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MDS Alert

SNFs: Look Out: SNF Intensive Therapy Gets MedPAC's Scrutiny

RUG rebasing and a revised PPS may be just around the corner.

As if adjusting to the final RUG-IV and MDS 3.0 wasn't enough for skilled nursing facilities this past year, the Medicare Payment Advisory Commission has stirred the payment reform pot even more -- and therapy is at the top of its hit list.

On March 16, 2012, MedPAC released a report to Congress (www.medpac.gov/documents/Mar12_EntireReport.pdf) suggesting various changes to reduce Medicare spending. Specific to SNFs, MedPAC recommended

1) Eliminating the market basket update;

2) Revising the prospective payment system for 2013, namely, funneling payments away from intensive therapy and toward medically complex care; and

3) Reducing payments to SNFs with relatively high rates of rehospitalizations.

Although these are merely suggestions for CMS to consider, none of which has been implemented, MedPAC's word is certainly a strong influence, and all eyes are watching to see if CMS will take the bait.

Does the End Justify the Means?

MedPAC's key point is for CMS "to more accurately pay for non-therapy ancillary services and to base therapy payments on patient characteristics." The Commission notes, however, that to accomplish this goal, CMS should "shift payment from facilities that concentrate on intensive therapy to facilities that treat medically complex patients."

Worst case: That could mean some facilities fall through the cracks or even close their doors. "In the absence of additional revenue from somewhere, decreasing Medicare payments is likely to be financially devastating to some nursing home providers," says **Rena R. Shephard, MH**A**, R**N**, R**A**C-M**T**, C-**NE**,** president & CEO of RRS Healthcare Consulting Services in San Diego.

"I think the proposed MedPAC changes are short-sighted, counter-intuitive, and counter-productive to the longer-term goals of the government to reduce recidivism," says **Garry Woessner, M**A**-CCC (**S**LP), MB**A**, CAS,** regional director of Benedictine Health System in Minneapolis. Reducing rehab payments hinders a SNF's ability to offer patients the highest frequency and intensity of therapy services necessary to return them to their home "with durable and sustainable outcomes -- outcomes that endure for the long-term," he says.

"Overall, APTA is very concerned about the MedPAC recommendations for SNFs payment cuts and rebasing as well as the recent payment cuts made by CMS," says **Roshunda Drummond-Dye, JD,** director of regulatory affairs for the American Physical Therapy Association. "We believe that all of these recommendations should be carefully weighed and analyzed before more major payment reductions are made to the Medicare SNF Prospective Payment System."

In other words, APTA feels SNFs should be able to adjust to the "growing pains" of all the recent changes and have a chance to properly evaluate their effectiveness before more major changes are introduced.

Watch out: The evidence suggests payment rebasing is not necessarily in therapy's favor. "Historically, nursing home providers have changed their therapy practices as regulations have made adjustments to the payments. Further making the case that the intensity of therapy provided often is not related to the needs of the specific resident," Shephard points out.

Reasons for changing therapy practices per payment adjustments include facility staff members making therapy decisions who do not understand all the nuances for rehab coverage, as well as pressure to maximize reimbursement, Shephard observes.

Major parties involved, including APTA, support working toward more accurate payments. But is it fair for therapy to take the blame -- and the hit?

"APTA believes that therapy frequency and duration should be based solely on the needs of the patient," Drummond-Dye affirms. However, curbing overutilization via "payment increases or decreases based upon utilization is a step in the wrong direction," she says.

Why: APTA worries this policy may "create incentives to provide minimal therapy to patients, therefore, hindering patient access to medically necessary therapy services," Drummond-Dye explains.

Rehospitalization Penalty Could Be Counterproductive

If MedPAC is looking for CMS to curb the utilization of intensive therapy, perhaps it should not be so quick to suggest penalizing facilities for rehospitalizations, experts say.

"If the government wants to prevent return hospitalizations and higher long-term costs, it should be investing more, not less, in therapy for people who are in their Medicare defined benefit period," Woessner says.

Food for thought: Citing a recent study of patients discharged in 2010 from one of Benedictine's highest quality therapy programs, Woessner reports that despite receiving the "best care," over 30 percent of patients experienced falls in their homes, with 12 percent resulting in an ER admission.

"We have set a goal for ourselves to reduce this recidivism, but reimbursement cuts will hinder our efforts and cost the government more in the long-term," Woessner argues. "We feel that Medicare reimbursement for therapy is becoming a constraint to achieving successful outcomes rather than an incentive."

Reducing rehospitalizations "is an exciting prospect to me, because it would represent an improvement in the quality of care for nursing home residents," Shephard says. Though, she notes that this move might "further encourage high-intensity therapy over the maximum amount of time."

Bottom line: Most stakeholders are on the same page about reducing rehospitalization rates, but want it done fairly. "We are eager to work with CMS and MedPAC to ensure that these recommendations are developed into policies that are clinically appropriate and that do not unfairly penalize SNF providers for unavoidable readmissions," Drummond-Dye says.