Course Overview

➤ Claims data experts will discuss 2019-2021 PDPM data trends specific to Virginia and explain how interdisciplinary teams can identify trends for their own organizations.

➤ They will provide guidance on defining key clinical data elements and MDS coding practices related to non-therapy ancillary points, nursing, and rehab in conjunction with the immediate reimbursement and financial impacts for communities.

➤ The session will also explore dynamics of care in the post-acute world including clinical decision-making methods to maintain quality of life and choice based on an understanding of how data is trending as well as to identify risks for recoupment based on CMS audit activities and Program Integrity guidance.
Health Care Paradigm Shift

- **Historical**
  - Provider-centric
  - Incentives for volume
  - Siloed care
  - Fee for service

- **Reforming**
  - Patient-centric
  - Incentives for outcomes
  - Coordinated care
  - Value-based/alternative payment

CMS Quality Strategy

- Better Care
  - Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe.

- Affordable Care
  - Reduce the cost of quality healthcare for individuals, families, employers, and government.

- Healthy People, Healthy Communities
  - Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.

Challenges in Prior Payment Models

- For skilled nursing facilities and home health agencies, payment was currently driven by the amount and types of services provided (e.g. therapy services)
- Prior prospective payment systems (PPS) don’t fit into the new payment environment of value over volume
  - Unified PAC PPS across home health, SNF, IRF, and LTCH
  - Alternative Payment Models (APMs)
Data Findings in Prior Payment Systems

- Numerous government findings of fraud and abuse by OIG and DOJ
- MedPAC Reports

CMS FINDINGS: SNF

“The two most notable trends... were that the percentage of residents classifying into the Ultra-High therapy category has increased steadily and, of greater concern, that the percentage of residents receiving just enough therapy to surpass the Ultra-High and Very-High therapy thresholds has also increased. (Specifically) “the percentage of claims-matched MDS assessments in the range of 720 minutes to 739 minutes, which is just enough to surpass the 720- minute threshold for RU groups, has increased from 5 percent in FY 2005 to 33 percent in FY 2013” and this trend has continued since that time.”

Section O Additions

Requiring reporting of minutes and days will allow for Compliance monitoring by CMS of daily intensity

<table>
<thead>
<tr>
<th>MDS Item Number</th>
<th>Item Name</th>
</tr>
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<tbody>
<tr>
<td>O0400A5</td>
<td>Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Therapy Start Date</td>
</tr>
<tr>
<td>O0400A6</td>
<td>Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Therapy End Date</td>
</tr>
<tr>
<td>O0400A7</td>
<td>Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Individual Minutes</td>
</tr>
<tr>
<td>O0400A8</td>
<td>Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Concurrent Minutes</td>
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<td>Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Group Minutes</td>
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<td>Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Days</td>
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<tr>
<td>O0400B5</td>
<td>Special Treatments, Procedures and Programs: Occupational Therapy: Therapy Start Date</td>
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<td>Special Treatments, Procedures and Programs: Occupational Therapy: Therapy End Date</td>
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<td>Special Treatments, Procedures and Programs: Occupational Therapy: Total Individual Minutes</td>
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<tr>
<td>O0400C9</td>
<td>Special Treatments, Procedures and Programs: Physical Therapy: Total Group Minutes</td>
</tr>
<tr>
<td>O0400C10</td>
<td>Special Treatments, Procedures and Programs: Physical Therapy: Total Days</td>
</tr>
</tbody>
</table>
PDPM: Major Features

- Group & concurrent therapy limitation
- Need for an accountability mechanism to ensure therapy is delivered when a therapy payment is made
- Revised assessment schedules
- Variable per diem rates for PT, OT, and non-therapy ancillary services; consistent payment across the episode for SLP and Nursing services
- Clinical conditions and comorbidities drive payment

Modes of Treatment

- Limits concurrent and group to no more than 25%, COMBINED, by discipline
- Will require completion of a discharge MDS to collect therapy minutes for compliance monitoring of 25% concurrent and group
- Utilization of group &/or concurrent must be based on needs of resident and must be well documented
- Non-fatal warning edit on validation report if exceed threshold
Goals of PDPM

- Based heavily on data analytics
- Derives payment from verifiable patient characteristics.
- Remove service-based metrics (e.g. therapy minutes) as determinant of payment
- Decrease administrative burden
- Reduce the complexity (number of component levels) compared to what was proposed in RCS-1

Under PDPM Skilled Nursing Facility Level of Care Definition Did Not Change

Care in a SNF is covered if all of the following four factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
- The patient requires these skilled services on a daily basis (see §30.6); and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)
- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.
Under PDPM Quality and Survey Expectations Did Not Change

- New Survey Process secondary to Phase II Requirements of Participation went into effect 11.28.2017
- Short and Long Stay Quality Measures are still in place
- Quality Reporting Program
- Value Based Purchasing
- 5 Star Rating System

PT
- All patients will be assigned to a case mix level
- 16 case mix levels based on clinical category (4) and functional level (Section GG items)

OT
- All patients will be assigned to a case mix level
- 16 case mix levels based on clinical category (4) and functional level (Section GG items)

SLP
- All patients will be assigned to a case mix level
- 12 case mix levels based on Presence of acute neuro condition, SLP related co-morbidity, or cognitive impairment & mechanically altered diet or swallowing disorder

Nursing
- All patients will be assigned to a case mix level
- 25 case mix levels based on clinical conditions, depression, 8 restorative services, function (section GG)

NTA
- All patients will be assigned to a case mix level
- 6 case mix levels based on conditions

Non Case Mix
- Non-Case Mix: Room and Board
Myth or Fact?

Medicare is requiring therapy to evaluate every patient that walks through the door.

Often a brief assessment or screening can help you determine if a full evaluation is warranted. Your clinical judgment and the needs of the patient remain paramount in the decision-making process.

Myth or Fact?

Medicare is requiring therapy to provide 10% group or concurrent treatment to every patient that walks through the door.

Under PDPM, group and concurrent therapy are restricted to 25% of a patient’s total episode of care, per therapy discipline. The use of group and concurrent therapy should always be clinically appropriate for the patient and part of an individualized plan of care. Administrative mandates to provide a certain percentage of group and/or concurrent therapy for every patient regardless of need (e.g. 10%) is not appropriate.
Myth or Fact?

**Medicare says only occupational therapy can provide cognitive treatment.**

Medicare is not dictating that cognition or swallowing can only be done by occupational therapists or speech-language pathologists. Each facility makes determinations on how to use therapy clinicians in compliance with state licensing laws. If your facility tells you Medicare no longer allows you to perform certain types of services, this is not based on Medicare policy.

Myth or Fact?

**Medicare has set productivity requirements.**

Productivity standards are an industry-developed mechanism to maintain profitability and manage staff, not a payment policy. It is not yet clear what impact PDPM will have on productivity standards.
Myth or Fact?

The definition of skill, which triggers coverage in SNFs, has not changed.

Myth or Fact?

If the patient has dysphagia tied to R13, I must report it via I69.

A comorbidity payment associated with dysphagia is currently limited to the I69 series ICD-10 codes. However, it shouldn’t be selected simply to trigger additional payment, particularly if the medical record does not support it. If R13 more accurately describes the patient it should be used and maintained in the medical record at a minimum and on the claim whenever possible. Comprehensive, accurate diagnostic coding on claims is the primary way we will effectuate change to the PDPM.
Myth or Fact?

If the patient has a high score on the BIMS, then I cannot provide cognitive treatment.

The BIMS is a screening tool, not a formal evaluation. A patient who has a medically necessary need for skilled cognitive interventions should receive these services regardless of the BIMS score.

CMS Audits - What should we prepare for?

• Changes in payment that result from changes in the coding or classification of SNF patients vs. actual changes in case mix.
• Changes in the volume and intensity of therapy services provided to SNF residents under PDPM compared to RUG-IV.
• Compliance with the group and concurrent therapy limit.
• Any increases in the use of mechanically altered diet among the SNF population that may suggest that beneficiaries are being prescribed such a diet based on facility financial considerations, rather than for clinical need.
• Any potential consequences (e.g., overutilization) of using cognitive impairment as a payment classifier in the SLP component.
• Facilities whose beneficiaries experience inappropriate early discharge or provision of fewer services (e.g., due to the variable per-diem adjustment).
• Stroke and trauma patients, as well as those with chronic conditions, to identify any adverse trends from application of the variable per-diem adjustment.
• Use of the interrupted-stay policy to identify SNFs whose residents experience frequent readmission, particularly facilities where the readmissions occur just outside the 3-day window used as part of the interrupted-stay policy.
Targeted Probe and Educate

- When Medicare Claims are submitted accurately, everyone benefits.
- CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.

- The goal: to help you quickly improve. Medicare Administrative Contractors (MACs) work with you, in person, to identify errors and help you correct them. Many common errors are simple – such as a missing physician’s signature – and are easily corrected.

Targeted Probe and Educate Cycle

How does it work?

- If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC).
- The MAC will review 20-40 of your claims and supporting medical records.
- You will be given at least a 45-day period to make changes and improve.
- If some claims are denied, you will be invited to a one-on-one education session.
- If complaint, you will not be reviewed again for at least 1 year on the selected topic.

*MACs may conduct additional review if significant changes in provider billing are detected.
Case Study

Mr. Brown was admitted following acute onset of cerebrovascular accident. He currently has a Swallowing Disorder and is rec’g a Mechanically Altered Diet in addition to parenteral feedings low intensity. He has aphasia and a mild cognitive impairment. Other active dx include COPD with SOB with lying flat. He requires partial/moderate assist with eating, oral hygiene and sit to lying to sit. He requires substantial/maximum assist with toileting hygiene, all transfers, and walking 50’ with two turns. He is unable to walk 150’. He is depressed.
Build the HIPPS

PT  
TN  
N  

SLP  
SL  
L  

NRS  
NL  

NTA  

Agenda

RESDAC Data  What is it? What can you do with it?

Virginia RESDAC – Latest Quarter

Useful Numbers
RESDAC Data

- Medicare and Medicaid data
- Research Identifiable Files (RIF)
- Standard Analytical Files (SAF)
- Medicare Provider Analysis and Review (MEDPAR)
- Much More

Questions we CAN’T answer with RESDAC

- How many therapy minutes are being provided under PDPM?
- Have outcomes improved or declined under PDPM?
- Anything related to PHQ-9, other than depression for clinically complex and special care. (More on this later.)
- Anything related to the BIMs
- Anything related to Managed Care
Questions we CAN answer with RESDAC

Length of Stay
ICD-10 Codes Used
HIPPS Analysis
DRG Codes coming from hospitals

Discharge patterns
Readmission Patterns
MUCH More

HIPPS Analysis
SAF Data includes HIPPS codes for EVERY stay
For example:

PT/OT – Medical Management with 6-9 GG Score

JCEC1
6-8 NTA Points
Special Care High – No Depression

SLP – Both Mechanically Altered Diet & Swallow Disorder/ No Acute Neuro, Comorbidities or Cognitive Impairment
### HIPPS Discipline CMI Pay

<table>
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<tr>
<th>HIPPS</th>
<th>Discipline</th>
<th>CMI</th>
<th>Pay</th>
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<td>PT</td>
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<td></td>
<td>OT</td>
<td>1.4500</td>
<td>$82.32</td>
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<td>SLP</td>
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<td>Nursing</td>
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<td></td>
<td><strong>$880.25</strong></td>
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<tr>
<td><strong>Total (4-20)</strong></td>
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<td></td>
<td><strong>$629.52</strong></td>
</tr>
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</table>
Principle Diagnosis Codes in VA SNFs

- **A419** - Sepsis, unspecified organism
- **G9341** - Metabolic encephalopathy
- **J9601** - Acute respiratory failure with hypoxia
- **N390** – Urinary tract infection, site not specified

---

**BON SECOUS ST MARYS HOSPITAL**

5901 BREMO RD
RICHMOND, VA

******

<table>
<thead>
<tr>
<th>Part A Discharges</th>
<th>Q4 2020</th>
<th>Q1 2021</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>To SNFs</td>
<td>167</td>
<td>187</td>
<td>354</td>
</tr>
<tr>
<td>Overall</td>
<td>1,418</td>
<td>1,444</td>
<td>2,862</td>
</tr>
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</table>

WESTPORT REHABILITATION AND NURSING CENTER
7300 FOREST AVE
RICHMOND, VA (1.9 miles)
ReAdm: 16% (1,700"
$16,566/1/day
ALOS: 21
Q4: 12
Q1: 26
Total: 38

GLENBURNIE REHAB & NURSING CENTER
1901 LIBBIE AVE
RICHMOND, VA (0.5 miles)
ReAdm: 11.2% (7,435"
$20,374/5/day
ALOS: 24
Q4: 22
Q1: 15
Total: 37

BETH SHOLOM HOME OF VIRGINIA
1600 JOHN ROLFE PARKWAY
RICHMOND, VA (6.9 miles)
ReAdm: 11% (1"
ALOS: 37
<table>
<thead>
<tr>
<th>Metric</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>NTAs</td>
<td></td>
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<tr>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>SLP</td>
<td></td>
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<tr>
<td>Depression</td>
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<tr>
<td>Metric</td>
<td>Score</td>
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<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>NTAs</td>
<td>Average</td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>SLP</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
</tbody>
</table>
RECENT OPENING AND CLOSING POLICY DECISIONS

Data Sources: Cases and deaths data from JHU CSSE. As of August 1, 2020, policy events are drawn from various state-specific sources. Prior to that, the data source for policy events was the National Governor’s Association.
### Metric Score

<table>
<thead>
<tr>
<th>Metric</th>
<th>Score</th>
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<tbody>
<tr>
<td>NTAs</td>
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<tr>
<td>Nursing</td>
<td>Average+</td>
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<tr>
<td>SLP</td>
<td></td>
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<tr>
<td>Depression</td>
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<tr>
<td>Metric</td>
<td>Score</td>
</tr>
<tr>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>NTAs</td>
<td>Average</td>
</tr>
<tr>
<td>Nursing</td>
<td>Average+</td>
</tr>
<tr>
<td>SLP</td>
<td><strong>Average</strong></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
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</table>

**Percent Depression Q1 - 2021**

[Map showing depression rates by state]
Metric | Score
--- | ---
NTAs | Average
Nursing | Average+
SLP | Average
Depression | Average-
### Metric Score

<table>
<thead>
<tr>
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<th>Score</th>
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<tr>
<td>NTAs</td>
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<tr>
<td>Nursing</td>
<td>Average+</td>
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<tr>
<td>SLP</td>
<td>Average</td>
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<tr>
<td>Depression</td>
<td>Average-</td>
</tr>
<tr>
<td>Rate</td>
<td>Average++</td>
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</tbody>
</table>
Let’s Focus Specifically on Virginia

Important Note: Not all averages are the same!
Swallowing Disorder and/or Mech Altered Diet

Neither 1 2 3 4 5
Any One 4
Any Two 3
All Three 2
None 1

Acute Neuro/SLP Comorbidities/Cognitive Impairment

Urban Base Rates for Virginia, Q1 2021 versus Nursing CMI
Self Evaluating

Total Factor Productivity in Nonfarm Business Since 2000

Source: Congressional Budget Office

Vertical bars indicate the duration of recessions.
Urban Base Rate Trend

Source: RESDAC

Composite Rate (Urban)

Source: RESDAC Q1 2021
How do we start?

Knowledge
Basic PDPM knowledge isn’t enough

Tools
AI - ASAP

What is AI?
1. Overhyped Buzzword
2. Important and Significant Advance in What Computers Can Do

What can AI do?
1. Classification
2. Prediction
H&P

MD

Hospitalist

HPMC Hospitalist History and Physical

Assessment/Plan:

Principal Problem:
GI bleed
Active Problems:
Hypertension
Hypothyroidism (acquired)
Fecal occult blood test positive
Dementia
DKD stage 4 due to type 2 diabetes mellitus (HCC)
Acute cystitis with hematuria
Cirrhosis (HCC)
Hypoglycemia
Dialysis
Acute-on-chronic kidney injury (HCC)

* No resolved hospital problems.*

Resolved Problems:

is a 65 y.o. female with PMHx stage IV kidney disease, cirrhosis with known esophageal varices, multiple AVMs, diverticulosis with prior GI bleed, and polycystic ovaries of vena cavae, lumbar region as reviewed in the EMR that presented to HPMC with Chief Complaint

Patient presents with
* Hypoglycemia
Attending #VHCA2021. Data guy: #yawn #MakeItStop
Super Scrubber®

- It will find 100% of the items you “missed”
- Zero False Positives
- 100% Indemnification against denials
Don’t Forget to Validate the Assumptions

- It will find 100% of the items you “missed” ← No. It won’t.

- Zero False Positives ← Only if you don’t use it.

- 100% Indemnification against denials ← JK
### Contract Therapy

<table>
<thead>
<tr>
<th>Category</th>
<th>PT</th>
<th>OT</th>
<th>Low</th>
<th>High</th>
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<tr>
<td>A 0.4% Major Joint Replacement or Spinal Surgery</td>
<td>1.59</td>
<td>1.44</td>
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<td>5</td>
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<tr>
<td>B 1.0% Major Joint Replacement or Spinal Surgery</td>
<td>1.7</td>
<td>1.63</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>C 2.4% Major Joint Replacement or Spinal Surgery</td>
<td>1.88</td>
<td>1.69</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>D 0.0% Major Joint Replacement or Spinal Surgery</td>
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<td>1.51</td>
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<td>24</td>
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<tr>
<td>E 2.3% Other Orthopedic</td>
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<td>1.41</td>
<td>0</td>
<td>5</td>
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<tr>
<td>F 5.8% Other Orthopedic</td>
<td>1.76</td>
<td>1.69</td>
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<tr>
<td>G 12.1% Other Orthopedic</td>
<td>1.77</td>
<td>1.69</td>
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<td>23</td>
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<tr>
<td>H 0.0% Other Orthopedic</td>
<td>1.46</td>
<td>1.38</td>
<td>24</td>
<td>24</td>
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<tr>
<td>I 9.3% Medical Management</td>
<td>1.91</td>
<td>1.88</td>
<td>0</td>
<td>5</td>
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<tr>
<td>J 13.0% Medical Management</td>
<td>1.92</td>
<td>1.86</td>
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<tr>
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<td>1.92</td>
<td>1.86</td>
<td>10</td>
<td>23</td>
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<tr>
<td>L 0.6% Medical Management</td>
<td>2.09</td>
<td>1.11</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>M 4.7% Non-Orthopedic Surgery and Acute Neurologic</td>
<td>1.27</td>
<td>1.3</td>
<td>0</td>
<td>5</td>
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<tr>
<td>N 4.6% Non-Orthopedic Surgery and Acute Neurologic</td>
<td>1.45</td>
<td>1.35</td>
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<td>9</td>
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<tr>
<td>O 9.2% Non-Orthopedic Surgery and Acute Neurologic</td>
<td>1.88</td>
<td>1.35</td>
<td>10</td>
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<tr>
<td>P 0.1% Non-Orthopedic Surgery and Acute Neurologic</td>
<td>2.08</td>
<td>1.09</td>
<td>24</td>
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</tbody>
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### SNF PEPPER CMS Target Areas

In general, the target areas are constructed as ratios and expressed as percents; the numerator represents episodes of care that may be identified as problematic, and the denominator represents episodes of care of a larger comparison group.

**PDPM High Utilization Codes**

*new as of the Q4FY20 release*

- N: Count of SNF claims where the first digit of the Health Insurance Prospective Payment System (HIPPS) code, representing the Physical and Occupational Therapy component, is one of the following: C, D, G, H, K, L, O, P.
- D: Count of all SNF claims
<table>
<thead>
<tr>
<th>Category</th>
<th>Change In PT &amp; OT (Urban – no WI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>$11.17 + $12.73</td>
</tr>
<tr>
<td>Other Orthopedic</td>
<td>$3.72 + $3.46</td>
</tr>
<tr>
<td>Medical Management</td>
<td>$6.20 + $5.78</td>
</tr>
<tr>
<td>Non-Orthopedic Surgery and Acute Neurologic</td>
<td>$4.34 + $4.04</td>
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</tbody>
</table>

Average PT/OT Change: **$12.28**

<table>
<thead>
<tr>
<th>Category</th>
<th>Change In Nursing (Urban – no WI)</th>
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<tbody>
<tr>
<td>Special Care High</td>
<td>-$14.06</td>
</tr>
<tr>
<td>Special Care Low</td>
<td>-$32.45</td>
</tr>
<tr>
<td>Clinically Complex</td>
<td>-$30.28</td>
</tr>
<tr>
<td>Reduced Physical Function</td>
<td>-$36.77</td>
</tr>
</tbody>
</table>

Average Nursing Change: **$28.39**
**Category** | **Change (Urban – no WI)**
---|---
Nursing | -$28.39
PT & OT | $12.28
Therapy Bill (@38%) | -$4.67

Net Change: **-$20.78 PER DAY**

---

**Useful Numbers**
Using data to inform our day-to-day activity
What’s an NTA Point Worth?

<table>
<thead>
<tr>
<th>NTA Points</th>
<th>Category</th>
<th>CMI</th>
<th>Rural VA</th>
<th>Days 4+</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>NF</td>
<td>0.72</td>
<td>$49.06</td>
<td>-</td>
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<tr>
<td>1</td>
<td>NE</td>
<td>0.96</td>
<td>$65.41</td>
<td>16.35</td>
</tr>
<tr>
<td>2</td>
<td>NE</td>
<td>0.96</td>
<td>$65.41</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>ND</td>
<td>1.33</td>
<td>$90.62</td>
<td>25.21</td>
</tr>
<tr>
<td>4</td>
<td>ND</td>
<td>1.33</td>
<td>$90.62</td>
<td>-</td>
</tr>
<tr>
<td>5</td>
<td>ND</td>
<td>1.33</td>
<td>$90.62</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>NC</td>
<td>1.84</td>
<td>$125.37</td>
<td>34.75</td>
</tr>
<tr>
<td>7</td>
<td>NC</td>
<td>1.84</td>
<td>$125.37</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>NC</td>
<td>1.84</td>
<td>$125.37</td>
<td>-</td>
</tr>
<tr>
<td>9</td>
<td>NB</td>
<td>2.53</td>
<td>$172.38</td>
<td>47.01</td>
</tr>
<tr>
<td>10</td>
<td>NB</td>
<td>2.53</td>
<td>$172.38</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
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<td>2.53</td>
<td>$172.38</td>
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<tr>
<td>12</td>
<td>NA</td>
<td>3.24</td>
<td>$220.75</td>
<td>48.37</td>
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</table>

Source: RESDAC Q1 2021
<table>
<thead>
<tr>
<th>Category</th>
<th>CMI</th>
<th>Avg/$$/point</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>3.24</td>
<td>$48.37</td>
</tr>
<tr>
<td>NB</td>
<td>2.53</td>
<td>$15.67</td>
</tr>
<tr>
<td>NC</td>
<td>1.84</td>
<td>$11.58</td>
</tr>
<tr>
<td>ND</td>
<td>1.33</td>
<td>$8.40</td>
</tr>
<tr>
<td>NE</td>
<td>0.96</td>
<td>$8.18</td>
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<tr>
<td>NF</td>
<td>0.72</td>
<td>$14.31</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average Value of a Point &gt;&gt; $18.60</td>
</tr>
</tbody>
</table>

![CMI for PDPM Nursing Categories](image)
### Average Rate Change for Nursing Categories

<table>
<thead>
<tr>
<th>From:</th>
<th>Reduced Physical Function</th>
<th>Clinically Complex</th>
<th>Special Care Low</th>
<th>Special Care High</th>
<th>Extensive Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral</td>
<td>$8.12</td>
<td>$28.13</td>
<td>$52.74</td>
<td>$80.57</td>
<td>$170.12</td>
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<tr>
<td>Reduced Physical Function</td>
<td>$20.01</td>
<td>$44.62</td>
<td>$72.45</td>
<td>$161.99</td>
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</tr>
<tr>
<td>Clinically Complex</td>
<td>$24.61</td>
<td>$52.44</td>
<td>$141.99</td>
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<td></td>
</tr>
<tr>
<td>Special Care Low</td>
<td>$27.83</td>
<td>$117.37</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Care High</td>
<td></td>
<td></td>
<td></td>
<td>$89.54</td>
<td></td>
</tr>
</tbody>
</table>

### Depression Trend

Source: RESDAC

- **US**
- **VA**
Depression

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>From</th>
<th>To</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA1</td>
<td>CA2</td>
<td>$ 84.90</td>
<td>$ 98.45</td>
<td>$ 13.55</td>
</tr>
<tr>
<td>CBC1</td>
<td>CBC2</td>
<td>$ 121.03</td>
<td>$ 139.99</td>
<td>$ 18.97</td>
</tr>
<tr>
<td>CDE1</td>
<td>CDE2</td>
<td>$ 146.32</td>
<td>$ 168.89</td>
<td>$ 22.58</td>
</tr>
<tr>
<td>LBC1</td>
<td>LBC2</td>
<td>$ 129.15</td>
<td>$ 155.35</td>
<td>$ 26.19</td>
</tr>
<tr>
<td>LDE1</td>
<td>LDE2</td>
<td>$ 156.25</td>
<td>$ 187.86</td>
<td>$ 31.61</td>
</tr>
<tr>
<td>HBC1</td>
<td>HBC2</td>
<td>$ 167.99</td>
<td>$ 202.31</td>
<td>$ 34.32</td>
</tr>
<tr>
<td>HDE1</td>
<td>HDE2</td>
<td>$ 179.73</td>
<td>$ 216.76</td>
<td>$ 37.03</td>
</tr>
</tbody>
</table>

Average >> $ 26.32

Source: RESDAC – Q1 2021
Key Points

Know your data!
- Your facility versus the state
- Your state versus the nation

Understand what’s at stake
- NTA Point (≈$18.60 / point)
- Depression (≈$26.32)
- Nursing Changes (≈ $20-$70 / day)

Understand the WHOLE impact of tools, not just the $$
- Proactive versus Retroactive
- Consider the Hours Required (It’s a real expense.)
- Consider your Independence (Can you ever go back?)

Key Points Continued

Have a plan to use AI
- Reading H&P Documents (Proactive)
- Auditing Generated Documentation (Proactive)
- Much More

Auditors have a plan to use AI on YOU!

The most successful facilities get three things right:
- SLP
- NTA
- Nursing
CMS has determined, through budget neutrality analysis, that even absent COVID related cases in 2020, i.e., active COVID dx. and or use of the 3-day stay waiver, there was a 5.0% increase in aggregate spending under the PDPM for FY 2020 due to the shift in case mix utilization, compared to FY 2019.

CMS observed slight decreases in the average CMI for the PT and OT rate components for SNF populations as compared to what was expected, as well as significant increases in the average CMI for the SLP (22.6%), Nursing (16.8%), and NTA (5.6%) for FY 2020 populations as compared to what was expected, for FY 2020 SNF population. CMS sees these significant increases in the average case-mix for these components as primarily responsible for the inadvertent increase in spending under PDPM.
Future Data: Impact of Parity?

Due to the indication of a 5.0% increase in spending for FY 2020 compared to FY 2019, CMS proposed a path towards recalibration of the parity adjustment that was in initially implemented with the PDPM in FY 2020 based on 2017 and 2018 data (46%), in order to achieve budget neutrality equally across all PDPM case mix adjusted components in FY 2022 (37%).

This would achieve a 5% reduction in SNF spending under PDPM or $1.7 billion.

To do this, each expected PDPM case mix index, based on 2017 and 2018 claims data, would be revised by the new parity adjustment factor of 37%. This equates to a 5% reduction in the proposed FY 22 case mix indexes.

Parity: Delayed Option

Delayed

• If this reduction was finalized in FY 2022 with a 1-year delayed implementation, this would mean that the full 5 percent reduction would be prospectively applied to the PDPM CMIs in FY 2023.

• If the reduction was finalized in FY 2022 with a 2-year delayed implementation, then the reduction in the PDPM CMIs would be applied prospectively beginning in FY 2024.
Parity: Phased Option

Phased

• With regard to a phased implementation strategy, this would mean that the amount of the reduction would be spread out over some number of years. Such an approach helps to mitigate the impact of the reduction in payments by applying only a portion of the reduction in a given year. For example, if CMS were to use a 2-year phased implementation approach to the 5 percent reduction discussed above, this would mean that the PDPM CMIs would be reduced by 2.5 percent in the first year of implementation and then reduced by the remaining 2.5 percent in the second and final year of implementation. So, for example, if this adjustment was finalized for FY 2022, then the PDPM CMIs would be reduced by 2.5 percent in FY 2022 and then reduced by an additional 2.5 percent in FY 2023.

• CMS notes that the number of years for a phased implementation approach could be as little as 2 years but as long as necessary to appropriately mitigate the yearly impact of the reduction. For example, CMS could implement a 5-year phased approach for this reduction, which would apply a one percent reduction to the PDPM CMIs each year for 5 years.

Parity: Combination Delayed/Phased

Combination Delayed/Phased

• CMS also notes that these mitigation strategies may be used in combination with each other. For example, CMS could finalize a 2-year phased approach with a 1-year delayed implementation. Using FY 2022 as the hypothetical year in which such an approach could be finalized, this would mean that there would be no reduction to the PDPM CMIs in FY 2022, a 2.5 percent reduction to the PDPM CMIs in FY 2023 and then a 2.5 percent reduction in the PDPM CMIs in FY 2024.
Parity: CMS Closing Thoughts

CMS finally indicates that, “We are considering these approaches as they may be warranted to mitigate potential negative impacts on providers resulting from implementation of such a reduction in the SNF PPS rates entirely within a single year in the event we determine that recalibrating the parity adjustment is necessary to achieve budget neutrality.

However, we believe that these alternatives would continue to reimburse in amounts that significantly exceed our intended policy in excess of the rates that would have been paid had we maintained the prior payment classification system rather than in a budget neutral manner as intended, and as we stated above, we believe it is imperative that we act in a well-considered but appropriately expedient manner once excess payments are identified.”

Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Quality Reporting Programs - RFI

CMS is working to further the mission to improve the quality of healthcare for beneficiaries through measurement, transparency, and public reporting of data.

The SNF QRP and CMS’ other quality programs are foundational for contributing to improvements in health care, enhancing patient outcomes, and informing consumer choice.

We believe that advancing our work with use of the FHIR standard offers the potential for supporting quality improvement and reporting which will improving care for our beneficiaries.

We are seeking feedback on our future plans to define digital quality measures (dQMs) for the SNF QRP.

We also are seeking feedback on the potential use of FHIR for dQMs within the SNF QRP aligning where possible with other quality programs.
Project Title: Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures

As part of its measure development process, Acumen and Abt convene groups of stakeholders and experts who contribute direction and input during measure development and maintenance. The TEP’s purpose is to provide input to Acumen and Abt on the development of PAC quality measures addressing function.

Holding a TEP allows Acumen and Abt to leverage the members’ experience, which increases the clinical and face validity of the measures. The TEP’s input will be used to guide improvements to the existing function measures and to inform new measure development.

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC and Abt Associates (hereafter referred to as Acumen and Abt respectively) to develop quality and cost measures for use in Post-Acute Care (PAC) Quality Reporting Programs (QRPs) as mandated by the Patient Protection and Affordable Care Act (PPACA) of 2010 and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. Acumen’s contract name is “Quality Measure & Assessment Instrument Development & Maintenance & QRP Support for the Long Term Care Hospital, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Quality Reporting Programs, & Nursing Home Compare.”
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