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## MEMORANDUM

**TO:** RHCF Members

**FROM:** Darius Kirstein, Director of Financial Policy & Analysis

**DATE:** May 15, 2017

**SUBJECT:** **Advanced Notice of SNF PPS Case Mix Revision Proposal**

**ROUTE TO:** Administrator, CFO, Therapy Director, DON

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### Introduction

The Centers for Medicare and Medicaid Services (CMS) is considering a major overhaul to the nursing home Medicare Part A rate setting methodology. Last week CMS published an [Advance Notice of Proposed Rulemaking \(ANPRM\)](#) which lays out a proposal developed by the Payment Model Research (PMR) project to replace the RUG-IV with a new case mix methodology, Resident Classification System, Version 1 (RCS-1). The agency is seeking comments on the model and its implementation which it intends to formally propose along with the Skilled Nursing Facility Prospective Payment System (SNF PPS) Rule for FFY 2019. That proposed rule will be published in the spring of 2018.

The existing Medicare Part A RUG-IV case mix classification system has been criticized for being too heavily oriented towards therapy, for incentivizing therapy volume and for insufficiently recognizing non-therapy costs. In developing an alternative model, CMS is seeking to remove service-based metrics (e.g., therapy minutes) as a primary driver of the rate setting methodology and derive payments from objective resident characteristics that are predictive of therapy and other service needs.

Specifically, instead of a resident being assessed into a RUG-IV category that determines the per-day payment under the current methodology, payment under the RCS-1 model would be the sum of four separate, case-mix adjusted components plus the current non-case-mix-adjusted component. For each component CMS would establish a base rate. Each base rate would be adjusted by the component-specific case mix derived from resident characteristics deemed relevant to that component.

**Figure 1**

PT+OT	SLP	NTA	Nursing	Non-Case-Mix
<ul style="list-style-type: none"> <li>Physical therapy (PT)</li> <li>Occupational therapy (OT)</li> <li>Evaluation for therapy (PT+OT)</li> </ul>	<ul style="list-style-type: none"> <li>Speech-Language Pathology (SLP)</li> <li>Evaluation for therapy (SLP)</li> </ul>	<ul style="list-style-type: none"> <li>Non-Therapy Ancillary (NTA) services</li> </ul>	<ul style="list-style-type: none"> <li>Nursing services</li> <li>Social services</li> </ul>	<ul style="list-style-type: none"> <li>Room and board</li> <li>Administrative costs</li> <li>Capital-related costs</li> </ul>

The five components, also shown in Figure 1 above, are:

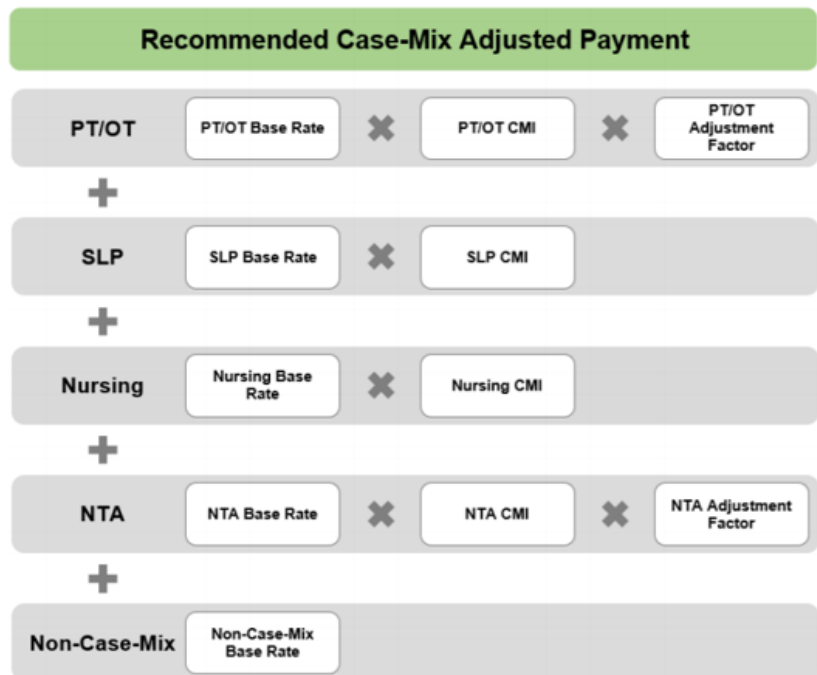
- A PT/OT base rate adjusted by one of 30 PT/OT case mix weights (based on clinical category, functional score and cognitive impairment) to yield a PT/OT component;
- A Speech/Language Pathology (SLP) base rate adjusted by one of 18 SLP case mix weights (based on the clinical reason for the SNF stay, presence of a swallowing disorder/mechanically altered diet, and SLP-related comorbidity or cognitive impairment) to yield an SLP component;
- A Nursing base rate adjusted by one of 43 nursing case mix weights (i.e., non-rehab RUGs) used in the current methodology (but with updated weights) to yield a nursing component;
- A Non-Therapy Ancillary(NTA) base rate adjusted by one of six NTA case mix weights (based on specific conditions and need for extensive services) to yield an NTA component;
- A non-case-mix component that would remain as it currently is in the new methodology.

The rate would be the sum of these five components subject to two additional adjustments. The RCS-1 model would incorporate an adjustment to the PT/OT and NTA components to reflect CMS findings that costs for these two components are higher at the beginning of a Part A stay and decrease as the stay progresses. This is discussed in greater detail later in this memo.

Additionally, the resulting rate would be wage-adjusted using the same hospital wage index and the same wage adjustment methodology as is currently used. The existing market basket methodology currently used to update base rates for inflation, including the forecast error and multifactor productivity adjustments, would also be maintained.

Figure 2 provides a visual representation of the proposed RCS-1 methodology.

**Figure 2**



## **Payment Models Research (PMR) Discussions and Materials**

In 2013, CMS contracted with Acumen, LLC, a firm specializing in policy research and analytics, to manage the Skilled Nursing Facility Payment Models Research (SNF PMR) Project. The SNF PMR was comprised of three phases. The first phase reviewed past research studies and policy issues related to SNF PPS therapy payment and examined options for improving or replacing the current system of paying for SNF therapy services.

The second phase expanded the scope of the project beyond therapy to include other aspects of SNF PPS. This phase included four meetings of Technical Expert Panels (TEPs) comprised of industry experts, stakeholders, clinicians as well as the Acumen and CMS research team. It was during this phase that the outlines of the proposed methodology were developed and preliminary impacts were modeled.

In the third phase which is currently underway, Acumen is developing supporting language and documentation as well as a technical report on the RCS-1 methodology, the alternative SNF PPS case-mix classification model under consideration.

The 2014 report on alternative model research as well as presentations and discussion summaries from each of the four Technical Expert Panel discussions are available on the CMS SNF PPS Payment Model Research page [here](#). The 215-page Technical Report released in April of this year that focuses on the RCS-1 model and describes the underlying data analyses is [here](#).

Notably, CMS is interested in implementing a model within the current statutory requirements, meaning that the requisite changes could be made administratively without requiring a change in federal law. Tables and information in this memo, including direct wording, are from the Advance Notice as well as the supporting technical reports.

### **The RCS-1 Model**

Under the RUG-IV case-mix model, residents are first categorized as either a rehabilitation resident or a non-rehabilitation resident, and then categorized further based on additional aspects of the resident's care. Under the RCS-I case-mix model, the primary focus is on categorizing the resident based on the clinical reasons for the resident's SNF stay.

The RCS-1 was developed to be a model of payment which derives almost exclusively from resident characteristics. More specifically, the RCS-I model under consideration separately identifies and adjusts four different case-mix components for the varied needs and characteristics of a resident's care and then combines these together with the non-case-mix component to form the full SNF PPS per diem rate for that resident. Key in the development of the model were the results of a number of regression analyses that allowed researchers to associate variations in costs to specific resident characteristics, and combinations of characteristics, that were consistent and predictive of these costs. Statistical modeling also allowed researchers to assign appropriate case mix weight for each grouping. Each of the four case-mix adjusted components relies on a set of different characteristics to assign the resident to a component-specific case mix group.

In calculating the base rate for each component of the RCS-1 model, CMS used the same data as used in the proposed RUG-IV rates for FFY 2018. The Urban and Rural base rates, by component, for RUG-IV and RCS-1 are shown in Figure 3. Each component is discussed individually below.

**Figure 3: Component Base Rates**

**Urban RUG-IV**

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	\$177.16	\$133.44	\$17.58	\$90.42

**Urban RCS-1**

Rate Component	Nursing	NTA	PT/OT	SLP	Non-Case-Mix
Per Diem Amount	\$100.91	\$76.12	\$126.76	\$24.14	\$90.35

**Rural RUG-IV**

Rate Component	Nursing - Case-Mix	Therapy - Case-Mix	Therapy - Non-Case-mix	Non-Case-Mix
Per Diem Amount	\$169.24	\$153.87	\$18.78	\$92.09

**Rural RCS-1**

Rate Component	Nursing	NTA	PT/OT	SLP	Non-Case-Mix
Per Diem Amount	\$96.40	\$72.72	\$141.47	\$31.06	\$92.02

### ***Component 1: Physical & Occupational Therapy (PT/OT)***

Research indicated that similar resident characteristics drove the need for Physical Therapy (PT) and Occupational Therapy (OT), but they were not the same as those that drove the need for Speech and Language Pathology (SLP). To separate the therapy base rate into two component (i.e., one therapy case mix component into separate OT/PT and SLP components), researchers used the same data sources as were used to calculate original 1998 base payment rates. They calculated the proportion of SLP to be 16 percent of the therapy base rate for urban areas and 18 percent in rural areas.

Once they had calculated the base rates for the components, researchers analyzed predictors of PT/OT costs. They determined that the three most relevant predictors of PT/OT costs per day were the clinical reasons for the SNF stay, the resident's functional status, and the presence of a cognitive impairment.

Researchers found ten clinical categories to be most predictive of resource utilization in SNFs and encompassed the bulk of SNF residents. They collapsed these into five clinical categories which were predictive of PT/OT costs and used them as a first step in assigning a resident into a PT/OT case mix group. The five clinical categories (with their component sub-categories shown in parentheses) are:

- Major Joint Replacement of Spinal Surgery
- Other Orthopedic (includes non-Surgical Orthopedic/Musculoskeletal, Orthopedic Surgery Other Than Major Joint)
- Non-Orthopedic Surgery
- Acute Neurologic
- Medical Management (includes Acute Infections, Cancers, Pulmonary, Cardiovascular & Coagulations)

Because analysis indicated that a resident's functional status was predictive of PT/OT costs, researchers incorporated an Activity of Daily Living (ADL) score as the second characteristic used to assign a resident into a PT/OT case mix group. The RCS-1 model differs from RUG-IV ADL considerations in that does not consider bed mobility, limits scoring to self-performance items and revises the scoring scale as shown in Figure 4.

**Figure 4**

<b>ADL Self-Performance Score</b>	<b>Transfer</b>	<b>Toileting</b>	<b>Eating</b>
<b>Independent</b>	+3	+3	+6
<b>Supervision</b>	+4	+4	+5
<b>Limited Assistance</b>	+6	+6	+4
<b>Extensive Assistance</b>	+5	+5	+3
<b>Total Dependence</b>	+2	+2	+2
<b>Activity Occurred only Once or Twice</b>	+1	+1	+1
<b>Activity did not Occur</b>	+0	+0	+0

Finally, the RCS-1 model would rely on a new cognitive measure, the Cognitive Functional Scale, which combines scores from the Brief Interview for Mental Status (BIMS) and Cognitive Performance Scale (CPS) into a single scale that can be used to compare cognitive function across all residents. This scale, shown below in Figure 5, categorizes a resident into one of four categories and is the third resident characteristic used to determine the resident's PT/OT case mix group.

**Figure 5**

<b>CFS Cognitive Scale</b>	<b>BIMS Score</b>	<b>CPS Score</b>
<b>Cognitively Intact</b>	13-15	-
<b>Mildly Impaired</b>	8-12	0-2
<b>Moderately Impaired</b>	0-7	3-4
<b>Severely Impaired</b>	-	5-6

Once a resident is categorized into an appropriate clinical category, assigned an ADL-based functional score, and characterized as having or not having a moderate to severe cognitive impairment, the characteristics are combined to categorize them into one of the thirty PT/OT case mix groups. The PT/OT case mix groups along with their case mix indexes and resident characteristics used in assigning a resident to one of the groups is shown in Figure 6. The PT/OT base rate is multiplied by the case mix index to arrive at the PT/OT component that is used to compute the rate.

**Figure 6**

Clinical Category	Function Score	Moderate/Severe Cognitive Impairment	Case-Mix Group	Case-Mix Index
Major Joint Replacement or Spinal Surgery	14-18	No	TA	1.82
	14-18	Yes	TB	1.59
	8-13	No	TC	1.73
	8-13	Yes	TD	1.45
	0-7	No	TE	1.68
	0-7	Yes	TF	1.36
Other Orthopedic	14-18	No	TG	1.70
	14-18	Yes	TH	1.55
	8-13	No	TI	1.58
	8-13	Yes	TJ	1.39
	0-7	No	TK	1.38
	0-7	Yes	TL	1.14
Acute Neurologic	14-18	No	TM	1.61
	14-18	Yes	TN	1.48
	8-13	No	TO	1.52
	8-13	Yes	TP	1.36
	0-7	No	TQ	1.47
	0-7	Yes	TR	1.17
Non-Orthopedic Surgery	14-18	No	TS	1.57
	14-18	Yes	TT	1.43
	8-13	No	TU	1.38
	8-13	Yes	TV	1.17
	0-7	No	TW	1.11
	0-7	Yes	TX	0.80
Medical Management	14-18	No	T1	1.55
	14-18	Yes	T2	1.39
	8-13	No	T3	1.36
	8-13	Yes	T4	1.17
	0-7	No	T5	1.10
	0-7	Yes	T6	0.82

**Rate Calculation Example:** a resident who falls into the non-orthopedic surgery clinical category; is able to transfer, toilet and eat independently which results in an ADL score of 12; and is not cognitively impaired, would be assessed into the “TU” PT/OT case mix group. This group has a case mix index of 1.38. The PT/OT base of \$126.76 (for urban areas) is multiplied by 1.38 to yield \$174.93 which represents the PT/OT component of the rate.

## **Component 2: Speech/Language Pathology (SLP)**

The characteristics found to be most relevant in predicting relative differences in Speech/Language Pathology costs were clinical reasons for the SNF stay; presence of a swallowing disorder or the need for a mechanically altered diet; and the presence of an SLP-related comorbidity or cognitive impairment. The clinical category found to correlate to SLP costs was “acute neurologic”, so the first step in assigning a SLP case mix group is to determine whether the resident has an acute neurologic condition or not.

A second driver of SLP costs, and therefore a characteristic selected to determine a resident’s SLP case mix group, was presence of a swallowing disorder and/or the need for a mechanically altered diet. Determining whether a resident has neither, either or both present would be the second step in assigning an SLP case mix category.

Finally, the presence of cognitive impairment and/or an SLP-related comorbidity were found to be relevant in predicting resident SLP costs. The ten SLP-related comorbidities are shown in Figure 7 below. Determining if a resident had a mild to severe cognitive impairment, had one of the listed comorbidities, had both a comorbidity and cognitive impairment, or neither is the final step in determining a resident's SPL case mix group.

**Figure 7**

Aphasia	Laryngeal Cancer
CVA, TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy (while Resident)	Oral Cancers
Ventilator (while Resident)	Speech and Language Deficits

Once a resident is assessed as having an acute neurologic condition or not; determined to have a swallowing disorder or to rely on a mechanically altered diet (either, neither or both); and found to have a cognitive impairment and/or an SLP-related comorbidity (either, neither or both), these characteristics are combined to categorize the individual into one of 18 SLP case mix groups shown in Figure 8.

**Figure 8**

Clinical Category	Presence of Swallowing Disorder or Mechanically-Altered Diet	SLP-related comorbidity or Mild to Severe Cognitive Impairment	Case-Mix Group	Case-Mix Index
Acute Neurologic	Both	Both	SA	4.19
	Both	Either	SB	3.71
	Both	Neither	SC	3.37
	Either	Both	SD	3.67
	Either	Either	SE	3.12
	Either	Neither	SF	2.54
	Neither	Both	SG	2.97
	Neither	Either	SH	2.06
	Neither	Neither	SI	1.28
Non-Neurologic	Both	Both	SJ	3.21
	Both	Either	SK	2.96
	Both	Neither	SL	2.63
	Either	Both	SM	2.62
	Either	Either	SN	2.22
	Either	Neither	SO	1.70
	Neither	Both	SP	1.91
	Neither	Either	SQ	1.38
	Neither	Neither	SR	0.61

**Rate Calculation Example:** A resident assessed with a non-neurologic condition who does not have a swallowing disorder nor requires a mechanically altered diet who has a mild cognitive impairment and



also has an SLP-related co-morbidity would be assessed into the “SP” SLP case mix group. This group has a case mix index of 1.91. The SLP base of \$24.14 (for urban areas) is multiplied by 1.91 to yield \$46.11 which is the SLP component of the rate.

### Component 3: Nursing

The RCS-1 methodology would separate the nursing component used in the RUG-IV methodology into a nursing component and a non-therapy ancillary (NTA) component, each of which would be subject to separate case mix adjustment. The original 1998 base rate calculations indicated the percentages attributable to nursing and NTA and these are the percentages that CMS is using in the RCS-1 model to separate the current nursing component into two parts. For urban areas, nursing (which also includes social services) represents 56.6 percent of the current nursing component base costs. The proportion is 57.3 percent for rural areas. The remainder is attributed to the NTA component.

**Figure 9**

RUG-IV Category	Current Nursing Case-Mix Index	Nursing Case-Mix Index		RUG-IV Category	Current Nursing Case-Mix Index	Nursing Case-Mix Index
ES3	3.58	3.84		CD1	1.38	1.51
ES2	2.67	2.90		CC2	1.29	1.49
ES1	2.32	2.77		CC1	1.15	1.30
HE2	2.22	2.27		CB2	1.15	1.37
HE1	1.74	2.02		CB1	1.02	1.19
HD2	2.04	2.08		CA2	0.88	1.03
HD1	1.60	1.86		CA1	0.78	0.89
HC2	1.89	2.06		BB2	0.97	1.05
HC1	1.48	1.84		BB1	0.90	0.97
HB2	1.86	1.88		BA2	0.70	0.74
HB1	1.46	1.67		BA1	0.64	0.68
LE2	1.96	1.88		PE2	1.50	1.60
LE1	1.54	1.68		PE1	1.40	1.47
LD2	1.86	1.84		PD2	1.38	1.48
LD1	1.46	1.64		PD1	1.28	1.36
LC2	1.56	1.55		PC2	1.10	1.23
LC1	1.22	1.39		PC1	1.02	1.13
LB2	1.45	1.48		PB2	0.84	0.98
LB1	1.14	1.32		PB1	0.78	0.90
CE2	1.68	1.84		PA2	0.59	0.68
CE1	1.50	1.60		PA1	0.54	0.63
CD2	1.56	1.74				

The RCS-1 model would rely on the same 43 non-rehabilitation categories as the current RUGS-IV methodology to determine the case mix for the nursing component, and residents would be assigned into the category based on the current methodology. However, case mix weights would be revised with



updated wage data and weight development would include the entire STRIVE population, including those residents that were classified into rehabilitation categories (whose data was not used when the current RUG-IV nursing case mix weights were developed). Adjustments would be made to correct for STRIVE oversampling and a 19 percent increase in the nursing component would be provided for residents with HIV/AIDS.

Figure 9 above shows the nursing component case mix figures for RCS-1 as well as the current RUG-IV weights.

**Rate Calculation Example:** *A resident meeting the CC1 Clinically Complex nursing RUG group criteria based on current RUG assignment rules would be assessed into the CC1 nursing case mix group. The group has a case mix index of 1.30. The nursing base of \$100.91 (for urban areas) is multiplied by 1.30 to yield \$131.18 which represents the nursing component of the rate.*

#### **Component 4: Non-Therapy Ancillary (NTA)**

In the RCS-1 model, Non-Therapy Ancillary (NTA) costs such as drugs, laboratory services, respiratory therapy and medical supplies will no longer be included in the nursing component as they are in the current methodology, but will rather be split out as a separate component with a separate and distinct case mix adjustment based on resident characteristics. Data analysis indicated that certain comorbidity conditions and extensive services were highly predictive of differences in NTA costs. Several of those conditions and characteristics were discarded due to coding reliability concerns as well as CMS wariness about creating perverse incentives.

The remaining 28 extensive services and conditions predictive of costs, listed below, were each assigned a point value. The points for each condition present or extensive service required would be summed for a total point score. The effect of this methodology is that the NTA component would adequately reflect relative differences in NTA costs of each condition or service, as well as the additive effect of multiple comorbidities.

**Figure 10: Non-Therapy Ancillary (NTA) Conditions and Extensive Services**

<b>Condition/Extensive Service</b>	<b>Source</b>	<b>NTA Tier</b>	<b>Points</b>
HIV/AIDS	SNF Claim	Ultra-High	8
Parenteral/IV Feeding – High Intensity	MDS Item K0510A2	Very-High	7
IV Medication	MDS Item O0100H2	High	5
Parenteral/IV Feeding – Low Intensity	MDS Item K0710A2, K0710B2	High	5
Ventilator/Respirator	MDS Item O0100F2	High	5
Transfusion	MDS Item O0100I2	Medium	2
Kidney Transplant Status	MDS Item I8000	Medium	2
Opportunistic Infections	MDS Item I8000	Medium	2
Infection with multi-resistant organisms	MDS Item I1700	Medium	2
Cystic Fibrosis	MDS Item I8000	Medium	2
Multiple Sclerosis (MS)	MDS Item I5200	Medium	2
Major Organ Transplant Status	MDS Item I8000	Medium	2

Condition/Extensive Service	Source	NTA Tier	Points
Tracheostomy	MDS Item O0100E2	Medium	2
Asthma, COPD, or Chronic Lung Disease	MDS Item I6200	Medium	2
Chemotherapy	MDS Item O0100A2	Medium	2
Diabetes Mellitus (DM)	MDS Item I2900	Medium	2
End-Stage Liver Disease	MDS Item I8000	Low	1
Wound Infection (other than foot)	MDS Item I2500	Low	1
Transplant	MDS Item I8000	Low	1
Infection Isolation	MDS Item O0100M2	Low	1
MRSA	MDS Item I8000	Low	1
Radiation	MDS Item O0100B2	Low	1
Diabetic Foot Ulcer	MDS Item M1040B	Low	1
Bone/Joint/Muscle Infections/Necrosis	MDS Item I8000	Low	1
Highest Ulcer Stage is Stage 4	MDS Item M300D1	Low	1

The model uses six NTA groupings, each representing a point score range and each with a distinct CMI weight. Residents would be categorized into an NTA case mix group based on their total NTA point score and their payment would include the NTA base rate adjusted by the category case mix weight. The resulting NTA Case Mix Classification Groups along with their case mix weights is shown in Figure 11.

**Figure 11: Non-Therapy Ancillary (NTA) Case Mix Groups**

NTA Score Range	NTA Group	NTA Case-mix Index
11+	NA	3.33
8-10	NB	2.59
6-7	NC	2.02
3-5	ND	1.52
1-2	NE	1.16
0	NF	0.83

**Rate Calculation Example:** A resident with Diabetes requiring IV medication would have a total point score of 7. This would place them in the “NC” NTA case mix group. The group has a case mix index of 2.02. The NTA base rate of \$76.12 (for urban areas) is multiplied by 2.02 to yield \$153.76 which represents the NTA component of the rate.

### **Variable Per-Diem Adjustment**

For each RUG category, the current RUG-IV methodology provides the same level of reimbursement for every day of a qualified Part A stay (assuming the resident’s RUG category remains unchanged). To address the concern that resource need may be greater at the beginning of the stay and decline as the stay progresses, CMS is considering incorporating adjustments that would result in higher rates at the beginning days of a stay and decline as the stay went forward.

Data analysis suggested that PT/OT as well as NTA costs are greatest at the beginning of a stay. Because the decline differs for PT/OT and NTA costs, CMS developed two separate decreasing adjustment schedules that could be applied to the PT/OT component and the NTA component to reflect this. Analysis suggests that SLP costs do not vary as a SNF stay progresses and there is insufficient data to gauge these differences for the nursing component, meaning that only the PT/OT and NTA components would be subject to this variable per-diem adjustment. Figures 12 and 13 below show the adjustment schedules that CMS is considering for PT/OT and NTA.

CMS also deliberated on how to address interrupted stay for purposes of resetting the variable per-day adjustment back to day one. To avoid creating an incentive for discharge and readmission, CMS intends to propose that in cases where a resident returns to the same SNF no more than three calendar days after discharge, the resident would be assigned the same classification as prior to discharged and the stay would be considered a continuation of the previous stay for variable per-diem adjustment purposes.

**Figure 12: PT/OT Variable Per-Diem Adjustment Factors**

<b>Medicare Payment Days</b>	<b>Adjustment Factor</b>
1-14	1.00
15-17	0.99
18-20	0.98
21-23	0.97
24-26	0.96
27-29	0.95
30-32	0.94
33-35	0.93
36-38	0.92
39-41	0.91
42-44	0.90
45-47	0.89
48-50	0.88
51-53	0.87
54-56	0.86
57-59	0.85
60-62	0.84
63-65	0.83
66-68	0.82
69-71	0.81
72-74	0.80
75-77	0.79
78-80	0.78
81-83	0.77
84-86	0.76
87-89	0.75
90-92	0.74
93-95	0.73
96-98	0.72
99-100	0.71

**Figure 13: NTA Variable Per-Diem Adjustment Factors**

Medicare Payment Days	Adjustment Factor
1-3	3.0
4-100	1.0

**Rate Calculation Example:** The table below provides an example of how the variable per-diem adjustment factors would be applied in calculating the rate for the first day vs. the 60<sup>th</sup> day of a resident's stay. Note that only the PT/OT and NTA components are subject to these adjustments and that while the PT/OT adjustment continues to decline during the entire stay, the NTA adjustment impacts only the first three days of the stay.

**Figure 14: Sample Rate with Per-Diem Adjustment Factors**

Component	Case-Mix Adjusted Rate (before variable adjustment)	Day 1		Day 60	
		Day 1 Variable Adjustment	Day 1 Rate (with variable adjustment)	Day 60 Variable Adjustment	Day 60 Rate (with variable adjustment)
PT/OT	\$ 174.93	1.0	\$ 174.93	0.8	\$ 146.94
SLP	\$ 46.11	na	\$ 46.11	na	\$ 46.11
Nursing	\$ 131.18	na	\$ 131.18	na	\$ 131.18
NTA	\$ 153.76	3.0	\$ 461.28	1.0	\$ 153.76
Non-Case Mix	\$ 90.35	na	\$ 90.35	na	\$ 90.35
<b>TOTAL</b>	<b>\$ 596.33</b>		<b>\$ 903.85</b>		<b>\$ 568.34</b>

As Figure 14 suggests, the total Medicare Part A rate under the RCS-1 methodology would be calculated by summing each of the four case-mix adjusted components. The PT/OT and NTA components would be further adjusted by their respective variable per-diem adjustment factors. The non-case mix component would be added to this and the wage-related portion of the rate would be wage-adjusted using the same wage index as is used in RUG-IV.

## Less Frequent PPS Assessments

CMS notes that the MDS assessments required under the current SNF PPS are largely driven by the therapy that a resident receives. The case-mix classification under the RCS-1 model under consideration relies to a much lesser extent on characteristics that may change frequently over the course of a resident's stay. Instead, it relies on more stable predictors of resource utilization by tying case-mix classification, to a much greater extent, to resident characteristics such as diagnosis information.

Given the greater reliance of the RCS-1 case-mix classification system (as compared to the RUG-IV model) on resident characteristics that are relatively stable over a resident's SNF stay, CMS is considering the possibility of reducing the number of MDS assessments that providers are required to complete. Specifically, CMS is considering using the 5-day SNF PPS scheduled assessment to classify a

resident under the RCS-1 model for the entirety of a resident's Part A SNF stay, with the significant change and discharge assessments as the only other required assessments.

While a Significant Change in Status Assessment (SCSA) could result in a payment change by reclassifying the resident into a different category for one or more of the case mix components, CMS is not inclined to consider a significant change as a reset for purposes of the variable per-diem adjustment.

## **Concurrent and Group Therapy**

CMS is concerned that since the RCS-1 methodology would not use minutes of therapy provided to classify the resident for payment purposes, that the methodology may incentivize group and concurrent therapy, over the kind of individualized therapy which is tailored to address each beneficiary's specific care needs which CMS believe is generally the most appropriate mode of therapy for SNF residents. To address this, CMS is considering limiting group and concurrent therapy on a discipline-specific basis to a total of 50 percent of therapy that a resident would receive (i.e., limit group and concurrent therapy each to 25 percent of the therapy provided to a resident).

## **Administrative Presumption of NH Level of Care**

Under the RUG-IV methodology, individuals that are initially assessed into one of the top 52 RUG categories are automatically presumed to be eligible for skilled level of care. CMS is inclined to continue a presumption of eligibility for those whose nursing case mix category falls in the Extensive Services, Special Care High, Special Care Low or Clinically Complex categories.

In addition, this presumption would also apply to those who fall into the most intensive functional score (14-18) category in the PT/OT component case mix as well as those assessed into the highest comorbidity score of the NTA component.

## **Impact Modeling**

Using the same data to develop RCS-1 base rates as is used in the current RUG-IV methodology and constraining case mix and other adjustments to be budget neutral, CMS compared the two methodologies to analyze the resident-level impact if the change in methodologies were to be made. Figure 15 on the following page shows selected resident characteristics, the percent of stays meeting that resident characteristic, and the estimated percent change in Medicare Part A rate for residents with that characteristic.

The most pronounced decrease (9.1 percent) would be in the ultra-high therapy RUG category which represents more than half of Medicare resident stays. Reimbursement for residents in lower rehabilitation groups and for non-rehabilitation residents would increase notably. The Advance Notice contains impact analysis for additional resident characteristics.

## **CMS Feedback Request**

Although the ANPRM outlines a fairly developed alternative to the current RUG-IV methodology used to set Medicare Part A rates for nursing homes, CMS has not yet formally proposed any of these provisions. Instead, the reason for the advance publication is to solicit comments that would inform the formal

proposal that CMS anticipates to publish in the FFY 2019 SNF PPS rule in spring of 2018. CMS is requesting comments on issues with the current SNF PPS, and what steps should be taken to refine the existing SNF PPS in response to those issues. In particular, they are soliciting comments on the adequacy and appropriateness of the RCS-1 case-mix model to serve as a replacement for the RUG-IV model.

**Figure 15: Resident-Level Impact Analysis of RCS-1**

Resident Characteristics	% of Stays	Percent Change
<b>Age</b>		
<65 years	9.6%	5.4%
65-74 years	21.3%	2.7%
75-84 years	34.0%	-0.3%
85-89 years	19.3%	-2.3%
90+ years	15.7%	-2.8%
<b>Medicare/Medicaid Dual Status</b>		
Dually enrolled	35.2%	2.9%
Not dually enrolled	64.8%	-1.9%
<b>Number of Utilization Days</b>		
1-15 days	33.3%	15.9%
16-30 days	31.6%	0.6%
31+ days	35.1%	-2.5%
<b>Number of Utilization Days = 100</b>		
No	97.4%	0.3%
Yes	2.6%	-2.7%
<b>CFS Level</b>		
Cognitive Intact	54.3%	-0.5%
Mildly Impaired	22.8%	1.6%
Moderately Impaired	18.2%	-1.8%
Severely Impaired	4.6%	6.1%
<b>IV Medication</b>		
No	91.4%	-2.0%
Yes	8.6%	22.9%
<b>Diabetes</b>		
No	65.0%	-2.8%
Yes	35.0%	5.2%
<b>Wound Infection</b>		
No	97.8%	-0.4%
Yes	2.2%	17.9%

Resident Characteristics	% of Stays	Percent Change
<b>Most Common Therapy Level</b>		
RU	54.0%	-9.1%
RV	22.7%	9.3%
RH	7.7%	24.4%
RM	3.7%	36.9%
RL	0.1%	49.3%
Non-Rehabilitation	11.7%	44.5%
<b>Physical Therapy Use</b>		
No	7.3%	24.2%
Yes	92.7%	-1.0%
<b>Occupational Therapy Use</b>		
No	8.6%	24.8%
Yes	91.4%	-1.2%
<b>Speech Language Pathology Use</b>		
No	58.4%	3.2%
Yes	41.6%	-3.1%
<b>Therapy Utilization</b>		
PT+OT+SLP	39.9%	-3.9%
PT+OT Only	50.4%	1.2%
PT+SLP Only	0.6%	22.9%
OT+SLP Only	0.5%	25.6%
PT Only	1.9%	34.9%
OT Only	0.7%	41.8%
SLP Only	0.7%	39.2%
Non-therapy	5.4%	20.0%

The stated goals of the agency in developing a potential alternative are:

- To create a model that compensates SNFs accurately based on the complexity of the particular beneficiaries they serve and the resources necessary in caring for those beneficiaries;

- To address CMS concerns, along with those of OIG and MedPAC, about current incentives for SNFs to deliver therapy to beneficiaries based on financial considerations, rather than the most effective course of treatment for beneficiaries; and
- To maintain simplicity by, to the extent possible, limiting the number and type of elements used to determine case-mix, as well as limiting the number of assessments necessary under the payment system.

CMS is interested in comments both on these goals as well as how effective the RCS-1 model is in addressing those goals. CMS also welcomes comments on logistical aspects of implementing revisions to the current SNF PPS, such as whether those revisions should be implemented in a budget neutral manner, and how much lead time providers and other stakeholders should receive before any finalized changes would be implemented. Finally, CMS invites comments on other potential issues that should be considered in implementing revisions to the current SNF PPS, such as potential effects on state Medicaid programs, potential behavioral changes, and the type of education and training that would be necessary to implement successfully any changes to the SNF PPS.

## **Conclusion**

The RCS-1 model that CMS is considering would represent a significant change in how Medicare reimburses nursing homes for post-acute care. It would rely much less on therapy which is the largest reimbursement driver in the current methodology and place more weight on nursing services and other clinical needs and characteristics. The methodology for calculating the rate would be more complex and Part A revenue would be less predictable. Payments would change as a resident's stay progressed. More aspects of a resident's unique characteristics and needs would factor into determining the resident's payment classification, which CMS argues would make for more resident centered care and reimbursement. Because the RCS-1 system would be based on specific resident characteristics predictive of resource utilization for each component, CMS believes that payments would be better aligned with resident needs.

While it is important for members to be familiar with the broad strokes of the methodology, including the concerns CMS is trying to address in developing the model, it would be premature to make any operational decisions based on this information. As noted above, the RCS-1 model is being presented for public comment; it is NOT being proposed for implementation at this time. CMS intends to publish it as a proposal in 2018 and that proposal may differ significantly from the current incarnation based on public comments received in response to this Advance Notice.

LeadingAge NY will submit comments and we urge members to do so as well, either directly to CMS or to us so that we may incorporate them into the association's comments. Please contact Darius Kirstein, [dkirstein@leadingageny.org](mailto:dkirstein@leadingageny.org), 518-867-8841, with questions, comments and input.