SNF PPS: New Patient Driven Payment Model Call

Moderated by: Leah Nguyen
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Table of Contents

Announcements & Introduction

Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event.

All lines will remain in a listen only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections you may disconnect at this time.

I will now turn the call over to Leah Nguyen, thank you. You may begin.

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS and I am your moderator today. I'd like to welcome you to this Medicare Learning Network Call on the Skilled Nursing Facilities Prospective Payment System. On October 1st, 2019 the new Patient Driven Payment Model or PDPM is replacing Resource Utilization Group version IV or RUG-IV.

During this call we will discuss this new case-mix classification system for SNF Part A beneficiaries, and the changeover from RUG-IV to PDPM. A question and answer session follows the presentation. Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL, go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press you may listen in, but please refrain from asking questions during the question and answer session. If you have inquiries, contact press@cms.hhs.gov. Again, at this time I'd like to turn the call over to Todd Smith Division Director from the Chronic Care Policy Group at CMS.

Presentation

Todd Smith: Thank you Leah. Good Afternoon everyone and Good Morning to everyone joining us from the west coast. My name is Todd Smith, I'm the Director of the Division of Institutional Post-Acute Care here at CMS and before we get started, I just want to let everyone know who is here in the room from the SNF team.

With me is Kia Sidbury, Bill Ullman, John Kane and Penny Gershman and John and Penny will be doing today's presentation. Before they do the presentation, I just want to take a moment to thank everyone that's on this call all of our stakeholders. As many of you know, back in May of 2017 the agency released an advanced notice of proposed rulemaking which proposed the model, a new model for the Skilled Nursing Facility Prospective Payment System.

And it's through that stakeholder engagement, that continuous stakeholder engagement that we were allowed to propose and finalize a rule this year with what we think is a payment model that will be an improvement on the Skilled Nursing Facility Prospective Payment System in that we will be paying based on value rather than volume. So, I just want to thank everyone for that continued engagement, it's very important to us.

Recently we even have a dedicated website which you'll see in today's presentation, the PDPM website, we also have a dedicated email box for any questions or concerns that you may have regarding the new payment system. So, with that, I'll turn it over to John — John Kane to begin today's presentation.

PDPM Overview

John Kane: Thank you Todd and Good Afternoon and Good Morning everyone and thank you all for being on today's call. We have a lot of material to cover today so without further ado let's get right into it. On slides 2 and 3 of the presentation we provide a list of the various acronyms that we use throughout this presentation.

As you can imagine there are quite a few acronyms related to this body of work, each of them is defined the first time they appear in the presentation. Slide 3 provides more of the acronyms found in the presentation, so we're just going to jump right to slide 4. Slide 4 outlines the agenda for today's presentation.

As you can see there are quite a few different topics for today's discussion. We also want to be sure to leave enough time to address your questions and so with that let's move to slide 5. The first topic today will be a general overview of PDPM, its various payment rate components and a discussion of how providers will use these various elements to classify SNF patients under the revised payment model.

Moving to slide 6, the issues with the current case-mix model RUG-IV are well known and understood. Fundamentally, the main issue with RUG-IV and more generally with the SNF Prospective Payment System since inception is that therapy payments under the SNF PPS are based almost entirely on merely the amount of therapy that the patient receives.

This has led to a perverse incentive whereby the decisions around how much therapy a SNF patient should receive can be divorced from the patient's unique characteristics, goals or needs. A good example of this which we have discussed in several rules and other agency publications over the past few years is something we have described as thresh holding which refers to patients receiving almost exactly the amount of therapy necessary to achieve a particular therapy payment group.

For example, a significant percentage of patients classified into the ultra-high rehabilitation category too significant to be an accurate reflection of that population individualized needs receives almost exactly 720 minutes of therapy per week which is the minimum amount necessary to classify patients in this high paying therapy category.

PDPM on the other hand which will be implemented October 1, 2019 improves the methodology used to classify SNF patients under the SNF PPS by having the patient's payment classification driven by that patient's unique characteristics and care needs rather than the volume of services provided.

Furthermore, PDPM improves over the existing payment structure by significantly reducing the administrative burden for providers resulting from SNF PPS policies and shifts payment to currently underserved beneficiaries without increasing total Medicare outlays. To see how PDPM is able to do this, let's look at how the classification methodology under PDPM compares to that used under RUG-IV.

Slide 7 provides a snapshot of the RUG-IV model. As noted on this slide, RUG-IV consists of two case-mix adjusted rate components; a therapy component which is adjusted to reflect relative resource use for therapy services, and a nursing component that is adjusted to reflect relative resource use for nursing and Non-Therapy Ancillary or NTA services.

Just a quick note that whenever we use the term Non-Therapy Ancillaries or NTAs, think drugs as drug costs are the primary cost driver behind NTA costs. As mentioned earlier, the primary issue with RUG-IV derives from the therapy component where payment is driven almost solely by the volume of services provided.

However, another issue with RUG-IV is how the nursing Case-Mix Index or CMI which is intended to reflect the relative resource intensity associated with the patient's nursing and NTA services does not currently reflect specific variations in NTA utilization. Furthermore, since well over 90 percent of patient days are paid for using a therapy payment group, the nursing CMI for most SNF patients is dictated by the patient's classification into a given therapy group.

For example, the nursing CMI for a patient classified into the group RVB is 1.11, while the nursing CMI for a patient classified into the group RUB where the only difference is in the amount of therapy that patient received is 1.56. This means that payment for nursing may be tied to changes in therapy utilization rather than specific changes in nursing need or resource intensity.

Turning to slide eight, PDPM on the other hand breaks these 2 cases mix adjusted components under RUG-IV into their constituent components. Specifically, the therapy component is broken into three case-mix adjusted components one for each therapy discipline; Physical Therapy, Occupational Therapy and Speech Language Pathology. The nursing component under RUG-IV is similarly broken into its constituent components specifically nursing and NTAs.

Each of these components is adjusted for separately from the other components using data driven patient characteristics that were vetted significantly by the public through a variety of different methods. This slide also makes reference to the Variable Per Diem adjustment under PDPM which we will discuss in further detail later in this presentation.

Slide 9 provides a similar snapshot to what we saw for RUG-IV except now for PDPM. I understand that this diagram may look more complicated than that for RUG-IV merely by the number of boxes present, but the methodology under PDPM is both simplistic and intuitive.

For each case-mix adjusted component, same as under RUG-IV there is a base rate which is multiplied against the CMI. However, under PDPM there is an additional adjustment that is made to three of the components associated with the Variable Per Diem adjustment. After adding all of these 5 case-mix adjusted components together with the non-case-mix component, one would get the total PDPM case-mix adjusted per diem rate.

This per diem rate is similar to how the RUG-IV per diem rates operate currently is then labor adjusted using the SNF wage index and then further adjusted for things such as the SNF Value-Based Purchasing Program. Moving to slide 10, we can see the effect of moving to this new case mixed model.

RUG-IV depicted on the left side of this slide demonstrates how under the current case-mix model all of the needs that a patient has are funneled down into a single payment group, while PDPM depicted on the right side of this slide accounts for each aspect of a patient's care and patients' needs independently. On slide 11 we see what this can mean for two different kinds of patients.

While RUG-IV boils everything down to a single RUG-IV group which can obscure significant differences between different patient types, PDPM is able to provide for a much more accurate and nuanced payment that is able to flexibly account for differences in patient need and characteristics. Let's now dive more specifically into each PDPM component to better understand how patients are classified under each one of the five case-mix adjusted components.

Patient Classification Under PDPM

As noted on slide 13, under PDPM each patient is classified into a group for each of the five case-mix adjusted components. However, the classification criteria used for each of these components is different. On the next series of slides, we will look at each component one by one to examine the relevant criteria used to classify patients under each rate component. On slide 14 we begin with the PT and OT components.

As opposed to RUG-IV where therapy payment is dictated by the volume of services provided, PDPM derives therapy payment from patient characteristics. For the PT and OT components those patient characteristics are the patient's clinical category and the patient's functional status. Moving to slide 15, we see that the patient's clinical category is a reflection of the patient's primary SNF diagnosis.

As will be discussed in greater detail later in this presentation, providers will report the patient's primary diagnosis in the form of an ICD-10-CM code on the MDS in item I0020B or I20B. Based on this diagnosis, using a crosswalk that is available on the PDPM website the patient is classified into one of 10 clinical categories. Those categories are listed here on slide 15 and basically represent buckets of similar diagnosis.

It is possible that the patient's clinical category may change depending on the presence of a surgery during the preceding hospital stay which is discussed later in this presentation. Based on the aforementioned crosswalk, the patient is classified into one and only one clinical category which then factors into different aspects of the patient's PDPM classification.

It is important to note that this primary diagnosis represents the primary reason that the patient was admitted to the SNF which may or may not be the same reason that the patient was admitted to the qualifying hospital stay. In other words, there is no necessary reason that the primary SNF diagnosis must match the primary hospital diagnosis from the prior hospital stay. We would further note as illustrated in the ICD-10 crosswalk on the PDPM website, not all diagnoses are considered valid primary diagnoses for the SNF stay.

In some cases, a diagnosis is listed as return to provider which means that these diagnoses will not provide a PDPM classification for the patient and the record would be rejected.

Moving to slide 16, once the patient is classified into a PDPM clinical category one can start to determine the PT and OT group into which that patient will be classified. As shown on slide 16, each of the PDPM clinical categories leads to one and only one of the collapsed PT and OT clinical categories.

For example, if the patient was classified in the Acute Neurologic clinical category, then this would lead them to be classified into the collapsed Non-Orthopedic Surgery and Acute Neurologic PT and OT category.

Slide 17 begins to discuss the other aspect involved in a patient's PT and OT classification which is the PT and OT functional score.

Similar to RUG-IV, a patient's functional status is relevant in terms of payment classification. However as opposed to RUG-IV which used items in section G of the MDS, PDPM utilizes items from section GG of the MDS which advances CMS's goal of using more standardized assessment items across payment settings. The types of items used for the PT and OT components are given on slide 17 so we will go into greater detail on these items on the next slide.

Slide 18 highlights the items used from section GG for determining the patient's PT and OT functional score. As you can see, we use several self-care items specifically those for eating, Oral Hygiene and Toileting Hygiene and then the average of a few groups of mobility items specifically those related to sit to lying activity, certain transfer items and two walking items.

The sum of these scores rounded to the nearest integer provides the patient's PT and OT functional score. Coupled with the patient's clinical category this would provide the patient's PT and OT payment classifications. As we are discussing calculation of the functional scores relevant under PDPM, slide 19 lists the items used to calculate the functional score used as part of the nursing component under PDPM.

You will note that all of the items listed here are also used for calculating the PT and OT functional score, though a few items used for the PT and OT score are not used for calculating the nursing functional score.

Slide 20 provides a crosswalk between the item response for each of the GG items listed on the previous two slides with a number of points that that response provides toward the patient's PT, OT, and nursing functional scores.

In just a moment we will discuss some important differences between how item responses are scored currently under RUG-IV versus how the responses are scored under PDPM. Slide 20 highlights the response scoring crosswalk for the non-walking items, while slide 21 provides the crosswalk between item responses and functional score points for the walking items.

Important to note is that a response of dependent or any response which might be characterized as a non-response such as that the patient refused or cases where the response is dashed, or activity is not attempted or scored as a zero. As mentioned just a moment ago, there are a few important differences between the functional scores used under RUG-IV and under PDPM as discussed on slide 22.

First, while an increasing score under Section G or RUG-IV indicates increasing patient dependence, an increasing score under Section GG or PDPM means increasing independence. Providers should take note of this reversal in the scoring logic. Second and perhaps more importantly from a payment accuracy standpoint is that as opposed to RUG-IV, there's not necessarily a linear relationship between payment and increasing dependence under PDPM.

For example, as noted on slide 22, for the PT and OT components payment for three of the collapsed PT and OT clinical categories is actually highest in the middle of the functional score curve than it is at either the extreme independent side or extreme dependent side.

Moving to slide 23, we see how these two classifications criteria the patient's clinical category and the patient's PT and OT functional score is used to attain the patient's PT and OT payment group.

For example, a patient in the major joint replacement clinical category with a PT and OT functional score of four would be classified into the group TA. As a result for that patient the PT base rate would be multiplied by a CMI of 1.53 and the OT base rate would be multiplied by a CMI of 1.49 to attain the patient's case-mix adjusted per diem component rates for PT and OT respectively. These amounts would then be multiplied by the Variable Per Diem adjustment as discussed later in this presentation.

We would note that while the classification criteria for the PT and OT components are the same, the base rates and CMIs for these components are different so each component must be calculated independently. There are a total of 16 PT and OT groups and each patient will be classified into one and only one PT and OT case-mix group.

Turning now to the SLP component under PDPM, slide 24 outlines the various classification criteria that are used to classify patients under this component. We will look at each one of these criteria over the next several slides so the first criteria has already been discussed. A patient's classification into the acute neurologic clinical category provides for a different SLP component classification than any other PDPM clinical category. So, this criterion is taken together with two other SLP criteria.

The first of these discussed on slide 25 is the presence of an SLP related comorbidity; specifically, there are 12 SLP related comorbidities such as Aphasia or Stroke that we identified in our data as being relevant in predicting increased utilization of SLP services. The patient qualifies for having an SLP related comorbidity if any one of the 12 conditions is recorded as being present.

In terms of how these conditions may be reported, this involves the provider coding certain items on the MDS or providing an ICD-10-CM code in section I8000 of the MDS. A crosswalk between the relevant ICD-10 codes and the SLP related comorbidities, as well as the items used for those SLP related comorbidities that do not require an ICD-10 code may be found in the classification walkthrough on the PDPM website.

The next aspect of determining a patient's SLP classification is the patient's cognitive score which is determined in a very similar manner as is currently done under RUG-IV. As noted on slide 26, both PDPM and RUG-IV use the Brief Interview for Mental Status or BIMS to determine the patient's cognitive status. In cases where the BIMS cannot be completed, a staff assessment for mental status is completed.

Under RUG-IV we then use the Cognitive Performance Scale or CPS to score the patient's cognitive status. Under PDPM we use a slightly different scale called the Cognitive Function Scale or CFS which allows us to compare the results of the BIMS to the staff assessment on a common scale.

On slide 27 we outline this combined scale which shows how the BIMS score compares the CPS score derived from the staff assessment. Based on this scale a patient will either be found to be Cognitively Intact or suffering from a Cognitive Impairment if the patient is even Mildly Impaired. In other words, any level of cognitive impairment mild or otherwise is sufficient to receive credit for this aspect of the SLP classification criteria.

Slide 28 outlines how the aforementioned SLP classification criteria factor into the patient's SLP classification. Specifically, under the first column of the table on slide 28, the patient is classified based on the absence of any of the three criteria previously discussed. That is an Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment or the presence of any one two or three of those criteria.

After this the patient is then further classified depending on the presence of a Mechanically Altered Diet as indicated by item K0510C2 on the MDS, and or the presence of a Swallowing Disorder as reported in item K0100 on the MDS. The patient is classified based on the absence of these two issues or the presence of one or both of them.

For example, a patient with a Mild Cognitive Impairment and a Swallowing Disorder but meeting no other SLP classification criteria would be classified into the group SE. As a result, the SLP base rate will be multiplied by 2.33 in order to obtain the patient's case-mix adjusted SLP component rate.

Shifting gears away from therapy, slide 29 discusses how patients are classified into a payment group under the nursing component of PDPM. Fortunately, nursing classification under PDPM is very similar to how patients are classified under RUG-IV using nearly all the same criteria. This is because nursing classification under RUG-IV captures well variations in relative degrees of nursing resource use.

The issue with the current nursing component as discussed earlier is that these nursing group criteria are not used under RUG-IV to determine the patient's nursing CMI but rather the amount of therapy the patient receives. Therefore, under PDPM we merely brought out the nursing component and used its criteria to independently classify the patient into a PDPM nursing group.

The only two differences between RUG-IV and PDPM in terms of nursing classification are the use of section GG of the MDS as discussed earlier, and that we have collapsed several of the functional groups together reducing the number of distinct nursing groups from 43 to 25. Slides 30 through 32 provide the nursing classification criteria which you should be familiar with from RUG-IV, as well as the GG based nursing functional score which leads to the patient's nursing classification group and associated CMI.

As with the other rate components, the nursing base rate is multiplied against the relevant nursing CMI for the payment group into which the patient classifies. This amount may be further adjusted for patients with AIDS as discussed later in this presentation. For now, let's move to slide 33 and the NTA component. The NTA component represents a significant improvement for the SNF PPS as we have long sought to create a separate component to specifically address variations in NTA utilization and costs.

As mentioned earlier, the primary cost driver for NTAs are drug costs as these costs tend to be driven by the various conditions and comorbidities that a person has, the NTA component is based entirely on the presence of certain comorbid conditions. In terms of how we use these conditions to classify patients into an NTA payment group, we considered a variety of possible options.

First, we considered a tier system which uses the patient's most costly comorbid condition as the basis for classification. And while this method does account for the fact that some conditions are more costly than others, it neglects to account for the increased cost of a patient having multiple conditions.

On the other side, we considered a method which looked at the total number of comorbid conditions as patients with more conditions tend to be more costly than those with fewer conditions. However, this method does not account for the fact that a single high cost condition may be more costly than two or three low cost conditions. Therefore, to best account for both of these issues, we designed an NTA comorbidity score which represents a weighted count of the patient's comorbidities with certain conditions counting for more points toward this score than others.

As discussed on slide 44 -- 34, to capture these comorbidities on the MDS providers may code a number of different items on the MDS with some conditions requiring an ICD-10-CM code to receive credit for that condition. A crosswalk between ICD-10 codes and the relevant NTA comorbidities may be found on the PDPM website.

Beginning on slide 35 and going through slide 38, we list the 50 conditions that we use for NTA classification under PDPM. You will note that each condition in the table lists the source on the MDS where that condition may be reported, as well as the number of points toward the patient's NTA comorbidity score associated with that condition. The patient's total NTA comorbidity score represents the sum of all points for the conditions from which that patient suffers and are reported on the MDS.

We must make an important note regarding one particular condition on this list which is AIDS. This condition is the most costly condition on the list which is why it has the most points associated with it. However due to certain state privacy laws, AIDS diagnosis information may not be reported on the patient assessment and may only be reported on the SNF claim. Therefore, as discussed in greater detail later in this presentation, we will continue to require that AIDS information be reported on the SNF claim in the same manner as it is now.

When the claim system identifies the relevant code on the claim, the patient's NTA classification will be revised accordingly with the patient being reclassified by the claim system into the appropriate NTA payment group based on the addition of eight points to the patient's NTA comorbidity score. Skipping to slide 39, we see the 6 payment groups for the NTA component based on the patient's NTA comorbidity score.

For example, a patient with an NTA comorbidity score of seven would be classified into group NC. As a result, the NTA base rate would then be multiplied by 1.85 to get the patient's case-mix adjusted NTA component rate. This amount would then be further adjusted by the appropriate Variable Per Diem adjustment as we will discuss in just a moment.

This total amount when added together with the other adjusted component rates and the non-case-mix component base rate equals the patient's total PDPM per diem rate. Turning to slide 40, we will now discuss the Variable Per Diem adjustment which is a very different type of change to the SNF PPS. As discussed on slide 40, the Social Security Act requires that the SNF PPS pay on a per diem basis meaning that each day of a patient's stay has an assigned payment rate.

Until now the SNF PPS utilized a constant per diem rate which means that the payment rate for a given payment group on day one is the same as the payment rate for that group on day 100. While this is certainly simpler than a Variable Per Diem rate, it does not account accurately for the manner in which costs are incurred shifting too much of SNF funding towards the end of a stay when costs tend to be lower, and not having sufficient funding at the beginning of a stay when costs are higher.

To address this issue, PDPM introduces a Variable Per Diem rate similar to the way payments are made under the Inpatient Psychiatric Facility PPS. Specifically, for the PT and OT and NTA components, the case-mix adjusted per diem rate is multiplied against a Variable Per Diem adjustment factor which follows a prescribed schedule of adjustment as shown on slide 41.

You will note that the schedule for PT and OT components is different from the schedule used for the NTA component. This is because NTA costs are incurred in a very different way than PT and OT costs. As the primary cost driver of NTA costs are drugs and because drugs for a SNF stay are expensed at the beginning of the stay rather than as constant cost over the course of the stay, a constant per diem rate for NTAs may disadvantage patients with high NTA needs or fail to reimburse facilities appropriately for the costs incurred.

To avoid this, the NTA schedule has a high adjustment factor for the first 3 days of the stay using no adjustment factor for the remaining portion of the stay. Alternatively, as PT and OT costs tend to begin high and decline more gradually over the course of the stay, the PT and OT components use no adjustments for the first 20 days of a patient's stay and then applies a two percent reduction to the respective component rates each week thereafter.

We would note that based on recent data, more than half of SNF stays end by day 20 so we do not expect that most stays will incur any adjustments for the PT and OT components. So, the only aspect of the Variable Per Diem schedule that will affect most stays would be the NTA adjustment which we hope will better ensure access for beneficiaries with high NTA needs.

Patient Classification Example

Now that we have a basic understanding of the various components under PDPM, let's consider an example of how two patients would be classified under RUG-IV and PDPM. On slide 43 we see the hypothetical characteristics of two different SNF patients who are creatively called patient A and patient B.

I will note that the first 4 characteristics listed in the table from Rehab Received to ADL score is all that is necessary in order to know what we pay for over 90 percent of the days under Part A currently. This is unacceptable as these four characteristics tell us almost nothing about the actual patient and only about the intensity of services that patient received.

Patient centered care requires a greater focus on the patient than this which is why nearly all of the remaining characteristics in the table those relevant for PDPM classification purposes relate to the patient's unique condition rather than the services received. Turning to slide 44, we see how these two very different patients are classified into the same RUG-IV group given that they both receive the same amount of therapy services, have the same ADL score and did not receive any extensive services.

This example is quite common too, too common frankly across the country as an example of how patients with very different characteristics, needs and goals are categorized in the same group under RUG-IV. Turning to slide 45 we can begin to see how PDPM would classify these two patients.

Patient A depicted on the left is classified into the Acute Neurologic and Non-Orthopedic Surgery group due to the presence of an Acute Neurologic condition, and the 10 to 23 functional score bin with a PT and OT

functional score of 10. Patient B depicted on the right is classified very differently due to receiving a Major Joint Replacement and having a PT and OT functional score of 10. Already just from these two components we can see how PDPM classifies these two different patients in two very different ways.

Moving to slide 46, under the SLP component patient A on the left is classified into the Any Two and Either groups due to the presence of an Acute Neurologic Condition, Moderate Cognitive Impairment and being on a Mechanically Altered Diet. Patient B however having no SLP related issues is classified into the None and Neither categories.

For the nursing component beginning on slide 47 and I will apologize now for the size of the font in these pictures, Patient A is classified into group LBC1 due to receiving dialysis services and having a nursing functional score of 7. On slide 48 we see that patient B is classified into group HBC2 due to the presence of septicemia and having a nursing functional score of 7 and exhibiting signs of depression.

I would note that while these two patients would have been classified into two different non-therapy groups under RUG-IV, we would never observe that difference in terms of payment as the therapy groups derive payment under RUG-IV. Finally, on slide 49 we see that patient A has an NTA comorbidity score of 7 due to receiving IV medication which counts for 5 points, and having diabetes which counts for 2 points for a total of 7 points. This would mean patient A is classified into the 6 to 8 score bin.

Patient B on the other hand has an NTA comorbidity score of 1 due to chronic pancreatitis, which counts for one point. As a result, patient B is classified in the 1 to 2 score bin. I would note again as stated before that while RUG-IV would classify these two patients into the same group despite the myriad of difference between them, PDPM is able to account for these differences and capture them in terms of differences in patient classification.

MDS Related Changes

Turning to slide 50, we're now going to discuss some of the additional policies related to PDPM implementation. On slide 51 we outline a number of different areas that we will examine beginning with the MDS related changes. And on that note, I will now turn the call over to Penny Gershman who'll discuss some of the MDS related changes that will go into effect next October.

Penny Gershman: Thanks John. Hi, everyone. I'll be starting on slide 52 and moving quickly to 53. We have made some changes to the MDS in order to support the implementation of PDPM.

It is important to understand that we are still using the MDS 3.0 for patient classification under PDPM as we did for RUG-IV. However, there are some pretty significant changes with regard to the MDS which is the streamlined assessment schedule and new items that we will get to in the next few slides.

Before we do that, it is important to note that the PDPM changes that will go into effect on October 1st, 2019 will have no effect on the OBRA assessment requirements. This is a question that has come up a lot since we published the final rule, so I will reiterate that the PDPM changes will not affect OBRA assessment requirements.

Moving on to slide 54, this is a slide that all of you are no doubt very familiar with. This is the current and very complex PPS assessment schedule under RUG-IV. You can see that there are a myriad of assessments that are done on a scheduled basis around days 5, 14, 30, 60 and 90 of a Part A stay, and unscheduled assessments that are completed when therapy starts and/or is changed as well as a significant change assessment that is completed when a patient's medical status changes.

On top of this there may be cases where an unscheduled assessment is needed at the same time as a scheduled assessment, and there are rules for combining these assessments. This is all really complex and there have been numerous questions and confusion related to these policies. Under RUG-IV this complexity was necessary in order to ensure accurate payment for SNF services, and in order to prevent certain questionable behaviors so we felt it was essential to have all of these assessments.

Let's compare this to slide 55 which is the new PPS assessment schedule under PDPM. As you can see the schedule will be significantly streamlined. Because we are using much more stable characteristics for classification such as the patient's primary diagnosis, this allows us to do fewer assessments to keep patients classified throughout the SNF stay.

Under PDPM the only PPS assessments will be the 5 day Scheduled Assessment, the optional Interim Payment Assessment or IPA and the PPS Discharge Assessment. This is a market improvement to the complex assessment schedule under RUG-IV. The 5 days Scheduled Assessment will continue to be done with an ARD of days 1 through 8.

Though as opposed to the current 5 days which sets payment for days 1 through 14 of the SNF stay, the 5 Day Assessment under PDPM will set payment for the entire Part A SNF stay unless an IPA is completed, and we will talk about the IPA in just a few minutes. The last assessment is not a Payment Assessment, it's the PPS Discharge Assessment which is the same assessment as it is now with some additional items added to monitor therapy usage and we'll get back to that a bit later as well.

Which brings us back to the IPA, let's move to slide 56. The IPA which stands for the Interim Payment Assessment is a new and Optional Assessment that will be coded on the MDS as AO310B8. By optional we mean that it is entirely up to the discretion of the provider to determine when and if this assessment should be completed. The IPA can be done when a patient's PDPM classification changes due to changes in medical characteristics.

If completed the associated payment window of the IPA is from whenever the ARD of the IPA which is determined by the provider relative to whatever triggering event occurred which prompted an IPA is through the end of the per diem stay unless another IPA is completed.

One very important thing to note about the IPA is that the completion of an IPA does not reset the Variable Per Diem schedule meaning that if the patient is in the middle of his or her SNF stay and an IPA is completed, the PDPM classification may change based on the IPA completion and the patient might be in a different payment category. However, the payment the SNF receives within that category will be based on the day of the Variable Per Diem schedule that was already established for that patient upon entering the SNF.

So, for example if an IPA has an ARD of day 12, then that payment begins on day 12 of the Variable Per Diem schedule. Another new assessment which will come into play in the near future is the OSA, this is an Optional State Assessment. This is not part -- a Part A PPS assessment, nevertheless we want to make providers aware of it. The OSA will be used by providers to report to states in order to receive payment for Medicaid residents.

From now until September 30th, 2019 providers will continue to use whatever current item set their state requires for Medicaid payments. From October 1st, 2019 until September 30th, 2020 for states that rely on the RUG assessment schedule for calculating case-mix groups for SNFs Patients CMS has created the OSA so that Medicaid payments are not adversely impacted when PDPM is implemented.

They still have the ability to determine the policy associated with this assessment to meet Medicaid payment needs. As stated before, this optional assessment will be in place from October 1st, 2019 through September 30th, 2020 only and after that date it will be up to the states to determine what assessments they will use to calculate payments for SNFs patients.

A resource mailbox has been created to answer questions related to the OSA and you can email your questions there at osamedicaidinfo@cms.hhs.gov, that's osamedicaidinfo@cms.hhs.gov. Slide 57 starts to talk about some of the new MDS items that will be in effect with PDPM. Let's start with item I20B SNF primary medical condition.

Most of you are probably familiar with the current item I20A, I20B is a completely new item. In cases where I20 SNF primary medical conditions is coded as one of responses 1 through 13, then you would proceed to I20B entering the ICD-10 code of primary diagnosis of the SNF patient including the decimal.

This should answer the question what is the main reason this person is being admitted to the SNF? In the FY 2019 SNF PPS final rule we discussed using item I8000, specifically the first line of item I8000 to code the primary SNF diagnosis for PDPM purposes. Though based on the comments that asks us to consider using the existing SNF primary diagnosis items in I20, we were able to relocate this primary diagnosis code for PDPM to the new I20B item.

We understand that SNF patients have many complex needs and may suffer from a number of different conditions, but the diagnosis covered in I20B should represent the primary or main reason that person is being admitted. We've received a number of questions regarding a mapping the I20 categories and the PDPM clinical categories.

We would clarify that I20 is not used directly for PDPM classification purposes but rather just the diagnosis coding into I20B. Further, I20A is not used as part of the PDPM classification, only a diagnosis coded in item I20B will be used to classify the patient into one of the 10 PDPM clinical categories.

Let's give an example for this coding. Ms. Kay is a 67-year-old female with a history of Alzheimer's dementia and diabetes who is admitted to a SNF after a stroke. The diagnosis of stroke as well as a history of Alzheimer's, dementia and diabetes is documented in this case history and a physical by the admitting physician. In this case I20 would be coded one stroke, I20B would be coded as I63.411, which is cerebral infarction due to embolism of the right middle cerebral artery.

This ICD-10 code would then be running up against the ICD-10 code clinical category crosswalk which is available on the PDPM website which indicates that this ICD-10 code maps for Acute Neurologic Clinical category. Another group of new items are J2100 through J5000 items which code past surgical history. These items are used to capture any major surgical procedures that occurred during the qualified hospital -- qualifying hospital stay that would require active care during the current SNF stay.

These items will be used in conjunction with the diagnosis code captured in I20B to classify patients into a PDPM category. J2100 will ask if there was a recent surgery during the preceding inpatient hospital stay that required SNF care. If the answer is 1, yes, the provider will proceed to J2300 through J5000 and fill out the check boxes that correlate to the surgery or surgeries received during the immediate prior inpatient hospital stay that requires SNF care.

It should be noted that generally speaking major surgery for item J2100 refers to a procedure that meets the following criteria; the resident was an inpatient in an acute hospital -- at acute care hospital excuse me for at least 1 day in the 30 days prior to admission to the Skilled Nursing Facility, and the surgery carried some degree of risk to the resident's life or the potential for severe disability.

Slide 58 includes the surgical procedures that can be checked after responding yes to item J 2100. You will note that we have grouped these procedures based on general surgical categories. If a patient has more than one surgery they can check off as many as appropriate, however only one is necessary for a patient to receive the surgical diagnosis.

As an example of how the surgical categories are used in conjunction with ICD-10 code diagnosis, excuse me ICD-10 diagnosis coded in item I20B, consider a patient where the primary diagnosis is coded as S02101D or fracture of base of skull right side subsequent encounter for fracture with routine healing. This diagnosis alone would classify the patient into the Acute Neurologic Group.

However, assume that the patient receives a neurological surgery in item J2600 neurosurgery brain surrounding tissue/blood vessels was checked off. By checking off the surgery following the ICD-10 mapping on the PDPM website, the patient's clinical category classification would change from Acute Neurologic to the Non-Orthopedic Surgery category.

Slide 59 discusses some more new MDS items, items O0425A1 to O0425C5 are new items that will be added to the PPS discharge assessment. These are not items that will affect payment directly; these items will be used to collect information on the amount and types of therapy provided to a given SNF patient over the entirety of the SNF Part A stay.

These items will use the look back of the entire SNF stay and ask providers to report in minutes by each discipline and needed therapy the amount of therapy received by the patient. There are two main reasons we're doing this. First, given the shift in payment incentives under PDPM we believe it is possible that some providers may reduce the amount of therapy provided to SNF patients despite no change in the patient's needs or goals.

Therefore, we want a way to track the therapy utilization before and after PDPM is put into effect, so we can make adjustments accordingly in the future. Second, we want to track the amount of concurrent and group

therapy being provided to patients to make sure that the therapies these patients receive continues to be as individualized as possible. This will be necessary to ensure compliance with the 25 percent concurrent therapy limits in each discipline during a Part A SNF stay, and we'll get to that in more detail in just a bit.

Another item step change will be the addition of column five to section GG on the IPA. This item will capture the interim functional performance of the patient. The look back of this item will be the 3-day window leading up to and including the ARD of the IPA and the two calendar days prior to the ARD. Otherwise this item is coded as the other items in section GG are coded.

Moving to slide 60, there are several existing MDS items which will be added to the swing bed assessment under PDPM. Until now these additional items have not been part of the swing bed PPS assessment form because they have not been used for payments. However, the presence of each of these items would be used to classify swing bed residents under the SNF PDPM.

These are K0100 Swallowing Disorder, I1300 Ulcerative Colitis or Crohn's disease or Inflammatory Bowel Disease, I4300 Active Diagnosis Aphasia and O0100D2 Special Treatments Procedures and Programs Suctioning While a Resident. Additionally, item I1300 Ulcerative Colitis or Crohn's disease or Inflammatory Bowel Disease will also be added to the current 5-day assessment in the IPA since they will be used to classify patients into payment categories.

There's certainly more that can be said about all these changes to the MDS but time does not permit getting into everything. Additional details on all of these changes will be available in the forthcoming MDS manual and draft item sets which we hope to have released in the near future.

Concurrent & Group Therapy Limit

Moving to slide 62, we spoke about the therapy collection items being added to the discharge assessment and we mentioned briefly that one purpose in collecting those therapy utilization items specifically the new items O0425A1 through O0425C5 would be to monitor the amount of concurrent and group therapy provided to patients in the SNF. Under RUG-IV there has been a 25 percent limit per discipline on group therapy provided in SNF, however there has been no limit in place for concurrent therapy.

A reminder that the definition of concurrent therapy is one therapist with two patients doing different activities, and the definition of group therapy is one therapist with four patients doing the same or similar activities. As mentioned before, under RUG-IV there has always been a limit for group therapy, but under PDPM we will now be expanding that 25 percent limit to include group and concurrent therapy. So, for each therapy disciplines that is PT, OT and SLP, a SNF Part A patient may receive no more than 25 percent group or concurrent therapy.

It is worth noting that for a number of years the amount of group and concurrent therapy reported on the MDS represented less than one percent of all therapy provided to SNF patients which we believe reflects the intense need for individualized therapy for SNF patients. We plan to monitor closely the amount of group and concurrent therapy provided to SNF patients under PDPM in concert with changes in the SNF population to identify any adverse trends related to therapy provision, and we will adjust our policies accordingly if necessary.

Slide 63 talks about compliance of the concurrent and group therapy limit. In the O0425 items, providers will record the amounts of group or concurrent therapy provided throughout the entire SNF stay. If the total number of concurrent and group minutes combined comprises more than 25 percent 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.

So how do we calculate compliance for this limit? Step 1 calculate the total therapy minutes by discipline. That is the number of minutes in O0425A, B or C1 plus O0425A, B or C2, plus O0425A, B or C3, then calculate the total group and concurrent therapy minutes by discipline in O0425A, B or C2, plus O0425A, B or C3.

Step 3 is to calculate the concurrent/group or the CG ratio which is the result of step 2 divided by the result of step 1. If the result of step three or the CG ratio is greater than 0.25 or 25 percent, then a provider would be out of compliance and will receive a warning on their final validation report.

Let's look at an example on slide 64; we are looking at one discipline here, PT. The patient received 2,000 total individual PT minutes as recorded on O0425C1. He or she received 600 concurrent PT minutes and 1,000 group PT minutes. So, going through the steps outlined on the last slide step 1, the total PT minutes are 3,600 so we got that by adding together O0425C1, C2 and C3.

Step 2, we add together O0425C2 and C3 to sum the concurrent and group minutes and get 1,600 minutes. Step 3 has us calculating the concurrent to group ratio which is done by dividing 3,600 by 1,600 and the result is 0.44. 0.44 is more than 0.25 so this patient is out of compliance and his provider will receive a warning on the final validation report.

Let's do one more example on slide 65, this time we're looking at a patient's SLP minutes. The total amounts of individual SLP minutes received as reported on O0425A1 and we recognize that on the slide it says C and we apologize for this typo, anyway this amount of minutes is 1,200, the amount of concurrent minutes is 100 and the amount of SLP group minutes is 200.

Once again using the formula described previously, in step 1 we add together the total individual concurrent and group SLP minutes and get 1,500 minutes. In step 2 we add the SLP concurrent and group minutes and get 300. The concurrent and group ratio is calculated by dividing 300 by 1,500 and we get 0.20. As 0.20 is less than 0.25 or 25 percent, they would be in compliance here and no warning would be given on the validation report.

As mentioned before, more specific detail on coding these items and all other items on the MDS will be available in the revised MDS manual and draft item set which we hope to release in the near future. Thank you for your time and I will now pass things back to John who will discuss interrupted stays.

Interrupted Stay Policy

John Kane: Thank you Penny. We will continue the discussion of the additional PDPM related policies with discussion of the interrupted stay policy. Slide 67 provides some background on the Interrupted Stay Policy. If you are familiar with the inpatient PPS or Inpatient Rehabilitation Facility PPS, then you have some familiarity

with an Interrupted Stay Policy as our policy is modeled on the one in those settings and for the same basic reason.

In those settings, the Interrupted Stay Policy exists to ensure that patients are not being frequently discharged and readmitted to the facility in order to obtain a new discharge payment. This is particularly important from a beneficiary safety and quality of care perspective as these types of discharges and readmissions can have grave consequences for beneficiaries due to the increased potential for patient transfer issues, record loss and other potential harms to the beneficiary's care, as well as a potentially significant administrative burden on providers having to complete new assessments on each readmission.

Under PDPM while we do not have a discharge type payment as in the other settings, the Variable Per Diem adjustment creates a similar type of incentive for these frequent discharge and readmission scenarios. To mitigate this possibility, we are implementing an interrupted stay policy concurrent with implementation of PDPM which will combine multiple SNF stays under certain conditions into a single stay.

Turning to slide 68, it states that if a patient is discharged from a SNF and readmitted to the same SNF no more than 3 consecutive days after discharge, then the subsequent stay is considered a continuation of the previous stay. This definition includes several important elements, 1st that the patient is discharged and readmitted to the SNF.

As noted on slide 68 and in response to questions that are on this issue that we had received, this policy applies in cases where the patient is discharged from a SNF Part A stay whether that is due to the patient no longer needing skilled care, transitioning to a different payer, or being physically discharged from the facility to an alternate location.

For example, if a patient remains in the facility on a Medicaid covered long term care stay but returns to Part A coverage at the same facility within that 3-day interruption window, then the stay is considered a continuation of the prior SNF stay. The second aspect of this definition is that they be readmitted to the same SNF. This means that the facility from which the patient is discharged and the facility into which the patient is admitted must be the same.

If it is a different facility even if the admission occurs within 3 days of the previous stay discharged, the new facility admission would be considered a new stay. Finally, the interruption window of 3 days more specifically this refers to the third midnight beginning with the midnight of the day on which the patient discharged counting as the first midnight. If a patient is not back in the facility by that third midnight, then any subsequent stay would be outside the interruption window and considered a new stay.

In terms of the impact on the provider, there are two effects of the interrupted stay policy. First, the PPS assessment schedule continues from the point just prior to discharge. In other words, no new PPS assessments are required when the patient returns from interrupted stay. For billing purposes, an interrupted stay is reported and treated similar to a leave of absence in terms of how it is reported on the claim and how it is treated in terms of the assessment calendar.

A provider may certainly complete an IPA if deemed appropriate upon the patient's return, but this is not required as the IPA is an optional assessment. Furthermore, a PPS discharge assessment should not be

completed for a patient when they begin an interrupted stay as the subsequent stay is considered a continuation of the prior stay.

However, it is important to note that OBRA requirements remain the same under PDPM, meaning that an OBRA discharge assessment is due upon patient discharge and a new admission assessment may be required depending on the manner in which the patient was discharged. Providers should consult the MDS manual for a discussion of OBRA requirements at discharge.

The second impact of the interrupted stay policy is that the Variable Per Diem adjustment is not reset in the case of an interrupted stay. This means that if a patient discharged on day 14 of their stay and returns on an interrupted stay, then they return day 14 of the Variable Per Diem schedule. If any of these conditions are not met that they be readmitted within the interruption window to the same facility, then the same -- then the subsequent stay is considered a new stay and the assessment and Variable Per Diem's schedule's reset.

Beginning on slide 69 and continuing to slide 70, we provide a series of examples intended to highlight how the interrupted stay policy would play out in various circumstances such as when the patient returns outside the interruption window as an example 1, is admitted to a different facility as an example 2, meets the conditions of readmission to the same facility or returning to Part A coverage within the interruption window as in examples 3 and 4 respectively.

Administrative Presumption

We hope these examples help provide clarity on how the interrupted stay policy plays out in different scenarios. Moving to slide 71, we begin to discuss the administrative presumption under the SNF PPS. Turning to slide 72, the administrative presumption refers to a policy in which a patient who is correctly assigned to one of the designated case-mix groups on the 5-day assessment is automatically presumed to meet the SNF level of care criterion that is necessary for coverage of a Part A SNF stay through the Assessment Reference Date for that assessment.

If a patient is not classified into one of these designated groups, it only means that they are not automatically presumed to have met the level of care criterion for SNF care but rather would rely on an individual determination for coverage. On slide 73, we outline the PDPM case-mix groups that are designated as meeting the presumption under PDPM.

It is important to note that a patient need not qualify for one of these groups for each component, but rather that a patient qualifying for any one of these groups under any of the PDPM components would be sufficient for the patient's stay to qualify for the administrative presumption.

It should be further noted that a patient's stay qualifying for the administrative presumption is not a guarantee of coverage for the SNF stay, but rather is intended to reduce the provider's administrative burden with regard to level of care determinations and more readily identifying those patients who most clearly meet the SNF level of care criterion at the outset of the SNF stay.

Payment for Patients with AIDS

Switching gears to a very different topic, we will now look at how PDPM adjust payment for a very specific patient population which is patients with AIDS. Turning to slide 75, it notes that under RUG-IV patients receive an increase of 128 percent in their per diem rate. This is the result of an adjustment contained in the Medicare Modernization Act of 2003 which was intended to capture in a relatively blunt forced manner the increased cost of caring for this patient population.

However, as noted on slide 75 this add on was merely an approximation of the added cost of caring for patients with AIDS and did not accurately target the aspects of their care that drive the increased payment which are nursing and NTA costs. In fact, given that RUG-IV payments are so heavily driven by therapy service volume, under the current system increases in the AIDS add on can be driven by increases in therapy utilization, while our data demonstrates that AIDS is actually associated with a statistically significant decrease in therapy utilization and cost.

Finally, we note that the provisions of the Medicare Modernization Act were expressly intended to exist only until such time as a more appropriate adjustment was determined which we have certified exists through the PDPM adjustment for patients with AIDS. On slide 76 we outline how PDPM adjust payments for this population. As noted above, the two areas of cost increases for this population are with regard to nursing and NTA costs. Therefore, to ensure proper targeting of the adjustment for these patients, PDPM makes an adjustment to the nursing and NTA component of the PDPM per diem rate for patients with AIDS.

Specifically, for the NTA component, patients with AIDS receive an additional 8 points to their NTA comorbidity score which automatically reclassifies these patients to a different NTA group. For example, if a patient had an NTA score of 1, then this would qualify that patient for the group NE. However, if it is reported on the claim using the same methodology as exists under RUG-IV that the patient has AIDS, then this patient would be automatically reclassified into group NB and receive the CMI for that group when calculating their NTA component costs.

Additionally, to capture the increase in nursing costs in treating patients with AIDS, if it is reported on the SNF claim that the patient has AIDS an 18% add on is applied specifically to the nursing component of the patient's PDPM per diem rate. Taken together these two adjustments provide for a much more accurate way of addressing the added cost for treating patients with AIDS.

Revised HIPPS Coding

We will now turn to a slightly different topic which is how all of these payment group classifications translate into payment codes that may be billed on a SNF claim. As noted on slide 78, based on the responses coded on the MDS, patients classify into a payment group under each of the 5 case-mix adjusted components. As under RUG-IV, the patient's payment classification is represented using a 5-character code called a Health Insurance Prospective Payment System code of HIPPS code.

Under RUG-IV the first three characters represent the patients RUG classification while the last two characters represent the assessment used to classify the patient. Under PDPM we use a different algorithm in terms of what each of those characters represent. As noted on this slide, the first character represents the patient’s PT

and OT payment group, the second his or her SLT payment group, the third his or her nursing payment group, the fourth his or her NTA payment group and finally the fifth the assessment used to classify the patient.

On slide 79 we provide a crosswalk between each of the PT, OT and NTA payment groups with the character that would be used in the HIPPS code to represent that payment group. For example, if the patient qualified for the PT and OT group TA, then the first character in the HIPPS code which represents the patient's PT and OT classification would be an A.
On slide 80 we find the crosswalk between the nursing payment groups and the associated character in the HIPPS code. For example, if the patient qualified for the group's CA1, then the third character in the HIPPS code which represents the nursing group would be a Q. Finally, on slide 81 we provide a crosswalk between the possible assessment indicators and the last character of the HIPPS code with the assessments which would prompt that character. Taken together these 5 characters will provide all of the payment classification information necessary to bill for a given patient.

On slide 82 we provide two examples of patient classification scenarios and the HIPPS codes that will be used to represent these scenarios on a claim. Despite the difference in the algorithm used to create the specific HIPPS codes, the manner in which these codes are reported on the claim remains the same and will be found in the same place on the MDS. One important difference between RUG-IV and PDPM as discussed on slide 83 is how providers bill defaults under PDPM.

As under RUG-IV, there are instances in which a provider may bill the default rate such as when an assessment is late or in certain circumstances when an assessment does not exist in our system. Also, as under RUG-IV, the default rate represents the lowest possible per diem rate. The groups associated with this rate are listed on slide 83. To bill default on a claim as opposed to the AAA00 code that has been used previously, the new default code under PDPM is ZZZZZ.

RUG-IV-PDPM Transition

Shifting gears once more, we now turn to discussion of the transition between RUG-IV and PDPM. Turning to slide 85, as discussed in the FY 2019 SNF PPS final rule there is no transition period between RUG-IV and PDPM but rather a hard switch from one system to the other. This is due to the immense potential for significant administrative burden and confusion that would arise from trying to run the RUG-IV and PDPM systems concurrently.

Therefore, as noted on slide 85, RUG-IV ends on September 30th, 2019 and PDPM begins on October 1, 2019. However, given the significant differences in patient assessment and policy between RUG-IV and PDPM, it is not possible for providers to receive a PDPM HIPPS code prior to October 1, 2019 when PDPM is implemented.

As such, in order for providers to obtain the necessary patient classification information to bill under PDPM beginning on October 1, 2019 all providers will be required to complete an IPA with an ARD no later than October 7th, 2019 for all SNF Part A patients whose Part A stay began before October 1, 2019 and continues past October 1, 2019 without interruption.

We've considered having providers conduct a discharge assessment and 5-day assessment for all patients but felt that this was too significant an administrative burden on providers while the IPA represents a shorter assessment than the 5-day assessment. Additionally, by using the IPA this avoids potential issues associated with identifying stays for quality monitoring purposes. We would note as noted on slide 85 that any transitional IPAs that have an ARD set for after October 7th, 2019 will be considered late and the relevant late assessment penalty would apply.

So please start PDPM well and ensure that the ARDs for these assessments are set appropriately. In terms of the other associative policies for PDPM, October 1 will be considered day one of the Variable Per Diem schedule under PDPM even if a patient began their stay prior to October 1, 2019. Further, interrupted stay policies begin on October 1. This means that the policy would only apply in cases where the patient's discharge from Part A began on or after October 1, 2019.

If the patient's Part A discharge began before October 1, 2019 and the patient is readmitted on or after October 1, 2019 then this will be considered a new stay and all PDPM policies would be effective. For example, the PDPM assessment schedule would apply for these patients beginning with new stay with a 5-day assessment and on day one of the Variable Per Diem schedule.

It is important to note that in order to bill under RUG-IV prior to October 1, 2019 the provider must have a valid RUG-IV HIPPS code for any days billed prior to October 1, 2019. Further, no special rules apply to RUG-IV prior to the implementation of PDPM. Otherwise stated, all RUG-IV rules continue to apply to all RUG-IV billing prior to October 1, 2019.

Medicaid Related Issues

We now turn to the last issue of our presentation before we move to the Q&A portion of today's call which is a discussion of issues related to PDPM implementation and Medicaid. On slide 87 we discuss the first of these issues which is related to the Upper Payment Limit calculation used as part of Medicaid payment. More specifically, the Upper Payment Limit or UPL represents the maximum a given Medicaid program may pay a type of provider in aggregate statewide in Medicaid fee for service.

Such programs cannot claim federal managed dollars for provider payments in excess of the applicable UPL. Now while we plan to implement PDPM in a budget neutral manner relative to SNF PPS outlays, PDPM does change how payment is made for SNF services which may impact on UPL calculations. States will need to evaluate this potential effect and we will work with states as necessary to aid in understanding how PDPM changes SNF payments and its impact on state programs.

So, moving to slide 88, we discuss an arguably more significant impact on states which is that some states utilize legacy federal payment models such as version of RUG-III or RUG-IV as the basis for Medicaid case-mix determinations. With PDPM implementation specifically all of the assessment related changes, CMS has decided to retire a number of legacy payment items as well as a number of different items that's currently in use under RUG-IV most notably the unscheduled assessments.

CMS will still report RUG-III and RUG-IV HIPPS codes based on state requirements, but this does mean a significant reduction in the number of assessments available to state programs. Due to this reduction in the

frequency and type of patient assessments under Medicare and the potential impact on case-mix states, as Penny mentioned earlier, we are introducing a new assessment type beginning October 1, 2019. This assessment the Optional State Assessment or OSA will be made available to states to use as they deem necessary for their providers.

General questions on the OSA can be submitted to our OSA resource box, but specific questions on the OSA and your state's requirements should be directed to the appropriate state agency. We'll now turn to the Q&A portion of the call but before we do that, I wanted to highlight on slide 90 the various resources we have available for providers is typically the PDPM website which houses a myriad of different educational and preparatory materials for providers and other stakeholders.

We also have there the resource boxes for PDPM related questions as well as questions related to the OSA. Please forgive any delay you may experience in our responses to these questions and we will endeavor to try and provide responses as timely as possible. Additionally, before we get into the Q&A portion of the call, we wanted to take a moment to address a few of the questions we received into the PDPM resource mailbox prior to today's call.

First, we received a number of questions regarding what changes may be occurring in different policy areas due to PDPM implementation? First and foremost, policies governing the provision and documentation of therapy services do not change under PDPM. SNF patients should receive therapy services based on the individualized needs, characteristics and goals.

Some stakeholders asked questions regarding the minimum amount of therapy that is necessary to provide under PDPM.

The answer to this question, regardless of case-mix classification system is the amount that is necessary to maintain or restore function for the patient consistent with that patient's needs and goals. We are aware of the possibility of some providers potentially stinting on therapy under PDPM and will be monitoring closely in case of such issues.

Additionally, we expect that if providers do limit therapy provision to their patients due to the change in payment incentives, this is likely to have a significant and negative impact on that provider's quality metrics which could thereby impact the facility's 5-star rating. We encourage all providers to base their decisions for therapy provision as well as any other services solely on the needs and interest of the patient and no other considerations.

Returning to the question of policies remaining unchanged under PDPM, we would note that policies surrounding student therapy provision, denial letters, NOMNCs, ABN, SNF Part A coverage criteria, over assessment policies, billing for therapy evaluations, certification and recertification requirements and scheduling and other general SNF PPS policies unrelated to patient assessment or case-mix classification remain unchanged under PDPM.

Another series of questions that we received from stakeholders related to how the coding in items I0020 and I0020A related to PDPM and the patient's clinical category. In short, they do not. The only items relevant in

determining the patient's PDPM clinical category are the diagnosis coded in item I0020B and the surgical information coded in the new section J items discussed earlier in this presentation.

Another general question we received related to the release of draft item sets, data specifications and other such materials. For all of these items we hope to release these items in draft form in early 2019 so be on the lookout for those. Another set of questions related to billing the interrupted stay and more general questions regarding billing instructions under PDPM.

In general, we expect to release revisions to the claims processing manual which will discuss changes to any billing rules under the SNF PPS. With specific regard to billing the interrupted stay, we anticipate following the same process as is used to report a leave of absence or LOA on the SNF claim. More details on this will be forthcoming in those manual revisions.

Finally, we received a number of questions regarding admissions right around the time of admission, right around the time of implementation and whether -- a PDPM implementation and whether or not special rules could or would apply to such cases such as permitting a short stay assessment without an accompanying discharge.

The answer to these questions is no, no special rules will apply to RUG-IV billing prior to October 1, 2019.In order to bill for any SNF days prior to October 1, 2019 the facility will need a RUG-IV HIPPS code obtained prior to the changeover to PDPM. And with that, I will turn the call back to Leah to begin the Q&A. Thanks everyone.

Question & Answer

Leah Nguyen: Thank you John. We will now take your questions. As a reminder this event is being recorded and transcribed. In an effort to get to as many questions as possible, each caller is limited to one question to allow more participants the opportunity to ask questions. Please send questions specific to your organization to the resource mailbox on slide 90 so our staff can do more research.

Preference will be given to general questions applicable to a larger audience and we'll be mindful of the time spent on each question. All right Dorothy, we're ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to ensure clarity. Once your line is open state your name and organization.

Please note your line will remain open during the time you're asking your question so anything you say, or any background noise will be heard in the conference. If you have more than one question, press star one to get back into the queue and we will address additional questions as time permits. Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

Your first question comes from the line of Joel VanEaton.

Joel VanEaton: This is Joel VanEaton with Broad River Rehab, thank you for taking my call. The first the questions that we're sending into the website will you guys add those to the fact, document some of these? The questions you answered today I had several that I had sent out there and none of those were really answered, so if somebody could answer that or if we're going to be emailed directly related to those questions.

But the specific question that I have related to the discussion today then has to do with the new items J2100 to J5000. As you know in the original information that came out PDPM there were other mapping tools available to look for what happened to the further designation of the PT, OT categories related to a potential surgery. In the example that you all gave today on acute neurologic it could map depending on the surgery to orthopedic or non-orthopedic which of course is two different categories on the PT and OT categories.

And with the event of the new items that you've added J2100 to J5000, how will the system know which of those two categories to pick if there are 2 surgeries that might meet those requirements selected out of J2100 to J5000? Before it was just one, now you got an opportunity to select more because there was only one opportunity to -- originally the way that it seemed to be designed was there was only one opportunity to select 1 surgery, now it's possible there were 2. Thank you.

John Kane: So first of all, it always seems like you're the 1st question, so it always makes me feel better when I see you're the 1st question first of all. So, but thank you very much for the question. So, for your first for the first thing that you raised we wanted to just sort of say that the FAQ document, the FAQ document as well as the FAQ sheets are likely going to be documents that do evolve to some extent.

As we get comments from people on things that they would want to see in them, definitely the FAQ document is going to evolve certainly from the questions that we received in advance of today's call. One person had actually asked this if we could add time stamps or add some way of making it clear, when those documents have been updated. We'll be sure to do that so that people know when those documents have been updated and what version that they have is the most up to date.

So, in general I will just say yes, those documents are going to be updated after this -- not immediately after this call but in the coming days after this call we'll start working on the updates for these materials. Now in specific reference to your question on how the surgery information relates back to the primary diagnosis, so yes so we're no longer using something like the ICD-10 PCS codes or anything like that, it's based on this checkbox mechanism and those section J items.

And basically, the way it would work is that if you look in the ICD-10 mappings that's available on the PDPM website there is for some of these diagnoses and not for all of them, for some of them there's just the diagnosis clinical category. But for some of them they have what I would refer to as a surgical correlate that is a category that you would fit into if you had a surgery during the prior hospital stay.

So basically, the way it works is that if a surgery is checked off in one of those section J items, and I believe if you look -- I believe this is discussed in the classification walkthrough that's on the website. I could be wrong on that. If it's not there it's definitely should be on the documentation on the SAS grouper logic that we had posted to our PDPM website. It talks about how that we've -- I don't believe we use the other items that are listed in those section J items.

But for any of the non-other, "non-other" surgical categories if any one of those is checked off then you get the surgical correlate associated with that diagnosis.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Mark McDavid.

Mark McDavid: Thank you, this is Mark McDavid with Seagrove Rehab Partners. Thanks so much for taking my call. My question was -- revolves around the IPA assessment, and I understand that it's optional. But I had listened to a presenter talk about a required optional feature of the IPA meaning that, depending on facility policy you may have a policy that ultimately made it required in certain circumstances, and that you may be held to IPA penalties much like COT penalties if you inappropriately applied your own policy.

So, I guess my question is, is it true will require as much like a COT is today when that COT falls in a scheduled assessment window and our ARD lands on the COT and we can choose to do the COT or not based on payment to the facility. So, in an IPA situation would it be truly the facility's discretion to choose to do the IPA whether the payment goes up or down?

Penny Gershman: Thanks for your question. As far as CMS is concerned the IPA is completely optional. There might be other facility requirements but those don't have to do with any of CMS's standards.

Leah Nguyen: Thank you.

Mark McDavid: Okay, thank you.

Operator: Your next question comes from the line of Jenny Caruso. Jenny, your line is open.

Jenny Caruso: Yes, thanks for taking my call. For the transitional assessment if you have a patient that comes in on September 29th, you'll need a 5-day for that if I'm correct and then you'll also need an IPA, and they could potentially both have the same ARD. Can you elaborate a little bit how that would happen?

John Kane: So, they couldn't have the same ARD because the 5 day that was completed for RUG-IV purposes would need to be completed prior to October 1st because after October 1st any assessment ARD is going to ping off of the assessment requirements and data specifications that are functional under PDPM. So, in order to get a RUG-IV HIPPS code that can be billed for any days September 30th or prior, you need to have an assessment that is completed during we'll just call it FY 2019.

For PDPM purposes the assessment would be completed -- those transitional IPAs that is completed during that first week of October and that would provide you with a PDPM HIPPS code that would begin billing on October 1st?

Jenny Caruso: So how would I get a RUG score if they came in on September 29th for the 5-day?

John Kane: You would have to complete the 5-day as well as possible so certainly a rehab RUG would be difficult to attain, non-therapy would potentially be more appropriate for that type of patient most likely.

Jenny Caruso: Okay, thank you.

Leah Nguyen: Thank you.

Operator: As a reminder, if your question has been answered press pound to remove yourself from the queue. Again, if your question has been answered you may press the pound key to remove yourself from the queue.

Your next question comes from the line of Jeff Needleman.

Jeff Needleman: Hi, are all the Medicare Advantage plans obligated to participate in PDM by October 1st?

John Kane: We have — we don't dictate to the private plans what they do so private as is currently will pay however they choose to pay.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Karen Barnett.

Karen Barnett: Hey, good afternoon. We are in the process of doing some analysis on our existing Medicare population and I noted that you addressed that section I20 you're not going to be providing a mapping of active diagnosis to diagnosis codes, and without that —you know, we're really hindered in some of the preparation work that we're doing. I'm just requesting that you reconsider providing that mapping for I20 for items one through 13. Thanks.

John Kane: So as mentioned earlier, I20 is not what is used to-to get you into a PDPM clinical category. What is used is the ICD-10-CM code that is coded into I20B. Now the way you get to I20B is through I20. So I20 in a sense is a gateway item where you code one of those categories one through 13. But regardless of what you put to those codes one through 13, the code that you put into I20B, the ICD-10 code in I20B is what is then used to get you into a PDPM clinical category.

Karen Barnett: So a-…

John Kane: And the mapping that we have currently on the -- one second, the mapping that we have on the PDPM website maps the ICD-10 codes that would be found in I20B to those PDPM clinical categories.

Karen Barnett: Right, I20B doesn't exist today on the MDS hence the request for what diagnosis codes make up I20 one through 13 today.

John Kane: Right we don't, I don't think we have that type of crosswalk and I think that I'm not sure that we would be in a position to create one.

Karen Barnett: All right, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Chris Crouch.

Chris Crouch: Thank you for taking my call, I'm from St. Louis, Missouri Bethesda Health Group. In the interrupted stay policy for the subsequent stay is considered a new stay, does there have to be a change in the payment group for the new stay?

John Kane: So, I'm sorry just to clarify your question, so you're saying if the -- if it was not an interrupted stay it was a new stay does there have to be a change in the person's payment group?

Chris Crouch: Yes.

John Kane: No, that person they could be in the same payment group, they could be in a different payment group.

Chris Crouch: Thank you for the clarification.

John Kane: No problem.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Carrie Zoller.

Carrie Zoller: Hi, thank you for taking my call. I just want to clarify in terms of the transition that will happen on October 1st. The absent for a short stay for those guests to admit on 27th, 28th the end of September in there is not something that we will be able to utilize?

John Kane: If the patient meets the criteria for a short stay assessment, as is the current policy under RUG-IV then a short stay assessment could be completed. But what we were saying -- one of the questions or there was actually a few people that I think submitted this question to our resource box were asking if it would be possible to do a short stay assessment without the accompanying discharge, and that's what we were saying that it would not be allowed.

So as long as it adheres to the short stay assessment policy that is found in chapter 6 of the MDS manual, then you're perfectly capable and able to do that.

Leah Nguyen: Thank you.

Carrie Zoller: Okay.

Operator: Your next question comes from the line of Sheryl Nicholson.

Sheryl Nicholson: Hi, this is Sheryl Nicholson from Los Angeles with Rockford. I'm curious when I'm looking at the categories for the more expensive medications that sort of thing, in stage renal disease is not included which all of us know that those are very -- can be very costly meds. Is there any chance of getting ESRD placed on that clinical list?

John Kane: So, one thing I would note is that a lot of the drugs that are associated with ESRD are unbundled and so as a result they don't factor into increases in like the SNF per diem rate. So that's part of the reason that they're likely not included in the NTA comorbidity score.

That being said and this is something that would certainly be interesting to hear from stakeholders is, if the conditions that we have for the NTA comorbidity score the frequency with which stakeholders would want us to examine the data to be able to update that listing. So, if anyone has suggestions on that we're certainly open to those types of suggestions, but at this point the conditions that we identified were those that were most costly in terms of raising the cost for those services that were bundled under the SNF Part A benefit.

Leah Nguyen: Thank you.

Sheryl Nicholson: Okay, thank you.

Operator: Your next question comes from the line of Bridgett Alexander.

Bridgett Alexander: Bridgett Alexander Baptist Memorial Hospital-Golden Triangle Columbus, Mississippi. With this new system here, I just had a question the PDPM system. Will we have to get a whole new software system or computer system, or will we be able to still use what we were using, it would just be different from the RUG? I'm just trying to see as far as equipment and requests. I hope my question makes sense.

John Kane: I think it makes sense. Unfortunately, not knowing what equipment and software programs you have available to you at the moment, it's difficult for me to answer. I will say that the grouping logic, the submission specifications for assessment, the schedule for assessment certainly are all very different under PDPM as compared to RUG-IV. Now we do provide free software to the public that is available through it's either the CMS site or one of our affiliated sites.

So, we provide free software that would be available when PDPM goes live. There are certainly private vendors that I'm sure will be developing their own software that has various bells and whistles and things that they'll attach to it so you certainly avail yourself of those software programs as well.

Bridgett Alexander: Well if I could just ask, I know jRAVEN was a new one. We were going from jRAVEN to American HealthTech and I know a lot of people use that. So, I'm just wondering will that be compatible, or will we have to just -- like what we're doing now is working and we visited some other areas and they're use American HealthTech. Currently for RUG score we're looking for improvement, so you're not for sure if American HealthTech is compatible or comparable with using this PDPM?

John Kane: So, they would obviously I mean so they are going to need to change the software in terms of what is being done. The current software that you have is likely, was likely developed to reflect the RUG-IV policy. So, it might be tracking things like when the COT was needed or tracking therapy utilizations things like that. Under PDPM it would track very different things. It would be tracking diagnosis; it would be pinging maybe for an IPA or just tracking when a 5-day needed to get completed. So, it might be the same.

So, the same company that you're referring to might create a new or is likely to create a new software program associated with PDPM, but you'd have to talk to the company to see what they're going to have available for their clients.

Bridgett Alexander: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Beth McMaster.

Beth McMaster: Hi, thank you for taking my call. I represent United Church of Christ Homes in Pennsylvania and my question is regarding the interrupted stay policy. When you're discussing a discharge from the SNF or an admission to a hospital, are you equating the admission whether it is inpatient, or observation stay days, or are you looking at those two things differently?

John Kane: So, for the purposes of the interrupted stay policy, if the Part A stay ends that is basically the triggering event for what begins the count for the interrupted stay. So, it's possible that they just go to the ER and come back a few hours later at which point they just sort of continue on from where they were the same as they do under the current policy.

But if their Part A stay actually ends either because they weren't in the facility over midnight and so discharge them out a facility, or because they were admitted to the hospital as an inpatient, so any one of those things that occurs in which the Part A stay ends then you would then that's what begins that count for the interrupted stay. And if they return to that facility within that interruption window that 3-day window, then it's considered a continuation of the prior stay.

So again, the triggering event for the interrupted stay rather than thinking about it in terms of hospital admissions or anything else, the main thing to think about as a triggering event is the ending of a Part A stay for whatever reason.

Beth McMaster: Okay, thank you.

John Kane: No problem.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Teresa DeSilvestro.

Teresa DeSilvestro: Yes hi, thank you for taking my call. My question is if the patient is out on and it does turn out to be an interrupted stay and then the patient is back and you're continuing along and then the patient discharges. When you are coding that discharge that NPE, are we going to be coding the total amount of therapy for that entire stay or only for the portion where that interruption started to where the discharge occurs if that makes sense?

John Kane: It does make sense. And what you'll be coding for those 0425 items is the amount of therapy they receive over the course of the entire Part A stay. And to the extent that you have multiple stays that using sort of current lingo, that you have multiple stays that have all been linked together under interrupted stay, then 0425 should represent the therapies that they receive over the course of that entire stay.

Teresa DeSilvestro: Great, thank you.

Operator: Your next question comes from the line of Jessica Karen.

Jessica Karen: Hi, thanks for taking my call. You may have mentioned this, but could you review again when the new RAI manual might be available?

John Kane: So, my understanding is that we are trying to get a draft manual, item sets, data specifications things like that out in early 2019. I don't want to be any more specific than that because that usually gets me into trouble. But early 2019 is when we are absolutely striving to get all of this stuff out, and really as soon as possible is when we're striving to get all of this stuff out there.

Leah Nguyen: Thank you.

Jessica Karen: Thank you.

Operator: Your next question comes from the line of John Pullham.

John Pullham: How do you get the base rate for OT, PT and SD?

John Kane: So, a little bit of a complex question. So, the way that the base rates generally are calculated as a result of our statutory requirements actually goes back to cost reports from 1995. And so that creates sort of the basic pool from which we develop those base rates. But then the base rates for the PDPM therapy components PT, OT and speech actually derive from more recent data that told us how much or basically what percentage of therapy services or therapy costs derive from each of those different disciplines?

And so, if you look in the -- you can look in our technical report that's on our SNF PMR website which you can access through the SNF PPS website. It's also we also discuss this in the proposed in the final rules from this past year from FY 2019. We talked about how we used more recent data to basically allocate the therapy base rate that existed under RUG-IV out into those disciplines based on the relative amount of cost attributable to each of those disciplines.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Paul McGinley.

Paul McGinley: Hello, Paul McGinley Alaris in New Jersey. My question is about the transition and it came before the person that was asking if a patient comes in on say 9/29 or even 9/28 and we're treating the patient at an RU level and the therapy group is going to be charging me at the RU level, but I'm only going to be able to do an MDS that is going to give me a PD1 RUG rate.

It's not possible to make an exception and allow the facilities to do a short stay for those patients that come in so that we're enabled to get the reimbursement that we're going to be paying out to the therapy groups? Thank you.

John Kane: So, a couple of things, I appreciate the question, but I would say a couple of things in response. So first as I noted before, if the short stay assessment rules apply that is if the patients stay falls within the guideline for short stay assessments that are outlined in chapter 6, then you're certainly it's certainly possible for you to do that.

That being said, I would actually I would disagree slightly with the suggestion that the person is being treated at an RU rate if the person was admitted on say 9/29 because you only had that person for 2 days so to suggest that person is going to receive 720 minutes of therapy over the course of the following week may or may not occur. I mean that's exactly why we created the COT assessment was because things occur, we don't know what's going to happen and so it's possible that while the intention was to get to an RU rate it's possible that that person only hits RM or RV based on what they can tolerate or based on what they need.

So, the idea here is that in order to bill for those RUG-IV days you need to be able to have the RUG-IV HIPPS code that was obtained using the assessment as it exists under the current system. And just because of all the changes that are going to be made with PDPM effective October 1, the assessment after October 1 is not going to be in a sort to really to kind of really give you that same RUG-IV HIPPS code that you would bill prior to October 1.

So that's why you would need that assessment prior to October 1 to get those RUG-IV billable days and then that transitional assessment will provide you with the billable code for beginning October 1st.

Leah Nguyen: Thank you.

Paul McGinley: I understand but it still puts facilities at a loss because again there are times when the short stay, we can achieve an RU, most times RH or RV. But even with that if it's at that level we're still not able to do an MDS and get that RUG score with the system that you have in place -- you're putting in place.

John Kane: True, but it's also possible that you would be receiving -- you'd still be receiving the per diem rate associated with the -- let's assume for a second you couldn't do a short stay assessment for whatever reason. Then what you would get is you'd get the non-therapy rate for that person which, so you'd still be getting reimbursed for the services provided.

It might not be at the high therapy rate that was intended and certainly it's possible on a short stay assessment case to get the RU based on the way that the algorithm works in terms of how a short stay translates into the various therapy groups. But you'd certainly -- you'd still be getting the non-therapy rate to reimburse the facility for the services that were being provided for those few days until it transitioned over to PDPM and then you'd be getting the PDPM rate starting on October 1.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Kathleen Brand.

Kathleen Brand: Hello. I guess my question is related to combining your admission OBRA with your 5-day and can we still do that? And okay let's -- example, they come in on the 29th of October you do your admission OBRA along with a 5-day. Now you're going to go do your PDPM in that first week -- you're not going to be required to do another admission OBRA are you?

John Kane: So, as I mentioned earlier the OBRA requirements stay exactly as they are which means that if you have an instance in which you can combine the 5-day and the admission assessment.

So, if you like you said if the person was admitted on October 29th or something like that and they're in the facility and you want to do the admission OBRA and do the 5-day, just like as under RUG-IV it just it limits the completion time associated with that assessment. Because while the 5-day assessment can be completed 14 days past ARD, the admission assessment has to be completed by day 14 so it just it limits you in that regard.

But other than that, the same terms of rules apply for combining the OBRA admission assessment with the 5-day under PDPM.

Leah Nguyen: Thank You

Kathleen Brand: Okay so if …

Leah Nguyen: Go ahead.

Operator: Your next question comes from the line of Marsha Harrison.

Marsha Harrison: Hi, thank you for taking my call. We just have a quick question. What is out there to keep residents from moving from one facility to another? So, say for instance they're in our facility for their 100 days and then they discharge and go to another facility then they get another 100 day stay. Is there anything in place for that or is that something that they will be able to do?

John Kane: No, so even -- so one of the things I mentioned is not changing are the existing sort of basic PPS coverage criteria. And one of those is that a beneficiary is has available to them 100 benefit days within a benefit period, but then in order to receive a new benefit period of 100 days there has to be a 60-day wellness period in which they are not receiving services at a skilled level basically below the Part A covered level.

And so, they couldn't just go from one facility with 100 days to another facility for 100 days. There would have to be a 60-day wellness period between those two stays in order to re-up their SNF benefits.

Marsha Harrison: Okay, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Steven Isaac.

Steven Isaac: Hello. (Inaudible)

Leah Nguyen: Hello, your line is open.

Steven Isaac: Yes, thank you yes. I just wanted to know for a patient that is discharging but coming back within 3 days, so when a patient is discharging you don't know if you're going to combine the over discharge with NP assessment is that correct? You would have to wait and see if the patient returns within 3 days?

John Kane: Right. So I mean if I were doing this my suggestion would be to hold off on completing the assessment or you could start the assessment and just hold off on signing it and submitting that assessment, which my impression from having talked to MDS coordinators in different places the 3 day most of the discharge assessments are not being completed and submitted within that 3 day window.

So, by the time that you'd be really doing those discharge assessments, you would know by that point that the person is either coming back within the interruption window or not. But my suggestion would be yes, that during the interruption window if you're thinking the person might come back I would say to hold, you could start to complete it but I would hold off on submitting that assessment until after you know if that person's coming back or not.

Steven Isaac: Okay and then my next question was about the J items. Somebody had asked if multiple surgery were checked off, but what if in the recent inpatient stay for example a patient had like a costectomy and then developed sepsis so or something that would cause their surgery to be a different category than their primary SNF, than the primary diagnosis for the SNF stay how would you change, I don't remember the exact example that was given but that would change their major classification but it's not their primary diagnosis?

John Kane: So okay so there's a couple of things that are happening in the example you're giving. So first you have the person that has the diagnosis and they have a surgery. So, the simplest case is you have a diagnosis derived from I20B, that diagnosis if you look in the ICD-10 mapping we have on our website has a surgical correlate. That is to say that you could have a non-surgical intervention or a surgical intervention. If one of the items on section J is checked off then you get the surgical correlate for that.

Now it sounds like the what you added to that scenario was that they also develop an infection which could potentially change their primary diagnosis. And in those kinds of cases the IPA would be there for you to be able to change that person's primary diagnosis and recode and leaving the recoding I20B with a new diagnosis as a result of the infection.

Steven Isaac: But this is...

Leah Nguyen: Thank you. As a reminder -- sorry. As a reminder if you have more than one question, you can press star 1 to get back into the queue and we will address additional questions as time permits. Dorothy, can we take our next caller?

Operator: Your next question comes from the line of Suzy Harvey.

Suzy Harvey: Hi, thanks for taking my call. I'm with BKD in Sprinkle, Missouri. I have a question about the PDPM transition. I understand that the days have to be by October 7th, but let's say you have a facility that has a lot of Medicare Part A and they are going to have to spread them out over that first seven days, can they use

the look back period into September to gather their data for that the new PDPM assessment that they're doing?

John Kane: So, the look back periods are what they are for the assessment. So, if they are completed at any point during that first week they may be looking back into the prior time and that's happened over any fiscal year transitions that we've had.

Suzy Harvey: Okay, I just want to make sure.

John Kane: Right. No, the other thing I want to say though is that for the assessment purposes for like the late assessment penalty really all that has to occur is that you have the ARD set for that assessment within that range, but you then have 14 days after that period to complete it. So, you can spread out the ARDs if you want to or you can keep all the ARDs exactly the same.

But what you really should be spreading out is just the workload of taking that 14-day completion period and completing those assessments. So just I want to be just want to make sure everyone's aware that the fact that the transitional IPAs have to have an ARD within that first week of October does not mean they have to be completed and submitted in that first week.

Suzy Harvey: Thank you, that's great.

John Kane: You're welcome.

Leah Nguyen: Thank you.

Operator: Your next -- as a reminder if your question has been answered, to remove yourself from the queue press the pound key.

Your next question comes from the line of Annette Romano.

Annette Romano: Yes hi, I'm calling from a hospital-based nursing home it's called The Transitional Care Unit. When we if we send the patient to the hospital, do we have to hold the bed? How does Medicare work with holding a bed if a patient goes out to the hospital?

Hello.

John Kane: Yes, sorry we were just having a sidebar. So, I mean so whatever the current policies are, and I think that this -- I think bed hold fall more into the survey interpretation side of the shop rather than as a payment question, but whatever the current policies are regarding bed holds would remain the same under PDPM. Nothing changes in that regard.

Bill Ullman: Yes, and basically Medicare does…

Annette Romano: It's a 20-bed unit we can't hold beds. It's a 20 bedded unit a sub-acute unit.

Bill Ullman: Well basically Medicare doesn't make bed hold payments unlike the Medicaid program. The beneficiary it's their option can make bed hold payments out of pocket if it's they're failing.

Annette Romano: Okay.

Annette Romano: Okay. That's the only way to hold the bed for a Medicare patient? Okay, thank you.

Bill Ullman: Right.

John Kane: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Brad Myers.

Brad Myers: Hello, this is Brad Myers from Carolina Therapy Services. I just wanted to make sure there was no reason to report a change in therapy utility or definitely if the patient has missed 3 consecutive days since we won't have the OMRAs anymore.

John Kane: So PDPM does eliminate the end of therapy OMRA, the start of therapy OMRA, the Change of Therapy OMRA. The one thing I would note however is that the various criterion that we use for SNF coverage such as the daily basis requirement and the skilled service requirement still do exist.

So, if the person is missing 3 days of therapy, if it happens once that's one thing but if it starts to happen frequently or if they're missing more than that that starts to beg the question of whether or not that person stay really meets the definition of skilled coverage under Part A.

So, just a word of caution on that that while there's not an assessment that necessarily needs to be done in that case, you should be at least wary of or at least be cognizant of the possibility of what those breaks in therapy mean in terms of the patient's overall Part A coverage.

Leah Nguyen: Thank you.

Brad Myers: Right. Thank you

Operator: Your next question comes from the line of Gary Eye.

Gary Eye: Hi, thanks for taking the call. Back on slide 59 you talk about tracking therapy before PDPM and tracking therapy after PDPM. What's the intended and expected usage of that information? What could result from that information?

John Kane: So as I mentioned earlier, we have been told by some providers we received comments during the rulemaking session that suggested that under PDPM given that it no longer incentivizes the high amounts of therapy we see under RUG-IV that there's a possibility that under PDPM that therapy services will decline that the volume of services for beneficiaries will decline as well as the individualized nature of those services.

So, we do plan on monitoring that and seeing how much of a change occurs in relation to any changes in the patient population. Because if we don't observe changes in the patient population and yet we do observe that there are significant changes either within a given facility, within a given region, within a given state or across the nation in terms of therapy provision and how it's being allocated, that would suggest that payment incentives are continuing to have an impact on care decisions as opposed to the needs of the patient then we'd have to consider first the scope of those -- of those issues again whether it be the facility level or the national level and then consider what intervention is appropriate.

The facility level being potential review of that facility's practices, at a national level considering policy alternatives to address the reduction in therapy services in terms of cost reduction.
Leah Nguyen: Thank you. Dorothy, we have time for one final question.

Operator: Your final question comes from the line of Maryanne Leonard.

Maryanne Leonard: Good afternoon, thank you. I have a -- my field is medical records and I have concerns regarding the assignment of the ICD-10 codes in this process and the training of the individuals who are assigning the codes.

But I mainly have a question about how the clinical categories have been determined because if you look at certain areas such as a stress fracture of a humerus it's not coded to a surgical orthopedic and there's no corollary that assigns that there's potential for a surgical orthopedic, but there is if you look at some of the other fracture codes both for stress fracture and for traumatic fracture. So, can you clarify how those categories were assigned and what was the determinant to identify whether or not there was a surgical aspect of it?

John Kane: Sure, so we had our own clinicians both in-house as well as through our contractor that did that -- through actually multiple contractors that did that mapping for us again in consultation with our in-house clinical staff. And so that was the main -- that was the primary way in which we developed the mapping itself. That mapping was part of our proposed rulemaking, I think we actually posted a version of it with our advanced notice of proposed rulemaking in May of 2017, was also part of our proposed rulemaking this past May.

And we actually have received comments on that mapping, we actually made some changes on our final rule as a result of some of those comments. And so, if you have concerns or questions about particular areas of the mapping please feel free to send those to us and we can take a look at them and we can determine if any changes in the mapping are necessary.

Maryanne Leonard: Okay, it's on the planning board. Thank you.

John Kane: Thank you.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that's all the time we have for questions today. If we did not get to your question you can email it to the address listed on slide 90. We hope you will take a few moments to evaluate your experience. See slide 91 for more information.

An audio recording and transcript will be available in about two weeks at go.cms.gov/npc. My name is Leah Nguyen, I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network event on Skilled Nursing Facility Prospective Payment System: New Patient Driven Payment Model.

Have a great day everyone.

Operator: Thank you for participating in today's conference call; you may now disconnect.