PDPM Playbook

Stage 5: Operationalize

Stage 5 is about maintaining the benefits made with the changes implemented throughout this journey. The focus is to remain compliant with PDPM in 2019 and to master these new processes in preparation for the eventual retirement of RUGS III and IV. In the future, more payors will be affected by this process and you need to be prepared. Now is the time to right-size these changes and scale them across your organization to get the right fit and outcomes for you.

This means that your journey doesn't end October 1, 2019. However, it also means that the path will become easier to navigate once you have the right tools and technology in place to support your people. Standardization of processes and practices builds in consistency, predictable outcomes, better insights, and promotes better care from staff. The focus now needs to be on monitoring progress and actioning insights, to make sure your hard work pays off moving forward.

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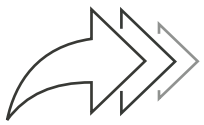
The most important part of this journey will be a successful transition of payment assessments from RUGs to PDPM in order for you to continue to be reimbursed for care and services. Remember that presumption of care carries over form RUGs to PDPM, and that the variable adjustments for PT/OT and NTA will start countdowns on the stipulated ARD of the assessment. Since the NTAs will pay out at the 300% rate for those first 3 days, make sure that a thorough review of conditions and diseases has been carried out in order to maximize the reimbursement during the transition period.

Transition Successfully to PDPM



Now that PDPM is in full effect, make sure that codinprocesses and tools are supporting PDPM

Ensure all residents have a comprehensive diagnosis list review in the context of PDPM

- Does the primary diagnosis map to a clinical category under PDPM?
- Are all NTA co-morbidities and conditions captured in the record for documentation on that initial IPA?
- Has the updated list been reviewed by the physician?

Has a transition plan for the completion of all Interim Payment Assessments been reviewed? The ARD needs to be completed between October 1 and October 7 but the completion time-frames follow the regular MDS process (ARD to completion date = 14 days, Completion Date to Submission = 14 days.)

- The plan should spread the work out so that it can be completed in a timely manner.
- Have a process for tracking ARD to completion (leverage technology for the transition scheduling)

Make sure office is prepared and resourced appropriately for the transition period.

- Payers must be updated with the correct rate templates.
- Effective dates must be correctly set for the transition.

Educate families and residents to the change in process.

- The cadence of assessments and type will change as well as the types of questions you may ask under PDPM — families and residents should understand why the changes are occurring.

Make sure the billing office is prepared and resourced appropriately for the transition period.

Now that PDPM is in full effect, make sure that coding processes and tools are supporting PDPM as intended and that MDS coordinators are comfortable with the processes and any new tools and functionality that takes effect as of October 1, 2019.

Monitor and Audit MDS With the New PDPM Rules.

Triple check your triple checks to ensure items are not missed.

Is it complete, accurate, and reflective of client needs?

- All of the updated MDS fields are in place, however we need to confirm that the processes still work with the actual tool.
- Do some chart reviews, transition volume is a great opportunity to get some additional data through audits and ensure the right data is getting captured at the right time.
- Does the care plan meet clients need and co-morbidities? Care Planning tags were up after the implementation of the ROP changes in 2016, and there will be additional scrutiny with surveys after the transition to PDPM.
- Make sure that other processes have not been disrupted — Medicaid and other payors that are not on PDPM still need to have their assessment schedules maintained during the focus on the transition.

Ability to bill for PDPM score and submit a clean claim

- During transition, ensure resources are present for any additional workload required.
- Report problems to vendors immediately
- Triple check your triple checks to ensure items are not missed.
- Ensure there isn't any disruption in the claims processed for on-PDPM payors.

Your success is dependent on the whole team following the standardized processes consistently and using the tools appropriately. Reviewing tools and processes to ensure outcomes are being achieved is not a one-time event. Oversight on care management needs to be a part of the business of care. Improving quality of care improves the quality of life of your residents, thus, you must ensure that gains made are maintained and become a part of the care process.

Monitor Care Delivery

Are staff following the standardized protocols?

- Are the tools used working?
- Is care content meeting the needs of clients and enabling compliance with regulations for survey?
- A new technologies are enabling teams to help the organization achieve goals?
- New technologies are improving care processes and helping staff to complete their tasks, not hindering processes?

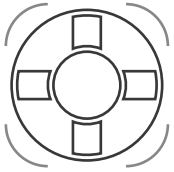
Are resident outcomes predictable and being achieved?

- Is the care content, systems, and processes leading to better insights for better care planning?
- Are the outcomes being achieved?
- Personalization of client preferences, strengths, and needs is easily accomplished in the standardized care plan and approaches to care.

CMS has stated that it will be looking to audit where there are extreme changes in the utilization of therapy minutes, where there has been a significant change to the overall reimbursement to the facility, or where a home has significantly exceeded national averages for reimbursement (outliers).

Ensure You Can Survive an Audit Without Claw Backs

Getting through PDPM doesn't end on October 1st — the process of getting assessments completed, claims submitted, and appropriate reimbursement received will continue past that date. Also, you must remember that shortly after the implementation, the reimbursement audits will start. CMS has stated that it will be looking to audit where there are extreme changes in the utilization of therapy minutes, where there has been a significant change to the overall reimbursement to the facility, or where a home has significantly exceeded national averages for reimbursement (outliers). The key to not losing money is in your concise and easy to find supportive documentation in the resident's records and clearly documented changes to resident population (Facility Assessment and QAPI programs will support these audits).



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- Audit to confirm that the correct information is received in a timely manner from the hospital to complete the MDS with the most accurate and comprehensive information.
- Audit to confirm that the correct supportive documentation has been recorded in a timely manner.


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audits will start.

October 1, 2019 sets a target for Medicare A reimbursement, but CMS will eventually retire RUGS III and IV payment models, which means that all payors will soon be making a change to reimbursement methodology. Don’t forget to ensure staff are aware when additional changes will be made to the different state and insurance payment models as technology setup changes may need to be made. Keep in mind, other process changes may need to be made and disruptions in reimbursement must be avoided.

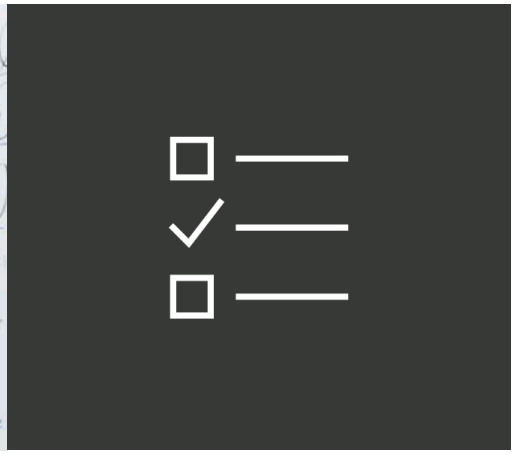
Scale Approaches For All Payors

Continue to monitor for when other payors will be changing model (RUG III and IV will be supported through October 1, 2020 but no further timelines have been provided. Understanding what state and insurances will do and when will affect the next plan)

- Understand impact on financial software and timelines for implementation to ensure setup changes and process changes can be implemented at the right time.
- Establish plans tied to those timeframes and ensure consistent communication and implementation across the organization.

Keep monitoring for compliance and apply lessons learned across the entire resident population.

- Quality doesn't happen overnight, and it isn't a one-time effort – make sure it is implemented throughout your quality improvement plans.



Conclusion

Your journey to PDPM is coming to a close, there's still work to do, but it gets easier from here. For now, let's focus on ensuring all the hard work you've done so far continues to pay off, starting with selecting the right residents and leveraging your new processes and workflows.

Eligibility Verification

Navigating the reimbursement rules associated with PDPM can be a time-consuming, frustrating endeavor with high stakes attached. With Eligibility Verification, the bottom-line protection process of insurance coverage checking of both existing and potential residents can be streamlined for greater efficiency and accuracy. Your revenue stream will no longer be interrupted by gaps in resident insurance coverage.

LET'S START OPERATIONALIZING!

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