FY 2012 SNF PPS Monitoring Activities

Introduction:

In the FY 2012 SNF PPS final rule, we committed to monitoring the impact of our FY 2012 policy changes on various aspects of the SNF PPS. Specifically, we committed to monitoring the impact of the following FY 2012 policy changes including the recalibration of the parity adjustment, allocation of group therapy and changes to the MDS including the introduction of the Change-of-Therapy (COT) Other Medicare Required Assessment (OMRA).

We present results below using the full FY 2011 data, as well as an initial look at the first quarter of FY 2012.

RUG Distributions:

FY 2011 Parity Adjustment with full year's data

The FY 2012 final rule used approximately 8 months worth of data to recalibrate the parity adjustment. Now that FY 2011 is over, we recalculated the parity adjustment based on the full year of FY 2011 data. The recalculated parity adjustment based on the full set of FY 2011 data would result in an adjustment of 19.52 percent, not significantly different from the 19.84 percent adjustment used to determine the FY 2012 case-mix weights.

FY 2012 first quarter utilization

- **Overall patient case mix is not significantly different from that observed in FY 2011**

Table 1 below illustrates a breakdown of the SNF case-mix distributions of service days by the major RUG classification categories for the full year of FY 2011 and for the first quarter of FY 2012.

Table 1: SNF Case-Mix Distributions by Major RUG-IV Category

	FY 2011	FY 2012
Rehabilitation Plus Extensive Services	2.38%	1.78%
Rehabilitation	89.5%	88.9%
Extensive Services	0.6%	0.6%
Special Care	4.0%	4.7%
Clinically Complex	2.1%	2.2%
Behavioral Symptoms and Cognitive Performance	0.3%	0.3%
Reduced Physical Function	1.2%	1.4%

As illustrated in Table 1, there have been small decreases in both the Rehabilitation and Rehabilitation Plus Extensive Services categories, and increases in some of the medically-based RUG categories, most notably Special Care. It should be noted that the recalibration of the parity adjustment applied only to those RUG-IV groups connected to therapy (Rehabilitation Plus Extensive Services and Rehabilitation). This caused a shift in the hierarchy of nursing case-mix weights among the various RUG-IV groups. Since

SNFs are permitted to "index maximize" when determining a resident's RUG classification (i.e., they are permitted to choose the RUG with the highest per diem payment, of those for which the resident qualifies), it is possible that the aforementioned case-mix distribution shifts are due to residents that had previously been classified into therapy groups but now index maximize into nursing groups instead.

- **The percentage of residents in Ultra-High Rehabilitation has increased from FY 2011**

While the percentage of residents classifying into therapy groups has decreased slightly (at least partly due to index maximization), there has also been an increase in the percentage of days at the highest therapy level. This is illustrated in Table 2 below.

Table 2: SNF Case-Mix Distribution for Therapy RUG-IV Groups, by Minor RUG-IV Therapy Categories

	FY 2011	**FY 2012**
Ultra-High Rehabilitation (≥ 720 minutes of therapy per week)	46.2%	46.7%
Very-High Rehabilitation (500 – 719 minutes of therapy per week)	27.3%	27.3%
High Rehabilitation (325 – 499 minutes of therapy per week)	10.9%	10.4%
Medium Rehabilitation (150 – 324 minutes of therapy per week)	7.4%	6.3%
Low Rehabilitation (45 – 149 minutes of therapy per week)	0.1%	0.1%

Although there have been decreases in the High and Medium therapy RUG-IV categories some of the decrease may be due to index maximization into the Special Care category.

Group Therapy Allocation:

To more accurately account for resource cost and to equalize the payment incentives across therapy modes, we allocated group therapy time beginning in FY 2012. We anticipated that this policy would result in some change to the type of therapy mode used for SNF residents. As noted in the section above, we have not observed any drop in patient case mix. However, as illustrated below in Table 3, **providers have significantly changed the mode of therapy since our STRIVE study (2006-2007).** During FY 2011, we implemented the allocation of concurrent therapy without the allocation of group therapy and providers shifted from concurrent therapy to group therapy. Initial FY 2012 data indicate that after the allocation of group therapy facilities are providing individual therapy almost exclusively.

Table 3: Mode of Therapy Provision

	STRIVE	FY 2011	FY 2012
Individual	74%	91%	99%
Concurrent	25%	1%	1%
Group	<1%	8%	0%

MDS 3.0 Changes:

In FY 2012, we introduced a new assessment called the COT OMRA to accurately capture the therapy services provided to SNF residents. For all residents receiving skilled therapy services, SNFs are required to conduct an informal check each week of the amount of therapy that a given resident received to ensure that the resident received enough therapy to maintain their qualification in their designated RUG-IV therapy classification. In cases where the resident's therapy is not consistent with their prior RUG-IV therapy classification, then the SNF must complete a COT OMRA to reclassify the resident into the appropriate RUG-IV therapy category. The COT OMRA changes payment retrospectively for the 7 day observation period and prospectively until a new assessment is done.

Table 4 below shows the distribution of all MDS assessment types as a percent of all MDS assessments. We note that the first part of FY 2012 quarter one included a transition period for the new policies, and therefore may not be entirely representative of all of FY 2012.

Table 4: Distribution of MDS assessment types

	FY 2011	FY 2012
Scheduled PPS assessment	95%	85%
Start-of-Therapy (SOT) assessment	2%	2%
End-of-Therapy (EOT) assessment (w/o Resumption)	3%	3%
Combined SOT/EOT	0%	0%
End-of-Therapy assessment (w/ Resumption) (EOT-R)	N/A	0%
Combined SOT/EOT-R	N/A	0%
Change-of-Therapy (COT) assessment	N/A	10%

In the FY 2012 SNF PPS final rule, we estimated that approximately 884,492 COT OMRAs would be submitted during FY 2012, based on an estimate of 62 COT OMRAs per facility per year for 14,266 SNF facilities (76 FR 49534). Based on the data presented in Table 4 and assuming that the number of COT OMRAs per quarter remains constant, we will have overestimated the total number of COT OMRAs that will be necessary in a given year. We will continue to monitor the number of COT OMRAs.