The Medicare Prospective Payment System

(Medicare, occupational therapy, prospective payment systems, third party reimbursement)

Susan J. Scott

In 1983 Congress adopted the most significant change in the Medicare program since its inception in 1965. Along with measures to ensure the solvency of the Social Security System into the next century, Congress approved a system of prospective payment for hospital inpatient services, whereby hospitals are paid a fixed sum per case according to a schedule of diagnosis related groups (DRGs). The program will be phased in over a four-year period that began October 1, 1983. Several types of hospitals and distinct part units of general hospitals are excluded from the system until 1985, when Congress will receive a report on a method of paying them prospectively. Information used to calculate the DRG rates was published September 1, 1983, as part of the interim final regulations. Other third party payers, such as state Medicaid systems and insurance companies, are considering converting to this method of payment, and several have adopted it. The implications for occupational therapy include a greater emphasis on reducing hospital length of stay, expanding outpatient care, increasing productivity, and a trend toward documentation and accounting consistent with computer technology.

This paper will examine the new Medicare Prospective Payment System for inpatient hospital services, which will affect the delivery of all services in hospitals, including occupational therapy. It will also describe some of the system expectations and implications for occupational therapy to help occupational therapy personnel prosper within the new system.

History of Medicare Payment for Hospital Services

When the Medicare program began in 1965, hospitals were reimbursed on a "reasonable cost" basis, that is, they were fully reimbursed for mandated services they provided to inpatients, and the only limitation placed on reimbursement was that the cost be "reasonable." This retrospective payment method fostered a sharp increase in Medicare hospital costs.

In 1972 Congress placed limits on the amount of reimbursement hospitals could receive for routine costs (essentially nursing care and hotel service). These limits are known as the Section 223 limits because the provision that established them was Section 223 of PL 92-603, the Medicare Amendments of 1972.

In 1982 Congress moved again to control hospital costs. As part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), it extended the Section 223 limits to ancillary services such as laboratory, x-ray, and rehabilitation services such as occupational therapy. This Act also placed target limits on the rate of increase in hospital operating costs and initiated paying hospitals on a per discharge basis. In 1983 Congress replaced this entire system of limiting or capping costs with a system of prospective payment per patient (case).

Reasons for Congressional Action

In 1965 health care accounted for 6 percent of America's gross national product (GNP). By 1982 it had reached 10.4 percent. This growth has been largely beneficial in improving the health and extending the life span of the American people. However, it is expensive, so Congress wanted to slow the rate of growth. The federal government's role in financing health care has grown from $3.6 billion in 1965 to $84.2 billion in

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1982 (see Figure 1). Government is now the single largest payer of health care costs (1).

In the Medicare program, spending for inpatient hospital services accounted for 67 percent of the total dollars spent on Part A and B benefits in 1982 (see Figure 2). Thus, it is not surprising that Congress selected hospital inpatient care as the sector of the health system for reform. The payment system was blamed for much of the problem. The cost-based retrospective system allowed hospitals to recover almost all of the monies spent on Medicare patients. Therefore, hospitals had little or no incentive to control costs and were encouraged to provide more services and acquire more technology.

The most important reason why Congress adopted a prospective system of payment for hospital services is that the Medicare trust fund, which pays for inpatient hospital services, faces insolvency by 1990 at the present rate of cost growth, so Congress needed to moderate or reverse the cost growth. The Social Security trust fund, which pays social security pensions, would have faced insolvency by July 1983 if Congress had not acted when it did. It adopted the Social Security Amendments of 1983, which included measures to ensure the solvency of the Social Security program into the next century and established a prospective payment system for Medicare inpatient hospital services (see Table 1).

The unit of payment for hospital inpatient services is a predetermined dollar rate per case. Patients (cases) are categorized by a method known as Diagnosis Related Groups (DRGs). The DRGs were developed from 23 Major Diagnostic Categories (MDCs) over a 10-year period by Yale University’s Center for Health Studies. A payment rate has been established for each of the 468 DRGs. (The September 1, 1983, Federal Register actually contains 470 DRGs, but two of them have no weighting factors assigned to them.) Hospitals will be paid these rates irrespective of the cost to the hospital of treating the patient. The rate is payment in full, non-negotiable, and not subject to appeal. If a hospital spends less money on the case than the DRG rate, it may keep the difference. If it spends more, it must absorb the loss. The rates are intended to reflect the variations in resource consumption of the different DRGs. For example, a quadruple bypass surgery patient consumes more resources than an appendectomy patient, so the DRG rate is higher. Figure 3 illustrates how cases are assigned to a DRG. Figure 4 illustrates MDC #7 and the DRGs derived from it.

The program will be phased in, by hospital fiscal year, over a four-year period (see Table 2). The transition involves movement from a hospital specific or hospital cost base (HCB) payment rate to a national rate. In the first year, the DRG rate will be largely hospital

<table>
<thead>
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<th>Table 1</th>
<th>The Medicare Prospective Payment Program</th>
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<tr>
<td>• Unit of payment = rate per case/discharge</td>
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<td>• Phased-in transition</td>
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<td>• Regional, rural, urban, and wage adjustments</td>
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<td>• Annual update of rates</td>
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Cases are first assigned to one of 23 Major Diagnostic Categories (MDCs). Then they are usually divided on the basis of whether the patient undergoes a surgical procedure or not. Then they may be divided by age and sex and finally by whether there was a complication or comorbid condition (CC). Each DRG has a number from 1 to 470. The DRGs will be determined by the Medicare intermediary from information furnished by the hospital, eventually on Uniform Bill #82.

Specific. By the third year, the rate will be primarily a combination of regional and national rates. In the fourth year, the rate will be 100 percent national. The regional rate will include rural, urban, and wage adjustments.

Certain hospital costs will be "passed through," which means that the hospital will be paid for these costs in addition to the DRG amount, and this payment will be based on actual spending. Capital costs (depreciation and interest on loans for capital improvements and new technology) and the direct cost of medical education will be passed through. However, Congress has indicated that these costs may soon be incorporated into the DRG payment rates.

The DRG rates will be updated annually and reviewed by a 15-member Prospective Payment Assessment Commission established by Congress. The commission will review the rate increases to ensure that they are adequate. The commission will also examine new technology and treatment techniques and make recommendations to Congress and the U.S. Department of Health and Human Services (HHS) on whether and how the new technology should be reflected in the DRG rates.

In addition to the "pass through" costs, the government has established two categories of "outliers" whereby a hospital can receive extra money for patients who are in the hospital longer or who incur higher costs than expected. A "day" outlier will be a patient whose length of stay for a particular diagnosis exceeds a prescribed threshold point. The prospective DRG payment is based on the average stay. If a patient exceeds that average by a significant amount, the hospital will be paid an amount equal to 60 percent of the per diem rate for that DRG for each appropriate day beyond the threshold point. For "cost" outliers Medicare will pay 60 percent of the difference between the cost threshold for that DRG and the actual costs of treating the patient.

The prospective payment system will have a medical review process conducted by fiscal intermediaries and by Peer Review Organizations (PROs). The new review program will concentrate on the necessity and appropriateness of admissions. Congress also has directed the reviewers to watch the following: (a) transfer of patients from acute care beds to psychiatric or rehabilitation beds (the latter two categories are exempt under the new system and would be paid on the basis of cost); (b) the accuracy of DRG assignment; (c) outliers; and (d) readmission patterns.

For patients who are admitted to one hospital but transferred for Table 2

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<th>Year</th>
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<tr>
<td>1</td>
<td>75% HCB + 25% regional DRG rate</td>
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<tr>
<td>2</td>
<td>50% HCB + 37.5% regional DRG rate + 12.5% national DRG rate</td>
</tr>
<tr>
<td>3</td>
<td>25% HCB + 37.5% regional DRG rate + 37.5% national DRG rate</td>
</tr>
<tr>
<td>4</td>
<td>100% national DRG rate</td>
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Figure 4
MDC7: Diseases and disorders of the hepatobiliary system and pancreas

Further treatment to a second hospital, Health Care Financing Administration (HCFA) has decided to make a DRG payment to one facility only and pay the other a per diem amount for each day of care. The DRG payment will go to the receiving hospital. The transferring hospital will receive a payment based on the number of days spent in the hospital (2).

Some hospitals and distinct part units of hospitals were excluded from the system by Congress. However, in 1985 the Secretary of Health and Human Services must report to Congress on a method for bringing the excluded entities into the prospective payment system. The excluded hospitals and units include psychiatric, children's, long-term care and rehabilitation hospitals, and rehabilitation and psychiatric units of general hospitals. Definitions of these units and hospitals, and criteria for their exclusion, have been established in federal regulations. Hospitals qualifying for this exemption must notify their regional Medicare office before the date they would be subject to prospective payment. Hospitals are to identify that they meet the criteria, which will be verified later through a certification process. Exempt hospitals and units will be paid on a reasonable cost basis subject to the TEFRA target limits.

The law permits states to establish their own hospital cost control programs and be exempt from the Medicare prospective payment system, provided the programs meet criteria established in federal regulations and as long as the cost to the Medicare program is no greater than it would have been under the national prospective payment system. As of late 1983, Maryland, Massachusetts, New Jersey, and New York had hospital cost control programs that qualify for this exemption.

The government proposes to safeguard the quality of care in the new program in a number of ways. Medicare officials will be doing hospital admission pattern monitoring to identify unusual changes in the volume of admissions, case mix, or patient discharge status. They will also do DRG verification to ensure that DRGs assigned are correct and not "creeping" into costlier classifications. Also, hospitals that are to be paid under the prospective payment system must contract with a PRO by October 1, 1984, which will monitor quality care.

System Expectations
If hospitals spend more money on patients than they receive in the DRG rates, they must absorb the loss. Therefore, they are in a constant state of financial risk under this program. Conversely, the opportunity exists for hospitals to increase their profits if they reduce costs and stay under the DRG rates. Hospitals then, whether they are profit or nonprofit, will be infinitely concerned with the cost of anything provided to patients. They will also be concerned about the cost benefit of services provided. Benefits will not necessarily be evaluated on the basis of whether they made the patient better, but whether they contributed to the patient leaving the hospital. Hospitals will greatly increase their use of computer services and products to track costs and patient data more accurately. There will be tremendous pressure to reduce patient length of stay. Hospital management will press for an increase in productivity from all staff and may review staffing patterns from the standpoint of who can do the job at the lowest cost. The hospital financial officer will have a greater influence on hospital operations than...
ever before. Many hospitals will specialize in treating the DRGs they do most effectively and profitably, and deemphasize DRGs that consistently lose money.

Physicians may have less autonomy over the length of time their patients stay in the hospital and what services they receive. There may be an increase in the visibility and control of family physicians rather than specialists. More physicians and physician groups may offer nontraditional, nonhospital-based health care services in ambulatory surgery centers, shopping center clinics, and through health maintenance organizations.

Implications for Occupational Therapy
Hospital-based occupational therapy personnel, particularly department managers, should understand the new payment system and recognize the need for change to adapt to it. The evaluation and treatment of patients should concentrate on reducing length of stay by addressing primarily those problems that keep the patient in the hospital. Close collaboration with discharge planners will be important so that the patient’s other problems will be addressed at home or in another facility. Treatment should begin as early in the hospital stay as possible, so early physician referrals will be critical.

Occupational therapy documentation will need to be consistent with current computer technology. Evaluations and progress reports should be streamlined and adapted to fit into the hospital’s system. In that way, occupational therapy information will be available by DRG, which will be essential for planning and budgeting.

The occupational therapy department may be pressured to handle more patients with few if any additional staff, so productivity and efficiency will be important. Productivity goals could be established, and therapists encouraged and rewarded for meeting the goals. Therapists may want to examine ways to meet treatment goals in fewer sessions. Staffing patterns should be examined and considered given to more and better use of certified occupational therapy assistants (COTAs), aides, volunteers, and parttime personnel. Work schedules could be changed to provide treatment in the evenings and over weekends.

Conclusion
The prospective payment DRG system applies to Medicare inpatient hospital services at the present time. However, Congress is considering a proposal to extend it to skilled nursing facilities. The new Medicare hospice program has a prospective payment system using a per diem rate for each of four levels of hospice care. In 1985 the Secretary of Health and Human Services must report to Congress on how the exempt entities (psychiatric, rehabilitation, long-term care and children’s hospitals, and rehabilitation and psychiatric units of general hospitals) could be included in the prospective payment system. Oklahoma and Kansas Blue Cross/Blue Shield began using prospective payment early in 1984, the Utah Medicaid program began using the system in mid-1983. Prospective payment is an idea whose time has apparently come and will probably be the dominant payment system for health care services throughout the 1980s.

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