Target areas for feedback on the proposal to replace RUG-IV with PDPM as the basis for SNF Medicare Part A reimbursement.

Listed below are target areas on which CMS is specifically requesting comments or that represent issues where significant changes have been made from the initially published RCS-1 methodology. The hyperlinks below each item provide direct links to the paragraph of the proposed regulation where the dsicussion of the issue begins.

1. ***BASIS FOR ASSIGNING CLINICAL CATEGORIES*** The first step in determining the OT & PT reimbursement under PDPM is to categorize the resident into a clinical category. CMS proposes to categorize a resident into a clinical category using item I8000 of the MDS which reports the ICD-10-CM code representing the primary reason for the resident's SNF stay. Additionally, residents who received a surgical procedure during their hospital stay would have an ICD-10-PCS code entered into the second line of item I8000 to ensure the appropriate clinical category.

   Please note that while CMS is proposing the above clinical categorization method, they are also considering an alternative approach that would use a resident's primary diagnosis shown on item I0020 as the basis for assigning a clinical category. This would require SNFs to select a primary diagnosis from a pre-populated list of most common SNF diagnoses, as opposed to relying on entered ICD-10 codes. CMS is specifically seeking feedback on the proposed and alternative modes of clinical classification.

   https://www.federalregister.gov/d/2018-09015/p-229

2. ***SELECTION OF SECTION GG ADL ITEMS*** Reimbursement for the PT, OT and nursing components are partly determined by ADL scores on selected ADL items. Unlike the previousl RCS-1 proposal the ADL scores are based on selected items from section GG of the MDS. Are there any concerns/comments on the appropriateness of the selected items? Any comments or concerns on the scoring?

   https://www.federalregister.gov/d/2018-09015/p-232 (ADLs in OT/PT components)

   https://www.federalregister.gov/d/2018-09015/p-262 (ADLs in nursing component)

3. ***CONSOLIDATED NURSING CATEGORIES*** PDPM would collapse the existing 46 nursing RUGs into 25 categories. Does the consolidation look appropriate? Does CMS' attempt to reduce the number of categories maintain enough granularity for the weights to reflect the costs of the prior 46 RUGs? CMS observed that: "*nursing resource use does not vary markedly between nursing case-mix groups defined by contiguous ADL score bins (for example, 11-14 and 15-16) but otherwise sharing the same clinical traits. This suggests that collapsing contiguous ADL score bins for RUGs that are otherwise defined by the same set of clinical traits is unlikely to notably*

affect payment accuracy." Does this seem appropriate? Do the relative CMI weights appear OK? Other concerns or comments?

https://www.federalregister.gov/d/2018-09015/p-261 (consolidation of 46 into 25 RUGs)

Table bellow for nursing CMI weights:

RUG-IV nursing RUG	Extensive services	Clinical conditions	Dpressn	Number of restorative nursing services	GG-based function score	PDPM nursing case-mix group	Nursing case-mix index
ES3	Trach & Vent				0-14	ES3	4.04
ES2	Trach or Vent				0-14	ES2	3.06
ES1	Infection				0-14	ES1	2.91
HE2/HD2		Serious medical conditions e.g. comatose, septicemia, respiratory therapy	Yes		0-5	HDE2	2.39
HE1/HD1			No		0-5	HDE1	1.99
HC2/HB2			Yes		6-14	HBC2	2.23
HC1/HB1			No		6-14	HBC1	1.85
LE2/LD2		Serious medical conditions e.g. radiation therapy or dialysis	Yes		0-5	LDE2	2.07
LE1/LD1			No		0-5	LDE1	1.72
LC2/LB2			Yes		6-14	LBC2	1.71
LC1/LB1			No		6-14	LBC1	1.43
CE2/CD2		Conditions requiring complex medical care e.g. pneumonia, surgical wounds, burns	Yes		0-5	CDE2	1.86
CE1/CD1			No		0-5	CDE1	1.62
CC2/CB2			Yes		6-14	CBC2	1.54
CA2			Yes		15-16	CA2	1.08
CC1/CB1			No		6-14	CBC1	1.34
CA1			No		15-16	CA1	0.94
BB2/BA2		Behavioral or cognitive symptoms		2 or more	11-16	BAB2	1.04
BB1/BA1				0-1	11-16	BAB1	0.99
PE2/PD2		Assistance with daily living and general supervision		2 or more	0-5	PDE2	1.57
PE1/PD1				0-1	0-5	PDE1	1.47
PC2/PB2				2 or more	6-14	PBC2	1.21
PA2				2 or more	15-16	PA2	0.7
PC1/PB1				0-1	6-14	PBC1	1.13
PA1				0-1	15-16	PA1	0.66

4. ***NON-THERAPY ANCILLARIES EXCLUDED/INCLUDED*** PDPM lists 50 conditions/extensive services with associated points that would drive the Non-Therapy Ancillary (NTA) component (listed below). CMS excluded several for fear of establishing perverse incentives or because of

reporting reliability concerns. Are there services that should be on the list that are not? Are there services listed that may be problematic? Are the point scores reasonable? Any other comments or concerns?

https://www.federalregister.gov/d/2018-09015/p-279

Condition/extensive service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Active Diagnoses: Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis—Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	MDS Item I2900	2
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	MDS Item M1040B	1
Narcolepsy and Cataplexy	MDS Item I8000	1
Cystic Fibrosis	MDS Item I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	MDS Item O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	MDS Item I1700	1
Special Treatments/Programs: Isolation Post-admit Code	MDS Item O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	MDS Item I8000	1
Morbid Obesity	MDS Item I8000	1
Special Treatments/Programs: Radiation Post-admit Code	MDS Item O0100B2	1
Highest Stage of Unhealed Pressure Ulcer—Stage 4	MDS Item M0300X1	1
Psoriatic Arthropathy and Systemic Sclerosis	MDS Item I8000	1
Chronic Pancreatitis	MDS Item I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	MDS Item M1040A, M1040B, M1040C	1

Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I8000	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy—Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Active Diagnoses: Malnutrition Code	MDS Item I5600	1
Disorders of Immunity—Except: RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

5. ***FEWER ASSESSMENT, NEW ITEMS, IPA*** PDPM would decrease the number of assessments and add an Interim Payment Assessment (IPA) that could be used to update certain key information reported on the 5 day assessment. Absent an IPA, the information reported on the 5-day assessment would be the basis of payment for the resident's entire stay. Are the rules that trigger an IPA assessment appropriate? Are the ARD and lookback timeframes proposed for the IPA sufficient? Are the consequences of failing to meet IPA filing timeframes good? Do you have comments on the items CMS seeks to add to the discharge assessment? Are there concerns regarding the elimination of the other assessments? Is the proposal to eliminate grace days OK?

   https://www.federalregister.gov/d/2018-09015/p-302 (starts here and extends for several paragraphs)

   https://www.federalregister.gov/d/2018-09015/p-318 (new Discharge Assessment items)

6. ***LIMITATION ON CONCURRENT AND GROUP THERAPY*** PDPM would divorce payment from therapy minutes but establish a combined limit of 25 percent for group and concurrent therapy. Are there concerns or comments on the proposed limitation to group and concurrent therapy?

   https://www.federalregister.gov/d/2018-09015/p-332