



The New Payment System for Nursing Homes: Patient Driven Payment Model (PDPM)

Richard Mollot
Long Term Care Community Coalition
www.nursinghome411.org

Toby Edelman
Center for Medicare Advocacy
www.medicareadvocacy.org

+ Today's Presenters & Organizations

- **Long Term Care Community Coalition:** LTCCC is a nonprofit organization dedicated to improving care & quality of life for the elderly & adult disabled in nursing homes and assisted living through policy analysis and advocacy as well as public education.
- **Center for Medicare Advocacy:** The Center is a national nonprofit, nonpartisan law organization that provides education, advocacy, and legal assistance to help older people and people with disabilities obtain access to Medicare and quality health care.
- **Toby Edelman:** Toby is the Senior Policy Attorney at the Center. She monitors implementation of the Nursing Home Reform Law and proposals to amend federal and state nursing home law; monitors federal and state quality improvement, complaint, and pay-for-performance initiatives. Prepares written analyses regarding these issues for advocates and legislators and works with Congressional and agency policymakers in Washington, DC and Baltimore, MD.
- **Richard Mollot:** Richard is the executive director of LTCCC.

+ Today's Program:

- Brief background on the nursing home system
 - Licensure & oversight
 - Payment for nursing home services
- The new, Patient Driven Payment Model for nursing home care
- Time for discussion & questions



Background on the Laws & Standards

+ The Nursing Home System in a Nutshell

- The vast majority of nursing homes are licensed to participate in Medicaid and/or Medicare.
- In order to participate in Medicaid/Medicare, a facility agrees to meet the standards provided for in the federal 1987 Nursing Home Reform Law (and other federal laws, like the 2010 Affordable Care Act).
- States may have ***additional*** protections, but no state can have less protections.
- Federal ***protections are for all the residents*** in a facility (generally speaking), whether their care is paid for by Medicare, Medicaid or private pay.



+ Nursing Home Reimbursement System (Payment)

■ Medicaid

- Primary payer of long term care in nursing homes.
- For people with limited income.
- Jointly funded by states and federal government.

■ Medicare

- Primary payer of short term care in nursing homes.
- Primarily for people aged 65+, but also for some younger people with disability status.
- Four Parts:
 1. **Part A** covers hospital (inpatient, formally admitted only), skilled nursing (only after being formally admitted to a hospital for three days and not for custodial care), and hospice services.
 2. **Part B** covers outpatient services including some providers' services while inpatient at a hospital, outpatient hospital charges, most provider office visits, and most professionally administered prescription drugs..
 3. **Part C**, also known as Medicare Advantage, refers to plans offered by private companies. These plans replace Parts A and B. They are required to provide at least the same service coverage as Parts A and B, often include the benefits of Part D, and always have an annual out-of-pocket spend limit (which A and B lack).
 4. **Part D** covers mostly self-administered prescription drugs.

- **Private pay** — a minority of nursing home care is not covered by one of the above programs.



PATIENT DRIVEN PAYMENT MODEL (PDPM)

NEW PROSPECTIVE PAYMENT SYSTEM FOR SNFS

- Effective Oct. 1, 2019, CMS will implement a new budget-neutral replacement for Resource Utilization Groups (RUG-IV).
- Patient-Driven Payment Model (PDPM) bases payment on resident characteristics, rather than on services provided. 83 Fed. Reg. 39162, 39183-39265 (Aug. 8, 2018).
 - Final rules are essentially unchanged from proposed rules, 83 Fed. Reg. 21018, 21034-21080 (May 8, 2018).
 - Different from earlier proposal, Resident Classification System, Version I, 82 Fed. Reg. 20980 (May 4, 2017).

PROBLEMS WITH RUG-IV

- Perceived overuse of therapy
 - In FY2017, for 60% of claims, SNFs billed Medicare for the three top highest of the 66 RUG-IV categories.
 - OIG and MedPAC also reported that RUG-IV encouraged excessive therapy and underpaid non-therapy ancillaries (chiefly drugs).
 - Lot of litigation under False Claims Act, particularly against chains, for overbilling, fraudulent billing.

PDPM OVERCOMPENSATES FOR CONCERNS ABOUT RUG-IV

- PDPM will pay less for residents who receive any therapy and more for residents who receive no therapy (according to CMS's Impact Analysis, Resident-Level, 83 Fed. Reg., 39257-39259, Table 37).
 - However, under Medicare statute, beneficiaries qualify for Part A coverage of SNF stay if they need rehabilitation services five days/week (or skilled nursing services seven days/week).

HOW RUGS WORKED

- Two case-mix adjusted categories
 - Nursing
 - Rehabilitation (more than 90% of beneficiaries)
 - The more minutes of therapy per day, the higher the daily reimbursement rate.

HOW PDPM WORKS (PART 1)

- Instead of RUGs' two case-mix adjusted components, PDPM creates six federal base payment rates:
 - Five components are case-mix adjusted (physical therapy, occupational therapy, speech language pathology, nursing, non-therapy ancillaries [primarily drugs]).
 - One component is not case-mix adjusted.

HOW PDPM WORKS (PART 2)

- Each of five case-mix adjusted components (PT, OT, ST, nursing, non-therapy ancillaries) has its own case-mix groups.
 - PT: 16 case-mix groups;
 - OT: 16 case-mix groups;
 - ST: 18 case-mix groups;
 - nursing: 25 case-mix groups;
 - non-therapy ancillaries: 6 case mix groups.

HOW PDPM WORKS (PART 3)

- CMS separately calculates the case-mix component by multiplying the case-mix index by the component federal base payment rate.

HOW PDPM WORKS (PART 4)

- CMS applies variable per day adjustment schedule, which reduces the daily payment for three case-mix categories on a sliding scale.
 - PT and OT: decline of 2% every seven days after day 20.
 - Non-therapy ancillaries (drugs): decline of 3% beginning on day four of Part A stay.

HOW PDPM WORKS (PART 5)

- CMS adds these five case-mix adjusted components to non case-mix adjustment component to come up with total daily rate. 83 Fed. Reg., 39225.

CMS'S ASSESSMENT OF IMPACT OF PDPM

- Final rules include two tables showing impact of PDPM's changes on residents and on facilities. 83 Fed. Reg., 39257-39259, Table 37 (residents), and 83 Fed. Reg., 39160-39161, Table 38 (facilities).

CMS'S ANALYSIS OF IMPACT ON RESIDENTS

- Higher rates if resident has
 - High non-therapy ancillary costs; receives extensive services; is dually eligible for Medicare and Medicaid; needs IV medication; has ESRD; has diabetes or a wound infection; needs amputation/prosthesis care; had longer prior inpatient stay. 83 Fed. Reg., 39257.

IMPACT ANALYSIS ON RESIDENTS (FROM TABLE 37)

- Higher rate if
 - Male
 - Under age 65
 - Medicare-covered stay in SNF of 1-15 days
 - Long inpatient hospital stay
 - Not receiving any therapy at SNF
 - Severely cognitively impaired
 - Needs ventilator

IMPACT ANALYSIS ON RESIDENTS (FROM TABLE 37)

- Lower rate if
 - Female
 - Over age 90
 - Medicare-covered SNF stay of 31+ days
 - 3-day prior inpatient hospital stay
 - Receives all three therapies (PT, OT, and ST)
 - Cognitively intact or mildly or moderately cognitively impaired
 - Not need ventilator or infection isolation

CMS'S ANALYSIS OF IMPACT ON FACILITIES

- Higher reimbursement if
 - “high proportion of non-rehabilitation residents;” small facilities; non-profit facilities; government-owned facilities; hospital-based and swing bed facilities.

IMPACT ANALYSIS ON FACILITIES (FROM TABLE 38)

- Higher reimbursement if
 - Rural West North Central facility
 - 90-100% of residents are dually eligible for Medicare and Medicaid
 - 0-10% of Medicare-covered stays are 100 days
 - 75-90% of Medicare-covered stays are billed as non-rehabilitation.

IMPACT ANALYSIS ON FACILITIES (FROM TABLE 38)

- Lower rate if
 - Urban Mid-Atlantic facility
 - Fewer than 25% of residents are dually eligible for Medicare and Medicaid
 - 25-100% of Medicare-covered stays are 100 days
 - 0 – 10% of Medicare covered stays are billed as non-rehabilitation.

POSSIBLE BENEFITS (PART 1)

- Residents who had been hard to place (e.g., residents needing ventilators) will be easier to place.
- BUT, will residents using ventilators get good care?
- Serious problems of infections, especially residents with ventilators.

DRUG-RESISTANT INFECTIONS FOR RESIDENTS USING VENTILATORS

- Drug-resistant infections prevalent in residents using ventilators.
 - Matt Richtel, Andrew Jacobs, “Nursing Homes Are a Breeding Ground for a Fatal Fungus,” *The New York Times* (Sep. 11, 2019), <https://www.nytimes.com/2019/09/11/health/nursing-homes-fungus.html?action=click&module=Well&pgtype=Homepage§ion=Health>.

POSSIBLE BENEFITS (PART 2)

- Staffing documentation will be critical to getting high rates.
 - Will RN staffing increase?
 - Will staffing increase on weekends, when many admissions occur?

POSSIBLE BENEFITS (PART 2)

- BUT, RUG nursing component covers both nursing and non-therapy ancillaries (drugs).
- In PDPM,
 - 57% of RUG nursing component is devoted to nursing;
 - 43% of RUG nursing component goes to drugs.
- So sufficient reimbursement recognized in PDPM for nursing?

POSSIBLE BENEFITS (PART 3)

- Will depression be identified and treated?
 - Trade press suggests identification and treatment of depression can boost payment by \$43/day and support longer lengths of stay.
- Will cognitive impairment be identified?
 - Trade press suggests \$21/day and longer lengths of stay.

TRADE PRESS

- Alex Spanko, “Treating Depression Could Emerge as a PDPM ‘Linchpin’ — Both for Payments and Better Outcomes,” *Skilled Nursing News* (Aug. 14, 2019), <https://skillednursingnews.com/2019/08/treating-depression-could-emerge-as-a-pdpm-lynchpin-both-for-payments-and-better-outcomes/>.

CONCERNS

- Enormous change in financial incentives.
- How will SNFs change practices to maximize profits?

CONCERNS ABOUT THERAPY

- What happens to therapy?
 - Will residents get the therapy they need?
 - Will residents continue to receive individual therapy?
- PDPM allows up to 25% of therapy to be provided in group or concurrent settings (instead of individual therapy, as 99% of therapy is now provided).
- But exceeding 25% cap leads only to “a non-fatal warning edit” – no penalty.

MORE CONCERNS ABOUT THERAPY

- Effective Oct. 1, 2019, CMS adds new items to Discharge Assessment to identify minutes of therapy and mode of therapy.
 - Monitoring of decline in therapy is possible, but will CMS do it and act on it?

CONCERNS ABOUT MAINTENANCE THERAPY

- What happens, especially, to maintenance therapy (*Jimmo*)?
 - Dismissive CMS comment in final rules: no special tracking of maintenance therapy is necessary.

CONCERNS ABOUT ASSESSMENT

- PDPM uses only 5-day assessment (not RUG's additional assessments on days 15, 30, 60, 90) to reduce “paperwork burden.”
 - Concern: Gaming of assessment information.
 - PDPM authorizes reclassification of resident under Interim Payment Assessment (IPA), but final rules (in change from proposed rules) do not include criteria for IPA.

CONCERNS ABOUT NURSING

- Aside from attention to five-day assessment, will there be sufficient reimbursement for nursing?

ON BALANCE

- Lot of concerns; need for careful monitoring and advocacy.

KEY ISSUES: LOOKING AHEAD

- An overview of a few key issues we are watching in the year ahead.
 1. Reducing survey frequency for “top-performing” facilities
 2. Special Focus Facility candidates
 3. Written informed consent for antipsychotic drugs

Note: Links to relevant resources are provided for each topic.

KEY ISSUES: LOOKING AHEAD

■ REDUCING SURVEY FREQUENCY

- CMS is working to reduce the frequency of standard surveys (annual health inspections) for so-called “top-performing” nursing homes. CMS believes that the proposal is justified because it would reduce burden and allow more resources to be available for overseeing poorly performing facilities.
- However, a facility’s favorable ranking does not necessarily mean residents experience quality care. For example, a recent federal report indicates that more than **1 in 5** nursing homes considered “above average” and “much above average” by CMS have been cited for abuse in a single year.
- **Solution: The Nursing Home Reform Law already allows for a flexible survey process. State survey agencies should utilize current standards to appropriately dedicate resources.**
- Center *Alert*: <https://www.medicareadvocacy.org/annual-surveys-at-nursing-facilities-are-essential-to-protect-residents/>.
- LTCCC Issue Brief: <https://nursinghome411.org/nursing-home-residents-at-risk-proposals-to-reduce-survey-frequency-for-top-performing-nursing-homes-is-dangerous/>.

KEY ISSUES: LOOKING AHEAD

■ SPECIAL FOCUS FACILITY (SFF) CANDIDATES

- The SFF program is an initiative to address poorly performing facilities with persistent problems through enhanced oversight. Due to limited resources, CMS currently caps the program to just 88 facilities nationwide. Consumers using CMS's Nursing Home Compare website are notified when a facility is participating in the program.
- A report by U.S. Senators Bob Casey (D-PA) and Pat Toomey (R-PA) found that CMS has also identified more than 400 additional nursing homes as SFF candidates based on their “persistent record of poor care.” Consumers using Nursing Home Compare are not notified of a facility's inclusion on the SFF candidate list when viewing that facility's profile.
- **Solution: CMS must properly alert consumers when a facility is a SFF candidate by integrating the candidate list into Nursing Home Compare.**
- Joint Statement from the Center and LTCCC: <https://nursinghome411.org/special-focus-facility-candidates-must-be-identified-on-nursing-home-compare/>.

KEY ISSUES: LOOKING AHEAD

■ WRITTEN INFORMED CONSENT FOR ANTIPSYCHOTIC DRUGS

- Approximately 20 percent of all residents nationwide are being administered off-label antipsychotic drugs. Too often, these drugs are used to chemically restrain residents exhibiting the behavioral symptoms of dementia, despite the FDA's "black box" warning against such use due to an increased risk of death.
- Residents currently have the right to be informed of, and participate in, their care. Residents also have the right to refuse care. However, no federal standard explicitly requires nursing homes to obtain a resident's written informed consent prior to administering an antipsychotic drug. This may be one explanation for the high rate of inappropriate antipsychotic drug use.
- **Solution: CMS must require facilities to obtain a resident's (or his/her representative's) written informed consent before administering an antipsychotic drug.**
- Joint Statement from the Center & LTCCC: <https://www.medicareadvocacy.org/stop-drugging-nursing-home-residents-without-their-written-consent/>.

+ LTCCC/CMA Statement on PDPM

**LONG TERM CARE
COMMUNITY COALITION**
Advancing Quality, Dignity & Justice

 **Center for
Medicare Advocacy**
MedicareAdvocacy.org

THE PATIENT DRIVEN PAYMENT MODEL IS HERE **WHAT DOES IT MEAN FOR RESIDENTS?**

On **October 1, 2019**, the Centers for Medicare & Medicaid Services (CMS) began implementing a new payment system for Medicare-covered nursing home care. The payment system is called the "[Patient Driven Payment Model](#)" (PDPM). PDPM creates a new set of financial incentives for nursing homes to consider when admitting and discharging residents, as well as providing resident care. Following is an example of some these incentives.

Nursing homes have a higher incentive to admit a resident if the resident is . . .

- A man
- Younger than 65 years old but not older than 74
- Disabled or has End-Stage Renal Disease
- Cognitively impaired (severely)

Nursing homes have a higher incentive to admit a resident if the resident needs . . .

- No therapy (or just one type of therapy)
- IV medication
- Tracheostomy and/or respiratory care
- Infection isolation

Nursing homes have a higher incentive to discharge a resident within . . .

- 15 days

Note: For CMS's full impact analysis, please see the [Final Rule](#).

While it will take some time to assess PDPM's effects on resident care, PDPM makes clear that skilled therapy will no longer be driving Medicare-covered nursing home care. Thus, a major concern is that residents may receive less therapy under the new payment system. Unfortunately, making matters worse for residents in need of skilled therapy, PDPM also allows 25 percent of a resident's total therapy regimen, by discipline, to be provided in group and/or concurrent therapy settings. Although CMS acknowledges that individual therapy is the best option because it is tailored to specific care needs, CMS makes clear that nursing homes will not be penalized for going over the 25 percent limit. As a result, in addition to less therapy services overall, residents may receive less individualized therapy under PDPM.

The Center for Medicare Advocacy and Long Term Care Community Coalition are especially concerned by PDPM's impact on maintenance therapy. As confirmed in the [Jimmo v. Sebelius Settlement Agreement](#), Medicare beneficiaries in nursing homes are entitled to receive skilled therapy to maintain their condition or to slow/prevent further decline. PDPM's preference for skilled nursing over skilled therapy, and incentives to discharge residents sooner, may mean that Medicare beneficiaries in need of maintenance therapy will ultimately pay the biggest price under the new payment system.

For more information about Medicare and nursing home care, please visit:
www.MedicareAdvocacy.org & www.NursingHome411.org.

**All statements and alerts are
available on our website,
www.nursinghome411.org.**

+ Issue Alert: Medicare Skilled Therapy



MEDICARE SKILLED THERAPY UNDER PDPM ISSUE ALERT

BACKGROUND

What is PDPM? The Patient Driven Payment Model (PDPM) is the latest payment system for Medicare-covered nursing home care. PDPM creates a new set of [financial incentives](#) for nursing homes when deciding whom to admit, what type of care to provide, and when to discharge a nursing home resident. Unfortunately, one of the biggest concerns surrounding PDPM's implementation is the risk it poses to residents in need of skilled therapy.

How Does PDPM Affect Therapy? The Centers for Medicare & Medicaid Services (CMS) indicates in the 2018 [final rule's impact analysis](#) that nursing homes have a greater financial incentive under the new payment system to provide little to no therapy to residents. Making matters worse, PDPM allows nursing homes to provide 25 percent of a resident's total therapy regime, by discipline, in group and/concurrent therapy settings *without* any penalty for exceeding that percentage. As a result, residents may experience both less therapy overall and less individualized therapy in particular under the new payment system.

How Have Nursing Homes Responded? Within days of PDPM's implementation, reports began to validate concerns about its effects on therapy. For example, Modern Healthcare [reported](#), "[s]killed-nursing chains have terminated or 'transitioned' many of their therapists. Those who remain have been asked to boost their productivity and quickly cycle through patients as well as increase their use of group and concurrent therapy rather than one-on-one sessions."

Where Does CMS Stand? While PDPM changes Medicare reimbursement, it does not change Medicare coverage and eligibility criteria. In [FAQs](#), CMS specifically states that "PDPM does not change the care needs of SNF patients, which should be the primary driver of care decisions, including the type, duration, and intensity of skilled therapies, made on behalf of SNF patients." *Thus, therapy decisions must still be based on clinical standards and judgment related to individual care needs.*

RESIDENTS' RIGHTS

Introduction. While therapy decisions must be based on the individualized care needs of residents, the financial incentives emphasize the need for increased vigilance in ensuring residents receive skilled therapy. Following are standards of care we have identified as being potentially useful when challenging a nursing home's decision not to provide, or provide little, skilled therapy to a resident.

Care Planning. Federal law requires nursing homes to provide residents with services that help them attain and maintain their highest practicable physical, mental, and psychosocial well-being in accordance with their written plan of care. 42 U.S.C. § 1395i-3(b)(2). Resident care plans must be person-centered and prepared with the participation, to the extent practicable, of the resident, family members, or legal representative. Federal regulations expand on these requirements and include (1) the right to participate in establishing expected goals and outcomes of care, including the type, amount, frequency, and duration of care; and (2) the right to receive the services in the care plan. 42 C.F.R. § 483.10(c)(2).

Page 1 of 2

Baseline Care Plan. Federal regulations require nursing homes to develop and implement a baseline care plan with 48 hours of a resident's admission. 42 C.F.R. § 483.21(a). The baseline care plan must include the minimum information necessary to properly care for a resident, including person-centered information related to therapy services.

Note: A more comprehensive care plan must be developed within 21 days of a resident's admission; however, PDPM financially incentivizes nursing homes to discharge residents within 15 days of admission. Therefore, some residents may never have a comprehensive care plan in place. Residents should make sure that a baseline care plan is implemented quickly and addresses their therapy needs.

Skilled Therapy. Federal regulations specify that nursing homes must provide skilled therapy services to residents, including physical therapy, occupational therapy, and speech language pathology, as required by the care plan. 42 C.F.R. § 483.65(a)(1)-(2). CMS's Interpretive Guidance for this standard notes that these therapies are specialized because they "are provided based on each resident's individual assessed rehabilitative needs based on their comprehensive plan of care and can only be performed by or under the supervision of qualified personnel."

MAINTENANCE THERAPY

Introduction. PDPM's effect on skilled therapy, combined with the financial incentive to discharge residents sooner, likely mean residents in need of ongoing maintenance therapy will face the biggest challenges under the new payment system. Following is key information about a court-approved settlement agreement that confirms Medicare coverage of maintenance programs.

Jimmo Settlement Agreement. The settlement agreement in [Jimmo v. Sebelius](#) required CMS to confirm that Medicare coverage depends on an individual's need for skilled nursing and/or therapy, **not** on his or her potential for improvement. As a result, residents in a Medicare-covered nursing home stay can receive skilled therapy to maintain their condition or to slow or prevent further decline. The *Jimmo* Settlement pertains to all Medicare beneficiaries nationwide, regardless of whether a resident has traditional Medicare or Medicare Advantage.

Medicare Appeals. A nursing home's decision to terminate Medicare-covered skilled therapy is appealable. Nursing homes are required to give residents the Notice of Medicare Non-Coverage (NOMNC) **TWO** days before the termination of skilled care. The NOMNC has instructions for requesting a redetermination and beginning the appeals process. In addition to identifying why skilled therapy is still medically necessary, residents or their representatives should use the *Jimmo* Settlement to educate providers, contractors, and administrative law judges about Medicare's coverage of maintenance therapy. For more information about Medicare appeals in light of the *Jimmo* Settlement, please see the [Center for Medicare Advocacy's Checklist Toolkit](#).

CONCLUSION

Residents in a Medicare-covered nursing home stay are entitled to skilled therapy services. Federal law and regulations give residents the right to participate in their care planning and request individualized therapy services. Nursing homes must provide therapy services to residents that are medically necessary and part of their care plans, including maintenance therapy. Although PDPM has created new financial incentives for nursing homes, resident care must still be based on clinical standards and judgments.

For more information about nursing home care, please visit www.NursingHome411.org or www.MedicareAdvocacy.org

+ Fact Sheet: Nursing Home Therapy Services

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

NURSING HOME THERAPY SERVICES FACT SHEET

Nursing homes are required to follow specific standards in order to ensure that residents receive appropriate care, have a good quality of life, and are treated with dignity. **You can use these standards to advocate for your rights.**

Following are the standards we have identified as essential when it comes to therapy services in nursing homes. LTCCC took descriptions directly from federal regulations and Guidance (as indicated by text in *italics*). For information about Medicare-covered skilled therapy services, please see LTCCC's [Issue Brief](#).

Standards of Care

Rehabilitative Services

42 C.F.R. § 483.40(c)(1)-(2) | F825

If rehabilitative services such as but not limited to physical therapy, speech language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, are required in the resident's comprehensive plan of care, the facility must—

- *Provide the required services, including specialized rehabilitation services . . . ; or*
- *Obtain the required services from an outside resource . . . from a Medicare and/or Medicaid provider of specialized rehabilitative services.*

Specialized Rehabilitative Services

42 C.F.R. § 483.65(a) | F825

If specialized rehabilitative services such as but not limited to physical therapy, speech language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity . . . are required in the resident's comprehensive plan of care, the facility must—

- *Provide the required services; or*
- *[O]btain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs . . .*

What Does "Specialized Rehabilitative Services" Mean?

The Centers for Medicare & Medicaid Services' (CMS's) Interpretative Guidance states that therapy services are specialized (or skilled) when "they are provided based on each resident's individual assessed rehabilitative needs based on their comprehensive plan of care and can only be performed by or under the supervision of qualified personnel."

Page 1 of 2

A Note about Care Planning

While the regulation specifically mentions the comprehensive care plan, nursing homes are also required to develop a baseline care plan **within 48 hours** of a resident's admission. Baseline care plans must include the minimum health care information necessary to properly care for a resident, including information about therapy services. For more information, please see our [Issue Alert](#).

Qualifications

42 C.F.R. § 483.65(b) | F826

Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

Who are "Qualified Personnel?"

According to CMS, the following types of care professionals are qualified personnel:

(1) physical therapists; **(2)** occupational therapists; **(3)** respiratory therapists; **(4)** speech-language pathologists; **(5)** physicians; **(6)** nurse practitioners; **(7)** clinical nurse specialists; and **(8)** physician's assistant, who is licensed or certified by the state to furnish therapy services.

Additionally, CMS notes that "qualified personnel may also include a physical therapist assistant (PTA), or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist."

Maintenance Therapy

A federal district court approved the settlement agreement in [Jimmo v. Sebelius](#) in 2013. The *Jimmo* Settlement required CMS to confirm that Medicare coverage depends on an individual's need for skilled nursing and/or therapy, **not** on his or her potential for improvement. See 42 C.F.R. § 409.32(c). As a result, residents in a Medicare-covered nursing home stay can receive skilled therapy to maintain their condition or to slow or prevent further decline. The Settlement pertains to all Medicare beneficiaries nationwide, regardless of whether a resident has traditional Medicare or Medicare Advantage. To learn more about the *Jimmo* Settlement, please see our [fact sheet](#).

The federal Nursing Home Reform Law also requires nursing homes to provide residents services that help them attain or maintain their highest practicable physical, mental, and psychosocial well-being. 42 U.S.C. § 1395i-3(b)(2). **CMS's Interpretative Guidance to the regulations notes that skilled therapy is within the scope of a facility's services. Thus, nursing homes should provide skilled therapy, including under a maintenance program, to any resident whose plan of care calls for it.**

For more information about nursing home care, please visit www.NursingHome411.org.

+ Coming Up

44

Recent Updates to Nursing Home Compare: Accessing Useful Information on Nursing Home Quality, Safety, and Staffing

November 19 at 1pm Eastern

Attend any LTCCC program in two easy ways:

1) To join the online meeting, about five minutes before the scheduled time of the meeting, go to the link below and follow the prompts to join the meeting.

Online Meeting Link: <https://join.freeconferencecall.com/richardmollot>.

2) To participate by phone, call (712) 770-4010. When prompted, enter the Access Code, 878277#. Press *6 to mute or unmute your phone line.

Watch past programs on our YouTube channel or listen/download the podcast via our website, www.nursinghome411.org.



Thank You For Joining Us Today!

45

Visit nursinghome411.org/join/ if you would like to...

- Receive alerts for future programs or
- Sign up for our newsletter and alerts.

You can also...

- Join us on **Facebook** at www.facebook.com/ltncc
- Follow us on **Twitter** at www.twitter.com/LTCconsumer
- Visit us on the **Web** at www.nursinghome411.org.

For LTC Ombudsmen in NY State

If you would like us to let your supervisor know that you attended this training program, please take the quick survey at:

<https://www.surveymonkey.com/r/ltncc-ltcop1>

For Family Members in NY State

connect with the Alliance of NY Family Councils at www.anyfc.org (or email info@anyfc.org).



Questions?

Comments?