CMS Update
New Initiatives in Post Acute Care

NASL

MARCH 2010

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* RUG-IV *

- Update of RUG-III classification model to RUG-IV classification model
  - STRIVE results
  - 14 Day “Look-back” Period
  - Concurrent Therapy
- Non-therapy Ancillaries
- Outliers

* RUG-IV *

- RUG-IV better targets payments to beneficiaries with greater needs.
  - Improved accuracy of Medicare payments.
  - Access to high quality SNF care will be maintained and enhanced.
- RUG-IV will go into effect October 1, 2010 in conjunction with the MDS 3.0.
- RUG-IV changes will be made on a budget-neutral basis.

* RUG_IV *

STRIVE Data Analysis

- Decisions made on multiple criteria:
  - Statistics
    - Variance explanation
    - Substantiality of differences
    - Increase overall range of group means
    - Make groups more homogeneous
    - Increase differences *between* groups
    - Replication of results in prior studies
  - Clinical sense
  - Incentives
    - Avoid items vulnerable to “inappropriate coding”
    - Encourage selected services
  - Consider impact on Medicare *and* Medicaid

* STRIVE Analysis *

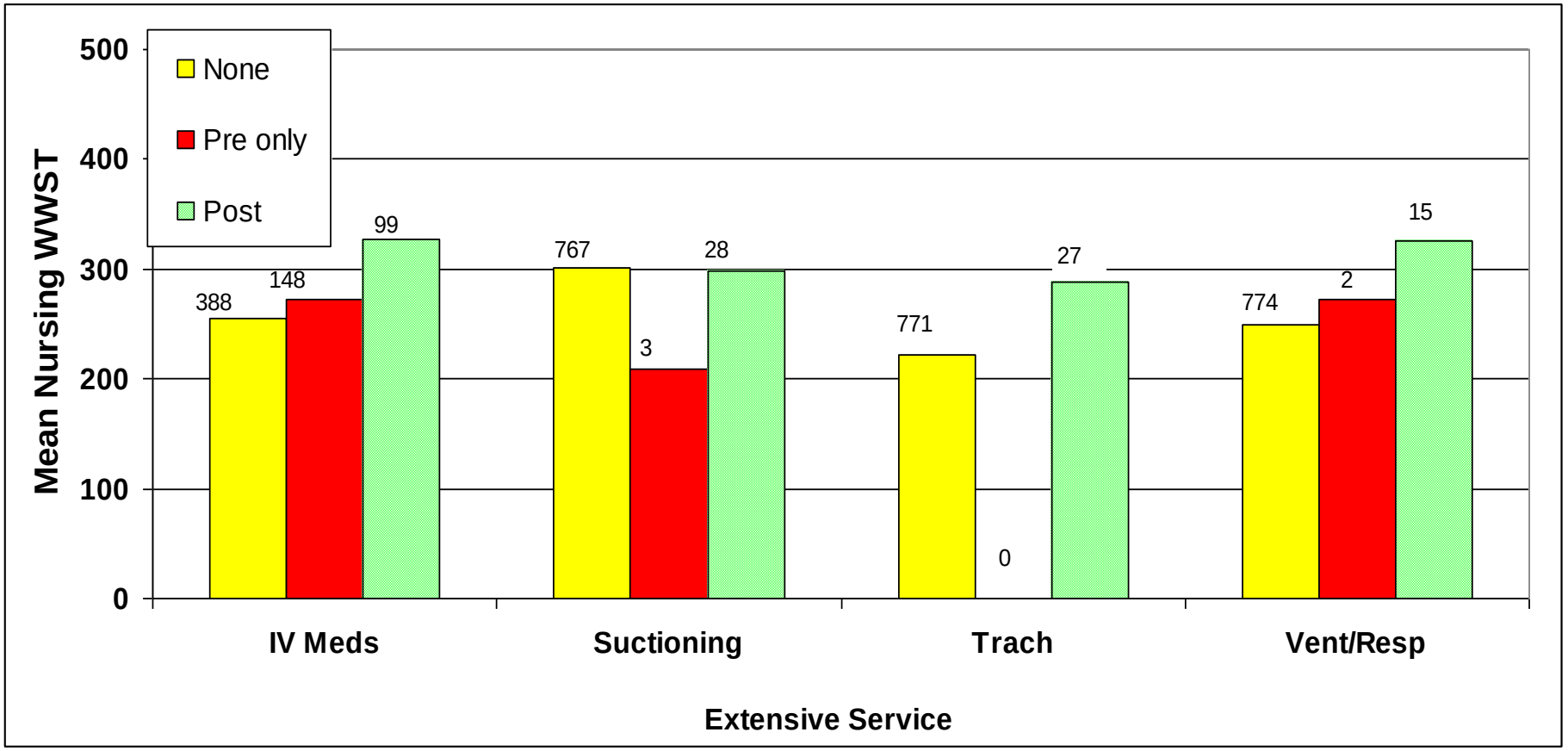
- **Issue: Does it make clinical sense to treat services furnished in the hospital the same as services provided during the SNF stay.**

- Research Question: Are there significant differences in resource use among early-stay residents who received:
  - No extensive services
  - Pre-admission extensive services only
  - Post-admission extensive services

- **Population:** 802 Strive residents with days of stay ≤7 days.

* STRIVE Results*

Mean Nursing WWST by Pre/Post Extensive Service



Conclusion: Patients receiving services during the SNF stay require significantly greater resources.

* RUG-IV Adjustment to the 14-Day "Look-Back" Period *

- Conclusion: Services furnished during the prior hospital stay do not translate into greater care needs after admission to the SNF.
  - Cannot be used as a proxy for medical complexity.
  - Inappropriately boosts payments for many non-complex cases.
- Deleted as an Extensive Services qualifier October 1, 2010.
- Will be captured on the MDS 3.0 for care-planning purposes.

Does it Make Clinical Sense?

- Rank these conditions from high to low based on the resources generally needed to treat a SNF beneficiary:
  1. Septicemia
  2. Ventilator-dependent
  3. IV Medication
  4. Comatose
  5. Surgical Wound Care

Average Resource Time from Strive Data

1.	Ventilator	405 (nursing minutes)
2.	Septicemia	213
3.	Comatose	197
4.	Surgical Wound Care	146
5.	IV Medication	130

RUG-III Payments

	Condition	Minutes	RUG Rate
1.	Ventilator (SE3)	405	$362
2.	Septicemia (CA2)	213	223
3.	Comatose(CC1)	197	248
4.	Surgical Wound (CC2)	146	253
5.	IV Medication (SE2)	130	276

Estimated RUG-IV Rates

	Condition	Min.	RUG-III	RUG-IV
1.	Ventilator (ES3)	405	$362	$646
2.	Septicemia (HB2)	213	223	380
3.	Comatose (HE1)	197	248	361
4.	Surgical Wounds (CC2)	146	253	293
5.	IV Medication (CB2)	130	276	272

Changes to Therapy Rates

- Eligibility Changes--Combined Rehabilitation/Extensive Groups
  - Strive data showed that over 90 percent of patients treated for joint replacements had an IV in the hospital.
  - In almost all cases, the IV was not continued after admission to the SNF.
  - IV medications prior to admission will no longer quality a case for the Extensive Services or Extensive Services/Rehabilitation groups

Changes to Therapy Rates – Concurrent Therapy

- Almost 30 percent of all Part A therapy provided is concurrent or group.
- Under RUG-III, therapy minutes are counted as if all services were individual.
- Under RUG-IV, therapist time will be allocated to each patient being treated by the same therapist at the same time.

Estimated RUG-IV Rates

- To estimate the impact of the RUG-IV policy changes, we calculated payments as if RUG-IV was in effect this year.
- If the patient receives the same level of therapy but is no longer eligible for the combined Extensive/Rehab group:
  - RUG- III RUX pays $617
  - RUG-IV RUC pays $621
- If allocation of concurrent therapy changes the RUG-IV group, there may be a slight reduction
  - Rug- IV RVC pays $539

* RUG-IV Model *

Updated RUG-III to RUG-IV Classification Model

- Proposed & Modified Characteristics by Category
  - Extensive
    - Change: Tracheostomy and ventilator/respirator care must be given post-admission to SNF
    - Added: Infection isolation as a post-admission treatment
    - Moved
      - To Special Care High – Parenteral/IV feeding
      - To Clinically Complex – IV medication
    - Dropped: Suctioning

* RUG-IV Model *

Updated RUG-III to RUG-IV Classification Model

- Proposed & Modified Characteristics by Category
  - Clinically Complex
    - Dropped
      - Internal Bleeding
      - Dehydration
      - Physician Orders

Using Statistics With Care

- It's important to remember that statistics are just numbers. They don't always tell you the entire story.
  - RUG-IV therapy CMIs decrease by 38%.
  - RUG-IV nursing CMIs increase by 18%.
  - Payment rates DO NOT decrease by 20%.

Using Statistics With Care

- The RUG-IV changes were made in a budget neutral manner.
- The therapy dollars did not disappear.
- By reducing the number of days paid at the combined extensive/rehabilitation rate, the dollars were redistributed to all the other RUG-IV groups.

* Non-Therapy Ancillaries *
Designing a Non-Therapy Rate Component

- NTAs currently reimbursed as part of the nursing component

- Work is underway to identify ways of better linking NTA payments to resource use.

* Non-Therapy Ancillaries *
Designing a Non-Therapy Rate Component

- Potential criteria for prospective payments for NTA costs include:
  - Information from available administrative data, i.e., data currently required on claims or MDS
  - Case-mix adjusted
  - Utilization of current data in National Claims History
  - Payments would be based on an add-on NTA index
  - Minimal number of payment groups to limit complexity
  - Utilizes clinically intuitive and readily understandable payment groups
  - Preliminary data analysis indicates that most high NTA costs are associated with drugs

* Non-Therapy Ancillaries *
Designing a Non-Therapy Rate Component

- CMS is working with MedPAC to develop a NTA model.
- Provider input will also be solicited
- Any NTA model will be introduced through the regulatory process.

* Outlier Research *

- The use of non-therapy ancillaries is highly variable.
- An NTA adjustment factor may not be enough to provide adequate payment for the most costly patients.
- CMS is considering an outlier policy for NTA services.
- Legislation would be required for implementation.

Questions