SNF proposed rule – revisions to case-mix methodology

Comments due: August 25, 2017

CMS intent – to propose case-mix refinements in the *FY 2019* SNF PPS proposed rule

Summary of changes

Goals of the change:

1. Create a model that compensates SNFs accurately based on complexity of residents
2. Address concerns about current incentives for SNFs to deliver therapy services
3. Maintain simplicity by limiting number/type of elements used to determine case-mix as well as limiting number of assessment necessary

Updates and wage adjustments:
**CMS would continue the practice of using SNF market basket adjustments, along with adjustments for geographic differences in wages.

Current RUG-IV system:

- Residents assigned to one of 66 RUG levels
- Therapy provisions drives the assigned level and determines not only the therapy payments, but also nursing payments
- All 3 therapy minutes (PT, OT, SLP) are added together to determine the case-mix classification
- Does not address the variation in nursing and non-therapy ancillary (NTA) services, with NTA incorporated into the nursing component
- Assessments are required at 5, 14, 30, 60, and 90 days to determine any changes in RUG level
- Each RUG is paid at a constant per diem rate, regardless of how many days a resident is classified in that particular RUG.

New RCS-I system (Resident Classification System, Version 1):

- Identifies and adjusts four different case-mix components for the varied needs/characteristics of resident care, then combines the together with the non-case-mix component to form the full PPS per diem rate
- Separates therapies into 2 components, PT/OT and SLP, and therapy minutes are not used to determine classify a resident into a group
- Nursing is a separate component for classification
- Non-therapy ancillary (NTA) is a separate component for classification
- Payment will be made based on the CMI for each component, multiplied by the federal base rate and adjusted to a variable per diem schedule.

Component 1:

PT/OT – 3 most relevant predictors of use: 1) clinical reasons for SNF stay, 2) resident functional status, 3) presence of cognitive impairment.

a. Five clinical categories identified to be used to determine PT/OT use:

TABLE 4: PT/OT Clinical Categories

Major Joint Replacement or Spinal Surgery
Other Orthopedic
Non-Orthopedic Surgery
Acute Neurologic
Medical Management

**CMS considering using item I8000 on the MDS 3.0 to report the resident's primary diagnosis by ICD-10 code, the primary reason for the resident's SNF Part A stay

b. Then – include resident's functional level – using 3 ADLs (transfers, eating, toileting) and eliminating bed mobility as is currently included. Rather than scoring on total of 4 points each, the three will be scored for total of 6 points each. Will use Section G of MDS 3.0 to obtain ADL score.
c. Then – include cognitive status – currently assessed using BIMS on MDS 3.0 but if the MDS directs assessors to skip the VMIS, then the CPS is used to assess cognition– CMS is considering using a new scale called the Cognitive Function Scale (CFS) which combines scores from the BIMS and CPS into one scale that allows comparing cognitive function across all residents.
d. All residents will be classified into one and only one of the 30 PT/OT case-mix groups.

TABLE 7: PT/OT Case-mix Classification Groups

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

Component 2:

SLP – 3 most relevant predictors of use: 1) clinical reasons for stay, 2) presence of swallowing disorder OR mechanically altered diet, 3) presence of an SLP-related comorbidity OR cognitive impairment.

Conditions in Table 8 were determined to be those SLP-related comorbidities which CMS believes best predict relative differences in SLP costs.

TABLE 8: SLP-related Comorbidities

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

SLP case-mix first determined by whether the resident has a neurologic condition, then assessed based on swallowing disorder/mechanically altered diet, and then cognitive impairment.

TABLE 9: SLP Case-Mix Classification Groups

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

All residents will be classified into one and only one of the 18 SLP case-mix groups.

Component 3:

Nursing – the intent is that residents who are more clinically complex or who have other indicators of acuity, including a higher ADL score, depression or restorative nursing, would receive higher payments.

CMS intends on using the RUG-IV non-rehab groups to classify residents based on their ADL score, use of extensive services, presence of conditions such as depression, pneumonia or septicemia and use of restorative nursing.

TABLE 10: Nursing Indexes under RCS-I Classification Model

RUG-IV Category	Current Nursing Case-Mix Index	Nursing Case-Mix Index
ES3	3.58	3.84
ES2	2.67	2.90
ES1	2.32	2.77
HE2	2.22	2.27
HE1	1.74	2.02
HD2	2.04	2.08
HD1	1.60	1.86
HC2	1.89	2.06
HC1	1.48	1.84
HB2	1.86	1.88
HB1	1.46	1.67
LE2	1.96	1.88

ANPRM

RUG-IV Category	Current Nursing Case-Mix Index	Nursing Case-Mix Index
LE1	1.54	1.68
LD2	1.86	1.84
LD1	1.46	1.64
LC2	1.56	1.55
LC1	1.22	1.39
LB2	1.45	1.48
LB1	1.14	1.32
CE2	1.68	1.84
CE1	1.50	1.60
CD2	1.56	1.74
CD1	1.38	1.51
CC2	1.29	1.49
CC1	1.15	1.30
CB2	1.15	1.37
CB1	1.02	1.19
CA2	0.88	1.03
CA1	0.78	0.89
BB2	0.97	1.05
BB1	0.90	0.97
BA2	0.70	0.74
BA1	0.64	0.68
PE2	1.50	1.60
PE1	1.40	1.47
PD2	1.38	1.48
PD1	1.28	1.36
PC2	1.10	1.23
PC1	1.02	1.13
PB2	0.84	0.98
PB1	0.78	0.90
PA2	0.59	0.68
PA1	0.54	0.63

All residents would be classified into one and only one of the 43 nursing case-mix groups. As part of the nursing component, CMS is considering a 19% increase in payment rate for residents with HIV/AIDS.

Component 4:

Non-therapy ancillary (NTA) – CMS determined 3 cost-related resident characteristics affecting NTA costs, 1) resident comorbidities, 2) use of extensive services, 3) resident age.

TABLE 11: Conditions and Extensive Services Used for NTA Classification

Condition/Extensive Service	Source	NTA Tier	Points
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

Condition/Extensive Service	Source	NTA Tier	Points
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
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
Osteomyelitis and Endocarditis	MDS Item I8000	Low	+1
Suctioning	MDS Item O0100D2	Low	+1
DVT/Pulmonary Embolism	MDS Item I8000	Low	+1

CMS is considering providing a crosswalk between the listed condition and the ICD-10-CM codes to serve as part of the NTA classification, as indicated by MDS item I8000.

In the case of parenteral/IV feeding, CMS is considering the possibility of separating this item into a high and low intensity item, as it currently defined in the RUG-IV system.

The current claims reporting mechanism would be used to determine a resident's HIV/AIDS score for purposes of the NTA classification, using a HIPPS code provided to the SNF on the validation report associated with that assessment.

TABLE 12: NTA Case-Mix Classification 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

All residents would be classified into one and only one of the 6 NTA case-mix groups.

Payment classifications under RCS-I:

The RCS-I system would classify each resident into 4 components and provide a single payment based on these classifications.

The payment for each component would be calculated by multiplying the CMI for the resident's group by the component federal base payment rate, and then by the specific adjustment factor in the variable per diem adjustment schedule.

TABLE 1: RCS-I Unadjusted Federal Rate Per Diem--Urban

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

TABLE 2: RCS-I Unadjusted Federal Rate Per Diem--Rural

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

The variable per diem adjustment schedule is intended to account for the effect of length of stay on per diem costs, which would be applied to PT/OT and NTA components, but not the SLP and nursing components. PT/OT adjustment factor would be a decline of 1 percent every 3 days after day 14. The NTA adjustment factor was set at 3.00 for the first 3 days and 1.00 after, reflecting the stabilization of resource use that CMS observed from data analysis.

TABLE 14: Variable Per-diem Adjustment Factors and Schedule – PT/OT

Medicare Payment Days	Adjustment Factor
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

TABLE 15: Variable Per-diem Adjustment Factors and Schedule – NTA

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

Use of the MDS 3.0:
CMS is considering the possibility of reducing administrative burden on providers by revising the assessments required under the RCS-I model to include:

- 5-day assessment to classify a resident under the RCS-I for purposes of the entire stay, with the exception of:
    - Reclassification using significant change in status assessment (SCSA) when criteria for a significant change are met. In this case, the SCSA would not reset

the variable per diem adjustment schedule, e.g. day 18 is day 18 on the schedule regardless of the SCSA being done to reclassify the RCS-I payment based on changes in the 4 components.

- CMS would continue to require a discharge assessment with added items to allow CMS to track therapy minutes over the course of a Part A stay.

TABLE 17: PPS Assessment Schedule

Medicare MDS Assessment Schedule Type	Assessment Reference Date	Applicable Standard Medicare Payment Days
5-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless a Significant Change in Status assessment is completed)
Significant Change In Status Assessment (SCSA)	No later than 14 days after significant change is identified	ARD of the assessment through Part A discharge (unless another Significant Change in Status assessment is completed)
PPS Discharge Assessment	Equal to the End Date of the Most Recent Medicare Stay (A2400C)	N/A

Other changes:

- CMS would limit concurrent therapy to no more than 25% of the resident's therapy minutes, consistent with the existing 25% limit on group therapy. In combination, the 2 limes would thus ensure that at least 50% of the therapy is provided on an individual basis. However, CMS is considering making the concurrent therapy limits discipline-specific.
- Interrupted stay policy – CMS is considering an interrupted stay policy similar to what is done in other settings when a patient returns to the same facility within 3 days of discharge.
  - In cases where the resident is readmitted to the same SNF more than 3 days after being discharged, CMS is considering the possibility of treating the readmission as a new stay, in which the resident would receive another 5-day assessment upon admission and the variable per diem adjustment for that resident would reset to day 1. The source of the readmission would not be relevant.
  - In cases where the resident is readmitted to a different SNF, regardless of the gap between discharge and readmission, the variable per diem adjustment would always reset to day 1.
- CMS is considering maintaining the administrative presumption mechanism where by a certain number of designated groups are automatically classified as meeting the SNF level of care definition; those in other groups would receive an individual level of care determination using existing criteria. CMS is considering the use of the functional score under the PT/OT component or the uppermost comorbidity score of the NTA component to help further refine whether the administrative presumption could be applied.

Impact analysis:

CMS anticipates higher payments for residents with high NTA costs, dual eligible residents, residents with ESRD and resident with longer qualifying inpatient stays.

Other areas noted in their analysis for potential higher payments: residents less than age 65, American Indian residents, mild cognitive impairment, use of IV medication, diabetic, wound treatments, prosthetic care, therapy levels RV/RH/RM/RL and non-rehab, single therapy discipline use, trach/vent/respirator care, infection isolation, small facilities (under 50 beds), non-profit facilities, government-owned facilities, and hospital-based and swing-bed facilities.

(Thanks to Jen Porter, from LeadingAge Wisconsin's sister Association in South Dakota for preparing this summary for the LeadingAge provider community.)

CMS recently completed an analysis of the impact of the RCS-1 system compared to RUGs for every Skilled Nursing Facility in the nation. ***The analysis is based on a revenue neutral transition to the new system based on residents from the 2014 federal fiscal year, and makes no assumptions about changes in resident needs since that time or changes in services due to the new system.*** LeadingAge Wisconsin has isolated the Wisconsin nursing facilities included in the CMS analysis and determined that 279 of the 362 Wisconsin's skilled nursing facilities are estimated by CMS to fare better under the proposed RCS-1 system (See: www.leadingagewi.org/media/47123/rugsreplacement3.pdf).

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