Proposed CMS SNF Program Changes Dramatically Alter Current Reimbursement Methodologies

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On April 27, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule outlining proposed quality program changes for skilled nursing facilities (SNFs) that includes a new Patient-Driven Payment Model (PDPM).

The PDPM outlined in the proposed rule represents a dramatic shift away from the current Medicare Part A reimbursement system, known as RUGS-IV. The PDPM (proposed to be effective 10/1/19) would transform payment from a volume-based system based largely upon the provision of resources (largely therapy minutes) to another volume-based system tied to the characteristics and needs of individual residents using five discreet case-mix factors.

Per diem reimbursement under PDPM would be calculated from the sum of these five case-max components, which are physical therapy, occupational therapy, speech-language pathology, nursing and non-therapy ancillaries (i.e. prescription drugs and other ancillary services). The per diem payments would "taper" (i.e. decrease) during the length of stay based upon certain components at different points in time. For example, the physical and occupational payments will begin to "taper" beginning on day 20 of the stay and non-therapy ancillary payment will begin to "taper" beginning on day 3.

PDPM GIVES WEIGHT TO NURSING SERVICES OVER REHAB

PDPM is the second version of a resident classification system released by CMS. The first version (RCS-1) was released as part of an Advance Notice of Proposed Rulemaking in 2017 and was widely criticized for being overly complex, relying upon old (or otherwise flawed) data and representing an undue "pendulum swing" away from the provision of rehabilitation services. After receiving significant input from various segments of providers and other stakeholder groups, CMS has released PDPM and specified an effective date of October 1, 2019.

While an improvement from RCS-1, PDPM continues to represent a purposeful departure from the current system based, upon other things, the belief by CMS that the RUGS-IV system was used by providers to inflate the provision of therapy services to gain additional reimbursement. Providers counter that the provision of rehabilitation at current levels is consistent with the needs of their residents and the regulatory mandate for SNFs that residents receive the necessary services to attain and maintain the "highest practicable" level of functioning.

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PDPM represents a realignment of the payment system to give greater weight to the provision of nursing services rather than rehabilitation services in skilled nursing facilities. There will be tremendous debate over whether PDPM goes too far to disincentivize the provision of physical therapy, occupational therapy and speech language pathology or whether it will fairly allocate case-mix components to truly ensure that resident needs are met.

OUTDATED DATA MAY NOT REFLECT CURRENT COSTS

As with RCS-1, CMS largely relies on data from the mid-1990s and mid-2000s to establish the methodology for the PDPM system. There will be lingering questions as to whether this old data is reliable in the current environment. For example, it is fair to question whether data reflecting the costs of non-therapy ancillary services such as prescription drugs (translated into a percentage for that case-mix component) from two decades ago is an accurate predictor of costs in this area.

It will take a tremendous amount of work to "operationalize" PDPM from the CMS as well as the provider perspective. There will need to be significant CMS manual development as well as a need to construct significant system and IT changes to make it happen. There will be the need for significant education and training for the provider community. SNF providers will need to invest in new tools to understand and model the new system and will need to develop new employee positions to collect, analyze and report the necessary information and coding for residents under the new system. SNF providers will likewise need to evaluate how the provision of rehabilitation will change under PDPM and decide whether they will need to change the manner in which they procure and organize the delivery of such services.

Virtually all of the stakeholders in the post-acute care community had reached the conclusion that there needed to be a new Part A SNF payment model. The debate has largely circled around what a new system would look like and when it could plausibly be implemented. It appears that CMS has now "put down its marker" on PDPM with an effective date of October 1, 2019. Whether that is a realistic date remains to be seen. Along with commentary on its methodological elements, we expect this will be prominent topic of stakeholder comments. For example, it is fair to ask whether CMS should model the new system in a smaller number of markets before implementing the system nationally.

While PDPM is directed to changing the Part A SNF landscape, it will have many other impacts. For example, alternative payment models such as those utilizing Accountable Care Organizations and bundled payments (such as BPCI) have utilized the Part A SNF system and will need to transform to reflect PDPM. Further, many Medicare Advantage plans utilize the current RUGS-IV system and will likewise need to change their payment methodologies. Finally, policymakers looking to develop a Unified Post-Acute Payment System (UPAC) by federal fiscal year 2024 will need to decide how another volume-based payment system such as PDPM will fit into this future payment structure. With PDPM, there are a myriad of changes coming and a relatively small amount of time to grapple with them all.

Comments to the Proposed Rule are due June 26, 2018. The proposed rule can be downloaded here.

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