Center for Medicare Advocacy

CMS Tries Again: Another New Skilled Nursing Facility Medicare Reimbursement System Proposed – If Implemented, Would Gut Therapy

medicareadvocacy.org/cms-tries-again-another-new-skilled-nursing-facility-medicare-reimbursement-system-proposed-if-implemented-would-gut-therapy

> Proposed changes to nursing facility payment under consideration by CMS would reduce financial incentives to provide therapy, and would do so with such force – providing higher reimbursement to skilled nursing facilities (SNFs) that provide residents fewer types of therapy over a shorter period of time, or no therapy at all – that it would actually encourage facilities not to provide therapy. Further, the Jimmo v. Sebelius mandate to cover maintenance therapy would be ignored.
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> **Comments on the NPRM are due June 26, 2018**. More details on the proposed changes below.

Ever since the prospective payment system for Medicare coverage of skilled nursing facilities (SNFs) was first implemented in 1998, the system has faced ongoing criticism. Critics, including the Medicare Payment Advisory Commission[1] and the Department of Health and Human Services' Office of Inspector General,[2] report that the reimbursement system encourages over-utilization of therapy services and provides insufficient payment for nursing services and inaccurate payment for non-therapy ancillary services (chiefly prescription drugs). In May 2017, the Centers for Medicare & Medicaid Services (CMS) published an Advance Notice of Proposed Rulemaking (ANPRM) to solicit comments on options under consideration for revising the reimbursement system.[3] CMS set out a proposed framework for a new Medicare payment system for SNFs, called Resident Classification System, Version I (RCS-I).

This May, as part of the annual update to Medicare SNF reimbursement, CMS abandoned RCS-I. Instead, CMS proposes a different revised reimbursement system for SNFs, now called Patient-Driven Payment Model (PDPM).[4] However, although CMS describes PDPM as different from RCS-I, in fact, many of the most troubling features are identical, if not worse. Concessions to the nursing home industry (including requirements for fewer resident assessments and permission to use group and concurrent therapy for up to 25% of a resident's therapy services) do not improve care for residents, and encourage gaming.

As described in detail in the NPRM (and illustrated in the chart below), PDPM dramatically changes the financial incentives for SNFs. **Under PDPM, as under RCS-I, SNFs would receive higher reimbursement if they provided 15 or fewer days of Medicare coverage and no therapy. Medicare reimbursement would also be higher if 50-75% of a SNF's Medicare days were billed as non-rehabilitation. In contrast, Medicare**

reimbursement would be lower for SNFs providing care to the oldest residents (age 90+), residents receiving three types of therapy, and residents having 31 or more days of care paid by Medicare.

Current Medicare Reimbursement System for SNFs

The current system, called Resource Utilization Groups (RUGs), uses a case-mix component and a non case-mix component (which reflects room and board and various capital costs). The case-mix component uses resident assessment information to determine a resident's classification for payment purposes. RUG-IV has two case-mix categories – nursing (which includes non-therapy ancillary services) and therapy (which includes physical, occupational, and speech therapy). A resident's RUG classification is based on the higher of the two case-mix categories. Payment for residents in therapy groups reflects the amount of therapy that a SNF reports providing. There are now 66 RUG-IV classifications based on resident assessment information. At this time, more than 90% of residents are assigned to a rehabilitation-based RUG.[5]

PDPM

Instead of the RUG-IVs' two components (nursing and therapy) for case-mix adjustment, PDPM creates six federal base payment rate components, five that are case-mix adjusted and one that is not. As described below, these components are used to determine the per diem rate:

Case mix-adjusted component (5 parts)

Nursing

1. Nursing (57% of current nursing component)
2. Non-therapy ancillary (43% of current nursing component)

Therapy

3. Physical therapy
4. Occupational therapy
5. Speech-language pathology

Non case-mix-adjusted component (1 part)[6]

Case-Mix Adjustments under PDPM

Area	Case-mix adjustment	Number of case-mix categories
Physical therapy[7]	*clinical reason for hospital stay (using either hospital or SNF (MDS) assessment); 4 clinical categories (major joint replacement or spinal surgery, non-orthopedic surgery and acute neurologic, other orthopedic, and medical management) *functional status (4 late-loss ADLs (bed mobility, transfer, eating, toileting) and 2 early-loss ADLs (oral hygiene, walking) NOT INCLUDING COMPONENT FOR COGNITIVE IMPAIRMENT	16 case-mix categories
Occupational therapy[8]	* clinical reason for hospital stay (using either hospital or SNF (MDS) assessment); 4 clinical categories (major joint replacement or spinal surgery, non-orthopedic surgery and acute neurologic, other orthopedic, and medical management) * functional status (4 late-loss ADLs (bed mobility, transfer, eating, toileting) and 2 early-loss ADLs (oral hygiene, walking) NOT INCLUDING COMPONENT FOR COGNITIVE IMPAIRMENT	16 case-mix groups
Speech language pathology[9]	*clinical reasons for hospital stay (using 2 clinical categories) *presence of swallowing disorder or mechanically-altered diet	18 case-mix groups
Nursing[10]	*uses CMS's staff-time motion study, called Staff Time and Resource Intensity Verification (STRIVE) that was used to develop case-mix categories for RUG-IV *functional status based on section GG of MDS	25 case-mix groups
Non-therapy ancillary[11]	*weighted count methodology	6 case-mix groups

Reporting that PT, OT, and NTA costs decline over the course of a resident's stay, while nursing and ST do not decline, CMS proposes a **variable per diem adjustment** for the three components that decline:

- A decline of 2% every 7 days after day 20 (0.3 * 7 = 2.1) for PT and OT. [12] Table 30

indicates, for example, an adjustment factor of 0.88 for Medicare payment days 56-62, up to a 0.76 adjustment factor for days 96-100.
- A decline of 3% beginning on day 4 of a Part A stay for NTA.[13]

(In contrast, RCS-I used a variable per diem adjustment that it applied to the rate as a whole, not to three portions of the per diem rate.[14])

To determine the per day rate for a particular resident, PDPM

- Classifies the resident into the five case-mix adjusted components (physical therapy, occupational therapy, speech and language pathology, nursing, and non-therapy ancillaries),
- Calculates the payment for each component by multiplying the case-mix index by the component federal base payment rate,
- Further calculates the payment for each component by applying the specific day in the variable per diem adjustment schedule, and
- Adds these five separately-calculated components to the non-case-mix adjusted component payment rate.[15]

Another significant change from RUG-IV is the proposal to use the 5-day assessment for the entirety of a resident's Part A stay.[16] Under RUG-IV, payments are adjusted to reflect scheduled assessments that are conducted on days 15, 30, 60, and 90.[17]

An Interim Payment Assessment (IPA) may be used to change a resident's classification in order to reflect a significant change in a resident's condition.[18] The Discharge Assessment collects information on amounts of therapy provided during the Medicare-covered stay.[19] CMS also proposes allowing facilities to use group therapy and concurrent therapy, for up to 25% of the therapy provided to a resident.[20]

Discussion of nursing in the NPRM is extremely limited.[21] Acknowledging that it was "unable to construct a measure of nursing utilization based on current data because facilities do not report resident specific nursing costs,"[22] CMS used the STRIVE methodology (developed between 2005 and 2009 and used to establish RUG-IV)[23] and the newer assessment rules (Section GG of MDS 3.0).[24]

Winners and Losers Under PDPM

As for RCS-I, CMS provides two Tables identifying the impact of the proposed reimbursement system on reimbursement rates for individual residents and for facilities. Although some of the specific changes are different from those that would have resulted if CMS had gone forward with RCS-I, the changes are in fact more pronounced in PDPM. Some key changes are highlighted.

Impact Analysis, Resident-Level[25]

Resident characteristics	**Higher reimbursement**	**% change PDPM**	**% change RCS-I**	**Lower reimbursement**	**% change PDPM**	**% change RCS-I**
Gender	Males	1.2%	1.2%	Females	-0.8%	-0.7%
Age	Residents under 65	7.2%	5.4%	Residents 90+ years	-4.3%	-2.8%
Medicare/Medicaid dual status	Residents who are dually eligible for Medicare and Medicaid	3.3%%	2.9%	Residents are not dually eligible for Medicare and Medicaid	-2.1%	-1.9%
Disability status	Residents who are disabled	4.8%	3.9%	**Residents who are aged**	**-1.7%**	**-1.2%**
Length of SNF stay	**Residents with SNF stays of 1-15 days**	**13.7%**	**15.9%**	**Residents with stays of 31+ days**	**-2.5%**	**-2.5%**
Use of 100-day SNF benefit	Residents not using 100 days	0.1%	0.3%	Residents using 100 days	-1.9%	-2.7%
Length of qualifying acute care stay	Residents with 31+ qualifying inpatient days	6.7%	4.6%	Residents with 3 qualifying inpatient days	-3.3%	-2.3%
Admitted with diagnosis of a stroke	Residents with a stroke	0.3%	0.7%	Residents without a stroke	0.0%	-0.1%
Presence of cognitive impairment	Residents who are severely cognitively impaired	8.8%	6.1%	Residents who are moderately cognitively impaired	-0.7%	-1.8%

Admitted with, or has diagnosis of, HIV	Residents without HIV	0.3%	0.2%	Residents with HIV	-40.5%	-40.0%
Receipt of IV medications during stay	**Residents with IV medication**	23.5%	22.9%	Residents without IV medication	-2.1%	-2.0%
Presence of wound infection	Residents with wound infections	22.2%	17.9%	Residents without wound infections	-0.3%	-2.8%
Receipt of therapy services during SNF stay	**Residents receiving a single therapy**	**44.2%**	**37.3%**	**Residents receiving 3 therapies**	**-3.1%**	**-3.9%**
	Residents not receiving any physical therapy	**50.9%**	**24.2%**	Residents receiving physical therapy	-0.7%	-1.0%
	Residents not receiving any occupational therapy	**47.7%**	**24.8%**	Residents receiving occupational therapy	-0.8%	-1.2%
	Residents receiving only occupational therapy	**47.9%**	**41.8%**	Residents receiving physical, occupational, and speech therapy	-3.1%	-3.9%
Non-therapy ancillary costs during SNF stay	Residents with NTA costs of $150	18.7%	19.2%	Residents with NTA costs of $10-$50	-3.1%	-3.1% (same)
Use of extensive services	Residents with tracheostomy	7.3%	18.1%			

The NPRM identifies the impact of PDPM on reimbursement rates for facilities.

Impact Analysis, Facility-Level[26]

Provider characteristics	**Higher reimbursement**	**% change PDPM**	**% change RCS-I**	**Lower reimbursement**	**% change PDPM**	**% change RCS-I**
Facility size	Small facilities, 0-49 beds	3.5%	6.7%	Facilities with 200+ beds	-1.8%	-0.7%
Ownership status	Non-profit facilities	**1.9%**	**3.1%**	**For-profit facilities**	**-0.7%**	**01.1%**
	Government-owned facilities	4.2%	7.6%			
Institution type	Hospital-based and swing-bed facilities	16.7%	15.8%			
% of SNF stays with 100 day utilization	**SNFs with 1-10% of their stays utilizing 100 days**	**0.1%**	**0.3%**	**SNFs with 25-100% of their stays utilizing 100 days**	**-3.6%**	**-3.9%**
% of SNF stays with Medicare/Medicaid dual enrollment	SNFs with 50-75% of their stays with dual eligible residents	1.3%	0.8%	SNFs with 0-10% of their stays with dual eligible residents	-1.3%	-1.7%
% of SNF utilization days billed as rehabilitation ultra high (RU)	SNFs with 1-10% of the utilization days billed as RU	27.6%	28.4%	SNFs with 90-100% of the utilization days billed as RU	-9.8%	-9.9%

% of SNF utilization days billed as non-rehabilitation	SNFs with 50-75% of the utilization days billed as non-rehabilitation	35.8%	45.6%	SNFs with 0-10% of the utilization days billed as non-rehabilitation	-1.5%	-2.2%

Center for Medicare Advocacy Concerns

As demonstrated by the charts above, the proposed revision to Medicare reimbursement for SNFs dramatically alters the Medicare benefit, encouraging less therapy and shorter Medicare-covered stays. PDPM does not necessarily improve nurse staffing levels.

Does PDPM Improve Reimbursement?

The short answer is no.

First, PDPM does not more accurately pay SNFs for providing care to residents who are in a Medicare Part A-covered stay; it simply reallocates payments. PDPM does not necessarily pay SNFs appropriately for providing the care and services they are required to provide under the federal Nursing Home Reform Law.[27] The revised Requirements of Participation are not reflected in the proposal.

Second, PDPM's overzealous reduced payments for therapy – giving higher reimbursement to SNFs that provide residents fewer types of therapy over a shorter period of time, or no therapy at all – actively encourage facilities *not* to provide therapy. *Jimmo's***[28]** mandate to cover maintenance nursing and therapy is completely ignored. People in need of this important care will be in jeopardy.

Finally, while PDPM eliminates what SNFs consider paperwork burdens (additional resident assessments) and reduces the number of case-mix categories (as compared to RCS-I), for purposes of reimbursement, it does little or nothing to increase reimbursement for nursing services.

Submitting Comments

Comments must be submitted by June 26, 2018. When commenting, refer to file code CMS-1696-P. Comments may be submitted electronically, at http://ww.regulations.gov, by regular mail, by express or overnight mail, or by hand or courier.[29] Contact the Center for Medicare Advocacy if you would like help with comments.

T. Edelman, May 2018

[1] MedPAC, *Report to the Congress: Medicare Payment Policy*, Chapter 8, page 200 (Mar. 2017) (calling for lower rates and a revised reimbursement system. "Under a revised design, payments would increase for medically complex stays and decrease for stays that include intensive therapy that is unrelated to a patient's care needs."), http://medpac.gov/docs/default-source/reports/mar17_entirereport.pdf?sfvrsn=0.
[2] OIG. *Questionable Billing by Skilled Nursing Facilities* (Dec. 2010), https://oig.hhs.gov/oei/reports/oei-02-09-00202.pdf; OIG, *Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009* (Nov. 2012), https://oig.hhs.gov/oei/reports/oei-02-09-00200.pdf; OIG, *The Medicare Payment System for Skilled Nursing Facilities Needs to be Reevaluated* (Sep. 2015), https://oig.hhs.gov/oei/reports/oei-02-13-00610.pdf).
[3] 82 Federal Register 20980 (May 4, 2017), https://www.gpo.gov/fdsys/pkg/FR-2017-05-04/pdf/2017-08519.pdf.
[4] 83 Fed. Reg. 21018, 21034-21080 (May 8, 2018), https://www.gpo.gov/fdsys/pkg/FR-2018-05-08/pdf/2018-09015.pdf.
[5] 83 Fed. Reg. 21018, 21034-21036.
[6] 83 Fed. Reg. 21018, 21037.
[7] 83 Fed. Reg. 21018, 21042-21049.
[8] 83 Fed. Reg. 21018, 21049-21049.
[9] 83 Fed. Reg. 21018, 20149-21051.
[10] 83 Fed. Reg. 21018, 21051-21055.
[11] 83 Fed. Reg. 21018, 21055-21059.
[12] 83 Fed. Reg. 21018, 21061, Table 30.
[13] 83 Fed. Reg. 21018, 20161, Table 31.
[14] 82 Fed. Reg. 20980, 21002, Table 14.
[15] 83 Fed. Reg. 21018, 21059.
[16] 83 Fed. Reg. 21018, 21062.
[17] 83 Red. Reg. 21018, 21062 Table 32.
[18] 83 Fed. Reg. 21018, 21062-21063, 21064, Table 33.
[19] 83 Fed. Reg. 21018, 21063-21064, Table 33.
[20] 83 Fed. Reg. 21018, 21065-21068.
[21] 83 Fed. Reg. 21018, 21051-21055.
[22] 83 Fed. Reg. 21018, 21052.
[23] CMS, *Time Study* (STRIVE), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/TimeStudy.html.
[24] 83 Fed. Reg. 21018, 21052-21054.
[25] 83 Fed. Reg. 21018, 21075-21077, Table 37.
[26] 81 Fed. Reg. 21018, 21077-21079, Table 38.
[27] 42 U.S.C. §1395 i-3(a)-(h), 1396r(a)-(h), Medicare and Medicaid, respectively.

[28] *See* the Center's extensive materials on *Jimmo* at https://www.medicareadvocacy.org/?s=Jimmo&op.x=0&op.y=0.
[29] 83 Fed. Reg. 21018.