PDPM Five Months In

Michael Torgan:

I'll go ahead and get started. I'd like to welcome everyone, talk a little bit about PDPM: Five Months In. I'm sure everybody's had some fun with it. My name is Michael Torgan. I'm a 30-year veteran in the healthcare post acute care space and ran one of the largest skilled nursing operations for about 10 years. I'm currently the chief operating officer for a company called Bespoke Healthcare Management which is a physician led and owned integrated healthcare delivery system from hospital, clinical trials, hospitalists program, IPA, physician IPA, hospice, home health.

Michael Torgan:

So I'm getting to see both sides of the world. I'd like to introduce our distinguished guests today. I'm going to start here on my immediate left. Steven Littlehale, I refer to him as the skilled nursing quality indicator savant. And I mean that sincerely. I've known Steve for over 20 years and he continues to impress me on everything that he does. He's a chief innovation officer at Zimmet Healthcare Services Group and chief clinical officer emeritus at PointRight. I'm still trying to figure out what that is, but we'll talk later.

Michael Torgan:

He's an internationally renowned author, speaker on a broad range of healthcare and post acute care topics. Steven's ability to synthesize complex information into strategic and tactical excellence has been the hallmark of his career. Steve has numerous publications including a popular monthly blog and McKnight's Long-Term Care News. If you're not subscribing to that, I suggest you do. It is truly outstanding. He's began his career spanning more than 30 years ranging from direct nursing to education, research and consulting. He has a BS in nursing from the University of Vermont and an MS in nursing from Georgetown University. He's a board-certified gerontological clinical specialist whose greatest professional joy is to celebrate those who share his passion for quality in US nursing homes.

Michael Torgan:

To his left, I'd like to introduce Dava Ashley. She is the president of Covenant Care. Covenant Care operates 38 skilled nursing facilities and four assisted living facilities in three states. Covenant Care also owns and operates Elevate Home Health and Affirma therapy company. It operated one of the largest Model 3 bundle payment programs. Dava started as a licensed nursing home administrator and she has more than three decades of progressive, responsible, and diverse experience leading people and resources to navigate through the many challenges and changes in healthcare industry. Dava received her bachelor from Southern Illinois University and earned her MBA in healthcare administration. She serves on numerous boards including the Evans Foundation and SEIU Education and Training Trust.

Michael Torgan:

To her left, I'd like to introduce Luann Gutierrez. She's the managing director for Greystone Healthcare Team on the portfolio lending group Bridge Financing to FHA, HUD, Fannie Mae and Freddie Mac permanent financing where she has worked for 13 years. The team has closed 5.5 billion in loans since fiscal year 2004 with 4.9 billion since fiscal year 2012. Miss Gutierrez previously served as vice president and senior healthcare underwriter at GMAC Commercial Mortgage for eight years and under wrote over a billion dollars in healthcare and/or senior housing loans. Prior to GMACCM, Miss Gutierrez spent nine years at Bank One holding various roles in commercial lending section including managing 250 billion in mortgage finance portfolio. She's a graduate of the University of Texas, Hook 'em Horns in Dallas with a BSBA in accounting.

Michael Torgan:

So PDM is here. We're five months into the process. Our goal of this session is to dive as deep as possible for one can with only five months into the process to review the results and the potential impact. We want to cover the impact on reimbursement and what might this say for how CMS will respond in light of what they did under RUGS IV. We want to be able to shed light on the impact on therapy services and how might CMS abuse this in light of their pre-identified concerns about reduction in therapy services especially with significant changes in group and concurrent therapy and what impact has there been on quality outcomes in the light of these changes.

Michael Torgan:

We want to review and discuss facility operations especially a new focus on ICD-10 coding and patient centric care. My battery just died so we go to the backup copy. Always be prepared, and it being a patient care centric. We also want to review the developing concerns in light of the optimism and what should we be really paying attention to that we might be overlooking around quality and overall impact on valuations to the healthcare industry, senior care industry. So with that, I'm going to turn it over to Steve and he's going to lead us on initial journey with his discussion and overview on what they have found at this time.

Steven Littlehale:

Terrific. Thank you very much, Michael and welcome everyone. Thank you for being here. This has been a really fascinating panel to prep for, for a couple of reasons. One, I absolutely adore my panelists that I'm working with. They bring something different to the table and it's really wonderful to be able to talk about PDPM but have such different perspectives to try to... And then turn to you and help you have the perspective that you're looking for. So that's been really helpful for me. It helps me think differently and helps me grow and I'm grateful for that and thank you to Nick for having this session.

Steven Littlehale:

I'm going to stand up because I can. PDPM five months in, it's really quite fascinating because when we began this journey of PDPM, of course it was called something different. At the time it was called RCS1. But really for over 10 years, 15 years, 18 years, there has been a lot of noise particularly coming from MedPAC to change the prior system, to change the RUG system to something different, and MedPAC has never really let up on that. They believed that the RUG system was really motivating the wrong behavior and they were right.

Steven Littlehale:

It was motivating quantity and not quality. And what happened is we, the industry followed the guidelines of that reimbursement system so much so that I think we really lost sense of the patient or the resident that we were caring for. So now PDPM has been implemented and as Michael said we're five months in, but MedPAC hasn't stopped yet and nor will they ever stop. That's their job. MedPAC is already talking about the next payment reform that's going to happen to our space, and that's not new news, although you might be saying to yourself we're only five months in and we're talking about payment reform.

Steven Littlehale:

If you go back to the Impact Act of 2014, it's all laid out. We're ultimately heading towards site neutral reimbursement and that'll happen probably around 2024. So this PDPM is a stepping stone to fulfilling

what is in the Impact Act and we might be able to share a little bit more about that in today's session But what I'm sharing with you on the slide now kind of makes me laugh. Now we all know that ink is expensive and the media is trying to sell headlines, but here we have pre PDPM where we're talking about costly rehab for the dying person in skilled nursing. How much money we were spending on rehab.

Steven Littlehale:

So that's the old system. That's the RUG world. And then PDPM was implemented and the headline becomes about how we're slashing the utilization of therapy. So there is no winning of course back to this statement that ink is expensive. There is no winning in this tug of war, but I just thought it was a really interesting place to begin the conversation. So for those of you who have never heard PDPM, let's do a big PDPM shout out for them. What does PDPM stand for?

Michael Torgan:

Patient driven payment model.

Steven Littlehale:

Patient driven payment model, not please don't pester me. It's patient driven payment model and it's the first time ever in an acronym does CMS actually acknowledge the fact that skilled nursing is caring for patients and not residents and I thought that was incredibly important to see that in print. PDPM is really separate sub mini reimbursement strategies all rolled into one component score. The only thing that is really not a variable component in the reimbursement is the CBSA. Everything else is independent. You can have a great reimbursement in one category and not so much in the other.

Steven Littlehale:

You have to really get into every single component of the score to really see how you're doing from a reimbursement perspective. You put it all together, you get a composite score and that is what reimbursement is all about. Okay. So everyone good with that so far? All right. So one of the important things that I think PDPM is highlighting for me is that Medicare fee-for-service reimbursement is only one itty-bitty tiny component when you're looking at reimbursement for skilled nursing. It is that one piece of the puzzle and it's a dwindling piece of the puzzle at that. So what do I mean by that?

Steven Littlehale:

When you look at Medicare Advantage penetration across the United States. The average is we heard earlier, 35%. We also know that many states have really embraced alternative payment models, or many parts of many states have embraced Alternative Payment Models, APMs that was all something that came out of Obamacare. APMs are really pulling away from. So that's another piece that's coming out of the Medicare fee-for-service reimbursement. Then we have other state regulations, SNF alternatives, people being pushed back into the community, et cetera, et cetera. So just looking at PDPM is really only getting a slight sliver of what's happening in skilled nursing.

Steven Littlehale:

The other point I wanted to make on this slide is that in the old days meaning pre PDPM, it was very easy to talk about an average per diem and to kind of have a really good sense of what was going on comparing one facility or one portfolio to another facility or another portfolio simply by answering the question what is your average per diem. PDPM makes that impossible to do and the reason why it

makes it impossible to do is that PDPM is front-loaded. It's the simplest way of saying it. It's front-loaded so when facilities have a tremendous, "Wow, your Medicare PDPM reimbursement per diem is so high," chances are they have a really short length of stay, and that's why it appears so high.

Steven Littlehale:

If you have the average length of stay that MedPAC describes closer to 25 days, you'll see a very different number. But facilities having short lengths of stay, maybe they're part of an ACO and their length of stay is around 15 days, their average Medicare reimbursement is going to look amazing and you'll get all excited, but you're kind of chasing the wrong metric there. The ACOs don't really understand that though.

Steven Littlehale:

In fact, we had a recent experience where an ACO said to their facilities in their preferred network, you really need to adopt this separate software to help track to help our care coordination and the skilled nursing said, "Are you kidding me? That is so expensive. I've done everything you told me to. I reduced my length of stay. I've reduced my rehospitalization rate. This is costing me a lot of money and you want me to adopt this expensive software." And the ACOs retort back was pre PDPM, your reimbursement rate was X and now it is X plus 15%. What are you complaining about? And they said, "Yes, but my length of stay is so much shorter," and again the metric is being so much influenced by the front loading of PDPM.

Steven Littlehale:

So please do keep that in mind when you're giving consideration to PDPM and how your portfolio is doing. Back to Medicare Advantage in APMs. So here on the left hand side you can see... I'm reminded that, yes indeed, I think I gave the wrong percentage. Did I say 25 or 35 for?

Dava Ashley:

You said 35.

Steven Littlehale:

Oh, I did say 35.

Dava Ashley:

Yeah.

Steven Littlehale:

Okay. Wow. So the nation is at 35%, but I was chatting earlier with Dava and she said to me the national rate is 35% and I said, "No, no, Dava. It's 37%." And then two seconds later, I'm like, "Oh, no. That's the wrong number." Why was I getting confused is because when we do advisory work at Zimmet Healthcare, I'm constantly looking at local factors in healthcare. National trends are completely meaningless. So when you look at California for example to follow this through, you can see that the density of managed care is much greater than in the United States.

Steven Littlehale:

So I'll go back to Dava and ask her so what is the California average?

Dava Ashley:

We're around 40%.

Steven Littlehale:

So California is around 40%. National average is 35. But what is even more interesting in California as an example is that the 1 million beneficiaries that just became beneficiaries in 2019, 1 million new beneficiaries 51.5% of them elected a managed care product in deferred fee-for-service. So it's not only thinking what is the actual penetration of NA in a state, but what is the velocity of growth in that state. All those things become very important into understanding what's going on in that marketplace. And on the right-hand side, when you're looking at standardized Medicare post-acute per capita change, you can look at this cutout and you can see, well, what's going on in Pittsburgh minus 19% and then you look at West Virginia and its plus 12%.

Steven Littlehale:

That's just a reflection of the adoption of these alternative payment models. There's a lot of APM's happening in Pittsburgh versus West Virginia. So that's going to make numbers like your Medicare per capita spend look completely different. So healthcare is local. There's so much nuance going on and ultimately PDPM is a dwindling piece of the puzzle and that's what all those slides were about. So let's talk only now about PDPM. This data is coming from core analytics. What we're doing our core analytics is we're pulling in UB data from over a thousand facilities across the United States. We're scrubbing that data before it leaves the building, before it goes out to the fiscal intermediaries for reimbursement.

Steven Littlehale:

We're analyzing that data and this is where these rates are coming from. We're also identifying opportunity and compliance issues within the data. All of the analysis is coming from that. So here you see those component scores that I told you we're all driving PDPM reimbursement. You can see comparing October, November, December that pretty much everything with the exception of PT/OT is heading up. Its increasing. Now CBSA doesn't change. It's not meant to change. Remember that was the fixed component. But everything else is variable and everything with... Well, even, no with the exception of PT/OT everything is increasing.

Steven Littlehale:

So that's a very important statement to hear. In the reimbursement rates, the average per diems, we're looking at about 11% increase over the RUG system overall. Now, the concept when PDPM was put in place, CMS declared 101 times over that it was going to be budget neutral. And in my blog on McKnight's, I declared that that was “beutral”, that that was absolutely bullthat this could possibly be neutral. And why did I say that is because simply CMS's analysis of neutrality came from provider data from 2017, and that data was reflective of coding practices from 2017, then the rules changed, and the MDS changed, and new items were added to the MDS.

Steven Littlehale:

So all of those factors meant that by the time it came time to play the game two years later, we had a different set of rules. Coding practices changed, et cetera and that there was no way that this was going to be neutral. So on the left hand side when we looked at CORE's database of facilities that are contributing UB data to us, you can see that when we did a same-store analysis, we found that CORE

SNFs that were expected to lose was 68.6%. So according to CMS, 68.6% of our database clients were going to lose in PDPM and 31 was going to gain.

Steven Littlehale:

Look to the other side of the screen. You can see in reality that 32.6 actually lost while 67.4 gained. So certainly if you're just looking at our clients, it is not a neutral game. And the other comment I'll make is when you talk to most people in the industry, they'll say, "It's up 5%, 6%". If you listen in on public earning calls, they'll talk about 5% and 6%. But many of those clients were the clients that were supposed to actually be negative in PDPM. They were the folks already speeding down the highway. They were really aggressive in the RUG system with therapy and therapy minutes. And on the PDPM if you just switched it over, they should have been the people that were bringing it down having a negative while others went up.

Steven Littlehale:

So when those folks are going from up to up. I think when all is said and done, we're going to see a much higher PDPM uptick than the 5 or 6% that we're hearing right now and our database alone is about 5.6%. Okay. So we could spend the rest of the day on this one slide but we're not going to and this is a lot of kind of PDPM gobbledygook, and I'll try to make the points as clear as could be.

Steven Littlehale:

So looking at speech and language pathology which is the upper left hand corner. If we were just looking at just that component score, you can see a couple of things. One the first circle on the top is that we have better capture. So the kinds of patients that we're caring for that have no issues identified or no care identified, that pool has gone down, simply better capture. Our patient population hasn't changed that much. People might like to say that but it's not true. People are still the same that we're caring for.

Steven Littlehale:

But the capture has gotten better. In that same upper left-hand corner, when you look at people who have both the comorbidities so I'm going to the very bottom, both where it says no ST on the UB, that's a little concerning and there's a couple of reasons that might be driving that. So these are folks that have swallowing disorders or mechanically altered diet, but it appears not on the MDS, but on the bill there's no indication that speech therapy is involved. So this brings a little concern.

Steven Littlehale:

Now, it's not an apples to apples comparison. This is the bottom line. Are we doing a better job at identifying the acuity, but are we then providing the care that is required based on that identification of acuity or are we simply not documenting it which this industry has a long history of doing. But the data is starting to show this pattern and it's great to capture the acuity but we have to be providing the care. You can see in the nursing components that the higher CMI components are actually increasing.

Steven Littlehale:

Look at special care high. We went from a 38.8% to a 41.1%. That is probably boiling down to a single element on the MDS that is being coded and better assessed. And again, the flip side is are we providing the care that goes along with checking that box on the MDS. Under NTAs, that's the far right hand corner. What I find amazing is that you can be in skilled nursing and still have about 20% of the

population with absolutely no NTAs coded. Why are they with us? It's almost an impossible condition. Chances are they are being coded in skilled nursing, they're just doing it improperly.

Steven Littlehale:

That's the, I'm sure as I'm standing here, response to that. You can't be getting skilled nursing without having some NTA, non-therapy ancillaries. You can see there's a considerable amount of growth when you're looking at six to eight points going from 8.8% up to 10.4.

Steven Littlehale:

Final slide, is that we do see that there's almost no sensitivity in the PT/OT component which means when CMS needs to make some tweaks better to start there because you can put anything down on the MDS and it's not going to really impact your PT/OT score. So that'll probably be where CMS will focus to add more sensitivity. Even though I'm giving you averages, there is still a huge variation between the upper and lower quartile. So there's room to grow. There is room for lots of movement within each of the components.

Steven Littlehale:

When we send out our 50 consultants into the field to validate what we're finding in the core database and in their PDPM claims, we're finding that there's plenty of care that is still not being documented. This has been the age old issue. We spend so much time documenting, we don't provide the care. Now, we're trying to provide the care and we have to catch up with the documentation.

Steven Littlehale:

We are finding instances where the care is not being delivered. The coding is not accurate. The definitions on the MDS, they're a moving target. We have a huge swath of MDS changes happening this October coming up and in definitional tweaks, those things are really hard to keep up with and I think that that's driving a lot of the confusion that we're seeing in the data.

Steven Littlehale:

Again, still under the category of missed opportunity. I'm giving you some guidelines here both from Core and from PointRight. You can see that when analyzing either the MDS data in the case of PointRight or the Core data, the UB data in the case of Core, we're still seeing that there in some instances are opportunity for improved capture particularly when you bump up the findings to what is in the literature for what this population should have in place in terms of depression and cognitive impairment. So there's the lay of the land, Michael.

Michael Torgan:

Thank you very much. Real informative, great place to start. PDPM has added a lot of complexity to an already complex environments. There's a lot of moving pieces to really grapple with in this and PDPM is not functioning in silo and really what I want to present to the panel to kind of start us off in discussion is what surprises have you seen that really haven't been brought to the forefront whether it's in reimbursement, rates versus revenue, whether it's in average length of stays, quality outcomes, documentation and what implications might you think it had for survey outcomes as you work through, as there's a higher concentration on patient centric models. So Dava, I want to start with you as an operator and of what your lens is and in response to it.

Dava Ashley:

First of all, I think CMS did get it right with PDPM. It's very much focused on the care of the patient and the clinical care of the patient versus therapy. So I, like other operators felt like that was a good thing. And so what we're seeing is the same as what Steven was talking about. Improvements in coding, improvements in really assessing the clinical comorbidities of the patient although we've always had to document. It wasn't always linked to reimbursement, but we've seen an improvement in the IDT mechanisms at our facility. I'll just speak for our facilities. Just that whole clinical team really focusing on what is the patient here for, what are the comorbidities. So I think that's been a really, really good thing for the industry.

Michael Torgan:

Luann?

Luann Gutierrez:

No, I would agree. I mean, I really don't have anything to disagree with. I'm looking at it from a lender perspective so we're not quite into the weeds as much as an operator would be, but I would agree. We have seen a decrease in the length of stay that he mentioned, we've definitely seen that we've seen the rise in the rates just like everyone has seen.

Michael Torgan:

Steve?

Steven Littlehale:

I think the big surprise was how well we did. I think that the industry was really well prepared for PDPM and hats off to all the operators in this room. I mean it was a huge effort in the industry really. This is a great success story. The other side from just looking at data, what the big surprise is how quickly compliance concerns are starting to be patented in the data. We're starting to see patterns of concern in the data that will become compliance issues. Now a compliance issue until you're actually peeling back and going on-site, it just may not even be a real authentic issue. It's just the data capture needs to catch up to the care being rendered or vice versa. But there's a lot of patterns we're seeing in the data.

Michael Torgan:

Just to follow up on that, Dava, have you seen anything where surveyors are using the PDPM model to kind of redirect their survey activities to Steve's point about compliance and what impact it might have on survey outcomes?

Dava Ashley:

We haven't seen any of that lately, but I think it's important to remember that really the needs of the patients we have to have the care plan that supports it. We have to have supporting documentation for the care that we're delivering. So I think we've been focused on that. We haven't seen the surveyors focus specifically on the PDPM piece.

Michael Torgan:

Okay. And to follow up on that Dava, what impact operationally have you seen, one of the biggest focus and biggest change from what you were doing as a day-to-day business function since the implementation?

Dava Ashley:

Well, for us it really wasn't a big change because the skill needs, the Medicare rules didn't really change. What we're going to skill the patient for, how care is delivered, we already and many operators too had patients with high acuity and clinical needs. So what we did see was the ability to capture the burden of care from a nursing perspective versus just therapy. So what we saw is really more of the therapists integrating more on the clinical side with our IDT team. So we saw that a lot. The strengthening of the interdisciplinary team. We saw more involvement with our physician groups to help us with comorbidities and making sure that we were properly identifying the patient centric needs, the care of the patient.

Steven Littlehale:

If I could add, when I've talked with operators and therapy groups nationally, there were folks who are doing it right which is what you just heard and there were folks who have changed their therapy contracts to basically mimic what the RUG system was doing and are now reimbursing therapists for every minute or reimbursing them off the component score for PT/OT and speech and language. So basically they've recreated the old world. That, I'll be very direct, is perpetuating yesterday's news. It's not the way to move forward. Integrating therapists into your IDT and not putting funky contractual restraints up is how we're going to achieve the best outcome possible as you have.

Dava Ashley:

And I just want to add on to that from the therapy piece because there's been a lot of press and news about the therapist. But at the end of the day the patients need therapy and it just depends. We left that and we should leave that care of the patient, what are the clinical needs up to the clinicians on that IDT and what is the amount of therapy that this patient needs to go home safely and to have a high quality outcome. So I think that's what CMS is looking for. They're looking for those outcomes that were still providing a high level of clinical quality to our patients and we're not having unintended consequences to our patients.

Michael Torgan:

So Steven and Dava to that point is CMS was very clear on their concerns on the rollout of PDPM specifically on the therapy component as they were saying on the budget neutral. And so can you go into a little bit more detail? We've heard from many of those in the industry who feel that there is not going to be a CMS response really and if they do it's going to be minimal as it was in RUGS when we had over an 11% change in adjustment. So if you could talk about the therapy and how might that influence and effect what CMS might do and what we should be concerned as a group that is focused on this line of business on how this plays out going forward? Steve, I can start with you.

Steven Littlehale:

Yeah, sure. I remember when PDPM was being implemented and people were saying, we have to be careful with this. We can't go out tomorrow and just slash therapy. And so the advice was to do it slowly and CMS won't notice. There are moments where I feel very proud to be in our industry and that was not one of them. Slow insipid trends are... They scream as much as a spike when you're looking at data in care

delivery. But as Dava was saying, our clients are coming to us for rehab. We sold them that for the last 25 years.

Steven Littlehale:

They weren't necessarily coming to us for excellent nursing care even though we're called nursing homes, they were coming to us for rehabilitation and most of them going home. So suddenly, it's the biggest bait and switch if then someone comes in the door and you don't give them therapy. It's a very losing proposition. I just don't believe that that's a national trend at all. I think we will see the rates go down, but they were inflated before so it'll be more appropriately managed, appropriately sourced to our residents and patients.

Steven Littlehale:

And the therapists outside of the physician is most often the most educated and oftentimes the most skilled person in the building. And to only allow them and only count them when they're putting someone in the parallel bars is such a disservice to our profession our organizations whether they're caring. They should be on the rehospitalization committee. They should be doing wound rounds with the interdisciplinary team and they should have a contract if you outsource instead of a contract that supports those kind of activities. Did I answer the question and then go over or did I not answer the question but went over?

Michael Torgan:

I want you to be a little bit more specific in terms of where you think therapy falls on how CMS views what's going on and what response should we be making to make sure that we don't get an unintended consequence as a result of it.

Steven Littlehale:

Okay. Since I don't believe that we're slashing and burning therapy and no therapy contract provider that I've spoken with said that their clients are. I don't think that that will be a concern that CMS will have to respond to. I think the implementation of the additional, sorry I'm geeking out, section GG measures that are going into effect in October are going to help CMS measure precisely what is going on of value in your organization under PDPM and I think that the clinical outcomes will ultimately be the judge and jury and guide CMS's hand in what they should do.

Steven Littlehale:

In my last blog I published last week was specifically talking about this issue like what does skilled nursing have to do to keep that money that we're earning intact and it is demonstrate better outcomes than we ever have before, and we have the tools to do that.

Michael Torgan:

So Luann, let me just pivot here a little bit. PDPM was in play, financing still needs to be done. How is your organization and other lenders looking at PDPM and its impact on financing and what you're doing on valuation and models?

Luann Gutierrez:

Well, I have to say that we are remaining cautiously optimistic. As has been stated here, the whole intent from CMS was for this to be budget neutral. And I know on our part because we have a book of business so on the homes that we actually have on our line, about 110, 120 we have yet to see any losers that we're going to have a decline. When you were showing your slide, I was like, "That's exactly what we're seeing because some of the loans from back when we were underwriting them, pre October 1st, we were showing that there were some homes that were going to have a slight decline so we were talking with the borrowers about that during the process and some of those aren't having that.

Luann Gutierrez:

So that's one of the concerns that we have is we're happy that there's some good positives here, but we are being very cautious about it because we're definitely taking... When we're looking at current performance, we're definitely taking a discount on October specifically because that one is just the odd spike. So we're looking at where the properties were historically where November, December and we're getting a few January numbers in now. We are looking at that to see kind of where is a median because I think one of the most disservices we could do would be over leverage of property right now. Really have an inflated value when I have to say I really think CMS is probably going to do something.

Luann Gutierrez:

I think they're going to reformulate the formula. They're going to do something to kind of level this out because it's just not sustainable with this many winners. So for us we're just trying to be careful that we don't over leverage and put the borrowers in a cash flow constraint either because if CMS does come back and make that correction, I don't want them to have more of a loan than they really can support with their ongoing cash flow.

Michael Torgan:

So Dava, when we talk about managed care, and I know that fits into this, some providers had contracts that were tied to RUGS, and how has managed care viewed PDPM through this process and what feedback have you gotten from those organizations?

Dava Ashley:

Well, I mean as everybody knows managed care didn't have to do anything with PDPM. They kind of got a pass to do that. So we saw a variety of things. We saw those that maybe we had a RUGS contract before that we're already thinking about moving to a leveled system do that. We saw others that said, "We're just going to keep it as it is," and they're just monitoring it. So it's really been kind of a mixed bag. We're not getting a lot of feedback from them. We've got a few that said, "Oh, we saw a little bit of an uptick in the rates, but I think they're still evaluating it just like I believe CMS is still looking at the data, looking at trying to get enough data to really make a good decision."

Michael Torgan:

So in Steve's presentation, there was a significant uptick in the per diem reimbursement and has that been able to give you some leverage to go back to the managed care organizations and kind of explain to them that the revenue model that they have gone off of is a little antiquated or a lot antiquated and here is the proof that we're now demonstrating in a much more accurate way than before around the cost of delivery of care?

Dava Ashley:

We've been doing that for a few years. Even before PDPM we've always tried to explain to our managed care partners the value proposition and really what kind of burden of care we are capturing and providing in the facilities. We have done that with PDPM, haven't been successful with that so far. I'm not sure if anybody has.

Michael Torgan:

So Steve, this is a question about kind of a means to the ends question. We have Impact Act that's still out there. We have home help that has had PDPM going to effect on January 1. We have site neutral that's coming into play in about three to four years and we have our own PDPM. A lot of acronyms in there, I apologize. Where do you think this ultimately leads on CMS's point of view and what you think eventually we need to be preparing for and using the PDPM path to really position ourselves appropriately in the site neutral component of care.

Steven Littlehale:

Sure. This shift to PDPM is definitely a very giant major step forward on value in quality over quantity. It's not however value-based purchasing. So very clearly it's not value based purchasing. There's many programs out there that are in our environment right now that is value-based purchasing. In skilled nursing it is solely focused on rehospitalization rates as an example, your VBP and some would argue it doesn't have a big enough teeth to make a difference.

Steven Littlehale:

But PDPM is definitely a very giant step forward on getting us to quality versus quantity and that has been a theme that even predates Obamacare but certainly has really kind of dug in and has been on a very systematic thoughtful path since ACA was signed. Let's talk a little bit about this business of site neutrality because that might be a surprise concept for some folks. In 2014, the Impact Act which was all about assuring that the Medicare benefit was going to be there for everyone moving forward and that we were delivering quality products et cetera, et cetera said that they ultimately are going to move to site neutral reimbursement.

Steven Littlehale:

The date is 2024 when it's required. CMS is required to look at what that might, contemplate what that might be basically to do all your research and by 2024 have it ready to go and then implement it. Since the Impact Act was released in 2014, MedPAC is saying, "No, no. How about now? How about now?" In every year they say, "No, no, no. How about now? Why don't we do it now? Why don't we skip PDPM and go right to site neutral payments and here's how to do it.

Steven Littlehale:

So they're ready to rock and roll on that, but some could say that Health and Human Services might be a little distracted right now and there's a lot going on and then we come into an election year and blah, blah, blah, blah, blah, blah. So this site neutrality what does that look like? More assessment items have been added to this thing called the minimum data set, added to the Oasis. Those are standard assessments that are done and anyone that happens into skilled nursing or home health, there's an equivalent for an earth and an LTAC. These same assessment items will allow CMS to judge outcomes based on site.

Steven Littlehale:

There's also a measure in that, these QRP measures that's called Medicare spent per beneficiary. So CMS can easily... And this is all publicly available. You can actually go now to Hospital Compare, Nursing Home Compare, Home Health Compare, all of those compare websites and look at a facility's average Medicare spend per beneficiary and you can compare that across all these different sites.

Steven Littlehale:

So ultimately CMS will have the clinical outcomes, the financial outcomes, all of the data that they need to say, "Okay, I'm good to go." If a person needs this kind of post acute care and it needs to be in an institution, this is the institution that wins. This is the silo or the segment rather, a better word. Segment within the post acute spector. If you need institutional care, go here. If you don't need institutional care, then this is the kind of care that makes the most sense financially and CMS will stop reimbursing based on that what the walls are, the type of sliver you happen to be residing in, be it in LTAC or in acute rehab or nursing home.

Steven Littlehale:

So the good news for a skilled nursing home is for operators and lenders is we are the cheapest game in town delivering a great product. So we win. As far as I can see when I play this game forward we win and that's great news for our industry plus, "Oh by the way, that silver wave, that's right behind us. That's about to engulf us all. That's going to help us a little bit as well. Is that what you were hoping to get at? Okay.

Michael Torgan:

So not to age anybody here on this panel, but we've got almost a hundred years of experience in this profession. And so based on your overall experience, government regulations, government policies, operational issues, financial models, what do you see is the positives that's come out of PDPM and what are the concerns that you might have that you're keeping an eye on as you go forward through the rest of the year? Luann, we'll start with you.

Luann Gutierrez:

I would say I think it's already been said here but I do like the fact that it's more patient or resident focused. And so they are looking at the outcome, so I think that's good. So I guess when you keep that in mind that it's ultimately the resident or the patient that we're focusing on, then I want to make sure do the borrowers that we lend to are they on top of do they have someone who comes through and does an audit on their coding, someone who's not entering the MDS data but someone else who's coming in just to make sure is the information being entered correctly, because I consistently hear that, that sometimes the data is not captured appropriately.

Luann Gutierrez:

So that's one thing I'd want to look at. I'd want to look at what are their referral sources. Are they connected with ACOs? Do they have a really good portal system where they're getting the good referrals in the information? Are they working with like the Zimmet team and learning some different information because we have referred borrowers. Have you talked to these guys? They know everything there is to know about data.

Luann Gutierrez:

So I think that's just some of the stuff. From our perspective, we want to make sure that the financial statements that we're being given is that real data, we can really, really rely on. Is the record-keeping well and is the data that we're getting, is it something that I can really rely on and know that that's good solid data, so that would be my concern.

Michael Torgan:

*So, Dava?

Dava Ashley:

I would say again that I think PDPM CMS got it right. It allows us to really get paid for the type of patients that we're seeing and have been seeing in our facilities for a number of years. The other thing I think it does, it allows our clinicians the flexibility to be very interdisciplinary and provide whatever care is needed for that patient and we get paid for it. I think that's a really good thing, putting the hands of the care with the clinicians and the patient trying to get the greatest outcomes possible I think is really, really good.

Dava Ashley:

I would caution everybody that to your point it's very important. As I said earlier, the rules didn't change on Medicare. It is critical that we have supporting documentation for anything that we're doing for our patients and anything that we're billing. I think CMS would be eyebrows up if there was... All of a sudden everybody was depressed, everybody had a swallowing problem. They'll look for things like that, trends that we shouldn't be doing if it's patient centric.

Dava Ashley:

If you read anything from John King who's the head of CMS that is kind of spearheading this PDPM, that's what they talk about. We want this to be patient specific where we don't want to see homogeneous across the board information. We want to see it really be patient specific, so I think that's really important. But I think the point that Steven had on his slides about the emergence of managed care, that's a reality. What did you say? 57% in California that turns 65 picksan MA plan. Then the fee-for-service pool becomes smaller.

Dava Ashley:

So the games that we may see right now in PDPM are great but we also have this other population of managed care that we have to be aware of. So when you're looking at the operation from your perspective, it's that whole population of the facility, not just the PDPM patients. It's really the whole operation.

Michael Torgan:

And a quick follow-up to that. I know it's early, but we've talked about quality indicators. Have you seen any impact that PDPM has had on air quality indicators or are they still relatively trending the same that they've had?

Dava Ashley:

Ours are trending the same as they always had.

Steven Littlehale:

[crosstalk 00:50:19] The look-back period for the quality measures are they're too long for us to see. We should start to see the beginning of any trending a movement if that's what's going to happen. We should just be now experiencing that. But I'm not quite sure that those QMs are sensitive enough to really have that impact. So everyone always asked what is the change in therapy minute utilization? I haven't seen that data yet, I've been looking but it hasn't been published yet. But again I think five months out, it's too early and I think we'll start to see that. Really in the next quarter, we'll start to see trends in therapy minute utilization and be able to have some thought about that.

Steven Littlehale:

But in terms of benefits that you asked about with PDPM, words are very important and I alluded earlier to the fact that this is the patient driven payment model and not its predecessor which was RCS-1 was resident and they changed to patient. Well, I think to myself, that's great. It's nice to have CMS acknowledged that skilled nursing is caring for people sick enough to be called patients and that they're different from residents and we shouldn't commingle the data or policies or regulatory oversight because they're completely different populations, but then I also think well where else do patients reside. Patient reside in hospitals.

Steven Littlehale:

So is this leading an opportunity for skilled nursing to think about certainly not the first time you've heard this, but skilled nursing admitting directly from the emergency room and there is no hospitalization. Is that what is next? I think frankly in some circumstances we could manage that patient who might be a geriatric frail medical person with pneumonia who needs close nursing and IVs, and respiratory that all happens in skilled nursing. So let's just completely skip the acute care segment.

Steven Littlehale:

Actually this came up in conversation yesterday around the coronavirus, if our hospital systems are so clogged and we're not going to have resources and I started thinking to myself how could skilled nursing be the admission point for someone who needs IV, medication, respiratory support, nursing oversight, isolation, et cetera. I mean, in some markets we do have folks that are very able to handle that.

Steven Littlehale:

The other benefit, Michael that happened with PDPM was the tail that's wagging the dog, that was the therapist in the RUG system and that has changed. And now nursing is sort of ground zero. I don't mean to say that it shouldn't be shared, but it's a nursing home. People come to a nursing home for nursing care or they used to. But anyway, the nurse is now central point and the question I have for the industry is well, are we prepared to take that on?

Steven Littlehale:

For the last 20 years we have been on the back seat and now we have to come front and center. Do we have the skill set to answer that need that requirement? I think we do. There's a staffing shortage, period, end of story. So that is some of the realities of that statement, but I think the tail wagging the dog in skilled nursing is dramatically changed for the better. I think that's really great.

Michael Torgan:

So Steve, you had mentioned earlier about keeping the eye focused on compliance.

Steven Littlehale:

Yes.

Michael Torgan:

This really highlights compliance at a completely different level than we've seen in the past. So I'd like to pose to the panel is where should we be looking? I know that there's something called the PEPPER report and I know that it's not much talked about, but clearly identifies and utilizes compliance components. So I'd like to open it up to the panel to really talk about this because I think it's important five months in as we talked and discuss the positives is what are the potential pitfalls that we really need to be looking out for? What do we need to do as a group to make sure that we position ourselves in a manner that we want to be positioned as CMS looks at this in a rebasing and a readjustment as you talked about, Dava? Luann, I'll start with you.

Luann Gutierrez:

I think for us, we just want to make sure that our client is on top of their game, that they know what's going on in their homes that they have the appropriate policies and procedures because we will ask them sometimes, "Do you have something online? How often do you have training for your staff? How often is that happening? Is it just for 15 minutes? Do you outsource it? Do you bring it in? How is that handled?"

Luann Gutierrez:

So we're looking from a lender perspective to make sure does our borrower know and understand everything that's occurring at their facilities and then if they are cited for anything how quickly are they reacting to it? And then also from a lender how quickly are they letting us know what's going on and giving us their game plan of what their plan of correction or what they're planning to do?

Dava Ashley:

I would say from a compliance perspective whether it's the health department or the OIG, anything like that, we have to focus on do we have the appropriate documentation to demonstrate the care that we're providing. Whatever we're providing for that patient we should have supporting clinical documentation that supports the MDS, that can be done in a number of ways, and the daily meeting which I know most facilities across the country do a daily clinical meeting reviewing the care of the patient, involving physicians and really focusing on the quality and the supporting documentation.

Dava Ashley:

Many facilities do a triple check type review at the end of the month on the claim like here's what we're submitting. Do we have the supporting documentation? Those are things that we've always done in this industry and I think a little bit of it is common sense. Say we're going to do something we have to have the back up to do that. We have to support what we're saying we're doing with the patient on the care plan. The clinical data has to be there. All of those have to just be tightened up.

Michael Torgan:

So five months in, have you made any changes from that modification of the way you're reviewing the documentation and the processes that you've set up as an operator?

Dava Ashley:

We haven't because we've always had these processes in place. We've always had strong clinical care management programs that occur in our facilities every day to look at the patients. We have physician involvement. We've had that process that I mentioned on triple-check. We have like a walking rounds program for our clinicians to actually look at the patient together. So we felt strongly that those systems that we've had in place forever will stay in place and they will serve us well to make sure that we're providing high quality of care for our patients, but also that we have their appropriate documentation. So for us, it was learning the new ins and outs or nuances of a new reimbursement system but the basics of what we're scaling the patient for, how we deliver care is the same, remains the same.

Luann Gutierrez:

And I will chime in. That's the one thing we have seen with the different clients that we talk with when we are asking them questions. We've had several of them say, "We're not really doing anything differently than the way we've always done it." And so I think if you have a good quality operator, they're always... I mean, that's just standard operating procedure for them. It's like she said. It's just learning the new way to put the puzzle pieces together, the way the CMS wants to see it, but we haven't changed the way we give the care.

Steven Littlehale:

I think next time we should make sure we have a bad operator on the panel who can talk about how they've changed, if they're willing. From a compliance perspective, Dava gave you I think a great example earlier when she was talking about how CMS doesn't want to see depression across the board. So let's talk about a little bit about that and one other example. When I was looking at the depression data both from Core analytics and from PointRight I started seeing in my brain, not a pattern but I start imagining how I would look at it if I was a compliance officer. Well, I want to see that the patients who have a financial benefit for being depressed under PDPM that it's not only those people who are depressed.

Steven Littlehale:

In other words, I want to see depression in all of the PDPM groups not just where there's a financial benefit. So that's point number one. So take it a little higher is you look at the financial drivers within PDPM, depression, cognitive impairment, mechanically altered diet, blah, blah, blah, blah, blah, on and on and on, and you just see how are you comparing to the nation, how are you comparing to people in your state because that'll help neutralize some of the case mix issues that are going on in a Medicaid system of reimbursement. Look to see if anyone within your portfolio is an extreme outlier and ask the question why?

Steven Littlehale:

Then part number two is it's fine that you are depressed and it's great that you coded on the MDS, but where's the care plan? What are you doing about it? And it doesn't need to be a drug, but it needs to be in the care plan. I mean, it seems so incredibly obvious but this is what gets us into trouble, time and time and time again. Another example is in the data that I shared with you, I showed you that special

care high was a category within the nursing component that has increased quite a bit. In fact, it went from 38% of people in that category went up to 46.1% percent. It's a big jump.

Steven Littlehale:

So then I look at the components within special care high and I asked myself, "Well, what's changing? What are we doing differently either assessment or care wise?" Well, if you ask me in July what that would have been, I would have said respiratory therapy being administered seven days within their initial stay. But it's really not. It's really not. In fact its shortness of breath when laying flat. All of a sudden, you're seeing this increase of our residents in the United States, patients in the United States who have shortness of breath while lying flat.

Steven Littlehale:

What are we doing? Are we not giving them their diuretic? Are we not raising the head of the bed so that they are laying flat? That's how it gets portrayed in the media. What evil thing have we done to our nation's elders when in reality is we were always assessing, we were always listening, please, to lungs. It wasn't making it to the MDS because we were focused on 10,000 other things that CMS told us were important and now we're checking that off on the MDS.

Steven Littlehale:

So that is a huge spike that we're seeing in care assessment. Now, we have to make sure that it's documented in the care plan that not only does a person have shortness of breath when laying flat, but what are we doing about it?

Michael Torgan:

Well, thank you all very much. We have a little time here for questions. I wanted to leave room to see if anybody had any questions for the panelists. If we can get a mic over to the front here. Can you raise your hand? Thank you.

Audience:

You mentioned earlier about the tail wagging the dog and a shift from therapy to nursing. Have you seen any changes as far as nursing expenses, nursing staffing levels, training. We also talked about a nursing shortage to begin with. Any more pressure on the nursing side?

Steven Littlehale:

I definitely want you to chime in on that. I can tell you from a data perspective, we're not seeing nursing ratios if you're looking at what is reported through PBJ. There's not a lot of movement there in regards to PDPM, but it's also a little early to see it on that sort of macro level. But Dava, you may have some thoughts.

Dava Ashley:

We haven't seen that. I think the question would be answered if your facility or you had a group of facilities that maybe are now taking a different level, a different type of patient that you might have seen some increase and we always do training for our nursing staff on competencies for different levels of acuity. We didn't see any increase as it relates to this new change.

Luann Gutierrez:

From a lending perspective we were kind of given the heads up that we should see an increase in the nursing and a decrease in the therapy, and that's kind of what was told to us, but now that it's occurred

in looking at our statements and looking at our existing portfolio, it's exactly what Steve was saying is we're really not seeing a huge increase in nursing. We haven't. Unless, like she said. Now, there has been a couple of loans we've been looking at recently and they actually do have the higher acuity residents and we are seeing it reflected in the nursing cost. We did see that jump up.

Steven Littlehale:

I would also think too on how the role is implemented, how the role of the nurse is understood and implemented, their job description, that is what really should be changing. I would also look to and I always get in trouble when I say this and I do not mean disrespect. A care manager, a case manager is an RN, it's not an LPN. So it could be that the nursing ratios don't move but you see a shift to, if you can find them more RNs over LPNs. That's where you might see some micro movement.

Michael Torgan:

I think there was another question.

Audience:

Yes. So going back to a comment that was made earlier about missed opportunities and I think it was related to some extent, failure to document or erroneous documentation, things like that. My understanding is there really are only two assessments necessary now related to PDPM, the admissions assessment and then the discharge assessment. I think what I've read is there are more data points along that admissions assessment. Do you guys think that in general that the streamlining of those assessments will help mitigate some of those documentation errors or issues or do you think that that will exacerbate the problem? And then just secondly, do you think the intermittent payment assessment which is discretionary will potentially become another missed opportunity?

Dava Ashley:

Do you want me to take that or do you want to?

Steven Littlehale:

I'm good with commenting on it, but I bet you have others.

Dava Ashley:

I would say that on the first part of it, it's really on that five-day, it's spending time capturing all of the clinical comorbidities, what is the primary diagnosis that we're treating this patient for. So there's more front-end work on getting the right clinical diagnosis, capturing data and documentation from the hospital to support our diagnosis. So we saw more of that and just we didn't see our HIMSS or our medical records people were coding right. So that wasn't the issue, it's having the clinical assessment of what are the clinical diagnosis and do we have the supporting documentation.

Dava Ashley:

On the IPA, I think you'll see that that's really based on the care of the patient and if there's a change of condition or the team decides to go back and hey, we missed this. This really would be we need to do this IPA to capture IV fluids or something that's happening with the patient. Reducing things.

Steven Littlehale:

I do agree. Fewer assessments are fewer opportunities to mess up in fewer places for CMS to find problems. Yes, the volume of MDS assessments have dramatically decreased, thank goodness but also the size of the MDS assessment has increased somewhat as well. I agree with the IPA. Too early to have a national figure to share with you about how often providers are using IPAs. Are they only doing it to increase their rate? Are they doing it also when the person improves which I don't expect anyone is going to do. And nor is CMS clear on how they should be responding with improvement. Does that answer your question? Okay. You bet.

Michael Torgan:

We got time for one more. Up in the front here.

Audience:

Thanks so much for the panel. Given that there appeared to be no losers in the system and that the system is not budget neutral, I was wondering how do you assess the likelihood of CMS actually correcting the rates and if they do correct the rates what would that correction look like? Would they just shave some percentages off the top? Will they be retroactive in how they apply? Only proactive? How are you assessing this? Thank you.

Michael Torgan:

So I think to say first, it's unfortunate with what's going on with coronavirus, but I think it's changed the attention of CMS at this time and it may actually delay any action that they take yet to be seen. They just came out with new guidelines of how to reimburse hospitals through this process, but I do believe there will be some correction and we were all talking about it earlier as a panel. The regs are supposed to come out, the initial guidelines in April. I don't think they're going to make that deadline with the new events that are occurring. So I think it gets pushed out maybe to sometime in 2021 before we see anything.

Michael Torgan:

And I think also we did get the benefit of a solid market basket increase of about 2.5% as a stable factor and that will obviously help in any offset that occurs in this process. So if they're talking about what people think projected is a 6% reduction, remember that there's a market basket piece in there that's going to hopefully offset that. I don't know if anybody else has anything to add.

Steven Littlehale:

I concur completely with what Michael is saying. The term you'll hear someone say clawback and it's such a wonderfully sensational word. I get this image in my head of a wrestling match and scratching. I don't think that that's real. I think the last time we had... What was the date RUG-IV...

Dava Ashley:

2011.

Michael Torgan:

It occurred I think in February 2012 for March of 2012.

Steven Littlehale:

Not to be too specific or anything, Michael. [crosstalk 01:11:09]

Michael Torgan:

It was painful.

Steven Littlehale:

That was the revenge of CMS. There were lots of reasons why it happened that way and a lot of that we, the industry own and shame on us. It has taken us a very long time to live beyond that, but we're not seeing that kind of behavior now. No mistakes have been made as it was in that case. I think we'll just have an adjustment in the rates. Do you agree with that?

Dava Ashley:

I do, but I think CMS is still looking at the data. I think it's too early for them. I mean, all I've read and what we've heard them say is probably they'd need at least six months of claims data to really look at all these elements that we've been talking about. Who knows what they will do but we think they definitely need the data.

Michael Torgan:

Yeah. PDPM is much more complicated in its evaluation than RUGS-IV was. So there may be a longer delay in terms of them being able to assess what that adjustment looks like on a go-forward basis. And then we could at that time also have a change in administration. So it's a lot of moving pieces in this process yet to be determined. So with that we've run out of time. I want to thank everybody for being here. I want to thank our panel.

Luann Gutierrez:

Thank you.

Michael Torgan:

Great discussion. Have a great day, everyone.

Dava Ashley:

Thank you, bye.

Michael Torgan:

Thank you.