Proposed Revisions to Medicare Case-Mix Classification Systems for Home Health and Skilled Nursing Facilities: A Comparison

The Centers for Medicare and Medicaid Services (CMS) is considering significant changes to the case-mix classification systems for home health agencies (HHAs) and skilled nursing facilities (SNFs). Although the practice settings are different, many components and goals of the proposed changes are similar. Both represent a major shift that would group patients in payment categories based on clinical conditions rather than basing payment on the number of therapy visits. Because many physical therapists (PTs) and physical therapist assistants (PTAs) are following both proposals, APTA developed this table to summarize and compare the key issues associated with the Home Health Groupings Model (HHGM) and SNF Resident Classification System, Version 1 (RCS-1).

ISSUE	HHGM	SNF VERSION 1 (RCS-I)
Reasons for update	• Concerns about overutilization, payment accuracy, and access for medically complex patients • CMS Report to Congress found that payment accuracy could be improved under the current payment system.[1] CMS reported the current home health PPS might discourage HHAs from serving patients with clinically complex and/or poorly controlled chronic conditions who require skilled nursing care but do not need therapy services. In addition, in its March 2017 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) reiterated a prior recommendation that CMS eliminate the use of the number of therapy visits as a payment factor in the home health PPS beginning in 2019.[2]	• Concerns about overutilization, payment accuracy, and access for medically complex patients • 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.[3] In 2013, CMS contracted with Acumen, LLC to explore alternative payment methodologies. Goals set by CMS for an alternative SNF PPS payment methodology are: – To pay SNFs accurately based on beneficiary complexity and required care resources; – To avoid incentivizing therapy delivery by payment policy; and, – To maintain simplicity (case-mix elements, resident assessment requirements).

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Major changes	• 30-day home health episode would replace current 60-day episode.	
	• Payment would be based directly on patient characteristics (eg, principal diagnosis, functional level, and comorbidities). Service utilization (therapy visits) would no longer be used to classify patients into a payment group.	• Payment would more directly rely on patient characteristics (eg, principal diagnosis, functional level, and comorbidities). Service utilization (therapy minutes) would no longer be used to classify patients into payment groups.
	• Nonroutine supplies costs would be included in the base rate.	• A 25% limit on concurrent therapy would be imposed, in addition to the existing 25% limit on group therapy. This would ensure residents of at least 50% of individual therapy per discipline.
	• Methodology to calculate the cost of an episode would change to cost per minute plus nonroutine supplies, using cost report data from HHAs. Current approach uses wage-weighted minutes of care based on data from the Bureau of Labor Statistics.	• Case-mix adjusted-components would expand from 2 (therapy and nursing) to 4—physical therapy/occupational therapy (PT/OT), speech-language pathology (SLP), nursing, and nontherapy ancillary (NTA)—and a single payment is provided.
	• Mandatory assessment frequency would not change.	• Mandatory assessments would be reduced to performance at day 5 and at SNF PPS discharge. Discharge assessment would be revised to enable therapy minutes tracking.

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Clinical structure of case-mix groups	• Each 30-day period of care would be placed into 1 of 144 home health resource groups (HHRGs). Currently there are 153 HHRGs for a 60-day period of care. • Each 30-day period would be classified as "early" (the first 30-day period in a sequence) or "late" (all subsequent 30-day periods in the sequence). • Each 30-day period would be placed into 1 of 2 admission source categories: community (if there was no acute or postacute stay in the 14 days preceding the start of the 30-day period) or institutional (if an acute or postacute stay occurred within the 14 days preceding the start of the period). • Based on the principal diagnosis reported on claims, the 30-day period would be placed into 1 of 6 clinical groups: musculoskeletal rehabilitation; neuro/stroke rehabilitation; wounds (post-op wound aftercare and skin/non-surgical wound care); complex nursing interventions; behavioral health care; and medication management, teaching and assessment. • Based on certain functional OASIS items,[4] each 30-day period within the clinical groupings above would be classified at 1 of 3 functional levels: low, medium, or high. The level would reflect the predicted costs for the 30-day period. CMS anticipates each functional level will each contain roughly 33% of the 30-day periods.	• Within each of the 4 case-mix-adjusted components, residents would be further classified into 1 of 97 case-mix groups, based on different criteria for each group: – PT/OT residents would be placed into 1 of 30 case-mix groups based on 5 clinical categories: major joint replacement or spinal surgery, other orthopedic surgery, acute neurologic surgery, nonorthopedic surgery, and medical management. Functional (transfer, toileting, and eating) and cognitive status would inform placement. – SLP residents would be placed into 1 of 18 SLP case-mix groups based on 3 categories of predictors: clinical reasons for the SNF stay, presence of a swallowing disorder or mechanically altered diet, and presence of a SLP-related comorbidity or cognitive impairment. – Nursing residents would be placed into 1 of 43 nursing case-mix groups based on relative differences in wage-weighted staff time across groups. CMS also is considering incorporating a nonrehabilitation RUG group, revising nursing CMIs using the most recent staff time measurement data, and increasing the nursing component for residents with AIDS. – NTA residents would be classified into 1 of 6 groups based on the resident's condition (eg, cystic fibrosis) and use of extensive services (eg, mechanical ventilation).

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	• Based on secondary diagnoses, the 30-day period would receive a comorbidity adjustment if any diagnosis codes listed on the home health claim are included on a list of comorbidities that occurred in at least 0.1% of 30-day periods and are associated with increased average resource use.	• Comorbidities would be considered in case-mix assignments and adjustments for the SLP and NTA payment components.
Estimated budgetary impact	• Before application of the home health payment update percentage for 2019, CMS estimates that aggregate payments in 2019 would: – Decrease by $950 million (-4.3%) if HHGM is implemented in a fully non-budget neutral manner – Decrease by $480 million (-2.2%) if HHGM is implemented in a partially non-budget neutral manner. CMS would use a partial budget-neutrality adjustment factor in 2019 and remove it in 2020.	• The Advance Notice of Proposed Rulemaking assumes budget neutrality. Acumen, which CMS contracted to identify alternatives to the current SNF model, estimates that a substantial budget-neutrality multiplier would be needed (1.43) to ensure budget neutrality in the transition from RUG-IV to RCS-I. Though not stated directly, this appears to work out to a payment reduction of about 33%.
Timeframe	• As proposed, the rule calls for implementation as of January 1, 2019.	• CMS states this is under active consideration for inclusion in the fiscal year 2019 rulemaking cycle.
Concerns	• Major shift from the current payment system. Could result in unintended consequences. Implementation should be deferred beyond the proposed date and phased-in over time. • Cost report data that would be used to calculate the cost per minute is unreliable and inaccurate. • Payment categories are too broad to be able to determine appropriate therapy needs. Patients may not receive the level and frequency of therapy services needed. • The Secretary of HHS does not have the statutory authority to implement these changes in a non-budget-neutral way. • Lack of budget neutrality will have a substantial impact on the HHA industry, potentially reducing access to services.	• Major shift from the current payment system. Could result in unintended consequences. Implementation should be deferred beyond the 2019 rulemaking cycle and phased-in over time. • Payment categories are too broad to be able to determine appropriate therapy needs. Patients may not receive the level and frequency of therapy services needed. • All other Medicare case-mix transitions for SNF have been implemented in a budget-neutral way. • CMS may also follow its proposal for HHAs and propose that this transition be done in a non-budget-neutral way.

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Model contractor report	Abt Associates. Medicare Home Health Prospective Payment System: Case-Mix Methodology Refinements. Overview of the Home Health Groupings Model. Cambridge, MA. November 18, 2016.	Acumen, LLC. Skilled Nursing Facilities Payment Models Research Technical Report. Burlingame, CA. April 2017.
Federal Register citation	Centers for Medicare & Medicaid Services. *Medicare and Medicaid Programs; CY 2018 Home Health Prospective Payment System Rate Update and Proposed 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements*. July 28, 2017. (81 FR 35270-35393)	Centers for Medicare & Medicaid Services. *Advance Notice of Proposed Rulemaking. Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-mix Methodology*. May 4, 2017. (84 FR 20980-21012).

[1]*Report to Congress. Medicare Home Health Study: An Investigation on Access to Care and Payment for Vulnerable Patient Populations*. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/HH-Report-to-Congress.pdf.
[2] MedPAC. Home Health Care Services. In: *Report to Congress: Medicare Payment Policy*. Washington, DC; March 2017;231. http://www.medpac.gov/docs/default-source/reports/mar17_entirereport224610adfa9c665e80adff00009edf9c.pdf?sfvrsn=0.
[3] For hyperlinks to reports (OIG 2010, 2012, 2015; MedPAC 2017; CMS 2014), see 82 FR 20982-20983.
[4] CMS proposes the following OASIS items for determining functional level: M1800, M1810, M1820, M1830, M1840, M1850, M1860, and M1032.