

Surviving the Prospective Payment System: Potential Problems and Solutions to Ensure Quality of Care

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Abstract

In response to diagnosis-related group payment systems and changing social structures, many hospital systems have created alternative discharge sites, thus shifting care to subacute units offering comprehensive inpatient programs of cost-effective restorative care. The growth in expenditures for these postacute services led to the implementation of the prospective payment system (PPS). This article discusses factors involved in calculating reimbursement and solutions to such problems as inadequate reimbursement, quality of care, and documentation requirements. For subacute care to succeed clinically and financially, a basis for collaboration between hospital-based referring physicians and subacute unit directors must be established; patient satisfaction and quality of care must be monitored closely; and a well-trained nursing staff with frequent in-service training in patient care should be employed. The reorganization tactics suggested in this article may help a subacute facility function in an efficient way at acceptable costs while maintaining high quality patient care.

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Advances in technology and an increase in life expectancy for the general population have resulted in an increasing demand for medical services. To prevent uncontrolled growth in the costs

of federally funded health insurance plans, the government has devised a variety of strategies to contain expenditures. For example, in the early 1980s Medicare introduced the diagnosis-related group (DRG) system of payment for inpatient care. Under this system, a fixed reimbursement rate was provided for patient care based on a national average of costs of treatment for a specific diagnosis. In some cases, this approach created financial disincentives for hospitals to provide prolonged care to medically complex patients. In response, many hospital systems created alternative discharge sites, thus shifting care to subacute care units focusing on comprehensive, cost-effective restorative care. Mounting pressure to further shorten acute care lengths of stay is increasing the popularity of these postacute services. Similarly, changes in society, reflected by evolution from an extended to a nuclear family structure, also have led to more demand for these longer-term, postacute forms of care.

As the number and type of alternative care sites have increased, federal efforts at cost containment have shifted to limit financial reimbursement to these facilities as well. One of the most recent moves involves the introduction of the Balanced Budget Act of 1997 and the prospective payment system (PPS) for all subacute and skilled care facilities. Economic pressure to contain treatment costs may threaten the financial health of many subacute units, especially as hospitals seek to limit admissions only to the sickest of the sick and treat them in the shortest possible amount of time.

The purpose of this article is to provide a brief overview of the changes in the approach to reimbursement faced by subacute care units and to highlight potential long-term effects resulting from the PPS. Although few reports in this area currently

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exist, possible solutions to some of the many challenges these organizations encounter, based on the experience and observations of the authors, are presented here along with several points that may be included for consideration on the national health policy agenda for healthcare providers and managers involved in subacute care.

... FACTORS LEADING TO INTRODUCTION
OF THE PROSPECTIVE PAYMENT SYSTEM ...

Under the DRG system of payment, reimbursement is based on a national average of the costs for treating patients with a specific diagnosis. Infrequently, additional reimbursement for the same DRG may be provided in selected situations in which either costs or length of stay is extremely great.¹ Therefore, the institution could benefit financially from discharging patients to other care settings for continued care before the average length of stay for that DRG payment is reached. To keep patients within the system and to ensure continuity of care, larger hospital systems have either built or established formal relationships with existing subacute care units. In this scenario, it has been possible for some of the more efficient healthcare systems to maximize revenue in both acute and subacute settings while providing a complete continuum of care to best meet most patients' needs. As evidenced by a growth in Medicare expenditures for subacute care from \$5 billion in 1988 to nearly \$35 billion in 1995, this relatively new component of the healthcare system has become increasingly popular. This growth in expenditures also reflects a trend toward cost-shifting from acute care facilities, which have fixed reimbursement, to affiliated subacute care facilities, which until recently received reimbursement under a cost-based strategy. To control the explosive growth in this sector of healthcare, a PPS for subacute and skilled facilities was created and introduced as part of the Balanced Budget Act of 1997.

... IMPLEMENTATION OF SUBACUTE
CARE PROSPECTIVE PAYMENT SYSTEM ...

In a departure from a fee-for-service approach to payment, the PPS established fixed per-diem rates for Medicare reimbursement based on acuity of care, adjusted for regional economic differences.^{2,3} This system generated a lump-sum payment strategy for all services rendered to a patient and has resulted

in a reduction in reimbursement to subacute care and skilled nursing facilities amounting to more than \$9.5 billion. To help ease the financial impact that might be caused by an immediate change in reimbursement, a 3-year transition period was proposed and implemented. For all facilities claiming Medicare reimbursement before 1995, a facility-specific cost was calculated from their 1995 operating expenses.⁴ Simultaneously, the Health Care Financing Administration established a federal rate based on a survey of average costs for several facilities throughout the nation.

During the first year of implementation, it was proposed that the reimbursement rate consist of a combination of a facility-specific cost (75%) and the federal rate (25%). Over subsequent years, it was anticipated that the federal rate for reimbursement would be sequentially phased in at 25% increments until the transition to a full federal rate was achieved by the fourth year. For facilities that opened after October 1, 1995, provision for the immediate use of the federal rate for reimbursement under the PPS was made, as they had no cost basis for 1995 from which to establish a facility-specific rate.

... FACTORS INVOLVED IN CALCULATING
REIMBURSEMENT ...

Under the PPS, reimbursement is based on a resource utilization group (RUG) score calculated from more than 100 elements in the minimum data set (MDS). The MDS, an 11-page form capturing patient information under several categories, provides the basis for assigning an RUG score. The MDS categories used in calculating the RUG score include cognitive, mood, and behavior patterns and physical functioning (eg, ability to feed oneself, perform transfers, ambulate). The RUG score, heavily influenced by patient functional status, also reflects the patient's medical status and comorbid conditions in addition to specific therapeutic requirements such as ongoing need for intravenous medication, supplemental oxygen, and wound care. Until April 2000, a total of 44 RUGs (RUGS-III) existed for the purpose of determining payment. This classification system has recently undergone extensive reorganization and has been expanded to 178 payment groups (Table 1).

Evaluation of a hospitalized patient and assignment of an RUG score do not guarantee that the reimbursement for subacute care services will be approved: A specific therapeutic plan reflecting skilled care needs must be identified for each patient. A wheelchair-bound stroke patient, for example, may

need lifetime physical therapy, but this patient would not qualify for admission to a skilled nursing facility solely on this basis. If, however, short-term physical therapy needs for transfer training or independence in activities of daily living were identified during a short hospital stay, it would be more easily possible to justify admission to a subacute care unit. This approach emphasizes the use of a subacute care unit as a facility in which discrete patient needs such as rehabilitation, wound care, or intravenous therapy can be met in a lower-cost nonhospital setting.

... EFFECTS OF THE PROSPECTIVE PAYMENT SYSTEM: POTENTIAL PROBLEMS AND POSSIBLE SOLUTIONS ...

Inadequate Reimbursement

Problem. Reimbursement for all services excluding those provided by a physician, nurse-practitioner, or physician extender is provided under the PPS in a lump-sum payment and is usually not adjusted for patients' disease severity or comorbid conditions.⁵ As stated previously, the MDS documents functional disability well (eg, need for assistance with eating, toileting, ambulation), but poorly reflects intensive nursing care needs for patients needing frequent intravenous therapy or complex wound care. As a consequence, admitting some patients with such needs may result in compensation inadequate to cover the costs of care rendered. An otherwise functional patient needing wound care referred for admission to a subacute care facility may, for example, have needs that do not qualify for supplemental reimbursement. In some groups, such as those receiving expensive immunosuppressive or chemotherapeutic agents, the financial consequences of this approach to reim-

bursement can be considerable and may create a strong disincentive to admit such patients. It is conceivable, therefore, that this reimbursement strategy may mean longer acute care stays for medically complex patients.

Solution. One potential approach involves actively educating physicians and directors of inpatient facilities on ways to partner with subacute care units without economically penalizing the unit for accepting those patients with uncertain medical needs. Clearly, a basis for collaboration between hospital-based referring physicians and subacute unit directors responsible for receiving patients must be established. This partnership is important for many reasons and may have a beneficial effect on the quality of care at many levels. First, subacute unit directors can be actively involved in screening prospective patients for clear-cut rehabilitation or skilled needs. When such needs are not evident, however, it may be appropriate to educate the referring physicians

Table 1. Revised Resource Utilization Group Score (RUGS-III) Classification System*

Category	No. of Sublevels
Extensive with rehabilitation (eg, high medical complexity and high rehabilitation needs)	
1. Ultrahigh (J)	12
2. Very high (K)	12
3. High (L)	12
4. Medium (M)	12
5. Low (N)	8
Rehabilitation groups	
1. Rehabilitation ultrahigh (U)	12
2. Rehabilitation very high (V)	12
3. Rehabilitation high (W)	12
4. Rehabilitation medium (X)	12
5. Rehabilitation low (Y)	8
Extensive services (E) (eg, intravenous therapy, ventilator, tracheostomy)	12
Special services (S) (eg, tube feedings, wound care)	12
Clinically complex (C) (eg, pneumonia, dialysis, depression)	22
Impaired cognitive (I) (eg, memory loss)	4
Behavior problem (B) (eg, wandering, abusive behavior, hallucinations)	4
Physical function (P) (impaired physical function)	12

*Each category is divided into sublevels depending on activities of daily living score and non-therapy ancillary services.

directly through person-to-person conversation or indirectly through a large group conference or grand round presentations. Such education efforts, in turn, may reduce the economic penalty associated with accepting patients without established needs for skilled care and should strengthen the basis for cooperation between acute and subacute care units.

Second, it may be appropriate in some cases for the acute care hospitalization to be extended by a few days to better clarify and justify the need for subacute care. For example, an acute care hospital stay could be extended to complete physical or occupational therapy evaluations for patients potentially needing rehabilitation or to make thorough diagnostic assessments of medically complex patients. The importance of this extension may best be appreciated when subacute unit directors educate referring physicians on the most appropriate uses of subacute care resources.

A system-based strategy that addresses this dilemma might be to create a separate reimbursement or RUG category to provide adequate reimbursement more closely in line with the needs and expenses encountered in the treatment of medically complex patients. Along these lines, reimbursement for patients with both aggressive medical care and rehabilitation needs also should be adjusted to more appropriately reflect the costs incurred in their care.

Recent revisions (to be implemented in fiscal year 2001) to the Balanced Budget Act have resulted in 3 major modifications to the RUG-based system⁶:

1. New RUG categories reflecting components of both rehabilitation needs and patients' medical complexity have been created.
2. Until the revisions are implemented, stop-gap provisions to increase payments to subacute units by 20% for extensive services to medically complex patients will be enacted.
3. The federal per-diem rate will be increased by 4% for fiscal year 2001 and 2002, applied equally to all RUG groups.

Problem. Before the PPS, subacute care units were capable of providing ongoing diagnostic evaluations for patients recently discharged from an acute inpatient care facility with incomplete plans for subsequent medical management. Under the current system, subacute facilities have limited incentives to initiate or continue diagnostic evaluations as the per-diem reimbursement for subacute services includes the costs of laboratory and other diagnostic evaluation. In many cases, these costs

may exceed the daily reimbursement rate provided to the subacute facility for all aspects of care.

Solution. Careful screening of all potential admissions by a physician well educated in subacute care (subacutist) will certainly be beneficial. Although national benchmarks do not currently exist, a subacutist, like a hospitalist, can be defined as a physician who practices primarily in a skilled care facility or subacute care setting. These physicians should be able to address efficiently rehabilitation issues and care for a wide variety of medical and surgical problems ranging from rehabilitation after major joint replacement or complex thoracic procedures to intensive rehabilitation after a cerebrovascular accident. A subacutist also should be knowledgeable about factors that affect reimbursement, as well as key changes effected by legislation such as the PPS. To be effective, subacutists also should communicate directly with referring physicians before patient transfer to improve subacutists' understanding of the complex medical issues affecting the patient and to avoid unnecessary testing or consultation. Again, the potential overall value of extending a hospital stay to complete medical evaluations, enabling a subacute facility to more efficiently meet the patient's unique medical needs, should not be underemphasized.

Quality of Care

Problem. The amount of physical therapy, measured in minutes, is a significant determinant for reimbursement among patients in whom rehabilitation is the only indication for subacute care. As subacute units face the challenge to reduce operational costs, a potential response may involve oversight of patients with similar treatment goals by a single therapist. Clearly this cost-containment approach may have implications for the quality of care. At the current time there are no standardized tools in place to monitor the quality of care provided at subacute units.

Solution. Patient satisfaction and quality of care must be monitored closely. A facility may benefit from monitoring its functional outcomes and patient satisfaction in addition to the traditional indicators like length of stay. Facilities also should compare their functional outcomes with national benchmarks. For this purpose, we advocate the use of institution-specific measures of treatment outcomes as well as the creation of a national registry of indicators of care. It is critical that both forms of data be available to patients as they seek to select a facility that best meets their needs.

Problem. Physicians providing care in subacute care facilities are not always available on-site to manage unforeseen medical problems that arise. Sometimes the only means for patient evaluation may be through an off-site emergency department. It is important to note that such occurrences may have negative financial consequences for a subacute unit, especially if the emergency department visit is later deemed medically unnecessary and payment is denied. Similarly, lack of coordinated care due to the involvement of multiple physicians both in the emergency department and at the subacute facility may contribute to unnecessary or duplicated efforts in evaluation and treatment. This may also compound the negative financial consequences of off-site emergent evaluation, unnecessarily prolonging stays at a subacute unit for some patients.

Another foreseeable strategy used by some subacute care units to control costs may involve the use of nursing aides rather than registered nurses in staffing subacute units. Using individuals with lower skill and training levels may be penny-wise but pound foolish: The quality and accuracy of assessment provided by more thoroughly trained nursing staff may be invaluable in forestalling acute hospitalizations that might otherwise have been avoidable.

Solution. Many facilities may benefit from having an in-house physician like a subacutist or a physician–nurse–practitioner team who are readily available to provide medical care in a timely and cost-effective manner. Instead of having many individual physicians each providing care for relatively few patients in a subacute care unit, a facility may benefit from having 1 or 2 full-time physicians (depending on the total number of beds in a unit and overall patient acuity). Use of a nurse-practitioner may supplement this approach both with respect to providing patient care and addressing medical issues quickly and efficiently. The role of nurse-practitioners may be further expanded by having them assume a leadership role in augmenting the skills of allied health professionals through regular in-service training programs. This proactive, physician-led management strategy also may result in fewer emergency department visits, fewer hospital readmissions, acceptable subacute lengths of stay, and improved patient satisfaction through better coordination of care.

The value of a well-trained nursing staff with frequent in-service training in patient care should not be underestimated. Nurses should be encouraged to create and maintain patient management protocols that can be implemented by all members of the

nursing team, while specifying the roles for each in clear detail.

The Minimum Data Set: Meeting Documentation Requirements for Reimbursement

Problem. The burden of MDS documentation falls heavily on the facility providing services. Completion and reporting of this document within the specified time interval are mandatory in order to claim appropriate reimbursement.^{6,7} It is also imperative that all relevant clinical data from the MDS be documented in the chart, as this information reflects the amount of care required and ultimately reflects the rationale for admission to a facility.

Solution. Because of the financial importance of document completion, some units have created a special MDS coordinator position. No less important in solving this problem is knowledge of MDS documentation guidelines and the key components tied to reimbursement among all physician and nursing staff.

Because the need for communication about patients' status has never been so great, an interdisciplinary team consisting of physicians, nurses, case managers, physical therapists, and the MDS coordinator should be created and should meet regularly to discuss each patient's progress in the unit. This strategy, increasing the likelihood that MDS documentation will be accurately and efficiently completed, also ensures that the treatment plans outlined for patients are clear and will be implemented during their stay.

... SUGGESTIONS FOR REORGANIZATION OF A SUBACUTE CARE UNIT ...

Changes in reimbursement plans for posthospital care reflected in the PPS challenge us to be creative in reorganizing subacute care units to ensure optimal reimbursement without compromising quality of care (Table 2). The following reorganization tactics may help a subacute facility function in an efficient way at acceptable costs while maintaining quality of patient care:

Standardizing Care

Standardized medical and rehabilitation care plans need to be developed for patients commonly referred to subacute care units. Patients with lower extremity joint replacement, for example, must have a rehabilitation care plan that will ensure that all patients receive similar postoperative care and will

achieve rehabilitation objectives within a prespecified time frame. Also, protocols for withdrawal of supplemental oxygen from oxygen-dependent patients and appropriate monitoring of patients on antibiotic therapy should prevent inappropriate therapy and excessive resource utilization and should result in fewer complications from common medical interventions.

Utilizing Ancillary Service

Since PPS reimbursement frequently depends on the number of minutes a patient spends in physical therapy, admission early in the day should improve the timeliness of the initial rehabilitation evaluation and initiation of therapy while enabling a facility to optimize reimbursement. Development of a drug formulary to replace expensive medications with other equally effective pharmaceutical agents should be invaluable in decreasing escalating drug costs at a facility.⁸ Similarly, full access to laboratory test results obtained during an inpatient stay may be crucial in

avoiding both inconvenience to the patient and unnecessary costs to the insurer.

Optimizing the Care Plan

As discussed previously, use of subacuteists to streamline patient care may help to control costs. Assessment of medical complexity and specific medical needs before admission must be undertaken to determine whether a given subacute care facility is well suited to provide care for patients with specific needs. Interviewing patients and family early during the stay will help identify barriers to discharge and alert discharge planners and social workers to specific needs so that appropriate services can be arranged. Such efforts may be critical in preventing a delay in discharge once the treatment plan has been completed.

Monitoring Outcomes

Routine review of monthly admission and discharge statistics is invaluable in assessing the quality of care provided. A sudden increase in emergency department visits from a subacute care facility, for example, may signal an important and significant change in physician practice, an increase in patient complexity, or changes in nursing staff. In each case, early recognition and investigation are crucial to designing a response to such changes. Similarly, patient satisfaction surveys may be useful in identifying unrecognized problems that need to be addressed in patient care delivery, problems that might otherwise go unnoticed by managers of subacute care units. Finally, a comparison of goals achieved with those anticipated should provide a reasonable overall assessment of the adequacy of the program in meeting patients' needs.

Table 2. Reorganizing the Subacute Care Unit to Preserve Quality of Care

Standardizing care	1. Medical and rehabilitation care plans for patients with similar goals
Utilizing ancillary services	1. Admission early in the day to enable rehabilitation and start of care plan from day 1 of admission 2. Development of a formulary for some commonly used medications 3. Prevention of duplication of laboratory testing
Optimizing care	1. Management of patients by a full-time subacute specialist 2. Review of all scheduled admissions a day before the admit day to evaluate patient complexity 3. Biweekly communication among team members involved in patient care 4. Identification of discharge needs early in patient care: Interviewing patient and family 5. Prompt discharge once the treatment plan is completed
Monitoring outcomes	1. Monthly review of statistics like admissions, discharge, length of stay, emergency department visits, and readmissions to the hospital 2. Patient satisfaction surveys 3. Functional outcomes

... CONCLUSIONS ...

For a large number of subacute care facilities, managing the effects of reimbursement reduction while providing high-quality care remains challenging. Inpatient facilities are increasingly faced

with difficult choices and limited options when arranging admissions to a subacute unit, especially when appropriate dispositions for these patients are limited. Some units, currently operating at a deficit in the hope for future federal relief from misguided or incomplete reimbursement strategies, may succumb to economic pressure at a time of increasing need. A growing coalition of healthcare groups calling for coverage of reimbursement gaps such as those discussed here are starting to assemble informally in efforts to ensure the quality of medical care provided in these healthcare venues.

Although reductions in reimbursement under the PPS have been substantial to date, it is encouraging to note that this system appears to have promoted efficiency and innovation in healthcare delivery. In reviewing the current and possible future effects of this system, we have identified several areas where change is possible or should be sought. Proactive solutions implemented now may allow subacute care facilities to survive the PPS while ensuring delivery of high-quality care for an increasing segment of the population needing their services. Careful screening of patients for medical complexity, identification of needs for skilled care, documentation of appropriate insurance coverage, and utilization review of resulting outcomes of care should help a facility prosper in the current environment.

In addition to the strategies discussed above, it is both appropriate and critically important that these problems be addressed at the national level, as the number of inpatients with complex medical needs appears to be increasing steadily. Both administrators and physician-managers of subacute care units should advocate for the special needs of patient

groups they serve and encourage the development of health policy that will ensure the availability of care beyond the hospital setting.

Although significant, the challenges to the delivery of effective, high-quality healthcare in subacute care settings are not insurmountable. Careful consideration of patient needs, routine monitoring of treatment outcomes, and other solutions discussed here may be useful in providing posthospital care successfully in this era of the PPS.

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