Summary of 2018 Skilled Nursing Center Prospective Payment System Proposed Rule and Pre-Rule on Possible New Payment System

*Our rates increase 1.0 percent starting October 1, 2017*

April 27, 2017

Today, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule [CMS-1679-P] outlining proposed Fiscal Year (FY) 2018 Medicare payment rates and quality programs for skilled nursing facilities (SNFs).

Additionally, CMS released a separate Advanced Notice of Proposed Rulemaking (ANPRM) [CMS-1686-ANPRM], or “pre-rule,” which solicits comment on potential revisions to the SNF payment system, based on research conducted under the SNF Payment Models Research project. CMS may, or may not, take action on the proposal discussed in the pre-rule.

**FY18 Payment Update Notice of Proposed Rulemaking**

Today, CMS issued our annual payment update regulation. The proposed rule for FY 2018 establishes a net market basket increase of 1.0 percent. CMS is also proposing to revise and rebase the market basket index by updating the base year from FY 2010 to FY 2014 (see below). Based on proposed changes contained within this proposed rule, CMS projects aggregate payments to SNFs will increase in FY 2018 by $390 million, or 1.0 percent, from payments in FY 2017.

In addition to the payment system updates, CMS also notes three sections in the Long Term Care Requirements of Participation which it believe cause undue provider burden and invites payment and regulatory ideas for submission to the Center for Medicare and Medicaid Innovation. Finally, the proposed rule includes two opportunities to innovate in SNF policy and broader Medicare policy.

Specifically, for FY 2018, the update is a result of last year’s “permanent doc fix”, which required all post-acute care (PAC) providers to receive a maximum market basket update of 1.0 percent in FY 2018 to offset part of the cost of the bill. The FY 2018 update would have otherwise been a net increase of 2.3 percent, which reflects an increase of 2.7 percent minus a 0.4 percent multifactor productivity adjustment as required by Section 3401(b) of the Affordable Care Act (ACA). No forecast error was incurred.
CMS is also proposing that beginning in FY 2018, SNFs that do not satisfy the reporting requirements for the FY 2018 SNF Quality Reporting Program (QRP) would have a penalty of a 2.0 percent reduction to the SNF market basket percentage change for that fiscal year, after any applicable adjustments. With application of this penalty, those SNFs that do not meet the reporting requirements would receive a market basket update of negative 1.0 percent.

Additionally, CMS proposes to revise and rebase the market basket base year from federal fiscal year 2010 to 2014. CMS updates the market basket base year every three to five years. The last rebase year was 2014. Of note, CMS is transitioning from a federal fiscal base year to calendar base year 2014. Additionally, CMS is taking a more granular approach to developing the cost category weights for the 2014-based SNF market basket. AHCA will conduct an in-depth analysis of the market basket base year update approach and provide that to members when available.

CMS specifies several elements of the SNF Value-based Purchasing (VBP) program, including a proposed formula to translate SNF performance into incentive payments as well as how and when the Agency intends to publish SNF performance for the public. The proposed rule also includes updates to the Quality Reporting Program (QRP), including modifications to existing SNF QRP measures as well as adoption of additional measures.

Below please find a highlights section and preliminary overview of the payment updates, the SNF value-based purchasing (VBP) program proposed new components, and the IMPACT Act quality reporting additions. Comments, suggestions and questions may be directed to Mike Cheek.
HIGHLIGHTS

- The proposed rule provides for a net market basket increase for SNFs of 1.0 percent beginning October 1, 2017. CMS is also proposing to revise and rebase the market basket index by updating the base year from FY 2010 to CY 2014.

- The 1.0 percent market basket update reflects a full market basket increase of 2.7 percent reduced by 0.4 percentage points, in accordance with the multifactor productivity adjustment required by Section 3401(b) of the Affordable Care Act (ACA). No forecast error was incurred.

- The market basket update of 1.0 percent for FY 2018 for the SNF PPS is based on the IHS Global Insight, Inc. (IGI) first quarter 2016 forecast with historical data through fourth quarter 2016. This figure could change when CMS issues the final rule based on more recent IGI data.

- CMS estimates that the net market basket update would increase Medicare SNF payments by approximately $390 million in FY 2018.

- As noted above, a forecast error correction was not needed. Since the difference between the estimated and actual amount of change in the market basket index was below the 0.5 percentage point threshold in FY 2016, the payment rates for FY 2018 are not impacted by the current IGI data.

- In accordance with the Medicare Modernization Act (MMA), the per diem rate for SNF patients with Acquired Immune Deficiency Syndrome (AIDS) had been increased by 128 percent as of October 1, 2004. Under the CMS proposed rule, this add-on will remain in effect for FY 2018.

- CMS proposes that beginning in FY 2018, SNFs that do not satisfy the reporting requirements for the FY 2018 SNF Quality Reporting Program (QRP), would have a penalty of a 2.0 percent reduction to the SNF market basket percentage change for that fiscal year, after any applicable adjustments. With application of this penalty, those SNFs that do not meet the reporting requirements would receive a market basket update of negative 1.0 percent for FY 2018.

- As noted earlier, the Skilled Nursing Facility VBP Program (SNF VBP) is discussed. Establishment of the program, which implements a 2 percent withhold to SNF Part A payments that can be earned back based on a SNF’s rehospitalization rate and level of improvement, is required by the Protecting Access to Medicare Act of 2014 (PAMA). CMS proposes that the performance period be based on the calendar year starting January 1, 2017. CMS proposes that the total amount of funds that would be available to for incentive payments for qualifying facilities in a fiscal year would be 60 percent of the amounts withheld from SNFs’ claims. AHCA/NCAL will continue to urge CMS to use 70 percent of the incentive pool for value-based payments.
The SNF NPRM contains a section on the SNF Quality Reporting Program (QRP), which is how CMS is operationalizing the IMPACT Act legislation. Last year, CMS finalized four measures for the SNF QRP and specified the changes necessary in the MDS. CMS also finalized the timeline for implementation of the SNF QRP measures from the 2016 and 2017 rules. Beginning with the FY 2020 SNF QRP, CMS proposes to remove the current pressure ulcer measure entitled Percent of Residents of Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and to replace it with a modified version of the measure entitled Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

Below is a more detailed discussion of the proposed rule. After each section, we have provided the contact information for AHCA staff whom you may contact with questions.
DISCUSSION

I. The SNF Market Basket

A. The SNF PPS Market Basket Update

Section 411(a) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (Pub. L. 114-10, enacted on April 16, 2015), otherwise known as the permanent doc fix, required all post-acute care (PAC) providers to receive a maximum of a 1.0 percent update to rates in FY 2018 to help offset the cost of the legislation. As such, this proposed rule provides for a net market basket increase for SNFs of 1.0 percent beginning October 1, 2017. Absent Section 411(a) of the MACRA, the FY 2018 market basket update would have reflected a full market basket increase of 2.7 percentage points, minus a 0.4 percentage point multifactor productivity adjustment required by Section 3401(b) of the ACA. No forecast error adjustment was incurred. CMS estimates that the net market basket update of 1.0 percent would increase Medicare SNF payments by approximately $390 million in FY 2018.

B. Forecast Error Adjustment to the SNF Market Basket

The regulations at 42 CFR §413.337(d)(2) provide for an adjustment to account for market basket forecast error. Adjustments consider the forecast error from the most recently available fiscal year for which there is final data and apply the difference between the forecasted and actual change in the market basket when the difference exceeds a specified threshold. CMS originally used a 0.25 percentage point threshold for this purpose but adopted a 0.5 percentage point threshold effective for FY 2008 and subsequent fiscal years. The adjustment reflects both upward and downward adjustments, as appropriate.

For FY 2016 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 2.3 percentage points, and the actual increase for FY 2016 was also 2.3 percentage points, resulting in no difference between the actual increase and the estimated increase.

Because the difference between the estimated and actual amount of change in the market basket index was 0 (and therefore does not exceed the 0.5 percentage point threshold), the FY 2018 market basket receives no forecast error adjustment. As noted earlier, an adjustment could be incurred in the final rule using more current IGI data. Table 2 shows the forecasted and actual market basket amounts for FY 2016.

Table 2

<table>
<thead>
<tr>
<th>INDEX</th>
<th>FORECASTED FY 2015 INCREASE*</th>
<th>ACTUAL FY 2015 INCREASE**</th>
<th>FY 2015 DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF</td>
<td>2.3</td>
<td>2.3</td>
<td>0.0</td>
</tr>
</tbody>
</table>

*Published in Federal Register; based on second quarter 2015 IGI forecast (2010-based index).
**Based on the first quarter 2017 IHS Global Insight forecast, with historical data through the fourth quarter 2016 (2010-based index).
C. Multifactor Productivity Adjustment

Section 3401(b) of the ACA requires that in FY 2012 (and in subsequent FYs), the market basket percentage under the SNF payment system as described in section 1888(e)(5)(B)(i) of the Act is to be reduced annually by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act, added by section 3401(a) of the ACA, sets forth the definition of this productivity adjustment.

The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (the MFP adjustment). This is projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost-reporting period, or other annual period.

The Bureau of Labor Statistics is the agency that publishes the official measure of private nonfarm business MFP adjustment. For the FY 2018 update, the MFP adjustment is calculated as the 10-year moving average of changes in MFP for the period ending September 30, 2018, which is estimated to be 0.4 percent.

Absent Section 411(a) of the MACRA, which capped the update to PAC providers in FY 2018 at 1.0 percent, the resulting MFP-adjusted SNF market basket update would have been equal to 2.3 percent, or 2.7 percent less 0.4 percentage points. The final update percentages would have been adjusted further by the wage index budget neutrality factor (see below).

D. Federal Rate Per Diem Components

CMS used the SNF market basket, adjusted for the forecast error correction and the multifactor productivity adjustment, as described above, to adjust each per diem component of the federal rates forward to reflect the change in the average prices for FY 2018 from average prices for FY 2017. CMS indicates it would further adjust the rates by a wage index budget neutrality factor, described later in this section. Tables 3 and 4 reflect the updated components of the unadjusted federal rates for FY 2018 prior to adjustment for case-mix.

Table 3

<table>
<thead>
<tr>
<th>RATE COMPONENT</th>
<th>NURSING CASE-MIX</th>
<th>THERAPY CASE-MIX</th>
<th>THERAPY NON-CASE-MIX</th>
<th>NON-CASE-MIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>PER DIEM AMOUNT</td>
<td>$177.16</td>
<td>$133.44</td>
<td>$17.58</td>
<td>$90.42</td>
</tr>
</tbody>
</table>
Table 4  
FY 2018 Unadjusted Federal Rate Per Diem  
Rural

<table>
<thead>
<tr>
<th>RATE COMPONENT</th>
<th>NURSING CASE-MIX</th>
<th>THERAPY CASE MIX</th>
<th>THERAPY NON-CASE-MIX</th>
<th>NON-CASE-MIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>PER DIEM AMOUNT</td>
<td>$169.24</td>
<td>$153.87</td>
<td>$18.78</td>
<td>$92.09</td>
</tr>
</tbody>
</table>

The proposed wage index is available on the CMS website [here](#). If you have any questions regarding Section I, please contact Mike Cheek.

II. Skilled Nursing Facility Value Based Purchasing Program

The Skilled Nursing Facility Value Based Purchasing Program (SNF VBP), which was part of the Protecting Access to Medicare Act of 2014 (PAMA), will cut SNFs part A payment rates up to 2% based on their national ranking on their rehospitalization score. The size of the cut is based on the “exchange function” formula and the amount of program savings required. The statute sets up the savings based on using 50-70 percent of an “incentive pool” created by calculating what is 2% of the total SNF Part A payments nationally in a defined year. This year’s rule clarifies which year this is based on and if they use 50 percent or 70 percent or some value in between.

A SNF’s rehospitalization score is the better of either an achievement score (i.e. the rehospitalization rate) or improvement score (i.e. the change in rehospitalization rate over time). The PAMA requires that the lower 40 percent of ranked SNFs will receive less than the top 60 percent of ranked SNFs. The rehospitalization score and withhold will be publicly reported.

In last year’s rule, CMS finalized a new rehospitalization measure, SNF Potentially Preventable Rehospitalization (PPR), to comply with PAMA requirements that CMS to transition from an all cause measure (SNF RM) to a potentially preventable measure. CMS also finalized how it will calculate the achievement score and improvement score to determine the overall rehospitalization score used to rank SNFs and determine their SNF Part A payment adjustment.

The achievement score will be based on a calendar year (CY) with the first year being CY 2017 (e.g. January 1, 2017 through December 31, 2017). SNFs in the bottom 25 percent nationally will receive zero points, and those in the top 5 percent will receive 100 points. The rest of the points will be based on a SNF’s ranking between the bottom 25 percent and top 5 percent. The improvement score will be based on improvement over a two-year period, initially comparing a SNF’s rehospitalization rate from CY 2015 to CY 2017. With no improvement, a SNF receives zero points. The rest is based on how much improvement occurs from the baseline to performance period, relative to the top 5 percent.
In the FY18 proposed rule, CMS specifies the following:

**a. Size of Incentive Pool:** CMS proposes that the total amount of funds that would be available for incentive payments for qualifying facilities in a fiscal year would be 60 percent of the amounts withheld from SNFs’ claims. AHCA/NCAL will continue to urge CMS to use 70 percent of the incentive pool for value-based payments.

**b. Inclusion/Exclusion of Smaller SNFs:** CMS reiterates that statute requires the Agency to include all SNFs in the VBP Program, and they do not believe they have the statutory authority to exclude any facilities from the withhold and/or value-based incentive payments. However, CMS is requesting feedback on accommodations the Agency can make to ensure that SNFs that are meeting quality goals are not wrongfully penalized. AHCA/NCAL will continue to relay concerns regarding inappropriate inclusion of facilities that would be adversely impacted.

**c. Exchange Function to Determine Payment Adjustment:** CMS proposes to use a logistic function for the FY 2019 SNF VBP Program and subsequent years, which is the exchange function AHCA/NCAL supported. AHCA/NCAL will analyze the formula in further detail to assess the impacts on members. We will also develop tools and resources to help members understand facility-level impacts.

**d. SNF VBP Public Reporting:** CMS proposes to begin publishing SNF performance data on Nursing Home Compare no later than October 1, 2017, and indicates that it will only publish performance information for which SNFs have had the opportunity to review and submit corrections. In addition, CMS proposes to publish SNF ranking data on both the Nursing Home Compare and Quality Net websites after August 1, 2018, when performance scores and incentive payments will be made. CMS intends to publish the ranking for each program year once performance scores and incentive payments are available to SNFs.

**e. Transition from SNFRM Measure to SNFPPR Measure:** CMS proposes to replace the SNFRM with the SNFPPR in the FY 2021 program year, which aligns with AHCA/NCAL’s recommendation to delay transition for two years. CMS states that it will continue to analyze SNF performance on the SNFPPR in comparison to the SNFRM and assess how the measure transition will impact the quality of care.

CMS does not propose changes but asks for comments and input on a number of other considerations for VBP, such as the inclusion of social economic status and other social risk factors in the risk adjustment for the rehospitalization measure. AHCA/NCAL will be reviewing these over the coming weeks and asking members for input on our response.

AHCA/NCAL staff will be analyzing this section in much greater detail given the impact this will have on SNFs Part A payment rates. Please contact David Gifford or Holly Harmon with any questions on this VBP section.
III. Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

The SNF NPRM contains a section on the SNF Quality Reporting Program (QRP), which is how CMS is operationalizing the IMPACT Act legislation. Last year, CMS finalized four measures for the SNF QRP and specified the changes necessary in the MDS. CMS also finalized the timeline for implementation of the SNF QRP measures from the 2016 and 2017 rules.

Beginning with the FY 2020 SNF QRP, CMS proposes to remove the current pressure ulcer measure entitled Percent of Residents of Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and to replace it with a modified version of the measure entitled Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

CMS also proposes to adopt four function outcome measures on resident functional status:

- Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)
- Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
- Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635)
- Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).

In addition, CMS proposes to modify two current SNF QRP measures:

- Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) modification would increase the length of the measurement period from 1 year to 2 years of claims data to expand the number of SNFs that meet the minimum stays threshold for public reporting. Additional modification would update the public reporting dates for this measure from calendar year to fiscal year.
- Discharge to Community-PAC SNF QRP measure modification would exclude baseline nursing facility residents from the measure, as these residents did not live in the community prior to the SNF stay. AHCA/NCAL has advocated for this exclusion from the Discharge to Community measure and is pleased to see CMS move forward on this issue.

Proposed Standardized Patient Assessment Data

CMS is proposing required standardized patient assessment data items per domain as outlined by IMPACT Act. AHCA has diligently advocated to CMS to use existing MDS items and not duplicate assessment items and we are pleased with this direction. CMS is proposing to use several items already existing in the MDS as standardized patient assessment data.
There are some areas where CMS is proposing expansion of the response options under current MDS items to provide a greater level of detail in the standardized patient assessment data. AHCA will examine CMS’s request for input about making changes to MDS sections for different clinical conditions and will be seeking member input on our response in the coming weeks.

**Proposed Public Display of SNF QRP Measure Data**

CMS is proposing, pending the availability of data, to publicly report data in CY 2018 for the SNF QRP measures currently in use:

Three assessment-based measures:
- Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631);
- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678); and
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF# 0674).

Three claims-based measures:
- Medicare Spending Per Beneficiary-PAC SNF QRP;
- Discharge to Community-PAC SNF QRP; and
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for SNF QRP

**Conclusion**

We recognize the addition of VBP and QRP to our annual payment rule represents a significant change in expectations of the profession. AHCA/NCAL is working to ensure coordinated discussions among various CMS divisions to maximize our impact. We hope you find this document useful and we look forward to your valuable thoughts and comments.

AHCA/NCAL staff will be reviewing the measure specifications carefully over the coming days. The lead contacts for this quality reporting section are Holly Harmon and David Gifford.

**IV. Other Key Provisions**

CMS also lays out two items related to regulatory oversight and solicits input on improving Medicare regulation and payment.

**A. Survey Team Composition**

CMS addresses confusion as to whether complaint survey teams fall under §488.314 which requires the survey team to include a registered nurse or §488.332 which does not require a registered nurse on the survey team. CMS is proposing that complaint surveys follow the requirement of §488.332, meaning that a complaint survey does not require a registered nurse to participate on the survey team.
B. Possible Burden Reduction in the Long-Term Care Requirements
CMS is asking for feedback regarding the potential impact of revisions to level of detail in the Requirements of Participation in the areas of grievance process, abuse and neglect reporting, QAPI and discharge notice requirement to state Ombudsman. Several of the requirements CMS has invited feedback on in this rule are areas AHCA/NCAL has diligently addressed with CMS advocating for relief from unnecessary and excessive regulatory burden.

C. Innovation in Medicare
CMS invites the SNF profession to bring ideas to the Center for Medicare and Medicaid Innovation (CMMI) to be tested under the Innovation Center’s demonstration authority. In the proposed rule, CMS specifically suggests the 3-day stay requirement as a possibility for a demonstration as well as payment ideas. Furthermore, as in the inpatient and long term care hospital rule, CMS is requesting input via a Request for Information ideas on how to reduce Medicare regulatory and payment burden throughout the Medicare program.
**Advanced Notice of Proposed Rulemaking (ANPRM)**

In addition to the regular annual proposed payment rule, CMS also released a pre-rule laying out a Resident Classification System, Version 1 (RCS-1) which could replace the existing SNF Prospective Payment System (SNF PPS). In the pre-rule, CMS solicits comments on the proposal as well as solicits other ideas for modernizing the existing SNF PPS.

Of note, CMS may advance a pre-rule to a proposed rule or an interim final rule but may not issue a final rule following comments on a pre-rule. Alternatively, based upon comments, CMS may note act upon a pre-rule at all.

**Resident Classification System, Version 1 (RCS-1)**

RCS-1 is the culmination of a five year CMS project studying how the Agency could address challenges with the current PPS. AHCA has been engaged in CMS’ efforts via participation in Technical Expert Panels (TEPs), development of a SNF PPS Coalition and via written comments submitted to CMS following the TEPs.

CMS’ strategy is to create a new patient-characteristic based payment methodology for an array of redesigned payment components. Under the new system, minutes would be discarded and care would be based upon patient characteristics. Resource Utilization Groups also would be eliminated and replaced with a Resident Classification System (RCS). CMS would assign a patient to a Resident Group for each component. See Chart 1 for an overview of the proposed resident groupings and related data sources. Each is discussed in more detail, below.

**Chart 1. Patient Characteristics and Related Resident Groupings**

<table>
<thead>
<tr>
<th>Component</th>
<th>Resident Characteristics</th>
<th># of Case Mix Groups</th>
<th>Data Sources</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy &amp; Occupational Therapy</td>
<td>• Clinical Categories • Functional Score • Cognitive Score</td>
<td>30</td>
<td>• MS-DRG • MDS (Late Loss ADLs) • MDS: Cognitive Functional Scale (CFS)</td>
<td>Funding pulled from existing therapy component</td>
</tr>
<tr>
<td>Speech-Language Pathology (SLP)</td>
<td>• Clinical Categories • Swallowing Disorder • SLP Comorbidity or Cognitive Impairments</td>
<td>12</td>
<td>• MS-DRG • MDS • MDS and CFS</td>
<td>Funding pulled from existing therapy component</td>
</tr>
<tr>
<td>Non-Therapy Ancillary</td>
<td>• Comorbidity Score</td>
<td>16</td>
<td>• Diagnosis codes (acute)</td>
<td>Not part of Acumen</td>
</tr>
</tbody>
</table>
CMSs’ project has three goals: 1) develop alternative approaches that improve adequacy and appropriateness of payment; 2) evaluate performance of each approach; and 3) select among alternatives which address PPS challenges. The Agency focused on development of alternatives which do not require statutory changes and can be developed and implemented based upon currently available data.

In terms of payment structure, CMS has proposed a per-diem payment approach consistent with their statutory payment authority. The proposal envisions frontloaded payments which pay a percentage of a stay by day. The payment amounts would front loaded with higher payments in the initial few days of a stay.

After certain points in a stay, the payments would drop or, hypothetically, stop. In regard to front loading and block pricing, CMS’s rationale is that the highest therapy and NTAS costs are during the first few days and drop significantly afterwards. They also view such an approach as a method of shortening lengths of stay. CMS is proposing to apply "interrupted stay" rules which affect the way provider payments would be made when patients discharge and readmit to the SNF. For discharges and readmits of less than or equal to 3 days, the current stay would continue and the normal variable payment schedule would apply (i.e. higher payments at the start of the stay which decline over time. At the same time, for discharges and related readmissions of greater than 3 days, a new stay would begin. A new 5 day assessment would generate a new payment period.

The overall model is designed to be budget-neutral at the resident group-level, but the model appears to have dials that can be adjusted at CMS direction. CMS could tighten access to services, and reduce utilization, under a given component through resident characteristic definitions, assessment tool modification, or through the payment structure (e.g., front loading approach). However, budget neutrality is yet to be determined by CMS. For purposes of the pre-rule, for example, CMS is proposing an additional limit on therapy delivery. Concurrent therapy would be limited to 25% of total therapy minutes, in addition to the existing 25% limitation on group therapy.

<table>
<thead>
<tr>
<th>Component</th>
<th>Resident Groupings</th>
<th># of Case Mix Groups</th>
<th>Methodology Proposed*</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>• Extensive Services</td>
<td>6</td>
<td>See Attachment under Tab X</td>
<td>Funding from existing nursing component</td>
</tr>
<tr>
<td></td>
<td>• Special Care High</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Special Care Low</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Clinically Complex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Behavioral Symptoms and Cognitive Performance</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Reduced Physical Function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Labor</td>
<td>Not Discussed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services (NTAS)</td>
<td>(associated with list of 27)</td>
<td>and SNF)</td>
<td>Scope but must come from Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• NTAS Tiers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Age</td>
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<td></td>
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</tr>
</tbody>
</table>

Component | Resident Groupings | # of Case Mix Groups | Methodology Proposed* | Funding                                      |
<table>
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<td></td>
</tr>
</tbody>
</table>
Each component would be adjusted using resident-centered case-mix adjustors. The adjustors vary among the four service-related components. Below is a brief overview of each proposed case mix classification system:

- **PT/OT:** 1) clinical categories (e.g., major joint replacement, other orthopedic, non-orthopedic surgery, acute neurologic, medical management); 2) a Center for Medicare designed functional measure, that is completely separate from IMPACT Act measures, and based upon three late-loss ADLs (transfer, eating, and toileting and Self Performance; 3) cognitive measure based upon MDS item B0700, “makes self understood. A final population split based on re-application of the functional measure would further refine groups those with more complex needs.

- **SLP:** 1) clinical categories (e.g., acute neurologic, other); 2) MDS Item B0700, “makes self understood;” 3) MDS item K0100Z, “swallowing disorder?;” 4) MDS Item G0110H1, “eating self-performance ADL.”

- **NTAS:** 1) use of extensive services classified into high, non, low, or medium; 2) comorbidity score; and 3) age.

- **Nursing:** Nursing would be based upon 2006-2008 STRIVE data with costs also developed from claims linked to cost to charge (CCR) data and aligned with STRIVE resident categories. Residents would be grouped based upon characteristics.

The beneficiary case mix is determined using information from the SNF 5-day assessment, claims (SNF, hospital, or prior PAC setting), and other possible sources as needed. PT/OT, SLP and NTAS modeling is based upon claims linked to cost-to-charge ratio data. CMS still is researching whether providers would receive payments for each component for each patient or an integrated payment. It also is as yet unclear whether a beneficiary assigned case-mix could change over the course of a stay.

In terms of changes in resident groupings, CMS is proposing to simplify the PPS MDS assessment calendar so that most patients will only have a 5-day assessment. A Significant Change assessment may be done in certain circumstances. This is a potential significant reduction in the number of MDS assessments and related staff hours.

AHCA will comment extensively on the proposal as the Association did throughout the RCS development process. For more information on the ANPRM, contact Mike Cheek at mccheek@ahca.org.