

The Patient-Driven Payment Model: Addressing Perverse Incentives, Creating New Ones

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In October 2019, Medicare, which spends \$30 billion on 2.4 million skilled nursing facility (SNF) stays annually, began reimbursing facilities using the Patient-Driven Payment Model (PDPM).¹ The PDPM replaces the Resource Utilization Groups (RUG) system, which had been used since 1998 and which many believe created perverse incentives that contributed to rapid growth and unwarranted variation in Medicare spending on postacute care.^{2,3} The PDPM was implemented to address these problems, and although it is a step forward, it also creates new risks for unintended consequences.³ This commentary explores these risks and what can be done to mitigate them.

Perverse Incentives in the Previous Payment System for SNFs

Medicare has historically reimbursed SNFs using the RUG system, in which the level of payments varied across 5 categories based on the number of therapy minutes provided weekly (Table 1). This system had sharp cutoffs and large payment differentials for therapy-minute thresholds separating each RUG category. Some SNFs are thought to have taken advantage of these features to increase revenue by moving patients into higher RUG payment categories, contributing to rapid growth in Medicare expenditures.⁴ Under the RUG system, an SNF received \$438 per day, on average, for a typical patient needing assistance with 6 to 10 activities of daily living in the “very high” RUG category (Table 1). If this same patient were placed in the “ultra-high” category, the per diem payments increased to \$601, on average. Between 2002 and 2016, the use of the ultra-high category increased from 7% to 63% of all SNF days reimbursed by Medicare⁵—a 9-fold increase. There was no corresponding change in case mix during this period.⁵

Large payment differentials among RUG categories also led to “high billing,” in which some SNFs systematically submitted claims just surpassing the therapy-minute threshold required for a payment category. In the earlier example, an SNF providing a patient with 719 minutes of therapy in a week would receive the very high category payment rate (\$438), but providing 720 minutes would raise payment to the ultra-high category rate (\$601).

TAKEAWAY POINTS

- ▶ The Patient-Driven Payment Model (PDPM) addresses perverse incentives in Medicare’s prior payment system for skilled nursing facilities by prioritizing patient needs over service volume.
- ▶ The PDPM has introduced new incentives that may be problematic, potentially leading to unintended consequences.
- ▶ Regulators should maintain close oversight of billing by skilled nursing facilities and patient outcomes as the PDPM takes effect to mitigate potential unintended consequences.

The \$163, or 37%, differential in the per diem payment between the very high and ultra-high categories created a strong incentive for SNFs to provide just enough therapy to move a patient into the higher-paying category, regardless of whether they required such intensive therapy. In a 2016 analysis, we found that nearly one-fifth of all SNFs billed 90% or more of their ultra-high category claims within 10 minutes of the payment threshold (ie, 720-730 therapy minutes).

Addressing Perverse Incentives in the RUG System Through the PDPM

As its name suggests, the PDPM is based on patient characteristics. Instead of paying SNFs based on the volume of therapy provided, the PDPM uses diagnoses and other clinical factors to set payment rates for 5 components that are summed to determine the per diem reimbursement: physical therapy, occupational therapy, speech language pathology services, nursing services, and nontherapy ancillary conditions and services. A sixth component, based on SNF resources used during the stay, is also added to this per diem reimbursement but does not vary by beneficiary risk.

Whereas the RUG system incentivized longer SNF stays and more therapy, the PDPM incentivizes shorter stays with less therapy through an adjustment factor for physical therapy, occupational therapy, and nontherapy ancillary conditions and services. After the first 20 days of the SNF stay, the adjustment factor is reduced by 2% every 6 days.

TABLE 1. Resource Utilization Groups Used for Medicare Billing by SNFs, Frequency of Use, and Average Allowed Amounts* in 2016

Payment Category		Total SNF Days Reimbursed	Percent of All Reimbursed SNF Days	Average Allowed Amount per Day*
Ultra-high: ≥720 minutes per week	Ultra-high rehab (with extensive services): ADL 11-16	356,972	63.50%	\$893
	Ultra-high rehab (with extensive services): ADL 2-10	262,107		\$847
	Ultra-high rehab: ADL 11-16	11,999,077		\$591
	Ultra-high rehab: ADL 6-10	16,506,224		\$601
	Ultra-high rehab: ADL 0-5	8,114,276		\$487
Very high: 500-719 minutes per week	Very high rehab (with extensive services): ADL 11-16	134,107	25.28%	\$680
	Very high rehab (with extensive services): ADL 2-10	115,816		\$609
	Very high rehab: ADL 11-16	5,258,837		\$494
	Very high rehab: ADL 6-10	5,515,627		\$438
	Very high rehab: ADL 0-5	3,802,744		\$427
High: 325-499 minutes per week	High rehab (with extensive services): ADL 11-16	48,987	7.76%	\$606
	High rehab (with extensive services): ADL 2-10	39,127		\$538
	High rehab: ADL 11-16	1,798,629		\$426
	High rehab: ADL 6-10	1,483,137		\$391
	High rehab: ADL 0-5	1,180,737		\$340
Medium: 150-324 minutes per week	Medium rehab (with extensive services): ADL 11-16	30,598	3.43%	\$567
	Medium rehab (with extensive services): ADL 2-10	12,470		\$502
	Medium rehab: ADL 11-16	886,886		\$374
	Medium rehab: ADL 6-10	597,320		\$357
	Medium rehab: ADL 0-5	483,969		\$290
Low: 45-149 minutes per week	Low rehab (with extensive services): ADL 2-16	455	0.02%	\$471
	Low rehab: ADL 11-16	11,870		\$363
	Low rehab: ADL 0-10	3663		\$232

ADL indicates activities of daily living; SNF, skilled nursing facility.

*Average allowed amounts include payments from Medicare to SNFs in addition to the amount of cost-sharing liability.

Source: Authors' analysis of the Skilled Nursing Facility Utilization and Payment Public Use File for 2016.

Potential Unintended Consequences of the PDPM

Although the PDPM addresses a key feature of the RUG system by replacing payment based on the volume of services delivered with payment based on patient characteristics, it has also introduced other incentives that may be problematic (Table 2). For example, the PDPM's component for nontherapy ancillary conditions and services, based on a list of 50 comorbidities and services, is weighted upward by 300% during the first 3 days of the stay. Ostensibly, this makes sense because the cost of providing SNF care is substantially higher at the beginning of a patient's stay. But certain comorbidities and services in this payment component can greatly increase reimbursements, and they thus carry the risk of being overreported and overutilized. An SNF located in an urban area, for instance, receives per diem payments that are \$175 higher during the first 3 days for a patient with diabetes and chronic obstructive pulmonary disease compared with payments for a patient without these 2 conditions.⁶ The provision of intravenous medication alone can increase the per diem rate by the same amount. SNFs are likely to invest in developing expertise in *International Classification of Diseases, Tenth Revision* coding, which was not required under

TABLE 2. Incentives Created by the Patient-Driven Payment Model and Their Potential Consequences for Patient Outcomes

Source of Incentive	Potential Effect on Provider Behavior	Potential Impact on Outcomes
Higher payment for nontherapy ancillary conditions and services	SNFs overreporting qualifying diagnoses	Higher costs
	SNFs overutilizing qualifying services	Higher costs
	SNFs admitting more complex patients	Unknown
	Shorter hospital length of stay	Increased risk of rehospitalization
Gradual lowering of per diem payments after 20 days	Shorter stays in SNFs	Negligible impact on outcomes
Volume of rehabilitation therapy no longer driving reimbursement	SNFs providing less rehabilitation therapy	Decreased functional improvement
		Increased risk of rehospitalization
		Lower odds of discharge to the community

SNF indicates skilled nursing facility.

the RUG system; therefore, as with other value-based payment models, regulators should monitor for gaming related to upcoding motivated by the PDPM.⁷⁻⁹

A related concern is that the prospect of higher payments for greater patient complexity could lead some SNFs to selectively admit sicker patients, who may require levels of care that are beyond a given SNF's abilities. If SNFs are willing to accept higher-acuity patients, hospitals—incentivized to reduce lengths of stay—may be willing to discharge patients “sicker and quicker.” Previous research has raised concerns about such practices.¹⁰ Substituting SNF care for hospital care has led to higher readmission rates for patients with certain conditions. Although financial penalties for hospitals with excessive readmissions may deter unsafe discharges to SNFs, these policies are increasingly under scrutiny themselves for potentially contributing to adverse consequences, including higher mortality rates for patients with certain conditions.¹¹

Finally, compared with the RUG system, the PDPM incentivizes shorter SNF stays and less therapy, which may have negative consequences for some patients. Although shorter SNF length of stay has not been associated with worse outcomes,^{12,13} findings of prior research suggest that less therapy can lead to decreased functional improvement, higher readmission rates, and a lower likelihood of discharge to the community.¹⁴⁻¹⁶

Conclusions

The PDPM brings welcome changes to SNF reimbursement by prioritizing patient needs over service volume, but it also carries the risk of new unintended consequences. These potential problems, which are features of other value-based payment systems, should be closely monitored and rigorously studied. Accountable care organizations and episodic payments that include postacute care offer some hope, as they incentivize healthcare organizations to discharge patients to SNFs only when appropriate and to refer patients to high-quality facilities. Findings of recent studies suggest that these payment programs have reduced postacute care spending, primarily through lower SNF utilization, without adversely affecting outcomes.^{13,17-19} The recently implemented SNF Value-Based Purchasing Program, which imposes financial penalties on SNFs with high hospital readmission rates, may also discourage facilities from accepting patients requiring care beyond their capabilities. It is not yet clear whether this negative incentive (maximum 2%) is large enough to prevent SNFs from accepting patients they are not equipped to care for. Regardless, policy makers should maintain close oversight of SNF billing practices and patient outcomes as the PDPM takes effect to mitigate potential unintended consequences. ■

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