

**Medicare Program; Prospective Payment System and Consolidated Billing for Skilled
Nursing Facilities: Revisions to Case-mix Methodology
[CMS-1686-ANPRM]**

Summary of Advance Notice of Proposed Rulemaking

On April 27, 2017, the Centers for Medicare and Medicaid Services (CMS) released an Advance Notice of Proposed Rulemaking (ANPRM) with comment entitled “Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-mix Methodology,” followed by *Federal Register* publication on May 4, 2017 (84 FR 20980-21012). **Comments on the advance notice are due to CMS by June 26, 2017.**

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I. Executive Summary

In this ANPRM, CMS seeks input about major changes to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) under active consideration for inclusion in the fiscal year (FY) 2019 rulemaking cycle. These changes are derived largely from the SNF Payment Models Research (PMR) project and are intended to improve the accuracy of the SNF PPS. Discussed in this ANPRM are:

- Replacement of the current Rehabilitation Utilization Groups, Version 4 (RUG-IV) case-mix adjustment methodology with the Resident Classification System, Version 1 (RCS-I) methodology for use in calculating the daily SNF PPS base payment rates;
- RCS-I implementation strategies and complementary SNF PPS policy changes; and,
- Overall cost impact and payment shifts among SNFs resulting from RCS-I implementation and related policy changes.

The RUG-IV system consists of two case-mix adjusted components (therapy and nursing). Based on results from the SNF PRM project, the RCS-I model creates four case-mix adjusted components (physical therapy/occupational therapy, speech-language pathology services, nursing services, and non-therapy ancillaries). CMS discusses how residents would be classified under each case-mix component and the resident-characteristics that could serve as appropriate predictors of varying resource intensity for each component.

CMS intends to propose case-mix refinements in the FY 2019 SNF proposed rule.

CMS broadly seeks comment on the ANPRM; commenters should refer to ANPRM sections on specific topics. CMS anticipates receiving a large number of public comments and will not respond to individual commenters. All comments received timely will be reviewed and may be considered further in future RCS-I iterations.

II. Background

Prospective per diem payment for the Medicare SNF benefit was mandated by provisions of the Balanced Budget Act of 1997 amending the Social Security Act (“the Act”). The Act also requires the Secretary to make case-mix adjustments to the per diem rates and to adjust for area wage variation. SNF PPS payments are determined by adjusting a federal per diem base payment (computed as separate urban and rural rates) for geographic factors and case mix. The case mix adjustment currently classifies residents into payment classification groups, called resource utilization groups (RUGs). The unadjusted federal per diem rate is the sum of the following components:

- A nursing component which is case-mixed adjusted,
- A therapy component which is case-mix adjusted for rehabilitation RUGs or a therapy component which is not case-mix adjusted for non-rehabilitation RUGs, and
- A non-case mix adjusted component reflecting the costs of room and board, linens, and administrative services.

The SNF PPS is updated annually, reflecting a productivity adjustment and SNF-specific market basket.

The SNF PPS was implemented in FY 1999 and employed the RUG-III resident classification system. The current RUG-IV system took effect in FY 2011. Each RUG is assigned a set of case-mix indexes (CMIs) that reflect relative differences in cost and resource intensity for each case-mixed adjusted component. The higher the CMI, the higher the expected intensity for each case-mix adjusted component. Under the existing methodology, there are two case-mix adjusted components: the nursing component and the therapy component. Nursing and therapy case-mix indices (CMIs) are assigned to each RUG resident classification group to capture resource use and cost differences across RUGs. Non-therapy ancillary (NTA) costs (e.g., drugs, lab tests) are embedded in the nursing component. Payment is based upon the higher per diem of a resident’s nursing or therapy RUG (most often the therapy RUG).

Since the implementation of the RUG-IV system, multiple reports from the Office of the Inspector General (OIG), the Medicare Payment Advisory Commission (MedPAC), and CMS have concluded that SNF payments are being inflated by therapy provision directed at maximizing billing rather than targeted to SNF residents’ needs, and all have called for SNF PPS changes.¹ In 2013, CMS contracted with Acumen, LLC, to conduct the SNF PMR project to explore alternative payment methodologies. Acumen has convened four Technical Expert Panels (TEPs) and produced multiple reports² that underpin many proposals in the ANPRM. Goals set by CMS for an alternative SNF PPS payment methodology are:

- To pay SNFs accurately based on beneficiary complexity and required care resources;

¹ For hyperlinks to reports (OIG 2010, 2012, 2015; MedPAC 2017; CMS 2014), see 82 FR 20982-20983.

² Available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html>.

- To avoid incentivizing therapy delivery by payment policy; and,
- To maintain simplicity (case-mix elements, resident assessment requirements).

III. Potential Revisions to the SNF PPS Payment Methodology

A. Revisions to SNF PPS Base Federal Payment Rate Components

The RCS-I resident classification system under consideration by CMS does not calculate new federal base payment rates. However, the two case-mix-adjusted components (therapy and nursing) of both the urban and rural base rates would be subdivided to yield a total of four case-mix-adjusted RCS-I components. The therapy case-mix component would be bifurcated into a physical therapy/occupational therapy (PT/OT) component and a Speech-Language Pathology (SLP) component with both components being case-mix-adjusted. The nursing case-mix component would be split into a nursing component and a NTA component; both components would be case-mix adjusted. Because under the RCS-I model, every SNF resident would be assigned to both a PT/OT classification group and an SLP group, the current therapy non-case mix adjusted component (which applies only to non-rehabilitation SNF residents) would no longer apply to any residents, and could be eliminated. Since the current non-case-mix adjusted component of the base rate represents costs that are consistent for all SNF residents (e.g., room and board), CMS believes this component would be retained unchanged.

CMS notes that the original base rate data sources were described in detail (63 FR 26256-26260) and it suggests using these same sources for the new, separate SLP and NTA service components. In the ANPRM, CMS describes the process used to determine the new SLP base rate. CMS followed the original (1998) base rate calculation process and excluded cost-limit-exempted facilities and costs related to exceptions payments and educational activities. These changes were necessary as the original data are no longer available; because the number of facilities and payments involved are small; and because CMS considers their exclusions to have negligible base rate impact. The data were standardized to control for case-mix and wage-rate effects. The fraction of therapy costs attributable to SLP versus PT/OT was determined using available, distinct SLP, PT, and OT cost centers data. The analysis showed the SLP fraction of the current therapy base rate component is 16% and 18% for urban and rural SNFs, respectively. CMS notes under the RCS-I model, it is considering separating the current therapy case mix component into a separate PT/OT component and a SLP component using these percentages.

For the nursing components, CMS notes that in 1998 the nursing and NTA percentages of the nursing base rate component were 57% and 43% for both urban and rural SNFs (63 FR 65561). CMS verified the nursing split percentages through a process similar to that used for the therapy split³. CMS suggests adopting a 57% nursing and 43% NTA cost split of the case-mix-adjusted nursing component for both urban and rural facilities for the RCS-I.

ANPRM Tables 1 and 2, reproduced below, show the federal base rates if the RCS-I system were applied to the proposed FY 2018 base rates. CMS suggests that under RCS-I, the SNF market basket and the hospital wage index would continue to be used for making annual updates to the SNF federal per diem rates.

³ The verification process yielded nursing/NTA fractions of 56%/44% for urban and 55%/45% for rural SNFs.

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

B. Potential Design and Methodology for Federal Rate Case-Mix Adjustment

CMS anticipates improving SNF PPS accuracy by moving from a heavily facility-centered resident classification system (RUG-IV) to a more resident-centered system (RCS-I). CMS notes that RUG-IV forces a SNF resident's diverse needs and characteristics into a single RUG-IV group for payment. Over 60% of covered SNF days were billed using one of three Ultra-High Rehabilitation RUGs in FY 2016, in which therapy minutes and the Activities of Daily Living (ADL) score dominate payment. RCS-I is designed to emphasize clinical characteristics over service provided in determining payment.

1. Data Sources Utilized for Developing RCS-I

CMS discusses the various data sources utilized by Acumen. Medicare beneficiary enrollment and demographic information were extracted from the CMS enrollment database and the Common Medicare Environment to create a study population for analysis. This study population was used as a resource use predictor and to assess subpopulation impacts of RCS-I. Medicare claims for Parts A and B from the Common Working File and Prescription Drug Event claims were analyzed. SNF claims were aggregated to reconstruct resident SNF stays that were then linked to claims for the qualifying, prior, acute care hospital admission. Other Medicare claims were used for clarification, verification, or subgroup analyses. SNF resident assessments reported to the Quality Improvement Evaluation System (QIES) containing the Minimum Data Set (MDS) were matched to SNF claims data.⁴ Additional variables from other post-acute care (PAC) providers potentially useful for SNF PMR analyses were also accessed through the QIES.⁵ Certification and Survey Provider Enhanced Reports were queried for facility-level characteristics (e.g., size, ownership), supplemented as needed from Medicare cost reports.

2. Resident Classification under RCS-I⁶

The SNF federal per diem base rates are designed to reflect the basic average cost to treat a typical SNF resident. Overlay of a case-mix classification system on base rates is intended to

⁴ The MDS is one of three parts of the Resident Assessment Instrument completed on each resident in a Medicare-certified nursing home on or about the 5th, 14th, 30th, 60th and 90th SNF days; the MDS includes information across more than 15 clinical categories such as nutritional status and need for restraints.

⁵ Sources included the Inpatient Rehabilitation Facility Resident Assessment Instrument (IRF-PAI) and the Home Health Outcome and Assessment Information Set (OASIS).

⁶ Full details of all analyses underpinning RCS-I are available in the SNF PMR technical report at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html>.

identify residents with materially different costs, so that to be useful, the system must incorporate resident characteristics that predict atypical costs and must be structured for operational feasibility.

In the following subsections, CMS describes each of the four case-mix adjusted components and the payment classification under the RCS-I classification model it is considering.

PT and OT Case-Mix Classification. The RUG-IV case-mix model sums together the minutes for all therapy types: PT, OT, and SLP. CMS notes that early SNF PMR analyses found little correlation between PT and OT costs per day with SLP daily costs⁷. In addition, there is poor overlap between MDS characteristics predictive of PT and OT resource use and those predictive for SLP. In contrast, PT and OT costs are highly correlated and are predicted by similar MDS data items. Given these results, CMS is considering combining PT and OT costs under a single case-mix adjusted component and address SLP costs through a separate case-mix adjusted component.

Identifying characteristics best predicting PT/OT costs per day was accomplished through cost regressions with a wide range of variables from multiple sources, including the MDS assessment, the prior inpatient and SNF, and clinical input. The analysis found that the three most relevant predictors of PT/OT costs per day were the clinical reasons for the SNF stay, functional status, and the presence of a cognitive impairment.

Under the RUG-IV case-mix model, residents are first sorted into rehabilitation versus non-rehabilitation cohorts, while under the RCS-I, residents are first sorted by the clinical reasons for the SNF stay. Empirical analysis demonstrated that the clinical basis for the resident's stay proved a strong predictor of therapy costs. With input from TEP members, analysis demonstrated five clinical categories predict varying degrees of PT/OT costs: major joint replacement or spinal surgery, other orthopedic, non-orthopedic surgery, acute neurologic and medical management.

Because data analysis showed RUG-IV function status (as measured by the ADL score) did not capture variations in PT/OT costs, CMS discusses possible revisions to the score. Under the RCS-I, the revised ADL score includes only the self-performance items for just three ADL areas (transfer, toileting, and eating) with each ADL area assessed on a 6-point scale. This produces a functional score that ranges from 0 to 18. Table 5 in the ANPRM provides the scoring algorithm used for each of the three ADL areas and how many points would be scored for each potential response for each area. With these revisions the ADL score correlates linearly with PT/OT costs.

Under RUG-IV, the cognitive status of a resident contributes to classification for only a very few residents. SNF PMR TEP members viewed cognitive status as a significant factor in PT/OT costs and this concept was supported by data analyses. RCS-I uses the Cognitive Function Scale (CFS); the CFS standardizes scoring across the two RUG-IV scales⁸ and the score correlates with PT/OT costs.

⁷ The SNF PMR uses costs as determined from charges and cost-to-charge ratios.

⁸ Brief Interview for Mental Status (BIMS) and Cognitive Performance Scale (CPS) scores are extracted from the MDS.

After identification of the variables for predicting the PT/OT costs, the Classification and Regression Tree (CART) statistical regression technique was applied to delimit the combined PT/OT case-mix groups for RCS-I. Thirty groups were identified; each group matches up to one clinical category, one function score range, plus one cognitive impairment level. PT/OT CMI's were calculated based upon two per diem level factors: average group costs versus the population average and average group variable per diem adjustment factor versus the population average. Table 7 from the ANPRM, reproduced below, shows the criteria for each group, along with the CMI for each group.

Under the RCS-I case-mix model, all residents would be classified into one, and only one of these 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

SLP Case-Mix Classification. CMS notes that many of the resident characteristics predicting higher PT/OT costs predicted lower SLP costs, arguing for a distinct, case-mix adjusted SLP component. CMS discusses the methodology, similar to that used for the RCS-I PT/OT analysis, used to identify predictors of SLP costs. Based on cost regression, three categories of predictors were identified relevant in predicting differences in SLP costs: clinical reasons for the SNF stay, presence of a swallowing disorder or mechanically-altered diet, and the presence of an SLP-related comorbidity or cognitive impairment. The analysis demonstrated one clinical group, the Acute Neurologic group, was particularly predictive of increased SLP costs. Therefore, for SLP purposes, under the RCS-I residents would be first sorted into the Acute Neurologic group or a residual Non-Neurologic group. Based on stakeholder input and additional analysis, CMS is considering classifying residents in the RCS-I based on the presence of a swallowing disorder, mechanically-altered diet, both, or neither. Lastly, based on analysis and input from the TEP and clinicians, CMS identified 12 SLP-related comorbidities that predict relative differences in SLP costs. (See Table 8 in the ANPRM.)

CART analysis was also used to delimit the SLP RCS-I case-mix groups for RCS-I. Eighteen groups were identified; each group links to one clinical SNF admission category; the presence of swallowing disorder/mechanically-altered diet; and cognitive impairment or SLP-related comorbidity. SLP CMI's were then calculated based upon the average per diem group costs versus the population average per diem costs. Table 9 from the ANPRM, reproduced below, shows the criteria for each group, along with the CMI for each group.

Under the RCS-I case-mix model, all residents would be classified into one, and only one, SLP case-mix group.

Table 9: SLP Case-Mix Classification Groups				
Clinical Category	Presence of Swallowing Disorder or Mechanically-Altered Diet	SLP-related Comorbidities 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
Non-Neurologic	Neither	Neither	SI	1.28
	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	

Table 9: SLP Case-Mix Classification Groups				
Clinical Category	Presence of Swallowing Disorder or Mechanically-Altered Diet	SLP-related Comorbidities or Mild to Severe Cognitive Impairment	Case-Mix Group	Case-Mix Index
	Neither	Neither	SR	0.61

Nursing Case-Mix Classification. The RUG-IV initially sorts residents into rehabilitation versus non-rehabilitation cohorts, with over 90 percent sorted into the former. CMS discusses the concerns related to the observations that therapy minutes far outweigh nursing needs in driving payment for rehabilitation residents. Within a single RUG group, the nursing component CMI's are often the same. The tight clustering of many SNF residents into only a few (Ultra-High) RUGs whose nursing CMI's vary little and whose ADL score ranges are wide, further minimizes the impact of resident nursing needs on payment, leaving therapy minutes as the primary payment determinant.

CMS is considering nursing payment revisions during RCS-I implementation including:

- Incorporating a non-rehabilitation RUG group into each nursing payment calculation;
- Basing nursing CMI's on the average per diem, nursing wage-weighted, staff time of each case-mix group relative to the entire SNF population average;
- Revising nursing CMI's using the most recent staff time measurement data⁹ for the entire SNF population rather than non-rehabilitation residents only; and
- Increasing the nursing component for residents with Acquired Immune Deficiency Syndrome (AIDS) by 19 percent, reflecting the most recent staff time measurement data.

CMS discusses the methodology used to determine nursing indexes under the RCS-I Classification model. CMS notes that to help ensure payment reflect the average relative resource used at the per diem level, nursing CMI's would be set to reflect case-mix related relative differences in wage-weighted staff time across groups. Table 10 in the ANPRM provides the nursing indexes under the RCS-I classification model.

Under the RCS-I case-mix model, all residents would be classified into one, and only one, of the 43 nursing case-mix groups.

Non-Therapy Ancillary (NTA) Case-Mix Classification. The current SNF PPS, in which NTA resource use is incorporated into the nursing component, has been criticized for failing to adequately and accurately reimburse NTA costs. CMS addresses this criticism by creating a separate NTA services component, distinct from the nursing services component. The proposed methodology mirrors that previously described for dividing therapy services into distinct PT/OT and SLP components. Cost regression models identified three resident characteristics predictive of NTA cost increases: resident comorbidities, use of extensive services (e.g., expensive, invasive), and resident age. Because age was a much weaker predictor and was not supported by TEP members, age was removed from NTA component payment calculations. For capturing

⁹ These data are from the Staff Time and Resource Intensity Verification (STRIVE) project (FY 2011 RUG-IV).

comorbidity information, SNF resident ICD-10-CM diagnoses (including those on the SNF Day 5 MDS assessment) were mapped to condition categories. Cost regressions identified 28 condition categories and types of extensive services as highly predictive of NTA cost differences (e.g., multiple sclerosis, mechanical ventilation). CMS notes that based on feedback from the TEP, some predictive services were excluded after the TEP linked them to creating potential adverse incentives for their use (e.g., oxygen therapy). TEP input also caused exclusion of some condition categories due to diagnostic coding unreliability (e.g., inflammatory bowel disease). Table 11 in the ANPRM provides the list of conditions and extensive services that would be used for NTA classification.

CMS discusses the different options it considered to capture the variation in NTA costs explained by the identified conditions and services. CMS is considering basing a resident's NTA score (which would be used to classify the resident into a NTA case-mix classification group) on a weighted-count methodology point system based upon NTA relative cost impact. Point values also reflect the additive NTA cost effects of multiple comorbidities. Points would be summed to classify each resident into one NTA case-mix group. CART analysis produced six RCS-I NTA case-mix groups. Table 12 in the ANPRM provides the NTA case-mix classification groups, including the CMI for each group.

To help ensure that payment reflects the relative resource use at the per diem level, CMIs would be set to reflect case-mix related relative differences in cost across groups. CMIs for the NTA component would be based on two factors: the average per diem costs of an NTA case-mix group relative to the SNF population average and the average variable per diem adjustment of the group relative to the SNF population average. Nearly all of the NTA predictive terms can be captured through one or more MDS items except for an HIV/AIDS diagnosis, as the latter is precluded from MDS reporting in 16 states. However, an existing mechanism for capturing an HIV/AIDS diagnosis through claims could be modified so that the relevant claims code would trigger an adjustment of the NTA case-mix group and per diem payment.

Payment Classifications under RCS-I. Currently RUG-IV places each resident into a single RUG that generates a single payment for all services. Under the RCS-I case-mix classification system, each resident is classified separately into the PT/OT, SLP, NTA, and nursing components and a single payment is provided. Under the RCS-I the single payment is the sum of all four adjusted component payments (CMI for the resident's group x the component federal base payment rate) plus the non-case mix component. Nursing payment would be increased by a HIV/AIDS adjustment if applicable, while variable per diem adjustments are made to the PT/OT and NTA components. The ANPRM reviews two examples of RCS-I payment calculations.

4. Variable Per Diem Adjustment Factors and Payment Schedule

The SNF PPS currently makes payment at a constant per diem rate for each RUG regardless of the duration of a resident's classification into a given RUG. SNF PRM analysis showed that resource utilization, as measured by claims-derived costs, varies during a SNF stay. PT/OT and NTA costs typically decline (at different rates) while SLP costs remain constant. Because

nursing costs are not tracked separately they could not be analyzed; TEP members believe these costs remain fairly constant during a SNF stay.

CMS is considering adjustments to the PT/OT and NTA components in the RCS-I Model to account for the effect of length of stay on per diem costs (variable per diem adjustments). CMS is not considering such adjustments to the SLP and nursing components because these resources tend to remain relatively constant over a SNF stay. In addition to considering a variable per diem adjustment, CMS is also considering to have separate adjustment schedules and indexes for the PT/OT component and the NTA component to more closely reflect the rate of decline in resource use for each component. Tables 14 and 15 from the ANPRM are reproduced below.

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

C. Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS), Version 3

1. Potential Revisions to the MDS Completion Schedule

To classify residents under the SNF PPS, CMS uses the MDS 3.0 RAI. The SNF PPS has been criticized for the administrative burden of its resident assessments (scheduled and unscheduled required assessments) and associated complex assessment rules. SNFs are required to complete scheduled assessments on days 5, 14, 30, 60, and 90. Unscheduled assessments, such as the Start of Therapy and the Significant Change in Status (SCSA) may be required when triggered by certain defined events. Unscheduled assessments may also mandate completion of the Care Area Assessment process along with the MDS reporting. All portions of the RAI data are used to classify SNF residents for payment.

Because many resident classification characteristics used in the RCS-I system are relatively stable over time, CMS is considering revising assessment requirements during RCS-I implementation. Mandatory assessments would be performed at Day 5 and at SNF PPS discharge; the discharge assessment would be revised to enable therapy minutes tracking. CMS is considering using the SCSA to reclassify residents from the initial 5-day classification. Because CMS is concerned that providers might be incentivized to conduct multiple SCSA's during a SNF stay, it is considering that in cases where an SCSA is completed, it would use the assessment to reclassify the resident for payment purposes but the resident's variable per diem schedule would continue and not be reset by SCSA submission.

2. Potential Revisions to SNF PPS Therapy Provision Policies

CMS discusses its concerns, based on prior experiences, that under the RCS-I model providers may base decisions regarding the mode of therapy for a given resident on financial considerations instead of the clinical needs of the resident. CMS is concerned that a shift from RUG-IV to RCS-I could incent concurrent and group therapy delivery because of reduced reliance on therapy minutes to determine payment. CMS is considering that RCS-I implementation should include an overall concurrent therapy limit per resident of 25 percent of a SNF resident's therapy minutes and make that limit discipline-specific (similar to existing group therapy constraints). CMS considered, but rejected, an overall 25 percent limit on concurrent and group therapy minutes combined.

3. Interrupted Stay Policy

An interrupted stay occurs when a resident leaves a SNF and returns to the same SNF one or more times within the same SNF Part A benefit period. Currently about 25% of benefit periods involve an interrupted stay and some SNF readmissions are contingent upon an intervening qualifying inpatient hospital stay. Unlike other Medicare PAC programs, the SNF PPS has not included an "interrupted stay" policy because under the RUG-IV given a resident's case-mix group, payment doesn't vary during a SNF stay (absent a change in RUG group assignment).

During RCS-I implementation, CMS is considering adding an interrupted stay policy since the proposed variable per diem adjustment results in different PT/OT and NTA payments at various times within SNF stays. After a detailed review of data related to multiple scenarios, CMS is considering:

- The variable per diem adjustment be reset whenever a resident is discharged then readmitted to a different SNF (where a new MDS assessment would be required);
- The variable per diem adjustment be reset when a resident is discharged then readmitted to the same SNF only if the resident were out of the SNF at least 3 days;
- Readmission of a resident to the same SNF more than 3 days after discharge would trigger a required new MDS assessment (and possible RCS-I reclassification); and
- The resident's RCS-I classification would not change from admission for a readmission to the same SNF occurring in 3 or fewer days after discharge (a new MDS assessment wouldn't be required, although the SNF could choose to complete an SCSA for reclassification if clinically appropriate).

D. Relationship of RCS-I to Existing SNF Level of Care Criteria

Presently, SNF level of care necessity determinations are coordinated with resident assessment and classifications processes, so that the initial assignment to specified RUGs presumptively qualifies the admission for SNF care. As part of RCS-I implementation, administrative presumption of SNF necessity would be applied at the initial MDS assessment:

- To residents assigned to the four most intensive RUG nursing categories (the RCS-I nursing component includes a non-rehabilitation nursing RUG-IV group assignment);
- To residents receiving the highest range PT/OT component functional score; and
- To residents receiving the uppermost NTA component comorbidity score.

Consistent with current practice, a beneficiary who is not assigned to one of the designated groups would receive an individual care determination using the existing administrative criteria.

E. Effect of RCS-I on Temporary AIDS Add-on Payment

Section 511(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provided for a temporary increase of 128 percent in the PPS per diem payment for any SNF residents with AIDS, effective with services furnished on or after October 1, 2004. The MMA specified that this special add-on was to remain in effect only until the Secretary certified there is an appropriate adjustment in the case-mix to compensate for the increase costs associated with residents with AIDS.

With RCS-I implementation, CMS notes the NTA component case-mix adjustment for AIDS appears to adequately address the added costs and CMS believes that it would be appropriate to issue the prescribed certification under the MMA. However, to capture any residual increased nursing costs, CMS is considering a 19 percent nursing component AIDS adjustment (based on regression analyses), that would be made using specific claims coding software programming (similar to that used for the NTA AIDS adjustment described in the ANPRM (82 FR 20998)). CMS believes the temporary add-on could be replaced by a permanent adjustment in the case mix that compensates for the increased costs associated with residents with AIDS.

F. Potential Impacts of RCS-I Implementation

CMS' impact analysis assumes that RCS-I implementation as described herein (plus associated policies) will be budget-neutral and will not require provider behavioral offsets. CMS also describes the methodology it used to apply a parity adjustment to the case-mix weights to maintain the relative value of each CMI while achieving parity on overall SNF payments under both the RCS-I and RUG-4 systems. CMS notes that it is not required to implement RCS-I in a budget neutral manner. **CMS solicits comments on whether it should consider implementing RCS-I in a manner that is not budget neutral.**

Projected payment shifts at the resident subpopulation and facility levels are provided in Tables 18 and 19, respectively (reproduced at the end of this summary). CMS notes the most significant resident-based payment shift will be from those with high therapy provision to those with more complex clinical needs. Resident groups with high NTA costs, end-stage renal disease, longer

SNF-qualifying inpatient hospital stays, and those dually eligible would also see SNF payment increases. For facilities, the most significant shift would be from facilities with high proportions of Ultra-High RUG group rehabilitation residents to those with high non-rehabilitation resident fractions. Potential increases are also forecasted for small, non-profit, government-owned, hospital-based and swing-bed facilities.

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

ANPRM TABLE 18: RCS-I Impact Analysis, Facility Level		
Resident Characteristics	% SNF Stays	Impact (%)
All Stays		
Sex		
Female	62.1	-0.7
Male	37.9	1.2
Age		
< 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
Race/Ethnicity		
White	85.2	-0.1
Black	10.6	0.4
Hispanic	1.6	-0.2
Asian	1.2	-0.8
Native American	0.4	6.6
Other/Unknown	1.1	0.7
Medicare/Medicaid Dual Status		
Dually enrolled	35.2	2.9
Not dually enrolled	64.8	-1.9
Original Reason Medicare Enrollment		
Aged	76.6	-1.2
Disabled	22.5	3.9
ESRD	0.9	10.0
Unknown	0.0	-3.3

ANPRM TABLE 18: RCS-I Impact Analysis, Facility Level		
Resident Characteristics	% SNF Stays	Impact (%)
Number of Utilization Das		
1-15	33.3	15.9
16-30	31.6	0.6
31+	35.1	-2.5
Number of Utilization Days = 100		
No	97.4	0.3
Yes	2.6	-2.7
Length of Qualifying Inpatient Stay (days)		
3	22.5	-2.3
4-30	73.6	0.5
31+	1.8	4.6
Presence Complications MS-DRG Qualifying Stay		
No complication	37.9	-2.3
CC/MCC	62.1	1.4
Stroke		
No	87.5	-0.1
Yes	12.5	0.7
Cognitive Functional Score Level (CFS)		
Intact	54.3	-0.5
Mildly Impaired	22.8	1.6
Moderately Impaired	18.2	-1.8
Severely Impaired	4.6	6.1
HIV		
No	99.7	0.2
Yes	0.3	-40.0
IV Medication		
No	91.4	-2.0
Yes	8.6	22.9
Diabetes		
No	65.0	-2.8
Yes	35.0	5.2
Wound Infection		
No	97.8	-0.4

ANPRM TABLE 18: RCS-I Impact Analysis, Facility Level		
Resident Characteristics	% SNF Stays	Impact (%)
Yes	2.2	17.9
Amputation/Prosthesis Care		
No	100.0	0
Yes	0	4.7
Most Common Therapy Level		
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
Number of Therapy Disciplines Used		
0	5.4	20.0
1	3.3	37.3
2	51.4	1.6
3	39.9	-3.9
PT Utilization		
No	7.3	24.2
Yes	92.7	-1.0
OT Utilization		
No	8.6	24.8
Yes	91.4	-1.2
SLP Utilization		
No	58.4	3.2
Yes	41.6	-3.1
Therapy Utilization		
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

ANPRM TABLE 18: RCS-I Impact Analysis, Facility Level		
Resident Characteristics	% SNF Stays	Impact (%)
NTA Costs (\$)		
0-10	10.9	-2.6
10-50	44.1	-3.2
50-150	32.1	3.5
150+	9.4	19.2
Extensive Services Level		
Tracheostomy/Ventilator/Respirator	0.4	18.1
Tracheostomy or Ventilator/Respirator	0.6	3.1
Infection Isolation	1.3	8.9
Neither	97.8	-0.3

ANPRM TABLE 19: RCS-I Impact Analysis, Facility Level		
Provider Characteristics	Percent of SNF Stays	Percent Change
Institutional type		
Freestanding	95.0	-0.5
Hospital-based/Swing Bed	5.0	15.8
Ownership		
For-profit	71.2	-1.1
Non-profit	23.9	3.1
Government	5.0	7.6
Location		
Urban	70.6	-0.8
Rural	29.4	3.7
Bed Size		
0-49	11.2	6.7
50-99	37.1	0.3
100-149	34.	-0.6
150-199	11.2	-0.5
200+	6.1	-0.7
Census division		
New England	6.2	2.1
Middle Atlantic	11.2	-1.3

ANPRM TABLE 19: RCS-I Impact Analysis, Facility Level		
Provider Characteristics	Percent of SNF Stays	Percent Change
East North Central	19.9	0.2
West North Central	12.8	6.9
South Atlantic	15.4	-0.8
East South Central	6.6	1.0
West South Central	13.2	-1.5
Mountain	4.7	0.9
Pacific	10.1	-1.3
% of Stays with 100 Utilization Days		
0-10	90.4	0.3
10-25	8.6	-3.2
25-100	1.0	-3.9
% of Stays with Medicare/Medicaid Dual Enrollment		
0-10	8.4	-1.7
10-25	17.2	-0.7
25-50	35.5	0.6
50-75	26.5	0.8
75-90	8.5	-0.4
90-100	3.8	-0.5
% of Utilization Days Billed as RU		
0-10	12.5	28.4
10-25	9.8	13.6
25-50	25.5	5.6
50-75	37.2	-1.9
75-90	13.0	-7.1
90-100	2.1	-9.9
% of Utilization Days Billed as Non-Rehabilitation		
0-10	70.4	-2.2
10-25	23.2	6.3
25-50	4.6	20.2
50-75	1.0	45.6
75-90	0.2	44.8
90-100	0.7	38.4