Replacing RUGs – CMS’ New SNF Payment System & How to Get Ready
Agenda

- **PDPM 101 (Lite) – Full version webinar on AHCA website**
  - Why PDPM is replacing RUGs on 10/1/2019
  - Overview of the PDPM Case-mix payment model
  - PDPM payment drivers & impacts
  - AHCA Tool & Resource Development

- **Getting Ready for PDPM**
  - Identification of PDPM Core Competencies
  - What AHCA members are saying about PDPM
  - Introduction to AHCA’s PDPM Core Competencies Tool

Questions or Suggestions
PDPM@ahca.org
Why PDPM is replacing RUGs
Implementation - October 1, 2019 (FY 2020)
DHHS/CMS Position on PDPM

“The PDPM would be a significant shift in how SNFs are paid and, we believe, a very positive one. It reflects our belief that we should not be paying providers in ways that drive overuse of services. Instead, we should pay providers based on the patients they treat, while assessing quality fairly.”

Secretary Alex M. Azar, Secretary of Health and Human Services, AHCA/NCAL Congressional Briefing. June 4, 2018
IMPACT Act of 2014 Outlined Intention of Creating Payment Systems Driven by Patient Characteristics

The IMPACT Act requires standardized patient assessment data across post-acute care (PAC) settings to enable:

- Improvements in quality of care and outcomes
- Comparisons of quality across PAC settings
- Transparency in data reporting
- Information exchange across PAC settings
- Enhanced care transitions and coordinated care
- Person-centered and goals-driven care planning and discharge planning
- Payment modeling based on individual characteristics

Payment driven by patient characteristics – Patient Driven Payment Model, SNF Quality Reporting Program, and SNF Value-Based Purchasing Program all advance the goals of the IMPACT Act
Primary Driver for Change: Bias Towards Therapy Utilization

<table>
<thead>
<tr>
<th>RUG</th>
<th>RUG Description</th>
<th>Total Days 2015</th>
<th>Distinct Beneficiaries Per RUG</th>
<th>Payment Per Day</th>
<th>Payment Per Beneficiary</th>
<th>Total Payment</th>
<th>Percent Total Days</th>
<th>Percent Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUB</td>
<td>Ultra-High Rehab - ADL 6-10</td>
<td>17,180,364</td>
<td>691,406</td>
<td>$505</td>
<td>$12,543</td>
<td>$8,672,521,672</td>
<td>25.9%</td>
<td>31.5%</td>
</tr>
<tr>
<td>RUC</td>
<td>Ultra-High Rehab - ADL 11-16</td>
<td>12,390,791</td>
<td>450,902</td>
<td>$493</td>
<td>$13,549</td>
<td>$6,109,148,624</td>
<td>18.7%</td>
<td>22.2%</td>
</tr>
<tr>
<td>RUA</td>
<td>Ultra-High Rehab - ADL 0-5</td>
<td>8,469,027</td>
<td>433,600</td>
<td>$402</td>
<td>$7,861</td>
<td>$3,408,497,106</td>
<td>12.8%</td>
<td>12.4%</td>
</tr>
<tr>
<td>RVB</td>
<td>Very-High Rehab - ADL 6-10</td>
<td>5,780,737</td>
<td>345,232</td>
<td>$343</td>
<td>$5,750</td>
<td>$1,985,100,869</td>
<td>8.7%</td>
<td>7.2%</td>
</tr>
<tr>
<td>RVC</td>
<td>Very-High Rehab - ADL 11-16</td>
<td>5,489,783</td>
<td>288,253</td>
<td>$396</td>
<td>$7,539</td>
<td>$2,173,072,574</td>
<td>8.3%</td>
<td>7.9%</td>
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<tr>
<td>RVA</td>
<td>Very-High Rehab - ADL 0-5</td>
<td>4,040,428</td>
<td>261,086</td>
<td>$339</td>
<td>$5,253</td>
<td>$1,371,439,036</td>
<td>6.1%</td>
<td>5.0%</td>
</tr>
<tr>
<td>RHC</td>
<td>High Rehab - ADL 11-16</td>
<td>1,995,681</td>
<td>127,628</td>
<td>$325</td>
<td>$5,077</td>
<td>$647,923,927</td>
<td>3.0%</td>
<td>2.4%</td>
</tr>
<tr>
<td>RHB</td>
<td>High Rehab - ADL 6-10</td>
<td>1,638,022</td>
<td>120,859</td>
<td>$290</td>
<td>$3,929</td>
<td>$474,802,692</td>
<td>2.5%</td>
<td>1.7%</td>
</tr>
<tr>
<td>RHA</td>
<td>High Rehab - ADL 0-5</td>
<td>1,327,023</td>
<td>101,126</td>
<td>$248</td>
<td>$3,255</td>
<td>$329,199,346</td>
<td>2.0%</td>
<td>1.2%</td>
</tr>
<tr>
<td>RMC</td>
<td>Medium Rehab - ADL 11-16</td>
<td>993,935</td>
<td>68,932</td>
<td>$266</td>
<td>$3,836</td>
<td>$264,416,664</td>
<td>1.5%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
# CMS Used a Payment Reform Framework for Development

<table>
<thead>
<tr>
<th>CMS Framework Element</th>
<th>Basis for Payment System Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remain within Existing Statutory Authority</td>
<td>• Average Per Diem Payment</td>
</tr>
<tr>
<td>Use Existing Data</td>
<td>• Cost Report Data</td>
</tr>
<tr>
<td></td>
<td>• Claims, MDS</td>
</tr>
<tr>
<td></td>
<td>• 2006 Nursing Research</td>
</tr>
<tr>
<td>Develop a Readily Implementable System – October 1, 2019</td>
<td>• Remains in Per Diem</td>
</tr>
<tr>
<td></td>
<td>• Builds on Existing Tools – MDS, Claims</td>
</tr>
<tr>
<td>Shifts Away from Therapy as Basis for Payment</td>
<td>• Payment based on Patient Characteristics</td>
</tr>
<tr>
<td></td>
<td>• Minutes only Counted at Discharge</td>
</tr>
</tbody>
</table>
Overview of the PDPM
Case-mix payment model
Important Features of PDPM

- Per Diem Payment
  *Budget-neutral
- Therapy Minutes No Longer Drive Payment
- Total Therapy Capped at 25% for Group and Concurrent Combined
- Admission Assessment Patient Characteristics Drive Payment
- Admission/IPA MDS Coding Timing & Accuracy Add Risk

Key PDPM features impact all areas of operations and care delivery
Fewer Assessments Required Under PDPM

**RUG-IV Assessments**
- Day 5 MDS
- Day 14 MDS
- Day 30 MDS
- Day 60 MDS
- Day 90 MDS
- Discharge MDS

**PDPM Assessments**
1. Elimination of MDS Schedule
2. Elimination of Other Medicare Required Assessment (OMRA)

- Day 5 MDS
- Optional Interim Payment Assessment
- Discharge MDS with Therapy Codes
PDPM Is Still a Per-diem Payment Model But Components Are Changed

**RUGs**
- Therapy
- Non-Case-Mix Therapy
- Nursing
- Non-Case-Mix

**PDPM**
- PT
- OT
- SLP
- Nursing
- NTAS
- Non-Case-Mix
PDPM includes variable per-diem payment adjustments that modify payment based on changes in utilization of these services over a stay.

<table>
<thead>
<tr>
<th>Service</th>
<th>Base Rate</th>
<th>CMI</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>PT Base Rate</td>
<td>PT CMI</td>
<td>PT Adjustment Factor</td>
</tr>
<tr>
<td>OT</td>
<td>OT Base Rate</td>
<td>OT CMI</td>
<td>OT Adjustment Factor</td>
</tr>
<tr>
<td>SLP</td>
<td>SLP Base Rate</td>
<td>SLP CMI</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>Nursing Base Rate</td>
<td>Nursing CMI</td>
<td></td>
</tr>
<tr>
<td>NTA</td>
<td>NTA Base Rate</td>
<td>NTA CMI</td>
<td>NTA Adjustment Factor</td>
</tr>
<tr>
<td>Non-Case Mix</td>
<td>Non-Case-Mix Base Rate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*RUGs HIV/AIDS add-on is replaced in PDPM with new 18% nursing component base rate adjustor and new NTA CMI factors (not shown)*
- NEW -

Variable Per-Diem

Day 4 - NTAS rates drop 2/3

Day 21 and every 7 days after - PT and OT rates drop 2%
PDPM Admission Processes Are Critical

Accuracy with Diagnosis & Coding
Impact Payments and Compliance Risk

Hospital Discharges
- Typical discharge information sufficient
- Surgery information – not PCS codes for Section J2000

SNF Admits
- SNF clinician diagnoses
- Admission MDS assessment timing and accuracy
- MDS coordinator codes based on MDS items & ICD-10 codes

Payment Classification
- Case-Mix Group (CMG) assigned for each component
- Patient characteristics for component CMGs differ

PT
OT
SLP
Nursing
NTAS
Two New Provisions May Impact CMGs and Payment Rates: (1) IPA

CMS Policy Not Finalized: 
**Triggering Event?**

- Does not return tapering to day-1 for PT/OT or NTAS
- While optional still requires monitoring
- Unclear how captured on claim

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Day 5 MDS | CMG Changes | Variable Per Diem Schedule Continues

Optional IPA | Discharge MDS with Therapy Codes
Two New Provisions May Impact CMGs and Payment Rates: (2) Interrupted Stay Policy

Heightened CMS Scrutiny

- No new admission assessment if $\leq 3$ days but can use IPA
- New admission assessment required if away $>3$ days
- Does return to day day-1 PT/OT/NTAS tapering

Bonus Payment Impacts?
Therapy Time No Longer Impacts Payments But Must Still Be Reported

• Therapy services are only to be reported on SNF PPS discharge MDS
• The following PT/OT/SLP service delivery items are to be reported separately by discipline
  • Start and end dates
  • Total treatment days during entire stay
  • Total individual 1:1 therapy minutes during entire stay
  • Total concurrent therapy minutes during entire stay
  • Total group therapy minutes during entire stay
• There is a 25% limit on the total amount of concurrent and or group therapy permitted per stay within each discipline
  • CMS will issue a non-fatal warning edit on validation report if limit surpassed
  • CMS will monitor and flag providers for audits, and revise policy if abused

Focus is on Person-Centered Care and Care Planning
Other PDPM Considerations

• Many PDPM MDS items also impact SNF QRP
  • 101 MDS items impact SNF QRP 2% adjustment for reporting

• How providers implement new PDPM IPA and Interrupted-Stay policies may impact SNF VBP hospital readmission ratings

• Uncertainty regarding whether, or how quickly, Medicaid, Medicare Advantage, ACO Conveners, CJR Bundle Holders, or other payers will transition to PDPM
SNF Responsibilities Which Remain Under PDPM

<table>
<thead>
<tr>
<th>SNF Responsibilities</th>
<th>SNF Action Steps</th>
</tr>
</thead>
</table>
| • Need for Daily Skilled Care  
  - Nursing 7d and/or Therapy 5-7d  
• Requirements of Participation  
• Survey & Certification  
• Annual Payment Rate Update  
• Consolidated Billing  
• SNF Quality Programs | • Maintain a Comprehensive Person-Centered Plan of Care  
• Continue to Monitor for NPRM Payment Updates  
• Therapy delivery must align with patients’ needs  
• CMS will monitor quality of care and related outcomes |
PDPM Payment Drivers
Many More MDS Items Impact PDPM than Under RUGs

### Under RUGs
- Over 90% of resident days reported via Rehab RUGs
- Rehab RUG rates determined by 20 MDS item fields
  - Therapy minutes/days – 12 items
  - ADLs – 8 items

### Under PDPM
- All PDPM component rates independently determined
- **161 MDS item fields**
  - PT – 14 MDS items
  - OT – 14 MDS items
  - SLP – 33 MDS items
  - Nursing – 129 MDS items
  - NTAS – 33 MDS items
PDPM Has More Case-Mix Adjusted Payment Components than RUGs

**Current RUG-IV Payment Model***

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Nursing</th>
<th>Non-Case-Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy Base Rate</td>
<td>Nursing Base Rate</td>
<td>Non-Case-Mix Base Rate</td>
</tr>
<tr>
<td>Therapy CMI</td>
<td>Nursing CMI</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Case Mix</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy Base Rate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Driven Payment Model (PDPM)**

<table>
<thead>
<tr>
<th>PT</th>
<th>OT</th>
<th>SLP</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT Base Rate</td>
<td>OT Base Rate</td>
<td>SLP Base Rate</td>
</tr>
<tr>
<td>PT CMI</td>
<td>OT CMI</td>
<td>SLP CMI</td>
</tr>
<tr>
<td>PT Adjustment Factor</td>
<td>OT Adjustment Factor</td>
<td>Non-Case-Mix Base Rate</td>
</tr>
</tbody>
</table>

**Hierarchical CMG assignment in RUGs favors therapy**

**Independent CMG assignment for each PDPM component**
PT and OT Component Drivers

Primary reason for SNF care
- ICD-10-CM code
- Type of inpatient surgery

Function*
- 4 functional score ranges

16 payment groups each
- 4 clinical categories

*10 MDS Section GG items must be assessed days 1-3 (before treatment started)
SLP Component Drivers

Primary reason for SNF care
  • Presence of acute neurologic condition

SLP comorbidities

Cognitive impairment

Mechanically altered diet

Swallowing disorder

12 payment groups

4 categories based on number of elements

3 categories based on number of elements
Nursing Component Drivers

**Extensive Services**

**Clinical Conditions**

**Adjustors**

- Depression
- Restorative nursing*
- Function**

3 base service categories

5 base clinical categories

Used to modify extensive services and clinical conditions

25 payment groups

* Restorative nursing requires a minimum of 6 days in a 7-day lookback (may impact ARD selection)
** 7 MDS Section GG items must be assessed days 1-3 (before treatment started)
NTAS Component Drivers

High NTAS cost conditions
High NTAS cost extensive services

Qualifying conditions and services assigned points:
• Sum of points for all conditions or services present will fall into one of 6 point ranges

6 payment groups
Great! ... But what does that mean to my revenue?
PDPM Shifts Payment to Patients with Complex Clinical Needs

Resident Population: $ Increase
- Residents who are dually enrolled
- Residents with longer prior inpatient stay
- Residents with complications in MS-DRG
- Residents who have high NTA costs & comorbidities
- Residents who receive extensive services (e.g., trach, ventilator)
- Residents who use IV medication
- Clinical categories: acute infections, cardiovascular, pulmonary, non-orthopedic surgery
- Vulnerable subpopulations: residents with addictions, bleeding disorders, behavioral issues, chronic neurological conditions, and bariatric care

Resident Population: $ Decrease
- Residents whose most common therapy level is RU
- Residents with fewer comorbidities
- Longer SNF LOS
Example Resident – Clinical Profile

• Admitted with stroke
• MDS Section G ADL score of 9
• MDS Section GG function nursing score = 7, PT/OT score = 10
• Moderate cognitive impairment
• Receives daily PT, OT, SLP = 730 minutes/week
• Resource-intensive nursing – dialysis, IV meds, mechanically modified diet
• Comorbidities – diabetes
### Example Resident – RUGs vs PDPM Drivers

<table>
<thead>
<tr>
<th>Resident Characteristics</th>
<th>Resident A Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehab Received</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy Minutes</td>
<td>730</td>
</tr>
<tr>
<td>Extensive Services</td>
<td>No</td>
</tr>
<tr>
<td>ADL Score</td>
<td>9</td>
</tr>
<tr>
<td>PT, OT, and SLP Clinical Category</td>
<td>Acute Neurologic</td>
</tr>
<tr>
<td>PT and OT Function Score</td>
<td>10</td>
</tr>
<tr>
<td>SLP Cognitive Impairment</td>
<td>Moderate</td>
</tr>
<tr>
<td>SLP Mechanically Altered Diet</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing Serious Medical Conditions</td>
<td>Dialysis</td>
</tr>
<tr>
<td>Nursing Function Score</td>
<td>7</td>
</tr>
<tr>
<td>NTAS Condition/Extensive Services Score</td>
<td>7 (IV meds, diabetes)</td>
</tr>
</tbody>
</table>

**RUB RUG category determinants**

**PDPM payment driver characteristics**
**Example Resident RUGs Rate**

<table>
<thead>
<tr>
<th>Component</th>
<th>Base Fed Rate</th>
<th>Case-Mix Index</th>
<th>Payment (per diem)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy</td>
<td>$136.67</td>
<td>1.87</td>
<td>$283.05</td>
</tr>
<tr>
<td>Non-case-mix therapy</td>
<td>NA for RUB</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Nursing</td>
<td>$181.44</td>
<td>1.56</td>
<td>$255.57</td>
</tr>
<tr>
<td>Non-case-mix nursing</td>
<td>$92.63</td>
<td></td>
<td>$92.63</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$631.25</strong></td>
</tr>
</tbody>
</table>

$631.25 per diem

x 30 day stay

= $18,937.50
Example Resident – SLP Case-Mix

Primary reason for SNF care
  • Presence of acute neurologic condition

SLP comorbidities
Cognitive impairment
Mechanically altered diet
Swallowing disorder

12 payment groups

2 of 3
1 of 2
## Example Resident – SLP Case-Mix

<table>
<thead>
<tr>
<th>Presence of 1) Acute Neurologic Condition, 2) SLP-Related Comorbidity, or 3) Cognitive Impairment?</th>
<th>Mechanically Altered Diet or Swallowing Disorder?</th>
<th>SLP Case-Mix Group</th>
<th>SLP Case-Mix Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Neither</td>
<td>SA</td>
<td>0.68</td>
</tr>
<tr>
<td>None</td>
<td>Either</td>
<td>SB</td>
<td>1.82</td>
</tr>
<tr>
<td>None</td>
<td>Both</td>
<td>SC</td>
<td>2.66</td>
</tr>
<tr>
<td>Any One</td>
<td>Neither</td>
<td>SD</td>
<td>1.46</td>
</tr>
<tr>
<td>Any One</td>
<td>Either</td>
<td>SE</td>
<td>2.33</td>
</tr>
<tr>
<td>Any One</td>
<td>Both</td>
<td>SF</td>
<td>2.97</td>
</tr>
<tr>
<td>Any Two</td>
<td>Neither</td>
<td>SG</td>
<td>2.04</td>
</tr>
<tr>
<td>Any Two</td>
<td>Either</td>
<td>SH</td>
<td>2.85</td>
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<tr>
<td>Any Two</td>
<td>Both</td>
<td>SI</td>
<td>3.51</td>
</tr>
<tr>
<td>Any Three</td>
<td>Neither</td>
<td>SJ</td>
<td>2.98</td>
</tr>
<tr>
<td>Any Three</td>
<td>Either</td>
<td>SK</td>
<td>3.69</td>
</tr>
<tr>
<td>Any Three</td>
<td>Both</td>
<td>SL</td>
<td>4.19</td>
</tr>
</tbody>
</table>
### Example Resident PDPM (Day 1-3)

<table>
<thead>
<tr>
<th>Component</th>
<th>Base Fed Rate</th>
<th>Case-Mix Index</th>
<th>Special Adjustors</th>
<th>Variable per diem</th>
<th>Payment (per diem)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>$59.33</td>
<td>1.55</td>
<td>x</td>
<td>1.00</td>
<td>$91.96</td>
</tr>
<tr>
<td>OT</td>
<td>$55.23</td>
<td>1.55</td>
<td>x</td>
<td>1.00</td>
<td>$85.61</td>
</tr>
<tr>
<td>SLP</td>
<td>$22.15</td>
<td>2.85</td>
<td>x</td>
<td></td>
<td>$63.13</td>
</tr>
<tr>
<td>NTA</td>
<td>$78.05</td>
<td>1.85</td>
<td>x</td>
<td>3.00</td>
<td>$433.18</td>
</tr>
<tr>
<td>Nursing</td>
<td>$103.46</td>
<td>1.43</td>
<td>1.00*</td>
<td></td>
<td>$148.10</td>
</tr>
<tr>
<td>Non-Case-Mix</td>
<td>$92.63</td>
<td></td>
<td></td>
<td></td>
<td>$92.63</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Total</strong> = $914.60*</td>
</tr>
</tbody>
</table>

*Except when resident has HIV/AIDS, then variable per diem adjustment = 1.18
Note: Rates are for urban facilities, CMS estimated if program went into effect FY19

*PDPM per-diem days 1-3 = $914.60
*RUGs per-diem all days = $631.25
Example Resident – PDPM 30 Days

Day 1-3 => 3 days @ $914.60 = $2,743.80
Day 4-20 => 17 days @ $625.81 = $10,638.77
Day 21-27 => 7 days @ $622.26 = $4,355.82
Day 28-30 => 3 days @ $618.71 = $1,856.13

Total = $19,594.52

Reminder: RUGs per-diem was $631.25 and 30 day total was $18,937.50
Examples of stumbling blocks

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What happens to my payment if I miss entering an MDS item that is a key driver of a PDPM payment component?
Example Resident:
What happens to NTA case-mix if the MDS IV medication item is not entered

<table>
<thead>
<tr>
<th>Condition/extensive service</th>
<th>Source</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>SNF Claim</td>
<td>8</td>
</tr>
<tr>
<td>Parenteral IV Feeding: Level High</td>
<td>MDS Item K0510A2, K0710A2</td>
<td>7</td>
</tr>
<tr>
<td>Special Treatments/Programs: Intravenous Medication Post-admit Code</td>
<td>MDS Item O0100H2</td>
<td>5</td>
</tr>
<tr>
<td>Special Treatments/Programs: Ventilator or Respirator Post-admit Code</td>
<td>MDS Item O0100F2</td>
<td>4</td>
</tr>
<tr>
<td>Parenteral IV feeding: Level Low</td>
<td>MDS Item K0510A2, K0710A2, K0710B2.</td>
<td>3</td>
</tr>
</tbody>
</table>

Failing to identify or incorrectly coding just one PDPM payment driver MDS item can have a significant impact on CMI

*resident has 2 NTA points for diabetes
## Example Resident – 30 Day Stay

### RUGs ➔ PDPM ➔ PDPM (missing data)

<table>
<thead>
<tr>
<th>Days</th>
<th>RUG-IV</th>
<th>PDPM With Accurate MDS</th>
<th>PDPM With Missing MDS IV Meds Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>$631.25</td>
<td>$914.60</td>
<td>$706.06</td>
</tr>
<tr>
<td>4-20</td>
<td>$631.25</td>
<td>$625.81</td>
<td>$556.20</td>
</tr>
<tr>
<td>21-27</td>
<td>$631.25</td>
<td>$622.26</td>
<td>$554.36</td>
</tr>
<tr>
<td>28-30</td>
<td>$631.25</td>
<td>$618.71</td>
<td>$552.52</td>
</tr>
<tr>
<td>30 Day Total</td>
<td>$18,937.50</td>
<td>$19,594.54</td>
<td>$17,111.70</td>
</tr>
</tbody>
</table>
What happens if I don’t pay attention to length of stay?
## Example Resident PDPM (Day 98-100)

<table>
<thead>
<tr>
<th>Component</th>
<th>Base Fed Rate</th>
<th>Case-Mix Index</th>
<th>Special Adjustors</th>
<th>Variable per diem</th>
<th>Payment (per diem)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT</td>
<td>$59.33</td>
<td>x</td>
<td>1.55</td>
<td>x</td>
<td>0.76</td>
</tr>
<tr>
<td>OT</td>
<td>$55.23</td>
<td>x</td>
<td>1.55</td>
<td>x</td>
<td>0.76</td>
</tr>
<tr>
<td>SLP</td>
<td>$22.15</td>
<td>x</td>
<td>2.85</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>NTA</td>
<td>$78.05</td>
<td>x</td>
<td>1.85</td>
<td>x</td>
<td>1.00</td>
</tr>
<tr>
<td>Nursing</td>
<td>$103.46</td>
<td>x</td>
<td>1.43</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Non-Case-Mix Component</td>
<td>$92.63</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Except when resident has HIV/AIDS, then variable per diem adjustment = 1.18
Note: Rates are for urban facilities, CMS estimated if program went into effect FY19

*PDPM per-diem days 1-3 = $914.60
*RUGs per-diem all days = $631.25
Example resident full 100 day stay

100 Day Stay Revenue
RUG-IV = $63,125
PDPM Correct MDS = $62,517
PDPM Missing IV Meds = $55,154
Getting Ready for PDPM & AHCA Resources
What Can Go Wrong If You Are Not Prepared for PDPM?

- If you deliver care that is not patient motivated or according to clinical needs,
- If you do not enter MDS and Claim information correctly,
- If you do not have appropriate staffing for case mix,
- If you do not optimize staffing and contracting resources appropriately,

Audits
- Incorrect Payment/Audits
- Lower Quality Outcomes
- Budget Errors and Margin Shortfall

Your organization’s compliance, quality, payment, and margins at risk
CMS Schedule for PDPM Changes and Updates

- **Q4 2018**: CMS: Draft MDS & data specs updates
- **Q1 2019**: CMS: Proposed rule—some modifications expected (i.e., IPA)
- **Q2 2019**: CMS: Final Rule
- **Q3 2019**: PDPM Go-Live 10/1
- **Q4 2019**: CMS Plan for Education and Training as Yet Unclear – AHCA is Moving Ahead As Possible
AHCA Membership Support Strategy in Transformational Era

Rationale for Arriving at AHCA PDPM Readiness Toolbox & Core Competencies

- Therapy Driven
- Hierarchical CMG Assignment
- Clinical Coding Does Not Impact Payment

RUGs Model Going Away

PDPM Fundamentally Different
- Move Away from Therapy Minutes
- Clinical Care Management Focus
- Clinical Assessment & Coding Critical for Payment

- New Payment Drivers
- Clinical Information Collection
- Staff Role Changes
- Infrastructure – Technology, Data and Vendor Relations

AHCA PDPM Readiness Toolbox to Prepare for PDPM
AHCA PDPM Readiness Tool & PDPM Core Competencies

• PDPM Analysis and Contractor Retained
• Member Interviews
  • SNFs can be successful under PDPM,
  • Four categories of “must do’s” which AHCA refers to as the “PDPM Core Competencies”
• Resource Development
  • “AHCA PDPM Readiness Review Toolkit & Core Competencies” to help members assess their current RUG-based operations
  • Aid with determining what changes are needed to be successful under PDPM
Four Keys to Success Under PDPM
What To Be Doing Now

1. Educate yourself about the new system
2. Develop accurate diagnostic and MDS coding capabilities
3. Evaluate and strengthen your ability to manage complex patients
4. Align resources
PDPM Next Steps – AHCA Member Support Activities & Resources
PDPM Work Shop – March 13

GET SMARTER IN A NEW PAYMENT ENVIRONMENT
PDPM Academy Work Shop Day in Collaboration with VHCA

- Apply the Core Competencies to SNF Vignettes
- Classify sample patients with expert guidance
- Learn to assess your market position in a PDPM environment
- Orientation to in depth AHCA tools such as Grouper Tool, MDS Guidance, PDPM messaging tools for referral sources and payers
CMS Schedule for PDPM Changes and Updates

CMS: Draft MDS & data specs updates
Q4 2018

CMS: Proposed rule—some modifications expected (i.e., IPA)
Q1 2019

CMS: Final Rule
Q2 2019

PDPM Go-Live 10/1
Q3 2019

Q4 2019

CMS Plan for Education and Training as Yet Unclear – AHCA is Moving Ahead As Possible
Readiness Tool Will be Updated and Additional Resources Added to Each Core Competency

Readiness Tool and Core Competencies Updates
- MDS and RAI Updates for PDPM
- FY20 Notice of Proposed Rulemaking
- FY20 Final Rule

Additions to Readiness Tool and Competencies
- Guidance on PDPM Grouper Tool
- AHCA Template PDPM Hospital Discharge Summary
- AHCA Template PDPM Compliance Policies
- AHCA Template PDPM Messaging Tools – Plans, ACOs, BPCI

Face to Face & Virtual Training Opportunities
- ICD-10 Virtual Training for AHCA Members
- State-by-State One-Day Trainings
- Monthly PDPM Webinars
- Webinars on How to Use Readiness Tool Updates and Additions