

FY 2012 SNF PPS Monitoring Activities: Quarter 2

Introduction:

In the FY 2012 SNF PPS final rule, we stated we would monitor the impact of certain FY 2012 policy changes on various aspects of the SNF PPS. Specifically, we have been monitoring the impact of the following FY 2012 policy changes:

- Recalibration of the FY 2011 SNF parity adjustment to align overall payments under RUG-IV with those under RUG-III.
- Allocation of group therapy time to pay more appropriately for group therapy services based on resource utilization and cost.
- Implementation of changes to the MDS 3.0 patient assessment instrument, most notably the introduction of the Change-of-Therapy (COT) Other Medicare Required Assessment (OMRA).

In January 2012, we issued the first quarterly memo which provided some observations associated with this monitoring effort. This memo represents an update to that January memo by utilizing data obtained during the second quarter of FY 2012.

We present results below using the full FY 2011 data, as well as data from the first and second quarters of FY 2012.

RUG Distributions:

FY 2012 utilization through second quarter of FY 2012

- **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 half of FY 2012.

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

	FY 2011	Q1 & Q2 FY 2012
Rehabilitation Plus Extensive Services	2.5%	1.8%
Rehabilitation	87.9%	88.5%
Extensive Services	0.6%	0.7%
Special Care	4.6%	5.0%
Clinically Complex	2.5%	2.3%
Behavioral Symptoms and Cognitive Performance	0.4%	0.3%
Reduced Physical Function	1.5%	1.5%

As illustrated in Table 1, there have been small decreases in both the Rehabilitation Plus Extensive Services category and in the overall percentage of service days in a rehabilitation

group, 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 during the first half of FY 2012.**

While the percentage of resident days that classify into therapy groups has not changed significantly during the first half of FY 2012, the data show an increase in the percentage of service days at the highest therapy level (Ultra High Rehabilitation) in the first half of FY 2012. 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	Q1 & Q2 FY 2012
Ultra-High Rehabilitation (≥ 720 minutes of therapy per week)	44.9%	46.2%
Very-High Rehabilitation (500 – 719 minutes of therapy per week)	26.9%	26.7%
High Rehabilitation (325 – 499 minutes of therapy per week)	10.8%	10.7%
Medium Rehabilitation (150 – 324 minutes of therapy per week)	7.6%	6.6%
Low Rehabilitation (45 – 149 minutes of therapy per week)	0.1%	0.1%

Although there have been decreases in the percentage of service days which classify into 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).**

Table 3: Mode of Therapy Provision

	STRIVE	FY 2011	Q1 & Q2 FY 2012
Individual	74%	91.8%	99.5%
Concurrent	25%	0.8%	0.4%
Group	<1%	7.4%	0.1%

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.

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, 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.

Table 4: Distribution of MDS assessment types

	FY 2011	Q1&Q2 FY 2012
Scheduled PPS assessment	95%	84%
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	11%

Prior to the implementation of the COT OMRA, scheduled PPS assessments comprised the vast majority of completed assessments. With the implementation of the COT OMRA for FY 2012, scheduled PPS assessments still comprise the vast majority of complete MDS assessments, though the COT OMRA is the most frequently completed OMRA. We will continue to monitor the number of COT OMRA's completed as part of the SNF PPS.