

CONTRACTING CONSIDERATIONS FOR REHAB SUPPLIERS IN THE PDPM AND VALUE-BASED PAYMENTS ERA

Sara M. Lord

VALUE BASED CARE – THE SNF PERSPECTIVE

EVALUATING NEW CARE MODELS IN THE VALUE-BASED PAYMENT ERA

- “Value” = Measuring health and clinical outcomes against the costs of providing care/services
- Shifting from fee-for-service to value-based models requires a profound shift in thinking, culture, planning – and how care/services are provided
 - Changes need to be applied throughout the facility
 - Success requires partnership/collaboration between all service providers and operations
- Within the industry, increasing adoption of Alternative Payment Models (APMs)
 - 2016: 30% of U.S. healthcare payments were linked to quality and value through APMs
 - 2018: 50% of healthcare payments were so linked

PROVIDERS NEED TO BE PREPARED FOR FUTURE RISK SHARING

- Models vary widely – but all prioritize value over volume
 - Fee-for-Service (no risk)
 - Pay-for-Coordination
 - Pay-for-Performance
 - Upside Shared Savings
 - Downside Shared Savings (shared risk)
 - Bundled Payment (episode-based)
 - Partial/Full Capitation
 - Global Budget (most risk)
- Note: many commercial and employer plans are also beginning to implement similar plans

SNF VALUE-BASED PURCHASING PROGRAM

- SNFs evaluated on 30-Day All-Cause Readmission Measure
- Eligible for incentive payments based on their relative performance
- Post-acute and long-term care providers re-evaluating their scope of services
- More active role in overall care coordination and management for patients
- Strategic priorities:
 - Reduced hospitalizations
 - Advanced care planning
 - Rigorous analytics
- Communicate expectations/outcomes
- Everyone is accountable

COMPLIANCE CONCERNS

- Value-based models encourage greater sharing/coordination of personnel, operations, information, technology, equipment, etc.
- Risk-sharing = closer partnerships = favored/preferred providers = greater scrutiny of financial arrangements/benefits
- Bonuses or performance incentives tied to quality metrics should stay within fair market value
- May see further fraud and abuse waivers for value-based arrangements, similar to those used in the Medicare Shared Savings Program (MSSP)

DATA, DATA, AND MORE DATA

- SNFs and providers need to know/share their data:
 - Readmission rates
 - Length of stay
 - Cost per patient/beneficiary
 - Patient satisfaction scores
 - Referrals
 - Services utilized within the facility

MORE DATA = MORE SCRUTINY = GREATER EXPECTATIONS FOR CONTRACTORS

- Contractors expected to monitor and test quality data
- Focus on accuracy of diagnosis coding
- Documentation should be detailed and accurate
- Quality (and all) metrics should be clear and benchmarked against performance
- *False certifications can be based on attestations of accuracy*
- Monitor overlapping/duplicate payments

THE THERAPISTS' PERSPECTIVE – WORKING WITH PDPM

EXPECTATIONS FOR PDPM - AND CONSEQUENCES

According to CMS, PDPM is meant to:

- More accurately reimburse SNFs for the clinical care provided to patients
- Lessen the incentive for SNFs to over-deliver therapy services
- Simplify the payment process for SNFs

Value-based Payments and PDPM radically transform the way SNFs do business

. . . And therefore also transform their relationships and the way they do business with providers

PAYMENT FOR SERVICES UNDER PDPM

- RUGS:
 - CMI had 2 components: Therapy and Nursing
- PDPM:
 - CMI has 5 components*:
 - Splits therapy component - Physical Therapy, Occupational Therapy, Speech Language Pathology services
 - Includes - Nursing and social services, Non-therapy ancillary (NTA) services
 - Sets separate base rates for each component:
 - For PT, OT, and NTA services - includes variable per-diem payment adjustments that modify payment based on changes in the use of these services during a patient's stay
 - *Plus 1 – Non-CMI-adjusted component covers costs/resources that don't vary by patient

FROM RUGS TO PDPM

- RUGS: Classified patients into therapy payment groups
 - Used volume of therapy services received as basis for payment
 - Therapy minutes received = *primary* determinant of payment
 - Rates were constant over LOS – as long as volume of services provided stayed constant
 - Therapists determined residents' overall care plan
- PDPM: Shifts from *volume of services* toward *patient's need for services*
 - Removes therapy hours as basis for reimbursement in favor of patient's classifications and *anticipated needs*
 - Therapy minutes delivered have no impact on reimbursement
 - [Actually incentivizes *fewer* therapy minutes]
 - PT/OT rates *decline* 2% every 7th day after patient has stayed 20 days
 - Therapists *don't* determine residents' overall care plan

PDPM CHANGES THE THERAPY PRACTICE MODEL

- RUGS: Disincentivized Group and Concurrent Therapy (typically >1%)
- PDPM: Allows up to 25% of therapy minutes in Concurrent and Group therapy.
- As part of the PPS Discharge Assessment, SNFs must report concurrent/group therapy minutes.
 - SNFS must break down therapy minutes by therapy mode (individual, concurrent and group) and discipline.
 - *But, there is no penalty for exceeding the 25% limit.*
 - SNFs only receive a warning edit on their assessment validation report if they exceed the 25% limit.
- SNFs can reduce therapy costs by maximizing group and concurrent therapy up to the 25% limit.
- Where does that leave therapists?

CMS EXPECTATIONS FOR THERAPY UTILIZATION UNDER PDPM

- “[W]e received a significant number of comments from stakeholders on the proposed rule who believe that the quality and volume of therapy services are likely to diminish under PDPM.”
- In declining suggestions that it should establish minimum thresholds for rehab therapy, CMS stated that “with the change to a patient driven model, *we expect more variation will appear in therapy costs.*”
 - CMS, Federal Register, Aug. 8, 2018.

BUT ON THE OTHER HAND ...

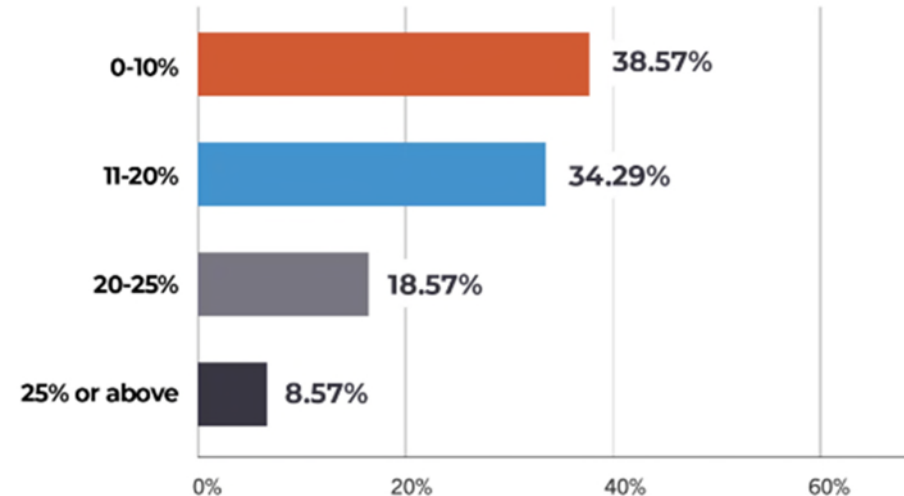
- “We continue to be concerned that under PDPM, providers may reduce the amount of therapy provided to SNF patients because of financial considerations.”
- “[I]t is possible that some providers may choose to reduce their provision of therapy services to increase margins under the PDPM ... we do intend to monitor behavior which may occur in response to PDPM.”
- “Should we discover that the amount of therapy under PDPM is distinctly different from the amount of therapy under RUG-IV, we will evaluate the potential reasons for this change and consider potential actions.”
 - CMS, Federal Register, Aug. 8, 2018.

EARLY RESULTS

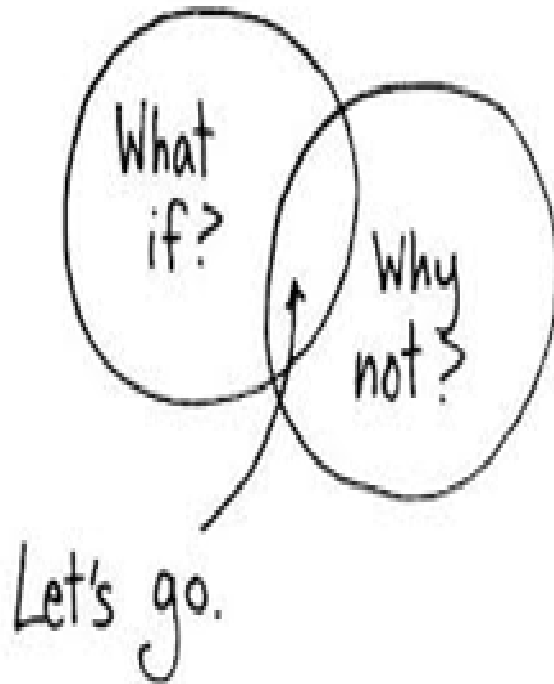
- 75% of SNN respondents had increased the use of group and concurrent therapy since 10/1/19.
- For over 60% of SNN respondents, the proportion exceeded 10%.
- Pre-10/1/19, less than 1% of rehab was being delivered as group or concurrent therapy.

- SKILLED NURSING NEWS survey (12/19)

What proportion of your overall therapy minutes do group and concurrent services now represent?



THE NEW DOCUMENTATION MINDSET



- Under RUGs, rehab therapy documentation focused on justifying the *provision* of therapy – including the frequency, intensity and duration of rehab.
- Under PDPM, the emphasis should extend to documenting reasons for the *non-provision* of therapy – including the absence, discontinuation, or low level of rehab services provided.

VBP/PDPM CREATE NEW RISKS AND RISK ALLOCATION ISSUES FOR THERAPY SUPPLIERS AND SNFS

OLD AND NEW RISKS

- How will value-based payments and PDPM reimbursement create new opportunities for plaintiffs to sue SNFs and rehab suppliers?
- What risks will rehab suppliers and SNFs face from a government investigation and enforcement (FCA) perspective?
- How will new documentation requirements and greater scrutiny increase denial of payment risks?
- What can SNFs and rehab suppliers do to protect themselves?
- Who bears responsibility for these decisions and actions?

LITIGATION RISKS

PRIVATE PLAINTIFF LITIGATION RISKS

- Historically, very little private plaintiff malpractice / neglect litigation involving rehab therapy
 - RUGs incentivized SNFs to provide more therapy, not less
- Under PDPM, the financial incentives work to **under**-provide therapy, increasing the risks of litigation based on:
 - Harm to Patient
 - Loss of Function
 - Failure to Improve
- Rehab contractors may find themselves on the hook for staffing decisions made by their SNF customers— and vice versa — making contract negotiations more important on both sides.
-

PDPM MAKES THE PLAINTIFF'S CASE EASIER

- If aggregate levels of therapy under PDPM show a significant drop from RUG levels, plaintiff lawyers can make case that too little therapy is being provided
- The PDPM categories incorporate the *expected therapy* for any given patient
- The PPS Discharge Assessment indicates *how much therapy the patient actually received*
- If the patient received significantly less therapy than their assessment warranted, plaintiff lawyers' job of showing harm has gotten much easier

THE FALSE CLAIMS ACT

- Any person who:
 - A. knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
 - B. knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; [or]
 - ...
 - G. knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,
- is liable ... for a civil penalty of not less than \$5,000 and not more than \$10,000, . . . plus 3 times the amount of damages which the Government sustains ...

LIABILITY EXTENDS BEYOND THE PROVIDER SUBMITTING THE MEDICARE CLAIM

- Thus, FCA liability can extend not only to the SNF that submits the claim to Medicare, but also to “any person who ...
 - *causes to be presented, a false or fraudulent claim for payment or approval;*” or
 - “*causes to be made or used, a false record or statement material to a false or fraudulent claim;*” or
 - “*makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government.*”

AND “KNOWINGLY” DOESN’T REQUIRE “KNOWING”

- For purposes of the False Claims Act, the terms “knowing” and “knowingly”:
 - A. “mean that a person, with respect to information –
 - (1) has actual knowledge of the information;
 - (2) acts in deliberate ignorance of the truth or falsity of the information;
or
 - (3) acts in reckless disregard of the truth or falsity of the information; and
 - B. require no proof of specific intent to defraud.”

FALSE CLAIMS ACT LITIGATION RISKS

- Rearview mirror risk:
 - A drastic post-PDPM reduction in therapy could cause the DOJ to believe (or vindicate the DOJ's existing belief) that too much therapy was being provided pre-PDPM.
 - 6 to 10 year statute of limitations.
- Prospective, post-PDPM risk:
 - Insufficient therapy might result in either:
 - A “worthless services” FCA case – billing for services that were so substandard that they were worthless.
 - Showing that the services were “worth less” is not sufficient; the services must have no value, not just diminished value.
 - An “implied certification” False Claims Act case.

WORTHLESS SERVICES

- Seeking reimbursement for services that were “so substandard as to be tantamount to no service at all”
 - *Not* services that were “worth less”
- Increased risks of “worthless care” from:
 - Reduced therapy services
 - Over-utilization of (less expensive) group and concurrent therapy
 - Lack of sufficient staffing and personnel
 - Inadequate and inadequately maintained equipment
- *Who is responsible for making these decisions?*

IMPLIED CERTIFICATION THEORY OF FCA LIABILITY

- Express false certification – provider falsely certifies compliance with a particular statute, regulation, or contractual term that is an express prerequisite to government payment.
- Implied false certification – violation of a statutory, regulatory, or contractual requirement with which the entity impliedly certified compliance by submitting a claim for payment.
 - The misrepresentation about compliance must be material to the payment decision – i.e., the government would have refused payment had it known about the misrepresentation.
- *Who is responsible for the decisions and information underlying the certifications?*

WHOSE RISK IS IT?

- If a patient sues alleging harm based on receiving too little therapy, who bears the risk?
- If the DOJ maintains that a claim by the SNF is false under the False Claims Act, who bears the risk?
 - If the DOJ alleges a worthless services theory based on inadequate staffing, who bears the risk?
 - If the DOJ alleges that certifications were false, who bears the risk?

WHOSE RISK IS IT?

- Contracts should answer and allocate risk based on answers to two key questions:
- Who (rehab contractor or SNF) is responsible for deciding therapy minutes?
- Which pricing methodology is in place?
 - Per-minute: incentivizes SNF to reduce therapy
 - Per diem or % of PDPM category, regardless of amount of therapy incentivizes rehab contractor to reduce minutes.
 - Hybrid pricing

PAYMENT DENIAL RISKS

PAYMENT DENIAL RISKS

- PDPM billing requires highly accurate documentation and coding of each patient's medical condition, ADL status, and co-morbidities
- Coding errors can result in reduced reimbursement to the SNF or recoupment where documentation does not support the PDPM category

PAYMENT DENIALS FOR CONCURRENT/GROUP THERAPY

- CMS recognizes that PDPM incentivizes SNFs to emphasize group and concurrent therapy over 1-on-1 therapy.
- Excessive group/concurrent therapy may result in payment denials:
 - “[S]ervices furnished to SNF residents may be considered reasonable and necessary inasmuch as the services are consistent with the individual's particular medical needs ... [E]xcessive levels of group and/or concurrent therapy could constitute a reason to deny SNF coverage for such stays.”
 - The “limit on group and concurrent therapy affords a significantly greater degree of flexibility on therapy modality than appears to be required to meet the needs of SNF residents, given that less than 1% of therapy currently being delivered is either group or concurrent therapy.”

DOCUMENTATION OF GROUP AND CONCURRENT THERAPY

- “Because group therapy is not appropriate for either all patients or all conditions, and in order to verify that group therapy is medically necessary and appropriate to the needs of each beneficiary, SNFs should include in the patient's plan of care an explicit justification for the use of group, rather than individual or concurrent, therapy. This description should include, but need not be limited to, the specific benefits to that particular patient of including the documented type and amount of group therapy; that is, how the prescribed type and amount of group therapy will meet the patient's needs and assist the patient in reaching the documented goals.”
- “[A]ll group and concurrent therapy should be well documented in a specific way to demonstrate why they are the most appropriate mode for the resident and reasonable and necessary for his or her individual condition.”

WHOSE RISK IS IT?

- If a payor denies or reduces payment, who is responsible?
- If there is conflicting documentation or lack of documentation to support coding, who is responsible – the SNF or the rehab supplier?
- In many current contracts, rehab suppliers indemnify for denials based on a lack of medical necessity. Now who should bear that responsibility?

CONTRACTUAL RESPONSIBILITY FOR CODING

- “Facility will be responsible for performing and completing the Minimum Data Set (‘MDS’) assessments for all residents and ensuring that the acuity level for each resident has been properly determined and documented to permit the resident to be assigned to the appropriate Patient Driven Patient Model (‘PDPM’) category.”
- “Facility assumes full responsibility for all billing, collection, and denials for Services, except as otherwise provided in this Agreement. Facility shall be responsible for assessing each Patient covered by the Medicare Prospective Payment System and ensuring that the Patient is coded into the correct Patient Driven Patient Model (‘PDPM’) category. Contractor shall provide to Facility rehabilitation-related information in its possession necessary for the portion of the PPS Discharge Assessment relating to therapy minutes.”

INDEMNIFICATION

- If the rehab supplier is determining therapy minutes, the SNF should insist on stronger indemnities from the contractor.
- If the SNF is deciding minutes, the rehab contractor may be justified in insisting on stronger indemnities from the SNF.
- Mirror image or reciprocal indemnities may seem “fair,” but may not properly align indemnity obligations with risks.

CONTRACTUAL INDEMNIFICATION

- “Facility shall indemnify and hold Contractor harmless from and against all claims, demands, costs, expense, liabilities and losses, including reasonable attorneys’ fees and litigation costs, arising out of or in connection with Facility’s operation of the nursing facility, including without limitation, determinations by Facility regarding clinical staffing levels or the level or amount of therapy to be provided to residents (except to the extent that such determinations are attributable to Contractor).”

ALLOCATING RISK THROUGH CONTRACTS

ACCOUNTING FOR RISK:

- SNFs and rehab suppliers should be aware of and plan for therapy litigation risk the same way that SNFs do now for nursing care litigation risk.
 - Plaintiffs' lawyers will likely focus on rehab in the same way they already pursue cases involving nursing care: *particularly changes in therapy utilization pre and post-PDPM*:
 - Changes in volume (did the intensity of therapy decrease?)
 - Changes in delivery (is there more group and concurrent?)
 - Sudden changes (i.e., in stays that overlap 10/1/19)
 - Changes that correlate to changes in Quality Measures
- Clearly allocating/assigning responsibility for these decisions will be critical

TAKEAWAYS

- Revisit contractual relationships to confirm that risks and rewards are properly aligned with parties' responsibilities and expectations.
- Complete and accurate therapy documentation will be more important than ever, including not only why patients receive therapy, but why they're not, and justifications for group and concurrent therapy.
- Seek to tie any changes in therapy provision to clinical needs and patient outcomes.
- *The more the supplier promises to do, the more liability it assumes.*

QUESTIONS?

Sara M. Lord

Arnall Golden Gregory LLP

202.677.4054

sara.lord@agg.com