Patient Driven Payment Model

Background & Finalized Changes to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS)

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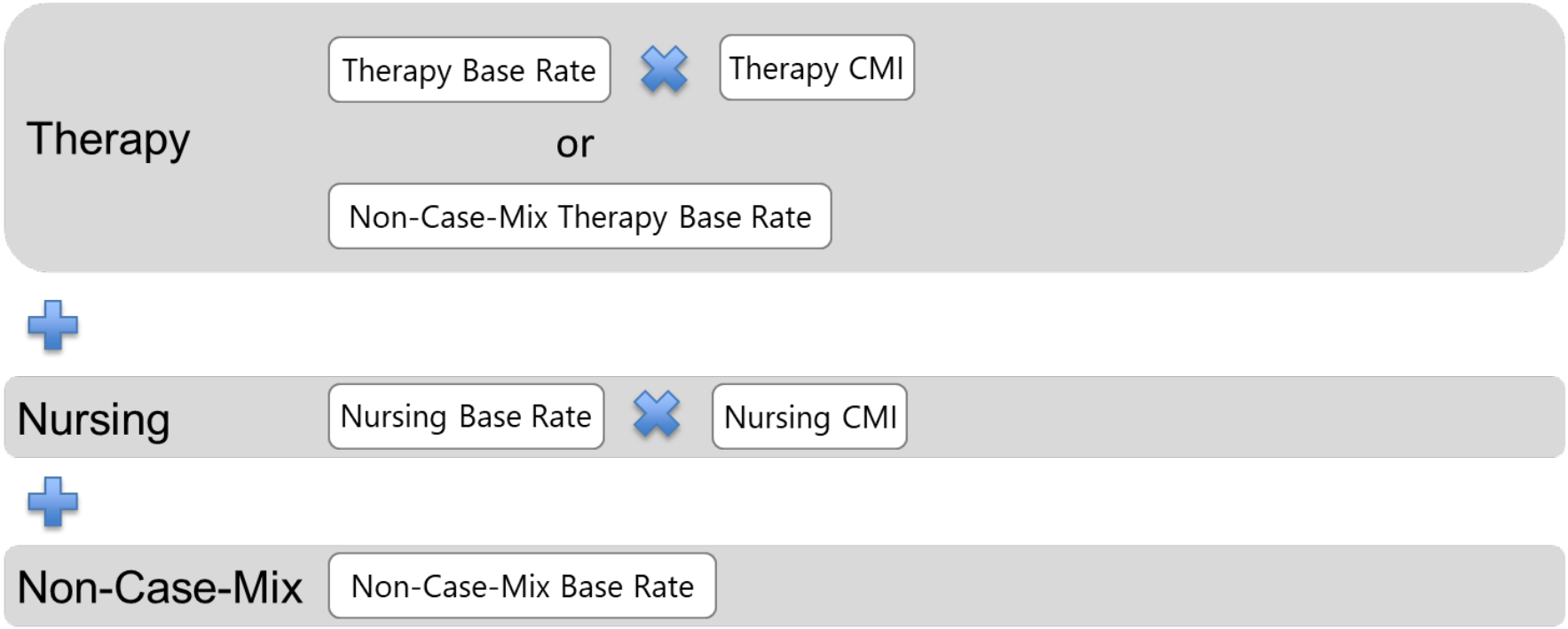
Project Overview

- Issues with the current case-mix model, the **Resource Utilization Groups, Version IV (RUG-IV)**, have been identified by CMS, OIG, MedPAC, the media, and others
  - Therapy payments under the SNF PPS are based primarily on the amount of therapy provided to a patient, regardless of the patient's unique characteristics, needs or goals

- The **Patient Driven Payment Model (PDPM)** represents a marked improvement over the RUG-IV model for the following reasons:
  - Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided
  - Significantly reduces administrative burden on providers
  - Improves SNF payments to currently underserved beneficiaries without increasing total Medicare payments

RUG-IV Components

- **RUG-IV** consists of two case-mix adjusted components:
  - Therapy: Based on volume of services provided
  - Nursing: The nursing case-mix index (CMI) does not currently reflect specific variations in non-therapy ancillary utilization

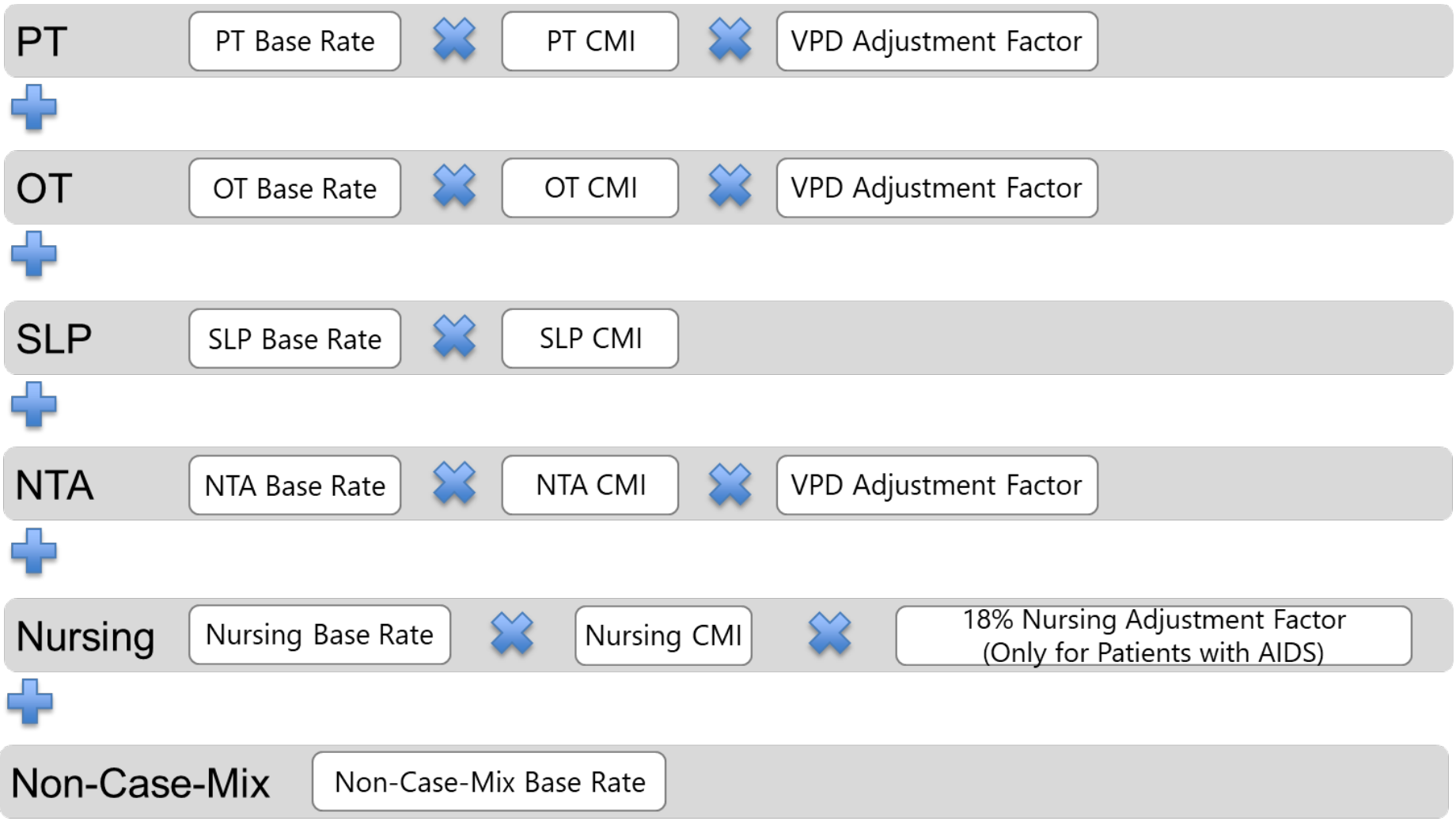


PDPM Components

- **PDPM** consists of five case-mix adjusted components, all based on data-driven, stakeholder-vetted patient characteristics:
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech Language Pathology (SLP)
  - Non-Therapy Ancillary (NTA)
  - Nursing

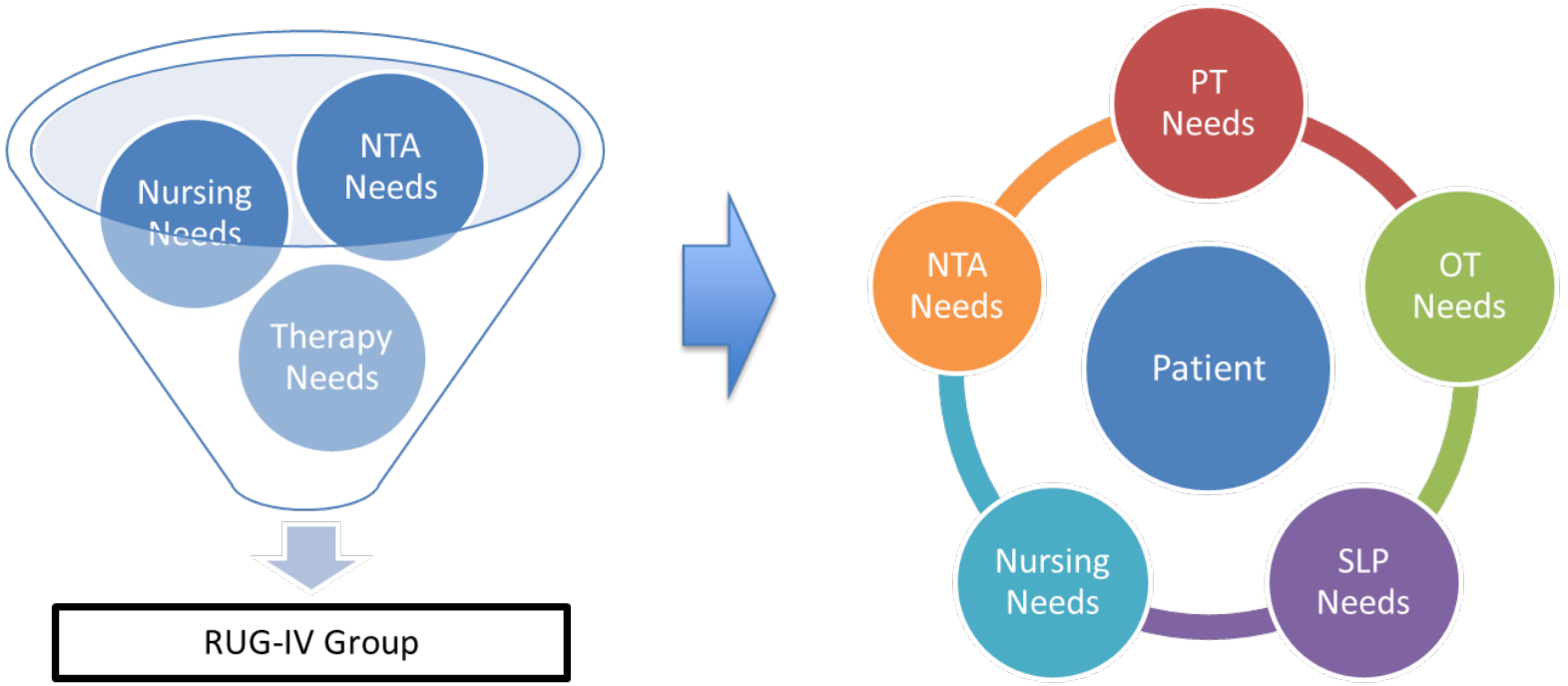
- PDPM also includes a “variable per diem (VPD) adjustment” that adjusts the per diem rate over the course of the stay

PDPM Snapshot



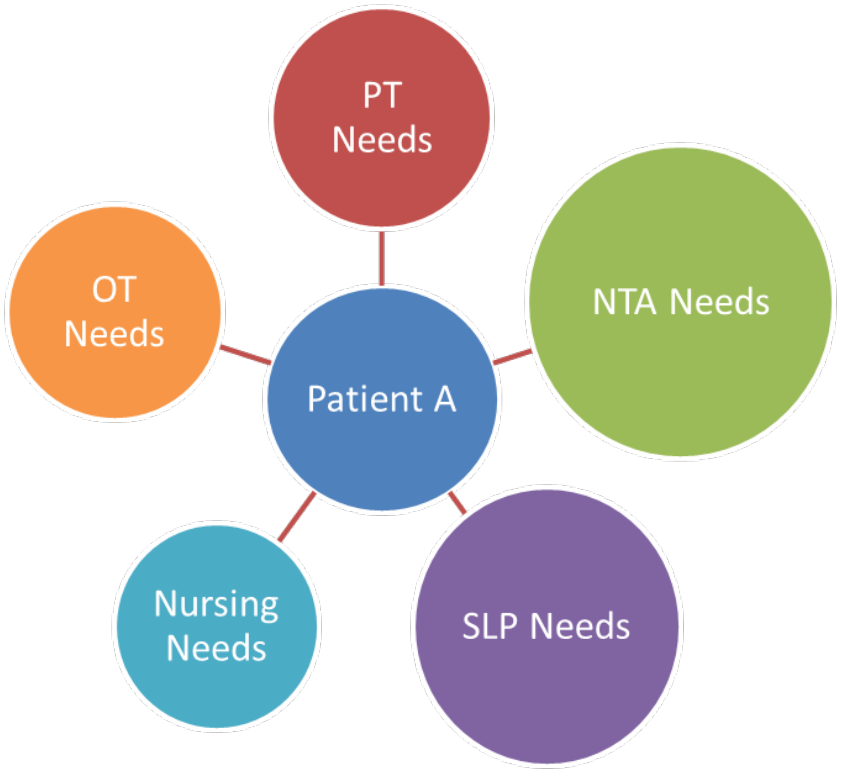
RUG-IV vs. PDPM

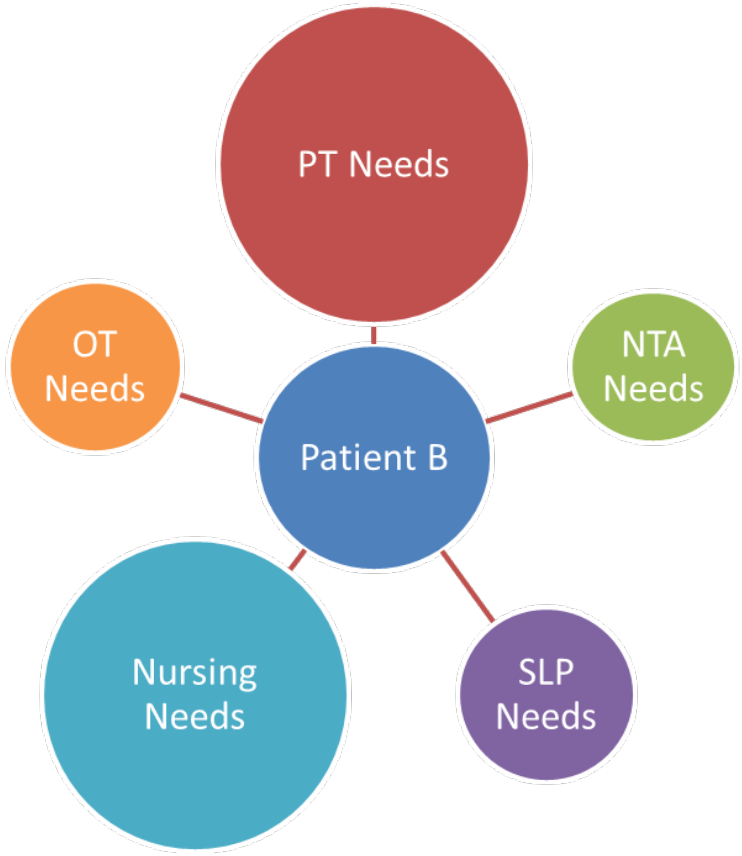
- While RUG-IV (left) reduces everything about a patient to a single, typically volume-driven, case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics, and goals of each patient



Effect of PDPM

- By addressing each individual patient's unique needs independently, PDPM improves payment accuracy and encourages a more patient-driven care model





PDPM Patient Classification

- Under PDPM, each patient is classified into a group for each of the five case-mix adjusted components: PT, OT, SLP, NTA, and Nursing

- Each component utilizes different criteria as the basis for patient classification:
  - PT: Clinical Category, Functional Score
  - OT: Clinical Category, Functional Score
  - SLP: Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment, Mechanically-altered Diet, Swallowing Disorder
  - NTA: NTA Comorbidity Score
  - Nursing: Same characteristics as under RUG-IV

PT & OT Components: RUG-IV & PDPM

- Under RUG-IV, the number of PT, OT, and SLP therapy treatment minutes are combined for a total number of treatment minutes that is used to classify a given patient into a given therapy RUG

- Under PDPM, patient characteristics will be used to predict the therapy costs associated with a given patient, rather than rely on service use

- For the PT & OT components, two classifications are used:
  - Clinical Category
  - Functional Status

PDPM Clinical Categories

- SNF patients are first classified into a clinical category based on the primary diagnosis for the SNF stay
- ICD-10-CM codes, coded on the MDS in Item I0020B, are mapped to a PDPM clinical category
  - Clinical classification may be adjusted by a surgical procedure that occurred during the prior inpatient stay, as coded in Section J
  - ICD-10 mapping available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

PDPM Clinical Categories	
Major Joint Replacement or Spinal Surgery	Cancer
Non-Surgical Orthopedic/Musculoskeletal	Pulmonary
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Cardiovascular and Coagulations
Acute Infections	Acute Neurologic
Medical Management	Non-Orthopedic Surgery

PT & OT Clinical Categories

- Based on data showing similar costs among certain clinical categories, the PT & OT components use four collapsed clinical categories for patient classification.

PDPM Clinical Categories	PT & OT Clinical Categories
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Acute Neurologic	Non-Orthopedic Surgery & Acute Neurologic
Non-Orthopedic Surgery	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	
Medical Management	Medical Management
Cancer	
Pulmonary	
Cardiovascular & Coagulations	
Acute Infections	

PT & OT Functional Score

- PDPM advances CMS' goal of using standardized assessment items across payment settings, by using items in Section GG of the MDS as the basis for patient functional assessments.

- The functional score for the PT & OT components is calculated as the sum of the scores on ten Section GG items:
  - Two bed mobility items
  - Three transfer items
  - One eating item
  - One toileting item
  - One oral hygiene item
  - Two walking items

PT & OT Functional Score: GG Items

- Section GG items included in the PT & OT functional score

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
GG0130B1 – Self-care: Oral Hygiene	0 – 4
GG0130C1 – Self-care: Toileting Hygiene	0 – 4
GG0170B1 – Mobility: Sit to Lying	0 – 4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed	
GG0170D1 – Mobility: Sit to Stand	0 – 4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	
GG0170F1 – Mobility: Toilet Transfer	
GG0170J1 – Mobility: Walk 50 feet with 2 turns	0 – 4 (average of 2 items)
GG0170K1 – Mobility: Walk 150 feet	

Nursing Functional Score: GG Items

- Section GG items included in the Nursing functional score

Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
GG0130C1 – Self-care: Toileting Hygiene	0 – 4
GG0170B1 – Mobility: Sit to Lying	0 – 4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed	
GG0170D1 – Mobility: Sit to Stand	0 – 4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	
GG0170F1 – Mobility: Toilet Transfer	

Functional Score: Item Response Crosswalk

- PT & OT and Nursing Functional Score Construction (Non-walking Items)

Item Response	Score
05, 06 – Set-up Assistance, Independent	4
04 – Supervision or touching assistance	3
03 – Partial/Moderate assistance	2
02 – Substantial/Maximal assistance	1
01, 07, 09, 10, 88, missing – Dependent, Refused, Not applicable, Not attempted due to environmental limitations, Not Attempted due to medical condition or safety concerns	0

- PT & OT Functional Score Construction (Walking Items)

Item Response	Score
05, 06 – Set-up Assistance, Independent	4
04 – Supervision or touching assistance	3
03 – Partial/Moderate assistance	2
02 – Substantial/Maximal assistance	1
01, 07, 09, 10, 88 – Dependent, Refused, Not applicable, Not attempted due to environmental limitations, Not Attempted due to medical condition or safety concerns, Resident Cannot Walk (Coded based on response to GG0170I1)	0

RUG-IV & PDPM Function Score Differences

- Notable differences between G and GG scoring methodologies:
  - Reverse scoring methodology:
    - Under Section G, increasing score means increasing dependence
    - Under Section GG, increasing score means increasing independence
  - Non-linear relationship to payment:
    - Under RUG-IV, increasing dependence, within a given RUG category, translates to higher payment
    - Under PDPM, there is not a direct relationship between increasing dependence and increasing payment
      - Example: For the PT & OT component, payment for three clinical categories is lower for the most and least dependent patients (who are less likely to require high therapy amounts of therapy), compared to those in between (who are more likely to require high amounts of therapy)

PT & OT Components: Payment Groups

Clinical Category	PT & OT Function Score	PT & OT Case Mix Group	PT CMI	OT CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.59
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.17
Medical Management	6-9	TJ	1.42	1.44
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.49
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

SLP Component

- For the SLP component, PDPM uses a number of different patient characteristics that were predictive of increased SLP costs:
  - Acute Neurologic clinical classification
  - Certain SLP-related comorbidities
  - Presence of cognitive impairment
  - Use of a mechanically-altered diet
  - Presence of swallowing disorder

SLP Comorbidities

- Twelve SLP comorbidities were identified as predictive of higher SLP costs
  - Conditions and services combined into a single SLP-related comorbidity flag
  - Patient qualifies if any of the conditions/services is present

SLP Comorbidities	
Aphasia	Laryngeal Cancer
CVA,TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy (while Resident)	Oral Cancers
Ventilator (while Resident)	Speech & Language Deficits

PDPM Cognitive Scoring

- Under RUG-IV, a patient's cognitive status is assessed using the Brief Interview for Mental Status (BIMS)
  - In cases where the BIMS cannot be completed, providers are required to perform a staff assessment for mental status
  - The Cognitive Performance Scale (CPS) is then used to score the patient's cognitive status based on the results of the staff assessment

- Under PDPM, a patient's cognitive status is assessed in exactly the same way as under RUG-IV (i.e., via the BIMS or staff assessment)
  - Scoring the patient's cognitive status, for purposes of classification, is based on the Cognitive Function Scale (CFS), which is able to provide consistent scoring across the BIMS and staff assessment

PDPM Cognitive Score: Methodology

- PDPM Cognitive Measure Classification Methodology

Cognitive Level	BIMS Score	CPS Score
Cognitively Intact	13 – 15	0
Mildly Impaired	8 – 12	1 – 2
Moderately Impaired	0 – 7	3 – 4
Severely Impaired	-	5 – 6

SLP Component: Payment Groups

Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	SLP Case Mix Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97
Any two	Neither	SG	2.04
Any two	Either	SH	2.85
Any two	Both	SI	3.51
All three	Neither	SJ	2.98
All three	Either	SK	3.69
All three	Both	SL	4.19

NTA Component

- NTA classification is based on the presence of certain comorbidities or use of certain extensive services

- We considered various options to incorporate comorbidities into payment.
  - Total number of comorbidities is linked to NTA costs, but a simple count of conditions overlooks differences in relative costliness
  - A tier system accounts for differences in relative costliness, but does not account for the number of comorbidities

- Comorbidity score is a weighted count of comorbidities
  - Comorbidities associated with high increases in NTA costs grouped into various point tiers
  - Points assigned for each additional comorbidity present, with more points awarded for higher-cost tiers

NTA Component: Comorbidity Coding

- Comorbidities and extensive services for NTA classification are derived from a variety of MDS sources, with some comorbidities identified by ICD-10-CM codes reported in Item I8000

- A mapping between ICD-10-CM codes and NTA comorbidities used for NTA classification is available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

- One comorbidity (HIV/AIDS) is reported on the SNF claim, in the same manner as under RUG-IV
  - The patient's NTA classification will be adjusted by the appropriate number of points for this condition by the CMS PRICER for patients with HIV/AIDS

NTA Component: Condition Listing (1)

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Diabetes Mellitus (DM) Code	MDS Item I2900	2

NTA Component: Condition Listing (2)

Condition/Extensive Service	Source	Points
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	MDS Item M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1

NTA Component: Condition Listing (3)

Condition/Extensive Service	Source	Points
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	MDS Item M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I1300	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy - Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Malnutrition Code	MDS Item I5600	1

NTA Component: Condition Listing (4)

Condition/Extensive Service	Source	Points
Disorders of Immunity - Except : RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

NTA Component: Payment Groups

NTA Score Range	NTA Case Mix Group	NTA Case Mix Index
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

Nursing Component

- RUG-IV classifies patients into a therapy RUG, based on how much therapy the patient receives, and a non-therapy RUG, based on certain patient characteristics.
  - Only one of these RUGs is used for payment purposes
  - Therapy RUGs are used to bill for over 90% of Part A days

- Therapy RUGs use a consistent nursing case-mix adjustment, which obscures clinically meaningful differences in nursing characteristics between patients in the same therapy RUG.

- PDPM utilizes the same basic nursing classification structure as RUG-IV, with certain modifications.
  - Function score based on Section GG of the MDS 3.0
  - Collapsed functional groups, reducing the number of nursing groups from 43 to 25

Nursing Component: Payment Groups (1)

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	Restorative Nursing Services	Function Score	CMG	CMI
ES3	Tracheostomy & Ventilator				0-14	ES3	4.04
ES2	Tracheostomy or Ventilator				0-14	ES2	3.06
ES1	Infection Isolation				0-14	ES1	2.91
HE2/HD2		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	Yes		0-5	HDE2	2.39
HE1/HD1		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	No		0-5	HDE1	1.99
HC2/HB2		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	Yes		6-14	HBC2	2.23
HC1/HB1		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	No		6-14	HBC1	1.85

Nursing Component: Payment Groups (2)

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	Restorative Nursing Services	Function Score	CMG	CMI
LE2/LD2		Serious medical conditions e.g. radiation therapy or dialysis	Yes		0-5	LDE2	2.07
LE1/LD1		Serious medical conditions e.g. radiation therapy or dialysis	No		0-5	LDE1	1.72
LC2/LB2		Serious medical conditions e.g. radiation therapy or dialysis	Yes		6-14	LBC2	1.71
LC1/LB1		Serious medical conditions e.g. radiation therapy or dialysis	No		6-14	LBC1	1.43
CE2/CD2		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes		0-5	CDE2	1.86
CE1/CD1		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	No		0-5	CDE1	1.62
CC2/CB2		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes		6-14	CBC2	1.54
CA2		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes		15-16	CA2	1.08

Nursing Component: Payment Groups (3)

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	Restorative Nursing Services	Function Score	CMG	CMI
CC1/CB1		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	No		6-14	CBC1	1.34
CA1		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	No		15-16	CA1	0.94
BB2/BA2		Behavioral or cognitive symptoms		2 or more	11-16	BAB2	1.04
BB1/BA1		Behavioral or cognitive symptoms		0-1	11-16	BAB1	0.99
PE2/PD2		Assistance with daily living and general supervision		2 or more	0-5	PDE2	1.57
PE1/PD1		Assistance with daily living and general supervision		0-1	0-5	PDE1	1.47
PC2/PB2		Assistance with daily living and general supervision		2 or more	6-14	PBC2	1.21
PA2		Assistance with daily living and general supervision		2 or more	15-16	PA2	0.7
PC1/PB1		Assistance with daily living and general supervision		0-1	6-14	PBC1	1.13
PA1		Assistance with daily living and general supervision		0-1	15-16	PA1	0.66

Variable Per Diem Adjustment

- The Social Security Act requires the SNF PPS to pay on a per-diem basis.
- Constant per diem rates do not accurately track changes in resource utilization throughout the stay, and may allocate too few resources for providers at beginning of stay.
- To account more accurately for the variability in patient costs over the course of a stay, under PDPM, an adjustment factor is applied (for certain components) and changes the per diem rate over the course of the stay.
  - Similar to what exists under the Inpatient Psychiatric Facility (IPF) PPS
- For the PT, OT, and NTA components, the case-mix adjusted per diem rate is multiplied against the variable per diem adjustment factor, following a schedule of adjustments for each day of the patient's stay.

Variable Per Diem Adjustment Schedules

- PT & OT Components

Day in Stay	Adjustment Factor	Day in Stay	Adjustment Factor
1-20	1.00	63-69	0.86
21-27	0.98	70-76	0.84
28-34	0.96	77-83	0.82
35-41	0.94	84-90	0.80
42-48	0.92	91-97	0.78
49-55	0.90	98-100	0.76
56-62	0.88		

- NTA Component

Day in Stay	Adjustment Factor
1-3	3.00
4-100	1.00

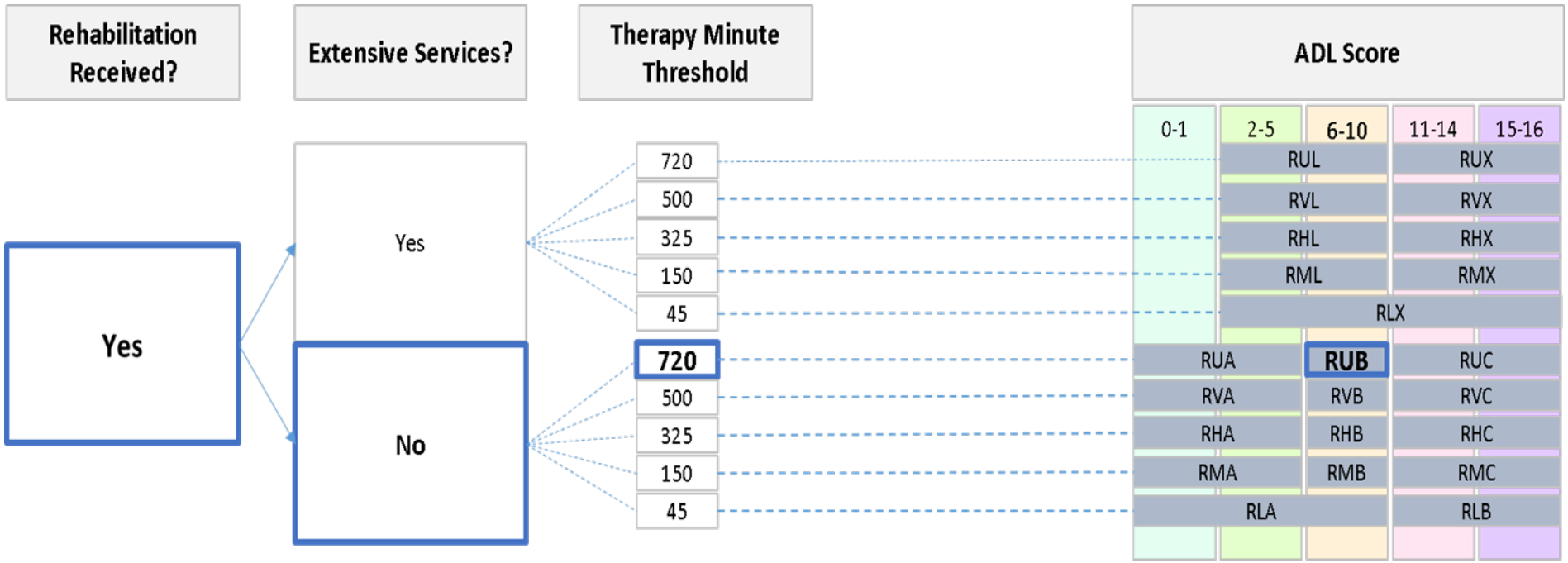
Patient Classification Example

- Consider two patients with the following characteristics:

Patient Characteristics	Patient A	Patient B
Rehabilitation Received?	Yes	Yes
Therapy Minutes	730	730
Extensive Services	No	No
ADL Score	9	9
Clinical Category	Acute Neurologic	Major Joint Replacement
PT & OT Functional Score	10	10
Nursing Function Score	7	7
Cognitive Impairment	Moderate	Intact
Swallowing Disorder?	No	No
Mechanically Altered Diet?	Yes	No
SLP Comorbidity?	No	No
Comorbidities	IV Medication and Diabetes	Chronic Pancreatitis
Other Conditions	Dialysis	Septicemia
Depression?	No	Yes

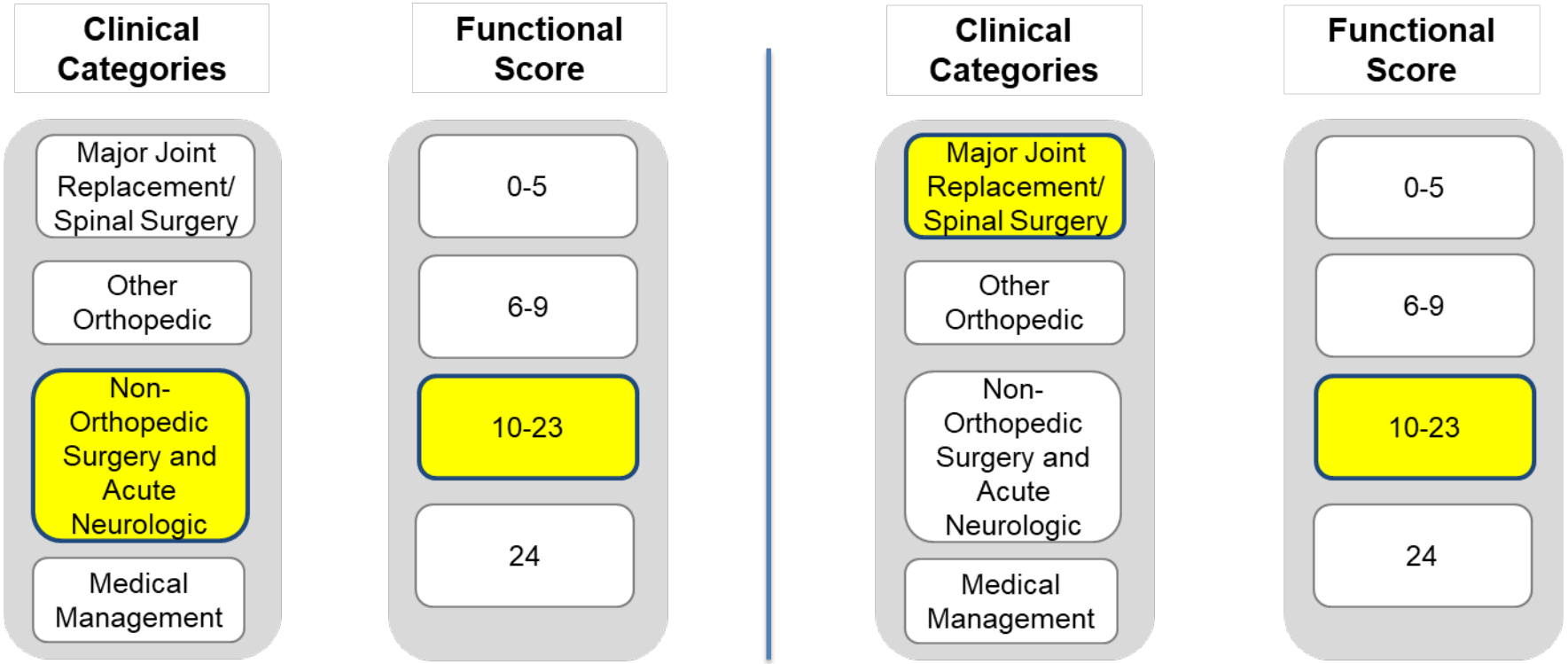
RUG-IV Classification

- Under the RUG-IV model, both patients would be classified into the same payment group because they received the same number of therapy minutes and received no extensive services, despite significant differences between them.



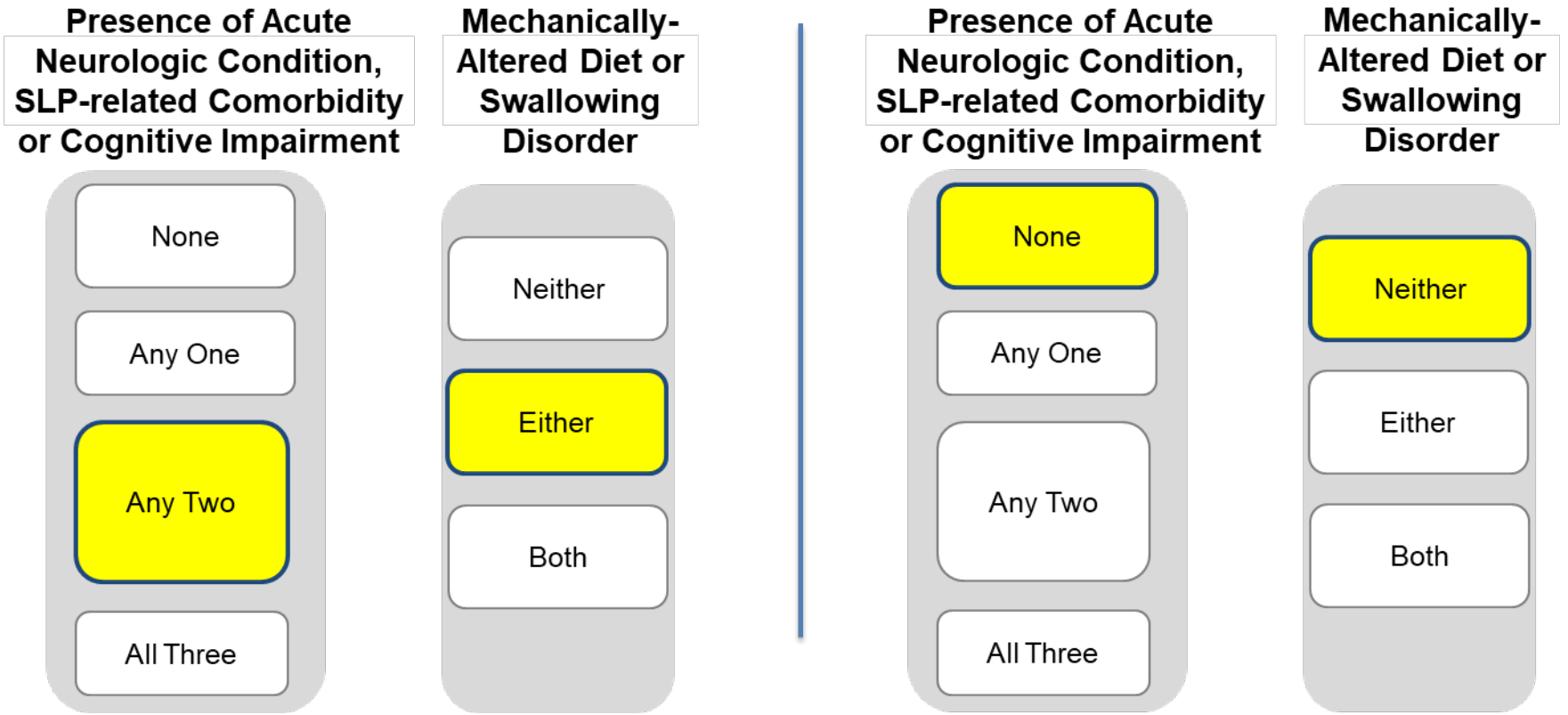
PDPM Classification: PT & OT Components

- Patient A (left) is classified into Acute Neurologic with PT and OT Functional Score of 10; Patient B (right) is classified into Major Joint Replacement/Spinal Surgery with a PT and OT Functional Score of 10.



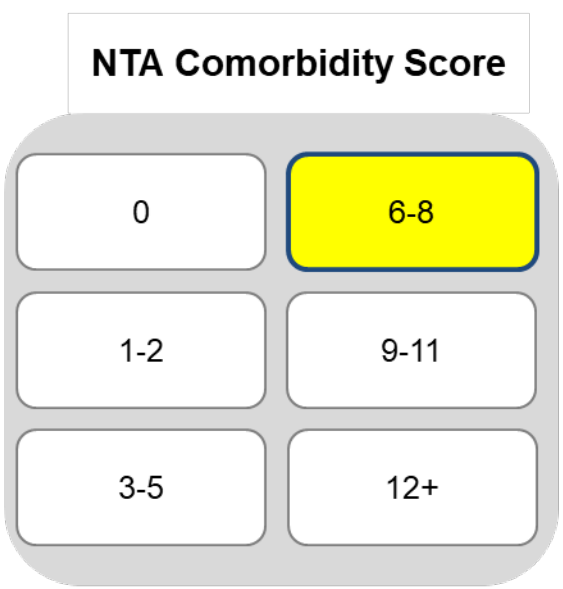
PDPM Classification: SLP Component

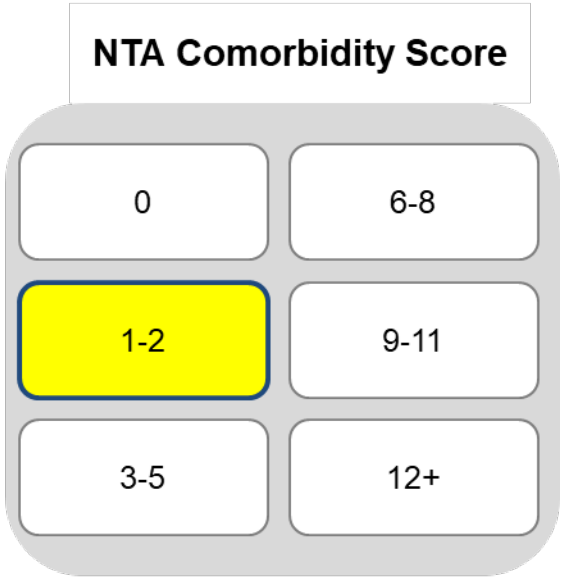
- Patient A (left) is classified into Acute Neurologic, has moderate cognitive impairment, and is on a mechanically-altered diet; and Patient B (right) is classified into non-neurologic with no SLP-classification related issue.



PDPM Classification: NTA Component

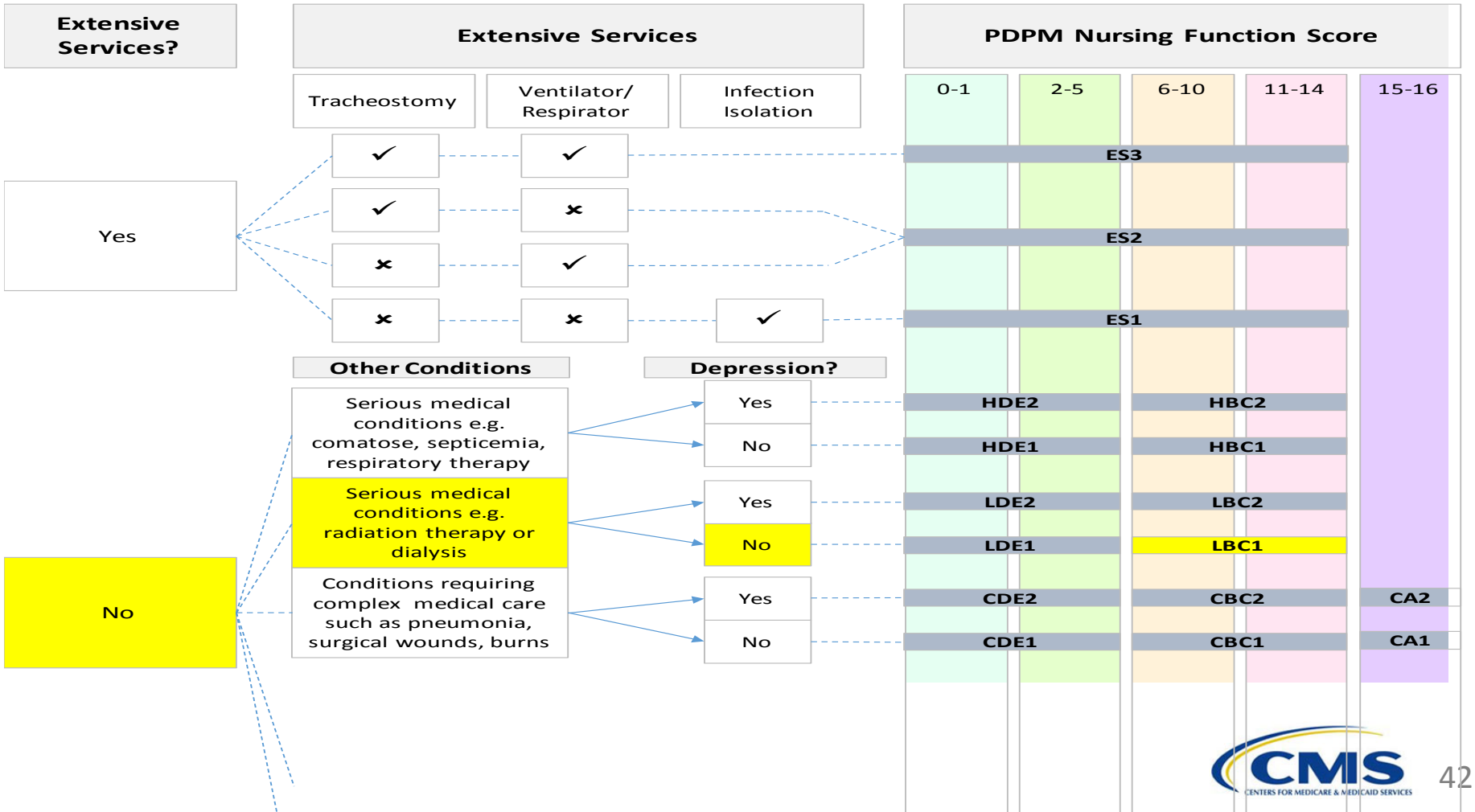
- Patient A (left) has an NTA Comorbidity Score of 7 from IV medication (5 points) and diabetes mellitus (2 points); Patient B (right) has an NTA Comorbidity Score of 1 from chronic pancreatitis (1 point).





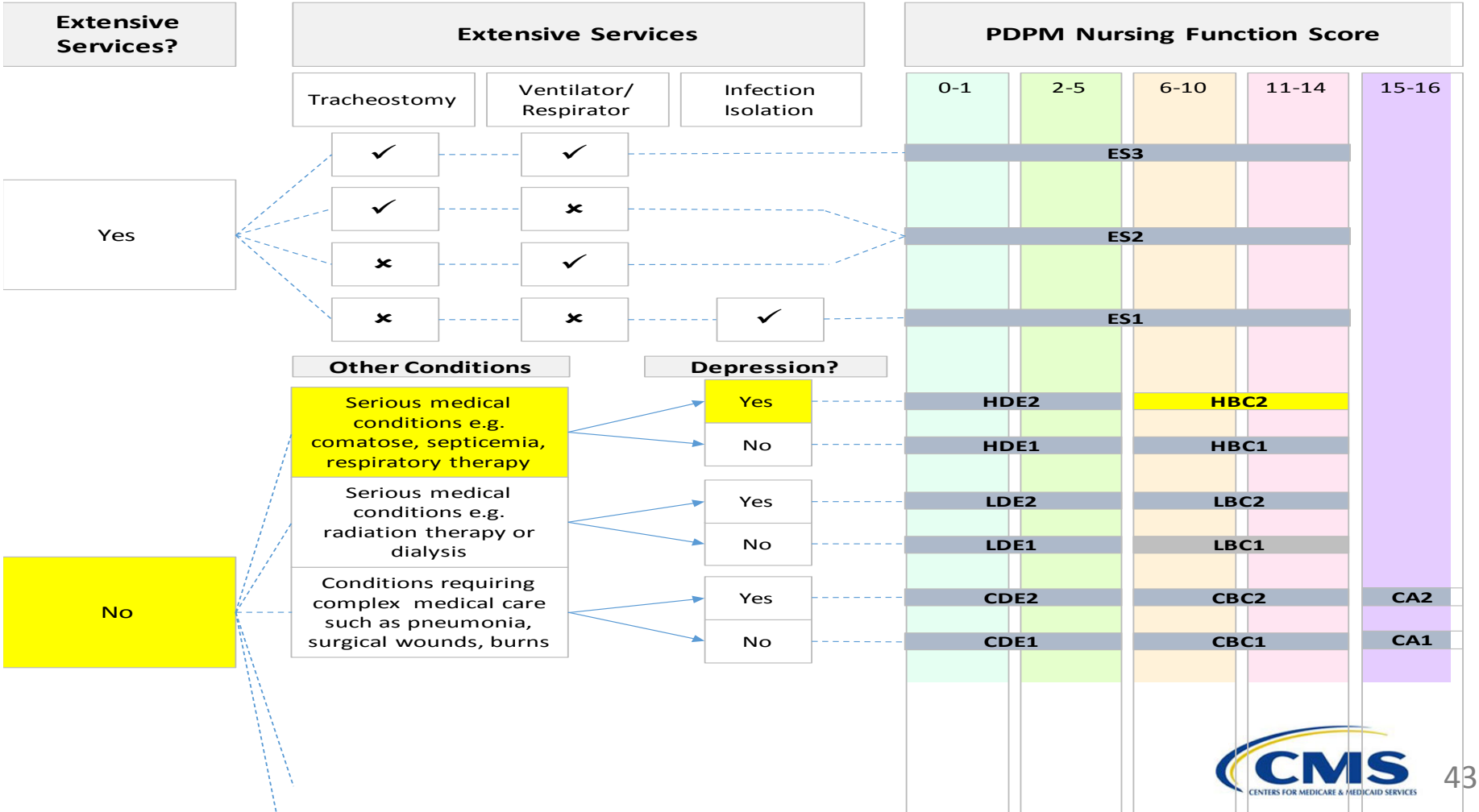
PDPM Classification: Nursing Component (1)

- Patient A is receiving dialysis services with a Nursing Function Score of 7 and is classified into LBC1.



PDPM Classification: Nursing Component (2)

- Patient B has septicemia and a Nursing Function Score of 7, exhibits signs of depression, and is classified into HBC2.



Additional PDPM Policies

- In addition to the case-mix refinements, PDPM also includes policy changes to the SNF PPS to be effective concurrent with implementation of PDPM.

- The areas discussed in the next slides are:
  - MDS Related Changes:
    - MDS Assessment Schedule
    - New MDS Item Sets
    - New MDS Items
  - Concurrent & Group Therapy Limit
  - Interrupted Stay Policy
  - Administrative Presumption
  - Payment for Patients with AIDS
  - Revised HIPPS Coding
  - RUG-IV – PDPM Transition

MDS Changes: Assessment Schedule

- Both RUG-IV and PDPM utilize the MDS 3.0 as the basis for patient assessment and classification.

- The assessment schedule for RUG-IV includes both scheduled and unscheduled assessments with a variety of rules governing timing, interaction among assessments, combining assessments, etc.
  - Frequent assessments are necessary, due to the focus of RUG-IV on such highly variable characteristics as service utilization

- The assessment schedule under PDPM is significantly more streamlined and simple to understand than the assessment schedule under RUG-IV.

- The changes to the assessment schedule under PDPM have no effect on any OBRA-related assessment requirements.

RUG-IV Assessment Schedule

- RUG-IV PPS Assessment Schedule

Scheduled Assessment			
Medicare MDS Assessment Schedule Type	**Assessment Reference Date**	**Assessment Reference Date Grace Days**	**Applicable Standard Medicare Payment Days**
5-day	Days 1-5	6-8	1 through 14
14-day	Days 13-14	15-18	15 through 30
30-day	Days 27-29	30-33	31 through 60
60-day	Days 57-59	60-63	61 through 90
90-day	Days 87-89	90-93	91 through 100
Unscheduled Assessment			
Start of Therapy OMRA	5-7 days after	start of therapy	Date of the first day of therapy through the end of the standard payment period
End of Therapy OMRA	1-3 days after	end of therapy	First non-therapy day through the end of the standard payment period
Change of Therapy OMRA	Day 7 (last day) of	COT observation period	The first day of the COT observation period until end of standard payment period, or until interrupted by the next COT-OMRA assessment or scheduled or unscheduled PPS Assessment
Significant Change in Status Assessment	No later than 14 days after	significant change identified	ARD of Assessment through the end of the standard payment period

PDPM Assessment Schedule

- PDPM Assessment Schedule

Medicare MDS Assessment Schedule Type	Assessment Reference Date	Applicable Standard Medicare Payment Days
Five-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed)
Interim Payment Assessment (IPA)	Optional Assessment	ARD of the assessment through Part A discharge (unless another IPA assessment is completed)
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A

MDS Changes: New Item Sets

- Interim Payment Assessment (IPA)
  - Optional Assessment: May be completed by providers in order to report a change in the patient's PDPM classification
    - Does not impact the variable per diem schedule
  - ARD: Determined by the provider
  - Payment Impact: Changes payment beginning on the ARD and continues until the end of the Part A stay or until another IPA is completed

- Optional State Assessment (OSA)
  - Solely to be used by providers to report on Medicaid-covered stays, per requirements set forth by their state
  - Allows providers in states using RUG-III or RUG-IV models as the basis for Medicaid payment to do so until September 30, 2020, at which point CMS support for legacy payment models will end.

MDS Changes: New & Revised Items (1)

- SNF Primary Diagnosis
  - Item I0020B (New Item)
  - This item is for providers to report, using an ICD-10-CM code, the patient's primary SNF diagnosis
  - "What is the main reason this person is being admitted to the SNF?"
  - Coded when I0020 is coded as any response 1 – 13

- Patient Surgical History
  - Items J2100 – J5000 (New Items)
  - These items are used to capture any major surgical procedures that occurred during the inpatient hospital stay that immediately preceded the SNF admission (i.e., the qualifying hospital stay)
  - Similar to the active diagnoses captured in Section I, these Section J items will be in the form of checkboxes

MDS Changes: Patient Surgical Categories

Item	Surgical Procedure Category	Item	Surgical Procedure Category
J2100	Recent Surgery Requiring Active SNF Care	J2610	Neuro surgery - peripheral and autonomic nervous system - open and percutaneous
J2300	Knee Replacement - partial or total	J2620	Neuro surgery - insertion or removal of spinal and brain neurostimulators, electrodes, catheters, and CSF drainage devices
J2310	Hip Replacement - partial or total	J2699	Neuro surgery - other
J2320	Ankle Replacement - partial or total	J2700	Cardiopulmonary surgery - heart or major blood vessels - open and percutaneous procedures
J2330	Shoulder Replacement - partial or total	J2710	Cardiopulmonary surgery - respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open and endoscopic
J2400	Spinal surgery - spinal cord or major spinal nerves	J2799	Cardiopulmonary surgery - other
J2410	Spinal surgery - fusion of spinal bones	J2800	Genitourinary surgery - male or female organs
J2420	Spinal surgery - lamina, discs, or facets	J2810	Genitourinary surgery - kidneys, ureter, adrenals, and bladder - open, laparoscopic
J2499	Spinal surgery - other	J2899	Genitourinary surgery - other
J2500	Ortho surgery - repair fractures of shoulder or arm	J2900	Major surgery - tendons, ligament, or muscles
J2510	Ortho surgery - repair fractures of pelvis, hip, leg, knee, or ankle	J2910	Major surgery - GI tract and abdominal contents from esophagus to anus, biliary tree, gall bladder, liver, pancreas, spleen - open, laparoscopic
J2520	Ortho surgery - repair but not replace joints	J2920	Major surgery - endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, and thymus - open
J2530	Ortho surgery - repair other bones	J2930	Major surgery - breast
J2599	Ortho surgery - other	J2940	Major surgery - deep ulcers, internal brachytherapy, bone marrow, stem cell harvest/transplant
J2600	Neuro surgery - brain, surrounding tissue/blood vessels	J5000	Major surgery - other not listed above

MDS Changes: New & Revised Items (2)

- Discharge Therapy Collection Items
  - Items 0425A1 – O0425C5 (New Items)
  - Using a look-back of the entire PPS stay, providers report, by each discipline and mode of therapy, the amount of therapy (in minutes) received by the patient
  - If the total amount of group/concurrent minutes, combined, comprises more than 25% of the total amount of therapy for that discipline, a warning message is issued on the final validation report

- Section GG Functional Items – Interim Performance
  - On the IPA, Section GG items will be derived from a new column “5” which will capture the interim performance of the patient
  - The look-back for this new column will be the three-day window leading up to and including the ARD of the IPA (ARD and the 2 calendar days prior to the ARD)

MDS Changes: New & Revised Items (3)

- Existing MDS Items Being Added to Swing Bed Assessment
  - K0100: Swallowing Disorder
  - I1300: Ulcerative Colitis or Crohn's Disease or Inflammatory Bowel Disease
  - I4300: Active Diagnosis: Aphasia
  - O0100D2: Special Treatments, Procedures & Programs: Suctioning, While a Resident

- Existing Items Being Added to 5-day PPS Assessment and IPA
  - I1300: Ulcerative Colitis or Crohn's Disease or Inflammatory Bowel Disease

Concurrent & Group Therapy Limit

- Under RUG-IV, no more than 25% of the therapy services delivered to SNF patients, for each discipline, may be provided in a group therapy setting, while there is no limit on concurrent therapy.

- Definitions:
  - Concurrent Therapy: One therapist with two patients doing different activities
  - Group Therapy: One therapist with four patients doing the same or similar activities

- Under PDPM, we use a combined limit both concurrent and group therapy to be no more than 25% of the therapy received by SNF patients, for each therapy discipline.

Concurrent & Group Limit: Compliance

- Compliance with the concurrent/group therapy limit will be monitored by new items on the PPS Discharge Assessment (O0425).
  - Providers will report the number of minutes, per mode and per discipline, for the entirety of the PPS stay
  - If the total number of concurrent and group minutes, combined, comprises more than 25% of the total therapy minutes provided to the patient, for any therapy discipline, then the provider will receive a warning message on their final validation report

- How to calculate compliance with the concurrent/group therapy limit.
  - Step 1: Total Therapy Minutes, by discipline
    (O0425X1 + O0425X2 + O0425X3)
  - Step 2: Total Concurrent and Group Therapy Minutes, by discipline (O0425X2 + O0425X3)
  - Step 3: C/G Ratio (Step 2 Result / Step 1 Result)
  - Step 4: If Step 3 Result is greater than 0.25, then non-compliant

Concurrent & Group Limit: Example 1

- Example 1
  - Total PT Individual Minutes (O0425C1): 2,000
  - Total PT Concurrent Minutes (O0425C2): 600
  - Total PT Group Minutes (O0425C3): 1,000

- Does this comply with the concurrent/group therapy limit?
  - Step 1: Total PT Minutes (O0425C1 + O0425C2 + O0425C3): 3,600
  - Step 2: Total PT Concurrent and Group Therapy Minutes (O0425C2 + O0425C3): 1,600
  - Step 3: C/G Ratio (Step 2 Result / Step 1 Result): 0.44
  - Step 4: 0.44 is greater than 0.25, therefore this is non-compliant

Concurrent & Group Limit: Example 2

- Example 2
  - Total SLP Individual Minutes (O0425C1): 1,200
  - Total SLP Concurrent Minutes (O0425C2): 100
  - Total SLP Group Minutes (O0425C3): 200

- Does this comply with the concurrent/group therapy limit?
  - Step 1: Total SLP Minutes (O0425C1 + O0425C2 + O0425C3): 1,500
  - Step 2: Total PT Concurrent and Group Therapy Minutes (O0425C2 + O0425C3): 300
  - Step 3: C/G Ratio (Step 2 Result / Step 1 Result): 0.20
  - Step 4: 0.20 is not greater than 0.25, therefore this is compliant

Interrupted Stay Policy: Background

- Given the introduction, under PDPM, of the variable per diem adjustment, there is a potential incentive for providers to discharge SNF patients from a covered Part A stay and then readmit the patient in order to reset the variable per diem schedule.

- Frequent patient readmissions and transfers represents a significant risk to patient care, as well as a potential administrative burden on providers from having to complete new patient assessments for each readmission.

- To mitigate this potential incentive, PDPM includes an interrupted stay policy, which would combine multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within a prescribed window.
  - This type of policy also exists in other post-acute care settings (e.g., Inpatient Rehabilitation Facility (IRF) PPS).

Interrupted Stay Policy

- If a patient is discharged from a SNF and readmitted to the same SNF no more than 3 consecutive calendar days after discharge, then the subsequent stay is considered a continuation of the previous stay.
  - Assessment schedule continues from the point just prior to discharge
  - Variable per diem schedule continues from the point just prior to discharge

- If patient is discharged from SNF and readmitted more than 3 consecutive calendar days after discharge, or admitted to a different SNF, then the subsequent stay is considered a new stay.
  - Assessment schedule and variable per diem schedule reset to day 1

Interrupted Stay Policy: Examples

- Example 1: Patient A is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and returns to same SNF on 11/25/19
  - New stay
  - Assessment Schedule: Reset; stay begins with new 5-day assessment
  - Variable Per Diem: Reset: stay begins on Day 1 of VPD Schedule
- Example 2: Patient B is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and admitted to different SNF on 11/22/19
  - New stay
  - Assessment Schedule: Reset; stay begins with new 5-day assessment
  - Variable Per Diem: Reset; stay begins on Day 1 of VPD Schedule
- Example 3: Patient C is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and returns to same SNF on 11/22/19
  - Continuation of previous stay
  - Assessment Schedule: No PPS assessments required, IPA optional
  - Variable Per Diem: Continues from Day 14 (Day of Discharge)

Administrative Presumption: Background

- The SNF PPS includes an administrative presumption in which a beneficiary who is correctly assigned one of the designated, more intensive case-mix classifiers on the 5-day PPS assessment is automatically classified as requiring an SNF level of care through the assessment reference date for that assessment.

- Those beneficiaries not assigned one of the designated classifiers are not automatically classified as either meeting or not meeting the level of care definition, but instead receive an individual determination using the existing administrative criteria.

Administrative Presumption: Classifiers

- The following PDPM classifiers are designated under the presumption:
  - Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;
  - PT & OT groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
  - SLP groups SC, SE, SF, SH, SI, SJ, SK, and SL; and
  - The NTA component's uppermost (12+) comorbidity group

RUG-IV Payment for SNF Patients with AIDS

- Under RUG-IV, patients with AIDS receive 128% increase in the per diem rate associated with their RUG-IV classification.

- This add-on was merely a general approximation of the added cost of caring for patients with AIDS, which was not accurately targeted at the specific rate components that actually account for the disparity in cost between those patients and others.
  - Two primary cost components that drive increased cost for this subpopulation are Nursing and NTA costs
  - Under RUG-IV, given most patients are classified into a therapy group and criteria used to classify patients into therapy groups, increased therapy utilization also increased impact of the AIDS add-on, contrary to research indicating that AIDS is actually associated with a statistically significant decrease in per diem therapy costs

PDPM Payment for SNF Patients with AIDS

- As the PDPM was developed, its rate components were specifically designed to account accurately and appropriately for the increased cost of AIDS-related care, as determined through our research.

- Accordingly, the PDPM addresses costs for this subpopulation in two ways.
  - Assigns those patients with AIDS the highest point value (8 points) of any condition or service for purposes of classification under its NTA component
  - 18% add-on to the PDPM Nursing component

- As under the previous RUG-IV model, the presence of an AIDS diagnosis continues to be identified through the SNF's entry of ICD-10-CM Code B20 on the SNF claim.

PDPM HIPPS Coding

- Based on responses on the MDS, patients are classified into payment groups, which are billed using a 5-character Health Insurance Prospective Payment System (HIPPS) code.

- The current RUG-IV HIPPS code follows a prescribed algorithm.
  - Character 1-3: RUG Code
  - Character 4-5: Assessment Indicator

- In order to accommodate the new payment groups, the PDPM HIPPS algorithm is revised as follows:
  - Character 1: PT/OT Payment Group
  - Character 2: SLP Payment Group
  - Character 3: NTA Payment Group
  - Character 4: Nursing Payment Group
  - Character 5: Assessment Indicator

PDPM HIPPS Coding Crosswalk: PT, OT, NTA

- PT/OT, SLP, NTA Payment Groups to HIPPS Translation

PT/OT Payment Group	SLP Payment Group	NTA Payment Group	HIPPS Character
TA	SA	NA	A
TB	SB	NB	B
TC	SC	NC	C
TD	SD	ND	D
TE	SE	NE	E
TF	SF	NF	F
TG	SG		G
TH	SH		H
TI	SI		I
TJ	SJ		J
TK	SK		K
TL	SL		L
TM			M
TN			N
TO			O
TP			P

PDPM HIPPS Coding Crosswalk: Nursing

- Nursing Payment Group to HIPPS Translation

Nursing Payment Group	HIPPS Character	Nursing Payment Group	HIPPS Character
ES3	A	CBC2	N
ES2	B	CA2	O
ES1	C	CBC1	P
HDE2	D	CA1	Q
HDE1	E	BAB2	R
HBC2	F	BAB1	S
HBC1	G	PDE2	T
LDE2	H	PDE1	U
LDE1	I	PBC2	V
LBC2	J	PA2	W
LBC1	K	PBC1	X
CDE2	L	PA1	Y
CDE1	M		

PDPM HIPPS Coding Crosswalk: AI

- Assessment Indicator (AI) Crosswalk

HIPPS Character	Assessment Type
0	IPA
1	PPS 5-day
6	OBRA Assessment (not coded as a PPS Assessment)

PDPM HIPPS Coding: Examples

- Example 1:
  - PT/OT Payment Group: TN
  - SLP Payment Group: SH
  - NTA Payment Group: NC
  - Nursing Payment Group: CBC2
  - Assessment Type: 5-day PPS Assessment
  - HIPPS Code: NHCN1

- Example 2:
  - PT/OT Payment Group: TC
  - SLP Payment Group: SD
  - NTA Payment Group: NE
  - Nursing Payment Group: PBC1
  - Assessment Type: 5-day PPS Assessment
  - HIPPS Code:CDEX1

RUG-IV & PDPM Transition

- As discussed in the FY 2019 SNF PPS Final Rule, there is no transition period between RUG-IV and PDPM, given that running both systems at the same time would be administratively infeasible for providers and CMS.
  - RUG-IV billing ends September 30, 2019
  - PDPM billing begins October 1, 2019

- To receive a PDPM HIPPS code that can be used for billing beginning October 1, 2019, all providers will be required to complete an IPA with an ARD no later than October 7, 2019 for all SNF Part A patients.
  - October 1, 2019 will be considered Day 1 of the VPD schedule under PDPM, even if the patient began their stay prior to October 1, 2019.
  - Any “transitional IPAs” with an ARD after October 7, 2019 will be considered late and relevant penalty for late assessments would apply

Medicaid Related Issues: UPL

- PDPM may have a number of effects on Medicaid programs.
  - Upper Payment Limit (UPL) Calculation
  - Case-mix Determinations

- UPL represents a limit on certain reimbursements for Medicaid providers.
  - Specifically, the UPL is the maximum a given State Medicaid program may pay a type of provider, in the aggregate, statewide in Medicaid fee-for-service (FFS)
  - State Medicaid programs cannot claim federal matching dollars for provider payments in excess of the applicable UPL

- While budget neutral in the aggregate, PDPM changes how payment is made for SNF services, which can have an impact on UPL calculations.
  - States will need to evaluate this effect to understand revisions in their UPL calculations

Medicaid Related Issues: Case-Mix

- For purposes of Medicaid reimbursement, states utilize a myriad of different payment methodologies to determine payment for NF patients.
  - Some states use a version of the RUG-III or RUG-IV models as the basis for patient classification and case-mix determinations

- With PDPM implementation, CMS will continue to report RUG-III and RUG-IV HIPPS codes, based on state requirements, in Item Z0200, through 9/30/2020.

- Case-mix states also may rely on PPS assessments to capture changes in patient case-mix, including scheduled and unscheduled assessments.
  - As of October 1, 2019, all scheduled PPS assessments (except the 5-day) and all current unscheduled PPS assessments will be retired
  - To fill this gap in assessments, CMS will introduce the Optional State Assessment (OSA), which may be required by states for NFs to report changes in patient status, consistent with their case-mix rules

Resources

- PDPM website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html
- For questions related to PDPM implementation and policy:
  - PDPM@cms.hhs.gov
- For questions related to the OSA:
  - OSAMedicaidinfo@cms.hhs.gov