



PDPM and the Evolution of Therapy Delivery in Skilled Nursing Facilities:

Clinical Integrity, Compliance Risk and the Shift from Volume to Value

Executive Summary: The implementation of the Patient-Driven Payment Model (PDPM) marked one of the most consequential reimbursement reforms in skilled nursing facility (SNF) history. By eliminating therapy minutes as the primary determinant of reimbursement, CMS fundamentally altered the operational and clinical dynamics of post-acute care delivery.

PDPM was not simply a payment recalibration. It was a policy-level acknowledgment that care intensity should reflect patient complexity — not service volume.

This whitepaper examines:

- The structural incentives embedded in prior reimbursement models
- The operational implications of PDPM
- Compliance and documentation risk exposure under the current framework
- The increasing importance of therapy's role in quality metrics and value-based purchasing
- A framework for building a PDPM-aligned therapy program

For SNF operators, the message is clear: success under PDPM requires clinical precision, documentation rigor, and operational alignment with value-based care principles.

The Pre-PDPM Environment: Structural Volume Incentives

Under the Resource Utilization Group (RUG-IV) system, therapy minutes directly influenced reimbursement classification. While clinicians prioritized patient care, the payment model structurally rewarded higher therapy utilization.

MedPAC and CMS analyses leading up to PDPM identified patterns of therapy volume clustering near reimbursement thresholds, raising concerns about whether payment policy inadvertently influenced service delivery patterns.

This structure created tension in several areas:



- Productivity pressure tied to reimbursement categories
- Risk of documentation focused on minutes rather than medical necessity
- Operational focus on utilization optimization
- Variability in therapy intensity patterns

Although most providers delivered appropriate care, the reimbursement design itself introduced risk.

PDPM: Structural Recalibration Toward Clinical Characteristics

Implemented in October 2019, PDPM replaced therapy-minute thresholds with a patient-characteristic-driven model.

Reimbursement now reflects:



- Primary diagnosis category
- Functional status
- Comorbidities
- Cognitive impairment
- Non-therapy ancillary (NTA) conditions

By disconnecting payment from therapy minutes, CMS removed the direct financial incentive to deliver care based on volume alone.

This was a material policy statement: clinical complexity, not therapy duration, should drive reimbursement.

Operational Implications for Skilled Nursing Facilities

PDPM's shift requires more than documentation updates. It necessitates operational recalibration.

1. Clinical Decision-Making Autonomy

Therapy intensity must now reflect:



- Functional presentation
- Medical necessity
- Resident goals
- Safety considerations
- Interdisciplinary planning

There is no universal therapy formula under PDPM.

2. Documentation Risk Exposure

While therapy minutes no longer drive payment, documentation quality has become more critical. Surveyors and auditors now evaluate:



- Skilled service justification
- Medical necessity documentation
- Care plan alignment

- Interdisciplinary coordination
- Outcome tracking

Weak documentation under PDPM can create:



- ADR risk
- Survey citations
- Payment vulnerability
- Value-Based Purchasing penalties

Under the volume-based model, therapy thresholds provided structural clarity. Under PDPM, documentation precision provides compliance protection.

3. Financial & Value-Based Performance Impact

PDPM operates within a broader CMS ecosystem emphasizing:



- Skilled Nursing Facility Value-Based Purchasing (SNF VBP)
- SNF Quality Reporting Program (QRP)
- Hospital readmission metrics
- Functional outcome measures
- Star rating performance

Therapy departments influence:



- Discharge outcomes
- Length of stay patterns
- Rehospitalization rates
- Functional improvement measures

Therapy is no longer simply a revenue center — it is a quality performance driver.

Cultural Implications: The Persistence of Volume Thinking

Although PDPM removed structural volume incentives, organizational culture may lag policy change.

Facilities that continue to emphasize:



- Rigid productivity quotas
 - Service maximization strategies
- Financial-first therapy planning may undermine the intent of PDPM.

Sustainable success requires:



- Clinician autonomy supported by strong oversight
- Data-informed care planning
- Outcome measurement discipline
- Alignment between therapy leadership and facility administration

PDPM provides the framework. Culture determines execution.

A PDPM-Aligned Therapy Framework

To operate successfully in the post-volume era, SNFs should evaluate therapy delivery across four core domains:

1. Clinical Appropriateness



- Care intensity matches patient complexity
- Skilled maintenance appropriately documented
- Interventions tied to measurable goals

2. Documentation Strength



- Skilled justification clearly articulated
- Progress notes demonstrate clinical reasoning
- MDS alignment is accurate and defensible

3. Interdisciplinary Integration



- Therapy collaborates with nursing and medical staff
- Discharge planning is coordinated
- Risk factors addressed proactively

4. Outcomes & Performance Monitoring



- Functional improvement tracked
- Rehospitalization data reviewed
- Star rating impact evaluated
- QRP measures monitored

Facilities that formalize these domains reduce compliance exposure while improving operational predictability.

Strategic Implications for SNF Leadership

Administrators and operators should ask:



- Does our therapy model reflect individualized care or historical productivity culture?
- Is documentation defensible under audit scrutiny?
- Does therapy actively support our VBP and star rating goals?

Are we measuring therapy performance beyond volume? The long-term risk under PDPM is not under-delivery of therapy. It is misalignment between clinical practice, documentation, and regulatory expectations.

Conclusion

PDPM did more than change reimbursement mechanics.

It validated a principle healthcare providers have long understood: residents are individuals with unique needs — not units of production.

CMS's model reflects this philosophy.

The responsibility now rests with providers to operationalize it through disciplined documentation, individualized care planning, and value-focused performance management.

Facilities that embrace this shift strategically will experience:



- Greater survey confidence
- Reduced compliance risk
- Stronger quality outcomes
- More predictable operational performance

About RehabVisions

RehabVisions partners with skilled nursing facilities to design and operate therapy programs aligned with PDPM's clinical and compliance framework.

Our approach emphasizes:



- Highly skilled and compassionate care delivery
- Documentation integrity and survey readiness
- Interdisciplinary collaboration
- Outcome-driven performance management

For facilities seeking alignment between regulatory expectations and operational execution, strategic therapy partnership becomes a critical leadership decision.

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