Issue Brief

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CMS Seeks Comments on Possible SNF and Nursing Home Revisions to Case-Mix

The Centers for Medicare and Medicaid Services has issued an advance notice of proposed rulemaking to solicit public comments on potential options the agency may consider for revising certain aspects of the existing skilled nursing facility prospective payment system payment methodology to improve its accuracy, based on the results of the SNF Payment Models Research project.

The document is currently on display at the *Federal Register* office. Publication is scheduled for May 4. A 60-day comment period ending June 26 is provided. A copy is at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-08519.pdf. This link will be superseded upon publication.

"In particular, we [CMS] are seeking comments on the possibility of replacing the SNF PPS' existing case-mix classification model, RUG-IV, with the RCS-I case mix model developed during the SNF PMR project. We also discuss and seek comment on options for how such a change could be implemented, as well as a number of other policy changes we may consider to complement implementation of RCS-I. We would note that we intend to propose case-mix refinements in the FY 2019 SNF PPS proposed rule, and this ANPRM serves to solicit comments on potential revisions we are considering proposing in such rulemaking."

CMS notes that its observed trends in the current SNF PPS strongly suggest that providers may be basing service provision on financial reasons rather than resident needs.

CMS says its goals in developing a potential alternative are as follows:

- 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; and
- To address concerns, along with those of the 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 to determine case-mix, as well as limiting the number of assessments necessary under the payment system.

COMMENT

It would appear that CMS is intent on changing the current RUG IV classification system to one based on a Resident Classification System. Moving to any new system will create "winners and losers." The bottom line to all will be the financial impact.

continued

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THE RCS-1 SYSTEM

The RCS-I case-mix classification system would classify each resident into four components (PT/OT; SLP; NTA; and nursing) 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 day in the variable per diem adjustment schedule.

CMS says that the most significant shift in Medicare payments created by implementation of the RCS-I case-mix model would be from facilities with a high proportion of rehabilitation residents (more specifically, facilities with high proportions of Ultra-High Rehabilitation residents), to facilities with high proportions of non-rehabilitation residents. Other facility types that may see higher relative payments under the RCS-I system are small facilities, non-profit facilities, government-owned facilities, and hospital-based and swing-bed facilities.

CMS provides the following impact table:

RCS-I Impact Analysis, Facility-level		
Provider Characteristics	**% of Providers**	**Percent Change**
All stays	100.0%	0.0%
Institution 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	34.3%	-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%
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%

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continued

RCS-I Impact Analysis, Facility-level		
Provider Characteristics	**% of Providers**	**Percent Change**
% 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%

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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