

Preparing for Medicare Payment Reform: The Skilled Nursing Facility Patient-Driven Payment Model (PDPM)

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Speaker:

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Session Outline

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- Course Introduction and Resources*
- Overview of Volume to Value Concept
- History of SNF PPS and Basic Concepts
- Review of PDPM
- Overarching CMS Initiatives
- Skilled Nursing Facility Initiatives and Systems
- Promoting OT's Role and Value
- Wrap-up

Presentation Abstract



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As health care reform has evolved in recent years, the focus has been on movement toward a system that supports value-based care and improved quality of care and away from a system driven by volume and payment rules. As part of this focus, the Centers for Medicare and Medicaid Services (CMS) have put forth efforts to reform the payment system for Skilled Nursing Facilities to a system that is driven by patient characteristics, factors, and care needs. As a result of these efforts, a new Medicare Skilled Nursing Facility (SNF) payment system, the Patient-Driven Payment Model (PDPM) is slated to take effect on October 1, 2019. The PDPM payment structure is based on a combination of components, including components related to nursing services, physical therapy services, occupational therapy services, speech-language pathology services, and non-therapy ancillary services, as well as an element referred to as a non-case-mix component. Certain patient characteristics and factors are specified as determinants of payment for each of the service components. For occupational therapy, these determinants include the primary reason for SNF care and the functional status of the patient. These payment reform efforts are also linked to the post-acute care reform provisions of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, quality programs, and outcome reporting, updates to the SNF Medicare Conditions of Participation, and the CMS Patients Over Paperwork initiative. This presentation will provide an overview of the PDPM, as well as the connection with other related CMS initiatives. This session will also provide an opportunity for participants to consider and explore the potential impact of the PDPM on occupational therapy service delivery and to consider and explore ways in which to facilitate transition to the new PDPM model.

Note: graphic throughout from https://upload.wikimedia.org/wikipedia/commons/thumb/7/71/Notepad_icon.svg/600px-Notepad_icon.svg.png

Learning Objectives



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Participants will be able to:

- Describe the structure of the Patient-Driven Payment Model
- Discuss the potential impact of the of the Patient-Driven Payment Model on occupational therapy service delivery and ways in which to facilitate transition to the new model
- Explain the connection between the Patient-Driven Payment Model and other Medicare Skilled Nursing Facility initiatives and updates
- Identify resources to support transition to the new payment model

Course Level and Intent



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Intermediate Level Course: Expect participants to have at least a basic understanding of skilled nursing home service delivery and related Medicare rules prior to participation in this course.

Intent: Review of the topic aimed at familiarizing participants with the changing skilled nursing facility prospective payment system, as well as at provoking thought about clinical practice and operational issues in preparation for the pending changes

Audience Survey

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- OT, OTA, Student, Other?
- Setting(s)?
- Job role(s)?
- Level of knowledge re: PDGM?
- Any subtopics of particular interest?

Resources



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- Course Handouts
 - Slides
 - Resources and References
- Embedded links
- Primary Resources:
 - CMS: <https://www.cms.gov/Medicare/Fee-for-Service-Payment/SNFPPS/PDPM.html>
 - AOTA: https://www.aota.org/Practice/Manage/value.aspx?promo_name=payment-quality&promo_create=Practice&promo_position=hero

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How Did We Get To this Point?



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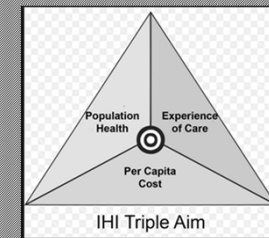
- Triple Aim - Populations, Quality & Cost
- Affordable Care Act
- IMPACT Act
- Specific to skilled nursing facilities (SNFs): Concerns about appropriate utilization of therapy services and system-driven financial incentives

Triple Aim



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- Patient/Population Safety
- Reduce Harm
- Patient & Family Engagement
- Effective Communication
- Coordinated Care
- Disease & Health Management
- Evidenced Based Care
- Affordable Value Based Care



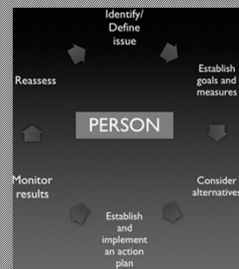
The IHI Triple Aim, retrieved from HealthPopuli.com

Focus on Quality



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- Quality as a Cycle
- Transparency
- Data Follows the Person
- HOW DO YOU DEFINE QUALITY?



Adams and Villano, 2018, slide 14

Affordable Care Act



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- Expand access to insurance coverage (e.g. Medicaid expansion)
- Increase consumer insurance protections
- Focus on prevention and wellness
- Optimize health quality and health systems performance
- Reduce rising health costs

<https://www.hhs.gov/healthcare/about-the-aca/index.html>

Improving Medicare Post-Acute Care Transformation Act IMPACT Act 2014



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The IMPACT Act: Standardized Patient Assessment Data Elements

- **Requirements for reporting assessment data:**

- Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions



- The data must be submitted with respect to admission and discharge for each patient, or more frequently as required

- **Data categories:**

- Functional status • Cognitive function and mental status • Special services, treatments, and interventions • Medical conditions and co-morbidities • Impairments • Other categories required by the Secretary

Center for Medicare and Medicaid Services. (2018).
<https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-06-21-IMPACT.html>

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Prospective Payment Systems

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- Used for Medicare Part A services
- Per diem rates using a case-mix methodology, adjusted for geographic labor/wage costs
- Payment rates and rules set through federal rule-making process
- An important concept: Resource Utilization
 - The care needed by a patient
 - Persons (Skilled, non-skilled, operational, etc.)
 - Supplies (Medical, Drugs, Equipment, etc.)
 - Time/Length of stay
 - Overhead costs

History of SNF Medicare Part A



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- Before SNF PPS reimbursement for SNF Medicare Part A services was retrospective and cost-based
- SNF PPS was implemented in 1998 per the Balanced Budget Act of 1997
 - Originally 44 Resource Utilization Groups (RUGs); refined to 53 RUGs in 2006; and to 66 RUGs in 2010; includes therapy, nursing and non-case-mix components
 - Some RUGs focused on level of Rehab Services (Low, Medium, High, Very High, Ultra High)
 - Currently Resource Utilization Group, Version IV
- Use Minimum Data Set (MDS) for Assessments
 - Currently MDS 3.0 v1.16.1
 - Instructions in Resident Assessment Instrument (RAI) Manual v1.16 (Oct. 2018)
 - Multiple schedule and unscheduled assessments, refined and changed over the years
 - Require reporting of therapy days, minutes, and modes

History of SNF Medicare Part A



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- Changed focus to patient characteristics and factors
 - 2013: Under contract with CMS, Acumen, LLC explores alternatives for therapy reimbursement under SNF PPS
 - May 2017: CMS posted an Advanced Notice of Proposed Rulemaking (ANPRM) to put forth and solicit stakeholder input on a potential new model for SNF PPS, called the Resident Classification System, Version 1 (RCS-1)
 - Feb. 1, 2018: CMS and Abt Associates convene a Technical Expert Panel for input on Home Health payment reform
 - April 2018 FY 2019 SNF Proposed Rule: CMS puts forth revised plan for SNF payment reform, renamed the Patient-Driven Patient Model for implementation FY 2020
 - August 2018; FY 2019 SNF Final Rule: CMS finalizes PDPM plan for implementation Oct. 1, 2019

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What is Changing?

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- New case-mix methodology and adjustments
- Therapy days and minutes no longer driving RUGs
- Patient characteristics and factors driving reimbursement
- SNF PPS assessment schedule
- Some MDS items (e.g., Sections I, J, and O; See MDS Changes Fact Sheet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/Downloads/PDPM_Fact_Sheet_MDS-Changes-V7_508.pdf)
- Rules about the amount of concurrent and group therapy
- Addition of an Interrupted Stay policy

What is not changing?

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- 3-Day Hospital Stay (expect for BPCI and ACO waivers)
- Need for daily skilled, reasonable, and medically necessary services of Nursing and/or Rehab
- Several MDS items
- OBRA assessment schedule
- Need for accurate and timely coding
- Need for comprehensive, outcome measure-based therapy evaluations
- Requirement that services be in accordance with accepted standards of practice and supported in the professional literature (i.e., evidence-based)
- Documentation requirements and the need for accurate, thorough, and timely documentation
- Need for interdisciplinary communication and collaboration

Current Case-Mix Adjusted Payment

Therapy

Therapy Base Rate \times Therapy CMI

OR

Non-Case-Mix Therapy Base Rate

+

Nursing

Nursing Base Rate \times Nursing CMI

+

Non-Case-Mix

Non-Case-Mix Base Rate

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From p. iii of Acumen, LLC April 2018 Skilled Nursing Facilities Patient-Driven Payment Model Technical Report at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Technical_Report_508.pdf

PDPM Snapshot

PT PT Base Rate \times PT CMI \times VPD Adjustment Factor

+

OT OT Base Rate \times OT CMI \times VPD Adjustment Factor

+

SLP SLP Base Rate \times SLP CMI

+

NTA NTA Base Rate \times NTA CMI \times VPD Adjustment Factor

+

Nursing Nursing Base Rate \times Nursing CMI \times 18% Nursing Adjustment Factor (Only for Patients with AIDS)

+

Non-Case-Mix Non-Case-Mix Base Rate

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From Slide 9 of CMS Dec. 11, 2018 SNF PPS PDPM Webinar at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending>

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.

From Slides 10 and 11 of CMS Dec. 11, 2018 SNF PPS PDPM Webinar at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending>

Assessment Schedule

Current SNF PPS	PDPM	OBRA
<p><u>Scheduled</u></p> <ul style="list-style-type: none"> 5-Day 14-Day 30-Day 60-Day 90-day 	<p><u>Unscheduled</u></p> <ul style="list-style-type: none"> SOT OMRA EOT OMRA EOT-R OMRA Short Stay COT OMRA Discharge Significant Change Significant Correction 	<p><u>OBRA</u></p> <ul style="list-style-type: none"> Admission (Interim Payment Adjustment (IPA) Discharge Significant Correction Interrupted Stay

PDPM Assessment Schedule

Medicare MDS Assessment 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

From Slide 55 of CMS Dec. 11, 2018 *SNF PPS PDPM Webinar* at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html#Page=2&DLEntries=10&DLSort=0&DLSortDir=descending>

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Table 1: Determinants of Payment in PDPM

PT	OT	SLP	Nursing	NTA
<ul style="list-style-type: none"> Primary reason for SNF care Functional status 	<ul style="list-style-type: none"> Primary reason for SNF care Functional status 	<ul style="list-style-type: none"> Primary reason for SNF care Cognitive status Presence of swallowing disorder or mechanically altered diet Other SLP-related comorbidities 	<ul style="list-style-type: none"> Clinical information from SNF stay Functional status Extensive services received Presence of depression Restorative nursing services received 	<ul style="list-style-type: none"> Comorbidities present Extensive services received
Point in the stay (variable per diem adjustment)	Point in the stay (variable per diem adjustment)		Also AIDS adjustment noted on previous slide	Point in the stay (variable per diem adjustment)

From p. viii of Acumen, LLC April 2018 Skilled Nursing Facilities Patient-Driven Payment Model Technical Report at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Technical_Report_508.pdf

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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

From p. 2 of PDPM Patient Classification Fact Sheet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_Template_Payment_Overview_v4_508.pdf

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Based on mapped ICD-10s for Primary Diagnosis (MDS Section I), Surgical History (MDS Section J); "Return-to-Provider" (RTP) claim function applied when submitted ICD-10 is not mapped

Collapsed Clinical Categories for PT and OT Classification

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

From p. 2 of PDPM Patient Classification Fact Sheet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_Template_Payment_Overview_v4_508.pdf

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Based on mapped ICD-10s for Primary Diagnosis (MDS Section I), Surgical History (MDS Section J); "Return-to-Provider" (RTP) claim function applied when submitted ICD-10 is not mapped

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PT and OT Function Score Construction (Except Walking Items)

Response	Description	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 and OT Function Score Construction for Walking Items

Response	Description	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*	0

*Coded based on response to GG01701 (Walk 10 feet?)

From p. 3 of PDPM Functional and Cognitive Scoring Fact Sheet
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_FunctionalCognitiveScoring_Final_v3_508.pdf

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Section GG Items Included in PT and OT Functional Score

Item	Description	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
GG0170C1	Mobility: Lying to sitting on side of bed	(average of 2 items)
GG0170D1	Mobility: Sit to stand	0-4
GG0170E1	Mobility: Chair/bed-to-chair transfer	(average of 3 items)
GG0170F1	Mobility: Toilet transfer	0-4
GG0170I1	Mobility: Walk 50 feet with 2 turns	(average of 2 items)
GG0170K1	Mobility: Walk 150 feet	

From p. 4 of PDPM Functional and Cognitive Scoring Fact Sheet
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_FunctionalCognitiveScoring_Final_v3_508.pdf

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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

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From Slide 23 of CMS Dec. 11, 2018 SNF PPS PDPM Webinar at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending>

Variable Per-diem Adjustment Factors and Schedule – PT and OT Components

Medicare Payment Days	Adjustment Factor	Medicare Payment Days	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		

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Meant to reflect historical changes in resource utilization

From p. 2 of Variable Per Diem Adjustment Fact Sheet at
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_VPD_v3_508.pdf

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

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From Slide 28 of CMS Dec. 11, 2018 SNF PPS PDPM Webinar at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntry=10&DLSort=0&DLSortDir=descending>

- Acute Neurological Condition as noted in primary reason for admission list
- Mechanically Altered Diet or Swallowing Disorder from MDS Section K items

SLP-Related 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
 - A mapping between ICD-10 codes and the SLP comorbidities is available on the PDPM webpage

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

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From Slide 25 of CMS Dec. 11, 2018 SNF PPS PDPM Webinar at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntry=10&DLSort=0&DLSortDir=descending>

Based on mapped ICD-10s for Comorbidities Diagnosis: "Return-to-Provider" (RTP) claim function applied when submitted ICD-10 is not mapped

Cognitive Score

Under PDPM, just as under RUG-IV, a patient's cognitive status is assessed using either the Brief Interview for Mental Status (BIMS). In cases where the BIMS cannot be completed, a Staff Assessment for Mental Status is completed. The Cognitive Performance Scale (CPS) is then used to score the patient based on the responses to the Staff Assessment.

Under RUG-IV, the BIMS and the CPS produced separate scores, with no single measure of cognitive status that allowed comparison across all patients. The new PDPM Cognitive Score is based on the Cognitive Function Scale (CFS), which combines scores from the BIMS and CPS into one scale that can be used to compare cognitive function across all patients.

In order to receive a PDPM classification, all required items must be completed. Either a BIMS score or CPS score is necessary to classify the patient under the SLP component.

PDPM Cognitive Score 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

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From p. 5 of PDPM Functional and Cognitive Scoring Fact Sheet
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_FunctionalCognitiveScoring_Final_v3_508.pdf

Modes of Therapy

- Definitions of modes unchanged
- Continue to be recorded in MDS Section O
- Focus on Individual
 - < 25% of total stay
 - CMS tracking patterns of utilization via entry of total days and minutes (MDS Section O) on discharge evaluation
 - Non-fatal error message if exceed 25%
- Co-treatment may still be provided when clinically appropriate

Additional note: Therapy days and minutes will also be entered in Section O for admission assessment 7-day lookback

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Nursing Component

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- Clinical Information from SNF Stay
- Functional Status
- Extensive Services Received
- Presence of Depression
- Restorative Nursing Services Received

(AIDS adjustment may also be applied)

Nursing Component

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- Uses same basic nursing classification structure as RUG-IV with some modification
 - Nursing RUG collapsed from 43 to 25
 - Extensive services
 - Special Care High
 - Special Care Low
 - Clinically Complex
 - Behavioral Symptoms and Cognitive Performance
 - Reduced Physical Function

Section GG Items Included in Nursing Functional Score

Item	Description	Score Range
GG0130A1	Self-care: Eating	0-4
GG0130C1	Self-care: Toileting Hygiene	0-4
GG0170B1	Mobility: Sit to lying	0-4
GG0170C1	Mobility: Lying to sitting on side of bed	(average of 2 items)
GG0170D1	Mobility: Sit to stand	0-4
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
		(average of 3 items)

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From p. 5 of PDPM Functional and Cognitive Scoring Fact Sheet
https://www.cms.gov/Medicare/Medicaid-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_FunctionalCognitiveScoring_Final_v3_508.pdf

PDPM Cognitive Score 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

Examples of Nursing Classification

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RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	Restorative Nursing Services	Function Score	CMG	CM1
E03	Tracheostomy & Ventilator				0-14	E03	4.04
E02	Tracheostomy or Ventilator				0-14	E02	3.06
E01	Infection Isolation				0-14	E01	2.91
HE2/H02		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	Yes		0-5	H0E2	2.39
HE1/H01		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	No		0-5	H0E1	1.99
BB0/BA2		Behavioral or cognitive symptoms	2 or more		11-16	BA02	1.04
BB1/BA1		Behavioral or cognitive symptoms	0-1		11-16	BA01	0.99
PE2/P02		Assistance with daily living and general supervision	2 or more		0-5	P0E2	1.57
PE1/P01		Assistance with daily living and general supervision	0-1		0-5	P0E1	1.47
PC2/P02		Assistance with daily living and general supervision	2 or more		6-14	P0C2	1.21

From Slides 30 and 32 of CMS Dec. 11, 2018 SNF PPS PDPM Webinar at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntry=10&DLSort=0&DLSortDir=descending>

Non-Therapy Ancillary (NTA) Component

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- Under RUG IV NTA was combined with nursing as one component, but under PDPM is a separate component
- Based on the presence of certain comorbidities or use of certain extensive services
 - Primarily driven by medication/drug costs
- Points assigned and tiered
- Examples:
 - HIV/AIDS = 8 points
 - Parenteral IV feeding: Level Low = 3 points
 - Diabetes Mellitus Code = 2 points

NTA Component: Payment Groups

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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

From Slide 39 of CMS Dec. 11, 2018 SNF PPS PDPM Webinar at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending>

Variable Per-diem Adjustment Factors and Schedule – NTA Component

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Medicare Payment Days	Adjustment Factor
1-3	3.0
4-100	1.0

Meant to reflect historical changes in resource utilization

From p. 2 of Variable Per Diem Adjustment Fact Sheet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_VPD_v3_508.pdf

Interrupted Stay Policy

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- 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
- Meant to decrease an unintended incentive for providers to discharge and readmit patients for the purpose of resetting the variable per diem adjustment schedule
 - Reduction of preventable hospital readmission is still a quality of care priority
 - Applies to in-facility discharge from/re-admission to Part A stay

From Slide 68 of CMS Dec. 11, 2018 SNF PPS PDPM Webinar at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending>

HIPPS Code Format

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- Character 1: PT/OT Payment Group
- Character 2: SLP Payment Group
- Character 3: Nursing Payment Group
- Character 4: NTA Payment Group
- Character 5: Assessment Indicator
(0=IPA; 1=5-day; 6= non-PPS coded OBRA)

Example:

PT/OT Payment Group: TN
SLP Payment Group: SH
Nursing Payment Group: CBC2
NTA Payment Group: NC
Assessment Type: 5-day PPS
HIPPS Code: NHNC1

From Slides 78 and 82 of CMS Dec. 11, 2018 *SNF PPS PDPM Webinar* at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending>

Base Rates

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Table 12—FY 2019 PDPM Unadjusted Federal Rate per Diem—Urban ¹

Rate component	Nursing	NTA	PT	OT	SLP	Non-case-mix
Per Diem Amount	\$103.46	\$78.05	\$59.33	\$55.23	\$22.15	\$92.63

¹ The rates shown in Tables 12 and 13 illustrate what the adjusted federal per diem rates would be for each of the case-mix adjusted components if we were to apply the proposed PDPM to the proposed FY 2019 base rates given in Tables 4 and 5.

Table 13—FY 2019 PDPM Unadjusted Federal Rate per Diem—Rural

Rate component	Nursing	NTA	PT	OT	SLP	Non-case-mix
Per Diem Amount	\$98.83	\$74.56	\$67.63	\$62.11	\$27.90	\$94.34

From p. 39193 of FY 2019 SNF PPS Final Rule <https://www.federalregister.gov/documents/2018/08/08/2018-16570/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>

Rate Calculation Formula

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PDPM Snapshot

PT PT Base Rate PT CMI VPD Adjustment Factor

OT OT Base Rate OT CMI VPD Adjustment Factor

SLP SLP Base Rate SLP CMI

NTA NTA Base Rate NTA CMI VPD Adjustment Factor

Nursing Nursing Base Rate Nursing CMI 18% Nursing Adjustment Factor (Only for Patients with AIDS)

Non-Case-Mix Non-Case-Mix Base Rate

From Slide 9 of CMS Dec. 11, 2018 *SNF PPS PDPM Webinar* at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-12-11-PPS.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending>

Changeover from RUG IV to PDPM

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- No transition period between RUG-IV and PDPM
 - RUG-IV through 09/30/2019
 - PDPM begins 10/01/2019
- For patients crossing from September to October under Medicare Part A benefits, an IPA assessment will need to be completed with and assessment reference date no later than 10/07/2019
 - For those patients, 10/01/2019 will be considered Day 1 of the Variable Per Diem Adjustment Schedule

Session Outline

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- Course Introduction and Resources
- Overview of Volume to Value Concept
- History of SNF PPS and Basic Concepts
- Review of PDPM
- Overarching CMS Initiatives*
- Skilled Nursing Facility Initiatives and Systems
- Promoting OT's Role and Value
- Wrap-up

Overarching CMS Initiatives

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- Quality programs
- Innovation
- Transparency
- Patients over Paperwork Initiative
- Effective transition/discharge planning
- Hospital readmission reduction

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Skilled Nursing Facility Updates and Changes

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- Updated Conditions of Participation
 - 3 Phases - Nov. 2016, 2017, 2019
 - Among areas of focus are resident rights, discharge planning, person-centered care, infection control, quality assurance and performance improvement, staff training
 - Details in Final Rule posted 10/04/2016 (<https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities#h-138>)
- MDS and RAI Manual Updates (Oct. 1, 2018)
 - Expanded Section GG
 - To full set of self-care and mobility items
 - Includes Prior Level of Function and Prior Device Use Items

Quality Initiatives

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- Increased accountability and transparency
 - Consumer awareness, engagement, and choice
 - Provider reputation
- May have financial incentives or penalties

Overlying Quality Initiatives

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- Post-Acute Care reform (IMPACT Act) (required for four PAC provider types - HHA, SNF, IRF, LTCH)
- Quality Reporting Program (QRP)
- Value-Based Purchasing Measure (VBP)
- SNF Quality Assurance and Performance Improvement (QAPI)
- 5-Star Rating Program and Nursing Home Compare Website
- Payroll-Based Journal (PBJ)
- Special Focus Facility (SFF) Initiative (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/SFFList.pdf>)
- Emergency Preparedness (required for HHAs and 16 other provider types)

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Overarching themes

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- OT and other rehab disciplines must move from being drivers of reimbursement to drivers of quality and outcomes
- Empowerment
 - Putting clinical decision-making in the hands of the clinicians together with focus on patient characteristics, factors, and engagement
 - Opportunities to show value and support parallel initiatives

A note about a reality that cannot be overlooked: Health care entities are businesses that cannot ignore financial and operational concerns, but the evolving changes look to promote best practices and to assure the right factors and incentives are driving patient care.

Through OT Practice

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- Occupation/Function
 - Mitigating Risks (Re-admissions)
 - Supporting quality and outcomes
- Evidence-based Practice
- Billing and Clinical Documentation
 - Accurate, Appropriate, Complete, Thorough
- Team Collaboration

For PDPM

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- Identifying, collaborating, documenting to support:
 - Clinical Category
 - Functional scoring

For Overlay of Other Initiatives Clinical and Operational Level

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- To promote quality
- To facilitate outcomes
- To support provider reputation
- To provide data that supports OT's role and value
- Etc.

Think About a Case Scenario

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- From an OT perspective.....
 - What occupations might you address?
 - What risks might OT intervention mitigate at the SNF and in regard to the client's discharge/transition plan?
 - How might you collaborate to support the components of PDPM?
 - How might you contribute to quality initiatives?
 - How might you document to support to support PDPM, quality of care, and outcomes?

Example - A Case Scenario

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An 82 year old female, with a history of COPD and macular degeneration, admitted after open reduction, internal fixation for a right hip fracture sustained when she fell while reaching to put some groceries away in a lower cupboard. She uses a portable oxygen tank that she transports via a basket in a wheeled walker. She plans to return to her assisted living facility (ALF) unit, where she was previously performing basic self-care activities independently, other than showering, for which she had a personal aide 3x/week. The aide also helped with laundry once a week. She took her main meal in the facility dining room at noontime, but independently prepared light meals and snacks. She took the facility van to the store every other week to purchase groceries and a couple of times a month for social activities. She also independently ambulated with the walker to and from various recreational and social activities within the ALF. Her daughter assists her with management of her finances because her mother was complaining of memory difficulties and being overwhelmed by the paperwork. Her daughter takes her to church every week and to family outings once or twice a month, using a car for transportation.

Sharing Thoughts About CMS Case Scenario #2

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- From an OT perspective.....
 - What occupations might you address?
 - What risks might OT intervention mitigate at the SNF and in regard the client's discharge/transition plan?
 - How might you collaborate to support the components of PDPM?
 - How might you contribute to quality initiatives?
 - How might you document to support to support PDPM, quality of care, and outcomes?

Factors to Consider and Think About as You Prepare for the Changes Ahead

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- Facilitators
- Barriers/Challenges
- Knowledge level and gaps
- Opportunities
- Protecting yourself from burnout (4th aim)
- Operational issues

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Where To Go From Here

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- Access Information and Stay informed
 - Course handout
 - CMS
 - AOTA
 - Other Education resources (Employers, courses, etc.)
- Show your value
 - AOTA Advocacy (comorbidities, interventions for cognition and swallowing)
 - Occupations
 - Evidence-based Practice
 - Billing and clinical documentation (also provides data)
 - Interdisciplinary Team Collaboration

A few more minutes...

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- How can ConnOTA help?
 - What/Where/When?;
 - What other type of info do you feel you need?
 - Make a note on your course assessment so there is follow up

Parting Words....

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- Approach with confidence
- Be engaged in the process and showing your value
- Learn and think about and prepare for the impact of the changes
- Embrace the opportunities and empower yourself, your clients, and your co-workers

Special Thanks....

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- For shared content and collaboration from:
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