

Changes in Medicare Payments to Skilled Nursing Facilities: Know the Facts!

Part 1

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Sarah Warren: Hello, everyone. Thank you for joining us today for this ASHA-sponsored webinar entitled “Changes in Medicare Payments to Skilled Nursing Facilities: Know the Facts.”

My name is Sarah Warren and I am the Director of Healthcare Policy for Medicare at the American Speech Language Hearing Association, and I'm joined today by ASHA member expert Renee Kinder who is the Vice President of Clinical Services at Encore Rehabilitation.

So, to start the presentation, let's talk a little bit about how Medicare pays for services in skilled nursing facilities at this time. The current system is known as the Resource Utilization Group RUG-IV payment system under the Prospective Payment System or PPS. There have been many challenges with the existing payment system for skilled nursing facilities under Medicare.

Primarily, the challenge has been around the way that the payment system is structured in that it pays for the minutes of therapy delivered to the patient. And so the more therapy services that are delivered to the patient, the more money the skilled nursing facility receives. And this has been considered a system that allows for manipulation or fraud in the payment system.

In that, the skilled nursing facility attempts to provide as much therapy as possible not because of what the patient needs, but because of what the reimbursement would be given the amount of therapy delivered. And so this has come under a lot of criticism and there are some similar criticisms of the home health payment system as well, but the focus of our presentation today, obviously, is skilled nursing facilities.

In addition to some concerns about the way the payment system is structured, that might lead to fraud or manipulation, there is also some concern that the existing prospective payment system under RUG-IV for skilled nursing facilities doesn't fit

into the new payment environment that we're transitioning to, a payment environment that really focuses on the value of services over the volume of services.

And you hear these referred to in different ways, as alternative payment models, value over volume, things of that nature. And so there is some concern that a PPS system that pays based on the minutes of therapy, the volume of therapy, doesn't fit into this new payment paradigm that we want to transition the healthcare system to.

There's also a significant interest in developing a unified post acute care payment system for Medicare that would encompass the four post acute care settings, home health, skilled nursing facilities, inpatient rehab facilities and long term care hospitals. And there's been a tremendous amount of background work and research done into if this would be feasible.

And if it is, when could it happen? And what that would look like, in terms of the impact on types of patients that we're going to do the settings and what the assessment tools look like among other issues that need to be worked out as we make this potential transition.

And I think that for our speech language pathology members working in skilled nursing facilities, we hear a lot from them pretty much on a daily basis about some of the challenges they encounter under the current SNF payment system.

For example, they're being instructed to pick up every single patient regardless of need and provide as much therapy as possible. Again, regardless of what the patient really needs in order to drive reimbursement.

We're also being given examples about limitations on what they can do, that they can never give more than a 15-minute evaluation for example and depending on the patient's condition limiting the evaluation to 15 minutes might be really inappropriate, might be impossible to really adequately evaluate that patient.

And so, in addition to concern about the payment system at large, ASHA has identified some concerns as it relates to our speech language pathology members that everyone agrees really needs to be addressed in some way.

And so to kind of further reinforce what we're seeing in terms of what policymakers, members of Congress, staff at the Medicare program, different

advisory panels like the Medicare Payment Advisory Commission, which is a congressional panel – the congressionally appointed panel, excuse me – that advises Congress on Medicare payment policy issues.

There's just a lot of concern about how the payment system has been used to drive reimbursement. There have been several Office of Inspector General and Department of Justice settlements between the federal government and some of the larger SNF chains that have sort of outlined some concerns about how the payment system, the current payment system is being manipulated, and med pack.

And so I just kind of wanted to provide one example of what we're seeing. And if you look at this (quote) on this slide, really shows from the final rule that put in our new payment system that we're going to be talking about in more detail in just a moment. You see in the final rule that CMS used to establish the new payment system, an example of the types of concerns that they've identified via claims reviews and chart audits, et cetera, and what they're trying to address.

And so you see that they've noticed since the RUG-IV payment system was put into place, that there is a high percentage of residence classifying into the ultra high therapy category, which is the one of the highest payment categories under the RUG-IV system that has increased steadily and that they're getting – patients getting just enough therapy to cross the threshold to drive the higher reimbursement.

And they're not seeing an associated correlation with the complexity or the needs of the patients. It's almost from their perspective based on the data that they've reviewed that oh, wow, if we provide 720 minutes or 721 minutes of therapy, we're going to get this higher payment rate. And so patients are hovering right at those thresholds within minutes of that threshold in order to trigger the payment.

And it's not that the payment is driven by a change in the patient characteristics over time. Medicare's data shows that perhaps, that the move towards providing more therapy is driven by this payment system rather than a change in patient needs or characteristics.

So, this transition, there's been tremendous criticism about the current payment system for many, many years. And in 2017, the Medicare program took this on in earnest. They proposed a change to the SNF payment system through rulemaking.

And they got – they went through a public comment period – received many public comments. ASHA obviously participated in that 2017 rulemaking process.

They hosted a technical expert panel of which Renee was our representative to try to delve into these issues and identify a way to fix the payment system to really drive focus on patient characteristics and value of the services over the volume of services. They ended up not finalizing their proposal in 2017 and then they re-proposed with some slight modifications in the 2018 rulemaking cycle.

And they finalize that proposal in, I believe, of September 2018, with the effective date of October 1 2019. So, ASHA has been involved all along the way since the beginning of this process. So, this is a process about two years or so in the making with the tremendous amount of stakeholder engagement. And the payment system, known as the Patient Driven Payment model will go into effect on October 1, 2019.

And so you're going to hear a lot about – excuse me – you're going to hear a lot about – you've probably already been hearing a lot about this magic switch that essentially is going to get flipped on October 1 2019. You're probably hearing grumblings among your colleagues, therapy colleagues. You're hearing things from your SNF administration about how things might be changing.

And I think a lot of folks may not know that it's known as the Patient Driven Payment model. They just know that this change is coming on October 1, and it's going to change the way that their services are paid under the Medicare payment system. And there's a lot of concern, a lot of consternation. And so, ASHA wants to work very hard to ensure that our members understand what is changing and what is not changing.

I think it is almost as important, if not more important, than what is changing, what is not changing under the Patient Driven Payment model, and how they can continue to play a valuable role in skilled nursing facilities given that instead of the minutes of therapy being provided, driving payment that the clinical characteristics of the patient are going to be driving that.

And so this is the first of a two-part webinar series that ASHA is doing with Renee. The first as I mentioned that we're engaged in right now is knowing the facts, understanding why the payment system is changed, knowing what is coming their way and how to work in that environment.

And the second piece is focused on knowing your value as a speech language pathologist, re-focusing and re-engaging on your value proposition in the skilled nursing facility. So, given that, I want to turn it over to Renee to talk about the major features and sort of an overview of the payment system itself. And then towards the end, we want to kind of reinforce facts and dispel some myths about the way the payment system will work effective October 1 2019. So, Renee, with that, I'd like to turn it over to you.

Renee Kinder: Thank you, Sarah. And I think we can agree that it's a very exciting time in our industry as Sarah alluded to. We're essentially seeing significant shifts across the entire post acute care spectrum and we're at a time where we're moving the reimbursement structure from a volume-based system to a value-based system.

And as we work through the next few sets of slides, you will see how the model was built, why it was built, and what some of the key factors are. What I hope you will see is that we are moving into a time where we are going to have reimbursement tied to individual patient beneficiary characteristics.

But let's begin by talking about what some of the major features are of the Patient Driven Payment model, and then we're going to discuss the goals and then lead into what is and is not changing under the new model. So, to begin, we do see some further structure given to groups and concurrent. What I will say about this is what we had in final rule looks a little bit different from what we had in proposed rule and this year.

So, we do know under PDPM that group and concurrent therapy does have some limit. So, there's a 25% limit by discipline per individual Medicare beneficiary. What we do see as far as a change and from what you all know as the Medicare Part A definition of group is going to potentially change into some language we saw in the proposed rule for this year.

So, right now, we know that for a group to meet the Medicare Part A definition you need for individuals schedule ahead of time that are doing something same or similar. What we saw in proposed rule is that and remember if they are alluded to, we're looking at shifts across this entire post acute care spectrum, is that Medicare's looking at potentially shifting the post acute care nest group definition to mirror the inpatient rehab facility definition which walked by a group of two to six.

So, to come there, we do have some variable rates under PDPMs. It's important for you to have an understanding of why those variations are present, but they traditionally impact our physical and occupational therapy. So, as we worked throughout the model how it was built, how it's structured, and look at how we have provided care in the past, you will see that there are some variable per diem rate for our PT and OT counterparts that have a level of regression throughout this day.

And then there's this interesting aspect known as non therapy ancillary, not really tied to therapy, but it accounts for medical complexities for individuals that come into our skilled nursing facility and that actually have a multiplier at the beginning of this day. Speech language pathology in addition to nursing has a consistent payment across the spectrum.

Additionally, major features from an SLP perspective are types that clinical categories and the comorbidities that will impact and drive our reimbursement. And those include the presence or absence of a mechanically altered diet, the presence or absence of a cognitive impairment, speech language pathology comorbidities, and then presence or absence of a swallowing disorder.

Now, for those of you that are hearing this information for the first time, you may be thinking, OK, these conditions are areas that I document within my electronic medical records. So, hopefully, I'm in a good place to support the clinical needs of the patients I'm serving because this is already part of what I'm documenting on a day-to-day basis.

However, another very important feature of PDPM is that all of these clinical areas, while tied to speech pathology, are going to be derived from the minimal data set within your facilities documentation system. (I think) we can slide. OK.

So, what is the goal for PDPM and we will go from goals to what is not changing and then we'll get into more specificity on how each of the individual six areas that build this model are constructed.

But to begin, we need to understand how CMS looked to build this model initially. So, as I mentioned on the last slide, we're looking at clinical portions of the minimal data set (with very) early in this day as determiners for our reimbursement.

So, how did CMS figure that out? As Sarah mentioned, there's been a significant amount of stakeholder engagement from ASHA and other professional

organizations in helping to mold what this model looks like. And when CMS was looking to build the model, they looked towards a group known as Acumen.

And what's important to know about Acumen is that they are a group of very intelligent statisticians. And so when they were looking to build an improved model that removes the metrics associated with the volume or the minutes of therapy, they looked to historical claims to determine how we as an industry have provided care, and then map the new system to those clinical categories.

So, it's important to know when you look at this model and say, Renee and Sarah, why is speech tied to these areas. It's because that's how we provided care in the past and that the areas that CMS was able to map speech clinical to based on historical claims data, which takes us to the next point.

This model is moving our reimbursement from the minute into patient characteristics, but what's very important for all of you to understand is that we have to have those patient characteristics documented appropriately. And we really are at a point in the industry where we have to move towards that greater level of inner professionalism in communication across the care teams.

Next point is that the minutes are removed. So, CMS is removing the minute as a determiner for your reimbursement, moving from RUGS to PDPM. However, when we look at the areas that CMS has stated they're going to audit moving into PDPM, they are going to continue to collect the volume of minutes within section or with the MDS.

The reason for that is that moving into a new reimbursement model, they're going to track provider behavior. So, if there is a sense that someone needs a specific level of care in September of this year, then there's an expectation on the end of CMS that they would need similar volume of care leading into October.

So, this is important for you to understand that the minutes are no longer a metric, but CMS is going to be tracking provider trends tied to minutes leading into the new model. There's also this aim to reduce administrative burden under PDPM. This is mostly tied to your MDS coordinators.

So, as you know, under the current RUG system, we've got this multitude of assessment windows, five-day, 14-day, 30-day, 60-day, 90-day assessment periods in addition to this seven-day rolling change of therapy window. Under the new

payment model, we are not going to have that level of assessment period. We're essentially going to have the initial patient assessment that's completed and a discharge assessment with some additional flexibility if we have significant change in clinical presentation.

However, you're not going to have this continual rolling assessment window that the MDS coordinators responsible in conjunction with the rehab team and monitoring. With that said, its reduced number of assessments but increase need for clinical accuracy very early in the stay leading into PDPM to ensure that you're capturing the case mix that's truly reflective of your individual patient presentation.

And then the last piece, we do have a reduced complexity. So, for those of you that have been following this model for some time, as Sarah mentioned, there's been a call for Med Pack to change the system. CMS consulted with Acumen in the first iteration of what we saw on the payment model was through RCS-1, and that was through an advance notice of proposed rulemaking, which is a unique ruling type that we don't typically see.

But what the AMPRN allowed the industry to do was to have kind of an adjustment period. So, it allowed a period of time – we actually had an extended comment window after RCS-1 was published for the industry to digest to understand and then give further comment back to the folks at CMS. And when we look at how the model was changed, we do see a reduced level of overall complexity moving from RCS-1 into PDPM.

Next, let's go into what is not changing? So, a lot of conversation and buzz, and I'm hoping some people are getting what we're talking about here today, which are the true facts. It's important for us care providers to demonstrate skill in what we're providing, but it's also important for us to understand the regulations tied to accessing that skill benefit after an individual leave the hospital stay.

And at the root of this model, that definition is not changing. So, as we mentioned in the beginning, a lot of the changes that we're seeing in the industry or crawl set post acute care spectrum. And depending on where you're practicing as far as locality or region or even part of the country, you may be one piece of that post acute care spectrum.

And when we say post acute, we're referring to your skilled nursing facilities, your inpatient rehab, your long term care hospitals and your home health agencies. So,

you might be one piece of that puzzle or you may be in a unique setting where you have the opportunity to touch patients multiple times across the spectrum.

And the changes as a result of PDPM are going to impact that post acute care skilled nursing facility piece. And as I mentioned, at the root of that, there's a foundational definition that is not changing. So, for an individual to come to you now and access that post acute care benefit in a skilled nursing facility, they have to meet these four coverage criteria that is not changing in October.

So, let's just read through these. I don't like to take it upon myself to edit or modify regulation. So, this is a slide that we really just need to kind of go through the meat and the substance. So, for an individual to access build care, they must need skilled nursing or skilled rehab services provided under the supervision of the professional, ordered by a physician and it also has to be rendered for the condition for which the patient received inpatient services.

That refers back to the hospital stay. So, for an individual that comes to you now or an individual that comes to you in October, we have to be providing a level of skilled care that's associated with that inpatient hospital stay or for condition that arises once the individual reaches the skilled nursing facility.

Secondly, and this is what makes – those of you that provide care in the skilled nursing facility, you understand the second need. So, there's a reason that folks that come to skilled nursing don't go immediately to home health. There's a reason they don't go immediately to outpatient services and it's typically because there's a level of clinical complexity, right. These aren't individuals that have these very clear cut diagnostic categories, but also they often have a number of comorbidities.

And you all have seen this. You have someone that comes to you, they're accessing that post acute care benefit, they've got one primary diagnosis and one is secondary, and that often causes them to require skilled care needs on a daily basis. So, these are folks that need to be in an inpatient for daily and skilled care.

Additionally, we have to be able to provide and document and show that services are reasonable and necessary tied to the illness or injury. And if you dig further into the Medicare benefit regulations, the reasonable and necessary care is tied to a multitude of areas. First and foremost, evidence-based practice, and this isn't really within the scope of today's session, but for those of you that have not taken the

opportunity to access ASHA's practice portal, a wealth of information there if you're looking for specific diagnostic category and what the evidence is.

So, I highly encourage you to use that platform. So, there has to be an evidence-based practice, we have to be able to show that our discipline and only our discipline and for us here today at speech can provide that level of care for it to be skilled, reasonable and necessary, and it has to be inappropriate frequency and duration of care.

So, moving onward, let's talk about what will not change. There are other quality initiatives that are in place. So, as Sarah mentioned at the beginning, changes across the spectrum, volume to value. Additionally, we see kind of all of these lanes of quality initiatives from CMS merging really beautifully together. And much of this is associated with the IMPACT Act of 2014.

And I remember being on the first CMS open door forums when they were talking about IMPACT and saying, this is not a sprint, this is a marathon. And it really has been a sprint, there been a lot of changes in a short period of time towards the SNF industry. But we're now seeing everything come together. We're in a really good place.

So, other quality initiatives that are not changing include the new survey process. So, for those of you that have had the opportunity to be engaged in a state survey in your skilled nursing facility since November 28, 2017, you've noticed some differences. And what's unique about the differences is that they look very similar to the structure that we see associated in MDS for PDPM. So, stick with me for a second if you've not been part or engaged in that process.

As far as part of the new state survey process, surveyors are using these critical element pathways to assess care and what's interesting about the pathways is that they start with looking at MDS data. And to take this to a more granular level, there are pathways associated with communication. There are pathways associated with dementia. There area pathways associated with the dining environment.

And surveyors are first guided to look at the minimal data set and see what we have documented there. Then they complete individual patient interviews and caregiver interviews. And what was so positive to see about these new survey pathways was that they have specific questions now that are tied to the rehab provider. We didn't have that before.

Historically, survey has been consistent – standard process, but we haven't always been engaged on the therapy end. So, now we have these very specific questions that are tied to the rehab provider so that we're further engaged in that care process. So, exciting, but also another piece of regulation that it's really nice to be aware of and prepare for if they come into your community.

Additional measures that are not changing that are tied to quality, the short and long stay quality measures, the quality reporting program, the value-based purchasing aspect, which is associated with us ensuring that the individuals that we care for do not end up back in the hospital after leaving our care.

And then finally, the five star rating system. So, all of these additional quality elements on top of this new reimbursement model that's aimed to be tied to value are all going to be in place in the future.

So, let's now – we've had a lot of high level conversation, to bring all of this back down to Earth, let's now move into what each of the individual reimbursement buckets or payment areas will look like under PDPM. So, as we mentioned, the volume and the minutes are gone and we now have these very specific payment areas that are tied to each of these clinical categories.

So, you see physical therapy, occupational therapy, speech language pathology, nursing, non-therapy ancillary and non-case mix, which is essentially associated with room and board. And all of these areas are derived from the MDS.

So, physical and occupational therapy are calculated exactly the same way. There is a bit of a slight differential in the overall case mix reimbursement from PT versus OT, but as far as how they're factored, they're factored in exactly the same way.

And they're looking at some key elements associated with clinical category. So, the clinical category associated with again, let's go back to that foundational definition, the reason that the individual was receiving cares an inpatient or condition that arises once they reach this nest. And then they're also looking at associated elements within Section GG of the MDS.

So, Section GG was added into the MDS in October of 2016 and it has areas associated with self-care and mobility. And it's also tied to QRP. So, from a

physical and occupational therapy standpoint, these are areas that hopefully, we've been coding really nicely as a team since they were initiated back in 2016.

Now, if we think big picture again, it's important to know that GG is also tied to the quality reporting program and it's also now embedded to the spectrum of care in the Oasis and the (inaudible) (pie). So, we see all of these measures becoming more consistent across the spectrum. And after all of this is calculated, we essentially land on 16 total case mix areas for (our PT and OT).

Let's get into speech. What I will say about speech and I have to speak to the advocacy of ASHA to get this as specific as possible when looking at historical claims. When they initially looked at speech claim data, there was a little bit of difficulty drilling down to the level of specificity on that initial diagnosis category associated with the acute care stay.

So, what CMS and Acumen, the group of statisticians, were able to determine is that around 5 percent of the time, speech pathology is treating for an acute neurologic condition. The other 95 percent was a little bit up in the air.

A few reasons for this, some of it tied to the codes and like the specificity and we were all there at that time under ICD-9. So, CMS did something very unique for the speech bucket or case next level. And that's just a tie speech related comorbidities into our case mix. That's not something that we see associated with the other therapy disciplines.

So, something that I want to make sure that you have an understanding of what those look like because they also have to be coded accurately within Section I, which is the active diagnosis page of the minimal data set. So, there are 12 total and so (peak case mix areas), they are tied to that first area that CMS was very clearly able to map our care to, which is an acute neurologic condition.

We also have this unique element tied to speech comorbidities, and then they're also looking at presence or absence of a cognitive impairment and the mechanically altered diet or swallowing disorder. So, the cognitive impairment we've also come a really long way with. When this was initially modeled, they were looking at one portion of Section B of the MDS, which was tied to spoken language understanding. We were able to broaden that definition significantly.

So, the cognitive impairment element is tied to two different data points within Section C as the MDS or – yes, Section C of the MDS tied to the bands and also tied to the staff interview. And the hope with that is that we're capturing a broader spectrum of cognitive impairment with the inclusion of the bands for interviewable patients, and the staff interview for non-interviewable patient.

I also want to make a point on the language that I'm using today. You're going to hear me say patient, you're going to hear me say beneficiary, but in addition to all of these changes across the industry, we do see this overall shift to more person-centered care. And at this point, a lot of the Medicare main rules and language are still using patient beneficiary, but it may be important dependent on the community where you're treating when you take this back that you kind of shift your language to more of the person, individual person.

The nursing is the next level. There are 25 total case mix areas for nursing. This has been a big advocacy piece for our nursing counterparts and that they now have a very distinct reimbursement level. And historically, the nursing levels were impacted by the volume of therapy in addition to this ADL in split which was tied to Section C or Section G of the MDS.

So, nurses now have their own distinct category. It's tied to clinical condition. It's tied to depression. It's tied to the number of restorative services and then similar to PT/OT, it's tied to portions of Section GG. Now, there are three portions of Section GG that are tied to PT/OT and not to nursing, and I want to mention these to all of you because there's one that you may be asked for feedback on.

So, there's a self-care item set that's associated with Section GG that's tied to oral hygiene. And it's a factor in the volume of the functional status measure for PT and OT, not immediately per se part of the definition for speech, but just want to make sure that you have that tidbit of information. Additionally, the mobility items set associated with walking are factored into PT/OT but not to nursing.

A couple other similarities between speech and nursing when they look back into (inaudible) that was that both of our disciplines typically provide consistent care from the start to the end of this day. For that reason, the reimbursement that's determined by the clinical documentation during that initial assessment is consistent from the start of the stay to the end of the stay. Now, that is not true for PT/OT.

So, as we mentioned at the beginning, there is a level of regression associated with PT/OT. And the reason for that is that when CMS looked at historical claims data, PT and OT typically treated more intensely at the beginning of the stay and then tapered off to the end. So, after day 20 of the stay, there is a 2 percent reduction every seven days in PT and OT reimbursement.

If you look at current claims data, I think around 24 days is the average length of stay in post acute care SNF. They've essentially allotted close to 100 percent of that benefit for those two disciplines based on what the current average length of stay is across the industry.

The next reimbursement level is known as non-therapy ancillary, but it's not really tied to therapy per se. NTA is a reimbursement area that's tied to the clinical complexity of the individual patient and this is something that the industry has been calling for for some time. There are those of you that certain communities that have long open their arms to the medically complex.

However, there's not been a definitive additional or supplemental reimbursement level to account for that. So, the NTA now allows that opportunity. Again, if the diagnosis are coded appropriately at the beginning of the stay, and this is factored in with a multiplier of three at the beginning of the stay.

So, the first three days are actually multiplied times three from a case perspective, and the reason for that is the medically complex patients take a greater level of care at the beginning of the stay. Additionally, their medications cost more. So, this is an added benefit for the communities that you're serving when they take in those medically complex patients to have that little boost for associated care and for (meds).

And then the final piece is associated with non-case mix or room and board. So, as we move into the next portion, which is a visual of what the speech pathology case mix area will look like, it's essentially built on the volume or the number of (appearance) and that's important for you to understand because it's different from PT and OT.

And typically, we're functioning in the same rehab department as our PT and OT counterparts. So, PT and OT are based on the level of impairment. So, Section GG and a scale from zero to four and the severity of the functional status impairment. Speech is different. Speech is built based on the number of impairments, and it's

not just the number of impairments, but it's also us having the number of impairment coded appropriately and working at a full and a professional level with our MDS coordinators early in the stay to ensure that we are capturing those elements.

So, presence or absence of acute neurological condition – where does that come from? Going to come from Section I of the MDS. And so, a few related comorbidities, largely coming from Sections I and O of the MDS, cognitive based impairment will largely come from or will wholly come from Section C of your MDS and that mechanically altered diet or swallowing disorder is coming from Section K of your MDS.

So, the swallowing disorder is coming from K0100 and the mechanically altered diet is documented in K0150 and that equates to 12 total case mix groups from a speech pathology perspective.

Now, when we talk about where we're falling in regards to historical claims data across the nation, we have around 44 percent of speech pathology cases not triggering any of these areas and I'm – there's a number of reasons for that and I don't think that we can give a broad spectrum answer on why these elements are not transferred over into the MDS, but what that does help us to understand is we have a lot of work to do between now and October to ensure that we are fully integrated in the Care Team encoding to the highest level of specificity.

So, if you're in a Skilled Nursing Facility where you're not engaged in 48-hour care plan or you're not engaged in the PPS meeting, now is really the time to make sure that you have that voice and that if you're seeing a swallowing disorder, if you're altering a diet (at bait) to start of care that that is getting communicated to the appropriate individuals so that you have the opportunity to get those coding elements added on to the MDS and so that you're able to capture the appropriate case mix that is going to be faster for the entirety of the stay.

The next slide just shows us some general rates of what the per diem is going to be per discipline. Now, this does not mean that speech pathology is going to obtain 22 dollars a day. So, this is the unadjusted case mix rate and the speech pathology case mix go from around 0.68 to 4.19 dependent on again that (you use the week) code so that will be multiplied times that 22 dollars a day.

So, the range goes from around 15 dollars a day dependent on your regional locality all the way up to upwards at 100 dollars a day, again based on your regional locality and what you have factored into your MDS.

The next portion that I want to go into type all of these areas of the MDS is the quality initiative and this is just a good slide to use if you're in an area where you're not fully engaged in that MDS process and you want to have a greater voice, this is a nice visual to share.

Section B is hearing speech vision. Section C is cognitive pattern. Section K is swallowing and nutritional status. Section O was where we're going to be collecting group and concurrence areas in addition to the volume of (sodas) that we provide.

If you're not engaged, this is a really nice kind of visual to share with either your therapy program managers, your rehab director, your administrator to say we really can help support you (under the full) and a professional level by having a further level of engagement.

One more point here before we get in to some of the complexities is that on a positive note, we do see a lot of our EMR vendors looking to embed the speech specific portions into our clinical documentation.

So, we've seen GG embedded for PT/OT since really 2016 when that regulation came out timed in to QRP, but what we now see is the vendors are looking to also embed Section (C then) Section K, swallowing and new nutritional status in addition to those medical complexities within to our EMRs so that if you are in an area where you have integration between your therapy documentation system and the MDS software, we can have more than electronic communication and ensuring that we're getting all of the data from all of the appropriate and applicable team members in order to support that clinical category.

Now, the next few slides are just to give you a basis on what we are talking about when we mention the fact that speech pathology has this unique element of their reimbursement tied to comorbidity.

And again, when you look at why we had certain codes from ICD-10 sequence tied to that speech comorbidity, you have to remember that CMS is embedding elements

that they (get the worse and sign) that we trended and there is an appropriate link based on historical claims data.

So, we do have some of the residual impairments from prior strokes and apraxia, dysphagia, laryngeal cancer, oral cancers and then we also had some elements tied to some of the Section I, speech and language deficits on this final slide here so that you have an understanding of what specific complexities and comorbidities are tied to reimbursement.

Now, is this a final, final list is I know what a lot of people are going to be asking because Sarah and I have done some trainings for some of the (sigs) and other groups that's typically a question we get.

I think some of the ICD-10 is fluid and they're still looking to do some mapping and if you are as into this as we are and spend a lot of time on the PDPM web page for CMS, you'll see that they are now making notation beside of the ICD-10 update files on even when they update those.

So, they are still appearing to be a bit fluid in nature and CMS is continuing to filter out some of those return to provider codes and fine-tune the accuracy on their end as well. So, I would say more to come on the ICD-10 and something that we need to make sure that we're staying on top of.

Additionally, I'm hoping some of you were thinking about how these codes land on the claim because in order for it to be counted as a complexity, it has to land on the claim and if you're in a community where there is not an effective system in place for identifying additional diagnoses, obtaining physician approval and then getting that on to the minimal data set.

Now is the time to have that conversation so that you get a nice system in place leading into October and people are trying to develop a system in Q8 at the last minute.

The next area that we wanted to show for reference simply gives you a crosswalk for the Cognitive Impairment Scale. As I mentioned, we've come a long way here.

We initially started with spoken language understanding and (we know that) how much bigger than that. So, I applaud the fact that we were able to get to this point where we have in the BIMS is still within the MDS and that is screening by nature.

So, what I want us as SLPs to remember is that we have a unique skill set in evaluating cognitive and language impairment so this is really a surface level screen and it is still need to be within our due diligence to do further in-depth testing to determine the root cause of the impairments, to determine if there is an evidence base for treating the impairment and then to develop that individualized treatment plan.

But from a scale perspective, this is the scale that would indicate a cognitive impairment. So, essentially if someone scores below a 13 on the brief interview of mental status, they are noted to be cognitively impaired and then you see the similar scale on the other end from a staff assessment, which is the second portion of the BIMS if someone is noted to be non-interviewable in nature.

So, to bring all of this together and show you what the case mix looks like, you'll see the scale here and essentially as I mentioned, speech pathology build on number of impairments versus volume of impairment so you're going to be looking at if they're none, one, two or three for the first column then for the swallowing disorder, mechanically altered diet, they're going to be looking at neither, either, both and then that brings you to the SLP case mix range between SA being the lowest and FL being the highest as associated with the greatest number of impairments.

Now, this SA area is the area where if we look at national data and I know that's a very gross big picture view, but 44 percent of the nation is falling into that category and so that should be an opener to us.

There may be instances where it should be none, neither, OK. No one has the acute neurologic condition or comorbidity or cognitive impairment and from a swallowing perspective, they're not triggering either and when appropriate, we want to code it that way. However, I do think that at this point and this is often secondary to the fact that the speech areas are a little bit new to being tied to this volume piece.

So, for PT/OT, their GG item sets have been tied to QRP since 2016. So, there's been a bit of a forced level of engagement associated with that piece. For speech, it's time for us to aim to have similar level of engagements for the Section C, Section K, Section I so that leading into October, we capture the appropriate case mix for those who are serving.

The next portion just goes through what the HIPPS code is. So, right now, you have a RUG leading into October, you will have a HIPPS and there's a HIPPS captured for every area of case mix. So, there's a PT and OT HIPPS. There is a speech HIPPS, a non-therapy ancillary HIPPS, a nursing HIPPS and then there's a final portion of the code that's tied to the assessment type.

We're going to move now into more of a case study to try to bring all of this down to Earth and also go through some of the modes of treatment areas. So, when we go through and Sarah you can go back, I'll highlight the modes of treatment again. OK.

So, as we mentioned before, there are limits on the modes of treatment group and concurrence of no more than 25 percent combined, where is this going to be tracked? It's going to be tracked within Section O of the MDS and CMS is going to use this at the end of the stay.

Now, you may be asking what happens if we provided a group and remember that there is now in the proposed rule, the group would be two to six individuals and would (mirror) (the Earth definition). What happens if we have someone that leaves early in the stay and we're passed that 25-percent limit?

CMS has said as of now that there is a non-fatal warning. Remember they are going to be auditing this. So, this is an audit area where they're going to look at significant shift in utilization for group and concurrent and the max is 25.

The national data for where we are now is less than one percent. So, it is a good idea at a minimum to have an idea of where you're trending as far as your communities providing care so that you can have an understanding of what significant shifts would truly entail.

The next portion is just going to give you a screenshot of what those pages look like in Section O so this will be further updates to the MDS to allow CMS to track the data and then some questions on what do we do if someone enters and exits our facility in a specific timeframe.

So, there is going to be a new interrupted stay policy that we'll talk about on the next slide and this will impact individuals dependent on where they go after they're admitted to an acute care stay.

So, if an individual discharges and returns to the same Skilled Nursing Facility by 12 o'clock on the third day of their interrupted window, the stay will be continued of the previous stay. So, essentially what that means is that they will fall into the same case mix as they were in prior.

However, if the absence exceed that three-day window or if the individual for whatever reason is readmitted to a different Skilled Nursing Facility, they will be receiving a new admission assessment so they may fall into similar or same case mix depending on clinical presentation, but there would be the option for them to fall into a different reimbursement area so that is something to be aware of, more than FYI for individuals if they leave your community and either come back or return to a different setting.

The next portion again is just more of an FYI on some of the regulatory language as far as administrative presumptions (on the) classifiers and these are tied to those HIPPS code. So, as I mentioned before, currently we have a RUG. You're going to be moving into a HIPPS and it's going to be determined based on the classifiers from your MDS coding.

We also have a visual on the next slide of this simplified MDS system so you have an idea of how that's going to impact your communities, but this is also a really nice visual to share what or why it's so important to have that MDS accuracy very early in the stay. So, we have essentially right now got this contained. You were rolling window. We're going to have some changes and it's so important for us to have that level of engagement as a result early in the stay.

Another assessment is going to be an option because as I mentioned, we got this limited assessment, but there was a call from the industry for what do we do if someone has significant change in status or significant medical event, but they don't go back out to the acute care hospital and what I'll say about this assessment is that I think it's going to be pretty rare that this is used and the reason is if you look at the clinical categories, they're pretty big picture.

So, you got acute neuro, you got other orthopedic, you have an elective joint, you have sinusurgery so this very specific broad spectrum of diagnostic categories that if you have the one that shift from a neuro to elective joint that's pretty significant.

But let's say that you have somebody that has one of the medical management categories, they may move from a COPD to an acute neuro and you need the

opportunity to change the assessment, we do have this opportunity via something known as an IPA or an Interim Payment Assessment. It is optional in nature, but it does allow the opportunity if need be to do a reassessment based on significant changes in function.

Now, with all of what we've learned thus far how CMS want to monitor and right now, we do see a level of auditing and monitoring from a CMS perspective based on volume.

So, if you look at what's included in the type of reports, if you look at how CMS is focusing their targeted probes in education or their TPEs, it typically begins with volume of service tied to your locality or region and though we know that CMS is going to continue to look at volume in Section O moving into PDPM, they're also adding a lot of really unique clinical element into their auditing and monitoring.

So, I want you all to think about your engagement in MDS coding. I also want you to think about your skill set and your specialty as a speech pathologist. So, there are a couple of areas that CMS is going to auditor specific to the speech case mix and those include any increased use in mechanically altered diet that suggest the beneficiaries are being prescribed such a diet based on financial considerations rather than clinical need.

They're also going to be looking at overutilization of a cognitive impairment as a patient classifier for speech pathology. They're going to be looking at significant changes in stroke and trauma, use of that interrupted stay policy, compliant with group and concurrent therapy, significant shifts in volume from PDPM from RUG to PDPM and overall coding.

So, while we want to be very engaged early in the stay in MDS accuracy and ensuring that we're part of that team, we also need to make sure that we continue to uphold our documentation standards to support our skilled needs.

So, for example let's say that you're in a community where social services or nursing (is being completing the) (inaudible) and for that reason, they're not picking up on the spectrum of a cognitive impairment that you may as an SLP and you go in and start supporting that coding and for an appropriate reason, there's a shift in the number of individuals with the cognitive impairment in your community.

We need to make sure that that's also supported by our clinical documentation. So, the MDS is one piece, the screening by nature, but if you as an SLP choose to provide your skilled level of care or treatment to an individual, you need to make sure that your documentation is supporting true eval, hands on assessment, evidence-based practice, et cetera, et cetera, which brings me to one more point and then we'll get into more of a case study.

Just because someone triggers speech areas, it doesn't always apply to speech need and vice versa and that's a point I want to make because we've gotten to the end of some of these presentations and that's not always been clear.

So, each of the case mix areas will be captured, but it's still up to you as it is up to the PT and OT to determine if there's a skilled therapy need. So, you still have that decision-making regardless of what's triggered on the MDS, (at least) you may have someone that the need is not associated with the most recent hospital stay or a need that's chronic in nature.

So, just keep that at the forefront of your mind that first and foremost, let's support the team, get the coding right, but you also need to ensure that your clinical documentation support your unique need.

So, the next slide just kind of sums up, when we are engaged in the MDS, these are the areas that from a therapy perspective, we can help be part of the team, but let's bring this all down to a true patient example.

So, let's say we have Mr. Brown, Mr. Brown was admitted following an acute onset of a CVA. He has a swallowing disorder. He is receiving a mechanically altered diet in addition to external nutrition at a low intensity. He has an aphasia. He has a mild cognitive impairment. He also has active COPD with shortness of breath when lying flat.

He requires partial/moderate assistance with eating, oral hygiene, sit to lying and lying to sit. He requires substantial max assistance with toileting, transfers, walking 50 feet with (two turns). He is unable to walk 150 feet and he is depressed.

So, what triggers for speech? We have this color coded for you on the next slide in pink for the speech pathology areas, but I also want to highlight for you the other areas so that you are aware that impacts the other disciplines.

So, speech is going to be impacted of course by that CVA, swallowing disorder, mechanically altered diet, the comorbidity. From that NTA perspective, just to give you an idea of what's capture from the medical complexity component, that would capture the COPD in addition to the external nutrition.

And I want to mention that because the external nutrition may be tied to a dysphagia, it may be tied to something nutritional, but the external nutrition piece from a reimbursement perspective is captured in that NTA.

The other ADL, self-care, mobility areas that you see in regards to eating, oral hygiene, et cetera or factored into the PT, OT and nursing, outside of that oral hygiene, which is only tied to PT, OT and the (two gate) areas.

So, in Mr. Brown's case, he is going to be essentially capturing all of the case mix components. So, he has an acute neuro. The second piece, he has the comorbidity. He has dysphagia, mild cognitive impairment in addition to the swallowing components.

We're going to move now turnover controls back to Sarah to go through some myths and facts.

Sarah Warren: Thank you Renee. So, I think – again I just would like to reinforce the tremendous value that Renee brought to this process and ensuring that in everything as she did on behalf of our SLP members working in SNF that we did the best we could to make a payment system, the transition to this new payment system reflective of what you guys do and associate some value with that and I think this is going to tie this (in a bow on this – tie bow) on this before I move in to the myth and facts.

I think the key thing is our clinical judgment and what triggered a skilled stay, which I think are two of the most critical elements of this transition are not changing and we need to continue to reinforce our role or introduce our role depending on the community that we're practicing in to reinforce our role as identifying appropriate patients, delivering value, identifying the quality metrics.

And I think we do – with all the things that we talked about that are not changing, I think that the paradigm shift of moving therapists from counting minutes to really bringing that value proposition home is going to be an important one to move toward.

So, I really hope that now that you hopefully have a (inaudible) understanding of how the payment system is changing when that right switch (flips) October 1st that you'll find that the second piece of this webinar that we're doing, which will really dive into the sections of the MDS, the sections of the quality reporting program will help you have those conversations to transition to this paradigm of value.

So, given that and given the tremendous amount of change that we're seeing, we are hearing a lot from our SLP members about what is actually going to happen. They're hearing a lot of rumors and either from their coworkers, from their administrators, from various social media venues that they're using to try to understand the change and we want to kind of try to (dispose) some of those myths.

So, a first one is Medicare is requiring us to evaluate every patient that walks through the door and this is a myth. Often a brief assessment or screening can help you determine if a full evaluation is warranted and to go back to the point that Renee and I have tried to hammer home throughout the course of this presentation, your clinical judgment as the SLP and the needs of the patient remained paramount on the decision-making process.

We also hear and we heard in the RUG-IV and we're continuing to hear that this might be a challenge (that focuses) under PDPM that Medicare is requiring us to evaluate and treat every patient that walks through the door so not only do you have to do an evaluation.

But we're hearing that you have to provide at least one treatment and our SLP members who call us are often under the impression from a conversation they've had with their rehab manager, their administrator or someone in a position of authority is that Medicare is requiring this and Medicare is not requiring you to do an evaluation and treatment of every single patient. That should be based on again their clinical judgment and the needs of the patient.

As Renee mentioned, one of the elements of the PDPM is this restriction at 25-percent group and concurrent combined per therapy discipline per patient and right now, under RUG-IV or/and given under PDPM, the group has set it for; however, there is a proposed change as Renee has talked about a couple of times to move that to two to six patients.

So, regardless of the size of the group whether it ends up remaining at four or transitioning to (the earth definition) of two to six patients, what does this limitation

of 25-percent limitation truly mean and group and concurrent always or individual treatment whatever the mode of treatment is always needs to be based on the individual needs of the patient and the clinical judgment of the therapist.

And so if you are being informed that you have to do a certain percentage of group, 10-percent group, 15-percent group, whatever that magic number is for every single patient that is not based on Medicare payment policy and it could be problematic because if all the patients are getting 10-percent or 15-percent group, you're not individualized in the plan of care and that could be problematic.

We're also hearing a lot of concerns around who can deliver, what types of therapy disciplines can deliver certain types of therapies. So, we're hearing a lot from our members that they're hearing from higher ups within their Skilled Nursing Facility that only occupational therapist can do cognitive treatment.

Medicare only allows occupational therapist to do this or Medicare only allows occupational therapist to provide swallowing treatment and again this is not part of either the current payment system or the transitioning payment system of PDPM.

Medicare is not dictating what forms – what types of therapy could be delivered by what types of therapy disciplines. Each facility needs to be making that determination based on state licensing law so occupational therapist, speech language pathologist, physical therapy should only be delivering services that are within the scope of practice of their – of their state licensing law and Medicare is not making any determinations about that.

And there's also a lot of concern about the future of therapist, but in particular for our membership, speech language pathologist in the Skilled Nursing Facility environment once PDPM goes into effect particularly given that it's not the amount of therapy you're providing, but the patient characteristics that are driving the payment.

And we're hearing that every SLP or a lot of SLPs will be fired from SNF once the PDPM goes into effect and I think that that isn't accurate because if SNFs plan appropriately and therapists work with their administration to re-achieve that interdisciplinary level of coordination that the concern about the layoff of SLPs in this environment will hopefully be addressed and we do really need therapist and the SNF industry together to fundamentally rethink how to effectively use therapists and SLPs in the PDPM environment.

We also hear a lot of concerns from our members about productivity and having to do a lot of work off the clock particularly as it relates to documentation or to treat a lot of patients in a single day and I think there are some perceptions out there perhaps that Medicare has put this productivity requirements into place and productivity has never been a part of the payment system for Medicare.

Productivity standards are established by Skilled Nursing Facilities to manage staff and to maintain profitability and it's not a payment policy. It's not clear at this point how productivity standards will change under PDPM.

I think right now we're looking at minutes of therapy driving payment and the productivity associated with that, what will the impact of mechanically altered diets have on productivity standards, those types of things I think those are on our radar screen to be looking for and monitoring, but what the – we won't really fully understand the productivity issue under PDPM until the payment system goes into effect.

So, then the final myth or fact, the definition of skill, which triggers coverage in a SNF has not changed and as Renee has done such a great job discussing throughout the course of this presentation that this is true, there is no change.

If someone was appropriate for therapy now or a speech language pathology now, they will be appropriate for speech language pathology on October 1st – on or after October 1st. So, we wanted to go ahead and reinforce that as well.

And then we have a couple of these acronyms here for your reference and I just again want to plug the second part of this webinar series that's going to really focus on the specifics about all the advice and guidance that we have alluded to throughout the course of this presentation related to demonstrating your value for QRP and for completion of the MDS and I think Renee and I both would welcome phone calls or e-mails with your specific questions and know too that this is a culmination of nearly two-and-a-half years of work.

It was based on historical data, MDS data and claims data and some of that data was very helpful and there were some areas where additional data would have been helpful to make an advocacy argument for changes, but I wanted to stress to our members that our advocacy on implementation of PDPM or Unified Post-Acute

Care Payment System if that were to come to fruition at some point down the road, those efforts are not stopping.

We continue even now to engage the Medicare Program on these issues, make sure that they are releasing data in a timely fashion. As Renee mentioned the ICD coding related to comorbidities is still a little fluid and we know that we still need to maintain, monitor that and educate our members on that as additional details come forward.

And we have identified some areas that we want to track once the payment system goes into effect in terms of quality and MDS and ICD coding to see if there is changes, to engage the industry and the Medicare Program as often as possible and relative real time rather than waiting for three to five years of claims data.

And so we are still engaged in tweaking this payment system and have a game plan for identifying potential challenges once it goes into effect so that we continue to advocate for appropriate changes to the payment system to make sure that it meets patient needs and to make sure that SLPs working in this environment have the ability and the tools that they need to effectively work in this environment.

So, with that, I just would like to thank everyone for their participation in today's webinar and I don't know if Renee has any concluding remarks.

Renee Kinder: I don't think so. Thank you for having me, and as Sarah mentioned, this is process and development so (a lot of these path) changes and we love hearing from people and giving your thoughts and questions so don't hesitate to reach out and hope that everybody enjoys the series.

Sarah Warren: Great. Thank you.

END