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Eli's Rehab Report

Long Term Care: Explore 2 Likely Payment Models for SNFs in the Near Future

Therapy minute-based payments are on the outs.

CMS has hinted at payment reform for skilled nursing facilities for quite some time and indicated its intentions quite clearly in a report alongside the proposed SNF PPS rule. This report (http://tinyurl.com/jw7pg2d) discusses four possible payment alternatives.

Top picks: Of the four, CMS has opted to consider two: 1) a patient characteristics model and 2) a hybrid model, blending patient characteristics and resource-based pricing.

"I think that the most likely model will be the patient characteristic one," says **Pauline Franko, PT, CEEAA**, owner of **Encompass Consulting & Education** in Tamarac, FL, based on the fact that a similar model is also in the works for Part B reimbursement. "It is also the model that would probably be the least subject to massive abuse, which is where we are with the current system."

A patient characteristics system would not be completely diagnosis based but be a combination of reasoning for skilled care along with the accompanying co-morbidities and complexities requiring a certain amount of therapy and nursing care, Franko explains. "The facility would get a flat rate and therefore would allocate cost based on patient need."

Franko also believes that CMS would add a quality bonus for good outcomes. "This may be a payment system similar to HHA where they get a percentage on admission and then the final payment will take into account their outcomes."

Flaws Becoming Obvious in Current Model

"We certainly support leaving the current payment system and coming up with another one," says **Mark Kander, MPH**, director of regulatory analysis for the **American Speech-Language Hearing Association**, namely because "the current system can lead to instances where administration is making clinical decisions."

For example, when it comes down to needing 20 more minutes to reach a higher RUG level, management will often step in and ask the therapist to squeeze in more therapy, Kander explains. Therapy time and duration should, instead, be completely the therapist's call.

Caught red-handed: If it's not already suspected that facilities are manipulating the system to reach higher RUGs, the therapy minutes speak for themselves. CMS shared data revealing a trend of patients classified in a Very High Rehab RUG (500 therapy minutes) most of these patients received just slightly more than 500 minutes. Likewise, data for the Ultra High Rehab RUG (720 minutes) revealed patients receiving total therapy minutes barely past 720.

"Those 500 and 720 minutes are a minimum, not a maximum," Kander says. "You can't get to those RUG levels until you reach those minutes. So why all of a sudden does a patient not need any more minutes after reaching those levels?"

Déjà vu: This issue is not unlike the problem several years ago with home health therapy where a higher payment level would be triggered at 10 visits ... and an unusual number of patients were receiving 10 or 11 visits.

ASHA supports the hybrid model. "The hybrid system would also allow an additional boost in payment when an outlier patient requires more resources than usual," Kander says. He predicts a new payment system three to four years from now.

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