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MDS Alert

PDPM Spotlight: Beware: Reimbursement May be Driving Workforce Decisions

There may be cause to anticipate a course "correction" as PDPM effects become apparent.

Skilled nursing facility staff across the country spent any spare time in the past year preparing for the Patient-Driven Payment Model (PDPM) and the accompanying changes to the assessment schedule for Medicare Part A patients - and the changes in facility reimbursement.

The changes inherent in the shift to PDPM were so immense that facility administrators, industry consultants, and MDS nurses (and everyone in between) had trouble predicting how the changes would affect day-to-day operations, as well as the bigger picture surrounding the delivery of care and its costs. Many facilities bet that the fewer assessments required by PDPM would mean less work, and that the switch from reimbursement being tied to therapy services would require fewer physical and occupational therapists.

If you've noticed that there seems to be the same work but fewer people to do it, you're not imagining things. Many people working in the long-term care industry have lost their jobs, with corporations or individual facilities either letting people go in one swoop at midnight on Sept. 30, 2019, or deciding not to fill open positions over the year, says **Kris Mastrangelo**, president and CEO of **Harmony Healthcare International** in Topsfield, Massachusetts.

Understand How Assessments are Affected

One major "bonus" touted of PDPM was that it would be less work, because it requires fewer assessments. In the most recent iteration of the Resource Utilization Groups (RUG-IV) system, MDS nurses or nurse assessment coordinators (NACs) needed to fill out a five-day assessment, a 14-day assessment, a 30-day assessment, a 60-day assessment, and a 90-day assessment.

However, nationally, the average length of stay is 21 days, Mastrangelo says. So even though the Centers for Medicare & Medicaid Services (CMS) eliminated the 14-, 30-, 60-, and 90-day assessments with PDPM, the average length of stay means only one assessment is removed.

"Surprisingly, the feedback is that the new PDPM system has not decreased the paperwork associated with MDS completion. In fact, it is taking the healthcare professionals more time to complete the MDSs because one assessment drives the payment for the entire Medicare stay," she says.

Harmony Healthcare International estimates that the MDS completion time historically took 2.5 to 3.0 hours per assessment. "Under the new PDPM system, the MDS completion time increased to approximately 5 hours per assessment. Some of this increased time is related to the need for more attention for the accurate coding of ICD-10 codes and the function score," she explains.

Beware of Role Juggling

Some companies sought to drastically reduce their therapy staff, believing that because CMS was no longer basing payment on therapy service hours alone, therapists were suddenly redundant. This may seem like a logical effect, but some organizations also eliminated nursing positions with the advent of PDPM, including roles responsible for assessments.

Some organizations switched full-time roles with benefits to per diem or part-time work, which shifts the numbers around, in terms of optics and uses fewer resources, but does not necessarily affect the actual workforce. Other

organizations are utilizing part-time and per diem staff less, if at all, Mastrangelo says.

Many of the decisions surrounding staffing and PDPM seem to include unilateral directives on service delivery, she adds.

The therapy and nursing staff adjustments beg the question: Is providing residents with the services and care they require the driving force behind staffing decisions across the long-term care industry? Resident needs aren't tied to final rules, reimbursement, or regulations, so a sudden switch of policy shouldn't, in theory, dictate staffing or services or care, in practice.

Reporting from The New York Times - and anonymous comments from SNF staff on the article - suggests that therapists are being hamstrung from making clinically appropriate decisions for residents' therapy by their organizations' focus on cost and reimbursement, to the residents' detriment.

One anonymous commenter, a therapist who says they hid their name and state so as not to get fired, describes concurrent or group therapy as analogous to "concurrent or group massage" and that conducting physical therapy in such a setting and acting as though piecemeal or scattered service is clinically useful for the resident is a "a total sham."

Another anonymous commenter describes how therapists are now instructed to maximize their productivity, which is leading to a lot of time catching up on documentation and paperwork after hours, off the clock.

When looking at salaried therapists who aren't necessarily paid for hours worked, the effects of PDPM on actual labor in SNFs may not be fully apparent.

Avoid Kneejerk Reactions

Beware of making big decisions that will impact your organization's day-to-day business, as well as its reputation, out of fear instead of a careful analysis of the data. With so much still not fully understood about PDPM's effects on rates and reimbursement, making major, lasting staffing changes may be tough on your residents' well-being and your organization's reputation.

The bottom line: "PDPM is far more complicated than the prior RUGS reimbursement system. Facility staff require on-site education, training, and support," Mastrangelo says.