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MDS Alert

Reimbursement Spotlight: See How PDPM is Shaking Out

Use the reflections from this report to better understand how PDPM is affecting facilities.

With more than a month of Patient-Driven Payment Model (PDPM) under your belt, you may be wondering how facilities are faring across the long-term care industry.

One major takeaway: "Financially, October 2019 claims support our belief that PDPM will NOT maintain budget-neutrality, making a rate recalibration (reduction) likely at some point," say **Marc Zimmet,** CEO of **Zimmet Healthcare Services Group LLC** and **Z-CORE Analytics**, and **Vincent Fedele,** director of analytics at **Zimmet Healthcare Services Group LLC**, in their October 2019 PDPM Reimbursement Analysis. They predict that a case-mix refinement and a rate recalibration are possible "as early as next year."

Understand how the Analysis Methods Change

With various care components - physical/occupational therapy (PT/OT), speech language therapy (SLP), nursing, and non-therapy ancillary (NTA) - driving reimbursement instead of therapy minutes, reimbursement rates are quite variable, making it a bit harder to determine how facilities are handling the change.

For example, "The NTA Component's value is tripled during the first three days of admission, and PT/OT is slowly tapered downward after day-20. This creates average-rate variability driven by length of stay that complicates budgeting and destabilizes relative analysis," Zimmet and Fedele say.

This means your facility's numbers may skew. "Simply stated, 'Average Medicare Rate' is no longer an adequate stand-alone measure of reimbursement performance, nor is the quotient fully reliable in financial modeling. Shorter stays drive average per diem payment higher, and therefore must be considered in the context of a facility's average length of stay (ALOS) when measured against the rates of others," they say.

Look to Top Performers' Numbers

Their analysis is based more than 20,000 PDPM claims submitted by 623 skilled nursing facilities from Oct. 1, 2019 through Nov. 17 in 35 states and the District of Columbia. The verdict: Approximately 91.5 percent of facilities analyzed came out better than they would have with Resource Utilization Group (RUG-IV) billing, while 8.5 percent experienced a negative impact.

"… the average PDPM rate of $584 would still be $26 more per day than Medicare would have paid had RUG-IV continued unabated," Zimmet and Fidele say. "The variation in PDPM Realized Rate average was significant. Top quartile performers billed nearly 20% more than the bottom quartile average."

Perhaps unsurprisingly, for-profit facilities received more reimbursement than nonprofits.

Peek into Component Shakedown

Zimmet and Fidele say that, within the PT/OT component of PDPM, Medical Management is the "predominant clinical category," which was in line with their informal polling of the therapy community. This may mean that PT/OT could be one of the first targets for the Centers for Medicare & Medicaid Services (CMS) to "refine."

They say that the SLP component proved interesting in their analysis: "25% more [residents] were identified as having an acute neurological diagnosis, cognitive impairment and SLP-related comorbidity but NOT a Mechanically Altered Diet or Swallowing Disorder than had one or both recognized. Dieticians maintain the opposite is far more likely."

Zimmet and Fidele hypothesize that the nursing component may prove to elicit more reimbursement once the learning curve for PDPM isn't quite so steep. Restorative nursing was not utilized very frequently; business models centered around that care as being driving force didn't seem to paint an accurate picture of how things played out, they say.

However, the potential is there: "Nearly 27% of October scores are sensitive to RNP capture (about $10/day). Despite all the attention drawn to RNP as an adjunct to declining therapy volume, only 10.6% of eligible patients received the service. While the goal should be to compliantly migrate these low paying scores up the hierarchy through appropriate clinical management, the time has never been better to formalize and execute a functional RNP to improve revenue and reduce pressure on the therapy department," they say.

Top tip: Audit your numbers in your Nursing Component for Special Care High/Low and Clinically Complex in the end splits. "If you take anything from this report, please review your October billing and count how many of your Nursing scores end in '2.' If you don't find any, your facility is either incredibly pleasant and soothing, or you're leaving upwards of $35 Medicare/day on the table; our advice is to pick them up," Zimmet and Fidele say.

The NTA component may not have been very effectively captured on the MDS, they say, but add that errors and omissions are already being corrected. While the Zimmet and Fidele analysis is mostly focused on reimbursement outright, the relative invisibility of NTA in their analysis suggests that there's a discrepancy between what CMS understands to be going on in nursing facility resident populations and what nurse assessment coordinators and other MDS professionals are capturing on the MDS itself.

Bottom line: Look at your Nursing numbers if your facility isn't receiving the reimbursement you expected. Zimmet and Fidele zeroed in on that category as the main difference in how facilities accrued reimbursement: "... we see the Nursing Component is clearly driving the separation between high performers and the bottom with a 35.1% spread. Nursing is especially relevant due to scale and absence of day-weight adjustment."

Resource: Read the whole report for more information on how Zimmet and Fidele analyzed the numbers and what their results show at www.zcoreanalytics.com/wp-content/uploads/2019/11/PDPM-Reimbursement-Analysis-2019.pdf.