PDPM FOR MEDICAL DIRECTORS

Why change is necessary

A WHITE PAPER

Dr. Steven Buslovich, MD, MSHCPM
Margaret Sayers, GNP, MS

EXECUTIVE SUMMARY

There are many challenges facing healthcare professionals and organizations caring for the older and chronically ill population in the U.S. today. The new Patient Driven Payment Model (PDPM), scheduled for implementation on October 1, 2019, is the most recent challenge and its impact will be felt by all professionals providing short-stay skilled services under Medicare Part A. The medical director has a significant role to play in leading the facility from today’s model of care and reimbursement to changes required under PDPM. While many aspects of quality measurement remain unchanged—e.g. hospital readmissions, length of stay, 5-star outcomes—under PDPM the assessment, communication, and documentation processes required to determine reimbursement will change for all disciplines.

The medical director in the nursing home today is an important member of its healthcare team, expected to be a leader with clinical and administrative knowledge and have responsibility for coordinating care and developing policies that lead to the provision of excellent care. In 2011 AMDA – The Society for Post-Acute and Long-Term Care Medicine (then known as the American Medical Directors Association) delineated the major roles and functions of the medical director and while all represent their vital part in the nursing home hierarchy, one function pertains to the current need to be educated and engaged in the implementation of PDPM in their facility: “Educated in federal and state regulations and economic factors impacting patient care”.¹

PDPM is complicated and the rules put forth by the Centers for Medicare & Medicaid Services (CMS) change periodically. The CMS website can overwhelm with a plethora of guidance and spreadsheets. Since the medical director is the lynchpin of clinical care in their facility this white paper will focus on PDPM’s impact on their responsibilities. The objectives of this white paper are to: 1) Present an overview of PDPM and its impact on the role of medical directors; 2) Explain the role of clinical complexity in reimbursement and the concept of frailty measurement as an evidence-based approach to predict clinical complexity; and 3) Present innovative software to guide medical directors as they begin to incorporate PDPM changes into their practice.

¹The Nursing Home Medical Director: Leader and Manager (AMDA White Paper A11), March 2011.
**PDPM OVERVIEW**

“To survive, and flourish, it is critically important to understand the nature of the changes impacting the (SNF) sector today. Failure to do so, particularly with the major disruption that is now just beginning to take hold, will likely result in some operators going out of business.”

Robert Kramer, *Provider*, November 2018

Kramer is referring to PDPM, a reimbursement model designed to disrupt the status quo, to improve resource allocation, and to provide more reimbursement to facilities treating vulnerable populations in the Medicare Part A, Short-Stay population. An additional goal is to curb the increasing costs of care for Medicare Part A, costs driven primarily by therapy minutes and not always supported by medical necessity. PDPM is designed to reward facilities caring for clinically complex patients, irrespective of the patient’s therapy needs.

PDPM was developed after multiple other reimbursement plan changes failed to curb the costs of care for this population, or to recognize the value of caring for the clinically complex patients who may be too ill or cognitively impaired to benefit from extensive rehab. The full spectrum of services provided in post-acute care will now be considered in calculating the PDPM per diem rate. In the RUGs model, therapy minutes drove the reimbursement rates and many facilities reported minutes of therapy not always based on clinical judgment, but rather as a driver of reimbursement.

*Two facts about PDPM must be noted and underscored: Under PDPM, reimbursement is driven by Patient Characteristics and ICD-10 Codes.*

It is wrongly assumed that clinical complexity results from specific ICD-10 codes for diagnosis, cognitive status and functional ability. While each of these contribute to clinical complexity, there are other contributing factors. These aren’t inherently known from medical diagnoses, yet impact patient outcomes, quality of life, and potential per diem reimbursement rates. To date no practical tools have been available to assess for clinical complexity, creating a stumbling block for all professionals. Under PDPM identifying patients at risk for extensive resource consumption is key to improving outcomes and optimizing resource use.

PDPM per diem rates are calculated from the admission 5-day Minimum Data Set (MDS), due by day 8 of the stay. All members of the multidisciplinary team have assessments to complete, communicate, and document to capture all the characteristics of the patient that will drive reimbursement. Without comprehensive and precise assessments, done in the required timeframe, reimbursement dollars will be left on the table and the facility will not thrive.

The per diem rate may be changed during the Medicare A stay if an Interim Payment
Assessment (IPA) is completed. An IPA might be completed if the Admission MDS did not capture the most accurate ICD-10 for the primary diagnosis. The IPA is most appropriate for a significant change of condition. Under PDPM the change in condition must impact at least one of the 1st tier diagnoses classifications and the condition cannot be reversible within 14 days. An IPA is NOT done for change in therapy minutes, or for missed diagnoses not captured on the 5-day MDS.

Aside from the Admission MDS and possible IPA MDS the only other MDS for a Medicare A short-stay patient will be completed upon discharge. This means that it is likely that the PDPM per diem rate will be set based on one MDS. To the engaged medical director, this means that their role is to assure that ICD-10 codes are accurate and documented in a timely manner so the required multidisciplinary assessments are accurately completed in the required timeframe. Being in a leadership role, it will be of great importance to assure that all clinicians under the medical director’s direction are aware of the PDPM requirements and fully engaged in the process of assessment, communication and documentation.

**PDPM AND THE MEDICAL DIRECTOR - SUMMARY**

1. Accurate ICD-10 codes are a must
2. State licensed medical provider’s responsibility
3. MDS nurses NOT trained coders
4. Timely admission assessments required
5. Capture all patient characteristics
6. Understand “clinical complexity”
7. Evaluate for depression, delirium, cognition
8. Educate all clinicians on PDPM expectations
9. Increase communication with all disciplines
10. Monitor levels of therapy provided

There continues to be a wide variation in medical director involvement in nursing home care, from the once a week or less “drive-by” visit to the provider with daily interactions with patients, families, and staff. Under the requirements of PDPM every medical director should expect to change their practice. Some will need to increase their hours, others must change their communication and documentation, still others require PDPM education. Every medical director needs to adapt to PDPM; how do you improve clinical care for the patients, optimize reimbursement for the facility, and thrive as a medical director caring for frail, clinically complex patients?

This is no small task and may in fact be discouraging or overwhelming.
PDPM COMPLEXITY OF CARE AND FRAILTY

PDPM is designed to compensate facilities for their Medicare Part A short-stay patients based on complexity of care rather than on therapy minutes. The assumptions surrounding clinical complexity, made by CMS, designer of PDPM, are that diagnoses and function, the key drivers of reimbursement, are descriptive and predictive of clinical complexity. As clinicians we know that specific diagnoses and functional decline impact the clinical care needs of the patient but do not reflect the full scope of the patient’s vulnerability, risk for bad outcomes and increasing complexity of care.

The risk metric better suited to predict clinical complexity is frailty. A frailty risk score is blind to diagnosis and instead relies on data points from multiple cross-system variables: function, cognition, motivation, nutrition, ADLs, IADLs, balance, strength, polypharmacy, etc. These are a few of the variables assessed in a comprehensive geriatric assessment and used to generate the frailty risk score. This risk-based score predicts clinical complexity and increased nursing services and supports the communication and documentation requirements under PDPM.

Frailty is a clinical syndrome of losses across multiple body systems; as frailty increases so does the risk for bad outcomes like falls, weight loss, skin breakdown, etc. The outcomes we all want to avoid are often unavoidable in the very frail patient. Frailty is the result of the natural aging process, the accumulation of chronic illnesses, and the loss of function and/or cognition. So, frailty is a good marker for clinical complexity and predicting nursing needs in the post-acute care patient.

But there are concerns within the medical community. The lack of clinical risk assessment tools available for clinicians managing patients with multiple diagnoses and frailty inhibits their ability to predict clinical complexity and nursing care needs, both drivers of reimbursement. Neither can be accurately predicted from a diagnosis alone yet ICD-10 coding will drive reimbursement.

These concerns are legitimate and will be addressed over time by education and engagement of those providing post-acute care across settings. Our focus is on the frailest patients receiving their care in the nursing home setting. Obvious cases of frailty are easy to detect, but more subtle functional deficits, especially when dementia is present, require careful discovery that includes gathering collateral information and using standardized screening tools.2

2 McGregor M, Krishner-Kow J. Why don’t doctors screen more for frailty? Healthy Debate.ca, University of British Columbia, Canada, May 25, 2016
Time is a scarce commodity and for the busy medical director mastering the details of a complicated insurance model is not a priority. For the sake of geriatric medicine and the care of our most vulnerable patients all clinicians must consider how to change some of their practices and still survive.

**PDPM REQUIRES SOFTWARE SOLUTIONS FOR MEDICAL DIRECTORS**

Health information technology (HIT) has the potential to bridge the gap between the challenges in the current medical director role and the culture change needed to improve the quality, accuracy, and efficiency of providing patient care and capturing reimbursement dollars under PDPM.

PDPM is intended to improve resource allocation and to provide more reimbursement to facilities treating vulnerable populations. PDPM determines payment based primarily on the ICD-10 code for the primary diagnosis; while having the most accurate ICD-10 code is important it is not always easy to obtain from the hospital discharge papers and it is not the equivalent of clinical complexity. A common misconception in the industry is that hospital discharge ICD-10 codes are accurate, comprehensive, and the best source for PDPM documentation requirements. The truth, which most medical directors are keenly aware of, though the facilities' and administrators aren’t, is that those diagnoses are often outdated, irrelevant for their SNF stay and inadequate for purposes of PDPM. Per regulation, only active diagnoses in the past seven days are appropriate to be used for PDPM coding. The only way to determine which are “active” is to rely on the attending practitioner evaluating and treating that patient at the facility. Additionally, the primary diagnosis is not the primary reason why the practitioner is seeing the patient; it is the primary diagnosis for their skilled admission, which is often incongruent to the hospital’s primary diagnoses for their hospital stay. This misalignment creates significant compliance risk in the industry, where facilities need to be closely collaborating with their medical staff to assure accuracy, alignment and consistency of the ICD-10 documentation from the practice provider to the facility MDS.

While the documentation and timeliness of the visits pose substantial challenges, the greatest challenge remains the ability to predict and manage clinical outcomes. The likelihood for facilities to become insolvent will drastically increase this year given all the financial and regulatory changes. If SNF facilities cannot yield optimal clinical outcomes, their referral sources may dry up and litigation costs may create an environment that can lead to their demise. To remain viable in the coming tsunami of change, SNF facilities, under the leadership of their medical directors, need to drive the best possible outcomes and establish stronger relationships with the hospitals and communities they serve.

For determining clinical complexity and predicting nursing care needs another measure is beneficial to identify risk for decline and complications. The best measure of risk and
vulnerability to poor outcomes is found in measuring frailty.\(^3\)

In order to meet these challenges and not only succeed, but exceed, state-of-art technology and innovation are required. Dated software will need to be replaced and new software options thoroughly vetted to assure they are incorporating PDPM-ready guidance, directing users in every discipline on best practices of care, including completeness and accuracy in documentation. Without this there is potential for poor outcomes, and significant risk that reimbursement dollars are left on the table. From pre-admission screening, thru MDS completion, and to every subsequent entry in the patient's record—accuracy and completeness are required.

The more comprehensive and complete the data the more accurate and useful will be the calculated scores.

This type of support will benefit medical directors by guiding each discipline in accurate, comprehensive, and timely completion of their required assessment.

Every medical director has many responsibilities already but under PDPM there will be a higher expectation for their involvement in admissions assessments, communications with all disciplines, and engagement in every aspect of PDPM optimization. There will be no more hours in their days and patients will continue to arrive quicker and sicker. For the medical director to survive and the facility to remain vital, changes will be required. Software solutions and other technologies can make a difference, though facility-based electronic health records are not focusing on the workflow and needs of the medical team.

\[\text{Only with a radical rethink of health systems, underpinned by technology-enabled care, can we achieve responsive and resilient health systems to thwart new challenges and generate value for more and value for many.}\]

\(^3\) Gill TM, et al. Trajectories of disability in the last year of life. NJM Apr 2010; 62(13)

\(^4\) Atun R. The National Health Service: value for money, value for many. Lancet 2015; 385: 917-918.