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PDPM Focus: PDPM May Affect HIV/AIDS Reimbursement Adjustment

Will switch from therapy billing in RUG-IV to include nursing in PDPM adequately cover the higher costs?

One aspect of the enormous transition to the Patient Driven Payment Model (PDPM) from the current Resource Utilization Groups (RUG-IV) system, which will go into effect Oct. 1, 2019, is the incorporation of nursing and nontherapy ancillary (NTA) costs into matrix of reimbursement.

Under the current RUG-IV categorization, the actual cost of caring for residents with HIV/AIDS is not necessarily reflected in the way the Centers for Medicare and Medicaid (CMS) designed reimbursement for skilled nursing facility residents.

Because the current RUG-IV system relies mostly on therapy hours for reimbursement, and because residents with HIV/AIDS don't necessarily receive more therapy hours then other residents, skilled nursing facilities weren't being fairly reimbursed for the true cost of care. Congress stepped in to help adjust reimbursement through a special per diem payment per resident with HIV/AIDS to better reflect the actual cost of care.

Background: Facilities have been able to bill at a higher rate for residents who have HIV/AIDS. "Section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Pub. L. 108-173) amended section 1888(e)(12) of the Social Security Act to enact a 128% increase in the PPS per diem payment for SNF residents with HIV/AIDS, effective for services provided on or after October 1, 2004. The adjustment for HIV/AIDS reflected research showing that SNF residents with HIV/AIDS were costlier than residents without this condition. In particular, the House Ways and Means Committee Report accompanying the MMA referenced HCFA-funded research by the Urban Institute as a justification for the adjustment," says **Acumen LLC**, a group that analyzes healthcare policy and data for government agencies, in Burlingame, California, in a report titled "Skilled Nursing Facilities Patient-Driven Payment Model Technical Report."

While residents with HIV/AIDS didn't incur more costs for actual therapy, their drug and nursing needs prove much more costly than residents who aren't battling these diseases. The current PPS per-diem payment adjustment negotiated and passed by Congress in 2004 has helped cover these costs, but the system is imperfect, in that it's more of a redistribution of reimbursement than an accurate accounting and reimbursement for resident care and costs.

"The study found that SNF residents with HIV/AIDS had much higher drug and nursing costs than other residents and recommended modifying the PPS to better match the NTA and nursing utilization of this population. However, the current HIV/AIDS payment adjustment is applied to all payment components. This means that residents who receive high therapy minutes, placing them in high-paying RUGs, receive a much larger per-diem add-on for HIV/AIDS than residents in non-rehabilitation RUGs, although their costs related to HIV/AIDS may be similar," Acumen says.

PDPM May Better Reflect Nursing Costs

With the switch to PDPM, the true cost discrepancies associated with residents with HIV/AIDS - the higher nursing needs and the drug costs - should be more self-evident in documentation, and, thus, in reimbursement.

"To determine whether the case-mix adjustment under PDPM appropriately compensates for costs of residents with HIV/AIDS, Acumen used HIV/AIDS status to separately predict costs per day for PT, OT, SLP, and NTA, controlling for case mix by including the PDPM resident groups as independent variables," Acumen explains.

"HIV/AIDS was associated with a negative and statistically significant decrease in PT, OT, and SLP costs per day. These results indicate HIV/AIDS is not associated with higher PT, OT, or SLP costs per day, when controlling for resident group," Acumen says.

"To determine whether the case-mix adjustment under PDPM appropriately compensates for costs of residents with HIV/AIDS, Acumen used HIV/AIDS status to separately predict costs per day for PT, OT, SLP, and NTA, controlling for case mix by including the PDPM resident groups as independent variables. Table 52 shows the results of this investigation. HIV/AIDS was associated with a negative and statistically significant decrease in PT, OT, and SLP costs per day. These results indicate HIV/AIDS is not associated with higher PT, OT, or SLP costs per day, when controlling for resident group.

"... HIV/AIDS was associated with a significant increase in NTA costs per day, even while controlling for case-mix assignment. However, these results suggest that the underestimation of NTA costs for residents with HIV/AIDS is balanced by overestimation of costs for the other ancillary components (PT, OT, and SLP). To explore this possibility, we used PDPM case-mix group assignment to predict PT, OT, SLP, and NTA costs per day for residents with HIV/AIDS. We summed predicted PT, OT, SLP, and NTA costs per day to estimate ancillary costs per day for residents with HIV/AIDS. We then compared this estimate to actual average ancillary costs per day for this subpopulation. As shown in Table 53, the recommended case-mix groups slightly overpredict ancillary costs for residents with HIV/AIDS, confirming that the overprediction of therapy costs balances the underprediction of NTA costs. Based on these findings, Acumen concluded that the recommended PT, OT, SLP, and NTA case-mix groups appropriately adjust for ancillary costs associated with the HIV/AIDS population," Acumen says.

Bottomline: Besides freeing facilities to focus on delivering truly resident-focused care, the transition to PDPM should more fairly reflect the costs of providing nursing care and not just various therapies.

Resource: Read the entire Acumen report on PDPM here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Technical_Report_508.pdf.