CMS Proposes to Revise SNF PPS Case-Mix Methodology for FY 2019

The other shoe has finally dropped. CMS has unveiled a long anticipated revision of the current RUG IV payment classification system. CMS presented its proposed revision to SNF case-mix methodology in an issuance on April 27, 2017, entitled Advance Notice of proposed rulemaking (ANPRM).[1] CMS in the ANPRM solicits comments, due no later than 5pm, on June 26, 2017, on options CMS may consider for revising certain aspects of the existing SNF PPS payment methodology, to improve its accuracy, based on the results of the SNF Payment Models Research Project. In particular, CMS is seeking comments on the possibility of replacing the SNF PPS' existing case-mix classification model, Resident Classification System, Version 4 (RUG-IV), with the Resident Classification System (RCS-I) case mix model developed during the SNF Payment Models Research.

CMS intends to propose case-mix refinements for implementation in the **FY 2019** SNF PPS proposed rule – not the FY 2018 proposed rule. CMS believes that the RCS-I classification model could improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care.

Similar to the current system, RUG-IV, the revised model, the RCS-I, would case-mix adjust for the following major cost categories: physical therapy (PT), occupational therapy (OT), speech language pathology (SLP) services, nursing services and non-therapy ancillaries (NTAs). However, where RUG-IV consists of ***two case-mix adjusted components (therapy and nursing), the RCS-I would create four (PT/OT, SLP, nursing, and NTA) for a more resident-centered case mix adjustment.***

A. The Goal of CMS Payment Methodology

The goal of CMS' payment methodology, which has always been to pay providers appropriately for appropriate services, may now, CMS hopes, be in sight. CMS has put a great deal of effort spanning a number of years to tweak, adjust and modify the SNF PPS payment methodology. However, this major revision, an alternative classification for SNF residents in Medicare Part A-covered stays, was developed by Acumen pursuant to a contract with the Centers for Medicare & Medicaid Services (CMS) (Contract No. HHSM-500-2011-00012I). Work started in 2013.[2]

A key tool is the concept of "case mix." Case-mix adjustment indicates that payment should be closely related to the cost of providing the appropriate amount of care to the resident or patient and, the governing SNF Medicare statute requires the Secretary to make an adjustment to the per diem rates to account for case-mix.

In general, the case-mix classification system currently used under the SNF PPS classifies residents into payment classification groups, called RUGs, based on various resident characteristics and the type and intensity of therapy services provided to the resident. Resident classification under the existing therapy component is ***based primarily on the amount of therapy the SNF chooses to provide to a SNF resident***. Under the RUG-IV model, residents are classified into rehabilitation groups, where payment is determined primarily based on the intensity of therapy services received by the resident, and into nursing

[1] The ANPRM was subsequently published in the Federal Register at 82 Federal Register 20980, May 4, 2017. See https://www.gpo.gov/fdsys/pkg/FR-2017-05-04/pdf/2017-08519.pdf

[2] See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html for CMS' summary of its SNF PPS Payment Model Research with a detailed review of the four Technical Expert Panels that addressed payment model issues. See also *Acumen's Skilled Nursing Facilities Payment Models Research Technical Report April 2017* at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/SNFPPS/Downloads/SNF_Payment_Models_Research_Technical_Report201704.pdf

groups, based on the intensity of nursing services received by the resident and other aspects of the resident's care and condition.

Over the years, however, CMS feared that the current system was failing to achieve its goal of appropriate payment for appropriate services. The system was not functioning as intended and, according to CMS, providers were using the inherent weaknesses in great part to chiefly maximize reimbursement. A variety of concerns have been raised with the current SNF PPS RUG-IV model.

In the Advance notice, CMS lays out these concerns, raised by CMS itself, MedPAC, and the OIG, in detail. We, in our April LTC Pharmacy News, in reviewing the MedPAC March Report, provided information on MedPAC's concerns and recommendations. Here are just a few of the collective concerns discussed by CMS in the ANPRM.

- The vast majority of Part A covered SNF days (over 90 percent) are paid using a rehabilitation RUG.

- The percentage of residents classifying into the Ultra-High therapy category has increased steadily and, of greater concern, the percentage of residents receiving just enough therapy to surpass the Ultra-High and Very-High therapy thresholds has also increased.

- While CMS indicates that it might be possible to attribute the increasing share of residents in the Ultra-High therapy category to increasing acuity within the SNF population, the agency nevertheless believes the increase in "thresholding" (that is, of providing just enough therapy for residents to surpass the relevant therapy thresholds) is a strong indication of service provision predicated on financial considerations rather than resident need.

- CMS has received comments from the public to the existence of internal pressure within SNFs that would override clinical judgment. Specifically, CMS states, the minimum therapy minute thresholds for each therapy RUG category are certainly not intended as ceilings or targets for therapy provision.

- Multiple reports from the OIG looking at data as far back as 2006 addressing questionable NF billing, inappropriate payment to SNFs.

- CMS comments that multiple reports from MedPAC detailing the drawbacks of the current SNF, and the issues raised in the OIG reports caused it, CMS, to consider significant revisions to the existing SNF PPS, in keeping with its overall responsibility to ensure that payments under the SNF PPS accurately reflect both resident needs and resource utilization.

- The MedPAC 2017 March Report providing recommendations for payment updates reflected the growing exasperation of the MedPAC members at the seeming indifference of CMS and the Hill to the concerns that MedPAC kept raising. Notably, in the March Report of 2017, MedPAC forcefully advocated yet again for SNF payment reform and detailed all the dollars that had been lost to Medicare over the years because of the SNF PPS deficiencies. See LTC Pharmacy News report, April 2017 issue, on MedPAC's 2017 March Report to Congress.

B. What Is Meant By Significant Revisions?

Under the RUG-IV system, therapy service provision determines not only therapy payments, but also nursing payments. Most resident days are paid using a rehabilitation RUG, and since assignment into a rehabilitation RUG is based on therapy service provision, **this means that therapy service provision effectively determines nursing payments for those residents who are assigned to a rehabilitation RUG.** Thus, CMS believes any attempts to revise the SNF PPS payment methodology to better account for therapy service provision under the SNF PPS would need to **be comprehensive and affect both the therapy and nursing case-mix components**.

CMS believes that the RCS-I model offers a significant revision in that it represents a substantial improvement over the RUG-IV model; it would better account for resident characteristics and care needs, thus better aligning SNF PPS payments with resource use and eliminating therapy provision-related financial incentives inherent in the current payment model used in the SNF PPS.

To better ensure that resident care decisions appropriately reflect each resident's actual care needs, CMS believes that it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from objective resident characteristics.

C. The Skilled Nursing Facility Payment Models Research Project

Beginning in 2013, CMS contracted with Acumen, LLC to identify potential alternatives to the existing methodology used to pay for services under the SNF PPS. Acumen in consort with CMS held several Technical Expert Panels from various aspects of the nursing facility and therapy servcies world. The recommendations developed under this contract, entitled the SNF PMR Project, form the basis of the ideas provided in the Advance Notice.[3]

D. Potential Revisions to SNF PPS Payment Methodology

Resident classification under the existing therapy component is ***based primarily on the amount of therapy the SNF chooses to provide to a SNF resident***. This is the core problem that CMS is trying to address and modify – substantially. But how to do this?

The governing statute requires that the Secretary provide for an appropriate adjustment to account for case mix and that such an adjustment shall be based on a resident classification system that accounts for the relative resource utilization of different patient types. The current case-mix classification system uses a combination of resident characteristics and service intensity metrics (for example, therapy minutes) to assign residents to one of 66 RUGs, each of which has a set of case-mix indices (CMIs) indicative of the relative cost to a SNF of treating residents within that classification category. However, according to CMS, incorporating service-based metrics into the payment system can incentivize the provision of services based on a facility's financial considerations rather than resident needs.

To better ensure that resident care decisions appropriately reflect each resident's actual care needs, CMS believes it is important to remove, to the extent possible, service-based metrics from the SNF PPS and derive payment from objective resident characteristics that are resident, and not facility, centered. To that end, RCS-I was developed to be a payment model which derives almost exclusively from verifiable resident characteristics.

While the RUG-IV model utilizes a host of service-based metrics (type and amount of care the SNF decides to provide) to classify the resident into a single RUG-IV group, the RCS-I model under consideration would separately identify and adjust for the varied needs and characteristics of a resident's care and **then** combine them together.

As part of the RCS-I case-mix model under consideration, CMS would bifurcate both the "nursing case-mix" and "therapy case-mix" components of the federal base payment rate into two components each, thereby creating **four case-mix adjusted components**. More specifically, CMS would separate the "therapy case-mix" rate component into a "Physical Therapy/Occupational Therapy" (PT/OT) component and a "Speech-Language Pathology" (SLP) component.

Based on the results of the SNF PMR, CMS would also separate the "nursing case-mix" rate component into a "nursing" component and a "Non- Therapy Ancillary" (NTA) component. CMS believes that the RCS-I classification model could improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care.

E. Potential Impacts of Implementing RCS-I

CMS provides a lengthy discussion of what it sees as potential impacts of RCS-I and solicits comments on its assumptions. A few key points include:

- The possibility that some providers may choose to reduce their provision of therapy services to increase margins under RCS–I.

- A number of states utilize some form of the RUG–IV casemix classification system as part of their Medicaid programs and that any change in Medicare policy can have an impact on state programs.

- To the extent that commenters may believe that behavior could change under RCS–I, CMS asks commenters to describe the types of behavioral changes CMS should expect.

- CMS solicits comments on what type of impact on states CMS should expect from implementing the revisions considered in this ANPRM.

- Another assumption made for these impacts is that, as with prior system transitions, CMS would implement the RCS–I case-mix system, along with the other policy changes discussed in section III of this ANPRM, in a budget neutral manner through application of a parity adjustment to the case-mix weights under the RCS–I model under consideration.

  CMS explains that it is making this assumption because, as with prior system transitions, in considering changes to the case-mix methodology, it does not intend to change the aggregate amount of Medicare payments to SNFs

  Rather, it seeks to utilize a case-mix methodology to classify residents in such a manner as to best ensure that payments made for specific residents are an accurate reflection of resource utilization without introducing potential incentives which could incentivize inappropriate care delivery, as CMS believes may exist under the current case-mix methodology.

However, CMS states unequivocally that it is not required to implement RCS–I in a budget neutral manner. It thus solicits comments on whether it should consider implementing RCS -I in a manner that is not budget neutral. The issue of the application of budget neutrality – whether and when it might or might not be required -- has been an issue for years. It is an issue that SNFs, we presume, keep an eye on.

F. Perspective from Providers of Post-Acute Care

SNF providers have told ***LTC Pharmacy News*** that the modifications to the SNF PPS system constitute a complex change to the current system and that at this time the industry does not have enough information to make a determination of its impact on individual facilities and the system as a whole. It is unclear how the implementation would affect individual facilities and the cost to do so. Further, there were certain SNF factors and requirements that Acumen did not consider.

There was also unease expressed about CMS' position that budget neutrality is not mandatory, thus leaving the door open for implementation with "savings" to the program. Representatives of SNFs such as the American Health Care Association (AHCA), and representatives that of rehabilitation therapists such as the National Association for the Support of Long Term Care (NASL) have their work cut out for them now with only 60 days to provide comments to CMS.