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Understanding the Patient-Driven Payment Model

What is the Patient-Driven Payment Model (PDPM)?

- New reimbursement system created by CMS with intent to;
  - Place more focus on the clinical diagnosis
  - Provide more resources for medically complex conditions
  - Simplify reimbursements

- Proposed classification model shifts focus to clinical considerations

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From RUG III to PDPM (1997 – 2019)

- 1997 Balanced Budget Act requires that the Secretary of Health and Human Services establish a SNF PPS (prospective payment system) by July of 1998
- Refinements take place over several years and RUGs III is replaced by RUGs IV effective in 2011
- Shift from prospective to retrospective payment with initiation of COT (change of therapy OMRA) and OMRA (other Medicare required assessment)
- Both CMS and MedPac have suggested for years that RUG IV incentivizes therapy utilization
- In May 2017, CMS releases ANPRM (Advanced Notice of Proposed Rule Making) and introduces RCS-I
- In response to comments and concerns with RCS-1 model, CMS releases newly proposed PDPM on April 27, 2018, CMS proposed rule for FY 2019...for implementation October 1, 2019 (FY 2020)

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What will this change accomplish?

- Addresses any CMS therapy utilization concerns
  - Reduces the emphasis on minutes of therapy
  - Separates the therapy component into 3 components
    - (PT, OT and SLP)
  - Better balance between therapy, nursing and other care
- Reduces the number of assessments
  1. 5-day MDS Assessment
  2. As needed – Interim Payment Assessment (IPA)
  3. Discharge MDS Assessment
- More accurately compensate for levels of care
  - Likely to see higher reimbursement for higher acuity patients

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Advantages of PDPM

- Improves targeting of resources to patients with varying therapy needs based on discipline (PT, OT, SLP)
- Nursing Case-Mix now separated into a Nursing component and a Non-Therapy Ancillary (NTA) component
- Enhances payment accuracy for services by:
  - Basing payment for each component on CMS's predicted resource utilization based on clinically relevant patient characteristics
  - *Introduces variable payment adjustments to the per-diem payment to recognize changes in resource utilization over the course of a patient's stay*
- Bases resident classification on objective clinical characteristics and minimizes the role of service provision as a determinant of payment
- Utilizes Section GG rather than Section G as measure of function

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How does it work?

- Daily rate for each patient is determined at 5-day assessment
- MDS data from the 5-day assessment is used to calculate five Case-Mix Index (CMI) clinically adjusted components
  1. Nursing CMI
  2. PT CMI
  3. OT CMI
  4. SLP CMI
  5. Non Therapy Ancillary CMI
  6. Non-case mix
- **Calculation:**
  - **Nursing + PT + OT + SLP + NTA + Non-case mix = Daily Rate**
    - PDPM CMIs are multiplied by the appropriate urban or rural base rate
    - Wage index multipliers are applied to determine actual payment rates

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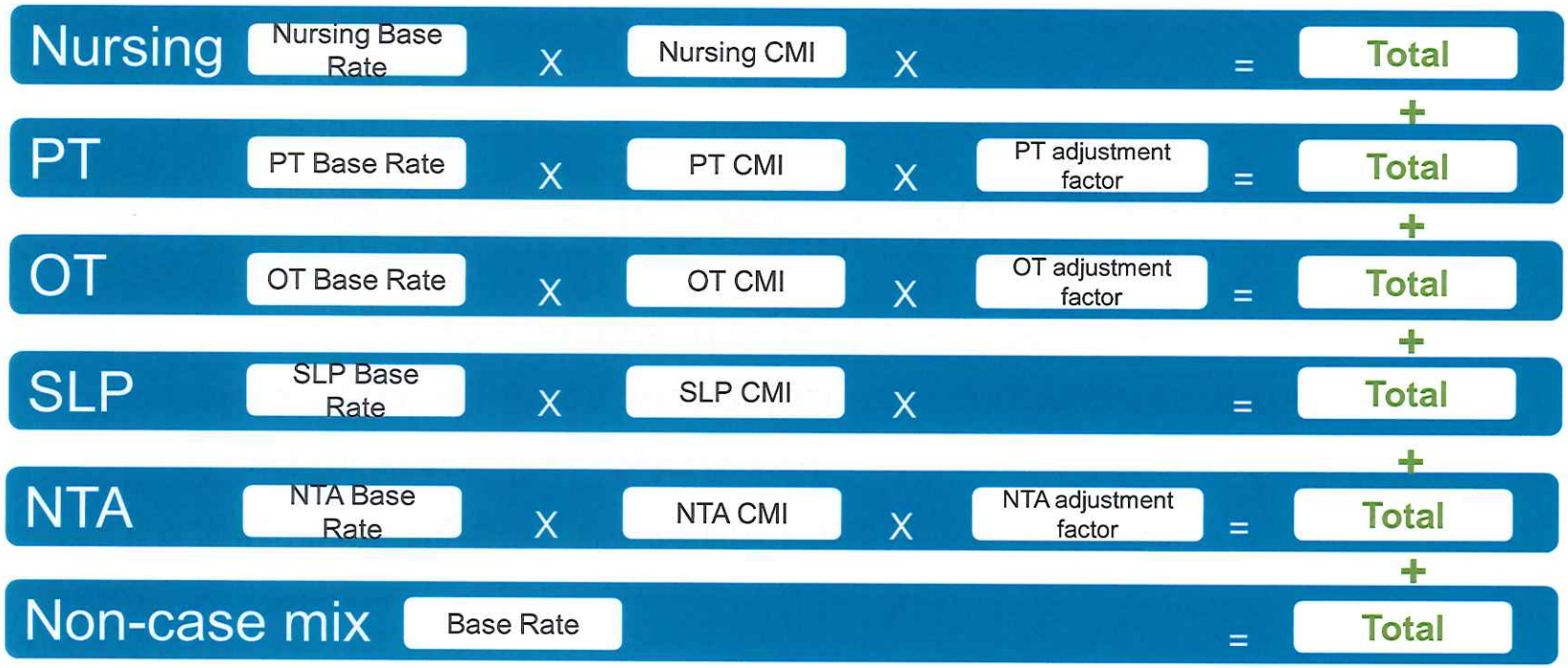
Total Case-mix adjusted per diem payment



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Skilled assessments under PDPM: 5-day

- 5-day
  - Classifies the patient for the entire Medicare Part A stay
  - Still allows for grace days (days 6-7-8)
  - Considers lots of variables but *not* just days and minutes of therapy
  - Will require that we understand patient characteristics upon admission for proper classification
  - The 5-day assessment can be combined with an OBRA assessment

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Skilled assessments under PDPM: IPA

- IPA-Interim Payment Assessment (optional assessment)
  - IPA has its own IPA item set containing only payment items and demographic items as necessary to attain a billing code under PDPM
  - Completed when there is a change in the patient's classification in at least one first-tier criteria that will change payment
  - Completed when there is a change in the resident such that the clinical status will not return to the 5-day baseline with a 14-day period.
  - New payment begins from ARD going forward
  - The IPA is completed no later than 14 days after a change is identified

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Skilled assessments under PDPM: IPA

- IPA-Interim Payment Assessment (optional assessment)
  - It should be noted that, in the case of an IPA, the items used for calculation of the patient's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1)
  - More than one IPA can be completed during a patient's stay if needed
  - Variable per diem adjustments are not affected by an IPA
  - The IPA cannot be combined with any other assessments

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Skilled assessments under PDPM: Discharge Assessment

- Discharge Assessment
  - Completed for all Medicare Part A discharges
  - New values added to Section O to collect therapy minutes
    - PT, OT, ST start and end dates
    - PT, OT, ST Individual Minutes
    - PT, OT, ST Group Minutes
    - PT, OT, ST Concurrent Minutes
    - Total number of days of treatment per discipline

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Interrupted Stay Policy

- If the resident is discharged from the SNF and returns to the ***SAME SNF*** by 12 am at the end of the 3rd day, the SNF will continue with the previous stay for the resident classification as well as the variable per diem adjustment schedule.
  - Note that if a resident drops to a non-skilled level of care or otherwise leaves Part A SNF care, the patient is considered to have been discharged for the purposes of the interrupted stay policy, even if the patient remains in the facility
- If the resident's absence exceeds 3 days ***OR*** the resident is admitted to a ***DIFFERENT SNF,*** the resident is classified as having a "new stay", which requires a new 5-day assessment upon admission and restart of the day count to day 1.

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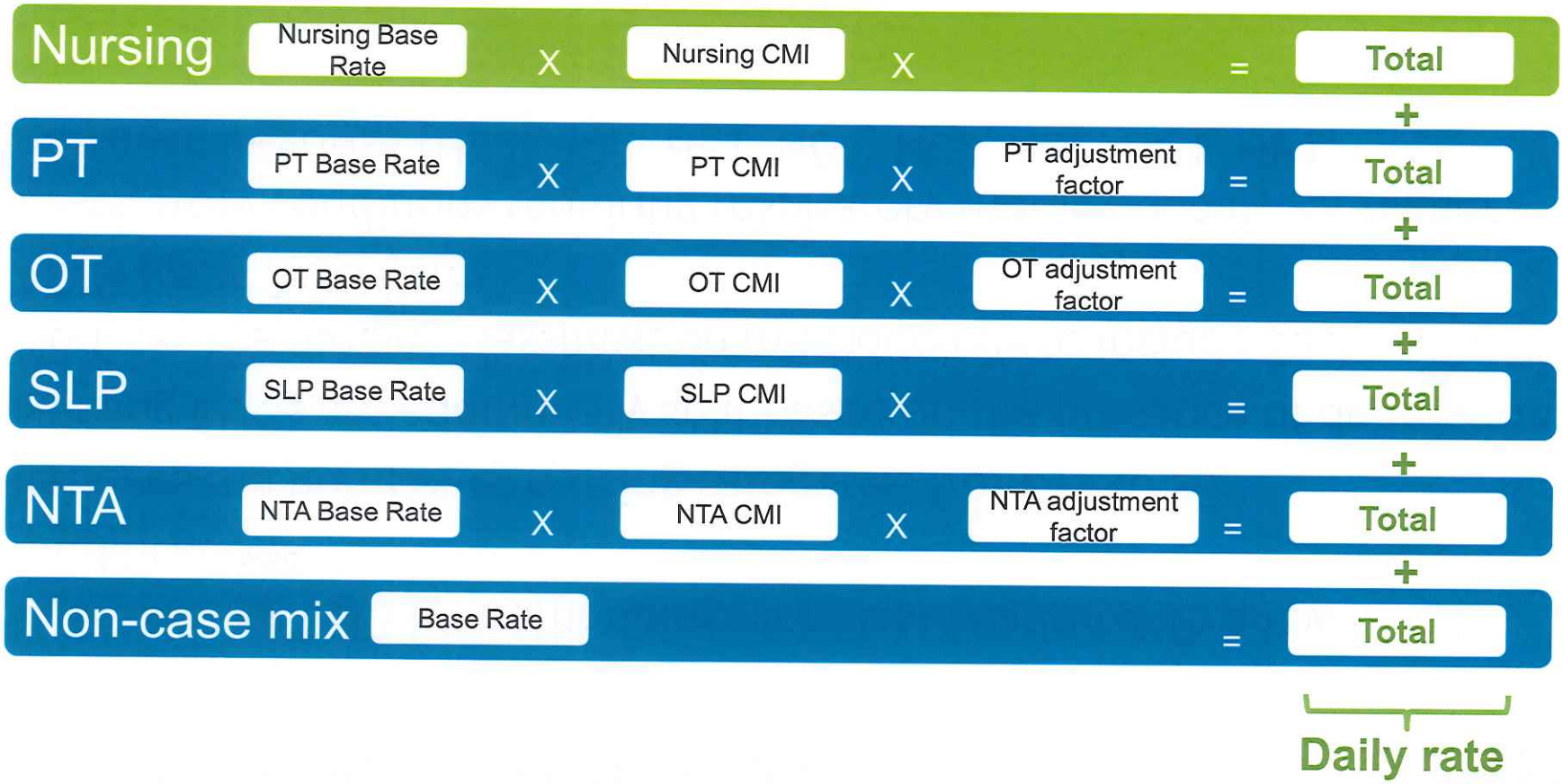
Nursing


Nursing
Nursing Base Rate
X
Nursing CMI
X
=
Total
+
PT
PT Base Rate
X
PT CMI
X
PT adjustment factor
=
Total
+
OT
OT Base Rate
X
OT CMI
X
OT adjustment factor
=
Total
+
SLP
SLP Base Rate
X
SLP CMI
X
=
Total
+
NTA
NTA Base Rate
X
NTA CMI
X
NTA adjustment factor
=
Total
+
Non-case mix
Base Rate
=
Total
Daily rate

Nursing Case-Mix Classification

- Uses existing RUG IV methodology for classification with a few modifications
- Reduces the number of nursing categories from 43 to 25
- Nursing RUGs are additionally split based on the presence of depression
- Updates the nursing classification methodology to include Section GG for ADL's (*uses 7 GG items*)
- Respiratory conditions requiring respiratory therapy qualify for higher nursing categories (HE2, HD2, HE1, HD1, HC2, HB2, HC1, HB1)

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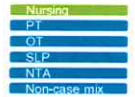
Nursing Functional Status



- Total of Section GG Item Scores = Functional Component

Section GG Item	Description	Score
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*	
GG0171J1	Mobility: Walk 50 feet with 2 turns	0-4 (average of 2 items)
GG0170K1	Mobility: Walk 150 feet	

*Nursing uses only 7 items to score function under Section GG

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Section GG scoring

- The scores in Section GG are rounded only at the end of the calculation.
  - For example, if the transfer items have 1, 1, and 0 points, the unrounded average is 0.66
  - This would be added to the other scores, unrounded, and
  - The total score at the end of the sum calculation would be rounded to the nearest integer
  - Example:

Section GG Item Description	Individual Item Score (range: 0-4)	Total scoring with averages
Self-care: Eating	3	3
Self-care: Toileting hygiene	1	1
Mobility: Sit to lying	1	-
Mobility: Lying to sitting on side of bed	1	-
Mobility: Sit to stand	0	.66
Mobility: Chair/bed to chair transfer	0	-
Mobility: Toilet transfer	0	0
		4.66 rounded to 5

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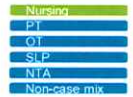
Nursing Categories/Functional Scores/CMI



Nursing RUG	GG Function Score	End Splits	CMI	Nursing RUG	GG Function Score	End Splits	CMI
ES3	0-14	Tracheostomy and Ventilator	4.04	CBC2	6-14	Depressed	1.54
ES2	0-14	Tracheostomy or Ventilator	3.06	CA2	15-16	Depressed	1.08
ES1	0-14	Infection Isolation	2.91	CBC1	6-14	Not Depressed	1.34
HDE2	0-5	Depressed	2.39	CA1	15-16	Not Depressed	0.94
HDE1	0-5	Not Depressed	1.99	BAB2	11-16	Nursing Rehab 2+	1.04
HBC2	6-14	Depressed	2.23	BAB1	11-16	Nursing Rehab 0-1	0.99
HBC1	6-14	Not Depressed	1.85	PDE2	0-5	Nursing Rehab 2+	1.57
LDE2	0-5	Depressed	2.07	PDE1	0-5	Nursing Rehab 0-1	1.47
LDE1	0-5	Not Depressed	1.72	PBC2	6-14	Nursing Rehab 2+	1.21
LBC2	6-14	Depressed	1.71	PA2	15-16	Nursing Rehab 2+	0.70
LBC1	6-14	Not Depressed	1.43	PBC1	6-14	Nursing Rehab 0-1	1.13
CDE2	0-5	Depressed	1.86	PA1	15-16	Nursing Rehab 0-1	0.66
CDE1	0-5	Not Depressed	1.62				

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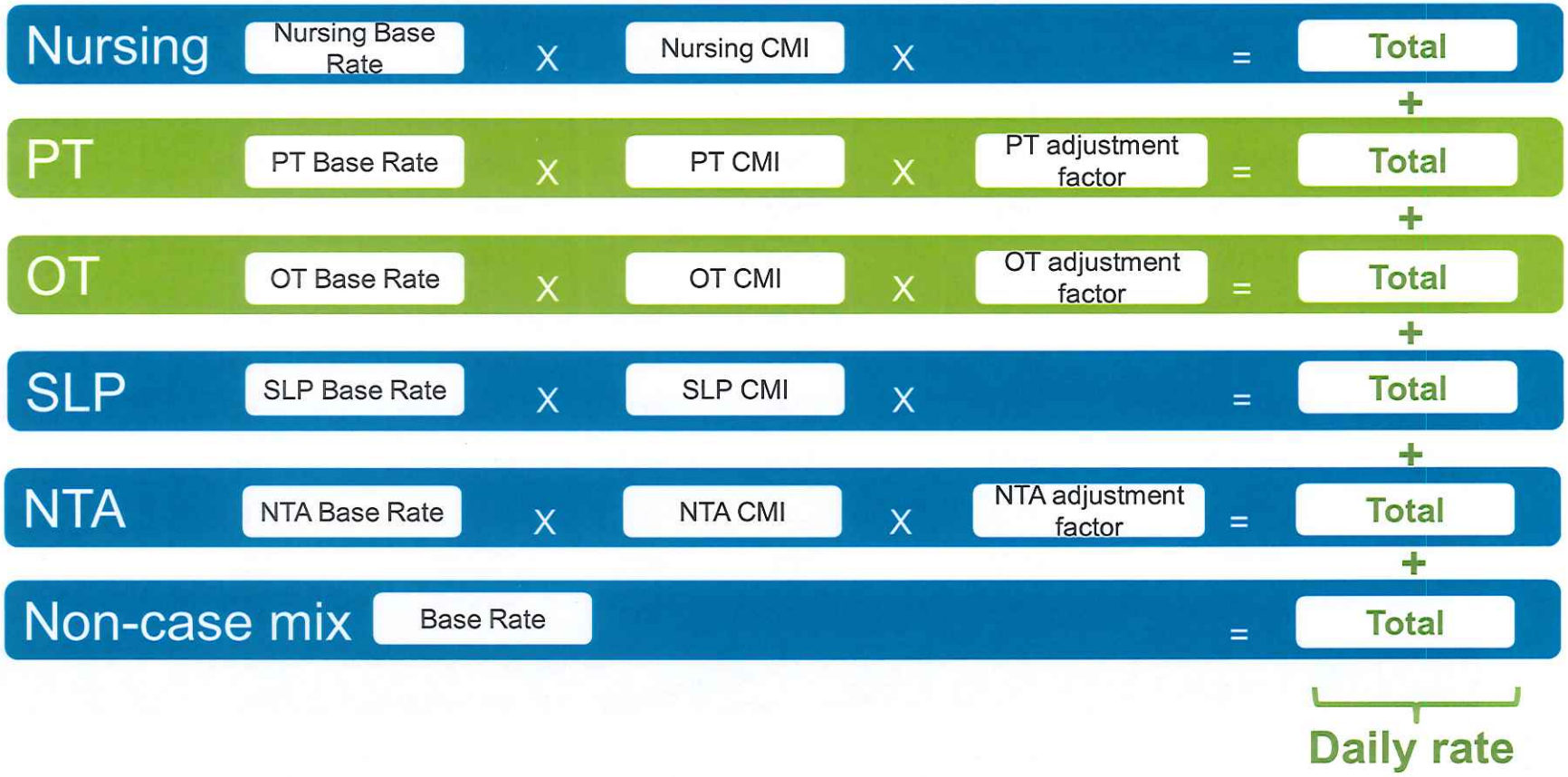
Physical and Occupational Therapy



CMI adjustments PT/OT

- After day 20, PT and OT daily rates decline 2% every 7 days
  - Adjustments will negatively impact reimbursements beginning on day 21

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

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Physical and Occupational Therapy CMI Calculation

- Based on two elements
  - Clinical Reason for the Stay
    - I0020B (ICD-10 CM code that represents the reason for the stay)
    - J2100, when indicated (Providers will select a surgical procedure category in a sub-item within J2100 to identify the relevant surgical procedure that occurred during the preceding hospital stay)
  - Functional Status from Section GG
    - Scores will range from 0-24
  - 16 Possible Groups

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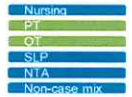
Physical and Occupational Therapy Clinical Categories



- Primary Diagnoses → 4 PT/OT Clinical categories

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

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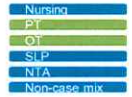
Physical and Occupational Therapy Functional Status



- Total of all of Section GG Item Scores = Functional Component

Section GG Item	Description	Score
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**	
GG0171J1	Mobility: Walk 50 feet with 2 turns	0-4 (average of 2 items)
GG0170K1	Mobility: Walk 150 feet	

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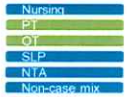
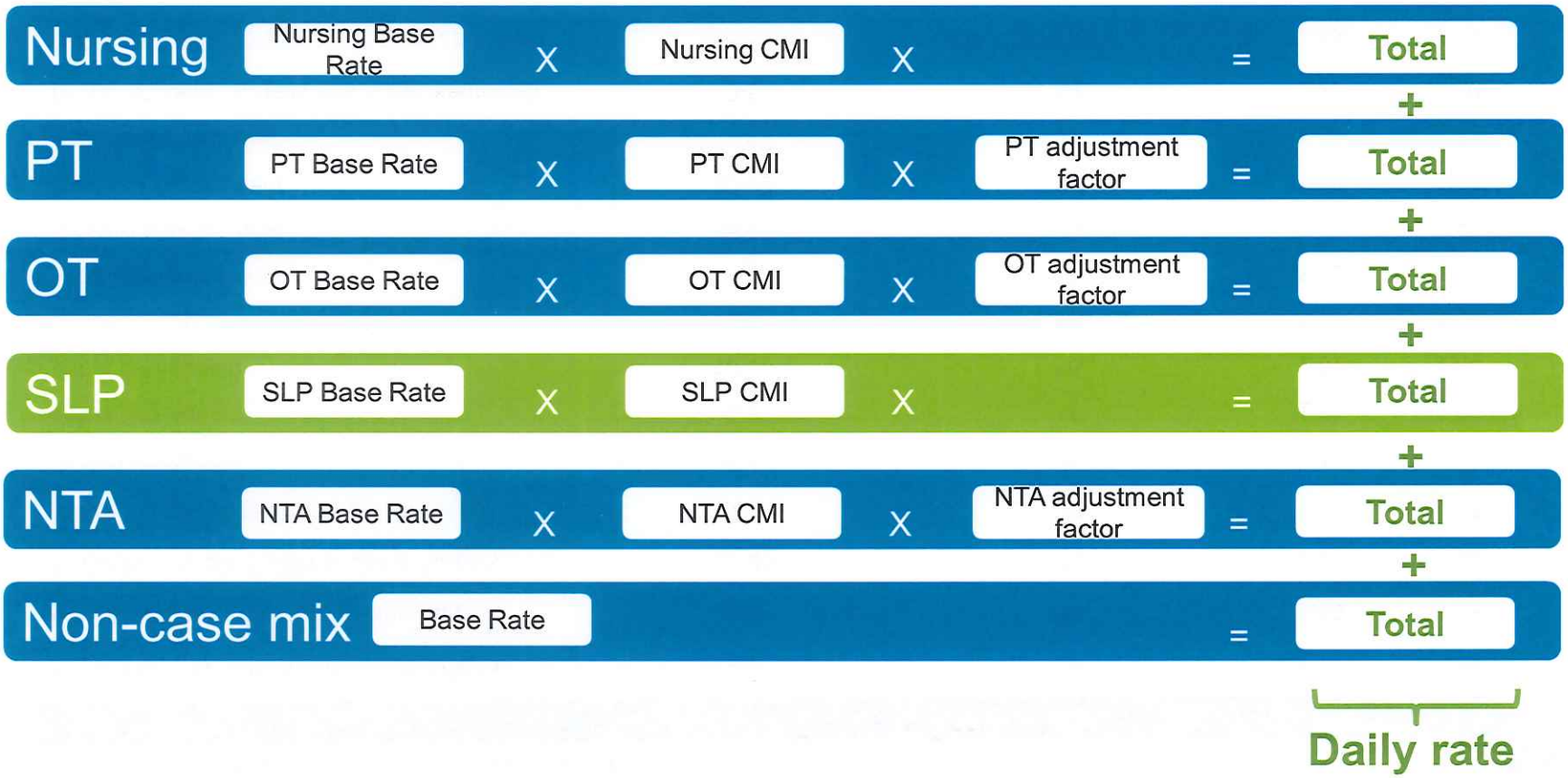
PT/OT Case-Mix Groups

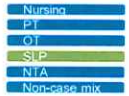


Clinical Category	Section GG Function	PT/OT Case-Mix Group	PT-CMI	OT-CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.69	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.68
Major Joint Replacement or Spinal Surgery	24	TD	1.92	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

Speech Language Pathology



Speech Language Pathology CMI Calculation



- Based on several elements
  - Clinical Reason for the Stay: Acute Neurologic or Non-Neurologic
    - I0020B (ICD-10 CM code that represents the reason for the stay)
    - J2100, when indicated (Providers will select a surgical procedure category in a sub-item within J2100 to identify the relevant surgical procedure that occurred during the preceding hospital stay)
  - Comorbidities, conditions and services from areas in Section I8000
  - Cognition – BIMs when available or calculated using additional fields in the MDS
  - Swallowing Impairment
  - Mechanically Altered Diet

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Speech Language Pathology Clinical Categories

- Primary Diagnoses → 2 ST Clinical categories

Primary Diagnosis Clinical Category	ST Clinical Category
Major Joint Replacement or Spinal Surgery	Non-Neurologic
Non-Surgical Orthopedic/Musculoskeletal	Non-Neurologic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery	Non-Neurologic
Acute Infections	Non-Neurologic
Medical Management	Non-Neurologic
Cancer	Non-Neurologic
Pulmonary	Non-Neurologic
Cardiovascular and Coagulations	Non-Neurologic
Acute Neurologic	Acute Neurologic
Non-Orthopedic Surgery	Non-Neurologic

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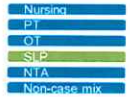
Speech Language Pathology Pertinent Elements



- Comorbidities

MDS Section/Description	MDS Section/Description
I4300 Aphasia	I8000 Dysphagia
I4500 CVA, TIA, Stroke	I8000 ALS
I4900 Hemiplegia or Hemiparesis	I8000 Oral Cancers
I5500 Traumatic Brain Injury	I8000 Speech and Language Deficits
I8000 Laryngeal Cancer	O0100E2 Tracheostomy Care while a Resident
I8000 Apraxia	O0100F2 Ventilator and Respirator while a Resident
I8000 A-J Other Pertinent Diagnoses	

- Swallowing – Section K0100Z
- Mechanically Altered Diet – Section K0510C2
- Cognitive Function Score – Section C
- 12 Possible Groups

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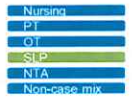
Cognitive Function Score (CFS)



CMS proposes to blend the BIMS (Brief Interview for Mental Status) and CPS (Cognitive Performance Scale) to arrive at a Cognitive Function Score The BIMS is used for residents that can be interviewed while the CPS is used for residents who are unable to participate in an interview.

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

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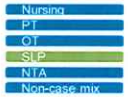
ST Case Mix Groups



Presence of Acute Neurologic Condition SLP Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	CMI
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

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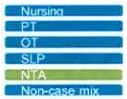
PDPM Base Rates (FY 2019)



	Nursing	PT	OT	ST	NTA	NCM
Urban	$ 103.46	$ 59.33	$ 55.23	$ 22.15	$ 78.05	$ 92.63
Rural	$ 98.83	$ 67.63	$ 62.11	$ 27.90	$ 74.56	$ 94.34

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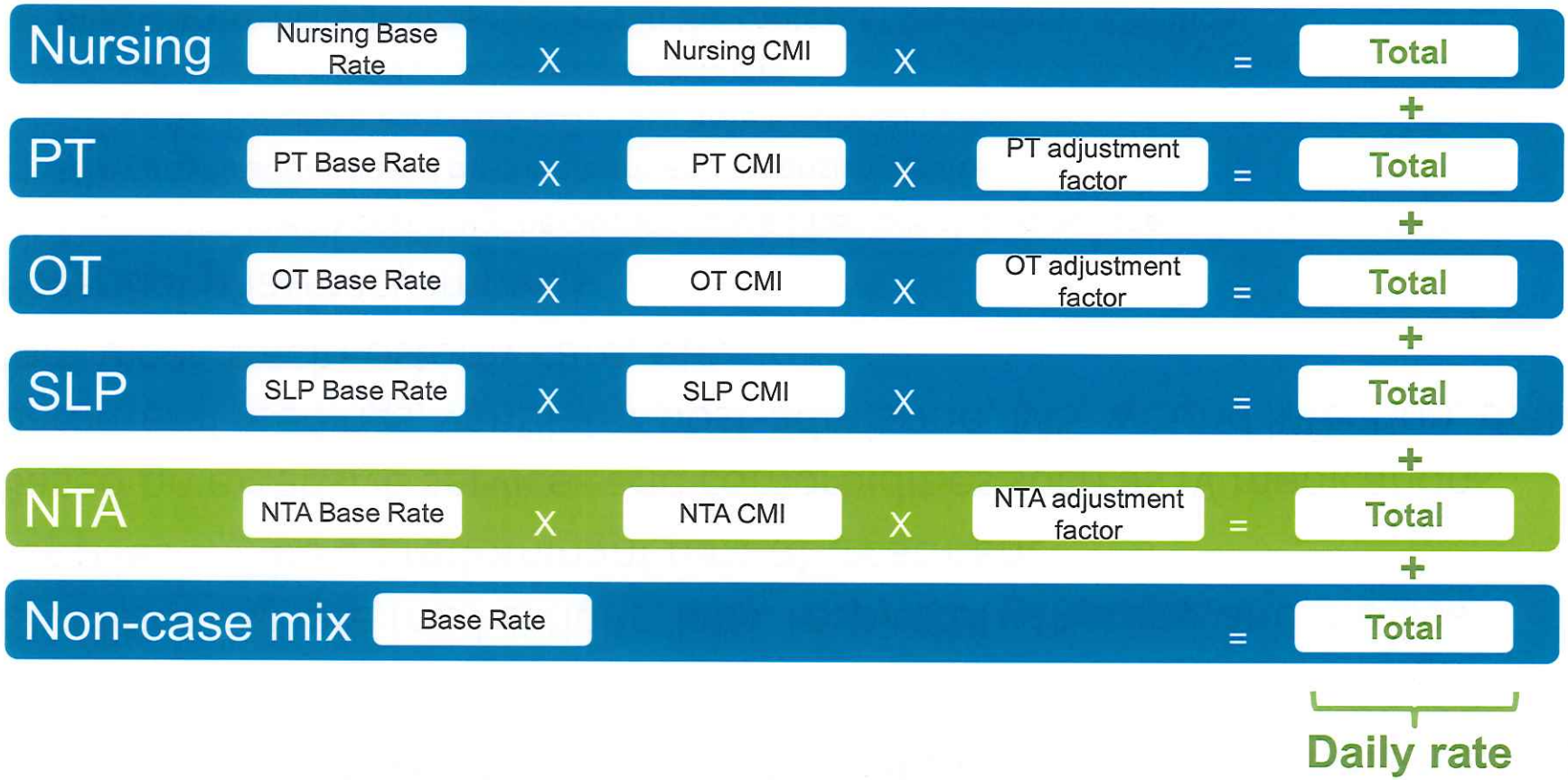
Non-Therapy Ancillary



What is Included in the Non-Therapy Ancillary (NTA) CMI?

- Conditions where medications, labs, respiratory therapy, and medical supplies will be a predominant part of treatment
- Based on extensive services and comorbidities such as IV medications, parenteral feedings, ventilator post-admission, MS, wound infection, diabetic foot ulcer, tracheostomy care, etc.
- Potential pharmacy impacts
  - Seeking the lowest cost drug therapy for new admissions should no longer be the objective
  - NTA classifications based on conditions and extensive services
    - Certain conditions earn more points that increase the daily rate
    - Others earn no points – no increase to daily rate
  - Imperative to manage drug costs within the context of the patients conditions

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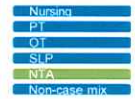
CMI adjustments NTA



- Reimbursement assumes higher NTA costs at the beginning of a patient's stay
  - First three days – the NTA rate is multiplied by 3
  - Adjustment will positively impact reimbursement for first three days

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

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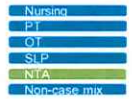
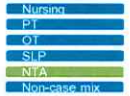
Non-Therapy Ancillary Conditions/Services



Comorbidities Included in NTA Comorbidity Score and Assigned Points		
Condition/Extensive Service	MDS Item	Points
HIV/AIDS	SNF Claim ICD-10 B20	8
Parenteral IV Feeding: Level High	K0510A2 K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	O0100H2	5
Special Treatments/Programs: Ventilator Post-admit Code	O0100F2	4
Parenteral IV feeding: Level Low	K0510A2 K0710A2 K0710B2	3
Lung Transplant Status	I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	O0100I2	2
Major Organ Transplant Status, Except Lung	I8000	2
Active Diagnoses: Multiple Sclerosis Code	I5200	2
Opportunistic Infections	I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	I8000	2
Chronic Myeloid Leukemia	I8000	2
Wound Infection Code	I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	I2900	2
Endocarditis	I8000	1
Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	M1040B	1
Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Special Treatments/Programs: Tracheostomy Post-admit Code	O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	I1700	1
Special Treatments/Programs: Isolation Post-admit Code	O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	I8000	1

Non-Therapy Ancillary Conditions/Services



Comorbidities Included in NTA Comorbidity Score and Assigned Points		
Condition/Extensive Service	MDS Item	Points
Morbid Obesity	I8000	1
Special Treatments/Programs: Radiation Post-admit Code	O0100B2	1
Highest Stage of Unhealed Pressure Ulcer - Stage 4	M0300X1	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	M1040A M1040B M1040C	1
Complications of Specified Implanted Device or Graft	I8000	1
Bladder and Bowel Appliances: Intermittent catheterization	H0100D	1
Inflammatory Bowel Disease	I8000	1
Aseptic Necrosis of Bone	I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	O0100D2	1
Cardio-Respiratory Failure and Shock	I8000	1
Myelodysplastic Syndromes and Myelofibrosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	I8000	1
Diabetic Retinopathy - Except : Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Nutritional Approaches While a Resident: Feeding Tube	K0510B2	1
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1
Active Diagnoses: Malnutrition Code	I5600	1
Disorders of Immunity - Except : RxCC97: Immune Disorders	I8000	1
Cirrhosis of Liver	I8000	1
Bladder and Bowel Appliances: Ostomy	H0100C	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1

Non-Therapy Ancillary CMI Calculation/Case-Mix Groups

- 6 Possible Categories
- Sum of 50 weighted MDS Items representing all resident comorbidities and extensive services
- Based on sum of points with points ranging from 0 -12+

NTA Score Range	NTA Case-Mix Group	CMI
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

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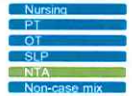
PDPM Base Rates (FY 2019)



	Nursing	PT	OT	ST	NTA	NCM
Urban	$ 103.46	$ 59.33	$ 55.23	$ 22.15	$ 78.05	$ 92.63
Rural	$ 98.83	$ 67.63	$ 62.11	$ 27.90	$ 74.56	$ 94.34

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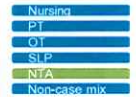
Impact of Adjustment on NTA



- Due to the first 3 days multiplier given the urban NTA payment of $78.05, the average per diem reimbursement decreased with length of stay
- 20 days LOS calculation TPN:[($144.39 x 3)x 3 days + ($144.39 x 17 days)] / 20 days = $187.71
- 20 days LOS calculation IV: [($104.59 x 3)x 3 days + ($104.59 x 17 days)] /20 days = $135.96

	Parenteral IV Feeding: Level High (TPN)	Intravenous Medication Post-admit Code
NTA points	7	5
CMI	1.85	1.34
Per Diem Amount	$144.39	$104.59
Average for 5 days LOS	$317.66	$230.09
Average for 7 days LOS	$268.16	$194.23
Average for 10 days LOS	$231.03	$167.34
Average for 14 days LOS	$206.28	$149.41
Average for 20 days LOS	$187.71	$135.96
Average for 30 days LOS	$173.27	$125.50

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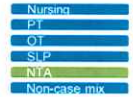
Maximizing the outcome relative to revenue



- TPN average cost is approximately $200/day
- IV antibiotic medication varies by drug type
  - Branded drug such as Eraxis approximately $215/day
  - Generic drug such as vancomycin approximately $60/day

	TPN	IV brand	IV generic
Cost	$200	$215	$60
5 days LOS margin	$117.66/day	$15.09/day	$170.09/day
10 days LOS margin	$31.03/day	$-47.66/day	$107.34/day
14 days LOS margin	$6.28/day	$-65.59/day	$89.41/day
20 days LOS margin	$-12.29/day	$-79.04/day	$75.96/day

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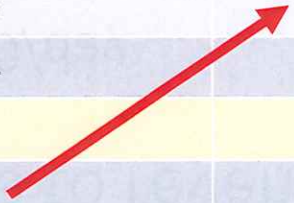
Impact of Adjustment on NTA – non IVs

Nursing
PT
OT
SLP
NTA
Non-case mix

- Due to the first 3 days multiplier, average per diem reimbursement decreased with length of stay

	Immune Disorders (RA); Inflammatory Bowel Disease (Crohn's); Untreated Pressure Ulcer Stage 4	Major Joint Replacement (Knee, Hip)
NTA points	1	0
CMI	0.96	0.72
Per Diem Amount	$74.93	$56.20
Average for 5 days LOS	$164.84	$123.63
Average for 7 days LOS	$139.15	$104.36
Average for 10 days LOS	$119.88	$89.91
Average for 14 days LOS	$107.04	$80.28
Average for 20 days LOS	$97.41	$73.05
Average for 30 days LOS	$89.91	$67.44



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Maximizing the outcome relative to revenue

- Medication to treat these conditions varies <u>significantly</u> by drug type
  - RA (1 point): branded drug (Enbrel) cost approximately $187/day
  - *RA (1 point): generic drugs to treat cost approximately $7/day*
  - Crohn's (1 point): branded drug (Humira) approximately $559/day
  - *Crohn's (1 point): generic approximately $7/day*
  - Pressure Ulcer (1 point): branded drug (Santyl) approximately $62/day
  - Knee replacement (0 points): branded drug (Eliquis) approximately $15/day

Drug identification will continue to be important

Nursing
PT
OT
SLP
NTA
Non-case mix

Examples of branded drugs that get zero points:	Indication	Rx cost per day	Percentage of the per diem (20 day LOS)
Eliquis	Clot Prevention	$ 15.00	21%
Xarelto	Clot Prevention	$ 15.00	21%
Restasis	Dry Eyes	$ 9.00	12%
Nuedexta	Behavioral Crying	$ 38.00	52%
Procrit	Anemia due to CKD	$ 75.00	103%
Aranesp	Anemia due to CKD	$ 112.00	153%
Sensipar	Hypercalcemia	$ 55.00	75%
Fanapt	Schizophrenia	$ 39.00	53%
Latuda	Schizophrenia	$ 42.00	57%
Namzaric	Dementia	$ 15.00	21%
1 point:			
Xifaxan 550mg	IBS	$ 75.00	77%

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PATIENT EXAMPLES

Patient Example : 87 Year Old Woman with COPD and DM

Patient is an 87 year old woman with diagnoses of **COPD and Diabetes Mellitus**. She went into the hospital due to an exacerbation of her COPD and has considerable difficulty breathing, exhibiting shortness of breath when lying and upon even mild exertion. She has **mild cognitive impairment** and requires assistance with activities of daily living.

Patient Example : 87 Year Old Woman with COPD and DM

Patient's functional scores are as follows:

- Eating (requires supervision or touching assistance: code 04) = function score of 3
- Oral hygiene (requires supervision or touching assistance: code 04) = function score of 3
- Toilet hygiene (require supervision or touching assistance: code 04) = function score of 3
- Bed mobility
  - Sit to lying (requires supervision or touching assistance: code 04) = function score of 3
  - Lying to sitting on side of bed (requires supervision or touching assistance: code 04) = function score of 3
    - Average of both skills = function score of 3
- Transfers
  - Sit to stand (Partial/moderate assistance: code 03) = function score of 2
  - Chair/bed to chair transfer (Partial/moderate assistance: code 03) = function score of 2
  - Toilet transfer (Partial/moderate assistance: code 03) = function score of 2
    - Average of all three skills = function score of 2
- Walking
  - Walk 50 feet with two turns (Partial/moderate assistance: code 03) = function score of 2
  - Walk 150 feet (Partial/moderate assistance: code 03) = function score of 2

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Nursing CMI Determinants

- Patient has COPD and shortness of breath when lying flat and is coded for this on the MDS
  - I6200, J1100C
- Nursing function score from Section GG is 10
- Patient has no depression
- HBC1 is in the Special Care High nursing level

Nursing RUG	GG Function Score	End Splits	CMI
HDE2	0-5	Depressed	2.39
HDE1	0-5	Not Depressed	1.99
HBC2	6-14	Depressed	2.23
HBC1	6-14	Not Depressed	1.85

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PT/OT CMI Determinants

- Patient's diagnosis of COPD maps to the *Pulmonary* Primary Diagnosis Clinical Category
  - PT/OT Clinical Category of *Medical Management*
- PT/OT functional score is 16

Clinical Category	Section GG Function	PT/OT Case-Mix Group	PT-CMI	OT-CMI
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

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ST CMI Determinants

- Patient's diagnosis of COPD maps to the *Pulmonary* Primary Diagnosis Clinical Category
  - ST Clinical Category of *Non-Neurologic*
- No swallowing disorder
- No mechanically altered diet
- Mild cognitive impairment

Presence of Acute Neurologic Condition SLP Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	CMI
Any one	Neither	SD	1.46
Any one	Either	SE	2.33
Any one	Both	SF	2.97

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NTA Comorbidities

Comorbidities	Score
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	2
Active Diagnoses: Diabetes Mellitus (DM) Code	2
Total	**4**

NTA Score Range	NTA Case-Mix Group	CMI
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

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Category and CMI placement

The patient's primary diagnosis of COPD qualifies her for placement into a Medical Management category for her stay at the skilled nursing facility. The categories and resultant CMI's that the patient qualifies for are as follows for each of the case-mix adjusted components:

Component	Case-mix group (CMG)	Case-mix index (CMI)
Nursing	HBC1	1.85
PT	TK	1.52
OT	TK	1.54
ST	SD	1.46
NTA	ND	1.34

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Daily payment for each component over 18 day stay

Component	Case-mix group	Case-mix index	Base Rate	Per diem
Nursing	HBC1	1.85	$103.46	$191.40
PT	TK	1.52	$ 59.33	$ 90.18
OT	TK	1.54	$ 55.23	$ 85.05
ST	SD	1.46	$ 22.15	$ 32.34
NTA	ND	1.34	$ 78.05	$104.59
Non case-mix			$ 92.63	$ 92.63
			PDPM Base per diem	$596.19
			PPS Per Diem – RVB	$468.94

	# of Days	PDPM Per Diem	PDPM Total	PPS Per Diem	PPS Total
Days 1-3	3	$ 805.03	$2,415.09	$468.94	$1,406.82
Days 4-18	15	$ 596.19	$8,942.85	$468.94	$7,034.10
Total	18	$631.00	$11,357.94	$468.94	$8,440.92

Patient Example : 79 Year Old Man with Femur Fracture

Patient is a 79 year old male with acute diagnosis of **femur fracture**. He is also recovering from a case of pneumonia but has no fever. The patient has no cognitive impairment but is **depressed**. The patient needs considerable assistance with activities of daily living.

Patient Example : 79 Year Old Man with Femur Fracture

Patient's functional scores are as follows:

- Eating (requires supervision or touching assistance: code 04) = function score of 3
- Oral hygiene (requires supervision or touching assistance: code 04) = function score of 3
- Toilet hygiene (require supervision or touching assistance: code 04) = function score of 3
- Bed mobility
  - Sit to lying (Partial/moderate assistance: code 03) = function score of 2
  - Lying to sitting on side of bed (Partial/moderate assistance: code 03) = function score of 2
    - Average of both skills = function score of 2
- Transfers
  - Sit to stand (Substantial/maximal assistance: code 02) = function score of 1
  - Chair/bed to chair transfer (Substantial/maximal assistance: code 02) = function score of 1
  - Toilet transfer (Substantial/maximal assistance: code 02) = function score of 1
    - Average of all three skills = function score of 1
- Walking
  - Walk 50 feet with two turns (Dependent: code 01) = function score of 0
  - Walk 150 feet (Dependent: code 01) = function score of 0
    - Average of both skills = function score of 0

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Nursing CMI Determinants

- Patient has diagnoses of femur fracture as well as pneumonia with no fever
- Nursing function score from Section GG is 9
- Patient is depressed
- CBC2 is in the Clinically Complex nursing level

Nursing RUG	GG Function Score	End Splits	CMI
CDE2	0-5	Depressed	1.86
CDE1	0-5	Not Depressed	1.62
CBC2	6-14	Depressed	1.54
CA2	15-16	Depressed	1.08
CBC1	6-14	Not Depressed	1.34
CA1	15-16	Not Depressed	0.94

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PT/OT CMI Determinants

- Patient's diagnosis of femur fracture maps to the *Orthopedic Surgery (except Major Joint and Spinal Surgery)* Primary Diagnosis Clinical Category
  - PT/OT Clinical Category of *Other Orthopedic*
- PT/OT functional score is 12

Clinical Category	Section GG Function	PT/OT Case-Mix Group	PT-CMI	OT-CMI
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

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ST CMI Determinants

- Patient's diagnosis of femur fracture maps to the maps to the *Orthopedic Surgery (except Major Joint and Spinal Surgery)* Primary Diagnosis Clinical Category
  - ST Clinical Category of *Non-Neurologic*
- No swallowing disorder
- No mechanically altered diet
- No comorbidities
- No cognitive impairment

Presence of Acute Neurologic Condition SLP Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	CMI
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.66

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NTA Comorbidities

Comorbidities	Score
No NTA related comorbidities	0
Total	**0**

NTA Score Range	NTA Case-Mix Group	CMI
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

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Category and CMI placement

The patient's primary diagnosis of femur fracture qualifies him for placement into the Other Orthopedic category for him stay at the skilled nursing facility. The categories and resultant CMI's that the patient qualifies for are as follows for each of the case-mix adjusted components:

Component	Case-mix group (CMG)	Case-mix index (CMI)
Nursing	CBC2	1.54
PT	TG	1.67
OT	TG	1.64
ST	SA	0.68
NTA	NF	0.72

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Daily payment for each component over 30 day stay

Component	Case-mix group	Case-mix index	Base Rate	Per diem
Nursing	CBC2	1.54	$103.46	$159.33
PT	TG	1.67	$ 59.33	$ 99.08
OT	TG	1.64	$ 55.23	$ 90.58
ST	SA	0.68	$ 22.15	$ 15.06
NTA	NF	0.72	$ 78.05	$56.20
Non case-mix			$ 92.63	$ 92.63
			PDPM Base per diem	$512.87
			PPS Per Diem – RUB	$631.22

	# of Days	PDPM Per Diem	PDPM Total	PPS Per Diem	PPS Total
Days 1-3	3	$ 625.27	$1,875.80	$631.22	$1,893.66
Days 4-20	17	$ 512.87	$8,718.87	$631.22	$10,730.74
Days 21-27	7	$ 510.89	$3,576.25	$631.22	$4,418.54
Days 28-30	3	$ 507.01	$1,521.03	$631.22	$1,893.66
Total	30	$ 523.06	$15,691.95	$631.22	$18,936.60

Review of Determinants of Payment under PDPM

Nursing	PT	OT	SLP	NTA
• Clinical information from SNF stay • Functional status • Extensive services received	• Primary reason for SNF care • Functional status	• Primary reason for SNF care • Functional status	• Primary reason for SNF care • Other SLP-related comorbidities • Cognitive status • Presence of swallowing disorder or mechanically altered diet	• Comorbidities present • Extensive services received
	• Point in the stay (variable per diem adjustment)	Point in the stay (variable per diem adjustment)		Point in the stay (variable per diem adjustment)
25 possible groups	• 16 possible groups	16 possible groups (separate payment as PT but with the same group)	12 possible groups	6 possible groups

PDPM Implementation October 1, 2019 (CMS FY 2020)

- Combined 25% limit on concurrent therapy and group therapy for each discipline of therapy provided (concurrent and group minutes are counted in full). Calculation is based on the entire stay.
- Payments will be redirected "from residents who are receiving very high amounts of therapy under RUGS IV to those with more complex medical needs."
- Providers will bill RUGS IV days or all days up to and including September 30, 2019 and then bill under PDPM for all days beginning October 1, 2019.
- Patients admitted in the last few days of September must have a 5-day MDS on or before September 30, 2019 to set a PPS RUG rate
- An IPA must be conducted on all patients to determine the clinical category between October 1, 2019 and October 7, 2019.
  - The completion of the changeover IPA does not entitle the patient to a new presumption of coverage

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PDPM Considerations

- Implementation will be budget neutral overall, but individual providers will likely see a shift in payment (up or down) from what they received under RUGS IV
- CMS anticipated that PDPM will reduce costs by $2 billion over the next 10 years
- PDPM does not alter any of the Medicare requirements for coverage or Rules of Participation
- CMS plans to closely monitor utilization, payment and quality trending which may change as a result of the implementation of PDPM.
- If changes in practice occur, CMS may take some action to address this

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Administrative Level of Care Presumption

- Beneficiary can be automatically classified as meeting the SNF level of care definition
- Simplifies the procedure of readily identifying beneficiaries with the greatest likelihood of meeting the level of care criteria
- For services provided after October 1, 2019 the qualifiers for the presumption under PDPM include:
  - Nursing groups: Extensive Services, Special Care High, Special Care Low, Clinically Complex
  - PT and OT groups: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, TO
  - SLP groups: SC, SE, SF, SH, SI, SJ, SK, SL
  - NTA group: Uppermost (12+ point) comorbidity group
- *Services provided to patients under a Medicare Part A stay must meet the statutory criteria of being reasonable and necessary to diagnose or treat a beneficiary's condition*

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Return to Provider: ICD-10 Diagnoses

- When a claim is submitted, it processes through a series of edits in the Fiscal Intermediary Standard System (FISS), to ensure the information submitted is complete and correct. If the claim has incomplete, incorrect or missing information, it will be sent back to the facility "return to provider" (RTP).
- CMS has created an ICD-10 Code to Clinical Category Mapping table which can be utilized to verify that ICD-10 Codes are billable under the PDPM model.
- RTP may be assigned due to lack of specificity in coding as ICD-10 coding requires the coder to assign laterality and other detailed characteristics

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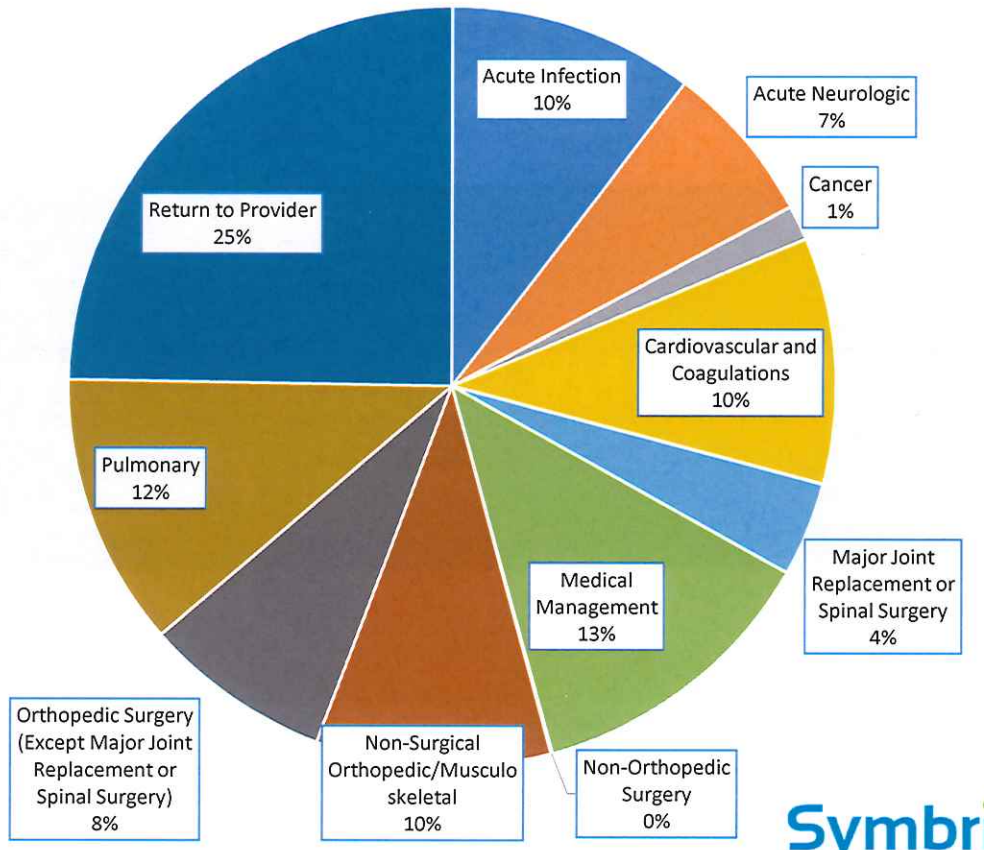
Aggregate Diagnostic Distribution for Symbria Clients



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DATA ANALYTICS AND HOW WE CAN HELP

PDPM Analytics

- Some communities will fare pretty well under PDPM while others will see declining revenues from Medicare under this system.
- 11 states are expected to see a reduction in reimbursement from what they are receiving under the RUG IV system (FY17 CMS Data).
- On average, our data analysis shows a 10% reduction in Rehab Ultra High (RU) patients. Communities with a high distribution of RU compared to others RUG categories will most likely see a reduction in their overall revenue.
- The NTA payment can greatly affect a community's reimbursement. Patients with an NTA CMI in the top 4 Case-Mix Groups have a positive reimbursement disposition under PDPM, even for RU patients.

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Estimating your remaining NTA after Drugs for an Admission

Symbria Rx offers a drug quote which is being enhanced to help clients know their drug costs for an admission but also how it affects the NTA payment. The expected Length of Stay and NTA score can be adjusted to see the effect on reimbursement.

Stay Length:

- 25 +

NTA Score:

NE (6 - 8)

Drug Quote

2. Search drug. View quote and edit or delete as needed.

Drug Name	Substitution	Form/ Strength	Quantity	Schedule	$PPD X 25
PENICILLIN G SODIUM		PENICILLIN SOD. 4MU / NS "IV"	2 Bags	per stay	$6.85
NOVOLIN R	HUMULIN R	100 UNIT/ML	1 Vial	2 X DAILY	$8.12
HUMULIN N KWIKPEN		100 UNIT/ML	1 Pen	4 X DAILY	$5.26
FRESHKOTE		FRESHKOTE EYE DROPS	3 Drops	1 X DAILY	$1.69
ELIQUIS		2.5 MG	10 Tablet	1 X DAILY	$69.48
TYLENOL	MAPAP	325 MG	16 Tablet	3 X DAILY	$0.31
MELATONIN TR		MELATONIN TR 5MG TAB	1 Tablet extended release	2 X DAILY	$0.16
FLO		8 MG	1 Capsule	1 X DAILY	$8.34

r a medication

Average NTA payment per day	$188.33
Total estimated drug cost per day	$100.21
Net NTA after drug cost per day	**$88.12**
Total NTA payment for length of stay	X 25 = $4,708.25
Total estimated drug cost for length of stay	X 25 = $2,505.33
NTA after drug cost for length of stay	**$2,202.92**

How Symbria works with our client partners...

- We focus on aligning outcomes and reimbursement for the PT, OT and SLP CMI's
- We provide guidance for managing drug cost, relative to your reimbursement for NTA CMI
  - We are updating our drug quote to reflect both medication costs and NTA reimbursement
- We can provide input and guidance for RT which is also a component of the NTA and nursing CMI's
- We can provide the analytics to track and prove your outcomes

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Now is the time for partnership and collaboration

Understand your data –Model the potential affects of this reimbursement change to client community.

- Initial results may not be accurate due to coding habits reflective of PPS.
- Obtain updated reports to track progress and understand true impact of PDPM

Collaborate through cross-functional teams

- Your MDS coordinator
- Nursing
- Admissions personnel
- Therapy manager
- Leadership team

Evaluate rehab contracts will have to change to ensure better alignment between community and rehab provider

- Consider options that promote mutual success
- Per diem pricing
- Percentage of full payment or rehab components
- Bundled payment for multiple service lines

Start a new marketing strategy to referral hospitals and implement pre-October 2019.

Assure clinical teams are trained and equipped to handle more medically complex patients

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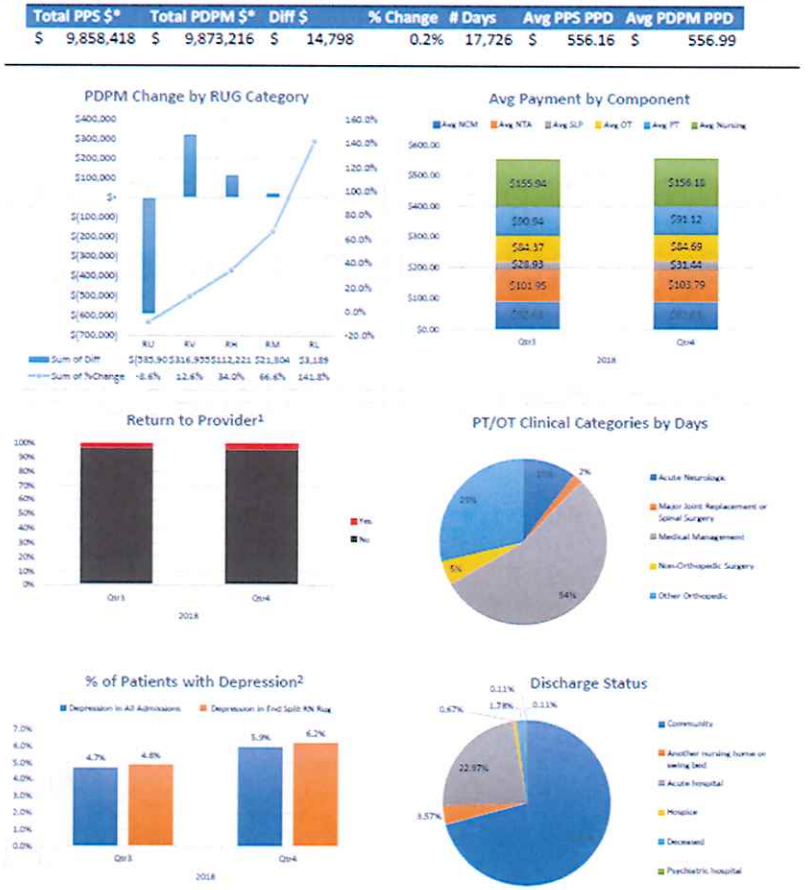
Analytics Options

- Other metrics include:
  - Revenue Comparison PPS/PDPM
  - PDPM Change by RUG
  - Average payment by component
  - Claims identified as Return to Provider
  - Clinical Categories by days
    - PT/OT Clinical Categories by days
    - Nursing Clinical Categories by days
    - Patients with identified presence of depression
    - Discharge Status/Destination



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Collaborate through cross-functional teams

- Assemble a PDPM implementation team
  - Community leadership representative
  - Admissions
  - Nursing
  - MDS
  - Therapy manager
  - Medical director
- Outline what is expected from each department in clear terms with timeframes
- Establish regular schedule to manage the implementation plan
- Assign "project management" role to ensure forward movement of the project

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Explore contract options that create alignment

- Review impact analysis information regarding how your community will fare under PDPM versus that current PPS model
- Share your strategic objectives with your rehabilitation and pharmacy providers
  - Level of service provision
  - Maintenance/enhancement of patient outcomes
- Discuss contract models that provide mutual opportunities for successful transition

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Streamline processes for upstream and downstream PAC partners

- Begin to communicate information needs to hospital referral partners
  - Comprehensive and accurate discharge information that will enable the MDS staff to correctly enter patient information into the 5-day MDS
  - Accurate ICD-10 coding
- Provide information to hospital partners regarding your community's niche programming and ability to provide care for those patients with extensive service needs (IV's, TPN, respiratory therapy)
- Review/create discharge reporting to home health or outpatient partners to ensure successful transition to home/next level of care services

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Assess development needs to ensure success under PDPM

- Work with leadership to develop a strategy regarding how to best serve the current patient mix within your community
- Identify opportunities to diversify patient mix
- Complete a skills assessment of nursing and rehabilitation staff to ensure that the skill sets of those providing treatment meet the level of care needs of the patients you serve
- Secure additional training as needed to be able to care for more complex patients
- Secure additional training for MDS personnel as relates to coding and scoring

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Auditing and Monitoring

- CMS is committed to maintaining a budget neutral program
- CMS has stated that they do not expect provider behavior to change under PDPM
- Under PPS there are 20 items that impact reimbursement
  - All related to therapy
- Under PDPM there are 161 items that contribute to the case-mix components for Nursing, PT, OT, ST and NTA
- CMS will make decisions regarding policy related to this program as they evaluate the data that is submitted by the providers
- Develop process to review documentation relative to the pertinent items as a "triple check" and safeguard for program integrity

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