The current revolution in the delivery of health care services in the United States has been marked by a moving away from a fee-for-service health care payment system to a managed care system of reimbursement. Historically, there has not been a direct link between those responsible for the financing of health care services and those who provide the services. Managed care integrates both the control of financing services and how services are delivered. Nowhere is this more clearly demonstrated than in the recent changes in Medicare’s approach to reimbursement for rehabilitation services provided at the skilled nursing facility (SNF) level of care.

Beginning July 1, 1998, Medicare will no longer reimburse an SNF on the basis of the facility’s costs for providing occupational therapy and other services (Balanced Budget Act, 1997, Public Law 105–33). Instead, payment for rehabilitation will be made prospectively on the basis of the patients’ therapy needs as defined by their classification into one of five rehabilitation categories. These categories are derived from the rehabilitation utilization groups-version III (RUGs-III) classification system. The RUGs-III classification system generally can be compared with the diagnosis-related groups reimbursement system presently used by the Health Care Financing Administration (HCFA) to classify patients receiving acute care. That is, this prospective payment system (PPS) will be used to control the costs of rehabilitation services provided in SNFs in the same manner that the hospital PPS controls inpatient acute care costs.

There are five rehabilitation categories under HCFA’s SNF classification system: ultra high, very high, high, medium, and low. Each category has preestablished service delivery parameters. For example, ultra high is defined as those patients who require a minimum of 720 minutes of therapy (i.e., occupational therapy, physical therapy, speech–language pathology) per week provided by at least two disciplines, with one providing services 5 days a week and the other providing services at least 3 days a week. Medicare will pay a preset dollar amount for the 720 minutes of service. This preset, or capitated, rate also can be adjusted for acuity. In taking the step to a PPS or a capitated rate system, Medicare has begun to move into a managed care mode of service delivery in SNFs.

In the past, under a fee-for-service or cost-based method of reimbursement, provider (our employers) profitability was realized by billing large numbers of units of service. Under managed care, the opposite will be true. Provider profitability will be realized only in cost containment. It will be the responsibility of the occupational therapy practitioner to find ways of providing appropriate services in a less costly manner and not simply to provide less service. To create the ways of providing services that produce good outcomes for the least cost, we as occupational therapy practitioners must shift our perception of consumers from that of passive recipients of our knowledge and expertise to that of active decision-making partners. In today’s health care delivery system, the services we render must be based not only on our professional judgment as to what the consumer needs, but also on what the consumer values and expects. The revolution in health care requires an evolution in our clinical decision-making process. Our decisions must be responsive to the values of all stakeholders—our values as well as those of the persons we treat, those who pay for our services, and those who employ us to provide the services. ▲

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