The Medicare SNF Resident Classification System (RCS-I):

A Rational Discussion on Payment Reform

By Marc Zimmet

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Nearly five months have passed since the Centers for Medicare & Medicaid Services (CMS) formally announced its intention to fundamentally reform the skilled nursing facility (SNF) Medicare Part A payment system. The May 4, 2017 Advanced Notice of Proposed Rulemaking (file code CMS-1686-ANPRM) targets October 1, 2018 as the date providers would transition to the new Resident Classification System (RCS).

Since then, quite a bit has transpired. Zimmet Healthcare has extensively studied and modeled the financial and operational impact of RCS on our clients. We have had in-depth discussions with national & state trade associations and industry thought leaders. We have also closely followed reaction to the rule, and it seems that every day, more "fake news" (sorry, I couldn't resist) is propagated by anxious stakeholders.

This document is designed to provide a rational interpretation of the impact RCS will have on our communities and the industry at large; but note – this is by no means an "RCS primer." As such, we encourage the readers of this paper to familiarize themselves with the mechanics of the proposed system before proceeding.

With that said, I'd like to share my personal thoughts on the new payment model.

First and foremost, RCS is unequivocally an improvement over the current RUG-based system. Although in all fairness, that's not saying much, as I have major concerns about the structural integrity of the new reimbursement methodology. In fact, I envision only three overriding benefits of RCS replacing RUGs:

1. More appropriate reimbursement for patients with complex medical needs who cannot tolerate two hours of therapy a day;
2. Significant reduction in the administrative burden relating to Minimum Data Set (MDS) scheduling and micro-management of therapy utilization;
3. Liberation from the ~~extortion~~ ~~tyranny~~ "enthusiasm" of overzealous post-payment auditors' subjective worldviews regarding the medical necessity of skilled therapy services.

What Makes a Good Payment System?

The integrity of a "prospective" healthcare payment system is predicated on its ability to statistically explain cost variations among patients of highly-varied acuity. Our current RUG model is horribly wanting in that regard. Specifically, RUG models explain as little as 21% of nursing resource use variance and less than 1% of non-therapy ancillary cost variance among Medicare beneficiaries. The acute-care MS-DRG system offers far more predictive power, and further improves reliability by including "high cost outlier" payments to address statistically aberrant patient-specific profiles. Surely, we can do better.

Yes, SNFs have fared well under RUGs, and Medicare remains our most important (i.e. profitable) pay source. But for context, there is a key distinction to consider in this narrative: The Resource Utilization Group is not a funding mechanism, it is a reimbursement-allocation delivery system. Medicare is critical to the SNF ecosystem because of the Federal government's overall SNF-program spending, and it will remain so regardless of its designated delivery system.

The problem today is that RUG groupings are (financially) "poorly targeted." The system inappropriately incentivizes the provision of (sometimes questionable) rehabilitation by "mispricing" physical, occupational and speech therapy, while inherently undervaluing often more expensive nursing interventions. In other words, the current reimbursement-delivery system sets marginal therapy revenue far in excess of the associated marginal cost to the SNF providing it. As a result, nearly 60% of all SNF Medicare days are billed at "Ultra High" RUGs, with 65% of those scores realized by delivering nearly the exact complement of treatment minutes required to achieve the "RU" designation. CMS and common sense dictate that this pattern must change.

Where are We Now?

RCS is not final. It may be implemented exactly as designed on October 1, 2018; it may be discarded completely in a redux of the aborted 2001 plan to adopt 256 RUGs; or we may find ourselves with a modified RCS on or after the current target date. CMS took the unusual step of publishing the ANPRM 18 months before proposed implementation. By comparison, we had only two months of official advance notice when Medicare transitioned from "cost-based" reimbursement to the initial Prospective Payment System (PPS) back in 1999, in what was designed as a significant funding reduction (although a three-year demonstration project was nearing completion and PPS rates were phased-in to mitigate provider shock).

CMS also uncharacteristically extended the RCS "comment period" to allow for comprehensive input from the provider community. These steps alone speak volumes about the magnitude of this payment reform initiative.

Comments submitted by most stakeholders (including ZHSG) were overwhelmingly against RCS implementation. Irrespective of near universal negative sentiment, my opinion is that we will indeed face payment reform (or at least significant payment "refinement") on October 1, 2018, effectuated as an amended version of the system detailed within the ANPRM – but of course I wouldn't bet on it.

You can read the full ANPRM, source material and ZHSG's comments here, and note that the following narrative assume RCS is implemented as originally described within the ANPRM.

The Major Changes

The most notable structural change is the shift from the current "utilization-driven" system to RCS' grouping based on patient condition, regardless of the amount of therapy provided. Next, we move from an administratively taxing MDS completion schedule to a system reliant solely on a single (5-day) assessment (absent significant changes or discharges / SNF readmissions).

"Rate construction" is also reimagined. If a RUG score can be metaphorically described as a closed fist, RCS is an open hand with all five digits moving independently. The "RCS Composite Rate" is calculated using five distinct and independent variables (PT/OT, SLP, Nursing, Non-Therapy Ancillary and Overhead), four of which are dynamic (the "Overhead" component is static per a facility's "core-based statistical area"). These four moving parts allow for over 139,000 unique RCS rate combinations, although many are mutually exclusive.

The RCS multi-factor composite rate imbues "reimbursement-sensitivity" to previously revenue-impotent services. For example, two residents receiving identical therapy protocols with similar activity of daily living (ADL) scores are assigned the same RUG today, regardless of condition or concurrent nursing acuities (save for ventilator, tracheostomy or isolation-infection care). The RCS payment-classification disregards therapy utilization in favor of diagnoses and non-therapy clinical modalities. The result is that the two residents just described could be assigned RCS composites priced hundreds of dollars per day apart, depending on their respective clinical profiles.

Life under RCS will require accurate "full-spectrum" acuity reporting that includes previously neglected MDS sections (e.g. respiratory therapy, restorative nursing, depression). And just like that, reimbursement management is shifted from the therapy department to nurses and coders.

Another major change is the "conscious decoupling" (again, I couldn't resist) of non-therapy ancillary (NTA) payments from the nursing component. RCS composite rates will reflect the relative intensity of patient-specific ancillary need. The NTA payment component is heavily weighted during the first three days of a benefit period, then normalizes for the balance of coverage (note the PT/OT component is also "day-weight adjusted," but to a lesser, more gradual degree).

Finally, ADL pricing ~~is a hot mess~~ may seem counterintuitive. Without getting overly technical, the RCS nursing component utilizes the same scoring methodology employed by RUG-IV, while the PT/OT component omits Bed Mobility and only scores Eating, Transfer and Toileting for "self-performance" (the other RCS composite components are not ADL-sensitive). The incongruity here is that higher dependence coding enhances the nursing rate, but decreases the PT/OT payment. Sometimes the nursing rate increase outweighs the PT/OT reduction, but sometimes it doesn't. Oh, and cognitive impairment decreases the PT/OT rate but increases the SLP component payment. Have fun with that one.

These fundamental "case-mix" changes will have a dramatic impact on treatment plans, documentation requirements and delivery models of restorative care.

Therapy Will Still Matter

Despite the fact that RCS reimbursement is completely disassociated from the amount of therapy a patient receives, post-acute rehabilitation will remain the primary catalyst driving SNF admissions. Patients want therapy and they want to go home – they don't care how or how much Medicare pays the SNF. Irrespective of RCS, therapy quality and outcomes will dominate the post-acute narrative as comparative data and "value-based" incentives are propagated throughout the healthcare continuum. Unfortunately, there is growing concern about a new perverse incentive RCS may invite.

To wit, I personally heard one industry "consultant" explain, "I'm advising SNFs to cut therapy to the bone." Um, ok, enjoy your next career because you won't last long in post-acute care. It's just common sense – we don't get paid for nursing or housekeeping based on patient-specific time, but last I checked most facilities still offer these "amenities." That said, I understand why an operator would reconsider their long-term therapy plans.

Case-in-point, the initial RCS-reaction from one of my clients was to abruptly abandon a fully-planned and funded $1 million expansion of their rehab gym. After a brief discussion, we distilled the department expansion down to a de facto marketing investment. The SNF's owner then realized that RCS will have zero bearing on a prospective admission's impression of her (yes "her") facility. I am happy to report that construction has begun.

Ok, but contract therapy companies will go out of business, right?

I have been accused on several occasions of advancing this fallacy. My response? "Not bloody likely." The contract therapy business model and Part A pricing structure will change, but the companies themselves will evolve. Expect them to enter the cauldron of RCS as "one trick ponies" and emerge as broad-spectrum "care management" concerns. After all, who decreed that two hours of one-on-one therapy engagement was the only way a person could regain function? We all know better than that.

To that end, we are engaged with several therapy companies to develop such broad-spectrum clinical support solutions. Contract providers will grow to manage SNF respiratory and restorative nursing programs, and perhaps oversee re-engineered "outcomes-based" Activity departments. They will provide massage therapy, acupuncture and even chiropractic services. Who knows, outcomes may improve! Many will add integrated ancillary modalities and care management technologies, and no doubt offer top flight consulting services – taking direct aim at my firm's core products and keeping me up at night, but I digress… Moral of the story – contract therapy will remain a relevant option for progressive post-acute rehabilitation management, albeit with greatly reduced therapy-specific staffing revenue (to the benefit of the SNF), augmented by new scalable therapeutic initiatives that offer cost-certainty to weary providers. Much more on this to come.

Don't Panic About Projections

On July 21, 2017, CMS released a "Provider-Specific RCS Impact Analysis" that compared 2014 Medicare RUG revenue to projected RCS reimbursement by regrouping assessments for every skilled nursing facility in the nation. Given that RCS is intended to be budget-neutral, not surprisingly the transition array represented a relatively balanced split between projected RCS "winners and losers." While the impact for many was innocuous, the overall facility-specific range was staggering: an additional $1.8 million for the biggest winner, and negative $3 million at the less fortunate end of the provider spectrum.

If your position gives you pause, take heart. There are several reasons why a projected loser should not factor these figures into their 2019 budget. Specifically, revised coding/capture strategies and therapy & administrative cost savings associated with RCS were not factored into the equation. I am confident that, if properly prepared, few facilities will be "net" losers under RCS relative to RUGs. Remember, many of these same facilities were projected losers under 2011's RUG-IV transition as well, so expect changes in provider behavior to once again mitigate much of the purported transition revenue shortfalls.

Invariably, however, certain patient profiles will carry significant reimbursement implications. For example, a *non-medically complex* RUB resident is priced at $616 today (unadjusted for wage index). That same resident may carry a rate of only $483 under RCS (RCS composite: TI, SR, PC1, NF, day 4). Trust me on the scoring (and remember therapy costs would likely decrease as well).

Conversely, a dialysis patient unable to tolerate therapy is priced at $366 today (RUG score LD1). That same resident may generate $626 per day under RCS (RCS composite: T5, SQ, LD1, NB, day 4). Again, trust me on the scoring.

That all said, should the RCS transition fail budget neutrality due to major changes in provider behavior, expect a fast rate "recalibration" from CMS to correct the forecast imbalance. See 2012's $4 billion SNF funding reduction for a reality check.

What Should SNFs do Today?

While the RCS structure and implementation date are subject to change, facilities should start measuring the reform's potential impact and considering risk abatement strategies. These include reviewing current and projected modes of therapy delivery and costs, auditing MDS accuracy (beyond the therapy and ADL sections), formalizing RCS-revenue-sensitive clinical modalities such as respiratory therapy and restorative nursing, and evaluating clinical capabilities to leverage RCS' rate-sensitivity to program expenses. An ICD-10 refresher course would be a prudent investment as well. You can start modeling the potential financial impact using ZHSG's RCS Rate Composite Simulator (the RCS-RCS – cute, right?) on our website. Call us for a temporary client login to access the Simulator.

The Bottom Line:

Medicare SNF payment reforming is coming. If not RCS on October 1, 2018, then something equally vexing soon thereafter. Expect some bruises along the way, but as long as Medicare continues to provide adequate funding for SNF post-acute services, we will adapt and succeed, and look back at this transition as just another speedbump along the way. The more pressing concern is the realization that RCS pales in comparison to other long-term threats we face such as Medicaid funding reform and the unabated escalation of Medicare Advantage enrollment. But those are stories for another time.

Feel free to contact Zimmet Healthcare at (877) SNF-2001 (or email info@zhealthcare.com) for more information about RCS-I or other SNF management support concerns.

About the author:

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Founded in 1993, ZHSG has grown from a small cost-reporting concern to a nationally recognized leader in reimbursement/compliance, outsourced management solutions, performance analytics and post-acute strategy. ZHSG is comprised of more than 50 full-time professionals and currently supports over 2,000 providers and related organizations nationwide. Our clients range from independent, not-for-profit and government sponsored facilities to national chains. In addition to providers, we advise state associations, ancillary companies, insurers, attorneys, private equity/lenders and other stakeholders that demand the highest level of service.