Skilled Nursing Facility Payment Models
Technical Expert Panel
Summary Report

December 2016

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1 INTRODUCTION

This report summarizes the technical expert panel (TEP) organized by Acumen, LLC to discuss Acumen's recommended payment alternative for skilled nursing facility (SNF) services in Medicare Part A. The TEP is part of Acumen's ongoing effort as part of a contract with the Centers for Medicare & Medicaid Services (CMS) to identify, evaluate, and recommend a comprehensive alternative to the current SNF Prospective Payment System (PPS). The TEP meeting summarized in this report was held to obtain feedback on Acumen's recommended payment alternative for the SNF PPS, with panelists providing comments and recommendations on various aspects of the recommended alternative. The SNF Payment Models TEP was held on October 14, 2016.

Beginning in 1998, Medicare has paid for services provided by SNFs under the Medicare Part A benefit on a per diem basis through the SNF PPS. Recommendations to change the reimbursement model have come from multiple sources, including the Medicare Payment Advisory Commission (MedPAC), the Office of the Inspector General (OIG), and research conducted by The Urban Institute that was commissioned by CMS. Reports published by these organizations advocate for a new payment model to promote individualized care for residents by using specific patient characteristics and care needs to ensure accurate payments for all services. To address these opportunities for improvement, CMS is considering alternative payment approaches to strengthen the overall SNF PPS system. The project aims to:

- Develop a comprehensive payment alternative for SNF services that promotes payment accuracy and positive resident outcomes
- Assess the impact of the payment alternative on SNF residents, SNF providers, and the overall Medicare system
- Recommend adjustments for adoption by CMS

Acumen will use the feedback provided by TEP panelists and summarized in this report to identify opportunities for improvement that can be incorporated as the project moves forward. This report begins by outlining the objectives, methods, and composition of the TEP panel. It then summarizes the discussion held by the TEP panelists, including recommendations made to Acumen. Finally, the report describes next steps Acumen will take to incorporate the TEP panel's recommendations into ongoing and future research.

2 PANEL OVERVIEW

This section presents an overview of the SNF payment models TEP. Section 2.1 summarizes the objectives of the TEP, Section 2.2 describes the structure of the TEP, Section 2.3 describes the materials provided to panelists, and Section 2.4 contains a list of all TEP panelists and brief descriptions of their backgrounds.

2.1 Objectives

The TEP had three main objectives:

- Review and discuss the proposed features of an alternative payment system.

- Assess whether the recommended payment system will achieve the intended goals of promoting payment accuracy and positive resident outcomes.

- Assess the impact of the recommended payment system on residents, providers, and the overall Medicare system.

To accomplish these objectives, the TEP reviewed the research exploring an alternative approach for each of the SNF payment system components, and made recommendations about the relative strengths and limitations of this approach.

2.2 Structure

The TEP was held on October 14, 2016, from 9:00 a.m. to 5:00 p.m., at CMS Headquarters in Baltimore, Maryland. The TEP was organized into a series of topic-specific discussion sessions. Throughout the day, panelists engaged in a structured discussion about SNF payments guided by a moderator unaffiliated with the project team. To motivate the discussion, Acumen project team members presented empirical results pertaining to different aspects of payment and posed specific discussion questions for each session. Table 1 shows the agenda for the day of the TEP.

Table 1: TEP Agenda

Session	Time	Topic
Session 1	9:00 to 9:45 AM	Introductions and Overview of Alternative Payment System
Session 2	9:45 to 11:00 AM	Recommendation for Revising Therapy Component
Break	11:00 to 11:15 AM	N/A
Session 3	11:15 AM to 12:15 AM	Recommendation for Non-Therapy Ancillary Component
Lunch	12:15 to 1:15 PM	N/A
Session 4	1:15 to 2:00 PM	Recommendation for Revising Nursing Component
Session 5	2:00 to 3:00 PM	Exploring Varying Per Diem Payments
Break	3:00 to 3:15 PM	N/A
Session 6	3:15 to 4:00 PM	Impact Analysis
Session 7	4:00 to 5:00 PM	Open Discussion

2.3   Materials

Prior to the TEP, Acumen provided panelists with an agenda, the presentation slides, a background document, a TEP charter stating the goals and duties of the panel, a list of TEP members, and a logistics document. The agenda outlined the scheduled discussion sessions, with a description of the objective of each session, the discussion topics, and discussion questions for review. The discussion questions can be found in Appendix A. Panelists were also encouraged to read the public report published at https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/downloads/summary_report_20140501.pdf, which summarizes the analysis and findings from the first phase of the project team's research.

2.4 Members

The TEP was composed of independent researchers and representatives from provider and consumer stakeholder organizations.

Table 2 lists the TEP panelists and their organizational affiliation in alphabetical order.

Table 2: TEP Panelists

Name	Organizational Affiliation
Rochelle Archuleta *MSHA, MBA*	Director of Policy, American Hospital Association
Alice Bell *PT, DPT, GCS*	Vice President of Clinical Services and Care Delivery Design, Genesis Rehab Services
Christine Bishop *PhD*	Professor of Labor Economics, Heller School for Social Policy and Management, Brandeis University
Anne Deutsch *PhD, RN, CRRN*	Senior Research Public Health Analyst, RTI International
Toby Edelman *Ed.M, JD*	Senior Policy Attorney, Center for Medicare Advocacy
Peggy Gourgues *MA, CCC-SLP*	Chief Operating Officer, Reliant Rehabilitation
Robyn Grant *MSW*	Director of Public Policy and Advocacy, National Consumer Voice for Quality Long-Term Care

Name	Organizational Affiliation
Renee Kinder *MS, CCC-SLP, RAC-CT*	Director of Clinical Education, Encore Rehabilitation
Judi Kulus *RN, MSN MAT, NHA, RAC-MT, DNS-CT, QCP*	Vice President of Curriculum Development, American Association of Nurse Assessment Coordination
Natalie Leland *PhD, OTR/L, BCG, FAOTA*	Assistant Professor, University of Southern California (USC) Division of Occupational Science and Occupational Therapy and the USC Davis School of Gerontology
Terry Moore *MPH, BSN*	Vice President of Health Policy, Abt Associates
Mary Ousley *RN*	Chief Strategic Officer, PruittHealth
Amy Vogelsmeier *PhD, RN, FAAN*	Associate Professor of Nursing, University of Missouri Sinclair School of Nursing
Rachel Werner *MD, PhD*	Professor of Medicine and Health Care Management, University of Pennsylvania
Douglas Wissoker *PhD*	Senior Fellow, Urban Institute

3   DISCUSSION AND RECOMMENDATIONS

This section summarizes the discussions held during the TEP and highlights the recommendations provided by panelists. The TEP included a brief introductory session, five discussion sessions covering topics related to developing an alternative SNF payment system, and an open discussion session at the end of the day, during which both TEP panelists and observers could offer their feedback. For the five content sessions (Sessions 2-6), the following sections present the sessions' background and context, describe the discussion, and compile the panelists' recommendations. The recommendations below are not intended to represent the consensus view of all TEP panelists, but rather suggestions of individual panelists. Where relevant, the sections below also include comments from observers made during the open discussion session that related to the discussion topics in the section.

The TEP contained the following content sessions, summarized below:

- [Session 2](): Recommendation for Revising Therapy Component (PT+OT and SLP)

- [Session 3](): Recommendation for Non-Therapy Ancillary Component

- [Session 4](): Recommendation for Revising Nursing Component

- [Session 5](): Exploring Varying Per Diem Payments

- [Session 6](): Impact Analysis

3.1   Session 2: Recommendation for Revising Therapy Component

This session's objective was to describe cost patterns of the two recommended therapy components and obtain feedback on the PT+OT and SLP resident groups. This session of the presentation consisted of three major topics:

- motivation to separate therapy into two components

- description of recommended PT+OT and SLP resident groups

- calculation of relative costliness

The project team presented evidence showing that speech language pathology (SLP) resource utilization does not correlate with costs for physical therapy (PT) or occupational therapy (OT), and it has different predictors. Therefore it is appropriate to predict SLP costs separately from PT+OT costs. Because PT and OT costs are strongly correlated and share similar predictors, it is advisable to have a single payment component that covers PT and OT services. Acumen described the resident characteristics used to predict utilization of PT+OT and SLP services. Finally, the project team presented the resident groups developed for PT+OT and SLP payment. Panelists were asked to consider the following questions:

(i) Do the resident groups used to classify residents for PT+OT and SLP payment include the major predictors of costs for these therapy disciplines?

(ii) Are there resident characteristics beyond those already considered that could predict high SLP utilization?

(iii) Do the recommended functional score algorithm and the recommended cognitive indicator appropriately represent the impact of these characteristics on therapy utilization?

(iv) Are there any potential adverse effects that should be considered if the recommendations for the PT+OT and SLP components are implemented?

3.1.1 Discussion

Discussion for this session focused on two major topics: data sources used to develop the PT+OT and SLP components, and the recommended criteria for PT+OT and SLP payment.

Data Sources

Panelists offered feedback on the data sources used to measure relative resource utilization. To calculate therapy costs, Acumen multiplied the charges from the SNF claims by the cost-to-charge ratio (CCR) from the facility cost report. TEP panelists raised concerns about the appropriateness of using current SNF data to develop a new payment system. They said that although the payment components developed by Acumen may reflect residents' current utilization of SNF services, current data may not fully reflect residents' care needs. For example, some panelists said current data may not reflect ongoing changes in care practices, particularly provision of maintenance therapy, following the *Jimmo v. Sebelius* settlement agreement. Additionally, some panelists said residents with chronic neurological conditions such as moderate dementia or Parkinson's disease may be under-served in the current payment system, so current utilization data for these residents may not reflect appropriate care practices. Some participants recommended using data from the Post-Acute Care Payment Reform Demonstration (PAC-PRD). Acumen said this data was investigated but that it was not pursued because the study population in the PAC-PRD study was not representative of the full post-acute population. Other participants said that despite the fact that the current payment system may have some data quality problems due to the homogeneity in therapy provision, current claims and cost report data are the best available because they reflect current practices for the full SNF population. The payment system can be revised in the future if care practices change.

TEP participants also discussed the data sources that would be used to determine resident classification for payment under the recommended system. Acumen described how clinical condition and treatment information from the inpatient setting were used for research purposes to develop the PT+OT and SLP resident groups. This prompted questions from panelists about the source of resident information that would be used for classification/payment purposes if this system were implemented. Some expressed a preference for a payment system based only on

information available on the Minimum Data Set (MDS) assessment administered in the SNF setting. Some warned that the MS-DRG for inpatient payments has often not been determined by the time of SNF admission. Acumen explained that clinical information on the SNF admitting diagnosis could be collected on the MDS in the future, which would replace the inpatient claims data that has been used for research purposes.

Criteria for PT+OT and SLP Payment

Discussion also focused on criteria for PT+OT and SLP payment. Clinical condition, functional status, and cognitive impairment were identified by Acumen as criteria for PT+OT payment in the recommended system. Participants said the removal of the incentive to provide therapy by eliminating therapy minutes as a criterion for payment was a positive step. They also welcomed the inclusion of the cognitive function scale (CFS) as an indicator of cognitive status in response to feedback from the Third TEP. Panelists said measures of mobility as well as "early loss" activities of daily living (ADLs) should also be included as criteria for PT+OT payment. Panelists asked whether the distinction between emergent and elective orthopedic surgeries was considered as a payment criterion. Acumen said this distinction was explored for resident classification purposes, but the specific type of orthopedic surgery (major joint replacement/spinal surgery or other orthopedic surgeries) is a better predictor of PT+OT costs than whether a surgery was emergent or elective. In their overall assessment of the PT+OT component, panelists expressed concern that the recommended payment alternative might impact access to therapy for SNF residents. However, they also pointed out that the current payment system creates an incentive to provide high amounts of therapy due to the use of therapy minutes to set payments.

Panelists also offered feedback on the recommended criteria for SLP payment. Clinical reasons for the prior inpatient stay, cognitive impairment, swallowing ability, and SLP-related comorbidities were selected as criteria for SLP payments. TEP members recommended further investigating resident characteristics that are predictive of whether a resident received SLP services. Panelists also stated that residents who are receiving certain treatments for swallowing disorders, in particular a mechanically altered diet, may not be recorded as manifesting symptoms of a swallowing disorder on the MDS because these treatments may prevent the swallowing disorder symptoms from arising. Because these treatments are not included in the recommended SLP component, facilities would receive lower payments for these residents although swallowing disorders are associated with higher SLP utilization. This could inadvertently reward facilities that do not provide treatment for the swallowing disorder, as it assigns higher payment for cases when symptoms are recorded in the MDS. Panelists said the inclusion of SLP-related comorbidities in response to feedback from the Third TEP was a positive change.

3.1.2 Recommendations

- Consider using data from the PAC-PRD study.

- Examine implementation issues surrounding use of clinical information from the inpatient setting.

- Explore mobility measures, "early loss" ADLs, and the distinction between emergent and elective orthopedic surgeries as criteria for PT+OT payment.

- Consider modifications to swallowing measure in the SLP component to account for residents who may not manifest swallowing conditions because they are receiving treatment, particularly a mechanically altered diet.

3.2   Session 3: Recommendation for Non-Therapy Ancillary Component

This session's objective was to describe the methodology for creating the non-therapy ancillary (NTA) payment component and obtain feedback on the recommended NTA payment groups. This session consisted of three major topics:

- motivation to create a separate NTA component

- description of recommended NTA resident groups

- calculation of relative costliness

Acumen explained that although current nursing payments are intended to cover NTA services, nursing case-mix indexes are based solely on utilization of nursing resources. As a result, nursing payments do not reflect variation in the utilization of NTA services. Creating a separate NTA payment component would better account for variation in NTA costs. Acumen described the resident characteristics used to predict utilization of NTA services and presented the recommended groups for NTA payment. Panelists were asked to address the following questions:

(i)   Do the resident groups used to classify residents for NTA payment include the major predictors of costs for these services?

(ii) Are there any additional comorbidities or services that should be considered for inclusion?

(iii) Are there any comorbidities or services that should be excluded because of adverse incentives? Specifically, is it appropriate to include IV medication and infection isolation? Are there ways to make these services less vulnerable to payment incentives?

(iv) Are there any potential adverse effects that should be considered if the recommendations for the NTA component are implemented?

3.2.1 Discussion

Panelist discussion focused on criteria for NTA payment. Acumen said two types of resident characteristics – comorbidities and age – were found to be strong predictors of NTA

costs per day. TEP participants applauded the inclusion of IV medications in the comorbidity score in response to feedback from the Third TEP, as well as the recommendation to create a separate NTA component to account for residents with high NTA costs. A number of panelists questioned the use of age as a NTA payment criterion. Acumen said age was included in the NTA component because NTA costs decline with age and therefore age is a strong predictor of NTA costs. Panelists said including age as a criterion for payment could create access issues for the older population. Additionally, some panelists said the trend of declining NTA costs with age could reflect treatment disparities based on age rather than reduced clinical need for older residents. As a result, they recommended removing age as a payment factor. TEP participants also questioned why parenteral/IV feeding was excluded from the comorbidity score. Acumen said clinicians recommended excluding this service because of adverse incentives. However, some panelists said including parenteral/IV feeding would not create adverse incentives and suggested that quality measures could address these concerns. Another participant questioned the reliability of data from SNF claims and cost reports that was used to explore predictors of NTA costs. However, Acumen pointed out that the resource use measure derived from claims and cost reports matched clinical expectations about the major drivers of NTA costs. One panelist said the NTA component should better account for residents with behavioral conditions.

3.2.2 Recommendations

- Remove age as a criterion for NTA payment.

- Consider including parenteral/IV feeding in the comorbidity score.

- Continue to include IV medications in the comorbidity score.

- Explore ways to better account for residents with behavioral conditions.

3.3 Session 4: Recommendation for Nursing Component

The session's objective was to describe the recommended case-mix adjustment for the nursing component and obtain feedback on the methodology to calculate relative costliness. This session consisted of two primary topics:

- current design of nursing component

- recommended methodology to assign residents to nursing groups and calculate relative costliness

Acumen explained that in the current payment system nursing payments for most residents depend on the number of therapy minutes received, with residents who undergo rehabilitation generally receiving higher nursing payments than non-rehabilitation residents. Limited variation in therapy minutes leads to limited variation in nursing payments across

residents, despite likely differences in nursing resource utilization across different types of residents. To better reflect variation in nursing utilization, Acumen recommended assigning all residents to non-rehabilitation resource utilization groups (RUGs) and calculating nursing indexes based on the nursing utilization of rehabilitation and non-rehabilitation residents assigned to each non-rehabilitation RUG. Panelists were asked to consider the following questions:

(i) Do non-rehabilitation RUGs adequately reflect variation in nursing utilization and the clinical reasons for that variation?

(ii) Is the methodology to calculate nursing weights appropriate? Are there ways it could be improved?

(iii) Are there any potential adverse effects that should be considered if the recommendations for the nursing component are implemented?

3.3.1 Discussion

Panelist discussion focused on the recommended methodology to re-calculate nursing indexes. Acumen recommended maintaining the current system used to case-mix adjust payment for variation in nursing utilization while removing therapy minutes as a criterion for nursing payment. Therefore, all residents would be classified in non-rehabilitation RUGs. However, since the indexes for the non-rehabilitation RUGs are only based on the non-rehabilitation population, they need to be re-calculated to reflect the nursing utilization of the rehabilitation population as well. To re-calculate nursing indexes, Acumen replicated methodology from the 2006-07 Staff Time Resource Intensity Verification (STRIVE) study, updating the measure of nursing resource utilization to reflect current SNF wages. Panelists questioned whether it was appropriate to use data from the STRIVE study given possible changes in the resident population since the study was conducted, changes in staffing levels in SNF facilities, and concerns about under-reporting of nursing minutes in the STRIVE study. Acumen said resident characteristics have not changed notably since the STRIVE study, with the exception of some functional measures, and that the methodology presented may be the best approach to updating the nursing component given the lack of resident-specific data on nursing utilization. Some panelists asked how social services and discharge planning were accounted for in the recommended nursing component. Acumen said the nursing component would cover these services but the lack of current, resident-specific data on utilization of these services makes it difficult to capture variation in use of these resources. Some participants said the relatively low nursing indexes for residents with behavioral or cognitive symptoms, including dementia, as well as for residents with reduced physical function, did not reflect the nursing resources required for these types of residents and could create access issues for these populations. Panelists expressed support for the overall approach of removing therapy provision as a criterion for nursing payment.

3.3.2 Recommendations

- Consider changes in resident characteristics and staffing levels as well as possible under-reporting of nursing minutes in the STRIVE study when determining how to use data from STRIVE study.

- Explore ways to better account for social services and discharge planning.

- Investigate approaches to better account for residents with behavioral/cognitive symptoms and residents with reduced physical function.

3.4 Session 5: Exploring Varying Per Diem Payments

The objective of this session was to describe the motivation for exploring varying per diem payments and obtain feedback on recommended payment structures. This session consisted of three primary topics:

- evidence of changes in per diem costs over stay lengths

- introduction of varying per diem payments to accurately reflect varying cost over a stay

- alternative payment structures for each component

Acumen explained that the distribution of costs over a stay exhibits different patterns for each recommended payment component. PT+OT costs initially slightly increase, and then decline steadily thereafter. NTA costs, driven by drug costs, are concentrated at the beginning of a stay, and are much lower thereafter. SLP costs remain relatively constant, moving only within a narrow range over the stay. The project team introduced the "block/linear" payment structure, which can reflect these differences in the distribution of costs over a stay. This approach utilizes an initial daily payment rate that is constant over the first set of days, then declines linearly thereafter. This payment structure is defined by four parameters: the initial payment rate, the length of the constant period (before payment declines), the initial rate for the post-constant period, and the linear rate of decline (slope). The following questions were proposed for discussion:

(i) Does the block/linear payment structure appropriately reflect resident costs over a stay, is a more complicated system needed, or would a simpler approach be sufficient?

(ii) Within a given payment component (e.g., PT+OT), should there be a single slope for all resident groups or should the slopes vary across resident groups?

(iii) Within a given payment component, should the length of the constant period vary across resident groups?

(iv) Should the NTA payment component have a continuous per diem rate, or should there be a break between the starting rate and the later rates?

(v) Are there any potential adverse effects that should be considered if varying per diem payments are implemented?

3.4.1 Discussion

Panelist discussion focused on the implementation and potential impact of varying per-diem payments. TEP participants expressed concern that payment for an entire stay would be based on the first assessment under the recommended payment system. Panelists said this would fail to capture residents who have greater care needs/costs later in a stay. Acumen said the recommended payment structures reflect relative resource use on average. However for an individual stay, payments may exceed or be less than costs. Current data shows that only a small percentage of residents would move to higher-paying case-mix groups later in a stay. One panelist pointed out that using the first assessment to set payment for the entire stay would be consistent with the Medicare payment system used in inpatient rehabilitation facilities (IRFs) and acute care hospitals. TEP participants said if payments decline over a stay to reflect current utilization patterns, this could create access issues for residents who require longer stays and incentivize premature discharges. Acumen said a constant per-diem payment for all components would not accurately reflect current utilization patterns and that if care practices change, payment structures can be adjusted.

3.4.2 Recommendations

- Consider impact of recommended payment structures on residents who have higher resource use later in a stay.

- Look at impact of recommended payment structures on residents who require longer stays.

3.5 Session 6: Impact Analysis

The objective of this session was to present an impact analysis of the recommended payment system and obtain feedback on methodology and results. This session consisted of four primary topics:

- candidate block/linear payment system

- description of resident and provider subpopulations examined

- description of impact metrics

- summary of key results

Acumen presented a candidate payment structure that was used to model the distribution of costs for each recommended payment component, using the resident groups presented in Sessions 2-4. This candidate payment structure was used to estimate payments for resident and provider populations of interest. The project team described the subpopulations that were examined and the metrics selected to assess the impact of the recommended payment system on

these groups. Finally, Acumen discussed key results of the impact analysis including populations estimated to receive higher and lower per-stay payments under the recommended payment alternative. The following questions were proposed for discussion:

(i)   Should impacts be explored for additional subpopulations of residents or providers?

(ii) Are there additional vulnerable subpopulations that should be examined?

(iii) Should some existing subpopulations be further stratified?

(iv) Are there additional metrics that should be explored to evaluate payment impacts?

(v)   Do the existing results suggest specific refinements that may be needed for the PT+OT, SLP, NTA, and nursing components? Are these refinements related to the resident groups or the features of per-diem payments (intercept/flat period/slope)?

3.5.1 Discussion

The project team summarized the resident and provider subpopulations explored, metrics used, and results of the impact analysis. Acumen examined resident subpopulations defined by demographic, enrollment, and service utilization characteristics, as well as potentially vulnerable populations such as dual-enrollees in Medicare and Medicaid, residents with high NTA costs, and residents receiving extensive services (several of these potentially vulnerable subpopulations were identified by prior TEPs). Acumen also examined provider subpopulations stratified by institution type, ownership, geographic location, size, and other characteristics. Metrics used in the analysis included the difference in the average per-stay payment between the current and recommended payment systems and the ratio of per-stay payment under the recommended system to current payment. The analysis assumed budget neutrality and no changes in provider behavior or coding practices. Subpopulations estimated to receive higher per-stay payments in the recommended payment system compared to the current system include: residents with high NTA costs, residents receiving extensive services, residents enrolled in Medicare and Medicaid, residents with end-stage renal disease (ESRD), residents with longer qualifying inpatient stays, and residents with diabetes, wound infections, or IV medications. Residents receiving "ultra high" levels of therapy (720 minutes or more per week) are estimated to receive lower per-stay payments under the recommended system. Providers that would receive higher per-stay payments under the recommended system include: non-profit facilities, government-owned facilities, hospital-based facilities, swing bed facilities, small facilities, and facilities with large proportions of non-rehabilitation residents and low proportions of residents in RU RUGs.

Panelists offered feedback on the populations and metrics examined in the impact analysis as well as the results of the analysis. In addition to the populations examined, panelists said post-stroke residents, residents with dementia, and residents recovering from amputations should be examined. One participant said impacts should be explored for each of the clinical categories used for resident classification in the recommended payment alternative. In terms of

metrics, participants said the impact analysis should investigate whether estimated payments will cover providers' costs and what percentage of providers will see payments decline or increase notably. Participants asked if any provider behavioral responses had been modeled. Acumen said the analysis did not include behavioral responses. Overall, participants said the results of the impact analysis show a shift of resources to resident and provider populations for whom the current payment system does not incentivize service, such as clinically complex residents. One participant said the recommended payment system was similar to models explored by MedPAC and was consistent with other Medicare payment settings.

3.5.2 Recommendations

- Add post-stroke residents, residents with dementia, and residents recovering from amputations to the subpopulations examined in the impact analysis.

- Explore impacts for each of the clinical categories used for resident classification.

- Also include in impact analysis whether estimated payments will cover providers' costs and what percentage of providers will see payments decline or increase notably.

- Model provider behavioral responses.

4 NEXT STEPS

Acumen is using the feedback received at the fourth TEP to further refine the recommended alternative SNF payment system. The following list describes ongoing and future steps Acumen plans to take based on recommendations described in Section 3 of the Technical Expert Panel Summary Report:

Recommendation for Revising Therapy Component

- Further investigate the predictive power of emergent v. elective orthopedic surgery.

- Explore how to account for residents who are receiving certain treatments for swallowing disorders, in particular a mechanically altered diet, who may not be recorded as manifesting symptoms of a swallowing disorder on the MDS because these treatments may prevent the swallowing disorder symptoms from arising.

- Further investigate resident characteristics that are predictive of whether a resident received SLP services.

- Investigate how SLP costs vary with the number of SLP-related comorbidities present.

- Determine how the MDS assessment would need to be modified, including collecting clinical information from the prior inpatient stay, to implement the recommended payment system.

Recommendation for Non-Therapy Ancillary Component

- Explore alternative classifications for NTA payment that do not incorporate age.

- Investigate whether to include parenteral/IV feeding as a comorbidity.

- Further investigate how the recommended payment system would account for residents with behavioral health issues.

- Explore higher-level aggregation of cost-to-charge ratios (CCRs) to address concerns with the reliability of cost reports.

Recommendation for Revising Nursing Component

- Further explore how the recommended payment would account for social services and discharge planning.

- Implement methodology to smooth nursing indexes to match RUG hierarchy.

- Examine changes in staffing levels and staff composition over time.

Exploring Varying Per Diem Payments

- Explore different payment structures for residents whose clinical needs remain constant or increase over a stay.

- Consider impact of recommended payment structures on residents who have higher resource use later in a stay and residents who require longer stays.

- Determine appropriate assessment schedule for payment and resident classification purposes.

Impact Analysis

- Add post-stroke residents, residents with dementia, emergent v. non-emergent surgery, chronic neurologic residents, and residents recovering from amputations to the subpopulations examined in the impact analysis.

- Explore impacts for each of the clinical categories used for resident classification.

- Examine impacts by facility quality measures.

- Also include in impact analysis whether estimated payments will cover providers' costs, what percentage of providers will see payments increase or decline notably, and ratio of estimated payments to costs for short v. long stays.

- Model provider behavioral responses.

APPENDIX A: DISCUSSION OBJECTIVES AND QUESTIONS

A.1   Session 2: Recommendation for Revising Therapy Component

Session Objective:

Describe cost patterns of the two recommended therapy components and obtain feedback on the PT+OT and SLP resident groups.

Session Discussion Questions:

- Do the resident groups used to classify residents for PT+OT and SLP payment include the major predictors of costs for these therapy disciplines?
- Are there resident characteristics beyond those already considered that could predict high SLP utilization?
- Do the recommended functional score algorithm and the recommended cognitive indicator appropriately represent the impact of these characteristics on therapy utilization?
- Are there any potential adverse effects that should be considered if the recommendations for the PT+OT and SLP components are implemented?

A.2   Session 3: Recommendation for Non-Therapy Ancillary Component

Session Objective:

Describe the non-therapy ancillary (NTA) component recommendation and obtain feedback on the NTA payment groups.

Session Discussion Questions:

- Do the resident groups used to classify residents for NTA payment include the major predictors of costs for these services?
- Are there any additional comorbidities or services that should be considered for inclusion?
- Are there any comorbidities or services that should be excluded because of adverse incentives? Specifically, is it appropriate to include IV medication and infection isolation? Are there ways to make these services less vulnerable to payment incentives?
- Are there any potential adverse effects that should be considered if the recommendations for the NTA component are implemented?

A.3   Session 4: Recommendation for Revising Nursing Component

Session Objective:

Describe the recommended nursing component and obtain feedback on the methodology to calculate relative costliness.

Session Discussion Questions:

- Do non-rehabilitation RUGs adequately reflect variation in nursing utilization and the clinical reasons for that variation?
- Is the methodology to calculate nursing weights appropriate? Are there ways it could be improved?
- Are there any potential adverse effects that should be considered if the recommendations for the nursing component are implemented?

A.4   Session 5: Exploring Varying Per Diem Payments

Session Objective:

Describe motivation for varying per diem payments and obtain feedback on recommended payment structures.

Session Discussion Questions:

- Does the block/linear payment structure appropriately reflect resident costs over a stay, is a more complicated system needed, or would a simpler approach be sufficient?
- Within a given payment component (e.g. PT+OT), should there be a single slope for all resident groups or should the slopes vary across resident groups?
- Within a given payment component, should the length of the constant period vary across resident groups?
- Should the NTA payment component have a continuous per diem rate, or should there be a break between the starting rate and the later rates?
- Are there any potential adverse effects that should be considered if varying per diem payments are implemented?

A.5   Session 6: Impact Analysis

Session Objective:

Present impact analysis of candidate block/linear payment system and obtain feedback on methodology and results.

Session Discussion Questions:

- Should impacts be explored for additional subpopulations of residents or providers?
- Are there additional vulnerable subpopulations that should be examined?
- Should some existing subpopulations be further stratified?
- Are there additional metrics that should be explored to evaluate payment impacts?
- Do the existing results suggest specific refinements that may be needed for the PT+OT, SLP, NTA, and nursing components? Are these refinements related to the resident groups or the features of per-diem payments (intercept/flat period/slope)?