NEXT UP FOR PATIENT DRIVEN PAYMENT MODEL? KEY LEGAL AND COMPLIANCE CONSIDERATIONS AHEAD FOR PDPM

With the October 1, 2019 beginning date now past for Patient Driven Payment Model ("PDPM"), the new skilled nursing case-mix classification mode under the Skilled Nursing Facility Prospective Payment System ("SNF PPS") for classifying SNF patients in a covered Medicare Part A stay, providers need to consider several key legal and compliance program considerations that they need to address on an ongoing basis.

PDPM OVERVIEW

Effective October 1, 2019, CMS replaced the current Resource Utilization Groups ("RUG") system and started using a new case-mix model, the PDPM. CMS believes the PDMP focuses on the patient's condition and resulting care needs rather than on the amount of care provided in order to determine Medicare payment.

PDPM classifies each resident into five primary components (nursing, physical therapy, occupational therapy, speech-language pathology and need for non-therapy), plus a sixth – non-case-mix – for overhead. The PDPM approach then provides a single payment based on the sum of these individual classifications. The payment for each component is calculated by multiplying the case-mix index for the resident's group first by the component federal base payment rate (either urban or rural) then by the specific day in the variable per diem adjustment schedule. PDPM uses ICD-10 diagnosis codes and other patient characteristics as the basis for patient classification.

LEGAL CONSIDERATIONS

Therapy Contract Review

If providers have not done so already it is imperative that they review their current therapy contracts if therapy is a contracted service. Therapy contract review is imperative as most, if not all therapy contracts under SNF PPS are based on ultra-high driven therapy utilizing RUG methodology. Under PDPM, while therapy is still a component of reimbursement, it is not the sole driver of reimbursement.

With the implementation of PDPM, providers will need to review their therapy contracts pricing methodology to determine if it is in line with PDPM. Prior to PDPM, payment was centered on the amount of therapy provided. This may not be favorable to providers given that therapy payments under PDPM decrease over time. Providers may want to consider payment methodologies such as a risk-based per diem, capitated rate or payment based on a percentage of the therapy rate component. Each of these payment methodologies are options but must be analyzed to determine which one best fits the needs of the provider.

Bringing Therapy In-House

With the advent of PDPM, some providers may want to consider bringing therapy in-house. However, before making that decision, providers should consider the pros and cons.

The advantage of bringing therapy in-house is that the provider may be able to save money by not having to contract with a therapy vendor if therapy delivery is properly structured. Another positive of bringing therapy in-house is that the provider has direct control over staffing and delivery of therapy. The major disadvantage of bringing therapy in-house is the considerable amount of resources necessary to hire and train staff. There will also be a considerable capital outlay to pay for the equipment necessary to provide therapy in-house.

COMPLIANCE PROGRAM CONSIDERATIONS

Resident Assessments

Under the PDPM, once a resident is classified into a case-mix group, that payment group would be maintained through the entire stay unless an Interim Payment Assessment ("IPA") is completed and reclassifies the patient into a different case-mix group. CMS made this interim assessment optional, thereby leaving the completion of this assessment at the discretion of the individual provider. As a result, these are expected to be infrequent.

Providers will be able to determine when IPAs will be completed for their patients to address potential changes in clinical status and what criteria should be used to decide when an IPA would be necessary. Since the IPA will be optional, providers should determine their own policies and procedures for when an IPA is completed.

Auditing and Monitoring

Section 483.85(c)(6) of Part 483 to Title 42 of the Code of Federal Regulations, the Requirements for States and Long-Term Care Facilities, requires that a provider takes reasonable steps to achieve compliance with the program's standards, policies and procedures. Those steps include utilizing monitoring and auditing systems reasonably designed to detect criminal, civil and administrative wrongdoing by the skilled nursing facility's staff, individuals providing services under a contractual arrangement or volunteers.

Providers should include PDPM elements and requirements into their risk assessments as they map out their key risk areas. Providers should identify the appropriate monitoring techniques and tools for the PDPM risk areas, as well as the appropriate auditing techniques and tools for those risk areas.

Education and Training

Providers need to educate and train on PDPM and ensure that education and training are incorporated into their compliance program. Given that PDPM is a totally new reimbursement mechanism, providers will want to train staff, at a minimum, on the following:

- ICD-10 Training as it drives the primary diagnosis of the resident.
- Therapy Over and Under Utilization as CMS has specifically stated they will target providers who exceed the 25 percent therapy cap on non-individualized therapy.
- MDS training will take on a greater importance as MDS coding under PDPM will take into account other factors other than therapy.
- Staff will need to be aware that the 5-, 14-, 30-, 60- and 90-day assessment will be transitioned to one 5-day assessment.
- Staff will need to be educated on the new interrupted stay readmission policy.

Audit Risk

Providers will likely be at an increased audit risk under PDPM. This is problematic due to the lack of CMS metrics or guidance on how audits will be conducted under PDPM. In the Preamble to the PDPM regulations, CMS responded to concerns raised that providers may "stint" on care or provide fewer services to patients by specifically stating that CMS plans to "monitor closely service utilization, payment, and quality trends which may change as a result of implementing PDPM." It is extremely important for providers to understand that, while therapy is not the reimbursement driver under PDPM as it was under SNF PPS, providers are still required to provide all therapy necessary if the resident requires therapy under the Medicare skilled nursing facility benefit. Providers who "stint" on residents requiring therapy will be audited.

The extent and frequency of the monitoring should take into account the provider's resources, prior compliance history and other risk factors particular to the provider. Specific risk areas to consider include:

- Interim Payment Assessment;
- Upcoding; and
- Care design driven by patient goals.

PRACTICAL TAKEAWAYS

- Providers should immediately review their therapy contracts to ensure how they are paid best coincides with PDPM.
- Providers should incorporate PDPM education and training into their compliance programs.
- Providers should determine their own policies and procedures for when an IPA is completed.
- Providers should include PDPM elements and requirements into their compliance program's monitoring and auditing areas. This is especially true given the risk of audit under PDPM.

If you have questions or would like additional information about this topic, please contact:

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