 minutes of time for therapist or nurse with resident/day).
- As much as \$1200-\$1800 extra reimbursement/week.

Alex Spanko, “Respiratory Therapy’s ‘Massive Skilled Nursing Opportunity Under PDPM,” *Skilled Nursing News* (Jul. 28, 2019), <https://skillednursingnews.com/?s=Respiratory+Therapy%27s+Massive+Skilled+Nursing+Opportunity>.

# MARKETING FOR VENTILATORS

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- First 6 weeks of PDPM

“Another surprise – we did not expect the Special Care High group to be so well represented on day 1.

Respiratory Therapy generated well-deserved attention, with several high-profile service providers marketing RT’s potential Return on Investment.”

Zimmer Healthcare Services Group, LLC, CORE Analytics, *PDPM Reimbursement Analysis: October 2019 Medicare Claims; Financial Impact, Observations, Rate Measures & Comparative Integrity*, page 9 (Nov. 18, 2019), <https://www.zcoreanalytics.com/wp-content/uploads/2019/11/PDPM-Reimbursement-Analysis-2019.pdf>.

# VENTILATORS

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- BUT, will residents using ventilators get good care?
- Serious problems of infections, especially residents with ventilators.



# DRUG-RESISTANT INFECTIONS FOR RESIDENTS USING VENTILATORS

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- Drug-resistant infections prevalent in residents using ventilators (because of low staffing levels, poor infection control practices).

Matt Richtel, Andrew Jacobs, “Nursing Homes Are a Breeding Ground for a Fatal Fungus,” *The New York Times* (Sep. 11, 2019), <https://www.nytimes.com/2019/09/11/health/nursing-homes-fungus.html?searchResultPosition=1>

# DIALYSIS

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- “Dialysis services have recently been highlighted as a major growth area” under PDPM, “both financially and clinically.”
  - Article highlights 2 SNFs
    - One facility is 1-star facility (much below average);
    - Other is 3 star (because 5-star quality measures boosts 2-star health surveys (below average) to 3 star rating).

Linda Yamshon, “Nursing Home Dialysis Demand Drives Post-PDPM Push to Specialty Services,” *Skilled Nursing News* (Nov. 25, 2019), <https://skillednursingnews.com/2019/11/nursing-home-dialysis-demand-drives-post-pdpm-push-to-specialty-services/>.

# FACILITY ASSESSMENT

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- If SNF is newly adding ventilator or dialysis coverage, it is required to do a facility assessment, 42 C.F.R. §483.70(e).
- Purpose of assessment is “to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies.”
- Assessment should address
  - “Resident population,” §483.70(e)(1) and
  - “Facility resources,” including equipment, services, staff, §483.70(e)(2).

# FACILITY ASSESSMENT

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- Assessment must be updated when there is a “substantial modification to any part of this assessment,” §483.70(e).
  - Examples of modifications: admission of residents not previously admitted, such as residents with ventilators or dialysis. State Operations Manual, Appendix PP, p. 619.

SOM, App. PP, [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf)

# FACILITY ASSESSMENT

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- F838, State Operations Manual, Pub. 100-7, Appendix PP, says facilities “strongly encouraged [but not required] to seek input from the resident/family council, residents, their representative(s), or families” about facility assessment. p. 618.

SOM, App. PP, [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf)

- Facility unlikely to give residents copy of assessment, but ask.

# DEFICIENCIES FOR FACILITY ASSESSMENT, F838, 2018-PRESENT

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- 631 facilities cited with F838 deficiency
  - B, C = 148 facilities
  - D, E, F = 473 facilities
  - G, H, I = 3 facilities
  - J, K, L = 7 facilities

# IMMEDIATE JEOPARDY DEFICIENCY, F838

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- Morgantown Health and Rehabilitation Center (WV), survey Nov. 15, 2018
  - 14 deficiencies, including 4 jeopardy deficiencies (resident preferences for care; nurse competencies; Facility Assessment; quality assurance)
    - Facility Assessment: staff not trained or competent in providing IV therapy via PICC),  
<https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=515049&INSPTYPE=STD&SURVEYDATE=11/15/2018>
  - Civil money penalty: \$308,013.

# RESIDENT ASSESSMENTS

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- How will assessments change?
- Will depression be identified and treated?
  - Trade press suggests identification and treatment of depression can boost payment by \$43/day and support longer lengths of stay.
- Will cognitive impairment be identified?
  - Trade press suggests \$21/day and longer lengths of stay are justifiable.

Alex Spanko, “Treating Depression Could Emerge as a PDPM ‘Lynchpin’ — Both for Payments and Better Outcomes,” *Skilled Nursing News* (Aug. 14, 2019),

<https://skillednursingnews.com/2019/08/treating-depression-could-emerge-as-a-pdpm-lynchpin-both-for-payments-and-better-outcomes/>.



# TRANSFER/DISCHARGE

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- If resident does not receive therapy 5 days/week, resident may not qualify for a Medicare-covered Part A stay.
- Facilities may give transfer/discharge notices.
- BUT, residents are entitled to 2 notices
  - Notice of Medicare noncoverage (NOMC)
  - Nursing Home Reform Law, transfer and discharge, 42 C.F.R. §483.15(c).

# TRANSFER/DISCHARGE

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- CMA, “‘Discharge’ from a Skilled Nursing Facility: What Does It Mean and What Rights Does a Resident Have?” (CMA Alert, Jan. 13, 2016).

<https://www.medicareadvocacy.org/discharge-from-a-skilled-nursing-facility-what-does-it-mean-and-what-rights-does-a-resident-have/>

(still accurate information, except for citation to federal transfer/discharge rules, now 42 C.F.R. §483.15(c))

# “INTERRUPTED STAY” POLICY

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- If resident is “discharged from SNF and subsequently readmitted to the same SNF (not a different SNF) within 3 days or less after the discharge,” Medicare coverage and payment resume from day of discharge.
- BUT if resident is readmitted to same SNF after 3 days (or to a different SNF, regardless of number of days between discharge and admission), SNF does new assessment (i.e., restarts the clock).

# NURSE STAFFING

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- Medicare reimbursement should more fully fund nurse staffing because of PDPM's stated focus on resident acuity.
- Staffing documentation will be critical to getting high rates.
  - BUT, will RN staffing increase? Will staffing increase on weekends, when many admissions occur?
  - Will new RNs be assigned solely/primarily to assessment?

# NURSE STAFFING

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- RUG nursing component covered both nursing and non-therapy ancillaries (drugs).
- In PDPM,
  - 57% of RUG nursing component is devoted to nursing;
  - 43% of RUG nursing component goes to drugs.
- So is sufficient reimbursement even recognized in PDPM for nursing?

# CONCERNS ABOUT SNF GAMING

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- PDPM uses only 5-day assessment (not RUG's additional assessments on days 14, 30, 60, 90) to reduce “paperwork burden.”
  - Concern: gaming of assessment information.
  - PDPM authorizes reclassification of resident under Interim Payment Assessment (IPA), but final rule do not include criteria for IPA.

# OTHER IMPLICATIONS OF PDPM

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- CMS anticipates shorter lengths of stay under PDPM.
  - RUGs: 20 days (large co-payment begins day 21).
- If Medicare no longer paying, residents then
  - Leave the SNF, or
  - Use Medicaid (if they are eligible for Medicaid), or
  - Pay out-of-pocket, becoming Medicaid-eligible sooner than if Medicare had continued paying.

# HOW SNFs HAVE DONE FINANCIALLY WITH PDPM

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- Laid off therapists across the country; did not hire additional nurses (first 6 weeks).
- SNFs made \$52/resident/day more than under RUGs (even without artificial inflation because of new assessments done on Oct. 1, \$26 more).

Zimmer Healthcare Services Group, LLC, CORE Analytics, *PDPM Reimbursement Analysis: October 2019 Medicare Claims; Financial Impact, Observations, Rate Measures & Comparative Integrity*, p. 9 (Nov. 18, 2019), <https://www.zcoreanalytics.com/wp-content/uploads/2019/11/PDPM-Reimbursement-Analysis-2019.pdf>.



# INDUSTRY ANALYSTS

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- Some analysts predict that CMS will recalibrate rates to reduce such large increase in per day payments (in what CMS intended to be a budget-neutral change in reimbursement).

# SUMMARY

## CONCERNS ABOUT PDPM

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- Enormous change in financial incentives.
- SNFs are changing practices to maximize profits.
- Lot of concerns about therapy, admissions, assessments, transfer/discharge, staffing, gaming.
- Need for careful monitoring and advocacy.

# ADDITIONAL RESOURCES FROM CENTER FOR MEDICARE ADVOCACY

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- Weekly Alerts (free emails),  
<https://www.medicareadvocacy.org/join/>.
- Self-help materials (free),  
<https://www.medicareadvocacy.org/take-action/self-help-packets-for-medicare-appeals/>.
- Monthly newsletter on nursing home enforcement issues (subscription, \$250/year),  
<https://secure.everyaction.com/LduW4G7pT0in77zVpBo4UQ2>.

Center for Medicare Advocacy,  
<https://www.medicareadvocacy.org/>.

# CMA

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